Passage of the

Health Boards (Membership and Elections) (Scotland) Bill 2008

SPPB 130
Passage of the

Health Boards (Membership And Elections) (Scotland) Bill 2008

SP Bill 13 (Session 3), subsequently 2009 asp 9

SPPB 130
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Foreword

Purpose of the series

The aim of this series is to bring together in a single place all the official Parliamentary documents relating to the passage of the Bill that becomes an Act of the Scottish Parliament (ASP). The list of documents included in any particular volume will depend on the nature of the Bill and the circumstances of its passage, but a typical volume will include:

- every print of the Bill (usually three – “As Introduced”, “As Amended at Stage 2” and “As Passed”);
- the accompanying documents published with the “As Introduced” print of the Bill (and any revised versions published at later Stages);
- every Marshalled List of amendments from Stages 2 and 3;
- every Groupings list from Stages 2 and 3;
- the lead Committee’s “Stage 1 report” (which itself includes reports of other committees involved in the Stage 1 process, relevant committee Minutes and extracts from the Official Report of Stage 1 proceedings);
- the Official Report of the Stage 1 and Stage 3 debates in the Parliament;
- the Official Report of Stage 2 committee consideration;
- the Minutes (or relevant extracts) of relevant Committee meetings and of the Parliament for Stages 1 and 3.

All documents included are re-printed in the original layout and format, but with minor typographical and layout errors corrected. An exception is the groupings of amendments for Stage 2 and Stage 3 (a list of amendments in debating order was included in the original documents to assist members during actual proceedings but is omitted here as the text of amendments is already contained in the relevant marshalled list).

Where documents in the volume include web-links to external sources or to documents not incorporated in this volume, these links have been checked and are correct at the time of publishing this volume. The Scottish Parliament is not responsible for the content of external Internet sites. The links in this volume will not be monitored after publication, and no guarantee can be given that all links will continue to be effective.

Documents in each volume are arranged in the order in which they relate to the passage of the Bill through its various stages, from introduction to passing. The Act itself is not included on the grounds that it is already generally available and is, in any case, not a Parliamentary publication.

Outline of the legislative process

Bills in the Scottish Parliament follow a three-stage process. The fundamentals of the process are laid down by section 36(1) of the Scotland Act 1998, and amplified by Chapter 9 of the Parliament’s Standing Orders. In outline, the process is as follows:
Introduction, followed by publication of the Bill and its accompanying documents;
Stage 1: the Bill is first referred to a relevant committee, which produces a report informed by evidence from interested parties, then the Parliament debates the Bill and decides whether to agree to its general principles;
Stage 2: the Bill returns to a committee for detailed consideration of amendments;
Stage 3: the Bill is considered by the Parliament, with consideration of further amendments followed by a debate and a decision on whether to pass the Bill.

After a Bill is passed, three law officers and the Secretary of State have a period of four weeks within which they may challenge the Bill under sections 33 and 35 of the Scotland Act respectively. The Bill may then be submitted for Royal Assent, at which point it becomes an Act.

Standing Orders allow for some variations from the above pattern in some cases. For example, Bills may be referred back to a committee during Stage 3 for further Stage 2 consideration. In addition, the procedures vary for certain categories of Bills, such as Committee Bills or Emergency Bills. For some volumes in the series, relevant proceedings prior to introduction (such as pre-legislative scrutiny of a draft Bill) may be included.

The reader who is unfamiliar with Bill procedures, or with the terminology of legislation more generally, is advised to consult in the first instance the Guidance on Public Bills published by the Parliament. That Guidance, and the Standing Orders, are available for sale from Stationery Office bookshops or free of charge on the Parliament’s website (www.scottish.parliament.uk).

The series is produced by the Legislation Team within the Parliament’s Chamber Office. Comments on this volume or on the series as a whole may be sent to the Legislation Team at the Scottish Parliament, Edinburgh EH99 1SP.

Notes on this volume

The Bill to which this volume relates followed the standard 3 stage process described above.

Volume 2 of the Health and Sport Committee’s Stage 1 Report was originally published on the web only. It is reproduced in full in this volume.

Two written submissions and two supplementary written submissions to the Health and Sport Committee not included in the Stage 1 Report are included in this volume after the Report.

The report of the Finance Committee on the Financial Memorandum was included in the Health and Sport Committee’s Stage 1 Report. The written evidence received by the Finance Committee, and relevant extracts from the Finance Committee’s minutes and Official Report of the evidence taken by it, are included in this volume after the Stage 1 Report.
Similarly, the report of the Subordinate Legislation Committee on the delegated powers in the Bill was included in the Stage 1 Report. Relevant extracts from the Subordinate Legislation Committee’s minutes and Official Report of the evidence taken by it are also included in this volume after the Stage 1 Report.

After Stage 1, at its meeting on 27 January 2009 the Subordinate Legislation Committee considered and noted the Scottish Government’s response to its report on the Bill at Stage 1. Material relating to that consideration is included in this volume.
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Schedule—Minor and consequential amendments
Health Boards (Membership and Elections) (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for the election of certain members of Health Boards; and for connected purposes.

Constitution of Health Boards

1 Constitution of Health Boards

(1) Schedule 1 (Health Boards) to the National Health Service (Scotland) Act 1978 (c.29) (the “1978 Act”) is amended as follows.

(2) For paragraph 2 substitute—

“2 (1) A Health Board is to consist of the following types of members—

(a) a chairman, and other members, appointed by the Scottish Ministers (“appointed members”),

(b) councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board (“councillor members”), and

(c) individuals elected as members of the Health Board at an election held under Schedule 1A (“elected members”).

(2) Regulations must, in relation to each Health Board, specify—

(a) the total number of members of the Board, and

(b) the number of each type of member.

(3) But—

(a) the total number of councillor members and elected members of a Board must amount to more than half the total number of members, and

(b) a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board.

(4) The conditions imposed by sub-paragraph (3) do not apply during any period when an elected member or, as the case may be, councillor member vacates office and the vacancy has not been filled.”.
(3) In paragraph 2A, for “persons appointed under paragraph 2 above” substitute “appointed members”.

(4) In paragraph 3—
(a) for “Appointments under paragraph 2 shall be made” substitute “An appointed member may be appointed only”, and
(b) sub-paragraph (a) is omitted.

(5) Before paragraph 11 insert—
“10A(1) An elected member holds office for a period beginning with the day after the day of the Health Board election at which the member was elected and ending on the day of the next following Health Board election in the Health Board area.

(2) Regulations may specify the circumstances in which—
(a) an elected member must vacate office before the end of that period, and
(b) the Scottish Ministers may determine that an elected member is to vacate office before the end of that period.”.

(6) In paragraph 11(a), for “chairman and members of Health Boards” substitute “appointed members and councillor members (including provision specifying circumstances in which the Scottish Ministers may determine that such a member is to vacate office)”.

(7) In paragraph 12, after “appointment” insert “or, as the case may be, election”.

Elected members of Health Boards

2 Health Board elections

(1) In section 2 of the 1978 Act (Health Boards), after subsection (10) insert—
“(10A) Schedule 1A makes provision for the election of individuals to be members of Health Boards.”.

(2) After Schedule 1 to the 1978 Act insert—

“SCHEDULE 1A
(introduced by section 2(10A))

HEALTH BOARD ELECTIONS

Health Board elections

1 An election held under this Schedule is known as a “Health Board election”.

Timing of Health Board elections

2 (1) A Health Board must hold the first Health Board election in the Health Board area on the day specified in election regulations.

(2) Election regulations may specify different days for the first election in different Health Board areas.

(3) A Health Board must hold subsequent Health Board elections on the first Thursday falling after the end of the period of 4 years beginning with the day of the previous election.
(4) But a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3) if the Scottish Ministers make an order under section 77 specifying the date of a Health Board election in that area.

**Electoral wards**

3 (1) Each Health Board area is to be comprised of a single electoral ward unless election regulations specify that a Health Board area is to be divided into more than one ward.

(2) If regulations specify such a division they must also specify—
   (a) the number of electoral wards in the Health Board area, and
   (b) the boundaries of those wards.

(3) Before regulations specifying such a division are made—
   (a) the Scottish Ministers must consult the Local Government Boundary Commission for Scotland, and
   (b) the Commission must give the Scottish Ministers advice about the boundaries of the electoral wards which the Health Board is to be divided into.

**Conduct of election**

4 (1) The Health Board must appoint an individual as the returning officer for each ward in which a Health Board election is to be held.

(2) Election regulations may make provision about—
   (a) the tenure and vacation of office of a returning officer,
   (b) the functions of a returning officer,
   (c) a returning officer’s fees and expenses,
   (d) any other matters relating to returning officers that the Scottish Ministers consider appropriate.

5 (1) The nomination of a candidate must be made—
   (a) within the period specified in election regulations (the “nomination period”), and
   (b) in accordance with any other requirement made in those regulations.

(2) A candidate may withdraw from a Health Board election at any time before the end of the nomination period.

6 Election regulations must specify the number of elected members to be elected in each electoral ward (the “specified number”).

7 If, at the end of the nomination period, the number of nominated candidates in an electoral ward is equal to or less than the specified number—
   (a) the Health Board election is not to be held in the ward, and
(b) on the day on which the election was to be held the returning officer must—
   (i) declare the nominated candidates (if any) to be deemed to have been elected as elected members for the ward, and
   (ii) if the number of nominated candidates is less than the specified number, declare the number of vacancies in the ward.

8 (1) In any other case, the specified number of elected members are to be elected for the electoral ward at a poll held in accordance with this paragraph.

(2) At the poll, each individual entitled to vote may vote by marking on the ballot paper—
   (a) the voter’s first preference from among the candidates, and
   (b) if the voter wishes to express a further preference for one or more candidates, the voter’s second and, if the voter wishes, subsequent preferences from among those candidates.

(3) Election regulations must, in particular, make provision about—
   (a) the manner in which and period during which votes may be cast,
   (b) the form and content of ballot papers,
   (c) the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated,
   (d) the procedure for counting votes,
   (e) the declaration of the result of the poll.

Candidates

9 Election regulations may make provision about—
   (a) who is qualified to be a candidate in a Health Board election, and
   (b) the circumstances in which an individual may be disqualified from being a candidate.

Franchise

10 (1) An individual is entitled to vote at a Health Board election if the individual—
   (a) is aged 16 or over, and
   (b) meets any further criteria specified in election regulations.

(2) Election regulations may determine, or set out the criteria for determining, the electoral ward in which an individual is entitled to vote.

(3) Election regulations may not entitle an individual to vote—
   (a) more than once in the same Health Board area, nor
   (b) in more than one Health Board area.
Election expenses

11 Election regulations may make provision about the expenses which may be incurred by any person in connection with a Health Board election.

Vacancies

5

12 (1) This paragraph applies if—

(a) a returning officer declares a vacancy in an electoral ward (see paragraph 7), or

(b) an elected member vacates office before the end of the period mentioned in paragraph 10A(1) of Schedule 1.

10

(2) The Scottish Ministers may—

(a) direct the Health Board with the vacancy to invite an unelected candidate to fill the vacancy, or

(b) appoint, in accordance with any provision made by election regulations, an individual to fill the vacancy.

15

(3) If a vacancy arises less than 6 months before the date of the next Health Board election in the Health Board area where it arises, the Scottish Ministers may, instead of taking action under sub-paragraph (2), direct the Health Board to leave the vacancy unfilled until that next election.

20

(4) An individual who fills a vacancy is to be deemed to be an elected member of the Health Board elected for the ward in which the vacancy occurred.

25

(5) In sub-paragraph (2)(a), an “unelected candidate” is an individual who—

(a) was a nominated candidate in the last Health Board election to be held in the Health Board area, and

(b) is identified by criteria specified in election regulations.

Election regulations

13 (1) The Scottish Ministers may make regulations (“election regulations”) in relation to any matter specified in this Schedule as something in relation to which provision may be made by election regulations.

(2) Election regulations may make further provision about Health Board elections (in so far as not already provided for in this Schedule).

(3) In particular, election regulations may provide that an enactment applies (with or without modifications specified in the regulations) or does not apply to Health Board elections.

(4) In sub-paragraph (3), “enactment” includes an Act of the Scottish Parliament and any instrument made under such an Act.”.

Scottish Ministers’ powers in relation to elected members

In section 77(2) of the 1978 Act (content of order declaring Health Board to be in default)—

(a) in paragraph (a), after “appointment” insert “or, as the case may be, election”, and
(b) in paragraph (b), after “appointment” insert “or, as the case may be, election”.

Pilot scheme and action following pilot

4 Pilot scheme

(1) Ministers may by order (the “pilot order”) appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order.

(2) Ministers may make one pilot order only (but this does not affect Ministers’ power to modify or revoke the order).

(3) The pilot order may bring sections 1 to 3 into force with such modifications as Ministers consider appropriate.

5 Report on pilot scheme

(1) No later than 5 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order, Ministers must publish a report containing—

(a) a description of the changes made to the 1978 Act by sections 1 to 3 and how the constitution of Health Boards was changed by those sections coming into force in the Health Board areas specified in the pilot order,

(b) a description of the Health Board elections held in the specified Health Board areas, and

(c) an evaluation of—

(i) the level of public participation in the Health Board elections,

(ii) whether having elected members on Health Boards led to increased engagement with patients and other members of the public in the specified Health Board areas.

(2) The report may contain—

(a) such other information, and

(b) an evaluation of such other matters,

as Ministers consider appropriate.

(3) Ministers must lay a copy of the published report before the Scottish Parliament.

6 Termination of pilot scheme

(1) The pilot order is revoked on the day falling 7 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order (but this does not affect Ministers’ power to revoke the order on an earlier date).

(2) If the pilot order is revoked before a roll-out order is made (see section 7), then, on the day the pilot order is revoked, sections 1 to 7 and paragraph 2 of the schedule are repealed.

7 Roll-out

(1) Ministers may by order (a “roll-out order”) appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order.

(2) When a roll-out order is made section 6 is repealed.
(3) A statutory instrument containing a roll-out order—
   (a) may not be made unless a report has been published under section 5(1), and
   (b) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

(4) A roll-out order may make such provision adding to, replacing or omitting any part of
   the text of, or otherwise modifying, any enactment (including this Act) as Ministers
   consider appropriate.

Final provisions

8 Minor and consequential amendments

The schedule contains minor and consequential amendments.

9 Key terms

In this Act—

   the “1978 Act” means the National Health Service (Scotland) Act 1978 (c.29),
   “Health Board” means a board constituted by an order under section 2(1)(a) of the
   1978 Act,
   “Health Board election” means an election held under Schedule 1A to the 1978
   Act (as inserted by section 2(2) of this Act),
   “Ministers” means the Scottish Ministers,
   “pilot order” has the meaning given by section 4(1),
   “roll-out order” has the meaning given by section 7(1).

10 Orders

(1) An order made under this Act is to be made by statutory instrument.

(2) Such an order may—
   (a) make different provision for different purposes (in particular, for different Health
       Board areas), and
   (b) contain any supplementary, incidental, consequential, transitional, transitory or
       saving provision which Ministers consider appropriate.

11 Commencement

(1) Sections 1 to 3 come into force in accordance with sections 4 and 7.

(2) Sections 4 to 7, 9, 10, 12 and this section come into force on Royal Assent.

(3) Section 8 and the schedule come into force on such day as Ministers may by order
     appoint.

12 Short title

This Act is called the Health Boards (Membership and Elections) (Scotland) Act 2008.
SCHEDULE
(introduced by section 8)

MINOR AND CONSEQUENTIAL AMENDMENTS

National Health Service (Scotland) Act 1978 (c.29)

1 In paragraph 4 of Schedule 1 to the 1978 Act, for the words from “the”, where it second occurs, to “prescribed” substitute “—

(a) the chairman of a Health Board,
(b) such other members of a Health Board as may be prescribed, and
(c) such members of committees and sub-committees of a Health Board as may be prescribed,”.

Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)

2 In schedule 2 to the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (the specified authorities), in the list headed “National Health Service bodies”, after “any Health Board” insert “, but Part 1 does not apply to appointments made under Schedule 1 to the National Health Service Scotland Act 1978 (c.29) of the following persons to a Health Board—

(a) a councillor member,
(b) an appointed member who is appointed by virtue of the member—
(i) holding a post in a university with a medical or dental school,
(ii) being employed as an officer of the Health Board, or
(iii) being a member of a body set up by a Health Board which represents health care professionals working in the Health Board area.”.
Health Boards (Membership and Elections) (Scotland) Bill

[AS INTRODUCED]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for the election of certain members of Health Boards; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 25 June 2008
Bill type: Executive Bill
HEALTH BOARD (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL

EXPLANATORY NOTES

(AND OTHER ACCOMPANYING DOCUMENTS)

CONTENTS

1. As required under Rule 9.3 of the Parliament’s Standing Orders the following documents are published to accompany the Health Board (Membership and Elections) (Scotland) Bill introduced in the Scottish Parliament on 25 June 2008:
   - Explanatory Notes;
   - a Financial Memorandum;
   - a Scottish Government Statement on legislative competence; and
   - the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 13–PM.
INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

4. The Bill will introduce, by way of pilots, elections to Health Boards in Scotland.

5. The Bill changes the constitution of Health Boards in Scotland and in particular changes the way some individuals become members of these Boards by introducing a system of elections whereby a proportion of the membership of each Health Board will be made up of elected members. The Bill also, for the first time, sets out on a statutory basis the membership of local authority councillor members on Health Boards and specifies that there must be at least one member per local authority within a Health Board area.

6. The Bill therefore makes a number of amendments to Schedule 1 to the National Health Service (Scotland) Act 1978 (the “1978 Act”) so as to change the make-up of Health Boards and inserts a new Schedule 1A into that Act setting out the framework for the elections.

7. The Bill provides for these changes to be introduced in certain areas on a pilot basis and provides for those pilot schemes to be evaluated before the changes are rolled-out to other areas.

8. The changes to Schedule 1 to the 1978 Act will not extend to Special Health Boards (these are Boards with special functions operating across Scotland as a whole). These Boards are set up by orders under the 1978 Act which commonly apply the provisions in Schedule 1 to that Act with appropriate modifications. Those orders will be amended where necessary to ensure that the new provisions inserted by this Bill are not applied to any Special Health Boards.

9. The Bill also extends the power of the Scottish Ministers to remunerate Health Board members to include power to remunerate members of committees and sub-committees of a Health Board.

COMMENTARY ON SECTIONS

Section 1 – Constitution of Health Boards

10. This section amends Schedule 1 to the 1978 Act. That Schedule currently contains provision about the constitution of Health Boards. In particular, it contains provisions about the
These documents relate to the Health Board (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

appointment of Health Board members (who are currently all appointed by the Scottish Ministers in accordance with this Schedule).

11. Subsection (2) substitutes a new paragraph for the existing paragraph 2 of Schedule 1 to the 1978 Act. New paragraph 2(1) specifies the three different types of member that will comprise a Health Board. These are—

- “appointed members” (a chairman and other members appointed by the Scottish Ministers);
- “councillor members” (councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board); and
- “elected members” (individuals elected as members of the Health Board at an election).

Note that the chairman must always be an appointed member.

12. New paragraph 2(2) provides that regulations must specify, in respect of each Health Board in Scotland, the total number of members of the Board and the number of that total which is to be represented by each type of member. Those numbers will differ from Board to Board.

13. New paragraph 2(3) provides that (a) the total number of councillor members and elected members of a Health Board must amount to more than half the total number of members and (b) a Board must contain at least one councillor member from each local authority whose area is wholly or partly within the area of the Health Board. So the regulations cannot specify numbers which would not be in accordance with those two conditions.

14. New paragraph 2(4) provides that these conditions do not apply during any period when an elected member or councillor member vacates office and the vacancy has not been filled. This ensures that in the event of a vacancy arising the Health Board will still be able to carry out its functions.

15. Subsection (3) amends paragraph 2A of Schedule 1 to the 1978 Act to ensure that it continues to be a requirement in the case of a prescribed Health Board that at least one of the appointed members must hold a post in a university with a medical or dental school. A “prescribed Health Board” is one which is prescribed in regulations as requiring a member holding one of these posts. Currently these are the Health Boards which have at least one university in their area with a medical or dental school.

16. Subsection (4) amends paragraph 3 of Schedule 1 to the 1978 Act to ensure that it continues to be a requirement that appointed members may be appointed only after consultation with universities and other relevant organisations. It also removes the existing sub-paragraph (a) of paragraph 3 to remove the requirement to consult each local authority in the area of the Health Board concerned. This is because local authorities will have their own councillor members. Under the current arrangements, the Scottish Ministers would normally appoint at least one councillor to each Health Board. Existing paragraph 3(a) ensured that such an appointment
These documents relate to the Health Board (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

could not be made without the local authority being consulted. New paragraph 2 of the Schedule now provides for local authorities to nominate the councillor member to be appointed.

17. Subsection (5) inserts new paragraph 10A into Schedule 1 to the 1978 Act. New paragraph 10A(1) sets out the usual period that an elected member holds office for and paragraph 10A(2) provides that regulations may specify the circumstances in which (a) an elected member must vacate office before the end of that period and (b) the Scottish Ministers may determine that an elected member is to vacate office before the end of that period. So the regulations may set out some things which would lead to an individual having to leave office as a Health Board member and others which would lead to the Scottish Ministers making a decision as to whether or not the individual could remain in office.

18. Subsection (6) amends paragraph 11(a) of Schedule 1 to the 1978 Act to ensure that it continues to be the case that regulations may make provision about the appointment, tenure and vacation of office of appointed members. This will also apply to councillor members. Further amendment has been made to ensure that the power in relation to these members can be used to make similar provision as may be made in relation to elected members under new paragraph 10A(2).

19. Subsection (7) amends paragraph 12 of Schedule 1 to the 1978 Act to ensure that it continues to be the case that the proceedings of a Health Board are not invalidated by any vacancy in membership or by any defect in the appointment of any member. This will also apply to councillor members and elected members.

Section 2 – Health Board elections

20. Subsection (1) inserts new subsection (10A) into section 2 of the 1978 Act. New subsection (10A) provides that Schedule 1A will make provision for the elections of individuals to be members of Health Boards.

21. Subsection (2) inserts new Schedule 1A into the 1978 Act, which makes provision for Health Board elections.

22. Paragraph 1 provides that an election held under Schedule 1A is known as a “Health Board election”.

23. Paragraph 2 provides for the timing of Health Board elections. It provides that election regulations will specify the day on which a Health Board must hold the first election in the Health Board area. This day could be different for different Health Board areas. Health Board elections will be held on a fixed 4 year cycle. However, a Health Board election may be held in a Health Board area before the day specified if the Scottish Ministers make an order under section 77 of the 1978 Act to declare that a Health Board is in default.

24. Paragraph 3 provides for electoral wards. It provides that each Health Board area is to be comprised of a single electoral ward unless election regulations specify that a Health Board area is to be divided into more than one ward. If regulations specify such a division then they must
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also specify the number of wards and the boundaries of those wards. Also, before regulations specifying such a division are made, the Scottish Ministers must consult the Local Government Boundary Commission for Scotland and the Commission must give them advice about the boundaries of the wards.

25. Paragraphs 4 to 8 deal with the conduct of elections. Paragraph 4 provides that the Health Board must appoint a returning officer for a Health Board election and sets out that election regulations will make provision about the tenure and vacation of office of a returning officer, the functions of a returning officer, the payment of a returning officer’s fees and expenses, and any other matters relating to the returning officers as the Scottish Ministers consider appropriate.

26. Paragraph 5 provides that the nomination of a candidate must be made within the period specified in election regulations and in accordance with any other requirements made in those regulations. It also provides that a candidate may withdraw from a Health Board election at any time before the end of the nomination period set out in regulations.

27. Paragraph 6 provides that election regulations must specify the number of elected members to be elected in each electoral ward.

28. Paragraph 7 makes provision for uncontested elections. If, at the end of the nomination period, the number of nominated candidates in an electoral ward is equal to or less than the number to be elected for that ward then—

(a) the Health Board election is not to be held in the ward, and

(b) on the day on which the election was supposed to be held, the returning officer must—

(i) declare the nominated candidates (if there are any) to be deemed to have been elected as elected members for the ward (so they are all effectively elected without a vote being held), and

(ii) if the number of nominated candidates is less than the number that is to be elected for that ward, declare the number of vacancies in the ward.

29. Paragraph 8 makes provision for contested elections. The number of members that are to be elected for a ward are to be elected at a poll. Sub-paragraph (2) provides that at the poll, each individual entitled to vote may do so by marking on the ballot paper the voter’s first preference from among the candidates. The voter can then express a second preference for another candidate and, if the voter wishes, subsequent preferences from amongst the candidates. This is the basic structure of a single transferable vote (STV) system. Sub-paragraph (3) states that election regulations must, in particular, make provision about the manner in which and period during which votes may be cast (for example, postal voting, electronic voting, or traditional ballots at polling stations), the form and content of ballot papers, the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated (that is to say, the mathematical formula to be used in the STV system), the procedure for counting votes, and the declaration of the result of the poll.
30. Paragraph 9 makes provision about the eligibility of individuals to be candidates. It provides that election regulations may make provision about who is qualified to be a candidate in a Health Board election, and the circumstances in which an individual may be disqualified from being a candidate.

31. Paragraph 10 makes provision about entitlement to vote (in other words, the franchise of Health Board elections). It provides that an individual is entitled to vote at a Health Board election if the individual is aged 16 and over and meets any further criteria specified in election regulations. It provides that election regulations may determine, or set out the criteria for determining, the electoral ward in which an individual is entitled to vote. It also provides that an individual cannot vote more than once in the same Health Board area, nor in more than one Health Board area.

32. Paragraph 11 makes provision about election expenses. It provides that election regulations may make provision about the expenses which may be incurred by any person in connection with the Health Board election.

33. Paragraph 12 deals with what happens when there is a vacancy amongst the elected members of a Health Board. It applies if a returning officer declares a vacancy in an electoral ward due to an insufficient number of candidates and also if an elected member vacates office before the end of the usual period. It provides that the Scottish Ministers may direct the Health Board with the vacancy to invite an unelected candidate to fill the vacancy (election regulations can set out criteria for determining which unelected candidate is to be invited) or alternatively the Scottish Ministers can appoint an individual to fill the vacancy. Clearly the first of these options would not be available if the vacancy arose due to an insufficient number of candidates in the first place.

34. If a vacancy arises less than 6 months before the date of the next scheduled Health Board election in the Health Board area where it arises, the Scottish Ministers may, instead of taking action to direct the Health Board to invite an unelected candidate or appoint an individual to fill the vacancy, direct the Health Board to leave the vacancy unfilled until the next Health Board election in the Health Board area (paragraph 12(3)). Paragraph 12 also provides that an individual who fills a vacancy is to be treated as if that individual was an elected member of the Health Board (sub-paragraph (4)).

35. Paragraph 13 confers power on the Scottish Ministers to make election regulations. It provides that the Scottish Ministers may make election regulations in relation to any matter specified in new Schedule 1A as something in relation to which provision may be made by election regulations. It also provides that the election regulations may make further provision about Health Board elections (if it is something not already provided for in new Schedule 1A). It also provides that election regulations may apply an enactment (with or without modifications specified in the regulations) or disapply an enactment to Health Board elections.

Section 3 – Scottish Ministers powers in relation to elected members

36. Section 3 amends section 77(2) of the 1978 Act to ensure that when an order is made to declare a Health Board to be in default the order must not only provide for the appointment of
new members, but also must make provision for an election and may make provision about what is to happen in the period until the election is held.

**Section 4 – Pilot scheme**

37. Subsection (1) provides that the Scottish Ministers may by order appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order. An order under this provision is known as a pilot order. It is not subject to any parliamentary procedure as it is a commencement order.

38. Subsection (2) provides that the Scottish Ministers may make one pilot order only, although this does not affect their power to modify or revoke the order.

39. Subsection (3) provides that the pilot order may bring sections 1 to 3 into force with such modifications as the Scottish Ministers consider appropriate.

**Section 5 – Report on pilot scheme**

40. Subsection (1) provides that no later than 5 years after the first election held in a Health Board area specified in the pilot order, the Scottish Ministers must publish a report. The report must contain the following things—

   (a) a description of the changes made to the 1978 Act by sections 1 to 3 and how the constitution of Health Boards was changed by those sections coming into force in the Health Board areas specified in the pilot order,

   (b) a description of the Health Board elections held in the Health Board areas, and

   (c) an evaluation of—

   (i) the level of public participation in the Health Board elections, and

   (ii) whether having elected members on Health Boards led to increased engagement with patients and other members of the public in the specified Health Board areas.

41. Subsection (2) provides that the report may contain such other information, and an evaluation of such other matters, as the Scottish Ministers consider appropriate.

42. Subsection (3) provides that the Scottish Ministers must lay a copy of the published report before the Scottish Parliament.

**Section 6 – Termination of pilot scheme**

43. Subsection (1) provides that the pilot order can only stay in force for 7 years after the day the first election is held in a Health Board area specified in the pilot order. But the Scottish Ministers could revoke the pilot order on an earlier date.

44. If the pilot order is revoked before a roll-out order is made under section 7 of the Bill, then, on the day the pilot order is revoked, sections 1 to 7 and paragraph 2 of the schedule are repealed.
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(subsection (2)). This means that in order for the main provisions of the Bill to continue to have effect in the areas specified in the pilot order, a roll-out order has to be made before the pilot order is revoked (note that the pilot order is automatically revoked under subsection (1) at the end of the 7 year time-limit). Another effect of the self-repealing provision of subsection (2) is that it would no longer be possible to bring the main provisions of the Bill into force in areas not specified in the pilot order.

Section 7 – Roll-out

45. Subsection (1) provides that the Scottish Ministers may by order appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. Such an order is known as a “roll-out order”. When a roll-out order is made it has the effect of repealing section 6 of the Bill (see subsection (2) of section 7). Repealing section 6 prevents the pilot order from being revoked after the expiry of the time limit in section 6(1) and therefore also stops the consequential repeal of the main provisions of the Bill under section 6(2). This means that sections 1 to 7 and paragraph 2 of the schedule will continue to have effect in respect of the Health Board areas specified in the pilot order and there is no bar on bringing those provisions into force in other areas.

46. Subsection (3) provides that a statutory instrument containing a roll-out order may not be made unless the evaluation report has been published, and that statutory instrument is subject to negative procedure in the Scottish Parliament.

47. Subsection (4) provides that a roll-out order may make such provision adding to, replacing or omitting any part of the text of, or otherwise modifying any enactment as the Scottish Ministers consider appropriate. One of the things that could be done under this power is amendment of new Schedule 1A to the 1978 Act in response to the evaluation of the pilot schemes. For example, where elements of the process have been seen to work less well in the pilot areas, changes could be made to the way the process works by amending Schedule 1A for the Health Boards which did not participate in the pilot scheme (where elections would be held for the first time) and for the pilot scheme Boards (in relation to the subsequent elections for those Boards).

Section 8 – Minor and consequential amendments

48. Section 8 introduces the schedule which contains minor and consequential amendments.
Schedule – Minor and consequential amendments

National Health Service (Scotland) Act 1978 (c.29)

49. Paragraph 1 amends paragraph 4 of Schedule 1 to the 1978 Act to extend the power in that paragraph which permits the Scottish Ministers to pay to the chairman of a Health Board and such other members of a Health Board as may be set out in regulations such remuneration as they may from time to time determine. The power is extended to include such members of committees and sub-committees of a Health Board as regulations may specify.

Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)

50. Paragraph 2 amends schedule 2 to the Public Appointments and Public Bodies etc. (Scotland) Act 2003 to exclude from the remit of the Commissioner for Public Appointments in Scotland the appointment to any Health Board of—

(a) councillor members, and
(b) appointed members who are appointed by virtue of the member either—
   (i) holding a post in a university with a medical or dental school,
   (ii) being employed as an officer of the Health Board (for example, the chief executive of the Health Board), or
   (iii) being a member of a body set up by a Health Board which represents healthcare professionals working in the Health Board area. This covers representative forums set up by Health Boards to allow them to consult with doctors, dentists, opticians, pharmacists and other professionals in the area. These bodies are currently known as Area Clinical Forums.

Section 9 – Key terms

51. Section 9 defines the key terms used in the Bill.

Section 10 – Orders

52. Subsection 10(1) provides that an order under the Bill is to be made by statutory instrument.

53. Subsection (2) provides that such an order may make different provision for different purposes and contain any supplementary, incidental, consequential, transitional, transitory or saving provision which the Scottish Ministers consider appropriate.

Section 11 – Commencement

54. Subsection (1) provides that sections 1 to 3 come into force in accordance with sections 4 and 7 (that is, the provisions relating to the pilot scheme and roll-out respectively).

55. Subsection (2) provides that sections 4 to 7 and 9 to 12 come into force on Royal Assent.
56. Subsection (3) provides that sections 8 and the schedule come into force on such day as the Scottish Ministers may by order appoint (a commencement order under this subsection is not subject to any parliamentary procedure).

FINANCIAL MEMORANDUM

INTRODUCTION

57. This document relates to the Health Board (Membership and Elections) (Scotland) Bill introduced in the Scottish Parliament on 25 June 2008. It has been prepared by Nicola Sturgeon, who is the member in charge of the Bill, to satisfy Rule 9.3.2 of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.

COSTS ON THE SCOTTISH ADMINISTRATION

58. The costs associated with this Bill and the implementation of the pilots are modest in the context of current NHS spending in Scotland of over £10bn per annum. These costs are based on 60% turnout; using the STV voting system; using an all postal ballot and are based on pilots which cover 20% of the electorate of Scotland. The costs provided are a best estimate based on studies of postal ballots conducted by the Electoral Commission and experience of postal ballots for Scotland’s National Parks Authorities. There are a number of variables which would cause the costs to fluctuate if they were adjusted. Precisely specifying the margins of such fluctuations would not be particularly productive. However it is reasonable to presume that an adjustment in any of the variables would result in a proportionate adjustment in the expected costs. For example, if the turnout is only 50%, the costs will be proportionately less because of reduced postage costs for the return of the postal ballots; if an STV system was not used then there would be a saving against the cost of hiring counting machines for the votes; and if a traditional ballot box were used then there would be a corresponding saving compared with postage for an all postal ballot.

59. The total electorate in Scotland is around 3.87m. On the basis of 20% coverage of the electorate in the 2 pilot areas this would equate to around 775,000 electors. The average cost per vote cast in all postal ballots (not using STV) is around £2.60. This is an average figure based on a number of evaluation studies of all postal ballots conducted by the Electoral Commission and takes account of the costs associated with non returned ballot papers. If we assume a 60% turn out in the pilot elections this would give an estimated cost of: 464,000 (60% of electorate) x £2.60 = £1.21 million. To this “baseline figure” would need to be added the costs of hiring the machines to count the votes in the STV system. The cost of the machines is very broadly dependent on the size of the electorate. The costs that follow are based on pilots in medium sized health board areas ie with an electorate of around 200-250,000. The estimated cost for hiring machines for 2 pilot areas would be around £450,000 x 2 = £0.90 million. The estimated cost of pilot elections to Health Boards in 2 pilot areas, using STV with a 60% turn out would be £1.21 million + £0.90 million = £2.11 million.

60. This cost (£2.11 million) does not include:
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- the remuneration costs of elected members;
- the cost of the evaluation study;
- any possible costs arising from extending the franchise; or
- any possible costs which we may wish to incur in providing advance information and advice for the public in the 2 pilot areas.

61. The costs associated with remunerating the elected members are based on the expectation that for the 2 pilot areas there would be around 20 elected members. These members would be remunerated at the current rate (around £7,500 pa). The cost would be 20 x £7,500 = £0.15 million pa – over 2 years for the pilots £0.30 million. However this would be offset by a reduction in the number of lay members on each Board although, as a result of the introduction of elected members onto the Health Board, there may be an increase in size and a rebalancing of representation on the Board. So the increase in remuneration costs will not be completely offset and the estimated total additional remuneration over 2 years is expected to be around £0.20 million. For each pilot area Board this will mean additional annual remuneration costs of around £50,000. The actual cost incurred will depend on the pilot areas chosen.

62. The estimated cost of the evaluation study will be around £0.25 million. This cost is broadly based on costs of similar work undertaken/commissioned by the Scottish Government in the recent past.

63. With regard to the costs of extending the franchise we cannot be precise at this stage. There are a number of different software systems used by Electoral Registration Offices (EROs) across Scotland and the costs associated with modifying the software to accommodate the extension will depend on the pilot area chosen and the software in use by the EROs covering the pilot areas. A rough estimate of the cost may be around £50,000 per pilot area ie £0.10 million for 2 pilot areas.

64. It would be prudent, given the pioneering nature of these pilot elections, to allow for some investment in public information/advice in the pilot areas. This would help ensure public understanding and support and may help boost the turnout and may amount to £0.10m for each pilot area ie £0.20 million for 2 pilot areas. It is anticipated that this level of funding would allow for a modest advertising campaign in the local press and for the production and distribution of written information.

65. The total cost of the pilots is likely to be met in 2010/11 and takes into account the factors set out above and is made up as follows:

£1.21 million “baseline” cost
£0.90 million cost of STV counting
£0.20 million additional remuneration
£0.25 million evaluation study
£0.10 million extension of the franchise
£0.20 million public information and advice
£2.86 million
66. If, following the evaluation of the pilots, Ministers bring forward to Parliament plans to roll out elections to all Health Boards then it is estimated that this will cost around £13.05m. This is the £2.61m cost (excluding the evaluation study) for the 20% electoral coverage in the 2 pilot areas multiplied up to 100% coverage i.e. £2.61 million x 5 = £13.05m. This cost will be met at each election to Health Boards. The intention is that the costs will be met from existing budgets.

67. The Scottish Government has no plans at this time to use the power inserted by paragraph 1 of the schedule to the Bill to pay committees and sub-committees of Health Boards but regards this Bill as the right opportunity to make provision for such a power so that the issue can be looked at in light of the new structure of Boards. In the event of that resulting in subordinate legislation specifying that payments be made to any particular committee or sub-committee the Government will provide a full analysis of the costs arising.

COSTS ON LOCAL AUTHORITIES

68. There are no costs falling to local authorities.

COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES

69. There are no costs falling to other bodies, individuals and businesses.

SCOTTISH GOVERNMENT STATEMENT ON LEGISLATIVE COMPETENCE

70. On 25 June 2008, the Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon) made the following statement:

“In my view, the provisions of the Health Board (Membership and Elections) (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

71. On 24 June 2008, the Presiding Officer (Alex Fergusson MSP) made the following statement:
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“In my view, the provisions of the Health Board (Membership and Elections) (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

1. This document relates to the Health Board (Membership and Elections) (Scotland) Bill introduced in the Scottish Parliament on 25 June 2008. It has been prepared by the Scottish Government to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 13–EN.

BACKGROUND AND BILL OVERVIEW

2. The Scottish Government is committed to improving public engagement and involvement with Health Boards. The Government recognises that people want to be involved in their local health services and that they want to be involved in the key decisions about the future development of the NHS in Scotland.

3. In December last year (2007) the Government published the “Better Health, Better Care” Action Plan which set out the Government’s vision of a mutual NHS in Scotland in which ownership and accountability are shared with the public and the staff. The Government is now beginning the process of implementing this Plan together with proposals to improve public engagement and involvement. The Government has already announced the implementation of independent scrutiny and how this will be embedded in the processes by which the NHS in Scotland develops proposals for future major service changes. In addition, the Government will soon be launching a consultation on the contents of a Patients’ Rights Bill. The Government will, furthermore, develop a participation standard to ensure that patient focus and public involvement become the core drivers of decision making and will require Health Boards to produce annual ownership reports setting out information on how to access local services, how to raise issues and concerns and on how to become engaged and involved in the design and delivery of local health services.

4. The Bill will, within this framework, introduce, by way of pilots, elections to Health Boards with the aim of improving public and community engagement and involvement. The Bill will give practical effect to the mutual/co-ownership concept of the NHS in Scotland by giving the public (the co-owners) the opportunity to vote onto their local Health Board their own representatives. The Bill will also allow the public voice to be heard and listened to at the heart of the decision making processes of Health Boards.
5. This Memorandum sets out the details of the consultation process and sets out, in more detail, the policy which underpins the significant areas of the Bill. The effects of the Bill on equal opportunities, human rights, island communities, local government and sustainable development are summarised in paragraphs 33 to 38 of this Memorandum.

CONSULTATION


7. The consultation was launched on 8 January 2008 at the Pearce Institute in Glasgow. The launch was attended by the media and the Cabinet Secretary for Health and Wellbeing took the opportunity to discuss the contents of the consultation with the representatives of some key stakeholder groups including the Scottish Health Council, Fair For All, Help the Aged and the Scottish Consumer Council.

8. The consultation document was split into two separate, but not mutually exclusive, sections. Section 1 asked questions about strengthening existing policies to ensure that the needs of local communities are heard more effectively within the current framework of appointed Health Boards. Section 2 asked for views on introducing new legislation to require elections to be held that would place locally elected members on Health Boards.

9. Copies of the consultation were sent out to a wide range of interested groups and it was also made available through the Scottish Government’s website and was offered in a number of formats. By the time the consultation closed on 1 April 2008, almost 2000 copies of the consultation had been distributed. Officials were also invited to a number of meetings across the country to discuss the contents of the consultation and help facilitate discussions before those concerned submitted their written responses. These meetings involved Regional Tenants Associations, Health Boards, Public Partnership Forums and Citizens Panels. A total of 142 responses were received from a broad range of organisations including Health Boards, local authorities, voluntary bodies, professional and trade union bodies and individuals.


11. Consultation responses acknowledged the need to improve the way in which Health Boards engaged and involved their local communities in the planning and decision making process around delivering health services. All acknowledged the progress that had been made over recent years but it was also acknowledged that further steps had to be taken. Individual respondents especially felt that the views of communities were not given sufficient weight when the Health Board considered options. They also felt that many consultations did not fully reflect the range of options that might be available, instead they reflected a narrower Health Board view. 13 of the 14 area Health Boards responded. All acknowledged the need to continue to improve their engagement with communities but were universally of the opinion that elections to Health Boards were not the way to achieve this. Opinion on elections was split between “for” and “against” among local authorities, a split that was reflected in all other types of respondent. In general, individuals or groups who were not currently directly involved with planning and
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delivery of health services tended to be for elections while those who were currently involved tended to be against the proposals.

12. The introduction of a legal requirement to include local councillors on Health Boards was not specifically consulted on but the Government considers this to be a logical reaction to the consistent message received from consultees that Health Boards’ engagement with communities needed to continue to be improved.

POLICY OBJECTIVES OF THE BILL

13. The Bill will set out the key principles relating to the introduction of elections, by way of pilots, to Health Boards. Further detailed arrangements for the implementation and conduct of elections, in the first place to Health Boards in the pilot areas, will be set out in subordinate legislation.

Membership and Accountability

- Elected members, together with councillors nominated by local authorities and appointed by Ministers, will form the majority of the members on each Health Board; the elected members will be remunerated at the same rate as current non-executive Health Board members.
- The appointment of the chairman of each Health Board will continue, as at present, to be a Ministerial appointment following the standard public appointment process.
- Health Boards will – as at present – be accountable to Ministers and will be required to comply with regulations and with Ministerial directions.

Elections, Franchise and Method of Voting

- The elections will be held on a fixed 4-year cycle.
- Each Health Board will be a single ward for the purposes of elections.
- The electoral system will be single transferable vote (STV).
- The franchise will be extended to include 16 and 17 year olds.
- The Bill will provide that pilots must precede full roll-out of elections. The number, location and length of pilots and the date of commencement will be included in subordinate legislation.
- The pilots must be evaluated, and a report on the evaluation laid before Parliament, before decisions are taken on full roll-out. If the decision is taken to support full roll-out this will not require further primary legislation.

Membership of Health Boards

14. The Bill sets out the broad types of members which will make up the membership structure of a Health Board. This membership structure consists of two types of members; those appointed by Ministers and those elected in a Health Board election.

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15. The members appointed by Ministers will consist of:

(a) those appointed following the current open and transparent public appointment process – this will include the chairman of each Health Board;

(b) a number of senior employees of the Health Board (Chief Officer, Chief Finance Officer, Director of Public Health, Medical Director and Nurse Director and a representative of the Area Partnership Forum);

(c) a representative of the Area Clinical Forum;

(d) a University member where a Health Board area encompasses a teaching hospital; and

(e) a local authority councillor nominated by each local authority within the area of Health Board.

16. This unique structure of elected and appointed members on a Health Board continues and gives practical effect to the partnership/mutual approach to the NHS in Scotland and retains the valuable and crucial links with local authorities through their continued membership of the Health Board. Within this structure it is reasonable and sensible to view the nominated councillors and elected members, added together, as forming a majority of elected representatives on each Health Board. The Government believes that the proposed membership structure retains sensible and practical continuity with current Health Board membership and that the adding of elected members will clearly strengthen and not detract from Health Boards.

17. Local councillors already play an important role on Health Boards but it is not a requirement that local authorities are represented on Health Boards. The Government considers the link between local authorities and Health Boards to be vital and as such it should be formalised in statute. This will protect the valuable mix of skills and experience that is brought together around the table as well as allowing consistent calculation of a majority of elected members.

Accountability

18. The consultation highlighted some concerns that, by altering the membership structure of Health Boards, there would arise issues around Health Boards following national policy and the danger of losing the “national” from the National Health Service.

19. The Government acknowledges these concerns and we have responded by continuing the appointment of the Health Board chairman by the Scottish Ministers (after the normal competitive public appointments process), and by retaining the current Ministerial powers relevant to retaining control over Health Boards. These include, crucially, the power to give directions to Health Boards on specific or general matters; and the power to terminate a Health Board member’s membership where that seems to be justified in the interests of the Service (this last power in relation to appointed members is currently set out in regulations; we will amend these to ensure that they cover councillor and elected members also). Although this power has not to our knowledge been used, its continued existence – in relation to councillor and elected as well as appointed Health Board members – will help ensure a coherent, consistent approach to healthcare policy across Scotland which people will expect us to safeguard. Finally the pilots
will enable these issues to be evaluated and for further consideration to be given on whether any further action is needed.

**Elections**

20. The Government’s overall approach to the conduct of the elections themselves is founded on four broad principles:

- the elections will be held at fixed 4 year intervals, with no limit on the number of terms that an elected member can serve on the Board (if re-elected).
- each Health Board area will be a single ward – the Government believes that a single ward may encourage a broad range of candidates to come forward for election from across the whole of the Board’s area; will reduce the possibility of uncontested elections in smaller wards and will reduce the detrimental impact of unrepresentative single issue candidates from particular geographic areas from dominating the election. However the Bill retains a degree of flexibility such that if it is decided that there should be wards this can be taken forward for pilots and/or full roll-out.
- the voting method will be STV – the use of the STV system will give the electorate the fullest freedom of choice and ability to express preferences between candidates seeking election. It will help ensure that all significant opinions are proportionally represented on a Health Board and it will help ensure that single issue candidates do not predominate.
- the extension of the franchise to include 16 and 17 year olds. This will open up opportunities for this age group to become involved in a substantive way in helping to make decisions about local health services.

21. The consultation on the Bill highlighted concerns about the cost of elections and therefore, within these broad principles, the approach will be to rigorously pursue efficient and cost effective methods of implementation commensurate with holding free and fair elections. The Government believes that introducing elections to Health Boards is a positive and significant investment in improving public engagement and involvement. Elections will, we believe, begin to address the deeply held concerns expressed during the consultation that public engagement and involvement with Health Boards needs to be improved.

22. Within these broadly accepted principles the responses to the consultation also revealed a wide range of views on how the elections themselves should be managed and conducted. The Government wishes to be responsive to this wide range of views and wants to allow the Parliament further opportunity to consider these detailed issues. The Bill, therefore, allows for this opportunity by making provision for the details of elections to be included in subsequent subordinate legislation. The subordinate legislation is intended to encompass, amongst other things, issues such as the timing of Health Board elections, conduct of elections, eligibility of prospective candidates and election expenses.
Pilots

23. The results of the consultation highlighted, as did many of the views expressed in the debate in Parliament on 21 February this year (2008) (Column 6256 of the Official Report of the Scottish Parliament http://www.scottish.parliament.uk/business/officialReports/meetingsParliament/or-08/sor0221-02.htm#), that a clear majority of those who are in favour of elections consider that we should pilot elections first before deciding on whether or not to implement a full roll-out across Scotland.

24. We have responded positively to this widely held view and the Bill sets out that the introduction of elections to Health Boards will only proceed by way of pilots. The Government also considers that it is essential that there will be a full and thorough evaluation of the pilots and the principal criteria to be used in this evaluation are set out in the Bill. The Government also considers that it is important for Parliament to be involved in the decision, taking into account the results of the evaluation, as to whether or not to roll-out elections to all Health Boards in Scotland.

Special Health Boards

25. Special Health Boards are Boards with special functions operating across Scotland as a whole. The provisions in this Bill will not extend to Special Health Boards. The Bill provides for locally elected representatives on local area Health Boards. Because Special Health Boards have a national remit it would not be appropriate to hold elections to these Boards.

Remuneration of Health Board committees and sub-committees

26. Paragraph 1 of the schedule to the Bill amends paragraph 4 of Schedule 1 to the 1978 Act to extend Ministers’ existing the power to pay Health Board members so that payments may be made to members of committees and sub-committees of Health Boards (so long as the committee or sub-committee is specified in regulations as one that may be paid).

27. Committees and sub-committees already take on a lot of important work for Health Boards and with the structure of Boards being radically altered by the Bill, some Boards may wish to increase the role of committees. Currently, committee members can be reimbursed for any expenses they incur in undertaking work for a Health Board (as can Board members). But only Board members may be remunerated for their work. The Government believes it is fair to allow for committee members to be similarly remunerated in appropriate cases.

28. Extending this power at this time also provides an opportunity to correct an existing anomaly relating to one of the committees of a Special Health Board. NHS Quality Improvement Scotland (NHS QIS) is a Special Health Board which is under a legal duty to have a committee known as the Scottish Health Council (SHC). The intention when the SHC was established was that the Chair and the six members of the SHC should be paid at the same rate as non-executive members of Health Boards. In line with this intention, NHS QIS set up the necessary arrangements and payments have been made since. However, the legislation establishing NHS QIS applies the provisions in Schedule 1 to the 1978 Act. Extending the
power to pay remuneration to committee members means that the application of Schedule 1 to NHS QIS will include power to remunerate members of the SHC.

ALTERNATIVE OPTIONS

29. In introducing proposals for elections to Health Boards, the Government wants to improve upon the current public engagement and involvement mechanisms. The roles played by Public Partnership Forums, the Scottish Health Council and others will continue but the introduction of elections will introduce, for the first time, a strong local voice to the decision making processes of Health Boards.

30. The Government is committed to improving public engagement and involvement with Health Boards and will be issuing guidance shortly to set out proposals as to how this will be achieved. However, the Government also believes that, on its own, this would not be sufficient to meet the widespread concerns expressed throughout the consultation period about the adequacy of current public engagement and involvement. The Government believes that elections to Health Boards will provide a robust and adequate answer to these concerns and we do not consider that this could be achieved by merely changing the way members of a Health Board are appointed, or the type of members that are appointed. We recognise the importance of local authority councillor members on Health Boards and the way that these appointments reflect and reinforce the joint planning and delivery of services. We consider that the current arrangement of one member per local authority is sufficient to ensure partnership working and service delivery.

31. The consultation clearly indicated that if we were to proceed with elections then we should do so initially by way of pilots. We also recognise the clearly expressed view from the consultation that before we move to decide on full roll-out, there should be a full and independent evaluation of the pilots. As part of the consultation a debate was held in Parliament on 21 February and there was broad support for proceeding by way of pilots and we would wish to build upon this Parliamentary consensus. We have reflected this in the Bill.

32. The Government’s view is that the most effective electoral system for electing Health Board members is the tried and tested system of the single transferable vote. This system is now in use in local government elections in Scotland. The Government has considered this method of voting against other methods and feel that this system offers advantages and safeguards when electing members to sit on their local Health Board. For example, there would be a greater spread of candidates standing; as every vote will count, there is likely to be a higher turnout; the ability for the electorate to express preferences amongst candidates is likely to prove popular; and, adopting the entire Health Board area as a single ward as opposed to smaller wards will prevent single issue candidates from predominating.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal Opportunities

33. The Bill’s provisions are not discriminatory on the basis of age, gender, race, disability, mental status or sexual orientation. The Bill’s provisions for the franchise will extend the
franchise for the first time in Scotland to include 16 and 17 year olds. This will open up opportunities for this age group to become involved in a substantive way in helping to make decisions about the planning and delivery of local health services. The policy of remunerating elected members (at the same rate as current Health Board members) is designed to ensure that there is equity between Health Board members and to ensure that no candidate is discouraged from standing because of financial issues.

34. The Government will ensure that, through the implementation of the pilots, the effects on equal opportunities are fully evaluated and taken into account before a decision is made on whether or not there should be full roll-out of elections to all Health Boards across Scotland.

**Human Rights**

35. The Scottish Government is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights. The Government does not consider the Bill to contain anything which raises substantive issues in this area.

**Island Communities**

36. The Government’s intention is that the provisions of the Bill will apply equally to all communities in Scotland. Nevertheless the Government is well aware of the particular issues for island communities when introducing a new set of elections. In preparing the detailed regulations for Health Board elections the Government will ensure that due account is taken of issues around voting procedures for remote communities. The overarching aim is that elections will increase the level of local engagement and involvement in Health Boards and it is essential that the detailed processes reflect the particular challenges of ensuring maximum engagement with island communities and all other more remote communities.

**Local Government**

37. COSLA and all local authorities have been consulted as part of the consultation on the Bill. Local authorities are already represented on Health Boards by one councillor from each local authority covered by a Health Board. The Bill does not propose any changes to this, but will provide for a statutory basis for the position. Local authorities also play a significant and important role in the implementation and development of Community Health Partnerships and Public Partnership Forums and we would expect this to continue and to develop in the future. The Bill does not propose any changes to these arrangements. Health Boards and local authorities already work closely and successfully together at the community and service planning level as well as co-operating on the joint delivery and management of specific services. The Bill does not propose any changes to these management and working systems and processes.

**Sustainable Development**

38. The Bill will have no impact on sustainable development.
HEALTH BOARD ELECTIONS (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL

DELEGATED POWERS MEMORANDUM

PURPOSE

1. This memorandum has been prepared by the Scottish Government in accordance with Rule 9.4A of the Parliament’s Standing Orders, in relation to the Health Boards (Membership and Elections) (Scotland) Bill. It describes the purpose of each of the subordinate legislation provisions and outlines the reasons for seeking the proposed powers. This memorandum should be read in conjunction with the Explanatory Notes, Policy Memorandum and Financial Memorandum for the Bill.

OUTLINE AND SCOPE OF THE BILL PROVISIONS

2. The Bill makes provision regarding the constitution of Health Boards and amends the National Health Service (Scotland) Act 1978 (“the 1978 Act”) to provide for Health Board elections. Such elections will be piloted in Health Board areas specified in the pilot order to be made under section 4. Following the pilots, the Scottish Ministers must publish a report, which must contain an evaluation of the pilots, and lay a copy of it before the Scottish Parliament. Following this, the Scottish Ministers may by order roll-out Health Board elections across Scotland. The Bill makes provision to extend the functions of the Local Government Boundary Commission should wards be required in Health Board areas. It also provides that individuals aged 16 and over are entitled to vote at a Health Board election and makes some minor and consequential amendments.

3. The scope of the Bill is restricted to the constitution of Health Boards. The Bill is not concerned with the functions of Health Boards.

SECTIONS OF THE BILL

4. The Bill is divided into twelve sections and a schedule which deal with the following proposed measures—

- Section 1 (constitution of Health Boards) amends Schedule 1 to the 1978 Act (which makes provision about the constitution of Health Boards). This provides that a Health Board is to consist of appointed members (including an appointed chairman), councillor members and elected members, but the total number of councillor
This document relates to the Health Board Elections (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

members and elected members must amount to more than half the total number of members. Further amendments are made as a consequence of this, including the insertion of new paragraph 10A which provides for the period an elected member holds office and confers a power on the Scottish Ministers to make regulations about the tenure of office of elected members.

- Sections 2 and 3 (elected members of Health Boards) amend the 1978 Act to provide for Health Board elections and the Scottish Ministers’ powers in relation to elected members. Section 2 inserts into section 2 of 1978 Act a new subsection (10A), which introducing new Schedule 1A which makes provision for the election of individuals to be members of Health Boards, and it also inserts new Schedule 1A. New Schedule 1A includes a number of regulation making powers regarding the timing of Health Board elections, electoral wards, conduct of elections, candidates, franchise, election expenses and vacancies. The provision on franchise provides that individuals aged 16 and over are entitled to vote at a Health Board election. Section 3 amends section 77(2) of the 1978 Act to provide that the Scottish Ministers may hold an election following an order declaring a Health Board to be in default.

- Section 4 (pilot scheme) provides that the Scottish Ministers may by the pilot order appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the pilot order. It also provides that the Scottish Ministers may make one order only and that the order may make such modifications to sections 1 to 3 as the Scottish Ministers consider appropriate.

- Section 5 (report on pilot scheme) provides that no later than 5 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order, the Scottish Ministers must publish a report, which must contain various matters, including an evaluation of the pilot, and lay a copy of it before the Scottish Parliament.

- Section 6 (termination of pilot scheme) provides that the pilot order is revoked on the day falling 7 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order. If the pilot order is revoked before a roll-out order is made, then, on the day the pilot order is revoked, sections 1 to 7 and paragraph 2 of the schedule are repealed. In other words, the pilot scheme is terminated and it no longer becomes possible to hold elections in any Health Board area.

- Section 7 (roll-out) provides that the Scottish Ministers may by roll-out order appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. When a roll-out order is made it has the effect of repealing section 6 (thus ensuring the Health Boards running the pilot scheme can continue to hold elections on a permanent basis). The roll-out order may make provision adding to, replacing or omitting any part of the text of, or otherwise modifying, any enactment as the Scottish Ministers consider appropriate.

- Sections 8 to 12 (final provisions) provide for minor and consequential amendments, key terms, orders, commencement and short title.

- The schedule (minor and consequential amendments) provides for minor and consequential amendments to the 1978 Act and the Public Appointments and Public Bodies etc. (Scotland) Act 2003.
5. Further information about the Bill’s provisions are contained in the Explanatory Notes and Financial Memorandum published separately as SP Bill 13–EN, and in the Policy Memorandum published separately as SP Bill 13–PM.

RATIONALE FOR SUBORDINATE LEGISLATION

6. The Bill contains a number of delegated powers provisions which are explained in more detail below. The Government has had regard when deciding where and how provision should be set out in subordinate legislation rather than on the face of the Bill to—

- the need to strike the right balance between the importance of the issue and providing flexibility to respond to changing circumstances;
- the need to make proper use of valuable Parliamentary time;
- the need to ensure that other areas of regulation can be developed in a coherent and consistent way by other authorities;
- the likely frequency of amendment;
- the possible need to change provisions in a co-ordinated way, for example to react to changes in approach when considering roll-out;
- the need to anticipate the unexpected, which might otherwise frustrate the purpose of the provision in primary legislation approved by Parliament.

7. Where subordinate legislation is required to implement Government policy some form of parliamentary procedure may be appropriate. A balance must be struck between the different levels of scrutiny involved in the procedures. In the Bill the balance reflects the view of the Government on the importance of the matter delegated by Parliament.

DELEGATED POWERS

8. This Memorandum describes the provisions of the Bill which confer power to make subordinate legislation. It sets out—

- the persons upon whom the power to make subordinate legislation is conferred and the form in which the power is to be exercised;
- why it is considered appropriate to delegate the power to subordinate legislation and the purpose of each such provision;
- the Parliamentary procedure, if any, to which the exercise of the power to make subordinate legislation is to be subject.

Section 1(2) (constitution of Health Boards) – Power to specify the total number of members of the Health Board and the number of each type of member

New paragraph 2(2) of Schedule 1 to the 1978 Act

Power conferred on: Scottish Ministers
Power exercisable by: Regulations made by Statutory Instrument
Parliamentary procedure: Negative resolution procedure
This document relates to the Health Board Elections (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

Provision

9. Section 1(2) of the Bill inserts a new paragraph 2(2) into Schedule 1 to the 1978 Act to give the Scottish Ministers powers to make regulations that must specify the total number of members of each Health Board and the number of each type of member on those Boards.

Reason for taking this power

10. It is considered appropriate to delegate the power to subordinate legislation because specifying the numbers of members and indeed the types of members for each Health Board may need amendment from time to time; for example to react to changes in approach required when considering roll-out or because the overall boundaries of Health Boards have been changed.

Choice of procedure

11. Statutory instruments made by virtue of Schedule 1 to the 1978 Act are subject to negative procedure in accordance with section 105(2) of the 1978 Act. Given that this is a power to be added to that Schedule, the Government considers that there should be no amendment to section 105 of the Act to make the election regulations subject to affirmative resolution procedure. The key point of interest as regards the number of each type of member on Health Boards is to do with which types of members will form the majority. That is specifically provided for in the Bill (see new paragraph 2(3)(a)). Beyond that, there is no significant public interest, so affirmative procedure is not considered appropriate. The regulations will therefore be subject to negative resolution procedure.

Section 1(5) (constitution of Health Boards) – Power to specify the circumstances in which an elected member must vacate office

New paragraph 10A(2) of Schedule 1 to the 1978 Act

Power conferred on: Scottish Ministers
Power exercisable by: Regulations made by Statutory Instrument
Parliamentary procedure: Negative resolution procedure

Provision

12. Section 1(5) of the Bill inserts a new paragraph 10A(2) into Schedule 1 to the 1978 Act to give the Scottish Ministers powers to make regulations that may specify the circumstances in which (a) an elected member must vacate office before the end of the period that a member normally holds office for, and (b) the Scottish Ministers may determine that an elected member is to vacate office before the end of that period.

Reason for taking this power

13. It is considered appropriate to delegate the power to subordinate legislation because specifying the circumstances in which an elected member must vacate office may need amendment from time to time, for example to react to changes in other areas of the law dealing with circumstances which might indicate that a person is not fit to be a Health Board member (such as insolvency or an area of criminal law). This is also consistent with the approach already
This document relates to the Health Board Elections (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

taken in paragraph 11 of Schedule 1 to the 1978 Act in respect of existing Health Board members (who are all currently appointed by the Scottish Ministers).

Choice of procedure

14. Statutory instruments made by virtue of Schedule 1 to the 1978 Act are subject to negative procedure in accordance with section 105(2) of the 1978 Act. Given that this is a power to be added to that Schedule, the Government consider that there should be no amendment to section 105 of the Act to make these regulations subject to affirmative resolution procedure. Further, there is no significant public interest, so affirmative procedure is not considered appropriate. The regulations will be subject to negative resolution procedure as are the current regulations dealing with the tenure and vacation of office of existing members (note that section 1(6) of the Bill makes a small amendment to the existing power in paragraph 11(a) of Schedule 1 to ensure that the powers relating to elected members and those relating to appointed members and councillor members are analogous).

Section 2(2) (Health Board elections) – Powers to make “election regulations”

Paragraph 13 of new Schedule 1A to the 1978 Act

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<tr>
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<tr>
<td>Power exercisable by:</td>
<td>Regulations made by Statutory Instrument</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative resolution procedure</td>
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Provision

15. Section 2(2) of the Bill inserts new Schedule 1A into the 1978 Act. This Schedule provides for Health Board elections. Paragraph 13 of Schedule 1A gives the Scottish Ministers powers to make regulations to be known as “election regulations” which can cover a range of things to do with Health Board elections. In particular, the preceding paragraphs of Schedule 1A specify that the power can be used to make the following provision—

- Paragraph 2(1) - Specify the day for the first election in a Health Board area;
- Paragraph 2(2) – Specify different days for different Health Board areas;
- Paragraph 3(1) - Specify that a Health Board area is to be divided into more than one ward (where the Scottish Ministers decide that a Health Board area is not to be comprised of a single ward);
- Paragraph 3(2)(a) - Specify the number of electoral wards in a Health Board area (if the area is to be divided);
- Paragraph 3(2)(b) - Specify the boundaries of those wards (again, only where the Scottish Ministers decide that a Health Board area is not to be comprised of a single ward);
- Paragraph 4(2)(a) - Make provision about the tenure and vacation of office of a returning officer;
- Paragraph 4(2)(b) - Make provision about the functions of the returning officer;
Paragraph 4(2)(c) - Make provision about the payment of the returning officer’s fees and expenses;
Paragraph 4(2)(d) - Make provision about any other matters relating to returning officers that the Scottish Ministers consider appropriate;
Paragraph 5(1) - Specify the “nomination period” and other requirements regarding the nomination of candidates;
Paragraph 6 - Specify the number of elected members to be elected in each electoral ward;
Paragraph 8(3)(a) - Make provision about the manner in which and period during which votes may be cast;
Paragraph 8(3)(b) - Make provision about the form and content of ballot papers;
Paragraph 8(3)(c) - Make provision about the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated;
Paragraph 8(3)(d) - Make provision about the procedure for counting votes;
Paragraph 8(3)(e) - Make provision about the declaration of the results of the poll;
Paragraph 9(a) - Make provision about who is qualified to be a candidate in a Health Board election;
Paragraph 9(b) - Make provision about the circumstances in which an individual may be disqualified from being a candidate;
Paragraph 10(1)(b) - Specify criteria regarding entitlement to vote;
Paragraph 10(2) - Determine, or set out criteria for determining, the electoral ward in which an individual is entitled to vote;
Paragraph 11 - Make provision about expenses which may be incurred by a person in connection with a Health Board election;
Paragraph 12(2)(b) - Make provision about appointing an individual to fill a vacancy;
Paragraph 12(5) - Specify criteria for identifying an “unelected candidate”.

16. As mentioned above, paragraph 13 of Schedule 1A confers on the Scottish Ministers the power to make election regulations. Sub-paragraph (1) provides that the Scottish Ministers may make election regulations in relation to any matter specified in the Schedule (set out above). Sub-paragraph (2) provides that election regulations may make further provision about Health Board elections. Sub-paragraphs (3) and (4) provide that in particular, election regulations may provide that an enactment (including an Act of the Scottish Parliament and any instruments made under such an Act) applies (with or without modifications specified in the regulations) or does not apply to Health Board elections.

Reason for taking this power

17. It is considered appropriate to delegate the power to provide for the detail of election regulations to subordinate legislation because these technical details may need amendment from time to time, for example to react to changes in established best practice in administering
This document relates to the Health Board Elections (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

elections or to cater for technological developments in the manner in which votes may be cast. The view is taken that this strikes the right balance between the importance of the issue and providing flexibility to respond to challenging circumstances.

18. Regulations made under this power will be mostly technical in nature. They will deal with the complex mechanics of conducting elections. It is not thought appropriate to include such bulky and technical provisions within the body of a piece of primary legislation. The approach of setting out the framework of the electoral system in primary legislation and the detailed provisions in secondary legislation is commonplace. See, for example The Loch Lomond and the Trossachs National Park Elections (Scotland) Order 2002 (SSI 2002/202), The Cairngorms National Park Elections (Scotland) Order 2003 (SSI 2003/2), and The Scottish Local Government Elections Order 2007 (SSI 2007/42).

Choice of procedure

19. Statutory instruments made by virtue of Schedule 1 to the 1978 Act are subject to negative procedure in accordance with section 105(2) of the 1978 Act. Given that new Schedule 1A is an extension of Schedule 1 (Health Boards), the Government considers that there should be no amendment to section 105 of the Act to make the election regulations subject to affirmative resolution procedure. The regulations will therefore be subject to negative resolution procedure.

Ancillary powers

20. Section 105(7) of the 1978 Act will apply to the effect that the powers conferred on the Scottish Ministers to make regulations may be exercised (a) either in relation to all cases to which the power extends, or in those cases subject to exceptions, or in relation to any specified cases or classes of case, and (b) subject to such other conditions or exceptions as the Scottish Ministers think fit, and shall include power to make such supplementary, incidental, consequential, transitory or saving provision as appears to the Scottish Ministers to be expedient.

Draft regulations

21. Although these regulations will be mostly technical in nature they will nevertheless be of significant size. The Government therefore intends to provide the lead committee with draft election regulations for consideration at Stage 1 of the Bill.

Section 4(1) (elected members: pilot scheme) – Powers to make the “pilot order”

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<td>Parliamentary procedure:</td>
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Provision

22. Section 4(1) of the Bill provides that the Scottish Ministers may by pilot order appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order. Subsection (2) provides that Ministers may make one pilot order only (but this does not affect the Ministers’ power to modify or revoke the order).
Reason for taking this power

23. This order is essentially a commencement order which will commence the substantive provisions of the Bill in respect of some Health Board areas so that the changes to Health Boards and the system of elections set out in the Bill can be piloted in those areas. By commencing the provisions by order, Ministers are able to be flexible about the starting date for the pilot elections. The order can therefore commence the pilots on a date that is appropriate for the Health Boards concerned, taking account of various factors such as the practical aspects of setting up the new elections. This degree of flexibility is common in respect of commencement powers.

24. Other than stating the commencement date and naming the Health Board areas to which it will relate, the pilot order is not intended to contain any further substantive provision. The order may contain such modifications of sections 1 to 3 as Ministers consider appropriate (subsection (3)). This is necessary to ensure that those provisions work in the context of a pilot scheme which is to be followed by an evaluation process before full roll-out. For example, sections 1 to 3 are quite properly drafted as if the elections system will, once up and running, continue for a number of electoral cycles but in the case of the pilot schemes it may not be appropriate to have the electoral cycle fixed as 4 years.

Choice of procedure

25. The pilot order is therefore nothing more than a commencement order and, as with any other commencement order, it is not considered appropriate to make it subject to any parliamentary procedure. If Parliament passes the Bill, it will have agreed that the changes to Health Boards set out in sections 1 to 3 are to be piloted in certain areas (as it will have agreed to section 4 of the Bill). The decision as to when to commence the pilot scheme is a matter of commencement of the Act passed by the Parliament and is something which is conventionally considered to be a matter for the Government.

Section 7(1) (roll-out) – Powers to make a “roll-out order”

**Power conferred on:** Scottish Ministers  
**Power exercisable by:** Order made by Statutory Instrument  
**Parliamentary procedure:** Negative resolution procedure

Provision

26. Section 7(1) of the Bill gives the Scottish Ministers power to make a roll-out order to appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. When a roll-out order is first made it has the effect of repealing section 6 of the Bill (see subsection (2)). Subsection (3) provides that a statutory instrument containing a roll-out order may not be made unless a report has been published under section 5(1) and that statutory instrument is subject to negative resolution procedure. Note that more than one roll-out order may be made. This allows for a staged approach to commencement following evaluation of the pilot schemes.
This document relates to the Health Board Elections (Membership and Elections) (Scotland) Bill (SP Bill 13) as introduced in the Scottish Parliament on 25 June 2008

Reason for taking this power

27. As with the pilot order it is important to have a degree of flexibility in specifying when the provisions of the Bill come into force in respect of each Health Board. Commencement by order delivers that flexibility.

Choice of procedure

28. Again, a roll-out order is essentially a commencement order which will commence the substantive elements of the Bill in respect of the areas where they were not commenced by the pilot order. In accordance with convention it ought to be subject to no parliamentary procedure given that Parliament will, by passing the Bill, have agreed to the concept of the substantive elements of the Bill being rolled-out following an evaluation report being published. However the Government considers an order made under this section to be an exceptional kind of commencement order because a roll-out order may do more than merely commence provisions of the Bill.

29. Firstly, when the first roll-out order is made it will have the effect of repealing section 6 and therefore nullifying the self-repealing provision in that section which ensures that any decision on roll-out has to be taken within a time limit. Clearly Parliament, if it passes the Bill, will also have agreed to that self-repealing time-limit. The Government therefore considers it appropriate to attach Parliamentary procedure to any order which rolls out the substantive provisions of the Bill to more areas whilst also overriding and eradicating the self-repealing time limit.

30. Secondly, a roll-out order may make provision adding to, replacing or omitting any part of the text of, or otherwise modifying, any enactment as Ministers consider appropriate (section 7(4)). This power may be used to make technical adjustments to ensure the smooth transition from the pilot schemes (for example, so as to ensure that all areas are put onto the same electoral cycle it may be necessary to deem the next elections held in the pilot areas to be the first elections in terms of paragraph 2 of new Schedule 1A to the 1978 Act). However it may also be used to make more substantive changes in consequence of findings of the evaluation report. In light of that, the Government considers it appropriate for such an order to attract parliamentary procedure. So despite roll-out orders being primarily about commencement they will be subject to negative resolution procedure. This strikes an appropriate balance between ensuring anything done in such an order which is not a simple commencement provision is brought to the attention of the Parliament and avoiding over-burdening the Parliamentary timetable with technical commencement orders.

Section 10 (Orders)

Provision

31. Section 10 of the Bill contains general subordinate legislation provisions. Subsection (1) provides that the powers in the Bill to make orders are exercisable by statutory instrument. Subsection (2) allows different provisions to be made for different purposes (in particular, for different Health Board areas) and permits the powers to be used to make supplementary, incidental, consequential, transitional, transitory or saving provisions which Ministers consider appropriate.
Section 11(3) (commencement) – Powers to appoint a day on which section 8 and the schedule will come into force

Power conferred on: Scottish Ministers  
Power exercisable by: Order made by Statutory Instrument  
Parliamentary procedure: None

Provision

32. Section 11(3) of the Bill gives the Scottish Ministers powers to appoint a day on which section 8 and the schedule will come into force.

Reason for taking this power

33. These provisions are intended to come into force following the pilot elections for the pilot areas and, if roll-out is agreed, following the first Health Board elections for the rest of Scotland. Therefore, the Scottish Ministers require flexibility in the appointed day.

Choice of procedure

34. As with any standard commencement order, orders under section 11(3) will be not be subject to any Parliamentary procedure.

The Schedule, paragraph 1 – amendment of paragraph 4 of Schedule 1 to the 1978 Act

Power conferred on: Scottish Ministers  
Power exercisable by: Order made by Statutory Instrument  
Parliamentary procedure: Negative resolution procedure

Provision

35. Paragraph 1 of the Schedule amends paragraph 4 of Schedule 1 to the 1978 Act by extending the categories of persons to whom the Scottish Ministers may pay remuneration to include such members of committees and sub-committees of a Health Board as they may prescribe. This extension recognises the fact that committees and sub-committees of Boards may undertake work for which remuneration would be available if it were undertaken by Health Board members.

Reason for taking this power and choice of procedure

36. This is an extension of the existing power of Scottish Ministers under paragraph 4 of Schedule 1 to the 1978 Act to prescribe the members of a Health Board to whom remuneration can be paid. As with that power, the power to prescribe members of committees and sub-committees of a Health Board to whom remuneration may be paid will be exercised by statutory instrument subject to negative procedure in terms of section 105(2) of the 1978 Act.
Amendment of the Health Boards (Membership and Procedure) (Scotland) Regulations 2001

37. The Government intends to amend the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302) for the Health Boards specified in the pilot order to implement the changes which will be necessary for those Boards as a result of bringing sections 1-3 of the Bill into force.
Health and Sport Committee

7th Report, 2008 (Session 3)

Stage 1 Report on the Health Boards (Membership and Elections) (Scotland) Bill

Volume 1: Report

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Health and Sport Committee
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Volume 1

Remit and membership

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Health and Sport Committee

Remit and membership

Remit:

To consider and report on (a) health policy and the NHS in Scotland and other matters falling within the responsibility of the Cabinet Secretary for Health and Wellbeing and (b) matters relating to sport falling within the responsibility of the Minister for Communities and Sport.

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INTRODUCTION

1. The Health Boards (Membership and Elections) (Scotland) Bill ("the Bill") was introduced by Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing ("the Cabinet Secretary"), on 25 June 2008. The Bill is accompanied by Explanatory Notes (SP Bill 13-EN), which include a Financial Memorandum, and a Policy Memorandum (SP Bill 13-PM), as required by the Parliament’s Standing Orders. The Parliament designated the Health and Sport Committee as lead committee for the Bill. Under Rule 9.6 of the Parliament's Standing Orders, it is for the lead committee to report to the Parliament on the general principles of the Bill.

2. This report sets out the policy intention behind the Bill and gives a brief overview of its main provisions, the Scottish Government’s consultation and the Committee’s scrutiny. It goes on to consider the likely impacts of the Bill on public involvement in NHS Scotland and the accountability of health boards and their members. In the remaining sections, the report considers the Bill’s provisions relating to the composition of health boards, arrangements for health board elections, the pilot and evaluation process, the Financial Memorandum and powers to make subordinate legislation. The Committee’s conclusions on the principles of the Bill are given at the end of the report.

Policy intention

3. The Policy Memorandum places the Bill within the context of the Scottish Government’s Better Health, Better Care action plan. It describes the Bill’s aims as—

- improving public and community engagement and involvement;

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• giving practical effect to the mutual/co-ownership concept of the NHS in Scotland by giving the public (the co-owners) the opportunity to vote onto their local health board their own representatives; and

• allowing the public voice to be heard and listened to at the heart of the decision-making process of health boards.2

Provisions of the Bill

4. The Bill provides for the introduction of direct elections to health boards, by way of pilots. At present, health boards are appointed entirely by Scottish Ministers through the public appointments process. Directors may be (a) senior employees of the health board, who serve as executive directors, or (b) non-executive directors. Local councillors have also been appointed as non-executive directors of health boards. The proportion of the board made up by executive and non-executive directors varies across Scotland.3

5. The Bill proposes that health boards would consist of three categories of member: a chairman and other members appointed by Scottish Ministers, local councillors also appointed by Scottish Ministers and members directly elected on a four-year mandate. The Bill further provides that councillor members and directly elected members counted together must form a majority of the board and that at least one councillor is appointed from each local authority within the health board area.4

6. Arrangements for holding health board elections are partly set out on the face of the Bill, with much of the detail left to subordinate legislation. The Scottish Government has provided the Committee with drafts of the regulations that are expected to be laid under the Bill. The Bill and draft regulations envisage an election using a form of single transferable vote, treating most health board areas as a single ward, with people eligible to vote from age 16.5

7. As noted above, the Bill provides that elections to health boards would be introduced on a pilot basis. The draft regulations and Financial Memorandum are premised on pilots being held in two health board areas. The Bill specifies that the pilots are to last for up to seven years, with the roll-out of direct elections to be authorised through subordinate legislation after an evaluation report has been laid before the Scottish Parliament.6

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3 Cabinet Secretary for Health and Wellbeing, written submission to the Health and Sport Committee, 2 September 2008
4 Health Boards (Membership and Elections) (Scotland) Bill section 1(2), and section 2(2) inserted schedule 1A paragraph 2(3). Available at: http://www.scottish.parliament.uk/s3/bills/13-HealthBoards/b13s3-introd.pdf [Accessed 11 December 2008]
5 Scottish Government, written submission to the Health and Sport Committee, 29 November 2008; Health Boards (Membership and Elections) (Scotland) Bill section 2(2) inserted schedule 1A paragraph 10(1)
6 Health Boards (Membership and Elections) (Scotland) Bill section 6(1), and section 7
Scottish Government consultation

8. The Scottish Government’s consultation on the proposals in the Bill ran from 8 January 2008 until 1 April 2008. The consultation paper was split into two sections: the first section dealt with existing arrangements to improve patient engagement with the NHS; the second section covered proposals to introduce direct elections to health boards. The Scottish Government received 142 responses to its consultation and published the Local Healthcare Bill Consultation: Analysis of Responses on 3 July 2008.

Committee scrutiny

9. The Committee issued a call for evidence on 2 July 2008 and received 59 written submissions from public, private and voluntary sector organisations as well as members of the public. On the basis of the written evidence received, the Committee took oral evidence from—

- Scottish Government officials (5 November 2008);
- NHS Ayrshire and Arran, NHS Lothian, NHS Tayside, the Electoral Commission, the Association of Electoral Administrators (Scotland and Northern Ireland Branch) (“AEA”) and the Society of Local Authority Chief Executives (“SOLACE”) (12 November 2008);
- the British Medical Association (“BMA”), Royal College of Nursing Scotland (“RCN”), UNISON, the Convention of Scottish Local Authorities (COSLA), South Lanarkshire Council, West Lothian Council, Consumer Focus Scotland, Inclusion Scotland and Voluntary Health Scotland (19 November 2008);
- the Cabinet Secretary for Health and Wellbeing (26 November 2008).

10. The Committee thanks all those who made submissions in response to the call for evidence and gave oral evidence. Written submissions received by the Committee and Official Reports of the oral evidence taken are annexed to this report.

PUBLIC PARTICIPATION IN THE HEALTH SERVICE

11. As stated earlier in this report, two of the key aims of this legislation as set out in the Policy Memorandum are to lead to more members of the public becoming involved in the health service and to give patients a greater say in how the health service is run.

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12. Establishing whether health board elections encourage public involvement is one of the key aims of the pilot process. Section 5(1) of the Bill specifies that the evaluation of the pilots to be laid before the Parliament must contain an assessment as to whether elected members have “led to increased engagement with patients and other members of the public”.\(^9\)

**Giving the public a greater say**

13. Of the 54 responses to the Committee analysed by the Scottish Parliament Information Centre (“SPiCe”), 20 were grouped as “unclear or made no comment” on the principle of direct elections to health boards. Of the remaining 34 responses, opinion was split: 15 (44%) were in favour of direct elections and 19 (56%) were against.\(^10\)

14. Many of the individuals and organisations that responded to the Committee’s call for evidence believed that the views of the public were not adequately represented within health-service decision-making, although their views differed on direct elections.

15. COSLA told the Committee that, when their health and wellbeing executive group discussed the issue,—

> “...many views were expressed on how we should achieve a more democratic and publicly accountable health board system. However, it was clear that the current system was acceptable to no member in the room. Some wanted directly elected boards and some wanted an increase in council representation, but everybody wanted more elected people at the table”.\(^11\)

16. UNISON told the Committee that it believed that the democratic element in health boards “is indirect in the extreme” and that its support for direct elections in public services was a point of principle.\(^12\) UNISON’s representative told the Committee—

> “The key point is that, since it was created in 1948, the NHS has not been directly accountable to and engaged with the public. It has been a top-down organisation—a we-know-best organisation that thinks that all the issues are far too complicated for mere mortals to understand and that democracy is therefore not appropriate. We have to change that culture, and that is why direct elections have come in.”\(^13\)

17. Some organisations argued that a significant benefit of having directly elected members is that they would be more accessible to the public. MS Society

\(^9\) Health Boards (Membership and Elections) (Scotland) Bill section 5(1)(c)


Scotland said that it envisaged elected members being “more accessible and amenable” to meeting with patient groups and charities.\textsuperscript{14} Howwood Community Council suggested the practice of elected representatives regularly holding surgeries with their electorate, as MSPs and MPs do, as an example of how having elected representatives on boards could improve patient engagement.\textsuperscript{15}

18. Organisations that were sceptical about direct elections, such as Consumer Focus Scotland, argued that this democratic element already exists, through boards’ accountability to ministers and the Parliament.\textsuperscript{16} The Royal College of Nursing argued that the public were already entitled to sit on health boards, by being appointed as non-executive directors.\textsuperscript{17} Some of those who submitted evidence, including an experienced non-executive director, argued that making the non-executive appointment route more accessible and giving extra support to non-executive directors was an alternative to direct election.\textsuperscript{18}

19. Some local authorities, such as South Lanarkshire Council, argued that greater democratic representation on health boards was desirable, but would be better achieved by increasing the number of local councillors on boards instead of direct elections. They drew attention to the increasing areas of joint working between councils and health boards and expressed the belief that, in view of councillors’ existing mandate to represent local people, there was no need to create an additional group of elected people with a potentially conflicting mandate.\textsuperscript{19}

20. The NHS boards that gave oral evidence generally accepted the need for greater public involvement and engagement in the service delivery of boards, but expressed scepticism about whether directly elected board members would achieve that aim. They also expressed reservations about the impact on the corporate governance and accountability of NHS Boards of having some members directly elected and others appointed.

21. The Cabinet Secretary told the Committee that patients and the public have a right to be heard in health board decision-making as co-owners of the NHS—

“Health boards take decisions on how vast amounts of taxpayers’ money are spent, which impacts on the most cherished and cared-about services in the country, so it is right that the population at large have a say over who sits on those boards, to make them more representative and more democratically credible.”\textsuperscript{20}

22. The Committee acknowledges the steps that have been taken to improve consultation by health boards with the public but notes, however, that the experience remains mixed. The Committee considers that there is a

\textsuperscript{14} MS Society Scotland, written submission to the Health and Sport Committee
\textsuperscript{15} Howwood Community Council, written submission to the Health and Sport Committee
\textsuperscript{18} Geraldine Strickland, written submission to the Health and Sport Committee
\textsuperscript{19} South Lanarkshire Council, written submission to the Health and Sport Committee
difference between the public having a right to be heard and the willingness of health boards actively to listen and reflect public concerns.

Diversifying public engagement

23. Some organisations suggested that direct elections would allow groups that found it difficult to participate in existing NHS structures, for example by being appointed as non-executive directors, greater opportunity to have a say in the running of the NHS. Representatives of Inclusion Scotland told the Committee that the appointments system “is dramatically failing disabled people and patients”, pointing to figures showing that 2% of appointees to public bodies are disabled, compared to 20% of the general population. They identified direct election as a possible opportunity for “people from all backgrounds to get involved”.21 However, they also noted that disabled people would face barriers to election that would need be overcome and expressed concern that disabled people who were elected could lose out financially as remuneration would be “clawed back” through the benefits system.22

24. Voluntary Health Scotland also felt that direct elections could widen participation by opening “a channel” for hard-to-reach or excluded groups to get involved with the support of third-sector organisations.23

25. While these two organisations saw direct elections as opening up opportunities for traditionally excluded groups, some respondents were concerned that direct election could further exclude them. For example, BMA Scotland cited evidence from New Zealand suggesting that those standing for direct election tended to come from health professional, local authority or other professional backgrounds and not from groups that did not previously engage with the health service.24 Stonewall Scotland raised concerns that moving away from the public appointments process would make the NHS “the only public service that is not guaranteed to have full cultural competence” and may marginalise unpopular minority groups.25

26. NHS Lothian told the Committee that it was already undertaking work to bring previously excluded groups into public engagement initiatives and expressed doubts that direct elections would assist in this process—

“On direct elections, we should bear it in mind that broad sections of the population do not engage with such processes […] we would want to use resources that would be expended on such elections to reach out to sections of the population with whom we have difficulty engaging on health and health inequalities issues, and who are unlikely to engage in a normal democratic process.”26

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22 Inclusion Scotland, supplementary written submission to the Health and Sport Committee
25 Stonewall Scotland, written submission to the Health and Sport Committee
27. The Cabinet Secretary told us that direct elections would allow health boards to better represent the “broad spectrum of opinions in the areas they represent”.27 She believed that the single transferable vote would help achieve this and that the impact on equality and diversity would be assessed as part of the evaluation of direct election pilots – although she did not believe that they were sufficient to solve some of the problems in themselves.28 She said—

“… boards with a majority of locally elected members will be able to confront issues and decisions with additional credibility and will help to re-establish public confidence in the decision-making process.”29

28. The Committee is concerned that efforts to promote diversity among appointees to public bodies appear to be failing. It is hoped that direct elections would have a positive role to play in this respect but the Committee has seen little concrete evidence to suggest this. The Committee therefore believes that elections alone will not be sufficient to bring about the change that is required. The Committee agrees with the Cabinet Secretary that any pilots should be subject to a rigorous evaluation of their impact on the diversity of people sitting on health boards. The Committee believes that it is important that this evaluation should also assess whether direct elections have made equalities issues more integral in the implementation of policies by pilot boards.

Impact on existing public participation schemes

29. As indicated above, some organisations made reference to existing initiatives being undertaken to improve public engagement. These initiatives include the development of public partnership forums within community health partnerships and the creation of independent scrutiny panels to examine controversial decisions. Evidence on their effectiveness was mixed. For example, NHS Tayside told the Committee that public partnership forums had done “a tremendous amount of excellent work” but that they were “not the whole answer” as their membership was not representative. They went on to outline other work in areas such as patient groups for particular conditions, voluntary groups and so forth.30

30. Our respondents disagreed on the implications of direct elections for these schemes. Organisations in favour of direct election tended to express the view that the two approaches would be mutually reinforcing. For example, Voluntary Health Scotland told the Committee that direct election would add a new “channel” for people to become involved in the health service that would complement existing initiatives. UNISON argued that “democracy is about the opportunity to engage at different levels” and that public engagement initiatives are “not a substitute for having a say at the top level in the organisation”.31

31. Organisations that were more sceptical about direct elections tended to view them as being in conflict with, or an alternative to, existing initiatives to increase public involvement. For example, BMA Scotland expressed concerns that policy emphasis would shift to direct elections to the detriment of existing initiatives, without the latter having had the time or resources to prove to be truly effective.\(^{32}\) NHS Lothian and NHS Tayside both indicated that the resources to fund health board elections would probably come at the expense of investment in other forms of public engagement.\(^{33}\)

32. The Cabinet Secretary told the Committee that she did not believe direct elections were incompatible with other initiatives to promote public engagement. She said—

“... the Government is committed to improving public engagement and involvement with health boards through further work with existing bodies, including community health partnerships and initiatives such as the development of a participation standard. However, direct elections represent a significant step in addition to strengthening engagement and involvement in ensuring that the public voice is heard and listened to at the heart of local national health service decision taking.”\(^{34}\)

33. The Committee recognises that progress has been made in consulting the public since 1999 but considers that NHS boards have yet to achieve adequate public participation and accountability.

34. The Committee believes that initiatives such as public participation forums are not mutually exclusive with direct elections and have the potential to complement them. However, the Committee accepts the point made by NHS boards that funding direct elections from existing health board allocations could have resource implications for other schemes to improve public participation.

**Participation in elections**

35. There was scepticism from some organisations that elections would be greeted with enthusiasm among the public. Several organisations, such as West Lothian Public Partnership Forum, cited relatively low turnouts in local and national government elections as evidence that there would be little public interest in voting in, or standing for, health board elections.\(^ {35}\) MS Society Scotland expressed support for direct elections; however, it was concerned that low turnout and higher-than-expected electoral costs could undermine elected members’ credibility.\(^ {36}\)

36. BMA Scotland cited the experience of other countries and states that hold elections to health service bodies as evidence that elections would not encourage

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\(^{32}\) Scottish Parliament Health and Sport Committee. *Official Report, 19th November 2008*, Col 1306; British Medical Association Scotland, written submission to the Health and Sport Committee


\(^{35}\) West Lothian Public Partnership Forum, written submission to the Health and Sport Committee

\(^{36}\) MS Society Scotland, written submission to the Health and Sport Committee
widespread public participation in the NHS. It pointed to turnout figures of less
than 0.07% (1 in 1,500) in some local elections to Boards of Governors of English
Foundation Trusts. BMA Scotland also cited reports on the outcome of health
board elections in New Zealand and Saskatchewan, Canada. In the case of
Saskatchewan, it said that the turnout in the 1999 health board elections was 10%
and a 2002 report had concluded—

“... health board elections are costly, cumbersome and produce low voter
turnout and have failed to foster a more active, engaged citizenry, committed
to common goals. In light of these experiences, their continued use should be
questioned if efficient, effective participation and public commitment are
desired goals.”37

37. In the case of New Zealand, BMA Scotland cited a 2005 report stating that
elections to district health boards had failed “to make a substantial contribution to
the democratisation of health care systems in New Zealand.”38 In oral evidence,
BMA Scotland and the RCN told the Committee that the number of candidates in
these elections had fallen sharply and turnout (50% in 2001, 43% in 2007), whilst
comparable with Scottish Parliament elections, had to be seen in the context of
New Zealand general election turnouts of over 80%.39 BMA Scotland said that the
New Zealand evidence suggested that people elected to boards were themselves
quite happy with direct elections but that “the population seems turned off by the
whole thing”.40

38. The Cabinet Secretary told the Committee that the falling turnout in New
Zealand health board elections followed a trend seen in national elections over the
same period.41 The Scottish Government told the Committee that it had taken
some lessons on board from the New Zealand experience in terms of the detail of
the Bill. In relation to the effects on public engagement, it was stated—

“Perhaps the directly elected members taking their seats on district health
boards did not prove to be as big an advantage as it was thought that it
would be in bringing local people on to the health board, but on the whole
people are happy with what is now in place in New Zealand. The study stated
that there was no case for change.”42

39. The Committee notes the experience of other countries as an indicator
of how health board elections might be received by the public in Scotland.
However, it notes that these experiences suggest that turnout in such
elections would be low relative to other elections and is concerned that this
could, if it were repeated in Scotland, undermine the credibility of directly
elected representatives.

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37 Quoted in BMA Scotland, written submission to the Health and Sport Committee
38 Quoted in BMA Scotland, written submission to the Health and Sport Committee
Public participation

40. The Committee agrees that public participation in health board decision-making needs to be increased. The Committee also agrees that direct elections to health boards have the potential to improve public participation and involvement. However, the Committee has not seen enough evidence to convince it that direct elections are necessarily the most effective way to achieve this goal.

ACCOUNTABILITY AND GOVERNANCE

Accountability of health boards

41. The Policy Memorandum for the Bill states that health boards would continue to be accountable to Scottish Ministers and would be required to comply with regulations and ministerial directions. In oral evidence to the Committee, Scottish Government officials told the Committee that accountability would remain with Scottish Ministers and directly elected health board members would be bound by the same corporate governance arrangements as non-elected members. In particular, elected board members would be expected to “maintain the board’s unity and solidarity rather than take up opposing positions”. The Cabinet Secretary reiterated this and stated that training would be in place for new board members.

42. Despite this, many of those who submitted evidence to the Committee were of the opinion that the presence of elected members would, in practice, lead to a change in the accountability of health boards. Some organisations supported this perceived shift in accountability as a major benefit of the Bill. For example, UNISON told the Committee that, whilst corporate governance arrangements would remain in place, “a form of local accountability” would also be created. It argued that this could lead to a culture change in the NHS. UNISON also argued for a “more local government-style model, whereby executive members would become advisers and officers to the health board” and directly elected members only would constitute the majority of elected members on the board.

43. Local Health Concern expressed similar views, identifying boards’ accountability to ministers as “the problem at present”. Its argument was that board members, including those appointed to give the “impression of public involvement”, cannot put the public’s views due to the risk of de-selection.

44. Similarly, Voluntary Health Scotland stated——
“Within the health-facing third sector in Scotland there is a generalised belief that health services should be accountable both to ministers and to the people they serve and whose taxes have enabled the NHS to exist.”\textsuperscript{50}

45. Other organisations, particularly NHS boards, expressed concern that the presence of directly elected members could confuse accountability and damage the national cohesion of the NHS. They saw a tension between boards as a whole being accountable to ministers but directly elected members considering themselves accountable primarily to their electorate. For example, the Chairman of NHS Lothian told us—

“My concern is that directly elected members might consider their sole accountability and loyalty to be to those who elected them, which could make them out of step with Government policy and the board’s agreed policy.”\textsuperscript{51}

46. NHS Tayside echoed this point, adding that ensuring boards’ compliance with decisions made by central government “would be a major problem.”\textsuperscript{52}

47. NHS Lothian was also concerned about the election of single-issue candidates, which they thought could “destabilise” boards.\textsuperscript{53} NHS Ayrshire and Arran was concerned that national policies decided by ministers could be opposed by councillors and elected members who, together, would make up the majority of the board.\textsuperscript{54} BMA Scotland warned that the “dual accountability” of directly elected health board members could lead to “an additional, and possibly conflicting political environment at the local level.”\textsuperscript{55} A number of organisations were concerned that directly elected members could bring party politics into health boards. For example, Local Health Concern proposed prohibiting “party” candidates.\textsuperscript{56}

48. As an example of how this tension might develop, NHS Health Scotland suggested that direct elections could hinder efforts to tackle health inequalities.\textsuperscript{57} Stonewall Scotland went further, arguing that ministerial control over boards had to be firm—

“A process which relies upon campaigning to a majority creates a very real danger of ignoring excluded groups, such as lesbian, gay, bi-sexual and trans-gender people. A focus on services of high public resonance such as consultant-led maternity or blue-light A&E risks marginalising services such as mental health.”\textsuperscript{58}

49. UNISON did not believe this dual accountability would cause difficulties for elected members or boards as a whole. It argued that local authorities are

\textsuperscript{50} Voluntary Health Scotland, written submission to the Health and Sport Committee
\textsuperscript{55} BMA Scotland, written submission to the Health and Sport Committee
\textsuperscript{56} Local Health Concern, written submission to the Health and Sport Committee
\textsuperscript{57} NHS Health Scotland, written submission to the Health and Sport Committee
\textsuperscript{58} Stonewall Scotland, written submission to the Health and Sport Committee
examples of directly elected bodies subject to lines of corporate governance and statutory control. This point was also made by the City of Edinburgh Council, which called for a “statutory reference” for the role of local authority elected members, in order to recognise the need of members to represent constituency and local authority views as well as fulfilling their duties as members of the board. UNISON argued that tensions between the local priorities of elected members and national policy could have positive results, such as ensuring policy better reflected local concerns.

50. Consumer Focus Scotland did not accept the comparison with local government, arguing that there is a fundamental difference between local government and a national service such as the NHS. It expressed concern that the public would expect directly elected members to have the lead policy role, as in local government, when in fact that responsibility remained with ministers. Other organisations echoed the concern that there may be a degree of disillusionment among the public once the limitations of directly elected members’ mandate became clear. For example, the British Dental Association said—

“In instances where difficult or unpopular decisions need to be taken, the presence of elected patient representatives may be useful in giving patients a real say in how these decisions are made. However, if appointed members or ministers are able to subsequently overturn the decisions of elected patient representatives, those individuals and those who elected them could feel disenfranchised.”

51. The Cabinet Secretary told the Committee that potential tension between local and national policy would not be created by direct election to boards; potential tension already existed wherever a local decision-making body had to implement national policies. She acknowledged examples where health board decisions had been overturned by ministers. She argued that the key benefit of direct elections was that the people implementing decisions locally would be better placed and would have greater credibility in applying those decisions. Finally, she denied that the proposal would destabilise boards—

“I would not propose or pursue any policy that I thought would have destabilising effect on our boards, so I fundamentally disagree with that point of view.”

52. The Committee accepts that the Bill does not alter health boards’ accountability to ministers. The Committee agrees that this is the correct approach to take in the interests of maintaining consistent national policy and standards across the NHS. The Committee accepts that tensions may develop on some issues between local and national priorities.

60 The City of Edinburgh Council, written submission to the Health and Sport Committee
63 British Dental Association, written submission to the Health and Sport Committee
53. Directly elected members would also be accountable to their electorate for the local delivery of policies set by ministers. The Committee considers that there is a danger of disillusionment with the process and with boards if the distinction between local accountability for delivery and national accountability for policy is not fully understood by the public. The Committee recommends that the Scottish Government ensures that there are public information campaigns accompanying pilots of, and any future, direct elections in order to raise awareness of the extent of directly elected members’ role and the fact that responsibility for policy remains with ministers.

COMPOSITION OF HEALTH BOARDS

54. Section 1 of the Bill sets out the types of member that would comprise health boards. The Bill specifies that the chairman of the board would be appointed by Scottish Ministers and continues to provide for members to be appointed directly by Scottish Ministers. The Bill also provides for a least one councillor for each local authority within the health board area to be appointed to the board by Scottish Ministers and for directly elected members to sit on the board. Councillors and elected members together must form a majority of the board.

Majority of elected members

55. NHS boards told us that their concerns about accountability and the possibility of boards opposing government policy, outlined above, were partly founded on the fact that the Bill provides for elected and councillor members to comprise a majority of the board. NHS Lothian suggested that, as an alternative, a few seats on the board could be allocated to individuals elected through opt-in elections, such as those held in some English foundation trusts.

56. Against this, the City of Edinburgh Council argued that it would be inequitable to expect elected members (be they councillors or directly elected members) to contest elections based on the decision-making record of a body in which they were a minority.

57. As discussed in paragraph 42, UNISON argued that local authority members should not count towards the majority of elected members on health boards.

Local authority members

58. In addition to providing for directly elected members, the Bill provides a statutory basis for the appointment of local councillors to health boards and sets a minimum presence of one councillor from each local authority within the health board area.

59. Glasgow City Council told the Committee—

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66 Health Boards (Membership and Elections) (Scotland) Bill section 1(2)
68 The City of Edinburgh Council, written submission to the Health and Sport Committee
69 UNISON, written submission to the Health and Sport Committee
70 Health Boards (Membership and Elections) (Scotland) Bill section 1(2)
“Local authority elected members bring a perspective to Health Board membership that not only cuts across NHS and local authority services but also broader themes of Community Planning. This can be invaluable in providing a broad context to inform debate about service change and the needs of communities.”

60. Some organisations, chiefly local authorities such as South Lanarkshire Council and Argyll and Bute Council, said that they would prefer a greater proportion of the board to be comprised of local councillors as an alternative to direct elections.

61. COSLA told the Committee that there was no consensus among local authorities on the precise composition of boards. However, its Spokesman for Health and Wellbeing did express the view that directly elected members and councillors could work together on boards without tension arising between them. Of the local authorities that submitted evidence to the Committee, four were in favour of direct elections to health boards and six were opposed. A further six did not express a clear opinion either way. COSLA representatives agreed that this reflected the representations that they had received.

62. UNISON told the Committee that local councillors saw their role on health boards as ensuring joined-up working between organisations, rather than acting as representatives of their electorate. As such, it did not believe that councillors should count towards the majority of elected members on the board. COSLA and South Lanarkshire Council rejected the claim that local authority members saw their role on health boards as being different from their representative role.

63. The Scottish Health Campaigns Network said that it did not support expanding local authority representation as this was often “variable in quality”, with some councillors remaining silent on issues within their areas.

64. The Cabinet Secretary said that local authority members should be on health boards “because local authorities and health boards are increasingly jointly responsible for decisions that impact on local services.” However, she pointed out that local authorities and health boards deal with different issues, despite this increasing overlap.

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71 Glasgow City Council, written submission to the Health and Sport Committee
72 South Lanarkshire Council, written submission to the Health and Sport Committee; Argyll and Bute Council, written submission to the Health and Sport Committee
74 SPICe Briefing 08/59, page 10.
75 COSLA, supplementary written submission to the Health and Sport Committee
76 Scottish Parliament Health and Sport Committee. *Official Report,* 19th November 2008, Col 1301; UNISON, written submission to the Health and Sport Committee
78 Scottish Health Campaigns Network, written submission to the Health and Sport Committee
65. The Committee believes that local councillors have an important role to play on health boards and welcomes a statutory basis for their presence.

Executive members

66. In addition to councillors, health boards are comprised of two types of appointed member – executive members who are senior employees of the board and non-executive members who are not board employees. NHS Lothian and NHS Tayside told us that they each have six executive members of the board out of a total of 26 and 22 board members respectively.\(^{81}\)

67. The Bill would preclude certain employees of health boards from standing for election, but would continue to allow them to be appointed by Scottish Ministers.\(^{82}\) Scottish Government officials told us that they envisaged that the list of people disqualified in this way would primarily consist of those who give advice to the board on a regular basis.\(^{83}\)

68. Some of the evidence the Committee received, such as that from the Alliance of Allied Health Professionals, advocated changes to the Bill to ensure the appointment of individuals from particular professions to health boards.\(^{84}\)

69. Some organisations expressed in evidence serious misgivings about executive members of the board being members of the board or having a vote at board meetings. For example, UNISON said that the board could not hold executive officers to account when those officers have a voting place on that board. However, it said that it would like to see clinical and staff representatives to continue to have a vote on the board.\(^{85}\) COSLA agreed. Its representatives found it “strange that an officer should be able to vote on a report that he or a member of his staff will have prepared”.\(^{86}\)

70. In answer to these criticisms, the RCN said that it “could not see how taking a vote away from one or other clinical lead on a board – someone who comes to the board with specific expertise – would necessarily lead to increased public engagement.”\(^{87}\)

71. The Cabinet Secretary said—

“it is right that we retain a mix of members on health boards. Executive directors, for example, bring the necessary managerial, financial and clinical expertise to the boards’ workings.”\(^{88}\)

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\(^{82}\) Scottish Government, supplementary written submission to the Health and Sport Committee


\(^{84}\) Alliance of Allied Health Professionals, written submission to the Health and Sport Committee


72. The Committee agrees that health board employees who regularly advise the board should be prohibited from standing for election to health boards, providing that the Scottish Government clarifies that the prohibition applies only where advice is tendered in a professional capacity and subject to clarification about the application of the term ‘regularly’.

ARRANGEMENTS FOR HEALTH BOARD ELECTIONS

Voting system

73. The Bill specifies a system of preferential voting for health board elections, with the detail to be specified in regulations.\(^8\) The draft regulations seen by the Committee would introduce a form of single transferable voting (‘STV’) comparable to that used in local government elections in Scotland.\(^9\) Relatively few organisations that submitted evidence commented on the use of the single transferable vote. Those that did, for example Fairshare Voting Reform or West Lothian Council, were generally supportive.\(^1\) However, some respondents, such as the Scottish Health Campaigns Network, expressed a preference for first-past-the-post voting.\(^2\)

Electoral boundaries

74. The Bill specifies that each health board area should normally be considered a single electoral ward for the purposes of health board elections. However, it would also allow election regulations to divide health board areas into multiple wards.\(^3\) Fairshare Voting Reform expressed concern about the use of the word “ward” in this context, suggesting that it could cause confusion with the wards used for local government elections.\(^4\)

75. The Cabinet Secretary told the Committee that a single-ward system and single transferable vote would help to ensure that boards were not dominated by candidates elected on single issues. Beyond this, it would be the electors’ decision as to whom they elected and she was not concerned by single-issue candidates being elected.\(^5\) Some organisations, such as NHS Lothian, had expressed the view that candidates elected on single issues had the potential to “destabilise” boards by focusing debate on a narrow range of issues.\(^6\) West Lothian Council told the Committee that, in its experience of working with councillors with single-issue mandates, this was not a problem.\(^7\)

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\(^8\) Health Boards (Membership and Elections) (Scotland) Bill section 2 inserted schedule 1A paragraph 8
\(^9\) Scottish Government, written submission to the Health and Sport Committee, 29 October 2008,
Draft Health Board Elections (Scotland) Regulations
\(^1\) Fairshare Voting Reform, written submission to the Health and Sport Committee; West Lothian Council, written submission to the Health and Sport Committee
\(^2\) Scottish Health Campaigns Network, written submission to the Health and Sport Committee
\(^3\) Health Boards (Membership and Elections) (Scotland) Bill section 2(1), inserted schedule 1A paragraph 3(1)
\(^4\) Fairshare Voting Reform, written submission to the Health and Sport Committee
76. UNISON told the Committee that, although it favoured single wards in principle, there was a case for splitting up larger, more rural health board areas into smaller wards to ensure a more equitable geographic spread of candidates. Highland Council told the Committee that NHS Highland would, if treated as a single ward, have an electorate of 220,000 – covering two local authority areas. It said that managing an all-postal ballot covering an area of this size “is beyond the experience of local government staff”. Electoral officials described it as “a mighty undertaking”.

77. Electoral officials, the Electoral Commission and the Local Government Boundary Commission all identified potential administrative difficulties caused by a lack of coterminosity between health board and local authority electoral boundaries. SOLACE also told the Committee that there could be community planning benefits to ensuring coterminosity. However, it accepted that it would be difficult to achieve. The Scottish Government told the Committee that it had no plans to alter health board boundaries to ensure coterminosity with local authority boundaries, either for the pilots or roll-out.

78. The Committee accepts that treating health board areas as a single electoral “ward” is reasonable in principle, but may cause difficulties in larger and more diverse health board areas. It therefore believes that the flexibility shown in the Bill is sensible.

Postal ballot

79. The draft election regulations shown to the Committee propose an all-postal ballot. Under existing arrangements for postal votes in local authority and national elections, voters are required to provide “personal identifiers” – for example, a signature – to ensure the security of their vote.

80. Electoral officials told the Committee that requiring personal identifiers in all-postal ballots would require collecting those identifiers from the 85% of the voting population who do not currently use postal ballots, and could disenfranchise voters who did not wish to comply with these regulations.

81. Despite identifying additional costs and administrative burdens associated with collecting personal identifiers, both the Electoral Commission and organisations representing electoral officials expressed the view that personal identifiers should be required in the case of a postal ballot as a matter of principle. The Electoral Commission told the Committee—

99 Highland Council, written submission to the Health and Sport Committee
101 SOLACE *et al*, written submission to the Health and Sport Committee; Electoral Commission, written submission to the Health and Sport Committee; Local Government Boundary Commission, written submission to the Health and Sport Committee
104 SOLACE *et al*, written submission to the Health and Sport Committee
“The principle we abide by is that if an election takes place, regardless of what it is for, it should be robust and accepted by everyone who is involved. The principles that we follow...should apply to health board elections just as they apply to other elections, so that following such an election, everyone who is involved in it can accept the result. For postal votes, we favour the use of personal identifiers.”

82. The City of Edinburgh Council stated that, in its view, not enough safeguards existed to undertake an entirely postal ballot. It added that it they would prefer to see consistency in approach across all elections, a view shared by the organisations representing electoral officials.

83. The Cabinet Secretary told the Committee that she did not intend to require personal identifiers for the pilot elections, although she said the issue could be revisited during roll-out. Firstly, she told the Committee that their use would “significantly increase the cost of the pilots” from, on average, £2.60 per vote to around £3.60 per vote. Secondly, she said that—

“it would significantly jeopardise the timescale for the pilots, given the significant amount of work that will have to be done, not just after voting to check identifiers, but at the front end of the process to establish the personal identifiers for every person in the population.”

84. The Committee considers that health board elections should be seen to be taken as seriously as other statutory elections. The experience of the Scottish general elections in May 2007 shows that the robustness of any new elections introduced in Scotland will rightly come under serious scrutiny. Whilst the Committee recognises that there would be significant cost and logistical implications, the Committee recommend that the Scottish Government reconsider using personal identifiers for postal votes in health board elections. If the cost and logistical implications are too great to be overcome, the Scottish Government may also have to reconsider holding an all-postal ballot.

Franchise

85. The Bill proposes allowing 16- and 17-year-olds to vote in health board elections. In general, those who expressed a view in principle on this issue were in favour of allowing 16- to 17-year-olds to vote in health board elections. However, some of those in favour, for example NHS Tayside, expressed the view that it should be considered in the context of other elections to ensure consistency. This was echoed by the AEA, which said that there was the potential for confusion

106 The City of Edinburgh Council, written submission to the Health and Sport Committee; SOLACE et al, written submission to the Health and Sport Committee
if 16- and 17-year-olds could vote in a health board election, but not in a local
authority election potentially on the same day.\textsuperscript{110}

86. The Electoral Commission opposed allowing 16- and 17-year-olds to vote in
health board elections, citing its 2004 report, \textit{The Age of Electoral Majority}, which
concluded that there was insufficient evidence of demand for such a change or of
a likely impact on young people.\textsuperscript{111}

87. Election officials expressed concern that including 16- and 17-year-olds on
the electoral register could raise child protection issues, if the details of 14- to 15-
year-old attainers were routinely collected and published.\textsuperscript{112}

88. The Scottish Government told the Committee that a special “young persons
register” would be created to record the details of 15-year-olds. This register would
not be made public.\textsuperscript{113} The Electoral Commission said that such an option might
make it harder to engage young people with the election process.\textsuperscript{114} The Cabinet
Secretary told us that—

\begin{quote}
“we want direct elections to health boards to include as many users of the
NHS as possible. That is an important way to introduce young people to the
democratic process as they reach adulthood, as it concerns a public service
of which they already have considerable experience.”\textsuperscript{115}
\end{quote}

89. The Committee has serious concerns about the proposal for a private
young persons’ register and does not find this to be a recognisable part
of the usual democratic process, while accepting that publication of the
register would raise wider child protection implications. These are
complicated issues to resolve and the Committee calls on the Scottish
Government to come forward with specific proposals to address those
concerns in advance of Stage 2.

90. The Cabinet Secretary stated in oral evidence that there is no hurdle in the
Bill that must be overcome in order to be eligible to stand for election. She said
she had “no intention of lodging an amendment that would have that effect”,
arguing that “people should be allowed to stand without having to overcome a
particular hurdle”. She also indicated willingness, however, to consider introducing
a hurdle if the Committee wanted to pursue the matter.\textsuperscript{116}

\begin{footnotes}
\textsuperscript{110} Scottish Parliament Health and Sport Committee. \textit{Official Report, 12th November 2008, Col}\n\textsuperscript{1289}
\textsuperscript{111} Electoral Commission, written submission to the Health and Sport Committee
\textsuperscript{112} SOLACE et al, written submission to the Health and Sport Committee
\textsuperscript{113} Scottish Parliament Health and Sport Committee. \textit{Official Report, 26th November 2008, Cols}\n\textsuperscript{1371-1372}
\textsuperscript{114} Scottish Parliament Health and Sport Committee. \textit{Official Report, 12th November 2008, Col}\n\textsuperscript{1281}
\textsuperscript{115} Scottish Parliament Health and Sport Committee. \textit{Official Report, 26th November 2008, Col}\n\textsuperscript{1347}
\textsuperscript{116} Scottish Parliament Health and Sport Committee. \textit{Official Report, 26th November 2008, Cols}\n\textsuperscript{1359-1360}
\end{footnotes}
91. The Committee believes that the Scottish Government should reconsider introducing a minimum threshold for candidacy to health board elections.

PILOTS

92. The evidence that the Committee received suggests a clear acceptance that pilots of health board elections should be introduced before introducing such elections nationwide. This majority view included organisations such as NHS Orkney which opposed the principle of health board elections, but welcomed the commitment to pilot the proposal first. Those organisations that opposed pilots, such as Local Health Concern, tended to favour immediate roll-out across all health boards and viewed pilots as an unnecessary delay.

93. Some organisations wanted guarantees that the pilot process would be independent and a robust test of the policy. BMA Scotland’s written evidence said that the evaluation should be carried out independently through a competitive tendering process and suggested that—

“… pilot projects are often accompanied by additional energy, support and resources, resulting in positive outcomes and evaluations. Subsequent roll-out of pilots, implemented without this initial level of interest and funding, can sometimes fail to generate the same results.”

94. The RCN suggested in its evidence that pilots of health board elections alone would not be sufficient to provide a robust test of the policy. The RCN proposed a three-way pilot programme, whereby one health board would run a pilot of elections, a second would receive an equivalent amount of funding to expand its existing public participation programmes and a third would continue with its existing arrangements. In oral evidence, RCN representatives told us—

“Our concern is that, if we plough forward with health board elections without testing other pilots at the same time, the pilot will simply test whether elections work. We believe that we should test how we ensure that the Scottish public are best engaged—and feel that they are being best engaged—within the decision-making of their local NHS board. We are not convinced that, on its own, piloting health board elections will do that.”

95. The idea that the pilot process should be wider than just a pilot of direct elections gained support in oral evidence from three NHS boards, BMA Scotland, Consumer Focus Scotland and Voluntary Health Scotland.

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117 NHS Orkney, written submission to the Health and Sport Committee
118 Local Health Concern, written submission to the Health and Sport Committee
119 BMA Scotland, written submission to the Health and Sport Committee
120 Royal College of Nursing Scotland, written submission to the Health and Sport Committee
96. The Cabinet Secretary stated that the evaluation would be “done independently”. She added that she was considering piloting alternative approaches in parallel with direct elections. She did not have any details of what these approaches would be at the time of the evidence session. She said, however, that the Bill’s purpose was to give the necessary statutory authority for health board elections to be tested through pilots and that piloting alternative approaches should not impact upon that.

97. The Committee believes that the pilot process should be a robust test of whether direct elections to health boards result in greater public participation in health board decision-making. The Committee welcomes the Cabinet Secretary’s commitment that the evaluation will be independent. The Committee recommends that the Scottish Government publish, in advance of the pilots beginning, the criteria on which success or failure will be judged.

98. In order to make the pilot of direct elections a robust test of the policy, it will be necessary for the Scottish Government to run additional pilots of initiatives to increase public participation alongside those for direct elections. The results of the pilots for direct elections should be compared with the outcome of these additional pilots and developments in boards where no initiative takes place. The Committee calls upon the Cabinet Secretary to come forward, before Stage 3, with a clear proposal and timetable for additional pilots, based upon the evidence the Committee has received.

FINANCIAL IMPACT

Finance Committee scrutiny

99. The Parliament’s Finance Committee considers the financial implications of legislation through scrutiny of financial memorandums produced to accompany bills introduced in the Parliament. The Finance Committee has a systematic approach to its consideration of financial memorandums, applying a different level of scrutiny depending on the significance of the proposals for public expenditure.

100. In relation to the Bill, the Finance Committee sought written evidence from organisations financially affected, using a standard questionnaire. It also took oral evidence from electoral and Scottish Government officials and produced a report to the Health and Sport Committee, attached as Annexe D to this report.

Financial Memorandum

101. The Financial Memorandum sets out the costs envisaged by the Scottish Government relating to the publicising and running of health board elections based on an assumed turnout of 60%, remuneration of elected members at around £7,500 per annum and running the evaluation of the pilot process. The Financial Memorandum is attached as Annexe D to this report.

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Memorandum initially set out total costs of £2.86 million for the two pilot boards envisaged in the draft regulations, with an estimate of £13.05 million for elections in all health boards.\textsuperscript{124}

102. The costs outlined in the Financial Memorandum were subsequently revised in a letter from the Cabinet Secretary to the Committee. As a result of this revision, the total costs in the case of roll-out were estimated at £16.65 million.\textsuperscript{125}

103. The Finance Committee, in its report to the Committee, stated that it would have been helpful for the Financial Memorandum to take greater account of the range of costs that could result from health board elections and supporting elected members – for example, depending on the size or demographics of the health board area.

**Funding health board elections**

104. Many of those who submitted evidence to the Committee expressed concern that the costs of running health board elections would result in less money being available for front-line health services. For example, the RCN stated that—

“... we are also deeply concerned by the increase of over £8 million pounds in the estimated recurring costs, from £5 million in the consultation document to £13.05 million in the notes to the Bill as published. This is to be met from existing budgets and we fear this could impact on frontline health services, particularly given the tight financial situation of this spending cycle.”\textsuperscript{126}

105. Several organisations believed that the costs of running health board elections may prove to be higher than anticipated. For example, the City of Edinburgh Council considered the £200,000 set aside for public information and advice to be insufficient.\textsuperscript{127} The Chartered Institute of Public Finance and Accountancy considered the calculation used to estimate the total cost of national health board elections to be “basic in nature”, and election officials said that they believed the costs “had not been fully investigated”.\textsuperscript{128} Scottish Government officials also told the Committee that the costs would increase by a further £1 per voter were personal identifiers to be used in the postal ballot and, in evidence to the Finance Committee\textsuperscript{129}, they revealed that Returning Officers’ personal fees were not covered by the Financial Memorandum.\textsuperscript{130}

106. NHS Ayrshire and Arran and NHS Lothian both accepted that, while the costs of running health board elections would be significant, they were small in the


\textsuperscript{125} Scottish Government, supplementary written submission to the Health and Sport Committee 12th September 2008

\textsuperscript{126} Royal College of Nursing Scotland, written submission to the Health and Sport Committee

\textsuperscript{127} The City of Edinburgh Council, written submission to the Health and Sport Committee

\textsuperscript{128} Chartered Institute of Public Finance and Accountancy, written submission to the Health and Sport Committee; SOLACE et al, written submission to the Health and Sport Committee

\textsuperscript{129} Scottish Parliament Health and Sport Committee. Official Report, 5th November 2008, Col 1254

\textsuperscript{130} Scottish Parliament Finance Committee (2008) Report to the Health and Sport Committee on the Health Boards (Membership and Elections) (Scotland) Bill, paragraph 31
context of overall health budgets. They both agreed that the costs being discussed could be absorbed without seriously impacting on front-line services. However, NHS Lothian and NHS Tayside both indicated that the costs would probably be funded from existing expenditure on public engagement, and NHS Ayrshire and Arran said that it would be a legitimate question to ask what would have to make way to fund direct elections.\(^{131}\)

107. The Scottish Government has undertaken to fund pilots of health board elections from central funding.\(^ {132}\) The Finance Committee in its report on the Financial Memorandum noted that, whilst additional funds would be allocated for pilot elections, there is still uncertainty about funding for health board elections should they be introduced nationwide.\(^ {133}\)

108. This Committee understands that, unlike the pilots, it is not planned that direct elections, once rolled out nationwide, would be centrally funded.\(^ {134}\)

109. The estimates of the costs of health board elections outlined in the Financial Memorandum are basic in nature and have already been subject to some change. In particular, the Committee does not believe that there is sufficient certainty about the total costs of health board elections were they to be rolled out nationwide. This is important in view of health boards’ assertions that funding direct elections could impact upon other public participation programmes.

110. There is a separate issue of the costs incurred should personal identifiers for postal votes be implemented. The Committee requests that the Scottish Government provide details of how much extra funding, in total, would be required to implement this system in the pilot elections.

111. The Committee endorses the Finance Committee’s recommendation that the evaluation of the pilots should include a full assessment of all the costs of the pilot exercise and a restatement of the expected roll-out costs.

**SUBORDINATE LEGISLATION**

112. The Subordinate Legislation Committee undertook scrutiny of the delegated powers contained in the Bill and took oral evidence from Scottish Government officials. Its report is included at Annexe E. The Subordinate Legislation Committee drew the Committee’s attention to a number of issues, which are discussed as follows.

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\(^{133}\) Finance Committee report, paragraph 38

\(^{134}\) *Official Report, Finance Committee, 4th November 2008*; Col 767
Power of Scottish Ministers to remove members

113. Section 1(5) of the Bill provides that regulations may be introduced to specify circumstances in which “the Scottish Ministers may determine that an elected member is to vacate office before the end of [their term].”

114. The Subordinate Legislation Committee drew these powers to the Committee’s attention on the following grounds and recommended that the regulations be subject to affirmative procedure—

(a) the evidence from the Scottish Government officials indicated an intention to apply the same criteria in relation to elected members, as may be applied to appointed and councillor members. However, as the Bill is drafted, future Regulations could set out different criteria for different types of member;

(b) the decision to allow Ministerial discretion to require early vacation from office in yet-to-be-prescribed circumstances applying to publicly elected members is a significant issue, which has the potential to be controversial,

(c) the Scottish Government in its written response and evidence have indicated that a “best interests of the national health service” test will be applied for all types of members, but as drafted the Bill will allow future regulations to change that criteria. (However, initial draft Regulations have been produced (amending the Health Boards (Membership and Procedure) (Scotland) Regulations 2001, which reflect that criteria.)

115. Several organisations, chiefly local authorities, expressed concern that the power to remove elected members from office could potentially undermine the democratic process. The City of Edinburgh Council stated that—

“Elected members should only be able to be removed from office if they are found to be in substantial breach of recognised codes of conduct, or other regulations, and on the recommendation of the Standards Commission.”

116. The Cabinet Secretary told the Committee that such powers had never been used in relation to appointed members and would be less likely to be used for elected members. However, she argued that the powers were necessary to ensure consistency across all health board members and reinforce boards’ accountability to ministers. She accepted that the use of the power to remove a directly elected member would be highly controversial—

“It would be very controversial for any health minister, now or in future, to remove a member from a health board. It would put the minister under great

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135 Health Boards (Membership and Elections) (Scotland) Bill section 1(5)
136 Scottish Parliament Subordinate Legislation Committee (2008) Report to the Health and Sport Committee on the Health Boards (Membership and Elections) (Scotland) Bill, paragraph 16
137 The City of Edinburgh Council, written submission to the Health and Sport Committee
scrutiny, requiring him or her to justify the decision. That in itself would operate as a discipline in the exercising of the power”.139

117. The Committee has difficulty with the power to remove elected board members from office, even in very exceptional circumstances and requires further clarification, prior to Stage 2, on what those circumstances might be and what safeguards would be in place.

Roll-out

118. Section 7 of the Bill provides for the roll-out of health board elections nationwide by use of a “roll-out order” subject to negative procedure. Section 7(3) states that such a roll-out order may only be made once an evaluation conforming to the requirements of section 5 has been published. The roll-out order may modify the text of the legislation, or any other enactment, as ministers consider appropriate.

119. The Subordinate Legislation Committee drew this power to the Committee’s attention on the grounds that—

“(a) the Parliament is being asked through the Bill to approve a delegated power (in section 7(4)) which contains this degree of flexibility to modify enactments at the time of a “roll-out”, by affirmative procedure regulations; and

(b) the Scottish Government has not to date clearly addressed the question as to why this power to modify enactments could not be drafted more narrowly. For example, by permitting only such modifications necessary to deliver the objectives of the Bill (on a roll-out). As currently framed this power could be used to amend matters of principle such as the franchise or STV voting mechanism.”140

120. In written evidence to the Subordinate Legislation Committee, the Scottish Government undertook to introduce an amendment at Stage 2 that would make the roll-out order subject to affirmative procedure if it modified the parent legislation.141 The Cabinet Secretary reiterated this in evidence to the Health and Sport Committee and said that this power would allow the Parliament to take account of issues arising from the pilots when rolling out elections across all health boards.142 She stressed that roll-out and amendments resulting from it could not take place without further parliamentary procedure and stated her view that the Parliament would remain “in the driving seat every step of the way”.143

140 Subordinate Legislation Committee report, paragraph 61
141 Scottish Government, supplementary written submission to the Subordinate Legislation Committee
121. The Committee believes that the decision to introduce health board elections to all health board areas involves a decision of principle that should be subject to rigorous parliamentary scrutiny. This view is reinforced by the fact that a roll-out order could fundamentally alter the proposals for health board elections outlined in the Bill.

122. The Bill as drafted ensures that roll-out cannot go ahead without parliamentary process. However, the Committee does not agree with the Cabinet Secretary that the arrangements for roll-out of health board elections specified in the Bill would put the Parliament in the “driving seat”\textsuperscript{144} of the process, especially as current plans are to roll out under negative procedure if the subordinate legislation would not lead to any “substantive changes in the text of the Bill”\textsuperscript{145}. In particular, whether the roll-out order is subject to affirmative or negative procedure, the Parliament would have no opportunity to propose its own amendments to the arrangements for health board elections at the time of roll-out. Furthermore, the timescales involved in the passing of subordinate legislation would be unlikely to allow the Parliament to gather its own evidence on roll-out, and rejection of a roll-out order would not constitute rejection of roll-out \textit{per se}.

123. The Committee recommends that the Bill be amended to make any roll-out order subject to a form of affirmative procedure that would place additional requirements on the Scottish Government (sometimes referred to as “super-affirmative” procedure). In particular, the Committee recommends that a requirement be placed on the Scottish Government to conduct a consultation on roll-out and lay the responses before the Parliament, in addition to the evaluation report. The Committee also recommends that the procedure require the Scottish Government to publish a draft version of the roll-out order at the same time as publishing the consultation. The Committee also recommends that, if a roll-out order is rejected by the Parliament, ministers should be required to lay an order under section 6 of the Bill revoking the pilot order.

124. Finally, the Committee recommends that, at the time of a draft roll-out order being published in the manner described above, the appropriate committee of the Parliament conduct an inquiry into it.

Revocation of pilots

125. Section 6 of the Bill provides that the pilot order would automatically be revoked after seven years and that ministers could revoke that order on an earlier date. If the pilot order were revoked prior to a roll-out order being made, then sections 1 to 7 of the Bill and paragraph 2 of the schedule to the Bill would be repealed.

126. The Subordinate Legislation Committee recommended that a revocation order prior to the expiry of seven years should be subject to affirmative procedure on the grounds that—

“This power is considered to be novel and unusual. It enables the Scottish Government to revoke the pilot arrangements and repeal Bill provisions without further Parliamentary procedure (within 7 years after the date of the first Health Board elections.)”\(^{146}\)

127. In evidence to the Committee, the Cabinet Secretary said that she was considering the case for revocation to be subject to parliamentary procedure, although she would not provide a guarantee that an amendment would be lodged.\(^ {147}\)

128. The Committee welcomes the Cabinet Secretary’s commitment to consider further the power to revoke pilots without parliamentary procedure. The Committee considers that ministers should not be able to abandon a policy agreed by the Parliament without its approval. The Committee agrees with the Subordinate Legislation Committee that this power should be subject to affirmative procedure.

129. The Committee notes that revocation of the pilots would also revoke the statutory basis for local authority members to sit on health boards. It calls on the Scottish Government to clarify its intentions in this respect, should pilots not be rolled out.

CONCLUSION

130. Whilst the evidence that the Committee received indicated a need to improve public accountability in health boards, the majority of the evidence received did not suggest an overwhelming case for direct elections or widespread enthusiasm for their introduction as a means of solving this problem. However, there was a broad consensus in the evidence that the proposal, if it proceeds, should be piloted. The Committee therefore believes that piloting direct elections, alongside pilots of alternative schemes, is the correct approach to take.

131. Given its title and drafting, the passing of this Bill by the Parliament could be interpreted as support for the principle of direct elections to health boards, rather than simply for the introduction of pilots to test that principle. The Committee believes that this is regrettable, as the purpose of pilots is to gather evidence on whether the policy will work. The Committee asks the Cabinet Secretary to consider whether changing the title of the Bill would be appropriate.

132. Taking into account all of the issues examined in this report, the Committee recommends to the Parliament that the general principles of the Bill be agreed to, on the understanding that such agreement relates to the

\(^{146}\) Subordinate Legislation Committee report, paragraph 52
introduction of a variety of pilots and should not be taken to pre-empt any decision that the Parliament may later be asked to take on the principle of rolling out direct elections to health boards nationwide.
HEALTH AND SPORT COMMITTEE

ANNEXE A: EXTRACT FROM THE MINUTES

18th Meeting, 2008 (Session 3)
Wednesday 18th June 2008

Forthcoming legislation: The Committee agreed that the clerks should issue a call for written evidence following introduction of the bill and also agreed to consider in private possible candidates for oral evidence following consideration of written evidence received; to delegate to the Convener responsibility for arranging for the SPCB to pay, under Rule 12.4.3, any expenses of witnesses in respect of consideration of this bill, and to consider in private drafts of the Committee’s report to the Parliament on the bill.

22nd Meeting, 2008 (Session 3)
Wednesday, 24th September 2008

Health Boards (Membership and Elections) (Scotland) Bill (in private): The Committee agreed its approach to scrutiny of the Bill at Stage 1.

26th Meeting, 2008 (Session 3)
Wednesday, 5th November 2008

Health Boards (Membership and Elections) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Kenneth Hogg, Deputy Director, Health Delivery, Beth Elliot, Solicitor, and Robert Kirkwood, Policy Officer, Scottish Government.

27th Meeting, 2008 (Session 3)
Wednesday, 12th November 2008

Supplementary Health Boards (Membership and Elections) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Prof Bill Stevely CBE, Chairman, NHS Ayrshire and Arran;

Dr Charles Winstanley, Chairman, and Prof Heather Tierney-Moore OBE, Director of Nursing, NHS Lothian;

Sandy Watson OBE, Chairman, and Peter Williamson, Director of Health Strategy, NHS Tayside;


Robert Jack, Society of Local Authority Chief Executives;
William Pollock, Chair, Scotland and Northern Ireland Branch, Association of Electoral Administrators.

28th Meeting, 2008 (Session 3)

Wednesday, 19th November 2008

Health Boards (Membership and Elections) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Dr Dean Marshall, Chair of Scottish General Practitioners Committee, British Medical Association;

Rachel Cackett, Policy Advisor, Royal College of Nursing Scotland;

Dave Watson, Scottish Organiser, Policy, UNISON;

Cllr. Ronnie McColl, Spokesman for Health and Wellbeing, and Ron Culley, Policy Manager, COSLA;

Harry Stevenson, Executive Director of Social Work Resources, South Lanarkshire Council;

Graeme Struthers, Head of Support Services, West Lothian Council;

Douglas Sinclair, Chair, and Liz MacDonald, Senior Policy Advocate, Consumer Focus Scotland;

Pat McGuigan, Director, and Bill Scott, Policy Officer, Inclusion Scotland;

Phil McAndrew, Information Officer, Voluntary Health Scotland.

Health Boards (Membership and Elections) (Scotland) Bill (in private): The Committee agreed to consider issues arising from the evidence at its next meeting.

29th Meeting, 2008 (Session 3)

Wednesday, 26th November 2008

Health Boards (Membership and Elections) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, Kenneth Hogg, Deputy Director, Health Delivery, Robert Kirkwood, Policy Officer, and Kathleen Preston, Solicitor, Scottish Government.

Health Boards (Membership and Elections) (Scotland) Bill (in private): The Committee considered options for its draft Stage 1 report.
30th Meeting, 2008 (Session 3)

Wednesday, 10th December 2008

Health Boards (Membership and Elections) (Scotland) Bill (in private): The Committee considered a draft Stage 1 report. Various changes were agreed to. The report, as amended, was agreed to.
Health and Sport Committee

7th Report, 2008 (Session 3)

CONTENTS

Remit and membership

ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

26th Meeting 2008 (Session 3), 5 November 2008

Written Evidence

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BMA Scotland
Royal College of Nursing Scotland
UNISON
COSLA
South Lanarkshire Council
West Lothian Council
Scottish Consumer Council
Inclusion Scotland
Voluntary Health Scotland

Oral Evidence

BMA Scotland
Royal College of Nursing Scotland
UNISON
COSLA
South Lanarkshire Council
West Lothian Council
Scottish Consumer Council
Inclusion Scotland
Voluntary Health Scotland

Supplementary Written Evidence

Royal College of Nursing Scotland
Inclusion Scotland

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Scottish Government
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Health and Sport Committee

Remit and membership

Remit:
To consider and report on (a) health policy and the NHS in Scotland and other matters falling within the responsibility of the Cabinet Secretary for Health and Wellbeing and (b) matters relating to sport falling within the responsibility of the Minister for Communities and Sport.

Membership:
Jackie Baillie
Helen Eadie
Ross Finnie (Deputy Convener)
Christine Grahame (Convener)
Michael Matheson
Ian McKee
Mary Scanlon
Dr Richard Simpson

Committee Clerking Team:

Clerk to the Committee
Callum Thomson

Senior Assistant Clerk
Douglas Thornton

Assistant Clerk
David Slater

Committee Assistant
Kiran Haksar
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

26th Meeting, 2008 (Session 3) 5 November 2008, Written Evidence

NICOLA STURGEON MSP, CABINET SECRETARY FOR HEALTH AND WELLBEING, SCOTTISH GOVERNMENT

Thank you for your letter of 19 August about the Health Boards (Membership and Elections) (Scotland) Bill which the Health and Sport Committee are due to begin scrutinising this autumn.

Please find attached an Appendix which provides specific responses to the Committee’s initial questions, as noted in your letter. I hope the Committee finds this information helpful ahead of the Stage One witness selection process. Please do not hesitate to get in touch should any further clarification be required.

I look forward to working with the Committee during the consideration of the Bill.

Nicola Sturgeon MSP,
Cabinet Secretary for Health and Wellbeing,
Scottish Government
3 September 2008

* * * * *

APPENDIX

Health Boards (Membership and Elections) (Scotland) Bill: Health and Sport Committee Questions, 19 August 2008

1. What alternative approaches to direct election, the single transferable vote and the designation of health board areas as single wards were considered during the development of the Bill? How were they evaluated?

The Government was elected on a manifesto which included the commitment to introduce direct elections to Health Boards. Although the Government is committed to improving public engagement and involvement with Health Boards through initiatives like the development of the Participation Standard, we believe that direct elections are necessary in order to adequately ensure that the public voice is heard and listened to at the heart of the local decision-making process. The responses to the consultation revealed a widespread concern about the need to re-establish public confidence in the decision-making of Health Boards. The Government believes that direct elections will help to address these concerns, providing an opportunity for local people and their representatives to both influence, and take accountability for, decisions made in respect of the local healthcare services that they fund as taxpayers. We believe this is fully consistent with the Government’s commitment to create a ‘co-owned’, mutual NHS.

The promotion of meaningful proportional representation at public elections through the use of the Single Transferable Vote (STV) is Government policy. The STV system gives the electorate the fullest freedom of choice, the ability to express preferences between candidates, and ensures that every vote counts. It will enable all significant strands of opinion within a Health Board area to be appropriately represented, and will help ensure that single issue candidates do not unduly predominate. We did consider the use of the “first past the post” method. However, we consider that the advantages of the STV system outweigh those of the “first past the post” method. We do recognise the issues which may arise from the use of the STV system, both from the voters’ perspective and from the method of counting the votes. This is of course not peculiar to Health Board elections, and steps will be taken based on experience with STV elections to ensure that such issues are mitigated as far as possible.

The Government believes that a single ward represents the most practicable way forward and we set out our reasoning in paragraph 20 of the policy memorandum: we believe that a single ward may encourage a broad range of candidates from across the Health Board area; that single wards
would reduce the possibility of uncontested elections in smaller wards; and that single wards will reduce the detrimental impact of single issue candidates from particular geographic areas dominating the election. We gave consideration to the use of multiple wards and concede that there are a number of potential advantages which could flow from their use. We also accept that this issue generated a considerable response during our consultation with a range of views being expressed. However, taking all the relevant issues into account, we continue to believe that the use of single wards, on balance, is the most appropriate way forward for Health Board elections. The pilots will allow an opportunity to assess the impact of single wards and enable the experience to be taken into account before final decisions on roll-out are taken. In recognition that the arguments in this case are finely balanced, the Bill retains a degree of flexibility such that, if it is decided that there should be wards, this can be taken forward for pilots and/or full roll-out.

2. **How will the existing level of public and patient engagement be measured for the purpose of the comparison required under Section 5(1) (c) (ii)?**

We are committed to a full and independent evaluation of the pilots. In the pilot areas the evaluation studies will be commissioned and structured to ensure that the level of public engagement and involvement both before and after direct elections is fully assessed. The precise methodology to be used in the evaluation studies will be finalised as part of the on-going developmental work but will almost certainly involve direct research into public views and perceptions.

3. **How was the composition of the appointed portion of health board membership, specified in paragraph 15 of the policy memorandum, arrived at? How does it differ from existing arrangements?**

The composition of the appointed Board members as proposed in paragraph 15 (a), (c), (d) and (e) of the policy memorandum reflects the current situation and therefore does not differ from current arrangements. In relation to paragraph 15 (b), the current number of Executive Directors on Health Boards varies across Scotland. Five Executive Director positions are referred to in paragraph 15 (b) of the policy memorandum. This is consistent with previous Government guidance to Health Boards on those Executive Director posts that should be full members of Boards for reasons of sound clinical, organisational and financial governance. Under the proposals for direct elections, some Health Boards in Scotland would need to reduce the current number of Executive Directors serving as Board members (along with a reduction in the number of non-Executive appointed members) to accommodate a majority of elected members (including Local Authority representatives) within a Health Board of a manageable size. Whilst other Directors (e.g. Director of Communications) would no longer have a formal place (and vote) on the Board, this does not of course preclude them from continuing to offer advice to the Board, and thereby informing its decision-making. Paragraph 15 (b) also refers to having a representative from the local Area Partnership Forum on Health Boards. As with the position set out for paragraph 15 (a), (c), (d) and (e), this reflects the current situation and therefore does not differ from current arrangements.

4. **What analysis supports the assertions of the benefits of including 16 and 17 year-olds in the franchise for health board elections, the single ward system and single transferable vote in paragraphs 20 and 32 of the policy memorandum?**

It is Government policy to consider extending the voting franchise to include 16 and 17 year-olds in elections over which the Scottish Government has control. We want direct elections to Health Boards to include as many users of the NHS as possible and that is why we propose to extend the franchise to 16 and 17 year-olds. We consider this to be an important way of introducing young people to the democratic process as they reach adulthood, within a public service of which they will already have experience.

As set out above, the Government believes that a single ward for each Health Board area is the most appropriate way forward. Analysis was carried out into the findings from the research undertaken based on the experience in New Zealand (where they have multiple wards) and this does not detract from the Government’s view that, on balance, a single ward area is the most appropriate way forward.
Similarly, the Government is committed to the use of the STV system and, for the reasons stated
above, we believe that STV will deliver the electoral outcome which best reflects the various
strands of opinion within a Health Board area. The Electoral Commission has undertaken work
which demonstrates that proportional voting systems result in electoral outcomes which do reflect,
as accurately as possible, the weight of opinion in an area and certainly more accurately than the
“first past the post” system.

5. How will the Scottish Government ensure that elections will be “efficient and cost
effective” as stated in paragraph 21 of the policy memorandum?

The overall approach to the elections is to pursue efficient and cost effective methods of
implementation, initially in the pilot areas. This will be achieved by the relevant pilot area Health
Boards working closely with the appointed Electoral Returning Officers to ensure that costs
incurred represent best value but which are commensurate with holding free and fair elections. As
with any other public sector body, we would expect Health Boards to be able to demonstrate a
value for money approach.

Whilst elections to Health Boards may appear a radical proposal, the provisions made by the Bill
and its underpinning regulations for the administration of the elections are very largely based on
established methods. This should help to ensure that the elections are as efficient and cost
effective as possible.

The Committee can also be assured that, in addition to the independent evaluation which will
inform a report to Parliament, the Government will maintain close oversight of progress with
elections, and of the performance of the pilot Boards themselves. This will be conducted through
the well established performance management relationship between the Boards and the Scottish
Government Health Directorates, and is in keeping with the policy that Health Boards with a directly
elected majority will – as at present – be accountable to Ministers.

6. What are the “particular issues for island communities” referred to in paragraph 36?

Our island communities are unique and we are all too well aware that an approach that may be
effective for an urban/rural mainland Health Board may not work when applied to an Island setting.
In delivering direct elections within the islands we will need to be mindful of this uniqueness and
ensure that those participating in the elections are able to do so without suffering barriers brought
about by remoteness or rurality.

We would concede that this is more pertinent when looking specifically at certain voting
procedures, e.g. the distance and difficulty certain island communities might face in being able to
physically cast their votes at traditional polling stations. It is largely the need to address such issues
of physical accessibility (which would also be a significant issue for voters in certain rural mainland
areas) that the Government have proposed that elections to Health Boards should be conducted on
wholly postal ballot basis.

7. Was any work done on the experience of other countries – specifically New Zealand
– during the preparation of the Bill? Did any responses to the consultation draw upon the
experiences of other countries?

Officials reviewed the available material on the experience arising from the implementation of the
New Zealand “model” of direct elections to Health Boards in the period leading up to the drafting of
the Bill. A major research study into the experiences of New Zealand following significant reforms
in their healthcare structure (including the introduction of direct elections to Health Boards) was
published in the autumn of 2007. This study examined aspects of direct elections to Health Boards
in New Zealand since their inception in 2001. A few of those who responded to our consultation
asked us to be mindful of the experiences elsewhere but there were no detailed submissions based
on the experiences of other countries. The drafting of the Bill was also informed by the experiences
of the Boards of the Scottish National Parks, which have contained a directly elected element since
2003.

8. What proportion of responses to the consultation (aside from health boards and local authorities) was broadly in favour of the principle of direct election to health boards? What proportion was opposed? How did this break down across categories of respondents?

Our consultation did not set out an overt question on whether respondents were “for” or “against” elections. Instead, we sought to examine the perceptions around patient and public involvement in the decision-making process and then, in light of the manifesto commitment, examine the views around how elections could best be delivered. A broad range of views were heard during the consultation with an overarching message that we should tread carefully in the introduction of any elections to Health Boards. Within the broad range of views, it seemed that those who were currently more fully involved with the NHS (e.g. as employees or those that had day-to-day contact for a number of reasons) were more reticent about the introduction of elections. Those who perceived themselves as currently more distanced from this very regular contact with the NHS appeared more supportive of elections. Copies of responses to the consultation are available on the Scottish Government website.

We feel that to split responses into “for” and “against” (even on a broadly speaking basis) for any individual group or body would be entirely subjective, and consultees may feel aggrieved if we were to interpret their response in such a way. For example, some respondents have said that they are against the introduction of elections but would consider pilots as a reasonable way forward. Some others have simply commented on our proposals and not clearly expressed a preference one way or another in terms of direct elections. We have carefully considered the views gathered as a result of the consultation and the Bill as drafted reflects the way in which we consider the policy could best be delivered.

NICOLA STURGEON MSP, CABINET SECRETARY FOR HEALTH AND WELLBEING, SCOTTISH GOVERNMENT

I am writing in respect of the Health Boards (Membership and Elections) (Scotland) Bill which the Health and Sport Committee is due to begin scrutinising this autumn. Some new information has very recently come to my attention that affects the Bill’s Financial Memorandum. I therefore wanted to write to both the Health & Sport and Finance Committees at the earliest opportunity to provide an update with the amended information ahead of Stage 1 consideration.

Firstly, updated advice received from Electoral Registration Officers (EROs) has suggested significant practical difficulties in amending the software systems used to maintain the electoral register for the purpose of extending the franchise to 16 and 17-year olds for any pilots taking place in spring 2010. We had previously planned to use the annual canvass of voters (which usually runs from summer to autumn each year) to capture data about 16 and 17 year olds in time for the pilot elections in the spring of 2010. It may no longer be sensible to rely upon this option. Taking into account the likely parliament timetable and given the practical concerns raised about software modification this may not give EROs sufficient time to prepare for altering the canvass, bearing in mind that they would not have the legal powers to carry out this work before legislation comes into force.

The Government therefore proposes taking a simpler administrative approach for the pilots that would minimise changes to electoral systems and processes. This would involve utilising the existing local authority franchise plus 16 and 17-year olds who are registered at the time of election. The system already contains data on 16 and 17-year old attainers. In effect, we would be using the rolling register which any eligible voter can subscribe to throughout the year, ahead of the cut-off point for any election. This would help to minimise the potential cost and additional work for EROs and others, and would avoid the need to consider potentially expensive and unworkable upgrades to existing IT systems which would cover only the pilot areas.

Paragraph 63 of the Financial Memorandum currently budgets for £50,000 per pilot Board area to cover the cost of extending the franchise. This cost was envisaged to be used in modifying

http://www.scotland.gov.uk/Publications/2008/05/27153350/0
software systems which would no longer be necessary under the revised approach. However, we propose to use this resource to bolster the existing budget for public information, advice and marketing. This would be used to maximise registration by encouraging eligible voters to register, including potentially targeted marketing for 16 and 17-year olds for example through talks in schools or publicity material distributed at youth clubs. For clarity, we have reflected these changes in revised paragraphs 63-65 of the Financial Memorandum, attached as an Annex.

Secondly, we have reviewed the methodologies we used in the Finance Memorandum, and have therefore revised the calculation of some of the estimated costs of rolling out elections to Health Boards, as set out in paragraph 66 of the Memorandum. In summary, the total estimated cost of £13.05m as set out in paragraph 66 should correctly be stated as £16.65m. I wanted to act quickly in writing to both Committees to set out the correct position ahead of the scrutiny of the Bill in Parliament. I have attached as an Annex replacement paragraphs for the relevant sections of the Financial Memorandum which take full account of the contents of this letter.

I am copying this letter to the Finance Committee and look forward to working with the Committee during the consideration of the Bill.

Nicola Sturgeon MSP,  
Cabinet Secretary for Health and Wellbeing,  
Scottish Government  
12 September 2008

APPENDIX

Health Boards (Membership and Elections) (Scotland) Bill: Amended Financial Memorandum

Replacement Paragraphs 63-66

63. With regard to the costs of extending the franchise for the purpose of pilot elections we propose taking a simple administrative approach that would minimise changes to current electoral systems and processes. This would involve utilising the existing local authority franchise plus 16 and 17-year olds who are registered at the time of election.

64. Given that the pilot elections will be based on the existing electoral local authority register together with the desire to involve as many eligible voters as possible (including 16 and 17-year olds), we think it would be prudent to allow for some investment in public information/advice in the pilot areas. This would help to maximise registration of eligible voters and help to promote public understanding and support. This approach may also ultimately boost turnout and we would envisage targeting some of the resources to encourage 16 and 17-year olds to register and vote, e.g. through talks at 6th forms, targeted leafleting of sports or social clubs etc. This may amount to £0.15 million for each pilot area i.e. £0.30 million for 2 pilot areas. It is anticipated that this level of funding would allow for an advertising campaign in the local press and for the production and distribution of written information.

65. The total costs of the pilots is likely to be met in 2010/11 and takes into account the factors set out above and is made up as follows:

<table>
<thead>
<tr>
<th>Cost</th>
<th>Area of Investment</th>
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<tbody>
<tr>
<td>£1.21 million</td>
<td>“baseline” cost</td>
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<tr>
<td>£0.90 million</td>
<td>Counting machines</td>
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<tr>
<td>£0.20 million</td>
<td>Additional remuneration</td>
</tr>
<tr>
<td>£0.25 million</td>
<td>Evaluation study</td>
</tr>
<tr>
<td>£0.30 million</td>
<td>Marketing/Public info &amp; advice</td>
</tr>
</tbody>
</table>
66. If, following the evaluation of the pilots, Ministers bring forward to Parliament plans to roll out elections to all Health Boards then it is estimated that this will cost around £16.65m. This consists of, in part, the relatively fixed costs of holding elections: the baseline cost (£1.21m) and marketing costs (£0.30m) for the 20% electoral coverage in the 2 pilot areas multiplied up to 100% coverage i.e. £1.51 million x 5 = £7.55m (excluding the one-off pilot evaluation study). This cost will be met at each election to Health Boards. The remainder of the total estimated cost of £16.65m consists of the recurring costs to Boards: the additional remuneration costs (£50,000 per Board multiplied by the full 4-year term of an elected Board = £200,000 multiplied by all 14 Health Boards in Scotland = £2.8m) and the costs of counting machines incurred by all Boards (£450,000 multiplied by 14 = £6.3m). The estimated roll out costs are set out in the table copied below. The intention is that the costs will be met from existing budgets.

<table>
<thead>
<tr>
<th>Area of Investment</th>
<th>Pilot Cost</th>
<th>Factor*</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>&quot;baseline&quot; cost</td>
<td>£1.21m</td>
<td>5</td>
<td>£6.05m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£6.05m</td>
</tr>
<tr>
<td>Count machines</td>
<td>£0.45m</td>
<td>14</td>
<td>£6.30m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£6.30m</td>
</tr>
<tr>
<td>Add remuneration</td>
<td>£0.05m</td>
<td>14</td>
<td>£0.70m</td>
<td>£0.70m</td>
<td>£0.70m</td>
<td>£0.70m</td>
<td>£2.80m</td>
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<tr>
<td>Marketing</td>
<td>£0.30m</td>
<td>5</td>
<td>£1.50m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£1.50m</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>£16.65m</td>
<td></td>
<td></td>
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</tbody>
</table>

*either multiplied by 5 (to calculate 100% electorate coverage from 20% pilot coverage) or by 14 (costs incurred by every Health Board)
The Scottish Ministers make the following Order in exercise of the powers conferred by sections 4(1), [4(3)] and 10(2) of the Health Boards (Membership and Elections) (Scotland) Act 2009(3) and all other powers enabling them to do so.

**Citation**

1. This Order may be cited as the Health Board Elections (Scotland) Pilot Order 200x.

**The appointed day for specified Health Board areas**

2.—(1) The day appointed for the coming into force of sections 1 to 3 of the Health Boards (Membership and Elections) (Scotland) Act 2009 for the areas for which;

(a) [Health Board 1], and

(b) [Health Board 2],

are constituted(4), is xx xxxx 20[ ].

[Modifications to sections 1 to 3 of the Health Boards (Membership and Elections) (Scotland) Act 2009

3. NOTE: If any such modification provisions are included in the Order, the intention is that it will be subject to affirmative procedure.]

---

**SCOTTISH STATUTORY INSTRUMENTS**

**DRAFT**

200x No.

**NATIONAL HEALTH SERVICE**

**REPRESENTATION OF THE PEOPLE**

The Health Boards (Membership) (Scotland) Regulations 200x

*Made*

*Laid before the Scottish Parliament*

*Coming into force*

The Scottish Ministers make the following Regulations in exercise of the powers conferred by sections 2(10), 105(7) and 108(1) of, and by paragraphs 2(2), 10A(2) and 11(a) of Schedule 1 to, the National Health Service (Scotland) Act 1978(5) and all other powers enabling them to do so.

(3) 2009asp x.

(4) [Health Boards 1 and 2] are constituted by the National Health Service (Determination of Areas of Health Boards) (Scotland) Order 1974 (SI 1974/266).

(5) 1978 c.29.
Citation and commencement

4. These Regulations may be cited as the Health Boards (Membership) (Scotland) Regulations 200x and come into force on [_______].

Number of members of particular Health Boards

5.—(1) The total number of members in relation to each Health Board mentioned in column 1 of the table below is the number mentioned in the corresponding entry in column 2.

(2) The number of appointed members in relation to each Health Board mentioned in column 1 of the table below is the number mentioned in the corresponding entry in column 3.

(3) The number of councillor members in relation to each Health Board mentioned in column 1 of the table below is the number mentioned in the corresponding entry in column 4.

(4) The number of elected members in relation to each Health Board mentioned in column 1 of the table below is the number mentioned in the corresponding entry in column 5.

<table>
<thead>
<tr>
<th>Column 1 Health Board</th>
<th>Column 2 Total number of members</th>
<th>Column 3 Number of appointed members</th>
<th>Column 4 Number of councillor members</th>
<th>Column 5 Number of elected members</th>
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<tbody>
<tr>
<td>[Board 1]</td>
<td>[x]</td>
<td>[x]</td>
<td>[x]</td>
<td>[x]</td>
</tr>
<tr>
<td>[Board 2]</td>
<td>[x]</td>
<td>[x]</td>
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Amendment of the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 for particular Health Boards

6. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001(6) are amended in terms of the Schedule in respect of each Health Board specified in column 1 of the table in regulation 2.

A member of the Scottish Executive

St Andrew’s House, 
Edinburgh 
200x

SCHEDULE

AMENDMENT OF THE HEALTH BOARDS (MEMBERSHIP AND PROCEDURE) (SCOTLAND) REGULATIONS 2001 FOR PARTICULAR HEALTH BOARDS

1.—(1) In regulation 1(2) (interpretation) omit the definitions of “the 1997 Act” and “the Charity Commissioners”.

(2) In regulation 2 (appointment and term of office)—

(a) omit paragraph (1);
(b) in paragraph (2) for “the members” substitute “the appointed members and the councillor members”; and
(c) in paragraph (3) for “a member” substitute “an appointed member or a councillor member”.

(3) In regulation 5 (resignation and removal of members)—
(a) in paragraph (1) after “appointment” insert “or, as the case may be, during the period mentioned in paragraph 10A(1) of Schedule 1 to the Act,”;
(b) in paragraph (2) after “appointment” insert “or, as the case may be, determine that that person is no longer to hold that office and accordingly that person shall forthwith vacate office”; and
(c) in paragraph (3) after “appointment” insert “or, as the case may be, determine that that person is no longer to hold that office and accordingly that person shall forthwith vacate office”.

(4) For regulation 6 (disqualification) substitute—

“Disqualification

6.—(1) Subject to paragraph (3), an individual is disqualified from being a member if the individual—

(a) is an undischarged bankrupt;
(b) is an incapable adult (within the meaning of section 1(6) of the Adults with Incapacity (Scotland) Act 2000 (asp 4));
(c) has, during the 5 years before the day the individual becomes a member, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Republic of Ireland of an offence for which the sentence imposed was imprisonment (whether suspended or not) for a period of three months or longer without the option of a fine;
(d) is disqualified from being included in any list kept under Part I or Part II of the Act or any list kept under equivalent legislation in England and Wales or Northern Ireland;
(e) is subject to a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 (c. 46) or equivalent legislation in Northern Ireland; or
(f) is disqualified from being a charity trustee by virtue of section 69(2)(c) or (d) of the Charities and Trustee Investment (Scotland) Act 2005 (asp 10).

(2) “Undischarged bankrupt” means an individual—

(a) whose estate has been sequestrated and who has not been discharged (or against whom a bankruptcy order has been made and is still in force);
(b) who has granted a trust deed for, or made a composition or arrangement with, creditors (and has not been discharged in respect of it);
(c) who is the subject of—

(i) a bankruptcy restrictions order, or an interim bankruptcy restrictions order, made under the Bankruptcy (Scotland) Act 1985 (c.66) or the Insolvency Act 1986 (c.45), or
(ii) a bankruptcy restrictions undertaking entered into under either of those Acts, or
(d) who has been adjudged bankrupt (and has not been discharged), or is subject to any other kind of order, arrangement or undertaking analogous to those described above, in England, Wales, Northern Ireland, the Channel Islands, the Isle of Man or the Republic of Ireland.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.”
The Scottish Ministers make the following Regulations in exercise of the powers conferred by paragraph 13 of Schedule 1A to the National Health Service (Scotland) Act 1978\(^a\) and all other powers enabling them to do so.

1 Citation and commencement
   (1) These regulations may be cited as the Health Board Elections (Scotland) Regulations 200x.
   (2) These regulations come into force on x xxx 200x.

2 Definitions
   (1) In these regulations, unless the context otherwise requires—
       the “1978 Act” means the National Health Service (Scotland) Act 1978 (c.29),
       the “1983 Act” means the Representation of the People Act 1983 (c.2),
       “absent voter” has the meaning given by rule 8,
       “absent voters list” has the meaning given by rule 9(1),
       “candidate statement” has the meaning given by rule 15(2),
       “the count” has the meaning given by rule 33(1)(a),
       “counting agent” means a person appointed under rule 21,
       “elected member” has the meaning given by paragraph 2(1)(c) of Schedule 1 to the 1978 Act,
       “election” means a Health Board election,
       “election court” has the meaning given by section 202(1) of the 1983 Act,
       “election day” means the day on which a Health Board election is held (see regulation 3 and paragraph 2(3) and (4) of Schedule 1A to the 1978 Act),

\(^a\) 1978 c.29.
“election notice” has the meaning given by rule 4,
“election petition” means a petition presented under Part 3 of the 1983 Act as that Part is applied to Health Board elections by regulation 7,
“electoral area” has the meaning given by section 204(1) of the 1983 Act,
“Health Board” means a Health Board constituted under section 2(1)(a) of the 1978 Act,
“Health Board election” has the meaning given by paragraph 1 of Schedule 1A to the 1978 Act,
“local government area” has the meaning given by section 204(1) of the 1983 Act,
“nomination period” has meaning given by rule 1,
“register of local government electors” means a register maintained under section 9(1)(b) of the 1983 Act,
“registration officer” has the meaning given by section 204(1) of the 1983 Act,
“relevant registration officer” has the meaning given by rule 6,
“returning officer” means returning officer for a Health Board election (see rule 2),
“specified number” has the meaning given by paragraph 6 of Schedule 1A to the 1978 Act,
“voter” means an individual entitled to vote at a Health Board election (see paragraph 10 of Schedule 1A to the 1978 Act and rule 5),
“voting pack” has the meaning given by rule 22(2),
“young persons register” has the meaning given by rule 7.

(2) Any reference in these regulations—
(a) to a numbered rule is a reference to the rule set out in schedule 1,
(b) to a numbered form is a reference to the form of that number set out in schedule 2.

3  Date of first elections in pilot areas
The first election in each Health Board area to which the [Health Board Elections (Scotland) Pilot Order 200x] applies is to be held on x xxxx 200x.

4  Health Board election rules
Schedule 1 contains rules applying to Health Board elections.

5  Forms
Schedule 2 contains forms relating to Health Board elections.

6  Identification of unelected candidate to fill vacancy
(1) For the purposes of paragraph 12(2)(a) of Schedule 1A to the 1978 Act, the “unelected candidate” who is to be invited to fill a vacancy is the individual who was credited at the last stage of the count at which a candidate was deemed to be elected with the greatest number of votes amongst the candidates who were not elected.
(2) But if that individual does not accept the invitation to be an elected member, the invitation may be extended to the individual with the next greatest number of votes at that stage.

(3) If two or more individuals were credited with the same number of votes, being the greatest or next greatest number of votes as specified in paragraph (1) or (2), the individual to be invited to fill the vacancy is to be determined by lot.

7 Application of Part 3 of the 1983 Act

(1) Part 3 of the 1983 Act applies to a Health Board election as it applies to an election of councillors in Scotland subject to the following modifications—

(a) any reference to—

(i) an election under the local government Act, or
(ii) a local government election (except for the reference in the definition of “elective office” in section 185),

is to be read as a reference to a Health Board election,

(b) any reference to a local authority is to be read as a reference to a Health Board,

(c) any reference to an election agent is to be read as a reference to a counting agent appointed under rule 21,

(d) any reference to councillors is to be read as a reference to elected members,

(e) for section 138(5) substitute—

“(5) Where two or more petitions are presented relating to the same Health Board election they shall be tried together.”,

(f) in section 147(2), for “constituency or local government area” substitute “Health Board area”,

(g) in section 159(3), for “councillor of any local authority in Scotland” substitute “member of any Health Board”,

(h) in section 160(4)(a)(i), after “Britain” insert “or at any Health Board election in Scotland”,

(i) in section 185—

(i) for the definition of “appropriate officer” substitute—

““appropriate officer” means the chairman of the Health Board for which the Health Board election in question was held.”,

(ii) for the definition of “candidate” substitute—

““candidate” means an individual nominated as a candidate in a Health Board election.”,

(iii) for the definition of “declaration as to election expenses” substitute—

““declaration as to election expenses” means a statement made by a candidate under rule 57(1) of schedule 1 to the Health Board Elections (Scotland) Regulations 200x”,

(iv) for the definition of “return as to election expenses” substitute—
“‘return as to election expenses’ means a statement made by a candidate under rule 57(1) of schedule 1 to the Health Board Elections (Scotland) Regulations 200x’.”
HEALTH BOARD ELECTION RULES

PART 1

TIMETABLE

Timetable

A Health Board election is to be conducted in accordance with the following timetable—

<table>
<thead>
<tr>
<th>Proceeding</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>1. Publication of election notice</td>
<td>At least 49 (but no more than 56) days before the election day.</td>
</tr>
<tr>
<td>2. Nomination period</td>
<td>Begins when election notice is published and ends at 5:00 p.m. on the day falling 35 days before the election day.</td>
</tr>
<tr>
<td>3. Sending of voting packs</td>
<td>At least 28 (but no more than 33) days before the election day.</td>
</tr>
<tr>
<td>5. Poll closes</td>
<td>4.00 p.m. on the election day.</td>
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</table>

PART 2

RETURNING OFFICERS

Returning officer

2 (1) The returning officer responsible for conducting a Health Board election is to be the returning officer for elections of councillors for the most populous local government area in the Health Board area (see section 41 of the 1983 Act).

(2) A returning officer may authorise any person to perform any of the officer’s functions (but such an authorisation affects neither the returning officer’s responsibility for delegated functions nor the officer’s ability to perform those functions personally),

(3) An election may not be questioned on grounds of defect in the title, or want of title, of the returning officer if that officer was then acting in the office giving the right to conduct the election.

Payments to returning officers

3 (1) The Health Board—

(a) must pay any expenses properly incurred by the returning officer in conducting an election, and

(b) may pay the returning officer an appropriate fee for conducting the election as the Board considers appropriate.
(2) A Health Board may make advance payments on account of expenses which the returning officer considers will be incurred.

**PART 3**

**ELECTION NOTICE**

*Notice of election*

4 (1) The returning officer must publish notice of a Health Board election (an “election notice”) in the form set out in Form 1 (or in a form to the like effect).

(2) The notice must specify—

(a) the nomination period,

(b) the place—

(i) where forms of nomination papers may be obtained, and

(ii) to which completed nomination papers must be delivered, and

(c) when the returning officer expects to issue voting packs, and

(d) when the poll closes.

**PART 4**

**VOTERS**

*Voters – eligibility*

5 (1) An individual aged 16 or over is entitled to vote at a Health Board election if, on the day on which the election notice is published, the individual—

(a) is registered—

(i) in a register of local government electors in respect of an address in the Health Board area, or

(ii) in the young persons register maintained for the Health Board area, and

(b) would be entitled to vote at a local government election in an electoral area falling wholly or partly in the Health Board area (or would be so entitled if aged 18 or over).

*Registration officer*

6 The “relevant registration officers” for a Health Board area are the registration officers for each local government area comprised in or forming part of the Health Board area.

*Young persons register*

7 (1) Each registration officer must maintain a young persons register.

(2) A person aged 15, 16 or 17 is entitled to be registered in a young persons register maintained by a registration officer if the person is—

(a) registered, in respect of an address in the Health Board area, in the register of local government electors maintained by the officer (by virtue of section 4(5) of the 1983 Act), or
(b) would, but for the person’s age, be entitled to be so registered.

(3) Each young persons register must contain—

(a) the names of—

(i) the young persons who are entitled to be registered in it by virtue of paragraph (2)(a), and

(ii) any young persons appearing to the registration officer to be entitled to be registered in it by virtue of paragraph (2)(b),

(b) the address in respect of which each young person is registered, and

(c) each registered young person’s special electoral number (being the number, or combination of letters and numbers, which the registration officer allocates to a registered young person).

(4) The following provisions of the 1983 Act (and any regulations made under those provisions) apply, with necessary modifications, to a young persons register as they apply to a register of local government electors—

(a) sections 9B and 9C (anonymous entry),

(b) section 10A, except for subsection (2) (applications),

(c) sections 13A and 13B (alterations),

(d) section 13D (false information).

(5) A young persons register for a Health Board area may be combined with—

(a) registers of parliamentary electors, or

(b) registers of local government electors,

but entries of persons must be marked to indicate which registers they are registered in.

Absent voters

8 (1) A person may apply to a relevant registration officer to have the person’s voting pack for a Health Board election delivered to an address other than the address in respect of which the person is registered in the register of local government electors, or young persons register, maintained by that officer.

(2) The relevant registration officer must grant an application if—

(a) it is valid (see paragraph (6)), and

(b) the officer satisfied that the applicant is (or will be by the time the next election notice is published) registered in the register of local government electors, or young persons register, in respect of an address within the Health Board area.

(3) A person whose application is granted under this rule is known as an “absent voter”.

(4) The relevant registration officer must notify an applicant of the officer’s decision on an application as soon as is reasonably practicable.

(5) Such a notification must, where an application is refused, give the reason for refusal.

(6) An application is invalid (and must not be granted) if received during the period beginning when an election notice is published in respect of an election in which the person is entitled to vote and ending when the poll at that election closes.
(7) A relevant registration officer who receives an invalid application must notify the applicant to explain why the application is invalid.

Absent voters list

9 (1) Each relevant registration officer must keep a list (the “absent voters list”) of the names of every absent voter together with the alternative addresses provided by them.

(2) A relevant registration officer must remove a voter from the absent voter’s list if the voter asks to be removed.

(3) Each relevant registration officer must make the absent voter’s list available for inspection at such place and times as the officer considers appropriate.

Duty to supply free copy of registers to returning officer

10 (1) Each relevant registration officer must, free of charge and as soon as is reasonably practicable after publication of an election notice, supply the returning officer with—

(a) an extract of the register of local government electors and the young persons register containing the details of every voter entitled to vote in the election, and

(b) an extract of the absent voters list containing the details of every absent voter entitled to vote in the election.

(2) Extracts must be provided in printed and data form.

(3) A returning officer may not disclose any information contained in the extracts, or make use of any such information, except for the purposes of the election.

Part 5

Candidates

11 (1) An individual is qualified to be a candidate at a Health Board election if—

(a) aged 16 or over,

(b) registered in the register of local government electors, or on the young persons register, in respect of an address in the Health Board area, and

(c) not disqualified from being a candidate.

(2) An individual is disqualified from being a candidate if the individual—

(a) is an appointed member or a councillor member of the Health Board,

(b) holds a post included in the list kept by the Health Board under rule 12,

(c) is an undischarged bankrupt,

(d) is an incapable adult (within the meaning of section 1(6) of the Adults with Incapacity (Scotland) Act 2000 (asp 4)),

(e) is disqualified from being elected under Part 3 of the 1983 Act,

(f) has, during the 5 years before being nominated as a candidate, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Republic of Ireland of an offence for which the sentence imposed was imprisonment (whether suspended or not) for a period of 3 months or longer without the option of a fine,
(g) is disqualified from being included in—
   (i) any list kept under Part 1 or 2 of the 1978 Act, or
   (ii) any list kept under equivalent legislation in England and Wales or Northern Ireland,

(h) is subject to a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 (c. 46) or equivalent legislation in Northern Ireland, or

(i) is disqualified from being a charity trustee by virtue of section 69(2)(c) or (d) of the Charities and Trustee Investment (Scotland) Act 2005 (asp 10),

(3) “Undischarged bankrupt” means an individual—
   (a) whose estate has been sequestrated and who has not been discharged (or against whom a bankruptcy order has been made and is still in force),
   (b) who has granted a trust deed for, or made a composition or arrangement with creditors (and has not been discharged in respect of it),
   (c) who is the subject of—
      (i) a bankruptcy restrictions order, or an interim bankruptcy restrictions order, made under the Bankruptcy (Scotland) Act 1985 (c.66) or the Insolvency Act 1986 (c.45), or
      (ii) a bankruptcy restrictions undertaking entered into under either of those Acts, or
   (d) who has been adjudged bankrupt (and has not been discharged), or is subject to any other kind of order, arrangement or undertaking analogous to those described above, in England, Wales, Northern Ireland, the Channel Islands, the Isle of Man or the Republic of Ireland.

List of restricted posts

12 (1) Each Health Board must keep a list of Health Board posts which involve—
   (a) giving advice on a regular basis to the Board (or to any of its committee or sub-committees), or
   (b) speaking on the Board’s behalf on a regular basis to journalists or broadcasters.

(2) The person appointed under section 3(1) of the Local Government and Housing Act 1989 (c.42) (the “adjudicator”) may give advice to a Health Board about the determination of any question arising by virtue of the Board’s duty to keep the list (and the Health Board must have regard to that advice when preparing and maintaining the list).

(3) An individual holding a Health Board post included in the list (or which the Health Board is proposing to so include) may apply to the adjudicator for the post to be exempt from list.

(4) A Health Board must give the adjudicator any information which the adjudicator may reasonably require for the purposes of determining such an application.

(5) If the adjudicator is satisfied that a post to which such an application relates does not involve any of the activities described in paragraph (1), the adjudicator must direct that the post—
(a) is not to be considered a restricted post, and
(b) is to be removed from (or is not to be included in) the list,
and a Health Board must comply with such a direction.

(6) The adjudicator must give priority to any such application which states that it is being made for the purpose of enabling the applicant to be a candidate in a forthcoming Health Board election.

Nomination papers

13 The returning officer must ensure that forms of nomination papers are available during the nomination period at the place specified in the election notice.

Nomination

14 (1) A candidate is nominated if a completed nomination paper (in, or as nearly as may be in, the form set out in Form 2) is delivered to the place specified in the election notice during the nomination period.

(2) A nomination paper is completed if it—
   (a) states the candidate’s full name and address,
   (b) states that the candidate consents to nomination,
   (c) is signed by the candidate and one witness, and
   (d) states the witness’ full name and address.

(3) If the candidate commonly uses a surname or forename which is different from any other name the candidate has, the nomination paper may state the commonly used name in addition to the other name.

Candidate statements

15 (1) A candidate may submit a candidate statement to the returning officer (together with the candidate’s nomination paper or at any other time before the nomination period ends).

(2) A candidate statement is a statement by the candidate—
   (a) not exceeding 250 words,
   (b) addressed to the voters in the Health Board election, and
   (c) which relates to that election only.

(3) A candidate statement may not include a description of a candidate which is likely to lead electors to associate the candidate with a registered political party unless—
   (a) the party is, on the day falling two days before the end of the nomination period, registered in respect of Scotland in the Great Britain register mentioned under Part 2 of the Political Parties, Elections and Referendums Act 2000b (“the 2000 Act”),
   (b) the description consists of either—
      (i) the name of the party registered under section 28 of the 2000 Act, or
      (ii) a description of the party registered under section 28A of the 2000 Act, and

b c. 41
(c) the description is authorised by a certificate—
   (i) issued by or on behalf of the party’s registered nominating officer, and
   (ii) received by the returning officer during the nomination period.

(4) A candidate statement may not include a description of a candidate which is likely to
lead electors to associate the candidate with two or more registered political parties
unless—
   (a) the parties are, on the day falling two days before the end of the nomination
       period, registered in respect of Scotland in the Great Britain register mentioned
       under Part 2 of the 2000 Act, and
   (b) the description is registered for the use of the parties under section 28B of the
       2000 Act, and
   (c) the description is authorised by a certificate—
       (i) issued by or on behalf of each party’s registered nominating officer, and
       (ii) received by the returning officer during the nomination period.

(5) “Registered political party” means a party registered under Part 2 of the 2000 Act on the
day falling two days before the end of the nomination period.

Withdrawal of nomination

16 (1) A nominated candidate may withdraw from an election for the purposes of paragraph
5(2) of Schedule 1A to the 1978 Act by delivering a notice of withdrawal to the
returning officer at the place to which completed nomination papers must be delivered.

(2) A notice of withdrawal must be—
   (a) in (or as nearly as may be in) the form set out in Form 3, and
   (b) signed by the candidate and one witness.

Prohibition of nomination in more than one Health Board election

17 (1) A candidate who is nominated in relation to more than one Health Board election must
withdraw in accordance with rule 16 from all but one of the elections.

(2) If such a candidate does not so withdraw the candidate is to be treated as having
withdrawn from every election for which the candidate was nominated.

Validity of nomination

18 (1) An candidate ceases to be nominated if—
   (a) the candidate withdraws before the nomination period ends,
   (b) the candidate is treated as having withdrawn under rule 17(2),
   (c) the candidate is disqualified by rule 11 (or becomes so disqualified before the
       nomination period ends),
   (d) the candidate dies before the nomination period ends, or
   (e) the returning officer decides, no later than 24 hours after the nomination period
       ends, that the candidate’s nomination paper is invalid.
(2) A returning officer may decide that a nomination paper is invalid only if it is not completed in accordance with rule 14(2).

(3) If a returning officer decides that a nomination paper is invalid, the officer must—
   (a) endorse on the paper the decision and the reasons for it,
   (b) sign the paper, and
   (c) send notice of the decision to the candidate’s address as stated on the paper.

(4) A returning officer’s decision on validity of a nomination paper is final (but does not prevent the validity of a nomination from being questioned on an election petition).

Correction of minor errors in nomination paper

19 (1) A returning officer may, no later than 24 hours after the nomination period ends, correct minor errors in a nomination paper.

(2) Anything done by a returning officer under this rule may not be questioned other than in proceedings on an election petition.

Inspection of nomination papers

20 The returning officer must make nomination papers available for inspection (and copying) at such reasonable times between the end of the nomination period and the poll closing as the returning officer considers appropriate.

Counting agents

21 (1) The returning officer must, no later than 24 hours after the nomination period ends, give each candidate written notice of the maximum number of counting agents each candidate may appoint.

(2) A candidate may appoint one or more counting agents (up to the maximum number determined by the returning officer) by giving the returning officer written notice of the counting agent’s names and addresses no later than 21 days before the election day.

(3) A counting agent is entitled to attend—
   (a) the sending of voting packs (if appointed before they are sent), and
   (b) the count.

PART 6

VOTING PACKS AND BALLOT PAPERS

Voting packs

22 (1) The returning officer send deliver a voting pack to each voter at—
   (a) the address in respect of which the voter is registered, or
   (b) if the voter is an absent voter, at the voter’s alternative address.

(2) A voting pack must contain—
   (a) a ballot paper (see rule 23),
(b) a copy of any candidate statements submitted by the candidates named on the ballot paper,

(c) instructions for completing the ballot paper and returning it to the returning officer (including details of the address to which it is to be returned and the deadline for returning it),

(d) information about how to obtain those instructions in other forms (for example: in Braille, in audible form or in a language other than English), and

(e) an envelope with the address to which the ballot paper is to be returned printed on it and which the voter may use to return the ballot paper (a “covering envelope”).

(3) A the returning officer may refuse to include a candidate statement in voting packs if the officer considers any of its content to be unlawful.

(4) The cost of returning the ballot paper in the covering envelope must be pre-paid by the returning officer.

(5) The returning officer may use—

(a) a universal service provider (within the meaning of the Postal Services Act 2000 (c.26)), or

(b) a commercial delivery firm,

for the purpose of sending voting packs.

(2) Where such a provider or firm is used—

(a) voting packs must be counted and delivered by the returning officer to the provider or firm, and

(b) the officer must obtain a receipt for that delivery endorsed by the provider or firm.

Ballot papers

23 (1) A ballot paper must—

(a) be in (or as nearly as may be in) the form set out in Form 4,

(b) contain the names and addresses of the nominated candidates as shown on the respective nomination papers (arranged alphabetically by surname),

(c) have a unique number (being a number, letters, a combination of letters and numbers or other identifying mark) printed on the back, and

(d) contain an official mark.

(2) The official mark must be kept secret (and must not be the same as the official mark used at a Health Board election held in the same Health Board area at any time during the previous 5 years)

(3) If a candidate’s nomination paper states that the candidate has a commonly used forename or surname (see rule 14(3)), the commonly used name (instead of any other name) must appear on the ballot paper.

Marking of lists when voting packs sent

24 (1) The returning officer must first send voting packs to every voter in the officer’s extract of the absent voters list and must—
(a) mark the unique number of the ballot paper contained in the voting pack sent to a voter against the entry corresponding to that voter in that extract,
(b) mark with the letter “A” each entry corresponding to an absent voter in the officer’s extracts of the register of local government electors and the young persons register so as to denote—
   (i) that the voter is an absent voter, and
   (ii) that a voting pack has been sent to the voter’s alternative address.

(2) The returning officer must then send voting packs to every voter in the officer’s extract of the young persons register (other than those marked “A”) and must—
   (a) mark the unique number of the ballot paper contained in the voting pack sent to a voter against the entry corresponding to that voter in that extract,
   (b) mark with the letter “Y” each entry corresponding to an absent voter in the officer’s extracts of the register of local government electors so as to denote—
       (i) that the voter is a young person, and
       (ii) that a voting pack has been sent to the voter.

(3) The returning officer must finally send a voting pack to every voter in the officer’s extract of the register of local government electors (other than those marked “A” or “Y”) and must mark the unique number of the ballot paper contained in the voting pack sent to a voter against the entry corresponding to that voter in that extract.

(4) If the returning officer is satisfied that 2 or more entries in the absent voters list, the young persons register or the register of local government electors relate to the same voter, the officer must not issue more than one voting pack to that voter.

Notice of sending of voting packs

25 (1) The returning officer must give each candidate at least 48 hours’ notice of the time and place at which the officer will send voting packs to voters.

(2) If the returning officer subsequently requires to send more voting packs to voters, the officer must, as soon as is reasonably practicable, notify each candidate of the time and place at which this will occur.

Voter without ballot paper

26 (1) A voter who has not received a voting pack by the day falling 7 days before the day on which the poll closes may apply to the returning officer for a replacement voting pack.

(2) Such an application—
   (a) may be made in writing or in person, and
   (b) must include evidence of the voter’s identity.

(3) The returning officer must issue a replacement voting pack only if—
   (a) the application is made at least 24 hours before the poll closes, and
   (b) the officer—
       (i) is satisfied as to the voter’s identity, and
       (ii) has no reason to doubt that the voter did not receive the original voting pack.
(4) The returning officer must keep a list containing—
   (a) the name and address of each voter to whom a replacement voting pack is issued, and
   (b) the number of the ballot paper contained in missing voting pack and of its replacement in respect of each such voter.

(5) Rules 22 and 23 apply to replacement voting packs as they apply to any voting pack (although a returning officer may hand a replacement voting pack to a voter in person).

**PART 7**

**CASTING OF VOTES**

**Casting of votes**

27 A voter casts a vote in a Health Board election by delivering a completed ballot paper to the returning officer at the address specified for that purpose in the voting pack.

**Ballot papers received late**

28 A ballot paper received by the returning officer after the poll closes is not to be counted unless the returning officer considers it reasonable to do so.

**Prohibition of disclosure of vote**

29 No voter may be required to state for whom the voter cast a vote in any legal proceedings.

**Notification of requirement of secrecy**

30 Every person attending proceedings in connection with the sending of voting packs or the receipt of ballot papers must maintain and aid in maintaining the secrecy of the voting and must not, except for some purpose authorised by law—
   (a) communicate, before the poll closes, to any person any information obtained at those proceedings as to the official mark, and
   (b) communicate, at any time, to any person any information obtained at those proceedings as to the number on the back of any ballot paper.

**Spoilt ballot papers and covering envelopes**

31 (1) If a voter inadvertently does something to the voter’s ballot paper so that it cannot be used as such (a “spoilt ballot paper”), the voter may return (by hand or by post) the spoilt ballot paper and the covering envelope to the returning officer.

(2) If a voter inadvertently does something to the voter’s covering envelope so that it cannot be used as such (a “spoilt covering envelope”), the voter may return (by hand or by post) the spoilt covering envelope to the returning officer.

(3) On receipt of a spoilt ballot paper and covering envelope or spoilt covering envelope, the returning officer must send (or give by hand) another voting pack or, as the case may be, covering envelope, to the voter unless the returning officer considers it is too late for a ballot paper to be returned before the poll closes.
(4) If the returning officer sends or gives a voter another voting pack in accordance with this rule, the officer must mark the unique number of the ballot paper contained in the voting pack against the entry corresponding to that voter in the officer’s extract of the register of local government electors or, as the case may be, extract of the young persons register.

**PART 8**

**THE COUNT**

*Ballot boxes*

32 (1) The returning officer must provide one or more ballot boxes for the receipt of ballot papers.

(2) Every ballot box must be marked with—
   (a) the words “ballot papers”, and
   (b) the name of the Health Board for which the Health Board election is held.

(3) Every covering envelope received by the returning officer before the poll closes is to be placed in a ballot box (other than those returned under rule 31).

(4) The returning officer must make provision for the safe custody of every ballot box.

(5) Every ballot box must be opened at the count.

*The count*

33 (1) The returning officer must—
   (a) make arrangements for the counting of votes (known as “the count”) as soon as practicable after the poll closes, and
   (b) give written notice to the counting agents of the time and place at which the count will occur.

(2) The returning officer must so far as practicable proceed continuously with the count allowing only time for refreshment.

But the returning officer may, with the agreement of the counting agents, exclude any hours between 7 p.m. on the evening following the poll closing and 9 a.m. on the following morning.

*Electronic counting*

34 (1) In these rules “electronic counting system” means such computer hardware and software, other equipment, data and services as is necessary in order to—
   (a) read electronically the votes marked and the unique number printed on each ballot paper,
   (b) calculate the number of votes cast for each candidate at the Health Board election, and
   (c) ensure the retention of a record of the votes cast for each candidate, without identifying the voters who cast those votes.
(2) The returning officer must conduct the count by means of an electronic counting system (and may do anything in connection with the count by electronic means in order to enable the count to be so conducted).

But if it is impossible or impracticable to conduct the count, or any part of it, using the electronic counting system, the returning officer may make arrangements for the count, or any part of it, to be conducted by other means.

(3) References in rules 39 to 44 to ballot papers and parcels of ballot papers include references to ballot papers and parcels in electronic form.

Attendance at the count

35 (1) Nobody may attend the count other than—
   (a) the returning officer and the officer’s staff,
   (b) the candidates and their partners, and
   (c) the counting agents.

But the returning officer may permit another person to attend the count if the officer is satisfied that doing so would not impede the efficient counting of the votes.

(3) The returning officer must give the counting agents such reasonable facilities for overseeing the count, and such information about the count, as the officer can give consistently with the orderly conduct of the proceedings and the performance of the officer’s duties.

Opening of ballot boxes and covering envelopes

36 (1) The count is begun by the returning officer opening each ballot box.

(2) The returning officer must then—
   (a) count and note the number of covering envelopes, and
   (b) open each covering envelope separately.

(3) If a covering envelope does not contain a ballot paper the returning officer must—
   (a) mark the covering envelope with the word “rejected”,
   (b) attach to it the contents (if any) of the envelope, and
   (c) place the envelope in a separate receptacle (the “rejected votes box”).

(4) If a covering envelope does contain a ballot paper, the returning officer must place it in a different receptacle from the rejected votes box.

Counting of ballot papers

37 The returning officer must count all the ballot papers which have been removed from the covering envelopes and record the number counted.

Rejected ballot papers

38 (1) A ballot paper is void and not to be counted if—
   (a) it does not bear a unique number in a form capable of being read by electronic means,
(b) the figure “1” is not placed on it in a manner which indicates a first preference for a candidate,
(c) the figure “1” is placed on it in that manner in respect of more than one candidate,
(d) anything is written or marked on it by which the voter can be identified (except for the unique number printed on the back), or
(e) it is unmarked or void for uncertainty.

(2) But a ballot paper on which the vote is marked—
(a) elsewhere than in the proper place,
(b) otherwise than by means of a figure indicating a first or subsequent preference, or
(c) by more than one mark,

is not void and must be counted if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences and the way the paper is marked does not itself identify the voter or allow the voter to be identified.

(3) The returning officer must mark the word “rejected” on any ballot paper which is not to be counted and place the paper in the rejected votes box.

(4) A counting agent may object to the returning officer’s decision not to count a ballot paper.

(5) If such an objection is made, the returning officer must mark the words “rejection objected to” on the ballot paper to which the objection relates.

(6) The returning officer must prepare a statement showing—
(a) the number of ballot papers which are not to be counted by virtue of each of sub-paragraphs (a) to (e) of paragraph (1), and
(b) the number of covering envelopes placed in the rejected votes box by virtue of rule 36(3).

First stage

39 (1) The returning officer must sort the valid ballot papers into parcels according to the candidates for whom first preference votes are given.

(2) The returning officer must then—
(a) count the number of ballot papers in each parcel,
(b) credit the candidate receiving the first preference vote with one vote for each ballot paper in that candidate’s parcel, and
(c) record those numbers.

(3) The returning officer must also ascertain and record the total number of valid ballot papers.

The quota

40 (1) The returning officer must divide the total number of valid ballot papers by a number exceeding by one the number of elected members to be elected in the Health Board election.
(2) The result of that division (rounding down any decimal places), increased by one, is the number of votes needed to secure the return of a candidate as an elected member (the “quota”).

Return of elected members

41 (1) If, at any stage of the count, the number of votes for a candidate equals or exceeds the quota, the candidate is deemed to be elected.

(2) A candidate is returned as an elected member when the candidate is declared to be elected in accordance with rule 50.

Transfer of ballot papers

42 (1) If, at the end of any stage of the count, the number of votes credited to a candidate exceeds the quota and one or more vacancies remain to be filled, the returning officer must (unless rule 46 applies) sort the ballot papers received by that candidate into further parcels so that they are grouped—

(a) according to the next available preference given on those papers, and

(b) if no such preference is given, as a parcel of non-transferable papers.

(2) The returning officer must—

(a) transfer each parcel of ballot papers referred to in paragraph (1)(a) to the continuing candidate for whom the next available preference is given on those papers, and

(b) credit the candidate with an additional number of votes calculated in accordance with paragraph (3).

(3) The vote on a ballot paper transferred under paragraph (2) has a value (the “transfer value”) calculated as follows—

\[ \text{A divided by B} \]

Where—

\[ \text{A} = \text{the value which is calculated by multiplying the surplus of the transferring candidate by the value of the ballot paper when received by that candidate, and} \]

\[ \text{B} = \text{the total number of votes credited to the transferring candidate.} \]

(4) For the purposes of paragraph (3)—

“transferring candidate” means the candidate from whom the ballot paper is being transferred, and

“the value of the ballot paper” means—

(i) for a ballot paper on which a first preference vote is given for the transferring candidate, one, and

(ii) for any other ballot paper, the transfer value of the ballot paper when received by the transferring candidate.

Transfer of ballot papers – supplementary provisions

43 (1) If, at the end of any stage of the count, the number of votes credited to two or more candidates exceeds the quota, the returning officer must—
(a) first sort the ballot papers of the candidate with the highest surplus, and
(b) then transfer the transferable papers of that candidate.

(2) If the surpluses in respect of two or more candidates are equal, the transferable ballot papers of the candidate who had the highest number of votes at the end of the most recent preceding stage at which they had unequal numbers must be transferred first.

(3) If the number of votes credited to two or more candidates were equal at all stages, the returning officer must decide, by lot, which candidate’s transferable papers are to be transferred first.

Exclusion of candidates

44 (1) If one or more vacancies remain to be filled and—

(a) the returning officer has transferred all ballot papers which are required by rule 42 or this rule to be transferred, or

(b) there are no ballot papers to be transferred under rule 42 or this rule,
the returning officer must (unless rule 46 applies) exclude from the election at that stage the candidate with the lowest number of votes.

(2) The returning officer must sort the ballot papers for the excluded candidate into parcels so that they are grouped—

(a) according to the next available preference given on those papers, and

(b) if no such preference is given, as a parcel of non-transferable papers.

(3) The returning officer must—

(a) transfer each parcel of ballot papers referred to in paragraph (2)(a) to the continuing candidate for whom the next available preference is given on those papers, and

(b) credit the candidate with an additional number of votes calculated in accordance with paragraph (4).

(4) The vote on a ballot paper transferred under paragraph (3) has a transfer value of one (unless the vote was transferred to the excluded candidate under rule 42 or this rule in which case it has the same transfer value as when transferred to the excluded candidate).

Exclusion of candidates – supplementary provisions

45 If, when a candidate is to be excluded under rule 44—

(a) two or more candidates have the same number of votes, and

(b) no other candidate has fewer votes,
the returning officer must exclude the candidate who had the lowest number of votes at the end of the most recent preceding stage at which they had unequal numbers.

If the number of votes credited to those candidates was equal at all stages, the returning officer must decide, by lot, which of those candidates to exclude.
Filling of last vacancies

46 If, at any stage of the count, the number of continuing candidates is equal to the number of vacancies remaining—
   (a) the continuing candidates are deemed to be elected, and
   (b) no further transfer is to be made.

Recount

47 (1) A candidate or a counting agent may require the returning officer to conduct a recount or further recount but only if the candidate or counting agent was present at the completion of the count or the previous recount.
   (2) The returning officer may refuse to conduct a recount or further recount if the officer considers the request to conduct it is unreasonable.
   (3) The candidates and counting agents present at the completion of the count or a recount must be given a reasonable opportunity to exercise the right to require a recount before any further steps are taken by the returning officer.

Decisions during the count

48 The returning officer’s decision (express or implied) on any question arising in respect of—
   (a) a ballot paper,
   (b) the exclusion of a candidate, or
   (c) the transfer of votes.
is final except to the extent that it may be reviewed on an election petition.

Counting of votes by means other than electronic counting

49 (1) If the returning officer makes arrangements in accordance with rule 34(2) for the count (or any part of it) to be conducted other than by means of an electronic counting system, these rules apply with the following modifications.
   (2) For rule 38(1)(a) substitute—
       “(a) it does not bear the official mark,”.
   (3) In rule 46, the existing text is treated as paragraph (1) and the following new paragraph is inserted—
       “(2) If only one vacancy remains unfilled and the number of votes then credited to any one continuing candidate (the “highest continuing candidate”) is equal to or greater than the total number of votes then credited to all the other continuing candidates—
           (a) the highest continuing candidate is deemed to be elected, and
           (b) no further transfer is to be made.”.
PART 9

DECLARATION OF THE RESULT

Declaration of result of poll

50 When the count (or a recount) results in all the vacancies being filled and no recount (or further recount) is to be held, the returning officer must as soon as is reasonably practicable—

(a) declare to be elected the candidates who have been deemed to be elected as elected members of the Health Board for which the election was held,

(b) give notice of the names of the elected candidates to the chairman of the Health Board, and

(c) give public notice of—

(i) the names of the elected candidates,

(ii) the number of first and subsequent preference votes for each candidate,

(iii) the number of ballot papers transferred and their transfer values at each stage of the count,

(iv) the number of votes credited to each candidate at each stage,

(v) the number of non-transferable ballot papers at each stage, and

(vi) the content of the statement prepared under rule 38(6).

Declaration of result where no poll held

51 If the returning officer makes a declaration under paragraph 7 of Schedule 1A to the 1978 Act—

(a) the declaration must be made before 11 a.m. on the day on which it is to be made, and

(b) the returning officer must give public notice of the details of the declaration.

PART 10

DOCUMENTS RELATING TO A HEALTH BOARD ELECTION

Sealing up of ballot papers

52 (1) As soon as is reasonably practicable after the result of a Health Board election has been declared, the returning officer must—

(a) seal up—

(i) the valid ballot papers into packets, and

(ii) the rejected ballot papers and the rejected covering envelopes together in one packet, and

(b) store an electronic copy of the information stored in the electronic counting system in a suitable device.

(2) The returning officer must not open the things sealed up under paragraph (1)(a).
(3) As soon as is reasonably practicable after the electronic copy mentioned in paragraph (1)(b) has been stored, the returning officer must ensure—

(a) that all electronic data or records relating to the Health Board election are removed from the electronic counting system, and

(b) that it (and any copy of the data or records other than the copy mentioned in paragraph (1)(b)) is destroyed in a manner which ensures that the confidentiality of the data or records is preserved.

Delivery of documents

53 (1) The returning officer must then deliver to the chairman of the Health Board for which the election was held—

(a) the things mentioned in rule 52(1),

(b) the extracts of the register of local government electors, young persons register and absent voters list sent to the officer under rule 10 and marked in accordance with rules 24 and 31(4),

(c) the list kept under rule 26(4), and

(d) the statement prepared under rule 38(6).

(2) The returning officer must mark on each thing to be forwarded—

(a) a description of it,

(b) the date on which the poll closed, and

(c) the name of the Health Board for which the election was held.

(3) No person is permitted to open or inspect anything forwarded to a Health Board chairman unless authorised by a sheriff principal or the Court of Session under rule 54.

Orders for production of documents

54 (1) A relevant sheriff principal or an election court may make an order for the inspection or production (including, if necessary, the opening) of anything forwarded to a Health Board chairman under rule 53.

(2) But a relevant sheriff principal may make such an order only if satisfied that it is required for the purpose of—

(a) instituting or proceeding with a prosecution for an offence in relation to ballot papers, or

(b) for the purpose of an election petition.

(3) An order under paragraph (1) may be made subject to such conditions as the sheriff principal or the election court considers appropriate.

(4) In making or carrying into effect an order under paragraph (1) care must be taken that the vote of any particular voter is not disclosed until it has been proved that—

(a) the voter voted in the Health Board election in question, and

(b) the vote has been declared by a competent court to be invalid.

(5) An appeal lies to the Court of Session from an order of a sheriff principal made under paragraph (1).
(6) Any power given to a sheriff principal under this rule may be exercised otherwise than in open court.

(7) If an order is made for the production by a Health Board chairman of anything in the chairman’s possession relating to a Health Board election—
   (a) the production of the thing by the chairman is conclusive evidence that the thing relates to that election, and
   (b) any mark made on the thing in accordance with rule 53(2) is evidence that thing is what it is stated to be by the mark.

(8) In this rule, “relevant sheriff principal” means—
   (a) the sheriff principal having jurisdiction in the Health Board area (or any part of it) for which the election in question was held, or
   (b) where more than one sheriff principal has such jurisdiction, any such sheriff principal.

Retention of documents

55 (1) The chairman of a Health Board must retain among the records of the Health Board—
   (a) for four years, the electronic copy mentioned in rule 52(1)(b), and
   (b) for one year, everything else forwarded to the chairman under rule 53.

(2) At the expiry of the period of four years or, as the case may be, one year, the Health Board chairman must destroy anything retained under this rule unless directed not to do so by a sheriff principal or the Court of Session under rule 54.

PART 11
ELECTION EXPENSES

Candidates’ election expenses

56 (1) A candidate at a Health Board election must not incur expenses on account of or in respect of the conduct or management of the election in excess of £250 (regardless of whether the expenses are incurred before, during or after the election).

(2) If a candidate’s election expenses exceed £250, any candidate or counting agent who—
   (a) incurred (or authorised the incurring of) those expenses, or
   (b) knew or ought reasonably to have known that election expenses would exceed £250,

is guilty of an illegal practice for the purposes of Part 3 of the 1983 Act.

Election expenses statements

57 (1) No later than 35 days after the day on which the result of a Health Board election is declared, every candidate at the election must deliver to the returning officer a statement of all payments made by that candidate on account of or in respect of the conduct or management of the election together with all bills or receipts relating to such payments.

(2) The statement must be in such form as the returning officer thinks fit.
PART 12
SPECIAL RULES RELATING TO INELIGIBLE CANDIDATES

Special rules where candidate becomes ineligible after end of nomination period

58 (1) This rule applies if a candidate, during the period from the end of the nomination period to the declaration of the result of the poll—
   (a) dies, or
   (b) becomes disqualified from being a candidate within the meaning of rule 11(2).

(2) If the result of the poll is such that the candidate is not declared to be elected as an elected member, the result of the poll stands.

(3) If the result of the poll is such that the candidate is declared to be elected as an elected member the returning officer must, when declaring the result, declare that—
   (a) the candidate is no longer eligible to be a candidate (or has died), and
   (b) accordingly there is a vacancy to be filled in accordance with paragraph 12 of Schedule 1A to the 1978 Act.
SCHEDULE 2
(introduced by regulation 5)

FORMS

[Form 1 – Notice of a health Board election]

[Form 2 – Nomination paper]

[Form 3 – Notice of withdrawal of nomination]

[Form 4 – Ballot paper]

Robert Kirkwood,
Policy Officer,
Scottish Government
29 October 2008
Scottish Parliament
Health and Sport Committee

Wednesday 5 November 2008

[THE CONVENER opened the meeting at 10:05]

Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

10:06

The Convener: We move on to take oral evidence on the bill. Today, we are taking evidence from the Scottish Government’s bill team. I welcome Kenneth Hogg, who is the deputy director of health delivery, Beth Elliot, solicitor, and Robert Kirkwood, policy officer. I will move straight to questions from members.

Mary Scanlon (Highlands and Islands) (Con): I have a couple of questions on paragraph 9 of proposed new schedule 1A to the National Health Service (Scotland) Act 1978.

I think that we all understand who is qualified to be a candidate, but who is likely to be disqualified? Would someone be disqualified on the grounds of age or political allegiance, or employment in the national health service?

Robert Kirkwood (Scottish Government Health Delivery Directorate): It will be open to people to stand for election and we would not put a bar on someone who had a particular political allegiance. Some people, however, would not be able to stand, perhaps because of their role in relation to the health board. That is in line with local government procedure, whereby some posts are specified as politically restricted, because the people in them have to provide regular advice or briefings to local government. We foresee something similar for health board elections.

Mary Scanlon: So would someone who works in a managerial capacity—as opposed to a doctor, consultant, nurse, physiotherapist, chiropodist, podiatrist or whatever—and fulfils their professional role but does not give advice to the health board be entitled to stand?

Beth Elliot (Scottish Government Legal Directorate): They would. The list of people who are disqualified from standing is set out in part 5 of schedule 1 to the draft Health Board Elections (Scotland) Regulations. I think that committee members have a copy of those.

Mary Scanlon: I did not get around to reading those regulations. Would you mind quickly running through the list?

Beth Elliot: It is basically those who are currently disqualified from standing as a member, such as undischarged bankrupts, those who are incapable, those who have been convicted of a criminal offence in certain cases, and those who have been disqualified from being a charity trustee. Those categories of people are set out in the regulations.
Mary Scanlon: So there is no bar on the basis of age.

Beth Elliot: No.

Mary Scanlon: There is only a bar if someone is employed in the NHS and gives advice to the health board, because that might cause a conflict of interest. Is that correct?

Beth Elliot: Yes. The regulations require the health board to have a list of restricted posts, and people in those posts would not be entitled to stand as a candidate. However, those are—

Mary Scanlon: Sorry, but I think that this is important, convener. Would Ms Elliot mind just giving me a brief outline of the restricted posts?

The Convener: Before we move on to that, I just point members to schedule 1 to the draft Health Board Elections (Scotland) Regulations, which refers to “List of restricted posts” at part 5, paragraph 12.

Mary Scanlon: That is fine. I will read that.

Paragraph 12(2)(b) of proposed new schedule 1A to the National Health Service (Scotland) Act 1978 indicates that, if a vacancy arose in a health board because, for example, an elected member resigned, someone could be appointed “to fill the vacancy.” In our Parliament’s electoral system, if a list member resigned, the next one on the list would be appointed. The bill indicates that, if a vacancy arose on a health board, an appointee would take the elected person’s place. Can someone explain the rationale behind that?

Beth Elliot: If there was a vacancy, the bill would allow the next person on the list to be appointed. The draft regulations set out that the unelected candidate who is next on the list can be nominated. The provision in paragraph 12(2)(b) of proposed new schedule 1A to the 1978 act, which states that the Scottish ministers can appoint a health board member, is intended to cover the worst-case scenario of not enough candidates standing. In those circumstances, the Scottish ministers would appoint someone.

Mary Scanlon: Paragraph 12(2), to which you referred, states that ministers may:

“(a) direct the Health Board … to invite an unelected candidate … or
(b) appoint, in accordance with”

provisions.

Beth Elliot: The unelected candidate is defined in paragraph 12(5) of proposed new schedule 1A to the 1978 act as being

“identified by criteria specified in election regulations.”

Mary Scanlon: So it would be someone who had stood.

Beth Elliot: Yes. It would be someone who had stood in the election.

Mary Scanlon: Okay. I have a final point for now. In elections for community councils, if there are 12 places and 12 people put their names forward, there is no election. If there were 12 vacancies for a health board and 12 people or fewer applied, would the election still go ahead?

Beth Elliot: No. If I can direct you to paragraph 7—

Mary Scanlon: Is that paragraph 7 of the regulations?

Beth Elliot: No, of the bill. Paragraph 7 of proposed new schedule 1A to the 1978 act states:

“If … the number of nominated candidates … is equal to or less than”

the number of members to be elected, then instead of having an election, the returning officer would declare those people to be elected.

Mary Scanlon: Okay. So there would be no need for an election, if the number of candidates was less than or equal to the number of vacancies.

Beth Elliot: That is right.

Mary Scanlon: I have other questions, but I will come back to them later.

The Convener: What would happen if, in an area where there was supposed to be an election, not enough people stood?

Beth Elliot: That would be covered by the provision in paragraph 12(2)(b) of proposed new schedule 1A to the 1978 act, which would be specified further in the election regulations.

The Convener: Have we got those?

Beth Elliot: You do have the election regulations.

The Convener: Is that the large document that I am holding up?

Beth Elliot: Yes.

The Convener: And where are the regulations in here?

Beth Elliot: I do not think that those particular provisions are in the election regulations at the moment. That is something that we need to consider further.

The Convener: So, in the case of an election being null and void because not enough people stood, we do not yet know what would happen.

Kenneth Hogg (Scottish Government Health Delivery Directorate): It is fair to say that if, under the proposed process, health board members were appointed by the Scottish ministers, they
would be bound by the public appointments system. The same process that is currently used to appoint chairs and non-executive members would be applied for any new health board members appointed by the Scottish ministers.

The Convener: So the process would revert to the old system.

Kenneth Hogg: If we reached the point of a directly elected board being unable to secure enough candidates for it to be quorate and competent and if the functioning of the board required the Scottish ministers to make appointments, we would revert to the public appointments system. However, that is very much a last resort, and the provisions are designed to avoid reaching that point.

10:15

The Convener: I do not want to hog the discussion, but I will pursue that point. Elections are to be held every four years. In the circumstances that we have discussed, would there be provision to hold an election within a shorter time, or would the reversion to the old system continue for the rest of the four-year period?

Kenneth Hogg: I think that that is provided for in the bill.

The Convener: What is provided for—the fact that an election could be held before the end of the four-year period?

Kenneth Hogg: Yes.

The Convener: Where is that?

Beth Elliot: We would have the power to have an earlier election.

The Convener: Where is that in the bill?

Beth Elliot: The power to have elections?

The Convener: Yes. Can you show me where that is?

Beth Elliot: The regulations do not currently include provisions on what happens if not enough people stand as candidates, which is something that we will consider further.

The Convener: I will finish this questioning, but the Subordinate Legislation Committee notes that the regulations will be made under negative procedure unless you substantively alter the bill. If you want a measure other than a four-yearly election—for when there is not sufficient interest to have an election under the new regime and you revert to the old regime— provision for that would have to be in the bill rather than regulations.

Kenneth Hogg: On page 3 of the bill, in the final part of paragraph 2, it says that “a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3)—

The Convener: Sorry, could you confirm where you mean?

Kenneth Hogg: Section 2(2) inserts some text into the 1978 act. The final part of that new text, subparagraph (4), is at the top of page 3 and states—

The Convener: Hang on. Please take me through the paper trail. You have taken me to section 2 of the bill, entitled “Health Board elections”.

Beth Elliot: Section 2(2) of the bill inserts a new schedule into the 1978 act, and we are talking about paragraph 2(4) of that new schedule.

The Convener: That says that “a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3) if the Scottish Ministers make an order under section 77” of the 1978 act.

Kenneth Hogg: That provides that we would not have to wait a full four years for an acceptable outcome. Elections could be held much sooner.

The Convener: So that may remedy the point, although I will have to look at that again more closely.

Ross Finnie (West of Scotland) (LD): As this is stage 1, I want to go back a step to be clear about the principles, although I appreciate that other members will have detailed questions that raise matters of principle. I will ask a quick question as a preliminary to my two more substantive questions: does the bill improve accountability, or is it about representation?

Kenneth Hogg: Both. The accountability point comes into the concept of mutuality, which was introduced in the Government’s “Better Health, Better Care” policy document issued in December 2007. That introduced the concept of co-ownership, including the public, of the NHS in Scotland. Accountability must continue to rest, through ministers, with the Scottish Parliament, but the concept of mutuality broadens the definition. The bill will allow for the voice of the public to be heard and to influence decision making in boards.

Ross Finnie: Which is representation.

Kenneth Hogg: Indeed.

Ross Finnie: I understand the rhetoric and the ambition behind mutuality. However, given that the Cabinet Secretary for Health and Wellbeing retains ultimate responsibility, I am not sure that you can argue cogently that the bill materially alters accountability.
Kenneth Hogg: That is correct. Accountability remains with the ministerial department and the directly elected members would be bound by the same corporate governance arrangements that other board members are bound by.

Ross Finnie: There are two parts to my question. I have learned from Mary Scanlon and others that what you should do is declare that you have one question and then ask it in three parts.

Mary Scanlon: It takes years of practice.

Ross Finnie: I know. I realise that I am new to all of this.

The Convener: I feel doomed.

Ross Finnie: I suppose that it depends on where you are, but certainly no less than 80 per cent of all health care is delivered in the community. How will the principles behind community health partnerships be developed if directly elected local councillors are pitted against directly elected health board members?

Kenneth Hogg: Community health partnerships already comprise local government and NHS—

The Convener: I must stop you there, Mr Hogg. Mr Finnie, we should be cautious and bear in mind the officials’ remit.

Ross Finnie: Indeed. I do not in any way want to suggest that Mr Kenneth Hogg is not aware of the full extent and limitation of his powers.

The Convener: I just wanted to put that on the record.

Ross Finnie: But I am sure that he is extraordinarily able to express his views on matters of principle.

The Convener: I cannot tell them anything, Mr Hogg. Please proceed.

Kenneth Hogg: We must avoid a situation in which board members, however they have been established, are pitted against each other. After all, they are working within a single board’s corporate governance arrangements for the single purpose of letting the board find the best ways of meeting its population’s health needs.

As is the case with appointed board members, all directly elected members will receive training and development on the expectations of board members and the responsibilities that come with the position. The point that board members should maintain the board’s unity and solidarity rather than take up opposing positions will be very much reinforced.

Ross Finnie: As the convener has rightly pointed out, there is a political element to all this that we are not going to pursue today. However, what is your view of the opinion expressed in written responses that, given the fact that accountability cannot be altered, the aim of broader representation might be better achieved by extending the membership of community health partnerships to the community? The view was not unanimously held, but elements of it were expressed in submissions by Glasgow City Council, East Lothian Council, the Royal College of Nursing, Argyll and Bute Council, NHS Forth Valley, Aberdeen City Council, the Convention of Scottish Local Authorities, North Lanarkshire Council, Highland Council and the City of Edinburgh Council. Are those organisations wholly misguided on that point?

Kenneth Hogg: Very mixed views were expressed in the consultation. For example, parties involved with the NHS were less or not at all supportive of the proposals, whereas those that were not involved were more supportive.

Although community health partnerships have a broader range of representation than other parts of the NHS, that representation does not include directly elected members of the public.

The bill would significantly broaden the ability of the NHS to engage with public representation. The bill puts on a statutory basis the requirement to include local authority representatives on health boards. Councillors do sit on health boards now, but not on a statutory basis, which the bill provides for.

I invite Robert Kirkwood to offer the committee some more detail on the consultation.

Robert Kirkwood: The committee’s consultation responses closely replicated those that we got to our own consultation, in that there was a spread of opinion on the way forward. We received a number of representations about enhancing the roles of local authorities, community health partnerships and public partnership forums. That was taken into account when we examined our responses. The bill proposes a way forward involving direct elections. One message that came from our consultation was that the existing mechanisms for public involvement and engagement also need strengthened.

Ross Finnie: I like the phrase, “there was a spread of opinion”.

That interesting expression means, “The vast majority were against the current proposals,” does it not?

Robert Kirkwood: In our consultation, we did not ask the question whether people were for or against. We received a genuine range of opinions.

Ross Finnie: One does not always need to ask the question—one often gets an answer anyway. It is difficult to read such responses without coming
to a conclusion that there was an overwhelming majority against—albeit with the split, to which Mr Hogg alluded, between those with health associations and those without—even within local authorities, which cannot be said to be in anyone’s pocket.

Kenneth Hogg: That spread of opinion was a reason in favour of holding pilot exercises. We want to test how the arrangements would work in practice. Even some of the respondents who were not in favour of direct elections to health boards expressed a preference for holding pilot exercises.

Ross Finnie: If, in interpreting the responses, your reaction was to suggest pilot exercises—which I think is a constructive reaction—why did the pilots not include the other models that were being suggested by those parties who were encouraging you either to consider extending the participation of councillors or to adopt other forms of representation. Your pilots are predicated solely on one principle.

Kenneth Hogg: That was the basis on which the Government particularly wanted to strengthen representation on health boards. We have acted to strengthen the role of local authority members by putting their participation on a statutory basis. We are taking other action across Government to strengthen public engagement and participation more generally, but the key policy objective was around the public’s voice being heard at the heart of decision making within health boards.

The Convener: I want to get this on the record for the sake of clarity—I do not want to contravene what you have just said. The responses that we got are shown on pages 9 to 11 of our briefing from the Scottish Parliament information centre. That is what we got, not what the Government got, and there is a difference. That is why I was getting a bit lost. In the table headed “Opinion on the principle of direct elections by category of respondent”, four local authorities were for, six were against and six were “Unclear/no comment”. Similarly, in the table “Opinion on the principle of election pilots”, five local authorities were for and 10 were in the category “Unclear/no comment”. We should not confuse the two sets of responses. You have been addressing the Government responses, I take it. They were different for us. I draw your attention to that distinction and to our SPICe briefing. I am not sure whether Ross Finnie wishes to return to the point.

Ross Finnie: No, I agree with what you said, convener, albeit with one reservation. If someone expressed a range of views including being against the proposal, but made a range of suggestions as to how they might approach the matter differently, that was recorded as “Unclear”. That was a little unhelpful.

The Convener: I wanted to get that clear, because I could not follow the figures that were being used. I have now been helped.

10:30

Michael Matheson (Falkirk West) (SNP): I return to the issue of those who will be restricted from standing in the elections. Beth Elliot said that the political restrictions that apply will be similar to those that apply in local government.

Beth Elliot: They will be similar to those that apply to existing health board members.

Michael Matheson: In local government, there is a very different approach. I understand that the system is based on a grade. When I was in local government, people were politically restricted once they had reached a spinal point in the local authority grading system, irrespective of whether they provided advice to elected members. Am I correct in saying that, in health boards, restrictions will apply to individual posts? I presume that there will be something of a moveable feast. Someone who is practising in the NHS and is not advising the board on anything may be called in to give advice on an issue that has arisen because of their expertise or because the matter is relevant to their department. Would they automatically be restricted thereafter as a result of that request?

Beth Elliot: The list of restricted posts will apply to those who give advice to the board or any of its committees or sub-committees on a regular basis. A one-off case of giving advice would not come within the definition of regular. The list is designed to cover those who give regular advice.

Michael Matheson: Let me change the scenario. If someone gives regular advice over a short period, will they be precluded from making representations to stand for election to the health board in the future? Someone could be called in to give advice on a sub-committee over a three-month period. The elections might not be for another three and a half years, and the person might give no further advice during that time. Would attending meetings of a sub-committee on three occasions to give advice be classified as giving advice on a regular basis and prevent someone from standing?

Kenneth Hogg: We do not anticipate that the lists will be very long. They will be reviewed regularly to ensure that they are not set in stone for a four-year period. If an NHS employee were elected to the health board and their work during the period for which they were elected involved giving advice, they could simply declare an interest. It would then be incumbent on the chair to manage proceedings such that that person did not play an active role in taking decisions. That scenario is different from the one that you outlined,
but I do not think that a lengthy and bureaucratic process will be needed for health boards to modify lists to ensure that they are up to date and accurate at the point at which candidates are invited to stand.

**Michael Matheson:** I have concerns about the issue, because it is common practice in a range of public agencies, including the NHS, to set up short-lived working groups to give advice to boards on different matters. You need to think more carefully about the definition of regular advice and to specify in more detail what that involves.

I understand that the chair of the health board cannot be an elected member. Why is that?

**Kenneth Hogg:** The point relates to an issue that Ross Finnie raised. Accountability continues to flow from health boards, through ministers, to Parliament. In the context of public appointments procedures, having a ministerially appointed chair is an important part of ensuring that the accountability structure is maintained.

**Michael Matheson:** That is helpful.

My final point is on the pilots. I understand that the pilot areas have not been announced yet.

**Kenneth Hogg:** That is correct.

**Michael Matheson:** What criteria have been used to decide which areas will be used as pilots? When do you expect them to be announced? If, after the pilots, we decide not to proceed with elections in other health board areas, what will happen to the health boards that have directly elected members on them?

**Kenneth Hogg:** The names of the health boards selected will need to be identified in time to be included in the regulations that will be laid following the passage of the bill.

Ministers want to make public the criteria for selecting the health boards and they will do so once they have made their decision.

Ministers are minded that there should be two pilot health boards, which should, between them, cover a representative geographical area of Scotland. One board area is likely to be predominantly rural and the other is likely to be predominantly urban.

Another factor that ministers will consider is the ease of transition from the boards’ current make-up to their future make-up. Board members serve on a rolling basis; their term of appointment expires. Ministers would not be attracted to making wholesale premature change to boards simply for the pilots. Therefore, they will take into account the extent to which boards include members who will come to the end of their term of appointment naturally between now and the time when the pilots start. The earliest date for elections would be 2010. Therefore, that is the earliest that pilots would start.

In the scenario that roll-out did not follow the pilots, the appointment of the elected members of the boards in question would expire. It would be for the Government of the day to decide whether to revert to the current policy of health board appointments or whether to introduce some other system.

**Michael Matheson:** So, if roll-out did not follow the pilots, the people who were elected to the two health boards through the pilots would serve out their four-year term.

**Kenneth Hogg:** That is correct.

**Michael Matheson:** That is helpful. Thank you.

**Mary Scanlon:** I made some notes, but I did not write down where I got the information from. It is my understanding that there will be only one pilot, but Michael Matheson is talking about two.

**Kenneth Hogg:** Ministers intend that there will be two pilot areas.

**Mary Scanlon:** Where is that stated? I cannot find a reference to it.

**Kenneth Hogg:** The bill does not specify the number of pilots. It would be possible to have more than two. One of the relevant factors would be cost. Our financial memorandum sets out costs based on the assumption that pilots will cover 20 per cent of the population at certain levels of turnout. There is an important correlation between the number of pilots and the costs of holding them.

**Michael Matheson:** I might have contributed to the confusion. There is one pilot in two areas, as opposed to two pilots.

**The Convener:** Section 5 provides that an appraisal and report must be submitted no later than five years after the election in the pilot area. That ties in with the timescale that we have discussed.

**Jackie Baillie (Dumbarton) (Lab):** A number of important principles have been established. I was worried about accountability, but it is now clear that that remains unchanged. It is equally clear that the single pilot is about a single approach, rather than a multiplicity of approaches to increase representation—that issue has been raised in evidence. What you said about that was enormously helpful.

I have some practical, detailed questions. You will forgive me if I start with the elections overall. I am slightly concerned that the nature of the election, its shape and form and who the candidates are—which are matters of substance—are dealt with simply in regulations. Is that...
common? I seem to recall that when the legislation on the national parks was introduced, the form and substance of the elections was very much part of the primary legislation.

Beth Elliot: We have put some important matters of principle on the face of the bill, such as extending the franchise to 16-year-olds, having single wards and using the single transferable vote. We considered it appropriate to put in regulations the detail of the election regime because it is a detailed system. It is not uncommon for the detail of an election regime to be put in regulations. We think that that strikes the appropriate balance as regards what should be included in the bill.

Jackie Baillie: Am I therefore incorrect about the National Parks (Scotland) Bill?

Beth Elliot: No; that bill had more substantive provisions on the face of it. Another example is that much of the detail of the overarching election regime in the Representation of the People Act 2000 is contained in subordinate legislation.

Jackie Baillie: But there might be an argument to put more on the face of the bill given the newness of the situation.

Beth Elliot: We think that we have struck the appropriate balance, which is why we have put the regulations before the committee.

Jackie Baillie: Thank you; that is helpful.

Are you aware of the interesting submission from the Local Government Boundary Commission that suggested that you might need to alter the boundaries between local government and the health boards? I am conscious that in some areas, health board boundaries bisect council boundaries. Was any consideration given to that?

Kenneth Hogg: Given that the approach is to take two pilots to test the essential principles of the proposals, we are not attracted to wholesale change to boundaries. In order to achieve that, where possible we are trying to take the simplest approach to holding the election and to getting the pilots up and running. Therefore, avoiding boundary changes would be part of that.

That leads to a separate issue about the extent to which local authority and health board boundaries are coterminous. That is one of the factors that Parliament and ministers might want to take into account in deciding on the pilots and whether they are minded to go for as simple an approach as possible, but it is not an absolute criterion.

Jackie Baillie: Forgive me if I have picked you up wrongly, but you seem to create a distinction between pilots and the roll-out. Should the pilots be successful and the changes be rolled out, we would need to look at boundaries, particularly as you are relying on returning officers in that context to run those elections for you.

Kenneth Hogg: Under the current proposals, we have no plans to change either health board or local authority boundaries in the roll-out scenario.

Jackie Baillie: You do not think that it is required, given your earlier comments.

Kenneth Hogg: No, we think that the elections would be workable.

Jackie Baillie: That is interesting, thank you.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): You have a situation in which a particular health board might relate to a number of different registration officers. Have you included in your eventual costs the fact that they will have to work hard not only to create a specific register for each health board that they cover but to introduce the register for young voters of 16 and 17 for each area? They might have to cover one, two or in some instances three areas. That seems administratively cumbersome but, more important, very expensive. My colleagues will ask about costs in a minute, but what I am speaking about is part of that cost equation.

Robert Kirkwood: We have taken into account those costs. We have used the national park elections model. The national parks cut across numerous local authority boundaries and the returning officer for the most populous local authority within the boundary administers the election.

Jackie Baillie: Given returning officers’ experience of running elections, you will appreciate that we find them a credible source of evidence. The returning officers expressed some concern at the extension of the franchise to 16 to 17-year-olds. Although I might be attracted to the idea, I was convinced by their evidence. They gave four principal reasons. First, “it would depart from the consistency for different elections”.

Secondly, “it would go against ‘putting the voter first’”— that was in the Gould recommendations, which the Parliament accepted. Thirdly, “the age of voting was recently reviewed by the Electoral Commission which recommended that 18 years of age remain as the age for voting”.

Fourthly, they expressed concern about “the practicalities of collecting information” because the requirement to collect it from 14 and 15-year-olds might give rise to child protection issues.
Did you consider those concerns? What is the answer to them?

10:45

Kenneth Hogg: The principle of extending the franchise to 16 and 17-year-olds is a policy decision of the current Government. Other options were considered, but that is the policy that will apply to elections. You are right to point out that it raises a number of practical questions about how we achieve it in practice. We have given that quite a lot of thought and have changed our proposals to reflect some of the difficulties.

Robert Kirkwood will explain how we will undertake the process of registration.

Robert Kirkwood: The extension of the franchise was the subject of discussion between ourselves and the electoral registration officers. We agreed that they would keep a young persons register and we have given them the power to do so within the regulations. That will allow them to keep the register and supply details of people on it to the returning officer, who can then administer the election. That was agreed with the electoral registration officers as the simplest and most effective way forward. It will allow the officers in the areas concerned to use their own systems to record 16 and 17-year-olds.

Jackie Baillie: I am sorry that I did not make it to the Finance Committee when you gave evidence to it yesterday. Your financial memorandum mentions that the cost of elections to health boards will be about £13 million, and you have revised that to £16 million, which is helpful. However, the electoral registration officers said that your assumed unit cost per vote is shy by about £1. You estimated it to be about £2.60 or thereabouts, but they said that it is £1 more expensive than that. That would add quite a lot to the figure in your financial memorandum.

Given the tight financial settlement that we hear about for health boards, and given that the Government has said that there will be no extra money, how robust are your figures? Given the current context of health boards, will they need to take the funds from front-line services?

Kenneth Hogg: That is an important point. The scenario in which the cost increases by £1 per vote would arise if we used personal identifiers as part of the canvass. We do not propose to do so. We weighed up the advantages of the added security that personal identifiers bring and balanced that against the significant additional costs that are involved and the administrative complexity—throughout the process—of using them. We therefore propose not to use personal identifiers in the elections.

Jackie Baillie: Given that personal identifiers are integral to the security of the electoral system and our trust in the result, I am surprised by that. Do you not anticipate any difficulty?

Kenneth Hogg: We propose to take the approach that has been taken with elections to the national park authorities, which do not use personal identifiers. We agree that the use of personal identifiers has security advantages, but the cost difference in particular led us to decide against their use. The base cost per vote that is set out in our financial memorandum is £2.60. That would increase to £3.60 if we used identifiers. We discussed the approach with the registration officers and they agreed that we have correctly assessed the issues of additional cost and complexity. They agree that our approach will be simpler. We accept that the downside is the loss of the additional security that is brought by personal identifiers.

Jackie Baillie: You chose your words carefully, but I will push you. What was the view of the electoral registration officers on whether you should abandon personal identifiers?

Robert Kirkwood: I am sorry, but I missed your question.

Jackie Baillie: That is okay; I am trying to push you to a conclusion. Were the electoral registration officers in favour of retaining personal identifiers, irrespective of their understanding of your analysis?

Robert Kirkwood: Yes. Electoral registration officers were in favour of retaining the identifiers.

Mary Scanlon: The evidence base for direct elections seems to come from Canada and New Zealand. The British Medical Association Scotland submission quotes research from Canada:

“the experience [in Saskatchewan] has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to common goals.”

It also quotes research from New Zealand:

“the electoral component of the DHB [District Health Board] system is failing to make a substantial contribution to the democratisation of health care governance in New Zealand”.

Those are hardly ringing endorsements of health board elections. Is there another evidence base that is much more positive towards those elections and which I should read to get a bit more excited about the elections?

The Convener: I long to see Mary Scanlon getting excited about the elections.

Mary Scanlon: I was up until 4 in the morning watching the American presidential election.

The Convener: Ditto.
Kenneth Hogg: We have learned lessons from the experience of others. For example, in 2001 New Zealand began with a system whereby members were directly elected to the district health boards. Initially, there was a first-past-the-post system with multimember wards. In 2004, based on a not wholly satisfactory experience, New Zealand moved to the single transferable vote system and single board-size wards for those elections. We have sought, whenever possible, to reflect the learning from other countries.

Robert Kirkwood: New Zealand has had direct elections since 2001. A study, which is quoted from in the SPICe briefing, was carried out in 2007. To summarise the report, it was felt that the fears of existing executive directors about directly elected members taking their place on district health boards had not been realised. Perhaps the directly elected members taking their seats on the boards did not prove to be as big an advantage as it was thought that it would be in bringing local people on to the health board, but on the whole people are happy with what is now in place in New Zealand. The study stated that there was no case for change.

Mary Scanlon: So when you say that people are happy, you mean that patients are happy and that there is a feeling that there is greater engagement, greater patient involvement and so on.

Robert Kirkwood: There is evidence—

Mary Scanlon: Has the evidence from the BMA, which was sent to the committee a couple of months ago, been overtaken by time and experience?

The Convener: We have got the evidence from the BMA. The question was about whether we would find evidence elsewhere. You have dealt with New Zealand, although the evidence has perhaps not excited Mary Scanlon.

Mary Scanlon: I will keep looking for a ringing endorsement of elections to health boards.

I represent the Highlands and Islands. My question refers in particular to Highland Health Board, which covers about 40 per cent of Scotland’s land mass. It has been put to me that all the elected members of the health board could come from the biggest population centre, which is Inverness, with no one representing the islands, Argyll and Bute, or Caithness and Sutherland. In that case, would there be an obligation on the health board to appoint members from the unrepresented areas to balance the geographic representation? If people were appointed on the basis of geography rather than on the basis of their ability, would that militate against the democratic principle that we are considering?

Kenneth Hogg: There will be no additional obligation on boards or anyone else to ensure that successful candidates provide a geographic spread or represent particular interests. However, in adopting an all-postal voting, STV, single-ward approach, we have identified the approach that is most likely to lead to the highest number of candidates standing and every vote counting, and to avoid a situation in which single-issue candidates might run—as could happen in the areas that you have identified—and be the predominant group among those who are elected to the board. We have come at the issue by choosing the best possible system up front rather than by seeking to apply balance retrospectively.

Mary Scanlon: So it is still possible that in the Highland NHS Board area all the elected board members could come from Inverness, even though it can take about a day to travel there from elsewhere. Is it true that there is nothing in the bill to redress that?

Kenneth Hogg: Yes.

Mary Scanlon: You mentioned single-issue candidates. Someone might stand for election to a health board simply because they do not want the local hospital to close. What have you done to address that? I missed that bit.

Kenneth Hogg: All that I was saying was that if we had opted for a multiward rather than a single-ward system, for example, a single-issue candidate would be more likely to be successful in such a situation.

Mary Scanlon: Let us say that someone wanted to save the Belford hospital in Fort William. Given that 22 per cent of the local population turned up to a public meeting on that subject a few years ago—it was one of the biggest public meetings ever to be held in Scotland—there is a significant enough vote there to enable a single-issue candidate to be elected under the system that the bill proposes.

Kenneth Hogg: Certainly. The use of STV rather than, for example, first past the post gives the best possible chance for such a voice to be heard.

The Convener: I suspect that that is democracy. Single-issue candidates have been elected to the Parliament.

Section 1 seems to enable Scottish ministers to redress any balance that might be missing across a large area, which is an issue that Mary Scanlon raised. Is that correct? Section 1(2) provides that

"councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board"
are one of the types of member that a health board is to consist of, so a balance is provided for if there are several local authorities in a health board area. However, that does not quite deal with Mary Scanlon’s point.

Section 1(2) also provides that

“a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board.”

I am thinking of Penicuik in my area. Although it is in Tweeddale, Ettrick and Lauderdale, it is part of Midlothian. In such circumstances, an element of balance is provided for. Is that correct?

Kenneth Hogg: It is. The bill provides not that there must be a majority of directly elected members but that there must be a majority of councillor members and directly elected members. There is that balance.

The Convener: I just wanted to clarify that.

Ian McKee (Lothians) (SNP): I am delighted that our manifesto commitment on direct elections to health boards is coming to fruition. I advise the witnesses not to listen too closely to the people who feel threatened by the advent of democracy into their tight little world. However, I have one or two specific questions, the first of which is on a small point. I know from experience that some health board committees regularly have general practitioners on them offering advice to the health board, although they are not employees of the health board and do not hold a health board post. Will a GP in such a position be banned from standing for election to the health board?

11:00

Robert Kirkwood: That would be entirely a matter for the board to decide. The decision would be based on the frequency of the advice that the individual gives. The draft Health Board Elections (Scotland) Regulations, which we have supplied to the committee, contain provisions to allow employees of health boards to appeal if they feel that their post has been wrongly identified as restricted. They will be able to go to the adjudicator to address that.

Ian McKee: So the board that is to be replaced by a democratically elected board will decide who can stand for election to the board that will replace it.

Robert Kirkwood: GPs are not employees of boards, but a board will take a decision on the advice that is given to it. Therefore, a GP could stand for election.

Kenneth Hogg: That is an important point. GPs will be able to stand for election. I would like to write to the committee to clarify the issue of whether a GP who chairs an important board committee and who therefore advises the board could stand for election. That is a different scenario from that involving a board employee.

Dr Simpson: To be clear, GPs who are employed by a board for other work—30 per cent of GPs are employed in specialist capacities—will not, I presume, be eligible.

Kenneth Hogg: Yes—they will be caught by the wider provision on employees.

The Convener: It would be helpful if you would write to the committee to clarify some of those subtleties. The issue revolves round the definition of the term “Health Board posts”.

Ian McKee: My next question is about the number of directly elected people that you envisage being on the boards. I might have missed something, but there are blanks in the draft Health Boards (Membership) (Scotland) Regulations. Obviously, there could be a majority of elected people on the board if there were enough of them. However, I gather from what you said earlier that that is not your intention. Is there a formula that you intend to use to decide what the number should be?

Robert Kirkwood: We do not have a formula as yet. We intend to specify different types of people who will be on the boards. In specifying those types, we will reach the balance that was alluded to earlier whereby the local authority members and the directly elected members, added together, will form a majority on the board. We do not intend to increase dramatically the overall size of boards.

Ian McKee: So there is no way in which a majority of board members could be directly elected.

Robert Kirkwood: Not under the current proposals.

Mary Scanlon: Just on that point—

The Convener: I feel redundant here. Is it a supplementary point, Mary?

Mary Scanlon: Yes.

The Convener: On you go.

Mary Scanlon: I will be brief. What restrictions will apply to dentists and to people who work in the Scottish Ambulance Service and NHS 24? What about people in the voluntary sector who are dependent on funding from a board? They may not give advice to the board but, if they are dependent on funding, they may therefore have an interest. Will you clarify that, too?

Kenneth Hogg: To clarify, the elections will not apply to special health boards; they will apply only to territorial boards.
Mary Scanlon: I understand that. I am asking whether someone from the Scottish Ambulance Service could stand for election.

Kenneth Hogg: Yes, they could, unless they were on the board’s restricted list. However, it is highly unlikely that that would occur.

Mary Scanlon: What about people from the voluntary sector? That is important.

Kenneth Hogg: They will be free to stand.

Mary Scanlon: So someone who is dependent on funding from the health board could stand and therefore could have an influence in the allocation of that funding.

Kenneth Hogg: Yes. I cannot think of a scenario in which a person who is not employed by a health board could be excluded.

The Convener: The key is the term “Health Board posts”. Perhaps I am wrong, but I cannot envisage how somebody in the voluntary sector can have a health board post. That is the first test and there are subsidiary tests that flow from that. I assume that, if somebody in the voluntary sector who is elected to a board has an interest, that will be declared and it will be for the chair to rule whether it is appropriate for them to take part in particular decisions. Is that a way of putting the situation?

Kenneth Hogg: Yes.

Ian McKee: Do you envisage that people who stand for election to a board will have the freedom to organise themselves along party-political lines?

Robert Kirkwood: There is certainly no proposal to proscribe political parties in the elections.

Ian McKee: Did you say proscribe?

Robert Kirkwood: Yes. If people are minded to do that, they will be able to.

Ian McKee: So that is a possibility.

Robert Kirkwood: Yes.

Ian McKee: You talked about the potential difficulty of non-coterminous boundaries between local authorities and health boards. How do boards cope with that at present, given the existence of community health partnerships, which are a mixture of both?

Kenneth Hogg: Many health boards have non-coterminous boundaries with local authorities and have to deal with the issue regularly in a variety of their committees, structures and processes. Greater Glasgow and Clyde NHS Board probably shares boundaries with the greatest number of local authorities.

Ian McKee: In practice, the situation raises no problem.

Kenneth Hogg: I mentioned it earlier in relation to the complexity or simplicity of organising elections. In relation to the substantive proposals, the situation will not cause any problems.

The Convener: I thank all the witnesses very much for their helpful evidence. Next week, we will have before us two panels—one made up of representatives of health boards and one made up of electoral registration officers and the Electoral Commission. I am sure that Miss Baillie will have lots of interesting questions.
26th Meeting, 2008 (Session 3) 5 November 2008, Supplementary Written Evidence

SCOTTISH GOVERNMENT

At the meeting of the Health and Sport Committee held on 5 November, I undertook to write to the Committee clarifying the position under the terms of the Health Board (Membership and Elections) (Scotland) Bill of GPs who serve on a Committee or Sub Committee of a Health Board and who also wish to seek election to the Board. I would also like to take this opportunity to clarify the position in respect of the provisions in the Bill relating to Board vacancies where insufficient candidates have stood for election: this was one of the main areas of questioning by the Committee on 5 November.

Eligibility

In Committee on 5 November, the specific question was asked whether a GP who heads a committee or sub committee of the health board would be eligible to stand for election to the Board. If that GP is not an employee of the health board, then they would be able to stand for election provided they were not covered by one of the other exemptions (e.g. being an undischarged bankrupt or an incapable adult) which are set out fully in Rule 11 of the Health Boards Elections (Scotland) Regulations – a draft of which was supplied to the Committee on 30 October. If the GP was employed by the Health Board directly, even on a part time basis, then it would be necessary for the Board to consider the content of Rule 12(1) (discussed below) when applied to the function carried out by that GP. In the case of disagreement, the adjudicator discussed below could be consulted and asked to rule accordingly.

It may also helpful here to set out a little of the relevant policy context. Our policy intention is to adopt, where appropriate, tried and tested methods of running elections. Therefore, in proposing criteria for restricting board employees from standing for office we have adopted similar provisions to those that apply to local authority employees for local government elections, contained in the Local Government and Housing Act 1989.

The Bill sets out in Schedule 1A, paragraph 9 (inserted into the National Health Service (Scotland) Act 1978 by section 2(2) of the Bill), that election regulations may make provision on who is qualified to be a candidate and in what circumstances an individual would be disqualified from standing. Rules 11 and 12 of Part 5 of the Schedule to the draft Health Board Elections (Scotland) Regulations contain the detail around how this would work in practice.

Rule 11(2)(b) of the draft Regulations provides that an individual is disqualified from being a candidate if the individual holds a post included in the list kept by the Health Board under rule 12. Rule 12(1) provides that each Health Board must keep a list of restricted posts. These would be posts that would involve giving advice on a regular basis to the Board or any of its committees, or if the post required speaking on the Board's behalf to journalists or broadcasters on a regular basis. Rule 12(2) allows for the adjudicator appointed under the Local Government and Housing Act 1989 to give advice to Boards in drawing up the lists of restricted posts and also to hear appeals against inclusion of particular posts in the list and to adjudicate accordingly. Although not explicit in the initial draft of our regulations, the policy intention is to follow the rules that apply to Scottish local authorities and define these posts as being held by paid office holders or employees. The draft regulations will be amended to ensure that this is made clear and I would like to thank the Committee for highlighting this issue.

Vacancies

On 5 November the Committee also asked a number of questions about vacancies for directly elected posts in the circumstances in which insufficient candidates have stood. Paragraphs 7 and 12 of Schedule 1A to the 1978 Act (inserted by section 2(2) of the Bill) set out the procedure for dealing with vacancies that may arise on a Health Board for elected members. Paragraph 7 provides that if the number of nominated candidates is equal to or less than the number of elected members to be specified in the Regulations then a Health Board election will not be held in that ward. The returning officer must declare the nominated candidates (if any) to be deemed to have been elected and declare the number of vacancies (if any) in the ward.
Paragraph 12(2)(b) allows for Scottish Ministers to appoint an individual to fill the vacancy in accordance with any provision made by election regulations. Such an individual would then be considered to be an elected member for the purposes of the legislation. As the Regulations only relate to the elections for the pilot board areas, we do not propose to include a provision that would allow for a further election to be held to fill vacant posts as this would be time consuming and add disproportionately to the overall cost of the pilots.

The draft Health Board Elections (Scotland) Regulations do not yet set out how Scottish Ministers may appoint individuals to fill such vacancies. We intend to give this issue further consideration. However it is anticipated that they will be appointed in the same way as other members of the Health Board appointed by Ministers i.e. they will be subject to the public appointments process that currently exists. We would expect that this situation is unlikely to arise and that there would be sufficient interest in Health Board elections to encourage candidates to stand, but it is important to have a fall-back position to allow Boards to function properly.

Kenneth Hogg  
Deputy Director of Delivery  
Scottish Government  
18 November 2008
NHS AYRSHIRE AND ARRAN


To this I would add the following comments on the proposed methodology for elections:

The Bill’s ‘single ward’ approach is viewed as seriously flawed as it would not assist geographical Health Boards in maximising participation in elections. Ward boundaries should recognise local authority boundaries where possible in order to enhance the important link between Health Boards and local authorities in service delivery. More local wards are likely to lead to local candidates who really do represent local people and would act as a barrier to the possibility of one part of a Board area dominating the election.

It is recognised that the election of Board members to Special Boards would require to be addressed differently. Wards would have to be much larger but there are good reasons for representation at a regional level at least, to ensure a balance between urban and rural representation.

A viable alternative to election of Board members might be increased access to the Board from patient groups, voluntary agencies and carers’ groups, who would better represent the views of the public using NHS services.

In conclusion, NHS Ayrshire & Arran would not support the introduction of direct elections to NHS Boards and would submit that other more creative methods of increasing public participation in decision making processes should be explored before adopting this approach.

Professor William Stevely,
Chairman,
NHS Ayrshire & Arran

NHS LOTHIAN

Introduction

NHS Lothian is pleased to respond to the call for evidence for the Committee’s consideration of this Bill at the Stage 1 debate.

NHS Lothian will make specific response to 3 of the questions set out in the call for evidence:-

- addressing the principle of direct elections
- the risks of having elected members on health boards
- whether alternatives to direct elections exist as a means to increasing public involvement in the NHS.

1. The Principle of Direct Elections

NHS Lothian’s position in response to previous consultations is not supportive of direct elections to health boards. Copies of previous responses are attached for the Committees information.

NHS Lothian has very good relationships with its 4 local authorities, all of whom are represented on the NHS Lothian Board. This model of governance, linked to the delivery of shared outcome agreements across health and social care, reductions in inequalities, strategic infrastructure, planning and economic alliances is, we believe, delivering benefits to the people of Lothian. In 2 of our Community Health (and Care) Partnerships, (The City of Edinburgh Council and West Lothian), we have director level joint appointments with dual accountability arrangements and joint boards of
governance. In areas of strategic planning and development, partnership working is embedded in all aspects of business.

We believe that we can demonstrate delivery of robust internal accountability through our current non-executive members. The board members of NHS Lothian, whether appointed or elected to local authorities, have high regard to the discharge of governance and scrutiny of performance. We are not convinced that direct elections to NHS boards would enhance this position. However we suspect that further wholesale change to the current system has the potential to destabilise boards. The fears of elections being overwhelmed by single issue candidates is we believe a real issue. Further adding another level of democratic representation to the current 4 layers, for many, is not seen as advantageous.

The Board is strongly of the opinion that the case for greater public involvement in the NHS is well made in the policy memorandum. However previous consultations have failed to set out what policy principles would be achieved by a mix of directly elected members and local authority councillors other than with regard to democratic representation. Establishing democratic processes would be a very small component of involving people in what we do and would align to civic responsibility. However NHS Lothian like many boards has wider and deeper processes to hear the voices of all our communities.

2. The Risks of Having Directly Elected Members

The current mix of members works well in NHS Lothian. Key stakeholders including academia share accountability with lay members from a range of backgrounds, many of whom are highly skilled in scrutiny at board level. Local authority councillors bring a focus on and accountability back to geographic constituencies and the delivery of joint outcomes across a range of functions.

A mix of 4 types of board members – appointed chair, stakeholder appointments (Employee Director etc.), local authority and directly elected members could stand to confuse a) the public; and b) the board itself. This mix of type, sort, process, representativeness and accountability will not assist public involvement, nor probably confidence in the running and decision making in the NHS.

3. Alternatives to Direct Elections

NHS Lothian suggests that if pilots are to be taken forward then the Bill be amended to include other types of pilots to test democratic process alternatives in selecting the membership of NHS Boards. We suggest that by only testing direct elections an opportunity is being missed to achieve the ambition of widening and strengthening the involvement of the public in our NHS. The emphasis on one model could detract from, and focus scarce resource on a single solution where actually other models could be tested.

NHS Lothian is currently discussing how it should implement the requirements in Better Health, Better Care to strengthen Involving People and Improving the Patient Experience.

Creating Mutuality - Learning from Foundation Trusts in England

In response to Better Health, Better Care: Action Plan (Scottish Executive 2007) and arising from discussion during the recent consultation by the Scottish Government on the Healthcare Bill, NHS Lothian is considering proposals for building accountability to local people and encouraging a new type of participation with local communities. The Department of Health in England introduced new accountability arrangements for Foundation Trusts which sought to strengthen local involvement within a framework of independence from central control. It is not suggested that this would be appropriate. However there are lessons that could be applied in the Scottish or NHS Lothian context to develop mutuality and participation.

In England, Foundation Trusts are Public Benefit corporations. NHS Lothian is proposing to build on the long history in Scotland of mutual societies and create an NHS Lothian mutual membership forum. This membership will then elect representatives to a new “Involving People Committee”, which would be a formal Board Committee.
Creating “Membership” of NHS Lothian

What are we proposing?

It would be possible to have a network of members who are eligible to vote and construct “representativeness” around existing Community Health Partnerships (CHPs) and Community Health Care Partnerships (CHCPs) (and therefore Local Authority boundaries) or major hospital sites or other community or geographic entities. Creating a “membership” database which is responsive to people’s preferences for engagement, would enable involvement to be more focused and appropriate to the interests of the member.

This approach could widen the participation of members of the public in Lothian. Being a mutual member would bring key benefits:

- general information on staying healthy and self care;
- regular information on plans and developments;
- opportunity to participate in and respond to consultations;
- help shape policies;
- join committees or groups;
- widen awareness for volunteering opportunities in health;
- build on our current PPFs and Patient Councils/networks and forums;
- ensure equality of opportunity for all our community to be involved in a meaningful way on issues they choose; and
- potentially stand for and vote to elect stakeholder member to the Board (who could be similar in role to that of the Employee Director) has in relation to staff as stakeholders.

There are outline proposals being discussed in NHS Lothian as we develop our Involving People, Improving the Patient Experience Strategy which will be consulted upon with our stakeholders.

4. Conclusion

NHS Lothian therefore concludes:

The policy memorandum and inconclusive consultation suggest that this Bill does not have widespread public acceptance.

The policy fails to demonstrate how other than by democratic representation public involvement will be strengthened in the NHS.

There are real risks from the proposed model to the stability of NHS boards and their current membership in their discharge of governance.

If the Bill is to progress it should be amended to enable and fund other pilots testing alternatives which could deliver strengthened public involvement in the NHS.

NHS Lothian proposes to pilot an alternative model of delivering mutuality by developing a membership organisation.


Appendix B (NHS Lothian response to the Health Committee’s inquiry into the Health Board Elections (Scotland) Bill) can be found at: http://www.scottish.parliament.uk/business/committees/health/reports-07/her07-01-02.htm#loth.

James Barbour
Chief Executive
NHS Lothian

NHS TAYSIDE

Tayside NHS Board recognises that for some considerable time there has been debate about the “democratic credentials” of Health Boards, and whether there exists a “democratic deficit” in the Health Service. The Board is also aware that in the recent past in parts of Scotland there has
developed over proposals for major service changes a rift between Health Boards and substantial sections of the local population.

It is therefore important that the matters around elected Board members and the wider issues of public involvement are given very careful consideration.

THE BOARD’S OVERALL POSITION

Tayside NHS Board’s starting position is that the Health Service is one of the most important – if not the most important - public service for the people of Scotland. It is essential, if the Health Service is to develop and advance, for it to build relationships with the people it serves in ways and to an extent that have not previously been seen. NHS Boards need the authority and the connectedness to take forward the new agendas which are about changing the shape of services away from more traditional hospital-based models, engaging people much more in their own care, encouraging people to adopt healthy lifestyles, and working with other agencies - including the third sector – to create integrated solutions to complex health and care issues.

In this regard, the concept of a mutual NHS put forward in Better Health, Better Care points a way forward which the Board strongly endorses. At the centre of this has to be participation and community engagement, supported by the extensive availability of appropriate and useable information upon which people can make a real contribution. Tayside NHS Board does not believe that the limited attempt to democratise Health Boards by electing some members to Boards will do much to enhance the concept of mutuality. For the Board, mutuality emphasises participation much more than representation.

This is not to say that the Board in any way is dismissive of the importance of democratic representation and accountability: The opposite is the case. However, the Board firmly believes that the present make-up of Boards fundamentally works. In the context of a national health service, democracy comes from citizens choosing Governments through elections to the Scottish Parliament where parties put forward different policy positions on the NHS and health to allow the electorate to make choices. Democratic accountability is achieved through ministerial accountability to the Scottish Parliament and Board chairs’ accountability to the Cabinet Secretary for Health and Wellbeing. The Board believes that the idea of national and local democracy do not necessarily sit comfortably together within the context of the Health Service where there is considerable central policy guidance and direction from ministers.

SPECIFIC CONCERNS REGARDING ELECTED MEMBERS

The Board also has some other important concerns about the impact the introduction of elected members will have on the operation of Boards. These are as follows:

1) A mixed system of elected and appointed members creates two systems and sources of legitimacy for Board members which may be difficult to reconcile. Currently, Board members, including councillors, are appointed by the Cabinet Secretary for Health and Wellbeing on the implicit basis that they accept national policy and are accountable through the Chair of the Board to the Cabinet Secretary for Health and Wellbeing. An elected member will clearly have to respond ultimately to their electorate – and rightly so – not to the Board’s Chair, or indeed necessarily the Cabinet Secretary for Health and Wellbeing. This could have negative consequences for the governing of Health Boards and work against the development of a corporate view on any issue which is one of the proven strengths of Boards in seeing through complex change and improvement.

2) The Board recognises that the NHS is an inherently political organisation, both locally and nationally. However, it is concerned that the direct election of members will lead to an intensification of the politicisation of the NHS locally. Democratisation of Boards will require competitive elections which will lead to the promotion of different policies by members and differentiation of stances on issues. Specifically, there is an uneasiness that this politicisation could create “opposition for opposition’s sake” to Government policy by members of other parties, ongoing debate around the Board table about national policy (rather than local delivery of it) which may lead to delay in effecting change, the discounting of the position of minority or excluded groups (such as Mentally Disordered Offenders, drug users) and will do nothing to build the
reassurance about the NHS among local people (which could be detrimental to the effectiveness of other forms of engagement).

3) If there is a low turnout in elections, which must be a strong possibility, this will not only undermine the legitimacy of elected members, but will more broadly diminish the Board’s overall legitimacy.

4) Boards are not Council chambers. The separation between policy and administration which exists in central and local government does not exist in Health Boards, where officials (including Executive Members of Boards), usually lead on policy and present matters in public. The role of non-executive members is about ensuring good governance, making sure that there is probity and propriety, providing strategic direction, focusing on performance, and providing challenge and support to executives. Elections of members would be taken to imply in most peoples’ minds that they had the lead policy role. This could fundamentally affect the operation of Boards, and draw officials directly into political controversy, including party politics, and change the relationship between executive and non-executive Board members.

5) The purpose of having Council members on Boards, which in the experience of Tayside has worked well and has been a positive step forward, would become uncertain. Not surprisingly, Council members have brought the representation of the views of local people into Board business. There is again here a dual system being put forward, the reason for which will not be evident to most people. What is the different legitimacy and validity between someone elected to a Council and someone elected directly to a Health Board?

6) One of the important current strengths of Health Boards is that people are appointed with a range of expertise, knowledge, experience and local connections and come together to provide a rounded perspective on strategy and individual policy decisions. The move towards electing some Board members in effect will diminish this distinct advantage, both in terms of reducing its scope and challenging it as a legitimate basis upon which to have a view. In other words, will legitimacy from representation ultimately take precedence over other sources of authority? The Bill formally endorses this perspective by stating that the majority on a Board should be constituted not by all non-executive members (as at present) but by elected and Council members only.

EXTENDING ENGAGEMENT AND INVOLVEMENT

The Board is supportive of the current model of Board composition, but it also strongly wishes to see improvements to that model. Some of these are already in hand. For example, independent scrutiny offers an opportunity, if carried out positively and collectively, for all stakeholders, including Board members, to re-assure themselves where necessary that proposals for service change have been properly developed and thought through. It is this very issue that has been at the heart of recent disquiet in some parts of Scotland about the legitimacy and connectedness to local communities of Health Boards. Independent scrutiny should go a long way to address this. There are also ongoing initiatives to involve patients, carers and the public more effectively.

There are three areas where the Board would wish to emphasise change to current arrangements:

1) While the Board supports the notion of members being appointed on the basis of their expertise, knowledge, experience and local connections, there are presently limits to this. There are clearly parts of the community that seldom or ever sit round the Board table. Boards need to have a profile that does not seem to preclude people because of their age, ethnic background or socio-economic status. Much more needs to be done to encourage and enable these different, but important and valuable perspectives, to be brought to the Board table.

2) There needs to be a much greater extension of engagement and involvement with local people in the NHS, not just round the Board table but across all aspects of local services. In recent years, much has been done to develop what is termed the Patient Focus where the NHS has increasingly been listening and talking to patients and carers, understanding their needs, and actively involving them in their own care. More needs to be done on this front, not least to extend the sections of the community involved and to support greater involvement of people in the management of their own care.
3) In addition to Patient Focus, the Board believes that community engagement needs to be taken forward to a much greater extent. Community engagement places an emphasis upon shifting the balance of power, working in partnership and involving people in the planning, development, management and delivery of services. To fulfil this responsibility, NHS Boards have to communicate routinely with the people in the communities they serve to inform them about their plans and performance and involve them in discussion about how best to improve things. There is a long way to go with this, although there are already in Tayside and elsewhere many examples of good practice. The potential is however enormous, particularly in terms of working with small, local communities where people will have a real opportunity to shape services.

COMMENTS ON MATTERS OTHER THAN THE PRINCIPLE OF ELECTED MEMBERS

In addition to comments on the advantages and disadvantages on the principle of Boards having elected members, the Committee has sought views on the application of this principle as covered in the Bill, irrespective of views on the principle of direct elections. In this regard, the Board would submit the following comments:

1) In terms of the composition of the Board, greater clarity in specifying the make-up of each Board, including the position of Council members, taking into account their knowledge and expertise, is to be welcomed.

2) It is not clear what is the benefit of, or rationale behind, putting a tighter limit than currently exists upon the professional backgrounds/organisational positions of senior Board employees who are able to be a member of a Health Board.

3) The arrangements for elections are broadly supported by the Board. The extension of the franchise to include 16 and 17 year olds is on balance welcomed, not least for the message it gives out to young people with whom it is essential the NHS and other agencies engage. There is however an inconsistency here in terms of the franchise for council and parliamentary elections remaining at 18. The Board also believes that having a single ward is essential. It is important that those elected to Boards are seen to represent all of the Health Board area and not just a particular geographic part or community.

4) The arrangements for pilots will require further detail in due course. At this stage, it is perhaps inevitable that it is not intended for the Bill to detail the management arrangements for this. The Board will be happy to comment further at the appropriate time. However, the evaluation criteria in respect of the report to be produced on the pilot scheme, even in the context of a parliamentary Bill, needs to be elaborated further. Specifically, it is not clear regarding 5(1)(c)(ii) whether it is being stated that having elected members on Health Boards should lead to increased engagement with patients and other members of the public. This suggests that the role of an elected member is to encourage engagement. At some point, however, if elections are to be meaningful, having elected members must be seen as an alternative to engagement through the concept of representation. Otherwise the purpose of so electing members is unclear.

5) The Board has no specific comments regarding the practical implications of bringing the Bill’s proposals into force. They appear sound insofar as they go. It is obviously important that there is the necessary time to put in the arrangements in place and engage the public in a new venture such as this in the designated Health Board areas, but again this is not necessarily the business of legislation.

6) Clearly, the costs of such arrangements will always attract a certain amount of excitement. The costs presented for elections in pilot areas are not unexpected and would appear valid. It is not possible to contemplate not doing this up to standards similar to elections to Councils. However, the Board would emphasise that, if these funds were made available across each Board area, they could make a sizeable contribution to the development of other means of public engagement, particularly community engagement. There is no doubt in the Board’s thinking that to make progress on public engagement, while shifting attitudes of NHS staff is a key part, resources will be required to make it happen - that is to inform, equip and support people to enable them to
CONCLUSION

The Board’s position on the election of some Board members was made clear in its response to the consultation on the 3rd April 2008. The Board recognises fully that engagement and involvement have to move forward on a significant scale. However, the Board wishes to see participation rather than representation being emphasised, not least because the future health agenda is not just about major service change but is about working with people to address Scotland’s poor and unequal health record. The election of Board members will establish a dual system of legitimacy which is likely to diminish the current source of strengths of Boards: creating a corporate view out of discussion round the Board table to create a lead locally for taking forward national policy; and having a range of knowledge, expertise and perspectives available to bring to the major issues of health and care locally. If elected members did not have such an impact on the government of Boards, it would seem unlikely that direct elections in effect were working or adding value. The Board knows that the current strengths do have to be further enhanced by extending the range of perspectives brought from the local community to the Board table and for the NHS as a whole to engage further with their communities. These will offer many positive and exciting opportunities to make a reality out of a mutual NHS, and in this context are not weaker alternatives to direct elections of some Board members.

For this reason, the Board does not wish to engage in a pilot for directly elected Board members but would, if it is considered desirable, be prepared to look at extending Council representation on the Board, and explore other options to extend the profile of Board membership without obviously making the Board unwieldy.

Sandy Watson,
Chairman,
NHS Tayside

ELECTORAL COMMISSION

The Electoral Commission welcomes the opportunity to provide written evidence on the Health Boards (Membership and Elections) (Scotland) Bill to the Health and Sport Committee of the Scottish Parliament.

The Electoral Commission was established as an independent UK-wide public body with the enactment of the Political Parties, Elections and Referendums Act 2000 (PPERA). As the Committee may be aware, the Commission’s remit in Scotland under PPERA only extends to Scottish Parliamentary, UK Parliamentary and European Parliamentary elections. Local government elections are a devolved matter to the Scottish Parliament as is the National Health Service. Section 10 of PPERA, however, allows the Commission to provide advice and assistance to relevant bodies, including the Scottish Parliament, on any matter in which it has skill and expertise. It is in this spirit that we offer our evidence to the Committee.

Our evidence focuses on the implications of the proposed Schedule 1A to the National Health Service (Scotland) Act 1978 which deals with the operational matters relating to the administration of the proposed elections as the area in which we have skills and experience. We consider it inappropriate for the Commission to comment on the principle of having direct elections to the health boards, their composition and operation once elections have been held. Those matters are for others to consider.

We also assume that the Committee has sought views on the Bill from Returning Officers and Electoral Registration Officers who will comment from the practitioner’s viewpoint on the running of such potential elections.

Status of elections

Although not stated in the Bill, we understand that there is a strong possibility that elections to all of Scotland’s health boards could be held on the same day and that they may be administered by the...
Returning Officers and Electoral Registration Officers of Scotland’s statutory elections. This would result in health board elections being on the same scale and status as say local government elections. The Commission is committed to putting the interests of the voter first and given the importance of the institutions to which candidates would be seeking election we believe the administration of any such elections should be to a comparable standard as those of other statutory elections in Scotland.

Timing of elections

The detail of when elections to health boards are to be held is left to regulations rather than being specified in the Bill. The timing of any health board election will need to be considered in the context of the current electoral cycle. This involves elections to the Scottish Parliament being held every four years on a fixed cycle; elections to the European Parliament being held on a five year cycle; and local government elections currently held on a four year cycle that coincides with the Scottish Parliamentary elections, although the Scottish Government indicated in its response to the Gould report that it intends to decouple local government elections from those to the Scottish Parliament. UK Parliamentary general elections must be held at least every five years, the date at the discretion of the Prime Minister. In considering how often and when health board elections are held, the following issues will need to be considered:

- Fixed term elections in Scotland are usually held in May or June. Consideration will need to be given to the time and resource constraints imposed on Electoral Registration Officers and Returning Officers in the run-up to other elections if they are to be involved in delivering health board elections.

- The annual canvass of electors is conducted during the autumn of each year with the register being published by 1 December. There are logistical problems with holding an election in this period and these would also apply to health board elections if the electoral register is to be used. Holding elections during the annual canvass can increase the possibility of voter confusion and therefore increases the need for an effective public awareness campaign.

Election timetable

The timetable for National Park Authority elections is considerably longer than that for local government or parliamentary elections due, we believe, to the all-postal nature of those elections. Five weeks from the close of nominations until polling day at a National Park Authority election is allowed compared to just over three weeks at a local government election. If health board elections were to be conducted on an all postal basis then given the printing and distribution of postal ballot packs is a time-consuming part of the electoral process we would suggest an extended timetable to allow sufficient time to complete this task.

Combination

The implications of electoral combination or the holding of elections for the health boards on the same day as other existing elections needs to be considered. The Commission, in responding to the recommendations made in the Gould Report, has supported the de-coupling of the Scottish Parliamentary and local government elections. At present, however, we are of the view that not enough evidence exists to state that combination is always or never in the best interests of the voter. We have called on both the UK and Scottish Governments to undertake such research as a matter of urgency.

Electoral wards

The presumption in the Bill is that each health board area will form a single electoral area unless regulations specify that the area will be divided into wards. Whether health boards are to be one electoral area or several the possibility of any such areas following the local government ward boundaries or multiples thereof should be considered in order to assist the Returning Officer in the smooth running of the election.

We note that the Local Government Boundary Commission for Scotland is to be consulted by Scottish Ministers on any division of a health board area into electoral wards. The possibility of
future changes to electoral boundaries in local government could cause administrative difficulties in conducting elections if the health boards operate within boundaries that are not coterminous with local authority ward boundaries. In considering the creation of any wards for health boards regard should be had for any boundaries created to be reviewed at regular intervals.

Conduct of election – Returning Officers

The Bill does not specify who will be appointed Returning Officer only that one shall be appointed for each ward. If Scotland’s 32 local government Returning Officers are to be appointed to this role or otherwise involved with the administration of health board elections, then there are major implications for the officers and their councils. We would suggest that the Health and Sport Committee seeks the views of Returning Officers on this possibility.

Voting system

The Commission has never commented on which electoral system is the most appropriate. We would, however, make the point that whatever system is chosen must be intelligible to the voter. Given that four different electoral systems are already used by Scottish electors we think it would be helpful to the voters if one of the existing electoral systems was to be employed.

The Bill also provides that the procedure for counting the votes shall be specified in election regulations. As the Single Transferable Vote electoral system is to be employed, it is conceivable that regulations may require the votes to be counting electronically.

Following the 2007 elections, the Gould report into the Scottish elections 2007 documented the problems that had occurred with the electronic counting system in chapter 8.2, outlined a number of options and made recommendations to improve the use of electronic counting at any future local government or combined elections. In our response to the Gould report the Electoral Commission made clear our concerns about the future use of electronic counting and we have reiterated those concerns and our recommendations in our report on the administration of the Greater London Authority elections 2008. We set out the steps that need to be taken, including:

- A cost-benefit analysis for the use of electronic counting.
- An implementation strategy with clear milestones for establishing procedures for testing, security and stakeholder assurance.
- A full analysis of the modifications required to electoral law to allow electronic counting to be undertaken with all the transparency and safeguards currently in place for manual counting
- Legislative amendments to PPERA and the Local Electoral Administration and Registration Services (Scotland) Act 2006 to guarantee full access to all relevant parts of any e-counting system or process for accredited observers.

It remains our view that these are the basic conditions that must be met and both the Scottish and UK Governments must address these before electronic counting is used again in Scotland.

Franchise

The franchise proposed by the Bill specifies that anyone aged 16 or over would be entitled to vote at health board elections and further criteria may be made by election regulations. Currently, any British, Irish, qualifying Commonwealth citizen or citizen of a European Union member state may vote in local government elections if they are registered with the Electoral Registration Officer for their area and are 18 years of age or older on the day of the election. 16 and 17 year olds can be added to the register as attainers in the year before they are eligible to vote but marked with the date they will turn 18.

The Bill envisages that the franchise for health board elections will be extended to include 16 and 17 year olds. The Electoral Commission’s 2004 report entitled ‘The age of electoral majority’ concluded that there was insufficient justification for reducing the voting age to 16 due to inadequate evidence either of public demand for a change in the voting age, or of any significant
likely impact on the engagement of young people. Currently, details of 16 and 17 year olds are required to be provided to the Electoral Registration Officer, including their date of birth, so that they are registered for the time when they will attain 18 years of age. If the voting age was lowered for health board elections to 16, then details of 14 and 15 year olds will need to be obtained and recorded so that they too will be on the register as soon as they attain 16 years of age. Such a move may have implications for those young people and we believe the Committee should seek further evidence of the consequences of collecting this information and making it publicly available as part of the electoral register.

While it is not specified in the Bill, election regulations could also widen the franchise compared to local government elections by, for example, enfranchising persons of any nationality who are resident in the health board area.

The implication of extending the franchise beyond the current local government franchise to either group means that the current electoral registers are not sufficient to be used at health board elections. The law may need to be changed to allow those people who are not currently entitled to be electors for local government elections to be included and marked on those registers or an entirely new register would need to be compiled. Any changes to the way the electoral register is compiled will almost inevitably create extra demands on the resources of Electoral Registration Officers and new logistical difficulties beyond those that we have recognised here may arise.

Clarification will need to be sought from the Scotland Office as to whether it would be permissible for the full register of local government electors to be used at health board elections or whether legislative change is required. The Representation of the People (Scotland) Regulations 2001, which govern the supply of the register of electors, have been specifically amended to allow the register to be used for elections to National Park Authorities.

**Ballot papers**

The Commission will publish a plan for the development of a set of standards on the accessibility, design and usability of ballot papers and associated stationery by the end of September 2008 and we expect to publish the finalised standards by early summer 2009. We expect this set of standards to inform future ballot paper designs and ballot papers for health board elections should conform to these standards.

**Arrangements for the poll**

The Bill leaves the arrangements for the poll to be made by election regulations. The Commission believes that electors have the right to cast their vote in a secure way which is convenient to them. Currently electors at statutory elections have the choice of voting in person at a polling station, voting by post or appointing another person to cast their vote by proxy. The Scottish Government has indicated that consideration is being given to holding health board elections by all-postal ballot. In areas where all-postal ballots have been held turnover has risen, although there is some evidence that turnout does decline again over time. All-postal ballots are expensive as the costs of preparing and sending the postal ballot packs have to be incurred for each elector. Postage costs are then also incurred with every postal ballot returned. The cost of providing a polling station is fixed regardless of the number of electors who choose to vote.

The Commission has significant reservations about the possibility that the proposed elections might be held on an all-postal basis. Without prejudice to that position, however, the Commission does not believe that a pilot to test the logistics of holding an all-postal pilot is necessary. A large number of all-postal pilots have been held across Great Britain for various elections and details of their evaluations are available on our website.

Following a number of high-profile abuses of the postal voting system, the Electoral Administration Act 2006 and the Local Electoral Administration and Registration Services (Scotland) Act 2006 introduced requirements for absent voters to provide personal identifiers to improve the security of the system. The identifiers, consisting of the elector’s signature and date of birth, have been collected by Electoral Registration Officers in Scotland and will be used at any election to the Scottish Parliament or the UK Parliament held after 7 August 2008. We expect that equivalent regulations will apply to European Parliamentary elections and Scottish local government elections.
by the end of 2008. Absent voters must provide these identifiers again on the postal voting statement that accompanies their ballot paper so that the Returning Officer can verify their identity.

The Commission understands that National Park Authority elections in Scotland are organised on an all-postal basis and do not require the Returning Officer to issue a postal voting statement to all absent voters. If health board elections were conducted as statutory elections and held without the need for a postal voting statement which included the absent voting identifiers, this would provide less security than at other elections held on a statutory basis on a Scotland-wide scale. The Commission believes that there should be consistency in the methods used for all elections conducted by Returning Officers to ensure that the levels of security in voting methods do not differ across different types of elections.

With that in mind, if elections to health boards are to be conducted entirely by post, serious consideration will need to be given as to how personal identifiers would be made available from the approximately 89% of the electorate that do not currently vote by post.

Practical implications and costs of the Bill if enacted

Elections to any organisation necessarily require financial and non-financial resources to successfully conduct them. Whatever funding mechanism is agreed upon, the Commission believes sufficient finance, staffing and resources should be made available to support a well-run election.

Andy O’Neill,
Head of Office Scotland,
The Electoral Commission

SOCIETY OF LOCAL AUTHORITY CHIEF EXECUTIVES (SCOTLAND) (SOLACE), SOCIETY OF LOCAL AUTHORITY ADMINISTRATORS IN SCOTLAND (SOLAR), ASSOCIATION OF ELECTORAL ADMINISTRATORS (SCOTLAND AND NORTHERN IRELAND BRANCH) (AEA) AND SCOTTISH ASSESSORS ASSOCIATION (SAA)

This report sets out the response of the four associations to the call by the Scottish Parliament’s Health and Sport Committee for views on the general principles of the Health Boards (Membership and Elections) (Scotland) Bill.

The Associations represent Returning Officers, Electoral Registration Officers and their deputes, and electoral administrators in Scotland with considerable experience of compiling electoral registers and conducting elections for local government and the Scottish, UK and European Parliaments. From this perspective, we have restricted our comments to the practicalities and operational aspects of the proposals in the Bill for Health Board elections. We make no comment on the principle of direct elections to Health Boards, believing that such matter is one of policy for elected representatives to consider.

In compiling these comments, we have sought to place the voters’ interests at the heart of the electoral process, as recommended in the Gould Report on the Scottish Parliament and council elections last year.

We consider that an all-postal ballot is not perhaps the most effective way of running these elections and that a conventional voting in person ballot option should be considered with postal voting as an available option. We strongly support the position of the Electoral Commission that “the administration of any such elections should be to a comparable standard as those of other statutory elections in Scotland”.

If the proposed elections to Health Boards were to be on an all-postal basis, the issue of Absent Voter Identifiers (AVIs) would have to be addressed. At present approximately 15% of voters across Scotland have AVIs and for an all-postal ballot 100% obviously would be required. There would be a danger of disenfranchising those who do not comply with the AVI requirements. Approximately 15% of absent voters did not submit identifiers as required and have now been removed from the absent voters’ list.
We have concerns over the proposed appointment of the Returning Officer and consider that the Returning Officer should be the local government Returning Officer appointed by councils in terms of Section 41 of the Representation of the People Act 1983, and that Scottish Ministers should appoint one of the local government Returning Officers where cross boundary issues arise.

We also consider that the elections should be organised on the same basis as any other election including the new procedures for the prevention of fraud, again following another of the Gould Report’s recommendations on consistency between elections. We also feel that any departure from this would add to the "cluttered administrative landscape of Scottish elections" that prevails at present.

Regarding the cycle of elections, we consider that the four year cycle would be appropriate and that the elections should be held by early March to avoid the April/May period of local government and Scottish Parliament election year(s). We also consider that the electoral registration canvass period between August and late November each year has to be avoided. Given that the new Health Board year begins on 1 April, early to mid March is felt to be an appropriate time for the elections so that new members can take up office on 1 April. We feel that 2010 is too early for the first elections as sufficient arrangements would not be in place by that time. In response to other consultations, the Associations have urged that planning for a local government STV election with e-counting in 2012 needs to start by January 2009 at the latest. If pilot elections to some health boards are to go ahead we would ask that the Scottish Government ensures that there is a joint co-ordinated approach and not two separate planning processes for two similar events in 2011 and 2012 and that it ensures that pilots in 2011 inform not only future health board elections but the local government elections in 2012. There is no time to lose if pilot elections are to be properly planned and resourced in 2011. The prospect of this emergent legislation being pursued in isolation and adversely impacting on preparations for 2012 is one which should be avoided at all costs.

We also consider that the proposals have to be introduced to avoid the period of National Park Authority elections and the proposed Crofting Board elections and any other elections which may be introduced, as this could lead to voter fatigue.

We are also of the view that if single transferable voting is to be introduced, it has to be consistent with the system used now for local government elections which is Weighted Inclusive Gregory (WIG) and e-counting should take place. We support the recommendation in the Gould Report that "electronic counting should be used alone for local government elections when the STV system is used". We believe that this recommendation should apply to direct elections to Health Boards too. We would also reiterate the Gould recommendation that the introduction of electronic voting for the 2011 elections is suspended until the electronic counting problems that arose for the 2007 local government elections are resolved. This timescale would mean that the proposed pilot elections to Health Boards could still take place.

We believe that the 'pilot' elections to Health Boards would allow the interest and demand from electors to be assessed and welcome the proposed evaluation which will report on the level of public participation in Health Board elections and will address whether having elected members on Boards has increased engagement with patients and the public. We would also suggest that the 'pilot' elections are used to assess the implementation of 'absent voter personal identifiers' required to ensure the integrity of postal ballots.

Due to the varying geographical sizes of Health Boards, we have concerns that each Health Board area would only be one ward, and welcome the discretion in the Bill to vary from one or more wards which could be made in Regulations.

With regard to the eligibility of 16 and 17 year olds to vote as proposed in the Bill, we consider that the registration issues which electoral registration officers would face could be overcome with sufficient resources. However, we consider that the position regarding lowering the age of voting to include 16 and 17 year olds should not be supported for Health Board elections for the following reasons –

- it would depart from the consistency for different elections throughout the UK;
• it would go against “putting the voter first” as in the Gould recommendations;

• the age of voting was recently reviewed by the Electoral Commission which recommended that 18 years of age remain as the age for voting; and

• the practicalities of collecting information in relation to 16 and 17 year olds would lead to the birth dates of 14 and 15 year old attainers being published on the register of electors. This may give rise to issues in relation to child protection.

We recommend that the local government register of electors is used as the franchise for Health Board elections although some 16 and 17 year olds may not be included and therefore be disenfranchised. This register will contain 17 year olds and some 16 year olds as attainers, but no one under 16. This recommendation also has the merit of making potentially difficult and costly adjustments to electoral registration computer systems unnecessary.

On a final point of detail in relation to the Bill we suggest, in relation to clause 1 (5) which states that the period of office for Board members should end "on the day of the next following Health Board election.....", that membership should end the day before the election. This would remove any dubiety about the use of health board resources during election day.

The cost of these elections we feel has not been fully investigated. There would need to be an assurance that the cost of any pilots, including the processing of AVIs, would be fully reimbursed by the Scottish Government to the Returning Officer and Electoral Registration Officer. We would also reiterate that if Health Board elections are to be organised by current Returning Officers, then Councils must be fully reimbursed for all costs involved. This would include not only the prescribed expenses that can be reimbursed through a Returning Officers’ fees and charges order, but also recognise the other election cost subsidies that occur.

We would welcome further consultation on the Regulations should the Bill be enacted. We believe that in drafting and implementing the Health Boards (Membership & Elections) Bill, further advice and guidance should be sought from the four Associations.

Finally any legislation to be introduced in connection with these elections must be enacted before the six month period recommended in the Gould Report.

SOLACE Solar AEA SAA
Tom Aitchison Gordon Blair William Pollock Brian Byrne
Returning Officer Depute Returning Officer Depute Returning Officer Electoral Registration Officer
The City Of Edinburgh Council West Lothian Council South Ayrshire Council Central Scotland Valuation Joint Board
Scottish Parliament
Health and Sport Committee
Wednesday 12 November 2008

[THE CONVENER opened the meeting at 10:02]

Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

10:03

The Convener: Item 2 is oral evidence at stage 1 of the Health Boards (Membership and Elections) (Scotland) Bill.

Our first panel of witnesses represent national health service boards. I welcome to the committee Peter Williamson, director of health strategy at NHS Tayside; Sandy Watson OBE, chairman of NHS Tayside; Heather Tierney-Moore, director of nursing at NHS Lothian; Dr Charles Winstanley, chair of NHS Lothian; and Professor Bill Stevely CBE, chairman of NHS Ayrshire and Arran. We thank you for your submissions, which we have all had the opportunity to read. We will move straight to questions.

Mary Scanlon (Highlands and Islands) (Con): I expected to pick up great enthusiasm for direct elections to health boards in reading the submissions last night, but the opposite is the case. In fact, I began to get seriously worried by some of the submissions. NHS Lothian’s submission states that the “system has the potential to destabilise boards”. NHS Ayrshire and Arran’s submission suggests that the bill would “undermine the operation of a national NHS”. NHS Tayside has not only adopted a policy of non-co-operation with the pilot scheme but says that the scheme “is likely to diminish the current source of strengths of Boards”.

I am picking up from those submissions the suggestion that direct elections to health boards will be a negative rather than a positive development. Can panel members elaborate on the points that I have picked up from their submissions?

Professor William Stevely CBE (Ayrshire and Arran NHS Board): Although it is certainly the case that Ayrshire and Arran NHS Board has consistently taken the view that elections are not a good way forward, I am here today to try to ensure that the committee is aware of issues that it needs to take into account in taking the bill forward. I view my appearance before the committee as being a way to help to ensure that the provisions of the bill will minimise the problems that we have foreseen.

I am still concerned about the real potential for a national policy, or a policy that is agreed here in Edinburgh, to be opposed by a majority of a board
that has a majority of elected members. Such a situation would perhaps arise only occasionally, but I could easily paint a scenario that would illustrate how it could happen. Such a scenario would not be helpful to the future of the NHS.

The Convener: Can you paint that scenario for us?

Professor Stevely: If I may be forgiven, I will use a case that arises from our experience. I have no wish to concentrate on the matter itself, but I want to use it as an illustration.

Most members will be aware that, prior to the 2007 elections to the Scottish Parliament, NHS Ayrshire and Arran had made proposals that involved the closure of one of its accident and emergency units. The proposals aroused a great deal of hostility in the local community. It is therefore reasonable to suggest that, had there been elections to the health board at that time, it is probable that that view would have had a big influence on who was elected to the board. That may be seen as a good thing, but we should park that idea for now. The scenario would have been that a majority of people sitting round the board table had been elected on the basis that they opposed the decision.

Members will allow me to suggest that a not unreasonable scenario would be that the previous Administration had ended up in overall control after the parliamentary elections. One would therefore have a proposal that had met the Administration’s prescription and that it had approved but which was now opposed by a majority of the board. That illustrates the tension that would have arisen.

The issue is not one that I am interested in at the moment, but that scenario would have left the majority of the board’s members opposing the proposal and wanting to change it, with the Administration potentially saying that it wanted to maintain what had previously been done. That illustrates the potential for discontinuity that could disrupt the business of a board for a considerable period.

Sandy Watson OBE (Tayside NHS Board): I do not accept the tag of “non-co-operation” that Mary Scanlon attaches to NHS Tayside. As Professor Stevely is, we are here this morning not to challenge the direction of travel. We are here in a spirit of willingness to be involved in a discussion that might lead to enhancement of the bill. That is the key point for us.

In the foreword to “Better Health, Better Care”, the Cabinet Secretary for Health and Wellbeing made it clear that she wants a more mutual NHS. The phrase that is used is “involvement, representation and a voice that is heard.” In our view, this debate is about involvement and representation. NHS Tayside’s view is that although the proposals that are currently before us would achieve representation, the question is whether they would achieve community engagement. We believe that we should explore that issue and add to the bill to ensure that community engagement is dealt with appropriately.

Dr Charles Winstanley (Lothian NHS Board): My colleagues have made some of the points that I wanted to make.

I emphasise that NHS Lothian sees the role of our board, especially its non-executive members, as governance and scrutiny of an entire system—a system that is very complicated. The lay members, apart from representing the public and patient interest, are selected because their backgrounds and professional skills can complement the board. The concern is that the proposals could lead to single-issue candidates. NHS Lothian has had recent experience of such a situation, which can destabilise the role of the board. Under the bill, narrow issues could become the entire focus of the board.

We think that there is a case for greater public involvement and we would welcome that. We find the idea of mutuality very exciting, but we already have wide and deep processes in place to enable us to hear the voices of all our communities. We would like later to suggest an additional part for a pilot, which would involve a different way of hearing from the community.

The Convener: I will leave that for the moment; other members may pick up on it. Mary Scanlon has a supplementary.

Mary Scanlon: Yes. It is worth putting on the record the final paragraph in the NHS Tayside submission, which states:

> the Board does not wish to engage in a pilot for directly elected Board members but would, if it is considered desirable, be prepared to look at extending Council representation on the Board.

I do not want anyone to think that I would put forward something that is inaccurate. I share some of those concerns. I will leave it at that.

The Convener: We will return to the matter, at which point Mary Scanlon can come back in.

Michael Matheson (Falkirk West) (SNP): Good morning. It would be helpful to the committee if each health board representative would spell out exactly whom they consulted when they decided on their responses to the policy proposal.

Dr Winstanley: I am happy to confirm that the board’s position was a board meeting item. As usual, the meeting was held in public. It was an open and clear process.
Professor Stevely: I am happy to say the same: we simply repeated the view that the board had given previously and which—as it had been fully discussed by the board—represents the board’s view. The process gave staff members the opportunity to contribute to the debate if they so wished.

Professor Heather Tierney-Moore OBE (Lothian NHS Board): We consulted widely through many of our patient involvement structures—patient councils, panels and so on. The view that the board ultimately took was supported by those people.

Michael Matheson: It would be helpful if the committee could see some of the evidence that you received from patient involvement groups that helped the board to formulate its view. Perhaps you will pass that to the committee.

In the case of two boards, only board members were consulted to any extent before the board came to a view on this policy intention.

Sandy Watson: That is also the view and position at NHS Tayside. The board was asked for comments for submission to the committee.

Michael Matheson: That is helpful.

I turn to the NHS Lothian submission. You said that the new system has the potential to destabilise boards. Will you spell out your evidence on that?

Dr Winstanley: I return to the point that I made earlier: my principal role is to ensure that the organisation’s activities and programmes reflect Government policy. I am accountable to the cabinet secretary and my board members are accountable to me. I expect their activities and behaviours to be in line with the organisational direction of travel.

My concern is that directly elected members might consider their sole accountability and loyalty to be to those who elected them, which could make them out of step with Government policy and the board’s agreed policy. Potentially, we could have two styles of director: those who work corporately and those who do not.

I repeat the point that I made earlier: although single issues are of concern, such valid concerns are only one part of the mosaic of our incredibly complex business. If single issues were to dominate board business and squeeze out debate on other issues, that could be destabilising.

Michael Matheson: That sounds more like opinion than evidence. You have presented no evidence on how that could destabilise boards.

Dr Winstanley: I can offer recent evidence. Our council members are welcome—the system works well—but at the moment the entire focus of one member from the council, who was elected on a single-issue ticket, is on that single issue. The situation provides an interesting illustration of what can happen when all debate is on a particular issue. The contribution of the board member tends to be limited to matters that relate to the single issue; the person is not part of discussions on other parts of our business. That is a practical example.

10:15

Michael Matheson: Has the situation destabilised your board?

Dr Winstanley: No, because we are a large board and there is only one single-issue member. However, if the bill were agreed to there would be far more.

Michael Matheson: NHS Lothian suggests in its submission that the inclusion of elected members on health boards would cause confusion. Why?

Dr Winstanley: Boundaries are an issue. Currently, we have an effective partnership with councils. We work closely with them on jointly funded projects and we have jointly funded posts. Members of the public can deal with us directly or talk to us via their council representatives, and the geographical alignment is clear.

There is potential for confusion. What would be the constituency of the directly elected members? How would that relate to council members, who might think that they already represented a geographical or territorial constituency? Who would represent whom?

Michael Matheson: In your submission you make five concluding points, the first of which is that the bill “does not have widespread public acceptance”.

On what basis do you make that assertion?

Professor Tierney-Moore: I think that our comment related to the report that came out following the consultation, in which different views were expressed by different sectors. There was support from some areas and less support from others.

Michael Matheson: Are you talking about the report on the consultation on the bill?

Professor Tierney-Moore: Yes.

Michael Matheson: Having read the report, how did you conclude that there is no “widespread public acceptance” of the bill?

Professor Tierney-Moore: That is our view—

Michael Matheson: It is your interpretation.

Professor Tierney-Moore: Yes.
Helen Eadie (Dunfermline East) (Lab): We talked about tension between policy that is determined at the centre and policy that is determined locally. I understand that in New Zealand a mechanism has been found to cope with that tension. Will the witnesses comment on how effectively that works and add to the information that we have about what happens in New Zealand?

The Convener: The witnesses might not have considered what happens in New Zealand.

Sandy Watson: I am not familiar with the situation in New Zealand, although I have read that the country seems to have cracked the issue in some respects, although we cannot always easily extrapolate.

What troubles the board at NHS Tayside is that because local government members plus elected members would be the majority, there would be the potential for clashes with Government policy at local level, regardless of which Government was in power. We must consider how the elected members would come to their positions. They would be elected by public ballot and might then be appointed by the cabinet secretary, but where would their loyalty lie in a crunch issue? Would it lie with the public via the ballot box or with the cabinet secretary? The issue is ultimately difficult to crack. Compliance would be a major problem.

Helen Eadie: In the submission from NHS Tayside, mention is made of mutuality, which we talked about. Mutuality means many things to many people. NHS Tayside states:

“For the Board, mutuality emphasises participation much more than representation.”

In the circles in which I move, it means both participation and representation. Would you like to expand on your comments?

Sandy Watson: Mrs Eadie makes an important point. Tayside NHS Board concedes that representation may be part of the jigsaw of mutuality; our concern is that the bill includes only one piece of that jigsaw. We argue strongly that community engagement should be examined at the same time. I am aware that Mrs Eadie, like me, has a local government background. In local government, the issue was dealt with through legislation that gave councils a statutory duty in respect of best value and a statutory duty to facilitate the process of community planning. Perhaps something of that nature should be considered for the health service.

Helen Eadie: In the last paragraph on page 3 of its submission, Tayside NHS Board talks about the evaluation criteria—I am sorry that all my questions relate to Tayside. It suggests that the criteria for assessment and monitoring of pilot projects are not clear enough. Would members of the panel like to elaborate on their thinking in that regard? Tayside NHS Board has raised an important issue.

Sandy Watson: The issue is the point at which it is most appropriate that the evaluation criteria be fully articulated. In my view, that should be part of the process when the pilot starts—we must be clear at the outset about what we are trying to achieve. I am going on the statements of the Cabinet Secretary for Health and Wellbeing in the introduction to “Better Health, Better Care”, which sets out the argument for mutuality. As I understand it, mutuality is essentially about there being public ownership of the direction of travel, so the evaluation criteria must ensure that public ownership is achieved. If, at the end of the day, we do not have public ownership of the direction of travel that is outlined in “Better Health, Better Care”, it will not happen.

Helen Eadie: I have one brief final question. I understand that the cabinet secretary will have the power to sack everyone on the board—both elected members and council members. What is your view on that provision?

Professor Stevely: That power is spelled out in the bill. However, the bill must say what happens next if a large proportion of board members are elected. Simply proceeding to another election, at which the same people were elected, would lead to an even more unfortunate stand-off. Some thought needs to be given to how the power will work and what the follow-up procedure will be.

Ross Finnie (West of Scotland) (LD): I preface my remarks by commenting on some of your opening observations. You suggested that the purpose of this morning’s meeting is simply to move the bill forward. I do not disagree entirely, but I point out, with due respect, that we are considering the bill at stage 1. Among other things, the committee must determine whether it approves of the principles of the bill. Although I do not want to get into a dispute on the matter, it is an important point.

Last week we heard from senior Government civil servants. We agreed that the bill is not about the line of accountability to the cabinet secretary but about engagement; you make the same point in your submissions. The public have expressed clear concerns about the legitimacy of the persons who would become non-executive members of boards. I know that this is almost impossible to do, but could we, for the moment, park the issue of qualifications and concentrate solely on where the members would come from and how they would get there? Rightly, one of the real issues in a body that is wholly and exclusively publicly funded is that there is a wish that a part of the legitimacy of those persons who serve as non-executive...
directors ought to derive from a democratic process.

I have a difficulty with the position of NHS Ayrshire and Arran and NHS Lothian in that, although you state that there is greater engagement, that engagement is generally below board level. Furthermore, I feel that you are slightly dismissive of the extent to which democratically elected people might play a role in the process. That is not quite the position of NHS Tayside, which has said that one of its experiments might involve greater councillor involvement.

I accept that work is being done below board level, but what about at board level? I accept what you said about tension, which is why I favour greater councillor involvement. That is my personal view, but I am interested to hear your views.

**Professor Tierney-Moore:** Four elected councillors sit as full members of NHS Lothian’s board: they have a stakeholder, non-executive director function. We would like to have at least one directly elected member from a defined constituency of people who are genuinely interested in and engaged with the functions of the health board, and we would spend time and effort to increase that constituency.

On direct elections, we should bear it in mind that broad sections of the population do not engage in such processes. Therefore, the section of the population that normally does so would be the only section that would do so in this context as well. You might argue that that would constitute a democratic process, but we would want to invest time, energy and resources in reaching out to sections of the population with whom we have difficulty engaging on health and health inequalities issues, and who are unlikely to engage in a normal democratic process.

**Peter Williamson (Tayside NHS Board):** The question of democratic elections to boards is important. We in NHS Tayside feel that, as you have already heard this morning, wedding those elections to the existing structure of the boards could make the operation of the board subject to certain risks—you could have a directly elected board, or the NHS board could be merged with the local authority. Our point was that, at present, boards are accountable to the Cabinet Secretary for Health and Wellbeing, whereas local authorities, obviously, are not. There would be appointed members as well as elected members. We have raised concerns about the idea of wedding the elected members to the current system and expecting that system to continue to operate as it has done up until now.

**Dr Winstanley:** On the point that Ross Finnie made about the sources of non-executive directors, it is worth making the point that the Office of the Commissioner for Public Appointments in Scotland is active in ensuring that the process is diverse and that applications will be encouraged from all sections of the community. Although boards will take a view on the necessary skill set, there are increasing efforts to ensure that non-executive directors come from all parts of society and are not perceived as being people who have a narrow range of business skills or who have been recycled from other boards.

10:30

**Ross Finnie:** I find all of those responses disappointing. I understand the tension of having two differently elected bodies. I am sorry that no one chose to comment on the submitted view that, because there are already elected members from councils on boards, representation is perfectly adequate. Your position seems to be, “We have councillors, one from each council, which is perfectly adequate. We don’t need any more of these wretched elected people. We certainly don’t want new, directly elected people. We are very happy with the composition of the board.”

With all due respect, that is rather complacent, given that the Government wishes to make a serious difference. I am not a member of that Government, and I do not agree with the idea of directly elected boards, but you are not providing me with an alternative proposition that would lead to engagement greater than that provided by people whose legitimacy derived from the fact that they had been subject to an election in their local area.

**Professor Stevely:** As the bill stands, it is clear that there will be a majority of elected members. That is where I see some of the major tensions coming in. I have no great problem with increasing the number of people who arrive at the board via some electoral process, but you can get into difficulties when the majority of members have come from that route. For example, one issue that worries me is that elections will be across whole board areas. My view is that there ought to be wards that match local authority boundaries, as that would help to minimise some of the issues that I can see arising.

**The Convener:** Pardon me for interrupting, but that issue relates more to process, whereas today we are considering the principle of democratic representation. That is the nub of this argument.

**Professor Stevely:** Indeed, but the point that I am trying to make is that there is the potential for single-issue campaigners to be elected, and we
are trying to find ways of minimising the impact of that on boards.

In addition, it is not clear what the overall size of boards will be, since the number of appointed members is not defined, and it could be any number, including just one—namely, the chairman. That leads to issues around the size that boards must be if they are to function properly and the impact of those who are elected as opposed to those who are appointed ex officio.

**The Convener:** Professor Tierney-Moore, you mentioned having direct elections from a defined constituency rather than the public at large. I do not know what you meant by that.

**Professor Tierney-Moore:** The idea is a development of what has happened with foundation trusts in England. There, people are eligible to be a member of a board if they have, for example, a particular association with hospitals or a particular relationship with primary care. Our idea is that we would create an on-going dialogue with such people in a way that was meaningful to them, and they would become a constituency of people who had a relationship with the board rather than be involved simply at the point of election. They could be provided with information and allowed to become involved at a committee level, at management level and in all sorts of other ways, and they would have the ability to elect people from their constituency.

**The Convener:** Can I stop you there? Who would select those people? Who would make up the list?

**Professor Tierney-Moore:** You would make it open to everyone. No one would be denied the ability to vote—they would all be allowed to engage—but the board would have a responsibility to have an on-going relationship with them rather than an episodic, election-based relationship.

**The Convener:** I am sorry, but I do not understand that. I am trying to understand what plan B is. You suggest that we should have directly elected members of the board from a particular group of people, not just the public at large. I do not know what you meant by that.

**Professor Tierney-Moore:** The system would be a way of developing engagement with the health service on an on-going basis that would be open to all, defined by population.

**The Convener:** I am again taking assistance from Richard Simpson. Would people be on a register?

**Professor Tierney-Moore:** Yes. They would sign up to be associated with the board.

**The Convener:** And people on that register could be elected to be members of the board.

**Professor Tierney-Moore:** Yes.

**The Convener:** Right—I understand that.

**Ross Finnie:** Convener, could we allow Dr Winstanley and Sandy Watson to respond to my question?

**Sandy Watson:** I would very much welcome that, convener. Tayside NHS Board accepts entirely the desire for greater democratisation. As Mr Finnie pointed out, our submission indicates that our preference is to have more elected members from local government on our board. The three that we have already have made a superb contribution to the working of the board. I, personally, and the board would welcome having more elected members from local government. That would also deal with Professor Stevely’s point about there being different local authority areas within health board areas. In our case, we have Angus Council, Dundee City Council and Perth and Kinross Council. Our suggestion would have the added financial advantage of not incurring the cost of running separate elections.

**Ian McKee (Lothians) (SNP):** I thank the witnesses for coming and for their interesting submissions. I want to clear up one aspect of the evidence. The Tayside NHS Board submission states:

“There are clearly parts of the community that seldom or ever sit round the Board table.”

It refers specifically to age, ethnic background and socioeconomic status. However, the Lothian NHS Board submission states:

“NHS Lothian’s non executive directors consider it important to re-emphasise their role in representing the public voice at Board level.”

That is a slightly different focus. Do the NHS Lothian witnesses agree with their colleagues in NHS Tayside that the representation of non-executive directors is at present biased towards certain sectors of the community and leaves out other sectors?

**Dr Winstanley:** I support the Commissioner for Public Appointments in Scotland’s assertion that there has not been a sufficiently diverse source of
non-executive directors. However, my fellow non-executive members of the board consider that they are there to represent the public and patient interest. They do that through an active programme of ambassodorial work, talking to community groups and getting out and visiting the community. They are not directly elected, but they see themselves as the representatives of the public.

Ian McKee: So they come from a skewed background, but they are responsible for representing people from backgrounds which they do not come.

Dr Winstanley: We look for a geographical spread in our non-executive directors. We want to have people from all over the region that NHS Lothian serves. I am sure that you will agree that, in many areas of public life, people represent the interests of a group without having an identical profile. We select non-executive members who have the breadth of vision and compassion to be able to relate to people who have not had the same route in life.

Ian McKee: I move on to how the public have a voice at present. Several submissions mentioned the functions of public partnership fora. How do people get on to those fora?

Sandy Watson: We seek expressions of interest and people come on board against that back-cloth. They do a tremendous amount of excellent work, but they would be the first to confess that they are not the whole answer. By and large, their members are middle class and elderly. They have made strong pleas to NHS Tayside to cast the net much more widely.

I chair a community engagement strategy group in Tayside. We started by mapping all the existing forms of engagement, which was a salutary process. A tremendous amount is already happening. There are patient groups for stroke, diabetes, cancer and so on; general practice patient groups; voluntary organisations; carers and carer organisations; and community and neighbourhood groups—I could go on.

We are focusing particularly on how we can get young people and older people more involved—a strategy for older people will go to the board tomorrow—and how we can use social marketing to change the culture to give people ownership of the agenda. NHS Tayside sees that as the way to go. Our ideal ticket would be a combination of that kind of approach and increasing democratisation, about which I spoke in response to questions from Mr Finnie. We should make boards more representative by having a few more elected members from local government join them, without throwing out the good skill mix that exists on boards, which is in the public’s interest.

Ian McKee: Does Tayside NHS Board appoint the members of PPFs?

Sandy Watson: No. Effectively, they appoint themselves by expressing an interest and coming together. I have attended meetings of patient partnership groups—which are not formally constituted—at which people have given us their views so that we can take them into account in our deliberations.

Professor Tierney-Moore: As Sandy Watson said, PPFs consist of people who have chosen to sign up, and they elect from among their members people who will have formal seats on our community health partnership sub-committee and so on. Although we are working hard to get diversity within those groups, the nature of the work, which involves people sitting on a committee to give their views, is such that it does not reach many people. Networking with other groups and having routes by which they can feed in their views, without necessarily being part of a formal committee structure, is important. That is why we favour a joint approach to engagement. PPFs are still at an early stage, although we can track specific examples of their influencing directly the work of the community health partnership and the university hospitals division. A great deal of development is needed to support them.

Ian McKee: One of your PPFs was dissolved recently. What was the mechanism for that?

Professor Tierney-Moore: The PPF was dissolved because of its inability to self-govern. The CHP had to intervene, with support from civil servants. We brought in someone to review the situation and independently to provide a way forward. The PPF has now re-formed. An independent chair has been elected to support its members through the process of re-engaging with one another and building a much broader base that will enable the PPF to function. It had become divided into factions and unable to self-govern.

Ian McKee: Who decided that the PPF was unable to self-govern?

Professor Tierney-Moore: The chair of the PPF, in discussion with the CHP.

The Convener: I think that we have exhausted that issue, unless one of the other witnesses wants to comment.

10:45

Professor Stevely: I simply add that it will be critical to evaluate the effectiveness of what is being done as mechanisms for engagement develop—we are actively considering new ways of engaging with people, to add to what we currently do—versus the effectiveness of pilots on the direct election of members.
Ian McKee: I do not know the circumstances of what Heather Tierney-Moore talked about, but I am concerned that one person’s dysfunctional PPF might be another person’s PPF that asked awkward questions that the board did not want to hear. I am interested in the mechanism whereby someone decides that a PPF is not functioning and should be dissolved.

Professor Tierney-Moore: The situation that I mentioned was brought to a head not by people challenging the board, asking difficult questions or wanting to make changes, which a number of our PPFs have done successfully—

The Convener: The question was about the process, not the particular circumstances. Who has the ultimate sanction to dissolve a PPF?

Professor Tierney-Moore: The specific issue was that the PPF wanted to review its constitution and potentially to agree a different membership of existing committees, but it could not agree on a new constitution, so—by its own actions—it could not function. It was not a question of a view being taken externally that the PPF was not functioning; the PPF could not agree a new constitution, so it could not elect a representative to sit on the CHP.

The Convener: It self-imploded, in other words, and the board did not instigate that.

Professor Tierney-Moore: Yes, exactly.

The Convener: Is that clear to Ian McKee?

Ian McKee: Yes.

Jackie Baillie (Dumbarton) (Lab): I want to establish information on boards’ make-up. How many members does NHS Lothian have? I did not want to pick on you, but we considered that issue earlier.

Dr Winstanley: From memory, I think that our board has 26 members, of whom the majority are non-executive members. Our executive directors are easily outnumbered by stakeholder and lay non-executive members and council members.

Jackie Baillie: How many of the non-executive members are appointed by the Scottish ministers and how many are elected local authority members?

Dr Winstanley: Boards have a member for each council. In our case, we have four members, who are from the City of Edinburgh Council, East Lothian Council, West Lothian Council and Midlothian Council. We also have representatives of staff groups: the employee director, a representative from primary care and a representative of allied health professionals are the staff non-executive members. In addition, we have lay members, who are all of the same seniority.

Jackie Baillie: How many executive directors do you have? Forgive me for asking that, but I am scarred by my experience of NHS Argyll and Clyde, where—not to put too fine a point on it—a payroll vote was in operation.

Sandy Watson: In Tayside, six out of 22 board members are executive directors. As Dr Winstanley said, the other 16 include a representative of the area clinical forum, a representative of the area partnership forum, the employee director, a representative of the university—

The Convener: Sorry to interrupt. Are we talking about Tayside?

Sandy Watson: Yes.

Dr Winstanley: Lothian has six executive directors. The number is small.

Jackie Baillie: You suggested that perhaps one person could emerge from the partnership forum structures and work their way through various levels to reach the top of the pyramid. Is it reasonable to expect one person to take on the mantle of representing many people?

Professor Tierney-Moore: All the research on engaging with the public shows that having one representative is never a good idea and there should be at least two representatives, not least to ensure that people are supported and have the ability to speak. We are not far down the road in thinking this through, but we want to explore whether we might have someone who would focus on hospital provision and someone who would focus on primary care and public health. We could cut it in different ways, but one would not be the right number in the long term. That is more about having a starting point.

Jackie Baillie: Should the bill pilot alternative approaches rather than just one approach? I have a fair idea of NHS Tayside’s preference, which is just to increase the number of local authority representatives on boards. Would the boards prefer to pilot the kind of approach that NHS Tayside has outlined? Would it be useful for the bill to propose piloting alternative approaches?

The Convener: I think that Richard Simpson has just deleted a question from his list.

Jackie Baillie: Excellent. I am saving you time, convener.

The Convener: I like to see you operating as a team. Who will answer Jackie Baillie’s question?

Professor Stevely: There would be value in having more than one approach on a variety of issues, including this one. We could consider, for example, how one increases the representation of the public partnership forum and whether to have whole-area elections as opposed to ward
elections. One could try two or three different mechanisms and thoroughly evaluate them to assess which one gave the best outcome in terms of people’s confidence in what we do, because that is what we are considering.

The Convener: All the witnesses should get the opportunity to answer on that one.

Dr Winstanley: I fully support testing more than one approach.

Sandy Watson: Likewise.

The Convener: So that is the view across the board.

Jackie Baillie: I suspect that my final question is about, dare I say it, the self-interest of boards. The costs in the financial memorandum have been updated, and it is now suggested that the total cost for Scotland-wide health board elections would be about £16 million, although there is debate about whether that would be sufficient. However, it is clear that, beyond the pilots, boards would be expected to absorb the costs of elections. What impact would that have? Could boards achieve the costs through efficiency savings without that impacting on front-line services?

Professor Stevely: We need a clearer idea of what the costs would be. However, as it stands, the costs that would fall to us, which do not take into account aspects such as expenses and returning officer costs, would be only about £200,000 per annum, if spread over the four years. While I am bound to say that that is significant, one cannot say that finding that amount of money would seriously hinder front-line services. However, it would be more of an issue if the amount was much larger than that. That is our initial estimate, which I think we provided to the committee in our submission.

Dr Winstanley: We estimated that the cost of elections, depending on turnout, would be between £0.25 million and £0.5 million. We have a budget of £1.4 billion, so we would be able to absorb that cost without causing serious disadvantage to patients, but the money would clearly need to come from current activities.

Professor Tierney-Moore: The amount of money that we want to spend on patient and public involvement generally and on work that links with learning from the patient experience is a significant resource. I have just put some figures together for the cost of taking that work forward effectively over the next few years. Lothian NHS Board wants to invest between £1 million and £1.5 million in that kind of activity. Clearly, anything that we spent on elections would make it more difficult for us to find the money to take that other work forward.

Peter Williamson: I echo that point. Lack of resources, for example the resources that are available for communication, holds back our engagement with people and impacts on the quality of that engagement. The committee should be aware that finding money for elections would require a trade-off with that other work. Whatever happens regarding elections to boards, further investment in engagement is required to move forward with a mutual NHS.

The Convener: I do not know whether Richard Simpson has any questions left.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Almost not. I began the morning with 10 questions, but my colleagues have whittled them down. However, I have a supplementary to Jackie Baillie’s earlier question, which dealt with a fundamental aspect. If money is to be spent on direct elections, what current public involvement measures would boards have to drop, given that the money comes from the same pot? Have boards considered what they would drop if the bill goes ahead? I have a final, tiny question.

The Convener: I love the way that members always prefaced “question” with “tiny”. It is a very elastic word on this committee.

Sandy Watson: The question is premature. Part of the process of the pilot is to work out exactly what the costs would be and how they might best be met. I would not like to commit myself at this stage to answering that question.

Professor Stevely: I take the same view. I expect that the costs of the pilot would be met centrally, which would allow us to see the real costs. Once the arrangements were rolled out, it would be legitimate to ask what needed to stop in order to fund the process.

The Convener: Dr Winstanley is nodding.

Dr Winstanley: I have nothing to add; I agree with both those points.

The Convener: Now for Dr Simpson’s “tiny” question.

Dr Simpson: The fundamental point behind what the Government is trying to achieve through the bill is the belief that boards currently are not adequately accountable and public confidence has been shaken by some of the events of the past 18 months to two years. Have any of the witnesses considered whether the mechanism for selecting and appointing non-executive members might be changed to enhance their credibility as being representative of their communities?

Professor Stevely: As Charles Winstanley has indicated, the Commissioner for Public Appointments in Scotland is exercised about the matter. Board chairs have discussed it, and we
fully support moves to ensure that the people who come forward and are appointed to boards are more representative, for example in terms of gender and disability. I confess that one would go more along those lines, rather than specifically ask whether people are representative in another sense, if you follow me. Elections might bring forward people who are representative in a sense, but who do not reflect the variety of people they represent, as is all too obvious in some national legislatures, which are not particularly representative along the lines that I have mentioned. We need to think about those issues in relation to the confidence of the communities that we serve.

The Convener: Mary Scanlon is indicating that she wishes to ask a supplementary question, but I want to end this evidence session shortly.

Mary Scanlon: I have an important point—which has not been raised today, although it was raised last week—about the list of people who are prohibited from standing for boards, in particular NHS professionals. No one may stand if they give advice to health boards, which rules out many potentially excellent health board candidates. How do you feel about that? Would the career prospects of those who are currently employed by the NHS be affected if they stood for a health board?

What do you think about having no remuneration for elected members? What do you think about the proposal regarding 16-year-olds voting? I am trying to imagine the people who will stand for election. I appreciate that many people with experience of the NHS could greatly contribute to the working of boards. I am slightly concerned that, under the bill, they will be prohibited from doing so.

The Convener: That was a classic Mary Scanlon supplementary—in several parts. The witnesses can deal with the bits that they want to answer. There is a sweeping-up exercise to be done—perhaps I should have done that.

Professor Stevely: We have an employee director on the board, which is valuable and should ensure that we tap into expertise on the board. That is my preferred approach. I do not believe that there should be a difference between elected and appointed members’ remuneration. If we are asking people to do a significant amount of work and to devote time and energy to it, they need to be remunerated accordingly.

The Convener: Has the point about prohibited lists and people giving advice been answered?

Professor Stevely: There is a grey area around when someone is barred. I am not aware of that having been a real issue.
Electoral Commission’s Scotland office; Robert Jack, from the Society of Local Authority Chief Executives and Senior Managers; and William Pollock, the chair of the Scotland and Northern Ireland branch of the Association of Electoral Administrators. Thank you for your written submissions. You will comment not on policy, but on process.

**Dr Simpson:** I will get in first this time.

**The Convener:** I knew that you would say that—you were wounded last time because everyone took your questions. I hope that you do not have 10.

**Dr Simpson:** No, I have only two. I thought that if I did not get in first they would be picked off by someone else. The proposal to allow 16 and 17-year-olds to vote in health board elections is a relatively new provision; it does not apply to the two external elections that we have considered recently—elections to national park boards and elections to the Crofters Commission. Would you like to comment further on the issue? SOLACE suggests in its submission that having people of 15—presumably—on the public electoral register, with their date of birth, would raise child protection issues.

**William Pollock (Association of Electoral Administrators):** Electoral registration officers expressed concerns about the extension of the franchise to 16 and 17-year-olds because information on those electors would have to be included on the register, as you pointed out. As you know, all registers include attainers—people who will come of age during the period to which a register applies. At the moment, people can be 16 when their name first appears on a register, because it covers more than one year. In this case, 14 and 15-year-olds could end up on the register. That raises issues of child protection, because they are under 16. It may be possible for them to appear in a separate document that is not quite so publicly accessible. I know that EROs are considering that option, but a cost will be associated with any additional security measures that are implemented. The association supports reducing the age of majority in all elections, but we have expressed concerns about the extension of the franchise to people below the age of 18 only for elections to health boards.

**The Convener:** The issue is on the cusp between policy and process.

**John McCormick (Electoral Commissioner):** I will add a codicil to William Pollock’s point. Having a closed register for attainers who are minors would raise issues of engagement with the electorate. Hopefully, those would be addressed.

**Dr Simpson:** My second question is about who would run the elections. At the moment, the health service has no skill in that area. Could the elections be run by someone else? Would boards have to appoint staff to run them?

**Robert Jack (Society of Local Authority Chief Executives and Senior Managers):** The bill and the draft regulations that have been published propose that the elections be run by local authorities, on behalf of boards. I understand that the returning officer for the most populous local authority area in a health board area would be the returning officer in board elections. That raises the question whether one returning officer would run the elections for a whole health board area or whether, if the area covered a number of local authorities, they would engage the assistance of other returning officers in that area. The current draft regulations envisage the appointment of one local authority returning officer for each election.

**Dr Simpson:** Is that a satisfactory way of proceeding?

**Robert Jack:** It would be an additional cost to local government, which is a concern.

**Dr Simpson:** Are we clear about whether the provision has been costed in the financial memorandum?

**Robert Jack:** I cannot answer that question.

11:15

**Jackie Baillie:** The integrity of any ballot is obviously important, so that we can trust in its outcome. In that context, what is your view of the suggestion that personal identifiers need not be used?

**John McCormick:** The Electoral Commission has a clear policy on personal identifiers, the use of which it favours, as a result of its experience in reporting on previous postal ballots. The principle that we abide by is that if an election takes place, regardless of what it is for, it should be robust and accepted by everyone who is involved. The principles that we follow—we would be happy to follow this up in a detailed submission, if the convener thinks that that would be useful—should apply to health board elections just as they apply to other elections, so that following such an election, everyone who is involved in it can accept the result. For postal votes, we favour the use of personal identifiers.

**Andy O’Neill (Electoral Commission):** From the Electoral Commission’s point of view, if health board elections are run by the returning officers, they will be perceived by us and the electorate as statutory elections—they would become the fifth statutory election in Scotland—so they must be robust. Particularly in Scotland post 3 May 2007, we cannot afford to have elections that are seen as less than robust.
The Convener: Please do not take us back to that horrible night.

Andy O’Neill: We would certainly want a robust and consistent electoral administrative process.

Robert Jack: The previous exchanges contain an important point of principle, which is about the extent to which one should try to achieve a simple, uniform and robust electoral system that applies to all statutory elections. At the heart of our joint submission is a concern that if we pick and mix in order to get a particular proposal into law, we will cause confusion across the various electoral systems.

When it comes to the use of identifiers, we face a bit of a dilemma because the potential exists for conflict with the idea of an all-postal ballot. There is no doubt that running an all-postal ballot that involves the use of identifiers is a more costly and complicated process. Concerns have been raised about whether people might deselect themselves from the register rather than go through the identifier process. At the moment, only people who apply for an absent vote go through it.

If health board elections are run as the draft regulations appear to suggest, on the same basis as elections to national park boards, for which identifiers are not required—no declaration of identity is necessary—we will run into issues that are of concern to us all, which relate to the probity of the process and the prevention of fraud. There are conflicting objectives. The people who framed the bill think that an all-postal ballot is the best approach, but that inevitably means that one must compromise on the use of identifiers or, if one does not, one faces all the issues of introducing the use of identifiers for 100 per cent of the electorate. Our main point is about consistency across the electoral system and not introducing compromises for the sake of getting a particular proposal through.

Jackie Baillie: Thank you.

In an interesting submission, the Local Government Boundary Commission suggested that local authorities and health boards should have coterminous boundaries for the purposes of consistency and avoiding confusion, but the Government has said that it has no plans to make changes in that regard. Is that crucial or can the problem be overcome?

The Convener: I think that I saw a ball being passed along between the witnesses.

Robert Jack: There are wider issues at stake than simply those to do with elections—there is a significant community planning dimension. Local government has long argued that if it can be achieved, coterminosity assists the community planning process. Elections are just part of that. How easy or difficult that is to achieve without changing health board or local authority boundaries is a matter of debate.

Undoubtedly, one finds that the community planning process appears to work better in areas where the health board and local authority have, by and large, coterminous boundaries, than it does in areas where there is a multiplicity of authorities. Having worked in an area in which there are three authorities to the one health board, I remember that the public consultation around the introduction of community health partnerships and the debate about whether they would be based on the local authority area or the health board area was quite a tortuous process. Coterminosity is a good thing, but it is not necessarily easy to achieve.

Andy O’Neill: Coterminosity is a difficult issue in Scotland, because we do not have very much of it and it is difficult to achieve. Where you do not have coterminosity, we would emphasise that you have to ensure that the electorate know who they are electing and who represents them—you have to make more effort and spend more resource to achieve that.

Michael Matheson: What are your views on the timetable for the elections? Given that the Government proposes a postal ballot, does there need to be a more extended timetable from the opening of nominations to polling day, as opposed to the shorter period that we have for local government elections? Is there an issue around how long the timetable has to be?

John McCormick: We favour a longer period for the postal vote, which we hope will improve participation. There is an issue about allowing a period of seven days between the close of nominations and the beginning of the voting period. It might be a challenge to gather all the voter information and print the ballot papers in that time. We certainly think that it is worth taking the advice of the Royal Mail and those involved in the printing of ballot papers and getting information about whether everything that needs to be done can be done in seven days. That is a serious concern. However, in general, we welcome the longer period for people to take part in the election.

Michael Matheson: What should the timescale be?

John McCormick: That is a matter of judgment. If the measure is to be rolled out throughout the country, it is a matter of testing with the professionals the capacity for the printing of the documents and the delivery of them by the Royal Mail. In different elections in different parts of the United Kingdom in the past, the issue of printing—around which there was a learning curve for me—was challenging, because it put a weight on the
small number of people who are able to provide that service. We recommend that others who are involved in that professional area should give advice on whether the deadline could be met.

Andy O’Neill: I support what John McCormick said. The capacity issue is important, in relation to not just the publication and printing of the ballot papers but the information packs, which we understand from the election rules would go out to all the electorate in an all-postal vote. There are issues around the legal checking of the entries and such like. There are instances in the Greater London Authority elections and some of the mayoral elections in England in which the information packs that are sent to the electorate have included information from each candidate.

You have to look at each election individually and see how it will be structured before you look at capacity and what will need to be produced for issue on postal pack day, if you want to call it that. That is why we suggest that civil servants need to talk to the returning officers and the printing industry and Royal Mail, which offers the freepost service, to decide what is needed to produce and then set an appropriate timetable in regulations.

Robert Jack: I concur with the view that the longer period is preferable. The draft regulations suggest that candidate statements will be issued, so it follows that quite a lot of pack assembly will be required. There are issues about deadlines being met so that the complete pack is available. That detail has to be teased out.

If someone does not receive their material, will the returning officer be entitled to send out more? With regard to the time between sending out and return, problems occurred in the 2007 elections with people not receiving packs. There is an issue, therefore, about the timescale for people applying for replacement packs and their being sent out. It would be preferable to have a longer timescale for health board elections, if that was possible.

Mary Scanlon: A point was raised about the varying geographical size of health board areas. I represent the Highlands and Islands region, which consists of the three Highland constituencies, plus Argyll and Bute. Someone from, say, Coll or Tiree might stand for election to Highland NHS Board, which is based in Inverness. However, it would take them at least a day to get to Inverness, a day for the meeting and a day to return. Issues arise, therefore, around not only travelling and representation but equity because the elected person would be unpaid, while appointed members would be paid.

I want to roll those issues into one. For elections to the health board in the Highlands, would it be wiser to use parliamentary constituency boundaries than to use a health board boundary? I ask the witnesses to consider the equity issue, too.

The Convener: I wonder whether that is an appropriate question for the panel. In this session, I wanted the committee to consider electoral processes rather than the quality of representation.

Mary Scanlon: The Electoral Commission’s written submission mentioned electoral areas.

The Convener: I raised the point because I was not sure about your question. However, feel free to ask it.

Mary Scanlon: The Electoral Commission has concerns about a health board area being the only electoral ward. If the witnesses do not want to talk about equity, that is fine. However, given that the issue of electoral areas was raised in the written submission, I think that the question is legitimate.

The Convener: I agree that questions about the electoral processes are relevant, so the witnesses can answer those.

Andy O’Neill: I can comment on a matter that is related to the electoral process, but not specifically about it. The candidate expenses limit is set at £250 in the draft regulations, and we wondered whether that was high enough. We assume that the regulations mean that a candidate would not have to pay for the elector’s information pack. However, we did some mathematics and if, say, a councillor stood as a candidate for the whole Western Isles, their total expenses would be approximately £7,000. Would £250 be enough to campaign in the Western Isles compared with doing so in an urban centre? I do not know. Of course, there is also the question of how much campaigning would be done. Again, I do not know the answer to that. However, we think that these aspects need to be looked at a little bit more.

Robert Jack: The comment to which Mrs Scanlon referred expresses concern about the proposed process for health board elections. There are questions around whether there should be a single transferable vote election over a whole health board area, and around how many places are to be filled and how large the electoral process would be. The issue is whether to break down the health board area into smaller subdivisions for an election. The point about remuneration is obviously not for this panel; it was raised during the previous witness session.

It seems to me that, whether or not the electoral ward is the whole health board area, someone who was elected to represent Coll or Tiree would still have to travel to and from health board meetings, so the travelling point is not germane to the point about electoral areas. Our point is that running a large election across a whole health...
board area is a mighty undertaking. If the area were to be subdivided, by whatever methodology, into smaller wards, several elections would be undertaken. We feel that that would be more efficacious for the purpose.

**Mary Scanlon:** At last week’s meeting, I made the point that, given that the population centre of the Highland NHS Board area is Inverness, it is more likely that someone from Inverness would stand as a candidate. For example, I live about two minutes from the health board’s headquarters, so it would be easy for me to stand, should I wish to do so.

Voter fatigue was raised in the joint submission from the Society of Local Authority Chief Executives and Senior Managers in Scotland, the Society of Local Authority Lawyers and Administrators in Scotland, the Scotland and Northern Ireland branch of the Association of Electoral Administrators and the Scottish Assessors Association. Again, the issue is probably relevant to the Highlands because, as well as having all the other elections, that area has had elections for the Cairngorms National Park Authority, and it is proposed that crofting board and health board elections will be held there. What background information led to Mr Pollock making the point about voter fatigue in his submission?

**Robert Jack:** That would involve the problems of using different electoral systems, if health board elections used all-postal ballots, because local authority elections do not use all-postal ballots. Holding health board and local authority elections on the same day might have merit. If so, the elections should use the same system, which they would if the proposed all-postal requirement were departed from.

Conversely, we are considering separating two coincident elections—those for the Scottish Parliament and local government. However, the community planning dimension may provide more of an argument for holding health board and local government elections on the same day.

**John McCormick:** We are broadly in favour of decombination, but if policy makers felt for other reasons that elections should be combined, we hope that the important issues that arise from using two different election systems on one day, which can lead to voter confusion, would receive special examination and emphasis. In general, we favour separate elections on separate days for separate systems.

**Helen Eadie:** I am not being parochial, but I highlight that Fife Health Board is coterminous with Fife Council. I am not making a bid for the pilot, but people might consider that.

**The Convener:** Have you undermined your own proposal by admitting your thoughts?

**Helen Eadie:** Your joint submission says that planning for the local government elections in 2012 needs to start no later than January 2009. You also say:

"The prospect of this emergent legislation being pursued in isolation and adversely impacting on preparations for 2012 is one which should be avoided at all costs."

Would anyone like to expand on that? It strikes me as important to ensure that planning does not take place in isolation and that people take on board all
the issues. Would you have ample time to have pilot elections, should you go ahead with them?

The Convener: Where has the invisible ball stopped now?

John McCormick: I think that the matter is mentioned in our colleagues’ submission, so I defer to them if they wish to speak first. I will take up the point afterwards.

William Pollock: If we had combined elections, that would have an impact on the timing of the pilots. We should consider the advice that was given to us in the Gould recommendation, which was that all election legislation should be in place at least six months before any election is held; that would impact on the electoral registration officers.

I return to a comment that I started with, although I realise that I might be straying into a policy issue: there would also be an impact on the 16 and 17-year-olds because if we were to combine a health board election with the local authority election in 2012, or whenever, it would be rather odd if 16 and 17-year-olds were able to vote in only one such election, which was combined with the local authority election at the same time on the same day. That would be bewildering and confusing, and would not put the interests of the voter first. That would have to be sorted out at some point before any combined election was put in place.

In relation to combined elections, we return to the point about boundaries and the possibility of administrative confusion as a result of current non-coterminous boundaries, although that can be overcome. However, there is a possibility that things would get a bit more muddled than if we had more easily recognisable and defined boundaries.

Helen Eadie: What about the timescale?

William Pollock: It is quite tight. Although 2012 seems a long way away, we will start planning next year for our next local authority elections. We might not even have any health board election pilots until 2010. Whatever review emerged from the pilots would have an impact and could cause us to adjust the regulations that apply to the election process. That might happen well into 2011 and then suddenly, in 2012, we could be running a combined election. We do not want a repeat of anything that happened in 2007.

Andy O’Neill: From the Electoral Commission’s point of view, Helen Eadie makes a good point. Planning is very good and we should allow adequate time to achieve it. That is one of the things that we all know did not occur in the lead-up to 2007.

One of the points from the Gould recommendations that we have developed is the idea of establishing a national electoral management board for Scotland, which would be a voluntary coming together of all the returning and electoral registration officers to deliver planning that is best done at national level. I think that you referred to colleagues’ responses about e-counting. On this side of the table, we all agree that if we go to e-counting in 2012—the assumed local government election date—we will need to start planning for it in January 2009 at the very latest. I agree that we need to plan, have more time, and do it nationally where appropriate.

John McCormick: I underline the point that there seems to be general acceptance of the six-month legislative window that is recommended in the Gould report. That proposal seems to be broadly accepted and is important in the context of health board elections.

The Convener: I thank you all very much for your evidence.
Further to my evidence to the Health and Sport Committee on 12 November 2008, and in response to the question by Michael Matheson (official report, page 1266) NHS Lothian widely distributed details of both the Local Healthcare Bill and the Health Boards (Membership and Elections) (Scotland) Bill to all our Public Partnership Forums (PPFs), Patient and Family Councils and networks. Three PPFs responded to The Parliament on the Local Healthcare Bill, one did not respond to Section 2 on direct elections, one expressed favour with the proposal and the other was not in favour. However no formal written responses were received from other patient networks on the direct elections proposals in either of the formal consultations.

We did also discuss our alternative proposals with a number of forums which have included patient and public representatives. In those we outlined the idea of developing a membership function with ongoing involvement and relationships with interested members of the public and patient groups.

I hope this answers the point raised by Michael Matheson.

Heather Tierney-Moore,
Nurse Director,
NHS Lothian
28th Meeting, 2008 (Session 3) 19 November 2008, Written Evidence

BMA SCOTLAND

BMA Scotland welcomes the opportunity to provide the Health Committee with written evidence on the Health Boards (Membership and Elections) (Scotland) Bill which would require direct elections, by members of the public, to seats on NHS Boards in Scotland.

We appreciate that the Scottish Government hopes to deliver greater public engagement and more transparent decision making on matters regarding local NHS service delivery. However BMA Scotland cannot support plans for direct elections to NHS Boards.

A service can only be responsive to its users if those users, and potential users, are involved and engaged in the provision of those services. We are committed to supporting mechanisms which will achieve this effectively, and allow for engagement of all those in our society, including those who have traditionally found it difficult to make their voice heard.

However, BMA Scotland does not believe that direct elections to NHS Boards will improve public engagement or resolve the underlying problems of dissatisfaction around service change. We are particularly concerned that:

- Evidence from other countries indicates that elections to health governing bodies have not achieved the anticipated improvements in engagement and public confidence.
- There is very little practical detail outlined in the bill. Draft regulations to accompany the bill should be made available before the completion of Stage 1.
- The provisions in the Bill under section 2 allow for the appointment of individuals to elected seats and the potential self-selection of candidates without the requirement for an election. This will not increase accountability to local communities, patients or the public.
- The cost of direct elections, even for the pilots, will divert much-needed resources from front-line services at a time when investment in the NHS is slowing.
- There is no published detail available on the Scottish Government’s commitments to strengthen and improve other areas of public and patient participation. A debate on the introduction of elections should be considered in the context of the wider alternatives that exist and with consideration of proposals to improve meaningful consultation and the improvement of existing public involvement structures.

It is important to note that the Scottish Government has acknowledged that responses to the consultation on the Local Healthcare Bill showed no clear consensus in support of the introduction of Health Board elections. BMA Scotland is concerned that this policy is being driven by political imperative rather than a clear evidence base.

This submission provides the BMA’s views on the general principles of the Bill, specific comment on particular sections of the Bill and finally, proposes some alternatives to legislation which it believes would be more effective in involving local communities in decisions about local service delivery.

The principle of elections and the evidence base

The Scottish Government has committed to delivering and developing services based on the best available evidence. We know of no evidence that introducing direct elections will improve public engagement and have only found evidence of concerns regarding elections to Health Board bodies where these have been introduced in other countries.

Health systems in other countries are similarly exploring new ways to engage patients in the decision making process for service provision, some of which have introduced elected members to governing health bodies. However, evidence from these countries shows that such measures have not resulted in the benefits anticipated. A report prepared for the Commission on the Future of Health Care in Canada in 2002 considered various initiatives to increase public participation and
citizen governance, including direct elections to regional health boards in Saskatchewan. It concluded that:

"the experience [in Saskatchewan] has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to common goals. In light of these experiences, their continued use should be questioned if efficient, effective participation and public commitment are desired goals"

Similarly, research into elections to district health boards in New Zealand, introduced in 2001, has suggested that “the electoral component of the DHB [District Health Board] system is failing to make a substantial contribution to the democratisation of health care governance in New Zealand”

The Scottish Government has stated that it believes that introducing direct elections to NHS Boards will change the way the public and patients view the NHS and promote confidence in the way in which services are planned and delivered. The evidence from elsewhere strongly suggests that this is unlikely to be the case, merely resulting in the diversion of much needed resources from front-line care and a reduction in available funding to improve current mechanisms for engagement which are more likely to be effective.

**Politicising the NHS**

As the Scottish Government’s analysis of responses to the consultation on the Local Healthcare Bill confirmed, there is considerable concern regarding the potential politicisation of NHS Boards and the detrimental impact that this could have. Politics inevitably has a role in the health service and it is right that Scottish Ministers should be responsible for allocation of funding, setting the broad national strategy for health and establishing an ethical framework within which policy and practice should evolve. Elections to NHS boards would create an additional, and possibly conflicting political environment at the local level, and there is a significant risk that decisions could be made to secure future votes rather than to evolve, innovate and develop services. It is not clear how the inevitable dual accountability of elected members to local electorates and Scottish Ministers will establish itself in practice.

Evidence from the Canadian experience of elections to district health boards showed that only those with the most to lose or to gain stood for election, usually as a result of threats of service closures. Research carried out into the experience of elected board members in Saskatchewan, Canada, found that 32% of board members admitted that public pressure sometimes forced their boards to make decisions that they would otherwise not have made and 41% had found that their position as a board member had provoked resentment from those in their community. There is therefore significant concern that areas which have not always gained widespread public sympathy or support, such as addiction services and services for those with long term mental health conditions, could be negatively impacted by any moves to determine priorities based on public demand.

**Lack of Genuine Representative Engagement**

In addition to the concerns regarding candidates outlined above, BMA Scotland does not believe that directly elected members will necessarily be representative of the community they seek to represent. Those who are arguably most reliant on NHS services, such as the elderly, recent immigrants, those who are seriously ill on a chronic basis and single young parents, are the least likely to stand for election to a body which is likely to require engagement and discussion on complex issues with professionals and senior managers, whilst also requiring significant and regular time commitments. Yet, these are the very people with whom the NHS needs to engage to ensure that services meet the needs of all those in our society, not just those who can make their views most volubly known. Sensitive and supportive engagement methods are needed to ensure that the most vulnerable in our society also have a voice in the process of determining service development and priorities. BMA Scotland does not believe that the process of electing members to Boards will ensure a representative approach to public and patient involvement in NHS decision making.
The BMA has significant concerns regarding section 2(2)12 (Vacancies) of the Bill which sets out provisions for “elected” members to be appointed if vacancies arise between election cycles. In such circumstances, these individuals will be “deemed to be an elected member” despite the fact that they have no democratic support or mandate from the constituency that they will be representing. This appears to undermine the argument for locally elected community representation and suggests a political tokenism, rather than a genuine attempt to engage local communities and patient representatives in effective, accountable decision making.

**Voter Turnout**

BMA Scotland has concerns regarding the potential level of turnout and participation in a local Health Board election process on a sustainable basis. Initial interest and publicity may encourage higher rates of participation in pilots but evidence from elsewhere suggests that voter turnout in such elections may be much lower than the Scottish Government anticipates over the longer term.

There has been a significant decline in voter turnout across the UK in the past three decades. Despite the interest and attention stimulated by the advent of Scottish devolution, turnout in Scottish Parliament elections has failed to reach any higher than an average of 58%, even for the first devolved elections in 1999. National elections, which in Scotland have been dominated by health issues, are naturally accompanied by high profile media coverage and debate on a scale unlikely to be matched by local Health Board elections, particularly as they are unlikely to be held on the same day across the country.

Experience in other countries also indicates that turnout and participation in elections may be an issue. For example, NHS Foundation Trusts in England conduct local elections to a Board of Governors. A report in the Daily Telegraph found that “as few as one in 1,500 people” were voting in elections for patient governors. The Telegraph provided an example from the Clatterbridge Centre for Oncology on the Wirral where 1,502 people voted out of a patient population of 2.3 million. As well as organising elections, Foundation Hospitals recruit local people to become “members” but the Telegraph found again that the record is poor. Sheffield Children’s NHS Trust only managed to sign up 1,161 members out of a population of 1.8 million and the Queen Victoria Trust in East Grinstead, West Sussex, which served a population of around 4.5 million only achieved 13,000 members. Similar difficulties were found in Saskatchewan health board elections in Canada, with only 10% turnout in 1999 elections.

There is therefore a risk that individuals with political aspirations or representatives from single issue campaign groups could seek election to NHS Boards to progress their own political careers or to use the NHS Board as a mechanism to further a single cause. Coupled with the likely low turnout for elections, this could mean that relatively small numbers of votes could secure a position on a Board for such candidates who could have a disproportionate influence over decisions which may not necessarily reflect the needs of the wider local community.

It would appear from the drafting of this Bill that the Scottish Government is paying little more than lip-service to democracy in local Health Boards. Paragraph 7 of Section 2 (2) (Conduct of election) makes a provision for uncontested elections whereby if the number of nominated candidates is equal to or less than the number to be elected then there will be no election but these individuals will be given a seat on the Board and will be declared to have been “elected”. This is little more than self-selection and means that the public will be represented by people who do not have a mandate to speak on their behalf.

**Board Effectiveness**

The Bill and accompanying memorandums fail to provide the level of detail required to assess many of the potential operational issues which will influence the effectiveness of the new Board governance arrangements. BMA Scotland would encourage the Health Committee to demand that the Scottish Government publishes the draft regulations referred to in the Bill during Stage 1 consideration to allow for greater understanding and consideration of the extent of the Government's proposals, particularly given the inflexibility of primary legislation. It is important that when considering the principles of this Bill that the parliament has full knowledge and understanding of the Scottish Government's intentions.
Given the level of detail to be contained within regulations, the BMA would also recommend that regulations are subject to affirmative parliamentary processes to ensure appropriate scrutiny.

One of the key issues to be determined by regulations relates to proposed membership of Boards. The policy memorandum accompanying the Bill suggests a number of members to be appointed by Ministers, including senior NHS staff. There is concern that the political drive to ensure a majority of elected members on the Board will inevitably reduce the number of internal stakeholders and staff who are required to participate in decision making in order to ensure organisational effectiveness. As a result, the Board would either be forced to limit key NHS staff participation or expand the size of the Board to an unworkable size to ensure a majority of elected members.

Financial Implications

The Scottish Government has indicated in the financial memorandum that the cost of introducing elections is estimated at £13.05 million although it is inevitable that this figure will rise over time as the details and operational implications become known. The introduction of the proposed pilots alone is estimated at £2.86 million, but much of this estimate is based on guess work dependent on a number of unknown factors. BMA Scotland is disappointed that, despite the acknowledgement by the Scottish Government of widespread concern regarding the costs associated with introducing direct elections, the financial calculations seem lacking in detail and are rudimentary at best. The method of estimating the roll out cost of the pilot processes appears particularly rough and ready, calculated merely by multiplying the cost of the pilot in two Health Board areas by five to assume 100% coverage of the population.

For example, we have particular concerns regarding the calculation of the estimated costs of additional remuneration of elected members. The financial memorandum clearly states that the estimated costs of the pilots are based on these running for two years, including additional remuneration costs for this period. In estimating the full cost of the roll out of the pilots to the whole of Scotland, the memorandum states that this has been calculated by multiplying the cost of the two pilot sites by five to represent 100% coverage. However, as the full cost of the roll out would require four years of remuneration to members between each election cycle, this estimate fails to include the cost of the additional two years. In addition to this, there are 14 Health Boards, not 10, and each Health Board will require remuneration for its elected members. It is also important to note that these estimates are based on the minimum number of elected members possible on each Health Board. It therefore appears that there has been a significant underestimation of the costs of additional remuneration of elected members for each four year election cycle by £1.8 million.

The fact that this has been overlooked does not promote confidence in the accuracy of other aspects of the financial projections, which have already risen from an estimated £5 million in the original consultation to £13.05 million in the financial memorandum accompanying the bill.

BMA Scotland is also concerned that the estimated budgets do not include any of the subsequent costs to Health Boards to support the newly elected Board members, such as training, administrative support or organisational development activities to promote understanding of the role of elected members within the NHS.

There is considerable concern that the cost of introducing and supporting direct elections is to be found from existing NHS budgets, particularly at a time when health spending is slowing for a number of economic reasons. The cost of the pilot alone could pay for:

- the treatment of 1,668 patients during an average inpatient stay in a Cardiac Care Unit
- the care of 40 premature or sick babies in a special care baby unit
- an additional 85 nurses

BMA Scotland believes that if elections to Health Boards are to be piloted the Scottish Government should provide the additional funding to finance this in order to prevent reductions in the provision of currently funded NHS services.
The Pilot Process

BMA Scotland welcomes the commitment to evaluate the pilots but has concerns about the independence of the evaluation process. It is important that the evaluation is carried out on an entirely independent basis, commissioned through a competitive tendering process. Confirmation of this by the Scottish Government would be welcome. It is also worth noting that pilot projects are often accompanied by additional energy, support and resources, resulting in positive outcomes and evaluations. Subsequent roll out of pilots, implemented without this initial level of interest and funding, can sometimes fail to generate the same results. It is important to establish realistic outcome measures on which the success or otherwise of these pilots will be determined. In the interests of public transparency these should be made public before the pilots are established. Much of the previous research has focused on quantitative issues, such the number of people involved and how often, rather than their contribution to defined outcomes and their effectiveness.

Effective Patient and Public Involvement – Alternatives to Elected Health Boards

As expressed in our response to the original Scottish Government consultation on a Local Healthcare Bill, BMA Scotland believes that there are more effective ways to engage with users and potential users of NHS services than the introduction of elected Health Boards. The Scottish Government has announced a number of initiatives and policies to improve patient and public involvement in decision-making and to encourage further transparency in the way in which decisions are reached. These include the introduction of standards for consultation to be developed by the Scottish Health Council, the establishment of Independent Scrutiny Panels and measures to strengthen and support the Public Partnership Forums (PPFs) of Community Health Partnerships.

It is unfortunate that more detail on many of these initiatives has not yet been made available. This reinforces concern that much of the policy emphasis on patient and public involvement will be focused on elected Health Boards to the detriment of other approaches, many of which BMA Scotland believes will prove much more effective in genuinely engaging with patients and the public to work together to improve services and build public confidence in the NHS.

The role of the Scottish Health Council

The Scottish Health Council (SHC) was established in 2003 to improve the way in which the public, patients and other stakeholders are involved in service design and decision-making in the NHS. It has a key role in the assessment and support of Health Board practices which aim to achieve this in each local area. It is inevitable that this new body would require a number of years to build up a picture of public and patient engagement across the NHS in Scotland before further strategies and initiatives could be planned to improve these. The responses to the Scottish Government consultation on a Local Healthcare Bill confirmed that there was still confusion regarding the role of SHC and a belief that it should have a more clearly defined and enforceable role in relation to Health Board activity in public involvement, as well as a higher profile among the public. We believe that these issues should be actively addressed by the Scottish Government to enable the SHC to fulfil its potential.

It is clear from the work that the SHC has undertaken that Health Boards need to understand that consultation creates an opportunity to develop ownership of decision-making and to be open and honest about the very real constraints within which services are provided. It is hoped that this will be encouraged in the anticipated standards for public consultation to be developed by the SHC.

Independent Scrutiny Panels and Public Confidence in Service Change

As stated in our response to the consultation on Independent Scrutiny Panels earlier this year, BMA Scotland welcomes the introduction of measures which would result in increased public confidence in the way that proposals are developed with regard to service changes, particularly where difficult decisions may have to be made. Since the introduction of the NHS Reform Act in 2004, it has been a legal requirement for Health Boards to consult with their local populations on service change. However, this process has, in some cases, lacked full public confidence and created the perception that public opinion does not count. It is important that this situation is addressed to instil public confidence in the provision of safe, effective and equitable health services for all in Scotland.
Health and Sport Committee, 7th Report, 2008 (Session 3), — Annexe B

There is concern that the multiplicity of initiatives proposed by the Scottish Government to address this issue, including both the introduction of independent scrutiny panels and elected Health Boards, will in fact ‘muddy the water’, confuse accountability and delay important decisions. It is our belief that Independent Scrutiny Panels should be allowed time to establish and allow for evaluation of their contribution to public engagement in decision making within the current system.

**Strengthening the role of Public Partnership Forums**

Community Health Partnerships (CHPs) were established in 2004 with the aim of devolving resources and decision-making to front-line staff, working in partnership with local communities and stakeholders. They were intended to bring together secondary and primary care stakeholders and clinicians to aid the development of clear patient pathways which would improve the patient experience and promote efficient use of resources. One of the key aims for CHPs, set out in statutory guidance, was to “involve the public, patients and carers in decisions concerning the delivery of health and social care for their communities” and ensure “effective public, patient and carer involvement by building on existing or developing new mechanisms”. One of these new mechanisms involved the statutory requirement for each CHP to establish a Public Partnership Forum (PPF). Each CHP is required to have at least one representative from the PPF on their Board to ensure communication between the Board of the CHP and the membership of the PPF.

PPFs have developed in different ways across Scotland, engaging with local communities and stakeholders in a variety of approaches dependent on local circumstances and geography. Feedback has suggested that they are viewed positively by stakeholders. However, capacity to support and undertake participatory activities at this level is varied and a more consistent approach to resourcing is required. It is disappointing to note that few CHPs have a dedicated budget for their PPF. These forums provide a real opportunity to engage with local people to support effective service development and to facilitate the shift towards delivering more healthcare outside hospitals. It is our belief that if these structures were resourced and empowered to operate as originally intended, PPFs could become a fundamental part of the local decision making process and achieve the objectives set out in the Bill without the need for costly Health Board elections. It is at this level that BMA Scotland believes public engagement would be most meaningful.

BMA Scotland is not advocating complacency with current structures and initiatives, but for the opportunity for these to be supported and developed further to ensure that they are able to fulfil their early potential. Public awareness of existing mechanisms for engagement must be promoted to ensure their continuing development, along with dedicated and sustainable funding for public involvement activities at local levels.

**Conclusion**

BMA Scotland does not support the principles of this Bill. There is a lack of evidence to suggest that directly elected Health Boards will improve public engagement. Indeed much of the evidence that exists points to the failure of this approach in engaging local communities in the decision making process.

The application of this bill appears to pay little more than lip-service to the democratic process with the ability to appoint ‘elected’ members to fill vacancies and for candidates to obtain a seat without election if the number of candidates is equal to or less than the number of seats available.

Alternatives exist to improve public engagement and it is disappointing that the Government has not given the Scottish Parliament the opportunity to consider these in conjunction with this bill.

BMA Scotland would urge the Health Committee to reject the principles of this Bill and instead consider conducting an inquiry into how the existing range of mechanisms can be improved to achieve greater public confidence and engagement in local decision making.

Gail Grant
Senior Public Affairs Officer,
BMA Scotland
The Royal College of Nursing (RCN) Scotland welcomes the opportunity to submit evidence to the Health and Sport Committee on the Health Board (Membership and Elections) (Scotland) Bill. As we are contributing to the Stage 1 debate, this submission focuses on general principles, rather than the detail of the Bill. We would welcome the opportunity to explain our position in person to the Committee.

RCN Scotland’s Key Points:

Both the consultation document and the policy memorandum to this Bill are clear that the intention of the legislation is to improve public engagement and involvement in the NHS. As such, any electoral pilot should not be commenced until the additional public and patient engagement policies promised in Better Health, Better Care\(^7\) have been agreed and are ready to implement. This will allow the synergy (or otherwise) between the various approaches to improved engagement to be tested appropriately.

The focus of any pilot to test patient and public involvement and engagement should be on outcome and not on process. The key question of any evaluation must not be “do direct elections work?”, but “how do we best ensure that the public and patients are involved in the planning and delivery of local NHS services in a meaningful and effective way?”

In light of the above point, we believe that piloting and evaluating a single approach to improving patient and public involvement is inadequate and will not ensure that public resources are best spent on achieving the desired outcome. We are, instead, proposing a set of three different pilots be launched, run and evaluated together.

Estimated full election costs between the consultation stage and the published Bill have risen exponentially, from £5 million to £13.05 million. We are deeply concerned that the estimated £2.86 million bill for the pilot sites alone represents a significant diversion of funds from frontline healthcare in the relevant Boards. This is a pilot in which Health Boards cannot be guaranteed an appropriate return in local engagement and the selected pilot Boards alone will be expected to meet these costs. As such RCN Scotland believes that this one-off funding should be provided by central Government.

In discussing the principles of this Bill, we would ask the committee to clearly note that this legislation is designed specifically to improve engagement and participation and not accountability. The notes to the Bill are clear that Boards will remain accountable to Ministers and not to the specific electoral ward(s) which voted in individual elected members.

Background to our proposed approach

RCN Scotland was clear in its response to the Scottish Government’s Local Healthcare Bill consultation that we support greater patient and public involvement in Health Boards, within the ethos of mutuality between patients, public and staff. Our submission made specific suggestion for improved representation at both local and Board level. We suggest:

- Creating a new public/patient stakeholder post on Health Boards, nominated from each Board’s Public Partnership Forums and/or Patient Councils;
- Investing in supporting Community Health Partnerships (CHPs) / NHS Boards to develop local engagement and build the skills of patient/public partners;
- Re-examining the role of local councillors in NHS Boards to allow them to discharge their duties as elected representatives;
- Re-examining the lay member selection process to ensure equality of opportunity;
- Ensuring communities can interrogate Health Board decision-making via the new Independent Scrutiny Panels;

\(^7\) e.g. The anticipated Patient Bill of Rights and the new participation standard for NHS Boards.
Clarifying the way in which findings of the Patient Experience Programme will influence NHS Boards and their performance management targets; and

Better promoting the ways in which people can engage with local NHS decision making. We are particular concerned that current forums may be dismissed as ineffectual simply because opportunities for engagement are inadequately publicised.

We continue to assert that this approach will be far more likely to “encourage greater public and patient involvement in the planning and delivery of local NHS services in Scotland”\(^8\) within the emerging culture of a mutual NHS which is jointly owned by patients, public and staff. In contrast, we are concerned that elections to Health Boards will:

Risk bypassing the national democratic process, in which the elected Government has, and will retain, ultimate responsibility for the success, or otherwise, of Scotland’s NHS;

Diminish the development of existing, but fledgling, patient and public forums (such as Public Partnership Forums and Patient Councils), which will not be able to “compete” with the democratic mandate of elected Board members. Similarly, we believe Health Board elections will invalidate the Independent Scrutiny process of non-elected panels;

Be contrary to the Scottish Government’s policy focus on overcoming inequalities, by limiting non-clinical and non-partnership Board seats to those who are, in practice, wealthy enough, eloquent enough and/or “acceptable” enough to be voted in; and

Distort the potential for genuine mutuality between patients, public and staff by placing elected lay members on a different footing in boards than appointed staff representation through both clinical and union seats. This does not support Scotland’s successful partnership approach, which is championed by the current Government.

Other organisations similarly criticised election proposals during the consultation, including: The Scottish Health Council, The Scottish Consumer Council, Stonewall Scotland, SAMH, Sense Scotland, Community Pharmacy Scotland, and a number of NHS Boards. RCN Scotland’s full response to the original consultation can be viewed at:


As the Government has now decided to forge ahead with proposals for elections, we do support plans to pilot the process. That said, we do not believe that the Government’s proposals for testing go far enough. The proposed pilot will not allow the Scottish Parliament, nor the wider public, patient and staff co-owners of the NHS, to truly evaluate whether this one approach will give all partners the very best, and most meaningful, opportunity to engage in joint ownership.

It is unfortunate that the additional commitments made by Government to improve other areas of public and patient participation, rights and responsibilities have yet to be published. These include proposals to strengthen the role of Public Partnership Forums, a Patients’ Rights Bill, and a new participation standard for NHS Boards\(^9\). As such we cannot evaluate the engagement opportunities in these proposals, nor clearly assess if, and how, they will dovetail with proposals for direct elections.

Finally, we are also deeply concerned by the increase of over £8 million pounds in the estimated recurring costs, from £5million in the consultation document to £13.05 million in the notes to the Bill as published. This is to be met from existing budgets and we fear this could impact on frontline health services, particularly given the tight financial situation of this spending review cycle. If such large amounts of NHS funding are to be diverted under central Government policy, we must be sure that this level of investment from Health Board budgets gives the best possible return in relation to patient and public engagement.


Our proposed approach

Firstly, we ask the Committee to ensure that any electoral pilot is not commenced until the additional public and patient engagement policies promised in Better Health, Better Care have been agreed and are ready to implement. This will allow the synergy (or otherwise) between them to be tested appropriately.

In addition, RCN Scotland is proposing a tripartite approach to the pilot and evaluation process which would be conducted within the current pilot budget of £2.86 million.

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<tr>
<th>RCN Scotland proposals for tripartite pilots to ensure effective patient / public engagement in the NHS</th>
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<td><strong>Health Board 1:</strong></td>
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<tr>
<td>Carry out an election as per the legislation passed by the Scottish Parliament. Simultaneously, fully implement all other Scottish Government policies around improved patient and public engagement and co-ownership, using any specific additional implementation monies committed by central Government for these initiatives.</td>
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<tr>
<td><strong>Health Board 2:</strong></td>
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<tr>
<td>Do not carry out an election. However, fully implement all other Scottish Government policies around improved patient and public engagement and co-ownership, using any specific additional implementation monies committed by central Government for these initiatives.</td>
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<tr>
<td><strong>Health Board 3:</strong></td>
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<tr>
<td>Do not carry out an election. However, fully implement all other Scottish Government policies around improved patient and public engagement and co-ownership, using any specific additional implementation monies committed by central Government for these initiatives. In addition, invest the £1.3 million identified as election costs for the 2nd pilot area under current Government proposals in additional measures to improve patient, public engagement within the context of a mutual NHS.</td>
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We would advocate such additional funding being invested in upskilling patients/public involved in PPFs or Patient Councils to eventually take on a nominated board role, investing in improvements in the current public appointments system and improving local publicity for opportunities to get involved in NHS service developments. However, we appreciate that the use of such monies should be open to wider consultation.

The three pilots should run concurrently and be given at least three years in which to evolve before the evaluation is completed. We have criticised the Government’s approach for too quickly adding new initiatives to ones yet to be fully tested. It is important that each approach is given sufficient time to prove its worth.

We believe that this tri-partite approach will ensure that it is outcome and not process that is placed at the heart of the evaluation, as befits the current climate of public sector performance measurement. The key question must not be “do direct elections work?” but “how do we best ensure that the public, and patients, are involved in the planning and delivery of local NHS services in a meaningful and effective way?”. This is the only way to ensure that patients and the public are placed at the heart of evaluation, alongside existing staff engagement initiatives.

We believe there would be much public and political support for such an approach. For example, in detailed discussions with one of Scotland’s largest Health Boards with a compelling track record in public and patient engagement we have found strong backing for our proposals. Many organisations that are concerned with equality, such as the Scottish Association for Mental Health and Stonewall Scotland, have supported our call for alternative pilots that invest in and strengthen the existing and planned measures to improve patient and public engagement.

We are still concerned that the estimated £2.86 million bill for the pilots, as proposed in the legislation, represents a significant diversion of funds from frontline healthcare in the relevant

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10 Est. £2.86million total cost for the 2 pilots, less £0.25million for evaluation = £2.61million for 2 pilots = £1.3million per pilot
boards. This is a pilot in which Health Boards cannot be guaranteed an appropriate return in local engagement and the selected pilot Boards alone will be expected to meet these costs. As such RCN Scotland believes that this one-off funding should be provided by central Government. We appreciate that this is no guarantee of future central funding. However, our proposed approach to a tripartite pilot will also ensure that future activities, which may draw heavily on precious NHS resources, are directed to the most effective, and fully tested, engagement strategies possible in the future.

Rachel Cackett,
Policy Advisor,
Royal College of Nursing Scotland

UNISON

Introduction

UNISON Scotland welcomes the opportunity to submit a response to the Health Committee regarding the Health Boards (Membership and Elections) (Scotland) Bill. We are Scotland’s largest public sector trade union representing over 160,000 members, more than 50,000 of whom work in health related services. UNISON supports moves to make all public service organisations more open, transparent and democratically accountable. UNISON Scotland believes that this Bill is an important contribution towards achieving this objective for health boards in Scotland.

Background

The main purposes of the Bill are to:

- alter the composition of health boards to include directly elected members and provide a statutory basis for the presence of local councillors as health board members;
- make provision for the holding of elections to health boards; and
- provide that these provisions are to come into force on a pilot basis.

This Bill follows a similar Members Bill proposed by Bill Butler MSP in 2006/7 that UNISON Scotland also supported.

Principles

UNISON Scotland supports the general principles of the Bill. We believe that all public service organisations should be open, transparent and democratically accountable and should encourage active participation from users, the community, staff and their trade unions. The increasing use of unelected bodies to run public services hinders this process.

Democratic structures create public bodies which are open and transparent in their dealing with the public. Scottish health board expenditure is over £8 billion and local democratic accountability is essential for expenditure of this level. Government at all levels must explain and accept responsibility for its actions.

Democracy requires that there is adequate opportunity for the public to participate in and influence the policy making process. This is more than being asked to comment on plans drawn up in private. It is also about defining the desired outcomes and the methods to achieve them. This proposal improves accountability by: allowing individuals to become board members; promoting debate about health care in local communities via the election process and makes boards directly accountable to the people they serve.

The Bill will support changes like the Freedom of Information (Scotland) Act 2002 and the requirement of the NHS Reform (Scotland) Act 2004 to involve service users. UNISON believes that the Bill will assist in changing the culture of health boards in Scotland from one of ‘we know best’ to one of openness and consultation.
High profile campaigns in recent years about hospital closures and availability of treatments on the NHS in Scotland demonstrate clearly that members of the public not only want to be part of the process of planning health care in their areas, but that they are willing to give up their time to do so.

UNISON Scotland also believes that this Bill has the benefit of greater democratic accountability while still retaining NHS expertise. It offers the prospect of developing genuine local partnerships with greater understanding of the complex issues facing the NHS in Scotland among the public. This is about decentralising power to local areas and also about allowing democratic control through the ballot box at all appropriate levels. We would therefore support the principle of direct elections to health boards.

Specific issues raised by the Health Committee on the principles of the Bill.

What the practical benefits of having elected members on health boards would be.

The practical benefits of having elected members accountable to the public would primarily be to change the culture of public engagement within health boards. Direct accountability gives a real and meaningful accountability that appointed board members can never have. The mix of both types of appointment also ensures that we get the best of both worlds, retaining staff and specialist expertise.

Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

Democracy costs. If we followed this argument to its logical conclusion we would have no parliament and appointed governors to run local administrative areas. Given the scale of health board expenditure (£7bn) the cost of democracy is modest.

What the risks are of having elected members on health boards

It has been argued that it will lead to parochialism, paralysis in decision making and that health issues are too complex for lay persons to understand. Whole board elections address the first of these arguments and there is no evidence from other democratically elected bodies that they are unable to reach decisions. Democratically elected bodies may engage better with the public and put more effort into explaining the reasons for change, but they are still capable of making difficult decisions. The last argument reflects the ‘we know best’ culture that is still prevalent amongst the health establishment. Elected members can and do reach decisions on complex matters at all levels of government after proper consultation and professional advice.

Whether elected members' scope for action will be affected by health boards' continuing accountability to Ministers

Almost all other democratically elected bodies have accountability elsewhere in one form or another. Legislation lays down standards for local authorities and Scottish Ministers have the power of direction under legislation. They also have indirect methods of direction through administrative action, budget and guidance.

However, local democracy may on occasion raise issues of conflict between national and local priorities or policy direction. That tension can be a positive driver for change. One persons ‘postcode lottery’ can be another’s ‘local priority’. Scotland is not a homogenous nation and it is unrealistic for NHS Scotland to operate as a national monolith where the centre always knows best.

Whether alternatives to direct election exist as a means to increasing public involvement in the NHS

UNISON Scotland does not view direct elections as a panacea to improving engagement with users of health services. As stated above we see local democracy as compatible with other changes to improve health board performance in this field introduced by successive Scottish Governments. Direct electoral accountability is one very important element of democracy, but it is not enough on its own. Participative engagement at all levels is also essential if we are to develop public services that are more accountable to the people they exist to serve.
Specific issues raised by the Health Committee on the mechanisms to introduce direct elections.

The composition of health boards as set out in the Bill

UNISON welcomes the provision that puts local authority members on a statutory basis. However, we do not believe that they should count towards the simple majority of elected members on a health board in Section 1(2) of the Bill.

The appointment of councillors to health boards was primarily done to recognise the key role local authorities have in promoting better health and the importance of joined up services through initiatives like Joint Future. Most councillors on health boards therefore see their primary role as representing their council, not as some form of directly elected member. We do not believe that councillors should have a monopoly on local democracy and the NHS is large enough to warrant its own dedicated democratic structures.

It is also unclear from the Bill what the role of senior officials is under the new board constitution. UNISON has always taken the view that officials should be advisors, not voting members, of the health boards they are employed by.

UNISON supports the retention of some appointed members and the current arrangements for staff representation through the Partnership Forum.

The arrangements for elections as set out in the Bill including the franchise, voting system and designation of each health board area as a single ward

The Bill essentially provides for the detailed management of elections to be developed through secondary legislation. We agree that this is a practical approach. UNISON has no strong views on the method of election we broadly support:

- Whole board election with the possible exception of large rural health boards.
- We agree that it is sensible to use an existing voting system rather than further confuse the electorate with a new system. We have no strong preference although we have previously supported STV for local authorities.

UNISON strongly supports extending the vote to those aged 16 and over. Young people in Scotland can marry at the age of 16, be called up to the armed forces, and pay tax and National Insurance. We believe that age discrimination is not only patronising, but also serves to alienate young people from society and the electoral process.

UNISON Scotland believes that as few people as possible should be restricted from serving on the health boards and that proper consideration is given to other ways to prevent conflicts of interest

The arrangements for piloting direct election as set out in the Bill

UNISON does not believe that pilots are necessary. However, we recognise that this approach holds the best prospect of achieving parliamentary support and dealing with the concerns of some organisations over the principle of direct elections.

We note that the Bill requires an evaluation no later than five years after the first election. We would favour an earlier evaluation before the end of the first term elections in the pilot boards. We believe the pilot board areas should include an urban board, a rural board and one that has elements of both.

The practical implications and cost of bringing the Bill's provisions into force

We see no practical difficulties in running elections that have not been addressed by local authorities or the National Parks. The National Parks offer a good model for extending democracy to the quango state. We have commented on the cost above.
**Conclusion**

UNISON supports moves to make all public service organisations more open, transparent and democratically accountable. We also support all moves which enhance individuals’ opportunities to participate in and influence decision making in their communities. UNISON believes that this Bill is an important step towards meeting both these aims in relation in health boards.

Matt Smith,
Scottish Secretary
UNISON

**COSLA**

1. COSLA welcomes the opportunity to provide written evidence to the Health and Sport Committee on the Health Boards (Membership and Elections) (Scotland) Bill.

**Context**

2. Committee members will be aware that COSLA is the representative organisation for all 32 Scottish local Councils. As such we endeavour to work on a consensus basis wherever possible and the following comments have therefore been based on the position agreed by COSLA in respect of the Scottish Government’s consultation exercise undertaken prior to the drafting of the Bill.

3. Should new issues emerge from Councils’ consideration of their written evidence submissions, COSLA will consider these and either make a further submission to the Committee or raise these if invited to participate in one of the Committee’s oral evidence sessions.

**Health and Sport Committee Questions and COSLA Position**

4. The invitation to submit written evidence included a number of specific questions. Those on which COSLA would wish to comment are as follows:

   - whether you support the principle of direct election to health boards

5. COSLA agrees that a continuation of the status quo is not an option. There is strong support for an increase in the number of democratically elected local authority members of Health Boards and a strengthening of their role. There has been a general acknowledgement of the positive contribution made by local authority councillors to the work of Boards which could be built upon. Given that direct elections are to be piloted and their roll out across Scotland will be dependant on the evaluation report of their operation, COSLA feels that the opportunity should be taken now to consider what steps could be taken within existing structures to improve Health Board engagement with their communities during this interim period and this is a matter that will be raised with the Minister.

   - whether those benefits would outweigh the costs arising from running such elections and supporting elected members;

6. COSLA has already highlighted the resource implications of the introduction of direct elections with the obvious consequent reduction in available funding for actual services and this continues to be an ongoing concern at a time of intense pressure on resources. The pilot(s) will have the benefit of identifying and quantifying the range of additional costs anticipated so a more informed decision can be taken on the financial element at the conclusion of the pilot(s).

   - whether alternatives to direct elections exist as a means to increasing public involvement in the NHS.

7. COSLA feels that there are a number of ways through which public involvement in the NHS could be improved. These include:-

   a) Building on the independent, external scrutiny of proposals for major changes in NHS services to be introduced following the Scottish Government’s consultation earlier this year;
b) The possibility of introducing a Duty of Best Value for Health Boards on a similar basis to that applicable to local government with independent scrutiny by Audit Scotland;

c) The potential offered by the Single Outcome Agreement (SOA) to strengthen accountabilities. The SOA process which binds community planning partners to a shared vision of the outcomes they wish to achieve jointly for their communities will not only strengthen local authority accountability both to the electorate and to the Scottish Government but will also introduce a new degree of accountability on the part of the NHS. Thus while COSLA agrees there is a need to strengthen accountability within the NHS, we contend that this could be achieved in part through SOAs, the Community Planning process and also through Community Health Partnerships.

As indicated above, as direct elections will not be rolled out across Scotland until 2012 at the earliest (if at all), we will be pursuing these options with Ministers.

- the arrangements for piloting direct election as set out in the Bill

8. The pilot(s) must be a genuine test of the policy. COSLA welcomes the proposal that the Scottish Parliament be involved in the decision as to whether direct elections will be rolled out after the evaluation of the pilot(s). COSLA has already requested direct involvement in this process.

Oral Evidence

9. COSLA would be pleased to expand on this submission, either by further correspondence or by participation in the oral evidence stage of the Bill’s progression through Parliament.

Sylvia Murry,
Policy Manager,
COSLA

SOUTH LANARKSHIRE COUNCIL

Thank you for the opportunity to respond to this Bill. South Lanarkshire Council has previously expressed opposition to the direct election of members to Health Boards, and the current Bill gives us some cause for concern around specific issues. These are discussed in the paragraphs below.

South Lanarkshire Council does not support the direct election of members to Boards. This has been our position since this was first proposed in 2007 and we have not seen any evidence to change our position. The Council is particularly concerned that direct elections to NHS Boards could result in the election of single issue candidates that could bring a narrow focus to discussions at Board level. The Government has recognised the need for a broad understanding of the determinants of health and that addressing health inequalities will demand a shift from health as the management of illness to a social model which addresses the underlying causes of ill health. Members of local authorities are uniquely qualified to bring a broader understanding of local areas, council services and policy developments to discussion at Board level. This could be lost with the introduction of direct elections to Boards.

In addition to this, the Bill raises implicit questions about the democratic mandate of local Councillors who will continue to be appointed to Health Boards. Historically members of the local Councils have sat on Health Boards as representatives of local communities. They will now sit with Board members who have been elected directly by local communities, but who may not have the wider understanding or appreciation of issues coming before Boards and how these interact with other policies or activities. There may be potential for a clash of opinion between the two types of elected members. In these cases, who actually represents the community? As discussed below, there are added complications as to ‘whose community’ based on local authority boundaries and where directly elected members actually are elected from within a Health Board area.

The Bill proposes to have one electoral ward per Health Board, unless otherwise specified. At this point there is no detail as to why a Health Board might be divided into more than one electoral ward. South Lanarkshire Council is one of two local authorities within NHS Lanarkshire and also forms a part of NHS Greater Glasgow and Clyde. This raises two issues for us:
The risk that there could be an imbalance of candidates in favour of one or other of the two local authorities making up NHS Lanarkshire elected to that Health Board. It is highly likely that candidates will both be nominated and elected in areas where there are public concerns about local health care provision or developments. This could mean that representation for local communities is not evenly distributed, but concentrated in small areas across the Health Board. This would be counter to the intention of the Bill which is to increase popular representation on Boards.

Cambuslang and Rutherglen remain part of NHS Greater Glasgow and Clyde, but from April 2009 residents will receive primary care services via the South Lanarkshire CHP, which is part of NHS Lanarkshire. Which electoral ward will residents be in – NHS Lanarkshire or NHS Greater Glasgow and Clyde?

The Bill does not discuss eligibility criteria for candidates nor does it consider how members should be held accountable to their electorate (though presumably this will be done when the time comes for re-election). Neither is consideration given to the type of support that directly elected members might require to equip them to play an active and constructive role as Board members. The Bill is not the place to tease this out, but it should be recognised that unless they are properly supported, there is a risk that directly elected members will not be able to fulfil their potential on Health Boards. Board meetings usually involve a large number of wordy documents, some of which contain technical terms or difficult concepts. Local councils often dedicate officer time to support their elected members to grasp the issues being discussed at Health Board meetings and provision will need to be made for similar support for other lay members.

The Bill suggests that elections would not take place at the same time as elections for local or central government, and it implies that administration for elections would be the responsibility of NHS Boards. We would like clarification on both of these issues. Timing of elections will be critical to ensure good turnout and to minimise confusion which can be created by multiple voting papers, or even having elections to different bodies within short periods of time. While local government has extensive experience in the successful running of elections, these are resource intensive and require careful planning.

The Bill sets the age for receipt of the franchise at 16 years, whereas it is 18 years for other elections. It is not clear how lists of potential voters will be compiled or who is expected to maintain these lists. Consideration will also need to be given to where students will register and/or vote if they are living away from home for a period of time to study.

We welcome the fact that the roll out order will not be given until after the pilot programmes have been evaluated. This is critical to ensure public confidence in the proposals. As part of the evaluation we suggest that the process for nomination and voting turnout should be included as public participation in the process is surely a key criterion of success. The financial implications are based on a 60% turnout – this is high relative to turnout in other types of election and may be an overestimate. For example, turnout for the last two local/national elections in Scotland ranged from 49.4% in 2003 to 52.2% in 2007. This varied considerably across constituencies. The principle behind directly elected members will also only be validated if there is sufficient interest within communities both to put forward candidates and to turn out to vote for them.

Harry Stevenson,
Executive Director,
South Lanarkshire Council

WEST LOTHIAN COUNCIL

In response to your call for written evidence on the Health Boards (Membership and Elections) (Scotland) Bill, please find attached a copy of the detailed response from West Lothian Council to the questions outlined in the Local Healthcare Bill, which addresses the main issues raised in this exercise [NB: Not reproduced. Available at: http://www.scotland.gov.uk/Resource/Doc/224732/0060838.pdf Accessed 11 December 2008].

West Lothian Council welcomes the opportunity to encourage greater public and patient involvement in the planning and delivery of local NHS services in Scotland.
In summary, West Lothian Council welcomes the increased democratisation of the NHS that would result from the introduction of direct elections to NHS Boards. The preferred option of West Lothian Council would be that 100% of NHS Board members be directly elected to ensure a sufficient degree of accountability and sense of local ownership.

Alex Linkston,
Chief Executive,
West Lothian Council

SCOTTISH CONSUMER COUNCIL (SCC)

The Scottish Consumer Council (SCC) submitted a response to the recent consultation on the proposals contained in this Bill, and welcomes the opportunity to re-state our views to the Health and Sport Committee.

The Government asked two questions in its recent consultation:

- Can patients and local communities be more effectively involved in decisions about how NHS services are planned and delivered, with NHS boards as currently constituted?
- Would the introduction of elections to health boards contribute to more effective involvement of patients and local communities in such decisions?

The SCC response to the first question was ‘yes’, and to the second question ‘no’. We argued that the introduction of elections would not contribute to more effective involvement of patients and local communities. We also argued that the composition of health boards involves questions of governance and accountability, and that it would be better to consider these wider issues rather than simply whether there should be elections to health boards.

1. **Do you support the principle of direct elections to health boards?**

The SCC does not believe that introducing direct elections will contribute either to more effective involvement of patients or local communities in the decision-making process, or to better governance in NHS boards. As a result, we do not support the principle of direct elections to NHS boards.

The role of NHS boards is to make decisions about how local services are delivered working within budgets and policies established by Ministers at national level. They have to weigh all the factors involved, including financial information, clinical evidence about the effects of decisions on services for patients, the implications for staffing levels, and the availability of particular kinds of staff or support services. In making those decisions, boards are answerable to Ministers.

The SCC considers that there significant problems with the ability of NHS boards to effectively fulfil their role in the governance of health services in their area. In its report on the health board in the Western Isles, the Audit Committee of the Scottish Parliament made some general comments on health boards:

The Committee is concerned that boards, as presently constructed, may not be able to rigorously and objectively hold management to account, and that the mix of skills available may be inadequate in some cases. The Committee would welcome further information from the Health Directorates on what checks are made to ensure that proper scrutiny by boards takes place. The Committee believes that the Health Directorates should give further thought to how the performance of boards can be made more transparent and publicly accountable.

It was a concern about the lack of proper scrutiny of decisions in health boards which led to the setting up of Independent Scrutiny Panels in 2007.

To ensure good governance in NHS boards there needs to be:

- effective independent external scrutiny of NHS Boards; and

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11 The Scottish Consumer Council became part of Consumer Focus Scotland from 1st October 2008.
an appropriate balance between executive and non-executive members.

The role of non-executive members of NHS boards needs to be strengthened, and we believe that the Scottish Government should consider how this can be done most effectively. One suggestion which the SCC has already made is that the proposed independent scrutiny panels could be set up with a focus on providing expert independent advice to non-executive board members, as a way of strengthening their ability to hold the management of NHS boards to account.

The current proposal for the introduction of elections does not address the question of how the role of non-executive members can be strengthened and what support these non-executives are given to empower them in their relationship to executive members. Simply electing people, rather than appointing them, will not make any significant difference to these shortcomings.

2 What would be the practical benefits of having elected members on health boards?

Elected members would be likely to have a higher public profile than most current non-executive board members, and so it might be easier for members of the public and special interest groups to lobby about particular concerns.

Elected members might take greater account of the impact of board decisions on specific local communities as they will perceive themselves to be answerable to their local communities in a way which appointed members probably do not. However, it is questionable whether a constituency which covers an entire health board area can be described as a local community.

The SCC does not believe that these factors outweigh the risks or justify the costs of introducing elected board members.

3 Would those benefits outweigh the costs arising from running such elections and supporting elected members?

The costs of introducing elections in all health boards is now estimated at £13.05 million, significantly more than the £5 million estimated during the consultation phase. This cost is to be met from existing budgets, and it is hard to believe that this money could not be used more effectively to improve public involvement, or patient care and safety, in other ways. The cost of the pilot elections will be around £2.86 million.

4 What would be the risks are of having elected members on health boards?

Undermining or replacing other patient and public involvement activity

There is a danger that having elections would be considered to be a substitute for an NHS board’s statutory duty to consult and involve members of their local communities, particularly when there are significant costs attached to holding these elections. The SCC would be concerned if the funding for holding elections came from the budget for patient focus and public involvement (PFPI) budgets.

Confusion about the role of the elected member

Members of the public may be confused about the roles and responsibilities of members. Board members, however they are selected, are not, in their role as board members, answerable to their local electorates, but to Scottish Ministers. They will undoubtedly try to ensure that the concerns and interests of their constituents are heard and considered as part of the decision making process, but they must make the decisions collectively which they believe are best for the whole of the NHS board area.

Inherent tensions between the political decisions taken by Scottish Ministers, and decisions taken by boards

While elections to local authorities can result in changes to policy and service provision, this is not possible with NHS bodies. The NHS is a service managed nationally in line with the policy of Scottish Ministers. Boards are required to ensure that the services provided in their local areas meet the requirements laid down by Ministers, and are not free to set their own priorities. There is danger that this will lead to tensions and disputes between Ministers and elected boards, and to unrealistic expectations on the part of patients.
Raised expectations
ELECTING people to boards may give consumers the impression that those elected can make a greater difference to how services are delivered than is actually the case. When the expectations of voters fail to be met, there will be greater mistrust of the NHS than there is currently.

Threat to a consistent national health service
The SCC believes that most consumers in Scotland want a consistent national health service across Scotland. We would be concerned if the introduction of elections encouraged greater variation in the nature or standard of care which patients could expect in different parts of the country.

Introduction of party politics into health boards
The SCC is concerned that introducing elections to NHS boards will lead to party politics being introduced to health boards. It will be impossible to exclude someone from standing on the basis of their political allegiance, and so it will be inevitable that voters will be influenced by this factor. However, even if a large group with a shared party allegiance was elected, they would not be able to change the national policy direction set by the Scottish Government.

5 Would elected members' scope for action be affected by health boards' continuing accountability to ministers?
Yes.

6 Are there alternatives to direct elections as a means to increasing public involvement in the NHS?
Patient and public involvement can happen at many levels and in many different ways, from supporting people to make decisions about their own care and treatment, through contributing to the design or redesign of services for particular patient groups, involvement in monitoring services, to representing patients on national working groups. The way local communities are involved in decisions about major service change has come under the spotlight in recent months, and proposals for the use of independent scrutiny panels have been produced.

It is undoubtedly the case that the sums of money allocated to elections to health boards could provide for a significant increase in support for patient and public involvement. For example, there could be additional support for Public Partnership Forums, the creation of a central resource to support patient focus and public involvement activity in Scotland at all levels, support for consumer representation at national level as advocated by the SCC, or the creation of patient champions in a range of healthcare settings.

7 Additional questions
The SCC has no views on most of the additional questions asked by the Committee, ie the composition of health boards, the arrangements for elections, the voting system, or the designation of each health board as a single ward.

The arrangements for piloting direct election as set out in the Bill; and

The practical implications and cost of bringing the Bill's provisions into force
It appears likely that the Bill will be passed and pilots will be held in two health board areas. While the SCC welcomes the commitment to piloting this process before rolling it out across the whole of Scotland, we would be interested to see an additional pilot being run, which would use the costs associated with elections (£1.4 million) being used in a third health board to invest in alternative ways of strengthening the involvement of patients and local communities. This could include:

- greater investment in Public Partnership Forums;
- piloting of training and support in consumer representation;
- funding of a post in the board to proactively seek patient and community involvement;
• community development work with local communities to support their involvement and interaction with health service providers; and

• support and training for non-executive board members.

Liz Macdonald,
Policy and Project Manager
Scottish Consumer Council

INCLUSION SCOTLAND

1.1 Background information: Inclusion Scotland (IS) is a consortium of disabled peoples’ organisations and individual disabled people. Through a process of structured development, IS aims to draw attention to the physical, social, economic, cultural and attitudinal barriers that affect our disabled people’s everyday lives. Inclusion Scotland consulted widely with our membership and disabled health professionals before framing our response.

2 Principles of the Bill

2.1 Inclusion Scotland strongly supports the principle of direct elections to Health Boards. We believe that this would be a huge step forward from the position where Health Boards are largely made up of appointees either from Local Authorities or the ‘great and the good’. We also believe that such elections would make Health Boards more democratically accountable to the people who need and use their services.

2.2 If the Bill’s supporters seek to effect real change then simply seeing the same people being elected to Health Boards as were previously appointed should not be a desired outcome.

2.3 In line with Inclusion Scotland’s support for greater democratic accountability we would favor the adoption of a system of election which ensured that the voice of patients (i.e. those who had long term health conditions) and disabled people was better represented on Boards.

2.4 Patients have traditionally been excluded from the governance of the services they rely on. This is no longer acceptable in a modern democracy and Health Board’s must in future include representatives of patient’s groups. Disabled people have also until very recently been excluded from public life and appointments to public bodies. This Bill provides the opportunity for that democratic deficit to be addressed also.

2.5 It is possible that the issue of proper representation of patients and disabled people could be achieved either through a system of reserved places (i.e. positive discrimination) and/or by adopting proportional representation in the elections which would assist candidates drawn from outwith the main political parties.

2.6 Inclusion Scotland fears that if disabled people are not represented on Health Boards then in the current economic climate funding priorities and policies may be agreed which disadvantage them.

2.7 If a system involving reserved places is eventually adopted then this should not preclude disabled people from also seeking election as ordinary members of a Health Board as the aim of the reserved places would be to achieve a minimum number of disabled people on Boards and not a maximum.

3 Conclusion

3.1 Inclusion Scotland strongly endorses the principle of direct elections to Health Boards and hopes that the Scottish parliament will seize this opportunity to ensure that the voices of patients and disabled people is directly represented on the new, elected Boards.
1 Introduction

Voluntary Health Scotland (VHS) welcomes the opportunity to respond to the Scottish Government's consultation on the Health Boards (Membership and Elections) (Scotland) Bill.

VHS (www.vhscotland.org.uk) is the first strategically-focused intermediary body for health-facing third sector organisations in the UK. Established in 2000, VHS articulates the common concerns and aspirations of its 300 members and promotes a broad vision of health in Scotland which it shares with the Scottish Government, the NHS and a wide range of stakeholders.

The third sector’s vision of health is one where:

- Health and wellbeing are defined broadly, to support all aspects of people’s lives;
- Opportunities for a healthy life are considered as a human right;
- People have the power to express their own health needs and to participate in the planning and delivery of health services;
- Access to services which maintain health and care for ill-health is fair and equitable;
- Services are delivered as close to home as possible; and
- Commitment to partnership working in the pursuit of health for all is sustained.

Voluntary Health Scotland and its members support the principle of democratic participation in the governance and activities of health services. Within this principle, there exists a variety of views as to how democratic participation should be framed and managed. To inform this response, VHS consulted its members during the months of July and August 2008.

Our response is also informed by earlier discussions which took place at SCVO’s dialogue event which took place in March 08 and by our submission at that time. Specific responses to individual questions are laid out below.

2 Responses to consultation

Question 1: Do you support the principle of direct elections to Health Boards?

The majority of VHS members who responded indicated that they were in favour of direct elections to NHS Boards. Some few respondents did not support the process and another small group were ambivalent. One respondent expressed the view that “ensuring the requirement for a broad spectrum of relevant expertise” was most likely to be achieved by direct elections.

Question 2: What are the practical benefits of having elected members on Health Boards?

Respondents listed a number of benefits in having directly elected members on Health Boards. These included:

- The potential for ensuring that “the patient voice has a stronger place in the governance and management of the NHS and that consultation is more meaningful than it currently is”
- Greater accountability of Boards, with “less potential for complacency”
- “Clearer community accountability; no more quangos”
- “Elected members will ensure that there is a balance of skills and knowledge at all levels”
Those few not in favour of direct elections could see no benefits at all in such a system.

**Question 3: Would the benefits outweigh the costs arising from running such elections and supporting elected members?**

VHS members’ responses to this question indicated concern about the costs. We note that the estimated cost of 2 pilot elections to Health Boards, using STV and with an anticipated 60% turn out would be £2.1m. And that across all Boards this would amount to about £13m.

VHS believes that there are considerable further hidden costs in setting up and administering direct elections. These include: advertising and extensive promotion of the value and process of elections to secure a broad geographical reach and to ensure access to all Equality Groups; the considerable costs of the commitment to train newly elected Board members; and the equally considerable costs (again, bearing in mind the needs of Equality Groups) of reimbursement of travel and out-of-pocket expenses for elected members with caring responsibilities.

Nevertheless, the costs probably fall considerably short of the costs of the PFPI Programme over the last six years, the success of which has been questionable in the eyes of many community groups.

In their responses to this present consultation, VHS members, while largely supporting the principle of direct elections had some doubts as to whether the benefits would outweigh the costs. Respondents stressed the need for ongoing costs to be closely monitored and some felt that elections would be an expensive way of seeing Boards dominated by “a few knowledgeable and politically astute individuals.”

Finally, some respondents expressed concerns about resources being diverted away from patient care and frontline services.

**Question 4: What are the risks of having elected members on Health Boards?**

In spite of voicing in principle support for direct elections, VHS respondents were sceptical of the capacity of either the process itself or of elected members to achieve truly democratic representation or to include marginalised groups and issues. Some comments were:

- “It would create more expensive bureaucracy”
- “It’s quite likely that people won’t get to know about it, and only a handful of people will put themselves forward; Some people with good skills may feel excluded from coming forward”
- “Board members are likely to treat a lay member as a token gesture”
- “The ‘unpopular’ issues – sexual health, HIV, drug misuse – may struggle to be given their place and agendas and resources devoted to more ‘popular’ concerns”
- “There is no guarantee that elected members will represent anybody but themselves and this does not increase public involvement”
- “What will happen if a lay individual with a single issue concern gets elected? These people are likely not to be able to participate in the full range of Board issues”

**Question 5: Do you think that elected members’ scope for action will be affected by Health Boards’ continuing accountability to ministers?**

Within the health-facing third sector in Scotland there is a generalised belief that health services should be accountable both to ministers and to the people they serve and whose taxes have enabled the NHS to exist.

Although VHS did not receive much comment on this issue from its members, some felt that elected members’ scope for action would be affected by Boards’ continuing accountability to ministers. One respondent said: “Yes, and this is correct” and another took the view that “this may
not be a bad thing if we want to maintain a truly national service”. Less positively, one respondent believed that “all scope for action will be determined by government direction and priorities”.

**Question 6: What alternatives to direct elections exist as a means to increasing public involvement in the NHS?**

Most VHS members (and the respondents to this present consultation among them) recognise that this and earlier Governments in Scotland have put very considerable resources into public involvement in the NHS, mainly through the PGPI Programme, a key feature of which is now the network of PPFs allied to CHPs.

We are also aware of the role and remit of the Scottish Health Council and its related functions of providing development assistance to Boards, alongside those of assessment of and progress on PPPI.

Despite this, we at VHS hear frequently of lack of purchase by the PFPI Programme and by the SHC on the more intractable areas of public involvement – in particular, the inclusion of people from excluded groups – minority ethnic communities, isolated older people, homeless people and young adults not in work or training, those from the deaf community and migrant communities.

Another concern is that of not being involved sufficiently early in policy and planning processes, resulting in lay participants feeling sidelined and inadequate.

While publicising the process of direct elections to such groups and encouraging individuals to stand for election presents a challenge, we believe that it can be done, through the many routes and channels in the third sector – channels which can be less daunting to excluded groups than the doors of the NHS. Voluntary Health Scotland is ready to help with facilitating this process.

There are in addition good guidelines for NHS Boards in pursuing public involvement – in particular the SGHWD’s own Advice Note on involving the public in CHPs and the Fair for All - The Wider Challenge strategy produced by the last Government, the general principles of which remain in force. The general view is that the principles contained in these documents have not been fully taken on board by all NHS staff.

As one respondent to this present consultation said: “We should not be talking alternatives but about what already exists. All NHS employees should receive awareness training and public involvement should be part of everyone’s role, and not just a tick-box exercise”.

Several respondents reinforced our view that VHS is a key agent in helping to make public involvement better. And one respondent provided the imaginative solution of “allocating to each CVS the opportunity for holding a local election to elect their representative”…thus providing…“an affective platform for public involvement in direct elections.”

**Question 7: What do you think of the composition of Health Boards as set in the Bill?**

Overall, there are fewer Voluntary Health Scotland members in favour of a majority of directly elected members than there are those against this composition. The concern appears to stem from the perception that over-strong domination by one or two “single issue” members could skew the agenda away from focusing on addressing inequalities and the range of issues which determine these.

One respondent commented: “Maybe there is scope to have an additional lay person without any knowledge of NHS structures or the PPFs and CHPs - this way the general questions would keep people focused”.

And another added: “This is fine if one works on the assumption that those elected will come from a variety of backgrounds and interests but I am concerned about how minority interests will be represented”. Clearly there are fears that the confident and vociferous could overshadow the voices of minorities, in numbers as well as dominance.
Question 8: What are your views on the arrangements for elections as set out in the Bill, including the franchise, voting system and designation of each Health Board area as a single ward?

Voluntary Health Scotland supports the argument that it is reasonable and sensible to view the nominated councillors and elected members as forming the majority of Health Board members. Some VHS members, however, expressed concerns that democracy would not be sufficiently maintained if nominated members were in the majority.

Those who responded were mostly happy with the proposal to extend the franchise to 16 and 17-year olds, although VHS would like to stress the necessity of having some type of educational programme to support the extended franchise – introducing this aspect of citizenship into senior high school PSD curriculum, for example.

VHS supports the proposed constituency boundaries being that of the area covered by the Health Board. We are also satisfied that STV as a method of voting would introduce the required element of PR and minimise the number of wasted votes.

Question 9: Do you agree with the arrangements for piloting direct elections as set out in the Bill?

Voluntary Health Scotland believes that it is important to pilot a process as potentially expensive and untried as this. Evaluation of the pilots is likely to reveal the extra hidden costs of direct elections and also to indicate where the voices of marginalised groups have been excluded.

All VHS respondents to this consultation were in favour of pilots, one respondent saying: “These are vital because I do not see generally a great appetite amongst the general public for elections and it will be important to see if this particular model works or not”.

Voluntary Health Scotland would be happy to advise on ways of ensure that excluded groups were both brought into the voting arrangements and had the opportunity to stand as candidates.

Question 10: Finally, what do you think of the practical implications and costs of bringing the Bill’s provisions into force?

Overall, Voluntary Health Scotland believes that whilst the cost of introducing the Bill is of some concern its introduction will compliment the existing PFPI Programme and as one respondent commented: “If it remains true to its original intent and doesn’t get hijacked by party politics both locally and nationally then the benefits will in the medium to long term, far outweigh the costs”.

Phil McAndrew,
Information Officer,
Voluntary Health Scotland
Scottish Parliament
Health and Sport Committee

Wednesday 19 November 2008

[THE CONVENER opened the meeting at 10:01]

Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

10:02

The Convener: Item 2 is oral evidence at stage 1 of the Health Boards (Membership and Elections) (Scotland) Bill. I welcome our first panel of witnesses. They are Dr Dean Marshall, chair of the Scottish general practitioners committee of the British Medical Association; Rachel Cackett, policy adviser for the Royal College of Nursing Scotland; and Dave Watson, Scottish organiser on policy for Unison. After reading the written evidence from the BMA and Unison, I was tempted to open with a debate, to allow each organisation to make its case before taking questions from members. We may try that at some point, because a face-to-face debate would be quite useful; I am sure that we will get to that. I invite questions from members.

Mary Scanlon (Highlands and Islands) (Con):
My first question is addressed to the witness from Unison. I note that you support the general principles of the bill. My question concerns the issue of equality. I understand that elected members of boards will not be paid, whereas appointed members will. In New Zealand, elected members are paid 24,000 dollars a year for 30 days' work. Is it fair and reasonable that elected members should not be paid for doing the same job as appointed members, who will?

Dave Watson (Unison):
You would expect me, as a trade union official, to respond that there ought to be some equity on the issue. We favour payments being made to people, regardless of the capacity in which they serve—for us, that is an equality issue that relates to access. If reasonable payments are not made, there is a risk that retired, wealthy people who can afford to serve on health boards will be able to do so but people who are more representative of the wider community will not. We have no difficulty with the suggestion that payments be made to people who serve on health boards and similar bodies.

Mary Scanlon:
Is it a condition of your support for the bill that all members of health boards should be paid equally for the job that they do?

Dave Watson:
No, we do not. Our view is that elected members are elected members in the same way as local councillors are and they should
be dismissed only on similar grounds—that is, the usual misconduct provisions would apply. That is a difference between elected members and appointed members.

**Mary Scanlon:** That might just be another condition of your support for the bill.

**Dave Watson:** I did not say that we agreed with every aspect of the bill; I said that we agreed with its principles.

**Mary Scanlon:** I thought that you might have some difficulty with that and I hope that you might have some difficulty with my third point. I represent the Highlands and Islands. Highland NHS Board, which we would think of as one ward, covers the area from Caithness down to Campbeltown and across to Nairn and the Cairngorms and includes 30 islands. It would be difficult for residents of Coll or Tiree to make themselves known. As health board members, they could be faced with a day to travel to a meeting in Inverness, a day for the meeting and a day to travel back. Given that the population centre for Highland NHS Board is Inverness, it is perhaps reasonable to assume that many of the people who would wish to stand for election to the board would come from there, which would disfranchise people who might wish to contribute to the health board but for whom that is impossible because of travel time, for geographic reasons and because of cost. How would you overcome that geographic, cost and time difficulty, which many people will face in an area such as the Highlands?

**Dave Watson:** In a previous existence, I was a union organiser for the Highlands, so I am well aware of the geographical challenges and the travelling. However, those challenges also apply at present to appointed members of any health boards that cover an area as large as the Highlands. We favour whole-board elections, but we have said that we are in favour of splitting up the elections in rural areas, of which the Highland NHS Board area is clearly one.

**Mary Scanlon:** Do you mean splitting the area up into the three community health partnerships—or four, as it is now with Argyll and Bute CHP?

**Dave Watson:** That is best decided in the Highlands, not imposed from Edinburgh, but what you suggest would certainly be a possible way of doing it.

**Mary Scanlon:** I have a question for the BMA. I asked the bill team about the BMA’s evidence on the New Zealand elections—the BMA’s approach is perhaps not quite as sceptical as mine, but it is on similar lines. The bill team said that “the fears of existing executive directors about directly elected members … had not been realised” and that

“on the whole people are happy with what is now in place in New Zealand.”—[Official Report, Health and Sport Committee, 5 November 2008; c 1255.]

However, I note from our briefings that the number of candidates fell drastically from seven per seat in 2001 to four per seat in 2004, so the candidates for health board elections are not fired with enthusiasm. Voter turnout also fell from 50 per cent to 43 per cent over the three elections that New Zealand has had. The BMA says that people are not happy or that the system is not working well, but the Government officials seem to think that that is wrong.

**Dr Dean Marshall** (British Medical Association Scotland): From the evidence that we have, the people who have been elected seem to be quite happy but, as you say, the population seems turned off by the whole thing, given that the number of candidates has fallen significantly. Also, asking people whether they are happy with how things have gone is not really a great way of assessing impact.

**Mary Scanlon:** I am simply using the words that the officials used.

**Dr Marshall:** So am I. People seem to be happy with the process but, as far as we can see, the outcome has not been measured properly. That is what we are concerned about.

**The Convener:** Those questions were directed specifically to Unison and the BMA, but do any of the other witnesses want to come in on that point?

**Rachel Cackett** (Royal College of Nursing Scotland): The numbers that are given in the briefings for voter turnout in New Zealand—which started fairly close to the election turnouts that we would expect here—are set in the context of a general election turnout that often tops 80 per cent. Therefore, we are talking about only half the number of people who would vote in a general election turning out to vote in a health board election. If that was transposed to Scotland, we would be looking at a very low turnout for health board elections. I am wary of simply transposing the results from another culture, but it is worth making clear that that is the context for voter turnout in the New Zealand health board elections.

**Mary Scanlon:** The concern is not just voter turnout but the fact that half as many candidates put themselves forward for election in 2004 as in 2001. I understand that figures are not yet available—at least, we do not have them—on the numbers of candidates in 2007. That perhaps supports Unison’s point about the spread of candidates that might come forward.

**Dave Watson:** It is difficult to draw comparisons between different electoral cultures, but I suggest that we should also consider the interest in health board issues in Scotland and the campaigns that
have taken place. I think that the broader interest in debates about the health service in Scotland might be reflected in people's interest in extending democracy to the health service.

Helen Eadie (Dunfermline East) (Lab): My question draws on the submissions from the Royal College of Nursing and from Unison, but I have other questions for the BMA later, so Dr Marshall need not feel left out.

The Royal College of Nursing and Unison clearly share the view that electoral accountability is an important element of democracy, but the Royal College of Nursing submission states:

"we would ask the committee to clearly note that this legislation is designed specifically to improve engagement and participation and not accountability."

I want to pick up on that important point. If the aim is to achieve much wider involvement from the community so that people are engaged in and can influence the decision-making process, is that addressed by the key element, or general principles, of the bill? I do not think that that is addressed by the bill.

Rachel Cackett: I welcome that question as, for us, that issue is key to the discussion of the principles of the bill at stage 1. The bill and the consultation paper state clearly that the proposals are designed to improve engagement. Although the principles of the evaluation that is mentioned in the bill are vague, it is clear that the evaluation will be about participation of the public and patients in decision making within the NHS. I know from hearing previous evidence to the committee that accountability is a key issue for committee members, but that is not how the bill is drafted and it is not the basic principle of the bill. The bill states clearly that accountability will remain with Scottish ministers.

The point that we are trying to make is that we support increased public engagement in health boards' decision making. However, if health board elections are the only way that is being piloted to achieve that outcome, we feel that that is not broad enough. If the committee, the Parliament and the Government want to ensure that best value is achieved from what will be a substantial amount of money, consideration should be given to piloting more than one approach to achieving that outcome of improving patient and public engagement.

The Government has proposed a number of other ways of improving public engagement, including through the participation standard that will be expected of the CHPs and the public partnerships forums, which are currently in varying stages of evolution. Our concern is that, if we plough forward with health board elections without testing other pilots at the same time, the pilot will simply test whether elections work. We believe that we should test how we ensure that the Scottish public are best engaged—and feel that they are being best engaged—within the decision making of their local NHS board. We are not convinced that, on its own, piloting health board elections will do that.

Dave Watson: Our position is that we do not believe that direct elections are a panacea for public engagement in the NHS. We have argued strongly that other initiatives—some are in the pipeline and others are proposed—would improve participative engagement. By engagement, I do not mean the exercises that some health boards have held in recent years, which were not participative at all. We would like those other initiatives to go ahead as well.

We should bear it in mind that MSPs are elected, but that does not mean that they do not consult. Governments are elected, but they engage in extensive consultations, as does this committee. No one suggests that electing people means that they can just go away into a darkened room to govern the country for four years. They engage in a variety of participative processes—

Ross Finnie (West of Scotland) (LD): Oh, I do not know.

The Convener: That point is being disputed sotto voce.

Dave Watson: Others might argue with that point, but I am more tactful—

Ross Finnie: I was referring to other countries.

The Convener: The reference was to other countries, I am being told in a postscript, rather than to democratic Scotland.

10:15

Dave Watson: Even councillors have been known to engage in citizens juries and other such arrangements. They get elected and participate and engage, so it not an either/or question. We can have direct elections and be accountable to an electorate as well as engaging and participating between elections in a variety of ways.

The key point is that, since it was created in 1948, the NHS has not been directly accountable to and engaged with the public. It has been a top-down organisation—a we-know-best organisation that thinks that all the issues are far too complicated for mere mortals to understand and that democracy is therefore not appropriate. We have to change that culture, and that is why direct elections have come in.

Rachel Cackett flagged up the subject of pilots. We would not want to stop all the other things. We supported the National Health Service Reform
(Scotland) Bill and are keen on trying all the various participatory arrangements that already exist or are in the pipeline. This bill deals with piloting direct elections, so the pilots should be about the different types of direct election that will complement the other participative engagement processes.

Dr Marshall: We certainly share the concerns that Rachel Cackett has expressed on behalf of the RCN. We also support public engagement and more transparent decision making, but we do not think that this is the way to do it.

On the back of Dave Watson’s comments, we have already had experience in Glasgow with the health visitors issue and the petition on that, which shows how the public can get involved and make a difference. We are concerned that there is no evidence that elections to health boards will improve engagement. I know that we did not want to look at other countries, but elections to foundation trusts in England have a very poor turnout; people have to opt in to vote and the figures are dreadful. We can see no evidence that elections to health boards will make a difference.

We should be improving and beefing up the CHPs and their public participation forums because they can result in the public getting involved.

The Convener: To turn your statement round, perhaps there had to be a petition and demonstrations because there was no public engagement.

Dr Marshall: Absolutely, but do we believe that having elected people on a board would have made a difference? There is no evidence that such elections solve the problem.

The Convener: I thought that you were saying that the public already have a route to change things through petitions and so on, so why do this.

Dr Marshall: No. We fully accept that there is a problem, but we do not think that the bill is the answer to that problem, nor is spending close to £20 million the way to solve it.

We are not denying that there is a problem but, as the RCN says, there are other ways of solving it, such as independent scrutiny panels, the CHP public participation forums, and the Scottish health council.

Rachel Cackett: Alongside the other measures that the Government wants to put in place and those that the previous Government brought in, there is one other difficulty with the bill. If the evaluation is focused entirely on the pilots—and I hope that there will be more discussion about the evaluation if that is what the decision whether to proceed with elections is to be based on—how will it decide whether it is the elections or all the other measures that have been taken that have improved participation? The evaluation needs to set its nets wide at the beginning and understand the relationship between the increased power of the CHPs, the work of the public partnership forums and the participation standard alongside the proposed elections.

Our position differs from that of the BMA in that we understand that increasing public participation in the NHS will involve spending more money. However, if the Parliament and Government want to spend more money, we have to be sure that we get the very best value for that money and that it gets the desired outcome. To me, that is about public engagement.

Helen Eadie: I am quite taken by the idea of looking at outcomes and not processes, and the RCN’s evidence says that that should be placed at the heart of the evaluation. I am also quite taken by the fact that you gave specific proposals for conducting the pilots in three different health boards, which would give a true comparison and allow better analysis and evaluation to be done. In light of that, I was also taken by a point in your evidence that was also made by other organisations, particularly those concerned with disability and equalities issues. How can we ensure that, in practice, it is not only those who, as you state in your submission, are “wealthy enough, eloquent enough and/or ‘acceptable’ enough to be voted in” who actually get elected to the boards? That is a critical point.

I wonder whether you can expand on your proposal to run three different pilots, which is worth considering. Further, I am concerned that the bill seems to point only to the end of the process. As the bill is framed, the Government could let the whole thing lie for seven years, which would bring the legislation to a halt without any recourse to Parliament. There seems to be no scrutiny role for the Parliament to evaluate what happens; it is simply down to ministers to do that. The Parliament must consider that issue. Can you pick up on those points?

Rachel Cackett: Certainly. We are keen to see more detail on the proposed evaluation before the bill process moves on. The bill is about piloting elections before the roll-out order is made. We are clear that the proposals in our written evidence for a tripartite approach are just our ideas. We feel strongly that having alternative pilots would allow a much bigger discussion.

Our proposal is that a pilot for direct elections should run in one board area and that only half the anticipated pilot money should be spent on that. In a second board area, we would like all the other processes that this and the previous Government
have put in place to be allowed to flourish for the same time as the direct elections pilot, using whatever new money is given to all boards but no additional funding above that. In a third board area, we suggest that the money that would have been spent on piloting a direct election should be invested in the other ways of increasing public participation that have been put in place. We would like an evaluation of those three different pilots that clearly focuses on outcomes, which would prevent the evaluation being about the numbers of people who vote. That criterion of itself would not allow public participation to continue through a four-year cycle.

Those are the proposals in our written evidence. We are happy to have further discussion on what they might look like.

**Helen Eadie:** I wonder whether I might ask a question of Unison as well, convener.

**The Convener:** Certainly. Is it on a different subject?

**Helen Eadie:** No. It is connected to this subject. I note that Unison said in its written evidence that it was not in favour of having any pilots. I wonder whether the Unison witness can comment on that. In doing so, he might give regard to the situation in Sweden and Denmark because I understand that health is a local authority function in those countries. That is another interesting example that the Parliament should perhaps consider. Perhaps there could be a visit to Denmark for the convener.

**The Convener:** I would love to go, but I will not get it. Every week a member suggests a trip, but we are just not getting anywhere with that. I do not know why. However, keep trying for us.

**Dave Watson:** I would go for New Zealand if I were you.

Unison is not in favour of the pilots per se, but we are happy to support them because we recognise their merit in building support in Parliament for direct elections and addressing concerns that colleagues here and elsewhere have raised about the measure. We say that because we come at the issue from a different perspective. That is why I am frankly not impressed by the argument that we should compare engagement models. For us, it is not an either/or issue. We believe that a principle is at stake. The difference between public and market-provided services is democracy—that is the key principle in this matter. Either we believe in democratic support for public services or we do not. Our strong view is that there should be wider democracy in public services because £8 billion of taxpayers' money is spent in health boards. At best, the democracy in health boards is indirect in the extreme, which we believe is simply not acceptable. There are many quangos in Scotland—140-odd at the last count—which spend an awful lot of taxpayers' money. Health boards are the biggest quangos in Scotland and they should be democratised. That is a matter of principle.

It is a dangerous argument, which we have heard before, to say that all sorts of people might get elected, such as the wealthy and strange, unacceptable people.

**The Convener:** Careful.

**Dave Watson:** Well, frankly, democracy is a strange beast. If we open up a Sunday newspaper, we might find a few views about people around this table.

**The Convener:** Some of us are feeling vulnerable, so do not go any further.

**Dave Watson:** I am doing my best to be tactful, but I am obviously not being successful.

In a democracy, unusual folk sometimes get elected, but that is the will of the electorate. I do not see how health boards will be any different in that respect. In fact, after my experience of serving on quangos, I am not satisfied that relying on the infallible ability of ministers to appoint wonderful people to such organisations is necessarily better than relying on the public's ability to elect sensible people to represent them in public services.

**Helen Eadie:** I do not think that you picked up on my point about the system in Denmark and Sweden.

**Dave Watson:** Sorry.

**The Convener:** I, too, must have missed that in Mr Watson's vigorous response.

**Dave Watson:** We are not in favour of that kind of solution; indeed, in 1948, Aneurin Bevan fought hard against it. We feel that the NHS is big enough in itself. Indeed, that is another reason why we are not much impressed by the argument advanced by the Convention of Scottish Local Authorities and local authorities that they should have the monopoly on local democracy. Health boards are large beasts, and the health service deserves to have its own democracy. It has never been our position that it should simply become a sub-committee of local government, and that view holds for the proposed structure.

**The Convener:** On the proposal to have councillors on boards, COSLA says that councillors represent the people in their area—and I might well raise that point with its representatives—whereas you argue that they are seen as representing their council.

**Dave Watson:** That is a very important point. I can think of many issues on which I have personally engaged with council representatives.
on health boards. It should be pointed out that councillors were brought on to the boards not in an effort to promote local democracy but because local authorities have important health functions that, quite rightly, have to be joined up with the NHS’s work. The best example of that work is probably joint future, but there are many others.

Councillors see their involvement in health boards as a means of ensuring that that work is joined up; they do not see themselves as acting as a kind of grand representative for a huge area. We believe that they should remain on health boards, but there is a distinction to be made. We disagree, for example, with the proposal in the bill that councillors should count towards the majority of directly elected members. They should be additional to that number.

The Convener: Thank you for putting that on the record.

Ross Finnie: I have two broad questions, the first of which directly follows on from Mr Watson’s comments. The issue of governance is pretty fundamental to the bill and, although your views on the matter are clear, I think that we should test them a little. For a start, Government officials made it clear to the committee that all this is not about accountability. Secondly, although there are proposals to change the composition of health boards, there is no proposal to change the corporate governance arrangements.

I will have to resort to phraseology that is not used, but I believe that a health board is distinct from, say, a local authority in that those on the board with experience in health might be described as the executives and those holding the executive to account the non-executives. The argument is about the composition of the non-executives. In your interesting and challenging evidence, your fundamental view is that, in this case, health boards should be likened to local authorities because the issue is accountability. With all due respect, democracy is not simply a matter of elections. Elections take place in all sorts of places; they happen even in states where there is no rule of law and where, as a result, very undesirable Governments get into power.

I do not want to seem disrespectful, because I think that that this is a very important avenue of exploration. However, you are fundamentally challenging not only what is believed to be the status of health boards but their relationship to the people who are appointed to them and their relationship to the Parliament and the Cabinet Secretary for Health and Wellbeing. I would like you to tease that out a bit, because, with all due respect, some of the statements that you made do not quite fit—unless other changes are to be made to the corporate governance of health boards.

10:30

Dave Watson: I could not agree more that democracy is not just about electing people. I know that you have been to events that we have run where we have explained our broader views about public services and what we mean by democracy. Democracy should be about direct elections where that is appropriate, but we are also talking about broader participative engagement—we prefer the term “deliberative engagement”—of communities in the decisions of all public bodies.

There are different types of accountability. We are not proposing any amendments to the bill to change the corporate governance arrangements that are in place. Those structures remain in place and the bill does not propose to change them. There is national accountability for national initiatives through the minister and a form of local accountability, which is where we think that direct elections have a role to play in starting to engage people in their communities.

There are interesting issues around that. We would argue that, although local authorities are directly elected, they are still subject to forms of corporate governance at national level. The previous Administration introduced a range of legislation that gave ministers the power to direct local authorities and others over a variety of issues, such as best value and education. A range of national standards is set out in that regard. That is national accountability.

There will be tensions around that on occasion, but I do not think that that is necessarily a bad thing. People say, “We couldn’t have that, because there would be a postcode lottery”. As I said in our evidence, one person’s postcode lottery is another person’s local initiative and priority. Priorities in the Highlands might be very different from priorities in Glasgow. It is right that people on local health boards decide their local priorities on that basis.

One area where we think that there is an accountability issue and a need to change the bill and the current structure of health boards is the role of executive members. I do not think that executive members can be held to account when they are voting members of the board. The process at the moment is fundamentally wrong. Local campaign groups and others who are concerned about local health issues say that they are completely nonplussed by the notion that executive directors of health boards can propose local initiatives and then vote on those proposals later in the process. That is wrong and we would like to see boards revert to a more local government-style model, whereby executive members would become advisers and officers to the health board.
Ross Finnie: That is a fundamental change.

Dave Watson: It is a significant change. It is an important change. If you want to call it “fundamental”, I am comfortable with that.

Ross Finnie: Come, come. We are agreeing about lots of things; let us not fall out about that. If you change a health board to a model where the only voting members are persons who have been elected to it and have no connection with the experience and knowledge of the affair, it would no longer be a board. I think that you are right; I am not disagreeing with you. You are proposing changing the health board model fundamentally to a local government model. I am not saying that that is necessarily wrong, but we should not try to fudge that. At the moment, the structure of corporate governance is more akin to a company structure, whereby the executive directors are persons who are believed—I choose my words carefully—to have some expertise in and experience of the subject with which they are dealing, and the non-executive directors are there to hold the executive directors to account. I do not want to fall out with you, but I think that what you are proposing is a pretty fundamental change. I do not dismiss it.

Dave Watson: Sure. It is a significant change, particularly in that area, but we are not saying that the only people who should have a say are the directly elected members. We are suggesting a halfway house. There would be people appointed for their expertise; clinical and staff representatives; and directly elected people. The only people who we are saying should not be voting members are the paid officials of the health board.

Ross Finnie: Would you apply that to all walks of life?

Dave Watson: Not in all walks of life. As a general principle, the present structure was a wrong move for a public service. It was introduced a few years ago, well before the Scottish Parliament was put in place. It became a trendy thing to do, in an attempt to ape the private sector. However, public services are not the same as market services—the values, ethos and structures are different. We cannot copy the market-tied provisions of a company and put them into a public service. The two are different, which is why, frankly, that approach has had its day. Having said that, we do not suggest that there should be direct elections to every quango in Scotland. Elections have been introduced for the national park authorities, which control a good deal less public money than health boards but, for small national quangos, it might be difficult to have direct elections. We might have to consider other ways of instilling greater democracy and participation. We want to consider a variety of options but, at present, direct elections are probably the best option for health boards.

Ross Finnie: My next question is for the British Medical Association and Royal College of Nursing witnesses, although Mr Watson may also want to respond. I have sympathy with the view that a raft of measures are already in place to improve public engagement in delivery of the health service—the composition of CHPs and community health and care partnerships points in that direction. However, I am not sure that such measures deal with concerns about the composition of health boards. We are back to the fundamental issue of the corporate governance of health boards. Regrettably, although all the measures to which the BMA and the RCN have referred will make fundamental differences to public engagement, they do not in any way touch on the public’s perception of the legitimacy of certain non-executive members of health boards. There is a feeling that the composition and corporate governance of health boards might be improved if the qualifications of more board members derived from their legitimacy in having been directly elected by local people. There are some suggestions, not just from local authorities, that the number of councillors on health boards should be increased.

I disagree that local authorities just want to preserve their interests. To give a bit of history, in my 22 years as a councillor, I knew all sorts of councillors who did not think of their role on the health board as being simply to ape the local authority’s view. They were independent people who represented the folk in their wards, and that was the only argument that they would ever hear.

Do you accept that the issue is not just about engagement—although that is crucial—but is also about the composition of boards? Although the suggestions from the RCN and the BMA are extraordinarily constructive, they do not address the heart of the issue, which is about the corporate governance of boards.

Rachel Cackett: In a way, I disagree with Mr Finnie about our proposal, as we say clearly that we are in no way against considering how members of the public are represented on health boards through non-executive directors. It will be no surprise to members to hear that the Royal College of Nursing also disagrees with some of Mr Watson’s points about the future governance of health boards. We have made it clear that we are willing to see members of the public on health boards; indeed, they already are.

I have a question to ask to Mr Finnie. If the present appointments are not representative of local people and people do not feel that they have access to the nominated non-executive members of health boards, why not, and are direct elections
the answer? I am not sure that we have sufficient understanding of why people feel that way to allow us to decide that the answer is direct elections to health boards.

There is a role for consideration of the governance arrangements and for members of the public to have much greater involvement in health boards. I hope that the pilot will show whether the electoral mandate of members of the health board—however big it ends up being—gives members what I think they are looking for. I am not, however, convinced that it will, hence our evidence. However, if the will of the committee and Parliament is to test that issue, it should be tested, but that should be done alongside other measures. I return to the point that the principle of the bill is engagement.

Ross Finnie: Before Dean Marshall answers, I want to press Rachel Cackett a little further. Do you disagree with those who say that there might be merit in increasing the number of local councillors on boards, rather than engagement being achieved in some other way?

Rachel Cackett: Through the concordat, local councils are now responsible for delivering a number of outcomes that might once have been regarded as being within the remit of public health agencies—the concordat contains a lot of health outcomes. It is therefore clear that councillors have an important role in delivery—that role might even border on the executive functions of health board members such as the nurse director. There has been movement towards joint delivery.

I am not sure that increasing the number of councillors would give you what I think you are looking for. However, there is currently councillor representation from every council and we welcomed that extension. It is important that every council within a health board boundary be represented, although I accept that council and health board boundaries are not coterminous.

Before I could answer Mr Finnie’s question, I would need to understand more about the expectations behind the wish to increase the number of councillors instead of having elections. Would having more councillors on the board increase the level of public engagement?

Dr Marshall: I share Mr Finnie’s concerns about the corporate responsibility of boards. BMA Scotland does not deny that a problem exists, but we say that the bill is not the answer to the problem. We do not think that it will improve public engagement or make decision making more transparent. There is no evidence that it will do so. We are not saying that no changes are required to the way in which health boards are structured, but the bill—or the significant amount of money that might be spent on it—is not the answer.

Members have commented on the current structures within CHPs. Another concern is that something that has happened commonly will just happen again: we introduce a new structure, but we do not fund it properly and we do not develop it, but we then say, “Oh—that’s not working. Let’s do something else.” Money is not the only answer. There are in place structures that could, if they were funded and developed properly, and if they were given powers, achieve some of what we want. They could get the public to engage more at local—CHP—level. Such structures exist but have never been properly developed. Our concern is that they will simply be forgotten and that we will have to move on to the next thing. That will not solve the problem.
really want to engage. The people we would get would be the people with time on their hands and the financial means to do it.

10:45

Jackie Baillie asked about the outcome; we are talking about the process. Our view is that the process will not get the people who can challenge the kind of thing to which you referred. A small sector of the population will stand for election and will be elected. That will not improve public engagement.

Many doctors do not get involved at health board level because of concerns about being bound by corporate responsibility. Doctors are employed by the board and issues arise in that regard, about which I also have concerns. The bill will not solve the problem. I thought that the bill was about improving public engagement. Our view is that it will not do that.

Rachel Cackett: I agree with much of what Dr Marshall said. It took a long time for nurse directors to become executive directors of health boards. They bring to boards their great expertise and promote the views of the staff with whom they work. The policy memorandum makes it clear that directors of nursing will continue to play their role: nowhere in the bill have I seen anything to suggest a change to their current role, except in respect of their part in the composition of a slightly changed board.

At this stage I am reluctant to go any further than what is set out in the bill. As Dr Marshall said, the bill is specifically about public engagement. I cannot see how taking a vote away from one or other clinical lead on a board—someone who comes to the board with specific expertise—would necessarily lead to increased public engagement.

Jackie Baillie: It might make it more transparent.

Rachel Cackett: If the process is transparent, how would taking the vote away from one or another member improve transparency? Boards simply need to make it clear how votes are cast.

Jackie Baillie: In some cases, the electoral ward area could be quite large. I am concerned about that. One need only consider the size of Highland NHS Board's and Greater Glasgow and Clyde NHS Board's areas. Many people in those areas do not fit the stereotype that you perhaps have in mind. In my area, 20,000 people take a very active interest in what goes on in their local health service—they come from all walks of life. You have to believe me on that.

Can the argument be made in favour of more localised elections, as with elections at local authority level? Are there inherent dangers in that approach? I am interested in the view of each panel member.

Dave Watson: If elections were broken down into groupings, a small pressure group could be elected and bat for one small area. The case for whole-board elections addresses that risk. We are talking about small numbers of directly elected members whose role will be slightly more strategic than that which local authority members have traditionally played.

As we said in our submission, since we first gave thought to the idea of directly elected members improving democracy in the NHS, changes have been made to health boards, including to their size. We have always said that a case can be made for rural health boards. We also see that a case can be made for boards in places such as Jackie Baillie’s area. NHS Greater Glasgow and Clyde covers a large area and serves very different communities. There is a case for splitting up health boards in such areas, and the resulting boards would still serve quite large areas. We would not want to be overly prescriptive on that, however.

As we said in our submission, we favour three pilots involving a rural health board, an urban health board and one that is a bit of both. I am happy for the pilots to test different ways of organising elections and to consider the size of electoral wards. Whatever we do, the areas will still be quite large; boards will not be parochial. There is not too much risk of losing the strategic role of health board members.

Rachel Cackett: There are risks either way. I return to the equality issues that we raised in our submission. If an electoral ward is too large, how will people know who they are voting for? How will people living in Lochgilphead feel engaged if they are represented by someone who lives in Wick? If the point is engagement, the proposal comes with its own problems.

I agree with Dave Watson: if electoral wards are too small, there is a risk that people will stand for election on a single issue. The problem was raised in the debate on Bill Butler’s Health Board Elections (Scotland) Bill. Both approaches raise issues of representation—that is why it is a good idea to have pilots. Only by testing the system will we be able to assess its impact.

Dr Marshall: The size of wards is important, but even small wards would not make a great deal of difference. If we have small wards in the Borders, people from the bigger towns of Galashiels and Peebles may still end up making decisions about a community hospital in Jedburgh.

The Convener: There is no longer a community hospital in Jedburgh.
Dr Marshall: I was giving an example. When I mentioned the Borders, I was aware that you represent the area, convener.

The issue of whether elections mean democracy has been raised. Do we really believe that elections to health boards will improve public engagement? I do not. As a general practitioner, I think that involving people at CHP level is a much more effective approach. It has been pointed out that there are concerns about single issues. Sometimes that is good, because people will engage on issues in which they are particularly interested. However, they may not want to stand for election in order to express a view on every part of the health service. Improvement of public engagement at local level would be a more effective approach. People find standing for elections quite daunting. They may want to engage on one issue and to disengage until another issue comes up. That is why we think the proposed electoral process will not improve public engagement or enable the people from whom we want to hear—because their voice is not heard anywhere else—to have their say.

Ian McKee (Lothians) (SNP): I return to an issue that Ross Finnie raised. The underlying reason for the introduction of the bill is that the public are not only users and potential users, but owners of the health service. For that reason, they should be represented on health boards not just as users, but as proprietors.

We have been told in evidence that elections to health boards could result in unbalanced representation of the public—the election of people who are wealthy and so on. This morning I looked at the website of Lothian NHS Board to see who is on the board at the moment. I found that members include an accountant, an ex-NHS civil servant, an ex-NHS nursing academic, an ex-NHS councillor, an investor from a large financial company and a housing association executive. At least one member has a close relative who is involved in NHS management, and the majority of members have close links with NHS management. It struck me that the current situation is a bit unbalanced. If we do not have direct elections to boards, how can we ensure that the public are represented on boards, as opposed to community health partnerships, where they give advice as users? How can the public’s ownership of the health service be reflected?

Rachel Cackett: It is possible at the moment for any member of the public to put themselves forward for membership of a board. As you said, at the moment only a certain group of people seem to do so. Health boards are multimillion-pound organisations, so we must ensure that board members have the skills to work with a multimillion-pound budget and to make the necessary decisions. There are more people in our communities who could take on that role than do so at the moment. What has happened to the current process to cause only the people such as those whom Ian McKee described, who are already part of the NHS, to apply for board posts? It would be interesting to find out how many members of the general public know that they currently have that option. I suspect that not many do, as it is not well publicised or advertised.

In our written evidence, we suggest that members of the public should play a different role on health boards. We would like more investment in that local approach, through things such as public partnership forums. That would mean that, rather than have a plethora of new initiatives to deal with a problem that we can all see, we would build up public partnership forums and acute-care based patient forums so that people who are engaged at local level can be upskilled and voted on to the board by their peers or local communities.

To pick up on what Dr Marshall was saying, it is fairly daunting to find oneself on the board of an organisation the size of those about which we are talking. If we want members of the public to have a fair say, to make a real difference and to hold those boards to account, we must ensure that they are upskilled to enable them to do that effectively, which is why the approach needs to start at the grass roots.

Dr Marshall: I would echo Rachel Cackett’s comments; the issue that she identifies is important. Being involved in a democratic organisation, I know that as soon as one is elected, one is seen to have lost touch with the real world and the grass roots.

I direct members’ attention to the composition of the elected boards in New Zealand. Some 37.4 per cent of the people who were elected to the boards had experience in the health professions, 30 per cent worked in things such as business or law or were company directors, 10 per cent had backgrounds in community work and 11.6 per cent were directly employed by the health boards. That shows that, even once they had direct elections to the health boards, they were still getting the same type of people—35 per cent of them had experience in local government. As Rachel Cackett said, we need to train people and give them the skills that they need to enable them to engage properly. The New Zealand experience does not support the view that the proposal would improve engagement among the people who do not currently engage with the health service.

Ian McKee: The training needs of people who are appointed must, however, be the same as those of people who are elected. Do the people
who are appointed magically come into possession of those skills?

Rachel Cackett: That is not really the point that I was trying to make. The New Zealand experience suggests that the people who currently put themselves forward for appointment are the same people who will put themselves forward for election, which means that the boards would continue to come from a fairly small pool of people who already possess a certain level of skill that can be built on through board training.

We all want boards that represent the length and breadth of each health board area and we all believe that the board should include people who have valuable skills and knowledge. However, it is unfair to expect people who have not had a senior management position and are not used to working at that level to immediately step up to that level if they have not been upskilled in a way that means that they want to put themselves forward for appointment or election. Every community organiser knows that you start at the base that you have and you build up from it. That is a key point.

Ian McKee: Some people who are elected to Parliament and to councils need to be upskilled. Would you suggest that people should be appointed to Parliament or councils rather than elected?

Rachel Cackett: It is always difficult to talk about elections to a bunch of elected members.

The Convener: I should point out that we come from pretty much the category that you have described—we have lawyers, accountants, economists and so on sitting around this table.

Helen Eadie: Not me.

The Convener: Helen excepted.

Rachel Cackett: One of the points that I wanted to make earlier about equality was that, unless you can meet people in their own environments and bring them up to a point at which they are able to stand for election to Parliament or to a health board, there is an unfair playing field. No one feels that any electoral system in the world has yet dealt with the issues of gender equality, race equality, lesbian, gay, bisexual and transgender equality and so on, because it can be hard for people who are affected by those equality issues to stand.

Dave Watson: One of the central issues is people’s view of public services and the role of the public in the democratic running of those services.

Sure—democracy is not perfect: we have all seen studies about the age of councillors, the gender mix on councils and so on. However, dressing up resistance to the proposals by saying that members of health boards should have appropriate skills is symptomatic of the health service’s paternalistic approach—I am sure that that is not the intention of those who have just spoken, of course. The health establishment has always had a top-down view of how the service should be run. The risk of following the suggestions that we have just heard is that not only would the “Joe Public” members have a different role on the board, but they would be second-class members, coming after the appointed experts on boards.

That would be a dangerous road to go down. To be frank, the health service is no bigger or more complex than local government, and if we went down that road, we would turn to local administration, with governors being appointed for areas. That happens in some parts of the world, but we do not have that culture in Scotland. I am pleased that we have a democratic culture instead, which we should be extending to the quango state.

11:00

The Convener: We are not going to get agreement on that, so let us move on.

Ian McKee: I have another couple of questions, convener. First, how are people chosen for public partnership forums? Is the choice democratic, and how representative are they? They will have a big influence on health care. Secondly, what influence do they have on overall health board policy and secondary care policy?

Dr Marshall: I will take the second question first. At the moment, the answer is that they have zero influence because of how the structures work. CHPs were introduced to create a more bottom-up approach, to engage the public and to allow them to influence how health boards make decisions. The structure exists, but it has never been properly implemented. We have conducted surveys of doctors who are involved in CHPs, and they have provided no evidence that partnerships influence matters at board level, because the system works from the top down. Basically, the boards tell them what to do and give them all the difficult jobs that they cannot resolve themselves. However, that is not a reason for saying that we should just get rid of them. We should be making the CHPs work—

Ian McKee: I have not suggested that we should get rid of them.

Dr Marshall: I am sorry. I did not mean that you had—I am saying that the structure exists but that we need to work with it. Patient participation workers try to engage members of the public by going to local meetings and trying to get people involved. When they work well, they succeed in engaging a variety of different people. In my area, that includes people who are not the usual
suspects, which is interesting. That level can work, but the problem is at the next step up, as CHPs do not have any chance of altering health board policy. We should do something about that, rather than work the other way round.

Rachel Cackett: At the risk of sounding like a woman who is being paternalistic, I agree with what Dean Marshall has just said in that the structures are not right in all PPFs. Unless those structures, which this and the previous Government have been committed to, are given the teeth that they need to make a difference and be influential, they will never succeed. They will not be developed—as we have suggested would be a good way forward—to ensure that the people at the grass roots who have real commitment to, and interest in, what happens to local services can make their voices heard at board level. We are keen that some of the work during the pilot period make their voices heard at board level. At the moment, voices do not pass in the relationship with both its CHP or CHCP and the board. At the moment, voices do not pass in the way that they should in many PPFs.

Dave Watson: We strongly support PPFs. They currently make a limited contribution, but they provide an opportunity. As we have said, democracy is about the opportunity to engage at different levels, and it is right to engage people in the limited way that, as Dean Marshall indicated, some people want to participate. Others may be prepared to participate in the wider sense, which is true for all our democratic institutions. However, that is not a substitute for having a say at the top level in the organisation, which is the whole point of having democratic levels at each stage.

The Convener: Nobody has raised this issue, so I want to challenge the panel on the role of the Scottish health council. The BMA says that the council’s role is “to improve the way in which the public, patients and other stakeholders are involved in service design”.

Let me use a slightly parochial example. When the closure of hospitals in Coldstream and Jedburgh was taking place and the health boards sat in front of the public, the public had no idea who the board members were. They perhaps knew the chair of the health board, but it was the first time many of them had seen other board members—people who were taking important decisions. The Scottish health council was required to determine how the process had taken place. The process was as clean as a whistle. All the proper procedures in the consultation had been gone through, but members of the public were not there to hear about that—they were there for the substance of the decision being dealt with.

We have heard about existing organisations that are not functioning. I am interested in the Scottish health council. You have said that its role is not clearly defined. I think people expected it to be almost appellate and to defend their interests with respect to the substance of decisions; they did not expect it simply to tell them that all the boxes had been ticked and that a decision had been made. Will you say something about that, as that is what you said in your submission?

Dr Marshall: We had the same view. Local health councils were disbanded and a new body was developed that was going to do all such things. However, as the convener said, it seems that a box is simply ticked to say that consultation has happened. There are no challenges on whether the consultation was appropriate or whether people were informed about what was going on.

The Scottish health council’s role must be clearly defined and it must be given a much stronger role in calling boards to account, because things are not working—I agree that it did not seem to develop as we expected it to. I am not clear about why we got rid of the local health councils, which were quite effective in raising issues in some areas.

The Convener: You are saying that there could be reforming and strengthening of the various branches that are supposed to increase public participation and make the public feel that they are being listened to. Strangely enough, all the decisions in the example that I used were taken as if there had been no consultation; in other words, it looked like a fix.

Dr Marshall: Absolutely. I return to the comment about being paternalistic. The medical profession feels just as disengaged from the consultation process. It would be a fine thing to have the chance to decide what we want to do, but everyone whom the consultation is meant to cover needs to get involved and to give their opinions. That said, because of the way in which health boards run consultations, they are paying lip service to those opinions. What has happened in Glasgow is the prime example of that.

The Convener: Mary Scanlon may ask a short supplementary question. There will be a short break after it is answered, as we have had quite a long session. I want everyone to know that, in case you are getting a little weary.

Mary Scanlon: Given all the points that have been made about potential candidates, what do you think about 16-year-olds standing for election to health boards?

Dave Watson: We are in favour of extending the franchise; in fact, we are in favour of extending the franchise in parliamentary and local government elections. At 16, people pay taxes, they can fight in the Army and so on, so why
should they not vote? Engaging people would provide an opportunity to build greater understanding of democratic institutions, particularly at the level in question. We are in favour of extending the franchise more broadly, and we think that the bill presents a good opportunity to get younger people more involved in the political process.

The Convener: Do the BMA or the RCN have any views on that?

Rachel Cackett: No.

Dr Marshall: No.

The Convener: Thank you very much for that extensive session. I suspend the meeting for four minutes.

11:09
Meeting suspended.

11:13
On resuming—

The Convener: I said that there would be a four-minute suspension, and I meant four minutes.

I welcome our second panel of witnesses and remind members that there will also be a third panel. The second panel sat through the previous evidence-taking session, so it knows where we are starting from.

Councillor Ronnie McColl is a spokesman on health and wellbeing for the Convention of Scottish Local Authorities; Ron Culley is a policy manager for that organisation; Harry Stevenson is executive director of social work resources for South Lanarkshire Council; and Graeme Struthers is head of support services for West Lothian Council. I thank all of you for providing written evidence, as the previous witnesses did. That evidence is before us.

We move straight to members’ questions. Does Jackie Baillie want to ensure that she is in early this time?

Jackie Baillie: Absolutely.

The Convener: You may ask a question after Ross Finnie. Ian McKee is not here yet, so he will ask questions at the end.

Ross Finnie: As I listened to the previous panel, I was concerned that, although much is being done to improve engagement, there is still a perception that an insufficient number of non-executive members of health boards—as opposed to bodies that filter into those boards—are able to understand or properly represent the public at large. In its evidence, COSLA clearly states that there is an argument for increasing the number of democratically elected local authority members of health boards. That is also South Lanarkshire Council’s position, although it is not West Lothian Council’s position, so we can have a healthy debate on the matter.

I would like COSLA and South Lanarkshire Council to expand on how that increase might be achieved and what a board’s structure should be. After that, I—or rather, the convener—will allow West Lothian Council to tell us why it thinks that that would be the wrong direction to take. First, though, I ask COSLA and South Lanarkshire Council to say why they propose would be better.

Are you influenced by the fact that about 80 per cent of care in our communities, as further refined by the single outcome agreements, necessitates greater co-operation, collaboration and breaking down of barriers between health boards and local authorities? Alternatively, do you believe that having directly elected health boards as against local councils is more a recipe for tension than a way to ease the problem?

11:15
Councillor Ronnie McColl (Convention of Scottish Local Authorities): When COSLA’s health and wellbeing executive group discussed the issue, many views were expressed on how we should achieve a more democratic and publicly accountable health board system. However, it was clear that the current system was acceptable to no member in the room. Some wanted directly elected boards and some wanted an increase in council representation, but everybody wanted more elected people at the table—no matter how—with voting rights, rather than unelected executive members with voting rights. Perhaps it is because we come from local government that we find it strange that an officer should be able to vote on a report that he or a member of his staff will have prepared, as a staff member will prepare a report for his director in the way that the director wants. That is a strange anomaly in the health board system.

We move straight to members’ questions. Does Jackie Baillie want to ensure that she is in early this time?

Jackie Baillie: Absolutely.

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Ron Culley (Convention of Scottish Local Authorities): I will build on that and return to what a previous witness said. COSLA’s view is certainly not that local authorities should have a monopoly on local democracy. If that were the case, we would have a resounding consensus on health board elections, but committee members will know that COSLA’s member councils have reached different perspectives on health board elections. That must frame our response to the committee, because we must present a balanced view. COSLA has agreed a view on some issues, but not on others.

As for the precise question about local authority members on health boards, councillors have the dual function of representing the local electorate and representing the council. Both functions are important to address the obvious direct democratic issue and to apply the thinking behind the joint future agenda. Mr Finnie spoke about partnership, which is central to the aspiration for the relationship between the health service and local government.

We should not forget that mechanisms for that already exist in other areas. Community planning partnerships will be responsible for single outcome agreements. In the context of single outcome agreements, it is recognised that in a number of areas, particularly in relation to health, neither health nor local government alone will be able to advance the agenda. That is why, on balance, we have come to the view that stronger representation by elected members would be to the benefit of health boards and would allow for a process that ties all the elements together.

Harry Stevenson (South Lanarkshire Council): My comments are partly based on my experience over the past seven or eight years of briefing two senior elected members in South Lanarkshire to be members of health boards: Greater Glasgow and Clyde NHS Board and Lanarkshire NHS Board. They have taken their role as board members very seriously. At no time, particularly in the early years as they developed their knowledge and experience, have they taken the view that they are there to get the best for the council. They genuinely have taken the view that they are members of the board and, on sensitive issues, the maturity of their approach has been helpful to everyone who lives in the local communities. They have a local mandate, they live locally and they see people in surgeries. They see the wider role of local government in relation to health and wellbeing. The issue is not only the delivery of services; the joint future initiative is about how we deliver services well to the public, but local government has a much broader interest in health and wellbeing, which the councillors I have briefed take seriously.

Although our response to the proposal of having direct elections is focused primarily on the specific issue, another point is that I have seen the councillors’ capacity and confidence build. If that continues with the addition of more representation and we get the balance right, it would not be unhelpful for boards.

Having spoken to senior colleagues in the health service over the years, I have no doubt that elected members have made a difference to how business is conducted at board meetings. I do not know whether the difference has been significant, but there is no doubt that a different form of questioning has taken place, in particular about the impact of decisions on the public and communities; so, to some extent, the presence of elected members has changed people’s behaviour at health board meetings. The conclusion we came to, therefore, is that if we have in place a system and structure that the public understand, is it not best to build on that?

Graeme Struthers (West Lothian Council): I will give some background information on the situation in West Lothian. I do not know whether committee members are aware that West Lothian Council has a coalition administration that includes three members who were elected on the single mandate of saving St John’s hospital. Therefore, we are perhaps unique among local authorities. That has helped to shape and mould our council’s response to the committee.

We want to open up democracy and increase the active role of the elected membership of health boards. Equally, we are not of the strict view that such members must be from local authorities. We want to move down the road of increasing democracy and accountability in health boards and see clearly the benefits of such an approach. We also have a view on the voting rights of officers. Our view is that we want to move away from officers having voting rights towards democracy and elected health board membership.

Ross Finnie: I do not know how many of your other directly elected members were representatives of the 80 per cent of care that is delivered in the community. It is an interesting point, and might make the other, single-issue councillors equally representative.

I would like all three witnesses to take up Graeme Struther’s last point. Views are emerging about the fundamental structure of health boards. You come from local government backgrounds so, not surprisingly, you appear to be saying—West Lothian certainly is—that we should remove executive members’ vote, which, given the corporate governance structure that is in place, is not surprising. I am bound to say, in parenthesis, that if people are exercised by the performance of executive members, they must, by logic, be
appalled by the performance of non-executive members, given that one is supposed to hold the other to account. West Lothian Council’s suggestion is that we should remove executive members from the board, which would mean that we would have, as we do in local government, a completely different structure of elected persons. Graeme Struthers might wish to elaborate on that point, but I would be interested in the views of others on the issue.

**Graeme Struthers:** In West Lothian Council’s view, a minimum of 51 per cent of board members should be elected members. The benefits and merits of having appointees to the board aside, our issue is with officers having voting rights. The council’s view is that, on balance, it is better to have a majority on the board being elected members, although we accept that there may still be appointees among the board membership. We disagree with having officers with voting rights.

**The Convener:** Your written submission says: “The preferred option of West Lothian Council would be that 100% of NHS Board members be directly elected”.

**Graeme Struthers:** Sorry—

**The Convener:** Page 1 of the council’s submission says “100%”.

**Graeme Struthers:** I apologise. The response that I have before me says that we are keen to have a minimum of 50 per cent plus 1 board member being directly elected to the—

**The Convener:** I cannot hear you clearly. Could you move your microphone?

**Graeme Struthers:** My understanding of the council’s response is that we seek a minimum of 50 per cent plus 1 being elected to the board.

**Ross Finnie:** That is not what it says in the paper that we have.

**Graeme Struthers:** My apologies. I have a different paper.

**The Convener:** So you seek a minimum of 51 per cent—

**Graeme Struthers:** Fifty. Yes.

**The Convener:** But you want it to be 100 per cent elected members. I am trying to follow this—I have jangling in my head, you see.

**Graeme Struthers:** Our starting point is a minimum of 51 per cent, acknowledging that an element of the board could be made up of unelected appointees. The 100 per cent figure takes it to one extreme.

**The Convener:** Are we clear?

**Ross Finnie:** Yes.

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**The Convener:** If it is clear, that is fine. I will read the Official Report afterwards, because I got lost just now, although that is my fault.

**Councillor McColl:** Although we want a majority of elected members on boards, the executive members have an important role to play. The health board will sometimes deal with technical or clinical issues. It is appropriate to have the executive members’ expertise at the table, and it is probably appropriate that they are allowed to vote. Local government and COSLA consider that the structure is far too top-heavy at the moment, with the non-elected element far outweighing the elected element at board meetings. The elected-member element, even if members were all to join together on a certain issue, would have no way of outvoting the non-elected element. I know that to my cost from my experience as a member of Argyll and Clyde NHS Board. About 70 to 75 per cent of members were executive members rather than local councillors.

**Ross Finnie:** So you are broadly in favour of those elements of the bill that require the majority of places to be held by non-executive members.

**Councillor McColl:** Yes.

**Ron Culley:** That is the view, but there is no consensus on a fundamental overhaul of the composition of health boards to make them entirely directly elected. We did not achieve consensus on that, so COSLA could not support it.

A number of arguments were presented. One of the issues was around accountability. If the purpose of a wholly democratic process was the creation of greater accountability, questions would remain around the role and accountability of health boards to ministers, particularly with regard to health improvement, efficiency, access and treatment—HEAT—targets. There were questions around how that relationship would work. Such views were expressed by those who did not agree with the idea that boards should be made up of 100 per cent directly elected representatives.

**Jackie Baillie:** I wish to pursue Ron Culley’s last point with Graeme Struthers. According to West Lothian Council’s paper, its optimal position is “that 100% of NHS Board members be directly elected”.

Let us stick with that optimal position, rather than with what you will settle for as a compromise. Do you have any concerns that such an approach signals a greater emphasis on local priorities than on national priorities? Do you think—as some people have suggested—that that could lead to the break-up of the national health service as we know it?

**Graeme Struthers:** As you point out, there could be issues with going to the extreme of
having 100 per cent elected members, for example about how that would be perceived and about the emphasis being placed on local issues, and we acknowledge those. However, a number of members on West Lothian Council were elected on a single issue, and our experience is that what you suggest has not transpired. It is a concern, but it has not been our experience. Therefore, I would not be concerned about the potential impact on the national health service.

11:30
Jackie Baillie: You say that three local candidates were elected as a consequence of the situation regarding St John’s hospital.

Graeme Struthers: That is correct. Yes.

Jackie Baillie: However, the electoral ward for your area would be substantially larger than the area that the hospital covers.

Graeme Struthers: It would cover the Lothian area.

Jackie Baillie: Indeed, and the prospect of such people getting elected might diminish as a consequence.

Graeme Struthers: Yes.

Jackie Baillie: NHS Greater Glasgow and Clyde covers a huge area—Ronnie McColl and I have been through the wars there. Does the panel have concerns about the electoral ward area being the same size as the health board area?

Graeme Struthers: Our proposal was for the ward size to be the same size as the local authority area. We had concerns about reducing the size to the size of local wards. Of the local authorities in the NHS Lothian area, the City of Edinburgh Council is the largest, but East Lothian Council, West Lothian Council and Midlothian Council are also in the mix. We thought that that would be an appropriate geographical allocation.

The Convener: Thank you. That is helpful. It is in your written submission.

Councillor McColl: I share those concerns. My local health board is NHS Greater Glasgow and Clyde and if the electoral ward covered the whole health board area, there might be nobody elected from the Clyde area. Personally, I would like to follow the model of the national park authorities. For example, the Loch Lomond and the Trossachs national park is very large and was split into electoral wards. That is the only way in which to ensure local democracy.

Harry Stevenson: It seems to me that the principle behind CHPs is to build local communities. In South Lanarkshire, they are organised into four localities within the local authority area, which builds engagement and capacity at a local level. That seems to make a bit more sense. In our written submission, we comment on the concerns that exist about that larger geography. Across Lanarkshire as a whole we have different communities, from urban to rural, and it would be difficult to get representation from them all.

Another issue could be the distortion of interest. A local interest might bring forward for election a lot of people who might not represent wider issues or the wider geographical area.

Jackie Baillie: I have one tiny point to take up with South Lanarkshire Council, which has the anomaly of Cambuslang and Rutherglen being part of NHS Greater Glasgow and Clyde but receiving services elsewhere. I am conscious of similar but small anomalies in different health board areas. The Boundary Commission for Scotland has recommended that small changes to health board boundaries should be considered to regularise those anomalies. Do you agree, especially in the context of the Government’s saying that it intends to make no changes whatever?

Harry Stevenson: To be frank, views on that have changed over the years. The key issue for local people and local members is being able to get good-quality services from the health service. Some of the issues in the past were more administrative and were to do with planning and policy rather than the delivery of services. We have seen changes anyway, over the past few years, and, to all intents and purposes, the NHS CHP for South Lanarkshire, which covers all the localities, including Rutherglen and Cambuslang, is now responsible for the delivery of services.

Guarantees were sought from NHS Greater Glasgow and Clyde on continued investment in the area, and mechanisms are in place. We have worked hard to ensure that the area is not disadvantaged by the fact that, by our terms, it has quite a large population even though it is only a relatively small part of the NHS Greater Glasgow and Clyde area.

The position on that moves around, but the key issue for the council is that people get good services.

Jackie Baillie: Thank you.

Councillor McColl: We did not take a view on the size, but it makes sense that people should know the voting areas. We should try to align all our voting systems, including those for Westminster and Holyrood, so that people vote for the same area each time and know the area that is being represented.
The Convener: That would be a bit difficult, and of course the current boundary changes are going in completely the opposite direction.

Helen Eadie: I was interested in South Lanarkshire Council’s submission, which says:

“Consideration will also need to be given to where students will register and/or vote if they are living away from home for a period of time to study.”

That made me think about other people who might have occasion to be away from home temporarily, such as people who are living away from home for a time because of work. I ask Harry Stevenson to expand on that point, which is important, especially if we are extending age limits.

Harry Stevenson: We should take a fairly simple approach to it. If we change the constitution and expect people to participate in health board elections, they will be the same as any other elections, and we will have to ask what arrangements will be made to ensure that people who are out of the area when an election takes place have a say in its outcome. I suggest not a sophisticated solution but that we recognise the technical matters to do with the administration of the elections, which are important to people. People will want to ensure that they have the opportunity to register their vote.

Helen Eadie: We spoke about international experience with the previous panel of witnesses. In our papers, we have seen experience from Saskatchewan in Canada, New Zealand and a little bit from Australia. I know about Denmark, Sweden and other Scandinavian countries, which do not treat health like a sub-committee of the local authority, as previous witnesses have said. Has COSLA or have any of the individual local authorities considered what happens in other countries about local authority responsibility for health? The budgets are big, particularly in Denmark, which I have visited. Will the witnesses comment on the international experience?

Ron Culley: I do not think that local government has any grand intention to build an empire around health at this minute.

The Convener: At this minute? You may regret having tagged that little phrase on at the end.

Ron Culley: We are committed to closer partnership working between local government and the health service. Our firm view is that there are structures in place that facilitate that process, such as community planning partnerships. They, of course, are broader than local government and the health service and bring in other interested parties such as the police and fire services. Through the single outcome agreements, there is a clear way for local community planning partners to work together to deliver for local communities. As we have discussed, a large part of that is to do with health outcomes. It is now recognised that not only the national health service but all the community planning partners should contribute to improving health in communities. That is beginning to be recognised in national policy that has been agreed between COSLA and the Scottish Government.

Partners can work together to promote health in diverse ways. Community health partnerships have a different role but, nonetheless, provide opportunities for local government and the health service to work together towards the improvement of health. That mechanism could be exploited more. There is a view among our members that CHPs have not always worked particularly well. It is clear that, in some parts of the country, they have been more successful than in others. That is why we welcome the Scottish Government’s commitment to undertake research to identify why some have worked and others have not worked so well.

Health bodies and local government—and other partners—need to work together, but the structures that are in place can facilitate that.

The Convener: So it is not a takeover.

Ron Culley: No.

Harry Stevenson: As I said earlier, the broader role of local government in health and wellbeing is important. Services that are delivered through leisure or housing channels and the regeneration of communities are key to how we improve the health of Scotland in the longer term. We have not had any discussions about that approach to things.

I happened to visit Denmark not long ago because of a contact that we have there, and I visited an acute hospital. From what I heard, some of the boundary issues that exist here, and the challenges around how to support patients or service users, were the same over there—there were still bits that did not quite fit in, regardless of the fact that the hospital was within one local authority. In every country, how well people work together, communicate and train staff for the same common purpose make a difference to people’s lives.

Helen Eadie: Denmark also has regional authorities, which are much bigger than our authorities in Scotland, and it is clear that that has an impact on the approach to the issue in the Danish system. We ought to make more such international comparisons, particularly with our European partners—we have something to learn from one another.

Graeme Struthers: West Lothian Council has not examined any of those other models. We have a successful CHCP partnership with NHS Lothian,
which has been running for more than three years. We are quite comfortable with the model that we have just now for meeting the requirements of the communities that we serve.

The Convener: So West Lothian Council is one of the good guys, but we do not know who the bad guys are in the CHPs that are not working. Nobody has named anyone.

Ron Culley: And I am not about to.

The Convener: I know you are not—I threw out the fishing line, but nothing got hooked.

Mary Scanlon: I will follow up some of Ross Finnie’s points. From the evidence that we have received, the committee has discovered that four local authorities out of 32 were in favour of direct elections. Does that tally with the responses that COSLA received? Those four authorities include Graeme Struthers’s council, of course.

Councillor McColl: There were various views. Some councils were not fully in favour of direct elections—there was a halfway house. There are very mixed views in the responses to COSLA, but the overriding issue is that the system that is currently in place should not be in place in the future. That is our position.

Mary Scanlon: The committee received responses from four councils that were in favour of direct elections, six that were against, and six that were unclear or wished to make no comment. Does that more or less reflect the responses to COSLA?

Ron Culley: I do not have that information to hand just now, but I am more than happy to re-examine our responses. It sounds about right, but we are happy to send the information on to the committee.

The Convener: Thank you.

Mary Scanlon: I would like some clarification on a point that Ross Finnie raised. COSLA’s submission states:

“There is strong support for an increase in the number of democratically elected local authority members”.

I am not sure that you told us what percentage of a health board you would want to be democratically elected local authority members.

Councillor McColl: We did not take a view on the number of local authority members. The mix of local authority members and directly elected members does not matter, as long as the number is greater than the number of executive directors who are not elected. The principle is that there should be a greater number of members who have been elected in some way than non-elected members.

The Convener: So it is a case of shifting the balance.

Councillor McColl: Yes.

Mary Scanlon: You are looking for an increase there.

Several witnesses have mentioned that health board elections might produce single-issue candidates. South Lanarkshire Council’s submission states:

“single issue candidates … could bring a narrow focus to discussions at Board level.”

We have also heard that that there could be a clash of opinion between the two types of elected member. Given that West Lothian Council has experience of the campaign to save St John’s hospital, has it had a problem with single-issue councillors? Have such councillors had a problem with embracing the full challenges and responsibilities of local government? I hope that that is not a difficult question.

11:45

The Convener: What gave the game away, Mary? Was it the expression on Graeme Struthers’s face?

Graeme Struthers: I am being put in a difficult position, but I will answer as best I can.

The Convener: You will have to learn to be a politician and keep a straight face for difficult questions.

Graeme Struthers: Absolutely.

Mary Scanlon: Ten out 10 for diplomacy.

Graeme Struthers: I will try to put my poker face on for this one. We have three council members who were single-issue candidates, but it is important to point out that they are part of, and support, the minority Scottish National Party administration. We have a complex situation in West Lothian. Initially, there were perhaps concerns about what the election of those members on a single-issue mandate would mean for their roles on the council and the health authority. However, their mandate has not affected their roles, which is down to the individuals themselves.

Mary Scanlon: So although they stood as single-issue candidates, they were obviously aware that that they had broader responsibilities.

Graeme Struthers: Absolutely.

Mary Scanlon: That is helpful.

Harry Stevenson: The election of single-issue candidates to a board to represent particular communities could distort board matters for the
duration of their membership. That is not to say that such board members could not develop wider interests, skill and expertise and contribute more fully. However, at the point of their election, matters could be distorted.

Mary Scanlon: Would single-issue candidates be an obstacle to the change that is necessary? Would their election be detrimental to progressing health care?

Harry Stevenson: We did not intend to imply in our submission that that would be the case. However, there is a risk that single-issue candidates could distort the election process because of strongly held feelings in a community or board area about a particular issue. That situation could change the dynamic and deter people who might otherwise have stood and been elected.

Mary Scanlon: I understand. My final question is one that I have asked before. You will know that all councillors are basically equal, at least from the payment point of view. How would a directly elected member who was paid only for their bus fares feel if they were sitting beside an appointed councillor member who was paid for doing the same job? Would that be fair? How would it work?

Harry Stevenson: At the most recent council elections, the decision to remunerate elected members was intended to ensure that a wider range of people would stand as candidates and be elected to councils. There are sometimes issues with volunteers. For example, if someone is a carer, support care must be provided to allow them to get out and participate in the life of their community, and—this is particularly important for someone on a low income—essential costs, such as bus fares and lunches, must be covered. It seems to me that it would be fair to look at such issues across the board and to treat everybody in the same way.

Mary Scanlon: I am really just asking what your view would be if half your councillors were paid and half were unpaid. How do you think they would feel about that? They would all have the same responsibilities and be expected to give the same commitment. In fact, they would all have a democratic mandate, rather than just being appointed. How would that situation affect morale?

Harry Stevenson: There is a good tradition of volunteering, and people give a lot of their time now. However, you are right that people would take a different view. You would have to be careful to guard against that.

Mary Scanlon: What do other witnesses think?

Councillor McColl: I speak as an elected member, but COSLA has not discussed the issue. However, it might become a problem because a directly elected member of a health board should get the same recompense as somebody who was appointed through the council system. It is probably more incumbent on us to ensure that directly elected members are looked after because they could have more training to do than an elected member who comes through the council system, as they would have access to in-house training in their council. A member of the public who was elected to a health board might have to put more time into getting up to speed on the issues, particularly if they were a single-issue candidate, because they would obviously have to vote on more than that single issue, and would need training and expertise to be able to do so. Remuneration must be considered.

Graeme Struthers: We do not want inequity between those who are remunerated and those who are not; neither do we want lack of remuneration to be a barrier to those who are considering standing as a candidate. We support equality around remuneration.

The Convener: The clerks have passed me a copy of the policy memorandum to the bill, which states, under the heading “Membership and Accountability”, that “the elected members will be remunerated at the same rate as current non-executive Health Board members.”

Mary Scanlon: That is not what I read.

Helen Eadie: The forthcoming regulations will distinctly not say that. Dr Ian McKee and I picked that up at the Subordinate Legislation Committee.

The Convener: I am obliged to hard-working committee members who sit on other committees—the Subordinate Legislation Committee shines again on the details that we need.

Mary Scanlon: My understanding is that such members will not be not paid.

The Convener: Thank you.

Helen Eadie: The other issue is that elected members could be sacked by the minister.

The Convener: I am obliged to Subordinate Legislation Committee members, who will scrutinise the draft regulations.

Ross Finnie: I direct a supplementary question to Councillor McColl, but others witnesses might wish to respond as well.

I appreciate that COSLA did not take a unanimous view on the matter, but you propagated a notion in your earlier evidence that, on balance, having greater numbers of local councillors on a health board might improve and strengthen the health board. Although we are still
taking evidence, I am already attracted to that direction of travel.

In response to Mary Scanlon, you said that as long as the councillors and directly elected members amounted to more than 50 per cent of board membership, your members might be satisfied. I am interested in how a local councillor who has been elected in a local government election and who then serves on a health board would respond when confronted by a person who has been elected for one purpose and one purpose only, given that that person would have the right to represent their constituents on the health board. How will that strengthen the local councillor’s role in making a broad contribution to the workings of the health board?

Councillor McColl: I think that you are speaking about two different avenues. The directly elected person has a direct mandate from the electorate to be on the health board, but a councillor also has a direct mandate as an elected person, although not necessarily in relation the health board. However, such a councillor certainly has responsibility for many health issues, as we have just heard. More and more often, matters are being dealt with jointly by health boards and councils, with more joint accountability, involving more projects—around, for example, “The Road to Recovery, “The same as you?” and “Equally well”—and legislation. For many such initiatives the money comes via health boards, not councils, although councils and elected members are responsible to their communities for helping to deliver the policies. I suppose that we have a mandate to be on a health board because—

Ross Finnie: I am not questioning that mandate, and I agree whole-heartedly with your proposition. My question is whether it helps the governance of a health board if councillors—whose legitimacy you have just explained very eloquently—are confronted by persons who might make a different claim because they have an explicit mandate. Does that not create a tension?

Councillor McColl: I do not think that it creates any tension. We have come across the same situation with national park authorities, to which councillors are appointed and other members are directly elected. Having been a member of one of those authorities for four years, I saw no such tension whatsoever. The idea is that everyone is there to work for the good of their community, regardless of the avenue through which they have been elected. That is the overriding consideration, and I do not think that there is a tension.

The Convener: There might be a slight confusion in the eyes of the public, who will not recognise that there are two different types of councillor on boards. They will think that all councillors are there on the same ticket. They will not discern between councillors who have been directly elected to a board and those who have been appointed to it. I am not challenging your view that all councillors will represent the people, but the public’s perception will be that they all have the same mandate. They will not notice that different electoral methods have been used.

Councillor McColl: Yes, but I do not think that that is a problem. At Holyrood, there are directly elected members and list members. The public do not think any less of a list member than they do of someone who was elected in a first-past-the-post system.

Ross Finnie: Come, come. List members are elected at the same election, on the same day and for the same purpose as constituency members. There is no connection between the situation that we are talking about and the situation at Holyrood. Such an analogy could be drawn if list members were elected in a different place, in a different vote and on a different mandate from constituency members. If list members were elected at a different time and for a different purpose, the Parliament would be very different.


Harry Stevenson: I make the observation that the scenario that we are considering would not be a new one. In the past, single-issue candidates have been elected to the Parliament and to our council—

The Convener: That is not the point. There will be two groups of people on health boards with the label of councillor. Councillor A will have been appointed to the board and councillor B will have been directly elected to it by the public for that specific purpose. Ross Finnie is quite correct. There will be two types of councillor on boards for different reasons and with different mandates. The public will perceive that they are all councillors; in that regard, there will be public confusion, which will not be good for councillors.

Harry Stevenson: The point that I was about to make was that when people phone up a local elected member, they will not think about whether that person was elected on a single-issue ticket; they will simply pass on to them the issue that they are concerned about.

The Convener: We will leave the discussion there.

I would like each of the witnesses to comment briefly on whether they are in favour of the proposed extension of the franchise to 16 and 17-year-olds. We have touched on that issue—students and lists have been mentioned. In addition, should health board elections take place on the same day as local authority elections, if—although I do not think that this has happened
yet—those elections are detached from Scottish Parliament elections? Please give short answers.

Councillor McColl: Again, COSLA did not take a position on that, but my view is that we should try to engage 16-year-olds. As has been said, a 16-year-old can go off and fight a war for us, so I think that they should be able to vote in health board elections.

The Convener: What about the date of the elections?

Councillor McColl: It would help with the issue of perception that you mentioned if they were held on the same day as council elections.

Harry Stevenson: I agree that holding the elections on the same day as council elections would ensure the maximum voter turnout and would avoid apathy. That would make a lot of sense. We have not taken a view on the extension of the age range.

Graeme Struthers: We did not take a view on the age range. We think that health board elections should be held every four years, in line with local authority elections, but obviously there is a lesson to be learned from what happened in 2007, when elections to the Scottish Parliament coincided with local authority elections, which created confusion. We support elections being held every four years, but we do not have a specific position on 16 and 17-year-olds being able to vote.

The Convener: Will extending the franchise to 16 and 17-year-olds and holding health board elections on the same day as local authority elections not cause confusion, as the franchise will be granted at a different age for health board elections?

Councillor McColl: Perhaps by that time 16-year-olds will be able to vote in local authority elections.

The Convener: Oh, I see—you have a hidden plot.

Helen Eadie: A point about administration was made in, I think, South Lanarkshire Council’s submission. When a register of voters is established, a mark is made on it to indicate whether someone is 16. Do you want to comment further on that?

The Convener: Very briefly, please, Mr Stevenson.

Harry Stevenson: That is a technical issue to do with the running of elections, which would need to be arranged properly.

The Convener: I thank all the witnesses for their evidence.

I welcome to the meeting our third and final panel of witnesses and thank them for sitting through the other evidence sessions. It has been a pretty long haul.

We have, from Consumer Focus Scotland, Douglas Sinclair, chair, and Liz Macdonald, senior policy advocate; from Inclusion Scotland, Pat McGuigan, director, and Bill Scott, policy officer; and from Voluntary Health Scotland, Phil McAndrew, information officer. We thank you for your submissions.

We will move straight to questions.

Helen Eadie: Good morning, everyone—or should I say good afternoon.

On page 3 of its submission, under the heading “Inherent tensions between the political decisions taken by Ministers, and decisions taken by boards”, the Scottish Consumer Council comments:

“There is danger that this will lead to tensions and disputes between Ministers and elected boards, and to unrealistic expectations on the part of patients.”

Local government has experienced such tensions, because the parties in power locally and nationally have not always been the same. I believe that in New Zealand there is a protocol that establishes some kind of modus operandi in that respect. Will you comment on that point?

Douglas Sinclair (Consumer Focus Scotland): There is a contradiction at the heart of the bill between what the public think it is about and what it is really about. When the public see the phrase direct elections in the title of legislation, they think that it is about local accountability and the capacity to change policy.

I do not think that the comparison with local government is fair. After all, the health service is a national service; it is about consistency. There is no evidence that consumers in Aberdeen and, say, Glasgow want a different service; both groups want a consistent health service with common standards. The difficulty is that the bill will raise expectations that cannot be delivered, and that it will cause confusion and create disillusionment.

The difference between local government and the NHS—

Helen Eadie: Will you comment first on the New Zealand example? I accept some of your points about the national aspect of the health service. However, in New Zealand, people have been able to accommodate such issues in an agreement.
Douglas Sinclair: With regard to Unison's evidence, my question is where we draw the line between local and national issues. You and I might agree that hospital car park charges are a local issue; however, the Cabinet Secretary for Health and Wellbeing made it into a national issue. John Swinney cannot do that in relation to local government. As you have already pointed out, ministers can sack health board members; John Swinney cannot do the same in local government.

The problem is that, if you raise the prospect of elections to health boards, people will naturally think, “Oh, it’s going to be like our council.” If I may say so, having the elections on the same day rather than on separate days will simply compound that confusion. Our view is that the proposal is not in the consumer’s interest because, rather than clarifying accountability, it will create confusion.

I ask Liz Macdonald to talk about the New Zealand experience.

The Convener: Liz, that was thrown at you.

Liz Macdonald (Consumer Focus Scotland): I have to admit that I do not know about the national-local relationship in New Zealand. We support the view that the BMA expressed in its evidence. The evidence from New Zealand suggests that elections have not significantly contributed to the democratisation of the health service. There are concerns about falling voter numbers and that the same people end up being elected to health boards. We note that evidence, but I am afraid that I am not aware of the agreement that you mentioned.

Helen Eadie: I am really struggling with the issue. When the Health Committee in the previous session considered the matter, we heard evidence that an agreement between the Government and the health boards would set the parameters and clarify how things would work. Could an agreement between central Government and local government not be set up in the bill? There will always be a degree of tension, but professionals can work out ways to address the issues.

I hear what the witnesses say, but I wonder whether we are commenting too much without really understanding what has been done in New Zealand, which might merit closer examination.

Douglas Sinclair: The issue is the extent to which the public wants variations in health standards. That relates to your point about local factors. What factors would you want to be different in, say, Argyll and Clyde or Highland? I do not know the answer, but I think that it would be difficult to have such differences. People want the same standard of treatment from the national health service regardless of where they are located.

Helen Eadie: They want the fundamental standards to be the same, but allowances must be made for local factors. For example, the health boards in Highland and Argyll and Clyde cover massive areas. Given our earlier discussion, it cannot be beyond the wit of professionals in the Government and elsewhere to sit down and set up agreements between the health boards and the Government.

Douglas Sinclair: With respect, that could be done within the existing system. Elections are not required to bring that about. There could be an agreement between the health minister and the health boards as to the division between decisions that health boards can take and decisions that are appropriate for the minister to take. That does not require legislative change.

The Convener: Before we move on, I ask you to consider making a distinction between national standards—we accept that there should not be a postcode lottery—and the method of delivery. Local people tend to raise issues about how things are delivered in their area. That includes issues to do with remote and rural areas. In my view, the concern is about delivery. Do you agree—you probably do not—that democratising the boards is about the delivery of services?

Douglas Sinclair: I do not disagree that the concern is about delivery. However, the issue is not democracy but something that Mr Finnie mentioned—the perceived effectiveness of the boards. Changing the status of members and making them elected rather than appointed will not change the deficiencies. That is the issue.

We suggest that there are three solutions to the problem. We agree with the proposition that the public lack trust and confidence in their health boards. They might like their GP and their hospital, but they have deep concerns about the effectiveness of the operation and responsiveness of health boards. We do not believe that elections are the answer because, as I said, they will confuse accountability.

We believe that there are three things that need to be done. First, we agree with the Royal College of Nursing that we must build on and increase patient involvement. If I may say so, there is a read-across to local government, in that there is a skills issue. In a study that we did on school closures, we found that education officers lacked training and skills in consulting the community. They did not know how to do it. That is equally true across all our public services, and there is a huge amount of work that we can build on there.

I agree with the convener’s point about the question mark over the Scottish health council. Is it an improvement agency or a scrutiny agency? If it is a scrutiny agency, it should be independent of
the NHS, otherwise the public will not have confidence in it.

Secondly, we believe that issues around governance need to be revisited. The skills, training and qualifications of non-executive members of health boards were highlighted in the Audit Committee’s report on Western Isles Health Board. Does the board have the right mix? Does it have the skills to hold people to account? Those are fundamental issues. At one level, we could see the Cabinet Secretary for Health and Wellbeing’s decision to appoint independent scrutiny panels as a vote of no confidence in the ability of the non-executive members of health boards concerned to do their job properly.

Do we have the right balance in health board governance? One must recognise that the health service is a national service. There is an accounting officer requirement, but there is a debate around whether health boards need the number of executives that they have.

I was interested in the RCN’s views on expertise and on making sure that expertise is listened to. People do not need a vote in order to be listened to. I draw an analogy with my experience in local government: if a director of social work had a fundamental issue, he had the right to be heard by the council. He did not have a vote, but he had the right to be heard. That relates to the transfer of the proper officer concept from local government and its potential application in the health service. There are some big issues around governance.

I come back to Mr McKee’s point about who owns the health service. The public own it, and they want continuous assurance that their local health board is fit for purpose and continuously improving. Our view is that health boards need independent scrutiny, which does not exist at the moment. Health board finances undergo partial scrutiny by the Auditor General for Scotland, but NHS Quality Improvement Scotland and the accountability reviews are internal to the health board and are not independent. Crerar made the fundamental point about scrutiny being independent.

To draw an analogy with local government again, we can look at the Accounts Commission for Scotland’s decision to hold a public hearing into Aberdeen City Council’s financial situation. That secured public confidence and shone a beacon of light into the operation of that council. We should compare and contrast that approach with accountability reviews and Western Isles Health Board. I am not seeking to score political points, but only the minister could decide whether to have an independent review into the health board. That does not give the public confidence, nor does it assure them that there is transparency and that all is well.

Therefore, the third element of rebuilding trust is to introduce independent scrutiny of health boards in the same way as there is independent scrutiny of local government. Our two biggest public services are health and local government. It is critical that they work together, which can be brought about by extending the duty of best value and independent inspection to health in the same way as those apply to local government. That is how to rebuild public confidence, rather than holding direct elections to health boards, which will confuse accountability.

The Convener: Mr Scott can comment on that in a moment. Before he does that, I welcome to the public gallery a contingent of Vietnamese politicians. I hope that this meeting does not put them off having committees. We are on our best behaviour. I welcome our visitors to the Scottish Parliament and to the Health and Sport Committee.

Bill Scott (Inclusion Scotland): We strongly support the principle of direct elections because we think that they bring a good method of scrutiny and accountability to the governance of health boards. Democracy is the best method that we have come up with so far. The public must be able to decide whether the services are being delivered locally in the way in which they want them to be delivered. Services such as maternity and accident and emergency services are crucial to local people, and we think that local people should have some input into the decision-making process.

12:15

Jackie Baillie: I have a short supplementary question. I do not think that the approaches that have been mentioned are necessarily mutually exclusive. I am interested to get more detail, because I care about independent inspection in the health service for other reasons. Which vehicle do the witnesses think would be appropriate to ensure that health boards are truly independent of ministers? Which would restore public confidence?

Douglas Sinclair: In his statement on scrutiny, John Swinney proposed that NHS QIS, parts of the Scottish Commission for the Regulation of Care and parts of the Mental Welfare Commission for Scotland should join to become an independent body. The bit that is missing is accountability review by ministers, which is the bit that needs to be independent. That function needs to be built into an independent scrutiny body that is accountable to Parliament and scrutinises the performance of health boards, not only on clinical issues but on the same issues that are scrutinised in local government. Under the best-value regime in local government, councils are asked whether they are continually improving and whether they are fit for purpose. The same question should be
asked—individually—of health boards. That could be done by Audit Scotland reporting to a scrutiny body.

**Jackie Baillie:** That is interesting. I would like to clarify one point. My understanding of NHS QIS and the proposed new body is that they would still be accountable to ministers.

**Douglas Sinclair:** NHS QIS is actually accountable to Kevin Woods.

**Jackie Baillie:** So it is not even accountable to ministers.

**Douglas Sinclair:** That is not transparent.

**Jackie Baillie:** The key issue for you is accountability to Parliament rather than to ministers.

**Douglas Sinclair:** Absolutely.

**Jackie Baillie:** Thank you. That is helpful.

**Ian McKee:** I am interested in other panel members’ views on what we have heard so far. I want to explore the interesting concept of independent advice to non-executive board members and ask Consumer Focus Scotland what it thinks the right balance of non-executive members on the board would be.

The problem is that non-executive board members use executive board members as their source of advice; there is a teacher-pupil relationship during the non-executive members’ term of office. It is therefore not surprising that they do not subject the board to the rigorous scrutiny that we would expect from the models that we have discussed. Rather than having an independent scrutiny panel, which would appear to be set up for specific instances, do you envisage the creation of a public body that is a continual source of advice to non-executive members of health boards throughout Scotland? Do you envisage the creation of a new institution?

**Douglas Sinclair:** No. There are two issues. First, there is the argument for external independent scrutiny, which is good practice in any public service. Secondly, there is the need to enhance the role of the non-executive members so they can challenge the executive members—I agree that it is difficult for them to challenge professional opinion. Our submission suggests that, on major issues, the non-executive members should be able to access independent advice. A fund of money in each health board should be ring fenced for the non-executive members to draw on if they feel that, although they have listened to the advice of the board’s experts, they want to take independent advice. That would help them to develop the confidence and the skills to undertake effective scrutiny of the executive members, which is not happening in the way that it should.

**Ian McKee:** Is there not a risk that the dominant role of the executive members has already been established? Non-executive members might not seek such advice because they are already immersed in the administrative culture.

**Douglas Sinclair:** There is a case for reviewing the governance of the health boards to consider the balance and the number of executive members on the board. I have given the reasons why such a review needs to be conducted. I am not arguing that there should be no executive directors on the health board, because it is a national health service and the accountable officer has specific responsibilities, but there is a debate about whether we need to have the current number of executive members on the health board or whether we could use different models. We could perhaps use models taken from local government, such as the proper officer model, in which the officer has the right to be heard, but not to vote. That model is capable of some degree of transfer to the health service.

**Ian McKee:** Of course, the local government model has elected members, which you are arguing against. I would be interested to hear the views of other panel members.

**Douglas Sinclair:** It comes back to the point that we are not comparing apples with apples. Local government is a separate tier of government that is accountable to its local electorate and people; the national health service is, as it says, a national service that is accountable through ministers to Parliament. The bill will not change accountability. The difficulty is that the public will think that, as a result of these direct elections, accountability will change. It will not, the public will find that confusing and I am worried that it will lead to even greater disillusionment with the health service.

**The Convener:** Before I let Ross Finnie in, I wonder whether the other witnesses will defend direct elections in the face of Mr Sinclair’s robust rejection. We have heard from Mr Scott; does Mr McAndrew or Mr McGuigan have anything to say?

**Phil McAndrew (Voluntary Health Scotland):** Voluntary Health Scotland supports the general principle of direct elections as a means of increasing the public’s democratic involvement in health delivery. Direct elections will provide patients with a stronger voice on health service delivery decisions and open up a channel for hard-to-reach or excluded equalities groups such as young people not in work or training, homeless people and isolated older people.

**The Convener:** How do you refute the evidence that suggests that those are exactly the people who do not put themselves forward for such roles and that the positions are filled instead by the
usual middle-class professionals and people who have connections to the NHS?

Phil McAndrew: Perhaps we are not approaching those people in the correct way.

What channels can members of the public use to get involved in the health service? Although a lot of good work is being done through the patient focus and public involvement programme in getting patients and the public involved, there is still room for improvement. As a layman with an information technology background, I tried to find out how I could get involved by using all the NHS board websites. Most websites had a section on getting involved and mentioned CHPs; some even mentioned public partnership forums, which is indeed the route by which the public can get involved. However, as I said, things could be improved, and I believe that direct elections will give people more involvement.

Bill Scott: I listened with great interest to some of the earlier comments about the suitability of people from certain backgrounds to be involved in decision making. I began to think that the 19th century chartists worked in vain because if that sort of argument had prevailed then, we would not have now the direct election of ordinary people to Parliament, local government and so on. Such comments are elitist conceptions. Disabled people have been excluded from public life for so long, but here is an opportunity for them to become involved in public life and they want to seize it with both hands. They are often, but not always, users of the health service—like everybody else, some of them use it more often because of conditions that they have—and they are experts on their conditions and the type of service that is being delivered to them. They should be allowed to get involved in making decisions about how that service is delivered to them, as should the general public.

The Convener: You might not have this information, but might we have a breakdown of the percentage of disabled people on boards, and on health boards in particular?

Bill Scott: I tried to get a breakdown of the numbers of disabled people on health boards, but was unable to get it from the Office of the Commissioner for Public Appointments in Scotland.

The Convener: We might see whether we can source it because it would be interesting to committee members.

Ross Finnie: Those last two pieces of evidence illustrate graphically the difficulty of where we are. Mr Scott argues cogently for a different form of representation, but I am not entirely clear that any of us—I include myself—are clear about where we are going in relation to the question that we are being asked.

We are not being asked to change. We are not being asked to address the point that Mr Sinclair raised. We are looking at a body that is directly accountable to ministers—that was confirmed by the officials’ evidence—so we are not looking at a different form of health board, à la local government; we are looking at a very different corporate model. Douglas Sinclair posited that we might need to rewrite that model and, although I do not disagree with that possibility, I am not sure that that is the question that we are being asked.

The difficulty for you—and for us—is to work out not how to get greater representation and engagement on health boards, legitimate though that undoubtedly is, but how to influence or affect the corporate governance of NHS boards.

To come back to Mr Scott, or indeed to Mr McAndrew, I am not at all clear about how the electoral wards that are posited in the bill will result in better representation for disabled people. If the present legislation for dealing with disability equality is failing, that is a separate question that needs to be addressed. If your figures are right, we are manifestly not doing enough about the representation of disabled people on public
bodies, but the fundamental question before the committee is how we affect the governance of health boards. That goes back to Mr Sinclair’s point that we are dealing with a body that is different to a local authority and, therefore, we need to ask whether direct elections would improve its effectiveness. That is fundamental. Mr Sinclair is suggesting that we need to take a fundamental look at the issue, but at this point I want to confine him and the rest of the panel to the question whether health board elections will prove more effective. That is, after all, the issue that we are dealing with. The issue of engagement might well be under discussion, but we are certainly not talking about accountability, which is already defined in health legislation.

12:30

Douglas Sinclair: Our position is quite clear: electing rather than appointing people will not, per se, remove the deficiencies of governance that you have mentioned.

I will make this point quickly, as I am in danger of repeating myself. Three things need to be done. First, health boards must become more responsive and their mechanisms for patient involvement and community engagement must be enhanced. There are good ideas out there, but they need to be rooted.

Secondly, there needs to be a review of governance, particularly with a view to increasing the effectiveness, skills and ability of non-executive members with regard to challenging decisions. Thirdly, there must be independent scrutiny. Those three measures will address not only your question of how we improve the corporate governance of health boards, but the equally important question of how the public’s trust in their local health board can be re-established.

Bill Scott: Opening the system up to democracy will fundamentally change it. Of course, that will not happen overnight—it will take some time—but the public’s perception of health boards and their views on what they want from them will change over time. It is no bad thing to let the light of democracy into the decision-making process. After all, although doing so will fundamentally alter things, we will still want national standards. There is no problem in that respect.

Jackie Baillie: But can we not have both approaches? As I said, they are not mutually exclusive.

Bill Scott: I do not think that they are.

Helen Eadie: I certainly agree with the approach that Ross Finnie has taken in his question; he analysed the difficulties quite well.

The evidence that we have taken this morning and the written submissions that we have received suggest that there is some merit in extending the couple of pilots that are proposed to be introduced across Scotland to the three-stage approach outlined by the RCN. Voluntary Health Scotland says that it accepts the bill’s general principles, but its submission is nevertheless peppered with caveats and concerns from its members that, for example, boards might be “dominated by ‘a few knowledgeable and politically astute individuals.’”

Would the pilots proposed by the RCN allow us to analyse and evaluate what is happening?

Moreover, certain points in Voluntary Health Scotland’s submission that have not yet been highlighted include the hidden costs in setting up and administering direct elections. One thing that people like me who have a local government background have always argued for is expenses for elected members with caring responsibilities. If, as the Subordinate Legislation Committee has said is likely, the people elected to these boards will not be remunerated, how on earth are some of these inequalities to be addressed?

The Convener: So the first question is about the three pilots and the second is about expenses for carers. If we can start with—

Helen Eadie: My question was about basing pilots on the RCN model.

Liz Macdonald: As the lady from the RCN pointed out, the bill has been presented very much as a response to the question of how the widest possible range of patients and local communities can be involved more in the health service and whether direct elections can contribute in that respect. The first question is the more important and certainly provides a very good argument for testing different models. Rather than putting considerable sums of money into piloting elections, it could be used to develop public and patient involvement in other board areas in different ways. We would definitely support that.

The Convener: We have had quite a long meeting, but I do not want to put words in your mouth, Mr McAndrew. Can I take it that you would not agree with that view?

Phil McAndrew: I agree with the RCN’s pilot proposal. It is a very good idea to have controls, instead of just doing the two pilots as proposed in the bill.

Bill Scott: I have not been able to consult my membership on that, but my personal view is that I do not see why the other things could and should not be done to increase public participation.

The Convener: I want to move on to the funding issue.
Bill Scott: There is a particular issue about public appointments and the fees that are paid to those who serve on public bodies. Most disabled people cannot benefit from those fees because they are clawed back by the benefits system. Most disabled people put themselves forward in the knowledge that they will be sitting alongside people who are being paid quite generously for giving their time to the public body, but that they themselves will not end up any better off for having served on the board. Disabled people have to live with that at the moment.

I am in favour of people being paid something for contributing in that way, as councillors are, but that is not on the table just now. We would be in favour of people being properly rewarded and compensated, because there will be care costs for some disabled people who take part in the boards. Personal assistants might need to be brought along, and so on, and if someone cannot meet those costs, they will be excluded whether they are appointed or elected.

The Convener: I take it that that is your position too, Mr McGuigan.

Pat McGuigan: Yes.

The Convener: Mary Scanlon, do you have a final point? Time is running on.

Mary Scanlon: I have a point that should be raised. It is from Consumer Focus Scotland. There is a danger that having elections “would be considered to be a substitute for an NHS board’s statutory duty to consult” and that money would come from the existing budgets for patient involvement. That is saying that the bill would not be of benefit, and the situation would be worse than what we have now. Is that a reasonable interpretation?

Douglas Sinclair: It is fair to say that elections are not cost neutral. The money has to be found from somewhere. That is self-evident.

Mary Scanlon: Yes, but my point was about health boards being less willing to consult and involve local communities because the assumption would be that elections—

Douglas Sinclair: All our public service organisations have to create a culture of engagement with the public. They should be doing proper consultation and they should be proper customer-led organisations, whether they are in local government or the health service.

Mary Scanlon: Are you saying that the elections might be seen as a substitute for proper involvement?

Douglas Sinclair: That is a possibility.

Mary Scanlon: Okay. My second question is for Phil McAndrew.

Someone said, on the theme of politically astute individuals, that health board elections would need to remain true to their original intent and not be hijacked by party politics. I wonder, however, given the financial and time costs of standing and the travel times involved in attending meetings, whether the people whom you have mentioned this morning and would want to see included, will be.

Phil McAndrew: I certainly hope so. The comment to which you refer was not about the expenses and so on that board members would receive, but about the total cost of running the elections. The concern is that it should be beneficial in the medium to long term.

On the point about the more excluded groups having access, as I understand the bill there are expenses of £7,500 per year per person. I did not realise that the Subordinate Legislation Committee had removed that.

Helen Eadie: We did not remove it.

Mary Scanlon: We are a bit confused about that just now.

My point was really about people having the money and time to stand for election; Dr McKee made the point earlier. Are the elections likely to be hijacked by party politics rather than lead to the conclusion that we all seek?

Phil McAndrew: That is a difficult question to answer. I hope that excluded groups will be able to find some funding—obviously not from the health boards—or backing so that people can stand for election.

Helen Eadie: For the record, convener, the Subordinate Legislation Committee did not remove the provision on expenses. It recommended that the Health and Sport Committee’s attention should be drawn to the issue.

The Convener: I do not know the correct position. We will try to clarify it, but I know that it will not have been the Subordinate Legislation Committee. We will find out what the position is on remuneration.

Helen Eadie: The minister made a proposal to the Subordinate Legislation Committee that we said we would draw to the attention of the lead committee. It is a policy matter for this committee.

The Convener: I do not want to get into a debate about it just now because there are conflicting views. We can find out; it is not rocket science. We will get that sorted out for our next meeting.

I thank you all. That concludes this evidence session.
Thank you very much for giving Royal College of Nursing (RCN) Scotland the opportunity to present evidence to the Health and Sport Committee on the Health Board (Membership and Elections) (Scotland) Bill. This allowed us to explain our proposal for a tripartite approach to piloting and evaluating direct elections to health boards alongside other ways to involve the public. The proposal aims to allow genuine testing of options to improve public engagement and involvement with health boards.

In light of this key principle of our position, which is not clearly reflected in the summary contained in the papers for this week’s Health and Sport Committee meeting, I am writing to reiterate our proposal.

Concerns

RCN Scotland has been clear throughout the consultation process for this Bill that we support greater patient and public involvement in health boards, within the ethos of mutuality between patients, public, and staff. This requires investment but we must ensure that any investment delivers value-for-money. As such, whilst we do not believe that direct elections will improve levels of public engagement, we welcome the Scottish Government’s commitment to pilot their proposal, and see this as an opportunity to truly test the approach. The evaluation of the pilots would be critically important.

If the Bill progresses in its current form, we are concerned in two respects:

That a single-option pilot does not allow for a genuine test of options for better engaging and involving patients and the public in health boards.\(^\text{12}\)

That, in light of ongoing uncertainty noted by the Finance Committee as to how the costs of a future full roll-out of elections would be funded, and financial pressures already present within NHS boards, we should be seeking greater assurance that investment from health board budgets provides the best possible return in relation to patient and public engagement.

Proposal: A Tripartite Approach to Compare Elections and Alternatives

To address these issues, RCN Scotland has proposed a tripartite approach to the pilot and evaluation process. This approach would see the direct election model receive comparative evaluation against two other models, drawn from other Scottish Government policies designed to improve patient and public engagement, and co-ownership. Consideration should be given as soon as possible as to the objective and content of an evaluation of the pilots. A summary of the three pilots that we are proposing is outlined below.

The pilots would operate in three areas concurrently, over three years, to allow each to evolve and be comprehensively evaluated.

The costs for the three pilots could be met within the approximate £2.86 million already identified to pilot direct elections.

<table>
<thead>
<tr>
<th>Health Board 1</th>
<th>Health Board 2</th>
<th>Health Board 3</th>
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<tr>
<td><strong>Direct Elections</strong></td>
<td>Yes, as per legislation passed by Scottish Parliament.</td>
<td>No.</td>
</tr>
<tr>
<td><strong>Scottish Government</strong></td>
<td>Yes, using specific additional funding</td>
<td>Yes, using specific additional funding</td>
</tr>
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\(^\text{12}\) RCN Scotland supports COSLA’s view that the pilots should be a genuine test of the policy.
I hope this summary of our position is useful to the Committee during the final considerations of the Bill at Stage 1.

Theresa Fyffe,
Director,
Royal College of Nursing Scotland

COSLA

I refer to the Health & Sport Committee’s request for further information regarding council responses to the Scottish Government’s consultation exercise on direct elections to health boards which preceded the above-mentioned bill.
Sixteen council responses were made available to COSLA. The nature of the questions posed means that a clear analysis is not possible without reference back to individual councils to ensure interpretation of views is accurate.

On that basis we would agree with the figures mentioned by Mary Scanlon during our oral evidence session on 19 November.

Given the nature of the bill which has emerged from the consultation exercise, COSLA would wish to reiterate its view* that, if the bill progresses and pilots are implemented, then:

- The pilots must be a genuine test of the policy;
- The scoping of the pilot proposals and the identification of the pilot areas should be worked up jointly by the Scottish Government and COSLA; and
- The pilot process should be jointly evaluated by the Scottish Government and COSLA.

* These comments on pilots are given in the context of testing the policy only and should not be construed, even if their assessment is positive, as an indication of automatic support for the introduction of direct elections.

Sylvia Murry, Policy Manager, COSLA

INCLUSION SCOTLAND

1 Public Appointments:

1.1 At present, the boards of public bodies do not reflect the diversity of the population in Scotland.

52% of the population is female, but women account for only 35% of board members and 17% of chairs.

Latest estimates suggest that 20% of the population in Scotland has a disability or long-term illness. Yet only 2.5% of chairs and members of public bodies have a declared disability.

The current figure for minority ethnic board members and chairs is 2.2%, broadly similar to the 2001 Census figure, but lower than the estimated BME population in Scotland today.

1.2 The pool of applicants fares little better. Only -

- 30% of applicants are female
- 7% declare a disability
- 2% are black or minority ethnic (BME)
- 40% are drawn from the 51-60 age group, which accounts for only 16% of the adult population.

1.3 In addition, during the past three years the average number of applicants for each post has fallen by 30%. (All above figures provided by the Commissioner for Public Appointments, http://www.publicappointments.org/consultations/documents/DiversityDeliversConsultationNov2007_FINALPDF_000.pdf).

"If public appointees continue to be drawn from the usual quarters the pool will become increasingly small and ever less reflective of the population" - Commissioner for Public Appointments.

1.4 In 2007 the proportion of applicants and appointees to Public Bodies who declared themselves as disabled fell (to 6.2% of applicants and 2% of appointees, see below). Inclusion
Scotland believes direct elections to boards would provide opportunities to disabled people’s participation which the current appointments system woefully fails to address.

2 Extracts from Response of Office of Commissioner for Public Appointments to Government’s Local Healthcare Bill

2.1 Question 10 - How could equality and diversity of candidates (for election to Health Boards) be promoted?

“While measures could be taken to encourage candidates from a variety of backgrounds to stand for election, in reality, the election process is likely to favour those who have the time, money (for example, because of loss of earnings), confidence, physical stamina and administrative support to mount an election campaign, in addition to the commitment needed to take up the role once elected…..The Commissioner is concerned that this may discourage many people from standing for election, including, for example, people with certain disabilities, people with caring responsibilities or people with less flexible working patterns”.

2.2 Inclusion Scotland observation - These barriers whilst real would affect both electoral candidates and people considering applying for appointment to boards. The real question should therefore be - “How can individuals whether appointed or elected be supported to overcome these barriers?”.

3 Benefits as a Barrier to Public Appointment

3.1 Current benefit rules largely do not allow disabled people to take-up certain kinds of public office without calling into question their eligibility for benefits. Other than local councilors and members of benefit appeals tribunals most public appointments are not specifically dealt with by these rules and must be performed according to the rules governing voluntary or ‘permitted’ work.

3.2 Local councillors

Unlike most other appointments, regulations allow benefit recipients to become Local Councillors. However the law and guidance for decision-makers is complicated. To further complicate matters, the rules covering councillors and councilors’ expenses differ depending on whether a disabled person is claiming Incapacity Benefit (IB) (now Employment Support Allowance) or Income Support (IS). However the salaried position of Scottish councillors has largely removed these barriers to participation in Scotland if not throughout the UK.

3.3 Other kinds of office or appointment - The new permitted work rules make it easier for disabled people to try out work by removing many of the restrictions previously imposed. However, they were not developed with a view to making public appointments more accessible to disabled people.

3.4 Public appointments can require a continuing and significant investment of a claimant’s time in return for which expenses or other payments may be made. While people receiving expenses alone will generally be okay and covered by the rules on voluntary work, those receiving payments other than expenses may come up against problems. Such payments may be regarded as earnings and if greater than £20 a week could lead to the withdrawal of incapacity benefits.

3.5 Most people who decide to apply for public office do so with little thought of increasing their weekly income. But they obviously want to protect any allowances they currently receive; after all no one should have to out of pocket for taking on a public appointment.

3.6 For those interested in taking up public appointments, it soon becomes clear that current benefit rules were not really designed with them in mind. If public bodies are to be representative and informed by experience, as the UK Government says it wants, then benefit rules will clearly have to be updated. Obviously benefits are a reserved matter but we would hope that it can be raised in joint Ministerial discussions.

3.7 One option might be to develop a new indefinite permitted work option to allow people to undertake duties associated with public office. This would extend the protection currently afforded to councillors to holders of other public office, allowing a weekly disregard of expenditure.
Alternatively the categories of exempt work, currently covering appointment to benefit appeals tribunals, could be extended to include other forms of public bodies work.

3.8 A more detailed briefing about benefit rules affecting public appointments is available on the Engage website at http://www.scope.org.uk/engage


1. Applicant and appointee statistics for the two years between April 2005 and March 2007 were analysed to establish the demographic profile of the people applying for public appointments and the profile of the people being appointed. This information provides a baseline against which changes can be measured.

Key findings

a) Applicants

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<th>April 05 – March 06</th>
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<tr>
<td>61-70</td>
<td>252</td>
<td>324</td>
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<tr>
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<td>30</td>
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<tr>
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<td>1603</td>
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<tr>
<td><strong>Unspecified</strong></td>
<td>105</td>
<td>72</td>
<td>4.3</td>
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The percentage of applicants who stated they were disabled declined and is low compared to current estimates for the general population, but may be a result of a number of factors including whether the applicant wishes to declare a disability.

b) **Board members**

**Appointments in total**

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<th></th>
<th>31 March 2007</th>
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<tr>
<td></td>
<td>Total</td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>Chairs</td>
<td>98</td>
<td>81</td>
<td>17</td>
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<tr>
<td>Members</td>
<td>629</td>
<td>391</td>
<td>238</td>
</tr>
<tr>
<td>BME Background</td>
<td>20</td>
<td>3%</td>
<td></td>
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<tr>
<td>Disabled</td>
<td>18</td>
<td>2.5%</td>
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<td>Total</td>
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<tr>
<td>Chairs</td>
<td>102</td>
<td>85</td>
<td>17</td>
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<tr>
<td>Members</td>
<td>647</td>
<td>409</td>
<td>238</td>
</tr>
<tr>
<td>BME Background</td>
<td>22</td>
<td>3%</td>
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<tr>
<td>Disabled</td>
<td>18</td>
<td>2%</td>
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**BME and disabled appointees**

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<tr>
<td></td>
<td>Total</td>
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<tr>
<td>BME background</td>
<td>5 (2.5%)</td>
<td>2 (1.2%)</td>
</tr>
<tr>
<td>Disabled</td>
<td>5 (2.5%)</td>
<td>1 (0.6%)</td>
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At 2.5% the representation of disabled people among appointees continues to fall far below the estimated 20% of the general population who are disabled.

Bill Scott,
Policy Officer,
Inclusion Scotland
The Convenor: Agenda item 2 is oral evidence at stage 1 of the Health Boards (Membership and Elections) (Scotland) Bill. I welcome from the Scottish Government the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP; Kenneth Hogg, who is deputy director of health delivery; Robert Kirkwood, who is a policy officer in the health delivery directorate; and Kathleen Preston, who is a solicitor. I invite the cabinet secretary to make some brief opening remarks.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): Thank you very much, convener.

Good morning, everybody. I welcome the opportunity to discuss the principle behind and the detailed provisions of the Health Boards (Membership and Elections) (Scotland) Bill. Members are aware that the commitment to democratise health boards through direct elections was a key Scottish National Party manifesto commitment.

I am aware from the committee’s previous evidence sessions that some groups have expressed the view that a preferable way forward would be the Government investing further in existing public engagement and involvement programmes. I make it clear at the outset that I do not see the situation as an either/or situation. As we made clear in our consultation process that preceded the bill’s introduction, the Government is committed to improving public engagement and involvement with health boards through further work with existing bodies, including community health partnerships, and initiatives such as the development of a participation standard. However, direct elections represent a significant step in addition to strengthening engagement and involvement in ensuring that the public voice is heard and listened to at the heart of local national health service decision making. I have never believed that having people directly elected to health boards would take away the need for difficult decisions to be made, but I believe that boards with a majority of locally elected members will be able to confront issues and decisions with additional credibility and will help to re-establish public confidence in the decision-making process.

The committee is aware that the principle of direct elections to health boards was considered during the passage of Bill Butler’s Health Board Elections (Scotland) Bill. We listened to the comments on and criticisms of that bill that were made during evidence sessions, and in drafting
the Health Boards (Membership and Elections) (Scotland) Bill, we tried to take on board many of those comments and criticisms.

As members are aware, the bill provides for extending the voting franchise to include 16 and 17-year-olds in the elections. That is the right thing to do—we want direct elections to health boards to include as many users of the NHS as possible. That is an important way to introduce young people to the democratic process as they reach adulthood, as it concerns a public service of which they already have considerable experience.

I acknowledge, as I have always done, that the proposals that the bill contains will have a radical effect on the composition and workings of health boards—that is the intention. A significant number of people who responded to our consultation and who have given evidence to the committee suggested that, because of that radical impact, we should take a cautious and a careful approach. I agree with that view, and we have responded by proposing pilot elections to health boards in the first instance to allow some of the issues to be tested in practice.

Although there is strong support for the principle of direct elections to health boards, it is fair to say that there is no absolute consensus for or against them at this stage. However, there is general consensus for the idea that testing the policy through pilots is a sound and reasonable way forward. We propose that pilot elections will take place in two board areas, preferably in spring 2010. I am sure that members will, during questioning, want me to go into more detail about the criteria that will be used in selecting the pilot areas.

Following discussion with the Subordinate Legislation Committee, we have undertaken to lodge a number of amendments at stage 2, which are intended to reinforce the Parliament’s ability to scrutinise any changes to what is proposed in the regulations that underpin the bill. In addition, I assure the committee that we have listened and are listening carefully to the views that have been expressed during the consultation and the committee evidence sessions. I look forward to continuing discussion and dialogue with the committee and others as the bill progresses through Parliament.

I am more than happy to take questions.

The Convener: That was helpful. I appreciate the undertaking to lodge amendments that the cabinet secretary mentioned. Will it be possible for the committee to see the thrust of those amendments before we conclude our stage 1 report? That might resolve some issues.

Nicola Sturgeon: I am happy to provide that, convener. The amendments will be technical, but they will have a substantive effect with regard to parliamentary procedure. For example, we have agreed to amend the bill to ensure that if any of the Scottish statutory instruments—a pilot order and an order for the roll-out of the elections—would lead to substantive changes in the text of the bill, affirmative procedure would be used in the Parliament.

The Convener: I see that Ross Finnie, Mary Scanlon and Michael Matheson have questions. Do I also see an indication from Ian McKee?

Ian McKee (Lothians) (SNP): I am smiling encouragingly, convener.

The Convener: The smile meant yes.

Ross Finnie: We have heard a wide range of evidence, and the cabinet secretary was right to say in her opening statement that a lot of people have expressed concerns—of which we are all aware—about the way in which health boards have conducted themselves. During our evidence taking, it has become clear that there is a great deal of disquiet about the way in which health board executives—and, equally, non-executives—have discharged their functions. That is the only conclusion that we can safely reach.

However, it has not been as clear that there has been “strong support”—to use your phrase, cabinet secretary—for the method that you have selected to deal with that problem: direct elections. A substantial number of people have appeared before the committee and, although they have seen some merit in the idea, to suggest that their evidence points to “strong support” is, with respect, to err a little with regard to what they have actually said.

I seek your comments on two issues. First, people who strongly supported the concept of elections went on, under questioning, to advocate a completely different way of running health boards. They went as far as to suggest that we ought to move towards a local government model in which almost everybody who would have a vote on decisions would be elected and therefore that those who are NHS officials would not vote. That raises a question about a different governance structure, which does not seem to be covered by the bill.

Secondly, although people have supported the idea of a pilot, they have not necessarily supported the view that the pilot should be only on whether direct elections are the only method of improving the capacity of a board to engage with the local population.

Would you care to comment on those two issues?

Nicola Sturgeon: I would be delighted to. I have read the Official Report of all the evidence that you
have taken, and I have read all the submissions to our consultation and to the committee. I will not try to speak for anybody, on either side of the debate, who has submitted evidence. They can present their own views; I am here to present my view and explain my thinking.

You are right to suggest that a fairly broad consensus exists that the status quo is not acceptable and that change is necessary. That is an important starting point. However, it is fair to say that even people who strongly support the principle of direct elections—and, obviously, I include myself in that group—would not argue that directly electing people to health boards is the only way in which we could, or should, address what I will for shorthand purposes describe as the democratic deficit in the NHS.

We may develop these points further during committee members’ questioning, but the bill is explicit about retaining the existing accountability structure for health boards. I believe that the health service should be national, so I believe that the lines of accountability must be maintained. Having directly elected members on health boards is about making the boards more representative. At the moment, health boards take decisions on local issues and on how best to implement national policies to suit local circumstances. The question for me is how we can ensure that the people who take such decisions reflect—as closely as any group of individuals can reflect—the broad spectrum of opinions in the areas that they represent. At a previous meeting, Ross Finnie pursued the distinction between accountability and representation. My firm view is that the bill is about representation.

Ross Finnie wondered why we were proposing pilots only of direct elections. Well, the bill is about direct elections. It is right to test the concept of direct elections properly. Pilots should take place in more than one health board area, and my view is that two areas should be selected. I am happy to go into detail on some of the criteria that might underlie the selection of the areas. The principle should be tested in health board areas that encompass a broad and representative sample of the Scottish population and which take in a broad geographical spread.

What I have suggested does not exclude testing other approaches to achieving better engagement and involvement in health boards. The ideas may not have been very well defined in the evidence that I have read in the Official Report, but some of them may not require legislation. I am not hostile to the idea of testing different approaches in parallel with piloting direct elections. However, this bill is about ensuring an adequate and robust pilot of direct elections. The bill relates to direct elections, so it is right that it should focus on pilots for direct elections.

10.15

Ross Finnie: That is helpful.

On the issue of corporate governance and democratic and democratically elected institutions, the evidence that we have received has been particularly interesting in the way that it has tested the relationship between the directly elected Scottish Parliament, which deals with national issues—the reason, of course, why you as cabinet secretary are directly accountable to Parliament for the provision of a national health service—and local government, which, as a separate tier of government, deals with the delivery of certain local elements within our constitution. With respect, however, the evidence does not make it clear how a body that is not a tier of government and yet has direct elections will interpose itself on our current constitutional arrangements. If you as cabinet secretary are concerned about local delivery and accountability—as I believe you are—why have you not sought to make better use of, or indeed to find a different use for, existing democratic structures of government? Why have you chosen some hybrid direct elections system instead? The case for such a move has not been particularly well made—not, I should add, by you, but in all the evidence that we have received.

Nicola Sturgeon: Let me try, then, to make that case.

As members know, one improvement that is introduced in the bill is that, for the first time, local authority membership on health boards will have statutory underpinning. Although that practice has developed, it has never before been set out in statute.

Leaving local government slightly to one side for the moment, I point out that health boards deal with slightly different issues from those that are dealt with by local government. That said, there is increasing overlap between and integration of health boards’ work and the work of local authorities. That is only right and is something that I am sure we all want to continue.

With regard to health, you are absolutely right in your narration of the current democratic and accountability structures. However, although I am accountable to Parliament for the workings of the NHS, under the current arrangements we have devolved to health boards responsibilities for taking decisions in local areas. That side of things has already been established.

As far as the bill is concerned, the question is how we put together the boards of people who are already making those decisions. Do we retain the
current appointments-based system or do we seek to democratise things to ensure that in future the people who take the decisions have democratic credibility and are representative of those who are affected by them? I think that it is right to make the system more democratic and representative, which is why I have introduced the bill.

Do I understand by your reference to hybrid systems that you want to know why we do not simply elect health boards?

**Ross Finnie:** I am sorry—I left the issue open. I was simply pointing out that that is how some of those who have given evidence have seen the proposal.

That said, the proposed system seems to be something of a hybrid sitting between a directly elected Scottish Parliament and local government. Of course, I accept the point about local health delivery—contrary to a great misconception, 80 per cent of the care under your control is delivered in the community, not in hospitals—and that there is a need to regularise things. However, if you intend to give statutory underpinning to local authority membership, would it not be better to involve more councillors in the system?

**Nicola Sturgeon:** But your so-called hybrid already exists in health boards, which, after all, comprise both executive and appointed directors. Even though they have no statutory underpinning, there are local authority, area clinical forum and area partnership forum representatives on health boards. The bill is simply about democratising that structure.

It is right that we retain a mix of members on health boards. Executive directors, for example, bring the necessary managerial, financial and clinical expertise to the boards’ workings. Because of the increasing integration and overlap between health and local authority functions, it is right to have local authority board membership. Health boards take decisions on how vast amounts of taxpayers’ money are spent, which impacts on the most cherished and cared-about services in the country, so it is right that the population at large have a say over who sits on those boards, to make them more representative and more democratically credible.

**Mary Scanlon (Highlands and Islands) (Con):** You used the word “democratising”, and rightly so. We are all democratically elected members of the Parliament. Of the 54 responses to the committee’s call for evidence, 15 were in favour of the proposals, including four out of 32 local authorities. Of the total, 27 per cent of respondents to our call for evidence were in favour. Being in a democracy, I am less than enthusiastic about the bill.

My problem is that the bill that we will be asked to pass is not just for pilot schemes; we would be passing a bill for health board elections. In all the 15 years for which I have been standing for election or serving in the Highlands and Islands, I have not heard anyone say that they would like a directly elected health board—for Shetland, Orkney, the Western Isles or Highland. I have been to some feisty, fiery public meetings about the Belford hospital in Fort William and about Caithness general hospital. On one occasion, 22 per cent of the local population turned up and spoke out; the health board listened to them and did not go ahead with its plans. To me, that is democracy in action.

When we have heard all the evidence, I will have to discuss my views with other members of my group. I might be minded to vote for pilot schemes but I am worried that, in doing so, I will be helping to introduce health board elections, which I am less than enthusiastic about.

I am looking at sections 5 and 6 of the bill. The pilot schemes are to be introduced in 2010. The reports will be made no later than five years after that—in 2015. The termination of the pilot could be seven years from now. My memory is not too bad just now, but if I am fortunate enough still to be here in seven years’ time, I might not be able to remember all the evidence that I have heard in order to make a decision then. What will happen in that regard? I want to get this on the record, because it is not entirely clear. If we vote for the pilot schemes, how can I be assured that that will not lead to an automatic shoo-in for direct elections? Considering the matter democratically, there is not a majority in favour of that.

**Nicola Sturgeon:** That is an important point, on which I hope that the bill provides assurance. The bill gives authority for pilot elections, and there would have to be a pilot order to bring those into being. After the pilots have been run, and after the evaluation has been performed, any roll-out of elections to other health board areas would have to go through further parliamentary procedure. The bill provides for negative procedure, unless substantive changes are made to the bill, in which case affirmative procedure might be used. In either case, it would be open to the Parliament to kick it out—not to go ahead with the roll-out—because further parliamentary procedure would be required. Whether the decision is made by Mary Scanlon, me and current members, or whether it is taken in a future session, it is entirely in the hands of the Parliament.

Mary Scanlon suggested that decisions will be taken a few years down the line, and that our memories might be rusty about the evidence that has been taken. It is up to every individual member what they base their decisions on, but...
decisions would presumably not be taken on the basis of the evidence that we are discussing now; they would be taken on the basis of the evaluation report from the pilot schemes, which would in effect offer an opinion on whether the pilots had been successful. Parliament would be able to make a reasoned and considered judgment whether to approve the roll-out of elections. I stress the point that there will be further parliamentary procedure between pilot elections and their evaluation, and any roll-out. At every stage, it is in the hands of Parliament.

Mary Scanlon: I mentioned those who are not in favour of direct elections to health boards. Given that the proposal was an SNP manifesto commitment, who would be tasked with carrying out the evaluation? Who would you appoint to do it?

Nicola Sturgeon: As you know, we have set aside in the financial memorandum the cost of carrying out the evaluation, which would require to be done independently. You are absolutely right that it would be for the Government to appoint people to carry out the evaluation, but it would be open to full parliamentary scrutiny. That is no different a procedure from that which is carried out in the evaluation of all sorts of things.

Your question is important, but the crucial point is that if the bill is passed in its current form, it will not give authority for health board elections to be held throughout the country; it will give authority for a pilot order. In order to move to roll-out, a roll-out order would have to be passed and that would require further parliamentary procedure.

Mary Scanlon: You will understand that, if the Government appoints someone to conduct an independent evaluation and the Government of the day—whether it is you or some other party—has a manifesto commitment in favour of such elections, I would be sceptical about the evaluation. We can probably park—

Nicola Sturgeon: The evaluation report will be laid formally before Parliament. If we have a pilot election in 2010, the board will have to run for at least two years, although the bill provides that it could run for as long as five years. I hope sincerely that the party that is in government now will still be in government at the time of the evaluation, but in theory it could be any one of the parties around the table. We have processes for evaluating things that will be undertaken in the case of the health board elections pilot, but the report will be laid before Parliament and open to the full scrutiny of the Parliament of the day. Parliament will have to give authority for any further roll-out on the basis of that evaluation. There can be no roll-out through the back door; the process will be up front and will require parliamentary procedure.

Mary Scanlon: It is the evaluation that concerns me, just as we have been concerned about consultation in certain parts of the country. I am entitled to be concerned about it.

Nicola Sturgeon: May I respond to your first point about support for the proposal? I have not done the numbers with regard to the responses to the committee’s call for evidence and I will not quote numbers from the Government consultation because I do not remember them exactly. Although I speak highly of all the health boards in the country, it is not surprising that they are more sceptical than others about their composition being changed radically. When the boards’ responses are stripped out from our consultation results, the percentages for and against change radically. I have spoken to many people, in the Highlands as well as in other parts of the country, who are strongly in favour of having a democratic element in health boards because they feel that their voice is not always heard. Unlike NHS Highland in the case of Belford hospital, some health boards do not listen when it comes to major hospital changes—I simply cite NHS Ayrshire and Arran and NHS Lanarkshire.

Mary Scanlon: The figures that I saw were in response to our call for evidence—

Nicola Sturgeon: I am not contradicting your figures; I am just making a point—

Mary Scanlon:—and came from the Scottish Parliament information centre—

The Convener: For the sake of the Official Report, I ask you not to speak over each other.

Mary Scanlon: I will move on to address points that have been raised in response to our call for evidence. The only real examples that we have are from New Zealand and Canada. In New Zealand, candidate numbers halved between the first and second elections and voter turnout went down by 7 per cent, which hardly displays ringing enthusiasm.

Let us return to Highland and consider a person in Badenoch and Strathspey, who votes in elections for the community council, the Crofters Commission, the national park board, the local authority and for the Scottish, Westminster and European Parliaments. That person currently faces seven elections and will now face elections for health boards. Given that enthusiasm has waned considerably since the elections started in New Zealand, do you have in mind something that would sustain enthusiasm in Scotland and avoid repeating the experience in New Zealand?

The Scottish Consumer Council’s submission states:

“There is a danger that having elections would be considered to be a substitute for an NHS board’s statutory
duty to consult and involve members of their local communities".
Have you addressed that issue?

10:30

Nicola Sturgeon: I will take those points in order. Notwithstanding the serious point that Mary Scanlon makes about voter fatigue and there being too many elections—which no doubt concerns us all from time to time—I take the view that we cannot have too much democracy, although I would be happy to relieve voters in Scotland of the need to vote in Westminster elections, if that would help. When we are dealing with bodies that take such important decisions, we should not be hostile to the notion of democratising them.

We have obviously considered examples such as New Zealand and we have tried to learn lessons from them but, more important, we have tried to devise a system that is right for Scotland. We can learn a certain amount from international examples, but we should not try to pretend that we should or could emulate those countries, because different countries have different circumstances.

I challenge the notion that enthusiasm has waned in New Zealand as Mary Scanlon suggests it has. Turnout has certainly reduced but, by the standards of some of our elections, turnout for health board elections in New Zealand remains quite high, and the reduction in turnout has been in line with the national trend for elections overall in New Zealand. It has not been peculiar to elections to health boards.

Many of the concerns that we are now hearing in Scotland were expressed before elections were introduced in New Zealand and have turned out not to be merited. There is now a strong consensus in New Zealand that their system works well and that people are happy for it to continue. The New Zealand experience can be read in different ways. It is important that we devise a system that is right for Scotland.

On whether there will be enough candidates, enough voters and whether there will be enough enthusiasm, I think that there will because I know—other members have the same experience—that people in Scotland are incredibly passionate about their national health service, so my view is that people will stand, people will vote and people will be enthusiastic. However, the fact that there is uncertainty in some people’s minds about all that is one reason why it is right to have a pilot that will allow those issues and others to be tested in practice. If it turns out—heaven forefend—that Mary Scanlon is right and I am wrong, Parliament will take that into account when it makes its decision about roll-out. That is why having pilots is the right approach.

The Convener: You said that the pilots must run for at least two years. I cannot find that anywhere in the legislation or draft regulations.

Nicola Sturgeon: I am double-checking, but I do not think that it is in the bill; we intend to include it in the regulations. The provision in the bill is that the evaluation report would require to be concluded no later than five years after the first election.

The Convener: I see that; it is in the bill. However, when you mentioned two years, I searched in vain for the figure.

Nicola Sturgeon: “Two years” is not in the bill. It would be open to the committee to suggest that we put it in the bill. My view is that we would have to run a pilot for at least two years to assess properly whether it was working.

The Convener: Section 6(1) of the bill states that

“The pilot order is revoked”

automatically after a specified period,

“but this does not affect Ministers’ power to revoke the order on an earlier date”.

First, that power would be affected if the pilot had to run for at least two years—there would be an embargo, as it were, and it could not be revoked for two years. Secondly, how would whoever is in power revoke the order earlier? What is the mechanism through which that would happen?

Nicola Sturgeon: The Subordinate Legislation Committee drew attention to that. In the bill as it stands, a revocation order would be without procedure. We are thinking further about the procedure that the Government—of any party—would require to go through to revoke the pilot order and thereby have the relevant sections of the bill fall. Perhaps we can come back to that in more detail later.

The Convener: And we now have the two years.

Nicola Sturgeon: It would be in the regulations that the pilot has to run for two years.

The Convener: Thank you for that clarification.

Mary Scanlon: I am sorry, convener, but one question has not been answered. The Scottish Consumer Council thought that the elections could be a substitute for consultation.

Nicola Sturgeon: My apologies; I did have that question down to answer.

The elections would not be a substitute for consultation. Nothing in the bill changes the
existing obligation—statutory or otherwise—on health boards to consult the public, so the elections would definitely not be a substitute. The consultation that preceded the bill’s introduction made it clear that we do not see direct elections as a substitute for means of engaging with the public that exist now or that might exist in the future.

Michael Matheson (Falkirk West) (SNP): I listened with interest to Mary Scanlon’s picture of health boards making proposals, consulting local communities and amending their proposals as a result of the communities’ views. That is not my experience, particularly in Lanarkshire, where the local community was overwhelmingly opposed to changes that were suggested by the health board and the health board decided to forge ahead with them anyway. Thankfully, the cabinet secretary eventually overturned the proposed changes.

I am sure that it will come as no surprise to the cabinet secretary that the majority of, if not all, the evidence that we have received from the health boards opposes the idea of directly elected health board members. I suspect it is a case of turkeys not voting for Christmas. However, in his evidence, the chair of Lothian NHS Board made a serious allegation that the policy proposal would destabilise health boards and the way in which they operate. When I asked why he believes that, he was unable to cite any evidence other than his opinion. What is your view? Do you believe that the policy will destabilise health boards?

Nicola Sturgeon: I would not propose or pursue any policy that I thought would have a destabilising effect on our health boards, so I fundamentally disagree with that point of view.

I have read, heard, and held discussions around the central question of whether having directly elected members on health boards would create or increase the potential for some health board members to be pitted against others, or for some health boards to be pitted against national Government. In theory, as soon as we create a local board to take decisions based on local circumstances, we create the possibility of tension with the national Government. You have already cited situations in which two health boards were directly in conflict with national policy on their accident and emergency departments.

Having directly elected members does not create that potential for tension. Such tension is rare because health boards do not tend to challenge Government policy; they decide how best to implement it to suit local circumstances. I contend that, in such a scenario, it is better to have making decisions on health boards people who are more likely to understand, and to be in tune with, local needs and circumstances. I believe that elected members are more likely to be that way.

Michael Matheson: You referred to the criteria that will be used to identify the health board areas that will be used as pilots. When I discussed that with a couple of health board members from my constituency, they did not share my enthusiasm that our board should be one of the pilot areas, for obvious reasons.

Nicola Sturgeon: Did you say that they do or do not share your enthusiasm?

Michael Matheson: They do not.

I am interested to know what criteria are being used to identify the health boards that will be selected and used as the pilots.

Nicola Sturgeon: I probably should not say this—I will go no further than what I am about to say, no matter how hard I am pressed. Despite some evidence from health boards, one or two board chairs have said privately to me that they would not be averse to theirs being a pilot board. There is a lot of enthusiasm among MSPs, councillors and members of the public in many areas to have their boards among the pilots.

When officials appeared at the committee previously, they said that we would publish the criteria for selecting the pilots. I will give a bit of insight into my thinking on that process; it is not rocket science. My view is that we should have two pilots. One should test elections in a predominantly rural part of Scotland and the other should do so in a predominantly rural part of the country, in order to get the spread of population and geography.

There is also a more practical and basic issue of continuity for health boards. We will consider which boards have currently appointed members whose term of office is closest to expiring, so that we do not have to terminate health board members’ terms of office early and so that we can try to have a smooth run-through.

Those are the key criteria that I will bring to bear on deciding on the pilot boards. So that people can understand the basis of my decisions, I will ensure that the criteria for making them are properly published for scrutiny before they are made. They will have to be made before we lay the regulations before Parliament.

Michael Matheson: What is the timeframe for your announcement of which boards will be selected for pilots?

Nicola Sturgeon: Assuming that everything goes smoothly with the bill, I reckon that the decision would be made in the spring or early summer next year.

Ian McKee: We have heard concern that people could be elected to health boards on single issues or on a section of their responsibilities but would
have to make decisions about the total responsibilities of the health board. Some sort of training would be required but, at present—as far as I can see—the non-executive members of a health board are trained by its executive members, which creates dependency. Should there be some sort of central training body for newly elected members of health boards?

Nicola Sturgeon: That is a good point. Local induction training takes place already. It is led by health boards themselves, as you say, and it is already augmented by specific training that the Chartered Institute of Public Finance and Accountancy provides. We have plans in progress to launch a national induction course early next year. It will provide specific courses that are designed to support the various roles that non-executive members of health boards play. That training function is important.

Ian McKee raised a broader issue about single-issue candidates. The bill has been drafted so as to minimise the chances of such candidates dominating elections. That is why we have gone for the single transferable vote and single-ward health board areas rather than multiward areas. Those provisions will significantly reduce the chances of single-issue candidates dominating elections. Beyond that, democracy prevails. Single-issue candidates have been elected to Parliament and are elected to councils: as well as pursuing their single issues, they manage to take part in the other decisions that those bodies make.

If voters want to elect a candidate because of a particular issue, democracy says that they have the right to do so. My experience is that, although some people get involved in existing public engagement mechanisms, such as public partnership forums, because they are passionate about a particular issue—there is nothing wrong with that—they tend to adapt well to the body’s broader work once they become immersed in and understand it. They take those wider responsibilities seriously, so I have little doubt but that the same would be the case with people who were directly elected on to health boards.

Ian McKee: Some concern has been expressed about how people would be appointed if not enough candidates stood. However, I will suggest the opposite: we may get a situation in which an immense number of candidates stand, perhaps on single issues or because of geographical factors. Do you intend to introduce some form of hurdle, such as a requirement that a certain number of people must support a nomination before the person can be added to the list of candidates? If you do not do that, we might end up with 500 names on a voting paper.

10:45

Nicola Sturgeon: There is no such hurdle in the bill and I have no intention of lodging an amendment that would have that effect. People should be allowed to stand without having to overcome a particular hurdle. However, if the committee wants to pursue the matter, I am sure that we can consider it. My instinctive view is that we should not introduce a hurdle and we should allow people the freedom to stand for election. Let us hope that you are right and many people come forward because they want to make a contribution. That would be positive.

Ian McKee: Finally, on the franchise, the committee heard the valid point from people who run elections that health board elections should be as authentic as elections to councils or Parliament. The witnesses think that the amount of money that has been allowed for the pilot elections and for the roll-out will not be sufficient to allow for, for example, voter identification, which is needed if we are to guarantee the elections’ integrity. Will you comment on that?

Nicola Sturgeon: Are you talking about the election expenses limit? You went on to mention security.

Ian McKee: I gather that the election will involve a postal vote. If a postal vote is to be secure, we need signatures and other details, which it appears are available for only about 20 per cent of the electorate.

Nicola Sturgeon: You are talking about personal identifiers.

Ian McKee: Yes.

Nicola Sturgeon: We took a judgment on the issue, certainly for the purposes of the pilots. A requirement for personal identifiers would have two effects. First, it would significantly increase the cost of the pilots. You will know from the financial memorandum that the cost per vote will be about £2.60; the cost would increase to about £3.60 per vote if personal identifiers were required. Secondly, it would significantly jeopardise the timescale for the pilots, given the significant amount of work that will have to be done, not just after voting to check identifiers, but at the front end of the process to establish the personal identifiers for every person in the population.

Currently, as you know, if you apply for a postal vote you must give your personal identifiers, which currently applies to about 15 to 20 per cent of the population: in an all-postal-vote election we would be talking about 100 per cent of the population. There is recent evidence that in the current system, people tend not to follow through on applications for a postal vote, because they do not want to give the identifiers. A requirement for
personal identifiers might have the effect of disenfranchising members of the public. Therefore, we took the judgment that, certainly in the pilots, the elections should go ahead without personal identifiers. I think that that is the right judgment, but when the pilots are evaluated and Parliament must decide whether to roll out the elections, Parliament might well want to revisit the issue.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Have you estimated the additional costs that would be incurred if personal identifiers were required? I think that the original estimate for roll-out was £13 million, but after the Finance Committee published its report a revised estimate of £16.8 million was given. Does the estimate include an element for personal identifiers, which would add significantly to the cost, as you said?

Nicola Sturgeon: The estimate in the financial memorandum does not include the cost of identifiers, either for the pilots or for the roll-out. As I said, the cost per vote would go up from £2.60 to £3.60 if personal identifiers were included. You can calculate the total cost from that—I hope that you will not force me to do the arithmetic.

It will be for Parliament to judge whether we made the right decision in relation to the pilots. When it comes to roll-out, Parliament might want to revisit the issue.

Dr Simpson: Is the cost of using personal identifiers included in the revised estimate of £16.8 million?

Nicola Sturgeon: No.

Dr Simpson: Right—so the cost would be even higher.

Nicola Sturgeon: The cost would be higher if personal identifiers were required.

Dr Simpson: I understand that.

I find the bill particularly difficult and I feel ambivalent about it. I have absolutely no doubts that every parliamentarian is convinced that health boards’ accountability to their local population is still inadequate, notwithstanding the report that I produced in 2000 or 1999 for the Health and Community Care Committee on Stobhill hospital and the consultation on it, and notwithstanding health boards’ movement on consulting the public and the huge variety of improvements in that respect. We are all agreed on the starting point, but there is not so much agreement on the proposed solution.

I do not, however, object to direct elections on the ground that they will increase tensions in the system. We have elected councillors, elected MSPs in Parliament and an elected Government. Although directly elected health board members will create yet another point of tension in the system, I do not have a problem with that because tensions can be positive and can produce dynamic solutions. My concern is that although it is true that it will be in two geographic areas, we will test only one type of pilot. Have you considered altering any proposals: for example, the proposal that there will be a majority of councillors and directly elected members? Could we have one pilot with a substantial proportion of councillors and only a few directly elected members, and another one with a minimum amount of councillor representation and a significant number of directly elected members? In other words, will we test more than one system, or will we simply test a single approach?

Nicola Sturgeon: I will try to answer that as constructively as I can. The bill proposes one system: direct elections, with health boards having a majority of directly elected and local-authority elected members. It is right that we should test that system adequately and properly, and the pilots that are proposed in the bill are designed to do that, on the basis that I spoke about earlier.

In considering the evidence, I have been struck that although the bill is designed to test one system, we might want to test other approaches in parallel. I do not have fully formed views on whether we should do that and, if so, what approaches we might want to test. We would not necessarily need legislation to do that. We already have councillor members of health boards without there being any statutory underpinning for that. While we test the system in the bill, we might want to trial other approaches. I am considering that and will be more than happy to discuss the issue further with the committee in due course. However, it is important that we are clear that the bill proposes one system and will give us the ability to test it properly through the pilots.

Dr Simpson: Have you considered appointing MSPs to boards, or allowing their appointment by the Government?

Nicola Sturgeon: Would I get to pick who they are? That might colour my view.

Dr Simpson: Either the Government or Parliament would do that. Since Parliament was created, there is huge interaction between MSPs and boards. There are regular meetings between health boards and groups of or individual MSPs, and MSPs have a keen appetite to be involved in the process. Have you considered putting that relationship on a different footing?

Nicola Sturgeon: I have not considered that formally, although, as with many things, it has passed through my mind in considering how to improve the working of health boards. I am not in favour of having MSPs on health boards—I will tell you why. We have local authority members on
health boards because local authorities and health boards are increasingly jointly responsible for decisions that impact on local services. Health boards are not accountable to local authorities; they are accountable to Parliament. To have members of Parliament on health boards would seriously confuse the lines of accountability. All health boards should have a well-developed and constructive relationship with the MSPs in their areas—I certainly hope they do—but to have MSPs on health boards would confuse and undermine the important line of accountability from boards to Parliament via Government.

Dr Simpson: It is helpful to have that on the record, as it has been put to me that that would be a less expensive way of proceeding.

The Convener: A buy-one-get-one-free sort of thing.

Mary Scanlon: Given that there is only one system for the pilot projects, is there an option to change the system at the end of the pilots, if we decide that we are in favour of health board elections but not exactly the system that was piloted?

Nicola Sturgeon: Yes—on the basis that Parliament always has the option to do what it likes. I cannot bind a future Parliament any more than this committee can. At the moment, however, the option is for the roll-out of elections on the basis that is set out in the bill. Parliament is, however, free to introduce any system it wants: it would be for the Parliament of the day to make that judgment.

Kathleen Preston (Scottish Government Legal Directorate): Section 7(4) of the bill allows for a roll-out order to make a provision to modify statute, including the act itself. If, as a result of the evaluation report following the pilots, it is decided that the Government wants to introduce direct elections in a form that is not precisely the same as the terms of the bill, it would be possible for the roll-out order to make the appropriate amendments.

Nicola Sturgeon: That relates to your first question, convener, which was about the amendments that we had agreed with the Subordinate Legislation Committee. Assuming that our amendments are accepted, if Parliament decides to roll out the proposals but with a slightly different proportion of elected members, for example, that would require an instrument to be agreed to under the affirmative procedure rather than under the negative procedure.

Ross Finnie: That is one of the matters that are exercising people. To what extent can one fundamentally change an act? I read section 4 with some concern. The minister is clear, and so is the bill, that we are talking about one system.

Nicola Sturgeon: Section 4 deals with the pilots; we are talking about the roll-out.

Ross Finnie: Yes. Section 7(4) is about the roll-out and enactment of the legislation. The clear principles of the bill are set out in section 1. I am not clear about the extent to which it is legally competent to make a serious change to what is set out in section 1 without compromising the short title.

Nicola Sturgeon: I have said what I have said about that requiring change using the affirmative procedure. However, it is a long time since my legal days, so I will allow the Government lawyer to answer that question.

Kathleen Preston: In passing the bill, Parliament will have agreed to the provision in section 7(4)—the bill itself would be the expression of Parliament’s consent to allowing that to happen. My view would be, therefore, that it would be both competent and legal to do that. Section 7(4) provides for the roll-out order to modify any statute, including the act itself. If Parliament passes the bill, Parliament will have agreed to that provision. That would be the legal power that would have been granted.

Nicola Sturgeon: The important point of principle is that nothing can happen beyond the pilots that would not require further parliamentary procedure—nothing in the bill will allow anything to happen without the agreement of Parliament. If the Government wanted to change sections 1 to 3, which deal with the composition of health boards, the change would be through an instrument under the affirmative procedure. Parliament is in the driving seat every step of the way.

11:00

Ross Finnie: The point is an important one. I will pursue it if I may, convener.

The Convener: You may.

Ross Finnie: I wholly accept what you say on the matter, cabinet secretary. That leads me to accept the proposition that the Parliament is wholly in control. However, the matter goes further than the points that the Subordinate Legislation Committee has brought to our attention. We are talking about a new principle that will see the Parliament both pass the principles of the bill that are enunciated in the short title and take unto itself powers under which it can completely change those principles. That is new parliamentary procedure that—

Nicola Sturgeon: I am doing what—

The Convener: One at a time, please.

Ross Finnie: The Parliament is being given the power to override the principles of the bill.
Nicola Sturgeon: The constraint on the Parliament remains, which is the short title of the bill. The Parliament cannot change the bill from being a health board elections bill into something else. That constraint applies to any amendment to any bill. The constraint keeps the Parliament within the general parameters of the bill.

Ross Finnie: I am grateful to you for putting that on the record, cabinet secretary. With respect, in response to an earlier question, you gave the impression that Parliament could use section 7(4) to effect fundamental change. What you have just said confirms that section 7(4) applies only if amendments stay within the parameters of the principles and short title of the bill.

The Convener: Am I therefore correct in understanding that, given that the short title says “to provide for the election of certain members of Health Boards”, the number of members that are put in place can be varied?

Nicola Sturgeon: If the Parliament agrees.

The Convener: We understand that Parliament must agree, but does it have to be kept within the terms of the short title?

Nicola Sturgeon: Yes. If Parliament agrees—

The Convener: The clerk has just pointed out that I quoted from the long title. That shows how long I, too, have been out of practice.

I will now bring in Helen Eadie, who has waited patiently to put her questions.

Helen Eadie (Dunfermline East) (Lab): Cabinet secretary, you said earlier that nothing would go forward under the bill that did not have recourse to the Parliament. That is not true. In its report, the Subordinate Legislation Committee said:

“This revocation order would be subject to no Parliamentary procedure.”

Nicola Sturgeon: I indicated that earlier.

Helen Eadie: As Ross Finnie rightly pointed out, we are concerned that the Subordinate Legislation Committee has said:

“This power is considered to be novel and unusual.”

The Subordinate Legislation Committee felt very strongly on the matter. We are talking about a measure that does not just tidy up the statute book—which was the evidence that the Subordinate Legislation Committee heard—but is something much more fundamental in nature. Can you assure the committee that you plan to lodge an amendment to address the issue? We seek to have that on the record.

Nicola Sturgeon: I think that the Official Report of the meeting will show that I deliberately highlighted the Subordinate Legislation Committee’s comment in an earlier response. I also said that we are reflecting further on the matter. I am not going to give the committee an absolute assurance today that we will lodge an amendment; I can say only that we are considering the matter. If it is helpful to the committee, I am happy to provide a further communication before you conclude your report.

Helen Eadie: Yes. No matter what Administration is in power, the Parliament as a whole will be concerned that legislation can simply be abandoned on the basis of a revocation order. As Ross Finnie and the Subordinate Legislation Committee have said, the situation is unique.

I turn to an issue of concern to some of the witnesses from whom we took evidence: the power to remove elected members. Section 1(6) amends the National Health Service (Scotland) Act 1978 to provide for “appointed members and councillor members (including provision specifying circumstances in which the Scottish Ministers may determine that such a member is to vacate office).”

The Subordinate Legislation Committee said:

“the decision to allow Ministerial discretion to require early vacation from office in yet-to-be-prescribed circumstances applying to publicly elected members is a significant issue, which has the potential to be controversial”.

As you will appreciate, people right across Scotland may or may not share the enthusiasm for direct elections to health boards. However, those who are enthusiastic will be angry that you could prescribe any circumstances under which ministers may determine that board members should vacate office early. I strongly agree with Unison and the other witnesses who said clearly that they did not feel that that provision was appropriate. In the Government response, you said that the test of whatever is in the best interests of the national health service will be applied for all types of member but, as drafted, the bill will allow future regulations to change the criteria. That will allow virtually anything to happen. A cabinet secretary—not you, but any cabinet secretary—might simply not like the colour of the politics of an individual, and a spurious reason could be thought up to remove them from a board. Can you justify that power?

Nicola Sturgeon: I can, although I do not for a minute diminish the importance of the issue that Helen Eadie referred to. It must be seen in the context of both the practical debate and the philosophical debate, which Ross Finnie characteristically sparked off in the previous meeting, on the difference between accountability
and representation. We have taken great care in the bill to maintain the lines of accountability and the current situation that, regardless of how health board members end up on a board, the same corporate governance and accountability arrangements and responsibilities apply to all of them.

The provision exists for a minister to remove any member of a health board. There may be a case that I have been unable to uncover but, to the best of my knowledge, that power has never been used. I find it difficult to believe that it would be used with directly elected members—in fact, it would probably be even less likely to be used—but we have to take a policy judgment. If we believe that health boards should retain the line of accountability and that all board members, regardless of how they end up on a board, should be treated equally, it is an important provision.

Helen Eadie: You mentioned accountability and representation. What weight will ministers give to each factor? I would have thought that representation is an important aspect of the bill. We are looking at having a minimum of 50 per cent of each board made up of elected members and councillors, so the question is of some concern. What weight would you give to representation versus accountability to ministers?

Nicola Sturgeon: We are not talking about an academic scenario. Right now, I have—and any successor in my job will have—the power to remove any member of a health board. I have certainly never used it, and I have not been able to unearth any occasion on which my predecessors have used it. However, the power exists to protect the NHS from a board member acting in a way that undermines the working of the health board to an extent that the delivery of services is disrupted. It is an in extremis power just now, and it would remain so in future.

Helen Eadie: There is another concern. Under the bill as drafted, future regulations could set out different criteria for different types of member. What do you say about that?

Nicola Sturgeon: Could you repeat that? I am not sure that I follow the question.

Helen Eadie: The point is that, "as the Bill is drafted, future Regulations could set out different criteria for different types of member".

The Convener: Could you tell us where you are reading that from, Helen?

Helen Eadie: From page 3 of the Subordinate Legislation Committee report. Paragraph 16(a) says:

"the evidence from the Scottish Government officials indicated an intention to apply the same criteria in relation to elected members, as may be applied to appointed and councillor members. However, as the Bill is drafted, future Regulations could set out different criteria for different types of member".

Nicola Sturgeon: That is the current position. The regulations as drafted—and they are draft regulations that we have made available to the committee—simply reflect the criteria that already exist in other legislation.

The Subordinate Legislation Committee is pointing to a theoretical possibility, but regulations that are produced by any future Government will have to be scrutinised and passed by Parliament. However, let me make clear that I have no policy intention of prescribing different criteria for different groups of members. All members of health boards should have the same responsibilities and accountabilities.

Helen Eadie: The Subordinate Legislation Committee raised another concern, with which I agree. The committee noted "that the scope and extent of these delegated powers in the Bill is wider than permitting removal of members where that is in the interests of the national health service. It permits a very wide discretion to put in future regulations any circumstances".

Would you be minded to narrow that scope?

Nicola Sturgeon: In the spirit of being open to all ideas, I will be quite happy to consider that. However, I stress that the power exists at present but has never, as far as I know, been used. Although it is important to discuss the issue, we should not lose perspective on what has happened in the past.

Helen Eadie: I think that you will agree that the issue could be very controversial. It is virtually unheard of for an elected member of any organisation—to be removed from office. However, it can happen.

Nicola Sturgeon: In a sense—oh, I am sorry. I am getting into trouble with the convener.

The Convener: I just wanted to make a point to Helen Eadie. If you intend to refer to the Subordinate Legislation Committee report, would you tell us which page you are on? You are very familiar with the report, but we are not so familiar with it.

Helen Eadie: Yes, of course.

Nicola Sturgeon: If Helen Eadie played back in her head the question that she asked me, she herself would provide the reassurance that she is asking me for. It would be very controversial for any health minister, now or in future, to remove a member from a health board. It would put the minister under great scrutiny, requiring him or her to justify the decision. That in itself would operate as a discipline in the exercising of the power—it
might be one reason why the power has never been used.

**The Convener:** But I think that Helen Eadie is making the point that trying to remove somebody who has been elected would be very different from trying to remove somebody who had been appointed.

**Helen Eadie:** That is right.

**Nicola Sturgeon:** But that underlines my point; it would make the removal even more controversial. Any health minister who chose to exercise the power would have to have the most compelling of reasons, to withstand the scrutiny that he or she would come under.

**Helen Eadie:** I accept that, but I think that you can see how controversy could arise. I am not the only one who has highlighted the point.

In conclusion, and at the risk of getting my throat cut by all my other colleagues, I would offer Fife for one of your pilots. It is coterminous with local government and police authority boundaries, so it would be a wonderful example.

**Nicola Sturgeon:** You will have to pass the bill first.

**The Convener:** Yes, Ms Eadie—that is you tied into supporting the principles of the bill. I would like to go to the next Labour group meeting to hear what is said.

I would like to raise a point in case it is not raised by others. Nobody has referred to Inclusion Scotland’s evidence to the committee, and it has struck me that many people who use the health service are people with disabilities of all kinds or with long-term conditions. However, we have been told that only 6.2 per cent of applicants to public bodies described themselves as disabled. Only 2 per cent of those appointed were disabled.

Two issues arise from that evidence and from supplementary evidence. I am not always in favour of positive discrimination, but is there some way in which the balance can be redressed? If we are talking about democratisation, boards should contain more people with such conditions.

Secondly, what about the impact on benefits? We have received supplementary evidence, which should be in the public domain, on benefits as a barrier to public appointment. Could people’s benefit payments be affected? If so, it might prevent people from offering themselves in the first place.

**Nicola Sturgeon:** I have read Inclusion Scotland’s evidence, which is compellingly in favour of direct elections. The convener alluded to the fact that the bill does not propose any element of positive discrimination, and we do not propose to include any such element. It could be strongly argued that the single transferable vote system helps to promote the broader representation of different groups in society. An equality and diversity element would be built into the evaluation of the pilots, so we would, at that stage, be able to assess whether the process of direct elections had led to the creation of boards that were more representative of a range of different interests than they had been previously.

Your point about benefits is valid. That is one of many areas in which devolved and reserved responsibilities run into each other—we do not have responsibility for or power over benefits. I am more than happy to examine the matter in detail and come back to the committee with more considered views.

11:15

**Dr Simpson:** My question is on the reduced age of voting. In principle, I do not have a problem with it, but we heard in evidence that problems might arise from the verification of 16 and 17-year-olds’ entitlement to vote and from placing their names on any sort of register when they are still below the age of 16. For example, there could be issues with regard to the publication of children’s names. Have you had any further thoughts on that? I think that the Subordinate Legislation Committee refers to it on page 6 of its report.

**Nicola Sturgeon:** I will ask Kenneth Hogg to say something about that in a moment.

As I said in my opening statement, and as I think Dr Simpson agreed, it is right in principle to include 16 and 17-year-olds in the franchise for health board elections. We made some changes to the financial memorandum in relation to that issue—we originally thought that it would require expensive software changes in different areas but, following discussions, we have concluded that it can be done more informally. Health boards, rather than electoral registration authorities, can maintain young persons registers with the names of the 16 and 17-year-olds who are already appearing on the electoral register as attainers.

Kenneth Hogg will say some more about how those discussions have progressed.

**Kenneth Hogg (Scottish Government Health Delivery Directorate):** We have moved towards a much simpler administrative system, which involves building on existing practice and the systems that are run by local authorities, rather than trying to tag the 16 and 17-year-olds on to the wider process that is used for general elections. That should build in security as, from the discussions that we have had, it appears to be a much more secure and stable process for achieving our goal.
**Dr Simpson:** Just to be clear, are you suggesting that all local authorities have a register of all 16 and 17-year-olds in some form?

**Kenneth Hogg:** Yes.

**Nicola Sturgeon:** We are all familiar with the electoral registers. As the member will know, people appear on the electoral register with their date of birth beside their name.

**Dr Simpson:** I accept that, but we heard from the Association of Electoral Administrators that 15-year-olds could appear on the register with their date of birth. At the moment, 16 and 17-year-olds are on the list in preparation for voting at 18—we could have 14 and 15-year-olds on the register who will vote at 16. Are you saying that there is a register of 14-year-olds from which that can be drawn? Is there a simple method?

**Nicola Sturgeon:** Rather than creating a register for 14 and 15-year-olds, as you suggest might happen, we will draw on the existing information that local authorities and electoral registration authorities have for 16 and 17-year-olds. It is much simpler than we originally envisaged.

**Dr Simpson:** I am still slightly lost. Are you saying that the Association of Electoral Administrators is wrong and that there is no question of publishing—and you will not need to do so—the name of any 15-year-old with their date of birth, in a similar way to the way in which we publish the names of 16 and 17-year-olds with their dates of birth at present?

**The Convener:** Robert Kirkwood gets to speak at last.

**Dr Simpson:** That was the purpose of my question.

**Robert Kirkwood (Scottish Government Health Delivery Directorate):** We have discussed a simple approach with electoral registration officers: we will have a young persons register within the pilot area, but it will be up to the individual electoral registration officer to decide on the best way to keep that. The young persons register, which will contain 15-year-old attainers in the pilot areas, will not be made public. However, the names of the people on that register who will be 16 on the date of the election can be combined with those on the local government register.

**Dr Simpson:** I am sorry to pursue the matter, but if we have direct elections and a group wants to elect a particular candidate and therefore wants to circulate election material, it will be precluded from forwarding that material to anyone whose age is not beyond 16, because it will not have access to them. At the moment, we can send stuff out to 16 and 17-year-olds to encourage them to vote when they get to 18.

**Nicola Sturgeon:** The answer to your question is yes. We have discussed the arrangement with the electoral registration officers, as Robert Kirkwood said, and they will maintain the register that includes 15-year-old attainers, but that will not necessarily be public. Therefore, the answer to your question is yes.

**The Convener:** That concludes today's evidence session, nearly on time. I thank the witnesses for their evidence, including those who had to wait a long time to say a few good words.
I would like to submit the following responses to the above call for evidence. There follows a response from Aberdeen City Council and a response from the Depute Returning Officer.

**Aberdeen City Council Response**

Aberdeen City Council wish to reiterate the response that was provided to the Scottish Government consultation in March. That was as follows:

"It is the view of Aberdeen City Council that adding more local authority councillors to NHS Boards would be a better solution than to introduce direct elections to NHS Boards. Additional councillors should be nominated by the local authority.

When the Local Healthcare Bill Consultation Document was discussed at the Policy and Strategy Committee on 4th March, the Committee wished to make the additional following point concerning the membership and operation of NHS Boards. The distinction between executive and non-executive members on NHS Boards should be removed and there should be a return to the situation where NHS Boards had a membership which was separate from officials. Officials of the health service who are currently the executive members, such as the Director of Finance, the Nurse Director and Medical Director, should not be board members. Those who are currently the non-executive members of NHS Boards, should be responsible for the overall running of the NHS Board and make the policy decisions that are then implemented by the officials of the health service. In this way, you have a similar situation to how local government is run, with elected members having overall responsibility for the running of the Council and appointed officials implementing those decisions."

**Depute Returning Officer Response**

It is essential that those given responsibility for administering health board elections be reimbursed the full cost of the elections.

Returning Officers should not be asked to take on an additional responsibility without adequate resource being provided for the purpose. In addition other aspects of direct elections to NHS Boards, such as their timing, should not compromise the ability to deliver existing statutory elections.

The Bill proposes to lower the voting age to 16. This will present difficulties as there currently does not exist an electoral register based on a voting age of 16. Careful consideration would need to be given to this issue with time and resources being made available to the ERO to produce such a register.

It has been proposed that each NHS Board area be designated as a single ward. It is worth considering that where health board and current electoral boundaries are not the same, this means the formulation of new electoral boundaries. Therefore, administration of the election becomes a more complicated exercise.

Roderick Macbeth,
Depute Returning Officer,
Aberdeen City Council

**ALLIED HEALTH PROFESSIONALS FORUM SCOTLAND**

**Introduction**

The Allied Health Professionals Forum Scotland (AHPFS) are happy to have the opportunity to respond to this call for written evidence to the Health and Sport Committee. Whilst acknowledging that the main purpose of the Bill is to introduce elections for Health Boards, we note that the call for evidence states:-
The Committee is also interested in hearing views on following points, regardless of whether or not you support the principle of direct election—

- the composition of health boards as set out in the Bill;

This submission will therefore reiterate the organizations’ original response to the consultation in calling for AHP representation as an “appointed Member” on the newly set up boards.

**AHP Directors on Health Boards**

It would be a major missed opportunity if the Bill addressed the important issues of greater patient and public involvement in Health Boards whilst at the same time neglected to remedy a situation which sees AHPs without the representation on Boards enjoyed by their professional colleagues in nursing and medicine.

AHPs are a grouping of nine very disparate professions whose caseload makes up one in six of the Scottish population. Numbers on Health Boards should be increased by one to give better representation of the nine professions treating one in six Scots, therefore also better reflecting the needs of those patients.

The rationale for having guaranteed AHP representation on Health Boards is particularly cogent in the climate of a Health Service which is moving away from Hospital based/acute services focus and instead placing more emphasis on the community based primary care services that are exemplified by many of the AHPs, for instance, podiatry where treatment is provided, not only in local clinics, but to patients in their own homes, if required.

While the AHP professional bodies and the Scottish Government have responded to challenges over the years, the broad structure of Health Boards has not altered accordingly. The creation of a Chief Health Professions Officer in Government, amended draft legislation to include AHPs on Community Health Partnerships committees, discrete AHP units and staff within the new Special Health Boards all demonstrate the move to a more inclusive NHS in Scotland. It is now time that Health Boards reflected such changes with the inclusion of AHPs at Board level and at the relevant strategic levels in NHS Scotland.

The establishment of a statutory requirement for the inclusion of an AHP Director on all NHS Boards would:

- Ensure AHP potential to improve Scotland’s health is effectively utilised to the optimum benefit of patients.
- Challenge and refresh the traditional models that have historically shaped, driven and produced Scotland’s health profile and improvement agenda to date.
- Represent a concrete example of the aim of delivering a ‘health service of all the talents’
- Support the mapping of AHP integration in service delivery in order to identify sources of lost opportunity and maximise public investment by working smarter
- Ensure integration of AHP (evidence based) added value in assessment of variation in practice across Scotland

**Implementation**

The inclusion of an AHP director in the appointed members of Health boards would be very easy to achieve. The AHP director would be one of the “appointed members” as stated below.

“1 Constitution of Health Boards

(1) Schedule 1 (Health Boards) to the National Health Service (Scotland) Act 1978 (c.29)
(the “1978 Act”) is amended as follows.

(2) For paragraph 2 substitute—

“2 (1) A Health Board is to consist of the following types of members—

(a) a chairman, and other members, appointed by the Scottish Ministers

(“appointed members”),”

This section of the Bill is subject to delegated powers of Scottish Ministers by Statutory Instrument. No amendment is necessary to the face of the bill.

Conclusion

We are asking the Health & Sport Committee to support the inclusion of an AHP Director on Health Boards. This would be of immense benefit to the ongoing efforts of AHPFS and individual AHP Professional Bodies in securing a level playing field of representation by all health professions, Doctors, Nurses and AHPs at a strategic level on Health Boards.

Karen Utting,
Scottish Policy Officer,
The Society Of Chiropodists and Podiatrists
On Behalf of Allied Health Professionals Forum Scotland

ANGUS COUNCIL

Angus Council does not support the principle of direct election to Health Boards. The Council would suggest that Local Health Boards should be constituted as joint boards with a composition which consists of local councillors whose number would reflect the political balance within each of the constituent councils. In addition, lay/stakeholder members would be appointed by the Scottish Government. This would help achieve the aim of increasing public involvement in the NHS.

Angus Council does support the aim of better engaging and involving local communities, however we do not agree that directly electing individuals to Health Boards necessarily is the solution to better engagement and involvement. A statutory duty to encourage public involvement is already in place and we would suggest that NHS Boards should be challenged to find out what the barriers to effective public consultation may be and produce actions plans to address the findings in their own local area.

One of the risks of having directly elected members on NHS Boards would be that you do not achieve equitable representation across groups. Lay members representing patients or other groups may bring their own agenda to the table and unless clear guidance on their role and remit is given and reinforced regularly they may not be effective members of the Board.

We are of the view that public engagement and involvement in the NHS could be enhanced if the profile of the Scottish Health Council was heightened. Also more publicity is required about the role and remit of Public Partnership Forums (PPFs). They should be encouraged to find ways of engaging the public using open and effective methods which best suit the needs of each local community.

Establishing a joint board would enhance the commitment to a community planning partnership (CPP) approach and support the Single Outcome Agreement agenda. NHS Boards are key members of the CPPs and their accountability to Ministers should (as with local authorities) be through the Single Outcome Agreements.

Community Planning Partnerships will currently vary in their impact on local communities however they can and should ensure that public engagement is a focus of their community plans and report on the effectiveness of this for all activity and not just NHS planning.
In our response to the Local Healthcare Bill consultation paper Angus Council noted that local councillors should form a majority of members on NHS Boards. We would continue to push this view. We are also of the view that NHS Board executive officers should not be appointed as Board members. Rather we see their role as providing advice to the Board.

Having noted our position above, that is, not supporting the principle of direct election to NHS Board, we note the proposals with regard to the franchise, voting system, designation of each health board area as a single ward, and arrangements for piloting direct elections.

Angus Council is extremely concerned about the estimated costs of both the piloting of elections and of the full elections. It is proposed that the total cost of pilots i.e. £2.86 million, and the roll out of elections i.e. £13.05 million will be met from existing budgets. Angus Council would rather see these resources being directed at front line service provision.

Angus Council

ARGYLL AND BUTE COUNCIL

Argyll and Bute Council has carefully considered the Consultation Paper on a possible Local Healthcare Bill and has responded to the Scottish Government in March 2008 on the proposals. This letter conveys the Council’s views on the Bill.

Patient focus and public involvement should be the core drivers of decision making in the NHS.

Section 1 – Making Things Better

Public Partnership Forums have been developed as vehicles for more proactive public and patient involvement in the work of CHPs and Health Boards. The development of CHP level and locality level PPFs should focus on developing the degree of input on local and strategic health matters.

The decision making processes are more obscure at higher levels and this is an area that requires to be opened up so that it is more democratically accountable. More than 50% of the seats on a Health Board should be held by Councillors appointed to the Board by the Councils within the Health Board area. The Chair of the Board should be appointed by the Board from amongst those Councillors. All other Board Members should be non-executive Board Members appointed by Scottish Ministers representative of the patient and broader community within the health board area.

This has the potential to add a number of dimensions to the work of Health Boards: in terms of accountability, democratic involvement, community engagement, closer development with Community Planning Partnerships.

Section 2 – A New Approach

The Council supports the democratisation of NHS Boards to bring greater accountability and control of NHS Boards, but does not support a process of electing directly members of health boards. The Council is concerned that the consultation on the question of direct elections is based on muddled thinking. The premise is that democratisation of the NHS is to take place against a back drop that Boards are to be accountable to Ministers and Parliament. Of course all public authorities are ultimately accountable to Parliament but the members of authorities who are elected are accountable to their electors. That is the essence of democracy. In the Council’s view:

a NHS Boards can best be opened up to greater accountability through increasing the number of elected Councillors on NHS Boards rather than through direct elections.

b Directly elected Members of Boards could not be accountable at the same time to Ministers and their electorate, if they are appointed by the latter.

c Directly elected Members of Boards could not be accountable to their electorate for delivering NHS services at levels determined and funded by Ministers.
It is a backward step to have potentially rival democratic processes if elected NHS Board members are not Councillors.

A potentially rival democratic process militates against joined up government for the delivery of health and social care.

In the Council’s view the answer lies in a solution that satisfies the key elements of democratic accountability; public involvement; joined up government and community planning.

The Council accordingly proposes that more than 50% of the seats on a Health Board should be held by Councillors appointed to the Board by the Councils within the Health Board area. The Chair of the Board should be appointed by the Board from amongst those Councillors. All other Board Members should be non-executive Board Members appointed by Scottish Ministers representative of the patient and broader community within the health board area.

This arrangement would assist all aspects of ensuring joined up working between the NHS Board and the Councils including through the community planning process. As well as being NHS Board members those Councillors would be the Council’s representatives on the relevant CHP and would take the lead in other health and social care partnerships at that level. No doubt one of them would be the Council’s health and social services spokesperson, and/or the chair of the relevant Council Committee, and be a member of the Council’s Executive, however termed.

The Council believes that accountability and control of NHS Boards can be achieved without embarking on all of the electoral processes, procedures and systems envisaged in the consultation paper.

These processes and procedures will be expensive. It is unsatisfactory to create a democratic public electoral system in which those who are elected are accountable to someone else. The public, who consider there are already too many electoral systems, would consider the money which will be required to run the proposed elections would be better spent on patient care, when there are already elected Councillors who could represent them on NHS Boards.

Nigel Stewart,
Head of Corporate Services,
Argyll and Bute Council

BLACKBURN COMMUNITY COUNCIL

We at Blackburn Community Council would very much welcome the elections of members to the Health Boards making them accountable to the people they serve who also pay their salaries.

The people must be consulted re matters concerning health issues locally & if members of the board were elected they could be held more accountable to the public & not just push through changes against public opinion.

In the past decisions have been made & passed very much against people's wishes, none more so than in Lothian where decisions affecting the people of West Lothian were made to transfer vital services to the Royal Infirmary Edinburgh from St. John's Hospital in Livingston.

This decision was pushed through in spite of public outcry & now all who have been affected know the high price that we have to pay. This is just one instance where Health Boards have made decisions for too long without having to justify their actions to the public. THIS MUST STOP!!!

A pilot scheme should be implemented as soon as possible & must be carefully monitored with the findings being made known to all.

Doreen Richardson,
Secretary Blackburn Community Council
BRITISH DENTAL ASSOCIATION

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

The BDA is pleased to respond to this consultation. Should you require any further information please do not hesitate to contact Andrew Lamb, Director of BDA Scotland on 0178 643 1723.

1) Does the BDA support the principle of direct election to health boards?

The BDA recognises the importance of improving public engagement in the way health services are delivered in Scotland in order to ensure that the needs of local populations are reflected in local service delivery, and that services need to be accountable to the general public. The BDA has concerns about whether direct elections to Health Boards are the best way to improve accountability or to increase the general public's involvement and understanding of Health Boards.

The decision to pilot direct elections first is to be welcomed. Systems must be in place to ensure that direct elections are effectively assessed over the pilot period and the general public must be consulted as to whether they feel direct elections have improved their involvement with Health Boards and Health Boards accountability to the public as part of their evaluation.

To a certain degree the principle of direct elections improves accountability as the public will have selected some of the members of the Board personally. However, the general public would need to be made aware of direct elections, and sufficiently understand the process involved and how they can engage with them. The level of potential engagement in direct elections should be assessed as a means to determine if this is how the public can best be engaged. Careful thought must also be given to who it is envisaged will put themselves forward for elections and the subsequent four year commitment. A clearer understanding is required on what the criteria for candidature will be. Only when these criteria have been seen and reviewed can comment be made about the effectiveness of direct elections in improving accountability.

The BDA feels the people most likely to put themselves forward for elections will be those who already enjoy a degree of engagement with Health Boards and local government such as campaigners in health or those with a vested interest in a particular issue. The BDA is concerned that many of the very people to whom services should be accountable, its users, will not have the confidence, time or ability to serve as an elected official on a Health Board. It has previously been acknowledged that many service users and carers lack the confidence to participate in community issues, whether due to low self esteem or a poor understanding of the systems.

The Scottish Government may need to invest more money and time in training service users in decision-making processes to encourage and facilitate meaningful engagement and build on public confidence to do so. Trained service users can then take their knowledge out into the wider community. Such projects are already in place, including Your Voice, Border Youth Forum and Something to Say.

Alternatives to direct elections, which build on established projects such as those mentioned above would need to be piloted simultaneously with the direct elections so that the public has a chance to engage in a variety of ways and assess which method has delivered the best results for all concerned.

Evidence from other countries which have introduced direct elections to health governing bodies shows that their introduction has failed to improve public engagement and confidence in the decision-making process. In Canada, a report prepared in 2002 for the Commission on the Future of Health Care in Canada concluded that:

"the experience (in Saskatchewan) has demonstrated that health board elections are costly, cumbersome and produce low voter turnout and have failed to foster a more active, engaged citizenry committed to common goals. In light of these experiences, their continued use should be questioned if efficient, effective participation and public commitment are desired goals."
Research into direct elections to district health boards in New Zealand, introduced in 2001, suggested that:

“the electoral component of the DHB (District Health Board) system is failing to make a substantial contribution to the democratisation of health care governance in New Zealand.”

a) What would the practical benefits of having elected members on health boards be?

The practical benefit would be showing a willingness to engage with the public and be accountable to them. For individuals with a particular interest or campaign groups, it may present an opportunity to put their views on one particular issue under the spotlight.

In instances where difficult or unpopular decisions need to be taken, the presence of elected patient representatives may be useful in giving patients a real say in how those decisions are made. However, if appointed members or ministers are able to subsequently overturn the decisions of elected patient representatives, those individuals and those who elected them could feel disenfranchised.

b) Would these benefits outweigh costs arising from running such elections and supporting elected members?

The money used to run direct elections and support those that are directly elected to ensure effective involvement might be better spent building on current projects looking to improve accountability and in training service users to engage effectively with Health Boards in less time consuming and complicated ways.

If user representatives were selected from a variety of backgrounds and were individuals who could take the knowledge and experience gained from their training out into the wider community, they could better help the general population engage with Health Boards. This might offer more cost-effective and long-term engagement than elections to health boards, which limit the number of people able to be involved.

Elected members would have to be given substantial training and support in the processes involved and in a broad range of health issues to effectively engage in decision making processes. There would also need to be a clear line of accountability from the elected member to the public. This risks placing the onus for ensuring the Board is accountable to the public solely on the elected members, when it should be on the whole Health Board.

c) What are the risks of having elected members on health boards?

A member may be elected on the basis of a key single issue affecting the community at the time of election, which may not be an issue in subsequent years. Such members may not have the expertise or motivation to resolve other issues outside of their area of concern. This may have an adverse impact on other services.

Another issue could be lack of interest in being elected to boards, either through no or insufficient numbers of expressions of interest. This scenario would raise the question of whether the engagement process would then end. Would it be considered adequate, for instance, for the Health Board merely to have afforded the opportunity to be elected?

d) Would elected members’ scope for action be affected by health boards continuing accountability to ministers?

Clarity is need on whether elected members are accountable to the public or ministers first. Elected members’ scope for action will only be as great as ministers will allow. Ministers have to be seen to be listening to what elected members are saying and to trust that what they are saying is for the benefit of the community. If the ministers do not trust them then direct election is not the correct way to proceed.

e) Do alternatives to direct election exist as a means to increasing public involvement in the NHS?

The BDA believes that many of the initiatives already introduced by the Scottish Government, such as standards for public consultation to be introduced by the Scottish Health Council (SHC), the establishment of Independent Scrutiny Boards and measures to strengthen and support the Public
Partnerships Forums (PPFs) of Community Health Partnerships (CHPs), have greater potential to successfully engage patients in decision making than direct elections.

For example, each CHP is required to have at least one representative from the PPF on the board to ensure communication between the board of the CHP and the membership of the PPF. PPFs have been viewed positively by stakeholders but few CHPs have a dedicated budget for them. With sufficient resource to operate as originally intended, PPFs have the potential to become a fundamental part of the local decision making process and promote meaningful public engagement in the decision making process.

Confusion around the role of the SHC remains. The Scottish Government should look to address issues raised, such as the call for a more clearly defined and enforceable role in relation to health board activity in public involvement and a higher profile among the public, to better equip the SHC to fulfil its potential to improve the way in which patients, the public and other stakeholders are involved in service design and decision making. Simultaneously, health boards need to better understand the benefits of consultation and honesty about the constraints within which services are provided. The BDA hopes this will be encouraged in the pending standards for public consultation to be developed by the SHC.

2) BDA views on the composition of health boards as set out in the Bill?

The BDA welcomes the amendment to paragraph 2A of schedule 1 to the 1978 Act to ensure that it continues to be a requirement in the case of a prescribed Health Board that at least one of the appointed members must hold a post in a university with a medical or dental school.

3) BDA views on the arrangements for elections as set out in the Bill including the franchise, voting system and designation of each health board area as a single ward?

The BDA would like to see guidance as to who will be considered to be qualified to be a candidate in a Health Board election before any pilots commence. Without such knowledge it is difficult to comment on whether all potential candidates are to be considered or whether certain groups of individuals may be excluded unnecessarily. We are also concerned that individuals from lower socioeconomic groups who are frequent users of health services, may not be able to engage in the process of direct elections, and the accountability gap will continue.

Clarification on the nomination process is required. Can individuals nominate themselves? Do they need to receive a certain numbers of nominations to put themselves forward? What criteria must they meet in order to be nominated? This is especially important in cases where there are not sufficient numbers of nominated candidates as the Bill makes provision for all nominees in these circumstances to automatically be elected, without an election taking place.

4) BDA views on the arrangements for piloting direct election as set out in the Bill?

The BDA notes that an evaluation of the pilots will not have to be made available until five years after the first election is held. The BDA further notes that Scottish Ministers may make a decision at any point during the pilot to roll out direct elections across areas involved in the pilots and that any amendments they wish to introduce can be made at this point. This raises a number of questions that must be addressed. Will the public be consulted on whether they view direct elections to have been a success and whether they wish to see rollout or termination of the scheme take place before any decision is made by Scottish ministers? Also, will provision be made for annual reports into progress to be made available assessing what has and has not worked and piloting recommended changes along the way rather than one final report after five years?

The BDA believes that such changes must be rigorously piloted and tested and the general public involved every step of the way in order to ascertain whether direct elections are the most effective means of improving accountability. If Scottish ministers are able to make modifications to enactments without consulting the public then trust in direct elections may be eroded.
5) BDA views on the practical implications and cost of bringing the Bill’s provisions into force?

The BDA notes that the estimated costs of introducing direct elections has risen from £5 million in the original consultation to £13.05 million in the financial memorandum accompanying the bill. This significant increase in costs still does not take into account the subsequent costs of supporting newly elected board members such as training needs, administrative support or organisational development activity to enhance understanding of their role as an elected member.

Of great concern is that the cost of introducing and supporting direct elections is to be found from existing NHS budgets. NHS dentistry in Scotland is already under-funded. The BDA believes that there should be a three-fold increase in the level of funding for general dental services in Scotland. The BDA would strongly oppose any diversion of resources away from the delivery of patient care to fund the process of electing patient representatives.

Andrew Lamb,
Director,
BDA Scotland

CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND

The Chartered Society of Physiotherapy Scotland welcomes the opportunity to make brief submission to the Health and Sport Committee of the Scottish Parliament on the Health Boards (Membership and Elections) (Scotland) Bill (SP Bill 13).

Along with other Allied Health Professional professional bodies, CSP Scotland would welcome consideration of the wider role, remit and membership of Scotland’s geographic health boards, but recognises that the specific nature of the legislation does not address these issues directly.

CSP Scotland would refer to the wider views laid out in the AHPF Scotland response to the Scottish Government consultation on local health boards, which stated:

Crucial to the future government agenda, as set out in Better Health Better Care, is the continued development of team working among all the staff and stakeholders in the NHS. The role of the allied health professionals must be seen in equal partnership if genuine progress is to be realised.

The establishment of a statutory requirement for the inclusion of an AHP Director on all NHS Boards would provide an equal strategic influence and enable the allied health professions to fulfill their leadership roles. Equitable and properly supported AHP representation on Health Boards would:

Since Devolution the Scottish health system has changed dramatically. The emergence of the AHPs as a distinct group within the NHS has found expression at every level of the NHS, from Community Partnerships to Special Health Boards. Only the geographic Health Boards have remained unchanged. The multidisciplinary team working and networking of the AHPs to cross considerable stratification in professional terms is a testament to the commitment of the allied health professionals to collaboration and modernisation in the NHS.

AHP Forum Scotland Submission to the Scottish Government Local Healthcare Bill Consultation – March 2008

As a forum member CSP Scotland supports the above position, and believes that the proposed legislation presents an opportunity to ensure that the right balance of interests and membership of health Boards is maintained, above and beyond legislation to govern the election of a portion of Health Board members.

CSP Scotland also supports the proposed aims of the legislation in terms of ensuring greater accountability, better engagement with communities, more patient involvement and better decision-making on Health Boards. There appear to be inevitable challenges regarding the election of members to health boards to achieve these ends. However, these are not areas where the Society would make specific comment as they concern those interests that are better represented by patient groups, political representatives and the communities themselves.
The following comments are submitted by CIPFA in response to the Committee’s call for evidence on the above Bill. These comments have been framed around the core headings which will form the basis for the Committee’s future consideration.

What the practical benefits of having elected members on health boards would be?

In CIPFA’s response to the Scottish Government’s consultation we concluded that the case to demonstrate how direct elections would result in improved governance and increased engagement in particular had not in fact been made. The Bill contains no specific requirement to seek out patient views, or to specifically consider them in making service planning decisions. Clarification is needed on whether the detailed role of an elected member will be included subsequent regulations.

The intended key practical benefit, understood to be engagement with stakeholders, may not be achieved solely by the introduction of direct elections. Consideration therefore requires to be given to alternative methods of achieving this goal.

Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

We have also briefly examined the financial memorandum and note that the projected cost of elections is £13M as applied to all Health Boards. The financial memorandum however contained basic calculations only which were based wholly on the estimated pilot cost for two pilot areas. The basis of the estimated costs for the pilot schemes was a per capita figure extrapolated over a projected electorate turnout. Again the calculation was basic in nature.

Notably, the estimate has increased from a stated figure of £5M in the initial Local Healthcare Bill Consultation. There is risk, given the limited lead-in time, that the actual expenditure could be in excess of the latest figure.

We note the stated intention that the cost will be ‘met from existing budgets’. There is however no further indication of the meaning of this statement. The Committee may wish to consider whether it is intended that increased efficiencies will form the funding basis or if there will be budget reductions faced by Health Boards in future.

What the risks are of having elected members on health boards

The Bill’s requirement for appointed members to be outnumbered by the elected and councillor members will modify the mix of skills, viewpoints, abilities, knowledge and experience on the board. The risk is that with less scope to appoint members with a specific experience and skills set, it may become difficult in practice to ensure the optimum skill mix on the board. As a result there should be a specific requirement in the Bill for board members to participate in a ‘governance skills’ assessment and development scheme.

Without this, there is the possibility that could place the board at risk in terms of its capacity to provide good governance, including effective public engagement. Training would naturally be expected to cover the need to consider service user requirements and to engage stakeholders.

The proposed remuneration for elected health board members does not compare favourably with the level of remuneration for elected local authority members. While financial reward may not be the reason why members seek election, a less than market rate may not attract the desired level of candidate.
Whether alternatives to direct election exist as a means to increasing public involvement in the NHS

The Good Governance Standard contains a specific core principle which addresses the engagement of stakeholders. Implementation and maintenance of the Good Governance Standard for the Public Services should result in improved governance. CIPFA considers that public engagement can in fact be improved independently of the implementation of direct elections.

The practical implications and cost of bringing the Bill’s provisions into force

We note that the Bill places reliance upon future regulation to enact the proposed primary powers contained in the Bill. This is comparable to The Local Government in Scotland Act 2003 which was reliant upon later regulation and/or statutory guidance. The passage of the Bill at the time gave no indication of any timescale when regulations would be brought forward. Elected MSP’s, passing the primary legislation at the time may have reasonably expected that all aspects of the Act would be enacted promptly. Section 40 of the Act addressed proposed changes to investment by local authorities. Some five years after introduction of the Act, this Section has not yet been enacted. The Committee may wish to ensure that the proposed timescale for future enactment is clearly set out.

The proposal for single ward representation can now be contrasted with local authorities where the most recent development has been the introduction of multi-member wards. The practicality of an elected health member representing a wider boundary than local government colleagues will require to be tested.

Finally, please note that the Head of CIPFA Scotland, Mrs Angela Scott has recently been appointed in a personal capacity as a non-executive board member of NHS Tayside. Mrs Scott contributed to this submission in her role as Head of CIPFA in Scotland.

Don Peebles,
Policy & Technical Manager,
CIPFA Scotland

THE CITY OF EDINBURGH COUNCIL

1. General Principles of the Bill

1.1 The principle of direct election to health boards:

1.1.1 The Council understands the need for improved transparency, accountability and scrutiny in public decision making and welcomes the position of the Scottish Government to encourage greater public and patient involvement in the planning and delivery of local NHS services in Scotland.

1.2 The practical benefits and costs of elected members on health boards:

1.2.1 The Council recognises that local democracy is a vital element of scrutiny of public services. The benefits of direct election in improved transparency, scrutiny and accountability are balanced by the costs of running elections and supporting elected members. However, the Council remains doubtful as to the public wish for the expense and complication of further elections. The Council suggests further research is undertaken to assess the public attitude.

1.3 The risks of having elected members on health boards

1.3.1 If elections are implemented, the ability of candidates to undertake the role of board members should be addressed through appropriately defined eligibility criteria and an effective code of conduct for all NHS Board members.

1.3.2 If communities support and elect groups or individuals who have a ‘manifesto’ relating to the Board’s work this should be seen as a strength rather than a threat. Any perceived risk of single issue candidates is reduced by ensuring constituencies are of significant size (i.e. local authority or
health board wide constituencies rather than a more local level), as candidates would need to promote the overall interest of the area rather than a single issue focus.

1.3.3 The Council is concerned about the impact on the democratic process if paragraph 10a is included in the Bill, and takes the view that Scottish Ministers should not have a role in removing elected members. Elected members should only be able to be removed from office if they are found to be in substantial breach of recognised codes of conduct, or other regulations, and on the recommendation of the Standards Commission. It is essential to develop a clear code of conduct for this procedure.

1.3.4 The Council would like to see democratic procedures followed to fill vacancies, and would favour the use of by-elections as an approach consistent with other STV elections in Scotland. The Gould report on the elections held in 2007 highlighted the diversity of election arrangements within Scotland and the potential this had for voter confusion. This would be increased by proposals to allow a candidate to be invited to fill a vacancy, whether based on the previous STV count process or a new process whereby Scottish Ministers select a candidate. An unelected candidate might not meet the criteria for election and might lack a clear base of support from electors.

1.4 The effect on elected members’ scope for action as a result of health boards’ continuing accountability to ministers

1.4.1 There is no problem in principle with accountability to Scottish Government for decisions at local level, which also applies in local government roles. It is important to have a statutory reference for the role of Council elected members in relation to the form of accountability required of Health Boards to Ministers. This must include recognition of the need to represent constituency and Council views as well as fulfilling Board Member duties.

1.5 Alternative approaches to direct election exist as a means to increasing public involvement in the NHS

1.5.1 It is proposed that enhancing and strengthening current arrangements would be a more cost-effective approach to the accountability and control of NHS Boards. The Council remains of the opinion that greater engagement with the public and more open decision making processes within NHS Boards improvements could be offered by improvements in the remits of:

• Scottish Health Council

• Public Partnership Forums (PPF)

• Community planning structures

• Effective engagement mechanisms in NHS Boards

• Council elected members on Health Boards and Health Partnerships

2. Process of Elections

2.1 The composition of health boards as set out in the Bill

2.1.1 The position that elected members must amount to more than half of the total number of health Board members is welcomed by the Council, which takes the view that it would be inequitable that the elected representatives were accountable while being a minority in the decision making process.

2.1.2 The Council acknowledges that representation of local authority councillors on health boards is to be set out on a statutory basis and would welcome clarity on the intended role of local authority elected members. In the Council’s view it will be unnecessary for local authorities to continue to appoint members to Boards as a means of accountability to the electorate, but Stakeholder involvement would still be appropriate.
2.2 The arrangements for elections

2.2.1 The extension of the franchise to include 16 and 17 years olds is an issue for the compilation of an appropriate electoral register. Additional planning time will be required to ensure to an effective and useable register is created.

2.2.2 This Council’s preference would be a proportional representation voting system. The system chosen must be intelligible to the voter. Given that four different electoral systems are already used by Scottish electors, it would be helpful for electors if one of these were employed.

2.2.3 At present, it remains the Council’s position that there are not enough safeguards in place to undertake a 100% postal election. The Council suggests that there should be consistency in the methods used for all elections conducted by Returning Officers to ensure that the levels of security in voting methods do not differ across different types of elections. The Council strongly supports the position of the Electoral Commission that ‘the administration of any such elections should be to a comparable standard as those of other statutory elections in Scotland’.

2.2.4 Personal identifiers, consisting of the elector’s signature and date of birth, are currently being collected by Electoral Registration Officers in Scotland. Absent voters must provide these identifiers again on the postal voting statement that accompanies their ballot paper so that the Returning Officer can verify their identity. If health board elections were conducted as statutory elections without the need for the postal voting statement including absent voting identifiers, this would provide less security than at other elections held on a statutory basis on a Scotland-wide scale.

2.2.5 The Council suggest that when planning and undertaking health board elections the recommendations of the Gould Report and views of the Electoral Commission are taken into consideration, especially if the elections are likely to fall within the same period as other Parliamentary or local government elections. The Council would reiterate the Gould recommendation that the introduction of electronic voting for the 2011 elections is suspended, until the electronic counting problems from the 2007 elections are resolved. The timescale of this recommendation falls within the timescale proposed for the ‘pilot’ elections to health boards.

2.2.6 In order to facilitate electronic counting for future elections, the Gould Report recommends that the proposed review of existing legislation and political involvement must ensure that the technology is properly integrated into the electoral process. In addition to this, the Council also supports the position that there should be no automatic rejection of doubtful ballot papers.

2.2.7 The Council would query the £200k budget allocated for public information and advice for the ‘pilot’ elections. This is a modest budget for the introduction of a new electoral process.

2.4 The arrangements for piloting direct election as set out in the Bill

2.4.1 The Council believes that ‘pilot’ elections would allow the interest and demand from residents to be assessed and welcomes the proposed evaluation of the level of public participation in health board elections and whether having elected members has increased engagement with patients and the public.

2.4.2 The Council would also suggest the ‘pilot elections’ are used to assess the implementation of the newly introduced ‘personal identifiers’ required to ensure the integrity of postal elections.

2.5 The practical implications and cost of bringing the Bill into force

2.5.1 The Council acknowledges the statement in paragraph 68 of the Health Board (Membership and Elections) Bill Financial Memorandum that ‘there are no costs falling to local authorities’. However, it is important to recognise that resources to support direct elections to NHS Boards are a fundamental issue in the effectiveness of a reform of this kind. The Council stresses that additional new resources must be found to cover these costs by Government and be seen to be in addition to the funding provided for NHS services.
2.5.2 The Council seeks clarification on the method of financing the roll out of direct elections to health boards. The Health Board (Membership and Elections) Bill Financial Memorandum states: ‘The intention is that the costs will be met from existing budgets’ (paragraph 66). Could the Scottish Government indicate from which organisation’s budget the cost of direct health board elections will be met, the Scottish Government or health boards?

2.5.3 The Council would also like to reiterate that if NHS elections are to be organised by current Returning Officers, then councils must be fully reimbursed for all costs involved. This would include the expenses that can be reimbursed through Returning Officers’ Fees and Charges and also the recognised ‘hidden’ subsidies such as accommodation costs, IT equipment and core staff time.

2.5.4 Both financial and non-financial resources are necessary to successfully conduct elections to any organisation. Whatever funding mechanism might be agreed upon, the Council would wish to see sufficient finance, staffing and resources made available to support a well-run election.

3. Other Issues

3.1 The Council supports the Electoral Commission’s reservations on using an ‘all-postal’ ballot for elections to health boards.

3.2 The Council is also of the view that in drafting and implementing the Health Board (Membership and Elections) Bill further advice should be sought from the appropriate professional associations: SOLACE (Scotland); SOLAR (the Society of Lawyers and Administrators in Local Government); AEA (The Association of Electoral Administrators); and SAA (the Scottish Assessors Association).

Jim Inch
Director of Corporate Services
City of Edinburgh Council

PROFESSOR COLIN REID

The following comments on the above Bill are submitted in a wholly personal capacity and do not represent the views of any institution or organization. They are very much along the same lines as the comments I submitted to the Scottish Government in response to its consultation paper on this topic earlier in the year. These views are informed by my general studies of public participation and governance but are not based on any direct experience of health boards nor on any direct empirical evidence.

Principle:

Although I support the goal of health boards being more responsive to their local communities, I do not believe that having directly elected members is the appropriate way to achieve this. My concerns cover several points which may be seen as taking a pessimistic view of the state of our democratic culture, but are, I fear, realistic. At the root of my concerns is my view that the elected members will not be representative and that the views of the public can be obtained in other ways that are simpler, better and cheaper. The very fact that so many issues in relation to electorate, wards, voting method and system, candidates, publicity, by-elections, expenses and more have to be resolved shows that this is a cumbersome way of achieving the goal and that concentrating on getting an electoral system that works will be a distraction from the underlying objective of more responsive decision-making.

Candidates:

The people who put themselves forward are likely to come from the usual sectors who engage with public bodies – predominantly middle-aged or elderly and middle-class with the education and experience that makes them confident in dealing with professionals and with the capacity to take time away from their usual roles. There are unlikely to be candidates from the young, the disadvantaged, the elderly poor, the young mothers, the chronically ill, those in rural areas a
distance from the health facilities, recent immigrants, etc. It is these disadvantaged groups who are most heavily reliant on the public health services and whose views it is most important to obtain, but who are least likely to put themselves forward. Whereas some “ordinary” people may be put off by the prospect of going through the current appointing process and not come forward fearing that they have no chance of success, others will be deterred by the prospect of facing an election, with the risk of very public failure. The process will attract a different sort of candidate, but not necessarily fill the gap that has been identified.

**Information for electors:**

Electors will not be able to ascertain properly what individual candidates stand for and what their attitude is on the many complex issues that will arise. Information can be disseminated (but at what cost?), e.g. by sending every elector a printed manifesto, but even if this does allow some basis for comparison (e.g. by a standard questionnaire asking candidates their views on a series of current issues) electors will have only a very limited basis for judging how deserving a candidate is of their support and how well s/he will be able to represent an elector’s views on new matters that arise. In any event there is a real risk of candidates campaigning on particular issues where their preferred outcome is incompatible with either the wider interest of the area or the specific goals of other successful candidates. The major dilemma facing health boards is that not everything that is desirable can be achieved within the inevitable financial constraints and having representatives elected on the basis of specific, often conflicting, priorities will not assist the difficult balancing exercises and long-term planning that have to be carried out.

**Voting method and turn-out:**

Recent experience suggests that, sadly, there is no enthusiasm for turning up to vote at polling stations and little confidence in electronic or other means of voting. Moreover experience of community councils, school boards etc. (and in relation to shareholders, association members etc.) suggests that even where an electoral process is narrowly focussed on a specific area or issue and where the electorate may feel reasonably well informed about the candidates, there is a lack of enthusiasm to participate. Representatives elected on a poor turnout have no authority – they can speak neither as experts nor as public representatives.

**Representativeness:**

I do not believe that having elected individuals will produce a board that can take decisions genuinely representative of its community’s views. A candidate who has campaigned strongly on a single issue has little authority as a representative on other issues. The elected members will have no way of ascertaining the views of the community at large and even the best will struggle to get away from their own inevitably limited experience to reflect the concerns and priorities of all sectors of the community they are supposed to be representing. Moreover, whereas an appointed board knows that it does not have by itself the legitimacy to speak for the community and must seek out the public’s views, a board with elected members may be content to rely on their views as representative and therefore make less effort to seek wider views.

**Conflicts of interest:**

Mechanisms will have to be put in place to deal with the conflicts of interest that will arise. At the most basic level, will employees of the health boards be able to stand as candidates? Will those involved in firms that are major contractors for the boards? I gather that experience in New Zealand of district health boards with elected and appointed members has not been happy in this respect and has led to litigation, removals and major inquiries – see the Controller and Auditor-General’s report available at [http://www.oag.govt.nz/2007/auckland-dhbs](http://www.oag.govt.nz/2007/auckland-dhbs) and the further investigation at [http://www.moh.govt.nz/moh.nsf/indexmh/hbdhb-conflicts-of-interest-report-17mar08](http://www.moh.govt.nz/moh.nsf/indexmh/hbdhb-conflicts-of-interest-report-17mar08). I do not know how far the presence of elected members contributed to these problems and the background in relation to controls on standards in public life will inevitably be different, but it seems that the experience in New Zealand on this issue, and on elected members more generally, should be investigated.

These views of how the electoral process will work may be unduly pessimistic, but my opinion is that as much progress towards the goal of more responsive decision-making can be achieved by
other means. Public consultation on and discussion of options at an earlier stage should be encouraged, when there is more scope for different options to be pursued and when it can be made clearer that favouring some priorities inevitably means less attention to others. Such consultation must involve active steps to reach out to the community, e.g. in colleges, workplaces, social activities etc, not just traditional public meetings and written consultations (apologies if this is doing a disservice to existing exercises that use imaginative and innovative methods to seek views).

To assist this effort, a scheme of “citizens’ juries” should be investigated and tested. These involve a number of people from an area devoting a day or two to being briefed on the background and context of the key issues to be decided, shown the options and how they impact on each other and then settling on priorities and the best way forward. Although there are problems over selection etc., this seems to offer the potential for a more truly participative approach and in particular can be targeted so as to ensure participation across the full social and economic range of the population. Such a process, conducted in a transparent manner, seems to offer more chance for proper public participation than poorly supported elections held at significant intervals with limited means for the electors to know what the candidates will do and no means for the successful candidates truly to know what the public wants.

Prof. Colin T. Reid,
Professor of Environmental Law,
University of Dundee

COMMUNITY PHARMACY SCOTLAND

Community Pharmacy Scotland (formerly known as the Scottish Pharmaceutical General Council) is the body recognised to represent Scotland’s 1200 community pharmacy contractors in negotiations with the Scottish Government on remuneration and terms of service relating to the provision of NHS pharmaceutical care services. Within our membership we represent all types of pharmacy, multiple or independent, situated throughout Scotland including a number of pharmacies in remote and rural locations.

Our prime focus in recent years has been the development of a new contract for pharmacy contractors, one which will call for the delivery of new services, potentially in novel ways, but continuing to place emphasis on the opportunity which community pharmacy offers in terms of access for patients to healthcare services.

For many members of the public their visits to a community pharmacy offer their only interaction with the NHS in Scotland. Community pharmacies offer services valued by those who are ill and have formally entered the “NHS” system. We also provide a service for those who are well but may wish to use a pharmacy to self-care in relation to minor ailments or public health measures or simply to make a purchase of toiletries.

Public input to the provision of pharmaceutical care services is most visible through the input of lay members to the deliberations of each Board’s Pharmacy Practices Committee or to the National Appeal Panel. These bodies determine whether an application for the granting of a new contract to provide pharmaceutical services is “necessary” or “desirable”.

Summary

Community Pharmacy Scotland is supportive of the need to encourage effective patient and public involvement. The views of patients are important to ensuring that service delivery meets the needs of patients but where we struggle is how you achieve that in a way which is consistent with good governance.

Delivery has to be seamless, it has to be consistent and it has to be high-quality but it must also ensure that it takes account of the needs of people in Scotland whatever their health needs. That is the difficulty for Health Board members to reconcile and direct elections will not solve that difficulty.
Section 1

This section has invited our views on-

Whether we support the principle of direct elections to health boards;

As previously responded to in the consultation on the Local Healthcare Bill Community Pharmacy Scotland are not in favour of the introduction of a system of direct elections to health boards for the following reasons:

• We see no need to depart from the inclusion on the Board of different categories of membership except for the inclusion of the Director of Pharmacy under senior health board staff

• We consider that the introduction of direct elections would lend itself to the promotion of particular individuals or sectors

• We think it would be harder to maintain good governance arrangements at Health Board level

• We consider it would be more difficult to provide consistency of services

• We consider the costs of the election process to be difficult to justify

• We fear that direct elections will politicise the process of health delivery.

What the practical benefits of having elected members on health boards would be;

Community Pharmacy Scotland are unclear of the benefits of having elected members over the current system for patient involvement and independent scrutiny, where those activities have become embedded in health board decision making processes.

This current system has yet to reach its full potential and perhaps it would be more appropriate to allow time for this system to become more embedded in health board decision making processes prior to embarking on the route of direct election.

Community Pharmacy Scotland however, concedes that Direct Election to Health Boards may alter the profile of participants that currently input to Health Board decision making. This change of profile might improve the perception to other members of the public that Boards are actively engaging with their constituents.

Whether those benefits would outweigh the costs arising from running such elections and supporting elected members;

Scrutiny and pressure on NHS funding and on the performance and competence of NHS staff has never been higher. The members of health Board should be subject to a similarly rigorous scrutiny of their performance and competence. Community Pharmacy Scotland feels that any benefits gained from having directly elected members to Health Boards are unlikely to outweigh the costs of holding the elections and supporting these members to achieve their full potential.

What are the risks of having elected member on health boards;

• We consider that the introduction of direct elections would lend itself to the promotion of particular individuals, sectors or policies

• We feel that there will be overdue emphasis on secondary care premises rather than service delivery appropriate to the person’s requirements

• The proposed format of re-election every four years may lend itself to a culture of short-termism in decision-making by the elected members who wish to gain popularity prior to standing for re-election.
We think it would be harder to maintain good governance arrangements within health boards with elected members as part of health boards. If the elected members of the Boards (as they hold the majority) continually prevent service change this could impact upon financial governance and the ability to deliver on national targets.

**Whether elected members’ scope for action will be affected by health boards’ continuing accountability to ministers**

If the over-riding priority is accountability to ministers then it seems inevitable that directly elected members scope for action will be limited. The question then is what ministers would propose to do about that.

Adopting a view on this question is difficult without seeing the pilot in action as then the continuing ability of the Board to be accountable to the ministers could be observed. If directly-elected members choose to follow paths which are polar opposite to minister’s policy this will clearly affect the health board’s continuing accountability with ministers.

**Whether alternatives to direct election exist as a means to increasing public involvement in the NHS**

The current system of patient involvement and independent scrutiny is improving Health Boards consultation on major service changes. Community Pharmacy Scotland note from the policy memorandum that the government will be adopting a participation standard to ensure that patient focus and public involvement become core drivers of decision making. As part of this standard the Health Boards will be expected to produce annual ownership reports setting out how to become involved in the design and delivery of local health services.

Community Pharmacy Scotland feels enabling public involvement through this means will be less costly and more effective than using direct elections.

**Section 2**

This section has asked for our views regardless of whether we support the principle of direct elections-

**The composition of health boards as set out in the Bill**

Community Pharmacy Scotland has reviewed the proposed constitution of members to the Health Board.

*Senior Employees of the Health Board*

Community Pharmacy Scotland notes that the Director of Pharmacy has been excluded from the list of senior members of the Board who assume by right a seat on the Board.

Due to the importance of the role of Director of Pharmacy in implementing the new Pharmacy contract, maximising the benefits and minimising the adverse effects of medicines (a major cost to the NHS), Community Pharmacy Scotland feels the Director of Pharmacy should also be considered for a place on the Health Board.

*Locally Elected Councillors*

Community Pharmacy Scotland note the inclusion of local elected councillors by right on the Health Boards and feel this is an important step to promote partnership working between NHS Boards and Local Councils, however a note of caution around the use of elected councillors in this role should not affect the time they have to support the functions of the local authority.

**The arrangements for elections as set out in the Bill including the franchise, voting system and designation of each health board area as a single ward**

Community Pharmacy Scotland has reviewed the proposed approach to Elections. Our views are:
Terms of Office
Community Pharmacy Scotland has some concerns around the ability of candidates to be re-elected to Health Boards. Community Pharmacy Scotland believes there is a risk of short-term populist views being adopted by members seeking re-election. These populist views may lead to poor decision making which have impact on the short, medium and long-term functioning of the Health Board.

Single Ward
Community Pharmacy Scotland is unsure of the validity of the assumption that the creation of a single ward will reduce the possibility of the detrimental impact of an unrepresentative single issue candidate. This may not be possible in all Health Board areas. Rural areas with pockets of large conurbations may well lead to this type of candidate being elected to the exclusion of residents in the more rural locations.

The arrangements for piloting direct election as set out in the Bill;

Community Pharmacy Scotland notes the proposed arrangements for the pilot and is satisfied on such. Community Pharmacy Scotland would be keen to see a rural, island and urban health board used in the pilot as this may expose some issues on the election methodology.

Community Pharmacy Scotland is also keen to ensure any evaluation of the pilots is given adequate time for reflection prior to adoption of a full rollout.

The practical implications and cost of bringing the Bill’s provisions into force

Community Pharmacy Scotland would be keen to minimise the cost of bringing the Bill provisions into force. We are keen that the elections are held at the same time as Scottish Parliament or UK Parliament as this would reduce cost and improve turnout. We do note however, this may also lead to confusion.

The cost of bringing this Bill into force should not be borne by the NHS.

Elspeth Weir,
Head of Policy & Development,
Community Pharmacy Scotland

THE CONSULTING ROOMS

We do not believe that spending £5 million or more on direct election to NHS boards would produce any benefit, but would divert funds from clinical care.

In order for lay people to receive and assimilate enough relevant information to elect candidates they would have to undergo a very lengthy and onerous training programme, placing a considerable burden on their time and travel expenses etc. It is not equitable to expect people to voluntarily undertake such training without due reimbursement.

You are asking people to judge candidates without the necessary background information. The interest of people in the NHS is a very personal subjective experience, not a hypothetical interest, so they may not see the relevance of voting for candidates.

If a topic is practical and relevant to the patient experience then people are often interested enough to take part in saying how they believe the patient journey can be improved. Direct election is not such a scenario.

Current regulation and scrutiny is stifling and expensive, so adding in direct elections looks like tokenism rather than a scientifically evaluated approach to change.

A lay person is overwhelmed by the complexity of formal meetings and may not feel empowered to speak out, nor can they speak for others as there is no such thing as a patient representative with a universal view.
Any lay candidates that come forward will usually be from special interest groups, often retired from work and do not span the range of diversity required in order for such a process to have any validity.

The process of dividing into electoral wards for planning and meeting purposes is too complex and causes enormous delays and wasted effort.

There could never be enough safeguards in place to ensure that a particular special interest group did not get their own personal agenda favoured and approved above all the competing priorities for funding.

Councillors elected to Boards will always be answerable to their particular affiliated political party rather than being independent.

If the purpose is genuinely to improve patient and public involvement in health care planning then you need to speak to experts first for advice such as Shirley McIver at the University of Birmingham Health Care Management Centre. The issues that concern and engage the public are those that are personal to them, involve real choices and hard decisions about priorities, and are local in nature.

**Example of Functional Scenario:**

A small amount of development money is available to be spend over 2 years that can either be used to: integrate dietetics into a one stop clinic for diabetes, to speed up the provision of hearing aids or to improve wheelchair ramps at 2 hospitals. There is not enough money to do all three things. The public and patient involvement meetings need to discuss how many people would benefit from the 3 different projects, how much they would each improve care and then when fully informed they could vote on which one would produce the most benefit to the area.

Because the problem is practical and involves an element of real choice then it can be properly debated and discussed unless a special interest group is present that is only concerned with satisfying their particular agenda.

**Example of Dysfunctional Scenario:**

People are encouraged at huge expense to vote and elect HB candidates. Unless they know the people involved they have no interest in the process. £5 million + is wasted because this scenario has no relevance to individuals.

*Surely all such proposed projects need to be evidence based rather than political gimmicks based on sound bites? This idea is only paying lip-service to patient and public involvement rather than seeking genuine change.*

Polly Parkinson,
The Consulting Rooms

**PROFESSOR DAVID BARLOW**

As Executive Dean of Medicine I am appointed as a non-executive member of the Greater Glasgow and Clyde Health Board. This appointment has been of enormous value in enabling me to serve both the Medical School and the Health Board in moving forward the joint collaborative working of the two organisations in seeking to serve the people of Glasgow and Clyde as well as helping advance medical knowledge and education more widely. My interpretation of the Bill is that the possibility of a senior medical school officer to be appointed to a Health Board is of value and that it would be a negative development if this were not to be possible.

Professor David H Barlow,
Executive Dean of Medicine,
The University of Glasgow
DUNFERMLINE & WEST FIFE PUBLIC PARTNERSHIP FORUM

Introduction

1. This paper responds to the call by the Scottish Parliament’s Health and Sport Committee for evidence from all interested parties on the general principles of the Health Boards (Membership and Elections) (Scotland) Bill, introduced by the Scottish Government on 25 June 2008.

2. The Bill’s stated aim is to improve public engagement and public involvement with Health Boards by allowing for the election of Health Board members, initially by way of pilots, which will remain in force for up to seven years, being fully evaluated after five years.

3. As with all Executive Bills, consideration of the Bill by the Scottish Parliament will be in three stages. The Health and Sport Committee, which is the lead Committee, intends that evidence received in this round of consultation will inform its consideration of the Bill at Stage 1, after which it will produce a report, for Parliamentary debate, on the general principles. If agreement is reached, the Bill will pass to Stage 2. If agreement is not reached, the Bill will fall.

4. This opportunity to contribute to the decision making process is welcomed by Dunfermline & West Fife PPF.

Direct Election to Health Boards

5. The PPF broadly supports the principle of direct election to Health Boards on the premise that elected members conceivably would be more responsible and responsive to the local population who voted them in, in contrast to the current arrangement whereby Health Board members are appointed by Ministers. This broad support, however, is not without caveats.

5.1 Practical Benefits?

5.1.1 More likely to reflect the opinions and requirements of local people rather than voice either their own opinions or those of government.

5.1.2 Have to hold surgeries (as do Councillors, MPs, etc) to collate the views/concerns of the public.

5.1.3 Seen as working on behalf of the public to improve the overall provision of health care.

5.2 Practical Considerations?

5.2.1 Are enough members of the public interested in health issues to turn out to vote? We think not. The turnout at Local Government, Scottish, UK and European elections has been declining over the years, calling into question the appetite of the public for yet more elections.

5.2.2 There is no evidence of a pool of people willing to stand for election, and the electoral process is not of itself free from barriers.

5.2.2 Would the cost of elections to Health Boards and support for elected members outweigh the benefits? [May well do]. There would certainly be significant financial implications on the public purse.

5.3 Risks of Having Elected Members on Health Boards?

5.3.1 Potential to lose talent and expertise deriving from existing Non-Executive Director and Stakeholder membership of Health Boards.

5.3.2 Potential for single-issue candidates to be elected, which runs the risk of distorting the business of NHS Boards.

5.3.3 Ability on the part of NHS Boards to address Equality and Diversity issues may suffer.
5.3.4 Relationships across NHS Boards and between Boards and Local Authorities could become more difficult if each Board has within it an increasing component which sees its accountability only to “a constituency” within its geographical area.

5.3.5 Groups which suffer from health inequalities are often not vocal or politically attractive, and electoral perspective is often shorter term than the long term perspective that NHS Boards need to take in addressing the health of local populations. Tensions such as this will increase with elected members in situ.

5.3.6 Potentially could fundamentally alter the nature of NHS Boards in a way that could undermine their effectiveness.

5.4 Alternatives to Direct Election?

5.4.1 The Better Health Better Care Action Plan (Section 1) refers to the good progress that Public Partnership Forums in CHPs have made in involving local communities in the design and delivery of health services, and promises a set of specific proposals during summer 2008 which will strengthen their role still further. This recognition is welcomed and, given this, a better option might be simply to consult with existing local public groups that have an active interest in health issues, eg PPFs, Patient Forums, Involving People Teams, Diabetes UK, Cancer Networks, Age Concern, etc, asking them to decide who best could represent them on local Health Boards.

5.4.2 The BHBC Action Plan additionally points to the work of Better Together – Scotland’s Patient Experience Programme, stating that the programme will make NHS Scotland a world leader in involving patients in the design of health care services. It also refers to consultation that will take place on a charter of mutual rights, which will set out the rights of patients to be treated as partners in their care, these actions being taken in the context of the development of a Participation Standard, which the Action Plan states will be developed in consultation with NHS Quality Improvement Scotland, the Scottish Health Council, Public Partnership Forums and others. As this Standard, once developed, will become a performance measure for NHS Boards and will ensure that patient focus and public involvement are core drivers of decision-making, a move to direct elections at this time, which is a new (rather than complementary) approach, might be pre-emptive.

5.5 Arrangements for Piloting Direct Election

The PPF’s preference for initial pilots, should these go ahead, is that there should be two, one city-based (eg Glasgow) and one rural (eg Fife) in order to see if improved public consultation and meaningful engagement results, and how effective the new approach is in encompassing all sections of the population. This would then enable, subject to full evaluation, lessons learned and best means and methods to be incorporated into any roll out nationally.

Summary

6. The PPF welcomes the broad aim and intention of the Bill to strengthen the requirement for the public voice to be heard in the decision making processes of Health Boards. As outlined in this response, however, much depends on how the proposals are implemented in practice.

Shirley Dempsey,
Locality Manager,
Dunfermline & West Fife
On behalf of the D&WF Public Partnership Forum

EAST LOTHIAN COUNCIL

East Lothian Council welcomes the Scottish Government’s intention to increase transparency, accountability and community engagement in the operation of NHS Boards. However we do not believe that direct elections are the most appropriate mechanism to achieve this.

The cost of any such elections would be significant, and would clearly be a diversion of financial resources which could otherwise be invested in front line services. These additional costs – plus
our concerns about levels of participation and turnout – mean that the piloting of the proposals will be absolutely crucial. Any pilots should be subject to rigorous, independent evaluation.

There is currently a modest degree of indirect community accountability in NHS Board operations, through local councillors’ membership. The Council sees considerable scope for enhancing this role, as an alternative to direct elections. At a time when councils and the NHS are working ever more closely (on all aspects of social care: health improvement: community planning generally) it seems unnecessary to be creating new, separate decision making structures.

The Council feels that councillors bring a great deal of relevant knowledge and experience to NHS Boards, with first hand experience of Best Value, self assessment, Single Outcome Agreements, Community Planning, along with their wider representative role.

The Council feels that a system of joint boards, drawing membership from each local authority in the NHS Board area, offers significant advantages over the status quo, with few disadvantages. We would be happy to explain this proposal in more detail, should the Committee view it of interest.

Brian Duncan,
Corporate Policy Manager,
East Lothian Council

EAST RENFREWSHIRE CHCP

1. Whether you support the principle of direct election to health boards

We consider that there are other ways to involve the public and the communities in the work of the NHS Board. East Renfrewshire, as an integrated Community Health and Care Partnership, has a very effective Public Partnership Forum (PPF) that draws on representatives from patients, carers, voluntary organisations and the public within the Council area who are involved in decision making processes regarding future strategy direction, e.g. Older People’s Strategy and redesign of services e.g. Integrated Mental Health and Learning Disability Team. Two members of the PPF have formal seats on the CHCP Committee which is a decision making body and a Sub-Committee of East Renfrewshire Council and NHS Greater Glasgow & Clyde Health Board. We have sought to ensure succession planning by enabling another two members of the PPF to attend every CHCP Committee as an official substitute and linking the work of the PPF with the community engagement processes of Community Planning within the Council area. One option for ensuring greater public involvement in the work of the NHS Boards and the decision making process would be to select representation from the public partnership forums within the NHS Board area to sit on the Board. The number of PPF members eligible to have a seat on the NHS Board would have to be carefully considered given the large size of the existing NHS Board in Greater Glasgow & Clyde.

2. What the practical benefits of having elected members on health boards would be

It would be seen to strengthen public and patient involvement in the Boards’ decision-making process. The representatives would also require to be accountable for their actions and decisions on the same basis as the existing board members.

3. Whether those benefits would outweigh the cost arising from running such elections and supporting elected members

We consider that it is debateable whether these benefits could outweigh the costs, as the costs in organising an election process could be fairly significant. This is particularly so, given that there are potentially other models to increase the public/patient involvement in boards.

4. What the risks are of having elected members on health boards

Key risk would be how it could be determined that the individual was in a position to represent the views of a significant proportion of the local population. Another risk would potentially be that an individual was only interested in a single issue e.g. cancer waiting times and not interested in participating in debating and taking decisions on all of the Boards business.
5. Whether elected members’ scope for action will be affected by health boards continuing accountability to ministers

This should not be an issue if members are elected to the Board with the same accountability arrangements as other members.

6. Whether alternatives to direct election exist as a means to increasing public involvement in the NHS

Yes other options exist as covered in number 1. In addition, the current framework for patient focused public involvement in the NHS could be extended and organised to support greater involvement of members of the public on a geographical basis within a given boards area.

In respect of the 4 other areas where views were sought, the following comments are offered:-

The composition of health boards as set out in the Bill

The CHCP view that there are more appropriate ways of achieving community involvement than by direct election to health boards has already been explained. Nevertheless, it would appear the proposals are to be introduced. On this basis, the suggested composition of boards, particularly the balance of appointed as against elected members is welcomed. This would also seem an opportune time to revisit the question of the need for councillor appointments to be made by Scottish Ministers. Councillors are democratically elected and as long as those councillors nominated by their respective councils comply with the guidelines on the appointment of councillors, then there appears to be no reason why the current appointment arrangements should continue.

The arrangements for elections as set out in the Bill including the franchise, voting system and designation of each health board area as a single ward

The CHCP has already stated that the franchise should be based on the local government electorate with candidacy subject to the same requirements as for local government elections. This would mean that the minimum voting age would be 18. Whilst extending the franchise is laudable, it would require the introduction of further bureaucratic processes in addition to those that would be required for board elections.

Whilst supportive of the use of STV for elections, the CHCP does not support the designation of each health board area as a single ward. It will be difficult enough for individuals to campaign across their local CH(C)P area let alone try to conduct a campaign across their full board area. This places them at a disadvantage when compared to those candidates with party political backing and support.

Secondly, this approach increases the possibility of board membership being dominated by individuals from a relatively small geographical area who have campaigned for membership on a single issue, as it is likely that people in that area would vote for these candidates. Using CH(C)Ps as the basis for election would at least guarantee a more geographically representative membership of the board.

The arrangements for piloting direct elections as set out in the Bill

See below

The practical implications and cost of bringing the Bill’s provisions into force

The main practical implications associated with the implementation of the Bill’s provisions relate to the electoral process itself. Clearly with their election experience, Returning Officers in local authorities are best placed to conduct any elections that take place, and further discussions will be required between the Scottish Government, health boards Electoral Registration Officers and the relevant ROs within a board’s area, to identify the appropriate RO to conduct the election.
In addition, as already stated in the CHCP committee’s earlier submission, with health board boundaries in many cases extending across both local authority and electoral registration boundaries, there are significant logistical issues to be resolved.

With regard to costs, these are based on a 60% turnout. This is considered to be an extremely optimistic figure. Furthermore, it is also proposed to undertake an all-postal ballot. This fails to take into account the new legislation which requires all postal voters to provide a sample signature and date of birth to their relevant Electoral Registration Officer. EROs have already carried out an exercise in respect of those individuals who were on the absent voters list. This resulted in a reduction in the number of people who registered for a postal vote. If the whole electorate were required to go through the same process there would (a) be significant costs involved which have not been taken into account, and (b) it is likely that not everyone would respond resulting in a large proportion of the electorate being disenfranchised.

Eamonn Daly
Principal Committee Services Officer
East Renfrewshire CHCP

FAIRSHARE VOTING REFORM

Fairshare welcomes the opportunity to contribute to this consultation on the legislation to provide for direct elections to NHS territorial Health Boards in Scotland. We shall be pleased for this response to be made public without reservation.

Fairshare has no policy on the question of whether any members of NHS Health Boards should be directly elected. Our concern is only that, if such elections are introduced, the voting system used should be one that will give fair and balanced representation of the local community each Health Board would be elected to serve.

Fairshare has made submissions to previous consultations on proposals for legislation to introduce direct elections for territorial Health Boards in Scotland. Some of the comments in those submissions go beyond the immediate scope of the current Bill, but they may provide useful background on some of the issues that may arise during the Stage 1 consideration.

Voting system

It is stated in the Policy Memorandum that the voting system will be the Single Transferable Vote (STV), but there is nothing in the Bill to ensure this. Preferential voting (“1, 2, 3”, etc) is prescribed in paragraph 8(2) of Schedule 1A, but there are several ways of counting such preferential votes that are quite different from STV. The use of STV should be prescribed in the Bill. It is, however, completely appropriate that the details of the voting system, including the form and content of the ballot papers and the procedure for counting votes, should be prescribed in subordinate Election Regulations.

Electoral wards

It is stated in the Policy Memorandum that each Health Board will be a single “ward” for the purposes of election. Before dealing with the main point, it should be noted that we have reservations about the use of the word “ward” in this context, both because its use elsewhere implies subdivision and because it may cause confusion with the much longer established use of the word “ward” to describe the electoral units for local government elections. It may be that a term such as “electoral district” that is not in current use in relation to public elections in Scotland would be more appropriate.

The proposal that each Health Board area should comprise one single electoral “ward” is stated in the Bill (Schedule 1A, paragraph 3(1), but the Bill also provides for a Health Board area to be divided into two or more “wards” without limitation. It would thus be possible for a Health Board area to be divided completely into single-member “wards”. This is clearly not the intention, but there is nothing in the Bill to prevent it. The wording in Schedule 1A should be amended to make it clear, firstly, that subdivision of a Health Board area should be the exception and not the rule, and
secondly, that subdivision of the whole or part of the area into single-member “wards” will not be permitted.

Local representation is an issue that was raised during consideration of an earlier proposal for Health Board elections. With any voting system there is always a compromise between maximising the proportionality and diversity of representation on the one hand and guaranteeing local representation on the other. The greater the number of members elected together, the more proportional the representation will be to the wishes of the voters and the greater the potential for diversity of direct representation. It is thus desirable that all the elected members should be elected together, i.e. from one “ward”. If, exceptionally, some subdivision of a Health Board area is considered essential, the resultant electoral “wards” should be as large as practicable.

STV-PR is a candidate-based voting system that provides the electors with the greatest choice in the selection of their local representatives. Those who vote can thus express their preferences for the candidates on the basis of the candidates’ skills and experience, their expressed views on important health issues, the locality where they live or on any other criterion that matters to the individual voter. With STV the candidates who are elected will be those who are most representative of those who voted. No voting system can do more.

Franchise

We support the proposal to extend the franchise for these elections to include 16 and 17 year olds living in the relevant Health Board area.

Cost of elections

On the basis of similar all-postal public elections held in the UK, we understand that the estimated costs for the proposed pilot elections given in the Financial Memorandum are realistic for the projected response rate of 60% in postal ballots.

Elections cannot be held without cost, but when considering the projected costs, the costs of the current method of selecting members of Health Boards must be taken into account. No estimate of the current costs has given in the Financial Memorandum or in the Scottish Government’s earlier consultation document, but these costs will be significant and should be set against any estimate of the costs of the elections that might replace the present appointment procedure. It must also be borne in mind that a transfer of costs would be involved, because all the costs of making appointments to the territorial Health Boards are currently borne centrally.

We are aware that in the not too distant future, STV could be used in elections to a number of directly elected bodies in Scotland, in addition to its use for Local Government elections and its proposed use for Health Board elections. These initiatives and potential initiatives fall within the responsibilities of different Directorates of the Scottish Government. There may be an opportunity for some significant long-term saving of costs if a coordinated approach is taken now to the future provision of the hardware and software needed to service all of these STV elections.

Fairshare is a cross-party and non-party organisation set up in February 2001 to campaign for the introduction of the Single Transferable Vote system of Proportional Representation (STV-PR) for local government elections in Scotland. In January 2005 Fairshare extended it objectives to promote reform of the voting systems used for all public elections in Scotland. Fairshare is constituted as a not-for-profit company limited by guarantee and maintains a network of Registered Supporters.

Dr James Gilmour,
Fairshare Campaign Committee,
Fairshare Voting Reform
Consultation Questions

1. Do you think the current proposals for independent scrutiny of service change proposals help achieve the aim of better engaging and involving local communities?

2. How could additional guidance to NHS Boards on making public consultation as effective as possible help achieve this aim?

3. Would the appointment of more lay members to NHS Boards – perhaps to directly represent patients or other groups – help achieve the aim? How might this be achieved?

4. In particular, would adding more local authority councillors (one councillor from each local authority whose area a Board serves is currently appointed to that Board) help achieve the aim? Could local authorities have a role in scrutinising public and community engagement?

5. Should we develop further the role of the Scottish Health Council to bring about more effective engagement and involvement? If so, what additional responsibilities could the Council take on and what would the benefits be?

6. How could the Public Partnership Forums associated with Community Health Partnerships encourage greater public engagement?

7. How could local Community Planning Partnerships best ensure improve public engagement with NHS planning?

8. What other measures could be introduced to increase effective engagement and involvement of the public with the NHS in Scotland?

The Council has previously commented on the issues noted above and therefore the Government is directed to the Council’s response on the Independent Scrutiny of NHS Decisions as forwarded to the Scottish Government on the 25th January 2008.

The Council’s response to the questions are grouped where appropriate.

In responding to ‘Better Health, Better Care’, the Council at its meeting in December 2007 noted its support for the principle of having an element of democratically elected members in the membership of NHS Boards in addition to local authority members and medical professionals. The response below reflects this position.

9. What eligibility criteria should candidates meet (e.g., should they be resident in the Board area? Should there be any other qualifications?)

10. How could equality and diversity of candidates be promoted?

11. Should candidates have to submit profile statements and declare any interests and/or relevant qualifications / skills / experience, for example membership of a political party or a pressure group?

12. Is there a case for excluding candidates standing as a representative of a political party?

13. In what circumstances might someone be disqualified from seeking election?

14. Who should be allowed to vote in the election? Should the same rules as apply to local authority elections be followed?
The same rules that govern Local Authority elections should be applied to NHS Board elections in relation to the eligibility of candidates for election. It is not, however, considered appropriate that Councillors, MSPs or Members of Parliament should be eligible to stand for election as members of Health Board. In addition, it should not be open for a candidate to stand as a representative of a political party, although being a member or activist of a political party should not be a disqualification from standing for election. In order to promote equality and diversity of candidates, it is important that the process of nomination is widely publicised and targets a range of interested groups.

15. How often should elections be held, and when? Local authority elections are held every 4 years. Should elections to NHS Boards follow the same pattern?

16. Should directly elected members form a majority of the members on a Board?

17. Should the existing categories of appointed Board members (lay members, stakeholder members and executive members) remain in place?

18. Among the appointed “stakeholder” members on NHS Boards are local authority Councillors. What should their role be if directly elected members sit on Boards?

19. Should NHS Board areas be divided up into electoral wards?

A four year term of office would seem appropriate for elected members of NHS Boards. This is consistent with the time frame for many other directly elected positions.

It is suggested that Boards be made up by equal numbers of elected members, Council representatives and medical professionals. The medical professionals could consist of existing executive directors. Currently, Local Authorities have one member on a Board. It is important that the number of Local Authority Members reflects the population on the area they represent.

For example, in the Forth Valley area this could mean 4 local Authority Members, 4 directly elected Members and 4 medical members. In addition it is further proposed that the Chairperson continue to be appointed by the Minister. This would mean a Board of 13.

It is suggested that directly elected Members should cover Scottish Parliamentary constituencies.

20. Would the emergence of groups or individuals with particular views be a difficulty or a potential threat to good governance and direction of the NHS in Scotland?

21. Should safeguards be introduced to prevent unrepresentative / disproportionate representation of a political party or special interest group on a Board, and if so what form might such safeguards take?

Given the balanced approach suggested above i.e. an equal balance of directly elected Members, medical professionals and Council representatives, it is unlikely that one group would have a dominant influence on the operations of a Board.

22. Would you favour a simple “first past the post” voting system, a proportional representation approach or another type of system?

23. How should voters be allowed to cast their votes? By postal ballot or at a polling station? Or either, depending on the voter’s choice?

In order to encourage voters it is suggested that the voting system must be straightforward and ensure the maximum number of people can vote. It is therefore suggested that the first past the post system be introduced for NHS Board elections. This should be operated by postal ballot.

24. Should directly elected Board members be remunerated? If so, at what rate – the same as appointed members currently receive?
Directly elected Board Members should be remunerated. The level of remuneration should be assessed when the extent of the role and responsibilities of a directly elected member is clearer.

25. Are should pilots a good idea?

26. How many pilots should there be?

27. How should pilot areas be selected?

28. How long should pilots run for?

29. What criteria should be used to assess and evaluate the pilots?

The impact of direct elections to NHS Boards may only be felt after a considerable period of time. If elections are deemed appropriate then they should be introduced to all Boards and not piloted.

30. Should NHS Boards continue to provide generally consistent levels of performance across Scotland and follow national policies and priorities? Or should elected NHS Boards have the freedom to exercise local discretion and flexibility?

31. Should current guidance e.g. on governance, priorities and performance standards be set out in future in legally-binding form, to ensure that elected Boards comply with them? What would be the advantages and disadvantages of this?

Given the broad nature of health priorities it is considered that there is flexibility and discretion for Boards to ensure that they address national priorities while meeting local needs. Local CHPs have a clear role in ensuring local priorities are identified and met.

While there may be legislation to establish direct elections to NHS Boards, it is not considered appropriate to legislate for performance standards.

32. Ministers currently have powers to remove members. Should they be able to remove elected members? What sort of reasons might justify such a power being used?

It is not considered appropriate that Ministers should have the power to remove directly elected Members. Members of a health board are bound by the terms in their code of conduct which can be enforced if necessary by the Standards Commission. This provides an adequate safeguard.

33. Should NHS resources be used to support direct elections? What do you think would be a reasonable amount to spend on elections?

It is not considered appropriate that NHS resources should be diverted from front line service delivery to support elections. This must be funded by the Scottish Government.

There has been no consideration in the consultation paper as to who would organise the elections. If Local Authorities were to organise these elections, discussions must take place with returning officers prior to legislation being drafted.

**Supplementary evidence by Falkirk Council SNP Group**

This response is in addition to the evidence sent on behalf of Falkirk Council.

In response to questions 15 - 19

“The SNP Group within Falkirk Council has expressed a view that the Government proposal of having a majority within the Health Board who are either appointed Councillors or elected representatives is the correct position to ensure accountability and democracy within this important area of public service”.

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“The SNP Group within Falkirk Council does not support the majority view within the Local Authority that in the case of Forth Valley there should be two Falkirk Council representatives with one of each from Stirling and Clackmannan. The reason for this is that health matters are not a geographical debate and that single policy direction is more important than geographical splits”.

“The SNP Group also does not have an opinion on the size of the Board and therefore does not associate itself with the submission from Falkirk Council intimating that the Board would consist of thirteen individuals. This would be a matter that we would wish to consider in greater detail after consultation between the Local Authorities and the Health Boards themselves”.

In response to questions 22 -23

“The SNP Group fully supports the Government's Single Transferable Vote proposals as the most democratic and accountable method of electing representatives to the Health Board. Recent elections to Local Authorities have been in the more democratic and accountable system of Single Transferable Votes and we do not wish to see the clock turned back to minorities controlling majorities”.

In response to question 24.

“The SNP Group within Falkirk Council supports the remuneration package proposed by the Scottish Government”.

In response to questions 25 - 29

“While the SNP Group within Falkirk Council supports the principle of piloting elections to Health Boards it does feel that the timetable for the roll out throughout Scotland is excessive and wishes to see this reduced significantly”.

In response to question 32

FALKIRK COUNCIL – SNP GROUP

I write to make a submission on behalf of the SNP group within Falkirk Council on the above Bill due to be put before Parliament at some point in the near future.

The answers to the specific questions posed as follows.

1) The SNP Group within Falkirk Council fully support the principle of direct elections to Health Boards

2) We believe that the practical benefits of having Elected Members on Health Boards would be to make those Boards more representative of the general public and less likely to be used as the tools of the Government of the day who invariably appointed most of the existing Board Members. This would have the impact of increasing democracy and accountability within the Health Boards where as the individual Board Members would have a constituency rather than a patronage.

3) The risks of having Elected Members on Health Boards would be if there was not a balance between Elected Members and professional Health Service representatives. However, we believe these would be minimised by a mechanism that allowed for a percentage, say 50% appointees from the relevant professional agencies within the Health Service.

4) We do not believe that Elected Members scope for action would be affected by Health Boards continuing accountability to Members as a similar principle exists within the Joint Fire and Police Boards

5) We have no doubt that other methods of ensuring public representation could be increased within the NHS Boards are available, such as increasing the number of local Councillors on each Board. However, we believe that this does not give the electoral credibility that is required in these matters.
6) We believe that the composition of Health Boards as set out in the Bill is broadly acceptable.

7) Equally, we agree that the arrangements as set out in the Bill, including the franchise voting system and designation of each Health Board area as a single ward, is equally both acceptable and practical.

8) The Scottish Government is best placed to determine the arrangements for piloting direct elections as set about in the Bill and we would not disagree with the proposals therein.

9) There is always a cost to democracy and indeed, there was a cost in the restructuring of the NHS Boards by the previous Executives when each local authority was granted once place for an Elected Member within the said Boards. Providing cost is kept to a minimum, does not impact on service delivery and can be justified in terms of increasing the accountability within the Health Service then this has to be welcomed.

I sincerely hope that the views expressed will be taken into consideration prior to the finalisation of the Bill

Councillor David Alexander,
SNP Group Leader,
Falkirk Council

GERALDINE STRICKLAND

I have been a non-executive director for nearly ten years. I am replying in a personal capacity.

I understand why the Government would want to encourage people to become elected to their position on the Health Board but perhaps better information how people are informed about the opportunity to become a non executive, and how the process is delivered would encourage a cross section of people to come forward.

Alternatives to election: Better information about what a non executive is and what they do.

I think more information to the general public about how people can be appointed, and what the role of non executives is, would be useful.

Appointing applications; interviews currently held in Edinburgh.

If a local panel were used, there would still be issues of someone getting in because they are ‘known’.

However, local interviews could be held, with Scottish Executive advisor and a local panel, as people cannot always travel to Edinburgh and this means more likely you would encourage a cross section of people.

Much of the work of a non executive now depends upon email and internet access; ensuring computer access for non executives would be useful and perhaps better use of resources. Not everyone has a computer, and this could exclude people from disadvantaged areas, who would probably make very good non executives.

Use local networks, such as the Council of Voluntary Services and Community Councils to encourage awareness.

- more publicity about what a non executive is, and how to become one so people know.

- Workshops and information days could be held, across communities to encourage awareness for people, this would be no more expensive than elections.

The costs of elections seem disproportionate in a climate of financial difficulty. Who would pay the costs?
Currently non executive’s remuneration is not high and there is no pension. If elected members were brought in, perhaps the cost would have to equate with councillors who receive much higher payments? This would entail another cost.

Accountability: Elected members would face the same challenges as currently with continuing accountability to ministers.

How would this balance with their own position as elected members?

I am not sure how robust selection would be, to ensure a cross section of the relevant skills and experience required to deliver the health service if elections were held, rather than appointments.

As a non executive, there are many challenging conflicts to balance, the patient should be at the heart of the policies, but there are conflicts to balance, with delivering equitable services across the region. An elected member might find it harder to balance the challenges of a corporate board to deliver health care and difficult decision making processes, with also the expectations and demands of the public; an elected member may be conflict here and may be influenced in decision making processes by the wishes of the population when in fact that is not necessarily the right decision. It perhaps would then be very difficult to implement change.

Geraldine Strickland

GLASGOW CITY COUNCIL

1. Introduction

1. Glasgow City Council has previously responded to the Scottish Government consultation on its Local Healthcare Bill. The Council offered views on public engagement with the NHS and particularly on public representation within NHS structures. It also raised a number of specific matters in relation to how the option of direct elections to Health Boards might be implemented.

1.1 The Council’s comments to the Health and Sport Committee are presented in two sections below. One responds to the request for views on the principles behind direct elections and the potential benefits and risks involved. The other looks at the detail of holding elections.

1.2 The Council’s views, in summary, are these:

• That further clarification is required from the Scottish Government on the administration of direct elections
• That treating a Health Board as a single ward may not respect the geographical and community diversity of most Board areas
• That the cost of direct elections does not represent good value in comparison with other means of engaging the public and local elected members in the work of the NHS
• That the proposed pilot of direct elections should be used to compare different voting systems in different Health Board areas.

2. Direct elections – policy issues

2.1 In its response to the Scottish Government consultation, the Council commended the model of public engagement which has been developed in Glasgow around Community Health & Care Partnerships (CHCP). It noted arrangements for CHCPs to seek the views of service users and the public and to engage them more fully in the planning of services. These arrangements are both robust and innovative. It was also stated that the scheme of establishment for Glasgow’s CHCPs makes provision for 5 local elected members on each CHCP Committee, one of whom chairs the CHCP.

2.2 The Council offered this approach to the Scottish Government as a successful model of partnership working. It recommended that greater consideration should be given to the role of local authority elected members within the NHS, allied with further development of public engagement
structures. In that light, the Council did not support direct elections of members of the public to Health Boards and it did not believe that the cost of implementing direct elections represents good value for public funds. The Council notes that the estimated cost of these elections has already risen from £5 million (stated in the consultation document of January 2008) to £13 million (stated in the Financial Memorandum to the Bill in June 2008).

2.3 The Council welcomes the Scottish Government’s recognition of the importance of local authority elected members on Health Boards and its commitment to formalise such representation in statute. It is suggested that the Scottish Government might also wish to review the levels of elected member involvement with Community Health Partnerships (CHPs), where it is understood that there are significant variations across the country.

2.4 Local authority elected members bring a perspective to Health Board membership that not only cuts across NHS and local authority services but also broader themes of Community Planning. This can be invaluable in providing a broad context to inform debate about service change and the needs of communities. It is a concern that ‘single issue’ candidates for direct election may struggle to maintain such a perspective or to draw upon the formal linkages which local authority members bring with them. The Council would acknowledge, however, that it is up to the voting public to choose their representatives and that working relationships between different groups of Health Board members will naturally develop over time.

2.5 The Committee asks whether elected members’ scope for action will be affected by the continued accountability of Health Boards to ministers. The Council does not see this as an issue, given that Health Boards exist within established governance structures. Accountability to ministers also ensures that there is a genuinely national aspect to the health service in providing equitable and high quality services across all of Scotland’s diverse communities. There will be, however, a need for candidates or newly elected members to be briefed on what membership of a Health Board entails and where the limits to their local decision-making lie. This may further inform both elected members and the public who vote for them of both the opportunities and challenges in looking to influence the planning and delivery of local health services.

3. Direct elections - implementation

3.1 The Scottish Government has introduced a Bill on direct elections to Health Boards. The Council notes that:

- There will be a majority of local authority members and directly elected members on each Health Board
- The franchise will be extended to 16/17 year olds
- There will be an all postal ballot and voter preferences for candidates will be expressed through STV
- Each Health Board area will be treated as a single ward
- Elections will take place on a four yearly basis
- There will be an initial pilot of elections in selected Health Board areas, which will be evaluated prior to roll-out across Scotland

3.2 The Council is aware that it will have to await the publication of election regulations for the detailed determination of how elections will be run. It would wish to raise the following matters for consideration by the Scottish Government prior to these regulations being drawn up.

3.3 It is stated that the Health Board will appoint a Returning Officer. The Greater Glasgow & Clyde NHS Board area covers 9 local authority areas either wholly or partially and 4 Electoral Registration Officers. One possibility would be for Glasgow City to manage the election count across the Board area on behalf of all the local authorities involved, as it currently does in its capacity as regional returning officer for the Scottish Parliament elections. If postal voting were the preferred option then consideration for a Scotland-wide contract might be investigated. Local
candidates would no doubt prefer to be present at local counts and the Scottish Government would therefore need to consider the merits of single or multiple count centres.

3.4 The Council has previously stated its belief that a pilot for direct elections should be used to compare different approaches to voting, including one all postal ballot. The Bill gives the impression that only a postal ballot is being considered, but the opportunity to pilot more than one method could allow useful comparisons to be made in terms of voter participation and costs of administration. The Financial Memorandum to the Bill, for instance, makes assumptions of a 60% postal vote return for the purposes of estimating the costs of administering elections.

3.5 The Council would also recommend that a pilot should be used to consider the effects of the geography of NHS Board areas, which would merit comparison between an urban and a rural area. It would also suggest that further consideration should be given to the matter of ward areas through the pilot. The Scottish Government has stated that local and directly elected members will form a majority on Health Boards. However, it will also need to think about whether an entire Health Board area is meaningful as a single ward, particularly in the light of differential population densities and natural boundaries across communities throughout Scotland.

3.6 An all postal ballot will require significant investment in staffing to ensure that new rules on signature checking can be adequately followed. This will need to take account too of the additional requirement to register 16 and 17 year old voters for the first time.

3.7 The Council would welcome further opportunities to discuss the matters raised above prior to clarification being provided in the election regulations.

Duncan Booker,
Principal Policy Officer,
Corporate Policy,
Glasgow City Council

HIGHLAND COUNCIL

Whether you support the principle of direct election to Health boards

In the Council’s response to the consultation document it was agreed that while the objectives of the consultation document of encouraging greater public involvement in the planning and delivery of local NHS Services are to be welcomed, there were a number of issues regarding direct election for NHS Boards which would have to be carefully considered, such as the type of electoral system used and their associated costs, combating current low turnout in elections, governance issues and the relationship with local authorities.

What the practical benefits of having directly elected members on health boards would be

It could be argued that having directly elected members on the health board could assist promoting transparency and openness in decision making and led to decisions being made which more accurately reflect the wishes of the communities.

However this could also be achieved through additional local authority elected Members being appointed as lay members to the board, as they already have been elected to represent their local community.

Additional local authority elected representatives could assist the Board in representing the views of local communities on the proposals for service planning and delivery issues. They would also be able to provide a wider strategic focus on the health needs of the community, linking in with other Health related Services such as Social Work and the voluntary sector.

Local Authorities already provide a community leadership role and have a wide experience in the scrutiny of public services and in engaging with local communities and could therefore perform the role of scrutinising the how effective the NHS Board’s public and community engagement activities are.
Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

Greater public involvement in the planning and delivery of local NHS Services is the key objective and it could be argued that this could be achieved without the need for direct elections.

In addition the Council’s view that the revised projected £13m cost of direct elections will prove to be an underestimation of the overall costs. If costs of come from the NHS budget it will have associated implications for that budget and front line service provision.

The Electoral Franchise

The extension of the electoral franchise to 16 / 17 year olds, this will result in increased costs being incurred by Electoral Registration Officers. Similarly, the postal vote system would need to collect the postal vote personal identifiers (PVPI’s) of the 85% of electors who do not already have a postal vote. If the PVPI’s were not collected, the election system could be not be considered as being secure and imply an acceptance of a degree of trust that is currently only found in Community Council elections.

The Electoral System and designation of each Health Board Area as a single Ward

The system of STV would need to be carefully considered. If the system was the same as that used in local government elections (weighted inclusive Gregory method) then electronic counting would be required. However, if the Classical Gregory method were to be used (as in Northern Ireland local government elections), manual counting may be possible.

The suggestion that each Health Board area would be treated as a single ward would create electoral administration problems. Using NHS Highland as an example, the Ward electorate would be approximately 220,000, covering two local authority areas. On the basis of an estimated 60% turnout, 132,000 postal ballot papers would be returned. Dealing with that volume of postal ballot papers is beyond the experience of local government staff and in terms of logistics, would be a step into the unknown. If a private sector contract were to be let to manage the process, costs would need to be re-evaluated, as count costs would inevitably increase. The costs outlined in the Financial Memorandum in the Explanatory Notes accompanying the Bill only refer to the direct costs of an election. The indirect costs (such as election management and electoral registration costs) have neither been referred to nor quantified.

What are the risks of having elected members on health boards

It could be problematic, if you have single issue candidates groups or individuals with particular views which could cause difficulties in terms of good governance and direction of the NHS in Scotland.

Whether elected members’ scope for action will be affected by health boards, continuing accountability to ministers

No, as each Board should provide generally consistent levels of performance across Scotland. There should be a balance between following national policies and priorities as directed by the Scottish Government and enabling the Board to have the freedom to exercise local discretion and flexibility.

Whether alternatives to direct elections exist as a means to increasing public involvement in the NHS

As well as introducing a statutory duty to encourage public involvement and establishing the Scottish Health Council (which helps to ensure that patient and public involvement is effective in the NHS), a number of other actions have been taken to improve public engagement with the NHS in Scotland:
• a requirement has been set that Boards should achieve year-on-year improvements in patient focus and public involvement as demonstrated by the annual reports of the Council;

• the principles and practice in Communities Scotland’s National Standards for Community Engagement have been endorsed as a guide to the NHS in Scotland in supporting everyday involvement of patients, carers and the public;

• national guidance has been developed on informing, engaging and consulting the public in the development of proposals for major service change;

• Public Partnership Forums have been developed as a vehicle for proactively involving the public in the work of the Community Health Partnerships and their parent NHS Boards;

• the role of local authority representatives appointed to Health Boards has been supported, to help ensure local accountability and improve joint working arrangements where services are jointly managed by NHS Boards and local authorities;

• the Annual Review process between Boards and Ministers meeting has been opened up to local people and organisations so they can discuss and question Boards’ stewardship and performance;

• the Scottish Government’s Patient Experience Programme is being implemented to help develop and enhance how the views of patients and the public can be used to deliver improvements to patient experience across Scotland.

Composition of Health Boards as set out in the Bill

Executive Directors should remain. It would seem that having elected members has effectively replaced lay members; however the Council still believes there is a key role for both Local Authority representatives and Chairs of Community Health Partnerships.

Practical Considerations

The Council does welcome the Committee’s recognition that there are practical implications in bringing the Bill’s provisions into force. Conducting elections requires considerable project management skills and requires considerable time. Should the Bill be approved by Parliament in early 2009, it is unlikely that the Election Rules will be able to be made in less that 1 year – 2010 – in view of the complexity of election legislation. Thereafter, Electoral Registration Officers would need time to collect PVPI’s and time would be required to put the postal pack printing and the conducting of the electronic count out to contract. This suggests that the earliest time that the elections could be held would be in the Autumn of 2011. The Council would not support combining the Health Board elections with the local government election, should that election be decoupled and moved to May 2012.

A further practical consideration is that the proposed elections are entering into a fairly cluttered electoral landscape. Indeed, the Governments proposals for Local Crofting Board elections will potentially add another statutory election. In some places in Highland, there will be elections to the European Parliament, UK Parliament, Scottish Parliament, Highland Council, Cairngorms National Park Authority; NHS Highland and a Crofting Board. Adding in Community Council election gives potentially 8 elections in a 4 / 5 year cycle. There is a possibility that some sections of the community may experience voter fatigue and decide not to participate in the elections.

John Bruce,
Elections Manager,
The Highland Council
HOWWOOD COMMUNITY COUNCIL

We have addressed the questions raised in the paper sent out, and commented in addition within those question areas.

1. Support the principle of the Bill?

We do. It is consistent with increasing democratic devolution and accountability.

2. Practical benefits?

Major benefits of directly elected Health Board members could include a clear source of accountability and contact with local groups and organisation such as Community Councils which have a statutory duty to act on their constituents’ behalf, advocating community views. Currently, there is virtually no communication from Health Boards or Community Health Partnerships. There is no sense of accountability to local people. Even the Scottish Health Council appears remote, communicates infrequently and is often so late with information that it is too late to contribute. This is despite recent considerable changes and developments in our area, formerly part of Argyll & Clyde. Local Authority elected members on the Health Board have added nothing to Community Councils’ understanding, communication or engagement in the health sector. Directly elected Health Board members might manage to communicate directly with constituents and run “surgeries” akin to Councillors’, MSPs’ and MPs’ surgeries.

3. Benefits outweigh costs?

Communication could hardly be worse so we imagine the benefits would worthwhile; we are unsure what the costs would be however.

4. Risks?

There are a number of risks including cost ineffectiveness and party politicisation of Health Boards. More risky though would be single issue groupings elected to Boards disrupting core functions. We suggested in the previous consultation that elected Health Board members make up 1 less than 50% of the membership to safeguard against this risk.

5. Accountability to Ministers affecting members scope for action?

It should not do so. It is right that Ministers, and central sources of standards and guidance, should impose some control over Boards’ activities to ensure a fair balance of services across the country and to take account of major rationing/funding decisions which have to be taken in the real world. There should however be good two way communication between Boards and Government with advice passing each way, and central Government should allow Boards flexibility to deliver services in the way best suited to local conditions, provided core standards are achieved.

6. Alternatives to direct election?

Current systems encouraging Boards and CHPs to consult do not work in our view as a Community Council. Indirect election (as in the current system with Local Authority members on Boards) fails to engage public at all. We have received no information or requests for views through the Council’s representatives on Greater Glasgow and Clyde Health Board or Renfrewshire CHP. We believe direct election is the best option for involving the public genuinely and giving the public identified people to contact and if appropriate to reject at future elections.

7. Board composition?

Our view as noted in 4 above, is that elected Boards members should make up just less than half the Board membership, with Executives, Chairman and directly appointed members making up the greater proportion.
8. **Election arrangements?**

In our view the electoral system should employ Single Transferable Voting, as local authorities now do, and Community Councils do in some areas. There should be one “super-ward” type constituency for each Local Authority in the Health Board area. The population proportions of LA areas within the Board boundary would dictate the number of elected Board members from each Council area. This would allow clarity over which Board members relate to each area, and would facilitate communication with Community Councils and other groups in the area.

9. **Piloting?**

Our view in the previous consultation was that piloting was unlikely to be helpful as geographical and sociological differences across Board areas may substantially limit generalisability of pilot results, and pilots would have to run for a prolonged period in order to demonstrate any reliable and valid outcome.

10. **Practical implications and costs of implementation?**

We do not feel qualified to comment on this area.

Nicholas Walker,
Howwood Community Council

**DR JOAN SCOTT**

Thank you for the opportunity to comment on the Health Boards Membership and Election Scotland Bill. My concern is that there is likely to be a low turnout for any elections to Health Boards and this would allow election on to Health Boards of minority interest groups, who may not have the communities’ interests as a whole at heart.

Dr Joan Scott,
West Linton Health Centre

**LOCAL GOVERNMENT BOUNDARY COMMISSION**

I am writing on behalf of the Local Government Boundary Commission for Scotland concerning the Health Boards (Membership and Elections) (Scotland) Bill.

The Commission welcomes the involvement that the Bill gives to the Commission by providing advice to Scottish Ministers under certain circumstances concerning the electoral arrangements for Health Boards. We believe that it is in the interests of the electorate that consistent principles are applied across the various public boundary making processes, and the Commission Secretariat, which advises on both local government and Parliamentary electoral boundaries (in the latter case serving the parliamentary Boundary Commission for Scotland) is well placed to provide such consistency.

The Commission is a non-political and independent advisory body and it is not its role to take a view on policy matters. However, the Commission would like to make two observations regarding the Bill as currently drafted which will affect the delivery of Ministers’ policy.

The Commission’s first observation is that the boundaries of Health Boards do not coincide in all cases with the boundaries of local authority areas. This has arisen because of changes to local authority boundaries since the definition of Health Board boundaries in 1974. Many of these changes are minor, each affecting a small number of households, but there are 2 major divergences. The first is in the area around Rutherglen which lies in South Lanarkshire Council area but is in Greater Glasgow Health Board area, and the second is in the area around Moodiesburn which lies in North Lanarkshire Council area but is in Greater Glasgow Health Board area. The majority of North Lanarkshire and South Lanarkshire Council areas are covered by Lanarkshire Health Board.
These discrepancies will make the administration and public understanding of elections to Health Boards more complex than would otherwise be the case. For example, the electoral register for the Borders Health Board elections would have to be determined by drawing on the electoral register for Scottish Borders and small parts of the electoral registers for East Lothian and Midlothian. The areas outside Scottish Borders served by the Health Board are not readily defined by existing ward boundaries. This will present complications both in communicating with the electorate and managing the elections. The relationship with local authority boundaries is more complex for some of the other Health Boards, notably Greater Glasgow Health Board which covers the area of 1 entire local authority, almost all of 5 further local authorities, substantial parts of North Lanarkshire and South Lanarkshire, and small parts of North Ayrshire and Stirling.

The Commission also understands that the fact that boundaries are not co-terminous presents some additional challenges in ensuring appropriate coordination between Health Board services and local authority services such as Housing and Social Work Services.

Therefore, having regard to these two factors, it seems to the Commission that in the interests of efficient and effective service delivery and clearer local accountability, there is a case for aligning Health Board and local authority boundaries wherever possible. Ministers have powers under the National Health Service (Scotland) Act 1978 to do this by Order, and some prior rationalisation of boundaries, using these powers, would greatly help the administration of any election to health boards based on the existing electoral registers.

The Commission’s second observation concerns the advice that it might be asked to give to Ministers concerning electoral wards for Health Board elections. The Commission’s recommendations on electoral wards for local authority elections are governed by a set of rules for the design of wards, set out in Schedule 6 of the Local Government (Scotland) Act 1973. It is important for the work of the Commission to have such rules in order to ensure that its recommendations are consistent and are based on a rationale that is transparent. The Bill as drafted makes no mention of rules or criteria which would provide the basis for the Commission’s advice to Ministers on sub-division into electoral wards for Health Board elections, nor does it set out what the mechanism for devising such rules would be. As currently drafted, the Bill would lead the Commission to use its discretion to devise rules for its own use.

If the Committee would find it helpful, the Commission and its Secretariat would be happy to give evidence in support of these observations.

Dr Hugh Buchanan
Secretary
Local Government Boundary Commission

LOCAL HEALTH CONCERN

Local Health Concern (LHC) is a group in West Fife set up to question service changes proposed by NHS Fife in 2003. We are registered with Electoral Commission to stand in Scottish Government Elections.


As you will see LHC were broadly in favour of Elected Boards. The reasons being given in January Consultation response.

Now that the Scottish Government has brought forward its Bill we will confine our comments to the way a Board would be voted in and constituted.

We would broadly accept the points made in the Bill in this respect but notice potential omissions of detail.

1. Elections to Boards should be concurrent with Local Authority Elections to maximise voter turn out.
2. All candidates should give a profile statement. This should include membership of a Political Party, Pressure Group or specific Health Related Group (e.g. Diabetes UK).

3. The use on Ballot Paper of a Political Party or Group as at (2) should not be allowed.

4. Candidates must live in Health Board Area in question and no NHS employee can stand.

5. By not breaking Health Board into sub-areas (CHP area) all elected members could end up coming from one area of Health Board.

6. There is a fear the Health Boards will stay politicalised (as some already are). As such we see a case for any retiring Councillor or MSP being barred from seeking election to a Health Board for a period of 4 years.

7. Whilst any elected Board Member would be entitled to expenses/loss of earnings, salaries should not be such that they act as a "Pension Top Up." Many members of the public involved in NHS Groups currently do so on an expenses only basis.

John Winton,
Chairman,
Local Health Concern

MS SOCIETY SCOTLAND

Introduction

The Multiple Sclerosis Society Scotland is the largest voluntary organisation for people affected by multiple sclerosis in Scotland, with almost 4,000 members across the country. An estimated 10,500 people in Scotland have MS, a higher prevalence than anywhere else in the world. MS is also more prevalent amongst women, with the ratio of women to men with MS around 3:1.

The MS Society is committed to bringing high standards of quality health and social care within reach of everyone affected by MS and to encourage and support medical and applied research into its cause and control.

The MS Society Scotland funds research, runs a holiday respite centre in North Berwick, provides grants to individuals and a range of education and training on MS. It also produces numerous publications on MS and runs a freephone specialist telephone information service.

There is also a network of volunteer branches across Scotland that provide advice and support to people affected by MS at a local level.

Principle of direct election to health boards

The Society welcomes the Scottish Government’s objective to encourage greater public and patient involvement in the planning and delivery of local NHS services in Scotland. The Society supports the principle of direct election to health boards and believes that elected boards will provide an important impetus to efforts to improve the transparency of decision-making in the NHS and facilitate community involvement in these decisions.

Practical benefits of elected members

Elected members should provide greater legitimacy to the decisions made by boards as well as providing new opportunities for communities to put their views on local health services to the elected members. For example, we would envisage elected members being more accessible and amenable to meeting with patient groups and charities than is currently the case with most boards. The directly elected members will also be able to raise issues about health care provision that have been raised with them in their community in the way that local authority councillors do on a range of services that local authorities provide. This should mean that in the long term communities perceive the NHS as more responsive to their concerns and needs.
Along with many other respondents, the Society highlighted the important role that local authority councillors currently play on Boards, not only in terms of the democratic scrutiny they can bring to their work but also with the agenda of closer working between Boards and local authorities. Directly elected members will complement the work done by councillors and perhaps provide a more effective outlet for two-way communication between NHS boards and local authorities.

**Costs of elected boards**

In its submission on the Scottish Government’s plans earlier this year the Society expressed the view that the potential cost of direct elections is a concern. The estimated cost of £5m for initial elections is undoubtedly a small amount in the overall scheme of NHS expenditure, but it could provide a considerable boost to specific areas such as neurological care for example.

Clearly another factor is that the greater the cost of the elections, the greater is the potential for the public to become frustrated or annoyed by the exercise which in turn could have an impact on electoral turn out or trust in elected Boards. We believe that £5m is probably about the limit for cost and that all possible ways of holding the cost of elections down should be investigated prior to even beginning to pilot elected Boards. If costs can be restricted then we are confident that most people will believe that the benefits will outweigh the costs.

**Risks of having elected members**

Some of the risks associated with elected boards were highlighted in the last session of Parliament. One of the key ones would be the potential emergence of groups or individuals with particular views or stances i.e. single issue slates, which would then seek to attain a controlling or influential position within a Board. This could not only potentially distort local health needs or priorities, but also represent a threat to the national cohesion of NHS Scotland, which has taken years to recover after the internal market system of the 1990’s was dismantled.

On a lower level there could also be a danger that electors will believe that elected board members can deal with individual problems or cases relating to health services in the way that an MSP or local councillor would do for other services. The role and responsibilities of the elected members will have to be carefully spelled out so that both they and the electorate are aware of what their powers are. Finally one practical concern is that very low turnout in elections to boards could potentially undermine some of the positive benefits if the elected members are subsequently not viewed as being representative or having a sufficiently wide mandate. Promoting the elections and encouraging turnout will therefore be critical to the overall success of introducing elected members.

**Elected members scope for action**

In the response to the Government’s consultation on its plans the Society expressed the view that it will be important for Boards to continue to provide generally consistent levels of service across Scotland and follow national policies and priorities. It is particularly important that Boards should continue to abide by national standards and guidance in order to ensure that patients can receive similar levels of care and service provision wherever they live in Scotland. The only realistic way of ensuring this is to maintain the accountability of boards to Ministers. This should not restrict innovation in the way in which decisions are made and the public involved, as well as changes to the way in which services are delivered, and this would offer considerable scope for the input of elected members.

**Alternatives to direct elections**

While the Society is supportive of elections to health boards there are a number of other developments that we believe should run alongside the introduction of elected members. One that we highlighted in our response to the Scottish Government is for the Scottish Health Council to be given a higher profile, for example through improved marketing and advertising, to help build the public’s understanding of its role and enhance their trust in it as a champion of patient and public involvement. Embedding it within an NHS quango was probably not particularly helpful in terms of its status and the public’s view of its independence from NHS Boards. Consideration could be given to making it truly independent of NHS Scotland bodies in order to give the public absolute confidence in its independence.
In terms of other measures for increasing effective engagement we would highlight the need for better information and publicity about the current engagement activities as a first step. All too often patients and the public are simply unaware of the ways in which they can become engaged in local healthcare decisions. While this has certainly improved in recent years there is still considerable scope for improvement.

The development of more interactive, web-based consultative mechanisms would also help to facilitate greater participation and feedback. Most board websites are very static and concentrate on providing information rather than encouraging participation and involvement. As people become more used to sharing their views and opinions on a range of subjects via online surveys and web based forums, it seems a natural, inclusive and cost-effective way for the NHS to reach out to service-users and the wider public on an ongoing basis.

Practical issues relating to the Bill

The Society believes that the composition of health boards as set out in the Bill gets the balance between elected members, councillors and appointed members right. We broadly agree with the arrangements for the elections asset out in the Bill and support piloting direct elections. We have already highlighted concerns about the cost and need to hold these at the lowest level possible.

Ryan Norton,  
Communications Manager,  
MS Society Scotland

NHS AYRSHIRE AND ARRAN STAFF SIDE

The Trade Unions do support the principle of direct election to Health Boards and believe that it would bring a greater sense of ownership of the health agenda to a local community.

- We believe that elected members on Health Boards would ensure that issues which are close to communities would feature more on the Health Board agenda and would allow the real views of the community to be articulated at Board meetings and would encourage a challenge to the centralist approach which is driven by Government and enacted by Boards.

- We feel that the cost would be relatively insignificant in the grand scheme of things and the real benefits to communities would be viewed as money well spent by those communities and that the support needed for these individuals would not be any greater than that which already exists for current Board members.

- There is an obvious risk of the ‘single issue’ vote and all that this could bring with it but the Scottish people can be trusted to ensure that these issues are not allowed to dominate the wider agenda. There is a further danger of increased political interference by various parties but given the hugely political nature of the NHS currently it would be hard to imagine that this would a major issue.

- Whether elected members issues would be compromised by their accountability to ministers is not new. Existing members are often accused of being ‘in the pay’ of Scottish Government and keen to hang onto their jobs and therefore less likely to challenge Board decision making when it is a political imperative. The skill of public servants in drafting the bill will be critical to its success as any notion that an elected member can be dismissed from the Board as a consequence of challenging government policy on a local issue must be avoided at all cost. The purpose of the role must surely be to deliver a balance between local and national thinking.

- We do not think that there is an alternative to elected members as the alternatives would not deliver the democratic mandate needed to fulfill the role.

Additional questions
Health and Sport Committee, 7th Report, 2008 (Session 3) — Annexe C

- We are content with the model described although feel that a more prescriptive model of executive membership to ensure a consistent approach across Scotland should be applied.

- We feel that the proposal to designate each Board area as a single ward is flawed and will not assist Boards in maximising the participation in elections. We feel that more local wards are likely to lead to local candidates providing the local population with an individual that they are able to identify with rather than the possibility of one area dominating the election driven by those who wish to manipulate the process to their advantage. There are likely to be specific issues which will arise from the election of Board members to Special Boards and in particular what their constituency actually is.

- We support the idea of a pilot before moving forward fully but caution against a ‘volunteer’ approach to this. It is important that it is tested in a ‘significant’ mainland Board and in an Island or Special Board to get a rounded view of the success or otherwise of this approach.

- We believe that this will bring challenges in its implementation but that these challenges are not insurmountable and will lead to greater democracy in the delivery of Health Services within Scotland.

In summary, the Trade Unions/Professional Organisations within NHS Ayrshire & Arran support the move to an element of direct election to Health Boards and ask the Scottish Parliament to deliver this in an effective and well planned way.

John Callaghan,
Employee Director,
NHS Ayrshire & Arran

NHS BORDERS

NHS Borders has a strong track record in engagement with local communities in the design of services and in setting priorities. We believe that our size, scale and close working relationships with community planning partners supports many of the objectives of the Bill.

We have sought comments from interested stakeholders, including community groups and Board members. An anonymised list of the comments we have received is attached. These comments reflect the views of a number of individuals, but do not represent the views of the Board.

Comments Received:

1. I favour open election to Health Boards if only to publicise and demonstrate openness and opportunity on an equal basis. However, I do not believe that, on their own, elections will bring about the representation anticipated. There is a need to engage more closely with Community Councils in seeking Board members thereby growing an involvement of communities and the councils who represent them in the work of the Board. Elections should be held in such a manner that they ensure at least geographical balance by holding them around clusters of communities.

2. I do not support the idea of elected members. It would not add any significant advantage to the abilities, experience and contribution of non-executives appointed previously because a) anyone who wishes to stand for election has always had the option to apply for a Board place b) if they have not been selected in the past it is presumably either because they were judged not to have the required competencies or there were better people available and therefore - c) an elected system is less likely to result in the most able individuals being appointed. It would add considerably to the cost and bureaucracy of the Board. It significantly increases the risks of single issue members or geographically focussed members skewing the Boards priorities. Indeed, if elected members come to the Board table with the intention of putting their constituents interests first, then a skewing of priorities is a highly likely outcome.

3. Non executives are appointed to many Boards which involve the use of public funding so why is this only directed at the NHS? People standing for election may be doing so for local issues.
4. My own view is that the current system for appointing NHS Board members does need to change. The existing system makes it extremely difficult for a very large percentage of the population to consider applying. The level of flexibility required of a non-executive member means that a potential applicant must either a) be retired; b) be self-employed and prepared to arrange their work commitments around Board commitments, c) be wealthy enough not to need to work; or, d) have a very understanding employer. This rules out a very substantial number of people who would have much to offer, and, inevitably, results in a narrow field of potential candidates. I also think that potential candidates must find the current application form very off-putting.

However, although I do advocate change, I am not convinced that the proposal to move to elected Board members would overcome the difficulties I’ve outlined. Moreover, the cost of the proposals would be considerable at a time when the NHS is stretched to meet service needs.

5. As an elected member of the Board I have experienced the very significant highs and lows. When you are elected you immediately are accountable to a constituency. However, you also have a clear corporate accountability which may (and has) put you in conflict with some of them. You are not prepared for this and it has the potential to produce a significant personal dilemma.

I also concur with the others concerns regarding cost of elections. When I was elected we adopted a one member one vote system (unusual in other Boards) basically because we only had 44 recognised stewards and H&S reps. It only cost £36 (for postage) but the time for administration was considerably more than we anticipated. Not sure I would support something that could take thousands from patient care with no guarantee of success.

6. There would have to be a way of conducting those elections that was completely inclusive, and which took into account people’s experiences. The essence behind this Act is to be open and inclusive and to ensure that the general public is represented on Boards properly. To elect a member would open up the opportunities perhaps, but it might be that articulate and people preoccupied with their own personal power would achieve the selection process, while those with greater experience may not achieve the necessary votes.

No system of bringing people in is perfect.

Practical benefits might be that the person might be closer to the ground/grassroots issues.

The costs of running such elections would outweigh any benefits and focus too much attention on the personalities in the Board implying they have more power than they do; we are a corporate group and cannot have disparate members other than within fair voting or discussion.

Elected members having scope for action could destabilise the operational workings of Board, with particular issues getting more attention – and might be keen to get in again so a fixed time would be necessary?

Alternatives are plenty; make it more inclusive, give people across the community a chance to consider themselves, get out into the community sector to seek applicants, and encourage the Scottish Executive to be more open in their choices, even with all the procedures in place, it still feels as if there are instances where people are elected to positions, by being known.

Elections might skew the strengths and experiences we need; for example if we need accountants, business experience, as well as clinical, or community. The present system of applying is good, and just needs improving to encourage people from all sectors to get involved?

7. I can see no benefits in particular. However I would support a review of how non-executives are recruited to Health Boards in order to make it more inclusive. I can see little extra benefit of having elected members rather than appointed members. I believe this would merely divert funds which could be used for patient care, with no recognisable benefit.

Elected members will be voted in either on the basis of a topical single issue (e.g. stop closures) or a party political basis, which will bias their viewpoints on the Board. It will be unclear what constituency the member is representing rather than the total borders population.
We may not have the useful set of skills and attributes that can be selected when appointing non executives under the current system as an election system will not select people on that basis.

Elected members are likely to view strategy and decision making on a short term basis as they are likely to be driven by the vote winning qualities of decisions rather than the long term good of the population and the Health Service. This may delay and prevent the difficult decision making that Boards need to undertake to fulfill their duties within their financial constraints.

Health will become even more of a political issue than it already is rather than being able to concentrate on providing the best services possible.

The current appointment process could be reviewed to encourage and allow people who would not currently apply for positions to do so. The variability of the demands on non executives means people must either be retired, wealthy, unemployed or successfully self employed in order to take on the role - this will not be changed by elections – in fact elections are likely to exclude more people.

If the arrangements are to be piloted then one of the factors evaluated must be the electoral turnout. If this is low (as is likely) then the results can be easily skewed by a one issue candidate and the voters influenced by that issue - the change should not go ahead unless a reasonable level of turnout occurs.

Susan Cowe,
Business Services Manager,
NHS Borders

NHS FORTH VALLEY

Please see below the response to the call for written evidence on the Health Boards (Membership and Elections) (Scotland) Bill on behalf of NHS Forth Valley. These comments are consistent to those previously submitted to the Scottish Government in response to the Consultation.

Support for the principle of direct election to health boards

The Government has introduced the proposal for direct elections to health boards with the aim that this will achieve greater patient and community involvement in planning and delivering local health services. NHS Boards and now CHP committees for the most part have well established and healthy partnership arrangements with elected membership, PPF, voluntary sector, and lay member representation and it is the view of NHS Forth Valley that these relationships should be allowed to develop as a means of achieving this aim rather than risk the introduction of additional bureaucracy through direct elections to health boards. For this reason, NHS Forth Valley has concerns about the proposal to introduce direct elections.

What the practical benefits of having elected members on health boards would be

The Policy memorandum suggests that the value of having elected members to Boards will be to give practical effect to the partnership/mutual approach to the NHS in Scotland. It is also noted that the Government has addressed several of the concerns that arose at the consultation stage by stating that, e.g. election regulations may make provision about who is qualified to be a candidate for election and the likelihood that each health board area will comprise of a single electoral ward thereby encouraging a broad range of candidates to come forward, reducing the possibility of uncontested elections in smaller wards or single issue candidates from dominating an election.

Whilst this appears sensible in theory and would, on paper, suggest that Boards would be more publicly accountable, there remains concern that elected members could not be representative of the public as a whole within a health board area and there are already mechanisms in place as discussed previously whereby views of the public and public involvement can be properly obtained at a local level.

It is also likely that, despite best efforts to encourage a wide range of candidates for election, the usual sectors of the population will invariably dominate leaving representation from the young, disadvantaged, minority ethnic groups, for example unrepresented at Board level.
It is noted that Councillors will remain appointed by Ministers following nomination within local authorities. NHS Forth Valley has already suggested that greater public involvement and engagement could be achieved if these Councillors were also to become members of their local CHP Committee this ensuring better linkage between local CHPs, its parent NHS Board and the Local Authority.

Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

Given that the benefit of elected members remains unclear and untested, the current view of NHS Forth Valley is that it is unlikely that benefits would outweigh the costs.

The financial memorandum describes how the costs have been estimated and that there are a number of variables that could cause fluctuations to the current figures. Indeed it is already noted that the costs have already risen from £5m in the consultation to £13m in the financial memorandum. It is unclear from these estimates if any funding has been allocated for individual candidates, for example, manifesto printing, or are candidates expected to self fund?

Given the current financial climate it seems likely that the costs associated with introducing direct elections might be better spent on direct patient care.

**What the risks are of having elected members on health boards**

Elected members are unlikely to have mechanisms in place to enable them to seek the views of the electorate and therefore would be elected on the basis of their manifesto. It would be difficult, therefore, for them to truly represent the local population and the risk to Boards is that their input is based on particular issues and a lack of understanding about the broader health board issues.

There is also concern that there will always be a need for health boards to make difficult decisions regardless of the level of public involvement and engagement that has taken place. Boards need to demonstrate conclusively that there has been adequate public involvement. Having elected members on health boards will not necessarily provide that assurance.

Careful thought would need to be given regarding the difficulty or the loss that Boards could suffer if they were unable to retain the calibre of non executive directors currently serving as Board members whose contribution is considerable and who are currently appointed after undergoing a rigorous and competitive appointments process.

Whether elected members scope for action will be affected by health boards continuing accountability to ministers

The question of achieving an effective national NHS strategy must be considered. Directly elected members could conceivably choose to focus exclusively on relatively narrow local issues that might be in conflict with national strategies. However, the Bill has attempted to clarify the accountability aspects of its proposal so all Board members would need to perform within these boundaries.

Local Authority Councillors are currently appointed to Health Boards and whilst they retain a wide range of constituency interests where health services are concerned, they already have a duty to consider how local authority services operate in conjunction with local NHS services as a whole.

**Whether alternatives to direct election exist as a means of increasing public involvement in the NHS**

As already stated current systems and processes for enabling Boards to better engage and involve patients and the public in service change at a local level should be extended by strengthening existing guidance and by creating a mechanism for Boards to share learning.

There may also be scope to consider increasing local authority membership to CHP Committees.

Turning now to your additional points as follows:-
The composition of health boards as set out in the Bill

This is broadly acceptable. The Bill proposes that the total number of councillor members and elected members of a Board must amount to more than half the total number of members. There is currently a benefit to Boards in having strong clinical and executive director input at Board level and it is important that this be retained and that decisions are made based on sound principles that support patient care.

The arrangements for elections as set out in the Bill including the franchise, voting system and designation of each health board area as a single ward

The approach proposed appears to be practical.

The arrangements for piloting direct election as set out in the Bill

NHS Forth Valley strongly supports the use of pilots to examine the efficacy of direct elections to health boards. It is important that the pilots should consider alternative voting methods. The arrangements proposed appear to suggest that the pilot will encompass the full 4 year election cycle before the pilot is reviewed and a report produced. This approach is supported.

The practical implications and cost of bringing the Bill’s provisions into force

NHS Forth Valley remains concerned, as previously stated, that the cost of introducing this legislation, albeit “modest in the context of current NHS spending in Scotland” is excessive and unnecessary given the financial climate. There are alternative options to achieving the aim of improving public and community engagement and involvement which should be pursued.

For a population of five million in Scotland which already has elections for MP, MSP, Local Authorities and Community Councils, it may be that a further tier of elections will lead to confusion and voter apathy. If there is low turn out representatives could be elected with little authority and would speak neither as experts nor as public representatives.

Beverley Finch,
Head of Corporate Services,
NHS Forth Valley

NHS HEALTH SCOTLAND

The Equalities and Planning Directorate within NHS Health Scotland welcomes the opportunity to contribute evidence to the Health and Sport Committee on the Health Boards (Membership and Elections) (Scotland) Bill.

Health Scotland established a new Equalities and Planning Directorate on 1st April 2008. The purpose of the Directorate is to provide a centre of expert advice and support to NHS Scotland on promoting equality and diversity, eliminating discrimination and reducing health inequalities. We work in partnership with NHS Boards and other stakeholders to enable all communities and individuals to improve their health.

We also welcome the Scottish Government’s intention to encourage greater involvement from communities in the planning and delivery of health services. This is underpinned by legislation such as the NHS Reform (Scotland) Act 2004, public sector equality duties on race, gender and disability as well as recent government policy such as Better Health, Better Care which proposes a more mutual NHS.

We would however like to raise a number of issues concerning the involvement of the full range of Scotland’s diverse individuals and communities on Health Boards through direct elections.

While progress has been made to engage and involve people from such communities – including those from the key equality groups, we still have much more work to do in establishing fair and meaningful relationships with people traditionally excluded and who continue to face barriers in engaging with public bodies such as NHS Scotland. At the same time there is a danger of such policies and procedures being informed by assumptions and stereotypes and we would encourage...
recognition of diversity within, as well as between, communities in order to prevent this from happening.

We would also like to highlight the potential risk of discriminatory practice as part of direct elections if traditionally excluded communities are not represented on Health Boards. This could perpetuate exclusion from the planning and delivery of local health services and is an issue that other Boards raised during the consultation on the proposed Bill.

We acknowledge that opening up opportunities for younger people to be involved in making decisions about health services is an encouraging step which will contribute towards more effective participation of younger people in public life. We look forward to hearing more about how the Government intends to achieve this and how people will be supported to participate. We would also like to hear more about how positive attitudes can be promoted towards the participation of particular equality groups in public life such as disabled people, people from minority ethnic communities, lesbian, gay, bisexual and transgender (LGBT) people, people from different faith groups and older people.

The Scottish Government’s commitment to make progress in reducing health inequalities in Scotland, recently articulated in Equally Well, is welcomed. Directly electing members of the public to Health Boards could potentially dilute efforts to tackle health inequalities if the voices of people from traditionally excluded communities are not represented on Health Boards. NHS Fife and NHS Lothian also raised these concerns during the consultation on the Bill.

Our Directorate will be working with all NHS Boards and Scottish Government to support a definition of health inequalities that is explicit about all the factors that can contribute to inequality in health.

We are also working with Boards to support the involvement and engagement of all communities in the planning, delivery and impact assessment of health services. Representation of a diverse range of people on Health Boards could contribute in efforts to take action to eliminate inequalities in health.

We welcome the proposals to evaluate the pilot elections and would ask that the evaluation includes involvement of diverse communities and key equality groups in the process.

On a more practical basis, we would hope that consideration will be given to:

- building the capacity of elected Board members to understand the full range of issues that contribute to inequalities in health, the links with equality and diversity and community involvement;
- reviewing and monitoring the composition of Health Boards to ensure appropriate public representation across the equality strands in order to identify and address any under-representation of particular groups in public appointments in Scotland; and
- election venues being held in fully accessible venues and communication available in a range of languages and formats to remove potential barriers for participation. While we understand the need to pursue efficient and cost effective implementation we would hope that this would not be at the expense of these practical measures.

Thank you for the opportunity to contribute our views to the Committee on the Bill.

Cath Denholm,
Director,
Equalities and Planning Directorate,
NHS Health Scotland

NHS NATIONAL WAITING TIMES CENTRE

The NHS National Waiting Times Centre is an NHS Special Board made up of two distinct parts – the Golden Jubilee National Hospital and the Beardmore Hotel and Conference Centre. For more
information on the NHS National Waiting Times Centre, please visit: www.nhsgoldenjubilee.co.uk and www.thebeardmore.com.

As a Special Health Board, we treat patients from across Scotland and are therefore not directly affected by the proposals to introduce direct elections to territorial NHS Boards. We believe given the national status of Special Boards (as established by orders under the 1978 Act) that it is sensible to exclude them from these proposals. Nevertheless, we welcome this opportunity to respond to the call for written evidence. We have not attempted to answer all of the questions posed and have restricted this response to those areas where we feel that we are best able to contribute.

**Direct elections to NHS Boards**

Individual Board members need to bring an independent judgement on strategy, performance, and governance as well as contribute fully to Board discussions and share responsibility for decisions. It is our considered opinion that any substantial shift to the current recruitment method could limit the pool of experienced and available talent.

It is true that this development may enhance the openness and honesty of an NHS Board to its local community. However, it is unclear whether the individuals elected would engage in the spirit of collective responsibility that is needed within a Board.

It is important to note that direct elections will very likely encourage “single issue” campaigners which may well interfere or conflict with other Board business.

Public sector funding should be directed to frontline patient/public care and services so we would highlight that any elections to health boards should be done in the most cost effective way possible.

**Public involvement and accountability**

The NHS National Waiting Times Centre welcomes any moves that allow greater patient and public involvement. To realise this aim, we have a number of lay groups such as our Disability Reference Group who are involved in designing and delivering our services from beginning to end. We believe that allowing patients to be involved in operational developments will ensure positive and effective improvements to front line services.

The current role of an NHS Board is to be accountable to the public and stakeholders. Although direct elections to Boards may give individuals a good grasp of strategic issues and allow them to be part of the decision making body, we are unsure whether this will lead to greater overall general public involvement. It is indeed questionable whether it will ensure increased accountability over and above the normal functions that are currently in place (for example, communications strategy, work undertaken by Patient Focus Public Involvement teams, Annual review and reports, Freedom of Information etc).

In practical terms we have reservations about how Health Board elections will deliver a result that genuinely reflects the wishes of the majority of the electorate. With turnout for political elections often low we hope that any future trial of this approach will consider the issue of turnout as one of its success criteria. Under these proposals it would be possible for a Board member to be elected on a very small turn out of votes. We believe such an outcome would undermine confidence in the new system and may lead to a lack of confidence in the mandate of any elected Members.

In summary, we believe that individuals put forward for direct elections should have the knowledge and expertise to enable them to discharge their full range of responsibilities. We have deep concerns about whether that will be the case. We are also unsure of the impact that direct elections will have on ensuring greater public involvement and accountability. With so many uncertainties remaining over the effectiveness of direct elections we support the decision to trial this system before a national launch. We believe the proposed trial should be extended both in terms of time and the number of boards involved. As it stands the trial only allows time for one election. By extending the trial for a second election (regarded as phase 2), with an additional Board involved, further lessons could be learned prior to any national launch.
Purpose of Report: To give NHS Orkney’s views on the questions raised by The Scottish Parliament’s Health and Sport Committee in seeking evidence from all NHS Boards on the new Health Boards (Membership and Elections) (Scotland) Bill, which was introduced by the Scottish Government on June 25th 2008.

Background: The main purpose of the Bill is to alter the composition of health boards to include directly elected members and provide a statutory basis for the presence of local councillors as health board members. The Bill also makes provision for the holding of elections to health boards and proposes these provisions are to come into force on a pilot basis.

NHS Orkney has already, in response to the consultation document on the Local Healthcare Bill, submitted a comprehensive report answering, from a local perspective, all of the 33 questions asked. We hope the Health and Sport Committee will take note of the Board’s views raised in that document which are unchanged.

Now, we specifically respond to the Health and Sport Committee’s additional questions which will inform its consideration of the Bill at Stage 1.

Q1 ‘Does the Board support the principle of direct elections to health boards.’

In our Local Healthcare Bill consultation response we said a flaw in the consultation was that the Board was not being asked whether or not it wanted elections, because the answer would be ‘No’. While the board is not against the principal of holding elections to health boards it feels the costs would outweigh any benefits and that there needs to be careful consideration of the balance between elected members and those formally appointed.

Q2: What would the practical benefits of having elected members on health boards be?

Better public involvement in the NHS is the reason given throughout the Bill which states there is universal recognition that there needs to be improvement in the way NHS and communities engage, although there are few suggestions as to how to achieve this. NHS Orkney therefore sees no benefits in having additional elected members on its board under the system highlighted in the Bill. In small rural areas there is a real risk that those who are elected are members of groups with particular issues rather than having wider interest across the whole range of health board priorities.

Q3: Would those benefits outweigh the costs arising from running such elections and supporting elected members?

No

Q4: What would be the risks be of having elected members on health Boards?

Here, in the earlier consultation, one highlight of concern we raised on this matter was the emergence and dominance of single issue candidates. The Bill has addressed this to a degree by not advocating a ward system for elections. In other words elected health board members would represent Orkney as a single entity. We discounted ‘politicising boards’ in our earlier submission but this was a fear expressed by others who responded to the healthcare bill consultation. We felt if there were elections all health board members should be elected and political candidates could not be barred from standing. Our key concerns are over the dilution or imbalance of the skill mix which would most likely happen if elections took place and of a dominance from those with particular issues they wish to have addressed by having a voice on the Board.
Q5: Will elected members scope for action be affected by health boards’ continuing accountability to ministers?

Yes. If someone is elected by the general public they are generally responsible to the general public and take heed of the public’s view. If they are responsible to a Cabinet Minister they are more likely to take a view that will not offend the government and meets the code of governance that all have to adhere to following appointment. This fundamental difference in approach could result in real tensions within the Board which detract from the business.

Q6: Do alternatives to direct elections exit as a means to increasing public involvement in the NHS?

Here we have evidence of our good work in Public Focused and Patient Involvement (PFPI) which has escalated over the past few months with members of NHS Open (Orkney Public Engagement Network) coming onto certain committees as well as having the Community reference Group in place which has provided an excellent accountability and advisory structure from the public. These are definitely less costly options that could be escalated and expanded upon.

In the next section the board has answered the questions even though it does not support the principle of direct elections unless all non-executive directors are elected.

Q7: Do NHS Orkney Board members support the composition of health boards as set out in the Bill?

No. The composition of boards would change and the size of the new boards could get out of hand to the extent that the balance of debate could be lost. The Bill states that elected members, including local authority representatives and those directly elected by the public, will form a majority of health board members. A Chair and other members will be appointed by Ministers, as at present. But this would most likely lead to a cut back in the number of executive directors at board level, which would be a derogatory step. To encompass everyone as we are now would mean a rise in the number of board members. In larger boards this could become unmanageable.

Q8 Do we support the arrangements for elections as set out in the Bill including the franchise, voting system and the designation of each health board as a single ward?

Here we should thank those responsible for accepting our point in the consultation regarding the single ward issue. As far as the elections go (The cost will be about £13M across Scotland), the NHS Orkney Board believe that any money used to fund elections, and support additional costs in the running of boards, should not be money that could be spent on front line health services but new money from central funding.

Initially NHS Orkney suggested elections be held on a four year cycle alongside those to local government. The Bill appears to support that view along with voting by Single Transferable Vote as per local authorities. There is a view, however, within NHS Orkney that, as an alternative, half of the board could be elected every two years thus ensuring better continuity of Non Executive Directors. We wish to express again all health Board Non Executives and the Chair should be appointed (other than the council representative).

Q9 Do we support the arrangements for piloting direct elections as set out in the Bill.

We supported pilots in our initial consultation and that remains our view. We also do not want NHS Orkney to be one of the three pilots.

Q10 Do we support the practical implications and costs of bringing the Bill’s provisions into force?

No, because there is no guidance on where the money is coming from to fund such elections, no clarity on what the make up of a board or the effects on organisation might be.

John Ross Scott,
Chair,
NHS Orkney
The contents of the Bill will be formally considered by North Lanarkshire Council’s Policy and Resources Committee at its next meeting – on 16 September – but, following consultation with the Vice-Convener of the Committee, the following comments are offered.

**Principle of Direct Elections to Health Boards:** The Council has already formed the view that the need to address the local responsibility and answerability of Health Boards should best be addressed by a further acknowledgement of the local elected mandate of members of local authorities – and that the non-appointed membership of Health Boards should be drawn either exclusively from members of local authorities appointed by the relevant Councils or, alternatively, should consist of such members and of local members of the Scottish Parliament.

**Practical Benefits of Directly Elected Members:** Having regard to the foregoing, the Council’s view was that the deficit in local answerability of Health Boards can more effectively be addressed by the extension of Council representation, as proposed by the Council, than by direct elections.

**Benefits and Costs of Direct Elections:** As indicated above, the Council is not of the view that direct elections would carry greater benefit than extension of Council representation: it will be noted, also, that extension of Council representation would not involve the cost of further elections.

**Risks of Directly Elected Members:** It is considered that the importation of direct election carries the risk of candidates being elected on a single issue basis with neither the capacity nor desire to address ongoing important issues in light of the wider needs of the whole communities served by a Health Board.

**Elected Members’ Scope for Action:** It is acknowledged that the parameters within which any Health Board may determine options are set not only by the powers of the Health Board and the resources available to it but, also, by the Health Board’s accountability to Ministers – and the corresponding accountability of Ministers to Parliament.

In addition, the following further views are offered.

**Composition of Health Boards as set out in the Bill:** It is suggested that the Bill should be extended to make statutory provision for an increased number of members to be nominated by local Councils: the minimum of one member from each Council area is considered entirely insufficient.

**Proposed Arrangement for Elections:** It is noted that there will be difficulties in extending the franchise: currently electoral registers do not include 16 and 17 year olds and, in addition to the software costs as identified in the financial memorandum, it is to be anticipated that there will be additional costs linked to the canvass.

**Ward Areas:** Having regard to local experience it is considered that, in the Lanarkshire Health Board area, there is clear justification for at least two wards – one coterminous with the boundaries of the North Lanarkshire Council area and one with the boundaries of the South Lanarkshire Council area.

**Voting System:** It is noted that the financial memorandum makes provision for the electronic counting of votes: the Council is, however, aware of the recommendations of the Electoral Commission with regard to electronic counting and the experience, elsewhere in Scotland, of difficulties with the electronic counting of votes following last year’s local government and Scottish parliamentary elections. It is suggested that account be taken of the Electoral Commission recommendations in determining the STV system to be selected.

**Practical Implications and Costs:** It is noted that the financial memorandum proceeds on the basis of elections covering 20% of the Scottish electorate and being conducted by all postal ballot: it is noted that the memorandum goes on to advise of the application of an ‘average cost’ of £2.60 per vote cast in an all postal ballot. This would appear to be an average cost based on a number of valuation studies conducted by the Electoral Commission over a period of time none of which used
the STV system. It is not clear that account has been taken, in estimating costs, of experience in the recent local government and Scottish parliamentary elections and it is considered that the costs are likely to exceed the projected figure.

**Postal Ballots:** The Council has previously indicated its concern with all postal ballots: it remains the case that, despite ease of application for postal votes, the vast majority of voters in North Lanarkshire prefer to vote at polling stations. It is considered that this preference should be acknowledged and that any election should not be confined to postal voting.

I hope that these submissions are of some assistance to the Health and Sport Committee in considering the Bill.

Yours sincerely,

John O'Hagan,
Executive Director,
Corporate Services,
North Lanarkshire Council

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**ORKNEY ISLANDS COUNCIL**

In response to your call for evidence from all interested parties on the general principles of the Health Boards (Membership and Elections) (Scotland) Bill, I wish to submit the following on behalf of Orkney Islands Council.

Members who responded were in favour of the principle of direct elections to health boards. Comments made included the following:

- Members would be accountable to the public/local electorate, leading to a genuine atmosphere of accountability.
- Such accountability would imply members would have to publicise their views on health matters prior to elections.
- Members would be more likely to work for the electorate.
- There would be more desire from the public to sit on health boards.

Members who responded largely felt the benefits would outweigh the costs arising from running such elections and supporting elected members.

When asked what the risks were of having elected members on health boards, the following comments were received:

- There are dangers that candidates might put themselves forward on party political grounds.
- The very fact that the public can intervene in the make up of health boards, albeit on a fairly regulated timescale, could lead to a lack of continuity within the board and an increase in 'catch up' time for new elected board members.
- Some members felt that elected members’ scope for action could be affected by health boards’ continuing accountability to Ministers. The following comments were made:
  - This accountability applied to some extent in local government and Ministers would always wield substantial powers.
  - The boards would have two masters and would be restricted in their actions.
Members on the whole felt alternatives to direct election would not exist as a means of increasing public involvement in the NHS. It was questioned how important the public rank involvement with the NHS. The suggestion was made that the public would rather be in a position to criticise than be criticised. In any case, it was believed that, for many ‘customers’, it was the quality of service that mattered.

Regardless of whether they supported the principle of direct election, with regard to the composition of health boards as set out in the Bill, while there was some agreement, the following comments were made:

- The number of members appointed by Scottish Ministers should be more specifically defined, perhaps as a percentage of the total board membership.
- A greater proportion of elected members should be included on the boards.
- No objections to staff continuing to be full members of boards as they are now.

In respect of arrangements for elections as set out in the Bill, including the franchise, voting system and designation of each health board area as a single ward, the following comments were submitted:

- It would seem sensible to have elections in the same year as local government elections, but it may be the case that a stronger health board could be elected if local authority membership was known prior to ‘public’ elections to health boards taking place.
- It would make sense if health board area boundaries were consistent with local authority area boundaries.

Members were content with the franchise, but did not think that the Single Transferrable Vote should be used as a voting system.

Members agreed with the arrangements for piloting direct election as set out in the Bill. However, there was a suggestion that, rather than having elections, local community councils could be asked to nominate members for appointment to health boards.

There were no comments on the practical implications and cost of bringing the Bill’s provisions into force.

Alistair Buchanan
Chief Executive
Orkney Islands Council

PROFESSOR RICHARD DAVISON

The Government aim of greater public participation in the running of the Health Boards should be regarded as a positive policy however the best method to achieve this objective is less clear. In addition public perception of problems within the NHS are often outside the control of individual Health Boards thus this proposal would not solve this problem from the public point of view.

On balance we would not support this method of membership of Health Boards as a way of increasing public involvement in the running of the NHS.

The key concerns of the proposed elections to Health Boards are:

Cost versus the tangible benefit – the projected total cost of £13m may be insignificant in terms of the overall budget but it still represents a significant sum that could be used in patient care. Would the benefit of public elections to the Health Board outweigh this cost should be a central question in any pilot evaluation.
Adequate representation – The ‘Policy Memorandum’ document suggests that the adoption of entire Health Board areas as a single ward would prevent single issue candidates predominating. This may reduce the possibility but not prevent it, open elections will always be susceptible to this.

Composition of the Health Board – There is a provision for at least one appointed member of the board to hold a post in a university with a medical or dental school. Why does this not include a nursing school as we believe they could equally contribute to the function of the board.

Prof R.C Richard Davidson,
Director of Research,
Sport and Exercise Science,
Napier University

ROBERT GORDON UNIVERSITY

The Robert Gordon University is pleased to respond to the Health and Sport Committee’s call for evidence on the Health Boards (Membership and Elections) (Scotland) Bill. As a University we have one over-riding concern regarding the composition of the Boards as set out in the Bill, which we address first in our response. In responding to the other questions we have drawn upon the expertise of Professor Valerie Maehle, Dean of our Faculty of Health and Social Care.

Composition of Boards as set out in the Bill

It is disappointing that only Universities with medical and dental schools have an appointed member to Boards. This does not reflect current practice within a modern health service. As the health care team is now key to service delivery with many of the non medical professions undertaking the roles of doctors it seems inappropriate that the focus remains only on Universities with medical schools.

The Board composition clearly supports the principle that those members directly representing the public’s views are in a position to affect decision making. However this type of balance between elected and appointed members may make the Chair position difficult as he/she is not elected and may lose credibility because of this.

Whether you support the principle of direct election to health boards

As there is no overall support for direct elections from the respondents to the consultation process and no other substantive evidence has been provided in support of the effectiveness of this mechanism for gaining true public involvement, it is hard to be supportive. This decision seems to go against one of the tenants of the NHS in Scotland that everything that it does should be evidence based.

What would be the practical benefits of having elected members on health boards

If this was regarded as the mechanism through which the public was represented and their voice heard, the number of consultation processes could be considerably reduced thus preventing the diversion of human and financial resource away form direct patient care. However, it is debatable that elected representatives would be able to provide the full spectrum of opinion that would be derived from a full consultation process.

Whether benefits would outweigh the costs arising from running such elections and supporting elected members.

Without knowing the detail of the likely cost and the costs of a typical consultation process it is not really possible to answer this question.

What are the risks of having elected members on health boards?

There could be confusion between the roles of these elected members and the local authority councillors which could result in conflict. As these elected members would have a mandate from
the public they may feel disinclined to be “corporate” and this could result in a Board that is very difficult to Chair and could become dysfunctional. Furthermore there is no guarantee that the hard to reach members of the public whose views are so difficult to obtain would actually vote in an election, therefore, these Board members could be representing fairly narrow sectors of the community resulting in little improvement in true public representation.

**Whether elected members scope for action will be affected by the health board’s continuing accountability to ministers**

Presumably a similar situation would be in place as exist with Local Authorities and Councillors. However elected members may be somewhat disillusioned at what they can do within the constraints placed upon health Boards as a result of the targets set by ministers.

**What alternatives to direct elections exist as a means to increasing public involvement in the NHS**

The full potential of the existing mechanisms i.e. Community Partnerships, CHPs Community Planning etc. has not been reached. More work needs to be done to promote these as a means by which the population can express it views. In to-days world the media could be used more effectively. As most of the population watch television then the voting systems used on television shows could be skewed to seek opinions regarding proposed changes to health service provision. It could also be used as a medium for informing the public. Perhaps the NHS in Scotland should have it’s own television station.

**Arrangements for elections**

The proposed arrangements seem appropriate and fair and following the standard system that is in place for other elections. It is unclear whether they will be held at the same time as local and national elections. If this was the case there could be confusion but the turnout might be better than if the health board elections are done separately.

Having a single electoral ward especially where there is a large geographical area may be counter productive. The public may feel equally distant from the decision makers as is currently the case.

While it is good to pilot this system before any rollout it will be a distraction to the business of running the health service for the Boards that are selected. The duration of the pilot is of sufficient length to allow a new system to bed down and really see if it has made an impact.

**Practical implications and cost of bringing the Bill’s provisions into force**

There will undoubtedly be significant costs incurred in implementing the Bill. With the continual financial challenges experienced by the Board to achieve service delivery the use of money for this purpose will cause tensions. There is also likely to be an impact on effectiveness of the Board and it relationships with partner institutions. This may place the pilot Board at a disadvantage especially in the early years and this needs to be recognised as it may impact on performance. The whole process could be considered as presenting a further distraction from the urgent business of providing quality health services for patients.

Duncan Cockburn
Office of the Principle and Vice Chancellor
Robert Gordon University

ROYAL COLLEGE OF GENERAL PRACTITIONERS

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.
The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent over 4000 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

The consultation document was reviewed by the Executive Officers of RCGP Scotland and distributed to members of the RCGP Scottish Council and the RCGP Scotland Strategic Patient Group (P3).

In direct response to the questions posed within the consultation, RCGP Scotland would like to make the following points:

1. Whether you support the principle of direct election to health boards

Feedback was mixed on this topic. Whilst the majority of respondents did not disagree with the idea in principle, some replies were very strongly against the move. Objections were cited on the grounds that alternative means of introducing greater accountability can be found that do not involve the risks or bureaucracy involved in this method. Concerns were also raised regarding elected members pursuing their own agenda and of low voter turnout.

2. What the practical benefits of having elected members on health boards would be

As seen in the above section, the provision for greater accountability would be seen as a welcome move. However general consensus was that, aside from this, no practical benefits could be seen in the specifics of the suggestions made.

3. Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

There was repeated concern over the financial implications of this change. In the current financial climate we feel that the costs involved are not justified by potential results, especially given the anticipated difficulty in generating interest from voters. It is felt that the cost spent on attracting voters would be far more than anticipated and not necessarily effective. Many members felt that more financially justifiable means could be found to increase accountability and public involvement.

4. What the risks are of having elected members on health boards

Overall we feel the main risk to this suggestion is the strong possibility of members being elected with a single issue or specific agenda in mind. The general apathy of the voting population could further exacerbate this, with most voters garnering interest in a specific area or viewpoint.

5. Whether elected members’ scope for action will be affected by health boards’ continuing accountability to ministers

We feel that the scope for action would inevitably be affected by accountability to ministers; but we feel that this would be an important and necessary safeguard.

6. Whether alternatives to direct election exist as a means to increasing public involvement in the NHS

We welcome the increase in accountability that the changes would provide, but would like to suggest that the development of focus groups or PPG’s would be a more efficient alternative to the elections in providing public involvement.

7. The composition of health boards as set out in the Bill

Responses were divided over the ratio of elected members to appointed members. Most members, however, felt that it would be important to maintain a majority of appointed members.
9. The arrangements for piloting direct election as set out in the Bill

We do not have any criticism of the arrangements of the piloting scheme. If the changes to Health Board elections were to be made, the pilot scheme is both an effective means of monitoring the move and a necessary safeguard.

We hope that these comments are useful and would welcome any updates regarding changes that may be made as a result of the discussion. If you wish any further information from the RCGP please contact at:

Dr Kenneth Lawton,
Chair,
Royal College of General Practitioners Scotland

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<th>SCOTTISH BORDERS COUNCIL RESPONSE – SEPTEMBER 2008</th>
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<td><strong>Point 1 – whether you support the principle of direct elections to health boards.</strong></td>
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| There are currently a confusing range of accountabilities and direct election may not resolve that, or increase citizen understanding of public accountability. Other options for increasing local accountability without direct elections should be considered. However, the principle is supported but the proportion should perhaps be no more than 30%.

| **Point 2 – what the practical benefits of having elected members on health boards would be.** |
| There would be more visible local accountability.

| **Point 3 – whether those benefits would outweigh the costs arising from running such elections and supporting elected members.** |
| Local accountability could outweigh the costs and it would need to be kept under review.

| **Point 4 – what the risks are of having elected members on health boards.** |
| This may lead to members with no clinical expertise or an over-preponderance of members pursuing single issues. It would be importance to achieve a balance of skills and knowledge.

| **Point 5 – whether elected members’ scope for action will be affected by health boards’ continuing accountability to ministers** |
| It is not clear what is meant by the phrase “elected members’ scope for action”.

| **Point 6 – whether alternatives to direct election exist as a means to increasing public involvement in the NHS.** |
| The reintroduction of Health Councils would increase public involvement.

David Hume
Chief Executive
Scottish Borders Council
16 September 2008

SCOTTISH COUNCIL ON DEAFNESS

Attachment accompanying this emailed response – pdf of SCoD Research Paper – Local Health Planning. Can be downloaded at
Scottish Council on Deafness (SCoD)
The Scottish Council on Deafness represents more than eighty organisations working with and on behalf of Deaf Sign Language users, Deafened, Deafblind and Hard of Hearing people in Scotland.

SCoD welcomes the opportunity to submit written evidence to the Health & Sport Committee on this Bill. Throughout this paper, the term “deaf” is used to describe Deaf, Deafblind and Deafened people, unless specified.

SCoD’s Written Evidence
SCoD submitted a response to the consultation on the Local Healthcare Bill in March of this year.

Although SCoD supports the general principle of direct election to health boards; at the present time, SCoD is not convinced that NHS Boards will be accommodating of deaf members or that the election process will be accessible to deaf people in Scotland. So our evidence has been written to highlight our reservations.

These reservations are:

1. At present, NHS Boards do not appear to be accessible to deaf people. As highlighted in our response, for example, NHS Greater Glasgow & Clyde Board holds bi-monthly meetings at 9.30am on the third Tuesday of the month. “Agendas for forthcoming meetings are usually available 24 hours prior to the meeting taking place, unless otherwise stated. Minutes are normally published 24 hours prior to the next meeting. Board Papers are made available on the morning of the meeting.”

As these papers are made available in English, Deaf BSL users either require more time to prepare or need to have the papers in BSL format. There is also an issue regarding the availability of communication support for all deaf people. Deafblind people may require a guide/communicator to help with understanding the paperwork. BSL/English interpreters, guide/communicators and Notetakers need preparation time with all available paperwork in order to provide appropriate communication support at the meeting – jargon, abbreviations, who’s who, etc.

SCoD recommends that all NHS Boards are given deaf awareness training and communication skills training in order to make them more accessible to deaf people in Scotland.

2. SCoD is concerned that any election process may not be fully accessible to deaf people, and therefore they may be reluctant to vote.

SCoD received two years funding from the Electoral Commission for an “Access to Democracy” Project, including the finances to employ a Project Co-ordinator to train and support Deaf BSL users, Deafblind and Deafened People, who will deliver workshops to deaf people throughout Scotland. This project aims to increase the confidence, understanding and awareness of deaf people to take a more active role in Scotland’s political process by increasing deaf people’s awareness of the electoral system, especially in Local Authority, Scottish Parliament, UK Parliament and European Parliament elections. The project will enable SCoD to work towards overcoming the communication and accessibility problems faced by members of the deaf communities.

BDA Wales received funding in 2003 for a similar project. From the pre-workshop questionnaires sent out to deaf people in Wales, “only 4.5% of people voted in elections due to lack of access to information.”

RNID Cymru estimates that there are 36,000 profoundly deaf people in Wales, therefore only 1620 profoundly deaf people have voted in elections. (http://www.rnid.org.uk/about/in_your_area/wales/statistics/) If the same percentage is applied to Scotland, of the 57,000 profoundly deaf people only 2565 people vote in elections.

3. With regard to the “Access to Democracy” project, the funding does not include providing information on how to become a candidate for election to office in the democratic process. This

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16 For more information about the Access to Democracy Project, go to http://www.scod.org.uk/Access_to_democracy-i-150.html

17 These figures are estimates and do include 16 – 18 year olds. There are no definitive statistics on the numbers of deaf people of voting age in the UK.

18 See footnote above.
additional information would have to be funded and produced in accessible formats to allow deaf people the opportunity to stand for election to NHS Boards.

In September 2007, using the Freedom of Information (Scotland) Act 2002, SCoD carried out a piece of research into the involvement of deaf people in the Scottish Health Council and NHS Community Health Partnerships. As you can see from the attached report, the results throughout Scotland are extremely varied. If NHS Boards are to involve deaf people in their area, then standards and good practice guidelines must be centralised and proper checks and balances put in place to ensure that deaf people are encouraged to stand for election and to vote in the proposed elections.

Mandy Reid,
Policy and Research Officer,
Scottish Council on Deafness

SCOTTISH HEALTH CAMPAIGNS NETWORK

Following on the consultation on the Local Healthcare Bill by the Scottish Government, the Scottish Health Campaigns Network welcomes the publication of The Health Board Membership and Elections) (Scotland) Bill.


Dr Robert L C Cumming,
Chairman,
Scottish Health Campaigns Network

SKILLS FOR HEALTH

Skills for Health is the Sector Skills Council (SSC) for the health sector. Our role covers all healthcare employers – including those in the NHS, independent and voluntary sectors. We are part of a UK network of Sector Skills Councils covering 85% of the UK economy. Our strategic aim is to develop a skilled, flexible and modernised workforce capable of improving productivity, performance and reducing health inequalities.

Our objectives are to:

- Engage with health sector employers to ensure we can be the authoritative sector voice on skills and workforce development for the whole sector
- Inform the development and application of workforce policy through research and the provision of robust market intelligence
- Implement solutions which deliver a skilled, flexible and modernised workforce capable of improving productivity, performance and reducing health inequalities
- Champion an approach to workforce planning and development that is based on the common currency of national workforce competences.

As the Sector Skills Council we have limited our response to those areas where we believe skills and workforce development can make a significant contribution to the aspirations of the Bill.

We support the principle of direct elections to Health Boards as a means of strengthening public involvement, engagement and accountability. In order to ensure that elected members are truly representative of local communities, we believe that opportunities for learning and development for those elected and those aspiring to such positions need to be made available. We suggest that the proposed pilots could provide opportunities for such development by providing a focus for:
Identifying the learning and development support required by elected members and evaluating the best methods of providing this.

Identifying the range of opportunities for people to become involved at all levels in health care organisations thereby providing them with the opportunity to develop the skills required as an elected member. Existing Public Partnership Forum’s could provide a focus for this.

Evaluation of the pilots should include these two elements and include some determination of the costs of providing such learning and development.

There are a range of National Workforce Competences and National Occupational Standards (NOS) available which could be used as a basis for the design of learning and development. In particular the Management and Leadership NOS developed by the Management Standards Centre and imported by Skills for Health into our own database is an important tool to support development in this area. These are subscribed to by other Sector Skills Councils, including Government Skills, through the Alliance of Sector Skills Councils. Further information on these is available from:


http://www.management-standards.org.uk/

In addition Skills for Health is currently undertaking work to identify a suite of competences relevant for a range of public and patient involvement activities. This will include those in positions of leadership and will explicitly include those competences required by the public and service users. This work is expected to be completed in December 2008. Further information on this work is available from Karen Walker, Health Policy Development Team.

In respect of the proposed composition of Health Boards we would stress the importance of ensuring that the right balance between executive and non-executive directors is achieved, the mechanisms for achieving this need to be clear and explicit.

Finally, we believe that an equality impact assessment should be undertaken to ensure that there is not the unintended outcome of narrowing rather than increasing the range of people represented on Boards. This relates strongly to our earlier point around ensuring that development opportunities are made available to those aspiring to Board membership.

Once again thank you for the opportunity to respond to this Call for Evidence and I can confirm that we are happy for our response to be made public.

Brian Payne,
Executive Director,
UK Networks and Strategy,
Skills for Health

STONEWALL SCOTLAND

1. Introduction

Stonewall Scotland was established in 2000. Since then we have been campaigning for equality and justice for gay, lesbian, bisexual and transgender (LGBT) people living in Scotland. We work with businesses, the public sector, the Scottish Executive, the Scottish Parliament and a range of partners to improve the 'lived experience' of LGBT people in Scotland.

The work we do involves campaigning on, and raising the profile of, LGBT issues; helping to explain new policies and legislation practically to stakeholders; developing public services to involve LGBT people in Scotland; and working with employers in the private, public and voluntary sector to tackle homophobic discrimination in the workplace.
We would like to thank you for this opportunity to respond to the consultation on the Local Healthcare Bill proposed by the Scottish Government.

2. Existing Structures

Stonewall Scotland have some concerns around the proposals included in this bill and we will outline these below. We think it is important first, however, to outline the existing public involvement mechanisms and current work using these structures.

NHS Scotland has existing structures to ensure local health boards involve their communities in their decisions. The Public Partnership Forums (PPF) set up through the NHS Reform (Scotland) Act 2004 and their roles are described in SEHD guidance available here [Link no longer operates]

The PPFs are used in developing new strategies for Local Health Boards and have input into how these strategies are developed.

The problems they face in effectively doing so are through a lack of proper investment in their support and structures. Support for PPFs from NHS staff usually comes as an ‘add-on’ to someone’s job. It is our opinion that a resource such as a PPF needs a full-time commitment to ensure engagement with the local communities and ‘buy in’ from Health Board members.

Community engagement takes time and real effort to sustain anything more than a tokenistic approach. It is our belief that with proper investment in existing PPF structures, NHS Scotland could lead the field in community engagement with Local Healthcare. If successful, this method would put the local communities, including those who still experience health inequalities, at the heart of their Healthcare Services and help to ensure service users become stakeholders in their own healthcare. There is an urgent need to use investment to build capacity of LGBT communities (and other excluded groups) to respond to public engagement opportunities. Many health boards and others are now seeking LGBT involvement but the capacity of local groups to respond is very low and requires substantial investment.

3. Direct Elections

It is our belief that direct elections to Local Health Boards will not of themselves increase the participation of the full diversity of local communities in their healthcare, especially those groups such as Lesbian, Gay, Bisexual and Transgender (LGBT) people who may be discriminated against or perceived as electorally un-attractive. A process which relies on campaigning to a majority creates a very real danger of ignoring excluded groups, such as LGBT people. A focus on services of high public resonance such as consultant-led maternity or blue-light A&E risks marginalising services such as mental health.

The Scottish Social Attitudes Survey shows that around 30% of Scottish people still think same-sex relationships are wrong, 51% saying it is acceptable for a service provider to refuse services to same-sex couples, and 50% said they would be unhappy if a relative married a transsexual person. These statistics show there is a long way to go to change attitudes to LGBT people in Scotland.

4. Equality and Diversity

With the Government’s own proposed strategy for ensuring equality and diversity in public appointments, there is a move to ensure that governance of public services represents the public they serve. If direct elections were to go ahead it would make the NHS the only public service that is not guaranteed to have full cultural competence and may be unrepresentative of LGBT people. This is not an acceptable position for Stonewall Scotland and has the potential to create a two tier system of public services for LGBT people.

If, however, elections were to go ahead there would have to be some safety net. As the current system involves ministerial control over board members, boards who do not work to reduce health inequalities can be ‘disciplined’ or indeed board members can be removed. Without this power
being retained over elected members, it is our concern that LGBT health priorities will be overlooked in favour of more politically favourable policies. It is however; hard to see how ministerial powers can be retained over an elected member.

5. Eligibility

Should the Bill pass and the Government implement an electoral system for health boards, it is our belief that criteria for disqualification from seeking election should be based on the candidate’s willingness to prioritise health needs. If a candidate has expressed the view that they will place their ‘moral views’ above the clinical needs of service users, their eligibility should be withdrawn. Access to and funding of LGBT specific services have been seen for some time as a clinical need, ensuring the continued reduction of health inequalities for the LGBT community. If a candidate expresses a wish to reduce these services on so called ‘moral’ grounds their eligibility should be withdrawn. Subsequent to election Ministers should use their powers to remove a member from office on the same grounds.

6. Discrimination Politics

This is of great concern to Stonewall Scotland. It is not that long ago that HIV was seen as ‘the gay plague’, or that campaigns on buses throughout Scotland fought to keep Clause 2a and indeed since then certain religious leaders spoke out against LGBT rights and ran on that platform for the 2007 Scottish Elections. LGBT people have only recently gained the legal right to service provision, something which is still seen as controversial.

It is our concern that these views around LGBT rights might be used by certain groups that seek to remove them, to campaign in Health Board elections. Instead of balanced debate around clinical priorities, it is our view that LGBT service provision will be seen as ‘PC nonsense’ and the potential of pitting children’s services against already scarce Gender Dysphoria treatment is a very real threat.

7. Assessment of Pilots

Where pilots take place the measure of success for these in our view must be that of positive health outcomes. These must be measured and disaggregated across the equality strands to determine whether any detrimental effect has been seen on certain groups. It must also include perception of healthcare services and electoral process amongst LGBT people and its effect on the already existing health inequalities. The views of LGBT groups, local and national, must be included.

8. National approach

Access to health services by LGBT people must remain consistent throughout Scotland. Perceptions around numbers of LGBT people in different local areas are often wrong and allowing a board discretionary power to remove or restrict services otherwise available in other areas would create a ‘postcode lottery’ for LGBT people’s access to healthcare. It is our view that not ensuring consistent levels of performance throughout Scotland will further increase health inequalities for LGBT people, especially those in remote and rural areas.

It is also of some concern to Stonewall Scotland that directly elected members of health boards could work outside of national standards frameworks. Directly elected health board members could potentially have the power to ignore and work outside these frameworks with no intervention by QIS, SHC or ministers. This has a very real potential to compound existing health inequalities and indeed create new ones.

9. LGBT Health Priorities

Stonewall’s report on Lesbian and Bisexual Women’s health shows the clear health inequalities that are not currently being addressed in Scotland. This report showed half of all L&B women under
20 have self-harmed compared to 1 in 15 generally and that 15% of Lesbian and Bisexual women under 20 have attempted to take their life compared with 0.12% of general population.19

An in depth look at suicidality of young Gay and Bisexual men in Edinburgh by Hutchison et al20 found that they are 6.7 times more likely to attempt suicide than the general population. Clements-Nolle et al21 also found that amongst Transgender people 32% of respondents had attempted suicide and over 60% had scored greater than 16 on the CES-D Scale (Centre for Epidemiological Studies – Depression Scale).

By comparing GHQ (General Health Questionnaire) scores greater than 4 of the general population in the Scottish Health Survey 2003 and scores greater than 4 in Warner et al22, it is possible to show that LGB people are around twice as likely to report clinical signs of mental health problems than the most socio economically deprived section of the general population (up to 45% LGB with GHQ >4 in Warner et al, around 20% General Population in 5th Quintile of Scottish Index of Multiple Deprivation in Scottish Health Survey 2003).

It is our view that the proposed 13 million pound costs for the elections would be better spent on reducing health inequalities. Ensuring better funding and reduced waiting times for Gender Dysphoria treatment or better investment in Mental Health promotion for LGBT people would produce real health outcomes that make a difference to the lives of service users.

Kevin Morris,
Health and Education Officer,
Stonewall Scotland

WEST LOTHIAN PUBLIC PARTNERSHIP FORUM

The call for written evidence on the Health Boards (Membership and Elections) (Scotland) bill was sent out to all 96 individual members of the PPF and all 34 Community Councils in West Lothian. Twenty-six responses have been received by telephone, post and email. The document was also discussed at the PPF meeting in August where members asked that Julie Cassidy the WL Patient & Public Involvement Officer collate and submit the responses on behalf of the PPF.

The following is the West Lothian PPF’s joint response to the Bill.

Do you support the principle of direct election to health boards?

The West Lothian Public Partnership Forum [WL PPF] would welcome the appointment of more lay members to NHS Boards and these members should be able to represent a wide range of interests, such as service specific user, public and voluntary sector groups. There should also be appointment of a lay member representative of each Public Partnership Forum [PPF] of a Community Health (and Care) Partnership [CH(C)P]. The selection and election of these representatives would be from within the membership of each PPF & CH(C)P. This would simplify the election process as we consider that the interest in "public" elections would be very low.

However, we do not agree with the proposal to directly elect members to the Health Boards. The WL PPF feel that because of the apathy of the public for local government and Parliamentary elections that if an election with public candidates was held, even with high publicity, the interest would more than likely be very low. The number of people voting at a public election for a NHS Health Board election would not justify the expense. It is also the view of the WL PPF that candidates who put themselves forward for election could be "political activists" and may be supported (indirectly) by a political party.

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Do the benefits outweigh the costs of running and supporting direct election?

No. Generally the WL PPF feel that although the document states the "The costs associated with this Bill and the implementation of the pilots are modest in the context of current NHS spending in Scotland". That this is still a significant amount of money and the money would be better spent ensuring that, the NHS engaged more effectively with patients and the public in regards to service delivery and change. This is ultimately public money and it should be spent on enhancing services and not on election processes. The NHS is a complex and technical service and those that are employed to make the decisions should be allowed to do their jobs effectively whilst ensuring appropriate and timely public engagement / consultation processes are adhered to.

What are the risks of having elected members on health boards?

The following direct responses were collated from PPF members -

1. Elections to Boards would be a real disaster bringing politics straight into NHS
2. Political bias, the elections could be used as a route for career Politicians
3. Human nature being what it is we will never eliminate bias - either political or single issue
4. Need to have lay member's on the Boards who are part of PPF structures and can link CH(C)P's and Boards a direct election might impede this process
5. Change criteria of how Boards operate and consult with public - not change whole system by having elections - more complex and not necessarily effective in engaging with people
6. Public members are not experts and don't want to be - we pay professionals to make decisions
7. Stronger communication with Boards and public - for God's sake don't destroy the healthy Boards - it would be expensively messy and they do a good job.
8. Elections are not the easy answer; make more effort to get the right people along to Boards - NHS needs to work harder at it -
9. Direct Election could see political party affiliations
10. Having a Lay Member won't make a difference if accountability structures not changed.

As a means of increasing public involvement do alternatives to direct elections exist?

Yes. As previously stated, the West Lothian Public Partnership Forum would welcome the appointment of more lay members to NHS Boards and these members should be able to represent a wide range of interests, such as specific service user, public and voluntary sector groups. There should also be appointment of a lay member representative from each Public Partnership Forum of a Community Health (and Care) Partnership. The selection and election of these representatives would be from within the membership of each PPF.

The selection of candidates should be made from a pool of people who wish to serve on the NHS Board, and the selection should be representative of geographical and health related interest. Candidates would require, to obtain a number of proposers but their selection should be made by a central committee, to ensure a balance between different patient/public interests.

There should remain the power for the Government to appoint members from business and elsewhere who have the relevant skills to run a multi department business.

The number of Local Authority members should remain as at present otherwise the size of the Boards would become cumbersome and dilute their executive function.
Remove perceived barriers and simplify things so people feel they can be involved more. Ensure more resources are put into groups such as the PPFs.

Currently the management of these groups is unregulated with each CH(C)P supporting their PPF in a different way. If the PPFs were used as they were initially intended, as mechanisms for the CH(C)Ps to engage at an early stage in the service development & change processes, then the public would see the service providers (NHS & CH(C)Ps) as being transparent and working together in partnership with the public to ensure the changes to the service are effective and fit for purpose.

Direct elections will not change the way the NHS works it will only make the Boards more guarded in the way they conduct their business.

Julie Cassidy,
West Lothian Patient and Public Involvement Officer,
Strathbrock Partnership Centre
ANNEXE D: REPORT BY THE FINANCE COMMITTEE

Report on the Financial Memorandum of the Health Boards (Membership and Elections) (Scotland) Bill

The Committee reports to the Health and Sport Committee as follows—

INTRODUCTION

1. The Health Boards (Membership and Elections) (Scotland) Bill (“the Bill”) was introduced in the Parliament on 2 June 2008. The Health and Sport Committee has been designated as the lead committee on the Bill at Stage 1. Under Standing Orders Rule 9.6, the lead committee at Stage 1 is required, among other things, to consider and report on the Bill’s Financial Memorandum. In doing so, it is required to consider any views submitted to it by the Finance Committee.

2. At its meeting on 16 September 2008, the Committee agreed to adopt level two scrutiny in relation to the Bill. However, on considering written evidence submitted, the Committee agreed to seek oral evidence from third parties, meaning that level 3 scrutiny was applied. At its meeting on 4 November, the Committee took evidence from the Electoral Registration Committee of the Scottish Assessors Association, and then from Scottish Government officials.

3. The Committee also received written evidence from:
   - NHS Ayrshire & Arran
   - NHS Fife
   - NHS Grampian
   - NHS Highland
   - NHS Lanarkshire
   - NHS Lothian
   - NHS Shetland
   - The Electoral Registration Committee of the Scottish Assessors Association (on behalf of all 15 Scottish electoral registration officers)
   - The City of Edinburgh Council
   - Clackmannanshire Council
   - Fife Council
   - Highland Council
   - Midlothian Council
   - North Lanarkshire Council
   - Orkney Council
   - South Ayrshire Council
   - West Dunbartonshire Council.

4. All written evidence received is annexed to this report. The Official Report of the evidence session can be found on the Parliament’s website, at: http://www.scottish.parliament.uk/s3/committees/finance/or-08/fi08-2501.htm

THE BILL

5. The Bill seeks to improve public engagement and involvement with Health Boards by introducing elections to territorial Health Boards in Scotland. It makes a number of amendments to Schedule 1 to the National Health Service (Scotland) Act 1978 so as to change the constitution of Health Boards, stipulating that a proportion of the membership of each Health Board will be made

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23 For information on the Committee’s three-level system of scrutiny for Financial Memoranda, please see http://www.scottish.parliament.uk/s3/committees/finance/financialMemo.htm
up of elected members. It also inserts a new Schedule 1A into that Act setting out the framework for the elections.

6. The Bill provides for regulations to specify, in respect of each Health Board in Scotland, the total number of members of the Board and the number of that total which is to be represented by each type of member. Those numbers are expected to differ from Board to Board. Elected members, together with Councillors nominated by local authorities and appointed by Scottish Ministers, will form the majority of the members on each Health Board. The elected members will be remunerated at the same rate as current non-executive Health Board members.

7. Elections are to be held on a fixed four-year cycle. Regulations can specify the manner in which elections are to be conducted, although the Financial Memorandum assumes that they will be wholly postal ballots. Each Health Board area is expected to be a single ward for the purposes of elections, although regulations can specify otherwise. A single transferable vote (STV) system will be used, and the franchise will be extended to include 16 and 17 year olds.

8. The Bill provides for introduction on a pilot basis in certain Health Board areas. The number, location and length of pilots and the date of commencement will be included in subordinate legislation. Only one pilot order may be made. The documents accompanying the Bill indicate that a pilot is likely to be implemented in two Health Board areas.

9. The pilot schemes must be evaluated, and a report on the evaluation laid before the Parliament, before a decision is taken on rolling out the changes to other areas. If the decision is taken to support full roll-out, this will be done by subordinate legislation and will not require further primary legislation. The provisions cannot be maintained, or extended beyond the pilot areas, if a roll-out order has not been made before the period of seven years has elapsed since the first pilot area election or before Ministers repeal the pilot order if they do so at an earlier date.

SUMMARY OF COSTS OUTLINED IN THE FINANCIAL MEMORANDUM

10. The Financial Memorandum states that the costs associated with the Bill are modest in the context of current annual NHS spending in Scotland of over £10 billion, and states that the intention is that the all costs will be met from existing Health Board budgets.

11. The estimated costs provided in the Financial Memorandum for pilot elections are based on there being two pilot areas, using the STV voting system in an all-postal ballot and covering around 20% of the electorate of Scotland. The average cost per vote cast in all postal ballots (not only those using STV) is estimated at around £2.60. The Financial Memorandum assumes a 60% turnout from a potential electorate of 775,000 in the pilot elections, giving an estimated cost of £1.21 million. The cost of hiring vote-counting machines depends on the size of the electorate, but is estimated at £0.90 million for two pilot areas. The actual costs incurred in pilot elections will, however, depend on the areas chosen.

12. There are a number of other stated variables which might cause the costs to fluctuate. However, there is no information in the Financial Memorandum about margins of uncertainty or the cost implications of different scenarios.

13. The Financial Memorandum assumes that there would be around 20 elected members in total between the two pilot areas. These members would be remunerated at the same rate as other current Health Board members (around £7,500 pa), making an annual cost of £0.15 million. However, this would be offset by a corresponding reduction in the number of lay members on each Board. This would bring the estimated total additional remuneration over two years down to around £0.20 million – i.e. for each Board in the pilot this will mean additional annual remuneration costs of around £50,000.

14. The estimated cost of the evaluation study of the pilots is around £0.25 million. Modifying software to accommodate the extension of the franchise to 16 and 17-year olds will depend on the pilot area chosen and the software in use by the appointed returning officers. The Financial Memorandum estimates that the cost may be roughly around £50,000 per pilot area. However, the Cabinet Secretary for Health and Well-Being wrote to the Committee on 12 September to say that
the Government now intends to take a simpler approach to identifying 16 and 17-year olds, without the need for upgrades to IT systems. Funds estimated for the IT systems will now be used to bolster the budget for public information campaigns.

15. The Financial Memorandum also estimates a cost of £0.20 million for investment in public information and advice in the pilot areas to help ensure public understanding, support and turnout. It is anticipated that this level of funding would allow for a modest advertising campaign in the local press and for the production and distribution of written information.

16. Taking the above cost headings together, the total estimated cost of pilots in two Health Board areas (i.e. for election costs and remuneration for two years) is likely to be £2.86 million and is mainly expected to be met in 2010/11.

17. The Financial Memorandum estimates that, if elections are rolled out to all Health Board areas, this will cost around £13.05 million in total.

18. The Bill also makes provision for remuneration of members of committees or sub-committees of Health Boards. However, there are no plans to use this power at present and so no cost estimate is included.

19. The Financial Memorandum states that there are no costs expected to fall on local authorities, other bodies, individuals or businesses.

SUMMARY OF EVIDENCE

The cost of pilot elections

20. The estimated cost of the planned pilot elections is put at £2.86 million in the Financial Memorandum. This is based on there being two pilot areas, and includes the cost of the postal ballot, counting machines, publicity and an evaluation study.

21. Scottish Government officials confirmed that Health Boards have not yet been identified for the pilots. However, ministers are expected to select one largely urban and one largely rural area in order to provide a relatively geographically representative pilot. The costs will vary depending on the areas chosen. Selecting two moderately sized areas would imply a lower cost, while two larger boards might increase the cost to just over £3.5 million.25

Roll-out of elections

22. As the pilot is intended to cover 20% of the electorate, the cost of a future full roll-out of elections to all territorial Health Boards is calculated in the Financial Memorandum by multiplying the main pilot costs (excluding the cost of the evaluation study) by five. The Financial Memorandum estimated the full roll-out cost at £13.05 million. However, there was no information in the Financial Memorandum to indicate whether simply factoring by five was a sound basis for the estimate. The Cabinet Secretary’s subsequent letter stated that the methodology had now been reviewed and gave a revised roll-out estimate of £16.65 million.

Meeting the costs

Allocating funds to Health Boards

23. The Financial Memorandum states that the costs associated with elections are small in proportion to overall health service funding and will be met from existing budgets. A number of those submitting written evidence stated that the costs will nonetheless have to be met from patient care budgets unless separate additional provision is made by the Scottish Government.26 The Committee, therefore, sought clarification.

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26 For example, see written submissions to the Finance Committee from NHS Lothian and NHS Shetland.
24. Scottish Government officials confirmed that “an absolute guarantee exists for the pilots” that funding will be provided by the Scottish Government and that Health Boards will not have to take money from front-line services to pay for elections.\(^ {27} \) They stated that, “in the first instance, the costs of pilots that fall within the current spending review period will be met from central Government additional funding without calling on health boards’ allocation resources.”\(^ {28} \) It will, therefore, be “necessary to identify the pilot costs separately in addition to the allocations that already exist for health boards as part of the 2007 spending review outcome”.\(^ {29} \)

25. The Committee noted that it has not yet been decided whether to provide a set sum within which a Health Board will be expected to deliver an election or to take an itemised approach to reimbursing actual costs incurred.\(^ {30} \)

26. Officials stated that a decision on any future roll-out of elections to all Health Boards would only be taken after evaluation of the pilot elections and would be made by a statutory instrument which would be subject to approval by the Parliament. They emphasised that a future roll-out would be beyond the current spending review period and stated that the costs “would need to be fully and explicitly taken into account in the setting of health boards’ budgets for future years” at the time of a future spending review.\(^ {31} \) It is not yet clear whether the cost of elections will be an additionally-specified and separately identifiable central budget line or will be factored into overall Health Board allocations. Scottish Government officials acknowledged that Health Boards had some concerns about the estimated costs, but confirmed that officials had not spoken to Health Boards since they submitted evidence.\(^ {32} \)

27. Scottish Government officials confirmed that, while the remuneration of board members will be an annual recurring cost, the bulk of the overall costs will be met only at each election to Health Boards (i.e. every four years). They also indicated that, if the proposal is rolled out, elections to all Health Boards would take place at the same time rather than being spread out over different financial years.\(^ {33} \)

Identifying electoral administration costs

28. Electoral Registration Officers are principally funded through the budgets of the local authorities served by each Officer. The 15 Scottish Officers stated that they do not have access to additional funds in-year, and so would need recompense in advance of any work to support Health Board elections, rather than a system for reclaiming expenses afterwards. Clackmannanshire Council said that experience shows that some registration costs cannot be recovered and effectively amount to a “hidden subsidy” from councils to centrally-funded elections.\(^ {34} \)

29. In oral evidence, Electoral Registration Officers clarified that registration activities are not regarded as part of an election as such, and so costs cannot be reclaimed as an election expense. They stated that there are, therefore, likely to be some relatively minor costs on local authorities rather than no costs as stated in the Financial Memorandum.\(^ {35} \)

30. Similarly, the Bill provides that a Health Board should appoint an individual as returning officer for the election. Current Returning Officers are likely to be designated. The City of Edinburgh Council emphasised that reimbursement must be made for all costs – those that can be recovered through Returning Officers’ Fees and Charges, and also any ‘hidden subsidies’ in accommodation and core staff costs.\(^ {36} \) It is not clear from the Financial Memorandum how the Scottish Government intends to ensure that all identified costs are actually recoverable.

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\(^ {34} \) Written submission to the Finance Committee.
\(^ {36} \) Written submission to the Finance Committee.
31. Scottish Government officials confirmed that “the costs of the elections will be fully reimbursed by the Scottish Government”, and clarified that the costs stated in the Financial Memorandum for hiring counting machines include provision for Returning Officers’ costs. However, officials said that no provision has been made for Returning Officers’ personal fees, which would amount to around £50,000 for elections to all Health Boards. Officials stated that further clarification on whether this fee would be claimed is required. The lead committee may wish to pursue this.

32. Officials also confirmed that a limit of £250 will be placed on the election expenses of candidates, but that these will not be met from the public purse.

The method of conducting the elections

33. The Bill provides for subordinate legislation to specify how the election will be conducted. The costs in the Financial Memorandum are based on an assumption of an all-postal ballot. It notes that costs may be lower if other voting methods are used, but does not provide any information on the estimated costs of alternative approaches.

34. Some of those submitting evidence suggested that postal ballot security requires voter identification confirmation procedures. The necessary personal identifiers to make a postal ballot secure were estimated to be available currently for only 15-20% of the Scottish electorate. Scottish Government officials confirmed that the intention is to use a simple postal vote without identifiers, and that the £2.60 per vote cost cited in the Financial Memorandum does not, therefore, include the cost of collecting these.

35. North Lanarkshire Council also stated that the average cost of £2.60 per voter is not based on the most recent relevant experience, but on National Park Authority elections that preceded recent developments in postal voting. However, Scottish Government officials stated that the costs are based on five English elections specifically because they used the STV system.

Extension of the franchise

36. Some of those submitting evidence suggested that the cost of extending the franchise proactively to all 16 and 17-year olds is considerable, with the legal and cost implications of gathering and displaying data on those under 16 needing clarified. The Cabinet Secretary has now indicated that a simpler approach will be taken, with the register restricted to including only those who are already 16 and apply to be included. The Cabinet Secretary’s letter indicated that the simpler approach has no need for IT upgrades and, therefore, no cost, and the funds previously estimated for IT upgrades will now be diverted to public information. Electoral Registration Officers confirmed that this “reactive” approach would require minimal changes to systems.

Other issues

37. NHS Highland states that travel expenses for board members in its area are considerable and no mention is made of this in the Financial Memorandum. Scottish Government officials acknowledged that the figures used are average ones that will need to be extrapolated to individual boards.

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41 Written submission to the Finance Committee.  
CONCLUSIONS

38. The Committee notes, and welcomes, confirmation from Scottish Government officials that additional funds will be provided to meet the full cost of elections to those Health Boards selected for the pilot scheme. However, the Committee notes the uncertainty which remains over how the costs of a future full roll-out of elections will be funded and recommends that the lead committee pursues this issue with the Cabinet Secretary.

39. There are a number of aspects of the Financial Memorandum which have been usefully clarified in the course of evidence. The Committee considers that it would have been helpful for the Financial Memorandum to have reflected the range of possibilities for some of these aspects. For example, upper and lower estimates could have been given for the cost of the pilot elections depending on which Health Board areas were selected as ‘representative’. An illustration of the variable costs that would have arisen depending on different levels of turnout would have been illustrative of potentially significant fluctuations. Similarly, information on the likely variation in costs arising from different methods of conducting the elections would have been helpful. Finally, information could have been provided on the likely variation in travel and subsistence costs for members between urban areas and large rural areas.

40. Supplementary information from the Cabinet Secretary on the approach to extending the franchise and the methodology for calculating the full roll-out costs was useful. However, it is unfortunate that this information was not produced in time to be included in the Financial Memorandum, and it remains the case that the Financial Memorandum at the time of introduction should provide the best estimate of the costs associated with the Bill.

41. In seeking to clarify how Health Boards might meet the costs of elections, Scottish Government officials emphasised that, “The bill will commit expenditure to the pilots and nothing else.”45 However, this is a misunderstanding both of the purpose of the Financial Memorandum and of the Finance Committee’s scrutiny of it. The Bill does not commit expenditure as such and the Committee’s role is not to approve expenditure. However, while a full roll-out of elections will not necessarily follow if the Bill is enacted, the Bill does provide the statutory framework for authorising such a roll-out without further primary legislation. Officials have confirmed that subordinate legislation will be brought forward if a full roll-out is to take place. The Scottish Government’s own guidance on the drafting of Financial Memoranda states,

a. “Where a Bill proposes powers, or implementation is dependent on the detail in secondary legislation (or further primary legislation), it may not be possible to be precise. In these cases, the Memorandum should say so. But this should be supported by an outline of the Executive’s current intentions, the financial implications of these intentions, and the effect of varying the major assumptions.”46

42. The Financial Memorandum is, therefore, required to provide the best estimate of the cost of this roll-out and it is the role of the Finance Committee to scrutinise this estimate.

43. The Committee acknowledges that a full roll-out will be subject to the Parliament’s consideration of an evaluation study and approval of subordinate legislation. Where significant expenditure associated with a Bill will only become apparent with subordinate legislation, the Committee has in the past noted that it will track the subsequent statutory instruments and seek to scrutinise the financial implications. The Committee gives notice that it will seek to do so for any instrument authorising roll-out of Health Board elections. The Committee, therefore, recommends that the lead committee should seek an assurance that the evaluation which must precede any decision to roll-out elections will include a full assessment of all the costs of the pilot exercise and a restatement of the expected full roll-out costs.

ANNEXE E: REPORT BY THE SUBORDINATE LEGISLATION COMMITTEE

Report on Health Boards (Membership and Elections) (Scotland) Bill at Stage 1

The Committee reports to the lead committee as follows—

1. At its meetings on 23 September, 28 October, 4 November, 11 November and 18 November, the Subordinate Legislation Committee considered the delegated powers provisions in the Health Boards (Membership and Elections) (Scotland) Bill at Stage 1. The Committee submits this report to the Health Committee, as the lead committee for the Bill, under Rule 9.6.2 of Standing Orders.

2. The Scottish Government provided the Parliament with a memorandum on the delegated powers provisions in the Bill and on 11 November, Government officials provided oral evidence to the Committee.47

3. The Committee’s correspondence with the Scottish Government is reproduced in the Annexe.

Delegated Powers Provisions

4. Generally, the Bill concerns the constitution and membership of Health Boards. It amends provisions on the membership of Health Boards contained in the National Health Service (Scotland) Act 1978 (“the 1978 Act”). It also provides for the election of certain members to Health Boards.

5. The Committee considered each of the delegated powers provisions in the Bill. The Committee determined that it did not need to draw the attention of the Parliament to the delegated powers in the following sections: 1(2), and 11(3). The Committee also approves without further comment the powers in Schedule paragraph 1, which amends paragraph 4 of Schedule 1 to the 1978 Act.

Section 1(5) and (6) (constitution of Health Boards) – Power to specify the circumstances in which an elected member must vacate office

6. Section 1(5)48 amends the 1978 Act to give Scottish Ministers a power to make regulations that may specify the circumstances in which (a) an elected member must vacate office before the end of the period that a member holds office, and (b) the Scottish Ministers may determine that an elected member is to vacate office before the end of that period.

7. Section 1(6) amends the 1978 Act to provide also that regulations may specify circumstances in which Scottish Ministers may determine that appointed and councillor members shall vacate office. Accordingly, the Bill provides that Scottish Ministers may determine when a member (elected, appointed or councillor) shall vacate office, and the circumstances in which this function may be exercised may be prescribed by regulations. The regulations would be subject to negative procedure.

8. The Committee considers that the scope of a new delegated power to make subordinate legislation ought to, in general, be drawn no more widely than is necessary. The Committee was concerned that this delegated power enables any circumstances to be prescribed within which Ministers would have a discretion to determine that a member shall vacate office.

9. The Committee therefore wrote to the Scottish Government to ask

- why it considers it necessary to provide Ministers with the power to prescribe circumstances within which they have a discretion to require members to vacate office; and

47 Delegated Powers Memorandum
48 Section 1(5) inserts a new paragraph 10A into Schedule 1 of the 1978 Act.
10. The Scottish Government's response is set out in full in the Annexe. The response stated that the Scottish Government intended to retain the current Ministerial powers relevant to retaining control over Health Boards, including the power to terminate a Health Board member’s membership, where that seemed to be justified in the interests of the National Health Service (NHS).

11. The response also emphasised it is intended that there be a consistency of approach between all types of Board member, whether elected, appointed or councillor, and for the line of accountability to be the same in all cases. It was considered appropriate to delegate this power to subordinate legislation since specifying circumstances in which an elected member should vacate office may need amendment from time to time.

12. The Committee explored this issue further in evidence with Government officials at its meeting on 11 November. In particular, members questioned whether it would be possible for the circumstances when Ministers have a discretion to dismiss members (e.g. when it is in the interests of the national health service) to be set out on the face of the Bill.

13. In evidence to the Committee, Beth Elliot of the Scottish Government Legal Directorate stated “The existing power on which the proposed power is based is in subordinate legislation. The power to remove an appointed member, if the Scottish Ministers consider that to be in the best interests of the national health service, is in subordinate legislation, which is why we have decided to put the proposed power into subordinate legislation.” (Col 414)

14. Robert Kirkwood of the Scottish Government’s Health Delivery Directorate also stated “We already have a power to remove appointed members of health boards if it is in the interests of the national health service to do so. The proposal is to extend the power to cover elected members.” (Col 413)

15. However, the Committee notes that the scope and extent of these delegated powers in the Bill is wider than permitting removal of members where that is in the interests of the national health service. It permits a very wide discretion to put in future regulations any circumstances under which Ministers may determine that members should vacate office early. (This is in addition to the power to prescribe circumstances in which, if they occur, members shall require to vacate office.)

16. The Committee therefore wishes to draw the attention of the lead committee to the following concerns—

   (a) the evidence from the Scottish Government officials indicated an intention to apply the same criteria in relation to elected members, as may be applied to appointed and councillor members. However, as the Bill is drafted, future Regulations could set out different criteria for different types of member;

   (b) the decision to allow Ministerial discretion to require early vacation from office in yet-to-be-prescribed circumstances applying to publicly elected members is a significant issue, which has the potential to be controversial;

   (c) the Scottish Government in its written response and evidence have indicated that a “best interests of the national health service” test will be applied for all types of members, but as drafted the Bill will allow future regulations to change that criteria. (However, initial draft Regulations have been produced (amending the Health Boards (Membership and Procedure) (Scotland) Regulations 2001, which reflect that criteria.)

Type of Procedure

17. Accordingly, the Committee wishes the Scottish Government to consider the above concerns further. Were the Parliament to conclude that this power should be exercisable in some form by regulations, the question arises as to what type of procedure would be most appropriate.
18. In considering this issue members have taken into account:

- that the existing powers are in negative regulations, and it is proposed to put the power into place by amendment of those regulations;
- the significance of this power, including its application to elected members;
- whether it should be necessary for the subject to be debated in committee or Parliament, as would apply for affirmative regulations.

19. The Scottish Government has indicated in evidence that a policy decision has been taken that the same powers to terminate office shall apply to elected members, as with appointed and councillor members.

20. The Committee has noted that the current general powers in the 1978 Act, in relation to vacation of office of Board members, are subject to negative procedure. The power to terminate membership in the interests of the health service has been prescribed, for appointed members, by negative procedure regulations. The Scottish Government has advised Parliament, however, that the intention is that the power of the Scottish Ministers to extend this test across to the elected members (in effect) is proposed to be arranged by amendment to those negative regulations.

21. In favour of the affirmative procedure, however, the application of these powers to vacate office to elected Board members may be viewed as a significant power and a significant change. Given the potential controversy that appears inherent in the policy of dismissing elected members by Ministerial discretion, affirmative procedure would permit the greatest level of Parliamentary scrutiny of the conditions in which such discretion will operate (although of course it will not permit scrutiny of individual cases of the exercise of that discretion).

22. Accordingly, should the Parliament conclude that Ministers should have power to set the circumstances in which they may dismiss elected members in regulations, the Committee considers that such regulations should be subject to affirmative procedure.

23. Section 1(5) of the Bill also inserts paragraph 10A(2)(a) of Schedule 1 to the 1978 Act. This enables regulations also to specify the circumstances in which an elected member must vacate office before the end of their period of office. This refers to specified circumstances, for example a serious conviction of a member, which if they arise will require the member to vacate office, rather than circumstances in which the Scottish Ministers shall have a discretion. The Committee agrees that that paragraph 10A(2)(a) is acceptable in principle, and can be subject to negative procedure.

Section 2: (inserting schedule 1A to the 1978 Act – election regulations)

24. Section 2(2) of the Bill inserts a new Schedule 1A into the 1978 Act which makes provision for Health Board elections. Paragraph 13 of that Schedule gives the Scottish Ministers powers to make “election regulations”. A substantial amount of the detail in relation to elections is to be set out in these regulations.

25. In addition paragraph 13(2) to (4) of Schedule 1A provides wide supplementary powers in relation to elections. Paragraph 13(2) permits “further provision” about Health Board elections. Paragraphs 13(3) and (4) permit the application of enactments, with or without modifications, to elections.

26. The Scottish Government has stated in their written response that it is considered appropriate to delegate these powers to subordinate legislation as their content shall largely be “technical detail” concerning the mechanics of conducting elections which may require to be amended from time to time. The Scottish Government response also stated that the use of subordinate legislation strikes the right balance between the importance of the provisions and providing flexibility to respond to changing circumstances.
27. Paragraph 10(1) of Schedule 1A provides for conferring the franchise (entitlement to vote) in Health Board elections to persons aged 16 and over. In addition, election regulations may specify "any further criteria" which is used to define the franchise. For example, conditions may be imposed as to residency, registration in an appropriate register, disqualification criteria such as criminal convictions, being detained in a mental hospital, or whatever criteria Ministers may determine from time to time may be applied.

28. The Committee notes that this approach differs substantially from that taken in sections 1 to 7C of the Representation of the People Act 1983 governing general and local elections. In that Act, much more detail of the franchise qualifications are set out in primary legislation, as are the circumstances in which persons are disqualified. The Committee has also noted that there is no attempt on the face of the Bill to define the franchise by reference to the local government franchise, as the Scottish Government has stated is the currently intended policy (apart from the significant change for Health Boards elections that persons aged 16 or over shall be entitled to vote.)

29. In the Committee's view there is little doubt that some flexibility in relation to operational matters is required. Technical and procedural arrangements for the conduct of elections are likely to change over time. Such details are appropriate for subordinate legislation. However, the Committee wished to explore further the scope and intended use of this power, given that it would cover significant matters such as the entitlement to vote and powers to ascertain who is entitled to vote.

30. The Committee therefore took evidence from Scottish Government officials on the intention to use election regulations to define the further criteria for the franchise. Members queried whether setting the franchise was not a matter of principle that should be set by Parliament in the Bill itself, and whether it would be possible to restrict the power to make future changes to the franchise to any made in relation to local government elections. (Col 415 – 417)

31. In response, officials pointed out that certain key policy decisions such as the reduced voting age of 16 years and above or single transferable voting (STV) appear on the face of the Bill and commented that flexibility was required, as it is proposed to test the arrangements by the pilot in 2 Health Board areas. (Col 416)

32. However, Beth Elliot also stated; “We are aware that there are other examples of elections in which the franchise, if the local government model has been used, is prescribed in the Bill. We have not, to date, taken that approach, but we can consider it further.” (Col 417)

33. In addition, following the Convener’s observation that the proposals might be clearer on the face of the Bill, the Government agreed to consider this further.

34. The Committee therefore wishes to draw to the attention of the lead committee that the Government has undertaken to consider these matters further.

35. The Committee also draws to the attention of the lead committee the Scottish Government’s undertaking to put forward an amendment at Stage 2 that would require affirmative procedure for these regulations. The Committee proposes to review the proposed amendments at Stage 2.

How entitlement to vote is to be ascertained

36. The Committee asked the Scottish Government questions in relation to how those entitled to the franchise were to be identified – in particular those aged 16 and 17; and what information might be required to facilitate registration or assessing entitlement to vote.

37. The Scottish Government responded that it was envisaged that electoral registration officers (ERO’s) would be responsible for identifying eligible voters and that discussions were ongoing in relation to this role. The response stated that it was not considered appropriate to make specific provision for such matters in the Bill or within the scope of the election regulations, since this would be too prescriptive.
38. The Committee notes that the Bill makes no particular provisions to the effect that election regulations either shall or may specify how individuals aged from 16 years are to be ascertained, or registered in order to be entitled to vote. The Bill also does not appear to make any specific provisions for the obtaining of any information from persons aged from 16 years.

39. The Committee has noted the Scottish Government’s evidence on the role of EROs, but also notes that no detail is offered on how current legislation will enable this, or on how information is to be obtained from 16/17 year olds. The Committee considers that the identification, registration and verification of who shall be entitled to vote is a matter of some practical importance and the Parliament might therefore expect that such matters could be added to the list of matters in the Bill, that elections regulations either may or must contain.

40. The Committee therefore highlights those matters above, in relation to how entitlement to vote is to be ascertained for those voting aged 16 and 17 years, and draws the attention of the lead committee to whether further explanation is required.

“Further provision” in election regulations - Paragraph 13(2) of Schedule 1A to the 1978 Act (as inserted by the Bill)

41. Paragraph 13(2) of Schedule 1A provides that election regulations may make further provision about Health Board elections (in so far as not already provided for in the Schedule 1A). The Committee raised a number of questions with the Scottish Government on the breadth of these supplementary additional powers in relation to election regulations.

42. The Committee was initially concerned that the new paragraph 13(2) made no attempt to limit the delegated powers beyond making any further provision in relation to Health Board elections. The Scottish Government response indicated that the policy proposal is that an initial pilot scheme will be followed by subsequent “roll-out” taking account of any issues arising in the pilot. It is therefore important in their view that election regulations should contain a power to make supplemental provision in relation to the election process. The response confirmed that the regulations would be subject to affirmative resolution procedure – whereas other supplemental provisions in regulations under the 1978 Act are subject to negative procedure.

43. Accordingly the Committee is satisfied with the Government’s explanation as to the proposed use of paragraph 13(2) of Schedule 1A to the 1978 Act (as inserted by the Bill).

Section 4(1) (elected members: pilot scheme) – Powers to make the “pilot order”

44. This power (to make the pilot order) is in effect a power to commence the substantive provisions in the Bill in relation to one or more Health Board areas in order to pilot elections. This power should be read in the context of sections 5 and 6, which provide for a report to Parliament after a pilot scheme and for revocation of the pilot order if the scheme is not rolled out across Scotland within 7 years of the first election. (Roll-out orders are considered under section 7 below.)

45. The Committee welcomes the Government’s undertaking in evidence that amendments would be lodged at Stage 2, to make a pilot order that modifies the Bill subject to affirmative procedure, and also where an amending order modifies the Bill.\(^{49}\)

46. However, the Committee also had concerns over the provisions which would enable Ministers to revoke a pilot order. Section 7 provides for the automatic revocation of the pilot order 7 years after the first election if the scheme has not been rolled out, and if the pilot order has not previously been revoked. If the pilot order is revoked by the Scottish Ministers before that date then very unusually the provisions in the Bill enabling Health Board elections are automatically repealed – see section 6(2).

47. Accordingly, Ministers are able to abandon Health Board elections through revocation of a pilot order. This revocation order would be subject to no Parliamentary procedure.

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\(^{49}\) Scottish Government Response and Col 417
48. The Committee had asked, following its second consideration of the Bill, if the Government could justify why Ministers should be empowered to revoke a pilot order (and so repeal the substantive provisions in the Bill) by order which is subject to no Parliamentary procedure. This is given that Parliament will have approved the introduction of elections in principle. Also, if the Government could reconsider whether any order revoking a pilot order should be subject to affirmative procedure. (Col 418)

49. In evidence to the Committee, Beth Elliot stated; “The pilot order allows for pilots to take place – it is akin to a commencement order in that respect. Once the pilot order is made, we do not consider that it is possible to uncommence the pilot process merely by revoking the pilot order. … Once the pilot order is made, either there will be a roll-out, in which case the order will not be needed, or nothing further will happen in which case revoking the pilot order will simply be a matter of tidying up the statute book.” (Col 418)

50. The Committee is not persuaded that revoking the pilot order simply has the effect of “tidying up” the statute book. Under section 6(2), a revocation of a pilot order will have the substantive effect of repealing the Bill provisions. The Committee also considers that since a roll-out order (or orders) would commence the provisions for the Health Board areas not stated in the pilot order, there is a separate implementation by areas, rather than the pilot order being superseded or made redundant by a roll out order.

51. A decision to revoke the pilot arrangements by order, which could be at any time before the expiry of 7 years, would be a significant step to reverse the implementation of the election arrangements.

52. Accordingly, the Committee wishes to draw the attention of the lead committee to the power contained in section 4(2) which permits the Scottish Ministers to revoke a pilot order. This power is considered to be novel and unusual. It enables the Scottish Government to revoke the pilot arrangements and repeal Bill provisions without further Parliamentary procedure (within 7 years after the date of the first Health Board elections.)

53. The Committee considers that this power should be subject to affirmative procedure.

Section 7(1) (roll-out) – Powers to make a “roll-out order”

54. Section 7(1) of the Bill gives the Scottish Ministers powers to make a “roll-out order” to appoint a day on which sections 1 to 3 are to come into force, in respect of Health Board areas not specified in the pilot order. When such an order is made the automatic repeal mechanism contained in section 6 is itself repealed. Health Board elections would then be in place permanently in terms of the pilot and roll-out orders.

55. Section 7(3) provides that a roll-out order may not be made unless a report has been published under section 5(1) by Ministers. The Bill currently proposes that the order be subject to negative resolution procedure. More than one roll-out order may be made. (This allows for a staged approach to commencement following evaluation of the pilot schemes.) However, there is nothing on the face of the Bill that requires a roll-out order (or a number of orders) to extend to the whole of Scotland.

56. A roll-out order can make such amendment or modifications to primary legislation as Ministers consider appropriate. While that is not a power without limit, it is extremely broad. It was clear from the Government’s evidence that it would be possible to use this power to radically alter matters of principle such as the franchise or STV mechanism.

57. The Committee put questions to the Government on the breadth of this power and asked it to reconsider whether any order made under section 7 containing modifications of enactments should be subject to affirmative procedure.

58. The Committee welcomes the confirmation by the Scottish Government that it shall bring forward an amendment at Stage 2 to provide that if a roll-out order in terms of section
7(3) contains modifications, it will be subject to affirmative procedure. The Committee will monitor the amendments at Stage 2.

59. However the Committee considers that this “Henry VIII” power, enabling regulations to amend primary legislation, should not be framed any more broadly than necessary, even where it is subject to affirmative procedure. The Committee therefore still had questions as to whether it would be possible to restrict any modifications to those that drive the Bill’s purpose.

60. Kenneth Hogg, Deputy Director of Health Delivery, reiterated the Scottish Government’s commitment to the use of affirmative procedure, but the Committee considers that no evidence was given as to the scope for restricting the power. (Col 420)

61. Accordingly the Committee wishes to draw to the attention of the lead committee that—
   (a) the Parliament is being asked through the Bill to approve a delegated power (in section 7(4)) which contains this degree of flexibility to modify enactments at the time of a “roll-out”, by affirmative procedure regulations; and
   (b) the Scottish Government has not to date clearly addressed the question as to why this power to modify enactments could not be drafted more narrowly. For example, by permitting only such modifications necessary to deliver the objectives of the Bill (on a roll-out). As currently framed this power could be used to amend matters of principle such as the franchise or STV voting mechanism.

62. The Committee had further questions on whether, if a decision is made to roll-out elections, this would be done across the whole of Scotland and within a certain period.

63. Robert Kirkwood confirmed in evidence that the intention was that any roll-out would apply to the whole of Scotland stating “If the Government of the day decides to roll out the scheme, the decision will automatically apply to the whole of Scotland.” (Col 420) However, the Committee notes that the Bill allows for more than one roll-out order with different areas, and there is nothing specified that requires the orders in total to eventually cover all Health Board areas.

64. The Committee therefore draws to the attention of the lead committee that the Bill allows for more than one roll-out order, and that section 7 of the Bill as drafted does not appear to make clear that if the Government determines to roll-out the proposals all Health Board areas would require to be included.
Scottish Government Response
Health Boards (Membership and Elections) (Scotland) Bill at stage 1

1. Thank you for your letter of 23 September 2008 to Paul Johnston regarding the Subordinate Legislation Committee’s consideration of the Health Boards (Membership and Elections) (Scotland) Bill at Stage 1.

2. For ease of reference I have copied over each of the points raised and annotated the Scottish Government response after each.

Section 1(5) and (6) (Constitution of Health Boards) – Power to specify the circumstances in which an elected member must vacate office

3. The Committee asked the Scottish Government—
   - to explain why it considers it necessary to provide Ministers with the power to prescribe circumstances within which they have a discretion to require members to vacate office; and
   - how it envisages exercising that power and the discretion provided.

4. Scottish Government response—
   (i) Responses to the Government’s consultation on the policy underpinning the Bill highlighted some concerns that by altering the membership structure of Health Boards, issues would arise around them following national policy. This is an important consideration in a ‘National’ Health Service.  
   (ii) The Government has acknowledged these concerns and intends to retain current Ministerial powers relevant to retaining control over Health Boards, including the power to terminate a Health Board member’s membership where that seems to be justified in the interests of the National Health Service. To our knowledge this power has not been used but its continued existence will help ensure a coherent and consistent approach to healthcare policy across Scotland.
   (iii) The intention is for consistency of approach between all types of Board member, whether elected or appointed, and for the line of accountability to Ministers to remain the same in all cases. We therefore envisage using the power to ensure that the provisions which currently apply to appointed members vacating office will also apply to elected members. The current provisions in relation to appointed members can be found in the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SI 2001/302). The Bill amends the existing power in paragraph 11(a) of Schedule 1 to the NHS (Scotland) Act 1978 to ensure that this power in relation to appointed and councillor members can be used to make similar provision as may be made in relation to elected members. It is considered appropriate to delegate this power to subordinate legislation because specifying circumstances in which an elected member should vacate office may need amendment from time to time, for example to react to changes in the types of member to be appointed or changes to disqualification provisions.
   (iv) We intend to provide the lead committee with a draft of the regulations relating to membership of Health Boards for consideration at Stage 1 of the Bill and will copy this to the Subordinate Legislation Committee at the same time.

Paragraph 13 of Schedule 1A to the 1978 Act (Health Board elections) power to make “election regulations” inserted by section 2(2) of the Bill

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50 See paras 18 and 19 of the Policy Memorandum accompanying the Bill.
5. **The Committee asked the Scottish Government—**

- to provide reasons why, given the substance and importance of the subject matter of criteria prescribing the franchise for health board elections, it is considered appropriate to provide for this to be set in subordinate legislation rather than determined by Parliament in primary legislation;

- what additional criteria it envisages will be specified in relation to the franchise;

- whether it would consider prescribing such matters on the face of the Bill similar to the approach taken in the Representation of the People Act 1983;

- if it is necessary to provide for some flexibility, to restrict a power to amend provisions on the face of the Bill in prescribed circumstances and subject to affirmative procedure.

6. **Scottish Government response—**

(i) The Scottish Government considers that the Bill strikes the right balance between the substance and importance of the subject matter of criteria prescribing the franchise for Health Board elections and allowing sufficient flexibility to respond to changing circumstances.

(ii) Paragraph 10(1)(a) of new Schedule 1A to be inserted into the 1978 Act by section 2 of the Bill provides that an individual is entitled to vote at a Health Board election if the individual is aged 16 or over. Extending the franchise to include 16 and 17 year olds is a key principle of the Government’s overall approach to these elections. It also differs from the voting age in other elections. Therefore we consider it important to put this particular criterion on the face of the Bill. Another example is the inclusion of the use of the Single Transferable Vote (Paragraph 8 (2)).

(iii) Any additional criteria is more suited to subordinate legislation as it involves technical details which may need amendment from time to time. The Committee may wish to note that the Local Governance Bill attempted to set out detailed election methodology but was amended during Parliamentary process to remove detail from the Bill and instead include it in subordinate legislation.

(iv) It is envisaged that the election regulations will specify that those entitled to vote at local government elections and registered to vote at an address within the Health Board area will be entitled to vote at a Health Board election.

(v) On further reflection, and given the issues highlighted by the Committee, we accept that the election regulations concern matters of substance and intend to put forward an amendment at Stage Two that would require affirmative procedure. We do not consider it appropriate to restrict a power to amend to “prescribed” circumstances because of the difficulty and uncertainty of prescribing in what circumstances amendments would be needed.

7. **The Committee asked the Scottish Government—**

- to explain how those entitled to the franchise are to be identified – in particular those aged 16 and 17;

- what information may require to be obtained from such persons in order to enable their registration for this purpose or to enable their entitlement to be assessed;

- whether it would not be appropriate to make specific provision for such matters in the Bill or within the scope of the election regulations.

8. **Scottish Government response—**
(i) As noted above, eligibility will be based on those entitled to vote as electors in local government elections with the addition of 16/17 year olds who would be entitled to vote in those elections but for age. We envisage electoral registration officers (EROs) being responsible for the identification of these eligible voters and are currently in discussions with them regarding this role.

(ii) We do not consider it appropriate to make specific provision for such matters in the Bill or within the scope of the election regulations. This approach would be too prescriptive since extension of the franchise is a new and unique scheme which may be subject to modification, for example use of another franchise instead of the local government model.

(iii) More detail will be contained in the election regulations, a draft of which will be provided to the lead committee for consideration at Stage 1 of the Bill and copied to the Subordinate Legislation Committee at the same time. We are consulting with EROs before finalising the draft.

9. The Committee asked the Scottish Government—

- to justify the breadth of the additional supplementary powers in relation to election regulations (in Schedule 1A, paragraph 13);
- how it envisages such powers would be exercised; and
- whether the supplementary powers might be capable of being framed more narrowly.

10. Scottish Government response—

(i) We consider that additional supplementary powers are required in relation to election regulations. It is one of the key principles behind the Government’s approach to Health Board elections that pilots must precede a full roll-out. This is a widely held view, supported by the results of the consultation and many of the views expressed in debate in Parliament on 21 February this year.51

(ii) The technical details of the election scheme are to be set out in subordinate legislation and we cannot predict with certainty what modifications may be necessary as a result of holding pilot elections. This is one of the main reasons why pilots are being used. We do not consider it appropriate to draw the power narrowly because of the risk that we would be unable to make necessary modifications to the election scheme. The power should be flexible enough to allow Scottish Ministers to respond to potentially unforeseen circumstances which may otherwise frustrate the purpose of the primary legislation. We intend to bring forward an amendment at Stage 2 requiring affirmative procedure for the election regulations which will enhance Parliamentary scrutiny.

(iii) More detail on how we intend to exercise these powers will be contained in the election regulations. As noted above, we intend to provide the lead committee with a draft of these regulations for consideration at Stage 1 of the Bill copied to the Subordinate Legislation Committee.

11. The Committee also asked the Scottish Government for further justification as to the use of negative resolution procedure, and in particular by addressing the following matters—

- that some of the matters to be prescribed in election regulations are matters of substance rather than technical matters, for example – criteria for entitlement to franchise, specification of election dates, specification of electoral wards, specification of number of members for wards, qualifications of candidates and their disqualification; and

51 See para 23 of the Policy Memorandum accompanying the Bill.
that the examples of use of subordinate legislation for provision as to elections (national park authorities and local elections) are subject to affirmative procedure and not negative procedure; and

• to ask whether it would be prepared to provide for affirmative procedure in relation to election regulations, or those which contain these substantive matters.

12. Scottish Government response—

(i) As noted above, we accept that at least some of the matters to be prescribed in election regulations are matters of substance and intend to put forward an amendment at Stage Two that would require affirmative procedure for the election regulations. We thank the Committee for drawing these issues to our attention.

Section 4(1) (elected members: pilot scheme) – Powers to make the “pilot order”

13. The Committee asked the Scottish Government—

• for further justification as to why the Henry VIII power in section 4(3) should permit amendments to the substantive provisions concerning Health Board elections without Parliamentary approval or the opportunity for annulment;

• what modifications it considers may be necessary and whether this power could be drawn more narrowly;

• to reconsider whether any order containing modifications to sections 1 to 3 or to their effect should be subject to affirmative procedure;

• for justification as to why Ministers should be empowered to revoke a pilot order (and therefore repeal the substantive provisions in the Bill) by order which is subject to no Parliamentary procedure given that Parliament will have approved the introduction of elections in principle; and

• to reconsider whether any order revoking a pilot order should be subject to affirmative procedure.

14. Scottish Government response—

(i) We consider it necessary to permit amendments to sections 1 to 3 by pilot order to allow sufficient flexibility for the pilot process to be fully effective. Piloting the Health Board elections before roll-out has obtained support in consultation and Parliament. Pilots are by their very nature designed to be adaptable and issues may arise during the course of the Parliamentary passage of the Bill which may lead to modifications being required. If the powers are too prescriptive then we may not obtain the full benefit of the pilot process, particularly since some aspects of the election scheme are prescribed on the face of the Bill rather than in regulations.

(ii) We will consider whether any particular modifications will be necessary in light of our discussions with EROs and Parliamentary consideration. The pilot process should reflect the broad principles governing our approach to these Health Board elections (including Health Board areas being single wards and STV voting) but we consider it sensible to retain the power to react to unexpected issues as they arise.

(iii) The power in section 4(1) to make a pilot order appointing a day on which sections 1 to 3 are to come into force in respect of the pilot Health Boards has the same effect as a commencement order. As is usual practice with commencement orders, this will not be subject to any Parliamentary procedure. We recognise that the power to modify sections 1 to 3 of the Bill
goes further than a normal commencement order. We intend to bring forward an amendment at Stage 2 to provide that if the pilot order contains modifications, it will be subject to affirmative procedure.

(iv) We would suggest that parliamentary procedure would not be required after the pilots as the Bill will either be rolled out (under a roll-out order) or no longer needed. There would be no need for pilot provisions to remain in place if a decision is made not to roll out. Removing provisions is therefore no more than a tidying up of the statute book.

**Section 7(1) (roll-out) – Powers to make a “roll-out order”**

15. The Committee asked the Scottish Government—

- for further justification as to why the Henry VIII power in section 7(4) should permit amendments to any enactment subject only to the criterion that it is “appropriate”;

- what modifications or amendments it considers may be necessary and whether this power could be drawn more narrowly to relate to delivery of the core purpose of the Bill;

- to reconsider whether any order made under section 7 containing modifications of enactments should be subject to affirmative procedure;

- whether it is intended that the power to make a roll-out order includes a power to revoke such an order and whether, given that the effect of such a revocation would be to negate the primary purpose of the Bill, such a power should be available to Ministers, or alternatively should be subject to affirmative procedure.

16. Scottish Government response—

(i) The Scottish Government accepts that the power in section 7(4) is broad. However we consider it necessary to permit amendments to enactments, including the Health Boards Bill itself, because the technical details of the election regime may need modifications to enactments in order to react to changes in approach following the roll-out and to ensure that the roll-out works correctly for pilot areas.

(ii) We cannot predict with any certainty what modifications or amendments may be necessary; that is the purpose of holding pilots. Therefore we require broad powers to allow sufficient flexibility to respond to issues as they arise. We will bring forward an amendment at Stage 2 requiring affirmative procedure for orders made under section 7 containing modifications of enactments.

(iii) One example where modification may be required is paragraph 2 of Schedule 1A of the Bill. It may be necessary to make a modification in the roll-out order so that the first election after the roll-out order is made is treated as the first election in those areas (despite elections having been held following the pilot order). This would allow elections to all Health Board areas to be on the same election cycle.

(iv) We do not consider that revoking a roll-out order would have the effect of uncommencing the roll-out. A roll out order is akin to a commencement order and commenced provisions cannot be uncommenced by revoking the commencing order. This explains why we have included section 6(2) of the Bill which provides for the repeal of sections 1 to 7 and paragraph 2 of the schedule if the pilot order is revoked before a roll-out order is made.
Given that NHS NSS is not directly affected by the Bill, the only comment that we would make is in relation to the Bill allowing “staff generally to be elected on to Health Boards”. Whilst as an organisation, we would have no issue with the principle, we would wish to understand whom they represented. We would also wish to understand how this might relate to the role of the Employee Director which, thus far has not been clearly laid out.

Ian Crichton,
Chief Executive,
NHS Health Services Scotland,
27 August 2008
Health Boards (Membership and Elections) (Scotland) Bill
Chartered Institute of Public Finance and Accountancy

The following comments are submitted by CIPFA in response to the Committee’s call for evidence on the above Bill. These comments have been framed around the core headings which will form the basis for the Committee’s future consideration.

What the practical benefits of having elected members on health boards would be?

In CIPFA’s response to the Scottish Government’s consultation we concluded that the case to demonstrate how direct elections would result in improved governance and increased engagement in particular had not in fact been made. The Bill contains no specific requirement to seek out patient views, or to specifically consider them in making service planning decisions. Clarification is needed on whether the detailed role of an elected member will be included subsequent regulations.

The intended key practical benefit, understood to be engagement with stakeholders, may not be achieved solely by the introduction of direct elections. Consideration therefore requires to be given to alternative methods of achieving this goal.

Whether those benefits would outweigh the costs arising from running such elections and supporting elected members

We have also briefly examined the financial memorandum and note that the projected cost of elections is £13M as applied to all Health Boards. The financial memorandum however contained basic calculations only which were based wholly on the estimated pilot cost for two pilot areas. The basis of the estimated costs for the pilot schemes was a per capita figure extrapolated over a projected electorate turnout. Again the calculation was basic in nature.

Notably, the estimate has increased from a stated figure of £5M in the initial Local Healthcare Bill Consultation. There is risk, given the limited lead-in time, that the actual expenditure could be in excess of the latest figure.
We note the stated intention that the cost will be ‘met from existing budgets’. There is however no further indication of the meaning of this statement. The Committee may wish to consider whether it is intended that increased efficiencies will form the funding basis or if there will be budget reductions faced by Health Boards in future.

**What the risks are of having elected members on health boards**

The Bill’s requirement for appointed members to be outnumbered by the elected and councillor members will modify the mix of skills, viewpoints, abilities, knowledge and experience on the board. The risk is that with less scope to appoint members with a specific experience and skills set, it may become difficult in practice to ensure the optimum skill mix on the board. As a result there should be a specific requirement in the Bill for board members to participate in a ‘governance skills’ assessment and development scheme.

Without this, there is the possibility that could place the board at risk in terms of its capacity to provide good governance, including effective public engagement. Training would naturally be expected to cover the need to consider service user requirements and to engage stakeholders.

The proposed remuneration for elected health board members does not compare favourably with the level of remuneration for elected local authority members. While financial reward may not be the reason why members seek election, a less than market rate may not attract the desired level of candidate.

**Whether alternatives to direct election exist as a means to increasing public involvement in the NHS.**

The Good Governance Standard contains a specific core principle which addresses the engagement of stakeholders. Implementation and maintenance of the Good Governance Standard for the Public Services should result in improved governance. CIPFA considers that public engagement can in fact be improved independently of the implementation of direct elections.

**The practical implications and cost of bringing the Bill’s provisions into force**

We note that the Bill places reliance upon future regulation to enact the proposed primary powers contained in the Bill. This is comparable to The Local Government in Scotland Act 2003 which was reliant upon later regulation and/or statutory guidance. The passage of the Bill at the time gave no indication of any timescale when regulations would be brought forward. Elected MSP’s, passing the primary legislation at the time may have reasonably expected that all aspects of the Act would be enacted promptly. Section 40 of the Act addressed proposed changes to investment by local authorities. Some five years after introduction of the Act, this Section has not yet been enacted. The Committee may wish to ensure that the proposed timescale for future enactment is clearly set out.
The proposal for single ward representation can now be contrasted with local authorities where the most recent development has been the introduction of multi-member wards. The practicality of an elected health member representing a wider boundary than local government colleagues will require to be tested.

Finally, please note that the Head of CIPFA Scotland, Mrs Angela Scott has recently been appointed in a personal capacity as a non-executive board member of NHS Tayside. Mrs Scott contributed to this submission in her role as Head of CIPFA in Scotland.

Don Peebles,
Policy & Technical Manager
CIPFA Scotland
1 September 2008
21 November 2008

David Slater
Assistant Clerk
Health & Sport Committee
Scottish Parliament
Holyrood
EDINBURGH

Dear David

HEALTH BOARDS (MEMBERSHIP AND ELECTIONS) (S) BILL

I refer to the Health & Sport Committee’s request for further information regarding council responses to the Scottish Government’s consultation exercise on direct elections to health boards which preceded the above-mentioned bill.

Sixteen council responses were made available to COSLA. The nature of the questions posed means that a clear analysis is not possible without reference back to individual councils to ensure interpretation of views is accurate.

On that basis we would agree with the figures mentioned by Mary Scanlon during our oral evidence session on 19 November.

Given the nature of the bill which has emerged from the consultation exercise, COSLA would wish to reiterate its view* that, if the bill progresses and pilots are implemented, then:

- The pilots must be a genuine test of the policy;
- The scoping of the pilot proposals and the identification of the pilot areas should be worked up jointly by the Scottish Government and COSLA; and
- The pilot process should be jointly evaluated by the Scottish Government and COSLA.

* These comments on pilots are given in the context of testing the policy only and should not be construed, even if their assessment is positive, as an indication of automatic support for the introduction of direct elections.

Yours sincerely

Sylvia Murray
Policy Manager
Dear Callum,

You will recall at the conclusion of the evidence giving session on 12 November 2008, I offered to give you some additional comments in light of the publication of the draft Health Board Elections (Scotland) Regulations by the Scottish Government.

**Legislative timescales**

Direct elections to health boards as currently proposed represent a new approach to the way elections are administered in Scotland. Returning Officers and Electoral Registration Officers need sufficient time to ascertain what the legislation requires of them and the best way to implement it. Therefore, in line with the recommendation of the Gould report, all the relevant legislation must be in place at least six months prior to the electoral event. This includes legislation for the young persons register being in place six months before Electoral Registration Officers begin to compile the register.

**Timetable**

Both the Scotland Office and Scottish Government are considering altering the election timetable for Scottish Parliamentary and local government elections respectively in light of recommendations made in the Gould report.

The deadlines for registration and applying for an absent vote are incompatible with the election timetable in that electors may register 11 working days in advance of election day but all the postal ballot packs must be issued four weeks before the poll.

As mentioned in our oral evidence to the Committee, we believe that civil servants must ascertain the practicalities and capacity with Returning Officers,
Electoral Registration Officers the print industry and Rotal Mail to print and distribute postal voting packs to the electorate within the timescales set out in the Regulations and alter these where necessary.

Accessibility

Arrangements have been made in previous all-postal elections to assist voters who are unable or do not wish to vote by post. These have included home visits by electoral staff and assistance and delivery points with a ballot box for hand delivery and staff available to provide information or assistance.

These measures were introduced to replicate the accessibility provisions that are available at polling stations. These include staff who can assist a voter to complete their postal voting pack, enlarged copies of the ballot paper, magnifying glasses and tactile voting templates.

The only accessibility requirement in either the Bill or the draft regulations is for the Returning Officer to provide information on how to obtain instructions to complete the ballot paper in another language or format. There is nothing to require the candidates’ information to be available in other languages or formats. We wish to see greater emphasis in any redrafted Regulations on making the election fully accessible to all voters.

Candidates expenses

Candidates at health board elections are not allowed to spend more than £250 during their election campaign, the same amount as candidates in one of the Cairngorm National Park electoral wards are allowed. Our understanding is that the cost of printing and distributing the candidate information statements will be borne by the Returning Officer. We would, however, still question whether £250 as an expenditure limit would allow candidates to pay for travel to attend hustings meetings and undertake any additional campaigning particularly in rural parts of Scotland where distances to travel may be considerable.

The expenses limits at Scottish local government elections are calculated at £600 plus five pence per elector registered in the ward. A Scottish Parliament constituency candidate has a limit of £7,150 plus either five pence per elector in a burgh constituency or plus seven pence per elector in a county constituency.

Transparency and accountability

There is no provision in the Bill or Regulations to permit independent observation of the electoral processes in accordance with international obligations. Observation by independent third parties is an important part of the democratic process by enabling transparency of electoral proceedings.
The Commission administers an observation scheme under the Political Parties, Elections and Referendums Act 200 and this scheme applies to Scottish, UK and European Parliamentary elections, as well as local government elections in England and Wales. The Scottish Government has also introduced a scheme in respect of local government elections under the Local Electoral Administration and Registration Services Act 2006.

While there is a requirement for any person attending the issue or receipt of postal votes to maintain the secrecy of the ballot contained within the draft Regulations, there is no equivalent requirement on persons attending the count. Equally, there does not appear to be any sanction for breaking the secrecy, unlike at other elections in Scotland.

Support, advice and guidance

There has been a desire to achieve greater consistency in electoral practices across Scotland in recent years. The Commission has assisted with this by providing written guidance to Returning Officers and Electoral Registration Officers since 2001. We are required to produce a statutory report on the administration of certain elections and we will launch a performance standards framework in 2009 to improve the quality of electoral administration.

An Electoral Management Board (EMB) of Returning Officers and Electoral Registration Officers is currently being established to plan and co-ordinate those aspects of a Scotland-wide election that are best organised nationally. We anticipate that the EMB would provide support for health board elections and the Committee may wish to discuss more detailed matters with the EMB should the Bill proceed.

I hope you and the Committee find these additional comments helpful in considering the implications of the Bill either at this stage or later in the legislative process.

Yours sincerely,

Andy O’Neill
Head of Office Scotland
Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

The Chairman of NHS Ayrshire and Arran submitted written comments on 25th August 2006 to the Health Committee and commented on the likely cost of elections. The Chairman also submitted comments in response to the call for evidence on the Bill in September 2008 and attached the earlier comments submitted to Roseanna Cunningham who at that time was Convenor of the Health Committee.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

Yes.

Did you have sufficient time to contribute to the consultation exercise?

Yes

Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the financial memorandum? If not, please provide details.

The Financial Memorandum sets out a reasonable estimate of the costs for the election process, however it misses out two aspects which are referred to in the Bill:

- Paragraph 4 of the Bill provides that the Health Board must appoint a returning Officer for the Health Board Election, however the Financial Memorandum makes no provision for the costs associated with this. There will be Returning Officer fees and expenses and other staff costs associated with the administration of an election, as well as the cost of counting machines.
- Paragraph 11 makes provision for election expenses for candidates. If any of these are to be met from the public purse, no provision is made for this in the Financial Memorandum.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

Based on the estimates within the Financial Memorandum, the cost for elections covering 20% of Scotland would be around £2.11 million, therefore on the basis that Ayrshire and Arran covers around 7.5% of the population of Scotland the costs to NHS Ayrshire and Arran would be around £800,000 every four years. This is a significant amount within the context of NHS Ayrshire and Arran being required to
achieve £11 million per annum of cash releasing efficiency savings which could otherwise be spent on Patient Services and to improve the health of our population.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

There are a number of uncertainties around timescales (rollout following a pilot for an unspecified period) and it would be advisable for the estimated costs to form part of the evaluation of the pilots to see how accurate the Financial Memorandum is. If the rollout order can be made by the Scottish Government without further Parliamentary approval, the Committee should consider seriously the uncertainties around the estimate of £13 million for all territorial Health Boards.

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

The current bill only applies to territorial Health Boards, so no estimate has been made as to the additional costs of elections for non-territorial Health Boards, should this policy be extended to them.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

The Bill extends the powers to pay members of Committees and Sub-Committees of a Health Board as regulations may specify. While the Scottish Government has no plans at this time to use the powers, there may be additional costs which cannot be quantified until the extent of these payments are specified.

SUBMISSION FROM NHS FIFE

Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

NHS Fife responded but in the response made no comment on the financial assumptions.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

Not applicable.

3. Did you have sufficient time to contribute to the consultation exercise?

Yes.
Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

The Bill will have financial implications. The Financial Memorandum sets out assumptions and estimates but correctly points out the level of uncertainty underpinning these. Some further detail e.g. method of electorate is required, and some of the variations e.g. electoral turnout are impossible to predict.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

More information is needed on the costs and the source of funding.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Yes.

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Yes.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

It is too early to say.

SUBMISSION FROM NHS GRAMPIAN

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

NHS Grampian provided a full response to the consultation exercise for the Bill reflecting the fact that Grampian welcomes the Government’s commitment to encourage greater patient and public involvement. However, NHS Grampian remains unconvinced that direct elections to NHS boards will deliver this.

NHS Grampian commented on the financial resources required to deliver direct elections expressing the firmly held view that if direct elections are introduced then there is a need for additional funding to be provided to cover the costs of administering the process. The funding should not be allocated by way of the NRAC formula.
2. **Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?**

   Given that the Financial Memorandum indicates that Health Boards would be required to meet the costs of Direct Elections, it would appear that NHS Grampian’s recommendation of additional funding has not been accepted.

3. **Did you have sufficient time to contribute to the consultation exercise?**

   Yes

4. **If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.**

   The Bill will have financial implications for NHS Grampian. In order to deliver Direct Elections, it is likely that funding that would have gone to front line services will require to be diverted.

5. **Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?**

   NHS Grampian recommends that costs are met by additional funding specifically targeted at direct elections.

6. **Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?**

   It is difficult to confirm any degree of certainty in terms of the costs that are likely to arise until the process is implemented in practice, whether that is in the form of a pilot or otherwise.

7. **If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?**

   If the Bill is part of a wider policy initiative it is hard to see how the costs can be accurately reflected in the Financial Memorandum at the stage.

8. **Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?**

   Yes.

   No.
### Consultation

1. **Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?**

   Yes, our response is enclosed. We commented in relation to question 33 – “Should NHS resources be used to support direct elections? What do you think would be a reasonable amount to spend on elections?” We said:
   - The costs of direct elections would apparently be a cost to the NHS, and Government and patients have to recognise that if implemented it will impact on patient care.
   - NHS resources must not be used to support campaigning activity.

2. **Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?**

   As the section on costs is headed “Costs on the Scottish Administration” in the Financial Memorandum, this appears to indicate that the Scottish Government will fully fund the costs of elections. Therefore our comments seem to have been reflected. However, clarity on this would be welcomed.

3. **Did you have sufficient time to contribute to the consultation exercise?**

   Yes.

### Costs

4. **If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.**

   The Bill indicates an increase in the number of Board members (20 elected members in each of the Pilot areas). This will significantly increase the costs to Health boards, with remuneration alone costing £150,000 each year for the elected members. In addition, in rural and Island Health Boards such as NHS Highland, the travel and subsistence expenses of Board Members are significant. Many members will regularly have to travel over 200 miles to attend meetings with those from the Islands having no alternative to regular overnight stays. The cost of travel and subsistence of additional members is likely to be in the region of £85,000 pa.

5. **Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should**

   The costs of Elections will be significant. If these costs are not to be met centrally, these can not be met from existing health board resources without reducing services.
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<th>Question</th>
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<tr>
<td>The salaries and expenses of all the additional Board members will be a significant ongoing cost and again cannot be met from existing resources without reducing expenditure on services.</td>
<td>Yes</td>
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<td>6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?</td>
<td>Yes</td>
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<td><strong>Wider Issues</strong></td>
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<td>7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?</td>
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**SUBMISSION FROM NHS LANARKSHIRE**

**Consultation**

1. **Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?**

   Yes.

2. **Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?**

   Yes. We expressed a view that the estimate by the Electoral Commission that the cost of initial elections across the 14 NHS Boards would be around £5, was low and that these costs would be likely to be exceeded. This view is confirmed in the estimate of £2.86m for the cost of running elections in 2 pilot areas.

3. **Did you have sufficient time to contribute to the consultation exercise?**

   Yes.
Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

It is felt that the principal costs of election, remuneration, etc. are covered in the Financial Memorandum.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

Based on an estimate of £2.86m to hold elections in 2 pilot areas, this could mean a cost of approximately £1.4m to hold elections within the NHS Lanarkshire Board area. On the basis of our annual uplift and the demands upon it, and the Cash Releasing Efficiency Saving requirement, identifying this sum from revenue would present the Board with a significant challenge. Allowing for the fact that we currently budget for Non Executive Board Members’ remuneration, we believe that it would be appropriate for the costs associated purely with the election to be met centrally.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Broadly speaking, yes.

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Paragraph 67 of the Financial Memorandum acknowledges the potential for subordinate legislation specifying payments to any particular Committee or Sub Committee, and indicates that the Government will provide a full analysis of the costs arising. This is welcomed.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

Please see the response to Question 7. Potentially there may be future costs for these issues but they are unclear and difficult to predict at this time.

As described in the response to the questions, the main costs to the Board is likely to be associated with the running of local elections. Based on the estimate for running 2 pilots, these are not insignificant, and if not funded centrally, will bring further pressure on the Board’s revenue allocation. Time will tell whether the estimate of the costs for operating the 2 pilots is realistic, and this will help with the quantification of the costs of elections within NHS Lanarkshire and throughout the wider NHS in Scotland.
SUBMISSION FROM NHS LOTHIAN

Consultation

1. NHS Lothian did respond during the consultation exercise.

2. NHS Lothian made limited comments about costs.

3. NHS Lothian had sufficient time to contribute to the exercise.

Costs

4. NHS Lothian has no experience of the costs incurred in running an election. We are therefore guided by our Local Authority partners and central Government conclusions.

5. NHS Lothian does not have these costs within our financial planning assumptions. We are also concerned that from the predictions in the Financial Memorandum para 59 that for a Board of our size that costs could be between £1.5m and £2.0m.

Central Government will be expected to meet the costs of this pilot and potential implementation across NHS Lothian in full and in doing so understand the impact that may have through funding available for other investments. NHS Lothian supports the desire to involve the public in its decision making processes and is putting in a new ‘Involving People, Improving the Patient Experience’ strategy to deliver this policy objective.

6. In NHS Lothian’s earlier submission of evidence we stated that in our view the potential costs of holding such elections were underestimated.

It is understood that Scottish Government has already made a submission to the Finance Committee of the Scottish Parliament requesting to revisit the costing in the Financial Memorandum (Official Report 16/9/08) and this appears to support the view in our earlier submitted evidence.

Due acknowledgement is given in the memorandum as to the variability of costs arising from not only turnout but widening the franchise, promotional costs, pilot evaluation and elected officers’ future remuneration. Cost movements are inevitable if alternative methods of voting and counting are employed other than those envisaged in the financial memorandum and the potential variability appears to be broadly consistent with the assumptions.

NHS Lothian would re-iterate the view that if such pilot and roll out costs are to extend to £13m for all boards, as set out in the Financial Memorandum, that it would be unlikely that these could be met from existing Health Board budgets. These already face the challenge of doubled recurring cost saving targets and substantially reduced percentage allocation uplifts in comparison to more recent years.
Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

Yes and yes.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

It is difficult to ascertain this. Our key comments in this regard were that the costs should not be met by local health boards, since this would require diverting resources from frontline areas. The Financial Memorandum states that the costs will be met ‘from existing budgets’ but it is not clear whether this means budgets held at government level or budgets held at local health board level.

3. Did you have sufficient time to contribute to the consultation exercise?

Yes

Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

See above – unclear if the costs will fall locally or centrally.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

As stated in our response to the consultation (sent to Claire Ferguson on 31 March 2008) we feel strongly that these costs should be met centrally. The Board has no uncommitted resources so any costs falling locally would have to be met by making savings in the front-line service.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Yes - the methodology seems reasonable.
Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

There is some uncertainty surrounding the costs but the methodology seems reasonable.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

No obvious direct future costs arising from the Bill. It is difficult to judge whether the election of members may generate future costs by influencing decisions made by local boards.

SUBMISSION FROM ELECTORAL REGISTRATION COMMITTEE OF THE SCOTTISH ASSESSORS’ ASSOCIATION

The response relates purely to the registration of electors and not to the elections management, and is made by the Electoral Registration Committee of the Scottish Assessors Association on behalf of all 15 Scottish EROs.

Consultation
1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

The SAA Electoral Registration Committee has taken part in consultation on the Bill including meetings with Scottish Government civil servants. We have also responded to requests for background information. The SAA has also taken part in a joint response with SOLACE, SOLAR, and AEA.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

Yes, but only if the register is used in the traditional format with no requirement for personal identifiers. The figures quoted at item 63 in the memorandum are estimates and would have to include consequential publication costs as well as software costs. At item 64, publicity should include advice on registration.

The cost of collecting personal identifiers is not included in the costs and could, if introduced (see 8 below), on average cost £1 per registered elector for postage including reminders and return costs. The ingathering of such a high number of identifiers would almost certainly require additional IT equipment e.g. servers, scanners and PCs. Additional costs would also be required for employing additional staff required to check and process the data received. Costs would include training, salaries and desk space.

3. Did you have sufficient time to contribute to the consultation exercise?
Yes

Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

See answer 2

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

Any specific work required should be recharged to the Scottish Government. As the costs of the Bill will affect EROs at the very early stages, and as EROs do not have access to additional funding mid-budget, it is essential that payments for required tasks are delivered prior to the work commencing and not after the costs have been incurred.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

See answers 2 and 5

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

No comment

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

The inference that an all postal ballot should be along the same lines as a National Park election ignores recent changes to postal voting for all other elections. Postal voting is recognised as inherently insecure and steps have been taken in all other elections to increase security. EROs have collected personal identifiers for all existing postal voters and these are used by returning officers to verify the identity of the postal voter. It is possible that this will eventually be considered to be necessary for Health Board elections but meanwhile the much greater costs of such a postal ballot have not been accounted for.

There are concerns regarding collection of data from attainers (14 & 15 year olds). There will be collection costs incurred but more importantly there may be legal issues regarding retention and display of this material. Legislation to resolve these issues would be likely to involve software costs, for instance in creating a separate
more secure register for young people or in flagging that a young person is in the register but no address is published.

**SUBMISSION FROM CITY OF EDINBURGH COUNCIL**

Following consideration by the Council’s Departments of the proposals for the introduction of the Health Boards (Membership and Elections) (Scotland) Bill and the likely effect on existing arrangements for joined up working between the NHS and the Council, the Council provided an Evidence Paper for the lead Committee. This included financial considerations, and we have now reviewed these in relation to the revised Financial Memorandum accompanying the Bill.

Views have been set out as requested on the questionnaire attached to your letter. The completed questionnaire attached here forms an administrative submission from myself as Chief Executive of the Council.

1. **Consultation**

   Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

   The Council responded to the consultation and also submitted evidence for the Committee. Financial issues were an important part of the responses made. It is the Council’s understanding that the Financial Memorandum which accompanies the Health Board (Membership and Elections) (Scotland) Bill states clearly in paragraph 68 that ‘there are no costs falling to local authorities’. The Financial Memorandum also states that there are ‘no costs falling to other bodies, individuals and businesses’. However, the Council is of the opinion that both financial and non-financial resources are necessary to successfully conduct elections to any organisation. Whatever funding mechanism might be agreed upon, the Council would wish to see sufficient finance, staffing and resources made available to support a well-run election.

2. **Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?**

   It is the Council’s position that the full costs of the proposed Health Board Elections have not been fully investigated. If the proposed 100% postal election method is progressed, the cost of collecting Absent Voter Identifiers (AVIs) will need to be considered. At present approximately 15% of voters across Scotland have AVIs and for an all-postal ballot 100% would be required if the integrity of a postal ballot is to be ensured. This would incur both costs and time constraints on the health board elections. At present, it remains the Council’s position that there are not enough safeguards in place to undertake a 100% postal election.

3. **Did you have sufficient time to contribute to the consultation exercise?**

   A greater time period would have allowed a fully considered position at both a political level and officer level. The response initially submitted was an
officer response as the Council reporting cycle requires a longer time period for which the consultation period did not allow.

4. Costs

If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

The Council acknowledges the statement in paragraph 68 of the Health Board (Membership and Elections) Bill Financial Memorandum that 'there are no costs falling to local authorities’. However, it is important to recognise that resources to support direct elections to NHS Boards are a fundamental issue in the effectiveness of a reform of this kind. The Council stresses that additional new resources must be found to cover these costs by Government and be seen to be in addition to the funding provided for NHS services. The revised financial memorandum (paragraph 66) gives increased estimates for election costs, indicating that the pilots will cost £2.1m with full roll out costs estimated at £16.65m, including £7.55m met at each election, and £9.1m recurring costs to Boards.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

The City of Edinburgh Council does not consider that there are any financial costs which will fall to the City of Edinburgh Council as a result of this Bill. Returning Officers’ Costs However, the Council would also like to reiterate that if NHS elections are to be organised by current Returning Officers, then councils must be fully reimbursed for all costs involved. This would include the expenses that can be reimbursed through Returning Officers’ Fees and Charges and also the recognised ‘hidden’ subsidies such as accommodation costs, IT equipment and core staff time. Electoral Registration Costs The extension of the franchise to include 16 and 17 years olds is an issue for the compilation an appropriate electoral register. Additional planning time will be required to ensure an effective and usable register is created. The Council notes that a simpler administrative process is now being proposed within the revised memorandum for incorporation of 16 and 17 year olds into an appropriate electoral register, and welcomes the Scottish Government’s revised position which was made as a result of advice from the Electoral Registration Officers (EROs). The Council is aware of the amendment made to the Financial Memorandum by the Cabinet Secretary on 12 September 2008 and considers that this now clarifies some of the electoral registration issues. The new estimated level of costs to roll out Health Board elections, increased from £13.05 million to £16.65 million, is likely to be a better reflection of the resources needed.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Points from consultation & submission

The Council seeks clarification on the method of financing both the pilot
elections and the possible roll out of direct elections to all health boards. The Health Board (Membership and Elections) Bill Financial Memorandum states: ‘The intention is that the costs will be met from existing budgets’ (paragraph 66). Could the Scottish Government indicate from which organisation’s budget the cost of direct health board elections will be met, the Scottish Government or health boards? The Council welcomes the increase in the marketing/public information budget from £0.2 million to £0.3 million as detailed in the most recent amendment to the Financial Memorandum. It remains the Council’s position that adequate marketing and public information is essential for the successful introduction of a new electoral process.

### 7. Wider Issues

If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Not applicable.

### 8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

It is not possible to quantify at this stage.

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**SUBMISSION FROM CLACKMANNANSHERE COUNCIL**

Your letter of 18th September invited comments from Chief Executives in respect of the responsibilities of Electoral Registration Officers (EROs) and the financial implications they would need to take into account to ensure compliance with the requirements. While I am sure that the ERO for this area will provide his own comments, I am happy to offer you a response from Clackmannanshire Council.

I do consider that it is unfortunate that there has been such a focus on all postal ballots in respect of the elections covered by this Bill. It occurs to me that the Health Board elections present an incredibly valuable opportunity for Parliament to be innovative, creative, and to support the modernisation of the electoral process more generally. A more open approach to ballot methodologies with adequate controls would have allowed, the opportunity to test and manage fresh approaches to ballot processes. I have made reference to this in the attached.

The Financial Memorandum (FM) clearly states in paragraph 68 that there are no costs falling to local authorities. Without clarity in respect of the designation of Returning Officers for these elections, it is not possible to comment on whether or not there is the potential for additional costs to be incurred in supporting administrative arrangements. For immediate purposes, the assumption is made
therefore that the Returning Officer will not be an employee of the Council and no
direct election support of any kind is anticipated as necessary.

The Electoral Registration Officer (ERO) will undoubtedly have a critical involvement
in these elections. The ERO is funded principally through the budget of the
authorities he serves and there is an unavoidable impact on Council finances where
his costs increase beyond any additional ‘income’ received. It is apparent through
past experience that, in every major election event, there will be some costs incurred
by the ERO which cannot be recovered through the Returning Officers Charges
Order. This accounts for part of the "hidden subsidy" that Councils contribute to
centrally funded elections. To avoid this situation arising with Health Board elections,
it is essential that, through whatever mechanism that is appropriate, **all identified
costs are actually recoverable**. The alternative will be a direct impact on Council
finances.

It is suggested that the intention to focus on all postal ballots for these elections is
short sighted and unnecessarily restrictive. Postal ballots, properly administered, are
expensive to deliver and the outcomes remain open to challenge. Given the
Government's history of concern over the potential for postal voting fraud, it is
anticipated that voter identity confirmation procedures (in line with those required
under the ROP Act ) will be required for these elections. That would require the ERO
to collect personal identifiers for a further 85% of those on the Electoral Register, to
store and manage these, and to provide them in a suitable form to the Returning
Officer at the time of an election. The RO in turn will require procedures and systems
designed to manage postal vote returns.

The resource impact on EROs in accomplishing this are indeed considerable and
could be avoided if a more flexible approach to ballot method was allowable in the
legislation.

The government and the Electoral Commission have, over the last year, taken a step
back from promoting pilot exercises in ballot procedures. Pilot exercises are the ideal
way of gaining confidence in the testing of changed or innovative voting processes.
Health Board elections could be an ideal focus for future pilots on, for example,
electronic voting, text voting, internet voting and varying methods of electronic
counting. There is/was perhaps an opportunity here to gain maximum benefit
through innovation and testing while at the same time avoiding the costs and
procedural difficulties of administering secure postal ballots.

The Bill proposes that citizens aged 16 and over should be able to take part in these
elections. As correctly identified, this proposal has cost and resource implications for
the ERO. The degree of impact will have a direct relationship with the model
procedure required by the ERO. For example - if the ERO is required to be proactive
and to annually publish the names of any citizen who will turn 16 during the following
12 months then the costs of software adaption, canvass and recording procedures
will be high. However, if the requirement was to be more reactive and to include
those reaching 16 in the monthly update lists for the register, the costs would be
much lower.
The FM provides information on cost calculations. It is suggested that the figures presented are misleading:

- The average cost per vote cast in all postal ballots (not using STV) is quoted as being around £2.60. This figure does not include the costs of collecting and applying postal voter identity checks. In a postal ballot which is designed to ensure confidence, the application of security check mechanisms will push this unit cost to a much higher level.
- The costs associated with the extension of the franchise will depend very much on the real need for software and procedure amendments. This in turn is dependent on the degree to which the ERO will be expected to be proactive.

SUBMISSION FROM FIFE COUNCIL

Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

Response – Yes. No comment was made on the financial assumptions.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

Response – N/A

3. Did you have sufficient time to contribute to the consultation exercise?

Response - Yes

Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

Response – There are no direct costs attributable to local authorities under the Bill and it is to be assumed that additional costs, for example, allowances and/or remuneration paid to Councillors appointed to a Health Board would be met by the Health Board.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

Response – See Answer 4.
6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Response – From experience in electoral administration, I believe that the financial memorandum accurately reflects the costs of conducting elections. However, this very much depends on the detail of subordinate legislation. In other elections, there have been increasing numbers of postal votes and, coupled with the introduction of legislation, the cost has been increasing dramatically. With the increasing outsourcing of matters relating to elections, e.g. issue of postal votes and electronic counting, it is impossible to accurately predict costs.

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Response – Yes – See Answer 6.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

Response – There may be future costs associated with the Bill as subordinate legislation is promoted and guidance around the elections is developed and this should be borne in mind as progress is made.

SUBMISSION FROM THE HIGHLAND COUNCIL

Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

The Highland Council did take part in the consultation exercise for the Bill and did comment on the financial assumptions made.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

The Financial Memorandum does reflect the Council’s comments on the direct cost of elections. However, it does not take account of the indirect costs.

3. Did you have sufficient time to contribute to the consultation exercise?

Yes, the Council had sufficient time to contribute to the consultation exercise.
Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

It is the view of the Highland Council’s view that the revised projected £13m cost of direct elections underestimates the overall costs. No provision has been made for indirect costs. If costs come from the NHS budget, it will have associated implications for that budget and front line service provision.

The extension of the electoral franchise to 16 / 17 year olds will result in increased costs being incurred by Electoral Registration Officers. If the postal vote system were to require the collection of postal vote personal identifiers (PVPIs), the PIs would need to be collected from the 85% of electors who do not already have a postal vote. If the PVPIs were not collected, the election system could be not be considered as being secure and imply an acceptance of a degree of trust that is currently found in National Park and Community Council elections.

The system of STV would need to be carefully considered. If the system was the same as that used in local government elections (Weighted Inclusive Gregory method) then electronic counting would be required. However, if the Gregory method were to be used (as in Northern Ireland Local Government elections), manual counting MAY be possible. There would be a difference in costs, dependant on the type of election system used.

The suggestion that each Health Board area would be treated as a single ward would create electoral administration problems. Using NHS Highland as an example, the Ward electorate would be approximately 220,000, covering two local authority areas. On the basis of an estimated 60% turnout, 132,000 postal ballot papers would be returned. Dealing with that volume of STV postal ballot papers, in a single ward, is beyond the current experience of local government staff. If a private sector contract were to be let to manage the process, costs would need to be re-evaluated, as count costs would almost certainly increase. The costs outlined in the Financial Memorandum in the Explanatory Notes accompanying the Bill only refer to the direct costs of an election. The indirect costs (such as core election management and electoral registration costs) have neither been referred to nor quantified.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

No. The Financial Memorandum, at paragraph 68, asserts that there are no costs falling to local authorities. It is assumed that the Returning Officer at the Health Board Elections will be the Local Authority Returning Officer and that the election will be administered by his staff. There is no mention of this anywhere in the Financial Memorandum. The Highland Council would expect re-imbursement of all expenditure incurred at any election, including management and administrative costs. If the Local Authority Returning Officer
is not to be responsible for administration of the election, the selected individual must have" the necessary skills, training and knowledge to carry out an election”

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

No, it does not. Further information on the detail of the whole election process is required – from the initial publication of the Notice of Election to the Declaration of the Results. Indeed, if the Result is challengeable in the Courts (perhaps through an Election Petition process?) additional unexpected costs may be incurred. Careful project management will be required to ensure the election process runs smoothly.

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

No comments

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

The Highland Council cannot anticipate future costs without the detail outlined in paragraph 6 above.

SUBMISSION FROM MIDLOTHIAN COUNCIL

I refer to your email in which you request, by letter of 18 September 2008, the views of all Local Authority Chief Executives in respect of the responsibilities of Electoral Registration Officers in regard to the above Bill.

I apologise for the delay in replying but can now inform you that the Council’s Chief Executive, Trevor Muir, wishes to comment from the electoral registration perspective that he endorses the views contained in the submission by the Scottish Assessors Association in response to the questionnaire. In particular he agrees that any specific electoral registration work arising from the Bill must be recharged to the Scottish Government.

I can also inform you that Midlothian Council has considered the details of the Bill and has agreed to note its contents on the basis of paragraph 69 of the Financial Memorandum which states: – “There are no costs falling to local authorities.”
SUBMISSION FROM NORTH LANARKSHIRE COUNCIL

North Lanarkshire Council did, indeed, participate in the consultation exercise for the Bill: at that stage, however, no comment was offered on the financial assumptions made.

Subsequently, however, in response to an invitation from the Health and Sport Committee of the Scottish Parliament, the Council’s Policy and Resources Committee approved a submission which, with regard to Finance, included the following:

“With regard to the proposed arrangements for elections it is noted that there will be difficulties in extending the franchise: currently electoral registers do not include 16 and 17 year olds and, in addition to the software costs as identified in the financial memorandum, it is to be anticipated that there will be additional costs linked to the canvass.

With regard to principal implications and costs, it is noted that the financial memorandum proceeds on the basis of elections covering 20% of the Scottish electorate and being conducted by an all postal ballot: it is noted that the memorandum goes on to advise of the application of an ‘average cost’ of £2.60 per vote cast in an all postal ballot. This would appear to be an average cost based on a number of valuation studies conducted by the Electoral Commission over a period of time none of which used the STV system. It is not clear that account has been taken in estimating costs of experience in the recent local government and Scottish parliamentary elections, and it is considered that the costs are likely to exceed the projected figure.”

It would appear that these comments are apposite, also, to the questions now posed – and on that basis it is not considered that the costs are accurately reflected in the financial memorandum.

SUBMISSION FROM ORKNEY COUNCIL

Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

The Council did take part in the consultation exercise but did not comment on the financial assumptions made.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

N/A

3. Did you have sufficient time to contribute to the consultation exercise?
Additional time would have been welcomed.

Costs
4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Wider Issues
7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

SUBMISSION FROM SOUTH AYRSHIRE COUNCIL

The costs associated with this Bill do not impact on local authorities.

As regards the estimated costs quoted in the Financial Memorandum, these are average figures taken from the available historical data. More precise figures will be able to be gathered from the proposed two pilots.

SUBMISSION FROM WEST DUNBARTONSHIRE COUNCIL

Consultation
1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

The Council did not itself take part in the consultation exercise, but senior officers of the Council were involved in the response submitted jointly by SOLACE, SOLAR, AEA and SAA, which represent Chief Executives, electoral administrators and Electoral Registration Officers.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

No. The extract from the Associations' response is below:
“The cost of these elections we feel has not been fully investigated. There would need to be an assurance that the cost of any pilots, including the processing of AVI’s, would be fully reimbursed by the Scottish Government to the Returning Officer and Electoral Registration Officer. We would also reiterate that if Health Board elections are to be organised by current Returning Officers, then Councils must be fully reimbursed for all costs involved. This would include not only the prescribed expenses that can be reimbursed through a Returning Officers’ fees and charges order, but also recognise the other election cost subsidies that occur.”

3. Did you have sufficient time to contribute to the consultation exercise?

Yes. Sufficient time was given to respond.

Costs

4. If the Bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

The costs would appear to be seriously understated. There is no evidence that the financial memorandum has taken ancillary costs involved in elections into consideration. There seems to be no real understanding of the additional workload which Health Board elections would place on local authorities and the resulting staffing and financial implications. Costs to the organisation of processing the elections and the count have not been considered in full. It is likely that the cost of a Health Board election would be equivalent to the sum of the costs of local government elections for the areas covered by the Health Board.

Electoral Registration Officers will incur additional costs by the proposed expansion of the electoral roll to include 16 and 17 year olds.

Following consultation, further decisions may have to be taken on the way the poll will be organised and a further costing exercise should be taken at that time, in full consultation with the professional Electoral Associations, to achieve more realistic estimates in view of the procedures to be implemented.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

The Council would not be able to meet the financial costs associated with the Bill. Costs would have to be assessed on a realistic basis and refunded in full through Health Boards themselves.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

No. It is not appropriate for election mailings to be issued by household rather than to individual electors, so if the integrity of the poll is to be maintained, there is no possibility of achieving significant reductions in the estimated costs. The likelihood is that the costs of the poll will be much higher than the estimates.
Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

It is not clear what is meant by a wider policy initiative. If the costs outlined in the Memorandum are insufficient for the Health Board election, it stands to reason that they would be equally unsatisfactory if rolled out more extensively.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

It is more than likely that future costs may arise, but it is not possible to quantify these at this time.
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

25th Meeting, 2008 (Session 3)

Tuesday 4 November 2008

Present:
Derek Brownlee
James Kelly
Alex Neil
Andrew Welsh (Convener)

Joe FitzPatrick
Lewis Macdonald (Committee Substitute)
Jeremy Purvis
David Whitton

Apologies were received from Jackie Baillie (Deputy Convener).

Health Boards (Membership and Elections) (Scotland) Bill: The Committee took evidence on the Financial Memorandum of the Health Boards (Membership and Elections) (Scotland) Bill from—

Peter Bales, Secretary, and Brian Byrne, Chair, Electoral Registration Committee of the Scottish Assessors’ Association;

Kenneth Hogg, Deputy Director of Health Delivery, and Robert Kirkwood, Policy Officer, Scottish Government.
Health Boards (Membership and Elections) (Scotland) Bill: Financial Memorandum

14:37

The Convener: Item 3 is evidence on the financial memorandum on the Health Boards (Membership and Elections) (Scotland) Bill. We were unable to take evidence on the financial memorandum last week because of illness. We agreed last week that at today’s meeting we wanted to take evidence from a health board and from electoral registration officers, as well as from Scottish Government officials. Unfortunately, the health boards that we invited were not able to attend. However, I am pleased to say that we have with us Peter Bales and Brian Byrne from the electoral registration committee of the Scottish Assessors Association. I welcome the witnesses to the meeting, thank them for agreeing to come at such short notice and invite them to make a short opening statement.

Brian Byrne (Scottish Assessors Association): I really just want to say what the association does. There are 14 Scottish assessors who are electoral registration officers and we have an electoral registration committee. There is a 15th electoral registration officer, who is not an assessor, who also attends the committee. He is from Dundee. Our answers to the questionnaire represent the views of all 15 electoral registration officers.

The Convener: Do you want to add anything, Mr Bales?

Peter Bales (Scottish Assessors Association): No.

The Convener: I invite questions from members. Jeremy Purvis and Joe FitzPatrick will take the lead, but all other members are welcome to ask questions—they should simply catch my eye. Jeremy Purvis wishes to go first.

Jeremy Purvis: Good afternoon. I hope that the witnesses have had the chance to read some of the local authority submissions that we have received. Their own submission was gratefully received by the committee.

Clackmannanshire Council’s submission identified that there might be hidden costs associated with the operation of the elections—that some of the costs of running the elections that the bill proposes might not be captured by the financial memorandum. If the witnesses agree, are they able to expand on what those hidden costs might be?
Brian Byrne: As you said, Clackmannanshire Council’s submission is mainly about running the elections. We deal with registration prior to elections. We would say that the costs will be fairly minimal, but they will not be non-existent, given that we will have to try to capture 16-year-olds in time to register.

Jeremy Purvis: I was interested that Clackmannanshire Council’s submission said:

“It is apparent through past experience that, in every major election event, there will be some costs incurred by the ERO which cannot be recovered through the Returning Officers Charges Order. This accounts for part of the ‘hidden subsidy’ that Councils contribute to centrally funded elections.”

Brian Byrne: That is because electoral registration is not really part of the election, so money that is spent on it cannot be reclaimed as an election expense. There will always be some additional expenditure on registration in the run-up to an election or when the rules for an election are changed. Technically, it is not election expenditure, so it cannot be reclaimed that way.

Jeremy Purvis: The financial memorandum states quite clearly that the bill will involve no costs for local authorities. Do you have any comments about the costs that it puts forward on preparations for the elections?

Brian Byrne: One part of the financial memorandum says that there will be no costs, but elsewhere the financial memorandum says that the costs will be minimal. It is more likely that there will be minimal costs than it is that there will be no costs. There will be some costs, but we are not talking about tens of thousands of pounds.

Jeremy Purvis: I will move on to postal voting. What would your responsibilities be if, following the pilots, a decision were taken to hold all-postal voting elections? What impact would that have on EROs?

Brian Byrne: If a simple postal voting system were used that did not involve any personal identifiers, the impact would be minimal. We would provide a list of all the voters and the returning officer, whoever that might be, would arrange for the ballot papers to be issued. If it were decided that a more secure system should be used, the registration officer would have to collect the security information—signature, date of birth and verification that the person was who they said that they were—and then pass it on to the returning officer.

Joe FitzPatrick (Dundee West) (SNP): My reading of the bill is that personal identifiers will not be used.

Brian Byrne: In those circumstances, postal voting is okay.

Joe FitzPatrick: Our role is not to discuss the politics of whether personal identifiers should be used; it is simply to consider what is in the bill. It is good to hear that the impact on you would be minimal.

Lewis Macdonald: On the same subject, from a professional point of view, would you be content to run a postal ballot that did not require the use of personal identifiers?

14:45

Brian Byrne: As I said, we would not run the ballot; we would provide the registration information. That is a fairly simple job for us if there is no security element. It is really a matter for the organisers of the election to decide whether they are happy to have a national park board-type election or whether they want a local government-type election, either for the status of the election or for the security of it.

Lewis Macdonald: But should the view be taken that any such election would have to be secure and free from the risk of fraud, there would be a cost associated with the collection of personal identifiers for people who are not currently postal voters.

Brian Byrne: If the voting were all postal and the election had to be fully secure—like a normal election is—security information would have to be collected from every voter. At the moment, that does not happen.

Lewis Macdonald: I understand from some of the submissions that we have received that, at the moment, broadly 85 per cent of electors are not postal voters.

Brian Byrne: On average, about 15 to 20 per cent of voters are postal voters.

Lewis Macdonald: How many people in Scotland are not postal voters? In broad terms, is it just over 3 million?

Brian Byrne: Yes.

Lewis Macdonald: So, if it cost £1 to collect security information for each of those voters to make an all-postal ballot secure, we would be talking about an additional £3 million or so.

Brian Byrne: Yes. It would cost at least £1 for each voter.

Lewis Macdonald: On the basis of your experience of postal votes.

Brian Byrne: The other thing about collecting personal identifiers is that some people drop off the register because they do not want to give identifiers, for whatever reason. So, if the process were extended to every voter, some people would drop off the register.
Lewis Macdonald: For clarity, is the £1 cost per registered voter the average cost of getting security information from people whom you have to chase up several times and from those who respond immediately?

Brian Byrne: Yes.

Jeremy Purvis: With regard to the operation of the pilot schemes, I understood from the 12 September letter from the Cabinet Secretary for Health and Wellbeing that the system of operating the franchise for the pilot schemes could be different from that which would be in place if the elections were rolled out. You have raised concerns about the software systems when it comes to extending the franchise to 16 and 17-year-olds. The simpler system will operate for the pilot schemes. Is it your understanding that the simpler system will be used for the full elections if the pilot schemes are rolled out?

Brian Byrne: I do not know whether the simpler system will be used for the full elections. If the system that is used is not simple, it will create lots of problems because 14 and 15-year-olds will have to be on the register in advance. For the pilot schemes, the suggestion is that the register should be kept strictly to 16-year-olds, who will apply when they reach the age of 16. It is more reactive than proactive.

Jeremy Purvis: We are keen to focus on the cost element of the systems rather than the policy element.

Brian Byrne: Sorry.

Jeremy Purvis: However, I would have thought that there are policy issues around capturing the details of 15-year-olds on a public record.

Brian Byrne: That would have a financial effect as well. The likely policy would be to protect the names, which would have a cost.

Jeremy Purvis: Will the information that you have provided on the upgrading of the software to make it consistent throughout Scotland still apply if the elections—other than the pilots—were rolled out across Scotland and operated under a rolling electoral system for 16 and 17-year-olds?

Brian Byrne: To get people who are younger than 16 on the register in time would incur the costs that we have suggested.

Joe FitzPatrick: But if the simpler system were used, there would not be that additional cost when the elections were rolled out.

Brian Byrne: Minimal changes would be required, but it would depend on the software system. Some software systems would find that easier than others.

Jeremy Purvis: I have a final question that follows on from the points that Lewis Macdonald raised about postal ballots. At the moment, are personal identifiers used for those who have registered as postal voters? Both within a pilot area and under the measures in the bill, if identifiers are not to be used, a parallel system will operate for postal voters. If a postal voter registers during an election cycle to be an elector in a health board election, identifiers will not be required and, therefore, will not be captured by EROs. The registration process will have to be duplicated for any local government or national Government election, at which stage personal identifiers will be requested. Is that correct?

Brian Byrne: As I understand it, if the proposal is to have a fully postal ballot without identifiers, no application will be needed. Every elector on the registration list will get a ballot paper and there will be no identifiers. I am not sure if that is what you mean.

Jeremy Purvis: It is. That will work on the basis of an all-postal ballot in perpetuity.

Brian Byrne: Yes; an all-postal ballot with no security.

Lewis Macdonald: Your submission refers to the national park elections as an alternative model to the local government elections. Do you provide the registers for those elections?

Brian Byrne: Yes.

Lewis Macdonald: Are they simple postal registers with no security checks?

Brian Byrne: Yes.

Lewis Macdonald: What is the turnout in national park elections?

Peter Bales: I believe that it was around 60 per cent in the Cairngorm area.

Lewis Macdonald: But there were no checks on the identity of those who cast postal ballots.

Brian Byrne: No.

The Convener: As there are no more questions and no final comments from our witnesses, I thank them for their attendance and their evidence.

We move on now to our next set of witnesses. I welcome officials from the Scottish Government bill team to the committee. Kenneth Hogg is deputy director of health delivery, and Robert Kirkwood is a policy officer in the bill team. You are welcome. I am told that you do not wish to make an opening statement; can you confirm that?

Kenneth Hogg (Scottish Government Health Delivery Directorate): Yes.
Jeremy Purvis: I will start with a straightforward question. Will the costs to the national health service of delivering the full elections—not just the pilots, which we will come on to in a moment—be met by NHS boards in the areas in which elections will take place, or will central funds be provided to compensate boards for those costs?

Kenneth Hogg: In the first instance, the costs of pilots that fall within the current spending review period will be met from central Government additional funding without calling on health boards’ allocated resources. If the pilots are then rolled out nationally, the elections will fall within a future spending review period and the costs of those elections will be taken into account then.

Joe FitzPatrick: What is the procedure for moving from the pilots, about which we have quite good detail, to rolling out the scheme?

Robert Kirkwood (Scottish Government Health Delivery Directorate): We will have the pilot elections, and there will then be a full evaluation. The evaluation report will come before Parliament before any decision is made on a roll out.

Joe FitzPatrick: Will the report go to the Subordinate Legislation Committee or elsewhere?

Robert Kirkwood: It will go to a committee, but the procedure will depend on whether there is a change to the bill; if there is, the affirmative procedure will be used.

Jeremy Purvis: I want to return to the question whether health boards will be required to cover the costs or whether the elections will be funded centrally. Mr Hogg said that the matter will be taken into account by ministers in the next funding round. The revised financial memorandum states that the costs will be £16.65 million. Is that correct? Has there been a change since September?

Robert Kirkwood: No.

Jeremy Purvis: So there is no change. Are you saying that no policy decision has been taken on whether the costs will be added to boards’ baselines? I am not clear about that, because your answer was simply that costs will be taken into account.

Kenneth Hogg: To an extent, the question whether the funding will be identified separately or will come from within boards’ allocations is slightly academic. We are saying that the costs of the elections will need to be included in the sums of money that are given to health boards in their general allocations. The health boards will be the mechanism through which the costs are met, but the Government will have a responsibility for ensuring that the boards are given sufficient funding to meet the costs of the elections as they are rolled out. Clearly, a lot will be learned from the pilots. That is why the proposal is to run pilots first, to have a full independent evaluation and then to consider that before deciding whether and how to roll out fully. There is certainly no attempt not to take into account the full roll-out costs of the elections.

Joe FitzPatrick: On that point, my understanding is that those decisions would be for the next spending review.

Kenneth Hogg: That is correct. The bill will commit expenditure to the pilots and nothing else. The pilots will run for a two-year period. The earliest date on which pilots could commence is 2010. A report would then be laid before Parliament, at the earliest during 2012. Therefore, the earliest date at which full roll-out could happen would be following 2012, so that is at least one, if not two, spending review periods away. The bill sets an end date by which the pilots must be rolled out if they are to be rolled out, otherwise the whole scheme fails.

Jeremy Purvis: You will appreciate that the issue is not academic. I will not put words into your mouth but, in answer to my question, you indicated that additional resource will be provided to health boards to ensure that they are compensated properly for the costs of running the elections. However, in answer to Mr FitzPatrick, you said that that is for the next spending review period, on which you cannot give any more information. There is no policy information in the financial memorandum about the on-going costs to the NHS, whether or not the cost is to the boards. The financial memorandum simply sets out the overall cost to the NHS in Scotland; it does not say whether boards will receive the exact amount of money to cover the operation of elections in their areas. That is not an academic point; it is a real point about the operation and costs of local health board elections. However, you have indicated that a policy position has been taken that the boards would be centrally recompensated, which is helpful. I ask you to comment on whether that is accurate.

Kenneth Hogg: I think that that is correct. My difficulty is that I do not know what health boards’ general allocations will be in future years—not just in future budgets, but in future spending reviews. However, the costs of running the elections, if they are rolled out, would need to be fully and explicitly taken into account in the setting of health boards’ budgets for future years.

Jeremy Purvis: I am grateful to you for putting that on the record. The committee will try to cross-reference what you have said with the information that the cabinet secretary has given us, because I could not find that point in that information.
I will move on to the operation of the elections. Those who have provided information to us have assumed that the elections would use existing returning officers, who are by and large officers of local authorities. Is that how the elections will operate?

Robert Kirkwood: Yes, that is right.

Jeremy Purvis: Submissions from some local authorities, including Clackmannanshire Council, refer to the possibility of hidden subsidies. Is the cost of the time of the returning officers and their staff taken into consideration in the financial memorandum?

Robert Kirkwood: Yes, the costs of the elections will be fully reimbursed by the Scottish Government.

Jeremy Purvis: That is helpful. Where are the costs for the pilots and for any on-going elections factored into the tables that appear in the 12 September letter from the cabinet secretary?

Robert Kirkwood: They are included in two areas. The baseline cost is taken from a number of Electoral Commission studies on local government elections in England. The counting machines line is an average cost that was taken from the 2007 local government elections in Scotland. Within that, provision is made for returning officers.

Jeremy Purvis: That is helpful. If my understanding is correct, the £1.21 million baseline cost is based on a 60 per cent turnout and a cost of £2.60 per single transferable vote. It would be difficult to have a read-across on that from south of the border, where STV is not used. The financial memorandum does not state that the baseline cost takes into account charges for the time of local authority chief executives, who will be required to operate and manage the elections and to act as returning officers.

Robert Kirkwood: The baseline cost figure includes stationery, the provision of ballot papers, postal costs, the provision of assistance points for people who wish to use them, the opening of the postal votes and a post-election survey to see how people managed with the postal vote.

An issue on which we require further clarification is the personal fee that is paid to returning officers. At the 2007 elections, that fee was in the region of £3,500. In an earlier conversation, officials from the Convention of Scottish Local Authorities thought that the personal fee would not be requested in the pilot elections. However, some of the submissions to the committee state otherwise, so we will need to reflect on that.

Jeremy Purvis: I also asked about the situation in the event of a roll-out of the elections.

Robert Kirkwood: If the 14 returning officers chose to request the personal fee, the cost would be in the region of £50,000.

Jeremy Purvis: What about the costs of returning officers’ staff?

Robert Kirkwood: That is included in the Electoral Commission figures and in the counting machines line.

The Convener: James Kelly has waited very patiently to ask a question.

James Kelly: I apologise if I sound pedantic, but I just want to be clear about the funding of the elections, on which I am a bit confused. It has been made clear that the pilot elections will be funded centrally and, in the event of roll-out being agreed, the costs will be incurred in a future spending review. In that future spending review, will the elections still be funded centrally by the Scottish Government, or will the costs be allocated against health board budgets, or has that decision still to be taken?

Kenneth Hogg: The pilots could be run in 2010 at the earliest, which means that they fall within the current spending review period. It is therefore necessary to identify the pilot costs separately in addition to the allocations that already exist for health boards as part of the 2007 spending review outcome. We have not done that, because we do not yet have health board budgets for future years, but the funding for the elections would flow through the health boards’ allocations as part of future spending reviews. The Government would then take that into account in setting the amount of money to be given to health boards in their general allocations.

Lewis Macdonald: I draw the officials’ attention to the evidence that a number of health boards have submitted. I will quote NHS Grampian’s submission, as that board covers the area that I represent, but its comments reflect those that a number of other boards have made. It states: “NHS Grampian recommends that costs are met by additional funding specifically targeted at direct elections”—in other words, ring-fenced funding.

It concludes: “Given that the Financial Memorandum indicates that Health Boards would be required to meet the costs”—in the way that Mr Hogg has just described—”it would appear that NHS Grampian’s recommendation of additional funding has not been accepted.” Is that a fair description of the position?
Lewis Macdonald: Have you discussed with health boards how the pilots will be funded, and how the potential roll-out of elections will be funded?

Robert Kirkwood: Health boards were involved in our consultation, within which the funding of elections was discussed. It was clear at that point that they wanted separate arrangements to be made, and that is what we will do for the pilots.

Lewis Macdonald: Can you explain why you—or ministers—have not accepted that argument for any future roll-out?

Kenneth Hogg: Perhaps I can comment on that. We have not “not accepted” that argument—it is simply that the bill only commits expenditure for the pilots, so we have addressed the issue in relation to the pilots now, within the current spending review period.

There is not currently a commitment to further expenditure. When that time comes, we would need to be clear about the way in which the expenditure will flow, and from which sources.

Lewis Macdonald: Does the Scottish Government believe that it has adequately addressed the points that health boards have raised with it? Have you discussed with health boards the evidence that they have submitted?

Kenneth Hogg: We are certainly well aware of the view that the costs to health boards of running elections should be provided in addition to the funding for front-line services that boards would have received anyway. That view has been clearly expressed and understood in the Scottish Government.

Lewis Macdonald: Do you share the disappointment of, I suspect, a number of committee members at the fact that health boards have not been able to attend this meeting to express their views directly?

Kenneth Hogg: It would be wrong of me to comment on the actions of other parties.

Lewis Macdonald: Have you discussed with health boards their attendance at this meeting?

Kenneth Hogg: We have not discussed the health boards’ attendance at this meeting.

Alex Neil (Central Scotland) (SNP): To be fair to the health boards, we decided only last week to invite them. We cannot fairly criticise them for not being able to turn up today, although it would have been helpful if at least one of them could have done so.

The measure focuses on the pilots, which you will then evaluate to decide whether the elections will be rolled out to the other health boards in Scotland. I have two questions. First, have you decided on the criteria for selecting which areas will host the pilots? I suggest that, in light of the draft decisions on accident and emergency provision, Ayrshire and Lanarkshire would be good candidates.

My second question is about the long term. You are right to suggest that questions about what will happen if elections are rolled out are a bit academic, but if they are rolled out, is it envisaged that they will be held throughout Scotland at the same time? If so, will all the expenditure fall once every four years, assuming that the members serve for four years, or will it be evened out so that, if the cost is £16 million, it will be £4 million a year?

Kenneth Hogg: I will answer the first question and ask my colleague Robert Kirkwood to answer the second.

Health boards have not yet been identified for the pilots. They will need to be identified by the time the regulations are laid following the bill’s passage. Ministers are minded to opt for two pilot boards that are geographically representative, and we therefore lean towards using one predominantly urban board and one predominantly rural board, but the decision has yet to be made. I make the link between that and the cost, however, given the questions that members have asked. Elements of the cost of the pilots will vary depending on which boards are chosen. The £2.86 million figure for the pilots in the financial memorandum is based on an assumption that 20 per cent of the population will be covered by the two boards.

Alex Neil: So it is assumed that that 20 per cent will be representative of the wider population.

Kenneth Hogg: Indeed. In practice, the costs could be less or more than that depending on which boards are chosen. I will give a couple of worked examples, sticking with the model of one predominantly rural board and one predominantly urban board. At the lower end of the spectrum, if we took moderately sized health boards such as Fife and Dumfries and Galloway, the total cost of the pilots would be just over £2 million rather than £2.86 million. On the other hand, if we took two of the largest boards in each category—say, Lothian and Highland—the cost would rise to just over £3.5 million. In either case, the cost would be fully met by the Scottish Government, but I want to be clear about the assumptions that underpin the costs in the financial memorandum.

Alex Neil: You said that the cost could vary from just over £2 million to just over £3 million
depending on which two boards are picked for the pilots. Is there a cap on how much you are prepared to spend on the pilots?

Kenneth Hogg: Ministers have not set a cap, but in practice there would be one if we chose the two largest boards because that would produce a ceiling for the maximum amount of money that could be spent. Given ministers’ preference for a representative sample, it is highly unlikely that the maximum will be spent.

The Convener: I am anxious to avoid a bidding war around the table.

Alex Neil: My second question was about the possible bulging of the costs.

Robert Kirkwood: I draw members’ attention to proposed new paragraph 66 of the financial memorandum, which shows that the costs will be fairly front loaded. The bulk of the costs will be met in year 1, but there will be recurring costs for members’ remuneration in years 2, 3 and 4.

David Whitton: For clarification, and to pick up what my colleague Lewis Macdonald said, have you spoken directly to the boards that sent in evidence to reassure them about the costs that they said they were facing?

Robert Kirkwood: No—we have not spoken to the boards since they submitted evidence.

David Whitton: Do you recognise as accurate the figures in their evidence?

Robert Kirkwood: We recognise the figures, but we have an issue with some of them. NHS Highland might have misinterpreted some figures.

David Whitton: Which ones?

Robert Kirkwood: NHS Highland’s submission refers to 20 elected members. We proposed two pilot board areas with 10 elected members each, rather than 20 elected members in one pilot board area. NHS Highland’s extrapolation of costs is therefore a bit out.

David Whitton: To ensure that I fully understand, are you saying that there is no chance of any money being taken from front-line services to pay for direct elections to health boards?

Kenneth Hogg: If elections were fully rolled out, the costs of running them throughout Scotland would be taken into account in the sums of money that are given to health boards as part of their general allocations.

David Whitton: You say that the costs will be taken into account, but that is not exactly what I asked. The evidence to the committee from various health boards is that if they have to pay to run the elections, the money will have to come from front-line services. Can you give boards a guarantee that they will not have to take money from front-line services to pay for directly elected health boards?

Kenneth Hogg: An absolute guarantee exists for the pilots, because they fall in the current expenditure period.

Jeremy Purvis: Mr Kirkwood asked us to look at paragraph 66 of the amended financial memorandum, which we are doing. It says:

“The estimated roll out costs are set out in the table copied below”,

which gives us the figure of £16 million. It also says:

“The intention is that the costs will be met from existing budgets.”

Will you explain that? That does not say that the pilots are outside the spending review and that any further costs will be taken into consideration. That says clearly that “The intention is that the costs”

of the roll-out

“will be met from existing budgets.”

Kenneth Hogg: The expenditure would be made by health boards from their allocations. The bill gives boards a power to make those payments. What is not in the scope of the financial memorandum or of the discussion is the size of health board budgets in many years’ time, when the roll-out might happen. Even estimating the costs at that time will depend largely on what is rolled out, which will be informed by the evaluation and the experience of the pilots.

The Convener: I am concerned about the questions that officials are being asked—there are questions that they can and cannot answer. If the committee has concerns, it can make them known in the report.

Jeremy Purvis: I understand that. I was trying to clarify what is in the financial memorandum. I want that to be crystal clear. The financial memorandum says:

“The intention is that the costs will be met from existing budgets.”

That means that boards would pay for elections, if they were rolled out. Whatever the cost was, boards would receive that money in addition to their baseline grant.

Kenneth Hogg: The decision would be for future spending reviews and budgets.

Jeremy Purvis: So the decision has not yet been taken. Is that correct?
Kenneth Hogg: By definition, that must be the case, because those budgets do not yet exist, whereas the budgets for the pilots do exist.

Jeremy Purvis: I am sorry—

The Convener: The official has given the answer. If members have concerns, they can put them in the report.

Joe FitzPatrick: One difficulty is that the spending that we are discussing would take place not only after the current spending review period, but—potentially—after a general election. The ministers and the Parliament that decide on the roll-out could be different.

Kenneth Hogg: Indeed.

Joe FitzPatrick: Obviously, I would expect far more SNP members.

The Convener: We are in danger of having a debate around the table, whereas we are here to seek information.

Lewis Macdonald: Further to the question of funding—not for the roll-out, which, as has been said, may be some time off, if it goes ahead, but for the pilot schemes—Mr Hogg has said that there is an absolute guarantee that the pilot schemes will be funded in full. However, Mr Kirkwood disagrees with the figures that have been presented by NHS Highland on the basis that he thinks that they overstate the likely costs. On what basis will you agree with health boards and the electoral registration officers what the costs will be?

It is disappointing that the health boards are not here to comment on the matter directly and to be subject to scrutiny for the assessments that they have made. Your giving a guarantee to fund in full presumes some discussion or agreement with health boards over what part of officers’ time and what part of the shared resource across the health boards are being absorbed by these elections that might be used for other purposes. Has that work begun? If not, how will it be taken forward?

Kenneth Hogg: Once the specific health boards have been identified, we will work closely with them over the period leading up to and beyond the pilots to establish how the elections will be held and what costs will be incurred. For some of the cost elements, there will be a direct correlation between the size of the board and the cost that is generated.

Lewis Macdonald: Do you intend to provide a global sum within which you expect boards to meet the costs? Or will you take an itemised approach involving so many hours of officers’ time plus so much additional expense? What will your general approach be?

Kenneth Hogg: The approach has yet to be finalised.

Lewis Macdonald: It appears that the £16.65 million that has been identified includes a substantial portion of remuneration and expenses for those people who are elected to boards. Do you accept, for example, NHS Highland’s view that the travel and subsistence costs of elected members in a large rural area will be different from those of elected members in urban areas? If so, which of those do you reflect in your global sum?

Robert Kirkwood: We recognise the differences between all health boards and the requirements of their members. The figure that we cite in the financial memorandum is a working figure that we can extrapolate to boards. It is taken from an average board, given the fact that we do not yet know which boards will be used for the pilots.

Lewis Macdonald: The figure could end up being quite a lot more or less, depending on which boards are used for the pilots.

Robert Kirkwood: Yes.

Lewis Macdonald: Does it include the election expenses of those who seek to be elected?

Robert Kirkwood: Election expenses have perhaps also been misunderstood. We have proposed a cap of £250 on what someone seeking election could spend. That is not £250 that would be given to someone who sought to be elected, to pay for their election expenses.

Lewis Macdonald: They or an organisation would pay for their expenses; the Government would not.

Robert Kirkwood: That is correct. The £250 is purely a cap on what someone could spend.

The Convener: We have had quite a long session and I remind the committee that we still have a major item on the agenda. I will give the final question to James Kelly.

James Kelly: The financial memorandum sets baseline costs of £1.21 million. Mr Hogg earlier alluded to the fact that the costs could vary, depending on the areas that were selected for the pilot elections. Do you not think that the financial memorandum should have reflected that by giving upper and lower limits for the baseline costs?

Kenneth Hogg: We can certainly provide further worked examples in writing if that would be helpful to the committee.

James Kelly: Yes, that would be helpful.

The Convener: Do you have any final comments?
Kenneth Hogg: Just one point of detail that refers back to an earlier question pertaining to cost. Part of the £1.21 million is the cost of £2.60 per vote. We specifically chose to base our costings on the five English pilots because they used STV, whereas other, more local examples did not. The English pilots were a more reliable basis on which to calculate the costs.

Also, your previous witness referred to the additional costs of running elections with personal identifiers. I can confirm that the intention is not to use personal identifiers, partly because of the additional cost and partly because of the administrative complexity that that would have brought to the process. We are keen to keep the process as simple and cost effective as possible; therefore, the extra £1 per vote on top of the £2.60 will not be incurred.

The Convener: Thank you for that clarification.

Jeremy Purvis: Will that apply to the rolled out elections, or is that the case only for the pilots?

Kenneth Hogg: That decision has been taken for the pilots and there has been no change to that for the roll-out. Were there to be a change from the pilots to the roll-out, the matter would return to Parliament under affirmative procedure. There would need to be a second parliamentary approval for that at that time.

Jeremy Purvis: So, the estimated costs of the roll-out in the table and the amended financial memorandum do not include the cost of seeking personal identifiers for postal voters.

Kenneth Hogg: That is correct. The figure of £16.65 million does not include the cost of using personal identifiers.

The Convener: I thank Robert Kirkwood and Kenneth Hogg for their attendance and for their expertise, which has been of great assistance to the committee.
SUBORDINATE LEGISLATION COMMITTEE

EXTRACT FROM THE MINUTES

31st Meeting, 2008 (Session 3)

Tuesday 11 November 2008

Present:

Malcolm Chisholm
Tom McCabe
Gil Paterson (Deputy Convener)

Helen Eadie
Ian McKee
Jamie Stone (Convener)

Apologies were received from Jackson Carlaw.

2. Health Boards (Membership and Elections) (Scotland) Bill: The Committee took oral evidence on the Bill at Stage 1 from—

Kenneth Hogg, Deputy Director of Health Delivery, Robert Kirkwood, Bill Team Policy Officer, and Beth Elliot, Solicitor, Scottish Government.

6. Health Boards (Membership and Elections) (Scotland) Bill: The Committee considered the evidence taken under item 2, and agreed to reconsider the bill in private at its meeting next week.
Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

14:15

The Convener: Agenda item 2 is stage 1 consideration of the Health Boards (Membership and Elections) (Scotland) Bill. I welcome the Scottish Government officials, who will answer questions. We have with us Kenneth Hogg, the deputy director of health delivery; Robert Kirkwood, the bill team policy officer; and Beth Elliot of the Scottish Government legal directorate.

The committee wrote to the Scottish Government about a number of delegated powers in the bill, and, after thinking about the Government’s response, we agreed that we wished to take evidence to explore further the intended use of those powers. The delegated powers that we shall address are as follows: sections 1(5) and 1(6), which confer the power to specify circumstances in which ministers may determine that members are to vacate office—a chilly phrase for the elected members present; section 2, in particular the power to set the criteria for the franchise of elections by subordinate legislation; section 4, which is about the pilot order, which has the effect of commencing the substantive provisions in the bill in relation to certain health board areas only in order to pilot the process; and section 7, which is about roll-out orders that have the effect of commencing the bill in areas that were not subject to the pilot scheme.

We will begin with questions on sections 1(5) and 1(6). Having regard to the committee’s remit, we are examining the issue of whether the circumstances in which ministers should have discretion—I use that word carefully—to dismiss members of a health board, including those who have been elected, should be set out in the bill or whether it is appropriate for ministers to set the limits of the power in subordinate legislation that can be amended from time to time. I invite Malcolm Chisholm to open the batting on that point.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I thank the officials for their response, which explains that the Government wishes to be able to ensure that national policy issues are addressed across health boards. I suppose that some people might think that it is quite a big leap from that statement to saying that the bill must confer a power to specify when there is discretion to dismiss members. Could you explain your thinking? Why does the need to ensure that national policy issues are addressed lead to putting all that into subordinate legislation?
Robert Kirkwood (Scottish Government Health Delivery Directorate): We intended that the measure would put all health board members on the same footing. We already have a power to remove appointed members of health boards if it is in the interests of the national health service to do so. The proposal is to extend the power to cover elected members.

Malcolm Chisholm: We are trying not to get into the policy substance of the point, but a lot of people will feel that elected members are in a slightly different category and that dismissing one is quite a serious and new thing to do. Given that that would be controversial, people will ask whether it would not be appropriate for those circumstances to be included in the bill and agreed by Parliament.

Kenneth Hogg (Scottish Government Health Delivery Directorate): To the best of my knowledge, the existing power to remove members has never been used, so I agree that it is something of a nuclear option. For example, it might be used in circumstances in which it was felt that a health board member was acting to subvert the accountability links between the health board, ministers and the Parliament. The rationale is to extend the provision to cover all health board members equally.

It has been quite an important point of principle, which we discussed with the Health and Sport Committee and the Finance Committee, that the elected members will be bound by the same corporate governance requirements as other members are, and that the inclusion of directly elected members does not alter the lines of accountability from health boards through ministers to the Parliament. We are therefore deliberately trying to keep all types of member on the same footing in order not to change the existing accountability lines.

Malcolm Chisholm: That would not necessarily lead you to the conclusion that the provision has to be in subordinate legislation. You gave an interesting general explanation of the circumstances in which someone might be dismissed, but is there not a strong argument for putting that in the bill? In a way, your explanation leads to a lot of the big policy issues of the bill and, although we are not here to discuss those issues today, one would think that when Parliament debates the bill, members will want to discuss that kind of situation. It is one of the issues that is thrown up by having directly elected members, traditional accountability arrangements and ministerial powers.

Kenneth Hogg: The view that has been taken to date is that it would be serious if the power to dismiss an elected member of a health board were ever to be used, and it would be equally serious if it were to be applied to an appointed member of a health board. We have sought not to distinguish between the two types of member in terms of their obligations and responsibilities as members of a health board.

Malcolm Chisholm: Even following that line of argument, your response talks about the "interests of the National Health Service."

Some might feel that that is a bit general, although, again, that is a policy issue that we will not explore. What would be the argument against that formulation of words, if that is what exists for current members of health boards, or would it not be appropriate in the bill? I am not saying that I support that point of view, but that form of words could be in the bill. At the moment, the bill is so general that people will have concerns about what is intended.

Beth Elliot (Scottish Government Legal Directorate): The existing power on which the proposed power is based is in subordinate legislation. The power to remove an appointed member, if the Scottish ministers consider that to be in the best interests of the national health service, is in subordinate legislation, which is why we have decided to put the proposed power into subordinate legislation. There is always a balance to be struck between what should be in the bill and what should be in subordinate legislation.

Malcolm Chisholm: Your final comment was useful. You are saying that you might well want to use the particular form of words that I mentioned in subordinate legislation, but your thinking is that if the current situation is governed by subordinate legislation, then the new situation should be.

Beth Elliot: That is one factor that was taken into account.

Malcolm Chisholm: That clarifies what you are saying, but I do not think that it will remove people’s concerns. At least we are a bit clearer about what you are thinking.

Helen Eadie (Dunfermline East) (Lab): I want to progress along the same lines as Malcolm Chisholm. An open power to set out any circumstances in which ministers would have discretion to dismiss members is broader than the "interests of the National Health Service" criterion, and it would clearly allow other criteria to be set. Why is that thought to be necessary and appropriate?

Kenneth Hogg: We are not seeking to broaden the circumstances in which a member could or should be removed, but simply to extend the provision to include directly elected members.
Helen Eadie: The committee needs to consider carefully how powers could be used, in addition to how the Government indicates that it would use them. Is it not possible to restrict the power in some way to address such concerns?

Kenneth Hogg: It would be possible to legislate to change the basis on which all members could be removed. That, however, is not the primary purpose of the bill, which is simply to include directly elected members in health board membership.

The bill could, in principle, do what you ask and legislate to change the basis on which all members could be removed, but we are not seeking to change the existing circumstances in that regard.

Helen Eadie: Would the Government consider, as an alternative means of addressing those concerns, making the exercise of the power to specify the limits of ministerial discretion subject to affirmative procedure?

Beth Elliot: The exercise of the power is currently subject to negative procedure, but we will take into account any comments from the committee in relation to that. The Government currently intends it to be subject to negative procedure, as the current regulations that apply to appointed members are subject to negative procedure.

The Convener: We move to section 2. Apropos of what Beth Elliot has just said, we are pleased that the Scottish Government has confirmed that it intends to amend the power to make election regulations so that it is subject to affirmative procedure—that is good news.

However, we have further questions about setting the criteria for the franchise at elections, in order to assess whether that should be set out in primary legislation by Parliament rather than in subordinate legislation. It is similar to what we discussed a few minutes ago.

Gil Paterson (West of Scotland) (SNP): Your response mentions the need to provide flexibility for changing circumstances with regard to the franchise. Can you explain what is envisaged? Is setting the franchise for the elections not a matter of principle that should be decided by Parliament?

Kenneth Hogg: Do you mean by altering the balance between secondary and primary legislation, or by some other route?

Gil Paterson: It is in regard to whether affirmative or negative legislation should be used.

Kenneth Hogg: I will begin, and ask my colleague to pick up on the detail in a moment. One of the points that we have borne in mind throughout the bill process is that we want to introduce the provisions through pilots. Following the responses to the consultation in advance of the bill, we are keen to test the provisions in practice in pilot areas.

We currently envisage that two health board areas will host the pilots, and we intend that they will cover a geographic area that is representative of Scotland: one largely urban, and one largely rural. We therefore want to retain the flexibility to amend proposals, if necessary, in the light of our experience of, and what we learn from, those pilots during the roll-out. That has informed our approach in deciding whether to include provisions in the regulations or on the face of the bill, and in making decisions between affirmative and negative procedure.

I ask Beth Elliot to comment further.

Beth Elliot: We have specified in the bill that the franchise includes those who are aged 16 or over. Certain key policies that relate to the way in which the elections will be held, such as the use of single transferable voting, are also prescribed in the bill. The other criteria that will be used to identify the franchise are set out in the regulations, a draft copy of which has been sent to the committee. That is our view on the appropriate split between what should be in the bill and what should be included in subordinate legislation.

Kenneth Hogg: Under the current draft, affirmative procedure would be required if the Government of the day wanted to change its mind about the use of STV, single wards or extending the franchise to 16 and 17-year-olds in rolling out the proposals.

Gil Paterson: I want to clarify that when I referred to negative legislation, I made a slip of the tongue—I should have been talking about primary and subordinate legislation.

If the intention is to follow the local government election model—apart from the age limit, which is to be reduced to 16—would it not be possible to restrict the power to make future changes to the franchise to any that are made in relation to local government elections?

Beth Elliot: I am sorry, I am not sure that I follow your question.

Gil Paterson: I will re-read it. If the intention is to follow the local government election model—apart from the age limit, which is to be reduced to 16—would it not be possible to restrict the power to make future changes to the franchise to any that are made in relation to local government elections?
Beth Elliot: The intention is to follow the local government model, with the exception of age. One reason that we have put further detail in the regulations rather than in the bill is because of the need to have a young person’s register to try to capture information about 16 and 17-year-olds. We considered that we needed a certain amount of flexibility in addition to the pilot process in order to see how that worked in practice.

We are aware that there are other examples of elections in which the franchise, if the local government model has been used, is prescribed in the bill. We have not, to date, taken that approach, but we can consider it further.

The Convener: Would you agree that that could be made a little clearer in the bill, apart from what you say about the age aspect? The fact that we asked the question means that we had not understood what you have just referred to.

Beth Elliot: That it is based on the local government model?

The Convener: Yes—would you take the opportunity to examine that and think about it?

Kenneth Hogg: Certainly.

The Convener: We move to section 4 and the pilot order.

We are pleased that the modifications to the bill with regard to the pilot order will be subject to affirmative procedure. However, we want to explore one or two other things, particularly the procedure to apply to amendments to the pilot order, and an order which revokes the pilot order and which—unusually—repeals the substantive provisions in the bill, if that is done before the bill is rolled out. That has caught our attention, because it appears that if the pilot is revoked that unravels the bill, which is, I believe, pretty unheard of. Ian McKee will ask questions on the matter.

Ian McKee (Lothians) (SNP): I am on the Health and Sport Committee as well as this one, and it is a bit like groundhog day, seeing the same witnesses about the same bill.

As the convener said, we welcome your commitment to lodge an amendment at stage 2 to make the pilot order that modifies the bill subject to affirmative procedure. Only one pilot order can be made, but it can be amended. If an amending order modifies the bill, will it also be subject to affirmative procedure?

Beth Elliot: Yes.

Ian McKee: I will move on to the procedure for revoking the pilot order. A revocation that takes effect before a roll-out order is made has the effect of repealing the election provisions in the bill. Are we correct in understanding that such an order would be subject to no parliamentary procedure?

Beth Elliot: Yes.

Ian McKee: Why is it considered appropriate that ministers should be subject to no parliamentary control or sanction in choosing to revoke the pilot and repeal the bill? Is that not a matter for Parliament?

Beth Elliot: We touched on that issue in our response. The pilot order allows for pilots to take place—it is akin to a commencement order in that respect. Once the pilot order is made, we do not consider that it is possible to uncommence the pilot process merely by revoking the pilot order.

The bill sets out the process that will take place: first, a pilot order will be made; secondly, there will be an evaluation; and finally, we will decide whether the scheme will be rolled out. Once the pilot order is made, either there will be a roll-out, in which case the order will not be needed, or nothing further will happen, in which case revoking the pilot order will simply be a matter of tidying up the statute book.

Ian McKee: I yield to your greater experience in these matters, but is it not unusual to repeal a bill simply by revoking the pilot order and without giving Parliament a say?

Beth Elliot: The issue arises because the bill sets out a pilot procedure—which is, I suspect, something that is fairly unusual to most bills. If the Parliament approves the bill’s principles, it will in effect approve the principle of pilots and the pilot scheme set out in the bill.

Ian McKee: So the Parliament would actually approve the minister’s ability to repeal the bill without Parliament’s further approval.

Beth Elliot: Yes, if that was what Parliament did.

Ian McKee: If Parliament passes the bill, that is what it will do.

Beth Elliot: Yes.

Malcolm Chisholm: As a new member on the committee, I do not know whether my questions will be appropriate, but describing a bill’s repeal as a tidying-up procedure sounds odd to me.

Beth Elliot: I was referring not to the repeal of the bill, but to the revoking of the pilot order.

Malcolm Chisholm: I know, but revoking the pilot order has the same effect as repealing the bill. Once the order is revoked, no directly elected health boards will be planned. In effect, such a move kills off the bill.

I take your guidance on this point, convener, but I presume that, given that there is no subordinate legislation to consider, we should not be exploring the issue. However, this ministerial power seems
to be subject to no parliamentary oversight whatever—not even a negative statutory instrument. Given the significance attached to such an order, that seems rather odd.

Beth Elliot: Parliament certainly has a role with regard to roll-out, as the roll-out order will be subject to the parliamentary process. However, it is up to ministers to determine whether there will be a roll-out.

Kenneth Hogg: Perhaps I can amplify that point. The issue perhaps arises because the provisions almost have a sole purpose: creating the pilots. It would take the Government of the day to decide that it positively wanted to roll out pilots across Scotland for that to happen. Equally, if the Government of the day did not want to roll out pilots across Scotland in line with its existing policy, or if Parliament did not ratify the provisions through the relevant procedure, the exercise would not happen. As I say, the point arises because of the focus on pilots in the first instance and the fact that two sets of decisions will be needed for roll-out to take place.

Malcolm Chisholm: I am speaking purely theoretically here—I am certainly not speaking on behalf of my party—but would it be the case that, if a new Government that did not support the idea of directly elected health boards came to power, it could simply revoke the pilot order and end the whole thing without Parliament being involved in any discussions or decisions?

Beth Elliot: Yes, because ministers decide on the roll-out. If ministers did not want the pilot to be rolled out or wanted to stop the provision, they could revoke the order.

Malcolm Chisholm: I am sure that that will be discussed when the bill is debated.

The Convener: We have probably gone as far as we are allowed to with this extremely interesting discussion. The committee has fulfilled its role as custodian of the parliamentary interest with regard to the bill; it is now for the Parliament and the relevant subject committees to take a view on the matter. The bill sets a most interesting precedent and will certainly be of interest as a mechanism that might be used in other legislation, but I will go no further than that in my comments.

With regard to section 7, on roll-out orders, a roll-out order can make such amendments or modifications to primary legislation, including the bill, as ministers consider appropriate. The Scottish Government has agreed to make such an order subject to affirmative procedure. However, we wish to explore further this power to amend primary legislation and how the bill’s provisions will be rolled out across Scotland.

Tom McCabe (Hamilton South) (Lab): You have given a welcome commitment that any roll-out orders that amend or modify legislation will be subject to affirmative procedure. However, the power is pretty wide, as it allows ministers to make any changes that they consider “appropriate”. Is it possible to restrict any such modifications to those that drive the bill’s purpose?

Kenneth Hogg: Our intention is that any provisions that modify enactments to the bill—in practical terms, textual amendments—should trigger the affirmative procedure. For example, any decision to use STV and not a first-past-the-post system, to extend the franchise to those aged 16 or to move to multimember wards would trigger the use of affirmative procedure, as it would modify the enactment in the legislation.

Tom McCabe: So, if a minister considers it appropriate to make any textual change at all to the bill, that change will be subject to affirmative procedure.

Kenneth Hogg: That is correct.

Tom McCabe: Good.

With its focus on pilots and roll-out orders, the bill is a bit different from previous legislation. Are you able to give a commitment that, if a decision is made to roll out these schemes, the roll-out will take place across the whole of Scotland and within a specified period?

Robert Kirkwood: The bill specifies a period of seven years, but that is very much a long-stop provision. It provides for the making of only one pilot order, which means that, once the order is made, we must move either to rolling out the scheme or to doing nothing further with the bill. If the Government of the day decides to roll out the scheme, all territorial health boards would have to be included.

Tom McCabe: So, if you decide that the pilot has been successful and that you want to roll out the scheme, the decision will automatically apply to the whole of Scotland.

Robert Kirkwood: Yes. Such a decision and any textual amendments to the act would be subject to parliamentary procedure.

Tom McCabe: But under the long-stop provision the process could take seven years.

Robert Kirkwood: Yes. That is the long stop set out in the bill.

Beth Elliot: As the bill allows for more than one roll-out order to be made, it could allow for a staged commencement of the process in different health boards according to the bill’s provisions. Of course, the policy question whether we do that or not is a different matter.
The Convener: As members have no other questions, I thank our three guests for their responses. We will complete our consideration of the bill at stage 1 next week, before we issue our report.
Further to the Committee evidence sessions in Parliament on the Health Boards (Membership and Elections) (Scotland) Bill, I thought it would be helpful if I wrote to you and set out the main areas that we would seek to amend at Stage 2. These are in response to both our own internal scrutiny and to the helpful issues raised during these Committee sessions in Parliament.

Election Regulations (section 2(2) of the Bill)

Section 2(2) inserts a new Schedule 1A into the National Health Service (Scotland) Act 1978. Paragraph 13 of Schedule 1A gives Scottish Ministers powers to make regulations to be known as election regulations. These regulations are currently subject to negative procedure.

In our letter to the Subordinate Legislation Committee of 6 October, we indicated that we would bring forward an amendment at Stage 2 that would apply affirmative procedure to these regulations in order to enhance Parliamentary scrutiny.

Returning Officers – Paragraph 4(1) of the proposed Schedule 1A provides that the Health Board must appoint returning officers. As set out in the draft election Regulations previously circulated to the Committee, the policy intention is that the returning officer for Health Board elections is the returning officer for elections of councillors for the most populous local government area in the Health Board area. We intend to bring forward an amendment at Stage 2 to reflect this.

Restricted Posts – This was brought up in paragraph 72 of your report. We intend to amend paragraph 9(b) of the proposed Schedule 1A to ensure that Health Boards are authorised to establish their list of restricted posts as is the case for Local Authorities. The identification of these posts and appeals process for those identified is set out in Rule 12 of our draft Elections Regulations that were supplied to your Committee in advance of their evidence sessions.
Pilot Order (section 4 of the Bill)

Section 4(1) provides that Scottish Ministers may, by pilot order, appoint a day on which sections 1 to 3 of the Bill are to come into force, with such modifications as Ministers consider appropriate, in respect of the Health Board areas specified in the Order. This Order is currently subject to no parliamentary procedure as it is akin to a commencement order.

However, we recognise that the power to modify goes further than a normal commencement order. So, in our letter to the SLC, we gave a commitment to bring forward an amendment at Stage 2 to provide that if the pilot order contains any modifications, i.e. express textual amendments, then the Pilot Order would be made subject to affirmative procedure.

Revocation of the Pilot Order (section 4 of the Bill)

If an issue were to arise within only one pilot area that was seen to be a threat to the operation of the NHS in that area, then Scottish Ministers could make use of their existing powers of direction or dismissal under the NHS (Scotland) Act 1978. Any issue with the pilots as a whole is different and I would agree that any move to revoke the pilot order in its entirety should be subject to Parliamentary procedure. We are currently considering amendments attracting parliamentary procedure to any Ministerial order that seeks to end pilots early. You also mentioned at paragraph 129 of your report that revocation would mean the removal of the statutory basis for Local Authority members being on a Health Board. If this happened, the Scottish Government would bring forward an amendment at the next available legislative opportunity to re-instate this. In the meantime, the places of Local Authority members would be ensured through the existing administrative process.

Length of Pilot Order (section 5 of the Bill)

I stated at Committee that the pilot schemes should last for a minimum of two years. The evaluation report on the pilots would be published no later than five years after the pilots began. We have considered the insertion of a minimum time requirement for pilots and I would propose that this should sit within section 5 of the Bill rather than sitting within subordinate legislation. An amendment reflecting this will be brought forward at Stage 2.

Roll Out of Elections (section 7 of the Bill)

Section 7(1) gives Scottish Ministers power to make a ‘roll-out order’ to appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. The roll-out order may modify any enactment, including the Bill, as Ministers consider appropriate and is currently subject to negative procedure.

Again, we gave an undertaking to the Subordinate Legislation Committee to bring forward an amendment requiring affirmative procedure for roll-out orders which make express textual amendments to enactments. However, given the exceptional nature of this legislation and the effect on NHS Boards, after further reflection I have instructed my officials to ensure that “super affirmative” procedure be adopted as recommended by the Committee and that this is reflected in the Bill at Stage 2.

I can assure the Committee that the tabling of the roll-out order will only follow a completely independent evaluation of the pilots.
Costs

One issue where the lead Committee asked for further information is around the costs associated with using personal identifiers for the pilot elections.

Using figures supplied by the Scottish Assessors Association, the cost of using identifiers would add, on average, £1 to the cost per registered elector. That would mean an additional £775,000 for pilots based on the figures used in the Financial Memorandum, which involved 20% of the population. The Scottish Assessors Association also indicated that there would be additional administration costs to support the use of personal identifiers.

The additional cost would mean the pilot scheme would cost £3.635m (up from £2.86m). Full roll out would cost £20.52m (up from £16.65m). Additional to these costs would be the administrative costs to support the process e.g. additional IT equipment, staff and accommodation.

As I stated in my evidence to the Health and Sport Committee on 26 November, we do not propose to use personal identifiers for the pilot elections due to the significant increase in cost and the effect it would have on the timetable. Discussions with Electoral Registration Officers have already highlighted to us the significant extra work that would have to be undertaken both initially in collecting identifiers but also as part of the process to check the identifiers during the vote itself. However, on the broader consideration of costs, I will instruct an amendment at Stage 2 that will ensure costs of pilots and potential roll out costs are fully considered as part of the independent evaluation of the pilots.

Pilot Arrangements

There were 2 generic issues that arose in the Committee stages with regard to the piloting of elections.

The Health and Sport Committee asked me to consider changing the title of the Bill. I have reflected on this and propose to bring forward an amendment to the long title of the Bill to reflect the fact that pilots have to take place initially.

The Health and Sport Committee report also asked that alternative approaches to increasing engagement and involvement should happen alongside the piloting of elections. I am happy to give an undertaking to bring forward details of non statutory pilot schemes that will run concurrently with elections in advance of Stage 3.

I hope this is helpful and I would like to pass on my thanks to you and your colleagues on the Committee for your useful input to the development of this Bill.

NICOLA STURGEON
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NICOLA STURGEON
EXTRACT FROM THE MINUTES OF PROCEEDINGS

Vol. 2, No. 46    Session 3

Meeting of the Parliament

Thursday 15 January 2009

Note: (DT) signifies a decision taken at Decision Time.

Health Boards (Membership and Elections) (Scotland) Bill: The Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon) moved S3M-3162—That the Parliament agrees to the general principles of the Health Boards (Membership and Elections) (Scotland) Bill.

Ross Finnie moved amendment S3M-3162.1 to motion S3M-3162—

insert at end—

“but, in so doing, noting the terms of the Health and Sport Committee’s Stage 1 report, calls on the Scottish Government to bring forward, ahead of Stage 3, firm proposals for the piloting of a variety of alternative schemes to improve public participation and shares the committee’s view that such agreement to the general principles should not be taken to pre-empt any decision that the Parliament may later be asked to take on the rolling out of direct elections to health boards nationwide.”

After debate, the amendment was agreed to (DT).

After debate, the motion as amended was agreed to (DT).

Accordingly the Parliament resolved—That the Parliament agrees to the general principles of the Health Boards (Membership and Elections) (Scotland) Bill but, in so doing, noting the terms of the Health and Sport Committee’s Stage 1 report, calls on the Scottish Government to bring forward, ahead of Stage 3, firm proposals for the piloting of a variety of alternative schemes to improve public participation and shares the committee’s view that such agreement to the general principles should not be taken to pre-empt any decision that the Parliament may later be asked to take on the rolling out of direct elections to health boards nationwide.

Health Boards (Membership and Elections) (Scotland) Bill: Financial Resolution:
The Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon) moved S3M-2937—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Health Boards (Membership and Elections) (Scotland) Bill, agrees to any expenditure of a kind referred to in paragraph 3(b)(iii) of Rule 9.12 of the Parliament’s Standing Orders arising in consequence of the Act.

The motion was agreed to (DT).
Scottish Parliament

Thursday 15 January 2009

[THE PRESIDING OFFICER opened the meeting at 09:15]

Health Boards
(Membership and Elections)
(Scotland) Bill: Stage 1

The Presiding Officer (Alex Fergusson):
Good morning. The first item of business is a debate on motion S3M-3162, in the name of Nicola Sturgeon, on the Health Boards (Membership and Elections) (Scotland) Bill. I remind members that the Presiding Officers will no longer give a warning when a member has one minute remaining to speak. However, we have a little flexibility this morning to allow members to take interventions. We will monitor the situation as the debate goes on.

09:15

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon):
I am pleased to open the debate on the general principles of the Health Boards (Membership and Elections) (Scotland) Bill. Before I get into the substance of my speech, I offer my thanks to the many organisations and individuals who took the time to participate in our consultation. I also offer my thanks to Christine Grahame and the Health and Sport Committee, as well as to colleagues on the Finance Committee and the Subordinate Legislation Committee, for their robust scrutiny of our proposals. I have been encouraged by the support for the principles of the bill from the many individuals to whom I have spoken the length and breadth of the country, the many patient representative groups that responded to the consultation, and organisations such as Unite and Unison, which are two of Scotland’s biggest trade unions.

At the outset, it is important to set the bill firmly in context. Members will recall that “Better Health, Better Care: Action Plan” set out our vision of a mutual national health service in which ownership and decision making are shared with the public and the staff who work in the service. The bill, together with our proposals to strengthen existing public engagement processes, our plans for a participation standard and ownership report, and our intention to introduce a new patients’ rights bill, is designed to bring to life the concept of mutuality.

Many people in all parts of Scotland believe—rightly, I think—that there is a real democratic deficit in the operation of our health boards. Too often, the public feel shut out of the big decisions that health boards take daily and which account for significant sums of public money. Sometimes, that exclusion from the decision-making process leads to deep-seated alienation from the decisions that are reached. There can surely be no better illustration of that than the decisions, which the present Government later overturned, to close the accident and emergency units in Ayr and Monklands hospitals.

The bill’s clear objective, therefore, is to allow the public voice to be heard and listened to at the heart of the decision-making process. That is how it should be: whether in cities with their challenges of health inequalities, or in rural areas that face the challenges of remoteness and rurality, people have strong views and, more important, they have real-life experience of what works and does not work. Therefore, people should be involved in consideration of developments in their areas and in the decisions about how resources are spent to best meet those challenges.

Of course, as I and others have said on many occasions, people being directly elected to health boards will not take away the need for difficult decisions, but I believe strongly that having elected members on health boards will enhance and improve the quality of decision making in the NHS. In my view—a view that, if anything, has been strengthened in the past few months—when people are involved in decision making, and when they understand and become persuaded of the reasons for change, they are far more likely to be drivers of change than they are to be barriers to it. Problems arise when people feel excluded from the process and are denied a say in decisions.

The Government is committed to democratisation of our NHS boards. We believe that democracy is a good thing and that opening up NHS boards to the public through elections will deliver better decision making and, ultimately, even better services than those we already enjoy.

However, I realise that many people, inside and outside Parliament, remain unconvinced. As well as powerful positive contributions from bodies such as Unison and Voluntary Health Scotland, the Health and Sport Committee heard a range of concerns from organisations such the British Medical Association. Those organisations’ voices are respected and their views should be listened to. Many of the concerns that have been voiced about direct elections have been addressed in the bill. For example, some people are concerned that the flip-side of local democracy could be a postcode lottery of provision. It is precisely to allay that concern that the bill proposes no change whatever to ministerial powers of direction or to
the clear line of accountability that exists from NHS boards, through me, to Parliament.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): Although I accept the need for accountability to the health minister, is not there something inconsistent about having directly elected members who can be dismissed by that minister? I make that point despite my support for the general principles of the bill.

Nicola Sturgeon: The health minister’s power to dismiss members of health boards already exists. As Malcolm Chisholm will be aware, I have been unable to uncover any example of that power being used. The chances of its being used in the future will remain very remote.

Malcolm Chisholm is correct that, with directly elected members, any health minister seeking to use the power would have to have the strongest possible reasons for dismissal because the decision would be subject to the closest scrutiny. However, it is right to retain the status quo because all members of health boards should be treated in the same way in that regard.

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): The Subordinate Legislation Committee’s concern was about the conflict whereby ministers will have the power to dismiss a person who had been democratically elected to a board.

Nicola Sturgeon: I may be wrong, but I predict that amendments will be lodged on the issue at stages 2 and 3, so I am sure that we will have more discussion. I have made clear my views in the Health and Sport Committee and this morning. Ultimately, however, the decision is for Parliament.

As I said, many of the concerns about direct elections are addressed in the bill, but some of the concerns are speculative. That does not necessarily mean that they are wrong; it simply means that questions such as whether people will want to stand or whether single-issue candidates will dominate can be answered only through experience.

Jim Tolson (Dunfermline West) (LD): Will the cabinet secretary give way?

Nicola Sturgeon: I want to make progress. I will take an intervention later, if I have time.

That is why we have responded to the significant number of people who said that we should pilot elections before deciding whether to introduce them throughout Scotland. That is the right approach. It is also right that Parliament, and not just the Government of the day, will decide whether to roll out the proposals throughout Scotland, and that it should do so only after a full and independent evaluation of the pilots. The bill as it stands will put Parliament in the driving seat, but in response to the Health and Sport Committee’s stage 1 report, I have agreed certain changes that will further strengthen Parliament’s hand. Earlier this week, I wrote to that committee and to Opposition spokespersons confirming that I will seek to amend the bill’s long title at stage 2 to make it clear that the bill is concerned primarily with pilots. I also confirmed that I will introduce an amendment to make the decision on roll-out subject to the super-affirmative procedure.

I will outline the proposed approach to the pilots. My view is that we should pilot the elections in two health board areas that are representative of Scotland’s population and geographical diversity. We must also test the pilots over a reasonable period. The bill provides for an evaluation of the impact of elections to be placed before Parliament not more than five years after the pilots commence. The bill proposes that a majority of a board’s members must consist of directly elected members and locally elected councillors. As an aside, it is worth noting that, for the first time ever, the bill will give statutory underpinning to local authority membership of boards. That is important, because the role of local authority members is vital to ensure seamless delivery of health and care services throughout an area. Our move to recognise in statute the important role of local authority members reinforces our commitment to building a strong partnership between the NHS and Scottish local authorities.

On the method of election, we propose the single transferable vote. In discussion with electoral administrators, we have agreed that we should use the same STV system that is used in local government elections. For the pilots, we propose an all-postal ballot, which is in line with the approach for national park board elections. We also propose to extend the voting franchise to include 16 and 17-year-olds. That is the right thing to do, because we want direct elections to health boards to include as many users of the NHS as possible. The measure is an important way in which to introduce young people to the democratic process as they reach adulthood, because it concerns a public service of which they will already have considerable experience.

A key focus of the discussions that have taken place on the bill—especially in the Finance Committee, which is not surprising—has been the costs of holding pilot elections. We have estimated those costs at £2.86 million. The figure is based on the costs of holding an all-postal ballot covering two health board areas that represent about 20 per cent of Scotland’s population. It would not be fair to expect health boards to bear the burden of those costs, so I have given a commitment that they will be met from central resources and not from health board budgets.
Before I draw my remarks to a close, I want to deal with the suggestion that was made during the consultation and in committee evidence-taking sessions that the democratic deficit in the NHS that I have described this morning could be dealt with through approaches other than direct elections. For example, some people have suggested that we should simply strengthen existing methods of engagement. I agree that we should do that; the consultation made clear that elected health boards would be only one part of the process.

I am committed to improving public engagement and involvement with health boards. All boards encourage community and public involvement, and will continue to do so. They also have a statutory duty to show year on year how they are improving their engagement with the public. We continue to strengthen the links between communities and the NHS through further work with bodies such as community health partnerships. I have already spoken about initiatives such as the development of a participation standard. Although all that is important, none of it is a substitute for direct elections to health boards. If we are truly to enhance public engagement and involvement, such measures and initiatives should go hand in hand with direct elections.

Others, including the Health and Sport Committee, suggested that we pilot alternative approaches to enhancing public involvement, and that we do so in parallel with the direct elections pilots. I agree that that would be a useful exercise. In advance of stage 3, I will introduce plans to conduct other forms of pilot, which will take place concurrently with the direct elections pilot in board areas that are not included in that pilot. That will allow Parliament to assess the impact of direct elections not just on their own merits, but against other potential methods of increasing public engagement and involvement. We should not lose sight of the fact that all the methods that we are discussing are simply means to an end, which is better public engagement and involvement.

I have made commitments both to the committee in writing and to Opposition spokespersons on the place of Parliament in the decision about roll-out of elections and on alternative pilots. Given those commitments, which I have repeated in Parliament today, some members may regard Ross Finnie’s amendment as superfluous. However, that is not a reason not to support it; I advise Parliament that SNP members will support the amendment at decision time this evening.

In conclusion, I have been encouraged by the level of interest in, and engagement with, our proposals across the country. What is proposed will undoubtedly result in a real change in the make-up of our health boards—a real shift in the balance of power. It will ensure locally mandated representation on health boards, while retaining the strengths of those who currently sit around the table on boards. Direct elections will represent a significant step towards ensuring that the public voice is heard and, more important, that it is listened to at the heart of NHS decision making.

I move,

That the Parliament agrees to the general principles of the Health Boards (Membership and Elections) (Scotland) Bill.

Ross Finnie (West of Scotland) (LD): I have difficulty recalling an occasion in the nearly 10 years that I have spent in Parliament, on which dealing with the principles of a bill, as set out in that bill, has been more difficult. At first blush, it is clear from the long title that—as the cabinet secretary cogently put it—the bill is about ensuring that direct elections are part and parcel of our system, and about the method by which such elections will take place. Curiously, however, when we reach sections 4 and 5 of the bill, we find that there is conditionality; perfectly reasonably, the bill specifies that Parliament will have powers. Do not get me wrong—I do not object to that. The cabinet secretary has very properly provided for Parliament to consider the matter before it decides whether to proceed. However, today we are being asked to vote on the general principles of the bill, so we need to ask ourselves what we are doing or pre-empting.

I appreciate that the rules of Parliament make it clear that in a stage 1 debate one should not seek to qualify the general principles of a bill. I have lodged my amendment, on which I spent a considerable amount of time—I am grateful to the chamber desk for assisting me with its drafting—simply to note and to make clear on the public record that we are not pre-empting the parliamentary decision for which the bill provides. No one is arguing that we should; nevertheless, the Liberal Democrats think that it is important for the amendment to be part of the resolution that Parliament approves.

In addition to being the Liberal Democrat spokesperson on health, I have the benefit of being a member of the Health and Sport Committee. I make my remarks as a Liberal Democrat spokesperson—I have no doubt that Christine Grahame will address in detail the issues that were raised with the committee. However, with the benefit of hindsight, I have come to the conclusion that the bill may not have started at entirely the right place. As the cabinet secretary indicated, there is considerable disquiet about the
way in which health boards are discharging their functions, although that is not spread evenly across health boards or across Scotland. There is a view that boards are not responsive and that board members are not clear about what they should do to engage with the public.

The evidence that was given to the Health and Sport Committee indicated that there is great disparity in how boards function—I am bound to say that I gained the impression that the corporate governance of our health boards is very vague. As each health board witness came before us, we did not get the impression that executive directors are clear about their functions or that non-executive directors, led by the chair, are clear about theirs. Even at this late stage, I am concerned, with the best will in the world, that bolting on a new system of non-executive directors will not necessarily work when we have given little attention to examining how the actual board structure does and does not function. I am not, however, suggesting that we hold a three-year inquiry into how health boards operate.

Nicola Sturgeon: No.

Ross Finnie: Not even I would suggest that. However, if we are properly to evaluate the pilots’ achievements, it would be helpful for us to have greater clarity about how boards discharge their functions and about the roles that executive and non-executive directors see themselves playing. The evidence that the committee took on that was very unclear.

The cabinet secretary posits that boards got it wrong on Monklands and Ayr. I do not necessarily agree, but if they did, how did that happen? How did allegedly sane and rational people who had been selected for office and who knew and understood their functions apparently so misrepresent the public whom they were supposed to represent? Even board members who are not directly elected have functions to discharge, but how they should do so is unclear.

I turn to the other provisions of the bill. I am grateful to the cabinet secretary for her public statements this morning and for the letters that she has written to the convener and members of the Health and Sport Committee and to the Subordinate Legislation Committee. There are two critical matters, apart from those that are addressed in my amendment. As the cabinet secretary said, it is now in her mind to amend the bill’s long title. Members will understand that that adds to my difficulties this morning because, given that the long title is in general terms the basis upon which one defines the principles of a bill, as soon as the cabinet secretary lodges that amendment she will by definition to some extent have changed the principles of the bill. She will not have changed the whole principle of the bill, but she will have qualified its principles.

Nicola Sturgeon: I know that Ross Finnie knows this, but he should acknowledge that although I will lodge an amendment it will be up to Parliament to decide whether it passes it.

Ross Finnie: I am aware of that, but I am also aware of the persuasive qualities of the cabinet secretary when she lodges amendments. I perhaps overestimated the effect of that, but I certainly had it in mind when I made that statement with some confidence.

The second important issue, which was a key recommendation in paragraph 123 of the committee’s report, is what we now rather inelegantly call the super-affirmative procedure. I am not sure that anyone who is of a legal persuasion will be terribly taken with that term, but it is nonetheless important because it means that if we come to the pilot stages—no matter what they are and no matter their form and shape—not only will the affirmative procedure be used, but no decision will be taken by Parliament without all the evidence being produced and published and without its being scrutinised by Parliament before the decision is taken.

The Liberal Democrat construct of introducing a reasoned amendment to point out that what is in the bill itself contains a degree of conditionality, and the two important undertakings that the cabinet secretary has given in her letters mean that she can be assured of our support. I am not entirely sure that that will give the Government a majority on the bill, but it will be terribly close when we come to the vote.

It is important that we now give thought to how we will test the various propositions and address the concerns of those who genuinely wonder, irrespective of the current state of the board structures, how to get a decent electoral system in place and how it will work. Although I and the Liberal Democrats are keen to extend the franchise to 16-year-olds, we know from the evidence to the committee that a number of disturbing issues that were raised have to be addressed if that is to be carried out properly. It is clear that there are issues relating to voter identification and the need to produce, in the lead-up to the process, information on how to maintain an electoral roll that does not interfere with the privacy of minors but which at the same time allows them to be scrutinised and examined in exactly the same way and on the same basis as any other elector. I hope that there will be wider discussion on what the alternatives might be and on the other propositions that the cabinet secretary has said she is prepared to bring forward as part and parcel of the process.
I and the Liberal Democrats share with the cabinet secretary the view that the objective must be to have health boards that operate efficiently and which appear definitively and definitely to understand their function and that, in so far as they are the keepers of the public purse at a lower level than Cabinet level, they also understand the importance of the input of the public. It was a little disappointing that, although during the committee’s evidence sessions a number of the health boards spoke a lot about how there could be wider engagement with the public, they always seemed to talk about it being below board level. I am not against that, as such engagement plays an important part in improving public engagement, but, given that the fundamental thrust of the criticism from parliamentarians across parties related to how the boards function, it was a little disappointing that so many of the chairs spent so much time saying, “If we deal with engagement below board level, that will be okay.” I say very gently to those chairs, “No, it won’t.” I would be happier if, as a fundamental starting point for the exercise, I knew why some of the corporate governance appears on the face of it to be more dysfunctional in some boards than in others. That is a crucial point.

As I say, I am happy if we have elections to health boards, but given that Parliament is much exercised by trying to improve the quality of care in our communities, and that we are trying to get rid of the existing barriers between local government and health boards, I remain to be convinced that creating directly elected health boards with a separate mandate from those who are elected to local government to represent the wider population as a whole, and having those two separate bodies will contribute to greater co-operation and collaboration in our health and care partnerships. That is a matter on which I and the Liberal Democrats have still to be persuaded, but we now have the possibility to move to stages 2 and 3, when such matters can be further examined.

I move amendment S3M-3162.1, to insert at end:

"but, in so doing, noting the terms of the Health and Sport Committee’s Stage 1 report, calls on the Scottish Government to bring forward, ahead of Stage 3, firm proposals for the piloting of a variety of alternative schemes to improve public participation and shares the committee’s view that such agreement to the general principles should not be taken to pre-empt any decision that the Parliament may later be asked to take on the rolling out of direct elections to health boards nationwide."

The Presiding Officer: I ask Christine Grahame to speak on behalf of the Health and Sport Committee. You have around seven minutes.

09:40

Christine Grahame (South of Scotland) (SNP): That constrains me—not a position in which I usually find myself, Presiding Officer.

I thank Ross Finnie for his thoughtful speech and for his amendment, which has meant that my speaking time has been cut by four minutes. I do not find that an unhappy position to be in because I think that we will be in groundhog day to some extent during the debate.

Ross Finnie: It was not deliberate.

Christine Grahame: I am delighted, in any case.

I also thank, on behalf of the committee, all the witnesses who gave written evidence. Everyone knows that volume 2 of the report itemises and lists a substantial cross-section of the submissions. I thank those who were called and came to the committee to supplement their written evidence with oral evidence. Although I suspect that there is still a great deal of work for the committee to do at stage 2, I thank members for delivering a unanimous report—it is always commendable when committees achieve that—following thorough debate, which was mixed with the usual humour for which we are known. We are, indeed, a venerable and humorous committee.

I also acknowledge Bill Butler, who is in the chamber and who did so much with his member’s bill to progress the matter. The member’s bill process is the way in which many issues come before Parliament, so I hope that more members’ bills get a breath of fresh air in Parliament and that we move on to pass them as legislation.

The committee recognises that we cannot stay where we are. As Ross Finnie and others have said, in relation to the closure of accident and emergency departments and the closure of community hospitals in areas that I represent, such as Jedburgh and Coldstream, it took people aback when anonymous figures—the public had no idea who they were—appeared at public meetings after alleged consultation, which is another issue, and told the meetings that various services were to close. It was obvious that we had hit on a democratic deficit. Perhaps a function of Parliament over the nine years of its existence has been to ensure not only that we are open to scrutiny but that when it comes to local authorities, housing associations and health boards people are much more engaged and more aware of their rights. That is as it should be.

We all know that not every local community will get what it wants, even if we have directly elected health boards, but we want them to feel that they have had a fair crack of the whip and, as Ross...
Finnie said, are engaged at all levels: not only at lower levels but at health board level.

I now move on to some of the key issues that the committee raised—I had better talk more slowly. There have been responses on many of the issues. I am grateful to the cabinet secretary for responding with such alacrity in her letter of 12 January to the committee, but one or two issues still remain open. We will poke at those at stage 2 and I remind the committee that, if we wish, we can call witnesses back at that stage to discuss amendments.

Paragraphs 22, 33 and 34 are key ones in the report. The recommendations in those paragraphs are about improving public consultation by health boards. We do not believe that public participation in, and the accountability of, many health boards has been adequate, although we know that the situation has improved. Evidence also suggests that efforts to promote diversity in health boards are failing. That point relates to evidence that we received about disabled people. There is also concern that if we have direct elections people who live in remote areas will have difficulty putting themselves forward for election—I am looking at Jamie Stone in respect of that point. If pilots go ahead, a rigorous evaluation of their impact on the diversity of health boards and on the equalities impacts of their policies should be made. The cabinet secretary has agreed to that recommendation.

The committee was not convinced that elections are necessarily the most effective way of achieving better engagement and accountability, although it agreed that they have the potential to do so. It did not see elections as necessarily excluding other initiatives such as public participation forums. The cabinet secretary agreed to that in her letter.

The bill will not change health boards’ accountability to ministers; the committee considered that to be the correct approach. However, Malcolm Chisholm raised the concern that the public might not appreciate the subtle difference between elected members’ local accountability on delivery and ministers’ national accountability on policy, which could lead to disillusionment. We suggested that, if the elections proceed, there should be a public information campaign so that people understand that the board is accountable to the cabinet secretary for policy delivery but that accountability for practical delivery on the ground would rest with health boards. It is a neat distinction, but there are going to be some difficulties if expectations are not always met, particularly if several single-issue members are elected to health boards; there could be tensions there.

In paragraphs 97 and 98 of our report, the committee supports the ideas of parallel pilots alongside those that are set out in the bill, and of comparing health board elections with other initiatives to improve public engagement. I have put a tick next to that point as well—the cabinet secretary has agreed to it.

The committee drew attention to uncertainty about the total costs of nationwide direct elections. The committee endorsed the Finance Committee’s call for a reassessment of roll-out costs in the light of a proper assessment of the pilot costs. Those recommendations are in paragraphs 109 and 111 of our report—there is a tick next to them because the cabinet secretary has also addressed that point.

The committee called for tighter parliamentary scrutiny of any decision to roll out health board elections or to abandon the pilots than is provided for in the bill. That involves a decision of principle. There is also a tick next to those paragraphs, and we are now going for the grand design and new plan with the super-affirmative procedure. We are all going to read the book on that—I hope that someone has produced one.

Overall, the committee did not believe that there was an overwhelming case for health board elections, but there was broad support for piloting the proposal. The committee therefore supports the introduction of pilots but stresses that that should not be taken as a decision to support health board elections per se. Notwithstanding some issues around amending the long title, the cabinet secretary has addressed that, so I have ticked it.

However, some of our recommendations do not have ticks. We said that personal identifiers should be required for all postal ballots and health board elections. The cabinet secretary is not planning to do that.

In addition, the committee did not consider the proposal for a private young person’s register to be a recognised part of the democratic process. I know that I said I would not talk for my full time, but I will read out what the committee report said.

"The experience of the Scottish general elections in May 2007 shows that the robustness of any new elections introduced in Scotland will rightly come under serious scrutiny. Whilst the Committee recognises that there would be significant cost and logistical implications, the Committee recommend that the Scottish Government reconsider using personal identifiers for postal votes in health board elections. If the cost and logistical implications are too great to be overcome, the Scottish Government may also have to reconsider holding an all-postal ballot."

That is a serious issue in the light of the public’s recent experience, and the minister might hit a bit of a brick wall with that one.
Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): I apologise to members in the chamber, but I make them and the Presiding Officer aware that I need to leave the chamber to attend another engagement. I do not mean any discourtesy, and I hope to be back to hear the closing speeches.

I welcome the debate as an opportunity to contribute to discussions on participation in our health services and their accountability. Like the cabinet secretary and the convener of the Health and Sport Committee, I thank those who contributed to the consultation. I also thank the committee for its helpful report and the cabinet secretary for the letter that was circulated earlier this week.

As we said in our manifesto for the 2007 Scottish Parliament elections, Labour Party policy is to support pilots for direct elections, so today we will support the general principles of the bill. It is worth putting on the record that Labour has a strong record in government of increasing the accountability of health boards to their communities. Ross Finnie raised a number of interesting issues around that.

We fully support community engagement with the NHS. Allowing the public’s voice to be heard, listened to and taken seriously must be at the heart of health boards’ decision-making processes. It is vital that we ensure that local communities are well served.

Labour implemented significant measures in the National Health Service Reform (Scotland) Act 2004. That legislation was designed to improve accountability and public involvement, and it made considerable progress towards that goal. The introduction of a single management tier through the abolition of the trust system simplified avenues of accountability, and community health partnerships were a step in the right direction for public involvement by providing parents, carers and the public with an opportunity to participate more fully in health boards’ decision-making processes.

Unison Scotland has highlighted the point that there is widespread support among patients groups for the bill’s principles. I am well aware of the strength of feeling in local communities about what they see as their local services.

However, public engagement must not just be about the major and often controversial issues involving hospitals. Such engagement must become the norm for the whole range of health services, and it must reach beyond the affluent and the articulate to include those who need support and advocacy to get their views heard. I am sure that we will return to those issues during discussions on the proposed patients’ rights bill.

Although I said that we will support the bill’s principles, we have serious concerns about the way in which the bill has been drafted. We recognise that the cabinet secretary has accepted that there are a number of areas in which amendments need to be made at stage 2. We will look at what more needs to be done. We must explore the concerns that have been raised and make constructive suggestions about the further work that could be done to ensure that the proposed pilot schemes are a valuable endeavour.

A number of criticisms have been made, including by the British Medical Association, that there is no evidence to show that directly elected health boards are effective and that the bill might be overpromising on public engagement. Unison has pointed out that directly elected health boards are not simply a substitute for other forms of public engagement.

It is also important that the cabinet secretary fully considers the concerns highlighted by the Health and Sport Committee. I emphasise one point that the committee raised: the pilots must be robust and fully assessed, and alternatives must be examined before roll-out is considered. We have already seen some important movement on that. The pilots must also be properly funded, and front-line patient care must be protected.

We should try to assess different models before any decision is taken on implementing a specific model. In her letter of 12 January, the cabinet secretary offered an undertaking "to bring forward details of non statutory pilot schemes that will run concurrently with elections".

She has committed to doing that before stage 3; I welcome that commitment and look forward to examining those details in due course.

The financial memorandum assumes that two identical pilots will be run in different areas, at a cost of £2.86 million. However, concern has been raised that that figure does not include the cost of the remuneration of elected members, the cost of the evaluation study, the cost associated with extending the franchise, and the cost of public awareness materials. I hope that the cabinet secretary will commit to looking at those areas.

The cabinet secretary has said that she will make clear proposals on the timetable for the additional public participation pilots. Now that that commitment has been given, the full costs associated with those proposals and the costs of the two original pilots need to be brought together clearly and concisely.
In its report, the committee says that it “does not believe that there is sufficient certainty about the total costs of health board elections were they to be rolled out nationwide”.

I am concerned by the growth in the estimates for a national roll-out of health board elections; we must continue to look at that area, which is of serious concern. When the bill was introduced, the Government gave an initial figure of £13 million, but that had risen to more than £16 million by October last year. Just this week, it seems that the estimated costs have now risen to more than £20 million. On the Government’s uncertainty, I echo the view of the Health and Sport Committee and the Finance Committee that the evaluation of the pilots must include a full assessment of all costs.

I am aware that I do not have a great deal of time left, but I wish to put on record serious concerns about the proposal to extend the franchise for the elections to 16 and 17-year-olds. Before someone digs out a previous quotation from me on this subject, I should say that it is fairly well known that, within the ranks of the Labour Party, I am one of those who are more sympathetic than others to the notion of 16 and 17-year-olds having the franchise. However, I do not believe that this bill provides us with the right mechanism to test that idea, given the concerns that have been rightly raised by the committee about the private nature of the register. I do not want the issue of the extension of the franchise to get in the way of our ability to consider properly the other issues around public engagement. I therefore ask the cabinet secretary to think again about the issue and perhaps to engage in further discussions before pushing forward with the proposal.

There is no doubt that there are serious issues that must be addressed around the implementation of the pilots. I draw the chamber’s attention to the salient point that was made by Malcolm Chisholm, and restate the fact that there are grave concerns about bringing in a piece of legislation that would give ministers the power to remove someone who had been directly elected by the public. We need to think hard and seriously before passing a bill that has that power at its core.

Improving public engagement and involvement in the NHS remains a cornerstone of Labour’s health policy. We will continue to scrutinise the proposals closely as the bill proceeds, and we welcome Ross Finnie’s amendment. As the cabinet secretary said—and as Ross Finnie perhaps recognises—the amendment is not strictly necessary, but we believe that it sends a strong signal, which is why we will support it.

09:57

Mary Scanlon (Highlands and Islands) (Con):
When I first approached the bill, I thought that its progress through the Health and Sport Committee and the chamber would be straightforward and that it would simply be passed with a few tweaks and amendments. However, the fact is that the bill has not exactly been wholly welcomed or endorsed by those who responded to the call for evidence. I can also confirm that, although I have been active in the political world in the Highlands and Islands for some time, I have never been asked to try to bring about health board elections. Further, when I asked my Labour and Liberal colleagues whether anyone in the Highlands had asked them to deliver health board elections, they said that that no one had.

Ross Finnie made a good point about the governance of health boards: we should not assume that all health boards are bad at consulting. Although I have my differences with Highland NHS Board, I can confirm that it consults on various issues. Thousands of people participated in the consultations on maternity services in Caithness and the proposed reduction in services at the Belford hospital in Fort William—indeed, one health board official returned to Inverness saying that he was traumatised by his experiences in Caithness. There was engagement and the health board listened to the public, which resulted in the retention of the services that we fought for.

Although we will support the bill at stage 1 today, that should not be taken as a guarantee of our support at stage 3. Of the 54 responses to the Health and Sport Committee, 15, or 27 per cent, were in favour of health board elections, and 19 were against. If we take out the 20 responses that expressed no preference, that still means that only 44 per cent were in favour while 56 per cent were against. Further, of the 19 responses that were against the proposal, only five were from NHS bodies, so we should not assume that it is only the NHS that is against elections to health boards—civic Scotland does not support the bill either. In any democratic system, that lack of support cannot be ignored.

There was more favourable support for the pilots, however, with 19 responses in favour and two against. On that basis, we will support the Liberal Democrats’ amendment. I am not entirely convinced that it is necessary, but I feel that putting a greater focus on the pilots and having something about them in writing would be helpful.

The Scottish Conservatives welcome the commitment of the Cabinet Secretary for Health and Wellbeing to reconsider the issue of restricted NHS posts, to make use of the super-affirmative
procedure, which none of us seemed to have heard of until now—

**Jamie Stone:** Not so.

**Mary Scanlon:** Those on the Subordinate Legislation Committee are, of course, familiar with it.

We also welcome the cabinet secretary’s commitment to ensure that thorough and independent evaluations of the pilots are conducted, to change the long title of the bill to reflect the emphasis on pilots, and “to bring forward details of non statutory pilot schemes that will run concurrently with elections in advance of stage 3.”

Like Cathy Jamieson, we are concerned that the cost of the full roll-out of the elections has risen from £13 million to £16 million—and we are still only at stage 1 of the bill. With the use of personal identifiers, we are looking at a cost of £20 million. Our main concern is that those funds will come from front-line NHS services.

I ask that more attention be paid to the issue of the NHS Highland electoral ward, which would cover more than 40 per cent of Scotland’s landmass and would include 30 islands. Its population centre is Inverness, which makes it likely that candidates will come from Inverness and the surrounding area. Although the salary will be the same for each member, members from further afield will have to pay considerable travel costs. More important, some of them will have to make a much greater time commitment than others. I give, as an example, the situation that an elected member from Tiree would find themselves in. The ferry takes three hours and 40 minutes to get to Oban from Tiree, and there would be a further three-hour journey by car, or a whole day’s journey by public transport, to get to Inverness. The shortest time that it would take a member from Tiree to get to Inverness and back would be six hours and 40 minutes each way, which means that they would need to allow for a day’s travel on either side of a meeting, with possibly two overnight stays. Anyone with a full-time or part-time job would find it impossible to make that commitment. A further problem is the issue of leafleting the NHS Highland area. How could a candidate afford to pay for the distribution of a leaflet across that huge area? All of that means that only those who are both time and money rich will stand.

I appreciate that not all meetings will be in Inverness, but, as it is the main population centre, it is likely that most of them will be.

**Ian McKee (Lothians) (SNP):** Is the member therefore not in favour of people who live in Tiree being appointed as non-executive members? They have to pay the same expenses and face the same travel time as would someone from Tiree who was elected to the board.

**Mary Scanlon:** We are not discussing that issue. Anyway, there is no doubt that, before an appointment is made, there is a discussion about whether the person is able to commit the time that is required. The point remains that NHS Highland has the largest health board area in Scotland.

I know that, in the Health and Sport Committee, Dr McKee has raised concerns about the potential politicisation of health boards, which is something that we do not want. However, it is likely that political parties will put forward candidates for the elections, given that they have the necessary organisation and experience.

**Jamie Stone:** Does the member agree that the fact that the weight of the population in the Highlands and Islands is around Inverness will skew the result and alter candidates’ chances?

**Mary Scanlon:** That is a possibility, and people in Caithness have been concerned for years about the fact that they do not have a representative on NHS Highland.

Although election expenses are to be determined by regulation, I presume that that will involve the maximum spend rather than assistance with election addresses and so on. I would like that to be clarified.

We are concerned that independent scrutiny panels, public partnership forums, health councils and other fairly new initiatives have not been given sufficient time to bed in prior to the introduction of the bill. We also remain concerned about ministers’ power to remove elected members from health boards.

However, my main point of concern involves the Government’s capacity to overturn health boards’ decisions. Its reversal of the plan to remove accident and emergency services from Ayr and Monklands hospitals was welcomed by many across Scotland. However, how difficult would it be for the Government to overturn a decision of an elected health board, following the intervention of an independent scrutiny panel? Would a minister take the advice of the directly elected health board or that of the independent scrutiny panel? I look forward to that issue being clarified later today.

**The Deputy Presiding Officer (Alasdair Morgan):** We now move to the open debate. We have some time in hand, so members may speak for up to seven and a half minutes if they so wish.

**Michael Matheson (Falkirk West) (SNP):** Presiding Officer, you were given notice of my delay in being present at the start of the debate.
Unfortunately, I missed the cabinet secretary’s opening speech due to Network Rail arranging a signal failure that affected my train journey this morning. As a regular train user, you will no doubt appreciate that difficulty.

Naturally, we are very proud of our national health service, which holds a unique place in the minds of people throughout Scotland. The NHS is a public service that people strongly believe belongs to them rather than to a particular Government at any given time. People believe that the service exists for the collective benefit of everyone in our society. I am always reassured by the public’s considerable depth of good will towards the staff who work in our NHS—which does not always apply to those who work in other public services—although that good will towards NHS staff often stops at the door of the health board.

In dealing with NHS issues, I am always aware of the fact that people have a level of emotional attachment to the NHS, particularly the local elements of the service. That emotional attachment often becomes extremely evident when health boards consider closing or reconfiguring local health services, as happened in the Forth Valley NHS Board area—which covers my constituency—and the Lanarkshire NHS Board area. Despite the public meetings and other events that took place, there was a genuine public perception that, before proposals even went out to consultation, the health boards had already decided how they would reconfigure services, which services would be closed and which hospitals would no longer provide particular services.

To some extent, people have become so cynical that they often feel that the consultation process is nothing more than a window-dressing exercise. We could get into a debate about whether that is true, but I believe that people have a genuine grievance. The issue is well illustrated by the thousands who turned out for the public consultation events that were organised by Lanarkshire NHS Board. Despite overwhelming opposition within that community to the proposals to close or reconfigure services, the board ignored the outcome of the consultation and tried to drive ahead with the proposed changes. In my view, such experiences undermine the public’s confidence that health boards listen to the communities that—I emphasise this point—they exist to serve.

I believe that having a directly elected element on our health boards provides the potential to create a level of openness and transparency in how our NHS operates that is missing. It is also worth reflecting on the fact that our NHS boards are responsible for spending some £8 billion-worth of taxpayers’ money every year. In my view, such a large budget justifies greater democratisation in how it is used.

Like other committee members, and other members who are present today, I felt that it came as no surprise that every health board that made a submission in response to the committee’s call for evidence on the bill opposed the idea of having any element of directly elected representation on health boards. Unison summed up the matter well:

“Opposition to the Bill in the main comes from the health establishment that believes health is too complex for mere mortals to comprehend. This reflects the ‘we know best’ top down health management culture that needs to be changed.”

One health board—Lothian NHS Board—that gave oral evidence to the committee went so far as to suggest that it had actually consulted patient groups and other interested parties before submitting its views to the committee. However, when we asked for evidence of that, it became clear that that was not the case whatsoever.

If there is one lesson that comes from our evidence-taking sessions, it is that some health boards—I think, sadly, the majority—seem to have forgotten that they exist to serve the public interest rather than their own interests. I believe that one result of having a directly elected element on our health boards is that it would help to refocus minds on that.

An extremely important point is that, once the pilots are up and running, health boards must not interpret the inclusion of an elected element as in some way removing the need to continue to engage with and consult the communities that they exist to serve. Like Cathy Jamieson, I agree that having directly elected health board members should complement on-going engagement with the communities that health boards exist to serve.

I turn to a couple of issues that were raised by the committee in its stage 1 report. The cabinet secretary’s response that she will provide details of other types of pilots before stage 3 consideration of the bill is extremely useful. I think that it would be worth running other types of pilots to see what value can be gained from them.

Another issue concerns restricted posts within the health service, the holders of which might not be entitled to stand for election to the health board. As currently drafted, new schedule 1A, which the bill would insert into the National Health Service (Scotland) Act 1978, could lead to a lack of consistency in how boards designate certain post holders as not being entitled to stand in a health board election. I believe that the amendments that the cabinet secretary plans to lodge at stage 2 will help to address that. It is extremely important that, if we are to have a
register of restricted posts—as is the case in local authorities—we have consistency in the way in which that is applied by health boards across the country.

Finally, like others, I am prepared to support the amendment to the motion, although I suspect that it may have been overtaken by events, given the cabinet secretary’s response. I hope that other members will be minded to support the general principles of the bill later today.

10:13

Bill Butler (Glasgow Anniesland) (Lab): I congratulate the Cabinet Secretary for Health and Wellbeing on introducing the bill. As Ms Sturgeon and others will be aware, Labour now has a policy of supporting pilots in which 50 per cent plus one—a simple majority—of health boards are directly elected. I am glad to say that I played some part in persuading my party of the efficacy of such a policy position. Although not a betting man, I would venture that the Government’s bill will gain support at stage 1, where previous efforts have—inevitably—failed. That is good news.

I welcome the Health and Sport Committee’s stage 1 report and the diligence of all its members, including its excellent convener, Christine Grahame, who made a detailed interrogation of the bill at stage 1. I said that I would refer to Christine Grahame in that fashion.

I have believed for some time that there is strong support across Scottish society for the introduction of direct public elections to Scotland’s NHS boards. I also believe that there is a compelling case for greater democracy, accountability and transparency in the decision-making process for local health services. I continue to believe that the best way to achieve greater accountability and transparency is through the introduction of direct public elections.

The bill will significantly increase public involvement in local NHS services by involving people in the planning and delivery of health care services in their communities. Its main aim of introducing more democracy into the operation of health boards does not mean—and I emphasise this point—that I believe that all health board decisions are necessarily wrong and detrimental to local health services. Such a view would be absurd. However, the undeniable problem with the way in which health boards currently operate and reach decisions lies as much in public perception as in the nature of those decisions. To an extent, the anger that some people feel about certain decisions is generated by the manner in which those decisions are seen to be made. They are made in secret, with little or no explanation offered; they are often predetermined; and they often ignore the views of the community and the responses that have been made to the board’s consultation process. Many people believe that health board consultations are fake, and that is not a happy situation.

Of course, there is no perfect method for consulting the public on major local health issues, so I do not believe that direct public elections would lead to everyone being happy with every decision that an NHS board makes. However, I contend that decisions made by health boards that have a large element of democratically elected members will have much more credibility than decisions made under the current system.

When reading the evidence given to the Health and Sport Committee, I did not see a convincing explanation of why the make-up of regional NHS boards should not contain a strong element of direct democratic accountability. Introducing greater democracy would mean more than just structural change: introducing electoral accountability would involve patients and communities and would provide an opportunity for public debate and greater access to information. The bill would lead to a sea change—as Unison contended—in the culture of NHS boards. That would be a very good thing.

Having said all that, problems with certain aspects of the bill will have to be rectified at either stage 2 or stage 3. If I have a major disappointment, it is that the Government has included in the bill a provision that “councillor members and elected members of a Board must” form a majority of the board. Let me say right away that I have nothing against councillors being appointed to boards. Indeed, their appointment was a welcome innovation of the previous Labour-led Executive. Councillors make a valuable contribution. However, I remain firmly of the view that they should not count as directly elected members of the health board. They are not directly elected to a health board; they are appointed by ministers. At stage 2, I intend to lodge an amendment that will state clearly that the directly elected element of the board should be a simple majority directly elected by communities at health board elections. To do what the Government suggests would be to dilute the principle of democratic accountability. It would be a step too far.

The bill is also deficient in that it permits the cabinet secretary to remove elected board members from office. That should not happen, even in exceptional circumstances. I therefore sincerely hope that the Government will think again. It is entirely unacceptable that anyone—no matter how exalted—be allowed, even in theory, to
overturn the decision of the electorate. Only the electorate can overturn such a decision—at the next electoral diet.

I stress that I support the idea of 16 and 17-year-olds being able to vote in health board elections—and I support such an extension in other types of election as well. That is a personal opinion; my political party has not yet come to a view on the issue. However, as far as the bill is concerned, I am apprehensive about the practicability of having a special young persons register, containing the details of 15-year-olds, that would not be made public. I do not know how that could possibly work. I share the committee’s concern about that, and I look forward to the Scottish Government presenting specific proposals to meet those genuine concerns.

An argument often used by conservative opponents of the bill—conservative with a small “c”—concerns the politicisation of health boards. I share that fear. As suggested by Local Health Concern, there should be a prohibition on party political slates—a point mentioned in paragraph 47 of the Health and Sport Committee’s report on the bill. Again, I will consider lodging a stage 2 amendment that I think will deal with concerns about the party politicisation of health boards.

Of course there is politicisation of health boards, and of course health boards indulge in politics. That is just the way of things.

Despite the reservations that I have expressed, I genuinely feel that the general principles of the bill are a welcome first step towards the positive extension of democracy and democratic accountability in our NHS. On that basis, Labour will support the bill at stage 1. I welcome the Government’s endeavours in this matter.

10:21

Ian McKee (Lothians) (SNP): First, I congratulate Bill Butler on all his work in this field over the years and on his wise contribution today, which I am sure that members on all sides of the chamber will take seriously.

Like most people in the chamber, I am a passionate supporter of a health service that is free at the point of need and paid for out of general taxation. However, I will tackle the question of public representation in a slightly different way from other speakers.

Ideal in theory the NHS may be, but it has one serious flaw. The people of this country were told for years that they had a first-rate health service that was the envy of the world and that it could exist, and be developed to an almost unlimited extent, without the pain of higher taxation. Normally, when we make a purchasing decision, we balance desire against cost and make a judgment accordingly. Is having four extra programmes on a dishwasher worth an extra £100? Perhaps not. But by divorcing the cost of health care from its quality or comprehensiveness, we have removed that vital link. We need to reconnect our function as taxpayers—as owners of the service—with our natural desire to ensure that it is of the highest quality, almost at any cost. We must enable the public to take part in difficult decision making, and the bill before us is one small step in that direction.

Territorial health boards are responsible for spending about £8 billion a year, which is almost as much as the amount spent by local authorities. Yet, although local authorities are subject to stringent local accountability, health boards have no such discipline. My local health board here in Lothian can be taken as an example. I know that the board is composed of dedicated, public-spirited individuals with the best interests of Lothian at heart. However, if we consider who the chairman and the non-executive members are, we would not be surprised to meet them all at the same Morningside drinks party. They are business consultants, accountants and academics to a woman or man. They have been appointed to represent the public interest, but how representative are they? Who knows their names, how can they be approached, and what do they know about the health needs of deprived areas or ethnic minorities, for example? That is why I favour direct elections to health boards.

It is perhaps not surprising that many of the protests about direct elections have come from those with vested interests in maintaining the status quo—from the “health is too complicated for ordinary people to understand” brigade. Well, I beg to differ. It is only when we have members of health boards who have submitted to the electoral process that we will begin to give local people real confidence in the way that their health service is run. If they subsequently lose that confidence, there is a remedy at the next election.

At this point, I emphasise the importance of arranging suitable training for newly elected members of health boards. At the moment, most non-executive members of a health board seem to receive their training from the executive members of that board. As a result, a master-pupil relationship develops right at the beginning, and that militates against good decision making later on.

Those who oppose the bill raise objections that require consideration. Direct elections have been tried in New Zealand and Canada, the objectors say, and have been unsuccessful. Well, although such elections may not have produced the instant transformation of health services promised by the
most fervent advocates, the evidence is that they can deliver beneficial results. In the most recent elections in New Zealand in 2007, 43 per cent of the population voted in district health board elections, as compared with 41 per cent in city council elections. That does not seem to indicate that people feel such elections to be useless. In Saskatchewan, I am glad to say that researchers found little evidence of politicisation of the electoral process, or of elected members considering themselves to be hostage to majority opinion on every issue.

Mary Scanlon: Does the member acknowledge that the turnout in New Zealand has fallen from 50 to 43 per cent and that the number of candidates has halved since the elections were first introduced?

Ian McKee: I appreciate that. The number of people who voted in ordinary elections in New Zealand fell, too. That was part of the general democratic process. I believe that the number of people putting themselves forward for election to the Scottish Parliament has more than halved since 1999. It is a characteristic of democracy throughout the world. I do not think that the 43 per cent turnout in New Zealand was indicative of a lack of confidence in the procedure.

There is the criticism that elected members of boards tend to come mainly from the same narrow backgrounds as appointees, although I believe that that will change in time. No matter. At least they will have been chosen by the public to represent them and will be available in surgeries and meetings to be consulted on the issues of the day, which will be a great improvement.

We are urged by the amendment, which the Government has accepted, to consider other methods of public involvement, but what are they? It is true that there are effective patient organisations, but we are debating the role of the public as owners of the health service, not just its immediate users. There is talk of extending the role of public partnership fora, but how do people get on to those bodies? By appointment. In any case, they relate only to community health partnerships, not to health boards that are also responsible for hospital services. In addition, such fora can be as easily dissolved as formed. Independent scrutiny bodies are suggested, but whereas those are useful tools for the consideration of specific issues, they are unsuited for guiding the general direction of services in a large area, and the Scottish health council is just another appointed body. I agree with the cabinet secretary that all such activities should continue alongside direct elections, but I do not see how they are alternatives to direct elections.

In conclusion—and at the risk of giving undue succour to my Conservative colleagues—I quote Winston Churchill, who said that

democracy is the worst form of Government except all those other forms that have been tried from time to time.

We have tried those other forms and they do not work. Let us now have the courage to embrace democracy.

10:27

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): This morning, rather like Dr McKee’s dishwasher, I have more than one programme—I have two. That is because I have two roles to play in the debate. First, I am the convener of the Subordinate Legislation Committee, which has been referred to by other members. Secondly, I am my party’s public health spokesman.

This is my big day. It is not often that the convener of the Subordinate Legislation Committee has the opportunity to talk at length about something, and I will take that opportunity with both hands. It is right and proper to put on record my and the committee’s thanks to a number of people who helped us in our scrutiny of the bill at stage 1. We thank the clerks and the Scottish Parliament’s legal team, and I thank the members of the committee. One of the most disconcerting things about being the convener of the Subordinate Legislation Committee was discovering that Dr Ian McKee and Jackson Carlaw read all their committee papers, so the opportunities for convener flannel are kept to zero. In praising Dr McKee, I may inadvertently have ruined his career within his party—but we will come to that later. The involvement of the cabinet secretary has been mentioned and I, too, thank her and her officials.

The committee conducted a robust examination of the bill. The letter from the cabinet secretary, dated 12 January, which has been referred to, answered some of our questions and those of the Health and Sport Committee and the Finance Committee. The Subordinate Legislation Committee is the Parliament’s watchdog; its job is to ensure that the powers that are introduced in bills, which might be conferred on ministers, are reasonable and that, at all times, the proper role of Parliament is safeguarded. It is right for me, as the convener of the committee, to recognise the fact that, in the cabinet secretary’s letter, there was a significant give on a number of fronts. I am sure that my fellow committee members from all parties agree with that. That is good for the Scottish Parliament, because it demonstrates that we are doing what we should be doing as a committee of the Parliament. It is also good for the Scottish
Government, as it means that better legislation will be made.

I must be careful, as must all members of the Subordinate Legislation Committee, to ensure that there is a clear dividing line—like that between my two programmes—between what the committee does, which is about the legalities of a bill, the powers that may or may not be conferred on ministers and the role of Parliament, and the subject matter of the bill, which we must keep off because it properly falls within the remit of the subject committee. Therefore, the issue of the cost of the pilot schemes—whether it is one figure or another and whether it has gone above £20 million—was emphatically not for the Subordinate Legislation Committee. That was a matter for the subject committee and it has accordingly been raised in the debate already.

Speaking in my other role, as my party’s public health spokesman, I note that the power that ministers will have to dismiss elected health board members appears somewhat scary. As I said in my intervention on the cabinet secretary, that would involve a minister cutting across the powers of a directly elected health board member. The cabinet secretary has given an undertaking to revisit the issue at a later stage in the bill process, and I am sure that we all await that with interest.

The issue of the identification of 16 and 17-year-old voters is also crucial. I accept Bill Butler’s point that the jury is out on that one and that the devil will be in the detail.

My colleague Ross Finnie has rightly expressed the Liberal Democrats’ continuing concern that the direct election of health board members could, in a bad week, set local authorities against health boards. That would be unfortunate, especially in times of limited resources when we must work together.

The issue that Mary Scanlon raised about what I might call the geographical deficit is obviously close to my heart. Members will know that I have repeatedly raised the issue to which Mary Scanlon alluded, concerning maternity services in the far north. Indeed, the very last parliamentary question that the late Donald Dewar answered was a supplementary question from me about maternity services in Caithness. That shows how far back the issue goes. It is arguable that we would never have arrived at the situation that was arrived at had the then health board had better representation on a geographic front. In my intervention on Mary Scanlon, I made the point that favouring a candidate from an area where the weight of the population lives over a candidate from an outlying area could disadvantage the outlying area. That would be in addition to the difficulties faced by people who have to travel, which Dr McKee talked about. That is a valid point for a later debate, and I make a plea that the issue of geographic representation be considered as the bill progresses.

Michael Matheson talked about the attitude, which we have all come across, that health is too important to be left to ordinary mortals, which seems to turn the debate on its head. Provided that there was geographic coverage, directly elected members could have made all the difference and could have headed off the situation that we faced in the far north long before I got to my feet and questioned Donald Dewar. That is a fair point, which it behoves us all to keep in mind.

The Liberal Democrats are extremely pleased that our amendment is being accepted by members throughout the chamber. As Cathy Jamieson said, it sends a strong signal about where we are coming from and that we must ensure that things can work before we go any further. The debate is being conducted very much in the same spirit as the interaction between the Subordinate Legislation Committee and the cabinet secretary and her team. In other words, we are all working together constructively to make better legislation. The Liberal Democrats wait with great interest to see the bill again at stages 2 and 3.
As a result of that experience, I am predisposed towards taking action to improve matters; in fact, in the previous parliamentary session, I voted for Bill Butler’s member’s bill. Like other members, I congratulate Mr Butler on his efforts in getting us to this point, and commend the Cabinet Secretary for Health and Wellbeing for taking the matter forward. In that context, I am happy to support the bill’s general principles, while echoing some of the concerns that have already been expressed about detail.

The bill does not directly improve health boards’ accountability to the public. Scottish Government officials have made it quite clear that nothing in the bill changes the current situation and that the board will still be responsible in policy terms to the cabinet secretary, whether or not its members are elected. I understand the reason for that; after all, it is important to have consistency across the NHS in Scotland. However, there is a very real possibility of creating tension between an elected member’s responsibility to their electorate and their responsibility to ministers. I am thinking in particular of cases of substantial service change on which there might be a clear difference of views. Inevitably there will be frustration and, ultimately, there might even be disillusionment, which is something that none of us wants.

As Ross Finnie rightly pointed out, we need to ask fundamental questions about corporate governance; how health boards work—or, indeed, do not work; and why in some cases they are so at odds with their communities. Although having directly elected members might have a positive effect—as I believe it will—it does not solve the underlying problem of governance structures that are perhaps tired and detached.

Given that opinion on direct health board elections is very divided, we should welcome the suggestion that pilots should be carried out. Initially, the Government intended to hold two identical pilots for direct elections using STV and extending the franchise to 16 and 17-year-olds. Before I turn to the detail of that proposal, I point out that the cabinet secretary has rightly accepted the Health and Sport Committee’s strong view that the Government must pilot more than one approach, and I look forward to seeing the details of those alternative pilots before we reach stage 3.

I want to raise three issues about the current pilot proposal. First, on extending the franchise to 16 and 17-year-olds, significant concern was expressed with regard to setting out details of 15-year-olds on a register with their date of majority. Such a move clearly raises child protection issues. The committee is looking for information on that point prior to stage 2 and I hope that the cabinet secretary will address it when she winds up.

Secondly, on ward boundaries, many of my constituents will be disappointed if it is decided that a ward should cover an entire health board area. In fact, I agree with Mary Scanlon on this point. How can we ensure representation from the very large and diverse geographical areas covered by NHS Greater Glasgow and Clyde or, indeed, by NHS Highland? If we do not have smaller wards, there is little chance that people in my area, who care passionately about their health service, will be elected.

The third area of concern is, as Christine Grahame pointed out, the lack of personal identifiers in a postal ballot. The Electoral Commission, local authorities and returning officers, as well as the committee, have said clearly that such identifiers must be used in a postal ballot. Given the experience of our May 2007 elections, any new elections must be rigorous and robust, and there should be confidence in the system and the people elected. The cabinet secretary has indicated that she is not minded to use personal identifiers. The committee has made it clear that, if that remains the case, she should reconsider the proposal for an all-postal ballot. If we are serious about making this work, we should follow the experts’ advice and ensure that no questions can be raised about the validity of the elections.

It is essential that, before any roll-out takes place, an independent evaluation of all the piloted approaches is carried out, with further consideration of the cost estimates. As a member of both the Finance Committee and the Health and Sport Committee, I have had two opportunities to scrutinise the bill. It is fair to say that the costs set out in the initial financial memorandum were quite basic; in fact, between evidence sessions, they were revised upwards by about £3 million. It has also been pointed out to the Health and Sport Committee that the financial memorandum does not include fees for returning officers, so there is obviously more work to be carried out in that respect.

Although the cabinet secretary has made a commitment to fund the pilots, there has been no commitment to fund any roll-out centrally. The health boards themselves have suggested that that might have an impact on public engagement budgets while, in written evidence, others have raised concerns about the impact on front-line services.

Nicola Sturgeon: That point was also raised in the committee’s evidence sessions. Does Jackie Baillie accept that, although I might state a personal opinion that any roll-out should be centrally funded, I cannot bind future Governments or indeed future Parliaments in that regard? After all, these decisions might be at least one spending
review and one or two parliamentary elections away.

Jackie Baillie: I entirely accept that, but any indication of the cabinet secretary’s intentions with regard to roll-out would be very welcome.

The bill leaves substantial matters to subordinate legislation that in many cases is subject to negative procedure. I will not repeat Jamie Stone’s points in that respect, but the fact is that Parliament requires more scrutiny of these matters. I am pleased that the cabinet secretary has recognised that and I look forward to the amendments that will be lodged at stage 2.

Finally, on the bill’s real-time impact, I am pleased that the cabinet secretary recognises the importance of public participation and consultation. I share her view: this bill is additional to that essential local engagement. As she will be aware, my local community is going through a consultation exercise on the Vale of Leven hospital; indeed, meetings are being held this and next week. One of my community representatives, who has campaigned about local health services for a long time now, asked an executive director of NHS Greater Glasgow and Clyde whether any of the pre-consultation discussions or written submissions had changed the content of the consultation. A deafening silence fell, and was broken by his response: “No.” Although he was then rescued by another senior executive officer, the cat was unfortunately out of the bag. Changing the attitudes of and culture among health board senior executive officers with regard to the legitimacy of the community’s views obviously remains a challenge, and I believe that having directly elected members on the board might make that kind of difference. I therefore support the bill’s general principles.

10:43

Gil Paterson (West of Scotland) (SNP): Before I begin, I want to acknowledge Bill Butler’s pioneering work on and commitment to this issue.

Having direct health board elections is fundamentally about restoring public confidence in the way in which health boards reach conclusions on issues of profound importance to the Scottish public, such as the future of hospital services—or, indeed, the future of hospitals themselves. Any changes that impact on people who have been made vulnerable as a result of illness must not only be made in their best interests, but be seen to be made in their best interests, and any rationale for such change must stand up to public scrutiny. However, as a result of what has happened for many years now in some health board consultations, the public’s confidence in their being listened to has reached an all-time low. The fact that the public no longer trust health boards must be addressed urgently for the good of not only the public, but health boards.

My experience of changes to vital services that Greater Glasgow and Clyde NHS Board has undertaken is that that public body has had a predetermined agenda. No matter what the evidence has been or the number of people who have been against its proposals, it was always going to be the winner. We got what it wanted, no matter the strength of our argument.

The Vale of Leven hospital provides a prime example of a health board complying with Labour’s centralisation master plan, which was going to be pushed through, no matter what the public said. The hospital had a fine record, but it was deliberately salami sliced to make it fit the bill for closure. If one bit and then another is taken away, the rest will fall. It was like undermining a building in perfect condition. It was bound to fail because its foundations were undermined. It was not until the Scottish National Party Government was elected that the centralisation agenda was challenged. In the case of the Vale of Leven hospital, independent experts contradicted the health board’s plans. As a result, we still have that hospital, and its long-term future is assured with the Government’s full support.

Jackie Baillie: Will the member join me in asking the health board to reconsider its proposals to remove services that are currently at the Vale of Leven hospital and transfer them to Paisley?

The Deputy Presiding Officer: Perhaps we could get back to the bill, Mr Paterson.

Gil Paterson: I would like to answer Jackie Baillie’s question, because it is valid and fundamental to understanding why we should have elected members on health boards. She and I know about the salami slicing that I mentioned earlier. The position now is that there has been an independent evaluation of what happened, and, unfortunately—I think that we are discussing anaesthetics—that report says that it would be dangerous if anaesthetic services remained at the Vale of Leven. I do not know about other members, but I would not be brave enough to suggest that they should stay, because of what happened. It shows that, if something is removed, the bricks start falling down and there is no longer a wall.

St Margaret’s of Scotland Hospice in Clydebank has made the claim, which it can justify, that when decisions were made about the removal of beds from that hospice that were funded by Greater Glasgow and Clyde NHS Board, the board did not consider how fundamental to the wellbeing of the hospice those beds were. No real consultation took place; in fact, Glasgow representatives took
decisions in Glasgow on the removal of funding for those beds. At the same time, funding for the same number of beds was being committed to a new private finance initiative project in Glasgow. I am quite happy to accept that I am a cynic, but I am not the only one who can be called that. I think that everybody in Clydebank would consider themselves cynics about the health board.

Direct elections to health boards will have benefits. If people are elected, they can be removed by the public in the same way that parliamentarians can. Anybody who is not paying attention to their electorate deserves exactly what they get. People will have confidence in any hard decisions that need to be taken, because board members will be answerable to the public. As Unison said, the proposals are not a panacea for improving health engagement, but they are an important step in changing the culture of engagement within health boards.

To put things simply, although hard decisions will be taken that I am sure not all members of the public will be happy with, they will be safe in the knowledge that decisions have been taken for legitimate reasons rather than on the basis of a preconceived agenda, and that they have not been taken only by people such as health board managers, for example, who are dependent on a job and may or may not keep shtum on any given matter that is handed down from on high. I like the idea of decisions being taken on merit after debate, rather than on the basis of a highlighted recommendation on a buff-coloured bit of paper. The balance of power must shift. The public must have their say to legitimise the boards and bring back confidence into the system.

I support the concept of elected health boards. They might be a little inconvenient for those who think that they know best or they might cost a little bit of money to administer, but I have a simple question: what will the real cost be if we do not have them?

10:50

Nanette Milne (North East Scotland) (Con): As members have said, there is no doubt that there has been growing dissatisfaction in the past few years with how health boards engage with the public on the provision of local services. We all remember during the previous session, under the previous Administration, the vociferous campaigns that were conducted to save maternity and A and E units in various parts of the country, very few of which were successful.

The enthusiasm and optimism ahead of the Kerr report, when people thought that they were, at last, to have real and meaningful input into the shaping of their NHS, soon gave way to anger and frustration when it came to the reconfiguration of local health service provision. Throughout the country, there was a sense that health boards were consulting the public on faits accomplis and pressing ahead with change in the teeth of local opposition. I am sure that I am not the only member who attended angry public meetings at which health board staff were accused of having closed minds and no real interest in local input.

It is generally recognised that there needs to be better engagement between the NHS and local communities—the cabinet secretary spelled that out, and it has been borne out in evidence to the Health and Sport Committee—but there seems to be little agreement about the best way of achieving it. The current situation is confusing. A number of bodies are responsible for various parts of public and patient involvement, such as the public partnership fora, the CHPs and the Scottish health council. There is a deal of scepticism about the effectiveness of those bodies. Only yesterday, I heard a popular practitioner decrying his local CHP. They said that it is a talking shop that is heavy with management and that general practitioners no longer engage with it. Such comments do not inspire public confidence; rather, they substantiate the general feeling that the consultation and engagement methods that NHS boards use still do not take sufficient notice of the views of patients and the public, and that the situation must improve.

In that context, I sympathise with the concept of having a proportion of directly elected members on health boards in order to give the public a place at the health board table when important matters and changes are being discussed and a direct input into the process before decisions are made. However, it is clear that there must also be significant input from professionals who are involved in running a service that is important to our wellbeing and extremely costly to run. A balance must be struck.

Two years ago, when Bill Butler proposed that health boards should have a majority of directly elected members, I voiced my concern that that could lead to short-term decision making, single-issue candidates and, occasionally, distorted priorities or delays in making difficult decisions, which could lead in some instances to care inequalities and an undermining of regional services planning. I am probably seen as part of the establishment, but I still have concerns about the bill’s proposals. I am concerned about directly elected members and appointed councillors—who are likely to be political recommendations—constituting a majority on health boards, although I accept that, as a group on their own, directly elected members would be in a minority. I certainly do not go along with Bill Butler’s continuing
commitment to having an outright majority of directly elected members.

Other valid concerns were expressed during the Health and Sport Committee’s consideration of the bill. For example, will elections to health boards result in genuine public representation or will they merely attract people who are time and financially rich or who are standing on a party ticket? As a result, will they lead to the politicisation of boards? Will the extension of the franchise to 16 and 17-year-olds lead to their representation on boards, or will time and money costs preclude that? Will the public actually become engaged with the electoral process or will there be voter apathy, as there has been in New Zealand? We know that turnout in New Zealand has decreased from 50 per cent, which it was at the outset in 2000, to 43 per cent in 2007. Will the costs outweigh the benefits? Will money be spent on elections that could be better spent on front-line services? Many questions are as yet unanswered.

I am relieved that, rather than seeking to introduce nationwide elections at this stage, the bill provides for pilot elections to be undertaken in certain health board areas. It is also right that, if the Parliament approves the bill, the Scottish Government should meet the costs of running the pilots and that those costs should not be paid out of health board budgets. However, I am concerned that if the pilots are a success and the roll-out of elections throughout Scotland is eventually approved, boards might have to divert money from front-line services to pay for them.

As there is a clear demand for the public’s views to be better represented and for greater involvement in decision making, and as that is not being achieved by other methods currently, I am content with my party’s willingness to support the general principles of the bill at stage 1. The proposed pilots should provide the substantive evidence that currently is not available on the workability and cost-effectiveness of health board elections.

It is important that the pilots are fully and thoroughly evaluated and that the results are presented to Parliament so that they can be scrutinised and debated ahead of any possible roll-out of elections. I welcome the cabinet secretary’s assurance to the Health and Sport Committee that the lodging of a roll-out order will only follow a completely independent evaluation of the pilots and that that roll-out will depend on the super-affirmative procedure, as recommended by the committee.

The costs of direct elections are considerable, so it is right that the Government intends to amend the bill at stage 2 to ensure that the cost of the pilots and any potential roll-out costs will be fully considered as part of the independent evaluation of the pilots.

As requested by the committee—this is also the subject of Ross Finnie’s amendment—it is right that other methods of increasing public engagement and involvement should be evaluated alongside the piloting of elections. I am pleased that the cabinet secretary has undertaken to present details of such methods, which will be piloted concurrently with elections.

The Health and Sport Committee is to be congratulated on its painstaking scrutiny of the bill and its recognition of the need for thorough evaluation and consideration of the results of the pilot schemes before any possible adoption of a national scheme for elections to health boards. Given the cabinet secretary’s undertakings in her response to the committee following its consideration of the bill, I am content with my party’s decision to support it at stage 1. However, as Mary Scanlon said, our support at stage 3 is by no means guaranteed.

10:57

Angela Constance (Livingston) (SNP): I put on record my thanks to Unison for its briefing, which cut succinctly through the verbiage of objections from health boards, called a spade a spade and got to the heart of the matter when it said:

“Opposition to the Bill in the main comes from the health establishment”.

Like Ian McKee and Michael Matheson, I object to the suggestion that health is too complex for mere mortals to comprehend. Implicit in many of the consultation responses that the Health and Sport Committee received is the idea that elected members would be too stupid. Indeed, I think that it was stated explicitly that elected members would be of variable quality. However, people of different abilities communicate with different people. The rather douce councillor or elected member might well be able to communicate a message more effectively to some parts of the community than would a polite professional accountant. The complexity of health issues and the size of budgets—£8 billion in Scotland and the best part of £1 billion in NHS Lothian—mean that there is all the more reason to address the democratic deficit. We are, after all, talking about vast amounts of public money.

As I drove into Parliament this morning I listened to Radio Scotland, on which doctors’ leaders were reported as saying that direct elections would lead to cliques and manipulators. I argue that a lack of democracy leads to cliques and manipulators. That level of debate exemplifies the establishment desperately hanging on to the status quo and its
disproportionate power and influence at the expense of public accountability and engagement.

Local authorities and elected members are not without criticism, but they make difficult and, from time to time, unpopular decisions and they prioritise resources to intervene and improve quality of life and indeed, to save lives in cases of child protection and the protection of vulnerable adults, which are complex areas. They have to make decisions about universal service provision and targeting services based on need.

There are, of course, more considered objections based on the experience of direct elections to health boards in other countries, such as low turnout, decreasing numbers of candidates and a lack of diversity among those who are elected. As Unison says, democracy is not a panacea, particularly not when it comes to improving diversity and representation of the underrepresented. We have only to look around the chamber to see the lack of women and ethnic minorities, but that is not an argument against democracy; it is a reason to find the right democratic process. It is also a good reason to have pilots.

The current system of appointments has failed to improve diversity in health boards. Indeed, the local health concern campaign expressed concerns that although the appointment system gave the impression of public involvement, people were not enabled to put forward their views through fear of deselection. I have a constituency case involving a woman from an ethnic minority who was a non-executive lay member of NHS Lothian. She is a woman of exceptional ability, who was a non-executive lay member of NHS Lothian. She is a woman of exceptional ability, non-political and non-partisan, who I believe was forced to resign in a non-transparent and underhand manner. That is an example of why the culture has to change.

Health boards have expressed some concerns about single-issue candidates. Again, they represent a misunderstanding and misrepresentation of the democratic process. The debate about the pros and cons of a single-issue candidate should be had in an election. I also suggest that it is the actions of NHS boards that have breathed life into single-issue campaigns, possibly because boards’ decisions were wrong, they had not persuaded the community of their decision, they had not meaningfully consulted the community or their decisions were not transparent in the first place. We have experienced all those failings in West Lothian.

I was disappointed by NHS Lothian’s evidence to the Health and Sport Committee, and I noted with interest Michael Matheson’s comment that NHS Lothian said that it had consulted when, in reality, it had not. I was disappointed by the comments about an elected councillor from West Lothian who was elected on issues relating to St John’s hospital. The evidence led by NHS Lothian singled him out and stated that his contribution was of limited value. NHS Lothian’s evidence also said that directly elected members posed a risk of destabilising boards and contributing to a lack of unity.

Mary Scanlon: Will the member give way?

Angela Constance: No, not today, thank you.

The tenor of some of NHS Lothian’s evidence would do more to damage unity of purpose and demonstrated an intolerance of difference and community concerns.

Perhaps I should not be too hard on health boards, because their views and experience are hampered by their lack of exposure to democracy—in essence, they just do not get it. I speak as a nationalist who has long been accused of being in a single-issue party. The reality is that elected members roll up their sleeves and, where there is common purpose, get on and work with their opponents for the greater good of the community. As Ian McKee said, the pilot elections to NHS boards offer an ideal opportunity for boards to embrace change and elected members.

Direct elections are desired and discussed in my constituency because they are seen as part and parcel of keeping health care local. Addressing the democratic deficit is part and parcel of celebrating value and protecting local services.

The Deputy Presiding Officer (Trish Godman): We now move to the wind-up speeches. I call Ross Finnie.

Ross Finnie: I seek clarification on that, Presiding Officer. I was invited to speak second because I moved the amendment.

The Deputy Presiding Officer: I am afraid that you are first according to my script.

Ross Finnie: If I am summing up officially on the amendment, I think that I should do so after hearing from the Conservative and Labour speakers.

The Deputy Presiding Officer: We usually follow the party order but, in this instance, I will call Jackson Carlaw.

11:05

Jackson Carlaw (West of Scotland) (Con): I genuinely looked forward to the debate, because it seems a long time since we first touched on health board elections in this third parliamentary session. In one way or another, all parties have been prepared to explore ways to extend the democratisation of health boards but, as time has passed, the devil has proved to be in the detail. I
am especially interested in understanding how all members’ thinking has evolved as they have wrestled with the complexities.

I appreciate the cabinet secretary’s case and her commitment to it, and I sympathise, but when members generally agree to a bill’s principles we have a responsibility to play devil’s advocate on the detail. One concern is that we should not overpromise. The bill will introduce public participation in determining who in a health board makes decisions, but not in taking those decisions. If the public were to take the decisions, the engagement process between health boards and the public would have to improve substantially. Perhaps the involvement of directly elected health board members will realise that, but we cannot promise that.

Bill Butler was spot on when he detailed his understanding of the public’s perception of how health boards operate the consultative process and when he said that the belief is widespread that outcomes are long predetermined. Ross Finnie complemented that by emphasising that many of us lack understanding of how health boards arrive at decisions and discharge their duties.

Cathy Jamieson made a comprehensive speech that touched on many issues, but particularly on costs. We share her concern that the financial memorandum might understate the position. Mary Scanlon underscored that point.

I was not sure about Michael Matheson’s point that directly elected health boards would take decisions in the interests of the public and not of health board members—I think that he said that. I might have fundamentally disagreed with health boards’ decisions and with their consultative processes, but I have never felt that health board members were taking decisions in their own interests.

Michael Matheson: The member picked up what I said incorrectly. I said that health boards have, to an extent, forgotten that their purpose is to serve the communities to which they provide services. Directly elected members would provide a more focused approach to engaging effectively when listening to communities.

Jackson Carlaw: I am happy to accept that.

Jackie Baillie gave a balanced critique and raised questions that are of common interest to us. I noted her point about the size of wards. She was right to say that voters in the NHS Greater Glasgow and Clyde area who live in East Renfrewshire would be unlikely to be concerned about what is happening in the Vale of Leven hospital, if they have even heard of it. Similarly, people who live in the Vale of Leven might be unconcerned about what is happening to residual geriatric services in Mearnskirk hospital. Ward size is a potential factor in public participation. However, as my colleague Mary Scanlon made clear, we will support the bill at stage 1.

As a Subordinate Legislation Committee member, I join Jamie Stone in acknowledging the cabinet secretary’s explicit response to the concerns of the committee, on which we serve with Ian McKee and others.

I say to Ross Finnie that discussions of the super-affirmative procedure are the stuff that keeps the Subordinate Legislation Committee going. At one point in the debate, I saw that about half the members in the chamber had been members of that committee this session. I am sure that they will testify that such discussions have all the fizz of a sparkling champagne.

Nicola Sturgeon: Will Jackson Carlaw enlighten the Parliament and explain in detail the super-affirmative procedure?

Jackson Carlaw: I fear that time does not permit that, even when the opportunity to speak is open ended.

Bill Butler: Will the member say what champagne he drinks?

Jackson Carlaw: In relation to the discussion that we are having, it is flat.

I will elaborate on a few matters that we need to understand more clearly if we are to support progress on pilot areas at stage 3. Our manifesto contained a commitment to support direct elections, but my confidence has been, if not shaken, certainly stirred by a deeper examination of the practicalities and potential consequences.

When the subject was first raised, I wondered about directly elected members’ ability to participate meaningfully in the detailed discussion of many substantive health issues. A feature of boards has been the widespread public perception that lay members have often felt obliged to defer to clinical or professional managerial experience, which is passionately represented, because lay members lack alternative advice or experience or the confidence to go out on a limb and oppose others’ wishes. The cabinet secretary imaginatively addressed the potential consequences of that situation at the extreme by establishing her independent scrutiny process, which allowed her to refer a decision by an appointed health board to independent scrutiny. As we all know, that was crucial in vindicating those who fought long and hard against proposed A and E closures.

In similar circumstances, how acceptable would such a referral be if the decisions were made by a health board the majority of whose members were directly elected? Surely that would make a referral more politically difficult and questionable. We need
to be assured that all directly elected members, who might well—although not necessarily—possess less working knowledge than appointed members, will have access to independent advice and support. That might be easier said than done, but if we are not satisfied of that, we could make dealing with issues that are of enormous public concern more difficult than at present.

Members have referred to the practicalities of standing for election, which reminds me of the arguments about establishing the Parliament. Some hoped that the Parliament would not be organised on party lines and that it would be a Parliament of all the talents. We have a distinguished independent member and other independent members have been elected, but the reality is that the requirement for the apparatus to mount and sustain a campaign leads inevitably to the involvement of political parties. It is therefore difficult to argue with certainty that in larger health boards at least, the practicalities of mounting an effective campaign would not be insurmountable for individuals, so we might end up with party-politicised health boards. That would be unhelpful. Heaven forfend that politically ambitious elected health board members should showboat in a dry run for political advancement and posture for political expedience rather than act in the NHS’s best interests. We need more evidence on how genuinely independent candidates are expected to manage an effective campaign and on how they are to manage the geography of a health board area as they represent the community in it—Mary Scanlon mentioned that.

How engaged the public will be is suspect on the basis of international evidence. Ian McKee quoted the figures from New Zealand, which showed a lack of engagement in local elections and health board elections, from which we cannot take comfort.

The British Medical Association made the practical point that an older person—perhaps one who suffers from cancer—could be appointed as a board member, but that such a person would be unlikely to stand for election. Direct elections could mean that some demographics would not be represented on boards, because of the age of people who felt able to participate in elections.

The proposal that the cabinet secretary should be able to dismiss elected members is curious—Bill Butler and others touched on that. I appreciate that she can dismiss appointed members—that is not peculiar—and that since a minority of members will still be appointed, all must be treated equally. However, the principle is somewhat curious.

On balance, we support the principle of having pilots. However, if we are to commit funds to them, we will need to be convinced at stage 3 that they are realistically expected to succeed.

11:13

Ross Finnie: Presiding Officer, I apologise for forgetting that, in our standing orders, amendments are irrelevant to winding up debates. My personal opinion is that that is curious, but that does not reflect on your good self.

I say to Jackson Carlaw that, as a substitute member of the Subordinate Legislation Committee, I am all too familiar with the fizz and excitement that pervade that committee as it proceeds not line by line as subject committees do, but comma by full stop, definite article, less-definite article, subject, noun, object and—occasionally—verb.

Jamie Stone: Prepositions.

Ross Finnie: Prepositions, too—occasionally. I am well aware of the situation.

More important, my claim to fame on the matter is that I am aware that the super-affirmative procedure is not new. It has not been created for this purpose. To my knowledge, the procedure has been applied on at least two previous occasions.

Jackie Baillie: Will the member take an intervention?

Ross Finnie: Not on a comma or other grammatical matter. When I reach a more substantive point, I will be happy to take an intervention.

The debate has been interesting and constructive. Indeed, it has exposed the difficulties that surround the management of health boards and the range of views that contribute to the process.

Bill Butler made an excellent speech, in which he articulated the position that he has long held on the need for directly elected health boards. However, he also wishes to introduce elements that are perfectly legitimate but which raise questions on what we mean when we talk about the structure of health boards. Bill Butler’s concerns may prompt him to lodge an amendment, the aim of which would be for directly elected members only to count in the majority. His proposal raises interesting questions, including the question whether the votes of councillors—given that they are appointed and not elected members—should be discounted.

Another issue is the position of the non-executive chairman. If the arrangement is for the non-executive chairman and all other non-executive members to hold to account the executive, it would be curious indeed for us then to say, “Well, that is what you are supposed to do,
but actually you do not have the same rights as them.” If people are asked to hold to account an executive, the non-executive chairman and all those who are not directly elected—those who are, to use the more pejorative phrase that Jackie Baillie introduced into the debate, the payroll vote—should be separate. That should be made clear to them, irrespective of whether direct elections are introduced.

Bill Butler: In terms of the payroll vote, perhaps the solution is to return to the situation of the late 1970s, when the people who held those positions sat on boards simply to give advice.

Ross Finnie: Curiously, I was about to address the matter. I understand that Unison holds that position, although I should make it clear that it said in evidence that, although it would go along with the proposal as far as it goes, it wishes to see health boards run on identical lines to local authorities.

With respect to Bill Butler, although debate on the issue that he raised is legitimate, it is not the matter that the cabinet secretary has brought before the chamber. She is not suggesting any change to the process for appointing those who are appointed to executive roles because of their clinical expertise. If one makes the argument that clinical expertise should be retained on an executive, one must also make it clear who the non-executives will be, who will act together and who will hold the executive to account. My concern is the great lack of clarity that there appears to be across Scotland on the matter.

Michael Matheson made a typically robust speech. However, when he and other members spoke about problems on health boards, I was struck by the fact that, although they spoke about health services, almost to a person they focused their remarks on hospitals. Given that 80 per cent of care is provided in our communities and only 20 per cent is provided in hospitals, there is a degree of dishonesty in making hospitals the great focus of attention. I accept that the situation might not change until we have more honest public debate on health service provision and where services are to be provided.

Ian McKee gave another typically robust speech, in which he spoke of the inadequate procedures in the appointment of board members. If people do not understand their role or if the wrong people are being selected, from a narrow choice, it begs serious questions on our procedures for appointment if an element of democracy is not involved. The question is equally valid across all forms of public life.

That issue leads me to address another area of difficulty: how to appoint those who hold executive responsibility. If we end up with a master-pupil relationship, something is fundamentally wrong with the appointment process. If appointees believe that they form part of an echo chamber for the executive, they clearly lack understanding of their role in the organisation. Those points will not disappear simply because we bolt on another structure for the appointment of non-executive directors. That is the fundamental point that I want to raise in this stage 1 debate.

The Liberal Democrats remain sceptical on the subject of direct elections to health boards. Democracy does not happen simply by having elections; it operates and functions properly in a range of structures, all of which have to be put in place and to operate in what I would describe as a liberal democracy. Elections do not of themselves produce a responsive democratic result. That remains my position.

I am pleased that there is unanimous support for the Liberal Democrat amendment, which places on the record the expressed views of the Health and Sport Committee. The wording of our amendment was lifted directly from paragraph 123 of the committee report. Our intention in so doing was to reflect accurately the committee’s findings. As Mary Scanlon said, we must be honest and open in the debate. On the basis of the evidence that was given to the committee, the case for direct elections was not wholly made.

I accept that some board members and boards display a lack of connection with the public view. That said, we should not denigrate all those who serve as non-executive directors on health boards. They are not some alien species who have an agenda for doing great harm to communities. Appointees may not wholly understand their role, the basis on which they were appointed may not be understood by the public, and the people with the right qualifications to fulfil the job may not have come forward. Notwithstanding all that, those who are appointed are not necessarily misguided.

The Liberal Democrats support the general principles of the bill. As I said, I am glad that there is widespread support for our amendment.

11:22

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Clearly, there is almost unanimity across the chamber for the principles of the bill. In no small measure, that is due to the work of the Health and Sport Committee and to those who gave evidence and responded to the consultation. I pay tribute to the responses that the cabinet secretary made in working with the committee. She also worked with the grain of the committee report in agreeing to make changes to the bill at later stages.
Cathy Jamieson outlined some of the history. There is no doubt that there is still a considerable measure of public dissatisfaction with the workings of health boards. That is notwithstanding the fact that since the Stobhill inquiry report—on which I had the pleasure of acting as reporter to the Health and Community Care Committee and which led to significant change in the consultation process at the beginning of the Parliament—we have seen the decluttering under which the number of boards fell from 42 to 14; the implementation of patient-focused public involvement in 2004; the creation of the Scottish health council in 2005; and the latest innovation of the independent scrutiny panel. From the evidence that the committee received and the general public discussion to which many members have referred, there is no doubt on the matter.

I think that we all can agree on the need to strengthen the public consultation process. Albeit that many members have made the point, it is important that we all say on the record that direct elections to health boards will not of themselves entirely solve the problem. The purpose of the bill—I hope that it achieves it—is to improve the accountability of boards. Among many members, Jackie Baillie, Michael Matheson and Gil Paterson referred to public dissatisfaction about the perception, at least, of the lack of accountability.

A number of members including Ian McKee and Angela Constance raised the issue of the diversity of boards. Based on Inclusion Scotland’s evidence, it is true to say that the boards do not have wide representation. That is the case for those who apply for board membership and for appointees. Indeed, women make up 35 per cent of board membership and yet form 52 per cent of the population. The age range of the majority of those appointed is between 51 and 60. There is also an underrepresentation of the disabled, although there is reasonable representation from the black and minority ethnic community, in that representation is almost equivalent to the BME population of Scotland.

Bill Butler and other members, including Michael Matheson, referred to the need for a change of culture. That is perhaps the bill’s most important potential achievement—we will see from the pilots. The culture needs to be changed. The decision by diktat, which was manifest in most boards in the 1990s, has changed to a culture in which attempts at consultation are made, but the diversity of consultation and the variations in practice have not yet been ironed out by the Scottish health council—although it is only just over three years old. It has some way to go to ensure that best practice is followed in consultation. Whether that is done using an open forum, citizens’ juries, or independent facilitators, the measures that are taken must provide confidence. If boards give answers of the sort that Jackie Baillie mentioned, and it is revealed that no changes were made to the consultation process despite various pre-consultation discussions, that betrays a continuing attitude problem. The cabinet secretary and other members have indicated clearly that boards will still need to take some very hard decisions that will be against, or will appear to be against, certain communities.

Today’s debate has sparked some interesting discussions, some of which do not come under the general principles of the bill that is before us, although they will nevertheless be important for the Parliament to consider. The structure of the board as a whole is important, not just the questions of directly elected members and of the appointment of lay members and how the lay membership might be made more diverse. There is a question around the role of executive members and whether they are in effect a composite group, the bulk of which, as a result of their health expertise and knowledge, are able to exert a disproportionate effect and act as a payroll vote, as someone described it. As a collective, their contributions might have an overbearing effect on boards. Perhaps we need to address that in future.

The issue of whether board membership should be 50 per cent plus one directly elected, or 50 per cent plus one local councillors and directly elected members will be determined at stage 2. Bill Butler has indicated his intention to move an amendment to apply the minimum to directly elected members. I very much welcome the fact that local councillors will have a legislated-for position on health boards, which will be helpful.

One pilot that the cabinet secretary might like to consider would be to have 50 per cent plus one councillors on one board. That would certainly be a lot less expensive, and it would incorporate the local communities’ views—councillors can be dismissed if they oppose the wishes of their communities.

Most members have welcomed the intention to consider other pilots. Another pilot might be to give money to a board to strengthen the consultation processes in a way that is proportionate to what the elections would have cost. We could see what difference that makes. Hopefully, we are genuinely proceeding with what we have all agreed is necessary.

Many members stressed the need for an independent review. That will be important for establishing the benefit of the directly elected boards under the pilots.

Many of the problems to which members have referred involve the postal voting system. Christine Grahame, Cathy Jamieson and others indicated
that, if the elections are to be valid, postal vote verification will probably be necessary. We have had trouble with elections before, and we do not want something to happen with the postal vote—perhaps because of a strong community issue—that would throw discredit on to direct health board elections. We recognise that postal voting would increase the costs.

Members raised the issue of 16-year-olds and 17-year-olds voting; the problem is not so much their voting, but whether the register, which would include 15-year-olds, should be open. That is a significant problem.

The costs of the election pilots have risen from £2.85 million to £3.63 million. The costs of the elections themselves have already risen from £13.5 million through £16.65 million to £20.52 million, if we include—according to the letter from the cabinet secretary—postal vote verification. I am sure that she will correct me during her summing-up speech if that is wrong. The Royal College of Nursing was concerned about the diversion of funding from front-line services.

Mary Scanlon and Jackie Baillie referred to the problem of the diversity in size of boards, and asked whether different constituencies within the board areas could be represented. That is indeed a significant problem, which will need to be examined closely. The need to ensure diversity and equality in the boards in totality once elected members join appointed members will create considerable administrative problems if we are to ensure that all groups are represented.

The pilots will allow us to test the important point on which the Parliament now appears to be entirely agreed: given that the current boards, notwithstanding the best efforts of lay members, are still not adequately accountable—or are not perceived to be adequately accountable—changes are necessary. The pilots, which our party will support—including the Liberal Democrat amendment—will test that adequately. They will allow us to ensure that Scotland’s health boards are recognised by their communities as accountable.

11:31

Nicola Sturgeon: I thank everyone who has contributed to the debate, which has been good and constructive. It has brought to the fore some important practical and philosophical issues.

First, I will respond to some of the points that were made in the opening speeches, beginning with Ross Finnie. Before this morning’s debate started, Ross Finnie promised me a Shakespearian performance. I will leave it to others to make up their minds; for my part, I think that he delivered admirably. I count Ross Finnie among the bigger sceptics when it comes to direct elections to health boards. I have always found that passing strange, given that his colleagues south of the border are enthusiastic supporters of directly electing people to health authorities. I think that I detected a possible softening of Ross Finnie’s position, however. If I was a Labour minister, I might refer to that as the green shoots of conversion—but I will leave that there.

Ross Finnie suggested that the bill did not start from the right place. I disagree on that. The principle of democracy is always exactly the right place to start. However, I agree with Ross Finnie’s view that the corporate governance of boards and the roles of non-executive members need to be better defined. There is some merit in that. Ian McKee was right to say that we must ensure that non-executives have the right training for the roles that they are asked to undertake. However, those arguments are neither here nor there in the consideration of whether those non-executive members should be appointed by ministers or directly elected by the public.

A restrained Christine Grahame is not a sight that I am used to; I am sure that it is not a sight that I will get the opportunity to become used to. Christine Grahame mentioned Bill Butler’s contribution, and I add my thanks to him. Bill Butler did much to progress the case for direct elections, and I can tell that he is delighted to have a Government in place that backs his view on the issue.

Christine Grahame reiterated many of the Health and Sport Committee’s recommendations, and she acknowledged that I have responded positively to many of them. Jamie Stone also made that acknowledgement when he spoke on behalf of the Subordinate Legislation Committee.

On Cathy Jamieson’s speech, I am pleased to have Labour’s support for pilot elections—at least at stage 1. Cathy Jamieson was right to narrate some of the improvements in public engagement that have taken place in recent years. NHS boards have come in for a fair bit of criticism today. I acknowledge and pay tribute to the work that boards have done in recent years to improve the quality of public engagement. The bill is not a substitute for that; it builds on and develops the work that has gone before.

Cathy Jamieson and other members raised the issue of 16-year-olds and 17-year-olds and private registers. I can inform members that, following discussions with electoral registration officers, we have, I think, identified a way forward, which will allow them to record details of 16-year-olds and 17-year-olds and attainers in their own way, using solutions that are right for them locally. I have no doubt that we will discuss that issue further at the later stages of the bill. It is important to remember
that the vast majority of relevant data for 16-year-olds and 17-year-olds is already on local government registers in the form of attainer materials.

Cathy Jamieson, Jackie Baillie, Nanette Milne and possibly other members mentioned the costs of roll-out. It is important to stress that the evaluation that we propose will include a full assessment of the cost. It will ultimately be for the Parliament to consider the costs in the context of the decision that it makes about the roll-out of elections. As I stated at the committee, my opinion is that, should roll-out happen, the costs should be borne centrally. However, as I said in my intervention on Jackie Baillie, I cannot bind future Governments or Parliaments.

Mary Scanlon pointed out that the bill is not wholly welcomed. She is, of course, absolutely right. That should not necessarily surprise us, because no radical change ever attracts unanimous support. As Michael Matheson said, it is not surprising that the people who would be most affected by the change—should it happen—are, at this stage, the least enthusiastic. However, health boards have worked hard to improve engagement and I have no doubt that they will also work hard to embrace elections if they happen.

Mary Scanlon welcomed many of the suggested amendments, although she raised a number of other issues, such as distance. In geographic areas such as the Highlands, distance is an issue whether members are appointed or elected. That is one of the reasons that she is enthusiastic—as I am—to advance and extend the use of technology such as videoconferencing in the NHS.

Mary Scanlon asked how easy it would be for a minister to overturn decisions that had been taken by directly elected boards. Having overturned health board decisions, I can tell her that it is never easy, regardless of how the board is put together. I hope that having directly elected members on boards would minimise the need for decisions to be overturned, although I readily acknowledge that it would not remove it altogether. Decisions that require ministerial approval will always have to be considered carefully case by case, and no minister who decides to go against a local board will find it easy.

Jackson Carlaw, Mary Scanlon and Richard Simpson raised issues with the size of electoral wards. There are judgments to be made on that, and the judgment at which the Government has arrived is that single-ward areas and STV diminish the chances of single-issue candidates dominating elections. On the other side of the debate are the issues that Mary Scanlon and Jackson Carlaw raised. People in one part of a health board area will not share the same priorities as those in other parts. Ultimately, it is for the Parliament to decide where the balance should lie.

Our proposals in the bill undoubtedly represent a significant and radical change. Involvement and participation in the NHS must extend right into the board room. Ross Finnie is absolutely right that the discussion about better involvement too often centres on involvement beneath the board level. However, direct elections will ensure that the public voice is heard at the board table.

I agree with all members who, like Angela Constance, take issue with the idea that health is too complicated a matter for mere mortals to be involved in. I make no apology for the fact that the bill is a radical move. As Michael Matheson said, the NHS spends record sums of public money: almost £10 billion every year, which is nearly a third of the Parliament's budget. Gil Paterson is right that those spending decisions have a direct impact on people's lives. Ian McKee was also right to point to the important relationship between decisions and their cost impact.

Given Bill Butler's contribution to the overall debate, I conclude by reflecting on something that he said and with which I agreed thoroughly. The bill does not mean that all—or even most or many—decisions that health boards take are wrong. I agree with Ross Finnie that the people who labour away in our health boards are doing a good job and tend to be doing it for the right reasons. Nor does the bill mean that health boards will no longer take decisions that are difficult, are unpopular or will be campaigned and protested against. However, it will mean that, in future, all those decisions will be influenced by the people who feel their impact. That is right. It is an important step forward and it builds on the work that has been done and what has been achieved to date. It is also why I am pleased that it appears that the general principles of the bill will be approved at stage 1. I look forward to the further discussions that will come at stages 2 and 3.
11:40

The Presiding Officer (Alex Fergusson): The next item of business is consideration of motion S3M-2937, in the name of John Swinney, on the financial resolution in respect of the Health Boards (Membership and Elections) (Scotland) Bill.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Health Boards (Membership and Elections) (Scotland) Bill, agrees to any expenditure of a kind referred to in paragraph 3(b)(iii) of Rule 9.12 of the Parliament’s Standing Orders arising in consequence of the Act.—[Nicola Sturgeon.]

The Presiding Officer: The question on the motion will be put at decision time.
SUBORDINATE LEGISLATION COMMITTEE

34th Meeting, 2009 (Session 3)

Tuesday 27 January 2009

Paper by the Clerk

HEALTH BOARDS (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL

Background

1. Under Rule 9.6.2 of Standing Orders the Committee submitted its report on the delegated powers provisions in the Health Boards (Membership and Elections) (Scotland) Bill to the Health and Sport Committee, as lead committee for the Bill, on 24 November.

2. On 12 January the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon MSP wrote to the Convener setting out the main areas that the Scottish Government intends to seek to amend at Stage 2. A number of amendments to the Bill are to be proposed in response to this Committee’s recommendations.

Section 1(5) and (6) (constitution of Health Boards) – Power to specify the circumstances in which an elected member must vacate office.

3. The Committee’s report drew to the attention of the lead committee a number of issues in relation to the delegated power to specify the circumstances in which an elected member must vacate office.

4. The Committee made only one specific recommendation in relation to this issue which is that, should the Parliament conclude that Ministers should have the power to set the circumstances in which they may dismiss elected members, these should be subject to affirmative procedure.

5. The Cabinet Secretary’s letter does not address issues relating to section 1(5) and (6).

Election Regulations (section 2(2) of the Bill)

6. The Cabinet Secretary’s letter confirms the Scottish Government’s intention to put forward an amendment at Stage 2 that would apply affirmative procedure to these regulations.
Pilot Order (section 4 of the Bill)

7. This power (to make the pilot order) is in effect a power to commence the substantive provisions in the Bill in relation to one or more Health Board areas in order to pilot elections.

8. The Scottish Government previously confirmed to the Committee (in a letter of 6 October) that it intended to lodge an amendment at Stage 2 to make a pilot order that modifies the Bill subject to affirmative procedure, and also where an amending order modifies the Bill.

9. In its report the Committee also raised issues relating to the provisions which would enable Ministers to revoke a pilot order. Section 7 provides for the automatic revocation of the pilot order 7 years after the first election if the scheme has not been rolled out and if the pilot order has not previously been revoked. If the pilot order is revoked by Ministers before that date then the provisions in the Bill enabling Health Board elections are automatically repealed.

10. The Committee drew this provision to the attention of the lead committee, highlighting the fact that it is novel and unusual. In its report, the Committee recommended that any order revoking a pilot order should be subject to affirmative procedure.

11. The Cabinet Secretary’s letter confirms the Scottish Government’s agreement that any move to revoke the pilot order in its entirety should be subject to parliamentary procedure and that it is currently considering amendments attracting parliamentary procedure to any Ministerial order that seeks to end pilots early.

Roll Out of Elections (section 7 of the Bill)

12. Section 7(1) of the Bill gives the Scottish Ministers powers to make a “roll-out order” to appoint a day on which sections 1 to 3 are to come into force, in respect of Health Board areas not specified in the pilot order.

13. The Bill currently proposes that the order be subject to negative resolution procedure. More than one roll-out order may be made. (This allows for a staged approach to commencement following evaluation of the pilot schemes.) There is nothing on the face of the Bill that requires a roll-out order (or a number of orders) to extend to the whole of Scotland.

14. A roll-out order can make such amendment or modifications to primary legislation as Ministers consider appropriate and is currently subject to negative procedure.
15. The Scottish Government had given a commitment to this Committee to bring forward an amendment requiring affirmative procedure for rollout orders which make express textual amendments to enactments.

16. However the Cabinet Secretary’s letter states that, given “the exceptional nature” of the legislation and the effect on NHS Boards the intention is to amend the Bill so that “super affirmative” procedure be adopted as recommended by the Health and Sport Committee.

Other Issues

17. The Cabinet Secretary’s letter makes reference to other amendments which the Scottish Government intends to bring forward at Stage 2, following consideration of the Bill by the Health and Sport Committee.

Progress of the Bill

18. The Bill passed Stage 1 on 15 January 2009. The clerks understand that the likely date for first consideration at Stage 2 in the Health and Sport Committee is 4 February.

Recommendation

Members are invited to note and comment on the Scottish Government’s response to the Committee’s report on the delegated powers provisions in the Health Board (Membership and Elections) (Scotland) Bill at Stage 1.

Shelagh McKinlay
Clerk to the Committee
SUBORDINATE LEGISLATION COMMITTEE

EXTRACT FROM THE MINUTES

4th Meeting, 2009 (Session 3)

Tuesday 27 January 2009

Present:

Malcolm Chisholm
Tom McCabe
Jamie Stone (Convener)

Bob Doris
Ian McKee (Deputy Convener)

Apologies were received from Jackson Carlaw.

Health Boards (Membership and Elections) (Scotland) Bill: The Committee noted the Scottish Government's response to the Committee's Stage 1 report.
Health Boards (Membership and Elections) (Scotland) Bill

14:20

The Convener: We have seen the letter of 12 January from the Deputy First Minister and Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, and the proper copy of our report was circulated to members before this meeting. Are there any comments?

Malcolm Chisholm (Edinburgh North and Leith) (Lab): The cabinet secretary’s letter was generally helpful. However, she does not address the issue that we discussed at some length: the power to dismiss an elected member of a health board. I suppose that there is a substantive policy issue there but, under our responsibilities, the committee was saying that if there were to be such a power, it should be prescribed in some way. The cabinet secretary is silent about that, and it is an obvious omission, but she has responded very positively in other ways to what we suggested.

The Convener: As there are no other points, we will leave it at that for the moment. The cabinet secretary’s response is pretty good and a lot of things have gone our way, although Malcolm Chisholm has pointed out the one glaring omission from her letter. Is everyone happy with that?

Members indicated agreement.
Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 8 Schedule
Sections 9 to 12 Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Ross Finnie

25 In section 1, page 1, line 8, after first <of> insert <a chairman, appointed by the Scottish Ministers, and>

Ross Finnie

26 In section 1, page 1, line 9, leave out <a chairman, and other>

Ross Finnie

27 In section 1, page 1, line 20, after <the> insert <chairman taken together with the>

Bill Butler

17 In section 1, page 1, line 20, leave out from <total> to <members,> in line 21 and insert <number of elected members of a Board must amount to more than the total number of councillor members and appointed members, but by no more than two,>

Ross Finnie

28 In section 1, page 1, line 25, after <when> insert <the chairman,>

Ross Finnie

29 In section 1, page 2, line 6, at end insert—

< ( ) After paragraph 3 insert—

“3A A person appointed as chairman of a Health Board may not be an employee of that Health Board.”>

Bill Butler

22 In section 1, page 2, line 11, at end insert—

< ( ) An elected member vacates office on becoming—

(a) a member of the European Parliament,
(b) a member of the House of Commons,
(c) a member of the House of Lords,
(d) a member of the Scottish Parliament, or
(e) a local authority councillor.

Bill Butler
23 In section 1, page 2, line 12, leave out <the> and insert <further>.

Jackie Baillie
30 In section 1, page 2, line 13, leave out from <, and> to end of line 15.

Nicola Sturgeon
1 In section 1, page 2, line 15, at end insert <,
and, in particular, may specify that an elected member is to vacate office on
becoming the holder of a post set out in a list of restricted posts maintained by
the Health Board concerned for that purpose.”.>

Ross Finnie
31 In section 1, page 2, line 16, leave out <chairman and>.

Ross Finnie
32 In section 1, page 2, line 18, after <that> insert <the chairman or>

Section 2

Nicola Sturgeon
2 In section 2, page 2, line 24, at end insert—
<(  ) In section 105 of the 1978 Act (regulations etc.)—
(a) in subsection (2), for “(3) and” substitute “(2A) to”, and
(b) after subsection (2) insert—
“(2A) No regulations shall be made under paragraph 13(1) of Schedule 1A (Health
Board elections) unless a draft has been laid before, and approved by
resolution of, the Scottish Parliament.”.>

Nicola Sturgeon
3 In section 2, page 3, line 10, at end insert <, and
( ) the number of elected members to be elected in each ward.>

Nicola Sturgeon
4 In section 2, page 3, line 18, leave out <The Health Board> and insert <Election regulations>
Nicola Sturgeon
5 In section 2, page 3, leave out lines 32 and 33

Nicola Sturgeon
6 In section 2, page 3, line 35, leave out <specified number> and insert <number of elected members to be elected for that ward>

Nicola Sturgeon
7 In section 2, page 4, line 5, leave out <specified number> and insert <number of elected members to be elected for the ward>

Nicola Sturgeon
8 In section 2, page 4, line 7, leave out <specified number of>

Jackie Baillie
33 In section 2, page 4, line 21, at end insert—
<(  ) If election regulations provide for votes in a Health Board election to be cast only by post, the regulations must also provide for a system of personal identifiers to be used in relation to the casting of such votes.>

Bill Butler
24 In section 2, page 4, line 22, at end insert—
<(  ) An individual is disqualified from being a candidate in a Health Board election if the individual is—
(a) a member of the European Parliament,
(b) a member of the House of Commons,
(c) a member of the House of Lords,
(d) a member of the Scottish Parliament, or
(e) a local authority councillor.>

Bill Butler
19 In section 2, page 4, line 23, after <make> insert <further>

Nicola Sturgeon
9 In section 2, page 4, line 26, at end insert <, and, in particular, may disqualify from being a candidate an individual holding a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.>

Ross Finnie
34 In section 2, page 4, line 29, leave out <16> and insert <18>
Section 4

Dr Richard Simpson
35 In section 4, page 6, line 5, at end insert <; but such an order may not be made until the person mentioned in section 5(1)(c) has been appointed.>

Nicola Sturgeon
10 In section 4, page 6, line 9, at end insert—
   <( ) An order to which this subsection applies may be made only if a draft of it has been laid before, and approved by a resolution of, the Scottish Parliament.>
   
   This subsection applies to—
   
   (a) a pilot order (or order amending a pilot order) which adds to, replaces or omits any part of the text of sections 1 to 3, and
   
   (b) an order revoking the pilot order.>

Section 5

Nicola Sturgeon
11 In section 5, page 6, line 11, at beginning insert <At least 2 but>

Dr Richard Simpson
36 In section 5, page 6, line 18, after <evaluation> insert <(carried out by an independent person)>

Dr Richard Simpson
37 In section 5, page 6, line 21, after <public> insert <or improved local accountability of the Health Board>

Dr Richard Simpson
38 In section 5, page 6, line 22, at end insert <, in particular in comparison with the effects on those matters of any projects of the type mentioned in subsection (2A) carried out in the period covered in the evaluation.>

Michael Matheson
20 In section 5, page 6, line 22, at end insert <, and
   
   ( ) the cost of holding the Health Board elections and the estimated cost of holding future Health Board elections in all Health Board areas.>

Dr Richard Simpson
39 In section 5, page 6, line 26, at end insert—
   
   <(2A) The type of projects referred to in subsection (1)(c)(ii) are projects in particular Health Board areas not specified in the pilot order whereby—>
(a) the total number of local authority councillors appointed as members of the Health Board exceeded the number of other members,

(b) a sum of money (equal to the amount which would have been required to hold a Health Board election had the Health Board area been specified in the pilot order) was spent on other ways of increasing engagement with patients and other members of the public in the Health Board area and improving the local accountability of the Health Board.

Dr Richard Simpson

40 In section 5, page 6, line 26, at end insert—

<(  ) A specification setting out how the evaluation mentioned in subsection (1)(c) is to be carried out must be published during the two months following the day appointed by virtue of section 4(1).>.

Dr Richard Simpson

41 In section 5, page 6, line 27, at end insert—

<(  ) For the purposes of paragraph (c) of subsection (1), and without prejudice to the generality of that paragraph, a person is not independent if he or she is—

(a) an employee of any Health Board mentioned in the pilot order,

(b) a member of any Health Board mentioned in the pilot order, or

(c) a member of staff of the Scottish Administration.>.

Section 6

Nicola Sturgeon

12 In section 6, page 6, line 32, after <If> insert—

<(  )>

Nicola Sturgeon

13 In section 6, page 6, line 32, leave out <(see section 7),> and insert <, or

(  ) a question of whether to resolve to approve a draft roll-out order is put to a meeting of the Scottish Parliament but is not agreed by the Parliament,>

Nicola Sturgeon

14 In section 6, page 6, line 33, after <revoked> insert <or on the day after the question is put (as the case may be)>.

Ross Finnie

42 In section 6, page 6, line 33, leave out <1> and insert <2>
After section 6

Ross Finnie

43 After section 6, insert—

Constitution of Health Boards following termination of pilot scheme

(1) This section applies if the pilot order is revoked.
(2) Section 1 is modified as provided in subsections (3) and (4).
(3) For subsection (2) substitute—

“(2) For paragraph 2 substitute—

2 (1) A Health Board is to consist of a chairman, appointed by the Scottish Ministers, and the following types of members—

(a) members appointed by the Scottish Ministers (“appointed members”), and
(b) councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board (“councillor members”).

(2) Regulations must, in relation to each Health Board, specify—

(a) the total number of members of the Board, and
(b) the number of each type of member.

(3) But a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board.

(4) The condition imposed by sub-paragraph (2) does not apply during any period when a councillor member vacates office and the vacancy has not been filled.”.

(4) Subsections (5) and (7) are omitted.

(5) Ministers may by order appoint a day on which subsections (2) to (4) come into force across Scotland.

(6) Section 1 is of no effect in any Health Board area in any period between the day on which sections 2 to 7 and paragraph 2 of the schedule are repealed under section 6(2) and the day appointed by virtue of subsection (5).>

Section 7

Michael Matheson

21 In section 7, page 7, line 1, leave out subsection (3) and insert—

<(3) A roll-out order may not be made unless—

(a) a report has been published under section 5(1), and
(b) a draft of the roll-out order has been laid before, and approved by a resolution of, the Scottish Parliament.

(3A) Before laying a draft of a roll-out order before the Scottish Parliament, Ministers must—>
(a) lay before the Scottish Parliament—
   (i) a copy of the proposed draft roll-out order, and
   (ii) a statement of their reasons for proposing to make the draft roll-out order,
(b) publicise the proposed draft roll-out order in such manner as they consider appropriate, and
(c) have regard to—
   (i) any representations about the proposed draft roll-out order,
   (ii) any resolution of the Scottish Parliament about the proposed draft roll-out order, and
   (iii) any report by a committee of the Scottish Parliament about the proposed draft roll-out order,

made during the 60 days following the day on which the proposed draft roll-out order was laid before the Scottish Parliament.

(3B) When laying a draft of a roll-out order before the Scottish Parliament, Ministers must—
   (a) where any representation, resolution or report is made in pursuance of subsection (3A)(c), lay a statement giving details of any representations, resolution or report and of their response, and
   (b) where the draft roll-out order includes material changes to the proposed draft roll-out order, lay a statement giving details of the proposed revisions and of their reasons for them.

Section 11

Ross Finnie

44 In section 11, page 7, line 28, leave out <sections 4 and> and insert <section 4 and section (Constitution of Health Boards following termination of pilot scheme) or, as the case may be,>

Long Title

Nicola Sturgeon

15 In the long title, page 1, line 2, after first <for> insert <piloting of>

Nicola Sturgeon

16 In the long title, page 1, line 2, after <Boards;> insert <to require the Scottish Ministers to report on those pilots; to confer a power to extend those elections to all Health Board areas following publication of that report;>
Groupings of Amendments for Stage 2

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted.

Groupings of amendments

**Composition of Health Boards**
25, 26, 27, 17, 28, 29, 31, 32

**Disqualification from being an elected member**
22, 23, 1, 24, 19, 9

**Power of Ministers to remove elected members**
30

**Election regulations**
2, 3, 4, 5, 6, 7, 8

**Personal identifiers in all-postal ballots**
33

**Age of voting**
34

**Evaluation of pilot**
35, 11, 36, 40, 41

**Pilot order: parliamentary procedure**
10

**Content of evaluation of pilot**
37, 38, 20, 39

**Roll-out order: parliamentary procedure**
12, 13, 14, 21
Constitution of Health Boards following termination of pilots
42, 43, 44

Long title
15, 16
HEALTH AND SPORT COMMITTEE

EXTRACT FROM THE MINUTES

4th Meeting, 2009 (Session 3)

Wednesday 4 February 2009

Present:

Jackie Baillie
Ross Finnie (Deputy Convener)
Michael Matheson
Mary Scanlon

Helen Eadie
Christine Grahame (Convener)
Ian McKee
Dr Richard Simpson

Also present: Bill Butler, Nicola Sturgeon (Cabinet Secretary for Health and Wellbeing)

Health Boards (Membership and Elections) (Scotland) Bill: The Committee considered the Bill at Stage 2.

The following amendments were agreed to (without division): 29, 22, 23, 30, 1, 2, 3, 4, 5, 6, 7, 8, 24, 19, 9, 10, 11, 36, 37, 20, 41, 12, 13, 14, 21, 15 and 16.

Amendment 33 was agreed to (by division: For 4, Against 3, Abstentions 1).

The following amendments were disagreed to (by division)—

25 (For 4, Against 4, Abstentions 0; amendment disagreed to on casting vote)
27 (For 4, Against 4, Abstentions 0; amendment disagreed to on casting vote)
17 (For 3, Against 5, Abstentions 0)
40 (For 4, Against 4, Abstentions 0; amendment disagreed to on casting vote).

The following amendments were moved and, with the agreement of the Committee, withdrawn: 34, 35 and 42.

The following amendments were not moved: 26, 28, 31, 32, 38, 39, 43, 44.

Sections 3, 8, schedule 1, sections 9, 10, 11 and 12 were agreed to without amendment.

Sections 1, 2, 4, 5, 6, 7 and the long title were agreed to as amended.

The Committee completed Stage 2 consideration of the Bill.
The Convener: This is the first day of the committee’s consideration of the Health Boards (Membership and Elections) (Scotland) Bill at stage 2. I welcome to the committee the Cabinet Secretary for Health and Wellbeing and her team. By way of a preamble, I remind members that use of a convener’s casting vote— I hope that I will not have to use it—is very different from use of the Presiding Officer’s casting vote. There is no protocol—the conveners liaison group was unanimously of the view that use of the casting vote should be at the discretion of each convener.

Section 1—Constitution of Health Boards

The Convener: Group 1 is on the composition of health boards. Amendment 25, in the name of Ross Finnie, is grouped with amendments 26, 27, 17, 28, 29, 31 and 32.

Ross Finnie (West of Scotland) (LD): Many and several aspects of health board governance were highlighted during stage 1 and in the committee’s stage 1 report. I have become somewhat exercised about the fact that there has been a bit of a drift—in some places, the position of chairman of the board has morphed with that of other board members. That is not true of all boards, but it is a drift.

From the evidence that we took at stage 1, it is clear to me that chairmen of boards should be seen to be independent and not representative of the executive. It should be set out in statute that chairmen are apart from the executive, and it should be demonstrable that they are among the non-executives on boards.

The first purpose of my amendments to section 1 is to ensure that the chairman is separated out and is not lumped in with other members of the board. My contention is that the chairman should be seen to be part of the independent vote on the board and should count as part of that.

If we leave the chairman to be counted along with the executive members and others, we will give completely the wrong signal about his position on the board. I accept that simply defining the position of the chairman in statute will not guarantee his independence. However, if we say in statute that he is to be counted among the executive members, we will create confusion about his role and independent position. It would be helpful if the bill, in addition to the other measures that it contains, were to set out clearly that the chairman of the board is intended to head
the non-executive directors, who hold the executive directors to account. To do otherwise is to blur the distinction between executive and non-executive directors; I believe that to be undesirable.

My amendments would provide for the chairman to be included with those who are more properly regarded as non-executive directors when it comes to deciding what constitutes a majority on the board. That is in stark contrast to the position of Bill Butler, which I respect. He has been entirely consistent on the matter and wishes only those who are elected to constitute a majority. That creates difficulties in the bill. Splitting the governance of the board between those who are elected and those who are not elected will add to the confusion about where the chairman of the board stands. If the chairman is counted as part of the executive, it is not clear to me what purpose he serves. In proper governance, the chairman should head the non-executive directors and hold the executive directors to account, so not including him on the non-executive side would be a mistake.

On those grounds, I have pleasure in commending my amendments to the committee.

I move amendment 25.

Bill Butler (Glasgow Anniesland) (Lab): Before I speak to amendment 17, I will make a couple of points about Ross Finnie's comments. I see the logic behind his proposals, but I fail to be convinced by it. It is not really appropriate simply to state in statute that the chairperson should be part of what Mr Finnie has described as the independent or non-executive part of the board. After all, we are talking not about one independent element, but about three different elements. The bill's explanatory notes make it clear that in section 1(2), which replaces schedule 2 to the National Health Service (Scotland) Act 1978, paragraph 2(1) of the new schedule sets out the "three different types of member" that will sit on a health board.

"These are:

• "appointed members" (a chairman and other members appointed by the Scottish Ministers);
• "councillor members" (councillors appointed by the Scottish Ministers following nomination by local authorities ... ); and
• "elected members" (individuals elected as members of the Health Board at an election)."

The description of the categories that Mr Finnie set out do not relate to the three categories that are set out in the bill. As amendment 17 makes clear, we are talking about the injection of a directly elected element that is not independent in some theoretical way but takes part in the board's work, as well as two other categories of appointed members.

That kind of injection is a good thing. One should never quote oneself, but as I said in my submission to the Government's consultation on its proposed local health care bill, I think that "Direct public elections would allow the public a mechanism to influence service delivery in their area".

I also believe that the public are clearly saying that "there must be greater openness and transparency, and there must be direct accountability".

After all, this is all about transparency and direct democratic accountability.

In my response to the consultation, I also said:

"I have yet to hear a convincing argument as to why the make-up of regional NHS boards should not contain a strong direct democratic element. Accordingly, as amendment 17 sets out, "I believe that 50 per cent, plus one, of the members of each health board—" or, depending on the arithmetic, "a simple majority—be directly elected to represent the local communities affected by its decisions. Boards must have a proper balance between those with expertise, knowledge and experience from working in the health service"— something that we should not lose— "and those who are most directly affected by changes—the public. I feel that the blend of experience and direct accountability" offered by amendment 17, which suggests simply that there be a simple majority "is about right."

Again, I emphasise that, as I said before:

"I support the retention of local authority members on NHS boards."

That innovation by the previous Liberal-Labour coalition Executive was a good thing. However, I then said in my response that:

"Unhappily, I believe that even with the inclusion of local authority members on each NHS board, the feeling remains that boards have failed to engage effectively with the communities they serve."

The bill can deal with that kind of corrosive and negative perception.

As I went on to say in my earlier submission: "I hope that direct public elections will succeed in making health boards work harder at explaining their proposals to the communities they represent and at engaging the public more directly, explaining the pros and cons of any changes to local health services clearly and openly. Only when that greater level of direct accountability and transparency has
been achieved will communities feel in any way reassured that health boards really listen to their members’ views.”

10:15

I was going to finish on that point, but I must not forget the cabinet secretary and a document in which, I am sure, she had a great deal of say—the Scottish National Party manifesto for the 2007 elections. Under the heading “Accountable healthcare”, on page 36, appears the following quotation. It is not the whole paragraph, but I do not think that I am wrenching it out of context.

“Sometimes difficult decisions must be made and local people should always be at the heart of the process. To ensure this is the case we will introduce direct elections to health boards. At least half of health board members will be elected by the public.”

I could not agree more with the cabinet secretary and the manifesto; I emphasise that I mean on that one specific element. It seems to me to be an unequivocal commitment that does not preclude the possibility of what amendment 17 suggests, which is a simple majority. I hope that colleagues will support amendment 17 and, of course, Mr Finnie’s amendments.

The Convener: I did not think that you had undergone a Damascene conversion just because you read from the SNP manifesto.

Ian McKee (Lothians) (SNP): I have a question for Ross Finnie about amendment 27. The chairman will be appointed, so adding the chairman to the total number of councillor and elected members of the board could result, at any one time, in less than half of the board bring made up of directly elected members. Is that correct?

The Convener: Ross Finnie may deal with that point when he sums up.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I am delighted that Bill Butler’s choice of reading material is so intellectually highbrow and stimulating. He is certainly setting a good example.

I am grateful for the opportunity to respond to the amendments in group 1. Ross Finnie’s amendments 25 to 29, 31 and 32 seek to separate the role of a health board chairman from that of the other appointed board members. From a presentational point of view, that might give the appearance of independence, and I am not unsympathetic to Ross Finnie’s rationale. However, in reality, even if Ross Finnie’s amendments were to be agreed to, the chair of a health board would still be appointed by Scottish ministers. Amendment 27 proposes that the chair, together with local councillors and directly elected members, would form the majority of a board. That would be a dilution of our proposals, which seek more balanced health boards with greater local and democratic representation. The amendments would mean that ministerial appointees could form the majority of board members. That runs counter to the bill’s proposals, so I cannot support it.

Amendments 25 and 26 might also have unintended consequences. The chair would not be considered a member of the health board, so any legislative provisions that refer to members of health boards would not then apply to the chair. For example, the 1978 act provides for the payment of travelling expenses to members of health boards. If amendments 25 and 26 were agreed to, that provision would not apply to the chairman.

Amendment 17, in the name of Bill Butler, seeks to achieve the opposite effect to that of Ross Finnie’s amendments by making a clear majority of a health board directly elected. Although I agree, as we all do, that the way in which health boards engage with and involve their communities must change, our approach of drawing the majority of members from local authorities and those who are directly elected represents the most sensible and balanced way of achieving that goal. It would mean that a majority on a health board would be democratically elected, and that is an important principle. As a result, I am not able to support amendment 17.

Amendment 29 would ensure that a health board chairman could not be an employee of that health board. That reflects current practice, so I see no reason why that should not be set out in legislation. Accordingly, I am happy to support the amendment and I encourage committee members to agree to it.

Ross Finnie: The debate has simply rehearsed the difficulties in trying to do two tasks that are related but slightly separate. Bill Butler’s clear proposition is that the majority of board members must be directly elected. That has been his consistent position. He talked about the democratic nature of the composition of boards. I do not seek to argue that point in my amendments. My concern is about how boards are run and managed.

My response to Ian McKee is that the difficulty is with the chairman. If the cabinet secretary—or rather, the Government; I will not personalise the matter—sought, in wishing to change how boards are appointed, to have one of the directly elected people appointed as a chairman, that might get rid of my fundamental difficulty, which is that the Government still wants to appoint the chair.
The phrase with which I respond to Bill Butler is "independent or non-executive"; I might be drawing on previous background in using that. I do not suggest for a minute that independent or non-executive board members are not wholly engaged in the governance process. I use that phrase more as it is used in well-established reports on corporate governance on ensuring that paid employees of a company, who have the necessary skills and expertise in technical matters, are held properly to account by non-executive or independent directors.

Boards will have chairs, no matter how they are appointed. The chair’s purpose is to head the non-executive or independent directors and lead them in holding the executive directors to account. If that is how a board is structured, it is odd to place the chairman on the side of the executive directors when taking a vote. That is a slight anomaly that arises from the bill.

On those grounds, I will press amendment 25.

**The Convener:** The question is, that amendment 25 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**
- Baillie, Jackie (Dumbarton) (Lab)
- Eadie, Helen (Dunfermline East) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**AGAINST**
- Grahame, Christine (South of Scotland) (SNP)
- Matheson, Michael (Falkirk West) (SNP)
- McKee, Ian (Lothians) (SNP)
- Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 4, Against 4, Abstentions 0.

As the vote is tied, I cast my vote against the amendment.

**Amendment 25 disagreed to.**

Ross Finnie: Amendment 26 is consequential on amendment 25, so I will not move it.

**Amendment 26 not moved.**

Ross Finnie: I can still move amendment 27, which is competent.

**Amendment 27 moved—[Ross Finnie].**

**The Convener:** The question is, that amendment 27 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**
- Baillie, Jackie (Dumbarton) (Lab)
- Eadie, Helen (Dunfermline East) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**AGAINST**
- Grahame, Christine (South of Scotland) (SNP)
- Matheson, Michael (Falkirk West) (SNP)
- McKee, Ian (Lothians) (SNP)
- Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The question is, that amendment 17 be agreed to. Are we agreed?

**Members:** No.

**The Convener:** There will be a division.

**FOR**
- Baillie, Jackie (Dumbarton) (Lab)
- Eadie, Helen (Dunfermline East) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

**AGAINST**
- Grahame, Christine (South of Scotland) (SNP)
- Matheson, Michael (Falkirk West) (SNP)
- McKee, Ian (Lothians) (SNP)
- Scanlon, Mary (Highlands and Islands) (Con)

**The Convener:** The result of the division is: For 3, Against 5, Abstentions 0.

**Amendment 17 disagreed to.**

**Amendment 28 not moved.**

**Amendment 29 moved—[Ross Finnie]—and agreed to.**

**The Convener:** Amendment 22, in the name of Bill Butler, is grouped with amendments 23, 1, 24, 19 and 9.

Bill Butler: Amendments 22 and 24 would prevent the party politicisation of direct health board elections. Concerns were expressed about that during the stage 1 debate and in the committee’s report. Amendment 23 is consequential on amendment 22, and amendment 19 is consequential on amendment 24.

The issue was directly referred to in the committee’s stage 1 report and the debate. Paragraph 47 of the report mentioned the fear that party politics could impinge on health board elections, and one organisation—Local Health Concern—suggested that there should be an attempt to prohibit party political slates. I have heard that argument before, and I think that it has
prevent—and I think that they will—political slates people legislation. The amendments seek to be able to do so under the representation of the disqualify such persons and we would, rightly, not wish—or, I think, would any of my colleagues—to disqualify such persons and we would, rightly, not be able to do so under the representation of the people legislation. The amendments seek to prevent—and I think that they will—political slates from standing formally as party political slates so described.

My belief—which is not contained in the amendment—is that the changes would encourage individual citizens to participate. If we say to the public, "This is not going to be the same old same old, and we want you not only to vote but to participate actively and to consider becoming a directly elected health board member", it will encourage local public-spirited citizens to come forward. People are already involved under the banner of health organisations such as the Royal National Institute for Deaf People, the Royal National Institute of Blind People and the Multiple Sclerosis Society. The amendments would act as an encouragement.

Basically, under amendment 24, those in elected posts would be proscribed from standing for a health board; under amendment 22, they would, by statute, have to vacate their directly elected health board place if they became an elected member, or an unelected member in the House of Lords. I ask colleagues to consider the amendments seriously; I hope that they can support them.

I move amendment 22.

10:30

The Convener: The cabinet secretary will speak to amendment 1 and other amendments in the group.

Nicola Sturgeon: I will speak first to amendments 1 and 9, which are in my name.

Amendment 1 clarifies that regulations may specify that an elected member must vacate office on becoming the holder of a restricted post that is set out in a list maintained by each health board. Amendment 9 is the equivalent amendment that clarifies that regulations may disqualify the holders of such restricted posts from standing for election. The amendments will ensure that regulations can enable health boards to keep lists of restricted posts that elected members will be prevented from holding. I believe that that is right because fulfilling such a dual role would bring a level of conflict into an elected member's purpose on the board.

Members will have seen from the draft regulations that were submitted at stage 1 that we propose that the responsibility for keeping a list of restricted posts should rest with each health board to allow them to respond flexibly to local administrative structures. However, we have built into the draft election regulations the right to allow anyone who finds themselves in a restricted post to appeal to the adjudicator appointed under the Local Government and Housing Act 1989. That mirrors equivalent restricted-post rules for Scottish local authorities.

The amendments in the name of Bill Butler would set out in the bill criteria for who can seek election to a health board and prevent those who hold political office from standing as candidates or holding office as elected members. I point out that MSPs are already prevented from sitting on health boards under the Scottish Parliament disqualification criteria, but it is right that all those individuals specified in amendments 22 and 24 are excluded from standing for election and from holding health board membership. Amendments 19 and 23 are consequential.

I am happy to support all the amendments in this group.

The Convener: Do any other members wish to speak?

Mary Scanlon (Highlands and Islands) (Con): I have been vocal about my concern about party politicisation, and I have used the Highlands as an example because I can speak only from my own experience. I come from the land that is dominated by independent councillors. In fact, as the cabinet secretary will know, the excellent chairwoman of Shetland NHS Board is also an independent councillor, and that works extremely well. I have seen many independent councillors being elected to health boards.

I must say that I am always tempted to vote for Bill Butler even if I do not agree with him, because of his excellent debating skills.

The Convener: And his charm.

Mary Scanlon: Well, charm gets you everywhere. It is always worth a mention, even though it is against party policy—and of course I would not go against party policy.
The Convener: So charm is against Conservative party policy.

Mary Scanlon: Not at all. I want to put on the record that I think that Bill Butler has excellent skills, but I would never vote against party policy.

Bill Butler referred to party politicisation, but that does not happen in every part of Scotland. In fact, there is excellent practice involving independent councillors playing a role on health boards, and it would be a sad day if many committed individuals who were not party political were removed from health boards. I appreciate the principle underlying what Bill Butler says—he has a point—but I wanted to put on the record my comments about independent councillors.

The Convener: I will let the cabinet secretary in before Bill Butler winds up.

Nicola Sturgeon: I just have a point of clarification, which Bill Butler may have covered. The amendments in his name would prevent a councillor from standing for election to a health board, but they would not prevent a councillor from being appointed to a health board. Mary Scanlon cited the example of the independent councillor who is an excellent chair of Shetland NHS Board—such an appointment would not become impossible because of Bill Butler’s amendments.

Bill Butler: I agree with the point that the cabinet secretary has just made. Mary Scanlon should not resist the temptation to vote with me—although I might say that some of my party colleagues have sometimes resisted that temptation in the past.

Jackie Baillie (Dumbarton) (Lab): Never!

Bill Butler: Of course, I exclude Jackie Baillie and others from that. I agree with Mary Scanlon that we should never vote against party policy—unless it is a matter of principle, of course.

Seriously, I am grateful to the cabinet secretary, and thus the Government, for accepting my amendments. They have a serious intent, which is to ensure that the party politicisation of directly elected health boards is made very difficult, if not impossible—and that will, I hope, encourage members of the public to take part in the process.

Amendment 22 agreed to.

Amendment 23 moved—[Bill Butler]—and agreed to.

The Convener: Amendment 30, in the name of Jackie Baillie, is in a group on its own.

Jackie Baillie: I will pass round some documents. My apologies, convener—you saw me stapling them together as we were coming into the committee room, and I hope that they are helpful.

Amendment 30 would remove the ministerial power to dismiss an elected member. The committee as a whole has had concerns about that, and I regret that that proposed ministerial power would set a precedent. I am not aware of any legislation whereby directly elected members can be dismissed in such a way.

There are some helpful examples from elsewhere of how elected members can be removed from office. I have managed to obtain a copy of the “Cairngorms National Park Authority: Members’ code of conduct”. The document is coming round the table—I apologise for the lateness of circulating it—and I draw members’ attention in particular to paragraphs 1.2 and 1.6, which set out the framework for the code.

Essentially, the Ethical Standards in Public Life etc (Scotland) Act 2000 provided for codes of conduct. As members will recall, it also established a Scottish Parliamentary Standards Commissioner to oversee the framework and to deal with alleged breaches of the code. Sanctions for a breach are helpfully outlined at annex A of the national park authority code. They include censure, suspension “for a maximum period of one year” and disqualification. There are further provisions that result in the possibility of disqualifying people not just from the national park authority but from other bodies.

I acknowledge the need to take powers, from time to time, to remove elected members from public office, but there are mechanisms for the removal of an elected member when there has been a breach of a code of conduct. The ministerial power provided for in the bill, which the committee found to be wide in nature, is therefore perhaps unnecessary.

I move amendment 30.

Nicola Sturgeon: I can genuinely see both sides of the argument. Some people have expressed the concern that altering the membership structures of health boards may threaten the national aspect of the NHS. One way to allay that concern is to retain the same lines of accountability for all board members. That is why we originally proposed that the Scottish ministers should have the power to make regulations that give them the discretion to remove an elected member from office—to ensure that appointed and elected members would be on the same footing in their accountability to ministers. That is one side of the argument.

I appreciate that, on the other side of the argument, there is a point of principle at stake: when members are directly elected to health boards, they should not be able to be removed
from the board simply at the discretion of ministers. As Jackie Baillie outlined, amendment 30 would remove the power to make regulations that give ministers a discretionary power to remove elected members.

I listened to the concerns that were expressed at stage 1, and I reflected further on the issue. Given those concerns, and given the fact that, although it is not impossible, it is difficult to envisage the circumstances in which a minister would exercise the power to remove a directly elected member, I have no appetite to resist the amendment and I would be comfortable if committee members agreed to it.

The Convener: Does Jackie Baillie wish to wind up the discussion on amendment 30?

Jackie Baillie: I will simply say that I am grateful for the cabinet secretary’s comments. She has acknowledged that it is difficult to envisage circumstances in which any minister would use the power to remove an elected member of a health board. However, it is right that we should be clear and set out codes of conduct so that any member of a health board is aware of the nature of a breach that would result in a sanction. I welcome the cabinet secretary’s views, and I will press amendment 30.

Amendment 30 agreed to.

Amendment 1 moved—[Nicola Sturgeon]—and agreed to.

Amendments 31 and 32 not moved.

Section 1, as amended, agreed to.

Section 2—Health Board elections

The Convener: Amendment 2, in the name of the minister, is grouped with amendments 3 to 8. I call the minister to move amendment 2 and to speak to all the other amendments in the group.

Nicola Sturgeon: I will speak to amendments 2 to 8. Following consideration—

The Convener: May I just stop you there? It is my fault, but nobody is actually saying at the beginning that they are moving the amendment.

Nicola Sturgeon: I was going to move it at the end.

The Convener: It is helpful—just for my memory—if we have actually moved it.

Nicola Sturgeon: Okay, I will move amendment 2, and I am now going to speak to amendments 2 to 8.

Following stage 1 consideration by the Subordinate Legislation Committee and this committee, I indicated that I would lodge an amendment to apply affirmative procedure to the election regulations. Amendment 2 fulfils that commitment. A draft of the election regulations will have to be approved by resolution of the Scottish Parliament before the regulations can be made.

Amendment 3 and amendments 5 to 8 are technical amendments. The default position, as set out in the bill, is that each health board area is to comprise a single electoral ward. The bill already provides that regulations must specify the number of elected members for each health board and that election regulations should specify the number of elected members per ward. Amendment 3 simply ensures that the same figure does not have to be duplicated in two sets of regulations. It provides that election regulations need specify the number of elected members per ward only where the health board area is divided into more than one ward. Amendments 5 to 8 are consequential on that change in the drafting.

The bill as introduced stated that the health board must appoint an individual as the returning officer for the elections. It is not the intention that the health board should determine who is appointed as the returning officer, and amendment 4 is a technical amendment that provides that the election regulations will specify who the returning officer should be.

I move amendment 2.

The Convener: As no committee member has indicated that they wish to speak, I offer the minister the opportunity to wind up the discussion.

Nicola Sturgeon: I am happy to leave it at that.

Amendment 2 agreed to.

Amendments 3 to 8 moved—[Nicola Sturgeon]—and agreed to.

The Convener: The fifth group of amendments is on personal identifiers in all-postal ballots. Amendment 33, in the name of Jackie Baillie, is the only amendment in the group.

Jackie Baillie: Having taken evidence from the Electoral Commission and from local authority returning officers, the committee held strong views on the issue that is raised in amendment 33.

Health board elections will be important. I hope that there will be considerable interest in them and that they will be hotly contested. The elections will be the democratic means by which local people can express their views, so it will be important that all votes are considered as valid and that no questions should arise over the ballot. The fact that postal ballots will be used suggests a clear need for the use of personal identifiers. However, if the ballot were to be conducted in a different way, that requirement would not be necessary. I hope that amendment 33 will enjoy the support of committee members and the cabinet secretary.

I move amendment 33.
Dr Richard Simpson (Mid Scotland and Fife) (Lab): Given the general difficulties in the 2007 election with voting and ballots, and the problems that have occurred in the south with postal votes, if we are serious about having proper elections and ballots for health boards, we need to use personal identifiers.

Ian McKee: In an ideal world I would agree with what has been said, but we do not live in an ideal world. Personal identifiers would add enormously to the cost of the procedures and to the delay. That would be wrong. We should not let the best be the enemy of the good, so we should proceed with the system that is in the bill. Later on, in the full roll-out, we can perhaps come to a different decision, but we need to get the procedure working.

Mary Scanlon: I have sympathy for Jackie Baillie’s and Richard Simpson’s points. Nonetheless, I am concerned about the escalating costs of the pilot and about the potential cost of roll-out. It would be helpful if the cabinet secretary said how much more costly it would be to use personal identifiers for the pilots and what the delay would be in introducing the pilots.

Nicola Sturgeon: I am aware that the committee discussed the issue at length and highlighted it in its stage 1 report. I hope that, from my reaction to amendments that we have debated and to some that we are yet to discuss, the committee will accept that I am taking seriously its comments and that, where possible, I am trying to accommodate its concerns and reach a consensus. However, I regret to say that, having considered the issue carefully, I cannot support amendment 33. Members will know from the draft election regulations that were submitted during stage 1 that we propose an all-postal ballot for the pilot health board elections, which follow the arrangements that are in place for national park elections in Scotland. I was glad that Jackie Baillie relied so heavily on the national park model with an earlier amendment.

Amendment 33 stipulates that personal identifiers would be used only with an all-postal ballot. As Jackie Baillie has conceded, if there was a traditional ballot—a mix of the ballot box and postal votes, as was the case in the 2007 election to which Richard Simpson drew our attention—the amendment would not require personal identifiers to be used for the postal votes that were cast. That is a somewhat anomalous position.

To return to the substance of amendment 33, I will try to answer the questions that Mary Scanlon posed. A requirement for personal identifiers for an all-postal ballot would entail significant additional expenditure, which we estimate to be at least £800,000 for the pilot elections. It would also inevitably postpone, by a considerable time, the start of the pilot elections if an all-postal ballot was used. I cannot say exactly how long the delay would be, but it is likely that it would be a considerable number of months, if not longer.

The method that is used in the pilot elections will be assessed as part of the evaluation. It is right and inevitable that the experiences of the pilot elections, including those of the method of voting, will form part of the evaluation report that will be placed before the Parliament. The Parliament will then be able to decide whether personal identifiers should be used for any roll-out of the elections. However, for the purposes of the pilot, my strong belief is that amendment 33 would introduce a disproportionate cost and an unnecessary delay in implementing the policy, which is designed to put communities at the heart of decision making in the health service, and the pilots, which are designed genuinely to test the viability of direct elections. I therefore ask Jackie Baillie to reflect on the comments and to consider withdrawing amendment 33.

Jackie Baillie: I listened carefully to what the cabinet secretary said. However, I treat seriously the evidence that we received from those with responsibility for running elections. Those experts, who have years of experience—which, frankly, those of us sitting round the table do not have—are clear that in all-postal ballots personal identifiers are required to secure the validity of the election.

Richard Simpson was right to point out that the outcome of the 2007 election and the chaos that ensued did not fill the public with confidence, and today I learned that questions have been asked by a member of the Scottish National Party and other people about a recent election elsewhere. That is the context in which we are operating. The important point is that the public should have confidence in the outcome of an election.

I accept the cabinet secretary’s point that the requirement for personal identifiers would cost £800,000. However the two pilots offer the opportunity to test whether such an approach is needed—that is the mechanism for evaluating the approach, rather than complete roll-out at a higher cost.

I was trying to be helpful when I suggested that personal identifiers should not be used in an election that involved a mixture of voting in person and voting by post, because traditionally in Scotland and elsewhere the overwhelming majority of people vote in person rather than by post. I press amendment 33.

The Convener: The question is, that amendment 33 be agreed to. Are we agreed?
Members: No.

The Convener: There will be a division.

For
Bailie, Jackie (Dumbarton) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against
Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

Abstentions
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 4, Against 3, Abstentions 1.

Amendment 33 agreed to.

Amendments 24 and 19 moved—[Bill Butler]—and agreed to.

Amendment 9 moved—[Nicola Sturgeon]—and agreed to.

The Convener: Group 6 is on age of voting. Amendment 34, in the name of Ross Finnie, is the only amendment in the group. I invite Ross Finnie to speak to and move amendment 34.

Ross Finnie: I normally obey your injunctions automatically, convener, but on this occasion I will speak to the amendment and reserve my position on moving it—

The Convener: The clerks are whispering to me that you must move the amendment but you have the right to seek to withdraw it after the debate.

Ross Finnie: Okay. That is the position that I wanted to protect. I believe that people who are under 18 should be able to vote, so it was with concern that I lodged amendment 34. I did so almost exclusively on the basis of the evidence that the committee heard. The committee said in paragraph 89 of our report at stage 1:

“The Committee has serious concerns about the proposal for a private young persons’ register and does not find this to be a recognisable part of the usual democratic process … These are complicated issues to resolve and the Committee calls on the Scottish Government to come forward with specific proposals to address those concerns in advance of Stage 2.”

Rather than bore members by repeating that position, I afford the cabinet secretary the opportunity to say whether she can accommodate the committee’s requirements. I will consider whether to press amendment 34 after I have heard from her.

I move amendment 34.

Nicola Sturgeon: I will deal briefly with the principle of the matter, because I suspect that most if not all members agree that it is right to give 16-year-olds the vote. Allowing young people to vote in health board elections would be a useful first step in introducing them to the democratic process.

Health issues affect everyone and it is right that we give 16 and 17-year-olds the opportunity to express their views on a service of which they will undoubtedly have had experience, and of which they will continue to have experience throughout their adult lives. Amendment 34 would deny 16 and 17-year-olds the opportunity to participate in shaping and delivering future health services. I believe that, in principle, it would be wrong to do that.

However, Ross Finnie focused on the practical issue, which I will now address. A key issue in extending the franchise is ensuring that 16 and 17-year-olds are registered to vote. There must be provisions in place to ensure that that is the case. During discussions with electoral registration officer representatives, the use of a young persons register was considered. Those discussions allowed us to identify a way forward that would enable local EROs to record details of 16 and 17-year-olds and attainers in their own way, using a solution that was right for them locally. Information on young persons would be kept in a private register. Details of how we propose that that register will operate are contained in the draft Health Board Elections (Scotland) Regulations, which we provided the committee with at stage 1.

I appreciate that the committee had concerns, and I undertook to re-examine the issue. I am not in a position today to offer the committee an alternative, but I certainly am in a position to say that we will have further discussions to find out whether there is a preferable way of ensuring that 16 and 17-year-olds can vote in health board elections. I know that that will not completely satisfy Ross Finnie, but I ask him to withdraw amendment 34, so that we do not lose the principle of giving 16 and 17-year-olds the ability to vote, on the basis that we might be able to satisfy him on the matter before stage 3. If we cannot do that, he will have the opportunity to re-lodge his amendment at that stage.

Dr Simpson: What the cabinet secretary has said is helpful. The central issue is the publication of names and addresses of people who are under the age of 16, which will be a difficult problem to solve.

The cabinet secretary indicated that there might be local variation in how the matter is handled. I would not want that to be the case; at stage 3, I would want to see a solution to the problems that we have all identified or a statement to the effect that the issue will be dealt with uniformly, on a national basis, rather than in a way that allows local variation.
Ross Finnie: The cabinet secretary has entirely anticipated the position in which I have placed myself. I feel quite strongly about young persons registers but, equally, I do not need to be persuaded on the principle of giving 16 and 17-year-olds a vote, so I am content to seek the committee’s agreement to withdraw amendment 34. However, I seek leave to lodge a similar amendment at stage 3, if necessary, and I very much hope that the cabinet secretary will produce concrete proposals before we have to vote on any such amendment at stage 3.

The Convener: As I understand it, you would be perfectly entitled to do that.

Amendment 34, by agreement, withdrawn.

Section 2, as amended, agreed to.

Section 3 agreed to.

Section 4—Pilot scheme

The Convener: Group 7 is on evaluation of the pilot. Amendment 35, in the name of Dr Richard Simpson, is grouped with amendments 11, 36, 40 and 41.

Dr Simpson: Section 4, together with the section that deals with the content of the evaluation of the pilots, is crucial to what is an unusual bill, in that it provides for the piloting of direct elections to health boards to find out whether they achieve the objectives that we all seek, which are to ensure public involvement and engagement and to ensure that health boards are accountable locally. Although local accountability has improved, as our stage 1 report showed, it is still highly variable, and further measures are required to improve it. One such possible measure is direct elections to health boards.

My series of amendments seeks to make it clear that the evaluation of all the pilots should be undertaken independently of Government and of health boards, and that it should be authoritative, independent and credible. If the committee agrees to the amendments in the group, the evaluation methodology will be made clear. Later amendments will lay out in detail what the evaluation is to cover.

The evaluation is crucial to any future decision of the Parliament to support or revoke the pilot scheme under the affirmative resolution procedure that we have agreed to today. The amendments in the group seek to establish the independence of the evaluator and the timing of their appointment. In addition, it seeks to ensure that publication of the evaluation process is made prior to the process getting under way. In that way, MSPs and the public can see exactly what is involved and can comment critically on the process as things move forward.

I move amendment 35.

11:00

Nicola Sturgeon: First, I will speak to amendment 11 in my name. It has always been our intention to let the pilot scheme operate for an appropriate length of time. That will allow the new board structure to deal with the full range of issues that health boards deal with at present. The bill says that ministers have to bring forward an evaluation report no later than five years from commencement of the pilots, but it does not set a minimum. The committee raised the issue with me at stage 1. Amendment 11 seeks to address the issue. Pilots will have to operate for a minimum of two years before a report can be published and laid before Parliament. The five-year long stop for publication of the evaluation report will remain in place.

The other amendments in the group, which are in the name of Richard Simpson, seek to ensure the independence of the evaluation process. I have given a clear commitment to the independence of the report, but I have no difficulty in supporting amendments 36 and 41 and I encourage the committee to agree to them.

Although I am sympathetic to amendment 35, the appointment date that he specifies is too restrictive. The pilot order may be made some time ahead of the first health board election. It is therefore more appropriate for the bill to provide for appointment ahead of the first election instead of before the making of the pilot order. If Richard Simpson agrees to withdraw amendment 35, I commit to lodging an amendment at stage 3 to link appointment to the first election date.

I am not minded to support amendment 40, although I will be interested to hear the views of members on the subject. The bill itself specifies the most important aspects of the evaluation. It is right that that is done in the bill. If the committee agrees to the other amendments in the group, it is important to secure the independence of the person who will carry out the evaluation. They will need a degree of flexibility to carry out the evaluation in whatever way they think is fit. Given that the key elements will be prescribed in legislation, the independent person needs to be able to adapt the ways in which they carry out the evaluation, as circumstances arise. It is not appropriate for ministers, or Parliament, to dictate in advance every last detail of how the independent person carries out the evaluation.

In accepting amendments 36 and 41, I ask Richard Simpson to withdraw amendment 35, not to move amendment 40 and to work with me on drafting a more appropriate amendment, which I will lodge at stage 3.
Ross Finnie: I seek clarity on an aspect of amendment 41. Is the last word in the amendment statutorily defined?

Nicola Sturgeon: I believe that it is. It is in the Scotland Act 1998. I am surprised that Ross Finnie does not know that.

Ross Finnie: I did not know that. I also could not find my copy of the act.

Nicola Sturgeon: I can recite it verbatim.

Ross Finnie: If I had found my copy, I would have checked.

Nicola Sturgeon: I thought that you were looking a bit stressed this morning.

Ross Finnie: The situation is serious.

The Convener: That is banner headlines for tomorrow, Ross.

Ross Finnie: I will find my copy.

The Convener: You have thrown Ross Finnie a challenge, cabinet secretary.

Dr Simpson: My concern is that, far too often, when setting up pilots—this was the case even when I was in government—we only subsequently consider what might be involved in the evaluation and who might produce it. As a result, evaluators often get involved so late in the process that their ability to influence the detail of how the evaluation is carried out is limited. That is true particularly of Government-ordered evaluations, for which the specification is often determined by the Government—although we will go on later to discuss the content of the evaluation.

The purpose of both the amendments with which the cabinet secretary is unhappy—amendments 35 and 40—is to ensure that the evaluator is appointed at an early enough stage and publishes proposals on how this important trial should be evaluated. Unlike most pilots, the health board elections pilot will not be able to be tested and altered as we go along. Given that the pilot will be fixed in an act and in subordinate legislation, the ability to make changes will be limited until we reach the stage of roll-out. I am concerned to ensure that the evaluator is in place early enough and publishes how the pilot will be evaluated so that the public can consider the matter.

The Convener, I am unsure—perhaps the clerks can advise—whether any other amendments will fall if I do not press amendment 35. It seems to me that, without amendment 35 specifying that the evaluator must be appointed before ministers make the pilot order, amendment 40 cannot require the specification to be published by the evaluator, who might not be in place. I have a slight difficulty with that. Amendment 40 will require that the specification on how the evaluation is to be carried out must be published within a certain time.

The Convener: Bear with me one moment.

I am advised that the other amendments are not consequential, but even if they were, the issue could be fixed at stage 3.

Dr Simpson: In that case, I will not press amendment 35. I will consider the amendment that the cabinet secretary lodges at stage 3. However, I will move amendment 40 because I want the evaluation specification to be published.

Amendment 35, by agreement, withdrawn.

The Convener: Amendment 10, in the name of Nicola Sturgeon, is in a group on its own.

Nicola Sturgeon: Amendment 10, which will amend section 4, “Pilot scheme”, responds positively to a point that was raised by the Subordinate Legislation Committee and supported by this committee in its stage 1 report.

Amendment 10 will ensure that the affirmative procedure applies if Scottish ministers make an order seeking to terminate the pilots. I believe that such an order would be a very extreme response to extreme circumstances and would be made only if a significant risk was posed to the operation of the NHS. However, it is right that, just as we ask Parliament to endorse the principles and implementation of the pilots, we should also allow Parliament the opportunity to play a role in any revocation.

Amendment 10 will also ensure that the affirmative procedure applies to the pilot order or to any order that amends the pilot order if it textually amends sections 1 to 3 of the bill. That will ensure that any such order will be subject to parliamentary scrutiny.

I move amendment 10.

Amendment 10 agreed to.

Section 4, as amended, agreed to.

Amendment 11 moved—[Nicola Sturgeon]—and agreed to.

Amendment 36 moved—[Dr Richard Simpson]—and agreed to.

The Convener: We can either take a little break now or press on. Do members agree that we should press on?

Members indicated agreement.

The Convener: Group 9 is on the content of the evaluation of the pilot. Amendment 37, in the name of Dr Simpson, is grouped with amendments 38, 20 and 39.
The Convener: That is an interesting phrase to use.

Dr Simpson: My amendments are designed collectively to ensure that the evaluation report covers all the issues that we wish to see covered. Those issues are not, of course, exclusive. On the advice of the Government and others, the independent evaluator may choose to include further elements. The amendments merely lay down some of the basic elements that will be covered.

Amendment 37 deals with improving the local accountability of health boards, which is what we want. Amendments 38 and 39 similarly seek to ensure that all the pilots that are going to be undertaken—the cabinet secretary has assured the committee that alternatives will be considered—will be included in the evaluation: it will not be restricted to the direct election pilots that we will approve through passing the bill.

My reference to Michael Matheson’s amendment 20, which I support, is that the costs should also be looked at.

I move amendment 37.

Michael Matheson (Falkirk West) (SNP): I thank Richard Simpson for alluding to my amendment.

Amendment 20 seeks to add to the bill a requirement that the evaluation of the pilots considers the costs of the health board elections. The committee will be aware that the Finance Committee’s report on the bill referred to the need for the evaluation that will precede a decision on rolling out health board elections to include a full assessment of the costs associated with the pilot. Along with that, the Finance Committee also recommended a restatement of the expected costs of any roll-out of health board elections. In effect, my amendment would deliver on those recommendations and place that additional requirement on the evaluation.

Nicola Sturgeon: I listened with interest to Richard Simpson and Michael Matheson. It is important to ensure that evaluation of the costs of the health board elections, and local accountability of health boards, be included in the evaluation. Accordingly, I support amendments 20 and 37, and I encourage the committee to do likewise.

I am not minded to support amendments 38 and 39, and I will take a couple of minutes to say why. Members know that I have already given a commitment in writing, which was reiterated in Parliament at stage 1, to make proposals for alternative non-statutory pilots to run concurrently with pilot elections in advance of stage 3. I certainly anticipate that any evaluation report would look at them, and not just at the pilots of direct elections.

I do not believe that agreement to amendments 38 and 39 would deliver Richard Simpson’s desired effect. They would not oblige the Scottish ministers to carry out the alternative pilots that are specified, but would mean simply that if such pilots were undertaken, the evaluation report should assess them against the direct election pilots. However, if different kinds of alternative pilots were to be undertaken, the amendments would not impose the requirement that they be evaluated against the direct elections pilots. Those are important points that Richard Simpson might want to consider.

In addition to those important issues, it is also important at this stage that we do not seek to limit the types of alternative pilots that we might want to conduct. For example, I do not think that we should limit ourselves to conducting only an alternative pilot that includes a majority of councillors; there are other possible alternatives. Also, I do not see why we should insist that an alternative pilot should necessarily incur the same level of expenditure as a direct election pilot. A legitimate point of comparison that we might want to make in the evaluation is whether an alternative approach could achieve better results for less expenditure.

As members know, we are considering the shape of alternative pilots that can be developed from and compared to direct election pilots. In that light, and in the light of some of the more technical issues that I have raised about the effect of his amendments, I ask Richard Simpson not to move amendments 38 and 39, but instead to await my proposals ahead of stage 3. That will leave him free to relodge his amendments at stage 3, should he decide to do so.

11:15

Dr Simpson: Does the cabinet secretary propose to introduce at least the outline form of the alternative pilots before stage 3? That would allow us to decide how we want to proceed with regard to the two amendments to which she has objected. If she gives us that assurance, which I think she has indicated previously she would do, I am happy not to move amendments 38 and 39.

Nicola Sturgeon: I think that I have given it before, but if it has not been clear I am happy to give the assurance that the outline of the alternative pilots will be shared with members in advance of stage 3.

Amendment 37 agreed to.
Amendment 38 not moved.

Amendment 20 moved—[Michael Matheson]—and agreed to.

Amendment 39 not moved.

Amendment 40 moved—[Dr Richard Simpson].

The Convener: The question is, that amendment 40 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Bailie, Jackie (Dumbarton) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST
Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Mc Kee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 4, Against 4, Abstentions 0.

I use my casting vote against the amendment.

Amendment 40 disagreed to.

Amendment 41 moved—[Dr Richard Simpson]—and agreed to.

Section 5, as amended, agreed to.

Section 6—Termination of pilot scheme

The Convener: Amendment 12, in the name of the cabinet secretary, is grouped with amendments 13, 14 and 21.

Nicola Sturgeon: Amendment 13 provides that as an automatic consequence of Parliament voting down a roll-out order, the pilot scheme will be terminated and the provisions of the bill relating to health board elections be repealed. The vote on roll-out will be subject to the super-affirmative procedure, should the committee agree to Michael Matheson’s amendment 21. Amendment 13 addresses the question that was raised by the committee in its report, about what would happen if a roll-out order were rejected by Parliament.

Amendments 12 and 14 are drafting amendments and are consequential on amendment 13.

Amendment 21, in Michael Matheson’s name, seeks to introduce the super-affirmative procedure for any roll-out order, which was a specific request of the committee in its stage 1 report. Given all my previous commitments on the issue, I am pleased to support amendment 21 and hope that the committee will do so, as well.

I move amendment 12.

Michael Matheson: The cabinet secretary referred to amendment 21. The committee had concerns about the procedure that would be used following evaluation of the pilots and made a clear recommendation that the super-affirmative procedure should be introduced for any future consideration of a roll-out. That is what amendment 21 will achieve.

Amendment 12 agreed to.

Amendments 13 and 14 moved—[Nicola Sturgeon]—and agreed to.

The Convener: Amendment 42, in the name of Ross Finnie, is grouped with amendments 43 and 44.

Ross Finnie: Section 6 of the bill sets out a sort of Armageddon scenario in which we would not be able to proceed with any variant of any pilot, whatever the circumstances. Unfortunately, however, section 6(2) would simply revoke sections 1 to 7 and, in so doing, would remove what I thought was the helpful introduction in the bill by the cabinet secretary of a statutory provision for councillors to be on health boards. I thought that that was a helpful amendment to the 1978 act. I have lodged amendments 42, 43 and 45 so that, if we ever used the provisions in section 6(2), we would remove the elements connected to the pilot orders but not the elements of section 1 that give statutory backing to the appointment of councillors to health boards.

I move amendment 42.

The Convener: I invite the cabinet secretary to speak.

Nicola Sturgeon: I support amendments 42, 43 and 45 in principle. I will come back to the “in principle” bit later. The bill gives statutory underpinning to the position of councillors on health boards, which I think everybody has welcomed. However, as Ross Finnie rightly pointed out, the statutory underpinning could be repealed if the legislation was repealed because of the process that is set out for piloting elections. Ross Finnie proposes that even though elected health boards might not be pursued in the future, that should not affect the statutory presence of local councillors on health boards. I think that that is right because local councillors play a key role on our health boards and it will be a positive step to give them statutory underpinning.

I therefore support the principle behind amendments 42, 43 and 45, although there are some technical deficiencies in their wording that will need to be dealt with if the amendments are to operate as Ross Finnie intends. For example, the interaction between the commencement provisions in amendment 43 and section 11 of the bill does not quite work, as the provisions are
drafted. I therefore ask Ross Finnie not to move amendment 43, but I give him a commitment that I will work with him to lodge amendments at stage 3 that will effectively implement what he proposes in amendment 43.

The Convener: That is an interesting offer, Ross. Are you prepared to take it?

Ross Finnie: It is the second offer that I have had this morning, so I feel very good now. I am not being "alluded to" now—I am having positive offers made to me. I think that that places me just a half-step above Michael Matheson. I have not yet had the important elevation to Presiding Officer, though. It really is a morning of promotions.

The Convener: That is a black spot for you, Ross.

Ross Finnie: If the cabinet secretary accepts amendments 42, 43 and 45 in principle, I am perfectly happy to accept her offer.

Amendment 42, by agreement, withdrawn.

Section 6, as amended, agreed to.

Amendment 43 not moved.

Section 7—Roll out

Amendment 21 moved—[Michael Matheson]—and agreed to.

Section 7, as amended, agreed to.

Section 8 agreed to.

Schedule agreed to.

Sections 9 and 10 agreed to.

Section 11—Commencement

Amendment 44 not moved.

Section 11 agreed to.

Section 12 agreed to.

Long Title

The Convener: Amendment 15, in the name of the cabinet secretary, is grouped with amendment 16.

Nicola Sturgeon: Amendments 15 and 16 relate to the long title of the bill. During an evidence session with the committee at stage 1, an issue arose around the bill’s title and the principles that Parliament would be required to sign up to if it passed the bill. For the avoidance of any doubt, I gave a commitment to amend the long title. Amendments 15 and 16 will do that and will make clear the precise route that needs to be followed in the introduction of elections to health boards.

I move amendment 15.

Amendment 15 agreed to.

Amendment 16 moved—[Nicola Sturgeon]—and agreed to.

Long title, as amended, agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank you all for the efficacy of the procedure. I thank the cabinet secretary and her team.
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Schedule—Minor and consequential amendments
Health Boards (Membership and Elections) (Scotland) Bill

[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for piloting of the election of certain members of Health Boards; to require the Scottish Ministers to report on those pilots; to confer a power to extend those elections to all Health Board areas following publication of that report; and for connected purposes.

Constitution of Health Boards

1 Constitution of Health Boards
(1) Schedule 1 (Health Boards) to the National Health Service (Scotland) Act 1978 (c.29) (the “1978 Act”) is amended as follows.
(2) For paragraph 2 substitute—

“2 (1) A Health Board is to consist of the following types of members—

(a) a chairman, and other members, appointed by the Scottish Ministers (“appointed members”),

(b) councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board (“councillor members”), and

(c) individuals elected as members of the Health Board at an election held under Schedule 1A (“elected members”).

(2) Regulations must, in relation to each Health Board, specify—

(a) the total number of members of the Board, and

(b) the number of each type of member.

(3) But—

(a) the total number of councillor members and elected members of a Board must amount to more than half the total number of members, and

(b) a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board.
(4) The conditions imposed by sub-paragraph (3) do not apply during any period when an elected member or, as the case may be, councillor member vacates office and the vacancy has not been filled.”.

(3) In paragraph 2A, for “persons appointed under paragraph 2 above” substitute “appointed members”.

(4) In paragraph 3—
(a) for “Appointments under paragraph 2 shall be made” substitute “An appointed member may be appointed only”, and

(b) sub-paragraph (a) is omitted.

(4A) After paragraph 3 insert—

“3A A person appointed as chairman of a Health Board may not be an employee of that Health Board.”.

(5) Before paragraph 11 insert—

“10A(1) An elected member holds office for a period beginning with the day after the day of the Health Board election at which the member was elected and ending on the day of the next following Health Board election in the Health Board area.

(1A) An elected member vacates office on becoming—
(a) a member of the European Parliament,
(b) a member of the House of Commons,
(c) a member of the House of Lords,
(d) a member of the Scottish Parliament, or
(e) a local authority councillor.

(2) Regulations may specify further circumstances in which an elected member must vacate office before the end of that period and, in particular, may specify that an elected member is to vacate office on becoming the holder of a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.”.

(6) In paragraph 11(a), for “chairman and members of Health Boards” substitute “appointed members and councillor members (including provision specifying circumstances in which the Scottish Ministers may determine that such a member is to vacate office)”.

(7) In paragraph 12, after “appointment” insert “or, as the case may be, election”.

Elected members of Health Boards

Health Board elections

(1) In section 2 of the 1978 Act (Health Boards), after subsection (10) insert—

“(10A)Schedule 1A makes provision for the election of individuals to be members of Health Boards.”.

(1A) In section 105 of the 1978 Act (regulations etc.)—
(a) in subsection (2), for “(3) and” substitute “(2A) to”, and

(b) after subsection (2) insert—
“(2A) No regulations shall be made under paragraph 13(1) of Schedule 1A (Health Board elections) unless a draft has been laid before, and approved by resolution of, the Scottish Parliament.”.

(2) After Schedule 1 to the 1978 Act insert—

“SCHEDULE 1A
(introduced by section 2(10A))

HEALTH BOARD ELECTIONS

Health Board elections

1 An election held under this Schedule is known as a “Health Board election”.

Timing of Health Board elections

2 (1) A Health Board must hold the first Health Board election in the Health Board area on the day specified in election regulations.

(2) Election regulations may specify different days for the first election in different Health Board areas.

3 (1) A Health Board must hold subsequent Health Board elections on the first Thursday falling after the end of the period of 4 years beginning with the day of the previous election.

(4) But a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3) if the Scottish Ministers make an order under section 77 specifying the date of a Health Board election in that area.

Electoral wards

3 (1) Each Health Board area is to be comprised of a single electoral ward unless election regulations specify that a Health Board area is to be divided into more than one ward.

(2) If regulations specify such a division they must also specify—

(a) the number of electoral wards in the Health Board area,

(b) the boundaries of those wards, and

(c) the number of elected members to be elected in each ward.

(3) Before regulations specifying such a division are made—

(a) the Scottish Ministers must consult the Local Government Boundary Commission for Scotland, and

(b) the Commission must give the Scottish Ministers advice about the boundaries of the electoral wards which the Health Board is to be divided into.

Conduct of election

4 (1) Election regulations must appoint an individual as the returning officer for each ward in which a Health Board election is to be held.

(2) Election regulations may make provision about—
(a) the tenure and vacation of office of a returning officer,
(b) the functions of a returning officer,
(c) a returning officer’s fees and expenses,
(d) any other matters relating to returning officers that the Scottish Ministers consider appropriate.

5 (1) The nomination of a candidate must be made—

(a) within the period specified in election regulations (the “nomination period”), and
(b) in accordance with any other requirement made in those regulations.

10 (2) A candidate may withdraw from a Health Board election at any time before the end of the nomination period.

7 If, at the end of the nomination period, the number of nominated candidates in an electoral ward is equal to or less than the number of elected members to be elected for that ward—

(a) the Health Board election is not to be held in the ward, and
(b) on the day on which the election was to be held the returning officer must—

(i) declare the nominated candidates (if any) to be deemed to have been elected as elected members for the ward, and
(ii) if the number of nominated candidates is less than the number of elected members to be elected for the ward, declare the number of vacancies in the ward.

8 (1) In any other case, the elected members are to be elected for the electoral ward at a poll held in accordance with this paragraph.

25 (2) At the poll, each individual entitled to vote may vote by marking on the ballot paper—

(a) the voter’s first preference from among the candidates, and
(b) if the voter wishes to express a further preference for one or more candidates, the voter’s second and, if the voter wishes, subsequent preferences from among those candidates.

30 (3) Election regulations must, in particular, make provision about—

(a) the manner in which and period during which votes may be cast,
(b) the form and content of ballot papers,
(c) the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated,
(d) the procedure for counting votes,
(e) the declaration of the result of the poll.
(4) If election regulations provide for votes in a Health Board election to be cast only by post, the regulations must also provide for a system of personal identifiers to be used in relation to the casting of such votes.

Candidates

9 (1) An individual is disqualified from being a candidate in a Health Board election if the individual is—
   (a) a member of the European Parliament,
   (b) a member of the House of Commons,
   (c) a member of the House of Lords,
   (d) a member of the Scottish Parliament, or
   (e) a local authority councillor.

(2) Election regulations may make further provision about—
   (a) who is qualified to be a candidate in a Health Board election, and
   (b) the circumstances in which an individual may be disqualified from being a candidate,

and, in particular, may disqualify from being a candidate an individual holding a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.

Franchise

10 (1) An individual is entitled to vote at a Health Board election if the individual—
   (a) is aged 16 or over, and
   (b) meets any further criteria specified in election regulations.

(2) Election regulations may determine, or set out the criteria for determining, the electoral ward in which an individual is entitled to vote.

(3) Election regulations may not entitle an individual to vote—
   (a) more than once in the same Health Board area, nor
   (b) in more than one Health Board area.

Election expenses

11 Election regulations may make provision about the expenses which may be incurred by any person in connection with a Health Board election.

Vacancies

12 (1) This paragraph applies if—
   (a) a returning officer declares a vacancy in an electoral ward (see paragraph 7), or
   (b) an elected member vacates office before the end of the period mentioned in paragraph 10A(1) of Schedule 1.
(2) The Scottish Ministers may—
   (a) direct the Health Board with the vacancy to invite an unelected candidate
to fill the vacancy, or
   (b) appoint, in accordance with any provision made by election regulations,
an individual to fill the vacancy.

(3) If a vacancy arises less than 6 months before the date of the next Health Board
election in the Health Board area where it arises, the Scottish Ministers may,
instead of taking action under sub-paragraph (2), direct the Health Board to
leave the vacancy unfilled until that next election.

(4) An individual who fills a vacancy is to be deemed to be an elected member of
the Health Board elected for the ward in which the vacancy occurred.

(5) In sub-paragraph (2)(a), an “unelected candidate” is an individual who—
   (a) was a nominated candidate in the last Health Board election to be held in
the Health Board area, and
   (b) is identified by criteria specified in election regulations.

Election regulations

13 (1) The Scottish Ministers may make regulations (“election regulations”) in
relation to any matter specified in this Schedule as something in relation to
which provision may be made by election regulations.

(2) Election regulations may make further provision about Health Board elections
(in so far as not already provided for in this Schedule).

(3) In particular, election regulations may provide that an enactment applies (with
or without modifications specified in the regulations) or does not apply to
Health Board elections.

(4) In sub-paragraph (3), “enactment” includes an Act of the Scottish Parliament
and any instrument made under such an Act.”.

3 Scottish Ministers’ powers in relation to elected members

In section 77(2) of the 1978 Act (content of order declaring Health Board to be in
default)—

(a) in paragraph (a), after “appointment” insert “or, as the case may be, election”, and
(b) in paragraph (b), after “appointment” insert “or, as the case may be, election”.

Pilot scheme and action following pilot

4 Pilot scheme

(1) Ministers may by order (the “pilot order”) appoint a day on which sections 1 to 3 are to
come into force in respect of the Health Board areas specified in the order.

(2) Ministers may make one pilot order only (but this does not affect Ministers’ power to
modify or revoke the order).

(3) The pilot order may bring sections 1 to 3 into force with such modifications as Ministers
consider appropriate.
An order to which this subsection applies may be made only if a draft of it has been laid before, and approved by a resolution of, the Scottish Parliament.

This subsection applies to—

(a) a pilot order (or order amending a pilot order) which adds to, replaces or omits any part of the text of sections 1 to 3, and

(b) an order revoking the pilot order.

5 Report on pilot scheme

(1) At least 2 but no later than 5 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order, Ministers must publish a report containing—

(a) a description of the changes made to the 1978 Act by sections 1 to 3 and how the constitution of Health Boards was changed by those sections coming into force in the Health Board areas specified in the pilot order,

(b) a description of the Health Board elections held in the specified Health Board areas, and

(c) an evaluation (carried out by an independent person) of—

(i) the level of public participation in the Health Board elections,

(ii) whether having elected members on Health Boards led to increased engagement with patients and other members of the public or improved local accountability of the Health Board in the specified Health Board areas, and

(iii) the cost of holding the Health Board elections and the estimated cost of holding future Health Board elections in all Health Board areas.

(2) The report may contain—

(a) such other information, and

(b) an evaluation of such other matters,

as Ministers consider appropriate.

(3) Ministers must lay a copy of the published report before the Scottish Parliament.

(4) For the purposes of paragraph (c) of subsection (1), and without prejudice to the generality of that paragraph, a person is not independent if he or she is—

(a) an employee of any Health Board mentioned in the pilot order,

(b) a member of any Health Board mentioned in the pilot order, or

(c) a member of staff of the Scottish Administration.

6 Termination of pilot scheme

(1) The pilot order is revoked on the day falling 7 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order (but this does not affect Ministers’ power to revoke the order on an earlier date).

(2) If—

(a) the pilot order is revoked before a roll-out order is made, or
(b) a question of whether to resolve to approve a draft roll-out order is put to a meeting of the Scottish Parliament but is not agreed by the Parliament, then, on the day the pilot order is revoked or on the day after the question is put (as the case may be), sections 1 to 7 and paragraph 2 of the schedule are repealed.

5 7  Roll-out

(1) Ministers may by order (a “roll-out order”) appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order.

(2) When a roll-out order is made section 6 is repealed.

(3) A roll-out order may not be made unless—

(a) a report has been published under section 5(1), and

(b) a draft of the roll-out order has been laid before, and approved by a resolution of, the Scottish Parliament.

(3A) Before laying a draft of a roll-out order before the Scottish Parliament, Ministers must—

(a) lay before the Scottish Parliament—

(i) a copy of the proposed draft roll-out order, and

(ii) a statement of their reasons for proposing to make the draft roll-out order,

(b) publicise the proposed draft roll-out order in such manner as they consider appropriate, and

(c) have regard to—

(i) any representations about the proposed draft roll-out order,

(ii) any resolution of the Scottish Parliament about the proposed draft roll-out order, and

(iii) any report by a committee of the Scottish Parliament about the proposed draft roll-out order,

made during the 60 days following the day on which the proposed draft roll-out order was laid before the Scottish Parliament.

(3B) When laying a draft of a roll-out order before the Scottish Parliament, Ministers must—

(a) where any representation, resolution or report is made in pursuance of subsection (3A)(c), lay a statement giving details of any representations, resolution or report and of their response, and

(b) where the draft roll-out order includes material changes to the proposed draft roll-out order, lay a statement giving details of the proposed revisions and of their reasons for them.

(4) A roll-out order may make such provision adding to, replacing or omitting any part of the text of, or otherwise modifying, any enactment (including this Act) as Ministers consider appropriate.

Final provisions

8  Minor and consequential amendments

The schedule contains minor and consequential amendments.
9 Key terms

In this Act—

the “1978 Act” means the National Health Service (Scotland) Act 1978 (c.29),
“Health Board” means a board constituted by an order under section 2(1)(a) of the 1978 Act,
“Health Board election” means an election held under Schedule 1A to the 1978 Act (as inserted by section 2(2) of this Act),
“Ministers” means the Scottish Ministers,
“pilot order” has the meaning given by section 4(1),
“roll-out order” has the meaning given by section 7(1).

10 Orders

(1) An order made under this Act is to be made by statutory instrument.

(2) Such an order may—

(a) make different provision for different purposes (in particular, for different Health Board areas), and

(b) contain any supplementary, incidental, consequential, transitional, transitory or saving provision which Ministers consider appropriate.

11 Commencement

(1) Sections 1 to 3 come into force in accordance with sections 4 and 7.

(2) Sections 4 to 7, 9, 10, 12 and this section come into force on Royal Assent.

(3) Section 8 and the schedule come into force on such day as Ministers may by order appoint.

12 Short title

This Act is called the Health Boards (Membership and Elections) (Scotland) Act 2009.
SCHEDULE
(introduced by section 8)

MINOR AND CONSEQUENTIAL AMENDMENTS

National Health Service (Scotland) Act 1978 (c.29)
5

1 In paragraph 4 of Schedule 1 to the 1978 Act, for the words from “the”, where it second occurs, to “prescribed” substitute “—

(a) the chairman of a Health Board,

(b) such other members of a Health Board as may be prescribed, and

(c) such members of committees and sub-committees of a Health Board as may be prescribed,”.

Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)
2

In schedule 2 to the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (the specified authorities), in the list headed “National Health Service bodies”, after “any Health Board” insert “, but Part 1 does not apply to appointments made under Schedule 1 to the National Health Service Scotland Act 1978 (c.29) of the following persons to a Health Board—

(a) a councillor member,

(b) an appointed member who is appointed by virtue of the member—

(i) holding a post in a university with a medical or dental school,

(ii) being employed as an officer of the Health Board, or

(iii) being a member of a body set up by a Health Board which represents health care professionals working in the Health Board area.”.
Health Boards (Membership and Elections) (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for piloting of the election of certain members of Health Boards; to require the Scottish Ministers to report on those pilots; to confer a power to extend those elections to all Health Board areas following publication of that report; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 25 June 2008
Bill type: Executive Bill
HEALTH BOARDS (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL
[AS AMENDED AT STAGE 2]

REVISED EXPLANATORY NOTES
(AND REVISED FINANCIAL MEMORANDUM)

CONTENTS

1. As required under Rules 9.7.8A and 9.7.8B of the Parliament’s Standing Orders the following documents are published to accompany the Health Boards (Membership and Elections) (Scotland) Bill (introduced in the Scottish Parliament on 25 June 2008) as amended at Stage 2:
   • revised Explanatory Notes; and
   • a revised Financial Memorandum.

Text has been added or deleted as necessary to reflect the amendments made to the Bill at Stage 2 and these changes are indicated by sidelining in the right margin.
INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Government in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL

4. The Bill will introduce, by way of pilots, elections to Health Boards in Scotland.

5. The Bill changes the constitution of Health Boards in Scotland and in particular changes the way some individuals become members of these Boards by introducing a system of elections whereby a proportion of the membership of each Health Board will be made up of elected members. The Bill also, for the first time, sets out on a statutory basis the membership of local authority councillor members on Health Boards and specifies that there must be at least one member per local authority within a Health Board area.

6. The Bill therefore makes a number of amendments to Schedule 1 to the National Health Service (Scotland) Act 1978 (the “1978 Act”) so as to change the make-up of Health Boards and inserts a new Schedule 1A into that Act setting out the framework for the elections.

7. The Bill provides for these changes to be introduced in certain areas on a pilot basis and provides for those pilot schemes to be evaluated before the changes are rolled-out to other areas.

8. The changes to Schedule 1 to the 1978 Act will not extend to Special Health Boards (these are Boards with special functions operating across Scotland as a whole). These Boards are set up by orders under the 1978 Act which commonly apply the provisions in Schedule 1 to that Act with appropriate modifications. Those orders will be amended where necessary to ensure that the new provisions inserted by this Bill are not applied to any Special Health Boards.

9. The Bill also extends the power of the Scottish Ministers to remunerate Health Board members to include power to remunerate members of committees and sub-committees of a Health Board.

COMMENTARY ON SECTIONS

Section 1 – Constitution of Health Boards

10. This section amends Schedule 1 to the 1978 Act. That Schedule currently contains provision about the constitution of Health Boards. In particular, it contains provisions about the
appointment of Health Board members (who are currently all appointed by the Scottish Ministers in accordance with this Schedule).

11. Subsection (2) substitutes a new paragraph for the existing paragraph 2 of Schedule 1 to the 1978 Act. New paragraph 2(1) specifies the three different types of member that will comprise a Health Board. These are—

- “appointed members” (a chairman and other members appointed by the Scottish Ministers);
- “councillor members” (councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board); and
- “elected members” (individuals elected as members of the Health Board at an election).

Note that the chairman must always be an appointed member but cannot be an employee of the Health Board.

12. New paragraph 2(2) provides that regulations must specify, in respect of each Health Board in Scotland, the total number of members of the Board and the number of that total which is to be represented by each type of member. Those numbers will differ from Board to Board.

13. New paragraph 2(3) provides that (a) the total number of councillor members and elected members of a Health Board must amount to more than half the total number of members and (b) a Board must contain at least one councillor member from each local authority whose area is wholly or partly within the area of the Health Board. So the regulations cannot specify numbers which would not be in accordance with those two conditions.

14. New paragraph 2(4) provides that these conditions do not apply during any period when an elected member or councillor member vacates office and the vacancy has not been filled. This ensures that in the event of a vacancy arising the Health Board will still be able to carry out its functions.

15. Subsection (3) amends paragraph 2A of Schedule 1 to the 1978 Act to ensure that it continues to be a requirement in the case of a prescribed Health Board that at least one of the appointed members must hold a post in a university with a medical or dental school. A “prescribed Health Board” is one which is prescribed in regulations as requiring a member holding one of these posts. Currently these are the Health Boards which have at least one university in their area with a medical or dental school.

16. Subsection (4) amends paragraph 3 of Schedule 1 to the 1978 Act to ensure that it continues to be a requirement that appointed members may be appointed only after consultation with universities and other relevant organisations. It also removes the existing sub-paragraph (a) of paragraph 3 to remove the requirement to consult each local authority in the area of the Health Board concerned. This is because local authorities will have their own councillor members. Under the current arrangements, the Scottish Ministers would normally appoint at least one
councillor to each Health Board. Existing paragraph 3(a) ensured that such an appointment could not be made without the local authority being consulted. New paragraph 2 of the Schedule now provides for local authorities to nominate the councillor member to be appointed.

17. Subsection (4A) inserts new paragraph 3A into Schedule 1 to the 1978 Act. New paragraph 3A stipulates that a person appointed as chairman of a Health Board may not be an employee of that Health Board.

18. Subsection (5) inserts new paragraph 10A into Schedule 1 to the 1978 Act. New paragraph 10A(1) sets out the usual period that an elected member holds office for. Paragraph 10A(1A) provides that an elected member must vacate office if they become the holder of one of the public offices specified in the paragraph. Paragraph 10A(2) provides that regulations may specify further circumstances in which an elected member must vacate office before the end of the period that they normally hold office for and, in particular, may specify that an elected member must vacate office on becoming the holder of a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose. The regulations may set out some things which would lead to an individual having to leave office as a Health Board member.

19. Subsection (6) amends paragraph 11A of Schedule 1 to the 1978 Act to ensure that it continues to be the case that regulations may make provision about the appointment, tenure and vacation of office of appointed members. This will also apply to councillor members.

20. Subsection (7) amends paragraph 12 of Schedule 1 to the 1978 Act to ensure that it continues to be the case that the proceedings of a Health Board are not invalidated by any vacancy in membership or by any defect in the appointment of any member. This will also apply to councillor members and elected members.

Section 2 – Health Board elections

21. Subsection (1) inserts new subsection (10A) into section 2 of the 1978 Act. New subsection (10A) provides that Schedule 1A will make provision for the elections of individuals to be members of Health Boards.

22. Subsection (1A) inserts new section 105(2A) into the 1978 Act. It provides that election regulations will be subject to affirmative resolution procedure.

23. Subsection (2) inserts new Schedule 1A into the 1978 Act, which makes provision for Health Board elections.

24. Paragraph 1 provides that an election held under Schedule 1A is known as a “Health Board election”.

25. Paragraph 2 provides for the timing of Health Board elections. It provides that election regulations will specify the day on which a Health Board must hold the first election in the Health Board area. This day could be different for different Health Board areas. Health Board elections will be held on a fixed 4 year cycle. However, a Health Board election may be held in
These documents relate to the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2 (SP Bill 13A)

a Health Board area before the day specified if the Scottish Ministers make an order under section 77 of the 1978 Act to declare that a Health Board is in default.

26. Paragraph 3 provides for electoral wards. It provides that each Health Board area is to be comprised of a single electoral ward unless election regulations specify that a Health Board area is to be divided into more than one ward. If regulations specify such a division then they must also specify the number of wards, the boundaries of those wards and the number of elected members to be elected in each ward. Also, before regulations specifying such a division are made, the Scottish Ministers must consult the Local Government Boundary Commission for Scotland and the Commission must give them advice about the boundaries of the wards.

27. Paragraphs 4 to 8 deal with the conduct of elections. Paragraph 4 provides that election regulations must appoint a returning officer for a Health Board election and sets out that election regulations will make provision about the tenure and vacation of office of a returning officer, the functions of a returning officer, the payment of a returning officer’s fees and expenses, and any other matters relating to the returning officers as the Scottish Ministers consider appropriate.

28. Paragraph 5 provides that the nomination of a candidate must be made within the period specified in election regulations and in accordance with any other requirements made in those regulations. It also provides that a candidate may withdraw from a Health Board election at any time before the end of the nomination period set out in regulations.

29. Paragraph 7 makes provision for uncontested elections. If, at the end of the nomination period, the number of nominated candidates in an electoral ward is equal to or less than the number to be elected for that ward then—

   (a) the Health Board election is not to be held in the ward, and

   (b) on the day on which the election was supposed to be held, the returning officer must—

      (i) declare the nominated candidates (if there are any) to be deemed to have been elected as elected members for the ward (so they are all effectively elected without a vote being held), and

      (ii) if the number of nominated candidates is less than the number that is to be elected for that ward, declare the number of vacancies in the ward.

30. Paragraph 8 makes provision for contested elections. The number of members that are to be elected for a ward are to be elected at a poll. Sub-paragraph (2) provides that at the poll, each individual entitled to vote may do so by marking on the ballot paper the voter’s first preference from among the candidates. The voter can then express a second preference for another candidate and, if the voter wishes, subsequent preferences from amongst the candidates. This is the basic structure of a single transferable vote (STV) system. Sub-paragraph (3) states that election regulations must, in particular, make provision about the manner in which and period during which votes may be cast (for example, postal voting, electronic voting, or traditional ballots at polling stations), the form and content of ballot papers, the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated (that is to say, the mathematical formula to be used in the STV system), the procedure
for counting votes, and the declaration of the result of the poll. Sub-paragraph (4) stipulates that where an all postal election is specified in regulations, these must also provide for the use of a system of personal identifiers.

31. Paragraph 9 makes provision about the eligibility of individuals to be candidates. Sub-paragraph (1) provides that an individual is disqualified from being a candidate in a Health Board election if they are holders of one of the public offices specified in the sub-paragraph. Sub-paragraph (2) provides that election regulations may make further provision about who is qualified to be a candidate in a Health Board election, and the circumstances in which an individual may be disqualified from being a candidate and may, in particular, disqualify individuals holding a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.

32. Paragraph 10 makes provision about entitlement to vote (in other words, the franchise of Health Board elections). It provides that an individual is entitled to vote at a Health Board election if the individual is aged 16 and over and meets any further criteria specified in election regulations. It provides that election regulations may determine, or set out the criteria for determining, the electoral ward in which an individual is entitled to vote. It also provides that an individual cannot vote more than once in the same Health Board area, nor in more than one Health Board area.

33. Paragraph 11 makes provision about election expenses. It provides that election regulations may make provision about the expenses which may be incurred by any person in connection with the Health Board election.

34. Paragraph 12 deals with what happens when there is a vacancy amongst the elected members of a Health Board. It applies if a returning officer declares a vacancy in an electoral ward due to an insufficient number of candidates and also if an elected member vacates office before the end of the usual period. It provides that the Scottish Ministers may direct the Health Board with the vacancy to invite an unelected candidate to fill the vacancy (election regulations can set out criteria for determining which unelected candidate is to be invited) or alternatively the Scottish Ministers can appoint an individual to fill the vacancy. Clearly the first of these options would not be available if the vacancy arose due to an insufficient number of candidates in the first place.

35. If a vacancy arises less than 6 months before the date of the next scheduled Health Board election in the Health Board area where it arises, the Scottish Ministers may, instead of taking action to direct the Health Board to invite an unelected candidate or appoint an individual to fill the vacancy, direct the Health Board to leave the vacancy unfilled until the next Health Board election in the Health Board area (paragraph 12(3)). Paragraph 12 also provides that an individual who fills a vacancy is to be treated as if that individual was an elected member of the Health Board (sub-paragraph (4)).

36. Paragraph 13 confers power on the Scottish Ministers to make election regulations. It provides that the Scottish Ministers may make election regulations in relation to any matter specified in new Schedule 1A as something in relation to which provision may be made by election regulations. It also provides that the election regulations may make further provision
about Health Board elections (if it is something not already provided for in new Schedule 1A). It also provides that election regulations may apply an enactment (with or without modifications specified in the regulations) or disapply an enactment to Health Board elections.

Section 3 – Scottish Ministers powers in relation to elected members

37. Section 3 amends section 77(2) of the 1978 Act to ensure that when an order is made to declare a Health Board to be in default the order must not only provide for the appointment of new members, but also must make provision for an election and may make provision about what is to happen in the period until the election is held.

Section 4 – Pilot scheme

38. Subsection (1) provides that the Scottish Ministers may by order appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order. An order under this provision is known as a pilot order.

39. Subsection (2) provides that the Scottish Ministers may make one pilot order only, although this does not affect their power to modify or revoke the order.

40. Subsection (3) provides that the pilot order may bring sections 1 to 3 into force with such modifications as the Scottish Ministers consider appropriate.

41. Subsection (4) sets out that affirmative resolution procedure will apply to a pilot order (or order amending a pilot order) which adds to, replaces or omits any part of the text of sections 1 to 3 of the Bill and to an order revoking the pilot order. Otherwise it will not be subject to any parliamentary procedure.

Section 5 – Report on pilot scheme

42. Subsection (1) provides that at least 2 but no later than 5 years after the first election held in a Health Board area specified in the pilot order, the Scottish Ministers must publish a report, carried out by an independent person. The report must contain the following things—

(a) a description of the changes made to the 1978 Act by sections 1 to 3 and how the constitution of Health Boards was changed by those sections coming into force in the Health Board areas specified in the pilot order,

(b) a description of the Health Board elections held in the Health Board areas, and

(c) an evaluation (carried out by an independent person) of—

(i) the level of public participation in the Health Board elections,

(ii) whether having elected members on Health Boards led to increased engagement with patients and other members of the public or improved local accountability of the Health Board in the specified Health Board areas, and
43. Subsection (2) provides that the report may contain such other information, and an evaluation of such other matters, as the Scottish Ministers consider appropriate.

44. Subsection (3) provides that the Scottish Ministers must lay a copy of the published report before the Scottish Parliament.

45. Subsection (4) sets out persons who would not be considered independent for the purpose of undertaking the evaluation.

Section 6 – Termination of pilot scheme

46. Subsection (1) provides that the pilot order can only stay in force for 7 years after the day the first election is held in a Health Board area specified in the pilot order. But the Scottish Ministers could revoke the pilot order on an earlier date.

47. If the pilot order is revoked before a roll-out order is made under section 7 of the Bill, or a question of whether to resolve to approve a draft roll-out order is not agreed by the Scottish Parliament, then, on the day the pilot order is revoked, or on the day after the question is put, sections 1 to 7 and paragraph 2 of the schedule are repealed (subsection (2)). This means that in order for the main provisions of the Bill to continue to have effect in the areas specified in the pilot order, a roll-out order has to be made before the pilot order is revoked (note that the pilot order is automatically revoked under subsection (1) at the end of the 7 year time-limit). Another effect of the self-repealing provision of subsection (2) is that it would no longer be possible to bring the main provisions of the Bill into force in areas not specified in the pilot order.

Section 7 – Roll-out

48. Subsection (1) provides that the Scottish Ministers may by order appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. Such an order is known as a “roll-out order”. When a roll-out order is made it has the effect of repealing section 6 of the Bill (see subsection (2) of section 7). Repealing section 6 prevents the pilot order from being revoked after the expiry of the time limit in section 6(1) and therefore also stops the consequential repeal of the main provisions of the Bill under section 6(2). This means that sections 1 to 7 and paragraph 2 of the schedule will continue to have effect in respect of the Health Board areas specified in the pilot order and there is no bar on bringing those provisions into force in other areas.

49. Subsection (3) provides that a statutory instrument containing a roll-out order may not be made unless the evaluation report has been published, and a draft of the roll-out order has been laid before, and approved by a resolution of, the Scottish Parliament.

50. Subsection (3A) provides that before laying a draft of a roll-out order before the Scottish Parliament, Ministers must:
• lay a copy of the proposed draft roll-out order and a statement of their reasons for proposing to make it before the Scottish Parliament;

• publicise the proposed draft roll-out order; and

• have regard to any representations, resolutions or committee reports of the Scottish Parliament about the proposed draft roll-out order made during the 60 days following the day on which the proposed draft roll-out order is laid before the Scottish Parliament.

51. Subsection (3B) provides that when laying a draft of a roll-out order before the Scottish Parliament, Scottish Ministers must lay a statement detailing any representations, resolutions or reports made along with their response and set out any material changes to the proposed draft roll-out order along with their reasons for these changes.

52. Subsection (4) provides that a roll-out order may make such provision adding to, replacing or omitting any part of the text of, or otherwise modifying any enactment as the Scottish Ministers consider appropriate. One of the things that could be done under this power is amendment of new Schedule 1A to the 1978 Act in response to the evaluation of the pilot schemes. For example, where elements of the process have been seen to work less well in the pilot areas, changes could be made to the way the process works by amending Schedule 1A for the Health Boards which did not participate in the pilot scheme (where elections would be held for the first time) and for the pilot scheme Boards (in relation to the subsequent elections for those Boards).

Section 8 – Minor and consequential amendments

53. Section 8 introduces the schedule which contains minor and consequential amendments.

Schedule – Minor and consequential amendments

National Health Service (Scotland) Act 1978 (c.29)

54. Paragraph 1 amends paragraph 4 of Schedule 1 to the 1978 Act to extend the power in that paragraph which permits the Scottish Ministers to pay to the chairman of a Health Board and such other members of a Health Board as may be set out in regulations such remuneration as they may from time to time determine. The power is extended to include such members of committees and sub-committees of a Health Board as regulations may specify.

Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)

55. Paragraph 2 amends schedule 2 to the Public Appointments and Public Bodies etc. (Scotland) Act 2003 to exclude from the remit of the Commissioner for Public Appointments in Scotland the appointment to any Health Board of—

(a) councillor members, and

(b) appointed members who are appointed by virtue of the member either—

(i) holding a post in a university with a medical or dental school,
(ii) being employed as an officer of the Health Board (for example, the chief executive of the Health Board), or

(iii) being a member of a body set up by a Health Board which represents healthcare professionals working in the Health Board area. This covers representative forums set up by Health Boards to allow them to consult with doctors, dentists, opticians, pharmacists and other professionals in the area. These bodies are currently known as Area Clinical Forums.

Section 9 – Key terms

56. Section 9 defines the key terms used in the Bill.

Section 10 – Orders

57. Subsection 10(1) provides that an order under the Bill is to be made by statutory instrument.

58. Subsection (2) provides that such an order may make different provision for different purposes and contain any supplementary, incidental, consequential, transitional, transitory or saving provision which the Scottish Ministers consider appropriate.

Section 11 – Commencement

59. Subsection (1) provides that sections 1 to 3 come into force in accordance with sections 4 and 7 (that is, the provisions relating to the pilot scheme and roll-out respectively).

60. Subsection (2) provides that sections 4 to 7 and 9 to 12 come into force on Royal Assent.

61. Subsection (3) provides that sections 8 and the schedule come into force on such day as the Scottish Ministers may by order appoint (a commencement order under this subsection is not subject to any parliamentary procedure).

———

REVISED FINANCIAL MEMORANDUM

INTRODUCTION

62. This document relates to the Health Boards (Membership and Elections) (Scotland) Bill (introduced in the Scottish Parliament on 25 June 2008) as amended at Stage 2. It has been prepared by Nicola Sturgeon, who is the member in charge of the Bill, to satisfy Rule 9.7.8B of the Parliament’s Standing Orders. It does not form part of the Bill and has not been endorsed by the Parliament.
COSTS ON THE SCOTTISH ADMINISTRATION

63. The costs associated with this Bill and the implementation of the pilots are modest in the context of current NHS spending in Scotland of over £10bn per annum. These costs are based on 60% turnout; using the STV voting system; using an all postal ballot and are based on pilots which cover 20% of the electorate of Scotland. The costs provided are a best estimate based on studies of postal ballots conducted by the Electoral Commission and experience of postal ballots for Scotland’s National Parks Authorities. There are a number of variables which would cause the costs to fluctuate if they were adjusted. Precisely specifying the margins of such fluctuations would not be particularly productive. However it is reasonable to presume that an adjustment in any of the variables would result in a proportionate adjustment in the expected costs. For example, if the turnout is only 50%, the costs will be proportionately less because of reduced postage costs for the return of the postal ballots; if an STV system was not used then there would be a saving against the cost of hiring counting machines for the votes; and if a traditional ballot box were used then there would be a corresponding saving compared with postage for an all postal ballot.

64. The total electorate in Scotland is around 3.87m. On the basis of 20% coverage of the electorate in the 2 pilot areas this would equate to around 775,000 electors. The average cost per vote cast in all postal ballots (not using STV) is around £2.60. This is an average figure based on a number of evaluation studies of all postal ballots conducted by the Electoral Commission and takes account of the costs associated with non returned ballot papers. If we assume a 60% turnout in the pilot elections this would give an estimated cost of: 464,000 (60% of electorate) x £2.60 = £1.21 million. To this “baseline figure” would need to be added the costs of hiring the machines to count the votes in the STV system. The cost of the machines is very broadly dependent on the size of the electorate. The costs that follow are based on pilots in medium sized health board areas ie with an electorate of around 200-250,000. The estimated cost for hiring machines for 2 pilot areas would be around £450,000 x 2 = £0.90 million. The estimated cost of pilot elections to Health Boards in 2 pilot areas, using STV with a 60% turn out would be £1.21 million + £0.90 million = €2.11 million.

65. This cost (£2.11 million) does not include:
   - the remuneration costs of elected members;
   - the cost of the evaluation study;
   - any possible costs arising from extending the franchise;
   - the costs associated with implementing a system of personal identifiers in the event that an all postal vote is used; or
   - any possible costs which we may wish to incur in providing advance information and advice for the public in the 2 pilot areas.

66. The costs associated with remunerating the elected members are based on the expectation that for the 2 pilot areas there would be around 20 elected members. These members would be remunerated at the current rate (around £7,500 pa). The cost would be 20 x £7,500 = £0.15 million pa – over 2 years for the pilots £0.30 million. However this would be offset by a reduction in the number of lay members on each Board although, as a result of the introduction
of elected members onto the Health Board, there may be an increase in size and a rebalancing of representation on the Board. So the increase in remuneration costs will not be completely offset and the estimated total additional remuneration over 2 years is expected to be around £0.20 million. For each pilot area Board this will mean additional annual remuneration costs of around £50,000. The actual cost incurred will depend on the pilot areas chosen.

67. The estimated cost of the evaluation study will be around £0.25 million. This cost is broadly based on costs of similar work undertaken/commissioned by the Scottish Government in the recent past.

68. With regard to the costs of extending the franchise for the purpose of pilot elections we propose taking a simple administrative approach that would minimise changes to current electoral systems and processes. This would involve utilising the existing local authority franchise plus 16 and 17-year olds who are registered at the time of election.

69. Given that the pilot elections will be based on the existing electoral local authority register together with the desire to involve as many eligible voters as possible (including 16 and 17-year olds), we think it would be prudent to allow for some investment in public information/advice in the pilot areas. This would help to maximise registration of eligible voters and help to promote public understanding and support. This approach may also ultimately boost turnout and we would envisage targeting some of the resources to encourage 16 and 17-year olds to register and vote, e.g. through talks at 6th forms, targeted leafleting of sports or social clubs etc. This may amount to £0.15 million for each pilot area i.e. £0.30 million for 2 pilot areas. It is anticipated that this level of funding would allow for an advertising campaign in the local press and for the production and distribution of written information.

70. If conducting an all postal election, using a system of personal identifiers would mean significant additional investment to allow electoral registration officers to collect the appropriate information from all those eligible to vote in the pilot elections. Information provided by the Electoral Registration Committee of the Scottish Assessors Association indicates that implementing a system of personal identifiers would, on average, cost around £1 per registered elector. Assuming the 775,000 electors in the pilot areas, personal identifiers would add £775,000 to the cost of pilots. There would also be additional costs to support this exercise, including additional IT equipment and the costs for additional staff to undertake the work involved in administering the process.

71. The total costs of the pilots is likely to be met in 2010/11 and takes into account the factors set out above and is made up as follows:

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<thead>
<tr>
<th>Cost</th>
<th>Area of Investment</th>
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<tr>
<td>£1.21 million</td>
<td>“baseline” cost</td>
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<tr>
<td>£0.90 million</td>
<td>Counting machines</td>
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<tr>
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<td>Additional remuneration</td>
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<td>Evaluation study</td>
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<td>Marketing/Public info &amp; advice</td>
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If, following the evaluation of the pilots, Ministers bring forward to Parliament plans to roll out elections to all Health Boards then it is estimated that this will cost around £20.52m. This consists of, in part, the relatively fixed costs of holding elections: the baseline cost (£1.21m) and marketing costs (£0.30m) for the 20% electoral coverage in the 2 pilot areas multiplied up to 100% coverage i.e. £1.51 million x 5 = £7.55m (excluding the one-off pilot evaluation study). This cost will be met at each election to Health Boards. If roll out occurs using an all postal voting method there are also the costs associated with the collection of personal identifiers, which for full roll-out will be the 3.87m electorate multiplied by £1 = £3.87m plus additional IT and staffing resources. The remainder of the total estimated cost of £20.52m consists of the recurring costs to Boards: the additional remuneration costs (£50,000 per Board multiplied by the full 4-year term of an elected Board = £200,000 multiplied by all 14 Health Boards in Scotland = £2.8m) and the costs of counting machines incurred by all Boards (£450,000 multiplied by 14 = £6.3m). The estimated roll out costs are set out in the table below. The intention is that the costs will be met from existing budgets.

<table>
<thead>
<tr>
<th>Area of Investment</th>
<th>Pilot Cost</th>
<th>Factor*</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>“baseline” cost</td>
<td>£1.21m</td>
<td>5</td>
<td>£6.05m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£6.05m</td>
</tr>
<tr>
<td>Count machines</td>
<td>£0.45m</td>
<td>14</td>
<td>£6.30m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£6.30m</td>
</tr>
<tr>
<td>Add remuneration</td>
<td>£0.05m</td>
<td>14</td>
<td>£0.70m</td>
<td>£0.70</td>
<td>£0.70</td>
<td>£0.70</td>
<td>£2.80m</td>
</tr>
<tr>
<td>Marketing</td>
<td>£0.30m</td>
<td>5</td>
<td>£1.50m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£1.50m</td>
</tr>
<tr>
<td>Personal Identifiers</td>
<td>£0.775m</td>
<td>5</td>
<td>£3.87m</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>£3.87m</td>
</tr>
</tbody>
</table>

*either multiplied by 5 (to calculate 100% electorate coverage from 20% pilot coverage) or by 14 (costs incurred by every Health Board)

The Scottish Government has no plans at this time to use the power inserted by paragraph 1 of the schedule to the Bill to pay committees and sub-committees of Health Boards but regards this Bill as the right opportunity to make provision for such a power so that the issue can be looked at in light of the new structure of Boards. In the event of that resulting in subordinate legislation specifying that payments be made to any particular committee or sub-committee the Government will provide a full analysis of the costs arising.

**COSTS ON LOCAL AUTHORITIES**

There are no costs falling to local authorities.

**COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES**

There are no costs falling to other bodies, individuals and businesses.
This document relates to the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2 (SP Bill 13A)

HEALTH BOARDS (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL

SUPPLEMENTARY DELEGATED POWERS MEMORANDUM

1. This supplementary Memorandum has been prepared by the Scottish Government in accordance with Rule 9.7.10 of the Parliament’s Standing Orders to assist consideration by the Subordinate Legislation Committee in accordance with Rule 9.7.9. It explains changes to the powers to make subordinate legislation under the Health Boards (Membership and Elections)(Scotland) Bill resulting from amendments at Stage 2. This supplementary Memorandum should be read in conjunction with the original Delegated Powers Memorandum for the Bill.

AMENDMENTS TO DELEGATED POWERS

2. During the Stage 2 proceedings, Scottish Ministers modified some of the delegated powers that were introduced by the Bill. These changes are designed to give Parliament a greater role in scrutinising subordinate legislation made under the Bill and respond positively to the comments made in both the Subordinate Legislation Committee and Health and Sport Committee. This includes the provision for “Super Affirmative” procedure to apply to any future roll out order for Health Board elections.

3. There follows a description of the relevant changes to the sections of the Bill

Section 1(5) (constitution of Health Boards) – Power to specify further circumstances in which an elected member must vacate office

New paragraph 10A(2) of Schedule 1 to the 1978 Act

Power conferred on: Scottish Ministers
Power exercisable by: Regulations made by Statutory Instrument
Parliamentary procedure: Negative resolution procedure

Provision

4. New paragraph 10A(1A) of Schedule 1 to the 1978 Act, as inserted at Stage 2 by section 1(5) of the Bill, already excludes the holders of specified public office from holding office as elected Health Board members. Section 1(5) of the Bill also inserts a new paragraph 10A(2) into Schedule 1 to the 1978 Act to give the Scottish Ministers powers to make regulations that may specify further circumstances in which an elected member must vacate office before the end of the period that a member normally holds office for. As a result of a Stage 2 amendment, the
This document relates to the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2 (SP Bill 13A)

regulations may now, in particular, specify that an elected member is to vacate office on becoming the holder of a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose. This was always the policy intention and the amendment simply ensures that regulations can make such provision.

Reason for taking this power

5. It is considered appropriate to delegate the power to subordinate legislation because specifying the circumstances in which an elected member must vacate office may need amendment from time to time, for example to react to changes in other areas of the law dealing with circumstances which might indicate that a person is not fit to be a Health Board member (such as insolvency or an area of criminal law).

6. Paragraph 10A(2)(b) of the Bill as drafted provided that Scottish Ministers could specify circumstances in which they determined that an elected member should vacate office. However this power was removed from the Bill at Stage 2 so Ministers can no longer make regulations which give themselves discretion to remove an elected member from office.

Choice of procedure

7. The regulations will continue to be subject to negative resolution procedure. Statutory instruments made by virtue of Schedule 1 to the 1978 Act are normally subject to negative procedure in accordance with section 105(2) of the 1978 Act. Given that this is a power to be added to that Schedule, the Government consider that there should be no amendment to section 105 of the Act to make these regulations subject to affirmative resolution procedure. Further, there is no significant public interest, so affirmative procedure is not considered appropriate.

Section 2(2) (Health Board elections) – Powers to make “election regulations”

Paragraph 13 of new Schedule 1A to the 1978 Act

Power conferred on: Scottish Ministers
Power exercisable by: Regulations made by Statutory Instrument
Parliamentary procedure: Affirmative resolution procedure

Provision

8. Section 2(2) of the Bill inserts new Schedule 1A into the 1978 Act. This Schedule provides for Health Board elections. Paragraph 13 of Schedule 1A gives the Scottish Ministers powers to make regulations to be known as “election regulations” which can cover a range of things to do with Health Board elections.

9. As outlined in the original Delegated Powers Memorandum, this power can be used to make provision as specified in Schedule 1A. The substantive changes made to Schedule 1A at Stage 2 are as follows.

10. Paragraph 3(2)(c) of Schedule 1A now provides that if election regulations specify that a Health Board area is to be divided into more than one ward then the regulations must also specify the number of elected members to be elected in each ward. The Bill as drafted
This document relates to the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2 (SP Bill 13A)

(paragraph 6 of Schedule 1A) provided that the election regulations had to specify the number of elected members to be elected in each electoral ward. Separate regulations also had to specify the total number of members of each Health Board and the number of each type of member (new paragraph 2(2) of Schedule 1 to the 1978 Act). The default position in the Bill is that Health Board areas will normally comprise a single ward. Therefore this had the effect of obliging 2 sets of regulations to specify the same figure. New paragraph 3(2)(c) of Schedule 1A avoids this duplication. There is no substantive effect on the proposals of the Bill.

11. Paragraph 4(1) of Schedule 1A now provides that election regulations may specify who is to be appointed as returning officer for each ward. The Bill as drafted provided that each Health Board would appoint an individual as the returning officer. The policy intention is that the returning officer responsible for conducting a Health Board election is to be the returning officer responsible for elections of councillors for the most populous local government area in the Health Board area. This is reflected in the draft election regulations that were circulated to the Committees before Stage 1. It is not therefore the intention that the Health Board determine who should be appointed as a returning officer; rather a specific person is to be appointed as set out in election regulations.

12. Following a Stage 2 amendment, Paragraph 8(4) of Schedule 1A now provides that if election regulations provide for votes in a Health Board election to be cast only by post, the regulations must also provide for a system of personal identifiers to be used. If a traditional ballot is used (e.g. a mixture of ballot box and postal ballot) then personal identifiers are not required.

13. Paragraph 9(2) provides that election regulations may make provision about who is qualified to be candidate in a Health Board election and about the circumstances in which an individual may be disqualified from being a candidate. This power was amended at Stage 2 to ensure that regulations may, in particular, disqualify from being a candidate an individual holding a restricted post set out in a list maintained by the Health Board concerned for that purpose. It has always been the policy intention to make the Health Boards responsible for establishing and maintaining their own list of restricted posts. This is reflected in the draft election regulations that were circulated to the Committees before Stage 1. The amendment therefore is of no substantive effect but ensures that election regulations can make such provision.

Choice of procedure

14. Statutory instruments made by virtue of Schedule 1 to the 1978 Act are normally subject to negative procedure in accordance with section 105(2) of the 1978 Act. However given that the election regulations concern matters of substance, the Government consider that the election regulations should be subject to affirmative resolution procedure. This is provided for by new section 105(2A) of the 1978 Act as inserted by section 2(1A) of the Bill at Stage 2.
Section 4 (elected members: pilot scheme) – Powers to make the “pilot order”

Power conferred on: Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: None; unless the pilot order (or order amending the pilot order) adds to, replaces or omits any part of the text of sections 1 to 3, or an order revokes the pilot order, in which case Affirmative Resolution Procedure

Provision

15. Section 4 of the Bill provides that the Scottish Ministers may by pilot order appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order. Subsection (2) provides that Ministers may make one pilot order only (but this does not affect the Ministers’ power to modify or revoke the order). Subsection (3) provides that the pilot order may bring sections 1 to 3 into force with such modifications as Ministers consider appropriate. These provisions were in the Bill as drafted; the only change at Stage 2 is in relation to the choice of procedure described below.

Choice of procedure

16. If Parliament passes the Bill, it will have agreed that the changes to Health Boards set out in sections 1 to 3 are to be piloted in certain areas (as it will have agreed to section 4 of the Bill). The decision as to when to commence the pilot scheme is a matter of commencement of the Act passed by the Parliament and is something which is conventionally considered to be a matter for the Government.

17. However the Government recognises that the power to modify goes further than a normal commencement order so if the pilot order contains any textual amendment to sections 1 to 3 of the Bill, it will be subject to affirmative procedure. The Government also agrees that any decision to revoke the pilot order should be subject to affirmative procedure since it would be a significant step to reverse the implementation of the election arrangements.

Section 7(1) (roll-out) – Powers to make a “roll-out order”

Power conferred on: Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: “Super affirmative” resolution procedure

Provision

18. Section 7(1) of the Bill gives the Scottish Ministers power to make a roll-out order to appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order. When a roll-out order is first made it has the effect of repealing section 6 of the Bill (see subsection (2)). Subsection (3) provides that a statutory instrument containing a roll-out order may not be made unless a report has been published under section 5(1) and a draft of the roll-out order has been laid before, and approved by a resolution of, the Scottish Parliament.
This document relates to the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2 (SP Bill 13A)

19. It should be noted that, following Stage 2 amendment, if a question of whether to resolve to approve a draft roll-out order is put to a meeting of the Scottish Parliament but is not agreed by the Parliament then on the day after the question is put, sections 1 to 7 and paragraph 2 of the schedule (ie the substantive provisions of the Bill relating to Health Board elections) are repealed (new section 6(2)(b) of the Bill inserted at Stage 2).

20. A Stage 2 amendment inserted section 7(3A) into the Bill. It provides that, before the draft roll-out order can be laid, Ministers must lay before Parliament a copy of the proposed draft roll-out order and their reasons for making it (section 7(3A)(a)). Ministers must also publicise the proposed draft roll-out order (section 7(3A)(b)) and consider and respond to any representations or Parliamentary report or resolution when laying the draft roll-out order before Parliament for affirmative approval (sections 7(3A)(c) and (3B)(a). Where the draft roll-out order includes material changes to the proposed draft roll-out order, Ministers must also lay a statement giving details of the proposed revisions and reasons for making the changes (section 7(3B)(b)).

Reason for taking this power

21. As with the pilot order it is important to have a degree of flexibility in specifying when the provisions of the Bill come into force in respect of each Health Board. Commencement by order delivers that flexibility.

Choice of procedure

22. Again, a roll-out order is essentially a commencement order which will commence the substantive elements of the Bill in respect of the areas where they were not commenced by the pilot order. In accordance with convention it ought to be subject to no parliamentary procedure given that Parliament will, by passing the Bill, have agreed to the concept of the substantive elements of the Bill being rolled-out following an evaluation report being published. However the Government considers an order made under this section to be an exceptional kind of commencement order because of the clear intention to pilot and evaluate Health Board elections before deciding to adopt them across Scotland and because a roll-out order may do more than merely commence provisions of the Bill.

23. When the first roll-out order is made it will have the effect of repealing section 6 and therefore nullifying the self-repealing provision in that section which ensures that any decision on roll-out has to be taken within a time limit. Clearly Parliament, if it passes the Bill, will also have agreed to that self-repealing time-limit. The Government therefore considers it appropriate to attach Parliamentary procedure to any order which rolls out the substantive provisions of the Bill to more areas whilst also overriding and eradicating the self-repealing time limit.

24. A roll-out order may make provision adding to, replacing or omitting any part of the text of, or otherwise modifying, any enactment as Ministers consider appropriate (section 7(4)). This power may be used to make technical adjustments to ensure the smooth transition from the pilot schemes (for example, so as to ensure that all areas are put onto the same electoral cycle it may be necessary to deem the next elections held in the pilot areas to be the first elections in terms of paragraph 2 of new Schedule 1A to the 1978 Act). However it may also be used to make more substantive changes in consequence of findings of the evaluation report. In light of these unique...
issues, the Government considers it appropriate for such an order to attract an exceptional parliamentary procedure. So despite roll-out orders being primarily about commencement they will be subject to additional procedures to ensure that anything done in such an order is brought to the attention of the Parliament and so should allow thorough scrutiny of policies and proposals in moving to any roll-out of elections.
Further to my evidence to the Committee at Stage 2 of the Health Boards (Membership and Elections) (Scotland) Bill, I wish to outline the approach that I intend to take in delivering non-statutory alternative pilots in addition to direct elections pilots.

The alternative pilot arrangements I outline in this letter will address a number of the suggestions made by Members during the passage of the Bill thus far and in the consultation that we carried out before the Bill was introduced. I propose to run two additional pilots: one in each of two Health Boards. These would involve a mix of the following approaches:

- strengthening the role of Public Partnership Forums by appointing at least one of their members to the local Health Board (N.B. many Health Boards have more than one PPF operating within their boundaries);

- reducing the number of Executive members on a Board to five (Boards currently have up to 10) and increasing the number of non-executive members. This is intended to give a clear majority to non-executive and councillor members;

- enhancing the public appointments process in the pilot area to increase the diversity around the Board table.

These changes represent a major change in the shape of a Board, with a clear emphasis on strengthening the existing structures to ensure the views of local communities, patients and public are heard. I have included more detail of the proposals in the Annex to this letter.
I intend to involve our stakeholders as active partners in developing these proposals further and I would be very happy to involve the Health and Sport Committee, and the spokespersons in the opposition parties, in the process, too. If the Bill becomes law, I would foresee development of proposals during the six to eight month period when the preparatory work for the election pilots will also be taking place.

These non-statutory pilot schemes would run concurrently with direct elections pilots and would be assessed in the same independent process that assesses the impact of direct elections. This would enable the impact of the alternative approach to be compared and contrasted with that of direct elections.

I hope this is helpful and would welcome any discussion in advance of Stage 3.

NICOLA STURGEON

Best Lines

NICOLA STURGEON
Annex

HEALTH BOARDS (MEMBERSHIP AND ELECTIONS) (SCOTLAND) BILL
ALTERNATE PILOT MODELS

Proposal 1: Enhancing the Role of Public Partnership Forums

Background

Community Health Partnerships have been established by NHS Boards as the key mechanism through which all primary and community based services are planned and delivered. They are driven by a focus on jointly agreed service improvements for local people working as part of a decentralised but integrated health and social care system. They provide an opportunity for partners to work together to improve the lives of the local communities which they serve by being aligned with Local Authority boundaries.

In 2007, the role of CHPs was reaffirmed in Better Health, Better Care. CHPs would increasingly be expected to work with their Local Authority and other partners to shift the balance of care; focusing more on health improvement and more continuous care in the community as well as achieving reductions in health inequalities. A key role of CHPs is actively involving the public, patients and carers in CHP decision making through Public Partnership Forums.

In order to devolve functions and resources from the Health Board to a CHP, CHPs must be established as committees or sub-committees of a Board.

Public Partnership Forums are made up of individuals, members of the public, patients, carers, local community groups and voluntary organisations. Participants do not need to be a member of an existing group and can take part as much or as little as they like.

PPFs are the main structure by which the CHPs link with the people of the communities that they serve, so that there is a meaningful and continuing dialogue with local people. The role of the Public Partnership Forums are to:

- Inform local people about the range and location of services and information for which the CHP is responsible
- Involve local users of service, carers and the public in discussion about how to improve local health services
- Support wider public involvement in planning and decision-making about services that are delivered locally.

Current Position

CHP committees are normally chaired by Non Executive Directors of NHS Boards who are accountable to NHS Board Chairmen. In many cases, the Local Authority member of the Board chairs his/her local CHP committee. The views and perspectives of professionals, staff, partners and the public are built into the committee arrangements of each CHP through regulations.
The views and experiences of the public and patients at CHP level are currently addressed through the work of local Public Partnership Forums and other community engagement mechanisms. At least one member of each PPF must be a member of the CHP committee with equal voting rights to all other members of the CHP committee.

Proposal

In essence, this would mean that at least one nominee from each PPF in the Health Board area would be appointed to the Board. To ensure the Health Board remains a manageable size, there would also be a reduction in the numbers of executive Board members and/or other appointed Board members in order to accommodate additional PPF members.

Effect

This would provide representation on a Health Board from service users. During the formulation of Better Health, Better Care, much was made of the benefits of involving patients and communities in the formulation of plans and service delivery. By placing PPF members on each Health Board, the Government would give practical effect to the proposals set out in BHBC. It would also provide for a direct line of engagement from the communities represented by the PPF, through the CHP and up to Health Board level.

Costs

There would be no additional cost to Boards.

Proposal 2: Limit Numbers of Executive Members

Background

An issue that has arisen in consultation and through the Committee stages in Parliament has been the position of executive members on Health Boards.

While the presence of an executive team on a Board of a private company is standard, some have drawn a comparison with Local Authorities, where only elected members are entitled to vote. Executives attend in an advisory capacity only. Currently, the number of executive members on NHS Boards and eligible to vote varies can be as many as 10.

While the role of the Executive members is to bring professional expertise to the Board table, it is not unfeasible that those executive directors who are not full 'voting members' could take on a role that is more akin to the executive team in a Local Authority.

Proposal

The number of Executive Directors appointed to a Board would be limited to five, with the mix of the executive team being left to the decision of the local Board. I would envisage this would involve the Chief Executive along with the Directors of Finance, Public Health, Nursing and the Medical Director. The numbers of non-executive members would increase accordingly.

In addition, Scottish Ministers would continue to appoint the Employee Director to the Board to represent the staff side.
Effect

This would address an issue that has arisen during the work on the Bill around the numbers and influence of Executive Board members. In doing so, it would continue to protect the valuable accountability and governance structures within Health Boards.

Costs

There would be no additional cost to Boards.

Proposal 3: Review of the Appointments Process

Background

The existing process of appointing Health Board members has come in for criticism. While improvements have been made in the age distribution of appointees in the public sector over recent years, there remains a perception that the appointments process favours professionals and therefore does not appear attainable for other groups in the community.

While changing the way in which appointment opportunities are advertised and trying to appeal to a broader audience would be useful, there would also have to be extensive support mechanisms in place to support the appointment of new members from the community, some of whom may not have experience of operating in the environment of a Board. Again, there have been advances made recently with the “On Board” scheme and the independent training offered by CIPFA. However, to ensure that any new appointees would be able to make an impact on the operation of the Health Board, additional training and development opportunities would be required.

Proposal

The Health and Wellbeing Public Appointments Unit would work closely with the Office of the Commissioner for Public Appointments in Scotland (OCPAS) to modify the way in which non-executive Board opportunities are advertised in the pilot areas. This would include looking at different strategies in line with the OCPAS publication Diversity Delivers to attract a more diverse range of applicants from local communities and engage with them to support them through the application process. Similarly, once the appointment takes place, arrangements would be put in place to deliver enhanced support for new non-executive Board members. This would be achieved through greater liaison with CIPFA and other bodies, such as the voluntary sector, to ensure that new members are able to operate confidently at Board level. In this regard, the initiatives which form the NHS Scotland “Board Effectiveness Project” (e.g. national/local induction and Committee specific training/development opportunities) will provide the required support for new members.

Effect

This would seek to open up the public appointments process to individuals and groups who would not normally consider themselves for a non-executive post on a Board. In doing so, it would ensure a more diverse Board with a greater range of backgrounds, which would also be able to enhance the discussion and decision making process of a Health Board.
Costs

There would be some moderate additional cost as we seek to use the best medium by which to target different groups in communities and there would also be some moderate cost in securing enhanced training for new non-executive directors.
SUBORDINATE LEGISLATION COMMITTEE

EXTRACT FROM THE MINUTES

8th Meeting, 2009 (Session 3)

Tuesday 3 March 2009

Present:

Bob Doris  Helen Eadie
Tom McCabe  Ian McKee (Deputy Convener)
Jamie Stone (Convener)

Apologies were received from Jackson Carlaw, Malcolm Chisholm.

**Health Boards (Membership and Elections) (Scotland) Bill:** The Committee consider the delegated powers provisions in this Bill after Stage 2, and agreed to write to the Scottish Government for further clarification before agreeing the terms of its report. It was further agreed that the clerks should draft an amendment in relation to section 7(1) for members consideration.
14:15

The Convener: I will have to take this step by step because there is a lot in front of us today. We are considering the supplementary delegated powers memorandum provided by the Scottish Government following amendments made to the bill during stage 2. Under rule 9.7.9 of standing orders, we report on new or substantially altered delegated powers provisions following stage 2 consideration. Members might wish to note that the stage 3 debate on the bill will be held on 12 March, and that the deadline for lodging amendments is Friday 6 March, which is nearly upon us, so there is not a lot of time.

Sections 1(5) and 1(6) confer powers to specify the circumstances in which elected, appointed or councillor members must vacate office. Are we content that the delegated powers contained in sections 1(5) and 1(6) of the bill, as amended, are acceptable in principle, and that they are subject to negative procedure?

Helen Eadie (Dunfermline East) (Lab): No, convener, I am not content with that. This is one example of a power that is so significant that it should be subject to affirmative procedure. The issue has been debated here and in the Health and Sport Committee. It is unheard of for any minister to remove any elected member from any position in Scotland. If that were to be allowed in any particular case, the Parliament would want to take a view on it, and not simply allow a Government minister to do it by negative resolution. I hope that we can lodge a stage 3 amendment to that effect.

The Convener: Is your point about elected members? They are not hit by the provision, are they?

Ian McKee (Lothians) (SNP): My understanding is that the cabinet secretary yielded to the good arguments that we made at previous meetings and took elected members out of the equation, so we are really just talking about the ability to remove people whom the cabinet secretary has appointed in the first place. It seems reasonable that the cabinet secretary who appoints can dis-appoint.

Helen Eadie: Your point is reasonable, but paragraph 3 on page 3 of our legal brief does not make that clear. That is why I have raised the point today. The legal brief says that the issue could be controversial, and it is. I agree with Ian McKee; I thought that the minister had yielded the
point at the Health and Sport Committee debate when we had that discussion. Paragraph 3 of page 3 of the legal brief says:

“For example, such a circumstance might be that Ministers consider that the member is not acting in the best interests of the NHS, so should be removed. The Committee might consider in relation to that flexibility, whether this can be justifiable, given that paragraph 2, Schedule 1 of the 1978 Act (as amended by section 1(2) of the Bill) provides that appointed members are appointed by Scottish Ministers, and councillor members are also appointed by Ministers, but following nomination by local authorities in the area of the Health Board.”

The way I read that, it seems to apply to elected members as well. If I have made a mistake, I apologise to the committee for taking up time.

The Convener: No, that is all right.

I read that paragraph as mentioning two categories. The beginning of the paragraph mentions “appointed and councillor members”. Those councillor members are chosen by their peers.

Tom McCabe (Hamilton South) (Lab): Is the distinction not that there will be people who are directly elected to the board, and other people, who have been elected to councils, who will be appointed by the minister to the health board? If the minister has taken care of the concern about the directly elected members, that is a good thing.

The Convener: That is how I read it.

Tom McCabe: Okay, but however the council-elected member, if I can call them that, gets on to the health board—I acknowledge that the minister appoints them—it would set quite a precedent if someone who has been democratically elected could then be removed from their position on the health board by a minister. That is quite a big decision to take. The minister might feel that there were good reasons for it, but, at the very least, there could be political reasons. Surely a safeguard would be that any intention to do that should be subject to affirmative rather than negative resolution. It would just be a safeguard, because taking that action is quite a big step.

Removing a health board member might be 100 per cent justified but, as we all know because of our experience, many people would claim different because it would become politics. It would be a politician who was being removed and the politician might not be of the same political hue as the minister.

Ian McKee: I can see Tom McCabe’s point that those people are elected to a council and then chosen by the council to be on the health board, but the fact remains that they will be appointed to the health board by the minister. If the minister appoints someone, they should be able to remove them. Presumably, as the decision to appoint a

health board member is not subject to affirmative resolution, the minister could choose right at the beginning not to appoint someone. The minister could say that they did not like the person. There would be political repercussions but, technically, if the minister appoints, then it is a ministerial appointment.

Helen Eadie: That is a reasonable argument, but it falls down because, if a minister has confidence in their decision they should not be afraid of the Parliament affirming that decision or otherwise. I still believe that the provision should be subject to affirmative rather than negative procedure. The minister might have good reason to remove someone from a health board, and Parliament might agree with it, but I still feel that affirmative procedure is right in this case.

Tom McCabe: Ian McKee makes a good point there. Surely if the minister has the power to appoint someone, they should have the power to deregister the same individual.

The fact remains that, the minute the minister appoints, the issue moves into the political arena to some degree, because they have appointed an existing politician. That brings consequences with it. Reversing that decision could be seen in different lights. It could be alleged that it is being done for the wrong reasons. It could be alleged that a view that that person had expressed or the approach that they had taken on the health board had been tainted by politics rather than being an objective assessment of the issues. So the decision to appoint in the first place brings consequences. We should not take the power away from the minister, but the minister should be required to explain any subsequent decision to Parliament in more detail.

Bob Doris (Glasgow) (SNP): I am not convinced. I take on board what Helen Eadie said about the minister being confident about why they were removing someone whom they had appointed from the health board, so why not require affirmative procedure. However, by that logic, we would require affirmative procedure for everything that Government does. We would say that the Government should be confident of what it was doing, so everything should be put through under affirmative procedure. So I am not totally convinced. It is in effect a power of patronage for the minister to appoint in the first place, so the same functions exist in terms of relieving that person of their post.

I also take on board what Tom McCabe said about the politicisation of dismissal, but when the Government goes to Parliament under affirmative procedure, Parliament is full of a variety of politicians and politics can surely be played on both sides of the fence. I do not think that that is a reason to use affirmative procedure. The health
board members in question might be elected councillors, but they are appointed to the health board, not directly elected to it, so I am not convinced that the power to remove them being subject to affirmative procedure would be the best way to go.

**Helen Eadie:** The Cabinet Secretary for Health and Wellbeing has acknowledged that it would be controversial if an elected representative were removed from any board. Usually, a member would be removed only in criminal circumstances or in the other circumstances that are outlined in our papers for this meeting.

All of us in the Parliament have scars caused by the mood of the public. People want their elected representatives, irrespective of how they reached their position, to be able to speak freely at meetings and not to feel under any kind of cosh. That is why I stick to my point and would be willing to press it to a vote. Affirmative procedure should be used in these cases. No work that the Parliament has done in recent years has been more important than this particular bill. It has galvanised public opinion; people feel very strongly about it.

**Tom McCabe:** I want to make it clear that such instances would be rare, and that in the vast majority of them the minister would take an objective decision. Once a minister has taken a decision, and if Parliament chooses to consider it, we have to be confident that even a Parliament made up of different politicians would be able to be objective. We need to be confident that, when the issue is serious enough, the Parliament can be equally objective.

From my experience of being a minister, I think that ministers will be objective. We need to be confident that, when the issue is serious enough, the Parliament can be equally objective.

**Ian McKee:** I totally accept that the minister, from whichever party they came, would be objective. However, there will be circumstances—if this ministerial power were ever used—in which it would not be in the interests of the individual or of society for the issue to be debated in Parliament, as it would be under the affirmative procedure. We should take that into account. For example, the individual’s health may have to be discussed.

**The Convener:** As I said earlier, the deadline for lodging amendments is Friday. We have had a good debate, and it will appear in the *Official Report*. I would rather not go to a division on this question, unless we absolutely have to. If Helen Eadie wishes, she could pursue the issue herself. She would be quite within her rights to do so.

What is being proposed is not hugely different from what has happened in the past. Helen, if we were to report to the lead committee and to Parliament, making it clear that two different points of view arose in the committee—yours and Ian McKee’s—would that be sufficient for you?

**Helen Eadie:** Yes.

**The Convener:** Would that be all right with the clerks?

**Shelagh McKinlay (Clerk):** Yes.

**The Convener:** I undertake to ensure that our difference of opinion is flagged up. In our report, we should give our colleagues a steer to look at the *Official Report* of today’s meeting, which will give the full flavour of our views.

**Members indicated agreement.**

**The Convener:** All right, let us move on.

Are members content that section 2(1A) of the bill, which inserts section 105(2A) into the National Health Service (Scotland) Act 1978—to provide that election regulations shall be subject to affirmative procedure—is acceptable?

**Members indicated agreement.**

**The Convener:** An additional provision in section 2(2) of the bill will insert schedule 1A to the 1978 act. Paragraph 3(2) of that schedule will provide that, if election regulations specify a division of a health board area into more than one ward, the regulations must also specify the number of elected members to be elected in each electoral ward. Is that acceptable?

**Members indicated agreement.**

**The Convener:** Committee members can imagine that that issue is of some interest to me. Where I come from is part of a very large health board area.

Section 2(2) of the bill will also insert paragraph 4(1) of schedule 1A to the 1978 act. That will provide that election regulations must appoint an individual as the returning officer for each ward in which a board election is to be held. Is that acceptable?

**Members indicated agreement.**

14:30

**The Convener:** Amended provisions in section 2(2) of the bill will insert paragraphs 7 and 8(1) of schedule 1A to the 1978 act, in relation to election regulations. Is that acceptable?

**Members indicated agreement.**

**The Convener:** Those changes only clarify the drafting.

An additional provision in section 2(2) inserts paragraph 8(4) of schedule 1A to the 1978 act. If
election regulations provide for votes in a health board election to be cast only by post, the regulations must also provide for a system of personal identifiers to be used. If a traditional ballot is used—that is, a mixture of ballot box and postal ballot—then personal identifiers will not be required. Is that acceptable?

Members indicated agreement.

The Convener: An additional provision in section 2(2) of the bill will insert paragraph 9(2) of schedule 1A to the 1978 act. It will provide that election regulations may disqualify from being a candidate an individual who holds a post that is on a list of restricted posts. The list will be maintained by the health board concerned for that purpose. Is that acceptable?

Members indicated agreement.

The Convener: That is rather similar to what has happened in local government for many years.

In section 4, “Pilot scheme”, amendments made to subsection (4) will amend the procedures in connection with a pilot order. Are members content to welcome the fact that the Government has amended section 4 of the bill in response to comments and recommendations made by this committee at stage 1?

Members indicated agreement.

The Convener: We have achieved a bit of a result there, and I think that we can put ourselves gently on the back, if MSPs are allowed to do that.

Section 6, “Termination of pilot scheme”, is where things get a bit more complicated. We discussed the issue at quite some length at stage 1. I will ask committee members whether they are content to draw two particular points to the attention of the lead committee and the Parliament.

The first concerns section 6(2) of the bill. Section 6(2) provides for the automatic repeal of sections 1 to 7 and paragraph 2 of the schedule if the pilot order is revoked, or on the day after the Parliament fails to resolve to approve a draft roll-out order. However, section 6 does not provide for the revocation of the pilot order in the event that the Parliament fails to approve a draft roll-out order—although it appears that that must be the effect of the repeal of sections 1 to 7. Do we agree to draw that point to the attention of the lead committee and the Parliament?

Members indicated agreement.

The Convener: The second point is this. If Parliament were to fail to approve a draft roll-out order, the bill does not appear to provide that, or make clear whether, on the automatic repeal of sections 1 to 7, the Scottish ministers are permitted any delegated powers to make any further or consequential provisions that might be needed in regard to the pilot area arrangements. This is given that such arrangements for elections, or the reorganisation of the membership of health boards, may have been implemented up to the date of any rejection of a roll-out order, by virtue of the pilot order. That assumes that such powers are sought, or may require to be taken, by the Scottish ministers in those circumstances, which is a matter to be considered by the Government. Do we agree to draw that point, too, to the attention of the lead committee and the Parliament?

Members indicated agreement.

The Convener: We have to go through such issues at length, for the purposes of the record. Our clerks will also bring those matters directly to the attention of the Scottish Government, given the very tight timescales involved.

Section 7(1) of the bill is on powers to make a “roll-out order”. A roll-out order in terms of section 7 of the bill shall be subject to the prescribed form of super-affirmative procedure—which has been described as “affirmative procedure with knobs on”. Is that acceptable?

Members indicated agreement.

The Convener: On section 7(3A)(c), do we agree to ask the Government to explain urgently—after all, it is 3 March today and we need the response in sufficient time to meet the deadline for stage 3 amendments—why the period of 60 calendar days that is specified for Parliament and committee consideration of a proposed draft roll-out order does not exclude any days during which the Parliament is dissolved or in recess? We are putting the question because the effect may be to give an insufficient period for parliamentary consideration of a proposed draft roll-out order after it is laid.

Ian McKee: I can see why the period does not exclude any days during which the Parliament is dissolved or in recess. Under certain circumstances, particularly if the order is laid just before the summer recess, the risk is that an inordinate length of time would be added to the passage of the legislation. We ought to take account of that before putting the question to the Government.

Helen Eadie: The difficulty in which we find ourselves is that this is the last meeting at which we can consider the Government’s response to any request for further information. We should have a fall-back position. I suggest that that takes the form of a stage 3 amendment. If we receive a reassurance from the Government that makes everyone round the table happy, we can withdraw the amendment on the day. I propose that we proceed on that basis.
**Tom McCabe:** I agree with that. It is obvious why the Government has done that. That said, the fact that recess days are not included hampers the Parliament’s ability to input to legislation. A contradiction is involved and it needs to be fixed, one way or another. As we have discussed, the 60-day period gives the Parliament the ability to input to legislation. However, if an instrument is laid immediately before the Parliament’s summer recess, the 60-day period elapses before we resume. I can see why the Government is trying to avoid having a time period that goes on for ever, but there is a contradiction and it should be fixed.

**Helen Eadie:** The restriction will apply, no matter which Government is in power.

**The Convener:** Today is 3 March. If we were to write to the Government tomorrow, we should receive a swift response. Depending on the response, are members content to leave it to me as convener to decide whether to lodge a stage 3 amendment?

**Helen Eadie:** Yes.

**Tom McCabe:** Yes.

**Ian McKee:** What is the wording of the amendment that you would lodge if the Government response is not satisfactory, convener?

**The Convener:** I would want to think about that. As Tom McCabe and Helen Eadie have said, we should have an amendment in our back pocket for use if necessary. I think that the response will be along the lines that Dr McKee suggests. That said, even if just to be tidy, we should have an amendment in hand.

**Ian McKee:** Confident though I am in your impartiality, skills and intelligence, convener, I am slightly reluctant to back anyone in lodging an amendment that I have not seen.

**The Convener:** If you turn to page 16 of the legal brief, you will see the proposed wording of the amendment.

**Ian McKee:** I have read it, but surely it needs to be in the *Official Report*.

**The Convener:** Absolutely. There is no problem in ensuring that. The amendment, which would be in my name, proposes to amend section 7(3A)(c), on page 8, line 25, by adding at the end:

“(no account being taken of any time during which the Scottish Parliament is dissolved or is in recess).”

**Ian McKee:** That is using a sledgehammer to crack a nut. We are concerned about legislation that might be introduced just before the summer recess. The amendment is more general than it needs to be.

**Bob Doris:** Perhaps we could be more specific. The time bar could apply to a period just before the summer recess. For example, we could say that the Government could not lay an instrument in the week before the recess.

**The Convener:** The clerk has said that an amendment could be drafted to take on board that point. Obviously, I would not move an amendment in the chamber without you guys having seen it and without you being happy with it.

**Helen Eadie:** Bob Doris’s point is a good one. People get a bad taste in their mouths when legislation is introduced right on the cusp of a recess and parliamentarians are not given the opportunity to express a view that reflects public opinion. Perhaps the clerks can draft a revised amendment and circulate it to members for agreement. Once that is done, the amendment can be lodged.

**The Convener:** Helen Eadie made the point clearly. If we all coalesce on what she said, would that be acceptable guidance for the clerks?

**Shelagh McKinlay:** We have no problem in drafting an amendment for members to consider informally.

**The Convener:** Have you got the steer that you need from us?

**Shelagh McKinlay:** Yes.

**Ian McKee:** Is there any precedent for lodging such amendments?

**The Convener:** There are precedents. I think that we did something similar about a year ago.

**Judith Morrison (Legal Adviser):** We lodged an amendment during stage 3 of the Glasgow Commonwealth Games Bill.

**The Convener:** That is right.

**Ian McKee:** Was there a similar process?

**The Convener:** Yes.

**Helen Eadie:** On that occasion, did you not seek leave to withdraw the amendment, convener?

**The Convener:** I did, but only with the consent of committee members. As members might recollect, I was hurtling around the chamber to seek your agreement before I did that.

**Helen Eadie:** That is right. I remember that.

**Bob Doris:** First, I would like to see the reassurance that the Government gives us. In proposing the wording “one week”, my intention was for the wording to be less open-ended than that of the proposed draft amendment.
The Convener: I suggest that we write to the Government along the lines that I have set out and that we do that as quickly as is humanly possible. Depending on the reply, I further propose that the clerks frame an amendment—I hope that I am being clear—that is not as blunt as the amendment in our legal brief but will take account of our concern about the long summer recess and undue delay. I will leave the actual wording to the wordsmiths.

Tom McCabe: I suggest that we go for a two-week window before the summer recess. If an instrument is laid before any other recess, two weeks are lost in any case. If we were to suggest such a restriction, the effect would be the same for all recesses—with the exception of the February recess, which is only one week.

The Convener: I have no intention of standing up in the chamber and speaking to an amendment for the glory of the moment or just to annoy the Government. I am not volunteering to do this for fun. I hope that we do not have to lodge an amendment, but if we come to that moment of truth, I would not be happy to stand up and speak to the amendment unless I had pretty much the unanimous support of the committee. If a section of the committee is deeply unhappy with the idea, it will not fly.

Helen Eadie: Members on both sides of the argument acknowledge the problem and agree that something needs to be done. As Bob Doris said, the Government’s response will be helpful in any solution. Perhaps its observation will solve the problem, but we should have a back-stop nonetheless.

The Convener: Are members content with that?

Members indicated agreement.

The Convener: I thought that there were two further questions for the committee, but I have put them. We have got ahead of ourselves. Is that not clever?
Subordinate Legislation Committee

17th Report, 2009 (Session 3)

Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2

Published by the Scottish Parliament on 11 March 2009
Subordinate Legislation Committee

Remit and membership

Remit:

1. The remit of the Subordinate Legislation Committee is to consider and report on-

   (a) any-

      (i) subordinate legislation laid before the Parliament;

      (ii) Scottish Statutory Instrument not laid before the Parliament but classified as general according to its subject matter,

   and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

   (c) general questions relating to powers to make subordinate legislation; and

   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

   (Standing Orders of the Scottish Parliament, Rule 6.11)

Membership:

Jackson Carlaw
Malcolm Chisholm
Bob Doris
Helen Eadie
Tom McCabe
Ian McKee (Deputy Convener)
Jamie Stone (Convener)
Committee Clerking Team:

Clerk to the Committee
Shelagh McKinlay

Assistant Clerk
Jake Thomas
The Committee reports to the Parliament as follows—

1. At its meetings on 3 and 10 March the Subordinate Legislation Committee considered the delegated powers provisions in the Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2. The Committee submits this report to the Parliament under Rule 9.7.9 of Standing Orders.

2. The Scottish Government provided the Parliament with a supplementary memorandum on the delegated powers provisions in the Bill. The Committee’s correspondence with the Scottish Government is reproduced in the Annexe.

Delegated Powers Provisions

3. Generally, the Bill concerns the constitution and membership of Health Boards. It amends provisions on the membership of Health Boards contained in the National Health Service (Scotland) Act 1978 (“the 1978 Act”). It also provides for the election of certain members to Health Boards.

4. The Committee determined that it did not need to draw the attention of the Parliament to the delegated powers in sections 2 and 4 of the Bill. The Committee also welcomed the amendments to section 4, proposed by the Scottish Government, in response to comments and recommendations made by the Committee in its Report at Stage 1.

Section 1(5) and (6) (Constitution of Health Boards) – Power to specify the circumstances in which elected, appointed or councillor members must vacate office

5. At introduction, section 1(5) of Bill amended the 1978 Act to give Scottish Ministers a power to make regulations that could specify the circumstances in which-
(a) an elected member must vacate office before the end of the period that a member held office, and (b) the Scottish Ministers could determine that an elected member is to vacate office before the end of that period.

6. Section 1(6) of the Bill amended the 1978 Act to provide also that regulations could specify circumstances in which Scottish Ministers may determine that appointed and councillor members shall vacate office. Accordingly, at introduction the Bill provided that Scottish Ministers could determine when a member (elected, appointed or councillor) shall vacate office, and the circumstances in which this function could be prescribed by regulations.

7. The Committee noted the substantial changes to section 1(5) of the Bill following Stage 2 proceedings, such that regulations may only specify further circumstances in which an elected member must vacate office before the end of the period of appointment, (particularly that an elected member is to vacate office on becoming the holder of a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose). The Ministerial power to specify the circumstances in which an elected member is to vacate office has been removed – so the Bill no longer provides for Ministerial discretion on this matter.

8. Section 1(6) of the Bill however, which was not amended at Stage 2, still provides that regulations may specify circumstances in which Scottish Ministers may determine that appointed and councillor members are to vacate office (as well as circumstances in which they simply must vacate office). The Bill provides that the regulations under section 1(5) and 1(6) are subject to negative procedure.

9. Members discussed the delegated powers and the proposed negative procedure. Helen Eadie MSP and Tom McCabe MSP expressed concerns about the power under section 1(6), in so far as it applies to councillor members of Health Boards. Particularly, Mrs Eadie and Mr McCabe felt that a power which enables regulations to specify circumstances in which Ministers may determine that councillor members are to vacate office should be subject to affirmative procedure. However, Bob Doris MSP and Ian McKee MSP were content with the proposed negative procedure.

10. Following discussion, members agreed that the difference of opinion within the Committee on this matter should be noted in the Committee’s report and that the attention of the Parliament should be drawn to the views expressed in the Official Report of the meeting.

Section 6 (termination of pilot scheme)

11. Section 6 does not directly confer any powers to make subordinate legislation. However, this section relates to the consequences of both a pilot order and a roll-out order and consequently members felt that it would be helpful to draw the attention of the Parliament to this provision.

12. The Bill provides that the pilot order is (automatically) revoked on the day 7 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order, but Ministers have the power to revoke the order earlier.
13. If the pilot order is revoked before a roll-out order is made, or if (under the revised procedures for a roll-out order) a question of whether to approve a draft roll out order is put to the Parliament but not agreed, then either on the day the pilot order is revoked, or on the day after the question is put (as the case may be), in effect the whole substance of the Bill is repealed.

14. Because now by section 4, the revocation of a pilot order is by affirmative procedure, and by section 7, a roll-out order is now by a form of “super-affirmative” procedure, the result is that once a pilot order has been made, then a revocation of that order, or any rejection of a subsequent roll-out order, requires to be affirmed by the Parliament. Accordingly, Parliament requires to affirm the repeal of the Bill provisions, in substance.

15. Members noted that, if there were to be a rejection of a roll-out order, by section 6 the substance of the Bill is repealed. There is no express provision, however, for what happens to the pilot order in this circumstance. Because the enabling power to make the pilot order would be repealed, with the rest of the Bill, we assume the pilot order would require to be revoked, to tidy-up the statute book. However, there may have been substantial arrangements for elections to Boards made in the pilot Health Board areas, by virtue of the pilot order up to that point.

16. Section 10 would not be repealed by section 6(2) if the pilot order is revoked, or a roll-out order is rejected. Section 10 permits supplemental or consequential provisions, but only in an order under the remaining provisions of the Act. As there may have been substantial arrangements made in the pilot areas for elections and re-constitution of Health Board memberships following on from the pilot order, the questions arises as to whether it is necessary for the Government to make some supplemental or consequential provisions (under section 10), at the point when section 6(2) repeals the substance of the Bill.

17. Again, the Bill does not appear to provide (or make clear) whether this would be permitted or required, on the repeal of the substance of the Bill under section 6. Section 6 would only provide for automatic repeal, and so termination of the powers under all of sections 1 to 7.

18. Accordingly, the Committee wishes to draw to the attention of the lead committee and the Parliament, that—

(a) section 6(2) of the Bill provides for the automatic repeal of sections 1 to 7 and paragraph 2 of the schedule, if the pilot order is revoked, or on the day after the Parliament fails to resolve to approve a draft roll-out order, but section 6 does not provide for the revocation of the pilot order in the event that the Parliament fails to approve a draft roll-out order (although it appears that must be the effect of the repeal of those sections); and

(b) were Parliament to fail to approve a draft roll-out order, the Bill does not appear to provide or make clear whether, on the automatic repeal of sections 1 to 7, the Scottish Ministers are permitted any delegated powers to make any further or consequential provisions that might be needed in regard to the pilot area arrangements. This is given that
such arrangements for elections, or the re-organisation of the membership of Health Boards, may have been implemented up to the date of any rejection of a roll-out order, by virtue of the pilot order. (This assumes that those powers are sought or may require to be taken by the Scottish Ministers in those circumstances, which is a matter to be considered by the Government).

Section 7(1) (roll-out) – Powers to make a “roll-out order”

19. Section 7 of the Bill was amended at Stage 2 such that the procedure attaching to a roll-out order should be a form of “super affirmative” procedure. This is, generally, where a proposed draft of the order is considered by the Parliament before the draft of the order is finally laid in Parliament.

20. The Committee agreed that the roll-out to further Health Board areas of the Bill provisions, including provisions which modify primary or secondary legislation, were significant matters and that the proposed form of “super affirmative” procedure is appropriate.

21. The Committee is therefore content that a roll-out order in terms of section 7 of the Bill shall be subject to the prescribed form of “super-affirmative” procedure.

22. Section 7(3A)(c) provides that Ministers must have regard to any representations about the proposed draft order, any resolution of the Parliament about that draft, and any Parliament committee report on the proposed draft, made “during the 60 days following the day on which the proposed draft roll-out order was laid before the Scottish Parliament.” This is prior to laying a draft of the order. The 60 day period here is a 60 calendar day period.

23. Concerns were expressed at Committee that the 60 day period takes no account of Parliamentary recesses. Members noted that in some cases, for example if the proposed draft roll-out order was laid just prior to the summer recess, the effect of the 60 day period could be that there is little or no time for Parliamentary consideration.

24. Members therefore agreed to ask the Scottish Government to explain why the period of 60 (calendar) days specified for Parliamentary and committee consideration of a proposed draft roll-out order does not exclude any days during which the Parliament is dissolved or in recess.

25. Members also agreed to ask the Scottish Government for a commitment to bring forward an amendment at Stage 3 to provide that the period of 60 days specified takes account of the effect of recess or dissolution days on the Parliament’s ability to consider the proposed draft roll-out order, ensuring that the 60 days include sufficient sitting days for the necessary Parliamentary consideration to take place.

26. The Scottish Government responded pointing out its concerns that excluding parliamentary recesses could in some circumstances mean that a proposed draft order laid over the summer recess would be left with the Parliament for
consideration until mid November, and that the order could not be made until early the following year.

27. However, the response went on to confirm that the Cabinet Secretary had instructed that an amendment be submitted at Stage 3 setting out that, after the proposed roll out order is laid before Parliament, the 60 day timescale must include at least 30 days when the Parliament is not dissolved or in recess.

28. The Committee therefore finds section 7 acceptable subject to the amendment proposed by the Government that the period of 60 days must include at least 30 days when the Parliament is not dissolved or in recess.
Letter to the Scottish Government,

Health Boards (Membership and Elections) (Scotland) Bill as amended at Stage 2

The Subordinate Legislation Committee considered the above Bill on Tuesday 3 March and agreed to write seeking a response on the following matter—

Section 7(1) (roll-out) – Powers to make a “roll-out order”

The Committee considered the new delegated power which provides for “super-affirmative” procedure in relation to a roll-out order.

The Committee noted that, although the Bill provides that the Minister must have regard to any representations about the proposed draft order, any resolution of the Parliament about that draft, and any Parliament committee report on the proposed draft, made “during the 60 days following the day on which the proposed draft roll-out order was laid before the Scottish Parliament”, the Bill does not take account of any Parliamentary recess or dissolution periods so that, in the worst case, a 60 day period could allow not Parliamentary consideration of the proposed draft.

The Committee therefore asks the Scottish Government to explain urgently (due to the deadline for Stage 3 amendments), in relation to section 7(3A)(c), why the period of 60 (calendar) days specified for Parliament and committee consideration of a proposed draft roll-out order does not exclude any days during which the Parliament is dissolved or in recess, so far as the effect of this may be that there is an insufficient period for Parliament consideration of a proposed draft roll-out order after it is laid.

The Committee also wishes to ask the Scottish Government (again urgently) for a commitment that it will bring forward an amendment at Stage 3 which will provide that the period of 60 days specified takes account of the effect of recess or dissolution days on the Parliament’s ability to consider the proposed draft roll-out order, ensuring that the 60 days will include sufficient sitting days for the necessary Parliamentary consideration to take place.

You may wish to note that the Committee today agreed that an amendment should be drafted to address this issue which may be lodged in the Convener’s name, depending on the response received by the Scottish Government.

Please email your response to the shared e-mail address above by 2.00pm on Wednesday 4 March 2009. This timescale is in order to enable members of the Committee to consider the response and then give further consideration to lodging a possible amendment in time for the deadline on Friday 6 March.

3 March 2009
Scottish Government Response
Health Boards (Membership and Elections) (Scotland) Bill as amended at stage 2

Thank you for your letter of 3 March 2009 to Paul Johnston regarding the Subordinate Legislation Committee’s consideration of the Health Boards (Membership and Elections) (Scotland) Bill and the provisions relating to making a roll-out order.

The procedure introduced by the amendment tabled at Stage 2 of the Bill, provides for greater parliamentary scrutiny of any roll out order. The 60 day time period that applies to the proposed draft roll out order is only one aspect of this procedure and is certainly not intended to try and circumvent any parliamentary procedure.

The 60 day period is expected to mirror the 12 week standard public consultation period that is used by the Government. In drafting the provision in this way we considered that it would appear unusual if, for instance, the 60 day period took place over the summer, that we would need to add on an additional 9 weeks to that period to allow for recess. A further delay caused by October recess could effectively mean having to leave the proposed draft for consideration with the Parliament until mid November and not being able to make the order until early the following year.

The Cabinet Secretary has considered the issue very carefully and has instructed that an amendment be submitted at Stage 3. The amendment will set out that, after the proposed roll out order is laid before Parliament, the 60 day timescale must include at least 30 days when the Parliament is not dissolved or in recess. This will ensure adequate time for Parliament to consider any proposed draft roll out order and avoid the possibility of having 2 recesses interrupting the procedure.

I hope this clarifies our position for the Committee.

4 March 2009
Health Boards (Membership and Elections) (Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 12  Schedule
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Bill Butler

1* In section 1, page 1, line 22, leave out from <total> to <members,> in line 23 and insert <number of elected members of a Board must amount to more than the total number of councillor members and appointed members, but by no more than two,>.

Helen Eadie

12* In section 1, page 2, line 32, at end insert—

<(  ) Section 105 of the 1978 Act (regulations etc.) is amended as follows.>
<(  ) After subsection (2) insert—

“(2A) No regulations shall be made under paragraph 11(a) of Schedule 1 (Health Boards) that include provision specifying circumstances in which the Scottish Ministers may determine that a councillor member is to vacate office unless a draft has been laid before, and approved by resolution of, the Scottish Parliament.”.>

Section 2

Helen Eadie

13 In section 2, page 2, line 40, leave out <(2)> and insert <(2A)>

Helen Eadie

14 In section 2, page 3, line 1, leave out <(2A)> and insert <(2B)>

Nicola Sturgeon

2 In section 2, page 5, leave out lines 1 to 3

Ross Finnie

3 In section 2, page 5, line 21, leave out <16> and insert <18>
Nicola Sturgeon

4 In section 2, page 5, line 22, at end insert—

<(  ) Such further criteria may, in particular, provide that an individual is entitled to vote at a Health Board election only if the individual—

(a) is registered in the register of local government electors in respect of an address in the Health Board area, and

(b) would be entitled to vote at a local government election in an electoral area falling wholly or partly in the Health Board area (or would be so entitled if aged 18 or over).>

Section 5

Dr Richard Simpson

5 In section 5, page 7, line 27, at end insert—

<(  ) Ministers must appoint a person to carry out the evaluation referred to in subsection (1)(c) at least 3 months before the first Health Board election is held.>

Section 6

Ross Finnie

6 In section 6, page 8, line 4, leave out from <sections> to <repealed> and insert <subsections (3) and (4) come into force.

(3) The following provisions of this Act are repealed—

(a) section 1(5) and (7),

(b) sections 2 to 5,

(c) subsections (1) and (2) of this section (except in so far as bringing this subsection and subsection (4) into force), and

(d) section 7,

and the amendments of the 1978 Act made by provisions so repealed are accordingly to cease to have effect.

(4) Paragraph 2 of Schedule 1 to the 1978 Act is amended as follows—

(a) in sub-paragraph (1)—

(i) after sub-paragraph (a) insert “and”,

(ii) sub-paragraph (c) and the word “and” immediately preceding it are repealed,

(b) for sub-paragraphs (3) and (4) substitute—

“(3) At least one councillor member must be appointed for each local authority whose area is wholly or partly within the area of the Board.”>
Section 7

Nicola Sturgeon

7 In section 7, page 8, line 25, leave out from first <the> to end of line 26 and insert <such period as Ministers may specify when laying the copy proposed draft roll-out order.>

   ( ) The period so specified must—

   (a) be no shorter than 60 days, and

   (b) include at least 30 days during which the Scottish Parliament is not dissolved or in recess.>

After section 7

Derek Brownlee

8 After section 7, insert—

<Annual financial impact report>

(1) As soon as is practicable, and no later than 6 months, after the end of a relevant period the Scottish Ministers must prepare and lay before the Scottish Parliament a report containing the information specified in subsection (2).

(2) That information is—

   (a) the costs—

      (i) incurred by the Scottish Administration and each of the groups of bodies mentioned in subsection (9); and

      (ii) estimated by the financial memorandum to be incurred by the Scottish Administration and each such group of bodies, in implementing this Act in the relevant period to which the report relates;

   (b) the total costs—

      (i) incurred by the Scottish Administration and each of the groups of bodies mentioned in subsection (9); and

      (ii) estimated by the financial memorandum to be incurred by the Scottish Administration and each such group of bodies, in implementing this Act in the period from Royal Assent to the end of the relevant period to which the report relates;

   (c) the difference between the figure listed for each of the Scottish Administration and the groups of bodies mentioned in subsection (9) by virtue of—

      (i) subsection (2)(a)(i); and

      (ii) subsection (2)(a)(ii); and

   (d) the difference between the figure listed for each of the Scottish Administration and the groups of bodies mentioned in subsection (9) by virtue of—

      (i) subsection (2)(b)(i); and

      (ii) subsection (2)(b)(ii).

(3) The difference identified by virtue of—
(a) subsection (2)(c) must be stated as an amount; and
(b) subsection (2)(c) or (d) must be stated as a percentage of the relevant figure in the financial memorandum (unless the relevant figure in the financial memorandum was zero).

(4) Subsection (5) applies where—
(a) any difference stated as mentioned in subsection (3)(a)—
   (i) is between £1 million and £5 million (but only where the relevant figure in the financial memorandum was zero); or
   (ii) exceeds £5 million;
(b) any difference stated as mentioned in subsection (3)(b) is—
   (i) less than 95%; or
   (ii) greater than 105%.

(5) The report must—
(a) explain the reason for the difference; and
(b) set out any action the Scottish Ministers propose to take as a result of the difference arising (or the reason for no action being proposed).

(6) In preparing the report the Scottish Ministers must—
(a) invite the groups of bodies mentioned in subsection (9) to provide them with such information as the groups of bodies consider relevant; and
(b) take account of any relevant information provided to them by those groups of bodies (whether in response to an invitation under paragraph (a) or otherwise).

(7) Where the financial memorandum provided information in relation to other bodies, individuals or businesses further broken down by body or person, the report may do likewise.

(8) Where the financial memorandum did not provide a cost in relation to any relevant period, the costs to be provided by virtue of subsection (2)(a)(ii) or (b)(ii) must be (or, as the case may be, include) the relevant figure for the most recent relevant period for which the financial memorandum did provide a cost.

(9) The groups of bodies are—
(a) local authorities;
(b) health boards;
(c) other bodies, individuals and businesses.

(10) The Scottish Parliament may (no earlier than whichever is the later of the end of 10 years after Royal Assent or any period covered in the financial memorandum) by resolution agree that no further reports require to be prepared or laid under subsection (1).

(11) For the purposes of subsection (10) a period is not covered in the financial memorandum if the only cost arising in that period is identified in the memorandum as an ongoing cost.

(12) In this section—
   “relevant period” means—
(a) the period between Royal Assent and the end of the first full financial year after that date;
(b) each subsequent financial year;

“financial memorandum” means the last financial memorandum published to accompany the Bill for this Act (and where that memorandum was a supplementary financial memorandum, means that memorandum as read with any previous financial memorandum) and, where a roll-out order has been made under section 7(1), the financial memorandum as read with any estimate of the cost of holding future Health Board elections in all Health Board areas made under section 5(1)(c)(iii).>

Section 11

Ross Finnie

In section 11, page 9, line 20, leave out <to> and insert <, 5, 6(1) and (2),>

Derek Brownlee

In section 11, page 9, line 20, after <7,> insert <(Annual financial impact report),>

Ross Finnie

In section 11, page 9, line 20, at end insert—

<( ) Section 6(2) provides for the commencement of section 6(3) and (4) in particular circumstances.>
Groupings of Amendments for Stage 3

This document provides procedural information which will assist in preparing for and following proceedings on the above Bill. The information provided is as follows:

- the list of groupings (that is, the order in which amendments will be debated). Any procedural points relevant to each group are noted.

Groupings of amendments

Note: The time limits indicated are those set out in the timetabling motion to be considered by the Parliament before the Stage 3 proceedings begin. If that motion is agreed to, debate on the groups above each line must be concluded by the time indicated, although the amendments in those groups may still be moved formally and disposed of later in the proceedings.

Group 1: Composition of Health Boards
1

Group 2: Power to remove councillor members
12, 13, 14

Debate to end no later than 30 minutes after proceedings begin

Group 3: Personal identifiers
2

Group 4: Entitlement to vote in Health Board elections
3, 4

Group 5: Evaluation report
5

Debate to end no later than 1 hour after proceedings begin

Group 6: Termination of pilots
6, 9, 11
Group 7: Roll out
7

Group 8: Annual financial impact report
8, 10

Debate to end no later than 1 hour 20 minutes after proceedings begin
EXTRACT FROM THE MINUTES OF PROCEEDINGS

Vol. 2, No. 60   Session 3

Meeting of the Parliament

Thursday 12 March 2009

Note: (DT) signifies a decision taken at Decision Time.

Health Boards (Membership and Elections) (Scotland) Bill: Bruce Crawford, on behalf of the Parliamentary Bureau, moved S3M-3671—That the Parliament agrees that, during Stage 3 of the Health Boards (Membership and Elections) (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limits indicated, each time limit being calculated from when the Stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended (other than a suspension following the first division in the Stage being called) or otherwise not in progress:

- Groups 1 and 2: 30 minutes
- Groups 3 to 5: 1 hour
- Groups 6 to 8: 1 hour 20 minutes.

The motion was agreed to.

Health Boards (Membership and Elections) (Scotland) Bill - Stage 3: The Bill was considered at Stage 3.

The following amendments were agreed to without division: 5, 6, 7, 9 and 11.

The following amendments were agreed to (by division)—
- 2 (For 61, Against 55, Abstentions 0)
- 4 (For 97, Against 16, Abstentions 0).

The following amendments were disagreed to (by division)—
- 1 (For 38, Against 77, Abstentions 1)
- 12 (For 54, Against 63, Abstentions 0)
- 3 (For 52, Against 62, Abstentions 0).

The following amendments were not moved: 13, 14, 8 and 10.

The Presiding Officer extended the time-limits in Business Motion S3M-3671 under Rule 9.8.4A (a) and (c).

Health Boards (Membership and Elections) (Scotland) Bill: The Cabinet Secretary for Health and Wellbeing moved S3M-3543—That the Parliament agrees that the Health Boards (Membership and Elections) (Scotland) Bill be passed.

After debate, the motion was agreed to (DT).
The Deputy Presiding Officer (Trish Godman): The next item of business is consideration of motion S3M-3671, in the name of Bruce Crawford, on behalf of the Parliamentary Bureau, setting out a timetable for stage 3 consideration of the Health Boards (Membership and Elections) (Scotland) Bill.

Motion moved,

That the Parliament agrees that, during Stage 3 of the Health Boards (Membership and Elections) (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limits indicated, each time limit being calculated from when the Stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended (other than a suspension following the first division in the Stage being called) or otherwise not in progress:

Groups 1 and 2: 30 minutes
Groups 3 to 5: 1 hour
Groups 6 to 8: 1 hour 20 minutes.—[Bruce Crawford.]

Motion agreed to.
Health Boards (Membership and Elections) (Scotland) Bill: Stage 3

The Deputy Presiding Officer (Trish Godman): The next item of business is stage 3 proceedings on the Health Boards (Membership and Elections) (Scotland) Bill. In dealing with amendments, members should have the bill as amended at stage 2, the marshalled list—that is, SP bill 13A-ML—and the groupings, which the Presiding Officer has agreed. The division bell will sound and proceedings will be suspended for five minutes for the first division this afternoon. The period of voting for the first division will be 30 seconds. Thereafter, I will allow a voting period of one minute for the first division after a debate and 30 seconds for all other divisions.

I take it that members understood all of that—good.

Section 1—Constitution of Health Boards

The Deputy Presiding Officer: Group 1 is on the composition of health boards. Amendment 1, in the name of Bill Butler, is the only amendment in the group.

Bill Butler (Glasgow Anniesland) (Lab): I am pleased to speak to amendment 1. Members will be aware that the bill’s explanatory notes make it clear that in section 1(2), which replaces schedule 1 to the National Health Service (Scotland) Act 1978, paragraph 2(1) of the new schedule sets out the “three different types of member” that will sit on a health board.

“These are:

• ‘appointed members’ (a chairman and other members appointed by the Scottish Ministers);

• ‘councillor members’ (councillors appointed by the Scottish Ministers following nomination by local authorities ... ); and

• ‘elected members’ (individuals elected as members of the Health Board at an election).”

As amendment 1 makes clear, we are talking about the injection of a directly elected element that is not independent in some theoretical way but which takes part in the board’s work, along with two other categories of appointed member. I believe that such an injection of democracy is a good thing. One should seldom quote oneself, but as I said in my submission to the Government’s consultation on its proposed local health care bill, “Direct public elections would allow the public a mechanism to influence service delivery in their area”.

I also believe that the public are clearly saying that “there must be greater openness and transparency, and there must be direct accountability”.

After all, the bill is about transparency and direct democratic accountability.

In my consultation response, I also said: “I have yet to hear a convincing argument as to why the make-up of regional NHS boards should not contain a strong direct democratic element. Accordingly, I propose that, as amendment 1 provides, 50 per cent plus one of the members of each health board—or, depending on the arithmetic, a simple majority—be directly elected to represent the local communities affected by its decisions.

Boards must have a proper balance between those with expertise, knowledge and experience from working in the health service—something that we should not lose—and those who are most directly affected by any proposed change, by which I mean the public. I feel that the blend of experience and direct accountability for which amendment 1 provides is about right.

Again, I emphasise that I support the retention of local authority members on NHS boards—as a former councillor, I do not have a problem with that—but, as the bill makes clear, the local authority members will not be directly elected to boards but be appointed by ministers.

I was going to finish on that point, but I must not forget the Cabinet Secretary for Health and Wellbeing. I suspect that she had a great say in the Scottish National Party manifesto for the 2011 elections—sorry, I meant for the 2007 elections; I hope it is not for 2011. On page 36, under the heading “Accountable healthcare”, appears the following quotation. I will not read out the whole paragraph, but I do not think that I have wrenched the quotation out of its context:

“Sometimes difficult decisions must be made and local people should always be at the heart of the process. To ensure this is the case we will introduce direct elections to health boards. At least half of health board members will be elected by the public.”

I could not agree more with the cabinet secretary and the manifesto—on that one specific aspect. It seems to me an unequivocal commitment, and it does not preclude the suggestion in amendment 1, which is for a simple majority. I hope that colleagues across the chamber will support the amendment.

I move amendment 1.

15:00

Ross Finnie (West of Scotland) (LD): I have no difficulty in acknowledging that Bill Butler’s
approach has been entirely consistent, both during discussions on his own member’s bill and during all the stages of this bill. However, the artificial distinction that he seeks to make could cause real difficulty.

Bill Butler is right to say that people who are elected as councillors in their local authority will then, technically, have to be appointed by the cabinet secretary to the health board, but there is surely a real distinction to be made between an individual who gains legitimacy from being elected to public office by the electorate and an individual who responds to an advertisement, placed by the civil service, inviting people to apply to be appointed to a health board.

If one does not acknowledge that real distinction, one runs into a real problem. One would be saying that people who are elected directly to a health board have greater legitimacy than people who are elected to serve their own constituency. That would be entirely false and a recipe for storing up a real sense of frustration. There would be two entirely different camps, both of whom—the people directly elected to the health board and the people elected to their constituency—ought properly to be able to say, “I represent the public.”

To introduce an artificial distinction into the bill, in the manner that Bill Butler suggests, is wholly wrong, and I and the other Liberal Democrats will oppose amendment 1. We wish to retain paragraph 2(3)(a) of schedule 1 to the National Health Service (Scotland) Act 1978 as it stands.

Jackie Baillie (Dumbarton) (Lab): I speak in support of amendment 1 in the name of my colleague Bill Butler. Members with a better memory than mine will recall that, during the previous session of Parliament, I was one of the Labour members who supported Bill Butler’s proposals for elections to health boards. I pay tribute to him for leading the debate and to the cabinet secretary for getting us where we are today.

Like many members, I am shaped by experience in the constituency. I have witnessed at first hand the dismissive and sometimes arrogant actions of successive heath boards and their contempt for the views of my local community. I therefore strongly believe in amendment 1 and in elections to health boards.

Amendment 1 seeks simply to ensure that directly elected members are in the majority—a simple 50 per cent plus one. In evidence taken by the Health and Sport Committee, it was suggested that the wrong type of person might be elected, that community activists who care about their local health services would somehow not be appropriate, and that strange people might win—people who could not possibly be allowed to be in the majority. We should just look around this chamber: sometimes unusual people do get elected, but that is the will of the electorate—that is democracy. The public are perfectly able to elect sensible people to represent them in public services, and health boards will be no different.

If we are serious about improving the operation of health boards, it is right that there is a majority of directly elected members. I do make a distinction: councillors on health boards are told that they cannot represent—[Interruption.]

The Deputy Presiding Officer: I am sorry, Ms Baillie. Mr Lochhead, would you mind sitting down? And please do not use electrical equipment when you are in the chamber.

Jackie Baillie: I said that strange people get elected—I rest my case, Presiding Officer.

I think that there is a distinction to be made and, with respect, that Ross Finnie is wrong on this occasion. Having directly elected members is the right place for us to be. I am sure that the cabinet secretary and the Minister for Public Health and Sport, who will have had a hand in the SNP manifesto, can be persuaded of the value of that approach. If they are not, I hope that at least the SNP back benchers will be. It was a promise in the SNP manifesto, and I would hate to see the commitment watered down.

I urge members to be radical and to support Bill Butler’s amendment.

The Deputy Presiding Officer: I call the cabinet secretary to speak to the amendment.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I am grateful for the opportunity to respond to amendment 1. I was tempted to intervene on Jackie Baillie and ask her to name names when she talked about unusual people, but she then did. Obviously, I disagree with her entirely, but I hope that that will be the only discordant note to be sounded this afternoon.

I recognise and pay tribute to Bill Butler’s involvement in the issue, and I am glad that he appears to be winning over his colleagues to his way of thinking. We have always been in agreement with him. I intended to quote Bill Butler in my speech, but he got there before me, so I will resist that temptation.

Amendment 1 seeks to make a clear majority of a health board’s members directly elected. Although, as evidenced by the bill, I strongly agree that the way in which health boards engage and involve their communities must change—and it will change as a result of the bill—I believe that our approach of having a majority of a board’s members drawn from local authorities and direct
elections represents the most balanced and sensible way to achieve that goal. That will not only ensure democratic input to and accountability of health boards, which is the rationale behind the bill; it will help to cement the joint working between health boards and councils that is so important in ensuring that we provide integrated services to the public.

Through our approach—and absolutely in line with our manifesto commitment before the election—we will ensure that the majority of a health board’s members are democratically elected. They will be either directly elected to the health board or elected as councillors. As a result, health boards will operate better.

I regret that I cannot support Bill Butler’s amendment. I suspect that he will not withdraw it, so I ask Parliament to vote against it.

The Deputy Presiding Officer: I call Bill Butler to wind up and to press or withdraw his amendment.

Bill Butler: I say to the cabinet secretary that she should never resist the temptation to quote me.

To Ross Finnie, I say that we have a disagreement but we will not fall out over it—well, not too much. The distinction is not between legitimacy and illegitimacy. The bill, as it is outlined in the explanatory notes, recognises three different categories of board member, two of which are appointed directly by the cabinet secretary.

Councillors and those who are directly elected through health board elections will not be appointed to health boards in the same way and cannot be construed as forming a democratic majority. The system fails the democratic test because councillors are elected at diets of council elections, which is not the case for directly elected health board members. If the electorate for a health board election are disappointed with a health board member, they are appointed rather immediately in a health board election, that is a serious point: if the electorate cannot get rid of a board member of an elected member. That is a serious point: if the electorate cannot get rid of that councillor, they must wait until the council health board elections.

Nottingham lectures in 1991—the litmus test of democracy, which is how the electorate can get rid of an elected member. That is a serious point: if the electorate cannot get rid of a board member immediately in a health board election, that member is different—they are appointed rather than directly elected.

I wholly agree with Jackie Baillie because she wholly agrees with me.

I hope that the cabinet secretary, even at this late stage, will think again. It would take only a nod from the cabinet secretary, who is also the Deputy First Minister for Scotland, to give the SNP back benchers the wherewithal to join Labour. We can form a majority today and, if we do, we will have health boards with a simple majority of directly elected members. What could be a more opportune moment than when we have pilots? Pilots could test whether the system works, so I ask the cabinet secretary to think again.

The Deputy Presiding Officer: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division. I suspend the proceedings for five minutes to allow the division bell to be rung and members to return to the chamber.

15:10

Meeting suspended.

15:15

On resuming—

The Deputy Presiding Officer: We move to the division on amendment 1.

FOR

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Branikin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Foulkes, George (Lothians) (Lab)
Gillon, Karen (Clydesdale) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Gray, lain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Tom (Hamilton South) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Mulligan, Mary (Linlithgow) (Lab)
Murray, Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)
AGAInst

Adam, Brian (Aberdeen North) (SNP)
Aitken, Bill (Glasgow) (Con)
Allan, Alasdair (Western Isles) (SNP)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brown, Keith (Ochil) (SNP)
Brown, Robert (Glasgow) (LD)
Brownlee, Derek (South of Scotland) (Con)
Campbell, Aileen (South of Scotland) (SNP)
Carlaw, Jackson (West of Scotland) (Con)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Finnie, Ross (West of Scotland) (LD)
FitzPatrick, Joe (Dundee West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hume, Jim (South of Scotland) (LD)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kidd, Bill (Glasgow) (SNP)
Lamont, John (Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Marwick, Tricia (Central Fife) (SNP)
Mathew, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McArthur, Liam (Orkney) (LD)
McGrigor, Jamie (Highlands and Islands) (Con)
McInnes, Alison (North East Scotland) (LD)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLaughlin, Anne (Glasgow) (SNP)
McLetchie, David (Edinburgh Pentlands) (Con)
McMillan, Stuart (West of Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Neil, Alex (Central Scotland) (SNP)
O'Donnell, Hugh (Central Scotland) (LD)
Paterson, Gil (West of Scotland) (SNP)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Russell, Michael (South of Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Tolson, Jim (Dunfermline West) (LD)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Wilson, Bill (West of Scotland) (SNP)
Wilson, John (Central Scotland) (SNP)

ABSTentions

MacDonald, Margo (Lothians) (Ind)

The Deputy Presiding Officer: The result of the division is: For 38, Against 77, Abstentions 1.

Amendment 1 disagreed to.

The Deputy Presiding Officer: Group 2 is on the power to remove councillor members. Amendment 12, in the name of Helen Eadie, is grouped with amendments 13 and 14.

Helen Eadie (Dunfermline East) (Lab): First, I point out that amendment 12 does not seek to remove ministers’ right to dismiss a council-elected health board member whom they have appointed. I acknowledge that the appointment of such members is up to ministers, but it would set quite a precedent if the same ministers decided to remove someone who has been democratically elected on to a council and nominated by the council for membership of the health board.

Ministers might well feel that there were good reasons for taking such a big decision, but such reasons could, at the very least, be perceived as political. As a result, one safeguard would be to make any such move subject to an affirmative, not negative, resolution. There would have to be safeguards given that it would be a very big step.

Although the removal of a health board member might be 100 per cent justified, experience suggests that such matters can become very political and that the people involved might make different claims. After all, ministers might remove a politician who, for example, was not of the same political hue as the Government. If ministers are confident about their decision, they will not be afraid of seeking Parliament’s affirmation or otherwise.

As I have said, the provisions should be subject to affirmative procedure. Ministers might have good reason for removing someone from a health board—and Parliament might well agree with them—but I feel that in this case affirmative procedure is the right way to go. As soon as ministers make an appointment, the matter moves into the political arena, because, as I have said, they appoint someone who is already a politician. That has consequences—[Interruption.]

The Deputy Presiding Officer: Excuse me, Ms Eadie. There is far too much noise in the chamber.
Helen Eadie: If such a decision is to be reversed, politicians need to be objective and confident that they are not simply wasting their time on the matter. I believe that ministers in the previous Administration were very objective, and I am sure that, in seeking the Parliament’s support and giving Parliament the right to take a view on such matters, ministers can be confident that parliamentarians can be just as objective.

This is an important and controversial matter. There have been few, if any, occasions on which a minister has removed a health board member in such circumstances—it might well have happened, but I must say that I am not aware of it. I hope that members understand that the point is not to take away the minister’s right to remove people but that the Parliament should fundamentally and finally decide whether to endorse the decision.

I move amendment 12.

Ross Finnie: The Liberal Democrat position is entirely consistent with that which we set out on amendment 1. We genuinely see a distinction when it comes to the legitimacy of members who have been elected to a board in the first place, notwithstanding their terms of appointment. Helen Eadie proposes an entirely sensible compromise, which strikes the right balance in recognising that there is an issue with the removal of an elected member. I am grateful to her for forcing me to read section 105 of the National Health Service (Scotland) Act 1978, which her amendment would amend. I cannot say that I found it particularly riveting, but at least I now know what the amendment means.

I hope that members will support amendment 12.

Nicola Sturgeon: I thank Helen Eadie for lodging amendments 12, 13 and 14. I do not agree with them, but I recognise that judgments on the issues are finely balanced. I understand that Helen Eadie pursued the issue with the Subordinate Legislation Committee, which considered it and decided not to proceed with it.

Members will recall that, at stage 2, I acknowledged the special position that the new category of directly elected health board members would occupy and agreed that they should not be removable at the discretion of the Scottish ministers. Helen Eadie’s amendments would set local councillor members apart from the other appointed members of a health board by ensuring that any regulations that specify circumstances in which ministers may determine that a council member is to vacate office are subject to the affirmative procedure.

The existing power in the National Health Service (Scotland) Act 1978 to make such regulations is subject to the negative procedure. It is also worth pointing out that no member of a health board has ever been dismissed under that legislation and that such a move would therefore be quite extraordinary. I dare say that that leaves it open to people such as Helen Eadie to say, “Well, why not agree to these amendments?” but a point of principle is involved.

The way in which local councillor members arrive on a health board is different from how a directly elected member will arrive on it. Currently, local authorities put forward their selected member for ministers to appoint. That process will continue, and the act will put the position of local councillor members on a statutory basis for the first time. That step has been welcomed, but councillor members will still be ministerial appointments, and the Scottish ministers should have the flexibility to remove members whom they have appointed if there are extraordinary circumstances to justify that.

It is important to stress that, if in an extreme scenario a health minister had to remove a local councillor member from a health board, the local authority would not be left without representation, and nor would the elected majority on the health board be affected, because the local authority would simply nominate another councillor to fill the vacancy.

As I said at the outset, the Subordinate Legislation Committee considered the matter and opted not to pursue it. I ask members to vote against Helen Eadie’s amendments, which I assume she will push to a vote. However, it is of course for Parliament to make a judgment on such matters.

Helen Eadie: The convener of the Subordinate Legislation Committee is sitting not far from the minister; in fact, he is next to her. The reality is that the views of committee members were finely balanced and that its convener chose to propose to its members that we should not divide on the issue. We did not object to that proposition, as he said that he would have felt very uncomfortable taking a view at that stage. I accepted that on the day and thought that that approach was entirely reasonable.

I remind members that my amendment would not take away the minister’s ability to sack someone or remove someone from office. It is about Parliament’s right to endorse or not endorse the minister’s view, which is fundamentally different from saying to the minister that she should not have the power to remove a councillor member. That is important.

In a matter as important as this, we must decide whether the removal of a councillor member should just go through on the nod, as under the negative procedure, or whether it should be the
conscious decision of Parliament under the affirmative procedure, which is what I am asking the Parliament to agree to. It is important that everyone agrees that, irrespective of whether a councillor member is appointed by the minister, the reality is that they are democratically elected by a community and recommended and nominated by a local authority. Very rarely does a local authority appoint someone to a position on a health board unless they are a senior politician, either from the ruling or opposition parties.

Parliament should understand the significance of the amendment, and I hope that it will vote with me. I will press amendment 12 and the consequential amendments if amendment 12 is agreed to.

The Deputy Presiding Officer: The question is, that amendment 12 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

FOR
Alexander, Ms Wendy (Paisley North) (Lab)
Bailie, Jackie (Dumfartown) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (Lab)
Foulkes, George (Lothians) (Lab)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Gray, lain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Hume, Jim (South of Scotland) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
MacDonald, Margo (Lothians) (Ind)
Macintosh, Ken (Eastwood) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McArthur, Liam (Orkney) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Tom (Hamilton South) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McInnes, Alison (North East Scotland) (LD)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (clydebank and Milngavie) (Lab)
Mulligan, Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Elaine (Dumfries) (Lab)
O'Donnell, Hugh (Central Scotland) (LD)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
 Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Tolson, Jim (Dunfermline West) (LD)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whittón, David (Strathkelvin and Bearsden) (Lab)

AGAINST
Adam, Brian (Aberdeen North) (SNP)
Aitken, Bill (Glasgow) (Con)
Allan, Alasdair (Western Isles) (SNP)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brown, Keith (Ochil) (SNP)
Brownlee, Derek (South of Scotland) (Con)
Campbell, Alileen (South of Scotland) (SNP)
Carlaw, Jackson (West of Scotland) (Con)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
FitzPatrick, Joe (Dundee West) (SNP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Goldie, Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hyson, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kidd, Bill (Glasgow) (SNP)
Lamont, John (Roxburgh and Berwickshire) (Con)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
Marwick, Tricia (Central Fife) (SNP)
Mathers, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McGrigor, Jamie (Highlands and Islands) (Con)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLaughlin, Anne (Glasgow) (SNP)
McLetchie, David (Edinburgh Pentlands) (Con)
McMillan, Stuart (West of Scotland) (SNP)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Neil, Alex (Central Scotland) (SNP)
Paterson, Gil (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
The Deputy Presiding Officer: The result of the division is: For 54, Against 63, Abstentions 0.

Amendment 12 disagreed to.

Section 2—Health Board elections

Amendments 13 and 14 not moved.

The Deputy Presiding Officer: Group 3 is on personal identifiers. Amendment 2, in the name of the minister, is the only amendment in the group.

Nicola Sturgeon: The use of personal identifiers for elections has caused a great deal of debate throughout the bill’s progress—I entirely understand why. The requirement for personal identifiers was introduced by Jackie Baillie at stage 2.

I say at the outset that I both understand and respect the motive of all those who have pursued the change. We all want a robust approach to the administration of elections, but I am not persuaded that it is proportionate to insist on personal identifiers for pilot elections, as opposed to full roll-out of the elections. Our proceeding with the requirement for personal identifiers would add in excess of £800,000 to the cost of the pilot elections—a sum that many will consider to be disproportionate to the overall cost of the pilot elections, which is just under £3 million.

However, the debate is not just about cost. It is also the case that to require personal identifiers would, I believe—unless we were prepared to abandon proposals for a postal ballot—be a considerable mistake, in that it would delay the pilots significantly. I do not believe that anyone in the chamber wants delay, whether they strongly support the principle of direct elections to health boards, as my colleagues and I do, or are more sceptical about direct elections but are keen to see the experience of the pilots. I do not believe that anyone wants delay in the process.

15:30

The arrangements that we propose to follow for the pilot elections are similar to those that are already in place for national park elections in Scotland. We want to follow that approach because we want to ensure that health board pilot elections can take place soon, and that the maximum number of people possible are able and willing to participate.

I stress that the bill is about what we will do in respect of the pilot elections. What we choose to do in the future, should Parliament agree to roll out direct elections, would be up to Parliament at that time. The operation of the elections will be assessed as part of the independent evaluation of the pilots, and that experience will form part of the report that will be placed before Parliament. If elections were to be rolled out, I, for one, think it is highly likely that it would be considered sensible and proportionate to insist on personal identifiers. I do not, however, believe that their use is proportionate for the pilot elections.

The original approach that we took in the bill at stage 1 represents a sensible and balanced approach that is proportionate to the scale of the proposed pilot elections and will, crucially, allow them to proceed both cost-effectively and within such timescales as I believe we all want.

I move amendment 2.

Jackie Baillie: I speak against the cabinet secretary’s amendment 2 because it seeks to remove the requirement for personal identifiers in postal ballots. Parliament should be aware that the Health and Sport Committee unanimously agreed the following on personal identifiers:

“The Committee considers that health board elections should be seen to be taken as seriously as other statutory elections. The experience of the Scottish general elections in May 2007 shows that the robustness of any new elections introduced in Scotland will rightly come under serious scrutiny.”

The committee recommended that “the Scottish Government reconsider using personal identifiers for postal votes in health board elections.”

That was the view of the whole committee and it remained the majority view at stage 2, so I am genuinely disappointed that the cabinet secretary has lodged this amendment at stage 3.

I will explain why I think amendment 2 is wrong. First, under existing arrangements for local and national elections, voters are, if they use a postal vote, required to provide personal identifiers—the identifier can be something as simple as a signature—which are, of course, used to ensure the security of the vote.

Members will surely not have forgotten the difficulties that we experienced in the 2007 Scottish Parliament elections. In some areas, questions were asked about the validity of the outcome because majorities were small and the number of rejected ballot papers was large. I even recollect that the Scottish National Party recently questioned the integrity of one aspect of the Glenrothes by-election result. The SNP was mistaken, but the validity of elections clearly exercises us all. I do not want there to be a scintilla of doubt about the validity of health board
elections. They will be important elections. They will be Scotland’s fifth set of statutory elections.

Margo MacDonald (Lothians) (Ind): Although I fully appreciate Jackie Baillie’s concern that the elections should be valid and seen to be so, the cabinet secretary said that she did not object to the use of personal identifiers per se, but to the expense that they would incur during a pilot. If the member could be assured that there is another cheaper way of monitoring, would she be satisfied with that?

Jackie Baillie: I am afraid not. I will come to explain why.

They elections will be the fifth set of statutory elections and will be run by returning officers, so they must be robust and consistent with other elections. I know that there will be considerable interest in them and that my local community shares my enthusiasm for them. I hope that they will be hotly contested, because the elections will represent the democratic means by which people will be able to express their views on their health boards. The cabinet secretary argued that personal identifiers would lead to increased costs and delay, so I find it strange that she has promised to consider them should there be roll-out of the elections. If the cost for the pilot is too high, the cost for the roll-out will be even higher. I say to Margo MacDonald that it is surely at the pilot stage that the proposal should be tested.

What price do we attach to democracy? How much do Scottish Parliament elections cost? There is no suggestion that we should do away with personal identifiers for those. We all believe in increasing voters’ access to postal votes. At the heart of the matter is the status that we accord to health board elections. I ask Parliament whether we are content to settle for a lower electoral standard than exists for local government, even though health boards are responsible for spending more than individual councils.

The cabinet secretary points to the elections to the boards of the national park authorities, which have postal ballots without identifiers. The annual budget of the Loch Lomond and the Trossachs National Park Authority is £7 million. The annual budget of Greater Glasgow and Clyde NHS Board is £2.6 billion. There is a difference.

I know that some people might not be convinced by what I think, so I ask them to look at the evidence from the experts, such as the Electoral Commission and local authority returning officers from throughout Scotland. They are the people who have the responsibility for overseeing and running our elections. They are the experts, and they all believe that personal identifiers should be used in postal ballots. If members will not listen to me, I ask them to listen to the experts and reject the cabinet secretary’s amendment.

Ross Finnie: I am sorry that Jackie Baillie did not quote paragraph 84 of the committee’s report in full. It is important for members to be aware that the committee was indeed cognisant of the potential cost. The final sentence of that paragraph states:

“If the cost and logistical implications are too great to be overcome, the Scottish Government may also have to reconsider holding an all-postal ballot.”

In the committee’s view, as stated in its report, there was no question but that all aspects of the efficacy of the elections and, regrettably, the costs that might be attached to them, must be considered.

The Liberal Democrats’ position is that we have to consider the end gain. There will be some form of pilot election. The result will have to be analysed and we will then have to come to a decision. If the pilot is to be valid, we must know that no questions about how persons came to be elected were asked at any stage. The Liberal Democrats believe that the experiment upon which the cabinet secretary seeks to embark is an important one. Regardless of the difficulties, if we are to have confidence in its outcome, we must have confidence in the basis upon which it takes place. We therefore oppose the cabinet secretary’s amendment.

Jackson Carlaw (West of Scotland) (Con): I listened with interest to both the cabinet secretary and Jackie Baillie. The case that Jackie Baillie made—or restated—for personal identifiers is powerful, particularly given the need to protect the integrity of our democracy in future national elections. However, I also listened with care to what the cabinet secretary said: Conservatives have concluded that we see a distinction between national elections and pilots for health board elections and that there is therefore no need for the use of personal identifiers in the pilot phase. The additional costs would be substantial and hugely disproportionate and would militate against the proposal in that they would almost undermine the desirability of the pilots in the first place. Secondly, we too are concerned about the delays that would be attendant upon them. With that in mind, we will support the cabinet secretary’s amendment.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I decided to comment because I suspected that Jackson Carlaw was going to make that speech. It seems to me that the Conservatives have a difficulty: their predominant objection is to the cost of the elections, yet the cabinet secretary made it clear that she has not ruled out the use of personal identifiers in full roll-out of the elections. If we are to test the proposal properly in the pilot
stage, we also need to test the costs. If we are to do that properly, we must include the use of personal identifiers.

I will not reiterate the arguments that my colleague Jackie Baillie has made, but I stress that what happened in 2007 makes the point about the credibility and validity of the pilot elections much more important than it would otherwise have been.

Mary Scanlon (Highlands and Islands) (Con): We are facing the most serious economic crisis since the 1930s. On that basis—by today’s standards—we judge that £800,000 is a huge amount of money.

Dr Simpson: I do not think that that alters my argument. The £800,000 cost for the pilots might make the difference between the elections being credible and not being credible. If the elections are questioned on the basis of credibility, Parliament will be in a very difficult position when we come to debate full roll-out. Therefore, I hope that Parliament will oppose the amendment.

Ian McKee (Lothians) (SNP): Jackie Baillie knows how much I admire her skills of persuasion and charm, but in this case I feel that she is in danger of making the best the enemy of the good. We heard good evidence that, in a perfect election, one would have personal identifiers, but we also heard evidence that including identifiers in the pilots would add £800,000 to the cost, and would delay their onset. The pilots might fail for all sorts of other reasons. If we go ahead with the full roll-out and decide that the elections are going to be the pattern for the health service in Scotland for many years to come, that will be the time to consider including identifiers. However, we can find out enough about the election process without having identifiers.

Jackie Baillie: Will the member take an intervention?

Ian McKee: I have finished my contribution, but I am always willing to hear Ms Baillie, if the Presiding Officer will allow her to intervene.

The Deputy Presiding Officer: I will let Ms Baillie in briefly.

Jackie Baillie: I am grateful to Ian McKee and I hope that I will be persuasive.

Aside from the minister and her officials, did anybody argue against having personal identifiers?

The Deputy Presiding Officer: I invite Ian McKee to respond to that briefly.

Ian McKee: We all agreed that having personal identifiers is the ideal way to run an election, but we are in the real world and we are trying out a pilot, which is entirely different from the full elections. That is the difference. As my Health and Sport Committee colleague Mary Scanlon said, £800,000 is a lot of money to spend just to gold-plate something, when a simpler version would do the job.

Nicola Sturgeon: I thank all members who have contributed to this interesting and important debate. I do not for a second diminish the importance of the issue.

Ross Finnie—and Jackie Baillie, more by implication—suggested that if the cost of personal identifiers in the pilots would be so great, we should reconsider having an all-postal ballot. I think that would be a mistake. It is important that we encourage and enable as many people as possible to participate in health board pilot elections. The argument also leads me to point out an anomaly in the amendments that Jackie Baillie got passed at stage 2. Those amendments require personal identifiers only in an all-postal ballot. If I were to decide that we should move instead to a traditional ballot, personal identifiers would not be required for those who opted to vote by post in such a ballot. That seems to be an anomalous and bizarre situation.

The second point that I want to make is about the principle. I accept the principle of personal identifiers leading to the security of the ballot when we are dealing with a national election, but we are talking about pilot elections. There are two reasons why I think personal identifiers are not proportionate in this case. One is the cost. I stress that I do not object to the incurring of costs for personal identifiers per se; I was, rather, pointing out the disproportionality of that cost in a pilot election. Should Parliament decide later to roll out elections, and decide that personal identifiers would be appropriate in that context—that would be Parliament’s decision, not mine—that cost, which would be disproportionate in a pilot election, would become proportionate in a national election.

Even if we are not worried about the cost, the requirement for personal identifiers would delay the pilots significantly, although we would try to minimise that. I want the pilots to go ahead and I know that Jackie Baillie wants them to go ahead. Even members who are not yet convinced that elected health boards are the way to go want the pilots to go ahead, so that they can assess the experience.

For all those reasons, I believe that personal identifiers for the pilots are not the right way to go. There would be a different consideration for full roll-out. I urge Parliament to vote for amendment 2.

15:45

The Deputy Presiding Officer: The question is, that amendment 2 be agreed to. Are we agreed?
The Deputy Presiding Officer: There will be a division.

**For**
- Adam, Brian (Aberdeen North) (SNP)
- Allian, Alasdair (Western Isles) (SNP)
- Broicklebank, Ted (Mid Scotland and Fife) (Con)
- Brown, Gavin (Lothians) (Con)
- Brown, Keith (Ochil) (SNP)
- Brownlee, Derek (South of Scotland) (Con)
- Campbell, Aileen (South of Scotland) (SNP)
- Carlaw, Jackson (West of Scotland) (Con)
- Coffey, Willie (Kilmarnock and Loudoun) (SNP)
- Constance, Angela (Livingston) (SNP)
- Crawford, Bruce (Stirling) (SNP)
- Cunningham, Roseanna (Perth) (SNP)
- Don, Nigel (North East Scotland) (SNP)
- Doris, Bob (Glasgow) (SNP)
- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Fabiani, Linda (Central Scotland) (SNP)
- FitzPatrick, Joe (Dundee West) (SNP)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Gibson, Kenneth (Cunninghame North) (SNP)
- Gibson, Rob (Highlands and Islands) (SNP)
- Goldie, Annabel (West of Scotland) (Con)
- Grahame, Christine (South of Scotland) (SNP)
- Harvie, Christopher (Mid Scotland and Fife) (SNP)
- Hepburn, Jamie (Central Scotland) (SNP)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Adam (South of Scotland) (SNP)
- Johnstone, Alex (North East Scotland) (Con)
- Kidd, Bill (Glasgow) (SNP)
- Lamont, John (Roxburgh and Berwickshire) (Con)
- Lochhead, Richard (Moray) (SNP)
- MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
- MacDonald, Margo (Lothians) (Ind)
- Marwick, Tricia (Central Fife) (SNP)
- Mather, Jim (Argyll and Bute) (SNP)
- Matheson, Michael (Hamish) (SNP)
- Maxwell, Stewart (West of Scotland) (SNP)
- McEwen, Shona (Dundee East) (SNP)
- McEwen, Stewart (South of Scotland) (SNP)
- McNeill, Pauline (Glasgow Kelvin) (Lab)
- McPherson, Julian (Central Scotland) (SNP)
- McKee, Ian (Lothians) (SNP)
- McKelvie, Christina (Central Scotland) (SNP)
- McLaughlin, Anne (Glasgow) (SNP)
- McLetchie, David (Edinburgh Pentlands) (SNP)
- McMillan, Stuart (Lothians) (SNP)
- Mather, Jim (Argyll and Bute) (SNP)
- Mather, Rob (Highlands and Islands) (SNP)
- Goldie, Annabel (West of Scotland) (Con)
- Grahame, Christine (South of Scotland) (SNP)
- Harvie, Christopher (Mid Scotland and Fife) (SNP)
- Hepburn, Jamie (Central Scotland) (SNP)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Adam (South of Scotland) (SNP)
- Johnstone, Alex (North East Scotland) (Con)
- Kidd, Bill (Glasgow) (SNP)
- Lamont, John (Roxburgh and Berwickshire) (Con)
- Lochhead, Richard (Moray) (SNP)
- MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
- MacDonald, Margo (Lothians) (Ind)
- Marwick, Tricia (Central Fife) (SNP)
- Mather,Jim (Argyll and Bute) (SNP)
- Matheson, Michael (Falkirk West) (SNP)
- Maxwell, Stewart (West of Scotland) (SNP)
- McEwen, Shona (Dundee East) (SNP)
- McEwen, Stewart (South of Scotland) (SNP)
- McNeill, Pauline (Glasgow Kelvin) (Lab)
- McPherson, Julian (Central Scotland) (SNP)
- McKee, Ian (Lothians) (SNP)
- McKelvie, Christina (Central Scotland) (SNP)
- McLaughlin, Anne (Glasgow) (SNP)
- McLetchie, David (Edinburgh Pentlands) (SNP)
- McMillan, Stuart (Lothians) (SNP)
- Mather, Jim (Argyll and Bute) (SNP)
- Mather, Rob (Highlands and Islands) (SNP)
- Goldie, Annabel (West of Scotland) (Con)
- Grahame, Christine (South of Scotland) (SNP)
- Harvie, Christopher (Mid Scotland and Fife) (SNP)
- Hepburn, Jamie (Central Scotland) (SNP)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Adam (South of Scotland) (SNP)
- Johnstone, Alex (North East Scotland) (Con)
- Kidd, Bill (Glasgow) (SNP)
- Lamont, John (Roxburgh and Berwickshire) (Con)
- Lochhead, Richard (Moray) (SNP)
- MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)
- MacDonald, Margo (Lothians) (Ind)
- Marwick, Tricia (Central Fife) (SNP)
- Mather, Jim (Argyll and Bute) (SNP)
- Matheson, Michael (Falkirk West) (SNP)
- Maxwell, Stewart (West of Scotland) (SNP)
- McEwen, Shona (Dundee East) (SNP)
- McEwen, Stewart (South of Scotland) (SNP)
- McNeill, Pauline (Glasgow Kelvin) (Lab)
- McPherson, Julian (Central Scotland) (SNP)
- McKee, Ian (Lothians) (SNP)
- McKelvie, Christina (Central Scotland) (SNP)
- McLaughlin, Anne (Glasgow) (SNP)
- McLetchie, David (Edinburgh Pentlands) (SNP)
- McMillan, Stuart (West of Scotland) (SNP)
- Milne, lanette (North East Scotland) (Con)
- Mitchell, Margaret (Central Scotland) (Con)
- Neil, Alex (Central Scotland) (SNP)
- Paterson, Gil (West of Scotland) (SNP)
- Robinson, Shona (Dundee East) (SNP)
- Russell, Michael (South of Scotland) (SNP)
- Salmond, Alex (Gordon) (SNP)
- Scanlon, Mary (Highlands and Islands) (Con)
- Scott, John (Ayr) (Con)
- Smith, Elizabeth (Mid Scotland and Fife) (Con)
- Somerville, Shirley-Anne (Lothians) (SNP)
- Stevenson, Stewart (Banff and Buchan) (SNP)
- Sturgeon, Nicola (Glasgow Govan) (SNP)
- Thompson, Dave (Highlands and Islands) (SNP)
- Watt, Maureen (North East Scotland) (SNP)
- Welsh, Andrew (Angus) (SNP)
- White, Sandra (Glasgow) (SNP)
- Wilson, Bill (West of Scotland) (SNP)
- Wilson, John (Central Scotland) (SNP)

**Against**
- Aitken, Bill (Glasgow) (Con)
- Alexander, Ms Wendy (Paisley North) (Lab)
- Baillie, Jackie (Dumbarton) (Lab)
- Baker, Claire (Mid Scotland and Fife) (Lab)
- Baker, Richard (North East Scotland) (Lab)
- Boyack, Sarah (Edinburgh Central) (Lab)
- Brankin, Rhona (Midlothian) (Lab)
- Brown, Robert (Glasgow) (LD)
- Butler, Bill (Glasgow Anniesland) (Lab)
- Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
- Curran, Margaret (Glasgow Baillieston) (Lab)
- Eadie, Helen (Dunfermline East) (Lab)
- Ferguson, Patricia (Glasgow Maryhill) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Foulkes, George (Lothians) (Lab)
- Gordon, Charlie (Glasgow Cathcart) (Lab)
- Gray, Iain (East Lothian) (Lab)
- Harper, Robin (Lothians) (Green)
- Harvie, Patrick (Glasgow) (Green)
- Henry, Hugh (Paisley South) (Lab)
- Hume, Jim (South of Scotland) (LD)
- Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
- Kelly, James (Glasgow Rutherglen) (Lab)
- Livingstone, Marilyn (Kirkcaldy) (Lab)
- Macdonald, Lewis (Aberdeen Central) (Lab)
- Macintosh, Ken (Eastwood) (Lab)
- Martin, Paul (Glasgow Springburn) (Lab)
- McArthur, Liam (Orkney) (LD)
- McAveety, Mr Frank (Glasgow Shettleston) (Lab)
- McCabe, Tom (Hamilton South) (Lab)
- McConnell, Jack (Motherwell and Wishaw) (Lab)
- McInnes, Alison (North East Scotland) (LD)
- McMahon, Michael (Hamilton North and Bellshill) (Lab)
- McNeill, Duncan (Greenock and Inverclyde) (Lab)
- McNeill, Pauline (Glasgow Kelvin) (Lab)
- McNulty, Des (Clydebank and Milngavie) (Lab)
- Mulligan, Mary (Linlithgow) (Lab)
- Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
- Murray, Elaine (Dumfries) (Lab)
- O'Donnell, Hugh (Central Scotland) (LD)
- Oldfather, Irene (Cunninghame South) (Lab)
- Park, John (Mid Scotland and Fife) (Lab)
- Peattie, Cathy (Falkirk East) (Lab)
- Pringle, Mike (Edinburgh South) (LD)
- Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
- Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
- Scott, Tavish (Shetland) (LD)
- Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
- Smith, Elaine (Coatbridge and Chryston) (Lab)
- Smith, Iain (North East Fife) (LD)
- Smith, Margaret (Edinburgh West) (LD)
- Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
- Tolson, Jim (Dunfermline West) (LD)
- Whitefield, Karen (Airdrie and Shotts) (Lab)
- Whitting, David (Strathkelvin and Bearsden) (Lab)

**Membership:** No.

The Deputy Presiding Officer: Amendment 2 agreed to.

The Deputy Presiding Officer: Group 4 is on entitlement to vote in health board elections. Amendment 3, in the name of Ross Finnie, is grouped with amendment 4.

Ross Finnie: Amendment 3 relates to a matter of some difficulty: how best we not only enable young people aged 16 and 17 to vote, but ensure that names can appear on an electoral register, given that details of persons who are 14 or 15
might appear on a public document. The matter caused serious concern during the committee’s consideration.

The cabinet secretary tried hard to resolve the issue and continues to do so. I do not blame her for the problem; she is somewhat in the hands of the electoral registration officers who run our systems. As we emerged from stage 1, the committee learned that there were grave concerns about proposals to have a private register, which would be inimical to the open approach that we operate in elections in this country.

I lodged a probing amendment at stage 2 and I find myself in the same position today, to try to secure the appearance on the register of the maximum number of people in the simplest way. I acknowledge that the cabinet secretary has made considerable progress on the matter. I understand that the idea of a private register has been dropped and that electoral registration officers have proposed an alternative scheme, which would allow 16 and 17-year-olds who are on the local government register by virtue of the annual canvass automatically to be registered to vote in health board elections. That takes us quite a bit further.

Given that electoral registration officers update registers monthly, as we all know, it is unfortunate that they cannot propose a simpler arrangement that would reduce the requirement for 16-year-olds to apply for a vote. Liberal Democrats are asking the cabinet secretary to give an undertaking to a young persons register, as it would allow EROs to use a straightforward approach than using a young persons register, which would allow 16 and 17-year-olds who are on the local government register by virtue of the annual canvass automatically to be registered to vote in health board elections. That takes us quite a bit further.

Given that electoral registration officers update registers monthly, as we all know, it is unfortunate that they cannot propose a simpler arrangement that would reduce the requirement for 16-year-olds to apply for a vote. Liberal Democrats are asking the cabinet secretary to give an undertaking to a young persons register, as it would allow EROs to use a straightforward approach than using a young persons register, which would allow 16 and 17-year-olds who are on the local government register by virtue of the annual canvass automatically to be registered to vote in health board elections. That takes us quite a bit further.

Nicola Sturgeon: I am sure that I could if the member asked to intervene.

George Foulkes: I am most grateful to the cabinet secretary for taking an intervention.

I agree with everything that the cabinet secretary has said about those aged 16 and over. However, those who are not entitled to vote at general elections comprise three groups of people: lunatics, prisoners and peers. What is their position in respect of the proposed health board elections?

Nicola Sturgeon: Perhaps Lord Foulkes should have declared an interest before asking that question. I look forward immensely to his voting for the bill at 5 o’clock this evening and to his enthusiastic participation in the first elections, if those are piloted by Lothian NHS Board—which, in case anyone gets the wrong idea, is a decision that I have not yet taken.

We are debating an important principle, which is that 16 and 17-year-olds should have the right to vote. I was in the process of saying that such a change is not easy to achieve because the current arrangements cater for those aged 18 and over. Concern has been expressed, particularly during the committee stages of the bill, about the original intention to use a private young persons register. Having listened carefully to those concerns, we have identified a way forward—the subject of amendment 4—that will use existing systems.

Let me briefly run through the key features of this alternative approach. First, those 16 and 17-year-olds who are already on the local government register by virtue of the annual canvass will automatically be registered to vote in health board elections. A cut-off date will be set, by which 16 and 17-year-olds who are not already on the register could apply to register so that they can vote in a health board election. The cut-off date will allow for registration of such voters and the preparation of a voting pack for them. Similarly, anyone whose 16th birthday falls before the cut-off date will be able to apply to register at any time up until the cut-off date once they have turned 16. We will maintain our original approach to publicising to 16 and 17-year-olds that they have a right to seek to register and participate in the elections.

The proposal means that a small minority—I hope very small—whose birthdays fall between the cut-off date and the election date will be excluded from the election. However, the approach will remove the need to store data on persons aged under 16 in a separate register. In my view, that deals with the concern that the committee expressed. Discussions with EROs have indicated that that would be a more straightforward approach than using a young persons register, as it would allow EROs to use
existing systems for maintaining the local government register.

Amendment 4 will ensure that the approach can be implemented in the election regulations that are made under the bill.

In response to Ross Finnie, I say that I believe that the approach represents a step forward from that which we discussed at an earlier stage of the bill. However, I am more than happy to agree with him that further work might still be required. I give him a clear commitment that we will continue to work with electoral registration officers, returning officers and the Electoral Commission to identify an even better system that will be robust enough to use if health board elections are rolled out across the country in the future.

I encourage members to vote for amendment 4.

The Deputy Presiding Officer: I can give Mary Scanlon and Cathy Jamieson only one minute each.

Mary Scanlon: We support amendment 3, which we will push to a vote if necessary, for reasons that are probably different from those of Ross Finnie.

The Scottish Conservatives supported the reduction in the voting age from 21 to 18, but it is not our policy to reduce the voting age to 16. The SNP Government has raised the age for buying cigarettes to 18 and proposes to raise the age for buying alcohol in off-licences to 21, yet it proposes to lower the voting age for health board elections to 16. Voters who will be too young to give blood or to buy cigarettes and alcohol would be tasked with voting for people who will address Scotland’s very serious public health problems. We are not convinced that lowering the voting age to 16 would increase voting turnout or interest in health board elections. If the piloted elections are to be considered on an equal basis with other elections, it would be consistent and appropriate to leave the voting age at 18.

I support amendment 3 in the name of Ross Finnie.

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): I, too, rise to support the amendment in Ross Finnie’s name. I appreciate that a considerable amount of work has been done on the subject. As I said in an earlier debate, I am one of those in my party who is more relaxed about the idea of people voting at 16. That said, we should work with the electoral registration officers to look at the matter more generally. We should not pilot voting for 16-year-olds at the same time that we are piloting other public participation issues and assessing how they have worked. For that reason, I, too, ask Ross Finnie to press amendment 3.

The Deputy Presiding Officer: To allow further debate on amendment 3, I exercise my powers under rule 9.8.4A (a) and 9.8.4A(c) to extend the time limit for the debate. I call Ross Finnie.

Ross Finnie: We now know the answer to the question who cannot vote in the health board elections: lunatics, peers, prisoners and those under 18. That is not a happy combination and I hope that Lord Foulkes will not be proud of it.

Like the cabinet secretary and my Liberal Democrat colleagues, I am very much in favour of the principle that persons under 18 should have the right to vote. It is disappointing therefore that no member of the Labour Party or Conservative Party raised any fundamental objection before the stage 3 debate. They raised no objection at committee. I can think of no evidence that has been adduced in the five or six weeks since the conclusion of the committee process that could have led any member to come to that conclusion.

I repeat what I said earlier: my purpose in lodging amendment 3 was not to interfere with the principle or the right of people under 18 to vote; my purpose was to extract from the cabinet secretary the undertaking—which, I am pleased to say, she has given graciously—that she will continue to work with the electoral registration officers to ensure that the maximum number of persons who are eligible to vote can vote. As other members who had concerns about the private register will be, I am extremely pleased that it will be no more and that its replacement is a system that should—if that further work is carried out—allow the maximum number of people to be included.

On that basis, I seek leave to withdraw amendment 3.

The Deputy Presiding Officer (Alasdair Morgan): Mr Finnie seeks leave to withdraw amendment 3. Are we agreed?

Members: No.

The Deputy Presiding Officer: The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

FOR
Altkin, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Bailie, Jackie (Dumbarton) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brownlee, Derek (South of Scotland) (Con)
Butler, Bill (Glasgow Anniesland) (Lab)
Carlaw, Jackson (West of Scotland) (Con)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Curran, Margaret (Glasgow Baillieston) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Foulkes, George (Lothians) (Lab)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West of Scotland) (Con)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Gray, Iain (East Lothian) (Lab)
Henry, Hugh (Paisley South) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Johnstone, Alex (North East Scotland) (Con)
Kelly, James (Glasgow Rutherglen) (Lab)
Lamont, John (Aberdeenshire and Aberdeenshire) (Con)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Ken (Eastwood) (Lab)
McKay, Paul (Glasgow Springburn) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McConnell, Jack (Motherwell and Wishaw) (Lab)
McGirr, Jamie (Highlands and Islands) (Con)
Mcleod, David (Edinburgh Pentlands) (Con)
McMahen, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Mulligan, Mary (Linlithgow) (Lab)
Murray, Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Peatle, Cathy (Falkirk East) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Elizabeth (Mid Scotland and Fife) (Con)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Whitton, David (Strathkelvin and Bearsden) (Lab)

AGAINST
Adam, Brian (Aberdeen North) (SNP)
Allan, Alasdair (Western Isles) (SNP)
Brown, Keith (Ochil) (SNP)
Brown, Robert (Glasgow) (LD)
Campbell, Aileen (South of Scotland) (SNP)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabian, Linda (Central Scotland) (SNP)
Finnie, Ross (West of Scotland) (LD)
FitzPatrick, Joe (Dundee West) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Graham, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hepburn, Jamie (Central Scotland) (SNP)
Hume, Jim (South of Scotland) (LD)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Kidd, Bill (Glasgow) (SNP)
Lochhead, Richard (Moray) (SNP)
MacAskill, Kenny (Edinburgh East and Musselburgh) (SNP)

Marwick, Tricia (Central Fife) (SNP)
Mather, Jim (Argyll and Bute) (SNP)
Matheson, Michael (Falkirk West) (SNP)
Maxwell, Stewart (West of Scotland) (SNP)
McArthur, Liam (Orkney) (LD)
McInnes, Alison (North East Scotland) (LD)
McKee, Ian (Lothians) (SNP)
McKelvie, Christina (Central Scotland) (SNP)
McLaughlin, Anne (Glasgow) (SNP)
McMillan, Stuart (West of Scotland) (SNP)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Neil, Alex (Central Scotland) (SNP)
O'Donnell, Hugh (Central Scotland) (LD)
Paterson, Gil (West of Scotland) (SNP)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Scotland) (LD)
Smith, Margaret (Edinburgh West) (LD)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)
Tolson, Jim (Dunfermline West) (LD)
Watt, Maureen (North East Scotland) (SNP)
Welsh, Andrew (Angus) (SNP)
White, Sandra (Glasgow) (SNP)
Wilson, Bill (West of Scotland) (SNP)
Wilson, John (Central Scotland) (SNP)

The Deputy Presiding Officer: The result of the division is: For 52, Against 62, Abstentions 0.

Amendment 3 disagreed to.

Amendment 4 moved—[Nicola Sturgeon].

The Deputy Presiding Officer: The question is, that amendment 4 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

FOR
Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Allan, Alasdair (Western Isles) (SNP)
Baillie, Jackie (Dumfartoon) (Lab)
Baker, Claire (Mid Scotland and Fife) (Lab)
Baker, Richard (North East Scotland) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brown, Keith (Ochil) (SNP)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Campbell, Aileen (South of Scotland) (SNP)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Coffey, Willie (Kilmarnock and Loudoun) (SNP)
Constance, Angela (Livingston) (SNP)
Crawford, Bruce (Stirling) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Margaret (Glasgow Baillieston) (Lab)
Don, Nigel (North East Scotland) (SNP)
Doris, Bob (Glasgow) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
FitzPatrick, Joe (Dundee West) (SNP)
Foulkes, George (Lothians) (Lab)
Gibson, Kenneth (Cunninghame North) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Gordon, Charlie (Glasgow Cathcart) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Gray, Iain (East Lothian) (Lab)
Harvie, Christopher (Mid Scotland and Fife) (SNP)
Hargreaves, Richard (Bute and Haddo) (SNP)
Harmston, Alexander (East Lothian) (SNP)
Hewison, Paul (Perth and Kinross) (LD)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Adam (South of Scotland) (SNP)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Kelly, James (Glasgow Rutherglen) (Lab)
Kidd, Bill (Glasgow) (SNP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Lucinda (Fife) (SNP)
Mather, Jim (South of Scotland) (LD)
McAteer, Rosemarie (South of Scotland) (SNP)
McKew, Ian (Cumbernauld and Kilsyth) (Lab)
McNeil, Duncan (North East Fife) (SNP)
Minto, Dr Michelle (Lothians) (SNP)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
O'Donnell, Hugh (Central Scotland) (LD)
Oldfather, Irene (Cunninghame South) (Lab)
Park, John (Mid Scotland and Fife) (Lab)
Paterson, Gil (West of Scotland) (SNP)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Russell, Michael (South of Scotland) (SNP)
Salmond, Alex (Gordon) (SNP)
Scott, Tavernish (Shetland) (LD)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Somerville, Shirley-Anne (Lothians) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow Govan) (SNP)
Thompson, Dave (Highlands and Islands) (SNP)

Against
Aitken, Bill (Glasgow) (Con)
Brocklebank, Ted (Mid Scotland and Fife) (Con)
Brown, Gavin (Lothians) (Con)
Brownlee, Derek (South of Scotland) (Con)
Carlaw, Jackson (West of Scotland) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Goldie, Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
Lamont, John (Roxburgh and Berwickshire) (Con)
McGrigor, Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Smith, Elizabeth (Mid Scotland and Fife) (Con)

The Deputy Presiding Officer: The result of the division is: For 97, Against 16, Abstentions 0.
Amendment 4 agreed to.

Section 5—Report on pilot scheme

16:00

The Deputy Presiding Officer: Group 5 is on the evaluation report. Amendment 5, in the name of Dr Richard Simpson, is the only amendment in the group. You will need to be very brief in speaking to the amendment, Dr Simpson, as we are out of time.

Dr Simpson: I will be brief. Amendment 5 recognises the crucial importance of having an independent evaluator in place sufficiently ahead of the pilot health board elections taking place. By agreeing to the amendment, we will ensure that the person who is tasked with the evaluation of the pilot schemes is appointed at least three months before the health board elections are held. That will allow them to set out fully the scope of their assessment and to establish a baseline around a board’s public engagement and local accountability activity prior to the elections.

I thank the cabinet secretary for working with me on the amendment.

I move amendment 5.

Nicola Sturgeon: Richard Simpson’s amendment simply ensures that there is adequate time for any independent person who is tasked with the evaluation of the pilot schemes to set out their approach. It also enables the existing structures in the pilot board areas to be assessed before any election. I thank him for lodging the
amendment, and I urge the Parliament to support it.

Amendment 5 agreed to.

Section 6—Termination of pilot scheme

The Deputy Presiding Officer: Group 6 is on termination of pilot schemes. Amendment 6, in the name of Ross Finnie, is grouped with amendments 9 and 11.

Ross Finnie: The bill has one very important feature: for the first time, it gives a statutory underpinning to the right of councillors to be members of health boards. Liberal Democrats believe that to be an important position. Unfortunately, however, under section 6, if the procedure for the pilots under the bill does not proceed, sections 1 to 3 will be repealed, which will have the effect of removing the statutory underpinning of the right of councillors to be members of health boards. That would be a retrograde step, and I am sure that it was not the original intention.

I moved an amendment to the same effect at stage 2, but I was advised by the minister that, although she was perfectly sympathetic to the position, she believed that the amendment could be better drafted. I accepted that, and I am grateful to the minister for assisting with the drafting of amendment 6 at this stage. I put it to the Parliament that it would be better to retain the statutory right of councillors to be members of health boards. By voting for amendment 6, and the consequential amendments 9 and 11, that will happen.

I move amendment 6.

Nicola Sturgeon: I agree entirely with Ross Finnie. Local authority members of health boards play a vital role in providing a link between the organisations that are charged with delivering health care and those that are charged with delivering social care to our communities. I am grateful to him for lodging his amendments, which will protect and enshrine the statutory position of local councillors on health boards, notwithstanding what might or might not happen with the roll-out of health board elections at a later stage. I am therefore happy to support the amendments.

Amendment 6 agreed to.

Section 7—Roll-out

The Deputy Presiding Officer: Group 7 is on roll-out. Amendment 7, in the name of the minister, is the only amendment in the group.

Nicola Sturgeon: Amendment 7 seeks to respond to concerns raised by the Subordinate Legislation Committee, not at stage 2 but at a recent meeting. The committee was concerned that the 60-day consultation period for a proposed draft roll-out order for elections might not be sufficient for parliamentary consideration if that period took place across a recess. The process is only one of the stages that any roll-out order would have to go through as part of the super-affirmative procedure that was introduced by an amendment in the name of Michael Matheson at stage 2.

I am happy to respond positively to the Subordinate Legislation Committee’s concerns, and I have lodged amendment 7 to guarantee that the period for consideration of such an order will be no shorter than 60 days, and that it must include at least 30 days when the Parliament is not dissolved or in recess.

I move amendment 7.

Amendment 7 agreed to.

After section 7

The Deputy Presiding Officer: Group 8 is on an annual financial impact report. Amendment 8, in the name of Derek Brownlee, is grouped with amendment 10.

Derek Brownlee (South of Scotland) (Con): In light of the very helpful undertaking that the Minister for Community Safety gave yesterday on a similar provision during the debate on the Damages (Asbestos-related Conditions) (Scotland) Bill, which was of general application, and of the Government’s commitment to work towards a non-legislative solution to deal with the principles that are raised in amendment 8, I do not seek to press it to a vote.

Amendment 8 not moved.

Section 11—Commencement

Amendment 9 moved—[Ross Finnie]—and agreed to.

Amendment 10 not moved.

Amendment 11 moved—[Ross Finnie]—and agreed to.

The Deputy Presiding Officer: That ends the consideration of amendments.
Health Boards (Membership and Elections) (Scotland) Bill

The Deputy Presiding Officer (Alasdair Morgan): The next item of business is a debate on motion S3M-3543, in the name of Nicola Sturgeon, on the Health Boards (Membership and Elections) (Scotland) Bill.

16:06

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I am extremely pleased to open the debate on what I consider to be an extremely important bill. I thank all those who contributed to its development. Many people took the time to become engaged during the consultation and the bill’s passage through the Parliament, and I believe that the bill that we have considered—and which I hope we will pass—is significantly better for their involvement.

I especially offer my thanks to the Health and Sport Committee, the Finance Committee and the Subordinate Legislation Committee for their extremely thorough scrutiny of the bill. I also thank the committee clerks, who worked hard to support committee members and enable them not only to scrutinise the bill but to improve it at different stages. I hope that committee members recognise that the Government has, in turn, worked hard to address as many of their concerns and comments as possible. We have made a number of amendments and, although we have not been able to agree on absolutely everything, we have found consensus on most of the contentious issues. I hope that all members agree that we have worked well together to strengthen the bill.

I also take the opportunity to place on record my sincere thanks to my officials in the bill team, who have worked extremely hard on a short but complex bill. Their work has produced a bill that delivers one of the Government’s key manifesto commitments in a way that is sensitive to the suggestions, comments and concerns that have been expressed throughout the bill process.

It is important to set the bill firmly in context. Members will recall that, in “Better Health, Better Care: Action Plan”, we set out our vision of a mutual national health service, in which ownership and decision making are shared with the public and the staff who work in the service. The bill—together with our proposals to strengthen existing public engagement processes, our plans for a participation standard and ownership report and our intention to introduce a new patients’ rights bill—is designed to bring to life the concept of mutuality.

Many people throughout Scotland believe that there is a democratic deficit in the operation of our health boards. Too often, the public have felt shut out of the big decisions that health boards take day and daily that account for significant sums of public money. The bill addresses that democratic deficit.

I believe that democracy is always a good thing and that opening up health boards to the public through elections will deliver better decision making and, ultimately, services that are even better than those that we already enjoy. The bill’s clear objective is to allow the public’s voice to be heard and, more important, to be listened to at the heart of the decision-making process, which is exactly how it should be.

Understandably, people have strong views, but, more important, they have real-life experiences of what does and does not work in the national health service. People should therefore be involved in considering developments in their area, in decisions about how resources are best spent to meet challenges and in the day-to-day decisions that impact on the health and lives of everybody in Scotland.

Of course, notwithstanding the passing of the bill, health boards will still be faced with regularly making many difficult decisions.

Gil Paterson (West of Scotland) (SNP): I think that we all recognise that there will always be difficult decisions. In recent years in particular, the impact of health board decisions on, for example, the St Margaret of Scotland hospice—the cabinet secretary knows a lot about that—and the Vale of Leven hospital has meant that the legitimacy and public standing of health boards have deteriorated. Does the cabinet secretary think that elections to health boards will raise expectations about the security of their decisions?

Nicola Sturgeon: I believe that to be the case, and I agree with Gil Paterson. The position is unfortunate because, despite the fact that difficult decisions must be made and that it is inevitable that sometimes health boards take decisions with which the public disagree, I believe that our health boards do a fantastic job on behalf of the people of Scotland on most occasions and that they deserve the country’s respect for that. I believe that the bill that we will—I hope—pass today will enhance not just the public’s ability to influence decisions but the standing of health boards in the communities that they serve.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): While welcoming the bill, does the cabinet secretary understand the concern of nurses that, under the alternative pilots outlined in her letter of 4 March, there may not be a position for a nurse director? Given how long and hard
they fought for that position, can she guarantee that there will continue to be a nurse director on the board under any alternative pilot?

Nicola Sturgeon: Malcolm Chisholm will be aware that one of the alternative pilots that we have proposed is intended to address what many people think is the imbalance in health boards between executive and non-executive directors. Indeed, members who are in the chamber have made that comment during the bill’s passage. One of the pilots will therefore look to limit the number of executive directors who have voting rights on health boards. Having said that, I hear what Malcolm Chisholm says and I agree with him about the importance of nurse directors. I will certainly take very seriously his point. Like other professionals in our health service, nurses make an enormous contribution and it is right that their voice is heard.

Elections to health boards does not take away the need to make difficult decisions, but, in my view, it ensures that the quality of the decision-making process is enhanced and improved. We know that, when people are involved in that process and understand and become persuaded of the reasons for change, they are far more likely to be drivers of change than barriers to it. However, I have listened at all stages of the bill to the voices of those who have urged caution. That is why the elections that the bill will enable will be piloted and independently evaluated before any decision is made on roll-out. It is right that we take that approach and that Parliament, and not just the Government of the day, will decide whether to roll out the proposals across Scotland.

I know that some people are concerned that the flip-side of local democracy could be a postcode lottery of provision. It is precisely to allay that concern that the bill will not change the ministerial powers of direction or the clear line of accountability that exists from health boards, through me, to Parliament.

I hope that members agree that we have responded positively to concerns expressed about the power of ministers to remove directly elected members. Indeed, we supported an amendment to that effect at stage 2.

The bill means that a majority of a board’s members must consist of directly elected members and locally elected councillors. For the first time, it gives statutory underpinning to local authority membership of boards, which I believe is extremely important.

The Deputy Presiding Officer: The minister should wind up.

Nicola Sturgeon: If the bill is passed, it will enhance the decision-making process, which will be a good thing for communities right across Scotland.

I move,

That the Parliament agrees that the Health Boards (Membership and Elections) (Scotland) Bill be passed.

16:15

Cathy Jamieson (Carrick, Cumnock and Doon Valley) (Lab): Like the cabinet secretary, I would like to thank everyone who has been involved in bringing the bill to this stage. Like her, I know just how hard the bill teams work. Although it might be a relatively small bill, a number of serious issues had to be teased out. I also thank the Health and Sport Committee.

It is, of course, Labour Party policy to support the introduction of pilots for directly elected health boards. I pay particular tribute to Unison Scotland, which has pressed that case through our policy-making processes, and to Bill Butler, Jackie Baillie, Helen Eadie and Richard Simpson, who have worked so hard to refine the bill so that we could reach a position in which we felt that supporting it was the right thing to do.

Having said all that good stuff, there are some cautionary notes that I would like to put on record, which I hope that the cabinet secretary will deal with when she sums up. She will be aware of some of the concerns that exist—particularly those of the Royal College of Nursing—about the situation that Malcolm Chisholm outlined, and I am grateful to her for her comments on the matter.

We were concerned to ensure that genuine alternatives to direct elections as a way of involving the public in meaningful participation would be introduced, and I think that the options that have been brought forward today still require some work. We might have to take some responsibility for that, given that we pressed the cabinet secretary to produce options in advance of stage 3. Option 1 would involve at least one member of each public partnership forum in a health board area being appointed to the health board, but if sufficient support and resources are not available to ensure that the PPFs work properly, simply appointing people from those bodies to health boards will not, in itself, necessarily ensure additional public participation.

The options that the cabinet secretary has developed include enhancement of the public appointments process to increase diversity. We have all struggled with that issue in relation to a range of public appointments over a number of years. I would certainly like more detail to be provided on how that proposal will be implemented and what specific actions will be taken to ensure that there is delivery.
A further point that I want to put on record relates to resources. There was considerable discussion of the cost of introducing the use of personal identifiers for health board elections. If we are to make public participation happen, adequate resources need to be set aside. The detail on that is sketchy. As I said in the stage 1 debate, I am keen to ensure that public participation is not just for the affluent and the articulate but that it stretches out to involve voluntary sector organisations, patient groups and people who live with and have to manage long-term conditions, so that we can ensure that those people have a genuine opportunity to influence the decisions that health boards ultimately make. I hope that the cabinet secretary will be able to deal with that point in her summing up.

A specific public participation issue was brought to my attention fairly recently. Information must be provided to people that is meaningful; it must also be accurate and up to date. A patient who went to their local general practice surgery picked up a leaflet that invited them, with great gusto, to have their local general practice surgery picked up a leaflet that invited them, with great gusto, to have their say in local health services. It described how to get involved, mentioned the public partnership forums and what they would do, and gave dates for a range of meetings. It was only on investigating the matter further that the person concerned discovered that the meetings that were referred to had taken place almost two years previously. There is little point in having the will to involve the public if that is not filtering down to the ground. If we are preventing people from participating by getting such basic things wrong, we still have a considerable amount of work to do.

Having made those points, I welcome the fact that we have reached this stage. We will support the bill at stage 3, even though members did not agree to all the amendments that we wanted. I hope that the cabinet secretary will continue to work on the points that I have raised. We will do what we can to ensure that the bill actually makes a difference in practice. At the end of the day, there are communities—geographical communities and communities of interest—who feel that their views have not been adequately represented by health boards in the past. That is what has to change, once the bill is implemented.

16:20

Mary Scanlon (Highlands and Islands) (Con): On behalf of my party, I thank the clerks and the excellent and feisty convener of the Health and Sport Committee, as well as all who have helped in the bill’s passage.

It is odd, to say the least, that in the midst of the worst economic recession this country has seen since the 1930s, the democratically elected representatives of this Parliament are passing a bill for elections to health boards, when the full costs of those elections, once they are eventually rolled out, will be taken from front-line services. However, I acknowledge that the costs of the pilot elections will not be taken from front-line services.

Written evidence to the committee did not offer a ringing endorsement. Only 27 per cent of responses were in favour of elections to health boards. Of the 19 responses against the proposal, only five were from national health service bodies. We should not therefore assume that it is the NHS that is against elections.

I hope that Jamie Stone will agree that not all health boards are poor at consulting. However, there is no doubt that the demand for elections comes from health board areas with a history of poor engagement. As I have said before, I have not met an MP or an MSP in the Highlands who has ever been asked to promote elections to health boards.

People in some parts of Scotland will now face eight elections—relating to their national park, the Crofters Commission, their community council, their local authority, the Scottish Parliament, Westminster, the European Parliament, and now their health board. However, we will support this bill to have pilot elections. It could be said that we belong to the sceptical side, but we will carefully consider the outcomes of the pilots and the extension of the franchise.

I have some concerns. I am trying to understand clearly in my mind what criteria will be used, in the evaluation process, to judge success or failure. Some people may think, because decisions went their way, that the pilot was successful; but others may think, because decisions did not go their way, that the pilot was a failure. We have not debated the evaluation process, which is for another day, but I am pleased that the cabinet secretary agreed to the use of the super-affirmative procedure. When we come to roll-out, parliamentarians will have to receive substantial information that spells out exactly why the elections proved beneficial for patient care.

The SNP naturally wants to keep to its manifesto pledge, but the cost to the NHS—taken from front-line services in the depth of today’s economic recession—has to be a significant consideration as it will have a serious impact.

One and the same consultation—or one and the same chance to participate, work in partnership, or form procedures for joint decision making—can lead to huge support and enormous criticism, sometimes depending on the outcome of decisions. I hope that the health boards used in the pilots will not avoid controversial decisions during the pilots; rather, I hope that they will take on the difficult decisions faced by the NHS today.
Change is needed in the NHS, to embrace new technology and new ways of working and to empower patients to take more responsibility for the management of their own care—a point that Cathy Jamieson raised. Sometimes, very difficult decisions must be made, and the challenge for elected members will be to face those tough choices to ensure that Scotland has an NHS that is fit for this century and fit for the patients who depend on it.

16:25

Ross Finnie (West of Scotland) (LD): It is fair to say that the proposition that directly elected health boards per se were going to address all the problems of NHS boards was one that underwhelmed my party by quite some way. Indeed, in looking at the bill in the first instance, we thought it curious because it was a bit of a hybrid. Section 1 purported that the bill would give effect to directly elected health boards. However, when one read sections 2 to 6, one found that what was really intended was simply to proceed with pilots to that purpose. I am pleased that the bill is now fundamentally different from the one that was introduced.

The bill is fundamentally different now because its long title—which, after all, sets the principles on which it is to be considered—makes clear that it is a bill to provide for pilots that might, after Parliament has given due and careful consideration to their results, lead to some other form of board. Also, as Mary Scanlon said, the serious changes that have been made to section 7, providing for the use of the super-affirmative procedure for roll-out orders, mean that the bill will allow the pilots to take place while making it clear that Parliament alone will decide which pilot might be rolled out.

As I have listened to the debate on the bill, in which I have taken a keen interest, one of my main difficulties has been with the bill’s starting point. The cabinet secretary and I exchanged views on the matter in discussing the committee’s report, but Bill Butler will be gratified to know that I will follow his example and resist the temptation to quote myself. I do not believe that direct elections will necessarily be the answer. The evidence shows that there is a completely mixed picture across Scotland. As Mary Scanlon points out, boards such as NHS Highland appear to have a higher level of engagement, whereas in some board areas the engagement is, frankly, downright awful—in fact, unacceptable. There is no doubt that the situation has resulted in great cynicism.

However, when one hears how the boards operate, what the balance is between executive and non-executive directors, what they believe to be their functions and how they act as a matter of corporate governance, one is left with a horribly confused picture. I became worried that if what is supposed to be the solution is simply bolted on to that confused picture, it may not work. Therefore, I repeat what I said in the debate at the committee stage: it would be helpful, even before we get to the stage of considering the pilots, to clarify the precise nature of the boards and the way in which they are supposed to function.

My view is supported by the cabinet secretary’s letter, which sets out the kind of pilots that she would contemplate. I share Cathy Jamieson’s view that those of us who posited the idea of pilots have a duty towards them, and I note with considerable interest that the cabinet secretary intends to involve stakeholders, active partners and the Health and Sport Committee. That will be helpful, as I recognise that we have a duty to contribute to that process.

A reason is given for the suggestion to reduce the number of executive members of a health board, but it is not based on any careful analysis of how the boards function at present. Nor does it follow that, apart from by increasing the ease with which a non-executive majority can be created, reducing the number of executive directors will address the issue of why, at present and with the current numbers, boards do not always function. That remains a fundamental issue, which is why some of us may wish to suggest different forms of board.

The Lib Dems have made our opinion clear throughout the passage of the bill that there is merit in an experiment in which local councillors have a greater degree of influence than they currently exercise.

I acknowledge the cabinet secretary’s role in the constructive work to change the bill fundamentally to recognise that it is there to create the circumstances in which pilots can take place. It means that the bill is now an instrument that the Liberal Democrats are prepared to support. That is how we will vote this evening.

16:30

Ian McKee (Lothians) (SNP): I acknowledge the hard work that Bill Butler put into the bill, which began long before I became an MSP. I hope that he achieves a sense of satisfaction at seeing his efforts come to fruition today. I acknowledge, too, the work that has been put in by my colleagues on the Health and Sport Committee. Together with the cabinet secretary, we have arrived at a bill that is a lot more satisfactory than it might have been.

The core difference between the health services of England and Scotland is that, in England, the public are largely seen as consumers of health services, while we, more in the tradition of Aneurin
Bevan, founder of the national health service, see the public also as owners. The difference is more than academic. Owners of a venture have responsibilities not only for the quality of the service that is provided but for how the venture is run, its direction, its funding, how it treats its staff and a variety of other factors that are of much less concern to a simple consumer.

To develop that theme, Governments in Scotland—particularly this one—have placed great emphasis on public ownership, whereas Governments in England have elected for choice and a much greater private involvement in the provision of services.

The problem is that up until now, those responsibilities of ownership in Scotland have not been accompanied by a mechanism whereby they can be easily discharged. The health minister of the day appoints members to health boards and those members decide collectively how the health service is run in their area of responsibility. Few members of the public know even the names of the non-executive health board members purportedly looking after their interests. They often come from a small section of middle-class society and are not easily accessible. The bill seeks to ensure that, in future, they are chosen by the voters in their area and are responsible for explaining to those voters any decisions that they make.

What are the alternatives that some say are more desirable? Various bodies are associated with representing the public voice in the health service. There are the illness-based organisations, which are organised and effective but which—very reasonably—are only interested in advocating their particular causes. Public partnership forums relate only to community health partnerships and not to hospital services, and are nearly all groupings of self-selected individuals, which can be dissolved at will by a health board. Independent scrutiny panels are great for considering specific issues but not for considering the entire direction of a service. The Scottish health council works largely through the efforts of self-selected volunteers. None of those bodies brings members of the public anywhere near the centre of local decision making, and all but independent scrutiny panels can easily be ignored.

It is perhaps not surprising that the most vituperative opposition to direct elections comes from those whose somewhat cosy world would be disturbed by them: existing health boards and professional organisations. They argue that directly elected members will not be representative of the community that they seek to represent. Do they really think that that representation is achieved at present by the non-executive directors who are on most health boards? They support investigating how the existing range of mechanisms can be improved to achieve greater public engagement in decision making, but those are meaningless words if existing mechanisms cannot possibly be adapted for that purpose. That is why I have doubts about the likelihood of success of the three alternative pilots that we have before us. I do not see how, at the end of the day, any of them can meaningfully involve the wider public in the decisions that affect them so much. We need the public to be at the centre of decision making, not at the fringe.

I began by highlighting the role of the public in Scotland as owners of the health service. Owners of anything often have to make difficult decisions, for example where to invest and how much. For too long, politicians from all sides have tended to treat the public more as children than as adults in that respect. In the past, we have too often said, “We can have the best health service in the world, free at the point of need, and not have to pay for it.” Now is the time to realise that we are dealing with responsible, sensible adults. They must be directly involved in spending decisions, rationing decisions and all the awkward but essential aspects of delivering an effective health service in the modern era.

Directly elected members of health boards will be visible, accessible and accountable to—and ultimately replaceable by—the public. I see no more effective way of running a responsive public service.

16:35

Bill Butler (Glasgow Anniesland) (Lab): First, I congratulate the Cabinet Secretary for Health and Wellbeing on introducing the bill. I am sorry only that she failed to accept my amendment, which would have ensured that a simple majority of 50 per cent of health board members plus one would have been directly elected by the public in health board elections. I never thought that I would see the day that Ms Sturgeon would be described as timid and conservative and I hope that it is simply an aberration.

However, I am a democrat. The Parliament’s will, as expressed earlier this afternoon, has been to reject Labour’s radical policy position and to opt for the Scottish National Party Government’s overly cautious position. Nevertheless, on the basis that half a loaf is better than none, the Labour Party will, as Cathy Jamieson has indicated, support the bill at decision time. It is still a significant reform that I hope can be built on in the years ahead. Finally, I applaud the work of the members of the Health and Sport Committee and its excellent convener, Christine Grahame.
I have believed for some time that there is strong support in Scottish society for the introduction of direct elections to Scotland’s NHS boards, I believe that there is a compelling case for greater democracy, accountability and transparency in decision-making processes for local health services, and I continue to believe that the introduction of direct public elections is the best way of achieving greater accountability and transparency.

The bill will significantly increase public involvement in local NHS services by involving people in the planning and delivery of health care services in their own communities. I emphasise that, in supporting its main aim of introducing more democracy into the operation of health boards, I am not saying that all health board decisions are necessarily wrong or detrimental to local health services. Such a view is simply absurd and I agree with members who have made the same point.

However, there is an undeniable problem with the operation of health boards and the way in which decisions are reached. The public perception is that such decisions are flawed. Indeed, the anger that some people feel about certain decisions is to an extent generated by the manner in which they are made. They are made in secret and are seen as being predetermined, with little or no explanation as to how they have been arrived at. They often ignore the community’s views and the responses that have been made in the board’s own consultation process.

Many people believe that health board consultations are, in effect, fake. That is not a happy situation; such a view corrodes confidence in socialised medicine and in our NHS. That is simply not acceptable.

As members know, there is no perfect method for consulting the public on major local health issues and I do not believe for a moment that direct public elections will lead to everyone being happy with every decision that is made by an NHS board. This policy is not a panacea. However, I contend that decisions that are made by health boards on which there is a large element of democratically elected members will have more credibility than decisions that are made under the current system.

Introducing greater democracy will mean more than just structural change. This kind of electoral accountability will involve patients and communities and will provide an opportunity for public debate and greater access to information. That is, of course, a good thing.

I believe that the bill will, as Unison correctly pointed out in its evidence to the committee, lead to a sea change in the culture of NHS boards. I believe that that will be a very good thing. We have all had enough of top-down bureaucratic decision making, which too often merely echoes vested interests. That is a bad thing.

There has been a fairly long journey to arrive at this juncture for some of us. Despite the reservations that I have expressed, I genuinely think that the bill is a welcome first step towards the positive extension of democracy and democratic accountability in our NHS. On that basis, Labour will support the motion at 5 o’clock. I welcome the Government’s endeavours on the matter and support the motion.

16:40

Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): It is appropriate to say a few words of thanks at this point. I thank my colleagues on the Subordinate Legislation Committee, two of whom are in the chamber, and the clerks to that committee. I should not forget the legal team, who backed us up at all times with detailed and expert advice. Without those people helping us, we would not have done as much as we managed to do. Like others, I thank the Cabinet Secretary for Health and Wellbeing and her team and the bill team for their thoughtful and effective responses to the Subordinate Legislation Committee’s comments.

It is clear that the issue of personal identifiers has divided members. The cabinet secretary made the point that what was proposed would delay things.

I acknowledge the work that Helen Eadie put in on the Subordinate Legislation Committee on the powers of ministers to dismiss elected members. I sought not to have a division in the committee on that because, apart from its role of considering the commas in and language and appropriateness of instruments, the Subordinate Legislation Committee has a role as the Parliament’s guardian in taking a view on which procedure should be used for an instrument. There are members of many parties in the Parliament, and it is helpful if the Subordinate Legislation Committee tries to speak with one voice as much as it can, as it has a role in representing the whole Parliament. However, we knew perfectly well when we took a decision on the powers of ministers to dismiss elected members that Helen Eadie would press her point in the way that she has done. So that my true colours as the convener of the Subordinate Legislation Committee can be known, I should say that I voted for Helen Eadie’s proposal. However, like Bill Butler, I accept the democratic will of the Parliament.

I recognise, as my colleague Ross Finnie does, the work that has been done on extending the franchise and recording the names of 16 and 17-
year-olds, and the significant moves that have been made in the right direction on that. I also compliment the cabinet secretary and her team on the speed with which they reacted to the points that we made in the Subordinate Legislation Committee on the roll-out order in particular. I recognise that the Parliament’s interests have been safeguarded, and thank her very much for that.

The cabinet secretary talked about addressing the democratic deficit and enshrining local councillors in and protecting them on health boards. To conclude my brief speech, I want to take up a point that Mary Scanlon made about the varying levels of accountability in health boards. There is no doubt that there was a perceived democratic deficit some time ago with respect to Highland NHS Board, which covers the areas that Mary Scanlon and I represent. It did not enjoy the support of ordinary people in the Highlands. Part of the perceived deficit was due to what might be referred to as a geographic bias. People in my constituency and in more far-flung parts of the Highlands said that everything was controlled in Inverness, which was why we reached the impasse that we did on issues such as maternity services in the far north of Scotland. The bill will, of course, help to address that issue, because there will now be elected representatives.

Mary Scanlon: It is probably not surprising that the other major concerns existed in Fort William, Ardnamurchan and Lochaber, where 22 per cent of the local population turned up to a public meeting on the health service. I think that Jamie Stone would agree that there was a good outcome for both of those excellent campaigns.

Jamie Stone: I completely accept Mary Scanlon’s point. People power was exercised in a way that was encouraging to all members. We all believe in democracy.

I come to my final point. Can the issue of geographic bias be remembered in view of the powers that remain to the cabinet secretary and ministers to appoint members of health boards? It would be a huge mistake for us to say that, simply because there are elected members in Highland, ministers need not worry about geographical coverage and may appoint only members who live in or around Inverness—the issue will still have power and weight.

As Ross Finnie said, we Liberal Democrats see the bill as a step in the right direction. We recognise that the democratic voice of the Parliament has spoken and will support the bill shortly.

16:45

Jackson Carlaw (West of Scotland) (Con): I offer just a few words in closing for the Conservatives. I congratulate all those who have contributed to the considerable work that was involved in taking the bill through the Parliament. Both Mary Scanlon and I pay tribute to Bill Butler for the passion that he has brought to the subject. I do not share his passion for every subject that he brings to the chamber, but he has led on this matter for a number of years. Not all parties approach the bill from the same perspective or with the same enthusiasm, but all have acted constructively to develop a final measure that commands support across the chamber. I thank and congratulate the cabinet secretary and the minister for the flexibility that they have shown throughout.

The purpose of the pilots is to test the policy. As representatives of a party that supports the principle of directly elected members serving on health boards—although, on the basis of the discussions that have taken place, we are slightly more sceptical about the issue than we once were—we will support the bill in a few minutes’ time.

It is important to note that the revised financial memorandum assumes that as much as 20 per cent of the electorate may be affected by the pilots. It is fair to suggest that such widespread coverage goes beyond what many members of the public assume to be the scope and reach of a pilot. For that reason, it is not enough to be glib about dealing later with general concerns that arise in relation to the pilots. A huge and committed effort will be required by all those who are involved in the pilots to ensure that, as a consequence, local health care is not compromised, but enhanced through greater transparency and accountability.

We must all wish the pilot areas every success. It will be unfortunate if the pilots fail, because one must assume that any judgment of failure will be made on the back of a collapse of public confidence, arising from situations too diverse to predict. Mindful of that point, I believe that ministers will have to be even more closely involved in the affairs of the pilot health boards than in those of boards elsewhere—not necessarily to interfere, but to satisfy themselves that the core business of the boards remains on course.

We have always argued that success will depend, in part, on those elected being supported sufficiently to enable them to make meaningful contributions and to have the courage of their convictions in any crunch vote; they must never be left feeling beleaguered or overwhelmed. However, we can all allow ourselves to be just a
little excited at the prospects offered by the pilots, in the hope that the public will come to feel engaged in the process. As the bill is a health measure, it is appropriate for me to conclude by saying that the proof of this pudding will be in the eating; we must all hope that it will sit easily in our stomachs. With that cheery thought, we wish the pilots well.

16:48

**Dr Richard Simpson (Mid Scotland and Fife) (Lab):** I join other members in thanking the cabinet secretary and the bill team for working flexibly with the Health and Sport Committee. I thank colleagues on the committee and all those who have given evidence on the bill for their work.

The Parliament can be proud of the fact that it has moved quite a long way since it was established in 1999. When we first gathered to look at the state of the NHS, the available guidance on how the public was to be consulted on health service issues was, to say the least, antiquated. As Ian McKee said, it reflected a situation in which the NHS was often autocratic and paternalistic. In the past 20 years or so, we have moved to a situation of far greater partnership in the delivery of health care. It is therefore entirely appropriate that the public should have a sense of ownership of how services are delivered at an operational and strategic level. The bill will help to deliver that.

Ross Finnie, Mary Scanlon and others have made the point that, in the period between 1999 and the introduction of the bill, a number of changes have substantially altered the process and have resulted in different health boards progressing at different rates. When considering the proposal for elected health boards, we should not allow that progress to be lost. Those boards that have moved are now involved in a process of genuine consultation, using public forums, citizens juries and a range of other mechanisms that have been introduced.

As many members have said, that does not remove the problem of making hard decisions when communities are divided. I remember the discussions on where the new hospital in the Forth Valley NHS Board area would be placed. Falkirk wanted it in Falkirk, Stirling wanted it in Stirling and, as I represented mainly the Clackmannan area, I did not care as long as we got a bridge that gave us rapid access to it. I ended up being the meat in the sandwich between the two groups, but a decision had to be made. There was wide consultation and a decision was reached that was accepted.

There were people around in 1999 whose view of consultation was, “This is the option that we have decided on, which is what you will accept, and we will now consult.” That is not consultation. Unfortunately, some health boards still have a culture problem in that respect, which will not be totally solved by the pilots.

Some may see the pilots as overly cautious; they may ask why we did not move to direct elections for all health boards. I sensed, from their final speeches, an unusual partnership developing between Dr McKee and Bill Butler. Had Dr McKee been in the Parliament in the previous session, there might have been a different configuration of support for Bill Butler’s proposal for directly elected health boards as a totality.

It is important that the evaluation of the pilots is robust, and the Parliament’s decisions today have reflected that. With due respect to our Conservative colleagues, it is not only about the economic climate, although that is important. The evaluation must be robust and must demonstrate that the elections add value to the process of ensuring democratic accountability, as well as a sense of ownership. It must also demonstrate that elections do not undermine the existing structures of participation, but add to them, and it must commence well before the elections so that the baselines of existing participation and consultation processes can be fully established.

The super-affirmative resolution, which will be accepted at decision time and was accepted in an amendment to the bill, has been an important element of the bill as it has emerged.

In 1948 we gained a new institution, which no party would now try to remove, but in doing so we lost one thing: local community control. Until that point, health services were local rather than national. When the Parliament votes at decision time, it will re-establish a degree of local control, which is important.

I support Ross Finnie’s view—I hope that the cabinet secretary will work with us on the matter—that the involvement of a substantial number of councillors, not only at the level of community health partnerships but on the health board, should be one of the alternative pilots. That would test a more economic version of representation, albeit indirect, and it would allow us to come back at the time of the super-affirmative resolution, if that occurs, and find out what the best method is for ensuring the democratic accountability that the whole of the Parliament wants.

16:53

**Nicola Sturgeon:** I thank all the members who have contributed to the debate; it is usually not fair to single out one, but for the purposes of this summation I will single out Bill Butler. He has doggedly pursued the issue and he deserves...
considerable credit for that. I am glad to see—I hope that it is not for the last time—that in the cause of progressive reform he has found the SNP Government to be perhaps a more willing partner than the previous Administration.

Bill Butler: Will the cabinet secretary take an intervention on that point?

Nicola Sturgeon: I know that I should not, but I will.

Bill Butler: I hope that this will not be the only time that the SNP brings something to the chamber that can be seen as progressive and radical.

Nicola Sturgeon: I will move swiftly on.

I will quickly address some of the points that have been made in the debate.

Cathy Jamieson said, rightly, that some further work is needed on our suggestions for alternative pilots. I acknowledged in the letter that I sent to Opposition spokespersons. I said that the details will be worked out in parallel with our preparations for elections and I offered to include not just the Health and Sport Committee but the Opposition parties in those further discussions. I hope that they will all take me up on that offer.

I thank Mary Scanlon and her colleagues for their constructive approach to the bill. It is fair to say that Mary Scanlon is, if not the biggest sceptic, one of the biggest sceptics in the Parliament about elected health boards. I hope that the pilot elections will help to persuade her of the case for them. It is to her credit that she has not allowed her scepticism to lead her to try to block the pilot elections and deny other people the right to participate. In her speech, she offered the view that there are too many elections in Scotland. Notwithstanding my earlier comment that democracy is always a good thing, I tend to agree, and that is why I will be only too happy to see the Westminster elections rendered redundant when Scotland becomes an independent country. We will be glad to be of service in that respect.

Ross Finnie said that elected health boards are not a panacea. I agree. Electing people directly to health boards can help to bridge the democratic gap that undoubtedly exists in the minds of many people—and in reality in many communities— throughout Scotland, but such elections will not in themselves deal with some of the culture issues that Richard Simpson mentioned. Dealing with those issues is part of a much bigger effort to ensure that the health service reflects the communities that it serves and listens to the views that are expressed. However, the elections will be a significant step in that direction.

Jamie Stone: In saying that, and given her remaining powers of appointment, is the cabinet secretary mindful of the point that I made about the geographic bias in a health board area as big as that of NHS Highland?

Nicola Sturgeon: I am always mindful of the points that Jamie Stone makes, and that one is no exception. The pilot elections will test such concerns.

If the bill is passed today—I am glad to say that it looks as if it will be—the intention is to pilot the elections in two health board areas that are representative of Scotland’s population and geographical diversity. The pilots will take place over a reasonable period. I hope to announce the decision on which boards will take part in the pilots before the Parliament goes into the summer recess.

I conclude by doing something that I did not do earlier this afternoon, and that is quoting Bill Butler. There is no doubt that the bill that we are about to pass represents a “significant reform”. As I said earlier, I believe that it is a significant progressive reform. It will undoubtedly result in a real change in the make-up of health boards and a shift in the balance of power in health boards. That is the intention of the bill, and rightly so. It will ensure that there is locally mandated representation on health boards while, crucially, retaining the strength of many of those who currently sit around the table.

Direct elections represent a significant step towards ensuring that the public voice is heard loudly and listened to at the heart of NHS decision making. I agree with Jackson Carlaw that that is an exciting prospect. As Ian McKee rightly said, the bill that we are about to pass begins to bring to life the concepts of mutuality and public ownership. I am delighted that there is a further benefit to the bill. In addition to the benefits for the running of the health service and ultimately for the quality of care that patients receive, it will allow 16 and 17-year-olds to participate in elections for the first time in the UK. That is a great step forward, and I hope that it is only the first step on the road to allowing 16 and 17-year-olds to vote in all elections.

I thank all members for their contributions. I hope that the Parliament votes unanimously to pass the bill. I believe that communities throughout Scotland will be grateful to us for doing so.

The Presiding Officer (Alex Fergusson): That was a noble effort, cabinet secretary, but I have no choice other than to suspend the meeting for 30 seconds.

16:59

Meeting suspended.
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Schedule—Minor and consequential amendments
Health Boards (Membership and Elections) (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for piloting of the election of certain members of Health Boards; to require the Scottish Ministers to report on those pilots; to confer a power to extend those elections to all Health Board areas following publication of that report; and for connected purposes.

1 Constitution of Health Boards

(1) Schedule 1 (Health Boards) to the National Health Service (Scotland) Act 1978 (c.29) (the “1978 Act”) is amended as follows.

(2) For paragraph 2 substitute—

“2 (1) A Health Board is to consist of the following types of members—

(a) a chairman, and other members, appointed by the Scottish Ministers (“appointed members”),

(b) councillors appointed by the Scottish Ministers following nomination by local authorities in the area of the Health Board (“councillor members”),

and

(c) individuals elected as members of the Health Board at an election held under Schedule 1A (“elected members”).

(2) Regulations must, in relation to each Health Board, specify—

(a) the total number of members of the Board, and

(b) the number of each type of member.

(3) But—

(a) the total number of councillor members and elected members of a Board must amount to more than half the total number of members, and

(b) a Board must contain at least one councillor member for each local authority whose area is wholly or partly within the area of the Board.
(4) The conditions imposed by sub-paragraph (3) do not apply during any period when an elected member or, as the case may be, councillor member vacates office and the vacancy has not been filled.”.

(3) In paragraph 2A, for “persons appointed under paragraph 2 above” substitute “appointed members”.

(4) In paragraph 3—
(a) for “Appointments under paragraph 2 shall be made” substitute “An appointed member may be appointed only”, and
(b) sub-paragraph (a) is omitted.

(4A) After paragraph 3 insert—

“3A A person appointed as chairman of a Health Board may not be an employee of that Health Board.”.

(5) Before paragraph 11 insert—

“10A(1) An elected member holds office for a period beginning with the day after the day of the Health Board election at which the member was elected and ending on the day of the next following Health Board election in the Health Board area.

(1A) An elected member vacates office on becoming—
(a) a member of the European Parliament,
(b) a member of the House of Commons,
(c) a member of the House of Lords,
(d) a member of the Scottish Parliament, or
(e) a local authority councillor.

(2) Regulations may specify further circumstances in which an elected member must vacate office before the end of that period and, in particular, may specify that an elected member is to vacate office on becoming the holder of a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.”.

(6) In paragraph 11(a), for “chairman and members of Health Boards” substitute “appointed members and councillor members (including provision specifying circumstances in which the Scottish Ministers may determine that such a member is to vacate office)”.

(7) In paragraph 12, after “appointment” insert “or, as the case may be, election”.

Elected members of Health Boards

Health Board elections

(1) In section 2 of the 1978 Act (Health Boards), after subsection (10) insert—

“(10A) Schedule 1A makes provision for the election of individuals to be members of Health Boards.”.

(1A) In section 105 of the 1978 Act (regulations etc.)—
(a) in subsection (2), for “(3) and” substitute “(2A) to”, and
(b) after subsection (2) insert—
“(2A) No regulations shall be made under paragraph 13(1) of Schedule 1A (Health Board elections) unless a draft has been laid before, and approved by resolution of, the Scottish Parliament.”.

(2) After Schedule 1 to the 1978 Act insert—

“SCHEDULE 1A
(introduced by section 2(10A))

HEALTH BOARD ELECTIONS

Health Board elections

1 An election held under this Schedule is known as a “Health Board election”.

Timing of Health Board elections

2 (1) A Health Board must hold the first Health Board election in the Health Board area on the day specified in election regulations.

(2) Election regulations may specify different days for the first election in different Health Board areas.

3 A Health Board must hold subsequent Health Board elections on the first Thursday falling after the end of the period of 4 years beginning with the day of the previous election.

(4) But a Health Board election may be held in a Health Board area before the day specified in sub-paragraph (3) if the Scottish Ministers make an order under section 77 specifying the date of a Health Board election in that area.

Electoral wards

3 (1) Each Health Board area is to be comprised of a single electoral ward unless election regulations specify that a Health Board area is to be divided into more than one ward.

(2) If regulations specify such a division they must also specify—

(a) the number of electoral wards in the Health Board area,

(b) the boundaries of those wards, and

(c) the number of elected members to be elected in each ward.

3 Before regulations specifying such a division are made—

(a) the Scottish Ministers must consult the Local Government Boundary Commission for Scotland, and

(b) the Commission must give the Scottish Ministers advice about the boundaries of the electoral wards which the Health Board is to be divided into.

Conduct of election

4 (1) Election regulations must appoint an individual as the returning officer for each ward in which a Health Board election is to be held.

(2) Election regulations may make provision about—
(a) the tenure and vacation of office of a returning officer,
(b) the functions of a returning officer,
(c) a returning officer’s fees and expenses,
(d) any other matters relating to returning officers that the Scottish Ministers consider appropriate.

5 (1) The nomination of a candidate must be made—
    (a) within the period specified in election regulations (the “nomination period”), and
    (b) in accordance with any other requirement made in those regulations.

10 (2) A candidate may withdraw from a Health Board election at any time before the end of the nomination period.

7 If, at the end of the nomination period, the number of nominated candidates in an electoral ward is equal to or less than the number of elected members to be elected for that ward—

15 (a) the Health Board election is not to be held in the ward, and
(b) on the day on which the election was to be held the returning officer must—
    (i) declare the nominated candidates (if any) to be deemed to have been elected as elected members for the ward, and
    (ii) if the number of nominated candidates is less than the number of elected members to be elected for the ward, declare the number of vacancies in the ward.

8 (1) In any other case, the elected members are to be elected for the electoral ward at a poll held in accordance with this paragraph.

25 (2) At the poll, each individual entitled to vote may vote by marking on the ballot paper—
    (a) the voter’s first preference from among the candidates, and
    (b) if the voter wishes to express a further preference for one or more candidates, the voter’s second and, if the voter wishes, subsequent preferences from among those candidates.

30 (3) Election regulations must, in particular, make provision about—
    (a) the manner in which and period during which votes may be cast,
    (b) the form and content of ballot papers,
    (c) the manner in which the number of votes which will secure the return of a candidate as an elected member is to be calculated,
    (d) the procedure for counting votes,
    (e) the declaration of the result of the poll.
Candidates

9 (1) An individual is disqualified from being a candidate in a Health Board election if the individual is—

(a) a member of the European Parliament,
(b) a member of the House of Commons,
(c) a member of the House of Lords,
(d) a member of the Scottish Parliament, or
(e) a local authority councillor.

(2) Election regulations may make further provision about—

(a) who is qualified to be a candidate in a Health Board election, and
(b) the circumstances in which an individual may be disqualified from being a candidate,

and, in particular, may disqualify from being a candidate an individual holding a post set out in a list of restricted posts maintained by the Health Board concerned for that purpose.

Franchise

10 (1) An individual is entitled to vote at a Health Board election if the individual—

(a) is aged 16 or over, and
(b) meets any further criteria specified in election regulations.

(1A) Such further criteria may, in particular, provide that an individual is entitled to vote at a Health Board election only if the individual—

(a) is registered in the register of local government electors in respect of an address in the Health Board area, and
(b) would be entitled to vote at a local government election in an electoral area falling wholly or partly in the Health Board area (or would be so entitled if aged 18 or over).

(2) Election regulations may determine, or set out the criteria for determining, the electoral ward in which an individual is entitled to vote.

(3) Election regulations may not entitle an individual to vote—

(a) more than once in the same Health Board area, nor
(b) in more than one Health Board area.

Election expenses

11 Election regulations may make provision about the expenses which may be incurred by any person in connection with a Health Board election.

Vacancies

12 (1) This paragraph applies if—
(a) a returning officer declares a vacancy in an electoral ward (see paragraph 7), or

(b) an elected member vacates office before the end of the period mentioned in paragraph 10A(1) of Schedule 1.

5 (2) The Scottish Ministers may—

(a) direct the Health Board with the vacancy to invite an unelected candidate to fill the vacancy, or

(b) appoint, in accordance with any provision made by election regulations, an individual to fill the vacancy.

10 (3) If a vacancy arises less than 6 months before the date of the next Health Board election in the Health Board area where it arises, the Scottish Ministers may, instead of taking action under sub-paragraph (2), direct the Health Board to leave the vacancy unfilled until that next election.

(4) An individual who fills a vacancy is to be deemed to be an elected member of the Health Board elected for the ward in which the vacancy occurred.

15 (5) In sub-paragraph (2)(a), an “unelected candidate” is an individual who—

(a) was a nominated candidate in the last Health Board election to be held in the Health Board area, and

(b) is identified by criteria specified in election regulations.

Election regulations

13 (1) The Scottish Ministers may make regulations (“election regulations”) in relation to any matter specified in this Schedule as something in relation to which provision may be made by election regulations.

(2) Election regulations may make further provision about Health Board elections (in so far as not already provided for in this Schedule).

(3) In particular, election regulations may provide that an enactment applies (with or without modifications specified in the regulations) or does not apply to Health Board elections.

(4) In sub-paragraph (3), “enactment” includes an Act of the Scottish Parliament and any instrument made under such an Act.”.

3 Scottish Ministers’ powers in relation to elected members

In section 77(2) of the 1978 Act (content of order declaring Health Board to be in default)—

(a) in paragraph (a), after “appointment” insert “or, as the case may be, election”, and

(b) in paragraph (b), after “appointment” insert “or, as the case may be, election”.

Pilot scheme and action following pilot

4 Pilot scheme

(1) Ministers may by order (the “pilot order”) appoint a day on which sections 1 to 3 are to come into force in respect of the Health Board areas specified in the order.
(2) Ministers may make one pilot order only (but this does not affect Ministers’ power to modify or revoke the order).

(3) The pilot order may bring sections 1 to 3 into force with such modifications as Ministers consider appropriate.

(4) An order to which this subsection applies may be made only if a draft of it has been laid before, and approved by a resolution of, the Scottish Parliament. This subsection applies to—

(a) a pilot order (or order amending a pilot order) which adds to, replaces or omits any part of the text of sections 1 to 3, and

(b) an order revoking the pilot order.

5 Report on pilot scheme

(1) At least 2 but no later than 5 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order, Ministers must publish a report containing—

(a) a description of the changes made to the 1978 Act by sections 1 to 3 and how the constitution of Health Boards was changed by those sections coming into force in the Health Board areas specified in the pilot order,

(b) a description of the Health Board elections held in the specified Health Board areas, and

(c) an evaluation (carried out by an independent person) of—

(i) the level of public participation in the Health Board elections,

(ii) whether having elected members on Health Boards led to increased engagement with patients and other members of the public or improved local accountability of the Health Board in the specified Health Board areas, and

(iii) the cost of holding the Health Board elections and the estimated cost of holding future Health Board elections in all Health Board areas.

(2) The report may contain—

(a) such other information, and

(b) an evaluation of such other matters,

as Ministers consider appropriate.

(2A) Ministers must appoint a person to carry out the evaluation referred to in subsection (1)(c) at least 3 months before the first Health Board election is held.

(3) Ministers must lay a copy of the published report before the Scottish Parliament.

(4) For the purposes of paragraph (c) of subsection (1), and without prejudice to the generality of that paragraph, a person is not independent if he or she is—

(a) an employee of any Health Board mentioned in the pilot order,

(b) a member of any Health Board mentioned in the pilot order, or

(c) a member of staff of the Scottish Administration.
6 Termination of pilot scheme

(1) The pilot order is revoked on the day falling 7 years after the earliest Health Board election to be held in a Health Board area specified in the pilot order (but this does not affect Ministers’ power to revoke the order on an earlier date).

(2) If—

(a) the pilot order is revoked before a roll-out order is made, or

(b) a question of whether to resolve to approve a draft roll-out order is put to a meeting of the Scottish Parliament but is not agreed by the Parliament,

then, on the day the pilot order is revoked or on the day after the question is put (as the case may be), subsections (3) and (4) come into force.

(3) The following provisions of this Act are repealed—

(a) section 1(5) and (7),

(b) sections 2 to 5,

(c) subsections (1) and (2) of this section (except in so far as bringing this subsection and subsection (4) into force), and

(d) section 7,

and the amendments of the 1978 Act made by provisions so repealed are accordingly to cease to have effect.

(4) Paragraph 2 of Schedule 1 to the 1978 Act is amended as follows—

(a) in sub-paragraph (1)—

(i) after sub-paragraph (a) insert “and”,

(ii) sub-paragraph (c) and the word “and” immediately preceding it are repealed,

(b) for sub-paragraphs (3) and (4) substitute—

“(3) At least one councillor member must be appointed for each local authority whose area is wholly or partly within the area of the Board.”.

7 Roll-out

(1) Ministers may by order (a “roll-out order”) appoint a day on which sections 1 to 3 are to come into force in respect of Health Board areas not specified in the pilot order.

(2) When a roll-out order is made section 6 is repealed.

(3) A roll-out order may not be made unless—

(a) a report has been published under section 5(1), and

(b) a draft of the roll-out order has been laid before, and approved by a resolution of, the Scottish Parliament.

(3A) Before laying a draft of a roll-out order before the Scottish Parliament, Ministers must—

(a) lay before the Scottish Parliament—

(i) a copy of the proposed draft roll-out order, and

(ii) a statement of their reasons for proposing to make the draft roll-out order,
(b) publicise the proposed draft roll-out order in such manner as they consider appropriate, and
(c) have regard to—
   (i) any representations about the proposed draft roll-out order,
   (ii) any resolution of the Scottish Parliament about the proposed draft roll-out order, and
   (iii) any report by a committee of the Scottish Parliament about the proposed draft roll-out order,

made during such period as Ministers may specify when laying the copy proposed draft roll-out order.

(3AA) The period so specified must—
   (a) be no shorter than 60 days, and
   (b) include at least 30 days during which the Scottish Parliament is not dissolved or in recess.

(3B) When laying a draft of a roll-out order before the Scottish Parliament, Ministers must—
   (a) where any representation, resolution or report is made in pursuance of subsection (3A)(c), lay a statement giving details of any representations, resolution or report and of their response, and
   (b) where the draft roll-out order includes material changes to the proposed draft roll-out order, lay a statement giving details of the proposed revisions and of their reasons for them.

(4) A roll-out order may make such provision adding to, replacing or omitting any part of the text of, or otherwise modifying, any enactment (including this Act) as Ministers consider appropriate.

Final provisions

8 Minor and consequential amendments
The schedule contains minor and consequential amendments.

9 Key terms
In this Act—

the “1978 Act” means the National Health Service (Scotland) Act 1978 (c.29),
“Health Board” means a board constituted by an order under section 2(1)(a) of the 1978 Act,
“Health Board election” means an election held under Schedule 1A to the 1978 Act (as inserted by section 2(2) of this Act),
“Ministers” means the Scottish Ministers,
“pilot order” has the meaning given by section 4(1),
“roll-out order” has the meaning given by section 7(1).
10 **Orders**

(1) An order made under this Act is to be made by statutory instrument.

(2) Such an order may—

(a) make different provision for different purposes (in particular, for different Health Board areas), and

(b) contain any supplementary, incidental, consequential, transitional, transitory or saving provision which Ministers consider appropriate.

11 **Commencement**

(1) Sections 1 to 3 come into force in accordance with sections 4 and 7.

(2) Sections 4, 5, 6(1) and (2), 7, 9, 10, 12 and this section come into force on Royal Assent.

(2A) Section 6(2) provides for the commencement of section 6(3) and (4) in particular circumstances.

(3) Section 8 and the schedule come into force on such day as Ministers may by order appoint.

12 **Short title**

This Act is called the Health Boards (Membership and Elections) (Scotland) Act 2009.
SCHEDULE
(introduced by section 8)

MINOR AND CONSEQUENTIAL AMENDMENTS

National Health Service (Scotland) Act 1978 (c.29)

1  In paragraph 4 of Schedule 1 to the 1978 Act, for the words from “the”, where it second occurs, to “prescribed” substitute “—

(a) the chairman of a Health Board,

(b) such other members of a Health Board as may be prescribed, and

(c) such members of committees and sub-committees of a Health Board as may be prescribed,”.

Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)

2  In schedule 2 to the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (the specified authorities), in the list headed “National Health Service bodies”, after “any Health Board” insert “, but Part 1 does not apply to appointments made under Schedule 1 to the National Health Service Scotland Act 1978 (c.29) of the following persons to a Health Board—

(a) a councillor member,

(b) an appointed member who is appointed by virtue of the member—

(i) holding a post in a university with a medical or dental school,

(ii) being employed as an officer of the Health Board, or

(iii) being a member of a body set up by a Health Board which represents health care professionals working in the Health Board area.”.
Health Boards (Membership and Elections) (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision about the constitution of Health Boards; to provide for piloting of the election of certain members of Health Boards; to require the Scottish Ministers to report on those pilots; to confer a power to extend those elections to all Health Board areas following publication of that report; and for connected purposes.

Introduced by: Nicola Sturgeon
On: 25 June 2008
Bill type: Executive Bill