Passage of the

National Health Service Reform (Scotland) Bill 2003

SPPB 69
Passage of the
National Health Service Reform (Scotland) Bill
2003

SP Bill 6 (Session 2), subsequently 2004 asp 7

SPPB 69
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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. Extracts from the Official Report are re-printed as corrected for the archive version of the Official Report.

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 Clerking and Reporting Directorate. 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 with no variations.

The Finance Committee reported to the Health Committee on the Bill at Stage 1. Its report and most of the written evidence it received are included at Annex A of the Stage 1 Report. However, the oral evidence taken by this committee and some supplementary correspondence was not included in that report and it is therefore included in this volume after the Stage 1 Report.

Forthcoming titles

The next titles in this series will be:

- SPPB 70: Antisocial Behaviour etc. (Scotland) Bill 2003
- SPPB 71: Local Governance (Scotland) Bill 2003
- SPPB 72: Tenements (Scotland) Bill 2004
- SPPB 73: School Education (Ministerial Powers and Independent Schools) (Scotland) Bill 2004
National Health Service Reform (Scotland) Bill
[AS INTRODUCED]

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Schedule 1 —Consequential amendments
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National Health Service Reform (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

PART 1

ORGANISATION AND OPERATION OF NATIONAL HEALTH SERVICE

Organisation

1 Disolution of National Health Service trusts: modification of enactments

In the National Health Service (Scotland) Act 1978 (c.29) (referred to in this Act as “the 1978 Act”), section 12A and Schedule 7A (establishment, functions, dissolution etc. of National Health Service trusts) are repealed.

2 Community health partnerships

After section 4 of the 1978 Act insert—

“Community health partnerships

4A Community health partnerships

15 (1) Every Health Board shall, within such period as the Scottish Ministers may specify, submit to them a scheme for the establishment of—

(a) a community health partnership for the area of the Board, or

(b) two or more community health partnerships for districts which, taken together, cover the whole area of the Board.

20 (2) The general function of a community health partnership is to co-ordinate, for its area or district, the planning, development and provision of the services which it is the function of its Health Board to provide, or secure the provision of, under or by virtue of this Act, with a view to improving those services.

(3) The Scottish Ministers may—
(a) approve (with or without modifications), or
(b) refuse to approve,
a scheme submitted to them under subsection (1) or (4).

(4) A Health Board—

(a) may, at any time,
(b) if so directed by the Scottish Ministers, must, within such period as they may specify,
submit to the Scottish Ministers a new scheme under this section.

(5) Regulations may make provision in relation to—

(a) the number of community health partnerships to be established for the area of a Health Board,
(b) the status, membership, procedures, staffing and expenses of a community health partnership,
(c) the form and content of, and the procedure in relation to, schemes under this section,
(d) the functions of a community health partnership and the exercise of those functions,
(e) such other matters with respect to community health partnerships as the Scottish Ministers think fit.

(6) Regulations made in pursuance of subsection (5)(d) may, in particular, include provision—

(a) specifying functions of a Health Board which are to be exercised on their behalf by a community health partnership,
(b) as to consideration by a community health partnership of matters relating to the planning, development and provision, in its area or district, of the services referred to in subsection (2),
(c) as to the submission by a community health partnership to its Health Board of—
   (i) advice and reports on the planning, development and provision, in its area or district, of such services,
   (ii) annual reports on its activities,
(d) as to consultation between a community health partnership and its Health Board,
(e) with a view to securing that persons to whom such services are being or may be provided, and other persons having an interest in the provision of such services, are involved in, and consulted on, the exercise by a community health partnership of its functions.”

Co-operation

3 Health Boards: duty of co-operation

Before section 13 of the 1978 Act insert—
“12I Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency

(1) In exercising their functions in relation to the planning and provision of services which it is their function to provide, or secure the provision of, under or by virtue of this Act, Health Boards shall co-operate with one another, and with Special Health Boards and the Agency, with a view to securing and advancing the health of the people of Scotland.

(2) Where, in pursuance of subsection (1), a Health Board undertake to provide, or secure the provision of, services for individuals for whose health care it is not their function to provide by virtue of section 2(1), the Health Board may—

(a) enter into arrangements with another Health Board, a Special Health Board or the Agency in relation to the provision of such services,

(b) do anything in relation to the provision of such services which they could do for the purpose of providing, or securing the provision of, such services for individuals for whose care it is their function to provide by virtue of section 2(1).

(3) Subsection (2) is without prejudice to any other power which a Health Board may have.”

Powers of intervention

4 Powers of intervention in case of service failure

After section 78 of the 1978 Act insert—

“78A Powers in case of service failure

(1) This section applies where—

(a) it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and

(b) the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

(i) to provide the service, or

(ii) to provide it to a standard which they regard as acceptable.

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

(a) a body falling within subsection (4), or

(b) one or more persons falling within subsection (5).

(3) In subsection (2), “specified” means specified in the direction.

(4) A body falls within this subsection if it is—

(a) a Health Board,

(b) a Special Health Board, or

(c) the Agency.
(5) A person falls within this subsection if the person is—
   (a) an employee of a Health Board, a Special Health Board or the Agency, or
   (b) a member of the staff of the Scottish Administration.

78B Relationship of sections 77, 78 and 78A
The powers conferred by each of sections 77, 78 and 78A are without prejudice to the powers conferred by the other two sections.”

Public involvement
After section 2A of the 1978 Act (inserted by section 7(2)) insert—

“2B Duty to encourage public involvement
(1) It is the duty of every Health Board and Special Health Board to take action with a view to securing, as respects services for which they are responsible, that persons to whom those services are being or may be provided are involved in, and consulted on—
   (a) the planning and development, and
   (b) decisions of the Health Board or Special Health Board affecting the operation, of those services.
(2) For the purposes of subsection (1) a Health Board or Special Health Board is responsible for services if they are services which it is the function of the Health Board or Special Health Board to provide, or secure the provision of, under or by virtue of this Act.”

6 Dissolution of local health councils
(1) Local health councils established by virtue of section 7 of the 1978 Act are dissolved on such date as the Scottish Ministers may by order made by statutory instrument specify.
(2) A statutory instrument containing an order under subsection (1) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

PART 2
PROMOTION OF HEALTH IMPROVEMENT

7 Duty to promote health improvement
(1) After section 1 of the 1978 Act insert—

“1A Duty of the Scottish Ministers to promote health improvement
(1) It is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland.
(2) The Scottish Ministers may do anything which they consider is likely to assist in discharging that duty including, in particular—
(a) giving financial assistance to any person,
(b) entering into arrangements or agreements with any person,
(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to section 1 and any other provision of this Act conferring or imposing functions on the Scottish Ministers.”

(2) After section 2 of that Act insert—

“2A Duty of Health Boards to promote health improvement

(1) It is the duty of every Health Board to promote the improvement of the physical and mental health of the people of Scotland.

(2) A Health Board may do anything which they consider is likely to assist in discharging that duty including, in particular—

(a) giving financial assistance to any person,
(b) entering into arrangements or agreements with any person,
(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to any other provision of this Act conferring or imposing functions on a Health Board.

(4) Anything done by a Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on the Health Board by the order under section 2(1)(a) which constituted the Board.”

PART 3
SUPPLEMENTARY

8 Ancillary provision

(1) The Scottish Ministers may by order made by statutory instrument make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—

(a) make different provision for different purposes,
(b) modify any enactment, instrument or document.

(3) A statutory instrument containing an order under this section (except where subsection (4) applies) is subject to annulment in pursuance of a resolution of the Parliament.

(4) No order under this section containing provisions which add to, replace or omit any part of the text of an Act is to be made unless a draft of the statutory instrument containing the order has been laid before, and approved by resolution of, the Parliament.
9  **Modification of enactments**

(1) Schedule 1 contains amendments consequential on the provisions of this Act.

(2) The enactments specified in column 1 of schedule 2 are repealed to the extent specified in column 2.

10  **Commencement and short title**

(1) The provisions of this Act, except section 8 and this section, come into force on such day as the Scottish Ministers may by order made by statutory instrument appoint.

(2) Different days may be appointed under this section for different purposes.

(3) This Act may be cited as the National Health Service Reform (Scotland) Act 2003.
SCHEDULE 1
(introduced by section 9)

CONSEQUENTIAL AMENDMENTS

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

1 (1) The 1978 Act is amended as follows.

(2) In section 12H(1) (duty of quality), for “, Special Health Board and NHS trust” substitute “and Special Health Board”.

(3) In section 75A (remission and repayment of charges and payment of travelling expenses), in subsection (2), for “, (c) or (d)” substitute “or (c)”.

(4) In section 86 (accounts), in each of subsections (3) and (4), for “to (c)” substitute “and (b)”.

(5) In section 102 (State hospitals), in subsection (4)(b), for “, the Agency or an NHS trust” substitute “or the Agency” and for “, Agency or trust” substitute “or Agency”.

(6) In section 105 (orders, regulations and directions), in subsection (4)(b), for the words from “12A(1)” to the end substitute “or 70(2)”.

(7) In Schedule 1 (Health Boards), in paragraph 8A, for “, the Agency or an NHS trust” substitute “or the Agency”.

(8) In Schedule 5 (Common Services Agency), in paragraph 8A, for “, a Health Board or an NHS trust” substitute “or a Health Board”.

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

2 (1) The Public Appointments and Public Bodies etc. (Scotland) Act 2003 is amended as follows.

(2) In section 7 (investment and borrowing), in subsection (7), for “to (6)” substitute “or (4)”.

(3) In section 9 (directions in relation to endowments), for the words “, and paragraph 6(1) of Schedule 7A to, the 1978 Act (which confer)” substitute “the 1978 Act (which confers)”.

SCHEDULE 2
(introduced by section 9)

REPEALS

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<td>National Health Service (Scotland) Act 1978 (c.29)</td>
<td>Section 7.</td>
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<td>In section 8(1), the words “and any NHS trusts in the area or combined areas” and “, any such NHS trust”.</td>
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<td>In section 9, in subsection (5), the words “and, where the Secretary of State so directs, an NHS trust”; and in subsection (7), the words “or, where</td>
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**Schedule 2—Repeals**

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<td>the Secretary of State so directs, NHS trusts”.</td>
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<td>In section 10(4), the words “the NHS trusts”, “or of the NHS trusts” and “or NHS trusts”.</td>
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<td>In section 13, the words “NHS trusts,”.</td>
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<td>Section 17A(2)(e).</td>
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<td>In section 17D, subsection (1)(a); and in subsection (2), paragraph (a) of the definition of “NHS employee”.</td>
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<td>In section 27(1)(b), the words “or by an NHS trust”.</td>
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<td>Section 35A.</td>
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<td>Section 73(c).</td>
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<td>Section 74(c) and the preceding “or”.</td>
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<td>Section 75A(1)(d) and the preceding “and”.</td>
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<td>Section 77(1)(aa).</td>
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<td>In section 82(2A), the words “or 6(2)”.</td>
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<td>Section 83(2).</td>
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<td>In section 84, in subsection (1), the words “or an NHS trust” and “or NHS trust”; in subsection (2), the words “or NHS trust” and “or NHS trusts”; and in subsection (3), the words “or an NHS trust”.</td>
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<td>In section 84A, in subsection (1), the words “or NHS trust”; subsection (2); and in subsections (3) to (7), the words “, NHS trust or local health council”, “NHS trust or council” and “NHS trust or the council” in each place where they occur.</td>
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<td>Section 85AA(7).</td>
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<td>Section 85(1)(f).</td>
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<td>In section 85A(4)(a), the words “or a local health council”.</td>
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<td><strong>5</strong></td>
<td>In section 85B, subsection (2)(d); and, in each of subsections (3)(a) and (4)(b), the words “or NHS trust”.</td>
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<td>In section 86, subsection (1)(c) and the preceding “and”; and subsection (1B).</td>
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<td>In section 101, the words “, an NHS trust”.</td>
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<td>Section 105(1A).</td>
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<td>In section 108, in the definition of “health service hospital”, the words “or vested in an NHS trust”; and the definitions of “local health council”, “National Health Service trust” and “operational date”.</td>
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<td><strong>15</strong> Health Services Act 1980 (c.53)</td>
<td>In Schedule 6, paragraph 1.</td>
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<td>National Health Service and Community Care Act 1990 (c.19)</td>
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<td>Section 29(3) and (4)(a) and (c).</td>
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<td>Schedule 6.</td>
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<td><strong>20</strong> Health Authorities Act 1995 (c.17)</td>
<td>In Schedule 9, in paragraph 19, sub-paragraphs (4), (7)(a)(ii), (11) to (14), (16), (17), (19), (21) and (22)(b) and (d).</td>
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<td>National Health Service (Primary Care) Act 1997 (c.46)</td>
<td>In Schedule 1, paragraph 102(7).</td>
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<td><strong>25</strong> Health Act 1999 (c.8)</td>
<td>In section 3, subsection (2)(a); and in subsection (3), paragraph (a) of the definition of “NHS employee”.</td>
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<td><strong>30</strong> Public Finance and Accountability (Scotland) Act 2000 (asp 1)</td>
<td>In Schedule 4, paragraphs 44, 45, 62 and 63.</td>
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| Abolition of Feudal Tenure etc. (Scotland) Act 2000 (asp 5)              | In section 18C, in subsection (1), the words “a National Health Service trust or”, “in either case” and “the trust or as the case may be”; and in subsection (3), the words “the trust or as the case
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<td>Community Care and Health (Scotland) Act 2002 (asp 5)</td>
<td>may be” and “the trust or, as the case may be,”. In section 22(1), in the definition of “NHS body”, paragraph (c).</td>
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<td>Scottish Public Services Ombudsman Act 2002 (asp 11)</td>
<td>In schedule 2, paragraph 4(c).</td>
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<tr>
<td>Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)</td>
<td>In section 5, in subsection (3), the words “and NHS trusts”; in subsection (5), the words from “(except” to “trust)”; and subsection (6). Section 6.</td>
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<tr>
<td>Title Conditions (Scotland) Act 2003 (asp 9)</td>
<td>In section 46, in subsection (1), the words “a National Health Service trust, or of”; in subsection (2), the words “the trust or” in both places where those words occur, and the words “its or”; and in subsection (3), the words “the trust or” and “as the case may be”.</td>
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</table>
National Health Service Reform (Scotland) Bill
[AS INTRODUCED]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

Introduced by: Malcolm Chisholm
On: 26 June 2003
Supported by: Mr Tom McCabe
Bill type: Executive Bill
NATIONAL HEALTH SERVICE REFORM (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 National Health Service Reform (Scotland) Bill introduced in the Scottish Parliament on 26 June 2003:
   - Explanatory Notes;
   - a Financial Memorandum;
   - an Executive Statement on legislative competence; and
   - the Presiding Officer’s Statement on legislative competence.

A Policy Memorandum is printed separately as SP Bill 6–PM.
INTRODUCTION

2. These Explanatory Notes have been prepared by the Scottish Executive 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 – AN OVERVIEW

4. The Bill takes forward the proposals in the White Paper Partnership for Care and fulfils the commitments in the Partnership Agreement (A Partnership for a Better Scotland: Partnership Agreement published in May 2003) to bring forward legislation to reform the National Health Service (NHS) by introducing provisions in relation to:
   - the dissolution of NHS Trusts;
   - establishing community health partnerships;
   - placing a duty on Health Boards to co-operate with each other, with Special Health Boards and with the Common Services Agency, in the interests of developing more effective regional planning of health services;
   - extending Ministerial powers to intervene to secure the quality of healthcare services;
   - placing a duty on Health Boards and Special Health Boards to involve the public in the planning, development and operation of health services; and
   - placing a duty on the Scottish Ministers and Health Boards to take action to promote health improvement.

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

6. The Bill is in three Parts:
   - Part 1: Organisation and operation of National Health Service;
   - Part 2: Promotion of health improvement;
   - Part 3: Supplementary.

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COMMENTARY ON SECTIONS

PART 1: ORGANISATION AND OPERATION OF NATIONAL HEALTH SERVICE

Section 1 – Dissolution of National Health Service trusts: modifications of enactments

7. This section repeals section 12A of, and Schedule 7A to, the 1978 Act, which are the main legislative provisions relating to NHS trusts. These provisions empower the Scottish Ministers to establish NHS trusts, dissolve trusts following consultation, and transfer their assets, rights and liabilities to Health Boards.

8. Schedules 1 and 2 include further amendments and repeals of enactments consequential on section 1.

Section 2 – Community health partnerships

9. Section 2 inserts a new section 4A into the 1978 Act which provides for the establishment of community health partnerships (CHPs). Subsection (1) requires every Health Board to produce a scheme for the establishment of CHPs within a period specified by the Scottish Ministers. A scheme for a Health Board may contain one or more CHPs to cover the area of the Health Board.

10. Subsection (2) provides that the general function of CHPs is to co-ordinate the planning, development and provision of services that Health Boards provide. The co-ordination is to take place with a view to improvement of those services.

11. Subsection (3) allows the Scottish Ministers to either approve the scheme, with or without modifications, or to reject the scheme. Subsection (4) allows Health Boards to submit to the Scottish Ministers a new scheme for CHPs in their Board area, and requires them to do so if directed by the Scottish Ministers.

12. Subsection (5) allows regulations to be made which may provide for: the number of CHPs to be established in the area of a Health Board; membership procedures, staffing and expenses; the procedures for submitting a scheme and their form and content; the functions which CHPs should have and how these functions should be exercised; and other matters relating to CHPs. Under section 105 of the 1978 Act, the regulations will be subject to negative resolution procedure before the Scottish Parliament.

13. Subsection (6) provides that regulations made under subsection (5)(d), in relation to a CHP’s functions, may in particular provide as follows: they may specify Health Board functions that are to be carried out by CHPs; explain the type of consideration CHPs should give to matters relating to the planning, development and provision of services in their area or district; the submission of advice and reports (on planning, development and provision of services as well as on their own activities); and ensure consultation between CHPs and Health Boards and other persons interested in the provision of services.
Section 3 – Health Boards: duty of co-operation

14. Section 3 inserts a new section 121 into the 1978 Act. That section places a new duty on Health Boards to co-operate with one another and with Special Health Boards and the Common Services Agency in exercising their functions in relation to the planning and provision of services. It enables Health Boards to make arrangements for the provision of services to persons from outwith their geographical area and in so doing, they may do anything which they could do in relation to provision of services to persons from within their own area.

Section 4 – Powers of intervention in case of service failure

15. Section 4 inserts two new sections into the 1978 Act: sections 78A and 78B. Section 78A gives the Scottish Ministers power, in the case of a failure by a body or person to provide a service under the 1978 Act to an acceptable standard, to direct that the relevant functions to which that service relates should be performed by another body or person.

16. Subsection (1) of section 78A describes when the section applies. The section will apply where a body or person has failed, is failing, or is likely to fail either to provide a service which it is their function under the 1978 Act to deliver or to provide that service to a standard that the Scottish Ministers regard as acceptable.

17. Subsections (2) and (3) provide that when section 78A applies, the Scottish Ministers may direct that another body, person or persons may perform specified functions of the body or person to ensure the provision of the service in question to a standard that the Scottish Ministers consider to be acceptable. The direction may specify the extent to which those functions are to be performed by the alternative body or person and the duration of the intervention.

18. Subsection (4) lists the bodies which may be identified in a direction made under subsection (2) (specifically a Health Board, a Special Health Board or the Common Services Agency).

19. Subsection (5) lists the persons who may be identified in a direction made under subsection (2): employees of the bodies listed in subsection (4) or of the Scottish Administration.

20. Section 78B makes it clear that the power in section 78A is additional to those in sections 77 and 78 of the 1978 Act, and that the powers in those sections are to be read separately.

Section 5 – Public involvement

21. Section 5 inserts a new section 2B into the 1978 Act covering public involvement. It will place a duty on Health Boards and Special Health Boards to ensure that patients and the public are involved in the development of services for which Boards are responsible, and consulted about decisions that will affect the operation of those services.
Section 6 – Dissolution of local health councils

22. Subsection (1) of section 6 provides for local health councils to be dissolved on a date specified in an order made by the Scottish Ministers. Under subsection (2), such an order will be subject to negative resolution procedure before the Scottish Parliament.

23. Schedules 1 and 2 include amendments and repeals of enactments consequential on the dissolution of local health councils.

PART 2: PROMOTION OF HEALTH IMPROVEMENT

Section 7 – Duty to promote health improvement

24. Section 7 inserts two new sections into the 1978 Act. It inserts section 1A, which places a duty upon the Scottish Ministers to promote health improvement, and section 2A, which places a duty upon Health Boards to promote health improvement. Section 1A will provide the Scottish Ministers with an express basis to act in their own right to implement a wide range of measures designed to improve health. It also provides that the duty shall not restrict any other functions of the Scottish Ministers, in particular those contained in section 1 of the 1978 Act. Section 2A of the 1978 Act confers upon Health Boards the same duty of health improvement and powers that the Scottish Ministers are given under section 1A.

25. Subsection (1) of section 1A makes it a duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland. Subsection (2) allows the Scottish Ministers to do anything that they think is likely to assist in promoting health improvement including:
   • giving direct financial assistance to any person;
   • entering into arrangements or agreements with any person;
   • co-operating with, or facilitating or co-ordinating the activities, of any person.

26. Subsections (1) and (2) of section 2A make corresponding provision in relation to Health Boards. Subsection (4) of section 2A provides that anything done by a Health Board under section 2A is to be treated as done in exercise of a function of Ministers delegated to the Health Board by way of an order made under section 2(1)(a) of the 1978 Act.

PART 3: SUPPLEMENTARY

Section 8 – Ancillary provision

27. Section 8 contains power to make any incidental, supplemental, consequential, transitional, transitory or saving provision in consequence of any provisions in the Bill. Such an order will be subject to negative resolution procedure before the Scottish Parliament (subsection (3)) unless the order contains amendments to primary legislation in which case the order will be subject to affirmative resolution procedure (subsection (4)).
Section 9 – Modification of enactments

28. Section 9 introduces schedule 1 (which makes consequential amendments) and schedule 2 (which contains consequential repeals).

Section 10 – Commencement and short title

29. Section 10 allows the Scottish Ministers to set different dates to commence different provisions of the Act.

FINANCIAL MEMORANDUM

INTRODUCTION

30. The Executive plans to increase investment in health over the lifetime of this Parliament and to match this investment with continued reform so that public services are designed and delivered around the needs of individuals and the communities within which they live.

31. As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure arising from the Bill. Nevertheless, whilst there will be no additional expenditure associated with the Bill, the following paragraphs discuss the financial implications of the changes arising from the Bill. The assessment that there will be no net additional expenditure for the Bill is considered to be an accurate one.

COSTS ON THE SCOTTISH ADMINISTRATION

Dissolution of NHS Trusts

32. Section 1 of the Bill and the related amendments and repeals in schedules 1 and 2 remove from the statute book references to NHS Trusts in Scotland. It is expected that, by the time these provisions are brought into effect, all NHS Trusts in Scotland will have been wound up using existing powers. Consequently, no costs will fall on the NHS as a result of enacting those provisions of the Bill.

Community health partnerships

33. The proposals for the submission by Health Boards to Scottish Ministers of schemes for the establishment of community health partnerships (CHPs) will not result in additional expenditure by the Executive or Health Boards. Arrangements are already in place in each area to support financially local health care co-operatives (LHCCs), which will be subsumed by CHPs once they are introduced. The funding for the enhanced role and responsibilities of CHPs will be met by a reallocation of existing resources within each Board, including monies currently set aside for LHCCs. CHPS will receive the funding provided for functions previously carried out by Health Boards or LHCCs. There will be fewer CHPs than LHCCs, which may reduce administrative costs.
Health Boards: duty of co-operation (regional planning)

34. It is not anticipated that Health Boards will need any additional funds to engage more substantively in regional consortia, whether to promote service redesign through managed clinical networks or in planning services in a more vertically integrated way or horizontally, for example on issues like workforce planning. Any additional costs on Health Boards as a result of the new duty to co-operate with each other will relate to management and administration, will be modest, and will be met within existing financial allocations. Boards are already co-operating in aspects of regionally- and nationally-planned services, and are meeting any associated costs within existing budgets. In addition, the Executive has allocated £1 million over 2002-03 and 2003-04 to support the development of managed clinical networks. Effective co-operation should result in reduced capital and running costs through more efficient use of resources in jointly planned and delivered services.

Powers of intervention

35. Costs will be incurred as a result of the new powers that the Bill proposes to confer on the Scottish Ministers only if these powers are used. If so, costs will depend on how the powers are used; the Executive would expect any such costs to be contained within existing NHS financial allocations. It is estimated that a task force which comprised 6 people and lasted for 10 months would incur costs in the order of £85,000. Potential costs would be commensurate with that amount.

Public involvement in the NHS and the dissolution of local health councils

36. The proposed statutory duty upon Health Boards to involve the public in the design and delivery of healthcare underpins existing practice in many respects. This new duty is not expected to lead to any significant additional expenditure although some adjustment of Boards’ priorities within their existing allocations may be necessary as public involvement becomes a higher priority.

37. Section 6 of the Bill provides for the dissolution of local health councils in Scotland. Local health councils are currently funded by the Executive. It is not envisaged that the costs of dissolving local health councils will exceed existing financial allocations. Future allocations to local health councils will transfer to NHS Quality Improvement Scotland on 1 April 2004 when the Scottish Health Council becomes operational as a committee of that Special Health Board. The Scottish Health Council will be responsible for monitoring the effectiveness of Boards in involving the public in the planning development and operation of health services. The £2,108,000 currently allocated to local health councils for 2003-04 will be sufficient to fund the new Scottish Health Council.

Duty to promote health improvement

38. The proposals relating to health improvement aim to address deficiencies in the interpretation of the 1978 Act, which is seen as laying a greater emphasis on treatment of illness by health services rather than on health services which have a role to play in health improvement.
39. These proposals are expected to be implemented in a cost neutral way. The proposed statutory duty for the Scottish Ministers will enable Ministers to pay grants or secure expenditure for the purposes of health improvement. At present Ministers may only fund Health Boards for such purposes or pay grants to voluntary bodies under section 16B of the 1978 Act. If Ministers wish to direct funding for health improvement to areas outwith the NHS or the voluntary sector, for example to local authorities as part of the community planning process, the expectation is that any such funding would come from a re-allocation of existing resources.

40. The proposed statutory duty of Health Boards to promote health improvement is expected to lead to some adjustment of emphasis within Boards’ activities as health improvement becomes a higher priority. It is not possible to estimate what additional expenditure Boards may incur on health improvement as a result of the proposed new duty but it is expected that Health Boards will be able to manage the readjustment of existing resources to reflect the adjustment of emphasis. Any additional funding for health improvement will be notified to Parliament through the normal Budget process.

COSTS ON LOCAL AUTHORITIES AND OTHER BODIES, INDIVIDUALS AND BUSINESSES

41. The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill.

SUMMARY

42. There will be no additional expenditure associated with this Bill. The following table summarises the financial implications:
These documents relate to the National Health Service Reform (Scotland) Bill (SP Bill 6) as introduced in the Scottish Parliament on 26 June 2003

<table>
<thead>
<tr>
<th>PROVISION</th>
<th>FINANCIAL IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissolution of NHS Trusts</td>
<td>No direct cost implications. Winding up of Trusts likely to produce modest reductions in administrative costs to be used by Health Boards to improve patient care.</td>
</tr>
<tr>
<td>Community health partnerships</td>
<td>No overall additional expenditure. Resources previously used to support local health care co-operatives will be used to fund community health partnerships.</td>
</tr>
<tr>
<td>Health Boards: duty of co-operation (regional planning)</td>
<td>No overall additional expenditure. Existing resources to be used more effectively.</td>
</tr>
<tr>
<td>Powers of intervention</td>
<td>No direct cost implication until used. If the power is used, any expenditure is expected to be modest and will be contained within existing NHS financial allocations.</td>
</tr>
<tr>
<td>Public involvement in the NHS and the dissolution of local health councils</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority. The cost of the new Scottish Health Council will be met from the £2.108 million currently allocated to Local Health Councils, which are being dissolved</td>
</tr>
<tr>
<td>Duty to promote health</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority.</td>
</tr>
<tr>
<td><strong>SUMMARY</strong></td>
<td>Overall additional expenditure as a result of the above provisions will be zero, for the Scottish Administration; local authorities and other bodies, individuals and businesses.</td>
</tr>
</tbody>
</table>
EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE

43. On 24 June 2003, the Minister for Health and Community Care (Malcolm Chisholm) made the following statement:

“In my view, the provisions of the National Health Service Reform (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE

44. On 24 June 2003, the Presiding Officer (Mr George Reid) made the following statement:

“In my view, the provisions of the National Health Service Reform (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”
INTRODUCTION

1. This document relates to the National Health Service Reform (Scotland) Bill introduced in the Scottish Parliament on 26 June 2003. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 6–EN.

POLICY OBJECTIVES OF THE BILL - BACKGROUND

2. This Bill builds on the Executive’s policies on reform of health care, set out in detail in Scotland’s Health White Paper Partnership for Care1 (published in February 2003), and on the priorities for improving public services set out in the Partnership Agreement2.

3. The Executive will continue to increase investment in health services, with the health budget rising by over 5% a year in real terms from its current base of £6.7 billion. Partnership for Care and the Partnership Agreement made clear that this investment must be matched by reforms to deliver improved health and better integrated health services that are more responsive to the needs of patients and communities. These intentions are backed up by commitments to legislate to abolish NHS Trusts, establish community health partnerships, ensure co-operation in delivering regional service, increase public involvement and promote health improvement. All of this will be underpinned by new powers for the Scottish Ministers to intervene in the case of service failure, as a last resort, to ensure that health care is delivered to acceptable standards.

POLICY OBJECTIVES OF THE BILL - SPECIFICS

Dissolution of National Health Service Trusts

Policy objective

4. The Executive’s policy objective in relation to NHS Trusts is to abolish them. The abolition of NHS Trusts forms an important part of the Executive’s aim of reshaping the NHS to ensure that patients’ interests are put first and that services are planned and provided in an efficient and integrated way, through collaboration within and among NHS bodies. This process

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This document relates to the NHS Reform (Scotland) Bill (SP Bill 6) as introduced in the Scottish Parliament on 26 June 2003

began with the White Paper *Designed to Care*\(^3\) in 1997, which announced the merger of some NHS Trusts and the dismantling of the NHS internal market. These changes were implemented in the period 1998-99.

5. The White Paper *Our National Health: a plan for action, a plan for change*\(^4\) carried the process further by announcing the intention to introduce unified Health Boards with overall responsibility for the governance and performance management of services provided by NHS Trusts in their area. These unified Health Boards would have wider representation to reflect community, staff and clinical and other professional interests. NHS Trusts were to retain their existing operational and legal responsibilities within the local health system, but with streamlined management arrangements and fewer non-executive directors. *Rebuilding our National Health Service*\(^5\) set out in more detail the Executive’s plans for governance arrangements for Boards and Trusts. These plans were implemented and unified Health Boards were established by October 2001.

6. *Partnership for Care* sets out the Executive’s intentions for health and healthcare policy, with an emphasis on integration of healthcare services and delegation of responsibility and decision-making to local level, as near as possible to where services are delivered to patients. The White Paper explained that this approach had organisational consequences, including the dissolution of NHS Trusts. It states that “[the Executive] will therefore continue dissolving Trusts, as is already happening in the Borders and Dumfries and Galloway, and we will legislate to remove the powers relating to NHS Trusts.”\(^6\)

7. The Health Department issued guidance to Health Boards on single system working in 2003\(^7\). This guidance aimed to help Health Boards bring forward practical proposals as soon as possible for the dissolution of remaining NHS Trusts as separate legal entities. This included guidance on the transfer of NHS Trust functions, staff and assets to the new operating divisions of Health Boards.

8. Powers already exist for the Scottish Ministers to dissolve NHS Trusts by subordinate legislation where an application is made by the Trust for dissolution. These were exercised to dissolve the four Trusts in Borders and Dumfries and Galloway. It is expected that these powers will be used to complete the dissolution process, and also to transfer assets, liabilities and rights from NHS Trusts to Health Boards. Ministers also have powers to dissolve NHS Trusts at their own initiative if it appears to them to be in the interests of the health service. Once all Trusts have been dissolved, statutory references to them will be removed. This requires new primary legislation, which the Executive proposes should be enacted through the Bill.

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Alternative approaches

9. The Executive expects that the remaining NHS Trusts will be dissolved voluntarily, using existing powers; but there is no alternative to primary legislation to achieve the stated policy intention of removing the powers relating or referring to NHS Trusts.

Consultation

10. The proposals for the abolition of NHS Trusts in Partnership for Care, and reflected in the Partnership Agreement, have been widely welcomed. A wide-ranging exercise was undertaken in 2002-03 across the NHS and among local authority and other partners under the title “Review of Management and Decision Making in NHSScotland”. This was led by the Chief Executive of the NHS in Scotland and overseen by a group chaired by the Minister for Health and Community Care. The Review’s conclusions informed the preparation of Partnership for Care. When an application is made by an NHS Trust for dissolution under existing legislation, consultation must be undertaken by the relevant Health Board. Consultations have been or are being held in Borders, Dumfries and Galloway and Argyll and Clyde Health Board areas.

Community health partnerships

Policy objective

11. The Executive’s policy is that care should be delivered as close to home as possible consistent with the provision of safe and effective healthcare, and that staff at the frontline should have the opportunity and resources to support the delivery of that objective. The White Paper Partnership for Care emphasises that the vast majority of health care is delivered by community based professionals and that these staff also have an expanding role in health improvement.

12. Partnership for Care proposes the development of community health partnerships (CHPs) as a key building block in the modernisation of services, with a vital role in partnership, service integration and redesign. It states that legislation would be brought forward “to require Health Boards to devolve appropriate resources and responsibility for decision making to frontline staff and ensure that CHPs provide an effective basis for the delivery of local healthcare services. The Partnership Agreement reaffirms the commitment “to legislate for NHS reforms and establish Community Health Partnerships”.

13. CHPs are intended to evolve from local health care co-operatives (LHCCs). LHCCs were established following the 1997 White Paper Designed to Care. They are not bodies created by statute but are voluntary associations of primary health care professionals who come together, along with other partner agencies such as local authorities, to consider the planning and delivery of NHS services. LHCCs are supported through the operational management arrangements of NHS Trusts or Health Boards, and so enabled to contribute to the planning and delivery of NHS services to meet the assessed needs of local communities. NHS Trusts/Health Boards involve LHCCs in decisions about the services that are to be delivered locally and the resources required to do so.

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8 Scottish Executive, Partnership for Care (2003) chapter 5
14. It is recognised that, while LHCCs have made good progress in developing into responsive and inclusive organisations, this has not been consistent across Scotland. The policy intention is to see CHPs, as successors to LHCCs, having a more consistent and strengthened role in service planning and delivery, with better accountability to local communities.

15. The enhanced role envisaged for CHPs includes the intention for them to:
   
   - ensure patients and communities, and a broad range of healthcare professionals, are fully involved in the planning and review of services;
   - establish a substantive partnership with local authority services;
   - have greater responsibility and influence in the deployment of resources by Health Boards;
   - play a more influential role in service redesign locally;
   - act as a focus for integrating health services, both primary and specialist, at local level; and
   - play a pivotal role in delivering health improvement for their local communities.

16. Health Boards are required to review the organisation and operation of their existing LHCCs with these objectives in mind. This will also include the development of a local public partnership forum (PPF) for each CHP to support effective dialogue with local communities. Boards are also required to work with local authority partners to produce plans aimed at ensuring more effective working with social care in appropriate locality arrangements. It is intended that CHPs will have greater capacity (than LHCCs) to play an effective role in the planning and management of local health services and be better matched with local authority counterparts.

17. In order to implement these objectives, the Bill makes provision requiring Health Boards to submit for approval by the Scottish Ministers schemes for the establishment of CHPs, which would cover the whole Health Board area. Boards would be required to include within their scheme:
   
   - the number of CHPs;
   - the membership of CHPs;
   - the delegated functions of CHPs and their role in the overall planning of services for the area;
   - the associated financial arrangements; and
   - arrangements for the involvement of the public and patients.

18. It is not intended that CHPs should become independent bodies separate from Health Boards, but that they should have a statutory function within Boards, thereby providing those involved in the provision of community based care a greater say in the design and delivery of services.
Alternative approaches

19. The current non-statutory arrangements for LHCCs have operated satisfactorily in that they have fostered the development of informal organisations which have become increasingly important in the delivery of local services. However, this has not been consistent across Scotland, and there are widely differing arrangements for devolution of responsibility and resources. The evolution into CHPs, which will have a key role in the overall planning of services in an area and co-ordinating the delivery of enhanced community based services, requires a more formal arrangement underpinned by legislation. The requirement for Health Boards to submit local schemes for approval by the Scottish Ministers will ensure that CHPs reflect the needs and priorities of local communities. The Scottish Ministers may specify minimum criteria for these schemes of delegation, in order to ensure that CHPs have the delegated powers and resources to deliver the intentions in Partnership for Care and the Partnership Agreement.

Consultation

20. The proposals for CHPs in Partnership for Care have been widely welcomed. These build on the recommendations of the review report of the LHCC Best Practice Group, Connecting Communities with the NHS, published in April 2001 and of the report of the Primary Care Modernisation Group, Making the Connections, published in March 2002. There was extensive consultation before the publication of both these reports. In addition, the Review of Management and Decision Making in the NHS undertaken in the latter half of 2002 had a subgroup dedicated to the consideration of LHCC development, and its proposals mirror closely the creation of, and more formal role for, CHPs.

Duty of co-operation: regional planning and managed clinical networks

Policy objective

21. Some types of health services, particularly, but not only, hospital-based services, are becoming more specialised and concentrated. To deliver such services successfully often requires highly developed skills and major investment in equipment and training. Some of these services can be offered most practically and economically to the whole population of Scotland from a small number of sites. Collaboration between Health Boards is necessary for successful planning and delivery of such services. Even where a service is not particularly specialised, there may be advantages in clinicians in neighbouring Board areas working together to share skills and resources in managed clinical networks. In addition, other aspects of health services such as workforce planning and training are considered to work best when tackled collaboratively, across Health Board boundaries – sometimes regionally and sometimes at a Scottish level.

22. The change programme Rebuilding our National Health Service, issued by the Health Department in May 2001, described the need for a more systematic approach to planning health services.

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9 Scottish Executive, Connecting Communities to the NHS (2001)
10 Scottish Executive, Making the Connections (2002)
   http://www.show.scot.nhs.uk/sehd/publications/mcbp/mcbp-00.htm
11 Scottish Executive, Rebuilding our National Health Service (2001) paragraphs 5.9 to 5.11
care services which are best provided on a regional or national basis. This was followed up in March 2002 by a Health Department letter\(^{12}\) that provided guidance on arrangements for regional planning of services.

23. Managed clinical networks have been established for the development of cancer services, based on 3 regional networks, and further regional managed clinical networks are emerging as part of the process of addressing the challenge of redesigning health services which include a significant tertiary element (i.e. based on one of the 4 teaching hospital centres). In September 2002 the Department issued a Health Department letter promoting the development of managed clinical networks in NHSScotland\(^{13}\).

24. The White Paper *Partnership for Care*\(^{14}\) described the Executive’s current policy on regional planning as a means of ensuring the sustainability and clinical quality of healthcare services for people in all parts of Scotland. The White Paper states that “Each NHS Board will have a formal duty to participate in regional planning groups and cross-Board managed clinical networks.” Steps are now being taken to appoint regional co-ordinators and the Department has also moved to establish a network of regional workforce co-ordinators (for workforce planning and implementation of the pay modernisation). The regional planning groups are considering a wider range of appropriate issues and are strengthening their links with other Boards in their area.

25. To implement the undertaking in “Partnership for Care”, the Executive proposes that Health Boards should be given a new statutory duty to co-operate with each other, the Common Services Agency and all Special Health Boards including the Scottish Ambulance Service and NHS24, with a view to securing and advancing the health of the people of Scotland. The Bill carries through this intention by imposing an appropriate duty on the Boards. It also makes clear that they may take action, including spending money and employing staff, to provide services that will benefit people throughout Scotland as well as in the Board’s own area. This will support the Boards’ participation in managed clinical networks that are set up to serve a wider population than that of a single Board. However, Boards’ prime responsibility will continue to be to ensure the provision of adequate healthcare services in their areas.

*Alternative approaches*

26. The current administrative arrangements to support regional planning and joint delivery of services operate satisfactorily, but as more services develop along regional lines, for example through managed clinical networks, more formal duties are necessary to ensure that Health Boards recognise responsibilities in relation to service delivery which may extend outwith their area. The Executive believes that this power is necessary to ensure that managed clinical networks and other regional and national initiatives can be satisfactorily developed and operated.


\(^{13}\) Scottish Executive, *Promoting the Development of Managed Clinical Networks in NHSScotland* (2002)  

Consultation

27. Since the White Paper was published in February 2003, the Health Department has received no representations against imposing a formal duty on Health Boards to participate in regional planning.

Powers of intervention in case of service failure

Policy objective

28. The Executive’s policy is that the NHS should offer high quality care to all users of the service, no matter where they live in Scotland or what their circumstances are. To help reinforce this policy, the Executive has established a framework for setting clinical and other standards and for reviewing the performance of NHS bodies against these. These standards and the review process are the responsibility of NHS Quality Improvement Scotland.

29. The aim of NHS Quality Improvement Scotland is to contribute to the highest quality of patient care in NHS Scotland by promoting best practice and ensuring effective clinical governance. One of its functions will be to carry out investigations and inquiries into serious service failures. The Executive is considering with NHS Quality Improvement Scotland the processes that need to be put in place to carry out this function, and the powers that need to be delegated for them to undertake inquiries. Information about current and proposed standards, and about the results of performance reviews, can be found on the NHSQIS web site15.

30. In addition, the Executive, on behalf of patients, has set clear targets for the NHS, particularly for waiting times for elective treatment. It has also introduced a performance assessment framework16 to gather and present systematic information about the performance of NHS bodies as part of the process of objective setting, monitoring and accountability between the Executive and the NHS.

31. The Executive believes it is important that if any part of the NHS consistently fails to achieve agreed quality standards or shows a marked decline in delivering an acceptable quality of care, support and guidance should be given to help improve performance. The Executive already has arrangements for escalating intervention under which recovery plans can be agreed with NHS bodies and monitored regularly. If performance improvement is not achieved by these means, further support in the form of additional management or professional staff can be brought in with agreement with the Board. The Board itself has the power - as the body responsible for performance overall and as the employer of Board staff - to make changes to the senior management team if it considers this to be necessary to improve performance.

32. If these steps fail to turn round performance, the Scottish Ministers can decide to give a direction to a Health Board. Directions may be general, or may relate to a specific area or matter. If for any reason a Board failed to comply with a direction, under existing legislation Ministers could choose to hold an inquiry and – if justified – hold the Board to be in default. It

15 http://www.nhshealthquality.org
http://www.scotland.gov.uk/library3/health/PAFaletterOB.PDF
would also be open to Ministers to terminate the appointment of the Chair or other Board members. These are very much powers of last resort and have rarely, if ever, been used.

33. The Executive believes that Ministers should be able to act in a targeted, timely and effective way where performance has failed, is failing, or seems likely to fail, to secure health services of an acceptable standard. The Executive considers that to declare a Board to be in default, and to remove Board members, while these actions could become necessary in extreme cases, may be too blunt and slow to rectify the delivery of a particular service. The Executive also believes that the power of direction may not be effective in cases where a particular service is in severe difficulties and a Board is not able, or not willing, to resolve these at its own hand.

34. The Partnership Agreement published on 16 May 2003 said: “We will work with health staff and Health Boards to improve the quality and consistency of care through national standards, inspection and support. Where the steps of development, inspection and support do not secure the improvement needed, we will extend Ministerial powers to intervene, as a last resort, to direct the Health Board to take the specified action to secure the quality of healthcare required.”

35. On the basis of an internal review of powers of intervention, and in line with the commitments in Partnership for Care and in the Partnership Agreement, the Executive believes that Ministers’ existing powers to give directions to Health Boards should be extended to enable Ministers, where a service is not being delivered to a standard which they consider to be acceptable, to transfer responsibility for providing specified services that are failing to a body or persons other than the relevant Health Board for a given period. This would enable Ministers to require that a failing service be managed by another Health Board or by an expert team specially constituted for the purpose until performance had been turned round. Such teams would need to have experience of the NHS, so as to be able to work within the broader framework of financial systems, staff agreements and clinical standards applying to health services.

36. The Bill therefore makes provision for Ministers to be empowered to act in this way, where Ministers consider it necessary; and where Ministers consider that a body or person responsible under the National Health Service (Scotland) Act 1978 for providing services has failed, is failing or is likely to fail to provide a service, or provide it to an acceptable standard. The test of necessity will require Ministers to have explored other means for restoring the service or quality of service, including in extreme cases the option of issuing a direction to the Board under section 2(5) of the 1978 Act.

Alternative approaches

37. The need for effective powers to enable Ministers to secure the provision of health services of an acceptable standard cannot be met satisfactorily by the existing power to give directions to Health Boards, and requires an extension of existing powers of last resort, as proposed in the Partnership Agreement. Such a capability for Ministers to act in relation to a particular failing service, to restore services to an acceptable standard, requires primary legislation.
Consultation

38. Since the White Paper and the Partnership Agreement were published, the Health Department has received no representations against taking such a power. The consultation paper on setting up NHS Quality Improvement Scotland, *A Quality and Standards Board for Health in Scotland*[^17], discussed the issue of the power to investigate serious service failure in clinical service delivery.

Public involvement in the NHS and dissolution of local health councils (LHCs)

Policy objective

39. The Executive’s policy objective in relation to public involvement is to ensure that the primary responsibility for involving people in the planning and redesign of health services rests with Health Boards, rather than giving the responsibility for representing the public to an outside body. It is proposed therefore to impose a duty to secure public involvement on Health Boards and Special Health Boards, and to abolish local health councils and to replace them with a new public involvement structure. This forms an important part of the Executive’s aim of reshaping the NHS to ensure that patients’ interests are put first and that modernised structures are in place to ensure public involvement in the design and delivery of care. The White Paper *Our National Health: a plan for action, a plan for change* recognised the often excellent work of local health councils but noted that “Health Councils themselves are keen to modernise and reform. They have since worked with us to devise modern public involvement structures which will support patients and communities and have direct influence on local NHS decision-making; influence which will lead to real changes on the ground.”

40. In December 2001, the Health Department published the policy framework document *Patient Focus and Public Involvement*[^18]. This placed a requirement upon the NHS to engage more directly with the public, with implications for the role of health councils. This was complemented by Health Department letter (2002)42[^19], which offered guidance on consultation and public involvement in service change. This guidance is currently being refined to reflect the recent experiences of public consultation. *Patient Focus and Public Involvement* reiterated concerns around the current local health council structure. It included a commitment to consulting on a new structure for public involvement that would revolve around the core functions of assessment, development and providing feedback. This included the creation of a new national body (the Scottish Health Council), which would have a strong local presence.

41. *Partnership for Care* sets out the Executive’s intentions with regard to public involvement. It notes that “we have asked NHS Boards to develop sustainable frameworks for public involvement…the new Scottish Health Council will in future monitor the performance and effectiveness of Boards in relation to public involvement, and will report regularly on the results. This will ensure that there is external scrutiny and quality assurance of what Boards are doing to involve the public.” This is reflected in the Partnership Agreement, which commits the

Executive to ensuring “public involvement in health reorganisation plans by obliging Health Boards to consult stakeholders more effectively”.

42. The powers to create local health councils were established in section 7 of the 1978 Act. Our intention is that the Bill will repeal section 7 and will instead require Health Boards and Special Health Boards to involve the public directly in considering the planning, development and operation of health services. It is proposed that the Scottish Health Council be created as part of NHS Quality Improvement Scotland reflecting the close link that needs to exist between quality and involvement. The role of the Scottish Health Council will be to provide leadership in securing greater public involvement in NHSScotland; to support the development of good practice in public involvement; and to ensure that quality improvement is driven by the needs of patients and service users.

43. Key to the effectiveness of the Scottish Health Council will be the establishment of local advisory councils, composed of interested members of the public, in each Health Board area. The advisory councils’ role will be to keep the Scottish Health Council aware of local issues and concerns and to advise it of local views on the extent and quality of the involvement activities of their local health services. The Advisory Councils will be expected to develop good links with the local voluntary sector and patient groups to promote communication and partnership between all those with an interest in public involvement.

Alternative approaches

44. It has been agreed that a modernised structure for public involvement is required and that the Scottish Health Council will be established, as part of NHS Quality Improvement Scotland, with a local presence. There is no alternative to primary legislation to achieve the stated policy intention of removing statutory references to local health councils and to create the new duty on Health Boards to secure public involvement.

Consultation

45. Proposals for a New Public Involvement Structure for NHSScotland was issued on 4 March 2003 following an extensive pre-consultation exercise with key stakeholders. This consultation period will expire on 9 June 2003 and the conclusions will inform the content of any guidance issued by Ministers on how the NHS should implement the new duty of public involvement. As noted above, the Executive approach to public involvement was set out in Partnership for Care, published in February, and reflected in the Partnership Agreement.

Health improvement

Policy objective

46. Partnership for Care signalled the Executive’s intention to raise the profile of health improvement and to “bring forward legislation to back up this commitment and ensure that Health Improvement is a priority for NHS Boards and Community Planning partners”. The

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http://www.scotland.gov.uk/library5/health/npis-00.asp

21 Scottish Executive, Partnership for Care (2003) page 11  
This document relates to the NHS Reform (Scotland) Bill (SP Bill 6) as introduced in the Scottish Parliament on 26 June 2003

thrust of health improvement policy in the Partnership Agreement develops consistently with the terms of the White Paper, notably the commitment to promote health improvement through joint health improvement plans and through community planning. This is reflected in the Partnership Agreement, which commits the Executive to taking “strong action to promote good health”.

47. The Executive believes that the Scottish Ministers should have a specific duty to promote health improvement. It is also the Executive’s view that Health Boards should also have a specific duty in relation to promoting health improvement. The intention is to enhance Ministers’ and Health Boards’ capacity to act, other than through the NHS or voluntary bodies as at present, and to provide an opportunity for specific links to the community planning agenda.

48. The Ministerial duty of health improvement set out in section 1 of the 1978 Act provides Ministers with a duty to secure health improvement through the health service. Specifying a clear Ministerial power to promote health improvement (at their own hand) would enable Ministers to provide clear national leadership, as referred to in Partnership for Care, and would provide a more secure statutory basis for a wider range of actions which Ministers might wish to take themselves.

49. In particular, Ministers currently have power to provide funds for health improvement only to voluntary organisations or via the NHS. A power for Ministers to allocate funding directly in support of health improvement would allow greater opportunities to direct how monies for health improvement are spent, by local authorities and other bodies.

50. In relation to local authorities, section 20 of the Local Government in Scotland Act 2003 created a new discretionary power which enables local authorities to do anything they consider is likely to promote or improve the well-being of their area and/or persons in it. Draft statutory guidance to local authorities relating to the power to advance well-being is currently out for consultation. The draft guidance includes health improvement as an example of activity for which the power may be used.

51. Section 15 of the Act lays a duty on local authorities to initiate, maintain and facilitate the community planning process. It is a duty of a local authority to invite and take suitable action to encourage all other public bodies and community bodies to participate in the community planning process. NHS Boards are amongst the major “other public bodies” involved in community planning and are required by the Act to participate in community planning. Local authorities take the lead role in community planning and this, together with their powers to advance well-being, will ensure that they are active in promoting health improvement.

Alternative approaches

52. The only way that legislation could be improved to make health improvement a priority for Health Boards is to provide a clear duty to the Scottish Ministers to promote the improvement of the health of the people of Scotland. This is over and above Ministers’ existing obligation to improve the health of the people of Scotland through the National Health Service.

53. In making health improvement a priority for community planning partners, the Scottish Ministers will not disturb existing legislation on community planning. The statutory guidance on the new power of well-being in the Local Government in Scotland Act 2003 embraces the need for health improvement. This, coupled with the new duty on Health Boards, will make health improvement a priority for Health Boards and community planning partners. The community planning process will ensure that they work together to deliver an improvement in the health of the people of Scotland.

Consultation

54. Since the White Paper was published in February 2003, the Health Department has received no representations against bringing forward legislation to back up the commitment that health improvement should be a priority for NHS Boards.

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

Equal opportunities

55. The Bill’s provisions are not discriminatory on the basis of gender, race, disability, marital status, religion or sexual orientation.

Human rights

56. The Executive is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights. As the Bill provisions in the main relate to the organisation of the functions of the National Health Service in Scotland, the Executive does not consider that the Bill provisions impact on human rights.

Island communities

57. The Bill, by laying a duty on Health Boards to co-operate with each other in relation to regional and cross-boundary services, is intended to promote the development of managed clinical networks. One aim of such networks is to sustain, as far as is consistent with clinical quality and safety, health services that are located as close as possible to the communities they serve, including communities in rural, sparsely populated and island areas.

Local government

58. The Executive is satisfied that the Bill will not have a direct impact on local government. The lead on implementing the legislation will fall to the Scottish Ministers and to Health Boards, who will receive support and guidance from the Executive. The intention is that the creation of community health partnerships will facilitate greater co-operation between health care professionals and local authorities in the delivery of community based health care services. Similarly, the new duty on the Scottish Ministers and on Health Boards to promote the improvement of the physical and mental health of the people of Scotland will be taken forward in liaison with local government. This is consistent with the Joint Futures agenda and the Executive’s commitment to community planning.
Sustainable development

59. *Meeting the Needs*..... describes how building a national effort to improve health, reducing inequalities in health, and making the NHS a “national health service”, and not a national illness service, is an integral part of sustainable development. The underpinning principles of social justice and taking individual and collective responsibility for actions that allow others to make best use of finite resources today and tomorrow run throughout this Bill.

60. Through placing a greater emphasis on health improvement the Executive is working to encourage people to take better care of themselves. Furthermore, the Executive is reforming the NHS in this Bill to improve access and ensure that the most effective use of resources is secured through better planning, both at a regional level, through managed clinical networks, and at a local level, through community health partnerships.

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Health Committee

3rd Report 2004 (Session 2)

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

3rd Report, 2004 (Session 2)

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Written Evidence
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British Medical Association (BMA)
Royal College of Nursing (RCN)
Oral Evidence
Christine Brown (Royal College of Nursing)
Pat Dawson (Royal College of Nursing)
Dr John Garner (British Medical Association)
Dr Bill O'Neill (British Medical Association)
Elaine Tait (Royal College of Physicians of Edinburgh)
Dr Mike Watson (Royal College of Physicians of Edinburgh)

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

Written Evidence
Scottish NHS Confederation
Convention of Scottish Local Authorities (COSLA)
Ayrshire and Arran NHS Board
Dumfries and Galloway NHS Board
UNISON

Oral Evidence
Danny Crawford (Unison)
Jim Devine (Unison)
George Irving (Ayrshire and Arran NHS Board)
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Alexis Jay (Convention of Scottish Local Authorities)
Christine Lenihan (Scottish NHS Confederation)
Hilary Robertson (Scottish NHS Confederation)
John Ross (Dumfries and Galloway NHS Board)
Councillor Kingsley Thomas (Convention of Scottish Local Authorities)
Malcolm Wright (Dumfries and Galloway NHS Board)

Additional Written Evidence
Scottish NHS Confederation
Convention of Scottish Local Authorities (COSLA)
Ayrshire and Arran NHS Board

16 December 2003 (17th Meeting, Session 2 (2003))

Written Evidence
Scottish Consumer Council
Scottish Association of Health Councils
Association of Local Health Care Cooperatives

Oral Evidence
Dr Kate Adamson (Scottish Association of Health Councils)
Martyn Evans (Scottish Consumer Council)
Liz Macdonald (Scottish Consumer Council)
Mr Warwick Shaw (Association of Local Health Care Cooperatives)
John Wright (Scottish Association of Health Councils)
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Written Evidence
- Orkney NHS Board
- Royal Pharmaceutical Society of Great Britain
- Allied Health Professions Forum Scotland
- Scottish Executive
- Scottish Executive

Oral Evidence
- Kathleen Bree (Orkney NHS Board)
- Judith Catherwood (Allied Health Professions Forum Scotland)
- Malcolm Chisholm (Minister for Health and Community Care)
- Steve Conway (Orkney NHS Board)
- Jenny Dewar (Orkney NHS Board)
- Stephanie Lawton (Orkney NHS Board)
- Kenryck Lloyd Jones (Allied Health Professions Forum Scotland)
- Asgher Mohammed (Royal Pharmaceutical Society of Great Britain, Scottish Department)
- David A M Thomson (Royal Pharmaceutical Society of Great Britain, Scottish Department)

Additional Written Evidence
- Orkney NHS Board
- Royal Pharmaceutical Society of Great Britain
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- Scottish Executive

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- Disability Rights Commission
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- Association of Directors of Social Work
- Royal College of Speech and Language Therapists
- Voluntary Health Services Scotland
- Optometry Scotland
- Sense Scotland
- GMB Scotland
- NHS Borders
- Chartered Society of Physiotherapy Scotland
- British Association of Dermatologists
Health Committee

Remit and membership

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

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

Committee Clerking Team:

Clerk to the Committee
Jennifer Smart

Senior Assistant Clerk
Graeme Elliott

Assistant Clerk
Hannah Reeve
INTRODUCTION

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

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

Background


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

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

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

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

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

**Provisions of the Bill**

*Organisation and operation of NHS*

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

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

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

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

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

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

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

Establishment of Community Health Partnerships

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Duty of Health Boards to co-operate*

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

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

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

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

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

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

**Powers of intervention**

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

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

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

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

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

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

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

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

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

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

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

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

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

37. He went on to add—

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

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

Public involvement and the dissolution of Local Health Councils

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

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

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

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

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

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

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

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

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

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

47. She went on to add—

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

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

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

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

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

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

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

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

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

Promotion of health improvement

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

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

**Financial consequences**

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

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

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

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

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

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

**Abolition of Trusts and the establishment of CHPs**

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

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

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

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

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

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

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

Duty to encourage public involvement

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

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

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

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

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

Other issues

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

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

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

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

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

RECOMMENDATION

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

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

75. Subject to the reservations expressed earlier in this report, the Committee recommends that the Parliament approves the general principles of the Bill.
Subordinate Legislation Committee

Report of the Subordinate Legislation Committee

Stage 1

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

Committee remit

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

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

Background

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

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

Subordinate legislation powers

General

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

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

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

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

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

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

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

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

Answer 1

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

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

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

Section 2 inserted subsection 4A  Community Health Partnerships

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

Answer 2

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

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

Report 2

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

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

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

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

Section 8(1) and (2) Ancillary provision

Background

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

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

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

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

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

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

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

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

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

Report 3

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

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

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

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

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

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

Provisions Conferring Power to Make Subordinate Legislation

Purpose

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

Outline and Scope of the Bill

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

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

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

4. The Bill is in three Parts:

   Part 1: Organisation and operation of National Health Service;
Subordinate Legislation Powers

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

Section 2 Community Health Partnerships

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

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

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

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

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

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

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

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

Section 6(1) Dissolution of local health councils

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

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

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

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

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

Section 8(1) and (2) Ancillary provision

Power conferred on: The Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary procedure: Negative resolution (section 8(3)) unless the Order contains provisions which add, replace or omit any part of the text of an Act in which case the Order is
subject to affirmative resolution procedure (section 8(4))

17. Section 8 deals with ancillary provisions.

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

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

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

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

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

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

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

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

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

From Scottish Executive Health Service Bills Team

National Health Service Reform (Scotland) Bill at Stage 1

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

Section 2 inserted subsection 4A(6)  Illustrative list

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

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

Section 2 inserted subsection 4A  Community Health Partnerships

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

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

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

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

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

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

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

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

Stage 1

The Committee reports to the Health Committee as follows—

Background

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

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

Introduction

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

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

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

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

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

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

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

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

Finance Memorandum

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

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

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

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

Summary of Evidence

NHS Trusts

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

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

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

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

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

Community Health Partnerships (CHPs)

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

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

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

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

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

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

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

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

**Co-operation between Health Boards**

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

**Intervention by Ministers**

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

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

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

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\(^9\) Clark, Col 322, Official report, 30 September 2003

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

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

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

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

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

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

Public Consultation

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

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

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

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

**Scottish Health Council**

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

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

**Health Improvement**

36. Evidence the Committee received indicated that it is reasonable to assume that the new duty to promote health will not result in any additional funding requirements but instead a review of how resources are allocated and prioritised.\(^\text{19}\)

It was recognised in some submissions, however, that more information about what this duty will mean will enable a more accurate assessment of its potential financial impact (if any).\(^\text{20}\)

**Conclusions and Recommendations**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBMISSION FROM SCOTTISH NHS CONFEDERATION

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

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

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

Dissolution of NHS trusts

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

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

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

Community Health Partnerships

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

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

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

Duty of co-operation

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

Ministers’ powers of intervention

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

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

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

Public involvement

The Confederation welcomes the inclusion of a formal duty for NHS boards to involve and consult with the public on the planning and development of services. The engagement of patients and communities in decision-making processes is a responsibility that NHS boards have taken increasingly seriously in recent years, and a number of boards in Scotland have already developed innovative and meaningful ways to ensure public involvement. For example, NHS Tayside has created three ‘public partnership’ groups of citizens who will work closely with the board to plan
services in their respective communities. NHS Highland has developed a pioneering ethical decision-making framework, which not only guides the board in its deliberations but also provides the public with a tool to monitor and hold to account the quality of the decision-making process within the local health system. The provision in the Bill will formalise the efforts being made in these and other NHS boards across Scotland, and will send an important message to patients and communities that they are valued partners in making decisions about the services that they use. The creation of the Scottish Health Council will underline this message and is fully supported by the Confederation, although we would urge that Ministers ensure that both the Council and its local offices are fully prepared for operation before the existing local health councils are dissolved. The Confederation does have some concern, however, about the estimate in the Financial Memorandum that the public involvement duty will involve no additional expenditure by NHS boards. Genuine, meaningful, continuous public involvement is not cheap, as NHS organisations have found through experience—it may require the provision of training both for NHS staff and for communities, for example—and whilst the Confederation fully agrees that it is crucial, it should not have to come at the expense of other services. Ministers should be prepared, if necessary, to back up the requirement with the provision of dedicated funds to the NHS to advance the public engagement agenda. Finally, we note that this section in the Bill negates the need for the proposed Members’ Bill by Paul Martin MSP. We would strongly encourage MSPs who wish to clarify or strengthen the duty to involve the public to do so through amendments to this Bill, rather than through separate legislation.

Promoting health improvement

The Confederation is delighted at the inclusion in the Bill of a formal duty for the Scottish Ministers to promote health improvement. We have long argued that improving Scotland’s health record is not and cannot be a job for the NHS alone and that a clear demonstration of strong national leadership from government is vital to ensure that the issue is a priority for all Scottish public bodies. In this instance, the phrase ‘Scottish Ministers’ in the Bill should not be interpreted as a piece of stock legal jargon but should be taken literally to mean that this is a duty for every member of the Scottish cabinet. So many areas of Executive responsibility have an integral role to play in promoting good health and preventing bad—not just health services, but also finance, housing, social justice, education, transport, the environment, community safety and enterprise—that the provision will only be of real effect if it genuinely cuts across every departmental boundary. We also welcome the corresponding duty for NHS boards to promote health improvement. Once again, this provision merely formalises a responsibility which every NHS board already acts upon, but its inclusion in the Bill sends an important message about the status of health improvement as a priority for the NHS. It means that innovations such as the newly announced Glasgow Centre for Population Health, along with countless other health improvement projects across Scotland, should be regarded as being as much a part of the core business of NHS Scotland as the day-to-day delivery of services in hospitals and the community. The framing of the legislation does not make it at all clear, however, how this duty will be carried out. Clauses (1)(2) and (2)(2) of section 7 are vague and their purpose is unclear. Why do they refer only to “any person” and not also to organisations or groups of people? To what end should the financial assistance be used? What form would arrangements or agreements take? It would be helpful to have more detail on the face of the legislation about what is meant by these clauses and what actions they will enable Ministers and boards to take.
<table>
<thead>
<tr>
<th>Provision</th>
<th>Financial Implications per Explanatory Notes</th>
<th>NHS Argyll &amp; Clyde Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissolution of NHS Trusts</td>
<td>No direct cost implications. Winding up of Trusts likely to produce modest reductions in administrative costs to be used by Health Boards to improve patient care.</td>
<td>- There is likely to be significant potential for cost savings through dissolution, for example, combining of administrative functions, eg Finance, HR, Telephonists etc, but there may be “one off” redundancy/early retirement costs required to achieve these potential benefits.</td>
</tr>
<tr>
<td>Community health partnerships</td>
<td>No overall additional expenditure. Resources previously used to support local health care cooperatives will be used to fund community health partnerships.</td>
<td>- Again, there may be potential to reduce administrative costs (subject to matters raised above) due to smaller number of Community Health Partnerships. However, in order to reallocate funding, some initial costs may be incurred. CHPs are significantly more complex than LHCCs and therefore additional management capacity may be required.</td>
</tr>
<tr>
<td>Health Boards: duty of co-operation (regional planning)</td>
<td>No overall additional expenditure. Existing resources to be used more effectively.</td>
<td>- Joint Planning should enable more cost effective use of resources. However, there will be set up costs required to develop an appropriate planning infrastructure.</td>
</tr>
<tr>
<td>Powers of intervention</td>
<td>No direct cost implication until used. If the power is used, any expenditure is expected to be modest and will be contained within existing NHS financial allocations.</td>
<td>- The estimated cost of a task force of 6 people for £85,000 is significantly understated. Individuals of appropriate calibre will have salary costs of up to £100,000 each. 6 people for 6 months would cost £200,000 minimum. This funding may not be available within local health systems.</td>
</tr>
<tr>
<td>Public involvement in the NHS and the dissolution of local health councils</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority. The cost of the new Scottish Health Council will be met from the £2.108 million currently allocated to Local Health Councils, which are being dissolved.</td>
<td>- There is potentially a substantial cost associated with Public Involvement although it is difficult to quantify. Many NHS systems are about to undertake significant modernisation projects. This requires the development of appropriate communications staff infrastructures as well as costs for publishing and venue hire.</td>
</tr>
<tr>
<td>Duty to promote health</td>
<td>No overall additional expenditure but change expected in pattern of expenditure as a result of new priority.</td>
<td>Agreed that this is likely to require a review of how resources are allocated and prioritised.</td>
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<tr>
<td>SUMMARY</td>
<td>Overall additional expenditure as a result of the above provisions will be zero, for the Scottish Administration; local authorities and other bodies, individuals and businesses.</td>
<td>The provisions of the Bill will provide opportunities to reduce costs in some areas, but additional investment may be required in order to achieve this outcome. However, it is unlikely that these costs will be significant in the context of the overall health budget.</td>
</tr>
</tbody>
</table>
General

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

Spending Review 2004 – Funding for Health Improvement Work

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

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

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

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

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

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

National Health Service Reform (Scotland) Bill

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

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

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

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

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

Community Health Partnerships

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

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

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

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

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

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

Section 13,14: what will they do?

Q: Do you agree with these overall roles?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 38: Workforce planning**

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

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

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

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

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

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

**Section 43-49: Working together**

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

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

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

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

Section 53: NHS Boards

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

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

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

Q: What do you see as the developmental priorities?

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

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

Performance management and review need to be realistic and achievable.

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

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

Section 56: What are the financial arrangements?

Q: Are the financial arrangements clear?

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

I hope you find the above comments useful.

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

Dissolution of NHS Trusts

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

Community Health Partnerships

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Support for NHS complaints is currently provided by many local Health Councils. Under the new arrangements this will no longer be a function of the new Scottish Health Council. NHS Boards will instead require to commission an independent support service to undertake this function. We believe that not only is a commissioned service unlikely to be truly independent but it is also likely to be more costly than the present arrangements.
SUBMISSION FROM WESTERN ISLES NHS BOARD

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

I refer to your letter dated 19th September 2003 asking that the Western Isles NHS Board provide evidence that no additional expenditure from the Introduction of the National Health Service Reform (Scotland) Bill introduced to the Scottish Parliament on 26th June 2003.

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

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

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

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

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

Dick Manson

Interim Chief Executive
SUBMISSION FROM NHS AYRSHIRE AND ARRAN

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

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

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

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

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

I trust the above is what you require.

Derek Lindsay

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

32 Dissolution of Trusts

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

33 Community Health Partnerships

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

34 Regional Planning

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

35 Powers of Intervention

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

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

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

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

38 Duty to Promote Health Improvement

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

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

Roger Gibbins, Chief Executive
SUBMISSION FROM BRITISH MEDICAL ASSOCIATION (BMA) SCOTLAND

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL - FINANCIAL MEMORANDUM

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

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

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

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

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

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

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

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

Dr John Garner

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

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

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

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

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

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

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

Yours sincerely

James Barbour
Chief Executive
NHS Lothian
Present:
Mr David Davidson
Janis Hughes (Deputy Convener)
Mr Duncan McNeil
Mike Rumbles
Christine Grahame (Convener)
Kate Maclean
Shona Robison

Also present: Carolyn Leckie.

Apologies were received from Helen Eadie and Dr Jean Turner.

The meeting opened at 9.30 am

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

The meeting closed at 10.34 am

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

11th Meeting, 2003 (Session 2)

Tuesday 4 November 2003

Present:

Helen Eadie  Christine Grahame (Convener)
Janis Hughes (Deputy Convener)  Kate Maclean
Mr Duncan McNeil  Mrs Nanette Milne (Committee Substitute)
Shona Robison  Mike Rumbles
Dr Jean Turner

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

Apologies: David Davidson

The meeting opened at 3.00 pm

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

The meeting closed at 4.29 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

15th Meeting, 2003 (Session 2)

Tuesday 2 December 2003

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

The meeting opened at 1.37 pm

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

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

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

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

The meeting closed at 4.13 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

16th Meeting, 2003 (Session 2)

Tuesday 9 December 2003

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

The meeting opened at 2.05 pm

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

Christine Lenihan, Chairman and Hilary Robertson, Director, Scottish NHS Confederation;
Alexis Jay, Director of Social Work Services and Housing, West Dunbartonshire and Councillor Kingsley Thomas, City of Edinburgh Council, CoSLA;
George Irving, Chairman and Wai-yin Hatton, Chief Executive, Ayrshire and Arran NHS Board;
Malcolm Wright, Chief Executive and John Ross CBE, Chairman, Dumfries and Galloway NHS Board; and
Jim Devine, Scottish Organiser, Health and Danny Crawford, Chief Officer, Greater Glasgow Health Council, UNISON.

The meeting closed at 4.35 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

17th Meeting, 2003 (Session 2)

Tuesday 16 December 2003

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

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

The meeting opened at 2.00 pm

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

Martyn Evans, Director and Liz MacDonald, Policy Manager, Scottish Consumer Council;

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

Warwick Shaw, Chairman, Association of Local Health Care Cooperatives

The meeting closed at 16.16 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

1st Meeting, 2004 (Session 2)

Tuesday 6th January 2004

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

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

Also present: Mrs Nanette Milne MSP

The meeting opened at 1.59 pm

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

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

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

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

The meeting closed at 4.56 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

4th Meeting, 2004 (Session 2)

Tuesday 27 January 2004

Present:

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

The meeting opened at 2.01 pm

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

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

The meeting closed at 3.22 pm

Jennifer Smart
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

5th Meeting, 2004 (Session 2)

Tuesday 3 February 2004

Present:

Mr David Davidson
Helen Eadie
Kate Maclean
Mike Rumbles

Christine Grahame (Convener)
Janis Hughes (Deputy Convener)
Shona Robison
Dr Jean Turner

Apologies were received from Duncan McNeil.

The meeting opened at 2.01 pm

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

The meeting closed at 2.27 pm

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

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

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

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

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

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

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

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

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

Do you support the general principles of the Bill and the key provisions it sets out?

The BMA supports the general principles of the Bill. Last year we welcomed the publication of Partnership for Care, the White Paper that preceded this proposed legislation. Our detailed views on the Bill are listed below:

Abolishing trusts

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

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

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

It is important to maintain an element of flexibility in the organizational structure of the ‘operating divisions’ so that they can be adapted to meet the needs that are particular to a local area.

Imposing a duty for public involvement in the NHS

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

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

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

Enhancing existing powers of intervention for Scottish ministers

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

Creating a new performance review body

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

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

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

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

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

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

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

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

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

Regional working between health boards

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

Omissions from the Bill

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

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

Consultation

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

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

Conclusion

The BMA welcomes proposals in Partnership for Care to reform the NHS in Scotland and therefore supports the general principles of this Bill.
Health Committee, 3rd Report, 2004 (Session 2) - Annex C

SUBMISSION BY THE ROYAL COLLEGE OF NURSING (RCN)

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

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

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

Part 1

Paragraph 1 - Dissolution of NHS Trusts

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

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

RCN Scotland is engaged with the Scottish Executive in delivering a Scotland wide Clinical Leadership Programme in which 70% of the NHS Boards participate. RCN Scotland is also launching from the 15th of October 2003 a campaign “Speaking Up” to promote nurse leadership. We are pleased that there seems to be moves in England to ensure nurses hold an Executive position on new Foundation Hospitals.

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

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

Paragraph 2 – Community Health Partnerships

RCN Scotland’s response is attached at Appendix B. We specifically would wish to see the following added after section 4 of the 1978 Act:
Community health partnerships
Explicit reference to patient/public involvement
Explicit reference to consultation with communities (service provision etc.)
Explicit reference to staff governance including staff representation and arrangements for staff consultation
Explicit reference to professional advisory networks
Paragraph 3 – Co-operation

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

Paragraph 4 – Powers of Intervention in case of service failure

RCN Scotland is supportive of much of this section however, there is one important omission. We believe that failure of staff governance systems should be added at 78A(I)(b) add a new (iii) to provide staff governance to a standard which they regard as acceptable. We understand that the Scottish Partnership Forum has secured Ministerial agreement that a Scottish Executive sponsored amendment would be put before the Parliament to meet the intentions outlined above.

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

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

Paragraph 5 – Public Involvement

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

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

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

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

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

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

Part 2

Promotion of Health Improvement

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

Part 3

Supplementary

We have no comment to add

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

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

MUNICH DECLARATION

NURSES AND MIDWIVES: A FORCE FOR HEALTH

17 June 2000

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

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

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

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

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

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

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

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

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

Appendix B

Community Health Partnerships

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

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

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

Paragraphs 13 & 14 – page 4

Do you agree with these overall roles?

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

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

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

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

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

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

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

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

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

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

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

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

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

Paragraphs 19-21

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

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

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

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

Paragraphs 22-25

What culture and style of working should underpin CHPs?

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

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

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

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

The intention of CHPs to be flexible and innovate would be supported by: -

- Clarity of inspection and monitoring regimes and focus on clinical governance mechanisms.
- Realistic standards, targets and performance assessment frameworks.
- Streamlining and integrating the policy demands from on high.

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

What Services will CHPs be responsible for?

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

Responses to Paragraphs 28-33 have been included elsewhere

Paragraphs 34-38

What Status will CHPs have?

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

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

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

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

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

Paragraph 39 and 40

What are the organisational arrangements for CHPs?

RCN Scotland welcomes the commitments set out in paragraph 39 and 40 to involve operational staff and the need for high levels of leadership, management and support services. In envisaging membership of CHP management teams, RCN Scotland is mindful of the need for:

a multi-professional composition, and,

the central role of nurses to the delivery of primary care and community care services.

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

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

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

Paragraphs 47-49

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

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

Paragraphs 50-52

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

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

Paragraphs 53-54

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

RCN Scotland suggests that the local performance management need to be:

• Integrated with existing systems, data, processes etc.
• Simple and relevant
• Recognise local conditions and variables

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

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

Specific - Comments for CHP Establishing Order 1978 Act Section 4

RCN Scotland would wish to see:

• Explicit reference to patient public involvement
• Explicit reference to consultation with communities (service provision etc.)
• Explicit reference to staff governance including staff representation and arrangements for staff consultation
• Explicit reference to professional advisory networks

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

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

Parliamentary Briefing

S2M-154 Patient Focus and Public Involvement in the NHS

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

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

Key International Political Agreements

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

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

The Need for Independence

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

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

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

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

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

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

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

Health Committee

Tuesday 2 December 2003

(Afternoon)

[THE CONVENER opened the meeting at 13:37]

National Health Service Reform (Scotland) Bill: Stage1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13:45

Elaine Tait (Royal College of Physicians of Edinburgh): It is important that there is clarity of responsibility within the new health boards. In the old trust structure it was clear who had responsibility for quality of care. It should be made explicit in the bill who has direct responsibility for quality of care. It should be made clear that that is done relatively seamlessly. In the longer term, there may be a saving on bureaucracy, but it has perhaps not been recognised that there will be a transitional cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Shona Robison: Sorry.

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

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

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

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

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

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

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

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

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

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

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

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

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

14:00

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

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

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

The Convener: My eyesight is also at fault.

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

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

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

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

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

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

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

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

Janis Hughes: That is helpful. Thank you.

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

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

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

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

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

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

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

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

Dr John Garner: I think so, yes.

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

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

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

The Convener: It is the pebble in the pool.

Pat Dawson: Absolutely.

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

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

(a) the planning and development, and

(b) decisions of the Health Board”.

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

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

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

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

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

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

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

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

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

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

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

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

14:15

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You also make a distinction between “involving people” and

“protecting and promoting patient rights”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I am confused about the RCN’s position.

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

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

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

**Mike Rumbles:** Point III on page 5 of your submission says: “RCN Scotland has supported the creation of the Scottish Health Council”, yet what you say is contrary to that. Do I misinterpret you?

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

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

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

**Pat Dawson:** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14:45

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pat Dawson: I am the fount of all knowledge.

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

Pat Dawson: They get their best advice from us.

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

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

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

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

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

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

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

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

Introduction

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

Dissolution of NHS Trusts

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

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

Community Health Partnerships (CHPs)

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

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

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

Duty of co-operation

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

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

Public Involvement

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

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

Promoting Health Improvement

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

We also welcome the corresponding duty for NHS boards to promote health improvement. One again, this provision simply formalises a responsibility which every NHS board already acts upon, but its inclusion in the Bill sends an important message about the status of health improvement as a priority for the NHS. We feel however that parts of this section of the Bill, specifically clauses (1)(2) and (2)(2) of section 7, are rather vague and their purpose unclear. We would welcome more clarity about what is meant by these clauses and what actions they will enable or require Ministers and boards to take.
9 December 2003 (16th Meeting, Session 2 (2003)), Written Evidence

COSLA, as the organisation representing 31 of Scotland’s councils, is pleased to have this opportunity to submit evidence on the National Health Service Reform (Scotland) Bill to the Scottish Parliament’s Health Committee.

General Comments and Summary

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

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

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

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

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

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

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

Acknowledgement of the links with Community Planning and Joint Future

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

Reflection of local democracy

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

Financial implications

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

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

Conclusion

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

COMMUNITY HEALTH PARTNERSHIPS

COSLA Response to Scottish Executive Consultation

General

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

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

CHPs – The Principle

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

The Local Authority role

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

Links with the Community Planning Process and the Joint Future Agenda

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

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

Local flexibility

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

Accountability

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

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

Boundaries

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

Organisational Arrangements

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

Scheme of establishment

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

Public Partnership Forums (PPF)

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

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

Health Improvement

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

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

Monitoring the Legislation

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

Conclusion

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

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL – FINANCIAL MEMORANDUM

General

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

Spending Review 2004 – Funding for Health Improvement Work

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

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

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

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

National Health Service Reform (Scotland) Bill

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

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

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

Community Health Partnerships

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

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

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

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

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

It was noted that Staff Governance was not included in the original Health Bill. To effectively show a balance across the three areas of accountability and governance this was an omission. If this is now to be reconsidered and included then employers will require to understand the implications of this in terms of employer liability.
Thank you for giving us (Dumfries and Galloway NHS Board) the opportunity to comment on the above (as requested in your letter of 26 September).

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

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

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

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

Introduction

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

Community Health Partnerships

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

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

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

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

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

Health Improvement

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

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

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

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

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

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

Public Involvement

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

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

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

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

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

UNISON Scotland firmly believes that all public service organisations (including the NHS in Scotland) should be open, transparent and democratically accountable and should encourage active participation from users, the community and staff and their trade unions and would therefore be supportive of direct elections to Health Boards. By having such elections the representatives would be accountable to the public, there would be a better cross section of opinion and it would mean representation from right across the spectrum taking in the public, clinicians and experienced business managers.
National Health Service Reform (Scotland) Bill: Stage 1

14:06

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14:15

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

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

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

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

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

Hilary Robertson: The Scottish NHS Confederation’s view of community health partnerships—one on which we have been working with our members to try to elicit a bit more detail about how they would work, what they would look like and what they would do—is that they are about more than community and social care or primary and community care: they should also include secondary care. From the health point of view, it is important that the partnerships aid joint working and the integration of secondary and primary care.

The Convener: Should anything on community health partnerships be added to the bill? Also, COSLA’s submission talks about guidance being “re-drafted to avoid duplication of existing structures” and suggests that we “Re-draft CHP guidance”.

What is happening with that? I do not know what that guidance is, and we are talking about operational duplication.

Alexis Jay: We are concerned about the draft guidance that the Scottish Executive issued on community health partnerships. It was put out for consultation and I believe that there was a vast number of responses. We did not feel that the draft guidance was specific enough about the Executive’s vision and what its intention was for community health partnerships. There was concern that there was potential overlap with the joint future agenda that was not clarified by the guidance. We hope that the final guidance will fuse together the different strands that are currently running in parallel.

The Convener: I understand that the final guidance is coming out early next year. Is that correct?

Alexis Jay: Perhaps. I am afraid that I would not know.

The Convener: I am being advised about that.

Hilary Robertson: I will make a point about public partnership forums, which will be part of community health partnerships. We envisage there being two distinct elements to the system. The public partnership forums will be about the continuing involvement of patients and the public, whereas community planning is more about consultation. We see those as two slightly different elements of the system.

The Convener: I do not think that you commented on whether anything about community health partnerships should be added to the face of the bill. We are talking about guidance and regulations, but should the matter be included in the primary legislation?

Councillor Thomas: I am not sure exactly what you mean when you use the term “the face of the bill”.

The Convener: I mean in the primary legislation.

Councillor Thomas: As I see it, the community health partnership—and beyond that the community health and social care partnership—is the one key vehicle for ensuring that all the principles that everybody signed up to in respect of the joint future agenda can be delivered at all the various levels within the health sector and local authorities. If adding a clear reference to that in the primary legislation would give a high-level commitment to that work, it would be useful.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The Scottish NHS Confederation’s submission accepts that the minister should be able to intervene where serious failures occur, but calls for more clarity on what intervention will mean. Should the definition of intervention and the circumstances in which the powers of intervention would be used be included in the bill or in regulations?

Hilary Robertson: It would be helpful to say in the bill what intervention means and, if possible, what the circumstances are in which it would occur. It is difficult to know from the provisions in
the bill how such intervention might work—some clarity about that would be helpful.

Christine Lenihan (Scottish NHS Confederation): Scottish NHS Confederation members understand that, rightly, responsibility lies with health boards. There should be strong local management, particularly through the performance assessment framework, which is the accountability mechanism, and the powers of intervention should be a last resort. At the same time, there needs to be a link to the indicators on the performance assessment framework to determine when use of the powers of intervention might be required in a supportive way rather than as a last resort.

Mr McNeil: Would regulations remove the flexibility for there to be ministerial intervention in a variety of circumstances?

Christine Lenihan: No, not necessarily. However, it is important to retain flexibility where the responsibility and accountability is located, which is in the local health system and through the very comprehensive assessment framework that is in place. The detail that our members might like to see is about what circumstances might trigger an intervention, who might trigger the intervention and where responsibility for the costs of the intervention might lie.

Mr McNeil: So regulations would suffice.

Christine Lenihan: We are not of that view. Our members are of the view that the definition of the powers of intervention should be enshrined in the bill.

Kate Maclean (Dundee West) (Lab): Do you not think that enshrining a statement of when and how powers of intervention are to be used in the bill would be very prescriptive and would lead to a lack of flexibility? If the detail in the bill is too prescriptive, the primary legislation might have to be changed in the future to allow intervention in circumstances that none of us can imagine now. We can consult on regulations and change them much more easily than we can change primary legislation—that can be a reason for including a matter in primary legislation, but in this case it might be better to retain some flexibility to deal with situations that might arise in the future.

Hilary Robertson: We concede that point, but it is important that there should be clear understanding of what is meant by intervention. That will depend on the wording in the bill; it would be helpful if there were a clearer definition of intervention in the bill, although perhaps the detail about how such intervention would be triggered and who would intervene should be in the regulations.

The Convener: That could be done without listing the circumstances.

Mr Davidson: I think that the witnesses from the Scottish NHS Confederation are making the point that if accountability is the factor that is behind this section of the bill, it must be defined. I presume that if such a definition were to be included in the bill, you would also welcome a provision to allow a health board to call on the minister to intervene at an early stage, rather than wait until the end of another accountancy period—if there was a problem with financial flow, for example. Is that the kind of flexibility—on the back of a definition—that you would like there to be?

Hilary Robertson: We agree that it is important that boards should be able to ask for support; that should be clearly recognised.

Intervention should be a last resort, but it must be timely. If there are indications that intervention is required, that intervention should be supportive and take place before the stage is reached at which the system is in complete crisis and probably beyond being able to make a speedy recovery. That is the key point. It would be better to put the explanations in regulations, which could be consulted on.

Mr Davidson: In the first session of Parliament, the Scottish NHS Confederation gave evidence to the Audit Committee, of which I was a member. It was clear that the confederation was looking to future legislation to tidy up the two-way process around difficulties that arise in the health service. I think that your main point today is that you would like accountability—and how people would step into that accountability process—to be defined in the bill.

Christine Lenihan: Yes, that is right. We do not take issue with the fact that there is already a comprehensive accountability framework in place and we agree that ministers should have powers of intervention. However, there needs to be clarity about the triggers for and timing of intervention and about whether intervention—albeit a last resort—would be a late last resort. There should always be flexibility to allow those who are accountable for local delivery to be responsible for that, but at the same time, our members would like to explore the possibility of there being a series of triggers for intervention and much clearer understanding about when and why powers of intervention would be used. Invariably, the use of those powers would have to be linked to the information that is in the performance assessment framework.

Mr Davidson: Perhaps it would be appropriate for the confederation to send the committee a short document that explains exactly what clarification is required.

Christine Lenihan: We would be happy to do that.
The Convener: That would be helpful.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like to pursue the point, because I am now a little more confused than I was. We are talking about the requirement for flexibility, but surely to put triggers in the bill would have the opposite effect. Section 4 amends the National Health Service (Scotland) Act 1978 to include a new section 78A, on powers of intervention in case of service failure. The new section 78A(1)(b) states that the powers apply where

“the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

(i) to provide the service, or

(ii) to provide it to a standard which they”—

that is, the Scottish ministers—

“regard as acceptable.”

It strikes me that the Parliament would be giving a tremendous amount of flexibility and power to the Scottish ministers where there was or was likely to be, in their opinion, service failure or failure in the standard to which service is provided. You seem to advocate that we should include triggers in the bill, but would that not narrow it down in certain circumstances?

14:30

Christine Lenihan: I think that we are talking about regulations rather than about the bill.

Hilary Robertson: Our plea for clarity is simply around what intervention means. Having read through the bill, we do not think that it is entirely clear what intervention would consist of. It might be helpful to define it, to say that intervention would happen in certain circumstances and to say what those circumstances are. We have already accepted the point that was made earlier, that it would be more appropriate to do that in regulations than in the bill.

Mike Rumbles: It seems to me that the ministers’ powers in the bill are clear and specific. Proposed new section 78A(2) states:

“The Scottish Ministers may, where they consider it necessary”—

to me, that is ultimately flexible—

“for the purpose of ensuring the provision of the service … to a standard which they regard as acceptable”—

again, that is incredibly flexible—

“direct that specified functions of the body”—

that is, the boards or whatever—

“or person … by virtue of this Act be performed, for a specified period and to a specified extent”.

So the ministers can instruct any health board or part of a health board to do whatever they want, to the standard that they specify. If the ministers are not happy, they can bring in, as stated in new section 78A(5),

“(a) an employee of a Health Board, a Special Health Board or the Agency,

or

(b) a member of the staff of the Scottish Administration.”

It seems to me that we are giving the ministers a tremendous amount of flexibility to take the decision to intervene, even before the service has failed, so I do not quite follow your argument.

Mr McNeil: A preference was stated in the written evidence from the Scottish NHS Confederation that intervention should be defined in the bill. That is not what you are saying now. You are saying that, on consideration, it should probably be done through regulations.

Hilary Robertson: Our written submission states that we would like a definition of intervention to be included either in the bill or in the regulations.

Mr McNeil: Your submission says that intervention should be defined

“either in regulations or, preferably, in the legislation itself”.

Hilary Robertson: Yes. We accept the point.

The Convener: On a point of information, it would be useful for the clerks to provide a note; these are amendments to existing statute, and it would be interesting to see where they slot into the National Health Service (Scotland) Act 1978, because that act might contain things that expand on the issue. The bill is not a stand-alone bill and should not be considered in a vacuum, so I ask the clerks to make that information available.

Are members content to move on?

Shona Robison (Dundee East) (SNP): I will move on to the issue of health councils. I do not think that either organisation referred specifically to health councils, although you referred to public involvement. Will the national health council that is proposed by the Executive be more or less independent than the current local health councils?
Christine Lenihan: The confederation supports a strong and effective independent voice for patients. It might not be appropriate for us to comment, as NHS boards are the organisations against which complaints would be made. NHS Quality Improvement Scotland has shown its capacity for independence in principle, but patient representation will be demonstrated as the process evolves. We strongly support the principle that an independent organisation should represent patients’ voices effectively.

Shona Robison: Do local health councils provide an effective patient voice?

Hilary Robertson: I am sure that individual boards would be better able to answer for their areas, but local health councils seem to perform a useful and valued function. Our concern is about patients’ and the public’s perceptions of the new arrangements. As professionals, we and our members have confidence that the new arrangements will provide the required degree of independence, but the public and patients might not have the same perception. We would like that to be kept under review.

We would be confident that NHS Quality Improvement Scotland would be the appropriate place to locate the Scottish health council, and Quality Improvement Scotland has shown its independence, but it would be helpful to test the water and gather opinions from the public and patients to find out whether they share our view.

Shona Robison: It is a bit unclear who will provide hands-on assistance locally. Local advisory councils are proposed, but there is talk about commissioning services to provide the advice and practical hands-on assistance that patients and the public receive at the moment. Do you have a view on whether that will work, and from whom services should be commissioned?

Hilary Robertson: No.

Shona Robison: That is fair enough. You do not have to have a view.

Christine Lenihan: I am not sure whether I can answer the question directly, but I can offer the information that is emerging that many of our members are, with the philosophy of consultation, exploring new ways to engage and communicate with the public—whether or not they are patients—as individuals rather than on a representative or group basis, as has often happened in the past. The NHS has a tremendous commitment to such engagement. The philosophy behind representing patients’ views through Quality Improvement Scotland or any other mechanism is the same; everyone is committed to finding ways to involve patients and members of the public as individuals in current and future care.

Shona Robison: Does COSLA have a view on health councils and the changes?

Councillor Thomas: Since October 2001, local authorities and health boards have had closer working arrangements. Health boards are benefiting from local authorities’ experience of tried and tested methods of consulting service users and carers in social work, and from the various consultative structures that we have long had for developing measures such as community care plans and children’s services plans. That expertise is being used in planning health service matters and consulting patients on them.

We value the local health council structures. Local authorities’ experience can help those bodies to consult more widely, whether on an individual or representative basis. All the local structures that councils have, and are developing, can be used to reach citizens and to discuss not only council services, but health service issues. We are doing that in Edinburgh.

Shona Robison: Obviously, we all welcome the duty to involve the public’s being placed on health boards, but how do we avoid that effort’s becoming tokenistic? There is huge public cynicism, and for good reason: some consultation has been very poor. What needs to be done to make the duty to involve the public mean something? How do we convince the public that the involvement is genuine and not merely a nice idea?

Hilary Robertson: There are quite a number of examples around Scotland of NHS boards’ finding new ways of involving people—ways that go well beyond what would be considered to be traditional consultation exercises—boards are learning from experience. In a number of parts of the country, before they actually need them, people are being asked how they would like services to be configured or provided. While they are well—that is, before they become patients—people are being asked what they want from the health service, how the service might be provided, and what would be particularly important to them. That is a relatively new approach. Examples from around the country are being shared, but it is fair to say that there is a lot of learning to be done about how to involve members of the public meaningfully, rather than tokenistically.

A challenge is to involve people in ways that do not focus on the usual suspects—if I may use that term—or on people who have a particular interest or represent a particular group. The challenge is to speak directly to the members of that group and to the people who use the services. NHS boards have been addressing that challenge willingly and enthusiastically. A lot of good practice has been shared and there is still much to be done—it is not an easy job—but I emphasise that health boards
are tackling the challenge and that they are enthusiastic about doing so.

Christine Lenihan: A view is emerging from our members that traditional consultation, which is necessarily issue-specific, may not be the only way forward. Hilary Robertson describes a continuous, meaningful and thoughtful engagement with individual members of the public; that is how members of the public will have a much more fruitful and effective influence on health boards’ plans.

Councillor Thomas: We need more effective consultation mechanisms, but we also need more effective feedback mechanisms. From their constituency case work, committee members will know the highly personal issues that can be raised in consultations. Quite often we cannot do everything; we cannot shape our services exactly as every individual would want us to. However, we need to be better at going back to people to explain why we have made certain decisions. We may need a better balance between trying to shape services to meet local community needs and trying to make services as universal as possible.

Mr Davidson: There is a view that NHS QIS looks at the delivery of patient care from a technical perspective. The health councils have said that they do not wish to be part of another organisation; they wish to stand alone as a new national body in a national framework. Do the health councils have a point when they say that they consider scrutiny differently from NHS QIS? The approach of NHS QIS is very technical and has the patients’ perspective. Is that approach reasonable? I put that question to COSLA first and then to the Scottish NHS Confederation.

14:45

Alexis Jay: I am not sure that we are entirely qualified to answer that question from the patients’ perspective. However, we would certainly promote such an approach and hope that councils would take it with their own services. What the consumer, customer or client—whatever you want to call them—thinks of the service is entirely valid and should form part of any process for developing services. We must hear that voice.

Christine Lenihan: I pointed out earlier that NHS QIS has already demonstrated its ability to be independent in setting standards—we might be able to link such an approach to the establishment of standards for quality in patient care. Indeed, those standards are rapidly being established. The confederation sees no reason why, in that respect, the independence of patient representation could not be replicated along the same lines, although perhaps not using exactly the same mechanism.

Mr Davidson: In other words, you would not object if the proposed new health council operated outwith NHS QIS.

Christine Lenihan: Our membership has no issue with Quality Improvement Scotland’s early demonstration of its capacity to be independent. Of course, we did not refer to that in our brief written submission because the Scottish NHS Confederation represents the bodies against which complaints would be made. As a result, we did not feel that it was appropriate to elaborate on that matter.

The Convener: Do you agree that, quite apart from the substantive question whether there would be a conflict of interest in that respect, there might be the perception of such a conflict?

Christine Lenihan: Possibly.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I want you to confirm your views on the importance of contact within all the services as well as the importance of an independent voice outwith them. It would be good if everyone who worked in the system had the time to feed back problems that were highlighted by any one person and to marry that information with what might be happening outwith the system in the local health council. After all, I get the impression that an awful lot of patients have to contact outside bodies because they have problems with feeding into a system that should exist—indeed, does exist—in the best services. I am beginning to think that when a patient complains to a nurse or doctor, the nurse or doctor is too busy to feed it up into the system. As I said, perhaps many problems could be defused if people within our services had more time to listen to and act on them. Do you feel that your systems are robust enough to comply with that?

Hilary Robertson: If I have understood your question correctly, I think that the situation that you described should be covered by the health boards’ complaints procedures, which have been consulted on recently. Of course people want sufficient time to listen to patients’ views; I have no doubt that staff within all our member organisations strive to do so. I expect that, where a problem has been identified and a complaint has been made, the complaints procedure that has been reviewed recently would kick in.

Forgive me if I misunderstood your question.

Dr Turner: I would have thought that, in a good organisation, very few general complaints would require to be dealt with under the full complaints procedure. However, improving the situation within the system would probably even be of help to the independent voice outwith it. We should be listening to people and correcting things as we go along. I find that, whatever the system, people feel
that they are not listened to, especially when they are in hospital or are dealing with a particular department. The problem should be sorted out there and then, before it becomes a complaint.

**Hilary Robertson:** That comment brings us back to the continuing involvement of the public and patients in the system. I am sure that everyone would agree that, however well we listen to people, our ability to listen could always be improved.

**Dr Turner:** The problem is that we very much need support from outwith the system because such support is currently lacking within organisations. Perhaps you do not agree with that.

**Christine Lenihan:** The principle of emphasising public and patient involvement as a continuing process rather than as a response to particular decision-making processes is part of that. As Hilary Robertson said, the complaints procedures, which have recently been reviewed and which operate in all NHS boards, are another part. Underlying Dr Turner’s question is a question about the point of the commitment to listen to individuals. NHS bodies are committed to doing that and Hilary Robertson mentioned some existing examples, such as NHS Shetland 100.

**The Convener:** Rather than list good examples of public involvement now, perhaps you would write to the committee on that issue. It would be useful for the committee to have those examples in written form.

**Christine Lenihan:** We would be pleased to do that.

**Mr McNeil:** The Scottish NHS Confederation welcomes the inclusion of formal duties on NHS boards to involve and consult the public on the development of services and to engage with patients. Who would not welcome that? We may be sent a list of good examples, but all too often we read about poor examples. I accept that public involvement goes across the board and does not focus only on clinical or maternity services reviews. You mentioned additional finances. For the fun of it, will you say whether we get good value for the money that we spend on consultation? I will not go through all my experience—

**The Convener:** You are on a springboard.

**Mr McNeil:** Consultation gives communities the expectation that they will be part of the planning process and not simply part of the education process. Reams of guidance have been brought forth, which is bureaucratic and time consuming. As it turns out, the process is confrontational and accusations have been made that it is less than honest, which leaves everybody cynical about it. Of course consultation is a good idea and we are all for it, but—until now—it has not helped the service to move and change. Instead, the process has made politicians and communities try to prevent changes. God forbid that politicians should influence the health service, which needs to change, renew itself and move on.

I almost question whether we should proceed through consultation, especially on specific issues. The bill builds on the myth that it is a good idea to consult, even though people are disengaged from the process. Do we get good value for the money that we spend on consultation? Do we need to cut through the bureaucracy and be more honest with people by telling them what the real situation is, rather than pretend for years that they are involved, thus slowing down the process of change?

**The Convener:** I am listening for a question. That may have been cathartic for you, but it was a speech.

**Mr McNeil:** There were a lot of questions in it.

**Christine Lenihan:** I will pick one of them to answer. The confederation does not underestimate the challenge of finding new, different and more meaningful ways in which to involve people. Part of the context in which we live is that people expect to be involved and informed. That does not mean that consultation should be only on change. Change is inevitable, not only in the delivery of health services and health care, but in the way in which we live. The challenge is to ensure that we communicate thoughtfully, realistically and meaningfully with the people who are involved in the process.

**The Convener:** You said that you are moving away from consultation on specific issues. We will return to that point.

**Mr McNeil:** The guidelines require us to consult on time scales in a specific way that can draw the process out for four or five years. Is that right? Do we need to look at that and shorten those time scales? Are we moving things forward or holding them back?

**The Convener:** Do the COSLA witnesses want to come in on that point? I am getting answers from the committee members, but they can speak for themselves.

**Councillor Thomas:** Health boards need to engage in general continuing consultation, and I genuinely believe that that has greatly improved in recent years with local authority members being on health boards. One of the reasons why that worked was that councillors, rather than senior officers, were put on the health boards. Not only did they knock heads together, but they brought to the boards the skill that politicians have for getting out and speaking to people about things. In
general, health boards are benefiting from the experience of local authority members, which aids the process. However, if what is in question is a set of proposals to open a facility, or even to close a facility—

The Convener: We are all aware of which one.

Councillor Thomas: Exactly. I am not aware of the full details, but I would be concerned if we were to get too tied down in the bureaucracy of how we consult. If that could extend the process to four or five years, I would be extremely concerned.

The Convener: I would like to move on, as I am conscious of the time.

Mike Rumbles: How do you feel that the new duty on health boards to promote health improvement complements local authorities’ duty to promote well-being? Does it complement it effectively?

Alexis Jay: The short answer is that the health boards’ new duty complements the local authorities’ duty very well. If you look at the range of activities that councils are engaged in and their contribution to health improvement over the years, environmental issues have been significant, as have leisure, sports, healthy eating, education and schools initiatives. We have a huge range of networks and are therefore extremely well placed to pursue health improvement. That is the position that we are in at the moment, as the situation has developed a bit more. We would certainly welcome strengthening of councils’ role in health improvement. We might be concerned about how that is to be funded and developed, but we believe that we have a significant role to play in that area, not just in conventional social care services but in the wider remit of councils across a wide range of functions.

Mike Rumbles: My question was really about whether you feel that there is any conflict between the councils doing the role that the bill gives to health boards.

Alexis Jay: That will depend on what the guidance eventually says about the role of councils. It appears to be absolutely appropriate that health improvement is located within community health partnerships. Of course, it will depend on how the structural arrangements work out, but I am confident that we could find ways through that. I know that health improvement staff across the board have some concerns. For example, one or two have said that they might not particularly like being managed by GPs and would prefer a wider scope in which to operate themselves. That is the kind of detail that needs to be worked out, but the development of health improvement through the proposals in the bill and its location in CHPs absolutely complements the relationship with councils. I am sure that we could work closely and co-operatively in ensuring that that is carried through.

Hilary Robertson: The Scottish NHS Confederation also sees the two duties as being complementary. It is clearly not just for the health service to try to improve health; it is important that the functions of other bodies are also taken into account and that the health improvement focus straddles all the appropriate departments, functions and bodies.

Mr Davidson: I would like to broaden the scope of the question to include money, which is the root of all evil, as we know. You have both made pretty strong remarks about the lack of money for consultation, but what about money for health promotion itself? Do you feel that there is enough clarity in the bill about funding and mixed funding? For example, there might be funding from the education department in a council to promote life-improvement education, while the health board might already have allocated money to that, although it might not be listed under the same budget heading.

15:00

We have to look at cross-boundary working on mixed budgets. We have already had disputes over care, in which a health board has a patient whose care needs are being assessed, and a council has a patient or resident whose care needs are being assessed, so there are two sets of appraisals. Does the bill need to look more closely at health improvement and at how budget definitions are organised, especially given that you both said there is no extra money for consultation?

Alexis Jay: Quite honestly, I do not know the direct answer to that question. We hear about the negative examples, but we have lots of good examples of aligned budgets. Many partnerships work closely and have aligned budgets. My council has funded health promotion activities in partnership with two health boards with which we have boundaries. Lots of good things are going on, and organisations are working together, but health promotion and health improvement are not well funded on the ground. We tend to scratch around a bit, looking for funding to back up new initiatives and for areas that we wish to promote. However, I could not be specific about how that should be presented in the bill.

Mr Davidson: Would you like to write to us with COSLA’s view?

Alexis Jay: Yes.

Hilary Robertson: I have one small point. There is plenty of scope for joint working. Perhaps it would be helpful to apply the joint future model to health improvement. We note that the bill places a
duty on health boards to promote health improvement, which includes giving them powers to provide financial assistance to any person. We interpret that to mean any body or organisation. That will encourage joint working between the health service and other partners, such as local authorities and any other relevant partner. We support that. More money is always welcome, of course.

Mr Davidson: Your understanding is, however, that such measures will come out of current funding.

Hilary Robertson: Yes.

Mr Davidson: We are talking about reprioritisation.

Hilary Robertson: Yes.

Mr Davidson: Are you appealing for more money?

Hilary Robertson: No. We are simply recognising—

Mr Davidson: We have the evidence, convener. She said, “No.”

The Convener: In summary, the financial memorandum states that “Overall additional expenditure as a result of the above provisions”—

which is all the provisions in the bill—

“will be zero”.

It also states:

“As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure”.

That is not the case, is it?

Christine Lenihan: If we are talking about the summary, we know that some of the structural changes—which is where we started our discussion—are not incurring the costs that might have been thought necessary before they were started. There are examples of single systems that are very advanced in their planning, which have management structures in place, and which are actually releasing efficiency savings that are being deployed within various health systems for other priorities. It is too early to say what will be required in terms of CHPs, but it seems unlikely that in the early days of their development there will be no need for resources from elsewhere in the system. However, on an on-going basis, that has yet to be determined.

The Convener: I am trying to work out whether that was a yes or a no.

Christine Lenihan: It is work in progress. Our evidence is that single-system working is releasing funds back into the system to be spent on other priorities. That is as much as the Scottish NHS Confederation can say at this stage.

The Convener: I recall evidence from last week that conflicts with that, which was that savings of £19 million would be made at some point following restructuring, but the money just disappeared and was never accounted for. I will have to look back at last week’s Official Report to see what it was. Does COSLA feel the same? Financial memoranda are important in all bills.

Councillor Thomas: We have already given evidence to the Finance Committee on that point. We have been clear that it is difficult for us to see how the measures can be cost neutral. The changes that we are seeking to engage and involve local communities, patients and service users will add to the cost, but it will be money well spent.

The Convener: That concludes our questions. Thank you all very much. If, on reflection, you feel that we have missed something, we would be content for you to write to the committee.

I will press on and welcome the next set of witnesses. While they are taking their chairs, I inform the committee that the videoconference with witnesses from Orkney will be on 6 January next year.

I will wait until you are all sitting comfortably. Some people will understand that reference from “Music with Mother” or “Listen with Mother”—I am rambling—it was “Listen with Mother”.

From Ayrshire and Arran NHS Board, I welcome George Irving, chairman, and Wai-yin Hatton, chief executive. I also welcome, from Dumfries and Galloway NHS Board, Malcolm Wright, chief executive, and John Ross CBE, chairman.

I ask the witnesses from Dumfries and Galloway to outline for the committee their experience of working within a national health service system that, like my area in the Borders, no longer has NHS trusts. Is that structural change necessary to improve services, and should it be rolled out throughout Scotland?

John Ross CBE (Dumfries and Galloway NHS Board): When the unified board was set up in October 2001, the chief executive and I had a long discussion about where the major challenges for Dumfries and Galloway would be, not in the next week or month, but 10 or 15 years ahead. We quickly identified for the board that the big challenge would be the demographic change in the population of Dumfries and Galloway: a 26 per cent increase in over-65s, a 26 per cent decrease in those aged 19 and below and an 11 per cent decrease in the working-age population. We realised at that stage that the status quo—a health
board and two trusts—was not an option and that we needed to think radically about how we would start to modernise services in Dumfries and Galloway if we were to cope with the challenges of the next 10 to 15 years. That was the basis of the decision, to which we came quickly, to have an integrated health care system in Dumfries and Galloway that would result in the dissolution of the two trusts.

The Convener: That is a practical example.

Malcolm Wright (Dumfries and Galloway NHS Board): After the discussion that the chairman and I had, we had a process of engagement and consultation. It took 14 months from our taking the initial idea to the NHS board and the minister giving us approval to explore different models to put in place a completely integrated structure.

When we undertook consultation with the public, the local authority and our staff, it was interesting to note that nobody was of the view that having three statutory organisations to run health services in a place the size of Dumfries and Galloway was sensible. We have a population of 147,000 and a staff of 4,200, and everyone was of the view that we could organise services better.

When we examined how patient care was managed, we came to the view that we should design our structures and processes to support the flow of patients through the NHS system. Therefore, we have set up a number of groupings that span primary care, secondary care and, in a number of instances, tertiary care, on a specialty-by-specialty basis. There are about eight or nine local groups for cancer, learning disabilities, mental health or children's services in which primary-care practitioners and secondary-care clinicians come together with the public and staff to plan services on a regional basis and to determine how they will be run.

In a number of those services, close working with the local authority has been very helpful. Coterminosity with the local authority has been a huge advantage. We have been able to do things jointly with the local authority, such as joint appointments for planning and commissioning services as well as for the delivery of services.

One of the consequences of working in a single system is that we have been able to make financial savings, although that was not the reason for doing it. We have managed to reinvest those savings in front-line patient services.

It has been helpful to remove some of the duplication that arose in the three NHS organisations. We have a single finance system, a single finance director, absolute transparency as to where the money is throughout the system, a single personnel system, and a single operational service for estates and capital planning. The fact that all those systems have come together has been helpful.

The key is the bringing together of clinicians from the primary and secondary sectors, examining how they can work in different ways, redesigning services and finding better ways of engaging the public. It has not all been plain sailing but we were glad to have gone there first. It is starting to produce benefits.

The Convener: Coterminosity seems to be the key, as does getting rid of duplication. Integration could work in rural areas. It works in the Borders, probably for the same reasons as it works in Dumfries and Galloway. There are problems if people do not know one another. If the system is rolled out throughout Scotland, will it work in urban areas in the way in which you have described? There will be different local authorities involved in such areas and professionals will not know one another in the same way as they tend to in rural areas.

John Ross: That might be possible but it will take greater effort. That said, it took an enormous amount of work for us to achieve what we did. It did not just happen; we had to drive very hard to achieve our ends. There is no doubt in my mind that the bringing together of primary and secondary services and, particularly, of clinicians who work in the primary and secondary sectors, is vital to the achievement of better care pathways.

The Convener: The people part must be important. The personnel who know and work with one another have to be prepared to buy into that. That is why I am interested in what you said about urban areas.

Mike Rumbles: I want to follow up what Malcolm Wright said because it is an important issue for the committee. We seem to have a problem knowing whether money will be saved if bodies are amalgamated into one board or authority. You said that savings were definitely made, but can you quantify those financial savings? Would we be able to make some judgment about whether money would be released by the process?

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

We had a good lead-in time of 14 months and were clear about where we were trying to go. We also took the view that we did not need three chief executives or three directors of finance and so on. We started with a blank sheet of paper and redesigned everything. People were leaving the
system anyway so we were able to use natural turnover and make the move relatively seamless through considering the individuals that we had and their strengths and capabilities, rather than simply design a structure on a blank sheet of paper. We matched the structure to the people that we had.

Mike Rumbles: The Executive says that substantial savings could be found by integrating, and that the savings could be channelled into the statutory requirement to engage with patients. From your experience, do you believe that such an approach could be replicated throughout Scotland? The Executive is saying one thing but some of our witnesses, such as those from COSLA, are saying that patient engagement will cost a lot more money and will not be cost neutral. That is the committee’s dilemma.

Malcolm Wright: My personal view is that public engagement is resource intensive if it is done well. Public engagement does not necessarily mean spending more money, but it involves staff time. I will give a brief example of a project that we have developed in Dumfries and Galloway around older people’s services in Mid and Upper Nithsdale. We and the local authority jointly agreed a model of care for older people in the region. It was signed off at a full joint meeting of the NHS board and the council.

We examined a particular part of the region that had a community hospital and a range of other services. Rather than go in and say, “This is what the local model will be”, we said, “This is where we think we want to get to.” We engaged with local elected members, community groups and a wide range of stakeholders, and the local health council was involved in helping to design the model. We took a good 18 months to consider different models and to work them up in the community. The community, staff and other stakeholders came back to us to say what the best fit was for their region. The project was resource intensive, but we think that we have a much more sustainable end result, whereas a less resource-intensive approach might have backfired and not met the objectives.

15:15

The Convener: Before we move on to questions from other members, would the witnesses from Ayrshire and Arran NHS Board like to comment? Please feel free to do so, even though my question was directed to the witnesses from Dumfries and Galloway.

George Irving (Ayrshire and Arran NHS Board): We have benefited from being a near neighbour of Dumfries and Galloway and we have been involved with the progress that has been made there. In Ayrshire and Arran, we welcome the move to single-system working, which we see as a natural progression from the unified system that we have now. It is a major step from integration to a single system, and one of our concerns is to ensure that our single system is based clearly on a model involving devolved decision making and control of resources. There is a concern that we might return to the old central command-and-control model that applied to single-system health boards in the past. We must be alert to that danger, and I hope that the bill, the regulations or the policy memorandum will reinforce that expectation of devolution, not centralisation.

As far as savings are concerned, it is an evolving situation for us. Certain conditions of service have to be observed. One would not design a single system in the way in which we are having to implement it. Therefore, although savings are evolving from the process, we do not foresee major savings immediately.

Mr Davidson: With the change to divisions as opposed to trusts, you have lost out on non-executive input at that level. Has that been a major loss? You now have a much smaller amount of non-executive input to discussion at the divisional level, albeit that you have strategic input at board level. How are you compensating for that, or is it not a loss for you?

Mr Ross: In Dumfries and Galloway, we do not envisage a division. We have a truly unified system, and the minister gave us permission to increase the number of non-executives from four to six, plus me. We think that we have sufficient non-executive input and involvement in the board. Also, the board is larger because we have a local authority member, a staff-side member and a clinical member on the board. The board is therefore much more inclusive than it was when it was a health board. Our non-executive involvement is sufficient to carry out the strategic thinking and, indeed, the governance duties that non-executives have to undertake.

Mr Davidson: There was certainly an important input on the governance side in the larger health boards, which had large machinery. Have you managed to change the model sufficiently to compensate for that, and to mix strategic staff and management?

Mr Ross: We have done so in Dumfries and Galloway, but I would not say that the model could be followed in larger areas, where there would have to be divisions. Our model is particular to Dumfries and Galloway, and I would not necessarily advocate its use elsewhere.

George Irving: We welcome the increase in non-executive input to the board, but we do not
see that as a loss to the divisions. The board has wide discretion about its committees and how they are formed. Although it is required at the moment to have the management teams as a nucleus, it has considerable flexibility to add non-executive members to those teams, and we certainly intend to do that. We do not envisage that denuding the operational level of non-executives.

Mr Davidson: Do you base your thinking on a geographic model of representation at non-executive level, or is it based simply on skills?

George Irving: It is based on skills.

Dr Turner: I was interested in the comment that primary and secondary care people talk more to one another, as that is essential if the system is to become more efficient. It might be too soon to find out whether patient waiting times have been reduced or whether patients are more satisfied in the long run, but have you noticed whether patients are treated better in the unified system and go through it more quickly? I imagine that that might well be the case.

John Ross: I will give an outline answer and ask the chief executive to be more specific.

It is too early to say, because we have had a change of culture as well as a change in our way of working. In the past, the culture was that clinicians in primary and secondary care worked in their own fields. The chief executive can give one or two examples of issues on which we are beginning to see improvements in the patient pathway, which is the most important improvement for patients.

Malcolm Wright: One of the advantages has been the development of integrated strategies across primary and secondary care. I mentioned the groups for mental health, learning disabilities and cancer—the improvements on those issues are not directly down to integration, but they are all part of the process. We have Scotland’s first managed clinical network for coronary heart disease, which is a good example. Patient representatives, who are supported by the local Hale and Hearty Club of patients with experience of using coronary heart disease services, sit round a table with primary care and secondary care clinicians. The network involves good dialogue on matters such as pre-hospital thrombolysis, door-to-needle times in the hospital and resuscitation issues such as resuscitation training in the hospital. I am not saying that we have gained huge improvements yet, but plans are in place that will allow us to make major advances in the future.

We are pressing down hard on overall waiting times in the system. We have met the Scottish Executive targets on waiting times in the past and we intend to do that this year. We are carrying out significant cross-system work that we have never done before to examine out-patient journeys. We have just approved a study of how we manage bed capacity throughout the region. The study will examine capacity in community hospitals, Garrick hospital in Stranraer and Dumfries and Galloway royal infirmary and will consider how to manage the beds as a single system. In the winter in particular, the infirmary comes under a lot of pressure and we might not use capacity in the community hospitals to maximum effect. The discussions are on-going, but we have the required mechanisms to drive the proposals forward.

Because we have a single board, management team and clinical integration group, and single groups for primary and secondary care for different disease groupings, many opportunities arise for dialogue and for planning throughout the system. We are starting to make improvements, but we have a long way to go.

The Convener: Kate Maclean has a question.

Kate Maclean: I want to return—

The Convener: Sorry, Wai-yin Hatton wants to speak. I have done it again—just because I used to be a Gallovidian, that does not mean that I am biased.

Wai-yin Hatton (Ayrshire and Arran NHS Board): I want to offer two pieces of evidence from Ayrshire and Arran. Although we have not yet gone down the route of formal integration, through the change in culture by which GPs and consultants work more closely we have reduced significantly the dreaded plastic surgery waiting list. The GP who is the chair of the area clinical forum spent a week reviewing the list, as a result of which some patients were rightly re-directed and treated more immediately.

The other example is similar to one of the examples from Dumfries and Galloway. Because clinicians now work together, they have found different ways of working. For example, there is a lot of pressure on our accident and emergency capacity, but GPs now naturally volunteer to do various locum sessions to help to ease the pressure. Such automatic and systematic volunteering was not so obvious before, because people saw themselves as being from two different legal bodies.

Kate Maclean: I have a couple of questions that go back to previous answers. Malcolm Wright said that an ancillary effect of restructuring was a £500,000 saving. The figure does not really mean anything on its own; what percentage of your budget does it represent? Will there be recurring savings of £500,000 year on year? Where is the money going? Is it committed to your health authority area and has it gone into improving services?
Malcolm Wright: It is £500,000 out of a total turnover of more than £170 million, plus the capital allocation to the board. The figure is significant but not massive. On 1 April, when we signed off our health and community care plan, we were able to put £1 million of investment into new clinical services. We were very proud to be able to do so. We were able to increase nursing staffing levels in Dumfries and Galloway royal infirmary, and to invest in a consulting gastroenterologist and in our infection control capacity. A list of things was on the stocks and prioritised and we were able to use some of our development money plus some of our savings.

We face huge challenges with the development of community health partnerships. We will have to consider the capacity of CHPs—in terms of management and clinicians—and how we will build critical mass within CHPs.

The Convener: We will come on to that topic shortly.

Malcolm Wright: Yes, but when we invest resources in future, community health partnerships will be up on the list.

Kate Maclean: You said that you had coterminous boundaries with your local authority. Does that make things easier than they are, for example, in my health authority area of Tayside, which has three main local authorities and a significant involvement with another two? Is such a set-up much more complicated?

Malcolm Wright: Having coterminous boundaries makes things hugely more straightforward. We are not talking just about health and the local authority; the police force and Scottish Enterprise Dumfries and Galloway also share the same coterminous boundary. We are able to design community planning on that basis—and not only at regional level. While we were going through our restructuring process, the local authority was going through a parallel restructuring process. We have tried to design our local health care co-operatives along the lines of the local authority area committees. We have local council ward boundaries that are coterminous with local health care co-operative boundaries. That may be the way forward for CHPs. We have a lot of coterminosity right the way through, which makes it much easier to plan for the future.

Kate Maclean: So, taking evidence from you is probably giving us the best-case scenario.

John Ross: I would say so.

Helen Eadie (Dunfermline East) (Lab): The best-practice group report has acknowledged that the development of local health care co-operatives has been patchy across Scotland. Community health partnerships are expected to evolve from the LHCCs. Will practice improve substantially by giving CHPs a statutory basis? Much of the detail of how they work will be subject to guidance.

The Convener: Let us start with Ayrshire and Arran for a change. You go for it—Dumfries and Galloway is always pushy.

George Irving: But we are always very interested to hear what is going on in Dumfries and Galloway.

We certainly welcome the evolution of LHCCs into CHPs. The CHPs are a different animal altogether. The LHCCs are very much in the NHS family, but the CHPs, which involve health and social care, are quite different.

We are fortunate in that our NHS board area encompasses three local authorities and our current LHCCs—we have three—are coterminous with them. Structurally, we are well geared up for the CHP route. However, we have some concerns. I heard the COSLA representatives talking about the Local Government in Scotland Act 2003. The government is rightly sensitive about the introduction of CHPs. In an addendum to the National Health Service Reform (Scotland) Bill, or in some form of regulation, it would be advisable at least to refer to the local government legislation. That would be a tactical move, because we are heavily dependent on our local authority partners.

The issue of the involvement of general practitioners was always going to be difficult. We are fortunate that all our GPs have opted in, but they could equally well opt out. Health service personnel have a statutory duty, but GPs do not. That was also a weakness of the LHCCs.

The concern has been expressed that we should not let CHPs become dominated by clinicians or general practitioners. We welcome CHPs very much and we are geared up for them—I think that we will implement them quickly—but we make some cautionary comments.

15:30

John Ross: I concur with George Irving. In Dumfries and Galloway, we were a bit concerned that minimum population figures were initially assigned to community health partnerships. We have four LHCCs, and as our population is 150,000, those LHCCs are small. However, as my chief executive said, those LHCCs’ boundaries are coterminous with the boundaries of the local authority area committees.

I am slightly concerned that if one community health partnership covered the 147,000 people in our area, it might negate the gains that we have made from close integration of primary and secondary care. I hope that the bill will allow flexibility for different health board areas to decide
the appropriate sizes for their community health partnerships.

On the positive side, community health partnerships’ closer involvement with local authorities and with elected members of local authorities in particular will strengthen CHPs and will allow closer working with social services and local authority services for the elderly. That will be a big advantage. Having a statute behind that will help.

Helen Eadie: You all support the statutory basis for moving forward. That is fine.

The Convener: I call Janis Hughes—I am sorry; I have not taken a response from Ayrshire and Arran NHS Board again.

George Irving: I will respond to Mrs Eadie’s point about the statutory basis. We have concerns about the proposal to make CHPs sub-committees of NHS boards and our major reservation is about locking CHPs firmly into the committee structures of NHS boards. We expect CHPs to have a wider role than that. We consider the CHP to be the vehicle for the joint future agenda and a local vehicle for community planning. CHPs have huge potential and need statutory underpinning, but they should not be too locked into the health system.

Helen Eadie: That concerns the equality issue and the importance of involving the community in planning, which relates to earlier discussion.

The Convener: I am loth to call Janis Hughes in case I cut short some witnesses again. I am becoming paranoid about that.

Janis Hughes: My question is about Ayrshire and Arran NHS Board’s submission, which says:

“Implications are further down the line and could lead to fragmentation of services unless steps are put in place to prevent this.”

Will you be specific about that? The bill is supposed to lead to better partnership working, so I am interested in your comments on fragmentation.

Wai-yin Hatton: We support fully the devolution agenda, which can be readily achieved through good delegation schemes, so that people who are on the front line know exactly the parameters and who has authority without having to keep returning to the health board.

We flag up two matters about which we are cautious. In an area that is as big as Ayrshire and Arran and which has a wide range of social problems and deprivation, we must ensure that we do not lose sight of the need to reduce inequalities in health when devolving powers to the front line. We could easily lose sight of that if the new bodies become autonomous infrastructures. Strategic clarity about the health issues that need to be addressed must be tied in.

The Dumfries and Galloway model probably highlighted some benefits of the economies of scale that can be gained from coming together. In a way, that is the opposite side of devolution. In supporting devolution, we must be cautious to avoid fragmenting potential teams. Ayrshire has three teams of different professionals but, in some areas, a team of professionals who are difficult to recruit might be lost. It is a question of ensuring that there is a good balance between a devolved structure, economy of scale and the maintenance of good professional standards for the whole county.

Janis Hughes: What steps could be taken to address the concerns that you have raised?

Wai-yin Hatton: Even though we have not yet come together as one legal body, we have been working together in that direction. All the decisions about changes and redeployment are taken jointly through a corporate team, which consists of chief executives and directors from the board and the two trusts. For the past year, we have been examining and assessing situations and problems together, to ensure that we consider all the different aspects before we come to a decision. That way, no one party or locality can take a decision in isolation, without taking account of the potential impact on other key colleagues.

George Irving: A further point is that, from next Wednesday, we will start operating as a shadow board for the new single system, while the current board works itself out of existence. The shadow board is now empowered to set up the new system—that is virtually what it is there for. Between now and next April, such issues will be on the agenda. We are fortunate that, this week, we received ministerial approval for the non-executive appointments. We can kick off fully as a shadow board next Wednesday. That will be important for us.

Janis Hughes: You think that that kind of proactive working will lead to a situation in which fragmentation will not occur.

George Irving: We are very committed to devolution and to equality throughout the area, but we do not want devolution to lead to dissolution and fragmentation. We want to ensure that there is a strategic centre for a highly devolved operational system.

The Convener: Does Dumfries and Galloway NHS Board wish to comment?

Malcolm Wright: No.

Helen Eadie: I overlooked a question. I meant to ask whether anything more on community health partnerships should be added to the bill.
George Irving: We are reluctant to propose changes on community health partnerships because that might remove flexibility. The policy memorandum and subsequent regulations are much more important than what is included in the bill.

However, I think that the bill should include a reference to the Local Government in Scotland Act 2003, given local authorities’ powers in relation to well-being and community planning. In Ayrshire and Arran, we are comfortable with the clear lead that local authorities must give on community planning. We firmly believe that that is where that responsibility should lie. The health authorities’ role in contributing to the community plan has major implications for the local health plan. At the moment, there is duplication in those plans, time scales are not being synchronised and worthless work is being done. That vehicle is also within the community planning partnership and it could be referred to in the main body of the bill.

Mr Davidson: I have a brief follow-up to Helen Eadie’s question. In my health board area, there are three local authorities—which, coincidentally, is the same situation as in Ayrshire and Arran—and there are three different joint future documents. It is not just the different geography that accounts for the fact that the documents are not identical. I want to tease that out. I understand why both boards seem to be keen on working closely with local government. Does Ayrshire and Arran NHS Board see a need for agreement on a single document throughout the three local authority areas or are you happy to have different documents?

George Irving: There is certainly a wide variation in needs and equalities—or inequalities—in the Ayrshire authorities. We think that local authorities should reserve their right to have community plans for their areas. As a board, we contribute to those plans. We do not send teams of people to the relevant meetings; a small number of the board’s senior officers take a common view from the board, which they input into the community health plans. Our three local authority members sit on the health board when such matters are being discussed. We are quite comfortable with the variations in the community plans for our community.

Mr Davidson: I have a question for both boards. You have heard us talking about the proposed new national Scottish health council. Will you give us your views on that? Do you feel that it will be more independent than the local health councils are and do you have any concerns about the loss of local representation? Do you think that the new local advisory committees and the new consultation duties will make up for what you have now?

Malcolm Wright: I will start to answer that. The proposed new system will offer a number of advantages, particularly in relation to consistency and scrutiny of public involvement processes within NHS boards. In our area, we have positive experience of working with our local health council—it has a continuing involvement with us in the management and development of strategy and it works with us to design how we go about public consultation.

There is some advantage to linking the new Scottish health council with NHS Quality Improvement Scotland. I agree with previous witnesses that NHS QIS has developed a track record of impartiality, so having the national health council linked with NHS QIS could be helpful. However, the key will be whether boards such as ourselves can develop a good working relationship with whatever structure is put in place at a local level. How things play out at the local level is the key, together with national consistency.

John Ross: I will provide a point of clarification. I agree with our chief executive that we have a good, strong local health council in Dumfries and Galloway; it is a useful sounding board and is able to question the decisions that we take. However, it is not entirely independent because Dumfries and Galloway NHS Board pays the chief executive’s salary and the board’s chief executive line manages the local health council’s chief executive. The local health council does not have total independence. Under the new arrangements, it might be even more independent than it is now.

Mr Davidson: Point taken.

Wai-yin Hatton: Ayrshire and Arran NHS Board has a slightly different view. Even though we have a very good working relationship with our current local health council—the chair of the health council sits as an adviser at the board table—we feel that the health councils should be much more independent. If they are not, their actions may be compromised even though they are doing the right thing.

We are going through a raft of challenging service changes and the health council has been positive; it has provided constructive criticism and support. If health councils are genuinely independent of the NHS system in its widest sense—even independent from NHS QIS—they will be a genuine independent patient advocacy and consultation group. They would not be compromised and people could not accuse them of having potential conflicts of interest. We have a slightly different view from that of other board areas.

Mr Davidson: I ask the representatives of both health boards what your public think of the local health councils and the changes that will take
place. Will they understand the differences that the changes to the system will make?

John Ross: To be honest, I do not believe that they will understand the differences. In some cases there is confusion in the public mind between the health council and the health board. I do not believe that the public would have strong views one way or the other.

George Irving: It depends on the profile of the health council locally. We have been fortunate that, due to circumstances, the health council has recently been involved in, for example, a major transport survey. The health council was involved in that survey independently of the board and it fed into the board. The health council has taken a lead in recent consultations on specific issues; that has elevated its profile and increased public interest in it.

I do not think that the public would see a huge difference, but I verify our chief executive’s comments that we believe that we should avoid institutionalising the proposed Scottish health council. We are not in favour of attaching it to NHS QIS, which has a clinical focus. The Scottish health council will have an independent lay focus. We would prefer those two bodies to be separate.

Shona Robison: Both health boards have said that the public may not notice a difference between the existing and proposed arrangements, but members of the public will notice a difference if they go along to get help with the complaints procedure or want to make a complaint. Currently, the local health council can walk the ward unannounced, but in the new set-up that will not be allowed, as the new Scottish health council will not have that advocacy role. It is explicitly stated that all that it will have is the role of monitoring the public involvement duty that the health board will have. Who will undertake the local health councils’ current tasks, such as face-to-face contact with the patient who is guided through the system when they want to make a complaint?

George Irving: I did not read the policy memorandum as making as clear a statement as that.

I understand that the Scottish health council’s advisory and local role—its link with local voluntary organisations and so on—and its monitoring function inevitably mean that it will raise issues, and rightly so, with the health service.

15:45

Shona Robison: The Minister for Health and Community Care’s view seems to be very much that the new Scottish health council will not have an advocacy role. Advocacy services will have to be commissioned at local level. That is my understanding of what has been proposed and is probably what is causing so much concern. For me, that very clear advocacy role will be lost. Although we are all in favour of making public involvement a duty, such an approach is not exclusive of the role that is played by local health councils. As it stands, the proposal does not follow the advocacy route. Instead, it seeks to ensure that public involvement will be monitored and, presumably, that advocacy services will be provided in some way, although not directly by local health councils. Are you concerned about that?

George Irving: Yes.

Shona Robison: If the proposal goes ahead, are there any obvious organisations in your area that would provide the advocacy service that is currently provided by the local health council or are you concerned that there are no such organisations?

George Irving: Although there are specific advocacy groups, needs groups and patient groups, there is no general service as such. I would be concerned if the local health councils lost that role completely. That said, my reading of the proposal was slightly different. I thought that flexibility would still be available if the health councils chose to avail themselves of it. I would expect that if they are to link with local organisations, monitor their performance and advise them accordingly, they would raise such issues—or arrange for them to be raised—with the health service.

Shona Robison: So you want the replacement local advisory councils to have the direct advocacy role that local health councils currently have. Indeed, you would be concerned if they did not have such a role.

George Irving: That is right.

Malcolm Wright: I am also concerned about where the proposal might lead. Our experience locally shows that the council and the NHS jointly commission advocacy services, which means that a single advocacy service plays into both the local authority and the health service. At the moment, that service happens to be provided by the local health council as a sort of arm’s-length organisation. I am concerned about where that will go in future and about whether those functions will be carried out by the local grouping or some other body.

Shona Robison: As it stands at the moment, it appears that no significant additional resources will be allocated in this respect other than what can be freed up through the reorganisation of services. Will public involvement cost money and, if so, where will the money come from?
John Ross: We will not necessarily have to shell out a lot of money to meet public involvement obligations. However, it will be costly in the sense that it will take NHS personnel-time to consult adequately and properly. As my chief executive Malcolm Wright has indicated, we have just found that to be the case. However, I see it as part and parcel of something that we will have to do in Dumfries and Galloway if we are going to modernise services. We have to dedicate the management resources that are required to consult meaningfully with communities where it is important to modernise services. That said, I do not want to put a figure on the percentage of our spend that will specifically be allocated to public consultation and involvement.

Wai-yin Hatton: Our campaigns cost additional staff time because we have to hire public places that are accessible and organise campaign material and leaflet drops to every household. However, one recent example highlighted the fact that, although such an approach resulted in additional costs, the proposal was enhanced before the health board considered it. The weighting of the criteria was changed in our appraisal exercise and public engagement led to two further options’ being offered. I hope that in such circumstances the public will understand the reasons why a preferred option is ultimately chosen because of the information that they receive and because they know that we genuinely take their views on board.

We have also initiated a partnership discussion with a range of public sector partners to find out how we can take advantage of each other’s transport networks and improve people’s access to hospitals and primary care locations. As a result, although a cost is involved, there is also a tremendous payback. We are simply investing in the improvement of future health services.

George Irving: As far as cost is concerned, there is also a duty on us rigorously to review how we currently undertake public consultation and how focused that consultation is. There are different forms of consultation; explanations in some cases and engagements or full consultations in others.

Sometimes we blindly rush into consultations because they are expected of us, and we do not effectively key into local authority systems, some of which are well established. In our area, for example, there are citizens’ juries—whether we think that those are positive or negative—and we could key into such bodies to avoid consulting people over and over again. Consultation and feedback can be sought on general or specific NHS services, but sometimes consultation is simply an over-elaborated explanation cloaked in the guise of consultation.

We must be more sophisticated about how we undertake consultations. For example, we have recent experience of meetings that were very counter-productive, both for the public and for the NHS. We must be clear about what we mean by consultation and how we do it. Savings can be made if consultation is done properly, but effective consultation can be costly.

Shona Robison: I think that we would all concur with that.

Malcolm Wright: I highlight two other matters. First, although the health service is changing, there are still training costs for educating staff about involving the public in the design and running of services.

Secondly, in Dumfries and Galloway, one of the actions in the community plan is to streamline the consultation processes that take place across public sector agencies. We have learned how to use existing local mechanisms, such as the seven local area committees.

In a rural area, the GP out-of-hours service presents a big challenge. We have engaged with the elected members on the local area committees and with members of the public to discuss the challenge and try to devise the models of care that will be available in the future. It can be advantageous to link in with the local authority.

Dr Turner: NHS boards will have a duty to promote health improvement. Will that be beneficial and, if so, in what way?

Wai-yin Hatton: We very much welcome the increased emphasis on and clarity about health improvement. At the end of the day, I am a patient as well as a member of the health authority.

I listened to witnesses who spoke earlier and the role of local authorities in community planning and community health partnerships demonstrates that the health service alone cannot deliver health improvement; there is inter-dependency. The bill gives us a greater chance of ensuring that we systematically work with our key partners. In a number of areas there are signs that funds are being pooled, rather than just aligned, and decisions about how we deploy resources—be those money, facilities, accommodation or people—can mean that we tackle health improvement more effectively.

A question was asked earlier about managed clinical networks. We are looking at integrating the health promotion functions of the board, the trusts and the local authorities, to see how we can take advantage of the managed health promotion network concept to continue to work with our external partners to improve health.

Malcolm Wright: We also strongly support the inclusion in the bill of the duty to promote health
improvement and the alignment with local authorities to consider money that is provided by the Scottish Executive. For example, the better neighbourhood services funding that the Scottish Executive provided to Dumfries and Galloway Council was discussed with community planning partners and then used to put in place a range of new facilities, such as youth clinics and youth services, which we used directly to focus on, for example, teenage pregnancy rates in the region.

We have made a commitment to endeavour, year on year, to increase the moneys that go from the general NHS allocation into ring-fenced health improvement programmes. On 1 April we were able to allocate £100,000 towards building more capacity for health improvement, for example, by taking forward smoking cessation programmes across the region. The bill reinforces a direction of travel to which we are already committed.

The Convener: Presumably, if the promotion of health improvement becomes a statutory duty, health boards will be entitled to more funding when they negotiate with the Executive.

Malcolm Wright: We get the money from the Executive anyway—

The Convener: That is not on the record; you will have to say something more—

George Irving: More optimistic.

Malcolm Wright: It reinforces our local work if money is put into such initiatives.

The Convener: I was being helpful. I will move on.

Mike Rumbles: My question is directed at Ayrshire and Arran NHS Board. In your written submission you referred to an omission from the bill, in that staff governance was not included. How would you like staff governance to be represented in the bill? Would you like the Executive to produce an amendment to ensure that health boards have a system in place to monitor and improve the governance of NHS staff?

Wai-yin Hatton: Something was put out for consultation, which we were pleased to see. In addition to setting up governance committees within each NHS board, staff governance needs to be elevated to the same level as clinical governance, because our biggest investment and asset is our staff. If we do not properly look after their health, well-being and conditions—and I do not mean pay conditions—potentially we will have a depleted group of staff to tackle the winter pressures. They might end up being patients themselves because of stress. If we are to compete with other industries so that good staff remain within the public sector, we need to give them genuine evidence of commitment, as well as evidence that we value them. That is why we feel strongly that the staff governance component needs to feature more prominently and explicitly in the bill, so that all bodies are required to deliver on that.

Mike Rumbles: I would be interested in any other comments.

John Ross: I support that.

The Convener: Thank you for your evidence. That concludes this evidence session. I will suspend for a few minutes. People have been peeling off, which is a warning to me. You are welcome to have a coffee. The same goes for the Unison representatives, who are about to give evidence and who have sat here patiently.

15:56
Meeting suspended.

16:04
On resuming—

The Convener: I welcome the very patient Unison representatives, who are, they tell me, in need of the health service because they are both suffering from the cold; I am glad that they are both sitting some distance away from me. Jim Devine is the Scottish organiser for health, and Danny Crawford is the chief officer of Greater Glasgow Health Council; both are from Unison. I know that they listened to the earlier evidence, which is helpful.

Janis Hughes: Your written evidence welcomes the abolition of trusts, but you make a number of points regarding community health partnerships, about which, as you will have heard from previous evidence, we are asking a lot of questions. As you know, following consultation much of the detail will be set out in regulations. Is there anything on community health partnerships that you would like to see in the bill, rather than in guidance?

Jim Devine (Unison): I will make a wider point. I was a member of the Bates committee that examined human resources and the joint future agenda, and I had genuine concerns. We have heard a lot about coterminosity. If we started with a blank sheet of paper, we would be talking about coterminous local authorities and health care bodies. Single-status agreements are coming to local authorities and agenda for change is coming to the health service.

Some of the advanced initiatives on the joint future agenda and LHCCs are falling down when it comes to bringing together workers from different partnership organisations that have different terms and conditions and different grievance and disciplinary procedures. There are major issues—for example, nurses have issues about
professional accountability. We even face the basic problem that some local authorities take a holiday on a particular Monday while the health professionals' holiday is the following Monday. The locality manager is employed by the health service and the local authority, but the situation may mean that services are shut.

We have to learn lessons. As a trade union, our concern is that although the initiative is good, we need to have more meat on the bones. I do not want to be prescriptive, but guidance needs to be produced on issues such as similar terms and conditions, grievance and disciplinary procedures, and accountability. Prior to becoming a full-time officer, I worked on the first primary psychiatric team to be based in a general practitioner practice. People began with enthusiasm, but they quickly learned that the colleague beside them from social work, who did exactly the same job, was on £3,000 or £4,000 more than they were, which created major difficulties. Guidance should be produced on the HR agenda. Staff who are employed by GPs should come back into the national health service. It has to be clear who the employer is and what the procedures are.

Janis Hughes: That is an important point, which you made strongly in your consultation submission. You say that you would like guidance. In your written submission, you mention local standards of treatment, access and referral, which you say could lead to a postcode lottery. Could that issue be dealt with in guidance, or would you prefer it to be included in the bill?

Jim Devine: This afternoon's debate has been partly about involving patients and staff. That could include having a Scottish strategy to examine what we are trying to do and the difficulties that we face; it should also include minimum standards. I am not convinced that we should have the current targets, because they give the health service a terrible kicking, which has a demoralising effect on staff. We can talk about the health service a terrible kicking, which has a demoralising effect on staff. We can talk about national minimum standards, and targets that are agreed locally with community involvement. It is not about saying that if Danny Crawford is in Glasglow and I am in Edinburgh, he will get a better service. There is a need for a minimum level of service. That is part of the earlier debate that you had about involvement.

The Convener: Does Danny Crawford wish to add to that?

Danny Crawford (Unison): No.

Mr Davidson: On the front page of your submission, you comment that you seek

"common conditions of service across all NHS Health Boards."

but you have not qualified that in relation to qualifications or responsibility. Does that mean that Unison is against anything other than a uniformly applied core arrangement? Are you in favour of flexibility to allow health boards in which there is a key shortage to attract staff to an expensive housing area or to somewhere that does not have the normal facilities that we might expect in the central belt?

Jim Devine: One of the problems that trusts created was that they had the right to determine local pay bargaining, the consequence of which is that we have staff working alongside one another on different terms and conditions. The differences are often minor, but they exist. For example, if you were on a trust contract, your annual leave entitlement would be less than mine would be if I had worked for the past 20 years in the national health service.

In the comment that you quoted, we are saying that, before we introduce agenda for change and get back to standardising the care that we want throughout Scotland, we need to get back to standardised terms and conditions. We need to have the baseline; if we do not have the baseline, we cannot introduce agenda for change, because, if terms and conditions are not standardised, we cannot introduce a pay modernisation system. It is frustrating enough to work on a joint future project or in an LHCC beside somebody who is on different terms and conditions, but I am sure that you can appreciate how much more frustrating it is to work in Stobhill hospital in north Glasgow alongside a colleague who is on different terms and conditions.

To be fair, we have sat down with the Scottish Executive and negotiated the low-pay deal, which has meant a standardisation of terms and conditions for ancillary staff, administrative and clerical staff and many nursing staff. As part of that agreement, we have a commitment to standardisation of terms and conditions by, I think, October 2004.

In the paragraph of our submission that you quoted, we make a point about associated employee status. That is very important, because we will not get the flexibility that we want in the delivery of care throughout Scotland if we have a Scottish strategy but do not introduce associated employee status. If Janis Hughes worked for Greater Glasgow NHS Board and left to go to, for example, Lothian NHS Board, she could lose a lot of her conditions of service. Doctors, on the other hand, have associated employee status, so they can move throughout Scotland and carry their conditions of service with them. That is not the case for nurses, porters, domestic staff or administrative and clerical staff. Although it might be argued that, because associated employee status concerns employment legislation, it is not a devolved matter, the advice that we have from our
The union supports national pay bargaining and, to be frank, we would be daft to throw that system away. We have recruitment and retention problems in Scotland, but there are greater problems elsewhere. For example, the vacancy level for nurses in Scotland is about 1.8 per cent, whereas London hospitals have a vacancy level of 30 to 35 per cent. That situation allows us to tap into the benefits of national bargaining. However, the other side is that we should have the right to tweak the machine in Scotland, which we have done. For example, through the low-pay deal, ancillary staff members now earn £5.35 an hour; that rate is not great, but it is different from the rate south of the border of £4.62 an hour. If you were to say that I want to have my cake and eat it, you would be quite right.

Mike Rumbles: I want to pursue the issue because it is of interest to me. In your job as a negotiator you want to get the best terms for your members, but if the Scottish Executive could give enhanced terms and conditions to your members in Scotland, would it be a difficulty that those conditions would not apply south of the border?

Jim Devine: No. We have already negotiated different conditions. That has caused me personal difficulties with my national officers, but it is not a difficulty for our members. If the Health Committee wants to give us a 10 per cent pay increase, we will happily accept that.

The Convener: Now I know why you are a negotiator.

Mr McNeil: My question is a little less exciting, but it is about a major issue. Unison’s evidence states:

“we need to move the debate on health away from hospitals and illness and onto prevention and healthy living.”

I am sure that everyone would agree that that is taken as read. Do you accept that the proposed duty on ministers and health boards to promote health improvement at least starts us on that journey?

Jim Devine: Yes. The important role of local authorities in promoting health improvement, which was mentioned in earlier evidence, must be considered. There have been great initiatives, such as the free entry into swimming baths in Glasgow. Health care must be considered in its broadest sense. When I worked in primary care psychiatry, I saw no one who had already been seen by a psychiatrist, but I was involved in taking people off medication. We held surgeries in a local leisure centre, which made people feel comfortable about access to the service. A few weeks ago, Greater Glasgow NHS Board had nurses in bookies’ shops. Such initiatives are to be welcomed because we must get the message out.

A few weeks ago, I made a speech about an ethical health policy, although as I am Robin Cook’s election agent, it is probably dangerous to
talk about that. We need to consider broader partnerships with local authorities and other bodies. We advocate banning smoking in public places. Our trade union believes that it is not acceptable for people, in effect, to kill other people while they are going about their work. That is a major health and safety issue. It is absolutely daft that people can walk into an NHS hospital, where health is supposed to be promoted, and see at the front door a vending machine that sells junk food. Simple strategies that can be implemented are to be welcomed.

**The Convener:** Do hospitals make money from those vending machines?

**Jim Devine:** I suspect that they do.

**The Convener:** That is why hospitals have them.

**Mr McNeil:** That is a simple point, but the problem is that a shop outside the hospital could sell the same items in abundance. Do you agree that although such initiatives can be debated and considered, they are complementary to overall health provision and would not necessarily reduce demand for health services or the need to provide acute services?

**Jim Devine:** I know where Duncan McNeil is trying to take me. It is interesting to read reports about the situation in Finland 15 years ago, when it had a greater problem with coronary heart disease in particular, and the situation there now. A community-based Government-driven campaign has been undertaken in Finland on healthy living, healthy lifestyles and healthy eating, and now it is being said that the demand on acute services is less. It would be wrong to pretend that implementing the strategy now would produce gains within five years. Healthy living will affect the next generation.

**Mr McNeil:** Jim Devine will be aware that such campaigns started in Finland not to improve health, but to address famine and hunger, and they have been undertaken for some time.

**The Convener:** I am conscious of the time, and the piper playing outside the building is annoying me enormously. As a Scot nat, I should not say that, but he is. We will move on.

**Helen Eadie:** Earlier, we discussed public involvement. Your submission says that Unison “welcomes the Scottish Executive’s pledge to involve staff and trade unions in all the stages of the planning process for establishing the new Scottish Health Council.”

Does Unison share the concerns of other organisations about the independence of a national health council that will be part of NHS Quality Improvement Scotland?

**Jim Devine:** Convener, may I hand over to my colleague? We are a double act today.
the new system is more bureaucratic and more costly. We would not want that to happen here. The system seems to work well and we are not sure why it would need to be changed.

**Dr Turner:** There is a duty to involve the public and it has been said that that will not involve significant additional resources. Will public involvement be improved in health service planning?

**Jim Devine:** It would be wrong to say that consulting will not cost. One practical example of that was the introduction of the patients charter. Any member of staff who works in an accident and emergency department will tell you that everybody who walks in the door knows all about their rights as a patient. We are not against the charter. However, when it was launched, there were videos, television adverts and letters, and people were told, on their appointment cards, about their rights as patients. It would be wrong to pretend that all that had no cost. If we want to communicate, to involve people and to make a mark, that will cost money.

**Danny Crawford:** Consultation will have an associated cost. That said, Unison’s position is that the NHS should be open, transparent and accountable. Making NHS boards the primary body responsible for public involvement is logical and appropriate. It will be the NHS boards that are hauled before this committee or the Public Petitions Committee to justify how they went about a consultation exercise.

In Glasgow, an issue arose to do with a secure care unit. The reporter who came back—an MSP at the time—said that the board had consulted beyond what it had to do. However, the point was that the amount of consultation that it had to do was not an amount that the public felt was appropriate. I do not think that the Scottish Parliament felt that it was appropriate either.

A step change is required to improve the way in which the health service engages with and consults the public. It is right and proper that the NHS board has that responsibility. That said, it does not have to be the only body with that responsibility. There should be a local independent body that comments not only on the appropriateness of how consultation is done, but on the particular issue.

**Mike Rumbles:** I asked the witnesses from Ayrshire and Arran NHS Board about improving the governance of NHS employees. Should the Executive introduce amendments to the bill to place a duty on health boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees?

**Jim Devine:** I totally agree with the comments that those witnesses made. In the Scottish health service, we have a unique form of industrial relations. We work in partnership, and we sit down with management, to get away from the confrontation that went on for many years. We work on the practicalities of the development of services and the provision of care. The most valuable resource in the provision of care is the staff. They want to feel part of the team and to feel valued. As the witnesses from Ayrshire and Arran said, if you are to have clinical governance—if the chief executive was making an assessment—staff governance should be there as well. That has been pushed by all the trade unions and professional bodies in Scotland.

16:30

**Mr Davidson:** I want to pursue the issue of the governance of NHS employees. What are Unison’s views on access to continuing professional development?

**Jim Devine:** We are very supportive of that, but it comes with a price. Over the past 15 years, the work load for health service workers has more than doubled, because of an increase in the throughput of patients. The difficulties that we all have are in getting people off wards and departments so that they can have a clear career structure. The new pay mechanism, agenda for change, makes development and the knowledge and skills framework a crucial part of people’s grading. Increasingly, people will want training and development and a clear strategy for that will be needed.

Under agenda for change, one hour’s work on processing a form will be the equivalent of 14 years in capacity for the Scottish health service. Managers will have to sit down with people and conduct an assessment of their situation. They will have to conduct a development review and consider people’s development and training needs. That work will have to be funded. Every hour of the process is the equivalent of 14 or 15 years of work, so there are major implications for health service capacity next year.

**Mr Davidson:** Do you agree that if staff have a higher skill base they will be able to take on more care, as well as more technical care?

**Jim Devine:** We are very supportive of the developing role of nurses and other staff. Tragically, my mum died during the summer, so I spent time in a hospital ward for about six weeks. Increasingly, all grades and disciplines of staff are taking on developing roles, compared with those that they had when I worked in the NHS. Nursing assistants take blood, while senior staff nurses run wards and departments. In Glasgow, there is talk of some nursing staff performing minor operations. We are supportive of such initiatives, but people
must be given the necessary training. Members will not be surprised to hear a trade union official say that not only do people need to be given training, but they need to be paid the going rate.

Mr Davidson: That will add to the difficulties that you have with the financial memorandum.

Jim Devine: I have a practical suggestion for the committee. Whenever the Scottish Executive makes an announcement on health, it should put a price tag on that. There are serious difficulties with morale, especially among senior managers, who on a daily basis confront members of the public who point out that, according to Gordon Brown and Jack McConnell, record amounts of money are being spent on health. If a manager cannot deliver the service when that is being said, who is lying? Is it the manager or, dare I say it, is it you, the politicians? Whenever an announcement is made, the Executive should indicate clearly the cost of the service.

Mr Davidson: I agree.

The Convener: As part of the package, should there be direct elections to NHS boards, on the basis that those would provide democratic accountability and transparency?

Jim Devine: That is an interesting question and I am not trying to duck it. Until six months ago, I would have said that there should not be direct elections to boards.

The Convener: You cannot now say no—in your submission you say that you are for direct elections.

Jim Devine: I know. I have attended the past three meetings of Greater Glasgow NHS Board, at which the closure of Yorkhill hospital was discussed. It is very interesting that the elected councillors were the people who were most nervous about making a hard decision. There may be a lesson there.

The Convener: I do not know what the lesson is, but you have hedged your bets cleverly. That concludes this evidence-taking session.

Danny Crawford: I do not want to prolong the discussion, but I would like to make a point about the statutory rights and responsibilities that currently lie with local health councils. My understanding of the position is the same as Shona Robison’s. The changes that will take place will mean that those rights and responsibilities will no longer lie with anyone. That is a very important point. The rights include the right to visit facilities and the right to get information from and make comment to NHS boards. Health councils also represent people. People representing patients’ interests and the public interest attend and have speaking rights at meetings of NHS boards. Hopefully, those rights will not be lost when the changes take place. We do not want the baby to be thrown out with the bath water. There ought to be change, but certain good aspects of the current system should be retained.

The Convener: If you have any other thoughts about issues that we have not asked about, please write to let us know after the meeting.

Meeting closed at 16:35.
9 December 2003 (16th Meeting, Session 2 (2003)), Supplementary Written Evidence

During the Scottish NHS Confederation’s oral evidence on the NHS Reform Bill evidence, the committee requested further information on two topics: the Confederation’s view of the power of intervention contained in the Bill; and examples of good practice in patient and public involvement in NHS Scotland. I am very pleased to enclose two short papers setting out this information, which I hope the committee will find useful.

The NHS Reform Bill: Powers of intervention - Clarification of the Scottish NHS Confederation’s position

In our written submission to the Health Committee on the NHS Reform Bill, on the matter of the ministerial power of intervention, the Scottish NHS Confederation stated that we would like to see further clarification of how the power of intervention would be used, either in regulation or on the face of the Bill. During our oral evidence to the committee, we accepted that this clarification could be achieved through regulations and we were invited to submit further information about our view of what is required.

The Confederation believes that it is vital that the principle of health services being planned and delivered by the individual local health systems themselves is preserved and that it would be helpful for the regulations to state this clearly.

We believe that part 4, section 1 of the Bill

\[
\text{it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—}
\]

\[
to provide the service, or
to provide it to a standard which they regard as acceptable
\]

sets out very broad circumstances in which intervention could take place.

We would like to see the inclusion of a benchmark by which the failure or likely failure of a service would be judged. The Ministers’ evaluation of failure must be based on a consistent standard that is accepted, fully understood by and implemented across the service. This would ensure that NHS Boards were entirely clear about the circumstances in which the power of intervention may be used.

We would suggest that the current NHS Scotland Performance and Accountability Framework would be an appropriate benchmark and that it could be specifically named as such. The Framework itself is regularly re-evaluated, monitored and updated as necessary, so there should be no risk of either the primary legislation or the regulations being overtaken by new developments in the standards for organisational, financial, clinical or staff governance.

We do not in any way oppose a power of intervention being created – indeed, we believe that timely, supportive intervention can be extremely effective and that the formalisation of the power will give local health systems an assurance that, should a crisis or potential crisis occur, support from the centre will be available.

In summary:
we agree that the regulations are the appropriate place for the details of when intervention will be triggered
the regulations should be agreed following consultation with the service and should use the Performance and Accountability Framework as a benchmark we do not oppose the power of intervention but see it as part of the central support mechanism for the service
we believe the circumstances required for intervention must be clearly understood so that the power will be used appropriately.

**Public Involvement in NHS Scotland**

This paper outlines a range of examples of patient and public involvement in NHS Scotland. These examples are a small sample of the innovative work being carried out in different settings and with different patient and community groups. However, they give an indication of the different approaches to continuing and in-depth patient and public engagement across NHS Scotland.

**NHS Tayside – ‘Healthy Tayside’ strategy**

NHS Tayside has developed a framework for sustainable and meaningful patient and public involvement for the long-term. A public partnership group has been created in each of the Perth, Angus and Dundee areas. These permanent small groups of 15-20 citizens will work closely with the NHS locally to help plan services to meet the needs of their communities. However, Tayside has also moved into previously uncharted territory in order to lay the foundations for a sustainable partnership of genuine engagement between the public and the NHS, not only in the planning and delivery of health services but also in improving the health of people in the area. A ‘Healthy Tayside’ think-tank, chaired by Canon Kenyon Wright, is addressing the development of a new health culture. The aim is to examine how the responsibility for health can be shared between the NHS, citizens and communities, with the involvement of educationalists, industry, housing and other stakeholders.

**Highland NHS Board – The Possible Highlander: 20/20 vision**

This public involvement project aimed to engage people who were not necessarily already patients or service users, in discussion about the kind of NHS they wanted to see and use over the next 10, 15 and 20 years. Three distinct groups of citizens – young people in 5th and 6th year, young mothers, and people in their mid-50s – many of whom lived in the most remote parts of the region, were asked, in a series of exercises, to talk about what they would need from the NHS at various stages in the future and what they thought its priorities should be. The exercise helped the Board to develop methods of engaging members of the public who are usually difficult to reach, and the results contributed to its overall health strategy for the region.

**NHS Shetland – The Shetland NHS 100**

The Shetland NHS 100 is a diverse panel of individual citizens, recruited through leaflets in the local press, who take part in regular meetings with senior NHS representatives. The meetings are a two-way process, with members of the panel able to generate their own topics for the agenda as well as being used as a sounding board and consultation forum by the NHS board. The Shetland 100 panel is also involved in designing and commenting on wider public consultations at their earliest stages. Panel members are able to register their particular interests, such as older people, on a database, and are then notified when, for example, an internal board strategic planning meeting will be discussing that issue. The panel member is then able to attend and contribute to that meeting if they wish.

Seventy six people are currently on the panel with around half of these taking a regular active role. The project will shortly be re-advertised to recruit a further 24 participants to bring the total to the full 100.

**Ayr, Prestwick and Troon Local Health Care Cooperative – Public Involvement Committee for Healthcare**

This LHCC recruited 22 individuals to a Public Involvement Committee for Healthcare by contacting people at random through the GPs’ lists. Committee members take part in discussions about the planning and delivery of new services and also raise issues of concern to the local population with all health care providers in the area. Communication is a two way process, with the chairman of the Committee and the LHCC Office Manager responsible for ensuring communication links within primary and secondary care providers. The benefits have included Committee members gaining an
insight into clinical priorities from a patient perspective, and opportunities for health care providers
to have open discussions with a diverse group of people.

**NHS Ayrshire and Arran – Dalmellington Area Centre**

The award winning Dalmellington Area Centre in Doon Valley is well known for locating on a single
site all council services, a GP surgery, dental surgery, police and other government agencies such
as the Benefits Agency. High quality ICT support and training are also available to local
businesses and individuals. Local people were involved from the outset in the design of the centre
and planning the delivery of services and a permanent centre users’ group continues to be involved
in operational issues.

**NHS Greater Glasgow – Multicultural Health Development Programme**

The Multicultural Health Development Programme has developed community forums which consist
of patients, carers and religious representatives from the diverse communities across Glasgow.
These forums give patients and carers an opportunity to voice health concerns and ensure that
their needs are addressed by policy planners and commissioners. Smaller local forums have also
been set up to support LHCCs with high minority ethnic populations.
Mr Davidson posed two questions to COSLA representatives during the Health Committee’s evidence session on 9 December 2003 which required further consideration -

Is there enough clarity in the Bill about funding and mixed funding? Does the Bill need to look more closely at health improvement and how budget definitions are organised?

Definitions

Before commenting on these issues, however, it is felt that it would be helpful to clarify certain definitions

It is important to recognise the distinction between health promotion, public health and health improvement as there is a tendency to use these terms interchangeably. Health promotion is only one means of delivering health improvement. The following is taken from a paper prepared by the Community Health Partnership Development Group.

When the terms ‘health improvement’ or ‘improving health’ are used in the current context, population health improvement is generally implied, rather than improving the health of a given individual. Health improvement is not the same as public health or health promotion. It is a goal, not a field of activity. It is a goal pursued through promoting good health, preventing ill health and maximising the population health impact of treatment and care services. It is the goal of public health and, within the public health function, of health promotion (which concentrates on promoting good health and preventing ill-health). It should be seen as the main goal of health care services as a whole. And it is the one single goal that unites the NHS, Local Authorities and other partners such as the voluntary sector.

There is not a simple response to Mr Davidson’s questions. In both cases, there are associated issues and the following comments address these.

Is there enough clarity in the Bill about funding and mixed funding?

The Bill is unclear in relation to funding issues which are explored in more detail in its accompanying policy and financial memoranda. In COSLA’s written evidence to the Parliament we have stated our belief that the contention that the implementation of the Bill will be financially neutral is inaccurate and does not, in particular, reflect the needs of the wider health improvement agenda. In this respect we believe that the Bill misses the opportunity to put in place a framework for a more co-ordinated approach to the planning, funding and execution of health improvement strategies which fits with other legislation – notable that relating to community planning.

COSLA is concerned about the initial narrow focus of the Bill in relation to health improvement. As currently drafted, the focus for responsibility for health improvement lies with the NHS. The reality is that the NHS is only one body working on the prevention of ill health. Local authorities and their voluntary sector partners also play a key role in this vital area of work - it is not an issue addressed exclusively by any one organisation and the Bill should reflect this.

COSLA is not calling for a prescriptive solution within the Bill but is rather looking for a mechanism that ensures both the NHS and Local Government work together to make best use of scarce public resources, promoting healthy lifestyles and working towards health improvement for all. At present Scottish Local Government is under a statutory obligation through the Local Government (Scotland) Act to work with NHS partners (and others) in the community planning processes. There is no reciprocal arrangement in the NHS Reform (Scotland) Bill. COSLA strongly believes that this is inequitable and is a fundamental weakness, open to misinterpretation, which is easily rectified.
Does the Bill need to look more closely at health improvement and how budget definitions are organised?

The lack of specific health improvement funding streams is acknowledged, as is the fact that many of the actions taken by councils to contribute to improved health and the reduction of ill health do not necessarily come under a specific health improvement budgetary heading. Within COSLA itself, health improvement is being mainstreamed across the range of the organisation’s work. Too often in the past the focus has been on the generation of specific outputs with the drive being to deliver a target only rather than the generation of long-term change. COSLA believes that the long-term goal of improving Scotland’s health cannot be attained unless there is a switch to an outcome centered approach.

COSLA also believes that the mainstreaming of health improvement funding within overall budgets, will facilitate the development of local solutions to local priorities, but within an agreed national framework. One example would be the recent announcement of £24 million to employ 600 physical activity co-ordinators in schools. In this announcement attention has focussed on the figures of £24 million and 600 posts rather than the outcome to be delivered by the initiative. COSLA would ask, would it have been better to develop the desired outcome and then charge the community planning partnership (which includes local NHS partners) with developing tasks to achieve that outcome? For COSLA this example reinforces the need for a statutory link between planning for the proposed Community Health Partnerships and Community Planning.

The annex to this paper summarises work being done in one particular local authority in and across a number of departments. This activity will obviously not be replicated exactly in all council areas but is indicative of the type of approach being adopted and illustrates the range of activities undertaken. Work listed relates to the council’s own initiatives, Scottish Executive initiatives, e.g. ‘Hungry for Success’, ongoing work that can cut across a number of council departments such as anti social behaviour and traditional core local authority business such as food safety and dog & pest control – areas of work which do not tend to attract headlines but which are nevertheless important elements in work to secure health improvement. Some of the activity is directly related to lifestyle issues and much to life circumstance issues. It illustrates the complexity of capturing spend on Health Improvement work and thus the advantages of the adoption of an outcome centred approach.

To cost the financial input to health improvement work in our sample council would require the costing of:

- full time secondment of quality development adviser to Health
- part of integration manager role in health improvement
- council contribution to role of health improvement officer
- environmental health officer role in improving health for children and older people
- social work strategy officer contribution to health improvement in relation to the national Choose Life Strategy
- corporate services officer contribution to staff health improvement
- staff counselling officer
- staff stress reduction programmes
- staff physical activity programmes
- staff contributions to drug and alcohol forum health improvement related work
- fitness instructors
- sports development advisers
- contributions to Welfare Advice

Conclusion

COSLA believes that the health improvement balance within the Bill is unhelpful and does not reflect the realities on the ground. The partnership between local authorities and local NHS Boards is improving through the development of Joint Health Improvement Plans, the statutory inclusion of NHS in the Community Planning agenda and the progress of the Joint Future Agenda.
There is a momentum on the ground that neither the Bill nor its the financial memorandum capture. Given that situation, here must be an acceptance that this Bill will have wider impacts than on the NHS and that the legislation should reflect this position. It is in this context that COSLA believes that the getting the correct emphasis, at the correct level, on strategy and financial planning for the targeting of health improvement activities is crucial. In this respect, the approach adopted for Joint Future for care and service delivery is regarded as a helpful model.

COSLA would be happy to work with the Health Committee and the Scottish Executive on this matter if that would be helpful.
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9 December 2003 (16th Meeting, Session 2 (2003)), Supplementary Written Evidence

The following are my observations as an NHS Board Chairman as distinct from the views of an NHS Board as a collective entity.

Primary

*Abolishing NHS Trusts*


These developments have resulted in a cultural change within the NHS in terms of integrated working and removal of service boundaries, paving the way for the now timeous abolition of NHS Trusts – the progression from integration to single system working, with the focus on devolution of decision making and control of resources and on the unimpeded patient’s journey.

Suggestion – that the Bill and/or Regulations should emphasise the requirement for single system NHS Boards to devolve as far as possible and appropriate decision making and control of resources to operational units and divisions. We must avoid replacing the Trust system with a central command and control arrangement.

*Public Involvement*

The duty imposed on Health Boards is welcomed and should translate what should be good practice into a statutory requirement. This should enhance good practice. The difficulty of the task in securing appropriate public involvement in planning and redesign of health services should, however, be acknowledged. It is also acknowledged that some local authorities have longer and wider experience of public involvement in planning, etc. and Health Boards should be encouraged or required to link with local authority partners as appropriate in such exercises.

Boards should be aware of the differences between explanation; engagement; consultation and be clear about which is appropriate and in what circumstances.

Suggestion – that this element of the Reform Bill be reviewed in terms of the requirements proposed for local authorities under the ‘Local Government (Scotland) Bill’, particularly in relation to community planning. Most health services are provided within the community. Duplication must be avoided particularly in relation to engagement or consultation.

The establishment of the Scottish Health Council is welcomed in terms of providing advice and leadership in promoting greater public involvement in NHS Scotland, by disseminating and distributing examples of good practice and by ensuring oversight of NHS Board activities via local Advisory Councils. The Scottish Health Council should be a “stand alone” body not subsumed within the NHS Quality Improvement Scotland. The third role envisaged for Advisory Councils in developing effective links with local voluntary organisations and patient groups is also welcomed. Local groups should, however, retain an advocacy function.

*Health Improvement*

The emphasis on health improvement is welcomed. NHS Boards should have a duty to participate in their local Community Planning process, which should be led by the appropriate local authority as, I believe, is re-emphasised in the Local Government (Scotland) Bill 2003. The same Bill, I understand, proposes a duty on local authorities to be responsible for the “well being of the local population”. A co-ordinated approach to community planning is, therefore, essential.
This has implications for NHS Boards in relation to the production of Local Health Plans, which currently are not synchronised in terms of timescale or content with local authority Community Plans.

Suggestion – that it be acknowledged in the Reform Bill or Regulations that local authorities have the lead role for community planning, to which NHS Boards have a duty to contribute and to which their respective Local Health Plans should relate. The Local Health Plan could and should become a more focused, operational document for NHS service delivery purposes.

I would, however, question the proposed Ministerial power to direct funds for health improvement, bypassing on occasions NHS Boards. Currently many health improvement initiatives undertaken by local authorities, voluntary organisations, local community groups and the NHS are fragmented and unco-ordinated – there is a wide range of activity. We should also acknowledge the current requirement to produce Joint Health Improvement Plans with local authority colleagues – an endeavour to integrate such provision. Direct funding from the Scottish Executive could, I suggest, exacerbate such fragmentation and lead to conflicts and uncertainties in terms of sources of funding.

Suggestion – that NHS funds for health improvement be channelled through NHS Boards and therefrom to, for example, Community Health Partnerships, which will have a major integrating and local service delivery, i.e. health improvement, role. Community Health Partnerships will be integral elements of the new single system NHS.

There is further concern that direct funding from the Centre could favour larger, national organisations and disfavour local initiative.

Powers of Intervention for Scottish Ministers.

The powers as proposed and as more fully conveyed in the Policy Memorandum to the Bill are valid and acknowledged.

Performance Review Body

The formal establishment of NHS Quality Improvement Scotland is welcomed, including powers of intervention. This should give consistency to the format of any regrettably required investigations or inquiries and ensure that lessons learned are appropriately conveyed.

Replacing Local Health Care Co-operatives with Community Health Partnerships

Welcomed. The establishment of CHPs is a natural progression from the introduction of LHCCs in 1997. Evolution but also major change and development. LHCCs were largely “within the NHS family” in terms of services and attitudes. CHPs should embrace health and well being in its widest sense – health improvement – health provision, social and voluntary care.

CHPs must not, however, merely replace Primary Care Trusts and the emphasis should be on devolution of decision making and control of resources to a local community level. I have concerns about recent proposals that CHPs could become committees of NHS Boards – this, I suggest, would over-formalise and constrain their activities and locate them too specifically within the NHS.

We should be aware of understandable sensitivities within local government to what could be viewed as an NHS dominated approach to promoting and providing local and community based health and well being. CHPs should be built on equal partnerships and not be viewed as a takeover of social care services by the NHS.

Suggestion – that the role of local government be recognised in the Reform Bill and cross-referred to the Local Government Bill in relation to local authority duties for community planning and the well being of local populations. The Bills should be viewed in partnership.

In relation to the NHS, again devolution of decision making and resources is imperative. We should avoid creating over-managed and over-bureaucratic local CHPs and provide appropriate
support services to them, so that their focus is on operational service delivery and responding to local need. The role of General Manager is of critical importance and will, I suggest, require major investment in design and training. Whereas promotion of and involvement in CHPs is a statutory, compulsory requirement for NHS staff, the involvement of general practitioners is still viewed as voluntary. This, I would suggest, has been a weakness in the current LHCC arrangement and could be a continued weakness into the CHP system.

Suggestion – that the voluntary nature of GP involvement be reviewed although it is anticipated that few, if any, will opt out, especially given the new GMS contract. Equally, it is important that CHPs be not re-arranged around GP practices in terms of true partnership working and avoidance of domination by one particular professional group. Again, the role of the General Manager assumes significant importance.

The introduction of CHPs is unreservedly welcomed in terms of developing responsive, devolved, integrated and comprehensive service provision, irrespective of service provider and professional background.

Suggestion – that CHPs are viewed as a new and much needed vehicle to promote and progress the Joint Future Agenda. This has major implications for local authorities and their community planning processes.

Statutory co-operation on Health Boards across regional boundaries.

Such requirements are welcomed if, on occasions, regrettably necessary. We should not require to be instructed to co-operate. We should wish and be committed to do so. Ayrshire and Arran has, for example, arranged for the Scottish Ambulance Service to be represented formally at Board meetings. This is merely a small example.

There can be considerable benefits from regional initiatives, for example in terms of specific support services, and the establishment of Managed Clinical Networks requires further promotion and invigoration. The duties of co-operation should enhance this.

Secondary


These are supported and no major omissions have been identified.

Consultation

This appears to be appropriate and responsive. I understand that duties of staff governance to NHS Boards have already been added to the Bill as a result of such initial consultations.

Practical Implications

These have been largely dealt with in terms of the seven primary points above.
The Scottish Consumer Council (SCC) is pleased to submit evidence to the Health Committee of the Scottish Parliament on this important piece of legislation. We have been involved in much of the discussion and debate about public involvement in the NHS, in relation to how NHS boards consult their communities, and in relation to the future of health councils in Scotland.

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

Principles

The SCC considers that the principles underlying the Bill are as follows:

- integration of services across primary and secondary care, and between health and social care
- delegation of power and resource from boards to communities
- promotion of public involvement
- promotion of health improvement
- services which are planned and delivered at the most appropriate level, i.e. community level, board level, on a regional basis, or at national level
- promotion of patient safety.

The SCC supports these principles.

Key provisions

The key provisions of the Bill are

- the abolition of trusts
- the creation of Community Health Partnerships
- new duties on NHS boards to promote health improvement
- to involve the public and to co-operate with other health boards
- the abolition of local health councils to allow for the creation of a Scottish Health Council
- the creation of a power to intervene in case of service failure
- duty on Scottish Ministers to promote health improvement

The SCC broadly supports these provisions but we would like to make the following comments on them.

Structural change

The structural changes proposed in the Bill, i.e. the abolition of trusts and the creation of CHPs, will not necessarily, in themselves, achieve the policy objectives which the Scottish Executive Health Department seeks to achieve through this Bill. Changes to structures do not necessarily create the changes in culture which are needed to effect real change. While the removal of separate primary and secondary care trusts may be seen as a necessary step towards greater integration between primary and secondary care, there are dangers that boards might recreate this division by establishing separate operating divisions for primary and secondary care.

Similarly, the devolution of resources and planning from board level to Community Health Partnership level will depend on the willingness of the board to do this.
Although CHPs are new bodies, and the intention is that there will be a greater degree of consistency than has been the case with Local Healthcare Co-operatives (LHCCs), they will, in most areas of Scotland, evolve from LHCCs, and so will take both the strengths and weakness of existing LHCCs with them. In parts of the country where the development of LHCCs has led to new energy and direction in primary care services, this is likely to carry forward effectively on the slightly larger canvas of the CHP. However, in other areas the new CHP may have to overcome the history of an LHCC which may not have been an effective vehicle for promoting interagency working or for planning services at local level.

**Partnership working**

The SCC understands, from the consultation which has taken place about Community Health Partnerships, that CHPs will be NHS bodies but will be expected to work in partnership with the other key agencies, particularly local authorities, and with their local communities. The SCC wholeheartedly supports inter-agency working between the NHS and local authority services, but creating a structure called a community health partnership does not in itself guarantee that partnership working will be any easier or more effective than it is at present. There is a danger that the new terminology may create confusion. There is an important distinction between an organisation which has a partnership structure, and one which is committed to partnership working.

**Duties**

The SCC agrees with the clear statutory requirement that NHS boards should promote health improvement, public involvement and working at regional level with other boards. It is, however, important to recognise that NHS boards cannot do this alone. In relation to both health improvement and public involvement they can only achieve significant improvement through working with other bodies. In relation to health improvement this will involve voluntary sector organisations, community health projects, and national initiatives such as the national demonstration projects.

In relation to public involvement there is a need to support the capacity of communities and individuals to be involved, and to create effective partnerships. The nature of public involvement is that it is a two (or more)-sided process, which requires both sides to be engaged. It is a way of working and a process which it is not entirely within the competence of the NHS to “deliver” on its own.

The SCC welcomes the duty on Scottish ministers to promote health improvement, which recognises that in any policy development or initiative the impact on public health should be a key consideration.

**Health councils**

Health councils in Scotland have acted as the voice of the patient for almost 30 years, and the SCC accepts that it is timely to review what their role should be in the changing world of the NHS. We agree that alongside many strengths, there are weaknesses in the current system. These include the perceived lack of independence of local health councils, whose members are appointed by NHS boards, and the variable pattern of activity across Scotland.

The SCC supports the creation of a Scottish Health Council at national level, with significant powers in relation to the monitoring and development of public involvement in the NHS. We have expressed our reservations about locating this new body within NHS Quality Improvement Scotland, and believe that there will need to be effective safeguards to allow the Scottish Health Council to develop an independent agenda and voice, in order to meet the needs of patients in Scotland.

**Powers of intervention**

The SCC welcomes the attention currently being given to patient safety, and believes that the power for Scottish ministers to intervene to secure the quality of healthcare services is an important part of this.
Consultation

The Scottish Executive developed many of the ideas contained in the legislation through various working groups, for example the LHCC Best Practice Group, the Primary Care Modernisation Group and through the Review of Management and Decision Making in the NHS. In parallel with the Review, there was a series of NHS Forum meetings which brought together a wide range of people working in different sectors, and patients and their representative groups, including the SCC. This provided an opportunity for those involved to take the issues to their wider networks and forums, although there was no formal widespread consultation process.

In relation to the proposals for the abolition of local health councils and the duty on NHS boards to encourage public involvement, there has been an extensive process of consultation. This involved a pre-consultation which was carried out by the SCC, and a report on this was published in May 2002. A formal consultation on the proposals then took place between March and June 2003. The consultation process leading up to the publication of the NHS Reform Bill has if anything been too long, with staff working in health councils experiencing a prolonged period of uncertainty about what would be happening to their jobs, and about their role and function.

The Scottish Executive Health Department has also recently consulted on Community Health Partnerships. Although this consultation document was not distributed widely outside the NHS, the SCC believes that most of those with an interest in responding to it will have come into contact with it through existing networks, for instance in the voluntary sector, or community health networks.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

Scottish Health Council

We believe that the Scottish Health Council should have the ability to speak authoritatively on behalf of patients to the NHS and to the Scottish Executive, and for this reason the SHC needs to be clearly independent of the NHS and of the Scottish Executive. Indeed, the independence and the perception of independence will be vital to the success of the SHC. It might therefore have been expected that the SHC would be an independent non-departmental public body (NDPB). However, policy makers do not favour the creation of new NDPBs, and the consultation proposes the establishment of the SHC within another organisation, in this case, NHS Quality Improvement Scotland.

While it is intended that NHS QIS should be seen to be “entirely independent of government and NHSScotland”, there may be a problem in the public perception of a body which has NHS clearly in its title, and which works closely with the NHS.

If the SHC is to be located within NHS QIS, or indeed any other body, it is vital that there are safeguards to ensure its independence, and to maintain a distinct identity for the council. The kind of conditions or safeguards which the SCC would like to see in place would include the following:

- a memorandum of agreement between the SHC and the host organisation, setting out the nature of their relationship to one another, covering the management of staff, and the relationship of the NHS QIS board to the SHC council
- a council to oversee the work of the SHC, and to approve its workplan, appointed through the public appointment process
- director of SHC to be answerable to the SHC council rather than to the NHS QIS board
- a separate budget under the control of its council
- its own research capacity.

In the changeover from local health councils to the local arms of the Scottish Health Council it will be important to try to retain the skills and knowledge which health council staff have developed, and the contacts they have within their local communities which will be useful in beginning to develop local networks of public and patient groups.
Community Health Partnerships

There is still a lack of clarity about the kind of bodies which CHPs will be. There is nothing in any guidance that we have seen to date which explains what the governance and management arrangements will be.

Public partnership forums

There is a great deal of uncertainty about the nature of the Public Partnership Forums which are discussed briefly in the recent consultation on Community Health Partnerships. There is nothing in the Bill about these forums, but they are likely to be one of the main ways in which CHPs will be made accountable to their local communities and so will be very important in practice.
Dissolution Of Health Councils And Establishment Of Scottish Health Council As Part Of NHSQIS

Health Councils generally welcome the proposal to establish a new Scottish Health Council as a national organisation with local offices, carrying out the same core functions in accordance with nationally agreed standards and procedures. Health Councils also recognise and support the need for strong links with NHS Quality Improvement Scotland. This will be particularly important in terms of standards development and in monitoring the performance of NHS Boards as part of the Performance Assessment Framework (PAF).

We consider that the independence of the new Scottish Health Council, to act and speak in the best interests of patients to be of paramount importance and believe that this can best be achieved by establishing the Scottish Health Council as a statutory independent body in its own right with its own board of governance, whilst maintaining close working relationships with NHS Quality Improvement Scotland. If however, the Scottish Health Council is to be established as part of NHSQIS, additional safeguards will be required to ensure that the Scottish Health Council is free to pursue its own agenda in the best interests of patients and is not “under the thumb” of NHSQIS. We believe therefore that the Scottish Health Council should not simply be established as another operating division of NHSQIS, but that its establishment together with its role, remit and powers must be underpinned by statute.

In terms of the proposed remit for the Scottish Health Council, this is more narrow and restrictive than that of existing Health Councils. We are therefore concerned that many of the existing functions carried out by Health Councils could simply disappear, unless alternative delivery mechanisms are identified, agreed and implemented, before existing Health Councils are abolished. The right of access to monitor NHS facilities from a patient and public perspective, which currently lies with the local Health Councils, should also transfer to the new Scottish Health Council and be a function of Local Advisory Councils. We also consider it to be important for the new Scottish Health Council to retain the same rights of representation on NHS Boards and additionally at strategic planning and organizational management levels within the proposed Community Health Partnerships. Another concern relates to the independent complaints system which is currently provided by many local Health Councils, but which in future, will be commissioned by NHS Boards themselves.

An area of particular concern is the lack of detail about the proposed role of lay members who will make up the Local Advisory Councils. Lay members in Health Councils currently play an important role in making public involvement a reality and we believe that they have an important role to play in the new organisation. Their active involvement will be particularly important in ensuring that the Scottish Health Council is not only independent from NHS bureaucracy, but is clearly seen to be so.

The question remains “Who is going to speak up for patients and the public”? We believe that an organisation that is championing public involvement must also be able to ensure that people’s voices are not only heard, but acted upon. There are many who are still unable or unwilling to speak for themselves and who need a strong organisation to speak for them. There are also many areas of NHS service provision, which are not covered by patients’ organisations and where we believe the new Scottish Health Council has a key role to play. As the proposals currently stand, there is a real danger that for some sections of the population, the patients’ voice will not be heard.

Funding The Scottish Health Council

We believe that if the new Scottish Health Council is to succeed, it must be properly resourced. The increased importance being given by the Scottish Executive to developing public involvement and the role proposed for the new organisation, requiring evidence based assessments to be undertaken in accordance with nationally agreed standards and procedures, will require leadership...
and management of the highest quality. The organisation will require highly skilled, trained and motivated staff. A comprehensive training and development programme will also be required for members of the Local Advisory Councils.

Funding is currently provided to many Health Councils by NHS Boards on an in-kind basis, and it will be essential to ensure that this is not lost to the new Scottish Health Council. We are not however suggesting that this funding should be taken away from NHS Boards at the expense of front-line services. This will therefore require additional funding for the new Scottish Health Council, over and above the existing provision.

Community Health Partnerships (CHPs)

Whilst we welcome the opportunity for patients and the public to participate in the planning of local health services through the establishment of Public Partnership Forums (PPFs), we note that these will not be independent bodies. Their precise role and remit remains unclear as does their relationship with the Local Advisory Councils of the Scottish Health Council. We consider it vitally important for the new Scottish Health Council to not only work closely with PPFs, but to also be actively involved in the development and assessment of the public involvement processes undertaken by CHPs and in monitoring outcomes.

Dissolution Of Trusts

Health Councils generally welcome the decision to abolish NHS Trusts and the opportunities that this presents to streamline administration and provide greater service integration across Board areas. We would however be concerned if this were to lead to greater centralisation and less openness.

Power Of Intervention In The Case Of Serious Service Failure

Whilst the powers conferred upon NHSQIS to intervene in the case of serious service failure are generally welcomed by Health Councils, we would caution that these should be used sparingly and only as an option of last resort.

Public Involvement – Duty On Health Boards

As the Scottish Health Council is to have the role of developing best practice and assessing how effectively NHS Boards carry out their Public Involvement duties, it will be essential for the new Scottish Health Council to be appropriately resourced to enable it to carry out these functions independently and in the best interests of patients and the public.
Introduction

The Association of LHCCs is pleased to add to the consideration of the National Health Service Reform (Scotland) Bill. As can be imagined the main focus of our evidence concerns the very welcome advent of Community Health Partnerships. We would wish to emphasise what we consider to be the key point emerging from the Primary Care Modernisation work and stated in the White Paper, CHPs should evolve from LHCCs. This is not explicitly stated in the Bill, although the idea is certainly included within the phrasing of the Bill.

LHCCs, though varying very widely in scope, character, composition, size and establishment are all characterised as slim management structures, operating with and in support of a group of clinicians focused on providing services for a (relatively) small and local population. They have done things differently, and they have made a difference. LHCCs have been very focussed on action and perhaps rather less on management process. Many NHS bodies are required by legislative, governance and statutory responsibilities to be accountability focussed. There is no doubt that at the outset the voluntary and co-operative nature of LHCCs was very important and helpful in arriving at shared, multi-disciplinary objectives, structures and styles of working.

Size has been an issue for LHCCs, so too has delegation of responsibility and flexibility by local NHS systems. LHCCs that are very local have resulted in local acute sectors, Local Authority partners and voluntary agencies having trouble identifying how and who to establish links with to discuss and develop interface arrangements. Some NHS systems, for a variety of reasons, have not been able and or willing to delegate budgets and responsibilities to LHCCs and by so doing give LHCCs the flexibility to develop services in their own way.

Attached to this evidence is the entire Association comment on the CHP consultation exercise. The specific areas on which we would wish to focus in our evidence are:

- The need for clarity but also flexibility about what the core elements of a CHP will be.
- Stay true to the benefits of LHCC and reinforce that CHPs evolve from LHCCs, low beaurocracy, short decision making paths, multi-disciplinary groups of clinicians making decisions and supported by senior management.
- Sufficient delegated resources of manpower, talent, influence and budget.
- Development and training of CHP Boards.
- Clarify how governance and accountability will flow CHP/NHS/LA.
- We welcome the proposal to provide funding for public involvement; this will enable us to do this in a very meaningful way.
- What is the PCO, will its functions be separate from CHP or integrated with, will depend on each area and number of CHPs
- Bottom up development in a sensible timescale.
- Recognition of other drivers and change, eg Pay Modernisation.

Core Elements Of A CHP

CHPs will undoubtedly develop over time. The roles and responsibilities will not necessarily be the same at the outset as they will be one year in. It is however important to be clear about the core functions. Notwithstanding this there must be flexibility about even the basic list of core elements and responsibilities as local circumstances may well make different approaches essential.

A key feature of CHPs will be the relationship with Local Authority partners. The initiative has been very much lead by Health from the outset and not taken account of some of the drivers and constraints of Local Authorities. The development of links between potential CHP systems and Local Authorities must be a key part of the schemes of establishment to be required of NHS Boards. Despite the best efforts within Joint Future work there remain some obstacles to joint
working, and one that is often mentioned are the differing terms and conditions of service between 
the systems for similar work.

There are 3 components to consider under “Core Elements”, roles, responsibilities and services.

Roles.  
CHPs must have a key role in:
• Community planning, which needs to be integrated with Health Planning process.
• Networks and interfacing with hospital services, voluntary sector and other statutory sectors in 
order to deliver integrated care and services for all.
• Identify and take account of available resources and employ them to maximum effect.
• Planning and delivering the health improvement agenda.
• Be involved with and influence NHS and SW strategic planning and resource allocation.
• Plan and deliver primary and community based services.
• Involving the public in all of their planning and governance arrangements.
• The quality and value agendas.  This must include decisions about which guidelines and 
initiatives are implemented within available resources.

Responsibilities.  
CHPs must have delegated authority and flexibility in order to deliver the roles outlined in 8 above.  
This must include appropriate budgets; this has not been the case universally for LHCCs.

Services.  
The list of services in the SEHD Summary of Consultation is an excellent start, but must not be 
taken as absolute, essential or exhaustive as local circumstances may suggest variation.  The list 
is:
• Independent contractor services
• Community related health services including community nursing; allied health professionals; 
and any community based integrated teams (e.g. rapid response teams, hospital at home)
• Community based midwifery services
• Relevant aspects of health promotion/education
• Community mental health services
• Community access to a range of outpatient and diagnostic services
• Community resource centres/hospitals
• Community assessment and rehabilitation
• Drug and alcohol services
• Voluntary services

Benefits Of LHCCs

LHCCs brought together an extremely powerful coalition of clinicians and management.  The 
synthesis of GPs with nursing and AHPs aligned many agendas, budgets and talents in a way that 
had not previously been the case.  They exhibited enthusiasm and a “can do” approach to life.

Within the constraints of budgets and delegated authority LHCCs showed imagination in 
developing services and resources.  LHCCs have not posed a threat to financial stability in NHS 
Boards, although the pressures on the prescribing budgets cannot be ignored.  It is however 
LHCCs in many areas that have led the work to reduce waste in prescribing budgets.

A balance will have to be achieved in order to maintain the involvement of clinicians, the energy 
and enthusiasm of LHCC managers and systems whilst establishing sufficient infrastructure to 
handle the increased responsibilities without causing the new CHPs to become unwieldy 
organisations focussed more on process than action.

Infrastructure

LHCCs have been established on a relative shoestring.  As Primary Care Trusts dissolve this will 
be more exposed.  It is important that CHP establishments are sufficient to handle the workload.  If 
one contrasts (English) PCTs and LHCCs they do exist at opposite ends of the infrastructure scale.
As NHS systems re-organise the opportunity to redeploy high quality staff within emerging CHPs should not be ignored or lost. Equally the role of LHCC General Managers should not be ignored; they have been highly influential in the successes of LHCCs along with Chairmen and other LHCC Board members.

**Development And Training Of CHP Boards**

We have not commented further on the composition of CHP Boards. Many of the members though will not have a background in management or leadership or may lack some important skills. Leadership and development training must be made available and funded (including backfill) not just for initial members but for succession planning too.

**Governance And Accountability**

CHPs are new; they will occupy a new place in the accountability and governance arrangements, in both the NHS and LA systems. These will need local development but guidance should ensure that these are neither unnecessarily onerous nor complex.

Given the size, importance and budgets involved the senior management should be appointed at Director level in order to ensure appropriate involvement.

**Public Involvement**

LHCCs have all involved the public, but to varying degrees. A specific responsibility and appropriate funding will enable this to be taken forward in a very meaningful way.

**Responsibilities Of Primary Care Organisation**

The new GMS contract places significant responsibilities (and workload) on the Primary Care Organisation (PCO). As CHPs are not to be statutory bodies they cannot hold these responsibilities. It is however very likely that many of the responsibilities will indeed be delegated to CHPs. This must be clear in the schemes of establishment and appropriate staff transferred to handle the work.

**Development Timescale**

We have referred to training and development and change over time. We would not wish to slow down the move to CHPs, and the likely timing of legislation is not worrying. It has to be recognised however that in order to deliver a sensible and coherent plan, and the necessary consultation to be complete, that too demanding a timescale will put too much focus on re-organisation rather than service delivery which should be our focus.

The co-operative element of the title LHCC was very important. It led to a bottom up scheme of development and a greater coherence within LHCCs. It would be important to involve staff, public and existing LHCCs fully in the development of local plans. The responsibility lies with NHS Boards, this must not mean that it becomes a directive process of NHS Boards setting up something which they describe as a CHP but has none of the characteristics of an LHCC.

**The Change Agenda**

The change agenda facing the whole public sector is huge. This is certainly true in the NHS and CHP development is but one item. The capacity to inspire and lead all of this change is finite, as is the enthusiasm of our workforce. Whilst change is a vital opportunity for all systems and often produces step change in services it can also be something of a challenge. LHCCs were a successful opportunity and challenge. The Association of LHCCs sees the establishment of CHPs as a change with similar potential.
National Health Service Reform (Scotland) Bill: Stage 1

14:02

The Convener: Item 3 on the agenda is on the National Health Service Reform (Scotland) Bill. I direct members to papers HC/S2/03/17/2, HC/S2/03/17/3 and HC/S2/03/17/4, which are the written submissions from our witnesses. I thank the witnesses for their submissions; it is helpful to have them before we take oral evidence.

I welcome Martyn Evans, director of the Scottish Consumer Council, and Liz Macdonald, the council’s policy manager. I also welcome John Wright, director of the Scottish Association of Health Councils, and Dr Kate Adamson, the convener of the association. If you want to speak in answer to a question, you should indicate or gesture in some manner. If anyone else wants to make a point, they should just come in, because I might not think to ask directly.

Mike Rumbles: The first question to our witnesses is straightforward and basic. Do you think that the changes to the structure of the national health service that are proposed in the bill will improve service delivery? Will the bill succeed in that aim?

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

The Convener: As I say, other witnesses should just feel free to comment.

Dr Kate Adamson (Scottish Association of Health Councils): Provided that the transfer between primary and secondary care is genuine and seamless, there will be huge advantages for the public and patients, from community care up to specialist services. The bill will be extremely beneficial if its provisions and the important cultural change that it envisions are implemented.

Mr Davidson: Is that because primary care and acute services will be subsumed into one board and will not be dealt with separately, as they are now?

John Wright: Yes.

Mr Davidson: How could that be remedied in the bill?

John Wright: I do not have any suggestions on how that could be remedied in the bill. That will depend on the way in which boards conduct their business and meetings—how those meetings are structured, how the public are made aware of the meetings and what the agenda items are.

Dr Adamson: It will also depend on the individual structures in the 15 areas. In some areas, the specialist acute services will be in association with the community health partnerships, whereas in other areas there is talk about operating divisions. It is critical that the proposed systems are studied so that they are effective.

Liz Macdonald (Scottish Consumer Council): It is also worth noting that the package is balanced. Although one could say that things will be more centralised at board level, there should—if the proposals work as I understand they are intended to work—be greater devolution of influence to a local level in the community health partnerships, which will be able to plan services for local communities based on local needs. There is a balance between the two developments.

Mr Davidson: Is that well enough covered in the bill?

Martyn Evans: There is a tension, but we cannot say how we would improve the bill in that respect, because that is not the issue. The policy intention is clear. It is about trying to balance the twin tracks of national standards and local control, which, although difficult to do, is the right approach to take. The more local control over service delivery there is, the more responsive the service will be in urban and rural Scotland. However, local control should be taken alongside an ambition to have national standards to end postcode prescribing and to end the situation where, if one is lucky enough to live in a particular area, one will get more and, if one is unlucky enough to live in another area, one will get less. There is a tension, but we could not amend the bill to deal with it.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In your written evidence, you support many of the principles of the bill. You say that one of the challenges is the nature and culture of the NHS.
Can you identify some of the barriers that will prevent us from applying the principles of the bill?

Martyn Evans: There are barriers, but we do not believe that they will prevent the principles of the bill from being applied. From our point of view, the clearest principle is the duty on health boards to involve and engage the public in a whole range of areas. That is a different way of working from the old managerial and professional way. From a consumer point of view, we do not say that the interest of service users should dominate; we just say that that interest should be balanced with and brought to the table alongside professional, managerial and financial interests.

The great challenge is in making that a reality within all the complex arrangements of service delivery and service planning within the NHS. We see those tensions played out most weeks in the press with regard to service change. The NHS is up to the challenges, but we do not think that the structure alone will deliver the improvements that we were asked about. However, that is one of the areas that require more work and more support, which the bill will bring.

Mr McNeil: Have you any ideas that you can bring to the table about how engagement and public involvement can be improved?

Martyn Evans: There are two mechanisms by which to do that. The first is the Scottish Executive’s current structure whereby a team helps NHS boards to deliver their required involvement with the public. The second is that the new Scottish health council will be able to develop the capacity of patients to find their own voice and to promote their own interests, although we are doubtful about whether the investment that is going into the health council will be sufficient to support its ambitious community development programme. I think that an amount of roughly £2 million is going into that area.

The Convener: I do not want to stray into the issue of the health councils, as we will come to them later. I ask members to stick to the generality.

Mr McNeil: Okay.

The Convener: I wonder whether our witnesses would comment on evidence that we received last week. My recollection is that the view was taken that integration might be easier in rural areas than in large conurbations, especially in respect of culture change and personnel. In practice, the process can already be seen in the Borders. I got the impression that the changes will be hard enough to achieve in rural areas and that they will be a bigger challenge in urban areas.

Dr Adamson: In rural areas, there tends to be more coterminosity with the local authority area. That is an important issue. In urban areas, a local authority might have to deal with two health boards, which can create tensions.

Martyn Evans: We agree that boundary issues are key. I understand that your previous witnesses talked about the fact that boundaries are different in different delivery areas. The big challenge for the whole public sector is to try to deliver coherent services where there are different boundaries. Indeed, where boundaries are different, different structures will have to be developed. We cannot plan for coterminous boundaries; we simply have to address the issue. However, those difficulties will be less in some of our rural communities. We do not doubt that, within the structure, rural services will be able to respond well to the challenges that they face.

Helen Eadie (Dunfermline East) (Lab): My question, which I invite any panel member to answer, is about the establishment of the community health partnerships. Given that the community health partnerships are expected to evolve from the local health care co-operatives, will practice be improved by giving them a statutory basis when much of the detail of how they will work will be subject to guidance, regulations and local variations?

The Convener: Dr Adamson has taken a very deep breath. I do not know what is coming next.

Dr Adamson: As I am on the community health partnership development group, I definitely took a deep breath. The LHCCs are comparatively new and have developed at different rates across Scotland. The fact that both the good and the bad from the LHCCs could be taken through to the community health partnerships, instead of only the good, is a problem. It really is a brave new world.

Liz Macdonald: As some of the committee’s previous discussions have shown, there seems to be continuing confusion about the nature of the community health partnerships. The bill might not be clear enough in that respect. Our understanding is that the community health partnerships will be bodies within the NHS that are expected to work in partnership with other agencies. However, the term “community health partnership” creates the impression that the CHP is in itself a partnership body. There is a need for more clarity in the bill, guidance or regulations about the governance and management structures of the CHPs.

Helen Eadie: You have pre-empted my other question, which was to ask whether anything should be added to the bill in respect of CHPs.

14:15

Martyn Evans: Because of the way in which language is used, “community” and “partnership"
can mean a lot of different things to different people. When CHPs are described, sometimes they clearly come across as NHS organisations and sometimes they come across as partnership organisations with other bodies that are outside the NHS. We think that the governance arrangements should be crystal clear, although we have not decided whether they should be set out in the bill. We certainly think that the committee should consider whether the bill would be improved if it contained clear governance arrangements for those organisations that are not clear about the services for which they are responsible.

Dr Adamson: There is definitely a governance issue. We must remember that local authorities, which will be part of the CHPs, have by definition different governance arrangements from health boards. That issue really needs to be considered.

Helen Eadie: If the witnesses form a view on the matter at some stage, it would be helpful if they could let us have it in writing.

The Convener: I am a little confused, as I thought that CHPs went across different disciplines. Paragraph 19 of the policy memorandum says:

“The evolution into CHPs, which will have a key role in the overall planning of services in an area and co-ordinating the delivery of enhanced community based services, requires a more formal arrangement underpinned by legislation.”

Perhaps a definition is needed in the bill.

At our meeting last week, a witness from Ayrshire and Arran NHS Board said:

“The CHPs are a different animal altogether. The LHCCs are very much in the NHS family, but the CHPs, which involve health and social care, are quite different.”—[Official Report, Health Committee, 9 December 2003; c 432.]

I have got it into my head that social work, housing and health would be part of the CHPs. Is that not correct?

Martyn Evans: We understood that CHPs would be NHS organisations that engage in partnership work with organisations that are outside the NHS. If we are confused about the matter—and we are saying that some of that confusion is caused by the language that the consultation paper uses—perhaps the governance arrangements would make the structure much clearer. We would have to press the Executive on what the policy intention is.

Liz Macdonald: Our view on what a CHP is is based on the recent consultation document, on the basis of which guidance for CHPs will be developed. In the document, the CHP is described as a “key NHS partner”.

The Convener: So it is an NHS animal.

Dr Adamson: It is an NHS animal. We hope that the guidance will be available at the beginning of February, after the next meeting of the development group. That will be an important time, when we will be interested in commenting on the guidance that comes out.

The Convener: It is interesting that the submission from the Scottish Consumer Council says:

“the new terminology may create confusion”.

It has done that for me.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The terminology creates confusion for me, too. I was speaking to some general practitioners, who will be heavily involved in community health partnerships, and they do not understand the system either. The definition must be clear. I have not been able to speak to anybody who has a clear idea of what is ahead.

The Convener: We can put that question to the minister.

Dr Adamson: There is some ambivalence on the matter. Although the development group will provide guidance, some areas have already considered local governance and establishment criteria. In my area—Highland—for example, that information exists in draft form and is waiting to run, but some areas have not yet reached the same level of development.

The Convener: We will seek clarification from the minister.

Shona Robison (Dundee East) (SNP): What are the witnesses’ general views of the proposals to dissolve the health council structure as we know it?

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

Martyn Evans: We welcome the national body. We welcome its independence from service providers, as the current health councils are not independent, in our view. We welcome the threefold function of the body, which comprises assessment, development and feedback, as is described in the papers accompanying the bill.

Dr Adamson: I have a problem over the independence issue, which I believe to be extremely important.

Shona Robison: We will obviously explore that issue a bit more shortly.
In its evidence, the Royal College of Nursing Scotland said that it was not necessary to get rid of health councils altogether and that the structure of the councils could be reformed, particularly with regard to their independence. The RCN said that getting rid of the health councils was a bit like throwing the baby out with the bath water. We could have a national body, but we could also maintain the current functions of local health councils. What do you think about that view?

Martyn Evans: I will deal with the matter of independence first and come back to the other issues. I was talking about independence from service providers. It is important to stress that, as the current health councils are not independent of the service providers—they are appointed and paid for by the service providers and their staff are on secondment from the service providers. We welcome the proposed Scottish health council, for which those things will not be true. As a consumer organisation, we do not think that the current state of affairs is satisfactory. However, there is a further question, which you will no doubt press us on, about the independence of the Scottish health council.

Liz MacDonald: On the abolition of the local health councils, I would say that, despite the fact that the Scottish health council is clearly to be a national body, there will still be local offices with local advisory groups. In that sense there will be a continuing presence of a form of local health council. We will have to wait and see how the local offices and local advisory councils develop their roles.

Shona Robison: There seems to be a lack of clarity around the various functions involved.

Liz MacDonald: Yes, although I think that that is a separate issue.

Martyn Evans: One of the functions that the local bodies may lose is complaints handling, which is done by some but not all of them. We are also concerned about how voice will be given to excluded and disadvantaged service providers. That is an important issue. There is also the matter of the visits that are currently possible.

I will address each of those points quickly. We believe that the complaints function is better handled by professional complaints bodies that are properly funded and have national service standards. That would be a step forward from the current ad hoc arrangements, whereby some health councils handle complaints and some do not. We want more clarity on and investment in that function.

At the moment, visits represent an important function, but they are undertaken by a very small number of people out of a very large organisation—after all, the NHS is the largest organisation in Scotland. In any one area, 10 or 12 people are visiting. We envisage a duty on NHS boards to involve the public in future, with the process of visits to be undertaken more extensively by patient and user groups, supported by the Scottish health council. We see that function not as being lost, but as being transferred from local health councils to patient groups, which will be more effective.

Shona Robison: How do we ensure that that happens?

Martyn Evans: As I said before, we are worried about the financial capacity of the Scottish health council to deliver that aspect of its work and to build on it. The committee has received evidence about how the voluntary sector can respond as far as visits are concerned. As for how we ensure that the visits function is maintained, my view is that more investment should be put into the Scottish health council for that purpose.

Shona Robison: If those questions are not answered, is there a danger that, in doing away with bodies that already carry out that function, we will be taking a leap in the dark and just hoping that things will be okay and that public and patient involvement will happen? We need to ensure that that function is a little more definite.

Martyn Evans: That definiteness will come from the assessment role of NHS Quality Improvement Scotland and the Scottish health council, which will assess local service delivery to see whether patient involvement and visits are being encouraged. Our view is that the uncertainty can be resolved through that mechanism. If there is uncertainty, it is up to NHS QIS and the Scottish health council, through their assessment functions, to ask why visits are not being allowed, why patient groups are not being encouraged to come in and why long-term patients organisations are not getting support to engage in that way. There is potential for a step change so that that important assessment role—which we agree the local health councils are carrying out well at present—is undertaken more extensively and effectively. Change and improvement will be better assessed through the NHS QIS and Scottish health council route.

Shona Robison: One of my colleagues will return to the finances later.

The Convener: We will move on to David Davidson’s question.

Mr Davidson: I have no wish to be accused of leading witnesses, but both organisations mention the following issue in their evidence. Do you think that if the national health council is part of NHS QIS, there is a risk that it will be unable to act independently? If so, do you think that the bill should say something about that, in the form of a
definition or whatever? Should the council be set up as an independent body and, if so, what kind of body should it be?

Dr Adamson: We think that independence is important. We are involved in a lot of discussion and negotiation with the Scottish Executive and NHS QIS and we are running a project to consider the future of the Scottish health council. If it is within NHS QIS, we will need many safeguards because the health council must have an independent voice. I must stress that that independent voice should always be evidence based—that is an important point, which must be covered in the organisation. We must have definite safeguards in governance rules and so on, so that the situation is maintained if the minister and the chairperson and chief executive of NHS QIS all change.

Mr Davidson: You are saying that you want that to be defined in statute.

Dr Adamson: It is essential that the existence of the Scottish health council be included in statute. Our understanding is that it is probably not legally possible to put it in primary legislation, but it could be in a statutory instrument. There is a question about whether it could be a statutory organisation if it were part of another organisation, such as NHS QIS, and we are seeking advice on that.

Martyn Evans: This is one of the most challenging issues. It is about objective and subjective independence. Objectively, NHS QIS is clearly an independent organisation. We have seen how it operates and how it has built up credibility as an independent organisation; it has involved patients and members of the public in its service standards. However, the public perception of NHS QIS is different; it is perceived to be part of the NHS because it has NHS in its title.

We believe that there should be additional safeguards, not about the objective side of it, as we believe that QIS is an independent organisation and that the minister is committed to the independence of the Scottish health council. The safeguards that we would like are: a memorandum of understanding between the QIS board and the Scottish health council; a council for the Scottish health council; a directorate answerable to the council; a budget; and research capacity.

To answer Mr Davidson’s question directly, the one bit that we think should be in the bill is the requirement to have a memorandum of understanding between the board of QIS and the entity called the Scottish health council. The bill does not have to define that memorandum, but the requirement must be there to ensure that something is put down on paper that sets out the rather complex relationship that is envisaged.

14:30

The Convener: I take it that you want the bill to say, “There shall be a memorandum of understanding.” Where would that be put? Would it be in regulations or guidance?

Martyn Evans: The content of the memorandum would be for negotiation between the board of QIS and what we suggest should be the non-executive council of the Scottish health council. The memorandum would be a way of working that the two parties had agreed and its content would not be laid out in statute. The statute could say, “There shall be a memorandum”. We have not put this in our evidence, but we have discussed the matter and we have heard what your witnesses have said. We think that a statutory basis for a memorandum may be helpful in dealing with the perceived lack of independence by giving the relationship some robustness.

The worry that people have is that somehow, behind closed doors, the voice and interests of the Scottish health council would be subsumed by the wider voice and interests of QIS. We have said to you here, and in our written evidence, that we believe that QIS is the right place for the Scottish health council to go; if the council was, like Caesar’s wife, above suspicion, that would help.

Mr Davidson: I take it, therefore, that you would not want NHS anywhere in the organisation’s name. Do you think that there is a potential stigma in being involved with NHS QIS?

Martyn Evans: The word stigma is too strong. It would be difficult to explain why an independent organisation was within an organisation called NHS QIS. It is not that we in any way doubt the independence of NHS QIS; we are just saying that, in explaining that, it would be difficult to get over the hurdle of the organisation having NHS in its title.

Dr Adamson: We have produced a side of A4 on our views on independence. The committee may like a copy.

The Convener: Oh, yes. Absolutely. If you submit that to us, we will have that as another public paper.

Mike Rumbles: I would like to pursue independence further. It is perhaps the one area in which the committee may decide to make recommendations to change the bill, depending on your evidence, as well as on other evidence that we have before us.

At the moment, the health councils are not perceived to be independent. Martyn Evans has just made the point that the Scottish health council would be independent, but that there is a problem of perception among the general public concerning
the proposals, as the council may not be considered to be independent. We also have written evidence from the Scottish Association of Health Councils that states:

“We consider the independence of the new Scottish Health Council, to act and speak in the best interests of patients to be of paramount importance”—

I do not see how its independence could be more important than that—

"and believe that this can best be achieved by establishing the Scottish Health Council as a statutory independent body in its own right with its own board of governance".

There seems to be a clear option of recommending to the Executive that it should go down that route, away from what it has suggested. However, I do not think that the committee would want to do that unless there was very strong evidence from everybody who had come before us that that would be best. We are getting that strong evidence from the health councils, but you are hedging your bets. Are you saying that it is not necessary for the committee to recommend a change to the bill as regards independence?

**Martyn Evans:** No, we are not saying that. I hope that we are not hedging our bets on this. The subjective view of independence would not be addressed if another special health board were created, because that also would be perceived to be part of the NHS. How could we get over that problem? In addition, if it were to be an independent organisation, its budget, at £2 million, is very modest. A lot of money would have to be spent on internal processes, so it would not be as efficient.

Also, the Scottish health council would have to build its independence and credibility. QIS has, in my experience, built that credibility of being independent within the NHS itself and in a wider policy field. I do not know whether it has had much impact in the public field, but it has had an impact in the wider policy field.

We would say that building on the safeguards within the structure of QIS is the best way forward, because putting the Scottish health council into a larger organisation gives you economies of scale, and the benefits of hitting the ground running and of the real independence that we believe is there.

**Mike Rumbles:** I would like to press you on one point. You asked, “Why create another health board?” That is what the proposal would mean, as far as you are concerned, but it would not have to be a health board. In fact, it would not necessarily have to be part of the NHS. If we think outside the box, we could think about health councils not actually being part of the National Health Service in Scotland. Do you see what I am getting at?

**Martyn Evans:** I do see that, but I was just responding to the proposal.

If the national health council were a wider body, perceived as part of the NHS, that part of our concern might not be there, but our other concerns would be. With only £2 million, a very small organisation would have to build its credibility. There is therefore a more pragmatic question to answer, and I would say, based on my experience of running small organisations, that such organisations can be efficient and effective. However, they can be more efficient and more effective by being part of a larger organisation, as the Scottish Consumer Council is.

**The Convener:** Before I bring in Shona Robison, I would just like to pick up on what you said about money. Martyn Evans referred to the £2 million mentioned in the explanatory notes, which state that the funding for the Scottish health council would be

“The £2,108,000 currently allocated to local health councils”.

Martyn Evans raised that figure, but the evidence from the Scottish Association of Health Councils states:

“This will therefore require additional funding for the new Scottish Health Council, over and above the existing provision.”

Does the Scottish Association of Health Councils think that we will need more than £2 million for the Scottish health council, and does the Scottish Consumer Council think that we need more than £2 million? The financial memorandum says that there will be

“no net additional expenditure arising from the Bill”,

and that that is considered an accurate assessment. Could we clear up that point about the funding?

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

We are talking about a fundamentally different type of organisation—a national organisation with local offices working on the same core functions to national standards. In such an organisation, there needs to be considerable investment in the training and development of staff and local members, and that is something that the existing
health council structure has not been funded to do. Establishing the new Scottish health council, as currently proposed, will involve significant additional costs over and above the £2.1 million, if we are to have an organisation that can hit the ground running and, most important, be effective for patients.

**The Convener:** Are you saying that more than £600,000 will be needed?

**John Wright:** I am saying that the £600,000 is basically—

**The Convener:** I understand that. I am asking how much more you are talking about.

**John Wright:** I cannot say how much more would be needed, but there would need to be training and development for staff so that there could be competent managers in the organisation. As a different type of organisation, the Scottish health council will need to invest in development and training for both staff and members.

**Martyn Evans:** We agree with John Wright that the in-kind contribution must be recognised and specified clearly, because the health boards make an important in-kind contribution.

On the financial memorandum saying that there will be no change in the £2.1 million that is available, if we were to go into the system without making any change, we would be asking the Scottish health council to achieve a significant step change in the culture of service delivery with the same level of resources that has been available in the past. We do not think that that level of resources is sufficient to meet the challenge. In our view, that challenge is about bringing the patient interest to the table alongside the well-organised professional interest that previous witnesses have mentioned and the well-organised financial and managerial interests within the NHS. The proposed sum is a very modest amount of money for bringing the patient interest up to the same level of understanding and influence that the professional and funding interests have.

We do not believe that the Scottish health council will necessarily cost any more money than the amount that is proposed, but we do not think that it will be able to do the job unless more money is put into it—that is slightly different from what John Wright is saying. It is not inevitable that the health council will cost more money, but it will not succeed unless there is an investment of more than £2 million.

**The Convener:** It will be useful to put that point to the minister.

**Shona Robison:** I want to respond to two of the points that have been made. I want to pick up Martyn Evans on what he said about independence. You seemed to imply that the fact that the health council would not be big enough or well enough resourced to stand alone was driving your thinking on where it should be located. Should not the question of where the health council should be located in order for it to be as independent as possible be a matter of principle? Should resourcing not be left aside when considering that principle? If resources were not an issue, would that change your view on where the health council should be located?

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

All that I can do is respond to the alternative proposal of which I am aware, which is that there could be an NHS special health board. We say that there is no doubt that such a board would also be objectively independent, but the perception would remain the same—because the board would be an NHS board—and, in addition, there would be practical issues, although I accept that they would not be matters of principle.

We share the view of our colleagues—we think that it is absolutely vital that the health council is an independent organisation.

**Shona Robison:** My second question is for the Scottish Association of Health Councils. You have heard what the Scottish Consumer Council has said about safeguards. In your evidence, you said that, if you do not get the structure that you want, “additional safeguards will be required” as a fallback. Are the safeguards that the Consumer Council was outlining the same kind of safeguards that you are in favour of or do you have other safeguards in mind? If so, can you let us know what those other safeguards are, either today, or subsequently in writing?

**John Wright:** As I recall, the points that Martyn Evans made about safeguards are similar to those that we would make. We have been trying to work up proposals in a bit more detail, by considering issues such as the relationship between the health council and the board of NHS QIS and how accountability would work within that organisation. We have tried to work out the issue in a bit more detail and I would be happy to share our information on what we think that the safeguards for the health council’s independence within NHS QIS would be.
The Convener: Please do. As you appreciate, some parts of the bill are more important than others and that key issue will have to be explored thoroughly by the committee.

Janis Hughes (Glasgow Rucherglen) (Lab): I refer to the written submission from the Association of Health Councils. You say that you are “concerned that many of the existing functions carried out by Health Councils could simply disappear, unless alternative delivery mechanisms are identified.”

Will you tell us what functions you are concerned might be lost under the proposal? What mechanisms could address those omissions?

14:45

Dr Adamson: We feel that it is extremely important to ensure that the public and patient voice is heard, although we are not suggesting that the Scottish health council necessarily has to be that voice.

The health boards have a duty to involve the public. However, there is a definite problem relating to the three to four-year interim development period, in which the health boards will have to develop new systems. We are currently considering various transition arrangements. We are also concerned about the arrangement whereby the public goes to a health board for information and the health board replies to their concerns. We have to ensure that the public’s voice is heard and that the health boards do not give them the information as a way of avoiding problems. The public must get independent information as well as information from the boards.

Janis Hughes: Do you think that the bill goes far enough in relation to public involvement and the duty that will be on boards to involve the public? Might there, therefore, be a role for health councils to play that might not be in the new proposals?

Dr Adamson: There is definitely a role in ensuring that this process is adequate. The role of the Scottish health council will be to assess whether it is adequate. However, there has to be a robust mechanism by which any problems can be flagged up.

Janis Hughes: What would you suggest as a robust mechanism? What should there be in the bill to address the elements that you think might be lost?

Dr Adamson: We are considering that at the moment. We are not experts in legislation so we have to take advice from people as regards the mechanisms that can be used.

The Convener: You can write to us with suggestions later on. You do not have to use statutory language; all we need is a steer.

John Wright: We do not want a situation in which we are hoping that everything will be all right on the night. There are clearly-defined functions that health councils currently carry out. Should the decision be to transfer some of those functions to another organisation, we would like to ensure that, in the planning process for the establishment of the national health council, consideration is given to how those functions will be transferred and that it is ensured that the organisation that is taking those functions on board is capable of doing so. Those functions and services that are currently available to the public should not fall down a hole or suddenly become unavailable. The transition has to be planned extremely carefully.

Dr Adamson: We are well aware that MSPs send people to the health councils to access information. We are concerned about the possibility of a void opening up in this area while the area of public involvement with the boards is developed.

Liz Macdonald: You asked about what sort of robust process would be needed. In a way, that brings us back to QIS, because that has developed ways of coming up with standards and then going out and checking whether those standards have been met. Part of the strength of the health council’s being associated with QIS is that it will buy into that robust process that is being developed in the context of public involvement.

Martyn Evans: I want to add something about functions being lost or not carried over. We have given our view about complaints and complaint handling and about the right of access in order to monitor services and I now want to agree with what Kate Adamson said about patient voice.

We agree with the policy direction that states that the Scottish health council will allow patients to find their own voice and to represent their own interests in all their diversity. Our concern is for those patients who are unable to do that for themselves: perhaps the very young; teenagers in particular; or perhaps homeless people seeking dental appointments, or whatever. We are talking about people at the margins who are disadvantaged. The Scottish health council must have a clear equality strategy and it must be able to give a voice to some of those people. It is our experience that such people cannot easily be helped to find their voice because of the nature of their circumstances and how they engage with the NHS.

Although we broadly approve of building a capacity to enable people to say how they find the
services, there are key groups in our society who will not be able to have a voice. We do not suggest that that should be covered by the bill; equalities statements are part of safeguarding a voice for the voiceless. That voice is not necessarily a national one, but a voice that says to the local service provider, “In your area, this is a failure,” or, “This is a concern that we have about our local office of the Scottish health council.”

I agree strongly with what Kate Adamson said about voice.

**Mr McNeil:** It is natural at a time of change that one focuses on what one might lose and on what one is losing. We have heard from the Scottish Consumer Council that it believes that it was time for a review of the health councils, that all was not perfect, that there were weaknesses in the system and that this is an opportunity for progress. Will you take the opportunity to identify some of the weaknesses that you perceive in the system? Can you tell us what we can improve through the review, rather than dwelling on what we might lose?

**John Wright:** I make it clear that we agree with and are supportive of the need for health councils to reform, as Dr Adamson said earlier. The basic principle is that we are talking about fundamental and structural reform of the health service, of which the health councils are part. With the changes that are taking place in the NHS, we recognise that health councils need to reform and respond to that change. We agree with the principle that the board should be responsible for public involvement. We are positive from that point of view.

We see this as an opportunity to improve what health councils do because it is not about what is good or bad for health councils; it is about being able to deliver outcomes for patients. That will be determined by the powers, the remit, the role and the responsibilities that are given to health councils. The separation from service providers, which you have already talked about, is a positive step.

I do not want to be totally negative and say that everything about being involved in NHS QIS is bad because that organisation has, as we have said, demonstrated its ability to act independently. It has powers to intervene and it has powers to bring about change in the NHS. Having those powers vested in the Scottish health council and giving it teeth to deliver will give significant advantages over the current set-up. Currently, health councils can go along to boards and point out issues, and the boards can simply pat them on the head and say, “Thanks very much, but we’re not going to do anything about it.” From the powers and responsibilities that will be given to the Scottish health council will flow the opportunity to deliver change for patients and to ensure that the patients are involved in the planning and delivery of the NHS and that they will be able to communicate their voice. There are many positive points there. Our concern is that the organisation is created in the right environment, with the appropriate powers and remit to be able to deliver, and that it not only has independence but is perceived to be independent.

**The Convener:** We see a slight difference in views between the two groups.

I ask Duncan McNeil whether he wants to proceed with a question on the complaints procedure before we move on to questions from David Davidson.

**Mr McNeil:** Yes, that might be helpful. I return to the concerns about the complaints system, which was mentioned both in your written evidence and earlier this morning, when we heard evidence of concerns over the lack of investment and focus. Will you say more about your concerns about the complaints service and whether you believe that giving the boards responsibility to establish such a service will be an improvement on the current set-up? Did you say earlier that not every board has a complaints system in place?

**Martyn Evans:** One of the weaknesses of the current system is that not every health council has a mechanism for dealing with complaints, so the pattern of service delivery throughout Scotland is variable. The extent of support depends on the individual board, so the system is not coherent. The new NHS complaints procedure that is coming through will cut out the middle level: it is about local service provision and resolution at the local level. The evidence that we took in our preconsultation work showed that few people knew about the role of local health councils. Other organisations that provide advice and assistance are well known; name recognition of some of them is around 90 per cent.

To be consistent, we must invest in a complaints support service throughout Scotland. The Scottish health council should have a role in defining who should take up the services locally and in monitoring how well they are provided. We welcome the greater focus on consistency throughout Scotland and we hope that there will be proper funding of support services for people who make complaints about the NHS. The evidence that we took showed that a significant number of people just want to be dealt with locally and reasonably quickly, rather than go through the existing escalating procedure, which takes a significant amount of time.

**Mr McNeil:** Does Kate Adamson want to say anything about that? There was quite a challenge there in relation to your perception of the number
of MSPs and other people who use the procedure. I do not use it; many of us use a direct route. The challenge from the Scottish Consumer Council was that it should not necessarily be the health councils that provide the support and that citizens advice bureaux or local advice groups with name recognition and accreditation should do that work.

Dr Adamson: Work is being done on the mechanisms under which complaints are dealt with and on whether health boards will have to deal with complaints or whether they will commission services. The extremely important point that Martyn Evans made is that adequate training and capacity must be built into the handling of complaints; health boards cannot take on that work without making considerable investment.

Martyn Evans: I do not want my criticisms of the system to be taken as criticisms of health council members or staff. The councils’ impact has been dramatic over the past 30 years; our criticism is of the structure and the method of service delivery. We have talked about the improvement that the proposals might bring. I say that in case I overstepped the mark in making my criticisms.

Mr Davidson: I go back to something that Liz Macdonald said about NHS QIS and its image, which rang a bell. It really comes down to what NHS QIS does. Many people see it as an organisation that audits and can intervene in professional delivery as opposed to one that deals with patient involvement. John Wright said clearly that the health councils welcome the ability of NHS QIS to step in to intervene. Does that mean that the health councils welcome the fact that NHS QIS has the power to intervene on delivery, and that NHS QIS is perceived as being more professional. Is there a role for the health councils to act as an independent body on behalf of patients and to take a case to NHS QIS?

Liz Macdonald: I am not sure that I understand your point.

Mr Davidson: John Wright said that the health councils welcome the fact that NHS QIS has the power to intervene on delivery, and that NHS QIS is perceived as being more professional. Is there a role for the health councils to act as an independent body on behalf of patients and to take a case to NHS QIS?

Liz Macdonald: If there is an established system for setting standards and monitoring them, there would be no need for ad hoc approaches, which seems to be what you are suggesting.

Mr Davidson: That is how the system operates at the moment.

Martyn Evans: The system does not operate that effectively at the moment. NHS QIS has a system of doing routine and regular reviews and writing those up in the expectation that there will be improvement. It has powers to intervene in service failure and it is grappling with how it undertakes those powers. There is no reason why the Scottish health council could not support a voluntary organisation that wanted NHS QIS to take action on a perceived service failure in a particular location. If the memorandum of agreement that we have suggested is drawn up, there is no reason why the Scottish health council should not use internal mechanisms to ask the QIS board to intervene in a perceived service failure. There is also no reason why the current structure would preclude your suggestion.

Liz Macdonald was saying that the current quality assurance system is a routine system—it is not a system for exceptional circumstances—and it is understood that service failure will be exceptional. There is a mechanism for dealing with service failures and if we suggested that the memorandum of agreement might be put into statute, we would be looking for that memorandum to have a route to service failure intervention. That would be a strong indicator of independence from the QIS board. NHS QIS would still have to decide whether to intervene on service failure but the Scottish health council could make such a proposal. In an open and transparent organisation, it would be known that such a proposal had been made and what the evidence for it was.

Dr Adamson: A close relationship with QIS is viewed as being extremely valuable; it will be the important relationship. There will be an advantage in that the Scottish health council will not necessarily have to go back to the boss organisation, as it has to have a voice in areas where problems are perceived to exist. The council will benefit from QIS’s experience in setting standards and considering outcomes, but it must be able to comment on those in its own right, especially where public involvement is concerned.

Dr Turner: Public involvement is very important. Given that the duty to involve the public will not be accompanied by significant additional resources, will it improve public involvement in health service planning?

Martyn Evans: We think that it will. As we said at the beginning, we are talking about a culture change. That might involve some investment in training but the major impact will be on service provision in public services for patients, in that their feedback will be respected and encouraged and their interests will be taken care of when service delivery and future services are planned.
I hope that we are not being naive when we say that we hope that the duty will improve NHS services in Scotland. It will make a major difference. The structures proposed in the bill, such as the capacity-building support that the Scottish health council will give, will be of major importance, and the statutory duty to involve the public and patients will also be of great importance. We are very optimistic about the changes that could take place in the NHS as a result of the bill.

**The Convener:** Do I detect dissent among the panel?

**Dr Adamson:** We are extremely concerned about the fact that public involvement by health boards is to be cost neutral. Unless that money is ring fenced, the problem that we have already of public involvement being considered not that important will definitely continue, and front-line services will be considered important as far as funding is concerned. There will be a conflict, unless the boards’ duty of public involvement is covered in another way.

**Dr Turner:** That is an important issue. The Scottish NHS Confederation said that the proposal would cost quite a lot of money because, to use its phrase, “Genuine, meaningful, continuous public involvement is not cheap”.

I agree with that. The feedback from patients is that public involvement is fine but people already want to be involved and there is nobody to listen to them. That is the main thing. There are not enough nurses on the wards and there is not enough time in surgeries, and when people try to relate to people in the NHS, they find that the people in the NHS do not seem to have the time to listen. Even if there were more staff to answer questions, a cost would be involved. Enormous costs could be involved in public involvement.

**Dr Adamson:** We support that attitude.

**Martyn Evans:** Our experience is that it does not cost public services huge amounts of money to focus on their service recipients. After all, that should be the nature of what their business is about. There is a difference between getting the views of the public service user and providing the time, to which Dr Turner referred, for a general practitioner to spend with a particular patient. The issues are different. It can be argued quite legitimately that, for clinical and medical reasons, GPs and others need more time to see their patients. However, our evidence is that a large organisation such as the NHS—it is the largest organisation in Scotland—does not need significant extra funding to focus on its service users. It needs a culture change to reassess how it spends its money but we do not think that it needs large amounts of extra money over and above what it currently receives.

**Mike Rumbles:** On that point, I think that the issue is one of perception. I note that Dr Kate Adamson said that more money would not be provided for the bill. However, my understanding from the evidence that we have received from previous witnesses is that the Executive has said not that there will be no more money but that the bill will not add any further costs. For instance, Dumfries and Galloway NHS Board—which is a small health board in comparison with others—said in evidence that it saved £500,000 through service reorganisation. That is quite a substantial sum of money. The bill will make changes from the top and if those savings were replicated elsewhere, that could make moneys available. As far as I understand it, the Executive is saying that people will be able to redirect such moneys to public involvement among other things. Do you not share that perception of the situation?

**Dr Adamson:** We have read the evidence that Dumfries and Galloway NHS Board gave, but £500,000 on the board’s turnover is not quite as good as it might sound at first hearing. We are talking about savings that will be made over quite some time but money will be required immediately to fund public involvement. Although the proposals may be cost neutral over time, there is definitely an issue over the initial cost.

**Mike Rumbles:** I want to pursue that point. You said, fairly, that the £500,000 is insignificant compared to the board’s turnover. However, the funding of health councils is £2 million Scotland-wide, is it not? If the 15 health boards each saved £500,000, that would amount to a total of £7.5 million. Surely that is a substantial sum to save. I am sure that the actual savings would be a lot more, would they not?

**Dr Adamson:** The health councils will continue with assessments and other functions, so the £2 million will not go to the boards for public involvement. Public involvement is a new process.

**Mike Rumbles:** You seem to misunderstand my point. You said in response to my question that £500,000 is not a particularly large sum in proportion to the turnover of Dumfries and Galloway NHS Board. I then used another comparative example: the £2 million for health councils Scotland-wide. I am not saying that that sum would go to public involvement—I understand that it will not. However, the point that I am trying to make is that we do not know how much money will be freed up through the savings process; it could be several million pounds. It seems to me that if Dumfries and Galloway NHS Board can make savings of £500,000, there will be generally a substantial sum of money that should be directed to public involvement. I was questioning your point that more money should be allocated.
Dr Adamson: I am talking about allocating more money during the set-up period rather than in five years’ time. I believe that that is an extremely important point. Dumfries and Galloway NHS Board said in its evidence that it could not guarantee that its saving would be mirrored in other areas.

The Convener: Three members want to ask supplementary questions. I ask them to be brief, so that we can move on. I am mindful that another witness is waiting.

Mr McNeil: I will be very brief. We have had a lot of evidence, including that from Dumfries and Galloway NHS Board, but I do not think that in any of that evidence anyone has described the cost of public involvement as being enormous amounts of money. We need to clarify that no one has given us such information; in fact, it is contrary to all the evidence that we have taken. What is your definition of enormous amounts of money?

Dr Adamson: It was not my intention to imply that enormous amounts of money would be involved. I want to ensure that the process of and the mechanisms for public involvement are covered. The Scottish Association of Health Councils has been considering the developing frameworks for public involvement that the boards are producing and the development of performance assessment. Our perception is that health boards are producing those things at different speeds. The frameworks are in operation, because the boards must produce them, but we do not have total confidence in the processes that they are undertaking.

Mr McNeil: That could be more to do with the culture than with the financial constraints.

Dr Adamson: It could be.

Dr Turner: My understanding—I wonder whether it is yours—is that public involvement is to take place throughout the whole health service and not just in the public’s interaction with health councils. Time is money in every other form of employment and business. Therefore, if the culture has to change and people have to find more time to interact with patients and relatives to feed back to health councils and consumer councils, an amount of money will be involved that has not yet been prescribed. We have no idea yet what that amount will be.

Dr Adamson: A lot of the public involvement has been on the part of lay people giving their time voluntarily. If employees of health boards are required to be involved, by definition there will be a cost.

15:15

Liz Macdonald: A lot of the talk has been along the lines that public involvement is something new that has not happened before, but it would be a mistake to think that. We have been working on public involvement in the health service for many years. Public involvement is going on, and there are lots of examples of good practice. We are not talking about a step change in funding; we are talking about the introduction of a statutory duty as another driver to push people down a road that a lot of people are already on.

Helen Eadie: When I first came to the Scottish Parliament the guidelines on public involvement had not been changed since 1947. That was a contentious issue in my area in Fife. I ask each witness to define public involvement for me, because I am aware that there are many examples of best practice.

The Convener: I ask the witnesses to be brief.

Martyn Evans: I will distinguish between service-user involvement and public involvement, because they get mixed up. Public involvement is often about service planning. It is about the whole range of people who may not currently use a service, but who have an interest in how that service is developed. That public involvement is basically a citizenship issue. It is about engaging with citizens who have the interests of young people and others at heart. Engaging the public as citizens in service planning is a complex matter. We see that when hospitals have to be closed or reorganised.

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

We make that distinction, but we are much more interested in service-user involvement, only because we are the Scottish Consumer Council, and that is our locus. However, we understand the public-policy issues around public involvement, because we believe that better decisions are made about huge allocations of money and time. Involving citizens in big strategic decisions is a modern way of working, and it is a better way of working in a democracy.

The Convener: I will take one definition only from each organisation.

Dr Adamson: I support Martyn Evans’s comments: there are the service users and there are the public. The service user often has their own interests; the public have a broader perception, but perhaps they do not understand the issues. It is essential that both groups are involved, and disadvantaged people must be enabled.
The Convener: I thank the witnesses. We will have a five-minute adjournment until 25 past 3.

15:18
Meeting suspended.

15:26
On resuming—

The Convener: I welcome Mr Warwick Shaw, chair of the Association of Local Health Care Cooperatives, a gentleman whom I met before in his work in the Scottish Borders. I will start off with a general question. Do you think that the change to the structure of the NHS as proposed in the bill is necessary or appropriate? That is quite a soft ball for you. Do you think that it will improve service delivery? That is a more difficult question.

Mr Warwick Shaw (Association of Local Health Care Cooperatives): I am speaking both as the chair of the association and as someone with a background in the NHS in the Borders. I think that the move to a single structure in the NHS in the Borders has been very valuable. It has enabled many improvements to begin, although I would not necessarily say that they have all been realised.

The Convener: I ask you to move the microphone a little closer to you.

Mr Shaw: Certainly, and I will move a bit closer to it as well.

The Convener: Thank you.

Mr Shaw: The reorganisation is an important one, and it offers many opportunities to improve services and the way in which they are delivered. That applies both to the public, who are the users of the service, and to the professionals, who deliver it.

Dr Turner: Do you think that the bill should explicitly state that community health partnerships should evolve from LHCCs? If so, why do you think that that would be beneficial?

Mr Shaw: I will answer the second part of the question first. When LHCCs evolved, as a result of a couple of phrases in the 1997 white paper, "Designed to Care", the guidance was broad and was very much an outline. It enabled front-line clinicians to feel far more involved than they had been in decisions on investment and on how services were shaped, and in how their lives were affected. The various reviews of LHCCs, the best-practice group and the primary care modernisation group have all identified that. There is a tremendous range of LHCCs, some of which have made a significant difference to the way in which services are provided. I am not suggesting that either big LHCCs or small LHCCs are the answer. It is not purely a question of size, although I think that we used that phrase in our evidence. It is much more an issue of attitude—I am perhaps phrasing that in a slightly different way than was done previously.

The Convener: If things have evolved in the way that you describe, what in fact is a community health partnership, or CHP—as one might work in the Borders, for example? I know that you are not here to give evidence on that, but if you have one in the Borders, you might as well tell us about it.

15:30
Mr Shaw: We do not actually have a community health partnership in the Borders; there is a unified NHS board. Many of the characteristics of a community health partnership are displayed in one of the LHCCs, but it has been set up as an LHCC, not a community health partnership, and therefore has fewer responsibilities and a slim infrastructure, as do most LHCCs.

What is a community health partnership? The association was invited to become part of the drafting process with the Scottish Executive Health Department, and we spent quite some time batting around what a community health partnership is. The summary of the consultation process contains quite a good description of what would be in a community health partnership, but that is rather different from what a community health partnership might do. Not only would there be services and staff within a community health partnership, the community health partnership would exercise influence over other areas, both within health services and within the local authority. I agree that community health partnership is not necessarily a tremendously helpful name to describe what is probably fundamentally an NHS body, albeit one with necessarily extremely strong links with the local authority partners.

Dr Turner: Can you give an example of something that is working well at LHCC level that would probably work well in a community health partnership with the local authority?

Mr Shaw: An example of that is the integration of the primary health care team at a level above the primary health care team—not just the general practitioners who work in a practice, who always work in close partnership, but the district nursing staff, the health visiting staff, community midwives, the local social worker and the local community practice nurse. All those people who work within a defined geographic area have always been able to work closely if there was the will for that locally. LHCCs have made that far more likely to be the case by allowing such joint working to take place.
at the planning level for those local primary care teams.

**Dr Turner:** That certainly happened in some areas before the creation of community health partnerships. All those people worked together in a geographical area. In connection with the local authority, would there be more involvement with social work and housing services?

**Mr Shaw:** Certainly.

**Dr Turner:** That is what I was wondering. Do you have any examples of that happening at the moment?

**Mr Shaw:** There are examples around Scotland, but things have evolved differently in different areas. In your constituency, there is a well-developed discharge team, which involves good co-operation between the local authority and the LHCC.

**Dr Turner:** Yes, that is right.

**Mr Shaw:** That is also the case elsewhere.

**Mr McNeil:** It is important to examine the relationships between local authorities and LHCCs. Some of the more developed LHCCs take an integrated approach, but that is not uniform throughout the country. What are the strengths and weaknesses of LHCCs? What are the best examples? Where are the weaknesses? Can the formation of community health partnerships be expected to improve those relationships or does the committee need to do something to ensure that that happens?

**Mr Shaw:** In most cases, the areas where LHCCs have worked better are those where there is already an element of coterminosity and one LHCC does not have to try to deal with two local authorities—or vice versa—or something more complex. The community health partnership is specified as being coterminous with a local authority or some obvious part thereof. If coterminosity is one of the key elements in the success of integrating local authorities and LHCC services, we can assume that CHPs will be better able to develop services jointly if coterminosity is rolled out across the CHP model.

**Janis Hughes:** I have a follow-on question. How much emphasis do you place on the importance of coterminosity? Particularly given the way in which things stand in the central belt at the moment, coterminosity will be quite difficult to achieve. I know that the issue has been raised with the Executive and that it is looking at it in the context of the consultation on CHPs. How important is it to keep the CHPs coterminous with the areas that they are to serve?

**Mr Shaw:** It would be useful, but it is not vital. Coterminosity makes things simpler and, if one can make things simpler, they are probably more likely to succeed.

**Janis Hughes:** Would it be better to have a smaller CHP and keep it coterminous than to go for a bigger group with no coterminosity?

**Mr Shaw:** There are advantages to both. If a community health partnership is too small, it will not be possible to achieve an economy of scale in infrastructure. If it is too large and it covers too big an area, the complexity of the infrastructure means that it will have to work far harder in order to engage with all the appropriate partners.

**Janis Hughes:** You alluded to the fact that one of the benefits of LHCCs is that they can react to local needs. LHCCs are composed of groups of health professionals who work together in their local area. Will the statutory basis that is proposed for the community health partnerships mean that they will be more bureaucratic? If so, will they lose some of their ability to react to local needs?

**Mr Shaw:** Most of the members of the Association of Local Health Care Cooperatives steering committee would be concerned if CHPs were to become what we would characterise as traditional NHS organisations—by that I mean if CHPs became relatively bureaucratic and procedure and governance driven, as opposed to how we characterise ourselves, which is as slim organisations that concentrate on trying to do something. We rely on the NHS infrastructure around us to provide the governance framework within which we operate.

**Janis Hughes:** Is there anything that could be added to the bill that would help the CHPs to avoid that bureaucratic quagmire?

**Mr Shaw:** Community health partnerships need to exist as part of an NHS body and not as statutory, independent bodies in their own right. As we move away from the trust model, there is a danger that we could almost recreate them.

**The Convener:** From reading proposed new section 4A of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the bill, I think that there can be more than one community health partnership in a board area. Is that correct?

**Mr Shaw:** Yes.

**The Convener:** I think that I was getting the wrong idea that there would be one community health partnership in a board area. I can see that, if the health board covers a big area, it might have two or three CHPs in its area. If CHPs were set up on an area basis, could that deal with the difficulties of coterminosity?

**Mr Shaw:** There will be one community health partnership in only a very few health board areas.
If that were to happen, it would almost be as if we had one structure sitting on top of another structure, which would not be terribly helpful. In many areas, the coterminosity of a community health partnership in a health board area will be with the sub-divisions of a local authority and not the entire local authority. One example is Ayrshire and Arran NHS Board, which is considering having three community health partnerships. I think that Argyll and Clyde NHS Board is considering having four.

The Convener: Is that because not all the local authority area is in the NHS board area?

Mr Shaw: That is right. However, there is a need to try to retain a more local focus. We do not want to have a community health partnership with a million patients in it.

The Convener: I was thinking that way, but I have just realised that I was thinking wrongly, which is a bad sign.

Mr Davidson: I turn to the practice outcomes, because the delivery of health care is what the bill is supposed to be about. As CHPs are supposed to evolve from LHCCs, do you think that practice will improve? CHPs will be given a statutory basis, but much will be laid down by regulation, by guidance and by local variations.

Mr Shaw: By defining what a community health partnership's responsibilities are, one gives a level of legitimacy if there is a different view at the health board level in each area. One of the reasons why LHCCs are at different stages of development around Scotland is the level of the support that they were given by local health boards and the level of freedom that those boards were prepared to delegate.

Mr Davidson: In other words, the new sense of freedom comes with responsibility.

Mr Shaw: Yes. Where the freedom was given, the responsibility was returned.

Mr Davidson: On CHPs, do you think that an addition should be made to the bill to enshrine flexibility in devolved management? The minister talks about that principle, but are you content that there is enough in the bill to demonstrate it?

Mr Shaw: There is the opportunity in the bill for that to take place, but if it were defined, that would probably be rather welcomed by the steering committee of the Association of Local Health Care Cooperatives.

Shona Robison: The financial memorandum to the bill states that the community health partnerships will not require any "overall additional expenditure". Do you agree?

Mr Shaw: Given that the bill is in the context of a significant reorganisation of every local NHS system, there will certainly be possibilities to redeploy staff and transfer resources that might be freed up from the unified system into community health partnerships. You should also bear it in mind that most CHPs will be an amalgamation of several LHCCs, so some management and administrative effort will be available. Whether that is at the right level and with the right skills is a different question. I am almost falling into the civil service trap of weasel words—

The Convener: Heaven forfend.

Mr Shaw: I think that it is possible that additional expenditure will not be required, but goodwill, imagination and a willingness to transfer good staff, rather than spare staff, will be needed.

Shona Robison: Let us see whether we can get you out of the civil service trap. Under infrastructure, your evidence says:

"LHCCs have been established on a relative shoestring... It is important that CHP establishments are sufficient to handle the workload."

Given that CHPs will involve several LHCCs, as you mentioned, CHPs will presumably involve several shoestrings. To me, that reflects a concern that community health partnerships might not be adequately resourced—that comes from your written evidence, but also from what you said about ensuring that CHPs have the right personnel. Your evidence goes on to say:

"As NHS systems re-organise the opportunity to redeploy high quality staff within emerging CHPs should not be ignored or lost."

Of course, staff cost money; they are not free. Do you think that we need to ensure that there are adequate resources for CHPs? If so, how do we do that?

Mr Shaw: My association’s steering committee would certainly agree with you, but it would also agree that one has to be realistic. NHS financial systems are already under some strain, and it would not be helpful to suggest that sums should be ring fenced for yet another style of organisation. It may well be helpful to the development of community health partnerships, but not to the overall NHS systems. I really think that we need to avoid trying to favour one group over another. Our evidence reflects the fact that there are two sides to the argument. There will be additional demands for an appropriate infrastructure for community health partnerships evolving from LHCCs, but that does not necessarily require investment from outside the existing envelope.

15:45

Shona Robison: So we run them on a shoestring as well.
Mr Shaw: As you yourself suggested, several shoestrings coming together can be plaited into a relatively substantial rope.

The Convener: A man of metaphors.

Mr Shaw: Hopefully not one who will hang himself. [Laughter.]

The Convener: He has thrown that rope to you. Clutch it, Shona.

Shona Robison: That is an interesting response. I am interested in what you are saying about balancing. We know that there are significant pressures on the NHS, and the Audit Scotland report makes interesting reading. However, we are also told—and we all agree—that what can be done in primary care should be done, so there will be an expectation that CHPs will deliver an awful lot more than LHCCs delivered. As we know, the success of LHCCs was very patchy across Scotland. I agree that it is a balancing act, but we also have huge expectations. Is there a danger that expectations of what can be delivered will be high and that, if we do not put in the necessary resources, those expectations could be dashed?

Mr Shaw: There is a difference between making resources available to a community health partnership and investing those resources in the management capacity and infrastructure of a community health partnership. Not an awful lot of managers actually treat people or provide services to individuals—some do, because they are also clinicians—but that is what we should be about. Rather than design our own empire, we should design something that is sufficient to meet the financial, organisational, planning and governance requirements. We should not just build an empire because we can.

Shona Robison: So we should keep bureaucracy to a minimum.

Mr Shaw: Yes. When LHCCs began, they were funded on a transfer of the old fund-holding manager allowance of £3 a head. I do not know whether that is well known to committee members, but that is pretty much what most LHCCs run on. Many of the larger ones manage to invest quite a lot of that in services and front-line staff rather than in their own organisation and infrastructure. Maybe we are our own worst enemies, as we have not provided ourselves with the infrastructure that there might have been money to provide, because we took a decision that it should be invested in services.

Shona Robison: That is interesting.

The Convener: In your written evidence you say:

“A key feature of CHPs will be the relationship with Local Authority partners.”

You go on to say:

“Despite the best efforts within Joint Future work there remain some obstacles to joint working, and one that is often mentioned are the differing terms and conditions of service between the systems for similar work.”

I do not know whether “some obstacles” is civil service speak, but I would like you to develop that point, because it has been raised before. If you are asking people to co-operate, they may be pretty hostile to one another if they are getting a lot less pay and their conditions are not so good.

Mr Shaw: One can be magnanimous if one is earning a lot more pay, but I do take your point.

The Convener: It is a serious point.

Mr Shaw: One of the oft-quoted examples is occupational therapy, where people with exactly the same professional qualification work on either side of the local authority-NHS boundary and are paid entirely differently.

The Convener: How much of a difference is there between people at the same level doing the same job? Thousands?

Mr Shaw: Not many thousands but a couple of thousands. It obviously depends on the grade as well. There are also differences between the terms and conditions of some care assistants in local authorities and those of health care assistants in NHS systems. Those differences generally favour those on the NHS side, not necessarily in hourly pay but in the continuity of employment.

The Convener: I do not want to spend too much time on this, but I want to flag it up because I think that what counts is the relationship between people at the coalface. We can have all the structures in the world in place, but the system will not work if there is hostility between people who are doing the same job because one of them is being paid a few thousand pounds less than the other.

Mr Shaw: Yes, and that is not something that can be resolved at a local level.

The Convener: You are right. We should bear that in mind.

Mr Davidson: Paragraph 9 of your submission says:

“CHPs must have delegated authority and flexibility in order to deliver the roles outlined … above. This must include appropriate budgets”.

Given that you have to come to some arrangement with the local authorities, which have their own budgets, do you think that there has to be better definition of how you use combined budgets on the basis that, in many cases, patients are assessed twice, by two different set-ups?
Mr Shaw: Yes, I do. That falls under what we term “governance and accountability” in our submission.

There are various drivers, performance assessment frameworks and so on and QIS and the social work inspectorate use entirely different systems. There will be entirely different deliverables for the NHS and the social work elements of community health partnerships. That will definitely present us with a challenge.

Mr Davidson: Does your association have any particular thoughts to share with us in relation to that problem, if you see it as a problem?

Mr Shaw: We have at least 15 or 20 different thoughts. It depends on the area from which the representative comes. Each area has specific issues and some work well while others do not. As a rule, we feel slightly at variance with the joint future drive that aligned budgets are safer than pooled budgets.

Mr Davidson: Convener, could we ask Mr Shaw to send us something from his committee on that area? The area is complex and I know that some of the local authorities are already concerned about who will drive the process because, obviously, the CHPs will be health organisations.

The Convener: Are you happy to do that after taking advice from the representatives?

Mr Shaw: We will have a go.

Mr McNeil: On public involvement, your submission says:

“LHCCs have all involved the public, but to varying degrees. A specific responsibility and appropriate funding will enable this to be taken forward in a very meaningful way.”

When there is a specific responsibility to involve the public, how will you do it better?

Mr Shaw: The level of public involvement has been immensely varied. Some LHCCs have an occasional chat with a member of the public, others have members of the public sitting on their boards and others embark on quite elaborate public involvement exercises. The more elaborate the exercise to involve the public, the greater the commitment and the expense. Most LHCCs will have tended to invest the money in services, as I said before, rather than in public involvement, which has not been a specific LHCC responsibility but has tended to reside at trust or health board level. As trusts disappear, public partnership forums are formed and the responsibility is given to LHCCs, there will be a structure in which public involvement must take place. There is an enthusiasm in LHCCs to do that work and involve the public more closely in the planning of the service. At this point I should say that I am grateful to the Scottish Consumer Council for drawing such a clear distinction between public and service user.

The Convener: That was helpful.

Mr McNeil: Your submission says that appropriate funding will enable the public to be involved in a meaningful way. However, the Scottish Consumer Council suggested that the problem was more cultural than financial.

Mr Shaw: That is a fair point. At the moment, however, LHCCs have no responsibility for public involvement and therefore not all of them dedicate any money to public involvement. In the future, LHCCs will have that responsibility and they will need to identify funds so that they can involve the public in a more meaningful way.

Mr McNeil: Have you done any work on how you would respond to that?

Mr Shaw: To be honest, we have not. We are waiting to see what the shape of public partnership fora might be. Many of us have made use of the local health council structures, but they are going to move on.

The Convener: That is tactful—we will also move on. Thank you for giving evidence, Mr Shaw. I hope that you found the experience as interesting as the committee has done.
SUBMISSION BY ORKNEY NHS BOARD

6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Evidence and Feedback from NHS Orkney on the National Health Service Reform (Scotland) Bill.

NHS Orkney is the smallest health board in Scotland. It serves a population of just under 20,000 people who live on 17 inhabited islands that form part of the Orkney archipelago. Delivering a sustainable primary care led health and social care service to the islands means that remote and rural issues are high on NHS Orkney's agenda.

These 3 questions were emailed to NHS Orkney's Board members and representatives of the advisory committees to the Board. These are the anonymised replies received.

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

One board member supports the principles of the Bill but is disappointed that, although Boards will have new statutory duties of public involvement and co-operation with other bodies, Staff Governance is not included as a statutory duty of Boards.

The absence of staff governance in the Bill is of concern to another board member. NHS Orkney is committed to staff partnership.

We don't have a LHCC in Orkney and I do not know what kind of animal a CHP will be. I do not know where it sits in relation to Joint Future Agenda. Is there duplication or conflict here?

There is the potential for tension between regional planning and local needs and decision-making. I hope that there will a correct balance of channelling resources and that individual Boards do not suffer and local decision-making is not unduly constrained.

What are your views on the quality of consultation, and the implementation of key concerns?

5 weeks is not long enough consultation process. In particular we would have thought Local Health Councils would want to consult their communities, given the proposal to abolish them and 5 weeks would not be long enough.

In remote and rural areas, Local Health Councils are very active & highly thought of by the communities they represent as being their voice within the NHS. Centralising LHCs would disadvantage these areas. We would have liked the consultation to have included this.

I welcome Health Boards participation in community planning and am glad of the emphases in Health Improvement. I would prefer that we have power to choose the way we spend the funds, as Scottish Executive directives don't always fit Orkney's situation.

Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?

No comments were received on this point.
SUBMISSION BY THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Key points

The Royal Pharmaceutical Society supports the general principles of the Bill.

The Society supports the evolutionary development of CHPs from LHCCs, building on the best elements of the existing structure.

Since the inception, pharmacists have strived to become more actively involved in the day to day running of LHCC’s.

However, pharmacists experienced difficulties in attending day time meetings of LHCCs as a result of the lack of necessary financial support.

Participants should be welcomed to the CHP table because of the contribution they can make and not because of an anticipated professional dominance.

The trend towards an inclusive approach in LHCCs should be continued and encouraged in CHPs.

Witnesses

David A M Thomson – Chairman, Royal Pharmaceutical Society Scottish Department
David Thomson has been a member of the Scottish Executive of the Society since 1996. He is Director of Pharmacy for Greater Glasgow Primary Care Trust and Vice Chair of the Association Scottish Trust Chief Pharmacists Primary Care Group. David Thomson is a member of the National Pharmacy Forum, the Greater Glasgow Area Pharmaceutical Committee and the Vaccine Strategy Group for Scotland. He is a past National Tutor for the Scottish Centre for Post Qualification Pharmaceutical Education.

Asgher Mohammed – Community Pharmacist, Paisley
Asgher Mohammed has been a practising independent community pharmacist for nearly 20 years. He was a pharmacy representative of and latterly chairman of Paisley Local Health Care Cooperative (LHCC). Currently he is a member of the College of Pharmacy Practice and the LHCC Professional Advisory Committee of NHS Argyll & Clyde. Recently Asgher won the first Scottish ‘Independent’ pharmacy practice of the year award. He has a passion for the pharmaceutical input towards improving patient care.

The Royal Pharmaceutical Society of Great Britain is the independent professional body of all pharmacists in Great Britain. The title of pharmacist is reserved for members of the Society. The Scottish Department of the Society represents those members that practice in Scotland. The Society in Scotland represents 4,000 pharmacists working in the community, hospitals, education, research and industry. In the community, pharmacists and their staff see nearly 600,000 people on a typical day across Scotland, more than any other health profession.

General Principles of the Bill

The Society supports the general principles of the Bill (as introduced). In particular, the Society supports the establishment of Community Health Partnerships (CHPs). CHPs are intended to evolve from LHCCs and must build on the best elements of the previous structure.

The introduction of Local Health Care Co-operatives (LHCCs) in 1999 was an attempt to develop health services relevant to that community. In general LHCCs were afforded a degree of licence in forming their own geographical boundaries around voluntary groups of primary care healthcare professionals. The principle was sound and encouraged innovative methods to identify and tackle issues of concern to that locality. At the outset, the structure of local management committees, required to return a GP majority, became GP dominated with other healthcare professionals
reluctant to become involved. Attempts to become more actively involved met with resistance and
certainly pharmacists reported difficulty in attracting the necessary financial support required to
attend daytime meetings.

Since the inception, pharmacists have strived to become more actively involved in the day to day
running of LHCCs. Many pharmacists are members of the LHCC Executive committee and other
key areas of influence within their organisation. One pharmacist, until recently, chaired an LHCC.

The trend towards a more inclusive approach must continue with participants welcomed to the
table because of the contribution they can make and not because of an anticipated professional
dominance traditionally accommodated in previous health service reforms.

Quality of Consultation and implementation of key concerns

The Society wishes to ensure that is properly involved in the consultation process. Pharmacy, as a
key stakeholder in the delivery on healthcare on behalf NHSScotland should be automatically
invited to submit its views.

Practical implications of putting these provisions in place and consideration of alternative
approaches

The change in emphasis at Ministerial and Health Board level with the explicit statement of the duty
to promote the improvement of the physical and mental health of the people of Scotland is
welcome. The Society highlights the developing discipline of Pharmaceutical Public Health in
Scotland and seeks to ensure that there is adequate access at Health Board and CHP level to
advice and support from specialists in this discipline across the country
SUBMISSION BY THE ALLIED HEALTH PROFESSIONS FORUM SCOTLAND

6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Allied Health Professions Forum Scotland

AHPF Scotland presents a strategic alliance representing diverse and independent health and social care professions in the UK. AHPF Scotland exists for the 13,000 professional members in Scotland, to encourage collaboration and liaison between members and professional bodies north of the Border.

AHPF Scotland Submission to the Health Committee of the Scottish Parliament on the National Health Service Reform (Scotland) Bill.

Introduction

The Allied Health Professions Forum Scotland (AHPF Scotland) should like to thank the Health Committee for the opportunity to give oral evidence on the National Health Services Scotland Reform (Scotland) Bill. The reform of services is of primary interest to all the member associations and their membership.

AHPF Scotland

The Allied Health Professions Forum Scotland exists to foster collaboration and encourage liaison between the allied health professional bodies. AHPF Scotland presents a strategic alliance representing diverse and independent health and social care professions in the UK. AHPF Scotland has recently been set up for the 13,000 professional members in Scotland, to encourage collaboration and liaison between members and professional bodies north of the Border.

Membership is open to any professional association representing Scottish health professionals, who are registrants (or prospective registrants) with the Health Professions Council, or who are state registered.

The following bodies are in membership of AHPF Scotland:
- Ambulance Service Association
- Art Therapies Advisory Group
- The British Association of Art Therapists
- The British Dramatherapy Association
- The Association of Professional Music Therapists
- The British Dietetic Association
- British Association/College of Occupational Therapists
- British Orthoptic Society
- British Association/College of Occupational Therapists
- Chartered Society of Physiotherapy
- Institute of Biomedical Science
- Registration Council of Scientists in Health Care
- Royal College of Speech and Language Therapists
- Society of Chiropodists and Podiatrists
- Society of Radiographers

The majority of staff represented by the above bodies work in the NHS in Scotland.

Overview of the NHS Reform Bill

Allied Health Professionals work in a very large variety of locations, delivering services to patients in acute and primary settings and promoting Scotland’s health. The Allied Health Professions have welcomed the direction outlined in the Scottish Executive white paper (Partnership for Care), and
broadly support the aims of the legislation to reduce bureaucracy and improve strategic planning and delivery in community health. What will be crucial is how the policy aims are interpreted in practised across the Health Board areas in Scotland.

The Allied Health Professions are crucial at every stage and every level in the planning and delivery of improved services and their inclusion in the decision making process is vital. The place of AHPs in the chain of services, and the role of AHP staff in reducing waiting times and improving services cannot be under stated. Whether with reference to the role of Radiography and waiting times in cancer care and acute services, or physiotherapy and rehabilitation in the community, the AHPs must be included in the design and delivery of services. Patient care can be severely adversely affected in circumstances where allied health professionals are not consulted, and this is increasingly recognised across the NHS in Scotland.

The place of the Allied Health Professions in the NHS

The inclusion of allied health professions in the planning decision making is not straightforward. As can be appreciated from the scope and diversity of the professional bodies, the allied health professions are organised in smaller units and do not have the ‘critical mass’ to organise themselves collectively to have a strong voice within health boards. Historically, the NHS has had a tendency to be dominated by the medical and nursing staff, and this simply reflects the collective numbers of such staff. The much smaller numbers and stratified nature of allied health professions has meant that their influence and ability to contribute to the planning and decision making process has been limited. AHPF Scotland has been established to ensure a stronger national voice for the AHPs in Scotland, but this level of organisation cannot be beneficial to patient care unless it is reflected by an improved voice for AHPs at a local, Health Board and hospital level.

In community settings also, Allied Health Professions report difficulties in being heard. In many parts of Scotland, AHPs have found themselves under represented at the management boards of LHCCs. It is not only the development of multi-professional services but development In line with the Scottish Executive white paper that must considered in this context. Improvements to services can only come from an inclusive environment, and the creation of Community Health Partnerships can deliver improvements if an inclusive approach is taken from the outset.

Recent efforts have been made by the Scottish Executive to redress the balance and the establishment of the AHP officer at the SEHD and specific AHP Posts on special Health Boards reflect this welcome shift in emphasis. This must now be reflected at a local level where health services are designed and delivered.

AHPF Representation

AHPF Scotland recognises that there are already a significant numbers of members the allied health professions on the Health Boards and LHCCs across Scotland. However, this has often resulted by default rather than by design. AHPF Scotland seeks the creation of reserved places for the Allied Health Professions on the new Health Boards, Management Committees and Community Health Partnerships to guarantee a voice for the Allied Health Professions. Whether a Dietician or an Occupational Therapist, an AHP Representative on decision-making structures would have a responsibility to consider the concerns of all the professions.

As a specific voice for the AHPs, the role of such members would act as a focus for the concerns of all allied health professionals, and reinforce the need for consultation and collaboration among all AHPs. This measure should not prevent professionals becoming members in another way, but should ensure adequate inclusion of professions to contribute to the process of designing and improving services.

Conclusion

AHPF Scotland welcomes the reforms of the Health service outlined in the legislation and believes the proposed changes present an opportunity to improve and modernise the health service in Scotland.
Crucial to this process must be the development of team working among all the staff of the NHS, and the role of the allied health professionals must be seen in equal partnership alongside the role of medical and nursing staff. To this end, AHPF Scotland seeks a reserved place for the Allied Health Professions on each of the Health Boards and Community Health Partnerships. This would create a focus for the inclusion of Allied Health Professions in decision making which otherwise proves very difficult, and would reflect the changes already taking place at a local and national level.

The Allied Health Professions

Art Therapists
Help patients to understand their problems and come up with solutions through the use of arts such as painting, drawing and sculpture.

Chiropodists/ Podiatrists
Diagnose and treat foot problems, carry out nail surgery and give advice on proper care of the foot especially for those with conditions such as diabetes.

Dieticians
Work with people to promote wellbeing, prevent food-related problems and treat ill health through diet.

Drama Therapists
Encourage patients to express the whole range of their emotions and to increase their understanding of themselves and others through drama.

Music Therapists
Help people to understand their behaviour and emotional difficulties through music.

Occupational Therapists

Orthoptists
Diagnose and treat a range of eye disorders and defects of vision.

Orthotists
Design and fit pieces of equipment known as orthoses to patients who need support for a weak arm, leg or spine.

Prosthetists
Provide care and advice for patients who have lost or were born without a limb, fitting the best possible artificial replacement.

Physiotherapists
Assess and treat people with physical problems caused by injury, ageing, disease or disability promoting recovery and relief from pain.

Radiographers
Diagnostic radiographers produce high quality images using all kinds of radiation, such as X-rays, and other tests to diagnose illness. Therapeutic Radiographers treat mainly cancer patients using radiation therapy, and occasionally drugs, and support their care through all phases of the illness.

Speech and Language Therapists
Assess, diagnose and treat people who have communication and/or swallowing difficulties.
6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

Amendments To NHS Reform (Scotland) Bill

I am writing to inform you about two new sections that I am intending introducing to the NHS Reform (Scotland) Bill at Stage 2. These will cover staff governance and equal opportunities.

Staff Governance

After the introduction of the Bill, a number of groups, including the Scottish Partnership Forum, expressed disappointment that the Bill had not included provisions to put staff governance on an equal footing with clinical and financial governance in the NHS. Staff governance is a system of corporate accountability for the fair and effective management of staff. A staff governance policy has been in place in NHSScotland since January 2002, however, it has not been a legal requirement to have such arrangements in place. I had originally intended to reserve this for inclusion in a future health Bill, but I have listened to the concerns and have decided to bring this forward and to include it in the NHS Reform (Scotland) Bill.

The staff governance provision will place a duty on Health Boards and Special Health Boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees.

Equal Opportunities

Similarly, NHSScotland has been working hard to encourage equal opportunities throughout the National Health Service. Partnership for Care details the commitment of NHSScotland to extend the principles set out in Fair for All across the NHS to ensure that the health service recognises and responds sensitively to the individual needs, background and circumstances of people’s lives. Work is ongoing to implement Fair for All and the requirements of the Race Relations (Amendment) Act, with support from the National Resource Centre for Ethnic Minority Health and the Commission for Racial Equality. Preparatory work has been undertaken with the Disability Rights Commission to ensure NHS compliance with the Disability Discrimination Act. An LGBT Health Needs Assessment project has been developed with support from Stonewall Scotland and work has been done to implement an “all faiths and none” approach to Spiritual Care with support from the Scottish faith groups and a Chaplaincy and Spiritual Care Unit.

The development of an Equality and Diversity Strategy for NHSScotland will also allow the NHS to comply with the Scottish Parliament’s mainstreaming agenda. The strategy will ensure that NHSScotland respects and values each individual patient, carer, member of the public and member of staff for who they are. It will make sure that NHS Scotland is provided with the support it needs to meet their needs and the needs of staff from minority groups or communities. The three existing equality commissions in Scotland have indicated that they believe this is the correct approach for NHSScotland and have agreed to work with us in the development of the strategy.

However, I recognise the importance of putting the requirement to encourage equal opportunities on a statutory basis where appropriate and that is why I am proposing to amend the NHS Reform Bill to require health service bodies to encourage equal opportunities when carrying out their statutory functions.

I hope that the Committee agrees that these are important issues, which are worthy of inclusion to the NHS Reform (Scotland) Bill. Further information on the detail of the amendments will be available in due course but I wanted to alert the Committee to my intentions now so that you are able to include the issues in your oral evidence taking at Stage One.
6 January 2004 (1st Meeting, Session 2 (2004)), Written Evidence

National Health Service Reform (Scotland) Bill

I refer to your letter of the 9 December in which you asked for further information on our proposals to amend the Bill to include staff governance and equal opportunities. You also asked for further information on the role of advocacy.

Staff Governance

On the 17 November, the Scottish Executive issued a consultation paper on its proposal to amend the Bill to include staff governance. This consultation paper provides further information on the amendment and also includes a draft section for consideration. I have enclosed a copy of the consultation paper with this letter. It can also be found on the internet at the following website:

http://www.show.scot.nhs.uk/sehd/publications/DC20031125StaffGov.pdf

If your committee members have more detailed questions about staff governance once they have looked at the consultation paper, we will, of course, be happy to address them.

Equal Opportunities

NHSScotland is required to act in accordance with current legislation on sex, race and disability discrimination and has specific duties under the Human Rights Act to act compatibly with the European Convention on Human Rights. An impending European Directive will also make discrimination illegal in employment on grounds of sexuality, religion and belief, and age. In addition these statutory obligations under UK and European law, the Scottish Executive is working to mainstream equal opportunities throughout NHSScotland to impact on the culture and attitude of those working in the organisation. To date, much of this mainstreaming work has been done in an administrative capacity.

Whilst equal opportunity rights are a reserved matter, it is within the competence of the Scottish Parliament to require public organisations to encourage equal opportunities. Such provision for equal opportunities is becoming more common in Scottish Bills and recent examples of this include the:

- Local Government in Scotland Act 2003 (s59);
- Mental Health (Care and Treatment) (Scotland) Act 2003 (s3); and
- Housing (Scotland) Act 2001 (s106).

We have instructed solicitors to draft an amendment that will require Health Boards, Special Health Boards and the Common Services Agency to encourage equal opportunities when discharging the functions given to them under the National Health Service (Scotland) Act 1978. They will also be required to observe all laws relating to equal opportunities. We envisage that the wording of the amendment will be similar to the sections listed above.

As I mentioned above, NHSScotland has been working to encourage equal opportunities and to mainstream it throughout the service so that it impacts on the culture and attitude of those working in the organisation. Therefore, it is not expected that this will have a significant impact on NHSScotland. Nevertheless, the Scottish Executive considers it important to put the requirement to encourage equal opportunities on a statutory basis where appropriate, which is why we are proposing this amendment.

Examples of the work NHSScotland is undertaking to encourage equal opportunities include the ongoing work to implement Fair for All and the requirements of the Race Relations (Amendment) Act, with support from the National Resource Centre for Ethnic Minority Health and the Commission for Racial Equality. Preparatory work has been undertaken with the Disability Rights
Commission to ensure NHSScotland compliance with the Disability Discrimination Act. An LGBT
Health Needs Assessment project has been developed with support from Stonewall Scotland and
work has been done to implement an “all faiths and none” approach to Spiritual Care with support
from the Scottish faith groups and a Chaplaincy and Spiritual Care Unit.

The development of an Equality and Diversity Strategy for NHSScotland will allow it to comply with
the Scottish Parliament’s mainstreaming agenda. The strategy will ensure that NHSScotland
respects and values each individual patient, carer, member of the public and member of staff for
who they are. It will make sure that NHSScotland is provided with the support it needs to meet their
needs and the needs of staff from minority groups or communities. The three existing equality
Commissions in Scotland have indicated that they believe this is the correct approach for
NHSScotland and have agreed to work with us in the development of the strategy.

Advocacy

Advocacy is an important way of enabling people to make informed choices about, and remain in
control of their own health care. Traditionally this has been mainly available to vulnerable groups,
such as people with mental health problems, learning difficulties or physical disabilities, and older
people. However, it should also be available more widely to all health service users where this is
needed.

Independent advocacy in Scotland is supported through the Advocacy Safeguards Agency, which
promotes and develops independent advocacy, and supports statutory agencies to develop these
services. Independent advocacy in Scotland is also supported by the Scottish Independent
Advocacy Alliance which provides advocacy projects with a network support structure. There is
also a requirement on Health Boards to work with their local authority partners to ensure integrated
advocacy is available to all who need it, and all Health Boards have developed an advocacy plan.
The Mental Health Act also gives new rights to mental health service users to have their interests
represented by independent advocates.

In terms of expressing views about health services, and ensuring that individual patients and carers
have the opportunity and where necessary the support to be heard, we intend that the new Scottish
Health Council will have the function of ensuring arrangements are in place to support individual
patient and carer feedback. It is the responsibility of NHS providers in the first place to make sure
that the views of people who use their services are actively sought, and that it is as easy as
possible for people to give them. The Scottish Health Council will also need to ensure there is an
independent body which can pass on the patient’s or carer’s views, and support him or her through
the process. The role of the Scottish Health Council will be to monitor and quality assure these
arrangements.

I hope that this letter provides the Committee with the additional information that they require.
Please do not hesitate to contact me if they would like any more information on the points raised in
this letter.
Scottish Parliament
Health Committee
Tuesday 6 January 2004
(Afternoon)

[THE CONVENER opened the meeting at 13:59]

National Health Service Reform (Scotland) Bill: Stage 1

The Convener (Christine Grahame): I welcome everyone to the first meeting in 2004 of the Health Committee. I have received no apologies. I remind members to switch off pagers and mobile phones. I welcome Nanette Milne, who is sitting in on the meeting to get acclimatised to the Health Committee.

I welcome also the panel of witnesses in Orkney from Orkney NHS Board. We are a bit apprehensive about doing the videoconference with them. Some of us have done one before, but it was a long time ago. I welcome Steve Conway, the director of operations; Jenny Dewar, the chair; Kathleen Bree, the director of allied health professions and nursing; and Stephanie Lawton, the head of human resources.

My first question is a simple one. Do you believe that the bill's proposed change to the structure of the national health service is necessary or appropriate? If you believe that it is, how will the change improve service delivery, which is what it is all about?

I ask one of the witnesses to act as chair of the panel and to direct questions to other members of the panel, if appropriate.

Steve Conway (Orkney NHS Board): If I may, I will answer the questions and ask the others on the panel to contribute as we go along.

In general, we believe that the bill’s principles are entirely appropriate and that they will enhance how we provide the services that the bill addresses. In many cases, the bill will merely formalise and impose a statutory duty in relation to service provision that we already undertake.

The Convener: What you are saying is that the bill will just make the provision of services that are already being provided a statutory duty. Is that correct?

Steve Conway: Yes.

Jenny Dewar (Orkney NHS Board): We ought to point out that we do not have NHS trusts in Orkney, so the big restructuring due to the move to single-system working will not affect us. Therefore, we have concentrated on other aspects of the bill.

The Convener: Are members finding the sound a bit difficult?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Yes.

The Convener: I am sorry, but I am informed that nothing can be done about it. We will just have to strain a little. Can the panel in Orkney hear us clearly?

Kathleen Bree (Orkney NHS Board): Yes.

The Convener: We will move on then.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In their written submission, the witnesses claim that there is potential for tension between regional planning and local needs and local decision making. Will they elaborate on that possibility and on the potential consequences?

Steve Conway: Yes. The first issue is about governance and non-executive directors’ involvement in decision making at a regional level as opposed to their current role at board level. The second issue is how we will be able to engage patients and the public actively in the processes at a local level when we are dealing with a regional issue.

Can you still hear me?

Mr McNeil: Yes—with difficulty.

Steve Conway: It went very quiet this end for a minute.

The next conflict that we are a little anxious about is the risks for boards, particularly island boards, if we have to move from the Arbuthnott funding formula to a regional funding formula. The same applies to the voting mechanism within a regional structure. We serve a population of 20,000. If regional planning is activated on a population basis, we do not believe that we will have the fair say that we would like to have.

The other aspect that is particularly relevant to us as an island board is that in the regional context we will have to ensure that everyone appreciates the significant differences in being an island. Those differences are not just about remoteness; there are many other issues.

The Convener: Would you like to develop that? What are the other issues? Perhaps it would help if you elaborated.

Steve Conway: We have 17 inhabited islands, some of which can be reached by plane and some
of which can be reached only by boat. All the islands can be reached only in certain weather conditions. That is not something with which Highland NHS Board, for example, will be overly familiar, although it has regional complexities that we do not share, such as the mileage between locations. Not all our islands have general practitioners. We are also different from other regions in that we have only six surgeons on the mainland, and we have only one hospital.

Jenny Dewar: Another issue that we face is a problem with the recruitment and retention of staff, because we have such a small population. We see regional planning as a way to help us to alleviate those problems by working across boundaries. We welcome the statutory underpinning of that function in the bill. It will make it legal for us to work for our populations but across boundaries.

Mr McNeil: Can you identify any benefits? You have a list of concerns, but you say in your evidence that you generally support the bill. What benefits do you envisage for areas such as yours, apart from the one that you have just described?

Steve Conway: The bill is about making better use of the resources that are available. We already do a lot of regional work, in that many of our clinical services are provided off Orkney by Grampian NHS Board and other health boards. The bill formalises that type of relationship, so it makes best use of scarce resources.

Janis Hughes (Glasgow Rutherglen) (Lab): Your written submission mentions that you do not know much about community health partnerships because you do not have a local health care co-operative in Orkney. Notwithstanding the fact that you are not particularly experienced, you will have read the proposals in the bill on community health partnerships and will be aware of the consultation process that is under way. Will community health partnerships help you to improve service delivery?

Kathleen Bree: We are signed up to the principle of community health partnerships and we see them as a positive move. Although we in Orkney do not have an LHCC as it is known elsewhere, I suppose that the board operates in a pseudo-LHCC way. We certainly envisage the community health partnership developing the involvement of the community and clinical staff in decision making on the development of services, which will be good for the local authority and other organisations. The community health partnership is a much-needed development and, from our perspective on the island, it is also the way forward for sustained services.

Janis Hughes: Could anything be added to the bill to help with community health partnerships, particularly given the issues that you face?
be managed so as to retain that expertise and commitment.

Shona Robison: Do you see a way of achieving that within the bill, or do you feel that the bill needs to be amended to reflect that and to ensure that that important role is maintained?

Jenny Dewar: I do not think that that will necessarily be achieved in the bill. In fact, I would be reluctant to see too tight a provision made in the bill, because I recognise that different health councils work in different ways in different areas. If anything, I would like there to be flexibility in the regulations and the set-up to allow boards to work with the local advisory councils and, at national level, with the Scottish health council to produce something that will achieve what we are looking for. Basically, we want to get people involved in our planning and service delivery and we want to get their views on how we provide services.

Mr McNeil: In your written evidence, you said:

“Local Health Councils are very active & highly thought of by the communities they represent as being their voice within the NHS.”

Were no health council members available to give us evidence today? Were they invited along? Did you attempt to involve health council members in giving evidence to the committee?

Jenny Dewar: No, because we felt that it was your role to invite council members if you wanted their views.

The Convener: I was about to come in with a pre-emptive strike before you answered. That is a matter that we should have considered. Having made that omission, we could now ask for written evidence. You are exonerated and we are not.

Mr David Davidson (North East Scotland) (Con): Are the witnesses satisfied that the new national health council, which the minister proposes in the bill, will be more independent than the local health councils?

Jenny Dewar: Yes, because at present health council members are appointed by health boards. I have reservations about the council coming under the umbrella of NHS Quality Improvement Scotland, as it is clear that there will not be quite as much independence as there could have been, although I see that the proposal reflects the need to focus on quality issues around health care services and on having an outside view of assessing those services.

Mr Davidson: We have received evidence from other groups and bodies that are worried about the new health council being perceived as being a part of NHS Quality Improvement Scotland. Is that a concern in the Orkney NHS Board area? Do you have any evidence for that concern?

Jenny Dewar: It is a concern among people who discuss the issues, but I would not say that it is an issue for the community as a whole—it would be daft to say that. People worry mostly about health care issues when such issues affect them directly.

Mr Davidson: Do I take it from what you say that the local health council acting as a representative of the community, if you like, and working locally does a job that you think is different from that which a new national body that sits within NHS QIS would do?

Jenny Dewar: Very much so. If we wanted to continue in the same way, taking on board our statutory role in public involvement, I would poach people from the health council and use them to facilitate community involvement in what we are doing, but that is not the role of the new advisory council.

Mr Davidson: Do you want to add anything about the independence of the national health council?

Jenny Dewar: No. I think that the proposals are misleading. There will be more independence than there is at present, but I would not regard the council as being totally independent.

The Convener: If any member of the panel wishes to say something, they should indicate that.

Kate Maclean (Dundee West) (Lab): I want to ask Jenny Dewar to expand on her response to Shona Robison’s question about local health councils. Many of the written submissions that we have received express concerns about the loss of local representation in the shape of health councils. I understand from your response to Shona Robison’s question that you expect local advisory councils to be made up of the same local people who are interested in health issues in the area. Is that the case? If it is, would that compensate for the dissolution of local health councils?

Jenny Dewar: That would happen in Orkney because of its small population and the fact that the same people take on community involvement wherever one looks and in whatever field. However, I can see that the picture could be quite different in the Highlands or greater Glasgow, for example, where there are much bigger pools of people to take on involvement.

Kate Maclean: I presume that if the health board has a duty of public involvement, technically every person who lives in the health board area could be involved in discussions and decisions about services. Are you confident that that will
happen? Would that also compensate for the loss of local health councils?

Jenny Dewar: At the moment, we support pulling people into whatever planning processes we undertake, whether they are health council members or come from other voluntary organisations. Perhaps Steve Conway will say a few words about the healthfit day that we had in that context. Essentially, there is a culture that we are proud of. We clearly reach out. I am absolutely convinced that there is room for improvement, but if we start from the basis that we want to involve people, we are halfway there. The issue is about getting the structures and processes right so that everybody is involved and not just those who put their names forward.

Steve Conway: I will give an example of that process. In December, we had a healthfit event. We invited interest groups, commissions, members of the public and patients to a core service review. The event was split over two days, when we considered all the aspects of service provision in Orkney. That demonstrates clearly that we involve the community in the processes, and that we acknowledge the benefit in doing so.

Dr Turner: On public involvement, we could learn a lot from Orkney because all the difficulties that you have up there make Orkney a microcosm of Scotland. It sounds as though people communicate well with each other. How will public involvement improve the consultation process in the NHS?

Kathleen Bree: I am sorry; we were debating who would answer. Public involvement can advise us on where we are not consulting effectively. The process is cyclical. By engaging the public, we can learn where the gaps are and about the places that we are not managing to reach. Even if only the usual suspects are willing to get involved, public involvement can inform us how we can expand our consultation process and advise us how we can engage with other people who might be reticent or who have not wanted to be involved in the past. The process is on-going. Members of the public can be our advisers as well as being consulted.

Jenny Dewar: Involvement rather than consultation is key.

Dr Turner: Have you thought of any new ways of involving the public other than what you have done already?

Kathleen Bree: I am sorry; we did not hear your question.

Dr Turner: Have you thought of any new ways of involving the people who do not normally get involved? You seem to do the job so well because of the nature of your geography. In fact, you have answered the question in your answers to other questions.

The Convener: I just want to clarify whether making it a duty to consult will make any real difference. If you are consulting the public to find out what is wrong with their NHS, does making such consultation a duty make any difference?

Steve Conway: I do not believe that it will in Orkney. As we keep emphasising, the community is very small. Kirkwall has a population of 12,000 to 14,000. Everybody that we deal with or meet has some influence on our thinking. I do not believe that making consultation a statutory responsibility will affect the way in which we undertake that responsibility.

The Convener: No, and you would not like to speculate about the effect on other health boards. That is not your job.

Steve Conway: We do appreciate the difficulties that much larger boards will face. I do not imagine for one minute that the Health Department is using the proposal as a stick to encourage larger health boards to involve the public, but it will help to focus their attention.

The Convener: Thank you.

Helen Eadie (Dunfermline East) (Lab): The evidence that the Health Committee has received, including a submission from the British Medical Association, suggests that there should be more detail about when the power of intervention should be used. What are your views on that?

Steve Conway: The intervention by ministers is the one area that we are concerned about. We in the NHS have clear structures and procedures in relation to performance, whether corporate or individual. Although we acknowledge that the bill's proposals are to be used only as a last resort, it is hard for us to imagine a situation in which ministerial involvement against an individual could occur without its affecting the whole board structure.

Stephanie Lawton (Orkney NHS Board): Building on the principles of staff governance and best practice, we would support the full exhaustion of all available internal procedures before resorting to ministerial involvement.

The Convener: Will you develop the notion of staff governance, please? What is meant by that term? You state in your written evidence:

“Staff Governance is not included as a statutory duty of Boards.”

Will you please develop the point, linking it to the power of intervention?

Stephanie Lawton: NHS Orkney fully embraces the principle of staff governance and supports its
implementation locally. We fully implement the partnership information network guidelines—the PIN guidelines—which allow for individual performance and, if necessary, corporate performance to be identified and measured. We view the intervention of ministerial powers very much as a last resort. We assume that other policies would be exhausted first.

The Convener: I think that the next question is a colleague’s. Take over please, David.

Mr Davidson: That is very kind of you, convener. We do play a team game down here now and again.

The point about staff governance’s not being a duty has been laboured—it is mentioned twice in the submission to the committee. What provisions would the witnesses have liked there to be in that regard, bearing in mind the fact that the minister proposes to lodge an amendment at stage 2 to place a duty on health boards and special health boards to ensure that they have in place systems to monitor and improve the governance of NHS employees? Are there any particular things that the committee should take from your ideas on staff governance?

Jenny Dewar: Before the bill’s publication, the board had three governance duties, only two of which were statutory and which were to do with clinical governance and financial governance. Retaining staff governance as a non-statutory duty would have given the wrong message to our staff about the importance that we attach to it, so I thoroughly welcome the news that an amendment is likely to appear at stage 2.

Mr Davidson: I repeat the final part of my question: what views should the committee take on board when we come to discuss the minister’s proposal at stage 2?

Jenny Dewar: I did not quite catch that, but I would be looking for the duty to be present and for it to be statutory. We would need the same flexibility as exists in relation to other issues in how boards implement the duty, bearing in mind the fact that boards must provide a system of governance.

Mr Davidson: Convener, perhaps we might ask Orkney NHS Board to send us something in writing about staff governance.

The Convener: Is the panel content to provide that?

Jenny Dewar: Yes, absolutely.

The Convener: Thank you very much.

Helen Eadie: I have a question about equal opportunities when they carry out their statutory functions? How do you envisage the measures’ being put into effect?

Stephanie Lawton: NHS Orkney fully supports the implementation of equal opportunities and has in place the necessary policies and procedures. A local race equality scheme is in operation and we monitor our requirements regularly in accordance with the Race Relations (Amendment) Act 2000. Race equality in Orkney is not a major concern, but we recognise that we have a responsibility and a requirement to monitor race equality matters and to promote equal opportunities, so we do that.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like to ask a supplementary question, after Helen Eadie has responded.

Helen Eadie: The points that I wanted to raise have largely been covered in the answers to my questions, but I would like the witnesses to give examples of disability issues that they encounter in relation to public involvement and equal opportunities, because I imagine that the engagement of people with disabilities in public participation is a matter of concern in Orkney, as it is everywhere.

14:30

Jenny Dewar: It is possible that issues around consultation are different in Orkney because they are centred on access. It is difficult for a person with a disability who lives on an island to come to Kirkwall for a meeting, although we make good use of electronic whiteboards and videoconferencing links.

It is also difficult—although I do not think that we do too badly at this—to ensure that people on the remote islands know what is going on. There are certainly channels of communication between staff. On the islands that have small populations, the general practitioner or the family health nurse provides a key focus and a means of disseminating information and receiving people’s views.

The real problems relate to access; they include transport and, for carers, the difficulty of finding someone to look after the person for whom they care—he or she might have to come from another island. The problems are practical, but they are not without solutions.

Mike Rumbles: I want to clarify a point about public involvement and to follow up Duncan McNeil’s question, when the suggestion that we should have invited the local health council to attend today’s meeting seemed to be put to one side. As I understand it, the invitation to attend today was made to NHS Orkney.
In your submission you said that local health councils are “highly thought of” in the community. That goes to the heart of one of the matters that the committee has been concerned with in its work on the bill and, indeed, in its work on the Primary Medical Services (Scotland) Bill, which we considered recently. In the National Health Service Reform (Scotland) Bill that we are now considering, the intention of section 5 is to underpin public involvement legally in order to ensure that patients—the people to whom services are delivered—

“are involved in …

(a) the planning and development, and

(b) decisions of the Health Board”.

I think that Duncan McNeil was making the point—I do not want to put words in his mouth—that if Orkney has a good local health council, which provides an effective voice for the community, it might have been useful to have brought that council along today so that we could hear that voice.

Do you believe that Orkney NHS Board currently involves the public effectively in its decision-making process?

**Steve Conway:** Yes. I accept that you regard it as an oversight that we did not bring someone from the local health council to today’s meeting. That was not a consideration, however—

**Mike Rumbles:** May I interrupt? I am not saying that there was an oversight on your part. I was not expecting someone from the local health council necessarily to attend, but I am interested in the background to your current thinking about public involvement.

**Steve Conway:** I accept that. Perhaps it would be helpful if I returned to the core service review, which is the best example that I can give of our commitment to public and patient involvement. That review represented probably the most fundamental and significant review of health care provision that our board has undertaken in recent history. It will inform the way in which we will work for at least the next 5 years. We are very sure that we involved all the interest groups, the local health council, patients and the public in that consultation. We will continue to involve them as we develop the review’s findings.

In addition to that, two representatives of the local health council attend all board meetings. They are sent the papers a week in advance of meetings so that they can consult other members of the health council.

**Kathleen Bree:** We also have representatives from the local health council on our corporate management team and our joint management team. In addition, a local health council representative is present at many of our clinical effectiveness steering group meetings. We have quite a list of committees and groups that are part and parcel of our decision-making process and on which the local health council is represented.

**Jenny Dewar:** I mentioned culture earlier. When a working group or committee is set up, a representative of the local health council or someone from the public is included when membership is being considered. It is usually easier to go through the local health council, because a member of the public is probably involved in the local health council anyway. We acknowledge that we need to work hard at widening that representation further but, for the moment, that is the way the process works, although we will develop it further.

**Mr Davidson:** I will take Mr Conway back to something that he said earlier. He said that he would be concerned about equality of funding if there was a move towards regional finance planning. That is obviously a crucial issue for Orkney; I am sure that it will be a crucial issue in other parts of Scotland, as well. Will you expand on why you are so concerned about equality of funding, given that there will be powers to treat patients outwith the board, and that money may flow a bit more easily with the patient? What would you like to see in the bill?

**Steve Conway:** I would like the bill to include more rounded recognition of the funding formulae that are used and an acknowledgement that there is a perception—in many cases, it is the reality—that the funding formulae that exist today can disadvantage island NHS boards. That might be compounded by any regional impositions that are placed on us, unless they are based fairly on the services that we provide and where we provide them.

**Mr Davidson:** You also said in your written submission that you were looking for the “power to choose the way we spend the funds, as Scottish Executive directives don’t always fit Orkney’s situation.”

Do you have anything to add to that comment?

**Steve Conway:** I confess that I was not in the organisation when that submission was produced for the committee, but I think that the basis of that comment was the fact that we spend 10 per cent of our annual allocation on treating patients off the islands. We therefore have to be careful about how the funding arrangements balance, compared to other boards that fund only provision within their own boundaries, other than the national services.

**Kathleen Bree:** I think that that comment was made about health improvement rather than about service delivery. Although I was not privy to that
comment, I think that the board was trying to emphasise that we sometimes have national directives that are relevant for health improvement, but do not necessarily address the priorities that we have in Orkney. For instance, the emphasis in Orkney would be more on alcohol than on drugs. I am not saying that we do not have some sort of drugs problem, but it is not our main problem; if we consider drugs, alcohol and substance misuse, alcohol is our top problem area. Therefore, when a national initiative on drugs comes out, we need more flexibility so that, rather than focus mainly on drugs problems, we can focus our resources on alcohol problems.

Mr Davidson: That is very helpful for clarity’s sake. Thank you.

The Convener: I thank the witnesses very much. We have finished our questions, but is there anything about which we ought to have asked but have not and on which you want to say something?

Steve Conway: No. Thank you very much for the opportunity to be here.

The Convener: I suspend the meeting for five minutes to allow the videoconferencing equipment to be taken out.

14:39

Meeting suspended.

14:45

On resuming—

The Convener: For our next panel of witnesses, I welcome David Thomson, who is the chairman of the Royal Pharmaceutical Society of Great Britain’s Scottish department and Asgher Mohammed—have I said that properly?

Asgher Mohammed (Royal Pharmaceutical Society of Great Britain, Scottish Department): Yes.

The Convener: Thank you. Asgher Mohammed is a community pharmacist in Paisley and a member of the Royal Pharmaceutical Society. From the Allied Health Professions Forum Scotland, I welcome Judith Catherwood, who is the convener, and Kenryck Lloyd Jones, who is the secretary. I refer members to papers HC/S2/04/1/2 and HC/S2/04/1/3, which are the written submissions from our witnesses.

Mr McNeil: In today’s written evidence and in previous submissions, many organisations have expressed broad support for the development of community health partnerships. Are the structural changes necessary to improve service delivery? How will the changes affect the divide between acute and primary care, and that between health and social care?

The Convener: I think that the witnesses heard the previous panel of witnesses. As with them, this panel does not have a chair because different organisations are giving evidence, so I ask people just to pitch in.

Asgher Mohammed: My experience of local health care co-operatives in the past five or six years is that where the finance that comes to the health board should go in primary and secondary care has always been debated. It is essential that we bring down the barriers between primary and secondary care; the bill’s provisions on that are to be welcomed. Changes to structures will also mean more change at grass-roots level. When practitioners work at the coalface, they need to address the changes that make a difference to people. The ethos of the bill is excellent because it is patient centred.

As for the effect on health and social care, it is obvious that different models of LHCCs operate throughout Scotland, but we in Paisley have always had good relationships with our local authority colleagues. That has been essential in allowing us to do all the good work that we have done. We could not have done that without our colleagues. The bill will cement such partnerships and we welcome it.

Judith Catherwood (Allied Health Professions Forum Scotland): For the allied health professions, the dissolution of trusts and the creation of unified health boards and community health partnerships bring many benefits. We support the changes very much, because our services have by nature been small and the creation of trusts generated operational difficulties in delivery of our services. The bringing together of services and the ability to deliver AHP services throughout a board area and across health and social care partnerships will be of great advantage to us. It will affect occupational therapy in particular, because occupational therapists who work in local authorities and those who work in health will have added advantages from working more closely together.

Kenryck Lloyd Jones (Allied Health Professions Forum Scotland): As the allied health professions think more of themselves as having a specific role, increasingly some are concentrated in acute settings and some are concentrated in primary settings. The professions are also increasingly aware of the differences between the two settings and of the need for joined-up thinking on service delivery and planning.
David A M Thomson (Royal Pharmaceutical Society of Great Britain, Scottish Department):
The bill can build on the current structure’s strengths and allow more multidisciplinary working across the perceived barrier between primary and secondary care, which is a relatively artificial barrier that should be removed. That involves schemes such as medicine management projects—which handle patients’ transfer between primary and secondary care—and a drug misuse project under which partnership working with social services supports patients using health care intervention and social care intervention at the same time. The bill offers the potential to build on such projects and to enhance dramatically the quality of patient care.

Mr McNeil: In evidence from the trade unions, we heard about problems and barriers to people working together; for instance, when occupational therapy is delivered for a local authority through the health service. Such problems arise because of different wages and conditions, for example. Have you come across such problems?

Judith Catherwood: Yes. I work in Elgin in Moray, where the OT service is moving towards integration. One difficulty is the differences in terms and conditions, particularly in pay and career structure. I cannot comment more, but there is a difficulty.

Asgher Mohammed: Duncan McNeil asked earlier whether the new structures are necessary to make a difference. If they are to make a difference, all the players must be involved at the level at which they can make a difference. We need the AHPs and pharmacists at the helm, along with our colleagues in the nursing and medical professions. Sometimes, we are not up there and we cannot make decisions for patients. The new structures will be good, but only if we are involved. It is important for the AHPs and pharmacists to be part of the structures, but the bill does not say explicitly that we should be there. We feel that we are sometimes marginalised. Both groups of professions should be involved in every structure in CHPs and above.

Mr McNeil: You argue the case for that strongly in your written evidence.

Dr Turner: What do you hope that the role of your respective organisations will be within the ambit of the new developments? How do you see your role developing?

Kenryck Lloyd Jones: We must remember that the AHPF is an organisation that has existed for only the past couple of years and that it still has no direct funding. To bring together the allied health professions, even at a national Scottish level, means bringing together a diverse range of professions. The challenge is how to do that locally. We must ensure that inclusion of allied health professions means that all the professions that make up the AHPs contribute to the decision-making structures. That is the challenge and it is what the AHPF has set out to achieve throughout Scotland.

Dr Turner: Will there be difficulties in doing that? Until now, the organisation has been very much medical and nurse led.

Kenryck Lloyd Jones: We accept fully that there will be difficulties, but that is not a reason not to do the work, which is necessary. If the Scottish Executive’s targets on everything from service standards to waiting lists are to be met, the allied health professions will have a crucial role. Therefore, the work must be done.

David A M Thomson: We must develop to accommodate expectations through the national strategy for pharmaceutical care. Much service development comes through the community pharmacy network—which enhances patients’ access to direct supply for minor ailments—and through the delivery of model schemes for pharmaceutical care. The network will need to be supported by individuals who are positioned within the structure and who can help to develop local systems.

Asgher Mohammed: We would expect pharmaceutical advice at board level on the health improvement strategy, which is one of the bill’s main focuses. Below that, we need pharmaceutical advice at community health partnership level and below that we have pharmacy locality groups, which are where the hard work will be done. We need good leadership at every level and we need to work with other professions.

It is essential that all the professions have their say. The experience in Paisley was that the LHCC’s not being general practitioner led made a huge difference to how it developed: it developed in a more multidisciplinary way. Much of the success of the Have A Heart Paisley national demonstration project was due to people working together at grass-roots level.

Dr Turner: Those are excellent answers. It is important that the bill work for the patient. If pharmacists are to do more for patients, do you envisage difficulties with how patient information will be communicated backwards and forwards? I take it that that is a big worry in being involved at different levels with patients.

David A M Thomson: Absolutely. The developments under “The Right Medicine: A Pharmaceutical Strategy for Scotland” will introduce computer and information technology links between community pharmacies and other prescribers so that community pharmacists will be
able to access NHSnet. There is a trend towards communication being exchanged electronically. Such links are probably 18 months to two years away so, until then, communication will need to be paper based. The arrangements will be in line with developments as they happen at the coalface. Communication is important but I think that it will be resolved by the introduction of IT.

The Convener: David Davidson also has a question.

Mr Davidson: As usual, I must declare that I was once secretary to the royal Scottish pharmaceutical society or, rather, the Scottish department of the Royal Pharmaceutical Society.

Mike Rumbles: Get it right, David.

The Convener: Can you remember what it was?

Mr Davidson: It was a long time ago, in another life.

Will you explain to the committee the important difference between the Royal Pharmaceutical Society and the Scottish Pharmaceutical General Council, which are the two organisations that interface with the Executive? In many cases, the people who will be most affected by the bill will be the contractors—such as community pharmacists—although I appreciate that Mr Thomson comes from a hospital background. The committee needs a fair understanding of the differences and the effects that they will have. The context is that the new pharmacy contract is still under negotiation, but it will be a critical part of how the CHPs will roll out. Will you give us some background information on that?

David A M Thomson: The Royal Pharmaceutical Society represents all pharmacists in Scotland and is the professional body for pharmacists. The Scottish Pharmaceutical General Council represents the interests of contractors, which are the high street pharmacies. We work extremely closely together. By virtue of its size, Scotland affords positive close and collaborative working.

The on-going discussions on development of the new contract are, I guess, entering a stage that will see the introduction of the more local services, so that it will be possible to handle minor ailments through community pharmacies. Those who are least able to afford medication will not be required to access the GP network in order to avoid paying directly for medication.

A medication review is being undertaken within the pharmacy setting in order to improve the quality of current care. Model schemes will be introduced to target patients who have specific disease states; for example, people with severe and enduring mental illness, the frail elderly and people with more chronic diseases such as asthma and epilepsy. The review also deals with the management of repeat supply, which accounts for about 80 per cent of prescription volume. That element will be transferred to the community pharmacy network and will be handled by the community pharmacist, who will have the important communication links back to the initial prescriber.

On the back of that, elements such as supplementary prescribing—which is being introduced just now—will radically change how health services will be delivered through pharmacies in the future. The services will be very patient focused, which will be to patients' advantage.

Mr Davidson: The pharmacy contract is not yet in place, yet it will be a major part of CHP delivery in communities. Would the Royal Pharmaceutical Society and the SPGC care to submit further evidence on the role of the pharmacy contract within the development of CHPs, given that the Minister for Health and Community Care has not really defined where this is going to come from and how it is going to run?

David A M Thomson: We would welcome that opportunity.

The Convener: I must mention our time scale: we would need that evidence as soon as possible before we move on to the next stage of the bill.

Mr McNeil: I want to return to the idea that, as everyone has agreed, the process must be a "development of team working", to use the words of the AHPF Scotland submission. Can such team working be achieved only by having X representatives on the health board and X representatives on the community health partnerships? In practical terms, can your organisations and networks sustain that level of activity? You are coming from a position in which you claim exclusion, to the opposite end of the spectrum, where you are represented at every level. Can you get agreement within your organisations about an appropriate level of involvement? Is that the only way in which you can achieve the influence that you seek in relation to the improvement of service delivery?

15:00

Asgher Mohammed: Both our organisations are relatively small. Experience of LHCCs throughout Scotland has been patchy. Some LHCCs have delivered an awful lot and team working has been great in each organisation. The problem is that LHCCs have not worked well in some areas because people have been excluded. That is because people have been given a choice and, although choice is sometimes very good and
I welcome it, sometimes it means that some professions become less able to promote their input to patient care. Both our organisations would have to be on the CHPs for us to have a voice by right. That is what we seek.

Kenryck Lloyd Jones: We are not necessarily talking about moving from a position of exclusion to one of inclusion. That is a rather extreme statement; as has been said, experience has been patchy. However, we seek a more systematic way of involving the allied health professionals, who, as has been stated, are a very diverse community. At the moment, those who fulfil an AHP role are at least minded to consult and include other members. For example, a dietitian will know that, to represent the allied health professions, they should consult physiotherapists, occupational therapists or radiographers. If that were to be taken away and if we were to have a representative who was a member of one of the allied health professions simply by coincidence or lucky chance, that person could consider themselves to be there to put forward what they happened to think and not necessarily to consult other colleagues in the same way that they would have done if they had had a specific representative role. That is why we have been quite strong in asking for diverse representation in the first place, instead of representation of a small interest group.

David A M Thomson: There are two aspects to that—the competence and the level of input relevant to their competence that the individual concerned can provide, whether they are a pharmacist, an AHP or whatever. At the moment, there is no requirement for a pharmacist to have a position at board level in the new structure, even though the drugs bill represents a massive input in that area.

We should not throw out the good work that has been done with the LHCCs. From the outset, pharmacists and health professionals have battled to get representation on the LHCC structures. The danger is that that good work might be written off and lost when the community health partnerships are introduced, which would have a hugely detrimental effect on the local structure.

Mike Rumbles: I want to pursue the issue of the allied health professionals’ diversity. There are about 11 different sets of professionals altogether in your grouping. You talk about the unsatisfactory nature of your representation on LHCCs, which you say has been ad hoc or down to chance. You argue for more systematic representation through the system of community health partnerships, boards and so on. Given that you embrace 11 different professional organisations—such as that for podiatrists and chiropodists—with 11 different interests, how would you recommend that we ensure that those interests are represented systematically? We could end up with a situation in a particular health board in which all your representatives were from a particular profession, such as chiropodists and podiatrists. What are you arguing for? How do you want things to pan out?

Judith Catherwood: I am a dietitian and Kenryck Lloyd Jones is a policy officer from the Chartered Society of Physiotherapy, but we represent the Allied Health Professions Forum Scotland. The forum has developed during the past few years and we now have an allied health professions officer at the Scottish Executive. A natural coming together of our professional groups has evolved during the past few years.

In health boards, it is natural for different senior people within the allied health professions grouping to take on different roles, depending on their level of expertise—as David Thomson said—or their level of interest in a particular topic. For example, in my area the podiatry lead took the lead in diabetes developments but she represented both herself and me; dietetics obviously has an impact on diabetes. We came to a good agreement about that situation and it worked satisfactorily. Equally, I might represent the AHPs in another capacity. Such work is about bringing us together and giving us the opportunity to have a voice. At the moment, that work is patchy and some health boards do not have much input from the allied health professions. We are happy to come to a compromise within our grouping, provided that there is a systematic way to include us.

Mike Rumbles: So you want representation, but it should be left to you to decide who the representatives are.

Judith Catherwood: Because of the different situations in different health boards, there needs to be flexibility. We heard from NHS Orkney, but the way in which it seeks to involve its AHPs might be different from that of NHS Glasgow. It depends on the size and scale of the health board.

Mike Rumbles: To be a little parochial about the matter, in my constituency there are three or four LHCCs. Let us say that there will be three community health partnerships and that your organisation will be represented on all of them. I could go to one meeting and your organisation would be represented by a dietitian, but it might also be represented by a dietitian at the other two meetings. You are arguing against the ad hoc approach in the current system, but will the new system not also have an ad hoc approach?

Kenryck Lloyd Jones: It might be a little over-deterministic to say that you want pro rata representation of every profession.
Mike Rumbles: I am only probing.

Kenryck Lloyd Jones: We must recognise that the allied health professions are regulated by a single body, the Health Professions Council. That body regulates a range of diverse professions and when it sends representatives to other bodies, or indeed to the Scottish Parliament, it does not necessarily think that it has to send one representative from each profession. The allied professions are mature; they know that physiotherapy is different from radiography, but they ensure that their approach reflects the natural evolution of the health professions. That is recognised in the developments at the Scottish Executive, which now has an allied health professions officer, and in the AHP positions at NHS Education for Scotland.

The professions remain distinct and they have their own professional bodies, but there is an increasing coming together and a recognition of team working is evolving. How does that work in practice at the local level? Perhaps dietitians will be good in one area and physiotherapists will be good in another area, but people might be happy with that. What should be measured is whether people feel sufficiently represented—if they do not, perhaps they can tackle the problem in their groupings. That is what is likely to happen.

The Convener: I follow your point.

Mike Rumbles: That is a good response.

Janis Hughes: Your organisations have made strong cases, both today and in your written submissions, for inclusion in community health partnerships. I do not think that the committee disagrees that representation on CHPs should be as wide as possible and should encompass, as far as possible, all the health groupings that exist in the health service.

How will community health partnerships improve service delivery in respect of working with agencies other than health agencies, such as local authorities and other outside organisations? At the moment, LHCCs focus pretty much on staff in health-related services, but how will things evolve?

David A M Thomson: There will be evolution. Most of my experience in this area is with joint addiction teams, which support individuals through rehabilitation programmes. Health aspects are catered for—probably through a methadone support facility—but the social problems that may have led people towards a habit in the first place are also catered for. There is partnership, which is helped when there is coterminosity between the health board and the local authority. For example, Glasgow City Council and the Greater Glasgow NHS Board have good working relationships in joint addiction teams. Addiction is the area in which I have seen joint working at its best.

Judith Catherwood: Another example, from my profession, would be work that has taken place in schools. In Moray, we have what is called a collective—which I think is the precursor to a community health partnership—and we have worked closely with our local authority, with which we are coterminous. Dietitians have had the opportunity of going into schools to educate pupils about healthy eating and health improvement. We have also been able to work with teachers and other agencies within schools to develop initiatives that encourage children to eat in a different way. We have worked with the catering service and have helped with the implementation of “Hungry for Success”. Joint working has opened doors for us that would not be open were we just closeted within the NHS.

Helen Eadie: I want to move on and ask about the powers of intervention. Should the definition of intervention, and of the circumstances under which the power of intervention will be used, be included in primary legislation or in regulations?

Asgher Mohammed: In Argyll and Clyde NHS Board, for the first time in Scottish history—I think—four chief executives lost their jobs overnight. I do not think that that has happened before and it happened because of the intervention of the Scottish Executive. There are two sides to this: sometimes you need a carrot and sometimes you need a stick. When all else has failed, it can be absolutely necessary for the stick to come out.

Helen Eadie: Should that power be included in the legislation or in regulations?

Asgher Mohammed: Yes, I think it should. Very occasionally, the power will be required as absolutely the last resort. However, that would happen only when all else has failed.

The Convener: I am sorry, did you say that the power should be in regulations, or in the primary legislation?

Asgher Mohammed: It would be better to have the power in regulations. In the unusual circumstances of its being necessary, the power should be there. We would hope that people would be mature and that things would not get to that stage; but, if it was absolutely necessary and in the interests of patient care, the power should be used as a last resort. That is my personal view.

The Convener: Would anyone else like to comment? This is an interesting seam.

David A M Thomson: The power would be used at the final stage. Governance issues that are covered in legislation for our professional bodies would, I hope, limit the requirement for intervention. Furthermore, the local performance programme would highlight issues before that final
stage was reached. However, I agree with Asgher Mohammed: there must be a deterrent that could be used if all else has failed.

Helen Eadie: If you feel that there should be an ultimate sanction, should it be in regulations or legislation? There is a distinction and it is important for the committee to know your view.

David A M Thomson: I would favour regulation.

Kate Maclean: Why would you favour regulation rather than having something in the bill? In other evidence, we have heard of concerns that, if the definition of intervention is not in the bill, people who deliver health services will not know what ministers’ powers will be and when they will be used.

David A M Thomson: So that it would be embedded within the NHS regulations.

Mike Rumbles: Convener, is there not confusion between—

The Convener: Yes. I am looking at section 4, which lays out “the powers of intervention in case of service failure”. If members look at that section of the bill they will see that the provision to intervene is in the primary legislation.

15:15

Kate Maclean: The powers of intervention are stated in the bill, but what Helen Eadie asked about and what I am asking about is whether the definitions should be in the bill or in regulations. I understand that there is more flexibility if the definitions are in regulations, because if the definitions are in the bill it is difficult to add something, as legislation would have to be changed to do so. Is that why you think that it is better for the definitions to be in regulations rather than in the bill?

David A M Thomson: It may be appropriate for us to submit a written statement after the meeting.

Mr Davidson: It would be nice to have the Royal Pharmaceutical Society’s view on how to deal with the matter because—as many members have said—we have received evidence that people want to see what the rules are so that health professionals can get on with their job. They want there to be a clearly defined procedure before the minister steps in so that they know that intervention will not take place at the whim of any future minister—I will not blame the current one. That is the idea that is emerging from the evidence that we have received.

It would be helpful if you could clarify why you favour the regulation system, which gives the ministers total flexibility unless the whole of the Parliament is united against it; that flies in the face of what the bill is intended to do.

Mike Rumbles: The bill gives a tremendous power to Scottish ministers. The proposed new section 78A(2) states:

“The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable”.

The point that we are making is that Scottish ministers will have a very open-ended power. Should that power be narrowed down? Is that wide power suitable or should it be narrowed?

David A M Thomson: As I said, it would probably be more appropriate to submit the answer in writing.

The Convener: I presume that there have been cases when such powers have been tested, when chief executives have been dismissed or whatever and there has been a test of what has been defined as a failure. That would give us guidance. It would be interesting to receive a written response. Rather than try to amend the bill on the hoof, we will now move on.

Mr Davidson: I will move on to the proposal to dissolve local health councils and set up a new national health council. Is your organisation satisfied that a new national health council, such as the one proposed by the Executive, will be more independent than the current local health councils? I ask you to comment on the fact that the minister has suggested that the new national health council should be placed within NHS QIS. Does that create an identity problem about the individuality and independence of the new national health council?

Kenryck Lloyd Jones: There is always concern when a body is to be set up about whether it will be reflective of the communities that it is supposed to represent. It is a question of how things will be done. The Allied Health Professions Forum has not had detailed discussions on the matter, so it would be wrong of me to say that anything that I will say is reflective of its policy. However, there are general concerns that public involvement should be seen to be working. That means that the public must know who their representatives are and how they are represented rather than discover after the fact that they were represented.

Mr Davidson: Do you have any comments on the perceived independence—or not—of the new health council?

Kenryck Lloyd Jones: NHS QIS is a relatively young body. All the bodies that we are discussing have a quasi-independent role. Whether the health council is perceived as being independent depends very much on one’s initial view of quangos as a whole, rather than the situation in this particular case.
Asgher Mohammed: At LHCC level, we have always found local health councils to be very useful. They give added value to our discussions. I tend to favour the view that was expressed from Orkney and believe that the new health council should be independent. If it comes under NHS QIS, that will be like having the person who checks and the person who punishes in the same department, which is not very fair. It would seem more logical and objective for the health council to be independent.

Mr Davidson: Are you suggesting that the role of the health council should be to address patients’ requirements, whereas NHS QIS should be responsible for regulation of standards?

Asgher Mohammed: Yes. The health council should examine NHS QIS. If not, who will police the police?

The Convener: What an interesting answer. I am not saying that the others are not interesting, but that answer was quite challenging.

Shona Robison: We have heard concerns expressed that the loss of health councils will mean a loss of local representation. Do you think that the duty on health boards to ensure public involvement will in some way compensate for that loss? How do you think it will improve public consultation in practice?

Judith Catherwood: The Allied Health Professions Forum Scotland has not discussed that issue in detail, but we welcome the fact that there will be an onus on boards and organisations to include the public in discussion and to have genuine consultation. In fact, there will be more than consultation—the public will be involved in key decision making. We are not opposed to that.

I am not hugely familiar with the different systems that are proposed, but at the local level health councils bring a great deal of expertise and provide a focal point where one can usually find the right person to serve on a group. They offer the support that is necessary for people to be involved, which is important. The new organisation should give the public a voice and the necessary training. I use the word “training” in a strange sense, but people need considerable support if they are to be members of a formal organisation such as an NHS board or a working group. I hope that whatever structure is put in place gives the public that opportunity.

David A M Thomson: We must also build on the strengths of the previous structure. The benefits gained from engagement with local health councils are embedded in the new structure. Pharmacies have used the local health councils often and well and their contribution is valued extremely highly. I do not want that to be lost.

Shona Robison: One of the roles that local health councils have now and will not have in the future is advocacy. They act as advocates on behalf of patients and members of the public. Are you concerned that they will no longer have that role?

David A M Thomson: That does not give me too much direct cause for concern. The community pharmacy network in Scotland is visited by 600,000 patients on a daily basis. The network was established mostly by private money, so if we do not look after our patients, we will not have a business. There is a commercial aspect to the issue, although it relates to the health service. In a way, pharmacists act as their patients’ advocates—they look after their local patients. There is huge loyalty to pharmacies—80 per cent of people use the same pharmacy on an on-going basis.

Shona Robison: I was thinking more about the role of health councils in helping people to find their way through the health service system—whether it be to make a complaint or to find out some information. The local health councils have played a very important role with regard to advocacy in its widest sense; however, that key role will be removed from them. Would you prefer them to retain that function?

David A M Thomson: Although that is certainly a strength of the local health councils, the likes of Epilepsy Scotland also have patient support groups. Such members’ interest groups might take on some of that role instead.

Asgher Mohammed: Having public involvement at board level is an excellent step, because health care professionals sometimes forget that they serve patients. Such public involvement is a great asset that we would not want to lose. As far as making complaints is concerned, most people should know which mechanisms to use. No matter whether they are in a doctor’s surgery, pharmacy or health centre, they should find it easy to complain and know who to complain to. It does not matter whether the CHP or the health board takes on the issue, as long as patients and the public find the system open, transparent and easy to use.

As I have said, it is good to have public involvement at health board level. Indeed, we need that representation at every level, including in CHPs and health boards. Without those people, we will lose the added value that their involvement brings.

Shona Robison: I have a further question for the allied health professionals. Across your professions, have you had any experience of public involvement in shaping your own services? How could we achieve such an objective in future?
Kenryck Lloyd Jones: As an example, direct access to physiotherapy is very popular. Indeed, in surveys that we have carried out with the general public, eight or nine out of 10 people have said that they would prefer to go directly to a physiotherapist—or, to mention another area, a dietitian—rather than go via a GP. Such an approach might also save a lot of GP time. The idea is to involve the public by providing them with access to the professions.

That said, as far as complaints are concerned, we should perhaps distinguish between public and individual involvement. After all, the public in its abstract form is different from the individual, and we need different systems for those two areas.

We should remember that a patient’s involvement in his or her treatment is now very much to the fore as far as education is concerned. Therapy is not merely carried out on people—in other words, someone does not come along and perform it—but happens through consultation with the patient as an agreed procedure. In the same way, the planning and delivery of services should involve the patient community and should not be something that they simply turn up to and receive.

Judith Catherwood: Although most AHP services have tried to involve the public, doing so has been quite a challenge. However, the opportunities presented by the introduction of community health partnerships and of statutory responsibilities with regard to community planning will allow us to have an interface with the public that might not have been as readily available before. As a result, community planning and public consultation will help us in that respect.

The Convener: Section 5 puts a duty on health boards to consult the public on “the planning and development, and ... decisions of the Health Board or Special Health Board affecting the operation ... of ... services.”

Such statements are all good and grand. However, there is a difference between anecdotal consultation and rigorous and thorough consultation and I note that the explanatory notes do not mention any extra money being made available for that work. If health boards will have a duty to consult the public, can such consultation be done for nothing or at neutral cost? If not, where will the money come from to enable proper consultation exercises to be conducted? If the money is not available, such statements are simply motherhood and apple pie.

Asgher Mohammed: In Paisley, we have had public representation on the executive group, the clinical governance group and other groups. Those public representatives have been paid for their time. It is not really fair on people to expect them to do something for nothing. People give up their time, energy and effort to help, so I think that we should pay them to come. So long as the payment reflects what people are doing and how much time is involved, that is fair and we ought to fund it.

The Convener: I was thinking not only about paying people to turn up, but about funding a consultation exercise in which people would be paid to run, in a professional manner, whatever consultation procedure was being used, so that the resulting data would have some value.

Asgher Mohammed: If you want good-quality work, you have to pay for it. It is better to pay to get the quality, so that you know exactly what you are getting. There should be provision for payment to be made, but that is not reflected in the bill. I agree that there should be funding, but it is not there at present.

The Convener: Separate from delivery of front-line services?

Asgher Mohammed: Yes.

The Convener: Do other witnesses want to comment?

Judith Catherwood: I agree. Any enhancement of the current system of formal consultation will take time. It takes time to co-ordinate the process, to collate all the comments and to put them into a document that the board and others can consider. That will certainly account for a bigger part of the resource that the NHS boards will need, so there will have to be a dedicated resource. How that will be funded I have no idea, but it will take money.

Helen Eadie: I would like Judith Catherwood, and anyone else who wants to answer, to amplify the point about the challenge of public consultation. The inference that I took from what you were saying was that that is a developing area of work and that different pilot projects are being undertaken across Scotland. What pilots are you aware of and what costs might have been involved in them? In an urban or semi-rural area, who pays to transport people to such meetings? Have you come across such problems before?

Judith Catherwood: I have quite limited experience, but you will be aware that NHS QIS recently published new standards for food, fluid and nutritional care, and in Grampian, where I work, we are looking to involve the public in a focus group exercise to try to get views from them on how we could improve the service and better implement the standards. That will obviously involve money, including, as you said, money to cover people’s time and their expenses for getting to venues. We will need some help to facilitate that and somebody to pull together all the comments.
That is just a small-scale example of what could eventually be a large undertaking.

Mr McNeil: We heard evidence from Borders NHS Board that the new structures that it has put in place have eliminated duplication of jobs and cut out levels of bureaucracy, so that the board can generate funds that can be allocated to the whole area of consultation. Apart from that, are not we talking about an on-going dialogue with patients at that level, rather than just the big consultations that take place on changes in services? Are not we talking about a cultural change?

Recently, pharmacists have been communicating very effectively with their customers. People were coming to me and saying, "My community pharmacy is under threat." In the right conditions, we can communicate effectively, and at no great expense, on issues that affect individuals and their communities. I wanted to say that on the record, because I do not think that it is the committee's view that consultation should be let go because it will cost money. Consultation may cost money, but we can generate that money through the new structures that we put in place. Do you agree?

Kenyck Lloyd Jones: Very much so. As you say, the culture is changing and evolving. The emphasis is now very much on inclusivity in all aspects of service provision.

The Convener: I think that the question, however, is whether savings can be made elsewhere in the bill that would pay for any additional costs. The question is quite simple. I think that that is what Duncan McNeil was asking about.

Mr McNeil: No. I think that I have made my point. I would like a response from the panel, convener.

David A M Thomson: Any redesign exercise, which is basically what we are discussing, could be directed at saving costs. As the example relating to pharmacies shows, a communication exercise can be conducted quite effectively without costing huge amounts of public money.

Mr McNeil: That is fine.

Helen Eadie: The minister has pledged an amendment that would require health service bodies to encourage equal opportunities when they perform their statutory functions. What do you think of the proposed amendment to give health bodies a duty to encourage equal opportunities? How do you envisage that proposal’s being put into effect? You might also want to comment on the cost implications of the proposal, as equal opportunities usually do not come without costs.

Kenyck Lloyd Jones: I am sure that every health board would say that equal opportunities are at the forefront of what they do. Nevertheless, making explicit the encouragement of equal opportunities would help to focus the agenda. I think that that was mentioned earlier in another context. Such an approach can be welcomed.

I do not know what you think the additional costs might be, but it is clear that equal opportunities should not be compromised to cut corners in respect of costs. Most professions would agree that equal opportunities are paramount. Just as equal opportunities are paramount for patients, they are paramount in respect of how the health service operates.

Asgher Mohammed: I have a personal view. From what I know about the Stephen Lawrence inquiry and what is happening throughout Britain, it has been mooted that there is institutionalised racism in the NHS, the police and the judiciary. If there is, we must welcome the proposed duty in the bill and matters must then be monitored. Will there be equal opportunities in reality, or will lip service simply be paid to them?

Helen Eadie: That is an important question, but can you think of any particular examples for which the proposed duty will have cost implications? I do not want to lead the witnesses but, to be going on with, I was thinking about issues relating to race relations, languages, disability and access. Do the witnesses want to comment on such issues?

The Convener: It would be useful if the witnesses wrote to the committee about those issues, if they want to, because it is hard to be put on the spot and asked to deal comprehensively with such matters. The committee would be interested in hearing about cost implications for the witnesses’ professions, if there are any. Important points have been raised. Race as well as disability issues could be dealt with—that would be extremely useful.

Asgher Mohammed: I have not experienced such problems myself.

The Convener: We did not presume that you had, but the point was well made.

I thank the witnesses for their evidence. There will be a suspension before the minister arrives. We have a long agenda to get through.

15:38 Meeting suspended.

15:45 On resuming—
The Convener: I welcome Malcolm Chisholm, the Minister for Health and Community Care; Lorna Clark, the bill team leader; and Iain Dewar, a member of the bill team at the Scottish Executive.

Janis Hughes: Much of the detail about community health partnerships will be left to regulations and guidelines; that detail has been consulted on recently. As you may know, we have spoken to a number of witnesses during the course of our discussions on CHPs and one of the issues that have been highlighted is that the local health care co-operative set-up can be patchy in different parts of the country. We would like assurances from you that the CHPs will not replicate the patchiness and the occasional inefficiencies of the LHCC network.

The Minister for Health and Community Care (Malcolm Chisholm): That is the intention. We do not generally want structural upheaval. We want CHPs to evolve from local health care co-operatives and to build on their strength. We want to get rid of what you describe as their “patchy” nature. There are, however, some excellent LHCCs throughout Scotland. I caught bits of the previous session, when the members of the Royal Pharmaceutical Society said that they wanted guaranteed representation. We will ensure that that takes place. When LHCCs were started, that was one of the issues on which there was no guidance; it was all left to local flexibility and freedom. There are strengths in that, which we do not want to lose because the last thing that we want from CHPs is a top-down situation. We have to be careful to get the balance right between local flexibility and certain standards. Who is represented on the committee of the CHP is something that we will want to lay down in regulations.

I regard CHPs as being a key policy and a key part of the bill. When people ask me why we do not have foundation hospitals in Scotland, I tell them that we have CHPs. We have our own reform agenda, of which CHPs are one of the most exciting parts. We want to try to make the planning and delivery of health care more responsive to the needs of local populations and to develop more services in primary care settings. The most important thing is perhaps that we have a vehicle for integration with social care and specialist services. In contrast with England, our attempt to develop single-system, integrated working is the most distinctive feature of our health reform agenda. We want single systems in a decentralised context, which is where CHPs are key.

Janis Hughes: We welcome that response. The witnesses from the Allied Health Professions Forum Scotland were keen that they be represented, and they wanted specific guidelines—or regulations—about membership. You have reassured me that those will be introduced.

One of the other areas that we have touched on in our evidence taking has been coterminosity with regard to CHPs. At the moment, LHCCs by and large expect that their boundaries will change; some may become larger and others may become smaller. That may lead to much more confusion with regard to coterminosity. How are your thoughts developing on that issue?

Malcolm Chisholm: It is a big issue, not least in a constituency such as that of Janis Hughes. Work is being done by local health systems in partnership with local authorities, and there are no proposals for community health partnerships to straddle local authority areas. In certain cases, however, they will cross two health board boundaries. We probably need to make a small amendment to proposed section 4A(1) of the National Health Service (Scotland) Act 1978 to make it clear that in some cases two health boards may be introducing a scheme of establishment. That is as far as it goes. We do not expect CHPs to straddle local authority areas. We will, in principle, have coterminosity with the local authority area. However, in the larger areas, for example Glasgow, there will be several CHPs for a particular local authority area, whereas in areas where the population is smaller, such as the Borders, there may be only one CHP in each local authority area.

The Convener: I have a more technical question. When you referred to the detail of the CHPs, you talked about the pharmacists and you mentioned regulations. However, you have also referred to guidelines. I can see why there has to be flexibility but, given the statutory import of regulations as opposed to guidelines, are you talking about regulations, or are you talking about guidelines, which is much looser?

Malcolm Chisholm: That is an important question and I understand why you are interested in it. I believe that we need both statutory guidance and regulations. We want a balance between what must be prescribed and must apply in every CHP, and having a certain amount of local flexibility. The last thing that we want is an inflexible blueprint. Therefore, my present thinking is that we should have a combination of regulations and statutory guidance. However, we want the Health Committee to consider that and comment on it, as it did with the previous bill.

The Convener: That is what I am coming to. Where are the guidance and the regulations in the brewing pot?
Malcolm Chisholm: The guidance is further ahead because we sent out a consultation document that was almost like guidance in its formulation. We have had a lot of feedback on that. We want to take that on board and issue a new document in perhaps a month. It would be good if we could share that with the committee so that it could examine the document and feel part of the process. However, the new document would obviously have to be only draft guidance, because there cannot be any final guidance until the Health Committee and the Parliament have had their say. Therefore, anything that goes out now is only draft guidance. However, members will understand that boards want to get on with the development of their work in that area.

Mr McNeil: We have heard today, again, of Orkney NHS Board’s concerns about the dissolution of local health councils. The board feels strongly that it has a particularly active health council, which is regarded as the voice of the community. The RCN has likened the dissolution of health councils to throwing the baby out with the bathwater. Why have you not thought about reforming health councils rather than abolishing them?

Malcolm Chisholm: In a way, what we are doing is reforming. I noticed that you picked out only one bit of the RCN’s position. Equally, the RCN supports the creation of the Scottish health council. I believe that we will be getting the best of both worlds. We want a national organisation—the Scottish health council. The RCN and most people who responded to the consultation agree with that. However, we also want a strong local base for the health council. The reality is that some local health councils are excellent but that they work in different ways.

One of the fundamental issues about local health councils is that NHS boards appoint them. I believe that it is important to have a body that oversees public involvement and that is independent of health care providers. We do not have, and never have had, that situation. Health care providers appoint local health councils. We want to set up a body that is independent of health care providers. The fundamental principles for me are independence from health care providers and a strong local base.

Obviously, we will have wider discussions today and in the future about how we make public involvement a lot better than it has been. The creation of the Scottish health council is fundamental to public involvement, because one of the council’s key roles will be to monitor and oversee that. The committee often tells me that a particular health board’s involvement with the public has not been good. It will be the Scottish health council’s role to point out such things and to report on every service change in terms of how public consultation has been conducted. The council will give reports to the minister and if a report said that public consultation had been inadequate, it would have to be done again more appropriately. Therefore, the creation of the Scottish health council will carry forward the public consultation agenda.

I understand people’s concerns about the council having a strong local presence and that is why the local advisory councils will be a necessary and key part of the process.

Mr McNeil: Do we not run the risk of demoralising people who have expressed a continuing interest on their community’s behalf? That could particularly be the case in a place such as Orkney, which has an active, involved health council. Does your one-size-fits-all proposal not contradict what that local community wants? Is there not a risk that those people will disengage and that your proposed structures will be second best?

Malcolm Chisholm: No, because those people will have an opportunity to be represented on the local advisory councils, which will be the local presence of the Scottish health council. In many cases, they will be the ideal people to fulfil that role. When I spoke recently at the conference of the Scottish Association of Health Councils, I was positive not only about the work that the health councils had done, but about the importance of their members’ being involved—if they want to be involved—in the new organisation. We have an implementation group, which fully involves the Scottish Association of Health Councils, that is helping to work up the detail of the proposal.

The other issue that the RCN flagged up is the Scottish health council’s place within NHS Quality Improvement Scotland. I do not know whether you will ask about that separately, but I will briefly describe the thinking on that. We want the Scottish health council to have as much clout and leverage as possible, and we think that that will be enhanced by its being part of NHS Quality Improvement Scotland, but it will have special status and safeguards to ensure that it will not in any sense be under NHS Quality Improvement Scotland’s thumb; it will have its own existence within that body. It is important that the Scottish health council be tied into the quality agenda because, as I have said on more than one occasion, the starting point for improving quality is the experience of every patient who passes through the health care system. Therefore, if the Scottish health council is part of NHS Quality Improvement Scotland, that adds to the leverage and influence of patient and public involvement.

Mr McNeil: Nevertheless, in Orkney, there is a group of people who complain that they have not
been able to consult their community about the changes and who wish to continue with the present format. If we are saying that communities should be able to decide, why can we not allow them to do so?

Malcolm Chisholm: I do not know—

Mr McNeil: When you talk to centralised bodies, which is the level at which you deal, what sort of dialogue do you find has taken place with those communities in which there is active consultation? I agree that, from the point of view of consultation, not all the health councils operate at the highest level and serve their communities effectively. In Scotland, all the best goalkeepers are dead goalkeepers, and we might be dealing with some mythology about how effective health councils are, but we have repeatedly had evidence of best-practice examples of health council members serving their communities and wishing to continue on that basis. At what appropriate level have we engaged those people to give them the opportunity to continue that service?

Malcolm Chisholm: They will still be able to do that. An important part of what we are saying is that there should be local advisory councils, but the Scottish Association of Health Councils, the RCN and nearly everybody else who responded to the consultation supported the creation of a Scottish health council. It has to have strong local roots and have local advisory councils, but people recognise that, over the years, the fact that the system applies differently in different areas has weakened, rather than strengthened, the system. The proposal gives a bigger prominence to the health council and flags up the importance of public involvement. We cannot have bodies monitoring such involvement if there are different standards in different parts of Scotland. We must have a clear national organisation with national standards, but it must have local councils as well. We are proposing the combination of a national organisation with local roots. I repeat that that was supported overwhelmingly in the consultation and that it was supported by the Scottish Association of Health Councils and the RCN.

The Convener: I make no comment. Does Shona Robison want to come in on this topic?

Shona Robison: I will come in now; I did not want to cut across the next question.

I have listened to what you have said, minister, and I do not particularly disagree with any of it, although we could perhaps debate how independent NHS QIS is—we will come to that in a few minutes—but I still do not understand why you feel that it is necessary to remove the key role of patient advocacy from the local health councils. Would it not be possible to have the structure that you suggest but still leave that important role at a local level? I have spoken to some of those who heard your speech at the conference, and they consider patient advocacy to be an important element of their work; it is the interface with patients and the public which, if you like, helps them through the system. I do not understand the thinking behind your belief that it is necessary to remove that role.

16:00

Malcolm Chisholm: You have given an interesting example, because some health councils have that role and others do not. Similarly, some health councils help with complaints and others do not. We have invested more in advocacy over the past two years than has ever been invested by anyone and we are building up independent local advocacy services. The role of the health council will be to monitor such services and to ensure that they are available. In a sense, that represents part of the shift in the role of health councils, which will ensure that processes are in place for public involvement, advocacy and complaints, rather than deliver everything themselves.

We can consider the matter in another way. In the past, you might say that the local health council substituted for the public. We are saying that we do not want a small group of people to speak on behalf of the public; we want much wider public involvement and we want there to be a group that ensures that such involvement happens, monitors it and does something about problems—or draws them to the attention of people who can do something about them.

That is not to say that the local health advisory council cannot speak for patients where that is appropriate—for example, if no other group can do so. I can provide you with a copy of a letter that I wrote to the Glasgow health council to clarify that point when it raised it with me and in the newspapers. We are not saying that local health advisory councils cannot have that role, but we do not want a model in which they do everything for the public; we want there to be wider public involvement, which the councils support and monitor, so that the public involvement agenda is much bigger than it has been in the past.

Shona Robison: I understand the logic of your thinking, but the issues that the Glasgow health council raised are interesting. You have begun to soften your position in relation to advocacy, as it appears that you are saying that if a local health advisory council so wishes, it will be able to continue to perform an advocacy role. That is interesting, because I think that, up to now, the assumption has been that that role will not remain with local councils. However, you are saying that there will be flexibility.
Malcolm Chisholm: That was the position in the original consultation document. I cannot read out the whole letter that I wrote to the Glasgow health council, but I will read out the relevant sentence, which basically repeats what was in the consultation document. The letter says:

“Where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.”

So the health council can have that role, although that is not its primary function.

Shona Robison: However, my first response to that is to ask who will define “adequately” and decide whether there has been adequate consultation or an appropriate group to speak for the patient.

Malcolm Chisholm: The Scottish health council will decide, as it says in the letter.

Shona Robison: So the Scottish health council will make that decision, but I can see that there might be problems—

Malcolm Chisholm: It will not be me who makes that decision.

Mike Rumbles: I want to pursue the matter. You have made it clear that the Scottish health council will monitor public involvement. Section 5, on public involvement, says that the health board must ensure that the people who use the services—patients or the people who will become patients—

“are involved in, and consulted on—

(a) the planning and development, and
(b) decisions of the Health Board”.

Consultation is quite separate from involvement and I am still unclear as to how you envisage that the health boards will fulfill their obligations under the bill to involve patients—and not just by consultation—in the decisions that are made by health boards.

Malcolm Chisholm: Involvement and consultation are the key words and perhaps they serve to summarise the big change—from consultation to involvement—that we are in the middle of. We all know that in the past, consultation meant end-stage consultation, whereas now we require involvement at a much earlier stage, including consultation during the process of coming up with options as well as consultation on what in the past might well have been a single option that had already been put forward.

Obviously, people are still dissatisfied with how consultation is carried out in many cases. The new draft guidance that was produced last year is still being revised and we need to have final guidance on how boards consult. Along with the guidance, we have run a programme of support for boards, which is what much of the patient focus and public involvement initiative has concentrated on. Some of the money for that initiative has been spent on working with boards to get them to improve consultation. We all, including the boards, accept that a steep learning curve is involved. The aim is to involve people at an early stage and not simply to consult at the end of the process; it is also to involve people on a wider range of issues than has been the case in the past.

Mike Rumbles: I want to pursue the point, although I understand and agree entirely with what you have said. The bill states that people should be “involved in … decisions of the Health Board”, which means involvement before decisions are made. However, I am trying to get you to tell us your view of how health boards will actually do that.

Malcolm Chisholm: That would require a detailed answer and, if I gave you a blueprint, you might not be happy. The public involvement team has produced a toolkit—a large document with a range of methods that boards can employ to engage with communities in ways in which they have not engaged in the past. That means not only using methods such as big formal public meetings. The document mentions different kinds of opinion panels and groups and a range of other options. The aim is to reach a wider range of people in new ways. We should not prescribe from the centre that boards should do A, B and C; we must be a wee bit more flexible than that.

The role of the Scottish health council is important. It is better to give boards a bit of flexibility and to have an independent body to consider whether the systems are adequate, rather than to over-prescribe from the centre by telling boards to carry out procedures A, B and C. That is our thinking.

The Convener: I want to clarify one point. You said that the Scottish health council will monitor what is done on the ground locally. That is fine because practices are not standardised at the moment. However, the policy memorandum states:

“The role of the Scottish Health Council will be to provide leadership in securing greater public involvement”.

That is a top-down role rather than simply a monitoring role. My concern is that the flexibility that ought to exist locally, given that standards must be met, will not exist and that systems will be imposed from above. Let us leave aside Quality Improvement Scotland at present. My problem with the language is that monitoring is perfectly laudable, but the top-down role is not.
Malcolm Chisholm: Which section of the policy memorandum was the quote from?

The Convener: Please excuse me, I have a sore throat. I have a legitimate lozenge in my mouth, not a Smartie. I am at paragraph 42 on page 10 of the memorandum.

Malcolm Chisholm: Right. The issue of the balance between national standards and local flexibility comes across in many topics. I do not have a problem with a body that is independent of me, and which has expertise in public involvement, providing leadership in securing greater public involvement. The council will not impose a blueprint, but it will ensure that the kind of failures of which the committee is aware will not happen any more. It is admirable that there should be a body that provides leadership and supports boards and others to carry out consultation better, which monitors the way in which they do so and which ensures that feedback from patients and the public, which is important, is received. I do not have a problem with that kind of leadership.

The Convener: With respect, minister, you used and continue to use the word “monitor”, but the policy memorandum does not say anything about monitoring. I do not have a difficulty with monitoring.

Malcolm Chisholm: Monitoring is part of the role. You flagged up the word “leadership”, which I do not have a problem with. Monitoring is part of a wider role that can be described generally as providing leadership and ensuring that things are done better than they have been done in the past. Monitoring is one way of describing the role, but it is not an exhaustive definition of what the Scottish health council will do; it is the bit that was relevant to what we were talking about a moment ago. A national body that provides leadership is a good thing, as long as it has local presence and flexibility, which are important.

Mr McNeil: I want to pursue the point made by Mike Rumbles. We should welcome the ambition to involve and consult people at health board level. That is really important. However, it will also be a long-term objective. Some of the bad communication and consultation that have taken place have done serious harm to the relationship between health boards and communities. I welcome the attempt to get things back on track.

We have discussed with others who have given evidence the expectation that involvement and consultation give to communities. In the longer-term planning of health boards—their priorities over a five or 10-year period—it is very important to get that right. Is there a case for suspending consultation programmes and ideas when services are facing radical change or are in crisis? My experience—which is shared by many—is that when we say that we will hold a consultation about a radical change to a service we create a false expectation in a community. We are being less than honest with that community. If radical change to a service in an area is necessary, is there not a case for being honest with the community and presenting proposals to it for debate, rather than giving the notion that consultation is taking place on two, three or four options? Honesty is vital in this process.

Malcolm Chisholm: That is an interesting suggestion. If we could produce an example of a situation in which there was genuinely no alternative, we could make a case for the approach that you suggest. However, there is usually more than one option, even when radical change is thought to be necessary. I do not see why the public should not be involved not only in giving a view on the options but in formulating those options in the first place. I understand the point that you are making, if there is genuinely thought to be no alternative to one course of action. However, even in that situation there would be a strong duty on boards to ensure that they explained the issues in a far better way than they have in the past and I would not be driven to the conclusion that public involvement should be suspended.

Mr McNeil: Perhaps I did not communicate my point effectively. I was not saying that the involvement of the public should not be welcomed. However, as the minister knows, in certain health board areas across the country there are situations in which a consultation process can take one, two or three years. During that process, the services on which the health board is consulting are collapsing along the road—irrespective of the consultation. In that situation, the consultation becomes meaningless. That is different from longer-term planning. We have created an expectation in the public. If the objective of involving and consulting communities is to be successful, we need to build up from the current very low point. How can we do that if we allow situations to develop in which, week by week, consultations are seen to become meaningless and people disengage from the process as a result?

Malcolm Chisholm: From your comments, one might draw some conclusions about the length of consultations. If they are taking place over the sort of time scales that you suggest, it would seem to be appropriate for them to be held more quickly. That point can be taken on board. The other conclusion that we can draw is that we should try to deal with issues before the crisis point is reached. Argyll and Clyde NHS Board may be mentioned in other contexts today. One of the problems with the board’s previous management was that it failed for too long to address some of
the issues in the area. That situation is to be avoided. There are many lessons to be learned from the situation that you describe, but I do not think—and you are not suggesting—that that should lead to a suspension of public involvement.

**Mike Rumbles:** I want to ensure that my understanding of what is before us is the same as yours. You should correct me if I am wrong, as I may be guilty of wishful thinking. The bill says that health boards must ensure that patients are "involved in" and "consulted on" the development of services. Those are two quite separate things, although they are part of the same process. The policy memorandum makes it clear that the Scottish health council will not only provide leadership but "support the development of good practice in public involvement".

That implies that the Scottish health council will have a monitoring role. Obviously, if good practice is to be spread across Scotland, the council will need to monitor what is happening.

16:15

I think that there is a second part to that process, which I want to check with you. As well as monitoring whether health boards throughout Scotland show good practice in public involvement, will the Scottish health council have a role in following up that monitoring and identification of good practice? What power will the Scottish health council have to ensure good practice in public involvement? Would the Scottish health council go back to you so that you could use your powers of intervention, or would it go directly to health boards? What process would the Scottish health council use and what power would it have?

**Malcolm Chisholm:** You are right that monitoring, which I flagged up in a particular context, is not the Scottish health council’s exclusive role. Monitoring is part of its role, but supporting development is another part, which you have emphasised. Ensuring that feedback from patients and the public not only takes place but is taken account of is perhaps the Scottish health council’s other key role.

It depends on the situation, but the Scottish health council will have a role in the most prominent controversial service changes that come into the Scottish Executive and its advice will be taken on board. It will have real teeth. As you know, at the moment consideration of whether the consultation on different service changes has been adequate has to be done by the health minister. Perhaps the most topical example of that is the questions that are being asked about the secure care unit in the west of Scotland.

Once it is set up, the Scottish health council will be the body that gives a view on all the processes that have taken place. If the Scottish health council says that the process has not been adequate, it will then be up to the minister and the Executive to take action to ensure that something is done about that. Such proposals would not be accepted if they did not get a green light from the Scottish health council.

**Dr Turner:** Will you provide us with clarification on patient advocacy and the complaint-handling role? It is important that it is easy for the person who has a problem to raise it. Will you clarify how the NHS boards will deal with that, given this flexibility? Will boards perhaps commission separately for that advocacy and complaint-handling role, as we have heard it suggested?

**Malcolm Chisholm:** Boards have already been commissioning independent advocacy services. I think that everyone would agree that there has been a big expansion of such services over the past two years. A lot of money has certainly gone into such services. That is the model that is being proposed for complaints as well.

I know that some concerns have been expressed about boards commissioning those services but the reality is that they have already been doing so for advocacy. We have taken a strong line with boards that they must commission independent advocacy organisations. Sometimes we have got into trouble because we have said that a body could not provide the service because it is not independent enough from the providers of services. If you look at the model for advocacy, you can have confidence that complaints will be handled by independent bodies.

We are saying that boards should ensure that that support is available to people. The role of the Scottish health council and the local health council bodies will be to ensure that those arrangements are working effectively. I repeat that not all health councils currently provide such support for complaints. Some do, but some do not. That is the way that the system works at the moment.

**Dr Turner:** From the health boards that use that process at present, are there any figures for the cost-effectiveness of that in comparison with the way that things were done before?

**Malcolm Chisholm:** I am not sure that cost-effectiveness is uppermost in our mind so much as the independence of the organisations and the level of the service that they provide to patients. We have put a considerable amount of money into advocacy, but the key thing is whether those bodies are independent and whether they are delivering a service to patients and service users more generally who need them. That should be the key criterion.
Dr Turner: Have you any evidence on how speedily the services operate? The patient sincerely wishes to have a result quite quickly. Does commissioning mean that cases are dealt with faster?

Malcolm Chisholm: We are in the middle of a process. I am not saying that we have all the services that we need. I am simply stating the fact that there has been a big increase in the number of independent advocacy services in the past two years. We have a lot more to do and we are saying that complaints are a new matter that has to be taken on board.

Mr Davidson: I will press you for more of a definition. You said that the advisory parts of the new Scottish health council may or may not deal with the advocacy role. You have talked a lot about establishing independent advocacy bodies, but you have not told us today or put in writing the definition of advocacy services and how that could be applied.

You suggest that the new health council will monitor those services, so I presume that what it monitors must be defined, or will it be left to develop models for use? You might recommend, or give a health board the right to establish, an advocacy service. For the sake of argument, I will mention a mental health advocacy service in Grampian that is in difficulty because of a lack of funding, of decision making and of patient expectation. I do not pick that out as a particular difficulty, but a difficulty does exist. Will we have clarity from the Health Department about what will be monitored?

Malcolm Chisholm: A range of services is involved. Advocacy is the service that is being picked out, and advocacy services basically support vulnerable people in dealing with health and social services and, in some cases, other bodies. Much work is being undertaken on advocacy. Two years ago, we produced a guide for commissioners in which we covered all the issues. Advocacy is one strand, but it might be different from the complaints procedure, although the matters could overlap. Some people with complaints might need the support of advocacy services, but others might not.

A key aspect of the patient focus and public involvement agenda is the analysis of different strands. I introduced the debate in the chamber in June partly to achieve clarity about that. Other strands are the patient agenda, patient experience, patient involvement and support for patients through advocacy and complaints procedures. The wider public involvement agenda is a citizens’ agenda and does not involve only those who are using health services. Advocacy is an important part of that, but it is by no means the only part.

Mr Davidson: I agree that the complaints procedure is slightly different, although some overlap exists. I do not argue about that. However, the Executive will give to a body that has not yet been created a role that it cannot define. That body will have to operate under some guidance. Will we have that eventually?

Malcolm Chisholm: I did not flag up advocacy services, so I am not sure how they entered the debate. To complicate matters, we have the Advocacy Safeguards Agency, which fulfils the role that has been described. Advocacy is probably the last of the matters that I would have flagged up as involving a central role for the Scottish health council, because we already have a body that monitors advocacy services. The Scottish health council will be concerned with wider public involvement, the complaints procedure and other matters. We already have a body that deals with advocacy services.

Mr Davidson: That is fine, but you suggested—we can check the Official Report—that local health councils or the new bodies could be involved in advocacy services. Will that be on a commissioning or agency basis? Who will decide?

Malcolm Chisholm: It will be interesting to check the record. I do not want to labour the point, but in the extract from the letter that I quoted, I did not use the word “advocacy”. The phrase that I used was “put forward the views expressed by the public.”

When members of the public express concern about a particular service, the local advisory council can put those views to the board. Advocacy is a slightly different concept, which refers to giving support to vulnerable people.

The Convener: We do not have the letter, but I understand that the minister has undertaken to provide the committee with a copy of it.

Mr Davidson: I am happy to wait for that clarification.

Helen Eadie: The evidence that the committee has heard indicates that there is great concern about the independence of the Scottish health council. Although the establishment of the council is welcomed, we are concerned about its inclusion within NHS QIS. Why was it decided to establish the Scottish health council in that way, as opposed to establishing it as a separate statutory body?

Malcolm Chisholm: Well—

The Convener: That was a heavy sigh, minister.

Malcolm Chisholm: That is partly because I have covered some of that question already—I got a bit ahead of myself. I am wondering how much to repeat.
As I said, it is important that the Scottish health council should be independent from health care providers—that is one reason to move away from the system of appointment by health boards. A contrary proposal, which might be the one that you put forward, is that we should set up the Scottish health council as a non-departmental public body that stands on its own. The first point is that, compared to other NDPBs, the health council will be a relatively small unit. There are certain logistical advantages in sharing support services with another body.

The more important reasons, which I have already touched on, are that we want to give the body as much clout and leverage as possible and that we see patient and public involvement as centrally connected to the quality agenda. The starting point for improving quality is the experience of every patient who goes through the health care system, so there is an intrinsic connection. In the consultation, the majority of people, although not all, welcomed that connection in principle.

The corollary of that is that we must ensure that the Scottish health council has a special status within NHS QIS and that there are safeguards for its independence within that body. We are working up the details of that with the Scottish Association of Health Councils; it is one of the key issues that the implementation group is considering.

You present an alternative scenario, in which the health council is set up as a relatively small NDPB, but we think that it is better for it to be connected to NHS QIS. As Martyn Evans said in his evidence, the reality is that NHS QIS operates as an independent body and, in that sense, I do not think that there is a problem with its independence from me. People have concerns—the RCN was concerned about how independent the health council would be within the organisation. We must ensure in the way in which we set up the council that it has its own existence within the umbrella organisation.

The Convener: My response to that is, “Why bother?” If you will have to build firewalls or moats around the council, why not just set it up separately?

Malcolm Chisholm: I always knew that that would be a major point of debate on the bill. Size is one practical reason why it would be difficult to make the council a separate body but, for me, the intrinsic connection between the patient and public agenda and quality is an important reason for connecting the council to NHS QIS. My perception is that the proposed structure will help to give the body greater clout and leverage, but I accept that there will be an interesting debate on the issue during the next few weeks.

Helen Eadie: The question is whether there will be management lines of accountability to NHS QIS; the answer to that will signal whether the body is independent. If the Scottish health council is accountable to the chief executive of NHS QIS, that will raise an issue.

Malcolm Chisholm: Most organisations have accountabilities. NHS QIS has accountabilities to the Scottish Executive, but in my view that does not mean that it does not operate independently. The relationship between NHS QIS and me might be the same as that between the Scottish health council and NHS QIS. Such a relationship does not mean that an organisation does not have the same space, as it were, and independence within the arrangements. No doubt if we set up a Scottish health council in the way that you suggest, someone might question its independence because it was accountable to me. The same arguments might well apply in a different form. That does not mean that the council will not be independent; it means that we have to set it up in such a way that it is given its own space.

16:30

Helen Eadie: I inferred from what you said—I cannot remember the precise words that you used—that the Scottish health council is to be included in NHS QIS because of its scale and because of accommodation issues, for example. Is that what you were driving at?

Malcolm Chisholm: That was the first reason that I gave. I said that that was not the most important reason, but that it was a factor. The Scottish health council will be a relatively small body in comparison to some NDPBs. In other situations we are attacked in the Parliament for having too many NDPBs, so it will be interesting if the Health Committee proposes a new one, but that is your right if that is what you want to do.

The Convener: I do not think that threatening us with that gets you out of it.

Perception is also an issue. You have rightly talked about the reality of the management line, but perception is often more important than reality. The perception seems to be that the new Scottish health council will not be independent.

Malcolm Chisholm: I am not sure which bit of the perception you are talking about. I have not read all the evidence that the committee has received, but Martyn Evans said that, although that is the perception, it is not the reality.

What are people frightened about? Is it such a bad thing in principle for the Scottish health council to be part of the body that is spearheading all the new work that is being done on the quality agenda, which is one of the most significant
advances in health care in recent times? Is it a problem that the Scottish health council will be part of such an organisation or is it a problem that it will be part of an organisation that has “NHS” in its title? To be honest, I do not know what the problem is.

The Convener: If you read the evidence that the committee has heard, that will give you guidance on that point. Many witnesses have raised the issue with us.

Helen Eadie: The issue has been raised by all the witnesses. People in informed circles have told me that they distinguish between quangos that have a budget to spend on front-line service delivery on behalf of the public, using public money, and other quangos. The issue is the extent to which an organisation should be an independent body. That sets hares running because one encounters issues of accountability—to whom should the independent body be accountable? The debate is bigger than can be covered by the quick response that we have received today.

The Convener: Yes, I think that it is.

I am conscious of time, so we will move on to questions from David Davidson.

Mr Davidson: I will try to be helpful to the minister and ask some fairly simple questions.

This afternoon, minister, you have told us about new roles that the Scottish health council will have. You have talked about consultations to the new advisory councils and you have talked about leadership, which has not yet been defined. You have also talked about monitoring and consultation. Those are all serious roles. When the Scottish Association of Health Councils gave evidence, it said that delivery was impossible—the word “impossible” is probably mine, before anybody criticises me—for the currently proposed £2.1 million because of the new roles that are being given to the health council and the need for the council to become a much more cohesive and professional organisation. Do you agree that the Scottish health council can do the job that you want it to do for £2.1 million? If not, what sum of money should it get?

Malcolm Chisholm: The implementation group is discussing many of those issues. I am sure that you agree that £2.1 million is a lot of money. Obviously, over time no wall is drawn around the sum of £2.1 million, but it is more than enough to set up the body and to get the show on the road. We must be mindful of the fact that that figure is not the sum total of the money that goes into the work on patient focus and public involvement—the figure of £14 million has been mentioned before for the work that has gone specifically into that initiative. It may well be that some of that money can supplement the £2.1 million. No one is saying that that is necessarily the end of the road, but I think that the sum is quite sufficient to set up the body.

Mr Davidson: Before the bill goes through the Parliament, could you give us a hint about what you think the budget that the Scottish health council needs to work to should be? It would not necessarily be able to deliver on that in the first year, while it is growing, as there may be front-end costs.

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

Mr Davidson: I want to move to another question on money. Will you outline any work that the Executive has done to reach the conclusion that the bill will not result in any net additional expenditure? Has the Executive made separate calculations of the savings and additional costs that the bill will produce in each of the affected departments?

Malcolm Chisholm: In general terms, we recognise that there will be costs and savings. The fundamental point that the financial memorandum makes is that the bill will not result in any expenditure beyond that which has been announced. For example, there is a new duty to improve health, but of course we have already announced the provision of large sums of money to increase the health improvement budget. The point of that is to spend the existing money more effectively.

There are some methodological difficulties, because it is not possible to be precise about the financial effect of the abolition of trusts, for example. We have used the figure from Dumfries and Galloway NHS Board, which I know has been used in committee, because that process has happened there—that has given the concrete figure of £500,000 over three years. Given that most boards have not been through that process yet, it is difficult to arrive at such concrete figures. However, we can say with confidence that abolishing trusts will certainly not cost more and will save some money, because of the rationalisation of various functions.

The situation is different in each case. On community health partnerships, there will be two main expenditures—those related to the provision of services and those associated with the
management of CHPs. Although most of the management costs already exist within the LHCCs and primary care trusts, the provision of service costs are subject to the much wider budgets relating to boards and service development.

We could go on to consider each of the different areas. I suppose that the power of intervention has been the most controversial in previous evidence-taking sessions. We were asked specifically to give a figure for that, but we did not think that that would be easy to do, as the situation would be different in each case. We used the example of Tayside NHS Board—that is how the figure of £85,000 was arrived at—but, if one were to base the calculation on the intervention in Argyll and Clyde last year, the figure would be higher than that. On the other hand, if one was to imagine what would have happened if the scenario that arose at the Beatson oncology centre two years ago had been dealt with under the power of intervention, the figure would have been less than £85,000. The figure is different in different cases.

As I said, there are some methodological difficulties with estimating the bill’s costs and savings, but we can go on doing the work and developing the figures as more information becomes available.

**Mr Davidson:** Will you share with us the financial assumptions that your department worked on and that resulted in the present state of the financial memorandum?

**Malcolm Chisholm:** As I have said, the financial memorandum was basically saying that the bill would not result in any expenditure beyond what had already been announced. It said that reprioritisation might be required in certain areas, so it was not ruling out the possibility that more money would be spent on particular areas, but its fundamental point was that the bill would not result in any expenditure beyond what had already been announced.

**Mr Davidson:** That is a net conclusion. Can we have the assumptions on which you have calculated where the savings and costs will come from?

**Malcolm Chisholm:** I accept that there is more work to be done on that issue, partly because new information on trusts and other areas becomes available all the time. That is something that we must keep working on. I am not claiming that the financial memorandum was ideal, but I think that some of the difficulties were the result of circumstances rather than of failings in the Health Department.

**Shona Robison:** You have already touched on the issue of additional resources for public consultation and said that £14 million was available for public involvement measures. Presumably that money is already in the system. However, will additional resources be required to meet the new duty, particularly given the staff time that will be needed to ensure that public involvement is adequate?

**Malcolm Chisholm:** We are talking about different budgets. The £14 million that you have mentioned is from the patient focus and public involvement initiative and is not included in health boards’ budgets. Instead, that money supports boards’ work, the advocacy work that we have already referred to and the fair for all initiative, which relates to ethnic minority health and is relevant to the equal opportunities provisions that we are proposing to add to the bill. Furthermore, there is the health council budget of £2.1 million that has been mentioned. Of course, as we will no doubt discuss in a moment, most of the money is with the boards—in other words, the money for the boards’ work on public involvement will be taken from their budgets, not from the budgets that I have just described.

The reality is that people are already working on those areas; the key thing is to get them to carry out that work better. Indeed, as I said earlier, much of the patient focus and public involvement initiative is about supporting boards in that respect. In most cases, the initiative is not about employing lots of new people, but about getting the people who are currently doing the work to do it better. As a result, I do not think that a fundamentally big increase in public expenditure will flow from the duty on public involvement.

**Shona Robison:** Do you accept that doing the work well might involve a wider range of staff than is currently involved? Given that the thrust behind the measure is that public involvement is everyone’s duty—not just the duty of the public involvement officer—such work might require more members of staff to become involved. Surely that will impact on available staff time. Will you monitor that situation? Moreover, given that we have all received feedback from boards about their tight budgets and the fact that they are strapped for cash, will you look at the matter again if it is proving difficult for boards to carry out the work without additional resources to free up staff time?

**Malcolm Chisholm:** I am always happy to look at things again, if necessary. However, the issue highlights the different strands of the agenda. The aspect of the agenda that will impact more on every member of health care staff is what I would describe as patient focus. Indeed, I spent most of the debate in June outlining that part of the agenda because, with the culture change in the NHS, staff are engaging with patients every day. The requirement to relate differently to patients and to take on board patients’ experiences will impact on every member of the health care team.
However, I do not think that every member of the health care team will routinely engage with the wider public as citizens. That activity will be more discrete.

As I said, patient focus is about people doing their existing jobs differently, whereas public involvement is probably more tied to specific members of staff who engage with the wider public. As those staff already exist, the issue is about ensuring that they do their job more effectively than they have in the past.

**Kate Maclean:** I have a couple of questions about the powers of intervention, the first of which is why such powers are needed and when and how they will be used. My second question centres on who will pay for those powers.

According to the evidence that we have received, everyone accepts that Scottish ministers should have the power to intervene if things go wrong, because they are accountable for the NHS in Scotland. However, people are concerned that the bill does not make it clear what is meant by intervention. Evidence that we have heard has suggested that some organisations would like intervention to be defined more clearly in the bill and we heard evidence today that other organisations would be satisfied with a definition in regulations. Can you clarify for the committee on the record when and how the powers of intervention would be used?

There seems to be no clarity about who would bear the cost of the powers of intervention. Earlier, you referred to previous evidence and to the estimate by the Scottish Executive of £85,000, which was based on ministerial intervention in Tayside NHS Board. However, we also heard that the cost of intervention in Argyll and Clyde NHS Board was £300,000. You said that the cost of intervention at the Beatson was less than £85,000, but if memory serves me correctly the Beatson had to close, which would save money.

Intervention has taken place mainly, although not solely, when a board runs into financial difficulties, as that is likely to be the first indication that there is a problem. It does not seem to be particularly fair that the board should bear the cost of that intervention. Evidence that we have heard suggests that some health boards are under the impression that the Scottish Executive will pick up the tab for intervention, whereas other boards are under the impression that they will have to do so. Can you clarify that issue?

16:45

**Malcolm Chisholm:** Intervention is envisaged very much as a last resort. There are many earlier steps that can be taken. Proposed new section 78A(2) states:

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

That is important, as it leaves open the possibility of challenge. A board could challenge a decision to intervene and there could be a judicial review, if intervention were thought not to be necessary. It is thought to be necessary only as a last resort.

On the first question, it would be very difficult in principle for us to describe in some way, either in the bill or in regulations, the situations in which intervention would arise. The bill states that intervention may take place when a body or person is failing to provide a service to a standard that is acceptable. I accept that that appears to be subjective, although any decision to intervene remains subject to challenge. I do not know how we could translate that into a description in the bill or in regulations. It would be interesting to hear suggestions, but I cannot imagine how we would do that.

Proceeding by examples is a good approach. In some ways, it is easier to use the concrete examples that we have. We were able to intervene at the Beatson and in Argyll and Clyde NHS Board because, ultimately, we secured the agreement of the relevant governing bodies to do so. Under the powers that we currently have, we could not have intervened without their agreement. That is why we need the new power. At some point, a board may say that it will not co-operate with us and that it wants to continue to provide a service itself.

I have given the examples of difficulties in the running of a cancer service and more wide-ranging difficulties in Argyll and Clyde. How would we describe those in the bill? That question defeats me. The basic idea is that intervention can take place when a service is judged to be failing. That is the right general description, because it relates to the issue about which the public are concerned. If there is a service failure in an area, under the new political arrangements in Scotland people want the centre—in the first instance, the Scottish Executive, but the Scottish Parliament could also call for intervention—to intervene. The general criterion of service failure is right, but it escapes me how we would write the details of that into the bill.

**Kate Maclean:** The second part of my question was about the cost of intervention.

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

Kate Maclean: I suspect that boards would not be envious of another board in which ministers were intervening, even if the cost of intervention were borne by the Scottish Executive.

Just for clarity, are you saying that the definition of intervention will not be in the bill or in regulations and that the cost of intervention—even if it is necessary because of severe financial problems caused by mismanagement—must still be borne by the health board, even if it amounts to £300,000 or more?

Malcolm Chisholm: We may need to clarify that, but that would have to be the formal position. As you know, we made a contribution in the case of Argyll and Clyde and I would not want to rule out that degree of flexibility. In my judgment, if we write into the bill that the costs will be borne by the Scottish Executive, that will cause more of a negative reaction, because although we might not be perceived as rewarding failure we would be seen as helping a board where there is failure. I think that that would create a negative reaction from boards that would ultimately have to bear the cost of such intervention.

The Convener: I do not know whether you intend to put that into regulations or guidance, but it would be helpful to have further thoughts from you on the costs of intervention. You seem to be saying that you will need to exercise discretion.

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

Kate Maclean: If a board is to operate without knowing when the Executive is likely to intervene, that seems to create some difficulty. I can accept that there perhaps should not be a definition in the bill, because that would not allow enough flexibility, but I cannot understand why the definition of intervention cannot be in guidance for boards. Without such definitions, how are they to know at what stage and for what reasons there will be an intervention?

Malcolm Chisholm: If members can come up with a form of words that would somehow capture what service failure is, I would be interested in hearing from them. The point is that intervention will not come like a bolt from the blue. It will happen very rarely, because a whole ladder of interventions would be used before the sort of intervention that we are now discussing would be made. Boards would know a long time before that happened, because the problems would have been flagged up.

Kate Maclean: Will that be in guidance, then? Will the stages that are reached before intervention be set out in guidance?

Malcolm Chisholm: The boards already know what the stages are, because when they get into difficulties the Executive intervenes in management support or in other areas. I do not imagine that that is something that boards do not know about already. I shall look further into the issue of guidance. Perhaps, for all I know, there is already some formal guidance. There has been a lot of guidance from the Scottish Executive Health Department over the years and I cannot say that I have read every single piece of it. However, I can certainly be confident in saying that boards know what the procedures are. As to whether those procedures are currently written down in guidance, I will have to get back to you.

Kate Maclean: Is that something that we could explore further through correspondence?

Malcolm Chisholm: We shall write to the convener.

The Convener: The policy memorandum refers to what happens at the end of the road, once you have sacked—to use a rather brutal word—a chair or other board members. The memorandum says:

“These are very much powers of last resort and have rarely, if ever, been used.”

It would be quite useful to know in what circumstances they have been used. That would give us some idea of the ultimate sanction in cases where you have had to intervene because the situation has been so bad that people have almost been suspended on the spot. I do not know about the other committee members, but that would certainly be useful for me.

Malcolm Chisholm: We can incorporate that information in our letter. It is now 26 years since the National Health Service (Scotland) Act 1978, but I am told that the most draconian power in that act—to hold an inquiry and then sack the board—has not been used.

The Convener: So, do you have to have a judicial inquiry?

Malcolm Chisholm: Part of the problem may be that the procedure is very cumbersome. That may be why it has never been used.
Mike Rumbles: I would like to pursue that point. My observation is that the definition is quite clear; it is wide and gives the minister a huge amount of power. You have just said that the power would be used as a last resort and that such interventions would happen very rarely. I take that on board and I am sure that that is the case.

However, the bill states that Scottish ministers may intervene

“where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable”.

That can be read in two ways. One way of reading it would be that intervention can take place if the minister—not anybody else—feels that it is necessary. That appears to be the objective test, according to my reading of the bill. Would not it be better to have said that Scottish ministers may intervene “where they consider it essential for the purpose of ensuring the provision of the service in question”, changing “necessary” to “essential” and leaving out

“to a standard which they regard as acceptable”?

If intervention is to be a last resort and a rare event, the provision does not need to be so all-encompassing.

Malcolm Chisholm: That is an interesting suggestion and it could give rise to an interesting amendment. I would not like to make a snap reaction to it, but I shall certainly reflect on what you have said.

The Convener: Thank you, minister. We have another short item before we go on to our private budget briefing and I know that you are coming back for that.
SUBMISSION BY ORKNEY NHS BOARD

6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

National Health Service Reform (Scotland) Bill – Inclusion of Staff Governance

Please find below supplementary evidence from NHS Orkney in relation to the inclusion of Staff Governance in the Reform (Scotland) Bill.

At the time of the submission of written evidence NHS Orkney Board members were concerned that staff governance would not be included in the Bill. However, we welcome the proposal from the Minister to lodge an amendment at Stage 2 to ensure that staff governance is included.

Staff governance forms the third component of governance combining with financial and clinical governance to complete the governance framework within which NHS Boards and Special Health Boards are required to operate. The inclusion will reinforce the parity with the other governance requirements.

NHS Orkney aims to support the creation of a culture where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the Board and is built upon partnership and collaboration. Staff Governance is a system of corporate accountability to ensure the fair and effective management of all staff. It is about monitoring NHS Orkney performance as employers. In particular the Staff Governance Committee is responsible for ensuring that the National Staff Governance Standard is met. NHS Orkney understand that there is a proposal to build on the standard by reflecting changes as NHS Scotland continues to evolve.

Effective people management is a key component in leading and supporting change in the Health Board. Ensuring we are able to recruit to meet the needs of the services, investing in knowledge and skills and providing a climate and organisational culture which promotes and encourages innovation are responsibilities of all managers. The staff governance standard reinforces this requirement and allows transparency throughout the organisation. NHS Orkney feel it is vital that staff understand the key components of the standard and how it relates to their employment within the Scottish HealthCare system and that the key components are not changed but strengthened.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

Thank you for your letter of the 9th January regarding our evidence session with the Health Committee on Tuesday 6th January. Please pass on our thanks to the Committee for the opportunity to give evidence on the NHS Reform Bill.

As you say in your letter the Committee requested some additional information from us on the following:

- the role of the pharmacy contract within the development of Community Health Partnerships;
- whether we feel definitions for the powers of intervention, including examples of the possible types of intervention, should be presented in primary or secondary legislation;

I understand that the Scottish Pharmaceutical General Council have already responded regarding the pharmacy contract. As this is their area of expertise and responsibility I feel that no further comment is required on this particular item.

Regarding the powers of intervention, the Society believe the powers should be defined more clearly to ensure that intervention is clearly the last resort irrespective of whether this is detailed in primary or secondary legislation. We also want to make the point that if local governance procedures are to be effective and if local communities and health professionals are to take responsibility for the NHS services in their area it should be clear that central power is seen to be kept to a minimum.

Thank you again for the opportunity to give evidence and do not hesitate to contact me if you require further information on this or any other matter in which you believe the Society could be of assistance.
6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

I am writing following the meeting of the Health Committee held on 6 January 2004 at which there was a request for information on the role of the pharmacy contract within the context of development of Community Health Partnerships.

The Scottish Pharmaceutical General Council represents Scotland’s 1150 community pharmacy contractors. We negotiate on their behalf with the Scottish Executive on the terms of service and remuneration for contractors’ NHS work. Currently SPGC is negotiating with the Scottish Executive on the proposed new contract for community pharmacy.

Negotiations on the new Scottish community pharmacy contract are still at an early stage. The aim of the new contract will be to deliver the Scottish Executive’s policies for the future provision of community pharmacy services as described in the Scottish Executive’s February 2002 publication, ‘The Right Medicine - A Strategy for Pharmaceutical Care in Scotland’.

The contract will be a national agreement, thereby avoiding creation of ‘postcode services’. We anticipate, however, that CHPs will have a responsibility for co-ordinating a small number of local services, such as pharmaceutical advice to nursing homes and out-of-hours provision.

SPGC does not anticipate that the new pharmacy contract will have a significant impact on the development of CHPs. However, in our submission to the Scottish Executive’s consultation on CHPs, SPGC made the following points which may be of interest to the Health Committee:

It will be vital that the CHPs be fully aware of all service developments within primary care. CHPs, in seeking to deliver local healthcare services, must take cognisance of what is already happening within individual professions and work to integrate these services within the overall local provision to ensure that services are provided with no unnecessary duplication of effort and waste of resource.

There will be opportunities for specific local benefits if CHPs give community pharmacy the opportunity to work in partnership with other primary care professionals and local stakeholders to deliver agreed healthcare messages. Such participation we see as an enhancement of the nationally agreed role.

There will be a need for CHPs to keep abreast of any agreements made nationally and in turn to feed back information on the success of such initiatives.

We assume the role of CHPs will lie in co-ordinating pharmacy’s contribution to local service provision overall.

I hope that this information is helpful to the Health Committee in its deliberations on the NHS Reform (Scotland) Bill.
Letter from Malcolm Chisholm MSP to Greater Glasgow Health Council

Many thanks for your letter of 13 October which raises issues around my address to the Scottish Association of Health Councils Annual Conference on 26 September.

The support and guidance from the Health Council movement has been very valuable to the development of the proposals for the new public involvement structure and the considerations of the detail of the new structure and its implementation. As you will be aware, a Steering Group has been established to advise the Implementation Team and many of the issues that you raise will be discussed on 21 November at the first meeting. As a member of the Scottish Association of Health Councils your health council will, of course, be kept up-to-date with developments.

You ask for clarity around 2 specific questions which I am happy to offer as far as possible at present. First, you ask about whether, in some circumstances, the Scottish Health Council may speak on behalf of patients. Our proposals are based on the premise that the NHS Boards will be successfully engaging with the patients and the public. This will be a duty placed upon them by the Reform Bill which will be underpinned by revised guidance on Informing, Engaging, and Consulting with Patients, Carers and the Public. Where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.

Secondly, you ask about the statutory rights and duties currently carried out by the health councils. This is an area that will be considered by the Steering Group and the Implementation Team. However, as you note, the consultation paper commits us to ensuring that all of the functions currently carried out by health councils continue, although not necessarily by the Scottish Health Council. It is important to reiterate that the new structure will not restrict Scottish Health Council access to information or opportunities for them to engage with the public, rather it will establish measures for them to ensure that NHS Boards develop effective and sustainable methods for consulting with and involving the public.

I do appreciate the concerns which exist in the health council movement during this period of relative uncertainty and will ensure that the information on progress from the Implementation Team is made available to all those that are interested. I am confident that the outcomes of the new structure will deliver better patient-focussed care and the increased involvement of the public in the design and implementation of health policies. All health councils will have a crucial role in ensuring the success of this and I hope that you and your colleagues look forward to this challenge.

Thank you again for your comments: they are very welcome.
SUBMISSION BY THE SCOTTISH EXECUTIVE

6 January (1st Meeting, Session 2 (2004)), Supplementary Written Evidence

Many thanks for giving me the opportunity on 6th January to give evidence to the Health Committee on the NHS Reform Bill: a piece of legislation which I believe will help to deliver improved health to the people of Scotland and better integrated health services that are more responsive to the needs of patients and communities.

At the Committee meeting, I undertook to get back to you on a couple of issues.

Public Involvement and the role of the Scottish Health Council

I have already sent to you a copy of the letter I sent to Mrs Patricia Bryson of Greater Glasgow Health Council, which helps to clarify the role of the Scottish Health Council. The Scottish Health Council will have three main functions, as outlined in the consultation paper A New Public Involvement Structure for NHSScotland: Proposals. These are:

- Assessment: to play a central role in the annual accountability review process, by ensuring that NHS Boards are discharging their duties in relation to monitoring the patient experience and to patient and public involvement;
- Development: to provide a critical mass of expertise and experience available to organisations representing the interests of service users and the public throughout Scotland, and to help develop and spread good practice in public involvement in the NHS;
- Feedback: to ensure that arrangements are in place to ensure that patients or carers who have views about their health services that they wish to express have the opportunity and, where necessary, the support to do so.

There are many ways in which individuals and the public can express their views of health services. The Scottish Health Council will support patients and carers in expressing these views and ensure arrangements are in place to support individual patient and carer feedback. NHS providers are mainly responsible for ensuring the views of the public are sought and listened to, and we will also expect them to ensure there is support for patients and carers in expressing views. The key role of the Scottish Health Council, as I explained, will be to monitor and quality assure these arrangements. As the letter states, however, where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public.

There is also an important role for the public partnership forums that will form part of the development of Community Health Partnerships. It is currently envisaged that places will be reserved on the CHP committee for members of the public partnership forum, who will be responsible for representing the wide range of public opinion. We see the public partnership forums as being able to represent a range of views and groups at local level, and they will have a major task to ensure that health services are responsive and in touch with the needs of the public locally.

As we established at the committee meeting, it is important to differentiate between expressing and advocating the views of the public (which will be done by individual members of the public, interest groups, community groups, community planning mechanisms and public partnership forums) and advocacy services which aim to support people in making informed choices about, and remaining in control of, their own health care. Traditionally advocacy has been mainly available to vulnerable groups, such as people with mental health problems, learning difficulties or physical disabilities, and older people. But it should also be available more widely to all health service users where this is needed.
Power of intervention

The committee also asked about the proposed new power of intervention, the prior steps to be taken before the power would be used, and whether guidance on these prior steps has been provided to the NHS. As I explained, the proposed new power of intervention is intended as a last resort, to be used only when other means of remedying service failure have failed or are clearly not going to work, and where the relationship between Scottish Ministers and the Health Board in question have broken down to the extent that the Board’s co-operation cannot be relied on.

Other administrative and formal measures that Scottish Ministers can use to intervene in the operation of Health Boards include:

- Asking the Health Board to produce a recovery plan with time bound actions, supported by regular monitoring meetings between the Health Department and the Health Board to check progress against the recovery plan;
- With the agreement of the Board, the Department can arrange for additional senior staff to strengthen the management team of a Health Board if, for example, a recovery plan has been produced, but is not being adhered to;
- Where control over capital or current expenditure has been inadequate, or there are serious doubts about regularity, propriety or value for money, the Department’s Accountable Officer can (in accordance with the terms of appointment) withdraw the appointment of a Board’s Chief Executive as NHS Accountable Officer;
- Terminating appointments to the Board by virtue of Regulation 5(2) of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001;
- Issuing a direction under section 2(5) of the National Health Service (Scotland) Act 1978; and
- Using the default powers under section 77 of the National Health Service (Scotland) Act 1978 and removing the entire Board.

You asked about the circumstances when Ministers had used existing formal powers of intervention. As I mentioned to you at the committee meeting, as far as the Department is aware, the section 77 default powers have never been used. The power to issue Directions to remedy service problems in a particular Board area has not been used since devolution, nor have Scottish Ministers used their formal power to terminate Board appointments. However, Ministers have on two occasions asked Health Board Chairs to consider their positions and in both cases resignations followed. One case followed what Ministers believed were serious problems relating to an important public consultation exercise; the other related to a widening financial deficit.

The proposed new power of intervention is designed to allow a quick, targeted response when a service has failed, is failing or is likely to fail and the relevant Board is unable or unwilling to cooperate with the Minister and the Department in putting the situation right. A decision to intervene would be based on clear evidence that service failure had occurred or was occurring. A range of potential failure would be covered by the proposed power. Clinical service failure could come to light, for example, through complaints from patients over poor treatment; NHS Quality Improvement Scotland reports about clinical standards not being met; whistle-blowing by members of staff; a lack of public confidence in a clinical service; a serious clinical event; or audit results showing comparatively poor or declining performance. Management failure may come to light through, for example sustained failure to meet performance targets such as waiting times; comparatively poor or declining performance demonstrated by key indicators within the performance assessment framework; poor external relationships with partners; failure to tackle strategic long-term issues; and low staff morale. Financial management failure will become apparent through large unexpected deficits and an inability to control these over time despite, for example, recovery plans being agreed and implemented. In all these examples, Scottish Ministers would have to be satisfied that the failure resulted in or was likely to result in inadequacy of a service.

Health Boards are familiar with the range of administrative interventions open to Scottish Ministers and the Health Department on Ministers’ behalf. The “escalating intervention protocol” was most recently sent to Health Boards as part of the consultation on the Performance Incentive Framework on the 18th July 2003. The protocol can be found in paragraphs 8-16 of Appendix A to the Appendix of this letter. The existing formal intervention mechanisms are set out in legislation.
I hope that this addresses all the outstanding issues that the Health Committee has raised. I look forward to reading your Stage 1 report on the Bill.

Appendix

PARTNERSHIP FOR CARE – PERFORMANCE INCENTIVE FRAMEWORK

1. Following from the White Paper “Partnership for Care”, I am writing to you to invite your comments on the development of the new Performance Incentive Framework.

2. In “Partnership for Care” it was stated that we would work with Boards to develop a new Performance Incentive Framework (PIF) in 2003. This would support good and improving performance in the NHS and balance the current escalating intervention protocol that is under review in light of the tabled Health Bill. The attached consultation paper sets out the initial thinking around the PIF and we look forward to working with you now to help shape the final version.

3. During the consultation period, we would be happy to meet and discuss any aspects of the proposed PIF with colleagues in the NHS. If you wish to arrange a meeting, you can contact Robert Kirkwood (0131-244 2556) or Andy Smith (0131-244 6918) who are leading the development. The closing date for comments on the proposals is 17 October 2003.

4. Any comments should be sent to:

Claire Flynn
Performance Management Division
Scottish Executive Health Department
2 E N
St Andrew’s House
Regent Road
EDINBURGH
EH1 3DG

Access to consultation responses

5. We will make all responses available to the public in the Scottish Executive Library 21 days after the closing date of the consultation unless confidentiality is requested.

6. All responses will be acknowledged.

Yours sincerely

JOHN ALDRIDGE
PARTNERSHIP FOR CARE

PERFORMANCE INCENTIVE FRAMEWORK

1. Scotland’s Health White Paper “Partnership for Care” published on 27 February 2003, gave a commitment to a new Performance Incentive Framework (PIF) to be developed in 2003 supporting NHS Boards who display good and/or improving performance.

Role of the Performance Incentive Framework
2. The PIF will seek offer clear and transparent incentives and will balance the escalating intervention protocol that already exists (see Appendix B).

3. This discussion paper is consistent with “Partnership for Care” as well as with “Rebuilding our NHS”, published in May 2001. These documents outlined a commitment to establishing a set of incentives to encourage good performance and act to intervene and support to turn round weak performance across NHS bodies. Also relevant to the development of the PIF is the fact that the Performance Assessment Framework (PAF) is now embedded in NHS Scotland; it provides systematic comparative performance information, which is published annually. It is broadly based, and looks at many indicators besides financial performance so we have a sound basis for assessing performance.

4. The next step is to set out and agree with the NHS appropriate and relevant incentives with which to acknowledge good performance. In doing so, we recognise that one of the most powerful acknowledgements is proper public and peer recognition of a job well done.

Operation of the Performance Incentive Framework
5. In framing proposals for incentives, we have been guided by the following principles:
   • incentives for NHS systems where things are going well or going better, in addition to support where performance is declining or weak;
   • greater clarity and predictability about when acknowledgement of success will be given and when intervention will occur, so that behaviour and performance are influenced over time;
   • acknowledgements which, wherever possible, are specific to meeting agreed targets, eg, on waiting;
   • a range of successes which can be acknowledged; and
   • the approach being open and transparent to the NHS, patients, public and other bodies.

6. It is expected that an effective PIF would have the following characteristics:
   • A balance between incentives and interventions.
   • Acknowledgement for sustained improvement in performance, not just one-year sprints that turn out to be unsustainable.
   • Takes account of where performance of individual Boards is starting from, as well as performance against Scottish averages.
   • System should be flexible enough to simultaneously deliver incentives and intervene in a Board that has areas of both good and declining performance.
   • Existing incentives/interventions are embraced by the new approach.
   • The PIF will not be purely financial.
   • It will have a high level of acceptance within the NHS.
   • It will not “penalise” the public in areas of poor or declining performance (poorly performing services already penalise the public by providing poor service – PIF should not make it worse).
   • The public should notice the difference a PIF system makes.

7. Examples of the incentives being considered are contained within Appendix A. These examples seek to build on current work and perceived good practice and create a framework around this. Over time, additional means of incentivising performance as well as additional interventions could be introduced. In the same way that the PAF changes slightly year on year the PIF could also develop to reflect changes in practice and legislation. The list at Appendix A should not be seen as exhaustive, indeed, there will be a number of areas that you may wish to see included within any final version of the PIF.
8. The actual operation of the PIF would be transparent, with clear triggers for each level of incentive or intervention. The responsibility for the use and targeting of incentives/intervention would rest with the Chief Executive of NHSScotland. While the incentives would be linked to the annual Accountability Review cycle, the intervention system is already in operation and would be invoked as and when required. The aim is to put the incentive aspects of the system into operation after the Accountability Reviews in summer 2004.

Consultation

9. The White Paper sets out that the NHS should be given appropriate incentives to encourage strong performance as well as relevant interventions when necessary. It is right, therefore, that the NHS will play a major role in the development and implementation of the PIF.

10. The closing date for comments on the proposals, as outlined in Appendix A to this paper, is 17 October 2003.

11. Any comments should be sent to:

Claire Flynn
Performance Management Division
Scottish Executive Health Department
2 E N
St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Health Department
Performance Management Division
Appendix A

1. **Individual/Group Recognition**

Public recognition and official thanks for a job well done. This would help to balance bad publicity when things go wrong. Incentives could include:

   a. Long & Good Service Award Scheme (currently under development) - rewards all staff from porters to consultants;
   
   b. "well done" visits by NHS Chief Executive and/or Health Ministers;
   
   c. plaque and/or "certificates" awarded to relevant staff;
   
   d. celebrate achievements recognised by external award giving bodies;
   
   e. media releases both national and local for the above;
   
   f. timing could be throughout the year but especially after the Accountability Review process in support of the publication of the Chief Executive’s letter to the NHS Board.

2. **Financial**

Break even for current financial year. Incentives could be:

   a. reduced detailed justification for capital schemes (already, provisionally, introduced as part of the revision of the capital allocation system;
   
   b. perhaps the flexibility around the use of specific funding allocations (eg, if allocation is made to improve discharge planning but NHS Board already has robust plans in place, then the Board should be allowed to divert these funds to another area of need).

3. **Specific Activity Performance**

Improving performance in specific selected activities (eg, waiting times, clinical outcomes). Incentives could be:

   a. reduced frequency of assessment (if annual reduce to every 2/3 years);
   
   b. reduced frequency of visits (if annual reduce to every 2/3 years);
   
   c. specific activities would not be part of Accountability Review process;
   
   d. preferential access to pilot schemes relevant to specific activity;
   
   e. preferential access to additional finance from SEHD for specific activities.

4. **Mutual Support**

A good performing Board in a specific activity helps a Board with poor or declining performance in that activity eg, by secondment and/or Task Force. Incentives could be:

   a. Department funds the good performing Boards' costs in relation to secondment/Task Force for agreed period.

5. **Dissemination of Good Practice**

A Board with good or improving performance in a specific activity disseminates the best practice to all other NHS Boards in Scotland. Incentives could be:
a. Department funds the good performing Boards' costs arising from the dissemination of best practice for one financial year.

b. Sabbaticals for individuals and the funding for back filling posts.

6. **Local Autonomy and Enhancement**

   Good performance by a Board on a number of pre-set indicators. Incentives could be:

   a. greater freedom to re-invest locally generated capital receipts (up to agreed limit).

7. The policy principle underpinning the success aspects of the system is that one of the most powerful acknowledgements is proper public and peer recognition of a job well done. This acknowledgement could be utilised frequently and regularly and would have an immediate impact. The acknowledgement will also be targeted specifically at the area of activity where sustained good performance has been identified.

8. The escalating intervention protocol detailed here is already in existence. This is targeted at addressing weaknesses in the local NHS system rather than seeking to target individuals. The Health Bill, currently being tabled in the Scottish Parliament, seeks to augment these powers by enabling timely and effective support to be given in areas where the health system is failing.

9. Currently, the escalating intervention protocol is as follows:

10. Meetings between officials from SEHD and NHS Board with SEHD providing help, advice and support with a view to resolving problems within a short, focused timescale.

11. Meetings between officials from SEHD and NHS Board lead to the production of a "recovery plan" (e.g., Grampian financial recovery plan). This plan will be closely monitored by the SEHD along with the usual complement of help, advice and support.

12. Where performance continues to be poor SEHD discusses with the NHS Board how management might be strengthened and takes the necessary action (e.g., Beatson Unit).

13. If performance continues to be poor the Department can choose to send in a Task Force to assist management (e.g., in Tayside and more recently Argyll & Clyde).

14. In addition to support/action above, the Chief Executive, NHSScotland can recommend to the Minister that he should request the Chair and non-executives of an NHS Board to seek the resignation of or dismiss the Chief Executive of the NHS Board.

15. Ministerial action can be taken to remove the Chair and/or members of an NHS Board.

16. The policy principle underpinning the support aspects of the system is that only in exceptional circumstances should action/support need to extend direct intervention by SEHD (such as using a Task Force). SEHD and NHS Boards will make every effort to resolve performance related issues with a strong presumption that early meeting between Board and Department will account for the vast majority of the necessary support/action measures.
We are pleased to offer some comments on the practical implications arising from the Bill. From an audit perspective these include the need for:

- strong governance and controls of the major budgets previously managed by trusts;
- transparency in accounting for the use of resources within the new unified boards; and
- relevant, clear and timely performance reporting.

**Transitional arrangements for the dissolution of trusts and the formation of unified health boards and community health partnerships (CHPs)**

Reorganisation presents opportunities, but risks are also involved. In the short term there are risks associated with the disruption of current management arrangements, and the transfer of services and functions. In the medium term, there are the risks that arise from new management arrangements and controls which have not been tested over time.

Specifically the following will need to be managed over the transitional phase as trusts are dissolved and unified health boards and CHPs are established:

- Keeping an open dialogue with partners and the public to ensure that their feedback is taken into account in the development of new structures;
- Ensuring that future structures are clear to planning partners and the public;
- Maintaining a proper governance framework within trusts during the transitional phase of restructuring;
- Ensuring the correct transfer of balances and assets to the unified health boards;
- Ensuring that appropriate staff responsibilities are maintained in particular areas where the separation of duties is essential for internal financial controls.

**New structures**

The unified health boards will be large complex organisations responsible for health strategy and the delivery of healthcare services. The boards will need to give a high priority to creating a sound framework of governance. If this is achieved in the early stages then the likelihood of major problems in future years is significantly reduced.

Specifically, the new bodies should:

- Ensure that board members have the right skills and training to undertake their wide-ranging roles;
- Clarify accountability arrangements and systems for performance management and reporting;
- Establish a robust risk and control framework to prevent a breakdown in core business systems, processes and controls which could lead ultimately to a failure to maintain services;
- Rationalise the key financial and operational systems to achieve efficiency gains;
- Ensure that key staff with the right skills and experience are retained or recruited to lead the new organisations and that these are designed in such a way as to achieve the most efficient management structure;
- Ensure the active involvement of local partners in the development of the new community health partnerships. This will mean that CHPs can participate fully in the development of joint services and community planning in local areas.
- Attempt to dovetail the new health structures with those of their key local partners.
Performance reporting

Best Value places a strong emphasis on continuous improvement in public services and public performance reporting. The health service is responsible for a large part of public expenditure in Scotland, and the public need assurances that this is being managed efficiently and effectively. There will need to be increased transparency in the way in which health resources are allocated and used. Over recent months we have seen a public debate about individual health boards’ priorities and the need to make difficult decisions about the best use of resources.

Health boards report to the Health Department and ultimately to Ministers. Chief Executives of health boards are Accountable Officers and as such are accountable to Parliament for the economic, efficient and effective use of resources.

The new unified health boards will need to put in place reporting mechanisms which allow Parliament and their local communities to know how they are discharging their duties in relation to:

- Matching service provision to the needs and priorities of the local population;
- Ensuring equity and access to care based on need;
- Delivering cost effective health services;
- Demonstrating continuous improvement in the quality of care provided to patients; and
- Contributing to the health improvement of their local population. This will need to be done in partnership with other agencies and has an obvious overlap with community planning under the Local Government Act.

Role of the auditor

Appointed auditors will keep a close eye on governance issues during the dissolution of trusts and in the setting up of the new structures.
SUBMISSION BY THE SCOTTISH SOCIETY FOR RHEUMATOLOGY

The Scottish Society for Rheumatology (SSR) is generally supportive of the overall direction of the National Health Service Reform (Scotland) Bill. However, we would like to respond to your request for comment on the three specific areas highlighted below:

General Principles and key provisions of the Bill

The SSR supports the general principles and key provisions of the Bill, however we would like to comment on the following specific provisions:

- The SSR supports moves which will facilitate the equitable delivery of quality services across the country and we have noted the measures to support appropriate quality standards. Both the British Society for Rheumatology (BSR) and SSR have been working closely to develop robust standards within our specialty. These will be based, in part, on evidence based guidelines such as those produced by the Scottish Intercollegiate Guideline Network (e.g. on early Rheumatoid Arthritis and Osteoporosis). We believe that the drive to ensure consistency in service delivery and equity of access to care will work to the advantage of our patients. At present, the failure to fully implement HTBS guidance on anti-TNF therapy in Rheumatoid Arthritis, for example, has led to an undesirable example of "postcode prescribing".

- The SSR supports recommendations to facilitate cross-boundary co-operation. This is consistent with our vision of how optimum rheumatology services should be delivered. In the recent Public Health Institute for Scotland Needs Assessment Report, “Rheumatoid Arthritis in Adults: Gaining Health From Effective Treatment”, for example, there is a specific recommendation that Health Boards in the North and West and Island Boards should consider planning services jointly. At present, artificial geographical barriers make this difficult to achieve.

- We welcome measures to further involve patients and public in service planning. We also support the role of professional bodies and patient groups such as Arthritis Care and National Osteoporosis Society who have a sophisticated understanding of the needs of those whom they represent. In this regard two current pieces of work being conducted by the Welsh Assembly and the Arthritis and Musculoskeletal Alliance (ARMA) may form a valuable template for service planning, namely the Welsh Assembly’s National Strategy for arthritis in Wales; and ARMA’s user-centred Standards of Care for people with musculoskeletal conditions project. We are concerned, however, as to how the dissolution of Local Health Councils fits with a desire for enhanced public consultation, as with their dissolution, a mechanism to influence the health agenda locally may be lost.

Practical implications of implementing the Bill

Our main concern regarding the implementation of the Bill is the continued distorting effect that the emphasis on current health priorities will continue to have on the Health Service in Scotland. 1 in 5 people in the UK live with arthritis, including both the young and the elderly. Musculoskeletal conditions are a major cause of physical disability in the community. Current demographic trends suggest that physical disability associated with osteoarthritis, and the need for joint replacement surgery, will increase by 66% by the year 2020. In spite of this, the absence of defined “priority status” for arthritis and other musculoskeletal conditions has led to a situation where it has become almost impossible to compete for new resource for rheumatology units, regardless of the strength of the evidence or the overall health benefit. We would therefore wish to see reassurance that the Bill’s provisions are applicable across the full range of health issues in Scotland and that where effective delivery of care is supported by the Bill, patients with arthritis and other musculoskeletal conditions do not “lose out” by being in “competition” for resource.

This response from the Scottish Society for Rheumatology relates to a specific area of Health provision. However, the area of musculoskeletal disease is of enormous importance within the overall framework of the NHS and we trust that these comments will receive due consideration.
SUBMISSION BY THE DISABILITY RIGHTS COMMISSION

Introduction

The Disability Rights Commission in Scotland welcomes the opportunity to comment on the general principles of the NHS Reform (Scotland) Bill. Access to appropriate health care, equipped to address the needs of all sections of Scottish society, is a matter of great concern to disabled people in Scotland and the DRC is anxious to ensure that that the Bill addresses these issues.

One in seven of Scotland’s population is disabled – 830,000 people. These figures cover a wide range of impairments and corresponding health needs. Disability is not a homogenous issue, nor are the needs of disabled people uniform. It is important to stress that having a disability is not the same as suffering from ill health. Disabled people are not ill, but a disabled person may have particular health priorities or require services to be delivered in a particular way. The Disability Rights Commission works to a social model of disability, which focuses not on individual impairments but on the physical and attitudinal barriers to disabled people’s full participation in society as equal citizens.

The DRC recognises that legislation has already been enacted by the Scottish Parliament to address particular aspects of the clinical needs of some disabled people in Scotland, such as the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. The NHS Reform (Scotland) Bill is however an opportunity to look in a holistic manner at how the National Health Service moves from being an illness management bureaucracy to a national health provision and promotion service which understands and can respond to the needs of an increasingly diverse Scotland, and ensure equality of treatment for all disabled people.

The DRC has been engaged with the Scottish Executive and NHS Scotland in discussions about extending the existing Fair for All provisions for black and ethnic minority (BME) communities to the field of disability. This process was initiated by the health White Paper (Partnership for Care, February 2003) which stated:

'We believe there is also a need for a more coherent approach within NHSScotland to meeting the needs of disabled people. In the European Year of Disabled People we will extend the principles set out in Fair for All across the NHS to ensure that our health services recognise and respond sensitively to the individual needs, backgrounds and circumstances of people’s lives'. (p.20)

A joint DRC/Scottish Executive/NHS Quality Improvement Scotland conference, Improving Disabled People’s Access to Health Provision, was held in Stirling on 28 February 2003, with the Minister for Health and Community Care outlining the Scottish Executive’s vision for the future of the Health Service in Scotland:

'Developing a patient focus in the delivery of health care involves a recognition of the diversity of patient needs and preferences. Clearly needs are likely to vary according to age, gender, disability, ethnicity, religion, culture and a wide range of other factors. A patient-focused health organisation will be aware of these and responsive to them.'

General Principles and Omissions

'Why couldn’t they check that I was hearing them properly? Even if I didn’t have a hearing aid, it should have been in my medical notes that I’m hard of hearing, because I’ve been to the doctor and the hearing aid clinic not that long ago. Or does each clinic only bother with the bit of you that they deal with?'

Delegate at Improving Disabled People’s Access to Health Provision

The ongoing work on Fair for All underpins the DRC’s main concern with the Bill. We are puzzled as to why, with work of such importance being undertaken by the Scottish Executive Health Department and NHS Scotland, the Policy Memorandum accompanying the Bill should describe it as equality neutral (paragraph 41, p.8: ‘The Bill’s provisions are not discriminatory on the grounds of gender, race, disability, marital status, religion or sexual orientation’). Fair for All is underpinned
by a broad equality and diversity approach and this should be reflected both in the Bill and in its accompanying documents.

To ensure that the equality and diversity values of Fair for All, which are central to a modern, patient-centred NHS, are at the heart of the new legislation, the Bill should place a statutory duty to encourage and observe equal opportunities on all public authorities covered by its provisions. Schedule 5 of the Scotland Act 1998 confers important powers of encouragement and observance of equal opportunities to the devolved Scottish institutions; such a duty on the face of the bill, far from being a hindrance or additional burden, would serve as an enabling principle, a linkage in statute between the ideals of Fair for All and the aims of the NHS Reform Bill.

Equality requirements have already been written into a number of pieces of devolved legislation, for example the Housing (Scotland) Act 2001 and the Local Government in Scotland Act 2003. There is therefore a clear precedent for such provisions and a template for the NHS Reform Bill to follow. The committee will be aware that the existing Fair for All which addresses the needs of BME communities grew out of the public duty in the Race Relations (Amendment) Act 2000 (RRAA). The Fair for All disability equality scheme should have a similar statutory footing through the NHS Reform Bill.

The argument could be made that the ongoing Fair for All work aims to go significantly beyond such a statutory duty and that such a requirement would therefore add nothing to the Bill. This line of argument could be supported by the fact that the BME Fair for All seeks to go beyond the duties of the RRAA. However, it is important that the commendable work being carried out under Fair for All is underpinned by a statutory duty. The DRC recognises and welcomes the Scottish Executive’s commitment to disability equality and in particular to ensuring that disabled people are not faced with barriers to appropriate health care. This is not however the same as placing a duty in statute on the relevant public authorities. Such a duty helps root the principles behind Fair for All and foster a culture of equality.

The ways in which statute underpins culture and values raises areas such as community care where there is an overlap between health and local authority service provision through the Joint Futures initiative. How in practice would these services work when local government is working to equal opportunities principles enshrined in statute and health is not? A statutory duty would do much to ensure that an equality culture began to permeate all relevant sections of the public sector.

Practical Implications of Putting these Provisions in Place and Consideration of Alternative Approaches

In my area the Health Board helps to fund our group [a disability forum] but they never come and ask us for help. We know most of the places to go for advice; we can point people to specific resources.

Delegate at Improving People’s Access to Health Provision

The Scottish Health Council (SHC) has the potential to be an important forum for ensuring that the health needs of disabled people are appropriately addressed. However, for the SHC to be effective in this regard disabled people must be properly represented and disability properly addressed. Tokenism must be avoided as well as the tendency to assume that any one disabled person speaks for all disabled people.

The SHC’s ability to act as a watchdog will be affected by how well it in turn is monitored and audited. The DRC would like further information on how this is to be done.

Similarly, the introduction of Community Health Partnerships (CHPs) offers opportunities to enter into greater and more meaningful dialogue with health service users than was previously the case, with the potential for better and more inclusive decisions being taken regarding the provision of frontline services. However, this will again be dependent on the quality and breadth of the consultation.
Conclusion

In summary, the DRC welcomes the general principles of the NHS Reform Bill, but believes that it must reflect the guiding principles of *Fair for All* as set out in the *Partnership for Care* White Paper. This entails a grounding of these principles in a statutory duty to encourage equal opportunities.

A statutory duty would also do much to ensure that the new structures and organisations proposed in the Bill carry with them the potential for more meaningful involvement of and engagement with disabled people in determining their own health and treatment needs.
SUBMISSION BY THE ROYAL COLLEGE OF ANAESTHETISTS

The overall aim of this bill is to reform the present organisation of the National Health Service in Scotland to produce improved efficiency and patient care. This is a worthy objective which is supported strongly by the Royal College of Anaesthetists. The additional aim of devolving decision making and resources to frontline NHS staff is also a welcome development.

The natural degree of competition which was engendered by the concept of NHS Trusts led in some cases to less efficient use of resources. It is of particular importance to consider how best to use the scarce manpower resources available now that the European Working Time Directive is acknowledged to have a considerable effect on the number of doctor-hours available for patient care. Public involvement is essential to achieve agreement on the best way to use the resources available to the NHS.

An essential requirement of improved care in the NHS is a high level of staff morale. If staff are highly motivated then they will expend considerable efforts in maintaining and improving the system: if not, it becomes progressively more difficult to maintain a high quality of care and also to effect significant change. The pressure on all frontline staff working in the health service has increased over the past years leading to a reduction in motivation. There has been too little recognition of what they have achieved in the past and it is essential to provide innovative support to the frontline staff.

The important point to re-establish is the concept that the frontline NHS staff ‘own’ the system in conjunction with, and on behalf of, the public who are their patients. Then they will be encouraged to make every effort to change for the better. Where they perceive that faceless bureaucrats are the owners, there will be less motivation to make the necessary extra effort to implement change.

Work already undertaken by NHS Quality Improvement has demonstrated the enthusiasm and dedication of NHS staff in setting and achieving the best standards of care for their patients. The proposal to empower NHS QIS to monitor and review quality standards is of major importance.

Requiring a duty of co-operation across regional boundaries is a further useful way to increase the efficiency of patient care in Scotland and is to be welcomed. Many links have developed over past years as a function of geography and the available transport routes. These links should be exploited across regional boundaries for the benefit of the health care of their populations.
The Scottish Regional Council of the Royal College of Pathologists welcomes the opportunity to comment on the NHS Reform Scotland Bill as requested in the call for evidence dated 12th September 2003.

The Scottish Council notes that the bill proposes the following measures:

- Abolishing NHS Trusts and removing statutory powers relating to or referring to NHS Trusts – the aim is to put patients’ interests first.
- Imposing a duty for Public Involvement in the NHS, giving Health Boards the primary responsibility for patient consultation on planning and redesign of services. Establishing Scottish Health Council to monitor performance and effectiveness of Boards in relation to public involvement, assisted by local advisory councils.
- Health Improvement – placing a duty on Health Boards to participate in community planning process, making health improvement a priority. Creating Ministerial power to choose how to direct funds for health improvement, removing obligations to channel funds through Health Boards.
- Enhancing existing powers of intervention for Scottish Ministers, as last resort, to ensure consistent delivery of service across the NHS to agreed clinical standards.
- Creating new performance review body, NHS Quality Improvement Scotland, to monitor and review quality standards, and to investigate serious service failures – potentially invoking new powers of intervention.
- Replacing Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs), and imposing duties on Health Boards to submit proposals for establishing CHPs to Scottish Ministers, requiring them to ‘devolve appropriate resources and responsibility for decision making to frontline staff…for the delivery of local healthcare services’ (SP Bill 4-PM p3)
- Creating statutory duty of co-operation on Health Board across regional boundaries – regionally and nationally where necessary – through series of managed clinical networks, to undertake regional planning to spend money and allocate resources throughout Scotland rather than individual Health Board Areas.

The Committee invites the views of organisations and individuals in written evidence on the following points—

Do you support the general principles of the Bill and the key provisions it sets out? Are there any omissions from the Bill that you would like to see added?

The Scottish Regional Council welcomes the key provisions in the Bill but is concerned that with the abolition of NHS Trusts there will be another major organisational upheaval in the NHS which will remove resources from the delivery of patient care rather than the stated goal of promoting high quality patient care.

The Scottish Regional Council notes the wish to promote greater public involvement in the running of the NHS and supports this proposal.

The promotion of Health Improvement programmes is to be welcomed. The proposal to create Ministerial powers to choose how to direct funds for health improvement should not normally override the due democratic processes of the Scottish Parliament.

Enhancing Ministerial powers in the area of ensuring consistency of healthcare delivery may be in the public interest as a last resort.

The creation of NHS QIS is welcomed

The creation of proposal to create CHPs is noted. The resources required to set up these partnerships must not be drawn from existing areas of patient care.
A Scotland-wide perspective on the management of the Health Service through managed clinical networks has the potential to deliver improvements in the consistency and quality of healthcare in Scotland.

*What are your views on the quality of consultation, and the implementation of key concerns?*

The Scottish Regional Council of the College is concerned about the timescale allowed for consultation (1 month) particularly as the request for comments was not sent directly to the Regional Council but to College Headquarters in London with an inevitable, be it brief delay occasioned by that roundabout consultation route.

*Have you any comment on the practical implications of putting these provisions in place and the consideration of alternative approaches?*

The proposals need to be implemented with as little disruption to the service as possible and with a view to minimising bureaucracy and resource wastage.
Introduction

T&G Scotland welcomes the opportunity to submit comments to the Scottish Parliament’s Health Committee regarding the general principles of the National Health Service Reform (Scotland) Bill.

As a union that represents members in a wide range of NHS occupations, including hospital porters, ambulance personnel, catering and cleaning staff and administration staff, the T&G has a major interest in and commitment to the development and advancement of policy in the area of Health and Community Care in Scotland. We trust that the committee will take our views on the principles and provisions of the Bill into account.

Our union notes that the main purpose of the Bill is to reform the organisation and management of the NHS in Scotland through the dissolution of NHS trusts and the integration of acute and primary care services into NHS Boards and to devolve decision making and resources to frontline staff through the establishment of Community Health partnerships.

Our union has stated on previous occasions that we would welcome legislation with the aim of ensuring the NHS is able to deliver high quality services for the Scottish people, which would, in particular:

- Abolish the internal market in the health service
- Focus health policies on patients needs
- Invest in health services and support carers
- Cut NHS bureaucracy

And

- Bring greater accountability and transparency to decision making, giving a voice to staff, patients and the public.

The need to reduce bureaucracy within the NHS through a shift from appointed bodies such as the Health Boards and NHS Trusts arrangements has, in our view, been evident for many years. The T&G has argued for a number of years that a new system involving the election of a wide range of community and staff representatives to bodies with responsibility for taking strategic local health service decisions would be the best way forward.

In light of this position, our union generally welcomes the principles of the National Health Service Reform (Scotland) Bill and we particularly welcome provisions for the dissolving of NHS Trusts with the aim of putting the patients’ interests first.

We would, however, suggest that further discussion is needed in regard to how the new Boards will be constituted, and who serves on them, to ensure constructive trade union involvement, as the representatives of workers within the NHS.

As previously stated, our union represents members in a wide range of NHS occupations and support roles ranging from porters to ambulance personnel. Despite the fact that these employees perform roles that are crucial to the smooth operation of the NHS and the maintenance of high standards, many of them are at the lower end of the NHS pay scale and their contribution does not often receive the recognition it deserves.

Much is proposed within the Bill with regards to devolving appropriate resources and responsibility for decision making to frontline staff. We therefore feel it will be necessary, in conjunction with reforming the organisation and management of the NHS, to ensure that the Scottish Executive also
commits to the development of a highly skilled and motivated NHS workforce, capable of delivering the highest possible standards of patient care, and in particular that it:

- Supports the contribution made by all members of the health care team
- Ensures fair pay and the best possible terms and conditions for all staff whether contracted to or directly employed by the NHS

And

- Invests in training and education for NHS staff.

T&G Scotland is of the firm belief that valuing NHS staff and supporting the contribution made by all members of the healthcare team should be an integral part of reforming and managing the NHS and achieving a fairer and more equitable approach to the delivery of NHS care in Scotland.

Therefore, whilst our union is generally supportive of the overall principles of the National Health Service Reform (Scotland) Bill, we hope that discussions and consultation will continue between all stakeholders and that the issues we have highlighted will be taken into consideration.
ADSW very much welcome the reforms proposed by the Bill. Whilst the main purpose of the Bill is the integration of primary and acute health care, social work is the key partner in supporting people to live in their communities.

The Joint Futures agenda has meant that social work and health are now better integrated and can secure better outcomes for older people and their carers. Social work and health have pooled resources (budgets, staff, buildings and equipment) and delegated responsibility to meet this objective. Therefore, changes to the management and accountability of health services and any new duties placed upon them will have a direct bearing on social work departments and local authorities as a whole.

Any change must improve the experience of patients and the patient journey. It is at the interface between primary and secondary care that most organisational problems arise. The Association therefore believes that the integration of these two sectors will make a positive impact on those who use health services.

The principles of the Bill

ADSW are supportive of the general principles of the Bill but would like to make comment on the following issues.

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

ADSW welcome the proposals for CHPs and are positive about the role they can play in improving accountability in the health service. However, CHPs must build upon the Joint Futures agenda and work with us to ensure that duplication and overlap does not occur. We strongly argue that existing partnership agreements should be used to develop the new structures. Diverting money and time into creating new processes should be resisted.

Because CHPs are seen as the successors to LHCCs, it may be worth examining how LHCCs have got on since they were introduced in 1997. It is our experience that their development across Scotland has been patchy. There are huge differences in the ways in which they operate currently and the level of involvement they have in managing services. ADSW appreciates the local flexibility of the model proposed but we must recognise that not everyone will start from the same place and would hope that the Bill can be shaped in such a way as to secure status and more uniformity to CHPs. We are also keen to see CHPs have equivalent standing to other parts of the NHS, such as the proposed operating divisions. Moreover, there must to be a single point of contact for decision-making.

A major stumbling block, as experienced in a number of areas, is the issue of boundaries. Where a population is not aligned there can be significant problems in trying to uniformly implement initiatives. We fully support the Executive’s clearly stated preference for co-terminosity with council boundaries and believe this should be rigorously pursued.

Creating a statutory duty of co-operation on Health Boards across regional boundaries.

We would like further clarification on these proposals and examination of what services this statutory duty would extend to.

Again, the issue of boundaries must be considered if we are serious about integration of services.
The Financial Memorandum

With regards to the Financial Memorandum that accompanies the Bill, we do not agree that the proposals are cost neutral. The costs of implementing the Joint Futures agenda – those of staff training, joint working groups, secondments, etc - were absorbed by social work and health. The changes that the Bill seeks to secure will not be effective without investment in front line staff – and this comes at a cost.

Likewise, the Bill’s commitment to public participation can only be achieved by resourcing groups and communities to do this.

The Association strongly supports the changes that the Bill will bring about but would urge that the costs be fully examined and properly funded.
General comments

RCSLT members welcome the opportunity to comment on the NHS Reform (Scotland) Bill.

Consultation around the bill has been helped by direct mailing of the Health Committee letter to RCSLT although this was initially to the London HQ. This prompted a response where as the press release did not. Smaller organisations lack the resources to continually monitor the Scottish Parliament website and so particularly welcome appropriately targeted mailings on issues of interest.

RCSLT are not clear about the accessibility of consultation to people with communication disability in Scotland but would wish to see this maximised. RCSLT members would welcome the opportunity to assist the committee with this goal. RCSLT support the general principles underlying the Bill. RCSLT have several comments regarding the provisions it sets out detailed below.

Part 1

Organisation and Operation of the National Health Service.

2 Community Health Partnerships
(5) (b) etc. and 6 (e)

RCSLT welcome the power of Ministers to regulate on matters such as membership of Community Health Partnerships and who they must consult. A key issue for SLTs throughout the health service is effective representation on service planning, implementation and monitoring bodies – such as LHCC bodies to date. SLTs (and other Allied Health Professions) are too often represented by colleagues from other disciplines who have restricted insight into the potential contribution SLTs do and / or could make to health. This leads to under utilisation of SLT skills, knowledge and experience in the delivery of health service priorities.

RCSLT believe that such regulation could introduce consistent and equitable integration of all members of the “health family” in to decision making across Scotland.

(6) (a)

SLT services are normally managed on a city or Board area wide basis. Although recognising the benefit of regulations around devolution of decision making from Board to CHP level RCSLT would anticipate problems in regulations which devolve management of services (such as SLT) down to CHP level. Fragmentation of services would inevitably affect service quality.

It is unclear if the Minister would be required to consult on regulations with stakeholders.

Co-operation

3.
RCSLT welcome this provision.

Powers of Intervention

4.
RCSLT welcome this provision but in reference to 4. (5) (a) ask how this relates to the Health Professions Council – the regulatory body for SLTs and others.

Public Involvement

5.
RCSLT strongly welcomes the statutory duty to consult with service users.

It would be helpful if the Bill was explicit regarding equitable consultation with the diverse range of service users.
SLTs are particularly interested in the effective inclusion of people with communication disability (e.g. difficulties reading, writing, communicating verbally etc. such as people who have had strokes, people with a learning disability). These service users, by virtue of their communication difficulties, are commonly excluded from consultations. They are also over represented in "hard to reach" communities and frequently suffer poor health as a direct result of their communication difficulties, e.g. mental illness.

Part 2

Promotion of Health Improvement

7 (1)

_Duty of Scottish Ministers to promote health improvement_
RCSLT welcome the explicit duty of Ministers to promote health improvement. It is assumed that "Ministers" refers to all Scottish Executive Ministers without exclusion.

7 (2)

_Duty of health boards to promote health improvement_
RCSLT also welcome this duty.
Voluntary Health Scotland - Background

Voluntary Health Scotland (VHS) is the national network of voluntary health organisations in Scotland, the first and only of its kind in the UK. VHS was launched in 2000, in response to the expressed needs of voluntary sector agencies for a strategic vision for the sector, the strengthening of voluntary-statutory sector partnerships and support for the voluntary health sector to make these things happen.

The 320 VHS members account for some 32% of the estimated voluntary health sector. Both national organisations, large and small, and locally based groups, some very broad in their scope, are represented in the VHS membership.

Over 1,000 agencies and groups in Scotland are active in working for health improvement, raising awareness of chronic and often neglected conditions, providing specialist advice and information, supporting carers and contributing to policy development. The sector:

- Employs up to 14,000 workers
- Supports 72,000 volunteers
- Has an annual turnover of £200m

The voluntary health sector works to improve health in Scotland by:

- Putting the voice of patients and local people at the centre and involving them in service development
- Promoting health and combating disadvantage
- Working across agency, sectoral and geographical boundaries
- Reaching marginalized groups
- Providing care at local primary and community level in partnership with statutory services
- Contributing to the development of health policy

These ways of addressing Scotland’s health needs place the voluntary health sector in a key position to work in partnership with NHS Boards and local authorities in Scotland.

VHS participated in the Review of Management and Decision-making in the NHS, contributing extensively to the discussions around the proposed changes to NHS Scotland in the context of the deliberations of Sub-Groups C & F. We have also prepared a paper describing the potential role of the voluntary and community sector in the development of CHPs and have submitted a response to the recent consultation on the Guidance on the proposed Community Health Partnerships.

Evidence

Does VHS support the general principles of the NHS Reform (Scotland) Bill and its key provisions? Does VHS discern any omissions?

Voluntary Health Scotland strongly supports the general principles underpinning the Bill. We welcome these in that they accord closely with the vision of health and health care developed as long ago as 1978 in the WHO Declaration of Alma Ata and incorporated into the practice of the voluntary health sector. Central to voluntary health sector belief and way of working are:

- Outcomes from service interventions must directly benefit patients and carers
- Full participation by patients, local people and communities must take place in the development of solutions to meet health needs

Weir B, for VHS - What does a Community Health Partnership mean for the voluntary sector?
• Co-operation, integration and partnership between people, services and sectors is necessary for the pursuit of health
• Care should be delivered as close to home as possible

In relation to the policy objectives and key provisions of the Bill:

**Part 1, Section 1 – Dissolution of NHS Trusts**

VHS supports the provisions to abolish NHS Trusts, in that this will remove any remaining elements of competition in health service delivery, replacing it with the collaboration and co-operation that will improve health outcomes for individuals and communities.

**Section 2 – Community Health Partnerships**

VHS supports the view that Community Health Partnerships (CHPs) offer the best opportunities for the collaboration and local co-ordination of services necessary for the improvement of health outcomes. We affirmed this in our response to the *Draft Guidance* on CHPs.

We believe that it is important that the voluntary sector is not only a key partner, but an equal partner in planning, developing and delivering joint approaches to local health and social care services. We believe that this can only be achieved where the CHP has a co-ordinating role, supported by statute.

In relation to the new Section 4A, Subsection 5 (b, c, d) therefore, we shall seek an explicit guarantee of voluntary sector membership of CHPs and of a voluntary sector role in the delivery of the designated CHP functions.

In relation to Subsection 6 (e), which refers to regulations made under Subsection 5(d), and in relation to the development of CHP functions, we shall seek robust consultation mechanisms for dialogue between CHPs and their NHS Boards to include patients, local members of the public and voluntary sector service providers.

**Section 3 – Health Boards: duty of co-operation**

VHS supports the SEHD’s policy objective of regional planning of services to meet the specialist needs of patients whilst maintaining quality of service. We also support the development of Managed Clinical Networks (MCNs). The NHS acknowledged the vital role of specialist voluntary sector agencies in MCNs at the launch conference in November 2002. Specialist voluntary organisations are already spearheading new MCNs for MS and Epilepsy, and we remind the Committee that most of the specialist voluntary health organisations have both a national and a regional presence.

In relation to the new Section 121 Subsections1 and 2(b), VHS will seek explicit inclusion of the voluntary sector under the Duty of Co-operation, and of the sector’s role as specialist service providers under the widened powers of NHS Boards to take any steps necessary to benefit specific health need throughout Scotland.

**Section 4 – Powers of intervention in case of service failure**

VHS supports the policy objective expressed in Section 4. Too often, constituent members – patients, carers, volunteers and staff – of specialist voluntary organisations report serious system failure at local level – complete lack of, or poor quality specialist service. Competing priorities and lack of resources are usually the only reason given by NHS Boards for such failures.

We believe that stronger ministerial powers are required to ensure a consistent quality of services across Scotland and that the presence of NHS Quality Improvement Scotland (NHSQIS) and the accountability mechanism embodied in the Performance assessment Framework (PAF) will support this.
VHS will continue to advocate for the voice of patients, carers and specialist voluntary organisations in the setting and monitoring of standards.

**Section 5 – Public Involvement**

VHS applauds the efforts made so far by the SEHD and by NHS Boards and Trusts and LHCCs to involve patients, carers and the public meaningfully in the modernised NHS. We note in particular the achievements of the patient Focus Public involvement (PFPI) Initiative.

VHS responded to the consultation on the proposed Scottish Health Council structure. In it, we expressed concern that under the proposed arrangements NHS Boards will now be in the position of both providing the service and acting as the voice of patients. In addition, siting the new Scottish Health Council within NHSQIS compromises its ability to maintain an objective public voice.

We are interested in the proposal for the development of local Public Partnership Fora as a mechanism for engaging with local communities. However, we are unsure as yet how these will evolve, how they will ensure fair representation and how they will link with other local structures for public involvement. The role of the voluntary sector in shaping and influencing the role of PPFs is vital.

Under new Section 2B the primary responsibility for public involvement must reside with NHS Boards, with the new Scottish Health Council (SHC) and Local Advisory Councils (LACs) providing the assessment, development and feedback functions.

Nowhere has it been made clear what the relationship between the PAF 5 (PFPI) Framework and the Scottish Health Council and local offices will be. In addition, we are unsatisfied with the PAF requirement only to monitor input from patients, the public and the voluntary sector at local level – we wish to see evidence of the outcomes of this involvement.

VHS believes that the voluntary sector is essential to public involvement in the NHS and will therefore seek explicit inclusion of the sector in the provisions laid out under new Section 2B (1) (a & b).

**Section 6 – Dissolution of Local Health Councils**

VHS recognises that this provision is required by the revised public involvement measures, but takes the view the new SHC and proposed LACs will only be able to offer more effective public involvement with the support of the voluntary sector.

**Part 2, Section 7 – Duty to promote health improvement**

Voluntary Health Scotland applauds the ongoing commitment of the Scottish Executive to promote health improvement and tackle health inequalities through the first and into the second term of the Scottish Parliament.

Many hundreds of voluntary organisations and community-based groups in Scotland work to a developmental agenda for improvement in health and reduction in health inequalities in local areas. In addition, voluntary and community groups are a significant force in three of the National Demonstration Projects and in Healthy Living Centre initiatives across Scotland. Increasingly, the sector is taking part in joint health improvement and community planning processes.

VHS therefore supports the policy objectives contained in new Sections 1A and 2A under Section 7 (1), giving Ministers and NHS Boards themselves both a duty and broader powers to improve health and to link with the community planning agenda. Ministerial powers to fund directly action to support health improvement would enable the voluntary sector to add even greater value to the agenda.

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2 Scottish Executive Health Department, Proposals for a New Public Involvement Structure for NHSScotland (2003)
Sections 1A (2) (a, b and c) and 2A (2) (a, b and c) include the giving of financial assistance to or entering into agreement with or facilitating the activities of others in the interests of furthering health improvement. In this context, VHS intends to press for greater direct investment in the voluntary health sector’s health improvement activities and fairer access to service delivery options, with costs and benefits assessed on an equitable basis. VHS will seek explicit reference to the sector’s role in community planning for health improvement.

What are the views of VHS on the quality of consultation and the implementation of key concerns?

VHS is satisfied with the quality of consultation on key areas thus far. We await results from the recent consultations on the New Public Involvement Structure for NHS Scotland and on the Guidance to Community Health Partnerships.

Voluntary Health Scotland is keen to take up the opportunity to provide oral evidence on the Bill in due course, making more detailed submission on amendments from the unique voluntary health sector position.

Does VHS have any comments on the practical implications of putting these provisions in place and the consideration of alternative approaches?

In our view, the main implementation issue arising from the Bill at this stage appears to be the hidden costs of implementation. We do not think that the process can be largely cost-neutral. The voluntary sector has most experience in the area of public involvement. The costs of effective consultation and engagement are high, in both time and human resource terms. We shall be urging the Executive to allocate sufficient resources for this.
Thank you for the opportunity to comment on this draft Bill, and for agreeing to this late submission.

As you may be aware, Optometry Scotland (OS) was established earlier this year as the single, unified representative body for the optometric profession in Scotland. OS member organisations are the Association of Optometrists (AOP), the College of Optometrists, the Federation of Ophthalmic and Dispensing Opticians (FODO), the Scottish Committee of Optometrists (SCO), and the Area Optical Committees (AOC) throughout Scotland.

In general, we are pleased to say that we are content with the thrust of the Bill as presently drafted. Our specific comments are:

- **Dissolution of NHS Service Dissolution of Trusts** - We welcome the dissolution of NHS Trusts and the establishment of the NHS Boards as we believe that a seamless, integrated care network is the most appropriate way of delivering a high quality service. Amongst other things, this should allow for better utilisation of the optometric resource in the managed care of people with eye problems.

- **Community Health Partnerships** – We consider the development of Community Health Partnerships to be a progressive step forward for patient care as it clearly allows for the development of integrated care pathways and clinical networks to facilitate the delivery of services in a new and innovative manner. Similarly the introduction of Local Care Partnerships (with local authorities) will provide improved holistic care for the public.

- **Public Involvement** – We are particularly pleased to see the emphasis given to encouraging public involvement in the delivery of health care in Scotland. We would commend you the Glasgow Integrated Eyecare Service, one important aspect of which has been the involvement of patient groups in service design and delivery.

- **Health Improvement** - OS welcomes the opportunity to participate in the planning process within CHPs. We believe that the development of this new culture where all carers work in a collaborative and cohesive manner will help fashion a framework for better integration within the NHS and amongst partner agencies and organisations.

- **NHS Quality Improvement Scotland** - OS welcomes the formation of a single quality body for health in Scotland. Optometrists have worked within some of the founding organisations such as SIGN, the HTBS and CSBS when considering the development of screening services for diabetic eye disease.

We hope these comments will prove helpful. OS would welcome the opportunity for further discussion on these and other associated topics and would be delighted to provide oral evidence to the Committee on any aspect of the profession and the delivery of eye care in Scotland should the opportunity arise.
Introduction

Sense Scotland offers a range of services for children, young people and adults who are deaf blind or who have multi-sensory impairment with additional physical, learning or communication difficulties. Our services are designed to provide continuity across age groups. We have particular experience in working with people who have additional complex health needs and work closely with families and colleagues from health, education and social work. This breadth and depth of approach to service delivery helps us take a wider perspective on the direction and implementation of new policies.

Comments

We support the main aim of the Bill, namely to abolish NHS Trusts and thereby to cut bureaucracy and improve efficiency. We have three main concerns with the proposal to establish single local health systems. These relate to the introduction of Community Health Partnerships and:

- structural change
- public participation
- CHPs and coordination.

CHPs and structural change

Section 2 notes that CHPs will replace local health care cooperatives (LHCCs), devolving management responsibility to frontline staff. We agree that local health services should meet the needs of individuals and communities and that CHPs should be designed so that they improve public involvement and local accountability.

Currently, LHCCs cover ‘natural communities’, with their size varying according to geography and population, in the range 20,000 to 150,000 people per LHCC. For example, GGHB has sixteen LHCCs, managing and delivering integrated services across defined areas. Each LHCC has, since being introduced in 1999, built up structures, staffing, relationships and working practices.

Paragraph 33 in the Financial Memorandum on CHPs notes that no additional expenditure will be incurred because there will be fewer CHPs than LHCCs. Fewer CHPs means that existing staffing structures, built up over the last four years since LHCCs were first introduced, will have to be replaced by new ones. That process will take time and introduce a period of uncertainty.

CHPs and public participation

We are not clear how the proposals will achieve improvements on participation. Fewer CHPs than LHCCs will result in less public participation and involvement, rather than bringing about any increase. The Bill does not give appropriate attention to how public participation will be improved. Section 5 of the Explanatory Notes provides a short statement on public involvement. We would have preferred to see public participation and involvement included within the section covering proposals for CHPs. As it is, neither the Bill nor the accompanying explanatory notes provides any clear understanding of what public participation will actually mean.

CHPs and co-ordination

We wish to make two points on the improvements in coordination that are expected as a result of introducing CHPs. The first is a general point, where we have concerns about what appears to be a fragmentation of initiatives on coordination. The second is a more specific point, relating to the Financial Memorandum in respect of costs on local authorities.

Sense Scotland has, over the past six years, responded to many central and local government initiatives in which proposals for improved coordination have played a major part, for example,
These and other consultations are giving rise to initiatives such as Joint Futures, Joint Management, Joint Resourcing, Single Shared Assessment, Coordinated Support Plans and so on. We believe that coordination is vital but we are concerned that not enough consideration is being given to the effect of the combination of these initiatives on frontline staff. Fragmentation is being caused by different lead agencies making proposals, on how coordination will be managed and achieved, without considering the overall effect of multiple requests for coordination.

Our more specific point relates to the Financial Memorandum covering ‘costs on local authorities and other bodies, individuals and businesses’. Paragraph 41 states:

_The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill._

In parallel with the NHS Reform Bill, the Additional Support for Learning (Scotland) Bill is, at the time of writing, about to begin its Parliamentary progress. A major strand of that Bill is that it will introduce Coordinated Support Plans (CSPs). CSPs will have an impact on services such as speech and language therapy, physiotherapy, occupational therapy, GP practices and others. Improved coordination between agencies is a priority but we are concerned that it will not happen if it is to be seen as a ‘nil cost’

The aforementioned Review of Speech and Language Therapy etc. report has confirmed that there are shortages of NHS therapists working with children and unacceptable waiting times for some children. While the funding of NHS therapists may lie out with the NHS Reform Bill proposals, the management structures within which any new staff will work will be within the remit of CHPs.

Taken together, we believe that it is optimistic to believe that there will be no additional costs on local authorities, or local authorities on CHP structures, under the proposed legislation.
Introduction

GMB Scotland welcomes the opportunity to submit comments following the call for written evidence from the Scottish Parliament’s Health Committee regarding the National Health Service Reform (Scotland) Bill.

GMB Scotland represents a broad spectrum of staff employed within the NHS and is committed to major developments and advancements in Health and Community Care Policy which are to the benefit of both Staff and members of the public.

National Health Service Reform (Scotland) Bill.

Dissolution of NHS Trusts

GMB Scotland welcomes any reform which ensures reorganisation of Trusts and changes to the management of the NHS i.e. the main focus of the Bill which ensures the following:

- The abolition of NHS Trusts
- Integration of both Acute & Primary Care Services under the auspices of NHS Boards.
- The devolution of decision making to frontline staff as a result of the establishment of Community Health Partnerships

Community Health Partnerships

GMB Scotland is supportive of legislation which encourages

- Localised service planning and delivery of care involving patients and healthcare staff
- Partnership working with Local Authorities which ensures a seamless package of care for the patient
- The delivery of a health improvement agenda which is focused on local need rather than national priorities.

Regional Planning of Health Services

GMB Scotland is encouraged by the need for co-operation between Health Boards to ensure healthcare based on patient need is delivered as effectively and efficiently as possible. This should, in theory, create an integrated NHS System across Scotland. To that end GMB Scotland would campaign for associated employer status applicable to all NHS Staff and would pursue the aim of all staff working in the NHS to become NHS Employees i.e. any remaining staff working for Private Contractors be returned to the NHS and GP Practice staff become direct employees of the newly constituted Health Boards. Associated employer status for NHS Staff would be advantageous for workforce planning and the recruitment & retention of staff within the NHS.

Public Involvement

GMB Scotland supports the need for greater public involvement to ensure quality services and the drive continuous improvement of health care provision. The emphasis however should be no greater than Trade Union/Professional Organisations involvement at Health Board Level. Both groups have an integral part to play in the development and improvement of services at local level. We believe that the Scottish Executive is committed to strong partnership working at National Level and would wish to see this transmitted to local situations.
Conclusion

The Scottish Executive is to be congratulated on its forward thinking in the modernisation of the NHS in Scotland and GMB Scotland welcome the proposals contained within the National Health Service Reform (Scotland) Bill. GMB Scotland would like to reinforce the following points:

- The integration of Acute & Primary Care NHS Trusts alongside the abolition of Trust Status creating NHS Boards and Community Health Partnerships is to be welcomed. GMB Scotland would like some reassurances on the constitution of said NHS Boards and CHPs which will include frontline staff in the decision making process.
- The need for the efficient delivery of effective healthcare at local level supported by meaningful investment based on local priorities.
- That Scotland has a “National” Health Service which has improved recruitment and retention of staff thus making headway towards an exemplar employer both in the remuneration and welfare of all Staff.
- The reduction in NHS bureaucracy resulting in reduction of wasted resources should be redirected back into Training and Development of current NHS Staff and thus investing in the NHS’s greatest asset which has been sadly lacking in recent years.

GMB Scotland is hopeful that these comments can be used in a constructive manner and would welcome any further involvement in the consultation process of the National Health Service Reform (Scotland) Bill.
Comments from NHS Borders Experience in moving to Single System Working

NHS Borders hereby submits evidence to the Scottish Parliament’s Health Committee, in particular on the proposal to dissolve NHS Trusts, thereby integrating the management of acute and primary care services into NHS Boards. The evidence is based on NHS Borders experience of moving to single system working.

In early 2002, the Board was given the opportunity to design future arrangements tailored to local circumstances which fitted with the policy direction set out in the Scottish Health Plan, Our National Health, a plan for action, a plan for change.

A key objective of the changes was to improve the coordination of care within the NHS and between the NHS, social care and other partners. A major aspect of achieving this was to remove the artificial organisational barriers which existed with two local NHS Trusts and a Health Board. The move to a single organisation opened up more opportunities to capitalise on the co-terminosity between NHS Borders, Scottish Borders council, Scottish Enterprise Borders and other agencies, especially in the joint action required to improve health and tackle health inequalities.

In addition to the structural change, great emphasis is placed on changing behaviours and relationships within the NHS and with partner organisations and this was evidenced in the consultation process. Successful implementation of an integrated health system depends, critically upon the development of new sets of behaviours, relationships and processes. Behaviours are aligned to the competencies required to deliver a more responsive and integrated service.

The Board managed the transition from the three separate NHS organisations to a single entity within the space of 15 months. Simultaneously NHS Borders remained focussed on the key deliverables for NHS Scotland.

The following are the immediate benefits of the move to a single organisation:

- Integrated planning and delivery of clinical care;
- Improved relationships across the system, with speedier decision making
- More focus for joint action between NHS and other partner organisations
- Management cost savings which have been reinvested in patient care

The involvement of the local authority in the integration project was crucial in ensuring a link with the Joint Future agenda and the wider concerted action to improve health and tackle inequalities in health.

The establishment of a single NHS organisation allowed the creation of a single set of management services supporting a single Board. Significant management cost savings were achieved and these were fully incorporated into the Board’s Local Health Plan
The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing physiotherapists, physiotherapy students and assistants. More than 98% of all physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest health care profession in the UK, and the largest of the allied health professions.

Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and other employers, such as sports clubs or large businesses. Three Scottish universities offer degrees in physiotherapy, and are among the most over-subscribed university courses in the country. Approximately 150 newly qualified physiotherapists graduate in Scotland each year.

Introduction

CSP Scotland has welcomed the broad direction of health policy outlined in the White paper Partnership for Care. The white paper proposed the removal of bureaucracy, the strengthening of local provision and the emphasis on collaboration, multidisciplinary team working and innovation and modernisation. All these proposals have been broadly welcomed by CSP Scotland, and note the degree of political consensus that has characterised Partnership for Care in Scotland. CSP Scotland continues to promote a genuinely national public health service which is both patient centred and values its staff.

The following submission will make broad comment on the proposed reforms, and then make more specific comment on the reform of community care structures and the establishment of Community Care Partnerships to replace Local Health Care Co-operatives in primary care.

Comment on Legislative Commitments

Abolishing NHS Trusts and removing statutory powers relating to or referring to NHS Trusts – the aim is to put patients’ interests first.

CSP Scotland has supported this measure. The dissolution of NHS Trusts removes the internal market structure that many health bodies, including CSP, has criticised. Ultimately it is the ‘competitive culture’ that deserves to be replaced by collaboration and choice. The abolition of NHS Trusts should also simplify services.

Imposing a duty for Public Involvement in the NHS, giving Health Boards the primary responsibility for patient consultation on planning and redesign of services.

CSP Scotland has welcomed measures to improve patient involvement, and supports the Scottish Executive aim to ensure that decisions take account of public views, and that public participation in decision making about health provision is facilitated. The duty should ensure that public involvement becomes part of the culture as well as of the new structures of NHSScotland. There is evidence to suggest that public involvement can help drive improvements in services, and public involvement may be essential for initiatives such as health promotion, where information must target the general public and be relevant to them.

Health Improvement – placing a duty on Health Boards to participate in community planning process, making health improvement a priority.

All physiotherapy has a health promotion component and chartered physiotherapists have an important role to play in improving public health and meeting national or local targets such as for
stroke, coronary heart disease and mental health. CSP Scotland strongly supports the duty placed on Health Boards to participate fully in health promotion, and believes that effective collaboration with local authorities, professional bodies and patient groups will also be necessary to improve Scotland’s health.

Creating Ministerial power to choose how to direct funds for health improvement, removing obligations to channel funds through Health Boards.

CSP Scotland is not opposed to this measure, and can see a number of advantages for service provision, provided that service fragmentation does not result.

Enhancing existing powers of intervention for Scottish Ministers, as last resort, to ensure consistent delivery of service across the NHS to agreed clinical standards.

CSP Scotland does not oppose this measure, although this power may not be necessary in view of the evidence and the existing powers of Ministers.

Creating statutory duty of co-operation on Health Board across regional boundaries – regionally and nationally where necessary

CSP Scotland supports the encouragement of co-operation between Health Boards and would go further in pointing to the benefits of collaboration and joint provision in areas where patients may seek services from the Health Board area adjacent to the area in which they live. Co-operation between Health Boards can also encourage further the culture of partnership working, and ensure that the design and delivery of services is seamless across health board areas as well as within them.

Replacing Local Health Care Co-operatives (LHCCs) with Community Health Partnerships (CHPs), and imposing duties on Health Boards to submit proposals for establishing CHPs to Scottish Ministers, requiring them to ‘devolve appropriate resources and responsibility for decision making to frontline staff…for the delivery of local healthcare services.

A significant proportion of physiotherapists work in local communities in a primary care setting and Chartered Physiotherapists are developing innovative services in primary care across Scotland. CSP Scotland members are committed to developing modern patient centred services that are flexible enough to respond to the diverse needs of different patient groups. CSP Scotland therefore has an essential interest in the future development of Community Care Partnerships (CHPs) and the following submission focuses on those aspects of the proposed legislation and guidance relevant to the practice and promotion of physiotherapy services.

NHS Reform and Community Health Partnerships

The following response has been drawn together from consultation with CSP members in Scotland surrounding the Scottish Executive consultation on Community Health Partnerships and the NHS Scotland Reform (Scotland) Bill.

Physiotherapy in the Community – Background

In order to continue to improve and expand services, CHPs must provide a clear role for physiotherapists and other allied health professions, in which their skills, expertise and contribution is recognised. The inclusion of physiotherapists in the decision making process will be vital to the success of CHPs and CSP Scotland recommends that any guidance specifically recognises the various roles played by all those in Community Care.

The role of physiotherapy is often overlooked in consultations or discussions relating to community care, but it plays a crucial role in health promotion, rehabilitation and enabling patients to maintain independence. Physiotherapy is a genuinely cradle-to-grave form of healthcare, ranging from neonatal treatments and paediatric to care of the elderly. Increasing numbers of physiotherapists are working in the community, cutting across traditional health and social care boundaries, as part of multidisciplinary teams that embrace other health professionals, social workers and others.
Community physiotherapists work with patients in their own homes, in their workplaces and in local health centres, sports centres and other community facilities. Physiotherapists have a unique range of skills and knowledge that enables them to respond to problems associated with injury, disability and illness, allowing patients to return to work or independent living, reducing the number of hospital admissions, and relieving pressure on other services.

Community physiotherapists undertake a wide range of generic and specialist treatments, and the following exemplify this work:

- **Cardiac rehabilitation**: Scotland has the second highest mortality rate from coronary heart disease (CHD) in Western Europe. Physiotherapists are key to prevention of CHD through cardiac rehabilitation programmes. This relatively inexpensive form of care has been proven to reduce mortality by at least 25%.

- **Strokes**: people in Scotland are 25% more likely to die from stroke than those in England and Wales. It is the third commonest cause of death. More than 20 research programmes have shown that integrated care involving physiotherapists and other healthcare professionals saves lives and prevents long term disability.

- **Care of older people**: falls are a major risk factor for older people, with hip fractures a common result. Half of those who sustain hip fractures are never able to walk again independently, and a quarter die within 18 months. Physiotherapy is a key tool in preventing the occurrence and recurrence of falls.

- **Musculo-skeletal care**: back pain and other musculo-skeletal conditions are responsible for the majority of working days lost every year through work-related illness. Back pain costs the NHS millions of pounds every year, and lost working days cost industry even more. Evidence shows that immediate access to physiotherapy reduces the costs of both, and speeds return to work.

- **Mental health**: physiotherapists use a number of therapies, such as massage, reflexology and acupuncture, to help people suffering from mental health problems, drug and alcohol dependencies and work-related stress.

- **Combating social exclusion**: physiotherapists work with a range of groups in society who can find it difficult to access health care through traditional means, and whose social exclusion increases their risk of ill-health. Physiotherapists have a vital role in health promotion, which also greatly benefits socially excluded groups.

All the above services must be taken account of during the strategic planning and delivery of health services in the community. If CHPs are to take on a greater strategic role, then the involvement of physiotherapists, along side other health professionals will be vital. CSP Scotland would therefore recommend that the Scottish Executive devotes resources to facilitating the full involvement of health professionals, and that this must be at the planning stage of partnership community objectives.

**The Need for Continuity**

The creation of management systems through CHP development must not lead to a break up of current systems, and must compliment or reinforce effective management.

The strategic role for CHPs must also compliment the responsibilities of Health Boards, which may also increase with the changes to Primary Medical Services. CSP Scotland has also warned against service fragmentation if health professionals were to be employed by GP practices. There can be significant problems that result from health professionals having to work in isolation, as this can substantially reduce opportunities for training and for continuing professional development.

There are also issues relating to a lack of clinical supervision and the absence of peer support where physiotherapists work in isolation. CSP Scotland seeks to encourage and promote professional collaboration and the promotion of best practice, among chartered physiotherapists as
professionals, and in the delivery of physiotherapy services. This is best achieved where health boards continue to have a co-ordinating role as the employer and the body that retains the obligations and duties. CSPs must be in a position to enhance that role and reflect the local service needs, while ensuring a comprehensive strategy remains in place for the health board region.

**Participation in Primary Care Structures**

Physiotherapists are currently key members of Local Health Care Co-operative (LHCC) teams, and can be expected to be working in CHPs, alongside medical and nursing staff, other allied health professionals, and social care services. LHCCs have become increasingly important in the delivery of primary and community care and the extension of their role, and the strengthened role for planning and delivery of services is a logical progression.

However, in many parts of Scotland, physiotherapists have found themselves excluded from the management boards of LHCCs, which are dominated by medical and nursing personnel. LHCC management boards are making vital decisions about delivery of local health services, which affect the working lives of frontline staff, but physiotherapists and other allied health professionals report often struggling to make their voices heard in the decision-making process. It is not only the development of multi-professional services but development in line with the white paper that must be considered in this context.

It should be noted that it is not only multi-professional services that must be developed, but the development of services to patients, that must be the ultimate goal. Services to patients are improved by the inclusive nature of the planning process. Greater awareness of new initiatives can be promoted, and examples include:

- Direct access to physiotherapy without the need for GP or hospital referral, reducing GP waiting times.
- Qualified physiotherapists administering steroid injections, reducing Orthopod waiting times.

Resources can be directed more efficiently and new initiatives and good practice can be spread more effectively where the decision making process involves all those that can contribute.

The whole primary and community care team must play a part in decision-making if genuinely integrated services are to be achieved, therefore it is vital that places are made for physiotherapists and other allied health professionals on all CHPs across Scotland. The development of multi-professional teams makes this progress essential. As a result, CSP Scotland proposes that all CHP Boards have a place reserved for allied health professionals.

**The Role of CHPs**

It will be vital the CHPs have a role in various developments of the evolution of health services. One area is Managed Clinical Networks (MCNs), where CHPs must have a role to play in facilitation and promoting the work of networks. It must be clear where MCNs sit in the new structures and how each will interact.

CSP Scotland welcomes the view that there will be continue to be flexibility in the shape and nature of health structures at a local level to reflect local need and the CHPs will not be developed on a ‘one size fits all approach’. Nevertheless, such flexibility must exist within clear guidance to protect minimum standards and promote good practice.

**Service Standards**

It will be important that equitable service standards are developed and maintained across health board areas. There remains a need to have a baseline for all services and outcomes, and to establish equity of service provision that can reflect and respond to differing local needs. Currently community health planning is variable across health boards and health board areas, and attention must be given to urban / rural distinctions and population pockets with specific needs.
CSP Scotland also welcome that CHPs will be accountable to Health Boards, but note that the distinction between strategic and operational functions may not be helpful in practice.

There appears to be insufficient attention in the proposals to integrated care. Service integration should not be an afterthought or an oversight, and CSP Scotland believes this feature of service design requires a much greater emphasis in the Scottish Executive proposals.

**Remaining Areas**

CSP Scotland would finally point to remaining questions that arise from the current consultation. The important question remains as to how CHPs will work with the Acute Sector. There must be some point of communication, collaboration and inclusion in decision making if integrated service provision is not to stop at the point of acute service provision.

In addition, the relationship with management levels and the local authority must be meaningful and not merely token gesture, and it is not clear how this will be achieved.

Ultimately CSP Scotland would support ‘bottom-up’ operational units to support strategic planning, but question whether this can or will be incorporated into the current proposals.

**Co-operation**

CSP Scotland supports the encouragement of co-operation between CHPs in the same area, and between Health Boards. There are clear benefits of collaboration and joint provision in areas where patients may seek services from adjacent areas in which they live.

Co-operation can also encourage further the culture of partnership working, and ensure that the design and delivery of services is seamless across within health board areas and even across them.

**Additional Resources**

The stated policy intention of the Scottish Executive to provide substantial additional resources for the development of primary care services (to accompany reform proposals) is also welcomed.

Nevertheless, CSP Scotland would seek reassurance that additional resources for primary care services are not found from reductions to other health service budgets.

**Self Referral**

One of the areas that the Society would identify as an opportunity within the current proposals is the extension of self-referral access to physiotherapy services. Physiotherapists are legally allowed to be the first point of contact for patients in the NHS, but the majority of patients still access physiotherapy via medical referral.

Evidence strongly suggests that direct access to physiotherapy in the NHS would have considerable benefits in terms of appropriate and timely referrals. A pilot study in Dundee showed a dramatic reduction of General Practitioner workload, and decreased absence from work, an increase in patient satisfaction and empowerment which demonstrates the value of direct access to physiotherapy in the NHS.

Direct access to physiotherapy is now being piloted in a number of areas in Scotland in community settings, and current indications are that this can provide genuine benefits for patients, who can seek physiotherapy services without the need for referral from a hospital or GP.

**Conclusion**

Chartered physiotherapists are committed to developing modern innovative services and CSP Scotland aims to work with all involved to deliver a genuinely national health service that is both patient centred and values its staff.
On behalf of the Scottish Dermatological Society and the Scottish Council of Dermatology, I would like to thank you for the opportunity to provide feedback on the NHS Bill.

We welcome aspects of the proposals, including Managed Clinical Networks, Clinical Leadership and Redesign and, of course, the emphasis on patient involvement (particularly those with common chronic skin ailments, such as psoriasis, dermatitis and leg ulcers).

Our main concern in secondary care provision for those with skin disease is that the new system may encourage selective development of perceived areas of priority, such as cancer and vascular disease, while squeezing future development of others, such as disabling chronic skin disease which, although non life threatening, do seriously impact on an individual's quality of life.

The dangers of prioritising one area at the expense of another are self evident. It will be important for the Community Health Partnerships to keep in mind a broad picture of specialist services. We see the membership and function of the CHPs to require clarification and underline the need for specialist service involvement within these structures.

Another matter of concern, which follows a similar theme, relates to central initiatives such as Managed Clinical Networks and Redesign, which although initially funded centrally, local Health Board funding will be essential to enable it to be sustainable. It is stated that Health Boards will be put under an obligation to support such structures after central funding has expired. In reality, existing Trusts who may have a different set of priorities, will be tempted to renge. We would like to emphasis the need for binding agreement to ensure that funding made centrally for a specific purpose is not used by the Health Boards as a subsidy for other areas.

In short, I would like to emphasise that in times of rapid change, we need to make sure that careful consideration is given to the broad picture and that systems are in place to ensure the continuity of development for the wide provision of secondary dermatology care.
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

8th Meeting, 2003 (Session 2)

Tuesday 30th September, 2003

Present:

Ms Wendy Alexander  Mr Ted Brocklebank
Fergus Ewing (Deputy Convener)  Kate Maclean
Des McNulty (Convener)  Jim Mather
Dr Elaine Murray  Jeremy Purvis
John Swinburne

Also present: Professor Arthur Midwinter (Budget Adviser).

National Health Service Reform (Scotland) Bill: The Committee took evidence on the Bill's Financial Memorandum from-

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

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

Alan McKeown, Team Leader, Health and Social Care, and Alexis Jay, Director of Social Work & Housing Services, West Dunbartonshire Council, COSLA.
Scottish Parliament
Finance Committee
Tuesday 30 September 2003
(Morning)

[THE CONVENER opened the meeting at 10:00]

National Health Service Reform (Scotland) Bill: Financial Memorandum

The Convener (Des McNulty): The bell has rung for 10 o’clock, so I welcome members, the press and the public to the Finance Committee’s eighth meeting in session 2. I remind people to switch off their pagers and mobile phones. We have received no apologies from committee members.

Agenda item 1 relates to the National Health Service Reform (Scotland) Bill, which the Minister for Health and Community Care introduced on 26 June. We have several witnesses to assist our consideration of the financial memorandum that accompanies the bill. From NHS Argyll and Clyde, we have John Mullin, who is the chair, and Neil Campbell, who is the chief executive; from the Scottish Association of Health Councils, we have John Wright, who is the director, and Dr Kate Adamson, who is the convener; and from the Convention of Scottish Local Authorities, we have Alan McKeown, who is the health and social care team leader, and Alexis Jay, who is the director of social work and housing services, at my local council—West Dunbartonshire Council.

Members have copies of the written submissions from NHS Argyll and Clyde, COSLA and the Scottish NHS Confederation. I welcome all the witnesses to the meeting. I am not sure whether we require opening statements, unless anybody is anxious to make one. We will press straight on to questions.

Did the Scottish Executive consult health boards when drawing up the financial memorandum?

Neil Campbell (Argyll and Clyde NHS Board): We were not consulted in a significant way. As a chief executive in NHS Scotland, I have been involved in general discussions at meetings of chief executives with the chief executive of NHS Scotland, but I am not aware of a specific consultation.

John Mullin (Argyll and Clyde NHS Board): General discussion has taken place in the chairmen’s group of NHS Scotland, but a specific consultation was not held.

The Convener: Paragraph 33 of the financial memorandum claims that community health partnerships can be created without additional expenditure, but I am a bit concerned about the extent to which that is possible, because many local health care co-operatives are not up to speed. Are present funds sufficient to sustain the current locality structures and to develop new structures when communities need them in addition to larger and fewer CHPs? Will the funds meet the infrastructure needs of enlarged representation on CHPs?

Neil Campbell: The structure and organisation of LHCCs is diverse between different health board areas. In some areas, significant opportunities will be presented to consolidate organisation and management arrangements upwards into community health partnerships. In some parts, opportunities are likely for financial savings on the basis of that consolidation upwards. At the same time, a strong and cohesive set of organisational and management arrangements can be created to deliver for communities what community health partnerships can do with local authorities. As that consolidation upwards will link with local authorities, I am sure that it will open a door to the better use of joint local management resources by health services and local government. Those opportunities will vary throughout Scotland.

In areas where LHCCs cover significant geographic areas with large populations, that consolidation upwards might not be as straightforward, because the need to maintain close contact with local communities at a more community-sensitive level will cause community health partnerships to consider how to devolve those relationships to local community areas.

The Convener: As a health board manager, you recognise that establishing CHPs will cost money.

Neil Campbell: Yes.

The Convener: How many CHPs can Argyll and Clyde afford?

Neil Campbell: We hope to form three partnerships that have co-terminous boundaries with our local authorities and two that are in partnership with Glasgow and the local authorities whose areas straddle Argyll and Clyde and Glasgow. We will need to contribute towards the cost of two partnerships with Glasgow and our local authority partners and three partnerships directly with our local authority partners. We are looking for a relationship with five partnerships in Argyll and Clyde.

The Convener: How much will that cost?

Neil Campbell: We are working on the assumption that we will have to manage the cost within the costs of the seven existing LHCCs.
Dr Kate Adamson (Scottish Association of Health Councils): Health boards will be responsible not only for community health partnerships, but for public participation forums. I would be interested to hear from Neil Campbell about that, because funding for such a purpose is not currently part of a health board’s remit and would be in excess of the funding for a local health care co-operative or community health partnership.

Alan McKeown (Convention of Scottish Local Authorities): The question has been raised whether managing public consultation should be the sole responsibility of CHPs. Our policy response strongly suggests that considerable added value would be created if we used the mechanisms that have been developed for community planning, which is a statutory responsibility. That is not highlighted. We suggest that we should make those links as a matter of policy, to benefit from the advantages and to make the potential savings.

Perhaps it is a bit early to tell whether enough money is available for CHPs. We can all accept that cost savings can be made. However, in the short term, it is unlikely that those savings will be realised, so an additional early hit might be needed. We must consider resources to support the formation of CHPs and all that accompanies them to make them effective on the ground with communities and partners.

Alexis Jay (West Dunbartonshire Council): There is a parallel with the joint future agenda, which involved integrating older people’s services. In our case, that was across two NHS boards and one local authority—such integration has happened throughout Scotland. That experience showed that there must be investment in development time to allow such changes to happen effectively. Although the costs of the joint future agenda were transitional, they were absorbed entirely by the partners.

We were supportive of the agenda and glad to undertake it, but there were hidden costs attached to it and nobody has calculated them. Those costs related to secondments, which nearly every partnership developed to ensure that the work progressed, and to staff training. We need to invest in front-line staff. Local leadership is needed with such a major change to ensure that the system is as effective as possible.

John Mullin: I concur with the comments of colleagues in COSLA about the role of community health partnerships in public involvement and about the community planning process. As members will know, we in Argyll and Clyde became a single system on 1 July. We have been keen to avoid unnecessary duplication. We believe that community planning can play a crucial role in the development of the health service not only locally but nationally. We are keen to see whether we can work with our local authority colleagues to take advantage of some of the positive work that has been done in Scotland to involve the public. I have a local authority background and I feel that the health service can learn a lot from how local authorities have engaged with the public over many years. We are keen to explore that avenue and to cut out any unnecessary duplication.

The Convener: There is a point about which I am not clear and no one is giving me an answer. Are there savings from the LHCCs that could move across into the community health partnerships? If not, how can the partnerships operate without additional resources?

Neil Campbell: It is difficult to say exactly how we will align the management arrangements in partnerships that do not yet exist. We have not received formal guidance on what the partnerships will be like or on the nature of their work. From work that we have done to develop LHCCs and from work that has been carried out over many years to develop relations with local government—through, for example, community planning—we have a good general idea of what CHPs will be like and of the kind of opportunities that they will present. However, we have not yet received any detailed guidance on the establishment of CHPs or on exactly the sort of work that they will do.

In Argyll and Clyde, the organisation and management arrangements relate to seven LHCCs. We have general managers, lead clinicians and some administrative functions in place. We will have five CHPs, two of which will be shared with Glasgow because of the cross-boundary organisation of the local authorities. Therefore, in establishing management arrangements, there will be a shared cost with Glasgow. In Argyll and Clyde, we will be able to redeploy the resources from seven LHCCs into three CHPs in our area and two that are shared. Standing back to consider that from my perspective as a manager, I see an opportunity to redeploy costs. In addition, by creating a single system, we change the whole nature of the work of a health board, which will also give rise to opportunities. We can consider how some work can be conducted more locally. Through CHPs, some resources can be redeployed from what was the health board work force.

If I understood it correctly, the question was whether that redeployment would fit with the cost of CHPs. It is very difficult to say. There will be hidden costs. I expect that the management of CHPs will be of a higher calibre, with higher skills, than that of LHCCs. CHPs will have wider responsibilities and will be more accountable. Their work responsibilities and their relations with
local authorities will require a higher calibre of manager. We have to identify those people. What do we do with people in existing LHCCs who have yet to achieve that level of competence—if they ever can? Do we make them redundant? Do we wait for them to move to other jobs? Do we carry them as excess in the system? As a manager, I have to recognise that there will be hidden costs.

My impression is that, in the short term, the establishment of CHPs will have a cost for the NHS that is above the cost of LHCCs. However, over time—a couple of years—that cost will be taken out of the system as we take the opportunities that arise. In making that comment, however, I am making assumptions. I do not have hard evidence. It is too early to be precise because the exact nature of CHPs has yet to be worked through. The detailed work that will be required with local authorities will have to be worked through and, in Argyll and Clyde’s case, there will also be detailed work with Glasgow.

10:15

The Convener: So you are saying that there will be an initial cost that might fade away over time but that you cannot quantify it.

Jim Mather (Highlands and Islands) (SNP): Reform is at the core of the bill and the Scottish NHS Confederation is about to launch a major project to help to define and shape the CHPs. How will you focus on value for money, on improved effectiveness and outcomes and on avoiding exporting costs on to patients? I am thinking particularly of the delivery of services in the community—close to the patient wherever possible. How can we play a full role in energising communities and making them more attractive places for people to live in—to invest their lives in, if you will?

Neil Campbell: I will comment on that first; COSLA may want to comment after. We have good experience of working with local government, both in community planning and in joint future work. Bringing together expertise from local government and the health service creates opportunities for better cross-boundary working between professional groups. Sharing expertise and skills among work forces creates real opportunities for services and local communities. CHPs will be a vehicle for that kind of work. We have not yet been provided with the exact details of what would be expected of us, as an NHS board, in that work. However, our experience to date of working with local authorities has been positive. It has enabled the kind of integration that creates opportunities for communities and it has allowed for substantial scrutiny of cost-effectiveness and value for money.

Alan McKeown: I will pick up on a point from that and then Alexis Jay will perhaps talk about the Chartered Institute of Public Finance and Accountancy guidelines. We have to consider more than simply value for money. Added value has to be seen in improved services—not only must we be able to say that there are improved services, but the people who use the service must be able to see a direct benefit. I am not saying that that has to happen immediately; it would be naive to suggest that. Partnership working with local government and joint future work take time and a lot of continued effort. We are not just changing services; we are changing culture in the way that two fairly monolithic organisations come together to work. That will take time. We have to consider more than just value for money.

Jim Mather: That is why my question was multifaceted. The key point was on improved effectiveness and outcomes and on the avoidance of exporting costs on to patients. The bill gives you an opportunity to be new brooms. How are you stepping up to the plate to address all the issues?

Alan McKeown: The bill represents a real challenge, but it has to be seen as an opportunity. It is a chance for us to start, right at the beginning, to work on the structure. We have to work through the guidance, get the culture right and get the key messages across. What we do has to be about partnership. We have spoken about community planning and the role of consultation. There is no point in twin-tracking things and then, at some point, saying that we need to bring them together. We should bring them together right here, right now. We should move forward collectively. That is a strong part of the COSLA response.

Dr Adamson: I absolutely concur with what has been said on cost-effectiveness. In rural areas, there is no doubt that the economy of scale that can be achieved through amalgamating LHCCs will be significant. However, as for delivery close to the ground, there is certainly a perception in Highland, where I come from and which is a very rural area—the most rural area—that services are being taken away from local areas. That is the perception among the professionals and local people.

Dr Elaine Murray (Dumfries) (Lab): I want to explore some of the fears expressed by Argyll and Clyde that the costs of the powers of intervention are not correctly calculated. You have said that the costs may be higher than the Executive suggests. Given the financial difficulties previously experienced by some health trusts, what would be a better estimate of the costs of those powers of intervention? I know that that is difficult to get a feeling for, as intervention would happen only under particular circumstances.
Are you concerned about the fact that the costs of intervention had to be borne by the trust when the problems might have arisen in the first place because of financial pressures? Are you concerned that intervention might make the situation worse rather than better?

John Mullin: I will start and Neil Campbell will follow with more detail. This time last year, I had to approach Trevor Jones, the chief executive of NHS Scotland, and ultimately Malcolm Chisholm to ask for support because I believed that, at that point, we had a major systemic management failure in Argyll and Clyde. We can therefore comment in some detail on the cost implications of the task force that was put into Argyll and Clyde. The task force spent a couple of months in Argyll and Clyde and prepared a report that has led to our taking a series of actions to ensure that we recover the system and finances of Argyll and Clyde and consider clinical recovery and clinical redesign.

To me, the suggested figures seem to bear no relation to the figures that we had to address within Argyll and Clyde. I will ask Neil Campbell to have a stab at specifying what those figures were and to comment on what they are likely to be in the future for other authorities.

I can perhaps answer the last part of Elaine Murray’s question. I agree that, in many cases, intervention will probably happen when organisations have experienced major financial problems. I have mentioned Argyll and Clyde, but members will also know about the problems that occurred in Tayside. For health boards such as Argyll and Clyde, which has to save £35 million over three years, any costs on top of that will be a considerable additional burden.

The Convener: Before Neil Campbell responds, I want to mention an issue that arose in relation to the Beatson intervention, which took place to address a specific example of service failure rather than to address issues across the health board. If NHS Quality Improvement Scotland identified other service failures, could there be further demands for ministerial intervention? That is an issue, which must have cost implications.

Neil Campbell: I cannot see how intervention can take place without substantial cost. I believe in intervention. Intervention is an important tool that needs to be available to the Scottish Executive Health Department in order to secure safety, quality and development of services for local communities, but it is a costly option. It requires people to be available to intervene. However, what do those people do while they are waiting to intervene? That is an issue, which must have cost implications.

Intervention requires people who are competent to carry out a variety of roles to be available to intervene. Such people are often at a significant point in their personal career development, so they are expensive. There may well be other work that those people can do while they are waiting to intervene, but it is unlikely that we can have any number of those people ready at the drop of a hat to go anywhere in Scotland to provide the necessary support.

In addition to the financial costs, the system of intervention involves a significant cost by the very fact that it displaces people who are carrying out certain roles. Often, no management decision can be taken to remove people from the system without cost. In the case of Argyll and Clyde, four chief executives were removed, at significant cost to the NHS. There was also the cost of the intervention team, which has only now, with effect from 1 September, come to an end. That was nine months of cost. Including salary costs, living costs and so on—the people were drawn from across Scotland—the intervention team probably cost in the region of £300,000.

The Convener: That is considerably more than the estimate that is given in the financial memorandum.

Neil Campbell: There is a cost to intervention. The intervention team also brings other people in its wake. In Argyll and Clyde, there were three people in the intervention team, but other people with expertise had to be brought in to do the other work that needed to be done. On behalf of the board, I commissioned work to validate financial data, because the system was in crisis and needed that kind of support. For all those reasons, intervention is a costly process, but I believe that it is a necessary process.

As I said, not all the costs are financial. There is a need to have available within NHS Scotland a high-quality group of people to be deployed. Those people will not be available to do other things.

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): The dilemma for the lay observer is that, although the financial memorandum assures us that the cost implications of the reform are negligible, that is not what we have heard from the witnesses so far. How can we—and you—reassure the public that the outcome of the reforms will be a better health service? How can we reassure people that the reforms will not simply be an exercise in diverting scarce public money away from front-line health provision and into yet more health board management?

Neil Campbell: The consequence of not having the ability to intervene in an NHS system that is failing is disaster for that system, which affects not only the management or the board but front-line services—the disaster strikes the people who need those services.
Let me describe Argyll and Clyde’s circumstances before intervention. Crucial front-line services for surgery and maternity services were not able to move forward to a position where they could be sustained for a large proportion of the population in Argyll and Clyde. The knock-on implication of our not being able to sustain surgery was that we were unable to sustain accident and emergency services, medical receiving and high-dependency unit and intensive-treatment unit facilities and services. That lack of decision making and inability to move forward as a system had a consequential impact on a diverse set of services. In mental health services, we were unable to recruit and retain staff in part of the patch. There was an impact on the continued development of community infrastructure and reprovision programmes. In rural services, there was an impact on recruitment and retention in primary care.

System failure has a massive knock-on ripple effect on front-line services and care. There is a need to invest so that opportunities are developed to deal with such failure through a power of intervention. That is crucial for the services that the public require and to which they have a right. I believe that intervention is an important aspect of the bill and that it should be developed. However, I am saying that there is a cost to it.

Mr Brokbleank: Are you refuting the guidance that we have been given, which is that the cost implications are negligible?

Neil Campbell: I am taking a view, which is based on my experience in Argyll and Clyde, that intervention involves a very significant up-front and on-going cost.

Ms Wendy Alexander (Paisley North) (Lab): We have opened up an important issue that we will need to explore with the Executive next week. Neil Campbell has highlighted that there are reservations not only about the costings that have been given for the power of intervention but about the scoping of that power. Perhaps between this week and next, the clerks could develop a line of questioning that examines the benchmarks. I am struck by the fact that we have experience of central intervention in schools. The Accounts Commission for Scotland might offer benchmarks for intervention in a single school, but that kind of intervention cannot be compared with intervention in health boards, which have budgets that run into hundreds of millions of pounds. I think that the proposal is neither scoped nor costed appropriately. It would be helpful to develop that line of questioning before we discuss the matter with the Executive next week.

10:30

I am aware that time is pressing, but I have one more question to ask. The bill raises the matter of public involvement in the NHS. In the evidence from Argyll and Clyde NHS Board, it is noted that many parts of the service are undergoing considerable redesign, and that the pressure for public consultation is, therefore, perhaps stronger now than it was in times past. Ted Brokbleank pointed out the dilemma in the balance between trying to direct as much resource as possible to front-line services and making the public aware of service redesign in their areas. With a view to the discussion that we will have with the Executive next week, do the witnesses have any observations about public involvement in the NHS and the associated costs, given the need to keep as much resource as possible for front-line service delivery?

John Wright (Scottish Association of Health Councils): First of all, I apologise to the committee for not submitting a paper earlier. The request to attend the meeting coincided with our association’s annual conference last week. However, I gave a paper to the clerk this morning.

The association is the membership organisation for health councils in Scotland. Members are aware that there are currently 15 local health councils, which are the statutory bodies. I clarify that for reasons that will be important later.

Although we are unable to determine whether the implementation of the National Health Service Reform (Scotland) Bill will be cost-neutral, we have some concerns about the statement in paragraph 37 of the financial memorandum, which says that existing budgets that have been allocated to health councils in Scotland will be sufficient for the new Scottish health council. Our reasons for that assertion of concern are based on feedback that we have requested from all the member health councils.

I will go through some of that feedback. First, the increased importance that has been given by the Scottish Executive to public involvement in planning, delivery and monitoring of health services was mentioned. The new Scottish health council will be fundamentally different from the organisations that exist at present. We are talking about an organisation—

The Convener: Perhaps we are straying into matters that are the subject of the submission. We are looking for a response to Wendy Alexander’s question.

John Wright: Okay. In paragraph 37 of the financial memorandum, it is stated that the existing financial arrangements are adequate. We believe that there are likely to be significantly increased costs for the new organisation.
One of the areas about which we are concerned is that, in addition to the budgeted figure of £2.1 million that is quoted in that paragraph, the 15 existing health councils are currently dependent on funding in kind from NHS boards. That funding varies from health council to health council, but it typically covers costs such as property rental, rates and IT expenditure. If the new organisation is to be truly independent of health service providers, we argue that those costs should be refunded directly to the Scottish health council and that the current in-kind funding arrangements should not continue. However, we do not suggest that that money should be taken away from NHS boards. Suffice it to say that funding must continue to be provided to the new Scottish health council. Although I cannot quantify the amount at this stage because I do not have the information from local councils, the funding from the existing budget of £2.1 million could be significant.

Alexis Jay: If we are serious about public and patient involvement, there must be some commitment to enabling and supporting people to participate. That means investment in capacity in communities; not just in formal organisations, but in groups that represent the different interests of patients so that we avoid making the initiative tokenistic.

Alan McKeown: I hope that I understood the question about public consultation correctly. As the bill is drafted, there is an issue about accountability of CHPs; we are concerned that they would be accountable only to NHS boards. That would be an opportunity missed to examine ways in which to marry accountability with communities through local government. I recommend strongly that the committee reflect that. COSLA takes the view that we should try to ensure that, rather than be accountable only to the local health board, CHPs are accountable to more people than that board. That goes to the heart of ensuring that local government and the NHS work more closely in order to deliver better services.

The Convener: You refer to what is primarily a policy, rather than financial, issue.

Before we move to the health boards' responses, I will pick up on a question that Wendy Alexander asked. Can we do any benchmarking for consultation processes? We have examples of a number of major consultation processes in various health boards. Is it possible to quantify what a major consultation process costs in time involved and associated staff time?

Neil Campbell: There will be an opportunity to benchmark. We could track significant changes that the public has been consulted on throughout Scotland. Whether that would be helpful is a matter of individual opinion. Much of what happens during consultation is discussion and provision of information. It is often a one-way process rather than a two-way process and it is not that good. It is not that intensive effort is not made and it is not that the intention is not good. Such a consultation process is not what the Finance Committee would expect of the health service and it is not what I expect as a chief executive with accountability for proper engagement with communities on major issues. Any figures that a benchmarking exercise came up with would not necessarily tell us what was effective.

The major challenge that consultation presents is to move beyond the process and into proper engagement with communities about the sort of issues that we face. In Argyll and Clyde, we must deliver a major reform programme in order to sustain our health services during the next five to 25 years. Engagement will be a major issue among the challenges that we face. Our challenges are similar to those that are faced throughout Scotland, but we have a set of acute circumstances on which we in Argyll and Clyde must engage now. That will mean a heavy draw on our resources over the coming years.

We are beginning to decide how we will undertake that process; there will be a cost of doing it effectively. That cost will not be for a brief process that concludes with a submission to the minister for approval of plans for change; rather, it will be a continuing process. When we have approval for plans to change, the education process of engagement needs to continue in order that we ensure that we get the best from that service change in whatever form it takes. That is a continuing responsibility of boards that goes way beyond the conclusion of formal consultation of the public and ministerial approval's having been given for changes.

John Mullin: I agree with everything that Neil Campbell said. I also voice my support for the comments that were made by Alexis Jay. There is a need for community capacity building. One can see from a number of consultations that have taken place the length and breadth of Scotland that some people still feel totally disenfranchised.

Whatever debates relate to—whether they are on maternity services or the west of Scotland secure unit—many people feel that some people are better able to register objections or to speak in public meetings and are therefore at an advantage. We are losing opportunities to engage with communities in the way in which Neil Campbell mentioned.

If we want people to get involved in the health service—or in any other service that is provided by a public agency—we must also support people's desire to become involved. That means that we have to invest in capacity building at local level.
Argyll and Clyde NHS Board has started to speak to its local authority partners in that regard because we see this as a win-win situation. We must work on capacity building. Speaking as the chair of that health board, the kind of consultation that currently exists is not the kind of consultation that I want.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): Our task is to find out how much the bill will cost. The financial memorandum does not say that the cost will be negligible; it says that it will be zero. However, we have learned from you that there might be far greater costs than are included in this paper.

My understanding is that, essentially, the bill replaces trusts with community health partnerships—that is to say, it replaces one sort of administration with another. I am struck by what constituents of mine have told me. For example, a husband and wife in my constituency, both of whom are waiting for operations, view the bill with some scepticism because they had hoped that the proposal would lead to less money’s being spent on administration and more on ensuring that the waiting lists that they are on are cut. That is not to criticise the health professionals; those whom I know in the Highlands are wholly committed to their task. However, having set that scene, I ask two simple questions. First, can each of you suggest what efficiency savings can be found in the administration that currently exists? Secondly, have you been asked by the Executive to volunteer such proposals in the context of the bill?

The Convener: Those are probably questions only for the representatives of the health boards.

Fergus Ewing: Not really. All of our witnesses have relevant expertise; I am interested to know what proposals they have for efficiency savings that would turn money that is spent on administration into money that is spent on front-line medical services? I would also like to know whether the Executive has asked them about that.

Neil Campbell: The overall changes that will be brought about by the partnership for care system under the National Health Service Reform (Scotland) Bill are much more far-reaching than it would be simply to replace trusts with community health partnerships. In fact, trusts will not be replaced by community health partnerships at all.

There will be integrated NHS systems with one manager instead of two, we will do that, to the extent that it would work best for the people involved.

The configuration will differ across board areas but the principle is that trusts will disappear entirely. Community health partnerships are a stepping up of local health care co-operatives, which are not statutory organisations. I understand that CHPs will not be statutory organisations, either.

10:45

There will be significant efficiency savings as a result of creating an integrated system. In Argyll and Clyde, we have four separate finance functions—one for the health board and one for each of the three trusts. After the changes, there will be one finance function with devolved components, which we expect to result in a saving of between £600,000 and £700,000.

Similarly, hiring and recruitment, which currently has three and a half distinct parts, will become one corporate function; we have taken the same approach to planning and to other corporate functions such as facilities management. To configure such matters in one organisation, rather than in four, will present opportunities for savings, which will put into the system money for some of the changes that are envisaged in the bill. However, it is too early to say whether the additional costs that I have described today will be met by those savings.

We have to ensure that in creating a single system in order to gain efficiency savings, we do not create a centralised bureaucracy in the image of the health boards of the 1990s. The thrust of the partnership for care system is to create at community level devolved organisational arrangements that are connected to local authority partners. The community health partnerships will be a key driver in that regard.

The Convener: Thank you. I ask for brief replies from our other witnesses because we are keeping the minister waiting.

Alexis Jay: I am not aware of the Scottish Executive’s having asked us specifically about efficiency savings. There are examples of people trying to ensure that efficiency savings are made, however. In my area, for example, we would examine first-line managers of specific health and community care services, local health care co-operatives and social work teams to examine where there is overlap and duplication. Where the overlap means that it would be possible to have one manager instead of two, we will do that, to the extent that it would work best for the people involved.

Dr Adamson: I do not think that I can answer the questions that were asked.

The Convener: I apologise to the witnesses for having to cut off our discussion at this stage, but I thank you all for coming to the committee today. If there are any further points that you would like to make following this discussion, we will be pleased to receive further submissions in writing.
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

9th Meeting, 2003 (Session 2)

Tuesday 7th October, 2003

Present:

Ms Wendy Alexander  Fergus Ewing (Deputy Convener)
Kate Maclean  Des McNulty (Convener)
Jim Mather  Dr Elaine Murray
Jeremy Purvis  John Swinburne

Also present: Professor Arthur Midwinter (Budget Adviser).

Apologies: Mr Ted Brocklebank.

National Health Service Reform (Scotland) Bill: The Committee took evidence on the Financial Memorandum of the Bill from-

Lorna Clark, Bill Team Manager; Dr Hamish Wilson, Head of Primary Care Division and Alistair Brown, Head of Performance Management Division, Health Department, Scottish Executive.
Scottish Parliament
Finance Committee
Tuesday 7 October 2003
(Morning)

[THE CONVENER opened the meeting at 10:03]

National Health Service Reform (Scotland) Bill:
Financial Memorandum

The Convener (Des McNulty): I welcome people to the ninth meeting of the Finance Committee in the second session of the Parliament. I welcome the press and the public and remind members and anyone else that pagers and mobile phones should be switched off. We have received apologies from Ted Brocklebank, but I think that everyone else is present.

The first item on the agenda is further consideration of the National Health Service Reform (Scotland) Bill. I welcome witnesses from the Scottish Executive Health Department: Lorna Clark, the bill team manager; Dr Hamish Wilson, head of the primary care division; and Alistair Brown, head of the performance management division.

Members have a copy of various written submissions, including one from the Scottish Association of Health Councils, which gave evidence to the committee last week. We also received a submission from the Scottish Executive yesterday by e-mail—a paper copy of that submission is available to members.

I invite the Executive witnesses to make a brief opening statement.

Lorna Clark (Scottish Executive Health Department): As we know that time is limited this morning, we thought that it would be helpful if we made a brief statement and responded to some of the main points that have been raised by those who have provided written evidence on the bill and those who gave oral evidence to the committee last week.

I will start by setting the matter in context. This year, the Scottish Executive will spend £7.2 billion on health, most of which is allocated to the 15 health boards to manage and deliver health care services in their areas. That represents a rise of £1 billion since 2001-02 and the amount that we spend on health will increase still further to £8.5 billion by 2005-06. In the light of those resources, the Scottish Executive stands by the statement in the financial memorandum that there will be no additional expenditure associated with the bill.

We are aware that some witnesses have argued that there will be start-up costs associated with the establishment of community health partnerships. Funding is already provided for the management of a larger number of local health care cooperatives and some of that funding will be used to assist with the evolutionary development of CHPs. In addition, money is available through the change and innovation fund to assist with service redesign. We believe that health boards already have the capacity to manage the evolutionary change from LHCCs to CHPs within their existing management resources. That is supported by NHS Ayrshire and Arran, which said in its submission that what is required is a redistribution of resources and that there should be no overall cost increase.

On the powers of intervention, the financial memorandum states that the costs will depend on how the powers are used. We note from the evidence that the committee received last week that Argyll and Clyde NHS Board’s experience of intervention cost about £300,000. We do not dispute that figure but we point out that that was a significant intervention that related to the departure of four staff at chief executive level. We suggest that any use of the intervention power following the bill is likely to be more targeted and therefore less expensive than was the case with NHS Argyll and Clyde. Of course, much depends on individual circumstances and it is difficult to indicate what an average intervention might cost, because each intervention is different and is costed according to the way in which it is run.

In practice, public involvement is already a core function of the national health service and, as such, is funded through the general financial allocation for the provision of health services. It is not a new or additional function; the bill simply makes the practice a statutory duty. The department is putting more money into public involvement nationally. Our patient focus and public involvement programme is investing some £4 million a year into national work to help the NHS, the voluntary sector, patients and the public to work together as equal partners and, by doing so, to improve the quality of the public consultation that is undertaken by the NHS. It is anticipated that the proposed Scottish health council will take over some of that responsibility and some of the central funding that supports that work.

The functions of the Scottish health council and its local advisory councils will be different from those of today’s local health councils. Although it is true that the Scottish health council will have some functions that were not previously carried
out by local health councils, it will not do many of the things that are currently undertaken by local health councils. The Executive’s view is that, on balance, the existing allocation to local health councils will be sufficient to set up and run the Scottish health council.

That was a brief summary and I look forward to discussing the issues further with the committee.

The Convener: Thank you for your statement and for giving us a copy in writing. By and large, the processes that are needed to abolish the trusts do not need legislation. What is required of the bill is a legislative tidy-up. However, there is an issue about the costs that are associated with the abolition of the trusts. Would it not be better to give us an outline balance sheet to show how the savings might be arrived at and how any additional costs might be met, rather than to assume that they will somehow be netted out of the process, which seems to be the substance of your comments?

Alistair Brown (Scottish Executive Health Department): The work that we have done and our discussions with the NHS suggest that the direct cost of abolishing trusts is very low and is entirely administrative. As you suggested, the abolition of trusts is already going ahead under the legislative provisions of the National Health Service (Scotland) Act 1978. It is clear to us from our conversations with those in the NHS that, as I said, the costs will be very low. Other witnesses have suggested to the committee that opportunities for savings will be presented through single-system working and, for example, developing joint human resources and finance functions that cover the former trusts and boards in a single area. We expect savings from that, but we expect board areas to redeploy those savings towards improving patient care.

The Convener: Would it not have been better to give us a true financial assessment of savings that can be clearly identified and of any additional costs, especially in the initial phases, rather than to assume that the overall effect on costs will be netted out?

Alistair Brown: Producing such a statement would be difficult for the Health Department because it would need to be accurate for each health board. In time, individual health boards may be able to describe costs that they have incurred and savings that they have realised, but we expect those figures to be small in comparison with the overall sums of money that are being discussed.

The Convener: My question relates to scrutiny and our function is to scrutinise. I might want to accept your assurances, but I have the reasonable expectation that you can provide some figures.

Alistair Brown: We cannot give the committee figures today. Dissolutions are already beginning so I repeat with confidence that the costs that are associated with dissolutions are not material. I will not say that they do not exist, because some staff must be deployed to draw up consultation measures and undertake consultation, but the costs are very small. We cannot yet indicate possible savings from single-system working, but we are beginning to observe its results in the Borders and in Dumfries and Galloway, where trusts were formally dissolved on 1 April this year.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): It is obviously the duty of ministers to provide a clear financial memorandum, which means providing a clear estimate of how much a bill will cost. Paragraph 42 of the financial memorandum says:

“There will be no additional expenditure”.

However, you just said that you cannot produce figures because they would need to be accurate and you do not know how much each health board’s proposals will cost. How did you conclude that no costs would be incurred, given proposed new section 4A(5) of the 1978 act, which entitles ministers to produce regulations that stipulate the number of CHPs, the number of staff and how CHPs operate? How many CHPs will be created and how much will they cost in total?

Alistair Brown: Your last point took me from the costs and savings that are associated with the dissolution of trusts to community health partnerships. One of my colleagues will have to comment on the partnerships.

Your first point was about whether we really know the costs that are associated with the bill and in particular with section 1, which is on the dissolution of trusts. We stand absolutely by the financial memorandum’s statement that no costs of any significance will be associated with dissolving trusts.

10:15

Dr Hamish Wilson (Scottish Executive Health Department): I will bring the committee up to date on community health partnerships. As was requested in the white paper “Partnership for Care”, each area is considering its current configuration of local health care co-operatives and what that might mean for community health partnerships. That exercise has not concluded, so although some areas have a fairly clear idea of the appropriate number of community health partnerships to deliver what the white paper requires, others have not reached that stage. However, the information that we have suggests that we are heading for about 50 partnerships. I stress that that figure is provisional and is based on the best information that is available. There are
roughly 80 local health care co-operatives in Scotland, so the number of bodies will change.

Fergus Ewing: We discovered this morning that one of the few times that ministers made any attempt to predict in the financial memorandum how much the bill would cost relates to the powers of intervention, whose use is expected to cost about £85,000. However, the witnesses today appeared to accept the figure of £300,000, so that error is of a factor of nearly 400 per cent.

The almost total lack of figures in the financial memorandum contrasts markedly with the approach that ministers took in the financial memorandum for the Vulnerable Witnesses (Scotland) Bill, which contains a clear list of figures and costed measures. Dr Wilson admitted that the Executive does not know how many CHPs will be created so, by definition, we do not know how much the bill will cost. The financial memorandum contains about as much hard fact as the average astrological chart does. The prediction might well have been made by Mystic Meg. That is simply not good enough.

Such a bill should not be introduced until the Minister for Finance and Public Services and his deputy can tell the Parliament how much it will cost. If the Executive cannot do that—the witnesses have admitted that they cannot—a clear balance sheet should be produced that shows ranges of estimates and of costs, as the convener said. Without that, we are being asked to sign a blank cheque and we do not know whether that is the case. Are not the financial memorandum and the lack of detail in the witnesses’ responses, which I presume that ministers support, unacceptable?

The Convener: I am not sure whether that was a political speech or a request for factual evidence, but I will allow the witnesses to respond on factual issues.

Alistair Brown: I will respond in a way that I hope is helpful on the costs of the powers of intervention. Mr Ewing is right to draw attention to the fact that the financial memorandum contains the figure of £85,000. The memorandum explains that that would be the cost of a task force that comprised six people and lasted 10 months.

In the Executive’s opening statement, we said that we would not disagree with the figure of £300,000 that Neil Campbell of NHS Argyll and Clyde submitted to the committee. Both figures are correct, because they represent different interventions at different times. The figure of £85,000 is taken from a parliamentary answer of December 2000. The question related to a task force that ministers asked to go into Tayside NHS Board in February that year and which completed its work in autumn 2000. According to the parliamentary answer, the cost of that task force was £84,467. That is where our figure of £85,000 came from, so I assure the committee that it has a factual basis.

Ms Wendy Alexander (Paisley North) (Lab): I will pursue that point. The figure might have a factual basis, but that is not the issue that the financial memorandum deals with. The memorandum concerns estimated costs for the forthcoming four years. We all appreciate the difficulties of costing prospective interventions, but at least four examples can be found in the past of interventions that the Parliament would have sought if the new powers had been available.

In the Parliament’s first year, the Ruddle inquiry was held and issues that were specific to Carstairs were considered. Those matters would be unlikely to fall under the bill’s provisions, but that was an area-specific intervention. The Tayside intervention, which Alistair Brown mentioned, then took place. The important issue is not the cost of that intervention as it was carried out but what might be the cost given the powers of intervention that are laid out in the bill and where those costs would fall. The question is whether the cost would fall to the Executive or the health boards.

In the third year, we had the example of the Beatson in Glasgow. Because of the legislative power that we are about to create for ministers, there will probably be some central intervention in future in such cases. No doubt Greater Glasgow NHS Board would be able to provide some indication of the costs. Most recently, we had the example of NHS Argyll and Clyde. Again, the powers in the bill make it likely that costs will accrue to the Executive.

We have had one intervention a year and more interventions are now likely because of the wider scope of the bill. It would be helpful if officials could write to us about the costs of the interventions in Tayside, the Beatson and Argyll and Clyde. It is a little surprising that those interventions were not considered when the financial memorandum was drawn up, but these things happen. The costs of those interventions could be agreed with the three health boards involved and used as a benchmark.

It is arguable that the sums of money involved are trivial when compared with a £7 billion budget. Had the financial memorandum said that the costs would be residual in such a budget, that would be fine. However, the artificial precision of £85,000 creates a danger. I do not think that that figure bears any relation to what the Tayside, Beatson or Argyll and Clyde interventions would have cost under the powers that we are creating.
Will you comment in more detail on the Argyll and Clyde case? I am disturbed by the justification in your paper, which says that the intervention was very significant and related to the departure of four staff at chief executive level. It seems to me that we should be costing not the outcome but the input. The input was a relatively small number of people who went in for a relatively short time. In the intervention team of four members, one was a senior local government official and one was from the private sector. On average, those people would be on a salary of, say, £100,000. The team spent six months looking into systemic mismanagement in a health board with a budget of hundreds of millions of pounds. Six months is a short time but the salaries of the four people would come to £200,000—let alone any backfill associated with their previous employment.

Do you envisage having intervention teams of fewer than four people, for periods of less than six months? That does not seem commensurate with the provisions in the bill or the likelihood—given past experience—of where interventions will have to take place. The outcome is not really the issue; the issue is the input required to intervene in the management of a health board.

The Convener: I think that there were several questions there.

Alistair Brown: Ms Alexander asked that we write to the committee about the costs of the interventions that she listed. We would, of course, be happy to do that as soon as we can.

The Convener: That would be welcome.

Alistair Brown: It may take us a little while to look back at papers that are now up to three or four years old.

I make one general point about the proposed new power of intervention in the bill. The policy intention is clear: it should be used as a power of last resort. The words “last resort” appear not in the white paper but in the Executive’s partnership agreement. We believe that that policy intention is carried into the wording of the bill, through the necessity test. In section 4 of the bill, proposed new section 78A(2) of the 1978 act states that “The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service”,

direct certain things. The lawyers advise us that that carries into the bill the policy intention that intervention should be a last resort—when other means of turning round poor or failing performance have been tried and failed, or when ministers judge that there is no reasonable prospect of such means succeeding.

I make that point to set Ms Alexander’s comments in context. One cannot assume that, had the proposed new powers been in effect back in 1999, ministers would have decided to use them in the Ruddle, Tayside, Beatson and Argyll and Clyde cases. The intervention in each of those four cases was based on agreement between the Scottish Executive Health Department and the health body concerned.

That observation may not be relevant to the cost of an intervention, once a decision to intervene has been taken, but it may help the committee to judge how frequently ministers expect the intervention powers to be used. The answer is that they will not be used frequently. They will be used as a last resort only after a range of other interventions and actions has been attempted.

I accept Ms Alexander’s comment about the artificial precision of the £85,000. We were trying to be helpful and I have made it clear where that number came from. It may help the committee if I explain why that figure seems small. The Tayside task force had a number of members and was in Tayside for nine or 10 months. At least one of the members was a recently retired senior chief executive in the health service. The cost of deploying him in Tayside was, in fact, remarkably low. I cannot give the committee the figures right now, but the additional cost to the public was very low. Other members of the Tayside task force had other jobs and were deployed for only one or two days a week.

Dr Elaine Murray (Dumfries) (Lab): Wendy Alexander raised a number of the points that concerned me. You have just suggested that the Tayside example may have been an exception because you had available to you a recently retired chief executive whose cost was relatively low. That would not be the case in every intervention. We have been considering Tayside and Argyll and Clyde but it is difficult to say which is the exception and which is the rule. It could be that Argyll and Clyde is more typical than Tayside. My genuine concern about the level of costs remains and, in its submission to the committee, the British Medical Association expressed a similar concern.

The financial memorandum seems to say that the cost burden would fall on the health board rather than on the Scottish Executive. Can you explain that to me? It would be surely be easier for the Executive to absorb the cost of an intervention than it would be for the health board, which might be in significant financial difficulties at the time of the intervention. Even £300,000 is a small sum when compared with the Health Department’s budget or with the end-year flexibility figures that we have been discussing recently.

Alistair Brown: We have been giving thought to the very question that Dr Murray raises. The question of who would bear any additional cost of
such an intervention would be for discussion between ministers and the department on one hand and the health board in difficulty on the other. The conclusion reached would depend on the circumstances. The financial memorandum certainly states that costs would be “contained within existing NHS financial allocations.”

That would be our starting point. If an NHS board argued that the costs would damage service provision, for example, ministers would listen very carefully to that argument.

10:30

**The Convener:** Has that discussion taken place in the specific context of NHS Argyll and Clyde?

**Alistair Brown:** I cannot provide a factual answer to that question now. I will have to write to the committee with the information.

**John Swinburne (Central Scotland) (SSCUP):** The public regard this exercise as rather meaningless. They believe that the structure of the NHS is top heavy. There are not enough people at the sharp end—the delivery end—doing the good work that nurses, surgeons, doctors and so on do, and there are too many systems analysts and people counting the number of patients who are bedblocking. Although the bill will not save any money, will it make the system more efficient?

**Lorna Clark:** We have figures for management costs in the NHS, which show them to be quite small.

**Dr Wilson:** For a number of years, management costs in the NHS have run at around 5 per cent of total revenue. As the financial memorandum makes clear, it is expected that that figure will not be exceeded as a result of the measures that are being taken and that management costs will be contained at 5 per cent of total revenue.

As Alistair Brown mentioned, the abolition of trusts and the reunification of NHS boards offer us an opportunity to make savings by ensuring that support services are provided in a more efficient manner than they have been in recent years. Alistair Brown gave some examples of that. One of the fundamental aims of the white paper and the partnership agreement is to ensure that clinicians in the front line are empowered to get on with delivering the services that they believe local communities need. The white paper makes it clear that one reason for creating community health partnerships, which have evolved from local health care co-operatives, is to continue enabling clinicians in the front line to feel that they are in the driving seat when delivering care with the resources that they require to respond to local communities’ needs.

**Kate Maclean (Dundee West) (Lab):** Like other members, I am concerned about the lack of financial clarity surrounding the bill. In response to Fergus Ewing’s question about the cost of intervention, Alastair Brown cited the cost of the Tayside task force as an example. However, in response to Wendy Alexander’s question he referred to various factors that kept the costs so low in Tayside. That leads one to believe that the figure that the financial memorandum provides for the cost of using the powers of intervention is inadequate.

Can you say more about the costs of dissolving trusts? In response to a number of questions, you said that those costs would be minimal. My experience is that with any kind of reorganisation there are often initial, non-recurring costs, which lead to savings a year or two down the road. If there are to be reforms and trusts are to be dissolved, leading to savings further down the road, it is difficult to believe that there will not be initial, non-recurring costs. I am concerned that we are being asked to agree to something with no idea of what costs and potential savings will be.

**Alistair Brown:** Kate Maclean suggests that the £85,000 is inadequate. The financial memorandum makes it clear that costs would be incurred only if the new powers were used and that the amount spent would depend on how the powers were used. That is an obvious statement, but it is worth my putting it on the record.

The cost estimate that I gave for the Tayside task force was the department’s final reckoning at the end of 2000; I regard it as accurate. We should not lose sight of the fact that powers of intervention may be used in future to pinpoint a particular service that has gone wrong. In those circumstances intervention would be limited and sharply targeted, so it might cost only £10,000 or £20,000.

Neil Campbell gave the committee the example of the intervention that took place in Argyll and Clyde NHS Board. I accept fully that, because of the nature of the difficulties there, that intervention had to be quite wide ranging and costs have been higher.

Kate Maclean’s second question was about the costs of dissolution of trusts and the savings that might arise from that. The most helpful thing that I can do is to point to the experience of Borders NHS Board and Dumfries and Galloway NHS Board, where trusts were dissolved with effect from 1 April. I have had conversations with the chief executives in both of those NHS systems on the abolition of trusts and in neither case were costs an issue. Both chief executives are working to rationalise administrative support in the NHS in their areas, especially in finance, human resources and information technology. Any
savings that can be made will be available for the boards to invest in patient care, if they so choose. I hope that that answer is helpful.

**Kate Maclean:** If the savings are in personnel, are there no initial redundancy or early retirement costs?

**Alistair Brown:** Since the publication in December 2000 of the white paper “Our National Health: A plan for action, a plan for change”, which indicated that the policy direction was to move towards unified NHS systems, the NHS has been preparing for what we describe as single-system working. Although the final policy decision to wind up all the trusts was made explicit only in the white paper that was published in February this year, boards have been planning prudently for that. Many of them have appointed chief executives of trusts on an acting or interim basis, so that the question of redundancy does not arise.

Because of the natural rate of turnover of staff, at any point in time boards will have vacancies to fill. They have used that naturally occurring facility to ensure that the changes associated with moving to single-system working cost either nothing or very little in severance. I am not aware of any severance payments’ having been paid in the two boards that have moved to dissolve trusts.

**Dr Murray:** One reason why costs in Dumfries and Galloway NHS Board were not high was that a number of senior staff, including two chief executives of the board and the two trusts, had left and people were employed in those positions on an acting basis. It was relatively straightforward for people to be redeployed in the board. I do not know that we can be absolutely certain that it will be as easy for every board in Scotland to accommodate its personnel as it was for Dumfries and Galloway NHS Board.

**Alistair Brown:** I accept Dr Murray’s point. However, like Dumfries and Galloway NHS Board, other boards have been planning with single-system working in view and have made what preparations they can.

**Jeremy Purvis (Tweeddale, Ettrick and Lauderdale) (LD):** I touch on the same issue in the context of Borders NHS Board, where there were previously three chief executives and where there is now one. In Borders NHS Board, redundancies and substantial costs were associated with the dissolution of trusts. Will a more co-ordinated approach to staffing reorganisation be taken throughout Scotland? When boards reorganise one by one, it is hard to relocate staff or to offer senior staff other opportunities in the NHS. Is it correct to say that if it were expected that the reorganisation would be carried out throughout Scotland, there would be more such opportunities for relocation and the burden of costs will not be that acute?

**Alistair Brown:** A co-ordinated approach to relocating senior staff would reduce severance or other costs. Each NHS board is legally a separate employer and must fulfil its contract with its employees, including its senior staff. We must be careful not to interfere with that situation, because it is governed by employment law and the private contracts between the parties.

The NHS in Scotland is not so big that people are unaware of any vacancies that might arise or of senior staff who might be available to fill them. As a result, there is already an informal exchange of information of the kind that you suggest. As I said, the Health Department would have to be careful about intervening formally in that process, given the existing private and contractual relationships between the individuals concerned and their separate NHS employers.

**Jeremy Purvis:** Substantial management time was taken up and consultancy costs incurred in the reorganisation in the Borders. Am I right in saying that those costs were met by the Executive?

**Alistair Brown:** Are you referring to consultancy costs?

**Jeremy Purvis:** Yes. I am referring in particular to management consultant costs.

**Alistair Brown:** Do you mean in advising the NHS board on the move to single-system working?

**Jeremy Purvis:** Yes.

**Alistair Brown:** As far as I am aware—and subject to checking—those costs were met by Borders NHS Board. However, if I find that I am wrong, I will write to the committee.

**Jeremy Purvis:** Substantial management time will be taken up if each board wishes to move to single-system working. After all, a board might have to hire management consultants to advise it on such a major reorganisation. As a follow-up to Kate Maclean’s question, are you confident that those costs will be met by efficiency savings that will result from single-system working? If so, have you received any indication from the boards that have reorganised about what they expect those greater efficiency savings to be?

**Alistair Brown:** We have received a general indication from the boards that have reorganised and from those that are planning to do so that they expect to realise efficiency savings from bringing together functions that are currently being repeated in the health board and each of the trusts. However, that is not the driving force behind the policy of moving to single-system working. The policy intention remains to make care more patient-centred, and to make the transition between primary and secondary care.
more seamless. That is reflected in some of the written submissions that the committee has received, such as that from the British Medical Association’s Scottish office.

Jeremy Purvis: In the bill as drafted, there is a danger that, if a large board simply redesignates trusts into divisions, rebadges them, maintains the current management levels and in effect does not move towards single-system working, there would be increased costs without greater efficiency savings. Are you alive to that possibility?

Alistair Brown: One has to draw a distinction between what might happen in the very short term and the opportunity that will thereafter open up for NHS systems to rationalise, for example, their support services. I certainly do not want to say to the committee that in some cases existing trusts will not be more or less substituted by new operating divisions after the trusts are dissolved. However, where that happens, I would not expect the NHS systems to stop there; I would expect that in time they would use such a step as a basis for further rationalisation. Although we are not pressing boards specifically to do that, we and many other stakeholders would encourage them to run their operations as efficiently as possible to ensure that as large a proportion as possible of their total income from the Health Department is devoted to patient care and front-line services.

10:45

Jim Mather (Highlands and Islands) (SNP): I want to build on that comment. In any other setting and in most other areas of endeavour, we would expect any reform to have measurable returns on investment, which would be laid out and carefully measured from the start and come with a firm cost ceiling. Surely that must also be the case in an area of expenditure that amounts to a third of the Scottish budget. Do you envisage establishing reporting mechanisms to monitor performance and to encourage adequate performance along the lines that you described a moment ago in terms of there being more resources for front-line services, bureaucracy that will decrease over time, higher staff morale, reduced staff turnover, shorter waiting times, better outcomes, increased throughput and cost savings from streamlining and rationalisation? Such firm measures could be taken then segmented to provide an appropriate bill of materials and to ensure that performance can be monitored at individual levels.

Alistair Brown: Mr Mather has provided a very full run-down of the aspects of NHS performance that we measure or that, in some cases—I want to make this clear to the committee—we would like to measure better than we do.

We should see the bill as the legislative implication of the policy that the Executive set out in “Partnership for Care: Scotland’s Health White Paper”, which was published at the end of February 2003. That white paper emphasises the importance of reform in the NHS to ensure that the additional resources that are being put in have maximum impact on the quality of patient care. We believe that the bill’s measures are necessary to give legislative effect to that policy.

The performance of each NHS area is measured in a variety of ways and at different levels of detail. For the committee, perhaps the most useful gathering of those measures is in what is referred to as the performance assessment framework, which contains something like 90 quantitative measures of performance and other qualitative assessments. The framework certainly covers issues such as waiting times, patient experience, outcomes from surgery and so on. However, we would like to develop better measures of, for example, patient experience and similar softer issues for which it is not always possible to find a reliable numeric measure. The department continues to work on that with the NHS and others who advise us on such matters. As a result, I think that I can answer “Yes” to Mr Mather’s question.

The Convener: I want to move on to a slightly more technical issue. The primary care trusts that have already brought in LHCCs with extended involvement of the public and local authorities are probably not going to incur huge additional costs from the bill’s proposed measures. However, I am concerned about less well-developed areas and locality structures in areas that will be overtaken by the new form of LHCCs. Given that the whole system depends on general practitioners’ buying into it, are you concerned about moving from about 80 LHCCs to about 50 CHPs, and about sustaining locality structures where there is no correspondence between the existing LHCC and the proposed CHP? After all, such structures need to be sustained in some form.

Dr Wilson: One of the fundamental aims is to build on the best of the LHCCs, as you have described. Each area has to strike a balance between representing, and being responsive to, a community and having the capacity to deliver the functions that the white paper, “Partnership for Care”, outlines for community health partnerships.

On commitment from primary care contractors, one of the issues that we face is that we rely heavily on clinical involvement, not just from general practitioners but from other primary care professionals, to ensure that LHCCs are responsive. One of the major development areas that we expect boards to address in examining CHPs is clinical leadership. We will continue to work with local areas on that to ensure that community health partnerships are both responsive to the community and have the clinical
leadership with buy-in from local clinical staff. We are trying to get the best from the LHCC model and work that into the new community health partnerships.

Given that LHCCs were voluntary initially, it is inevitable that there has been variable progress on them throughout Scotland. That is why it was felt that it was important to give community health partnerships a more formal place in the NHS so that they could be seen as an important part of what happens in the NHS locally and thereby gain credibility with the partners with which they work—local authorities are key to that.

All those factors put together seek to reinforce the principles behind “Partnership for Care”, which is about communities, clinical buy-in and improving relationships with local authorities, the voluntary sector and so on.

**The Convener:** The two core questions are whether the smaller locality structures will continue to be supported under the new model and whether funds are available to ensure that the needs of enlarged representation will be met. I am not sure what your answer was to either question.

**Dr Wilson:** One has to consider each area to answer that question. We have already heard from a number of areas that wish to maintain within their community health partnerships’ local identity—not necessarily a formal management structure, but something that maintains a locality’s identity. That already exists within LHCCs. It is expected that there will be a shift of management effort from the LHCCs and other bits of the system, such as existing trusts or NHS boards, into community health partnerships. Equally, we will try to ensure that communication and other systems that exist are not lost in this new endeavour.

**The Convener:** I move on to interventions and projected costs, on which we have had lengthy discussion. One thing that concerns me is the looseness of how the bill is drafted in relation to the possibility of interventions. It is clear that if there were a relatively limited number of major interventions, the costs could be contained by either the health board or NHS Scotland. What concerns me is that if NHS Quality Improvement Scotland finds many examples of inferior services, ministers could be obliged to intervene more than they have until now, for example in the four cases that Wendy Alexander mentioned. Would that have a substantial projected cost?

**Alistair Brown:** The section of the bill that deals with powers of intervention grants a power to ministers rather than imposes a duty on them. The simple answer to your question is that ministers would use the power only where they felt it was justified and they chose to do so. It is relevant to repeat what I said earlier: the power of intervention is clearly intended to be used only as a last resort. The necessity test to which we refer conveys the policy intention through into the wording of the bill. I hope that that will help to reassure you. All the same, it is important that the power of intervention is available where it is necessary. We have therefore not constrained the power heavily in the drafting of the bill.

**Jim Mather:** I want to go back to measurement. It is clear that 90 measures are too many for external reporting. What smaller number of measurements should the Parliament use to judge future performance?

**Alistair Brown:** That is an interesting question. I will attempt briefly to justify why we have as many as 90 measures. We use the measures internally, although all 90 are reported publicly and are on the “Scottish health on the web” website. We use the measures to inform the discussions on performance that we have annually with NHS boards; it is important that we can look right across the range of their operations.

You asked which of the 90 measures and the qualitative assessments the Parliament and the Finance Committee would want to concentrate on. You have your own source of advice and expertise on such matters, so it is difficult for the Executive to give you a view on that. A lot depends on what is taking up the committee’s attention at any given time. The indicators are designed deliberately to give a broad spectrum of measures. They relate to access, which is about how easy it is for people to receive health care and how long they have to wait for it; to quality, which is about how good the clinical outcomes are; to efficiency and to finance. Although there are not many indicators on the finance side, there are enough to enable us to monitor accurately how boards are performing. There are also indicators relating to patients’ experience. We examine the incidence of healthcare associated infection and boards’ performance in relation to patient focus and public involvement. The committee would be able to choose from a broad spectrum of measures at any given time, depending on where its interests and investigations were leading it.

**Jim Mather:** I believe that it would be helpful if there were three or four key indicators that all parties knew were being measured at the macro level and that would be reported on consistently on a long-term basis. Do you agree with that?

**Alistair Brown:** Relative priorities and importance is a matter for ministers rather than for me. Mr Chisholm has recently agreed the 12 NHS priorities for 2004-05—the planning year that we are looking forward to—and they are the same 12 that he agreed for 2003-04.
The Convener: I am anxious that we are drifting a wee bit from the bill.

Jeremy Purvis: I have two quick questions on CHPs. We heard from the Scottish Association of Health Councils—this is supported by what Dr Wilson said this morning—that the nature of LHCCs’ evolution from their initial voluntary basis meant that they received considerable funding in kind, which might not be available under a more structured system when they become CHPs. Do you share that view?

Dr Wilson: I wonder whether there is confusion between LHCCs and local health councils. Perhaps the comment that you referred to was made in relation to local health councils rather than to local health care co-operatives. LHCCs receive funding directly from the NHS boards or primary care trusts.

11:00

Jeremy Purvis: Is it anticipated that the new CHPs will incur more management costs because of the kind of work in which they may be involved. For example, their role in joint commissioning means that they will have a greater responsibility than their predecessors. Will not that increase the costs?

Dr Wilson: The creation of community health partnerships will not, in itself, require additional management to support joint working between the health service and local authorities in social care, children’s services and so on. The CHPs will give local authorities a specific focus at the individual community level. That is why there is a wish for greater coterminosity between community health partnerships and local authorities.

The whole joint future agenda is a practical example of joint commissioning that is already in place for NHS boards and local authorities. That effort would continue whether or not community health partnerships existed, although community health partnerships provide a clear focus for such activity in the NHS and there may be a practical advantage in their being coterminous with their local authorities. We do not see CHPs creating any additional financial pressures. The joint future agenda is a parallel agenda, which we wish to bring into the whole equation; it is not an extra.

The Convener: There is an issue that I am still slightly unconvinced about. You are placing additional duties on CHPs with regard to public participation. I suspect that you will have to consider staffing issues and get more skilled staff into some positions, and other issues might arise in relation to liaison with local authorities that will incur other costs. The financial memorandum suggests that those additional costs can be met out of the existing funds for the LHCCs. Can you give us any further information about how you went about making that estimation?

Dr Wilson: The financial memorandum makes reference to a reallocation of existing resources within each board, including the funding that is allocated to LHCCs; it does not refer only to the funding that currently supports LHCCs. As Alistair Brown said, as NHS trusts change and operating divisions or their successors come into place—and as NHS boards themselves change—they have the opportunity to enhance the support that is given to community health partnerships for specific functions that may be devolved from NHS boards or from what are currently NHS trusts. It is about not just the money that is used to support LHCCs, but the whole management infrastructure that exists in the NHS.

The Convener: That gives rise to a further issue. The LHCC money is at least identified. Now you are talking about other money that might be reallocated, which you have not been able to quantify for us. You are saying that health boards might be able to contribute other money to the process of establishing the CHPs. To make your argument convincing, you must be able to say how much more than the LHCCs the CHPs will cost and how funding to meet that additional cost will be derived.

Dr Wilson: Yes. That takes us back to our earlier discussion about the timing of events. At present, because local NHS board areas are considering how best they can configure their services for the future, it has not been possible for us to do what you have described.

The Convener: I want to press you on another issue. One of the specific requirements of the bill is more systematic public consultation. Last week, we had some difficulty in getting from the health boards a sense of what that additional consultation would cost. Your assumption seems to be that health boards can meet the cost of the additional consultation from their current allocation. The same assumption is made in relation to the new Scottish health council being able to absorb the money that goes to the local health councils. It seems quite convenient that we can get more for less. Can you say more to convince us of that?

Lorna Clark: Public involvement is not a new duty; it is something that NHS boards ensure routinely. The extent to which there is public involvement will depend on what sort of service change is being considered. For example, if a health board or a GP practice is considering a small change in how it operates, it will undertake a reasonably small consultation exercise on that. If a major service change is being considered, one would expect the consultation to incur a bit of a cost. Boards have been consulting in that way for years; it is not something new.
By introducing a statutory duty for public involvement, the bill recognises the increased priority that public involvement is being given. Some of the evidence that the committee took from NHS boards such as Ayrshire and Arran NHS Board reiterated our point that boards expect to have to involve the public. Involving the public in determining how services operate is a fundamental part of what the NHS does; the bill simply makes that statutory. We are not changing the way in which NHS boards go about their consultation; we are putting more money in from the centre to assist public consultation and to help to build capacity at a local level.

Boards are already involving the public in service redesign and consideration of how they can do things differently. The duty simply puts that on a statutory footing. We are not placing any additional responsibility on NHS boards; we are just formalising what they do at the moment.

The Convener: Yes, but there is an issue about how ministers are expressing the policy intention of the bill. They are presenting the change in the volume of public consultation that people can expect as a major step change, yet the financial memorandum seems to suggest that that can be achieved at no additional cost. I wonder whether those two expressions of intent can be reconciled.

Lorna Clark: The Executive is investing something like an additional £4 million a year, as part of our patient focus and public involvement programme, to help with capacity planning, to ensure that NHS staff are better equipped for the commitments that are required of them, and to ensure that patients and the public are better equipped to be equal partners with the NHS in being consulted and in reacting to consultations. Additional central money is being allocated over and above what NHS boards receive at the moment. That commitment is on-going and is not a direct consequence of the bill. For some time, we have been working on increasing capacity and NHS boards’ ability to undertake public involvement. The bill formalises that; it does not do anything particularly new.

The Convener: The general lesson to draw from that response—which perhaps came out of the earlier questions about the abolition of NHS trusts—is that, to get a better assessment of what is going on, we require more information than we are being given. If the information that we receive focuses narrowly on the specific impact of the legislative process, we will not get the full perspective that we require. If significant resources are already going into public consultation and participation, which the bill formalises, we need to get the whole financial picture of that.

Fergus Ewing: I want to return to our core function and the prediction that the minister has made, which is supported in paragraph 42 of the financial memorandum, which states:

“There will be no additional expenditure associated with this Bill.”

We have heard from the witnesses today that there will be some savings, but they do not know how much those will be, so they cannot say. We have heard that there will be extra costs, but they do not know how much those will be, so they cannot say. On the other hand, page 9 of the explanatory notes makes claims about the dissolution of NHS trusts, CHPs, health boards and powers of intervention, all of which have been either contradicted or seriously questioned in several of the written submissions that we have received.

For example, Highland NHS Board says:

“CHPs may increase costs if central economies of scale are lost.”

Argyll and Clyde NHS Board points out that CHPs are significantly more expensive than LHCCs. The witnesses have been unable to say how many CHPs there will be; they do not know. They do not know how many staff there will be. They have said that people are planning for single-system working, but Highland NHS Board says that there may be additional “unfunded” costs in relation to the dissolution of trusts and redundancy costs. I presume that it is not being suggested that any health board has set aside redundancy costs in future budgets, because I would have thought that they could not legally do that.

I wanted to bring all that together and put it to the witnesses that the financial memorandum is the Denis Norden of financial memorandums, in that it is hoped that it will be all right on the night. If that is felt to be too facetious, perhaps they will answer these two questions for me. First, to what percentage are they still confident that paragraph 42 is correct, when it states

“There will be no additional expenditure”? Second, how confident are they—in percentage terms—that there will not be additional expenditure in the first year of operation?

Lorna Clark: We are confident that no additional costs will be attached to the bill. My colleagues and I have gone through the different sections of the bill and tried to explain how we have come to believe that. A lot of what the bill seems to do is evolutionary—it builds on things that we are already doing. Boards have been working towards single-system working for some time and have been planning what they need to do.

We are confident that what we have said in the financial memorandum is correct.
Fergus Ewing: So there is no chance that you could be wrong.

Alistair Brown: It is important that we understand that the financial memorandum expresses the Executive’s and ministers’ expectation that there will be no additional expenditure; we are not providing an absolute guarantee. Within the world of the NHS, an NHS board could decide to use the occasion of the dissolution of its trusts to do things better locally. It might decide—and it would be quite within its rights to do so—to put more money into some aspect of its administration and less into something else, or it might decide to allocate more of its annual increase to something flowing from the dissolution of trusts.

We are not saying that those will never happen, and there is nothing to prevent NHS boards from taking steps of that kind, but we are saying that we have a confident expectation that no additional expenditure will flow as a direct consequence of this piece of legislation. I believe that that is as far as we can reasonably go. I hope the committee agrees with that.

The Convener: I think the Finance Committee tends to be sceptical at all times.

I have one final question, on health promotion and the requirements in paragraphs 38, 39 and 40, which describe the statutory duty that will be placed on boards in relation to health improvement. If the statutory function is to be meaningful, how can it be carried out without additional expenditure? In addition, who will audit the boards’ provision in meeting that statutory function, because there is a gap in terms of the reorganisation?

Lorna Clark: Health boards are given an annual allocation and it is up to them to determine within the sums that are available to them how they will manage and deliver local health care systems that meet the health care needs of their local population. A lot of boards have been doing work on health improvement. As with the duty on public involvement, we are building on and making more explicit what a lot of boards have been doing already.

The most recent figures that are available show NHS boards’ planned expenditure on health promotion in 2002-03 as around £24 million. That funding is incorporated in the resources that they have and will continue to flow into the present time.

If my colleagues are unable to answer the question about how that expenditure will be monitored, we can find out and get back to you.

The Convener: That would be helpful. On behalf of the committee, I thank the witnesses for coming along this morning.
Thank you for your letter of 8 October regarding the additional information Scottish Executive officials agreed to provide during their appearance before the Finance Committee on the 7 October. The purpose of this letter is to supply the requested information.

Costs of Intervention (Col 327)

The Committee sought a breakdown of the costs of previous interventions by Ministers and the Health Department in the NHS in Scotland, with particular reference to the State Hospital, Carstairs (the Ruddle Inquiry); Tayside NHS Board; the Beatson Oncology Centre (Greater Glasgow NHS Board); and NHS Argyll and Clyde.

In attempting to quantify the costs of previous interventions, judgement has to be exercised about which costs are directly attributable to Ministers’ intervention and which would have been incurred regardless of the intervention. In some cases, the majority of the cost of an intervention is attributable to the salary costs of existing NHS senior staff. Additional costs to the public purse in these circumstances would consist of any extra payments made to the employees directly involved in the intervention, and to other staff who step up temporarily to backfill their posts. In other cases, external expertise has been brought in to reinforce NHS resources. The full cost of that expertise represents a net additional cost to the public purse.

Ruddle Case

The Ruddle case has been mentioned as an example of Ministerial intervention in the NHS. Were the proposals in the NHS Reform (Scotland) Bill to be enacted and were a similar situation to the Ruddle case to arise thereafter, it is not clear to us that it would be necessary or appropriate to use these powers. As explained to the committee on 7 October, the new powers are intended to be used as last resort to enable Ministers to direct that specified services should be taken over by another NHS Board or by a nominated team where the services are failing and where the Board in question is unable or unwilling to improve performance. In the Ruddle case, the State Hospital Board was willing to develop and provide additional treatment services for patients including the psychological interventions that were relevant to the case. Ministers asked the Mental Welfare Commission (MWC) to carry out an inquiry, and the Board co-operated fully. In light of the MWC Inquiry report, an action plan was agreed and implemented by the Board. Ministers provided additional resources to support the action plan. The Department monitored its implementation. In addition, the Executive proposed, and the Scottish Parliament passed, legislation bearing on the case, with the aim of closing the legal loophole that had allowed Mr Ruddle to appeal successfully against his detention in the State Hospital. These are not circumstances in which Ministers would in future be likely to choose to exercise their proposed new powers of intervention.

As to the additional costs of the Ruddle case, no intervention team was deployed at the State Hospital. There were therefore no direct additional costs of intervention. A substantial amount of legal and administrative time at Ministerial and senior official level was devoted to considering and attempting to resolve the case, but as far as we are able to ascertain now, this amounted to a redeployment of effort rather than net additional effort and therefore no additional financial costs were incurred. The MWC undertook an inquiry at Ministers’ invitation. Although it is part of the statutory function of the MWC to investigate
matters of concern, the Scottish Executive allocated an additional £10,000 to the MWC for undertaking this specific inquiry.

Of course there would have been “opportunity costs” in the State Hospital, in the Executive and in the MWC – other things that were not done because staff were concentrating on the Ruddle case. It is not now possible to say what these other things were, nor to quantify their cost or value.

Many hours of Parliamentary time were devoted to considering and passing the Mental Health (Care and Safety) (Scotland) Act 1999. Again, the costs of this time were already being met by the public purse in the form of MSPs’ and Parliamentary staff’s salaries and related expenses and no net additional costs arose. The question of opportunity costs in Parliamentary terms remains unquantifiable.

Ministers decided to increase the State Hospital Board’s annual financial allocation by £0.9 million following the report of the MWC Inquiry, to support implementation of the agreed action plan. It could be argued that this was a financial consequence of Ministers’ intervention following the Ruddle case. It represented an improvement in services for the patient group in question, was intended to enable implementation of the MWC recommendations, and flowed from Ministerial policy decisions. Such decisions are made frequently, and the attendant costs cannot in our view validly be attributed to the process of intervention. They are costs associated with the policy decisions themselves.

Tayside NHS Board

The then Minister for Health and Community Care established the Tayside Task Force in February 2000, following reports by Tayside University Hospitals Trust that they were forecasting a shortfall of up to £12 million. The Task Force consisted of Professor Frank Clark, recently retired Chief Executive of Lanarkshire Health Board; Mr Cameron Revie, a partner in Price Waterhouse Coopers; Mr David Bolton, a senior manager in NHS Lothian; Mr Mike Fuller, National Officer with the trade union MSF; and Professor David Rowley, a senior clinician employed by NHS Tayside.

The Task Force published a report in June 2000 highlighting problems such as a lack of effective financial control and other issues. Following this, a number of changes were implemented and improvements made, including the production of a financial recovery plan demonstrating how the acute hospitals Trust would move back to a position of financial balance. In view of the improving picture and the appointment of new permanent chairs to Tayside NHS Board and to the Trust, the Minister decided to withdraw the Task Force at the end of November 2000. The direct costs of the intervention in Tayside NHS Board, as reported in response to Parliamentary question S1W-11575, was £84,467. We are satisfied that this figure is accurate. These costs were met by NHS Tayside.

As a result of implementing the financial recovery plan, the preparation of which was led and overseen by the Task Force, NHS Tayside is now in financial balance. The statutory auditors have commended NHS Tayside for effective financial governance arrangements. It could be argued therefore that the intervention has helped, if not to save money in NHS Tayside, then to ensure that the budget is properly planned, controlled and applied.

Beatson Oncology Centre

In December 2001, the Minister for Health and Community Care, Mr Malcolm Chisholm, announced that a new Director would take over day to day management responsibility for
the Beatson Oncology Centre from North Glasgow Hospitals NHS Trust, reporting direct to the chief executive of NHS Greater Glasgow. Dr Adam Bryson was appointed to the post with immediate effect, on secondment from his permanent post as medical director of the National Services Division of the Common Services Agency. At the same time, the Minister asked for urgent action to bring forward the preparation of plans for the replacement of the Beatson’s facilities on the Gartnavel Hospital site.

Dr Bryson remained in post until the recruitment of a new permanent Clinical Director at the Beatson. Dr Bryson returned to National Services Directorate in May 2003. While Dr Bryson was seconded to the Beatson Centre, temporary arrangements were made to cover his post as medical director at NSD. No other staff were seconded or appointed through the Minister’s intervention. The additional costs to the NHS of arranging backfill for Br Bryson’s post were less than £75,000 for the 18-month period. These costs were met by NHS Greater Glasgow.

NHS Argyll and Clyde

On 17 December 2002, the Minister announced that, following a report from a support group, an interim management team had been sent in to tackle strategic and operational challenges at NHS Argyll and Clyde, following the decision of the chief executives of the NHS Board and the three Trusts to step down to make way for a fresh approach. The interim management team comprised Mr Neil Campbell, chief executive of Grampian NHS Board; Mr Terry Kirchin, former general manager of the Scottish Centre for Infection and Environmental Health and former director of human resources at Lanarkshire Primary Care NHS Trust; and James Hobson, a senior manager with Price Waterhouse Coopers, Glasgow.

Following the intervention, NHS Argyll and Clyde moved to implement a decision of the Board, made in autumn 2002, to put in place single system working across the area, leading to the dissolution of the NHS Trusts and their replacement with operating divisions which are formally part of the NHS Board. The Trusts were dissolved with effect from 1 July 2003. The NHS Board also took steps to fill permanently the post of Board chief executive and to make other key appointments. After an open competition, Neil Campbell was appointed Board chief executive with effect from 1 September 2003. The Board also appointed Terry Kirchin, on an interim basis, as Director of the Paisley and Renfrewshire division; and, after an internal competition, James Hobson was appointed substantively as Finance Director of the Board. The total employment and other costs of the three members of the interim management team up to the time of their appointments as members of staff of NHS Argyll and Clyde, as calculated by the Board, is £232,000. Other costs were incurred through the Board using the services of external consultants and others to advise on aspects of financial management and of restructuring of management functions. This amounted to £25,000. In addition, the support group which investigated strategic issues in NHS Argyll and Clyde prior to the 17 December announcement had incurred costs of £42,000.

When all related costs are included, the total cost estimated by NHS Argyll and Clyde is approximately £300,000, as provided to the Committee by Mr Campbell. Mr Campbell was of course the chief executive of NHS Grampian and the net additional costs of his contributing to the interim management team in Argyll and Clyde are limited to backfilling costs in Grampian. The chief executive post there is being filled on a temporary basis by the Board’s Director of Finance and additional costs are modest.

Attribution of Costs in Argyll and Clyde (Col 328)
The Committee also sought further information about the Department's consideration, with Argyll and Clyde NHS Board, of the attribution of costs between the NHS Board and the Department.

The costs were met by NHS Argyll and Clyde, with a contribution of £147,000 from the Department.

Other Matters

In addition to the points raised in your letter, a number of other points were made in the examination by the Committee on which we would like to offer further information and observations.

Costs of Dissolving Trusts (Col 323)

At the oral evidence session on 7 October, the Committee sought information about the costs of dissolving NHS Trusts. We took the view – as we said to the Committee – that these are not material and consist of some senior NHS staff time devoted to preparing and responding to consultation exercises, Board time spent considering dissolution proposals, and small amounts of legal staff time to prepare formal documentation. None of this represents net additional costs, since the staff time in question is already being paid for. In time, some NHS Boards may spend money on replacing signs, although a number of NHS Boards have already begun to adopt the common “NHS area Board” title for signs and publications etc. NHS Boards have not raised with us any concerns about costs associated with dissolution. Any costs will be residual in the context of NHS Board allocations and will be absorbed by the Boards.

The Committee also suggested that there will be costs associated with management restructuring following dissolution of Trusts. We agree that there may be costs of this kind. We take the view, however, that where these costs occur they are a consequence of decisions made by NHS Boards about internal management structures. We do not agree that they are a direct cost of dissolving Trusts. Management restructuring costs will vary considerably from one Board to another, and so will the timescale within which they fall. To gather information about these costs would require information to be collected from each NHS Board area. Our enquiries of Boards indicate that they are not forecasting material costs and have not therefore prepared estimates of these costs. However we have obtained reports from NHS Borders and NHS Dumfries and Galloway, both of which have completed management restructurings following dissolution, as the Committee is aware. The Boards were able to draw on modest additional funding from the Health Department to support restructuring.

NHS Borders have reported to us in respect of management restructuring that:

“The majority of the costs have been borne from within existing resources (i.e. chiefly existing staff being designated to manage and/or contribute to the process). A limited amount of additional non-recurring funding was made available by the then Strategic Change Unit of the Scottish Executive Health Department to resource external facilitation for the change programme. The total funding that was made available in 2001/02 and 2002/03 was around £100,000.”

Borders go on to estimate that management cost savings amounting to around £500,000 will be realised over the three year period to March 2004.
In giving his oral evidence to the Committee, Alistair Brown stated (Col 332) that as far as he was aware – and subject to checking – the management consultant costs incurred in the reorganisation of NHS Borders were met by NHS Borders. It would appear that these costs were met out of the £100,000 made available by the Scottish Executive Health Department.

NHS Dumfries and Galloway estimate that cost savings approaching £500,000 a year are being realised from the series of management changes and rationalisations flowing from moving to single system working. In response to our request, the Board has not drawn attention to any costs associated with the restructuring.

As the Financial Memorandum to the NHS Reform Bill states, NHS Trusts are currently being wound up now under existing powers in the NHS (Scotland) Act 1978. The measures in the Reform Bill are not necessary to enable the dissolution of individual Trusts. They simply update the statute book to bring it into line with the policy that Trusts will no longer be a feature on the NHS landscape in future. Consequently the measures in the Bill have themselves no financial implications. Any costs and savings resulting from the dissolution of Trusts will depend on decisions made or being made by the Boards themselves. These decisions are matters for the Boards and are not discussed beforehand with the Department.

Auditing Health Board provision on health improvement (Col 341)

The Committee also asked how the Scottish Executive will audit the Boards provision on health improvement to ensure that they have met their statutory provision to promote the improvement of the physical and mental health of the people of Scotland.

Health Board provision on health improvement is currently monitored annually through Section 1 of the Performance Assessment Framework (PAF). A self-assessment instrument is completed each year by NHS Boards to assess their progress towards becoming Public Health Organisations.

The purpose of the self-assessment instrument is to:

- Review NHS Boards’ steps to develop services, activities and programmes related to the eight key health improvement functions. These are:

  1. Monitoring and assessing the population’s health and well-being
  2. Developing healthy public policy
  3. Detecting and preventing disease and disability
  4. Maximising the health impact of services
  5. Protecting the population from hazards which damage their health
  6. Supporting the development of personal skills necessary for health and well-being
  7. Strengthening community action for health
  8. Carrying out research to develop health improvement.

- Ascertain how NHS Boards are taking forward the key health improvement priorities of alcohol; diet; drug misuse; health inequalities; mental health; physical activity; oral health; sexual health and tobacco.
• Obtain NHS Boards' views on their own key local achievements in health improvement and identify examples of good practice.
• Facilitate NHS Boards' efforts in developing public health governance
• Facilitate ongoing review and continuous improvement within NHS Boards in relation to health improvement and reducing health inequalities.

An Expert Group with representation from the NHS Chief Executive’s Group, Health Promotion Managers Group, Directors of Public Health Group, NHS Health Scotland, NHS Quality Improvement Scotland, COSLA, and the Scottish Executive Health Department reports on the progress Boards are making. The self-assessment instrument also asks for information on what NHS Boards spend from their total allocation on health improvement along with details of plans for further investment. All funding streams have to be identified in the total spend. Feedback is given to Boards on the information provided in the self-assessment instruments and the information is used in the Accountability Review process.

Local Health Plans are also scrutinised to ensure that NHS Boards have health improvement in all areas and that Joint Health Improvement Plans (JHIPs) are being prepared and resources made available for initiatives such as Integrated Community Schools.

Conclusion

I hope that this letter provides the Committee with all the information it has asked for. In summarising, I would like to reiterate the point that this Bill reflects many of the changes that are happening as NHSScotland evolves to improve the health services it delivers. Capacity exists within the management of NHSScotland to manage change and to redesign structures and services to improve health care – it is what NHS managers do. Much of this capacity will be deployed in making the changes outlined in the Bill. Therefore, effecting these changes will not result in additional expenditure.

How Health Boards deploy the resources available to them is a matter for them and this is consistent with the spirit of Partnership for Care, which seeks to devolve responsibility down from St. Andrews House to those managers and clinicians who will be managing and designing services once they have consulted with patients and the public. The existing capacity of the NHS to manage change is one of the main reasons why, in responding to Rule 9.3.2 of the Standing Orders of The Scottish Parliament, the Executive has stated that it is our best estimate that there will be no additional administrative, compliance and other costs that will fall upon the Scottish administration, local authorities, other bodies, individuals and businesses as a consequence of the provisions in this Bill.

Lorna Clark
Bill Team Manager
22 October 2003
SCOTTISH EXECUTIVE RESPONSE TO STAGE 1 REPORT ON THE NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

NHS REFORM (SCOTLAND) BILL – STAGE 1 REPORT

I am writing to thank the Committee for the work they have done to produce the Stage 1 report and for recommending that the Parliament approves the general principles of the Bill. I thought it might also be helpful if I addressed some of the comments that you have made in your report in advance of the Stage 1 debate.

Establishment of Community Health Partnerships

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

It is our intention to consult on drafts of the regulations and the statutory guidance. As soon as they are available, I will send copies to you and will of course have regard to the Committee’s comments when finalising these documents.

Duty of Health Boards to co-operate

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

Guidance is available on the services that are most likely to benefit from being organised on a regional basis. Appendix 1 of HDL(2002)10 gives an indication of the population that certain services should be planned for. Health Board Chief Executives are now strengthening the machinery of regional planning in anticipation of this proposed new duty, including the arrangements for deciding what issues will be subject each year to planning reviews at a regional level. The Health Department Letter (HDL) is a helpful part of the clinical background to this work, but the appendix to the HDL is not definitive or comprehensive.

Public Involvement and the dissolution of Local Health Councils

“Due to the level of public interest in the consultation process, the Committee welcomes further guidance on consultation which the Minister has confirmed he is preparing (Col 534). We seek a commitment from the Minister to improve the current situation and would expect the Committee to be fully consulted and to play an important scrutiny role in relation to the draft guidance.”

The current interim guidance on public involvement, which issued in May 2002, was developed with wide involvement of interested parties. We are currently finalising the guidance and it is our intention to issue it to key stakeholders for comment. I shall send a copy to the Committee and will of course have regard to their comments when finalising the document.
“The Committee is not convinced that the Scottish Health Council should necessarily be part of NHS QIS. The Committee therefore invites the Minister to report to the Committee on progress regarding his work in conjunction with the Scottish Association of Health Councils to guarantee the independence of the actions of the Scottish Health Council. We seek confirmation that the Minister in his discussions with the Scottish Association of Health Councils will address in particular two issues: the question of shared management and, as a consequence of this, the safeguarding of independence of action.”

The Steering Group setting up the new Scottish Health Council and its Local Advisory Councils will consider management issues and the safeguarding of independence. The Convener, Vice-Convener and Director of the Scottish Association of Health Councils are members of the Steering Group. I am happy to undertake to report to the Committee on the progress made in these discussions.

“The Committee would welcome further clarification on the role of Local [Advisory] Health Councils in patient advocacy.”

In relation to advocacy services, which aim to support people in making informed choices about, and remaining in control of, their own health care, Local Advisory Councils will have an important role in ensuring that Boards are making these services available to ensure that patients are capable of expressing their viewpoints. Traditionally, advocacy services have been mainly available to vulnerable groups, such as people with mental health problems, learning difficulties, physical disabilities and older people, but these should be available more widely to all health service users where this is needed.

The Local Advisory Councils will also have an important role in ensuring that the Health Boards hear, understand and act upon the views, concerns and experiences of patients, carers, patient organisations and communities. This is a wider role than advocacy in the traditional sense, which is about supporting individuals and helping them to speak for themselves in their relationship with health services. Health Boards will be responsible for ensuring that patients are supported to express their views about the health services they use either individually or through local interest or community groups and through the new Public Partnership Forums. This assessment role will see the Local Advisory Council engaging directly with their local community and, through this direct awareness of local issues and concerns, make sure that the Board is dealing with them effectively. Where they feel the patient’s viewpoint is not adequately being considered or where there is not an appropriate patient support group, the Local Advisory Council will put forward the views of the patient and ensure that appropriate action is taken. This direct engagement of patients with NHS service providers has, I believe, the potential to involve a much wider range of people and interests and will be a more effective way of ensuring that the patients’ voice is heard.

Financial consequences

Abolition of Trusts and the establishment of CHPs

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

As far as the abolition of NHS Trusts and the formation of operating divisions is concerned, our expectation in formulating the policy was that set up costs would be low and that modest savings - which would fully offset these costs - would arise through NHS Boards combining support services and discontinuing the activities of Trust Boards. This expectation has been borne out in practice among the Boards that have completed their restructurings: the Committee has had evidence from NHS Dumfries and Galloway and indirectly from NHS Borders that net savings have been made. We would expect these to be reinvested in patient services.

As regards the formation of Community Health Partnerships, Health Boards will make arrangements that are appropriate for their Board area. As I have explained, it would be extremely difficult to estimate what the costs of this would be. However, we can confidently say that this re-organisation can be done within the existing management resources that NHS Boards have. I can also give the re-assurance to the Health Committee that re-organisation will not be at the expense of funding to front-line services.

I hope that the Committee will find the above information useful and I look forward to debating the issues further with them as the Bill progresses.

Malcolm Chisholm MSP
23 February 2004
Note: (DT) signifies a decision taken at Decision Time.

**National Health Service Reform (Scotland) Bill – Stage 1:** The Minister for Health and Community Care (Malcolm Chisholm) moved S2M-215—That the Parliament agrees to the general principles of the National Health Service Reform (Scotland) Bill.

Shona Robison moved amendment S2M-215.1 to motion S2M-215—

Insert at end—

“but, in so doing, believes that there must be safeguards in place to ensure the independence of the proposed new Scottish Health Council and is concerned about the lack of detail in the Financial Memorandum regarding potential additional costs arising from the Bill.”

After debate, the amendment was disagreed to ((DT) by division: For 39, Against 77, Abstentions 0).

The motion was then agreed to ((DT) by division: For 94, Against 17, Abstentions 5).

**National Health Service Reform (Scotland) Bill – Financial Resolution:** The Minister for Health and Community Care (Malcolm Chisholm) moved S2M-227—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the National Health Service Reform (Scotland) Bill, agrees to any increase in expenditure of the Scottish Ministers payable out of the Scottish Consolidated Fund in consequence of the Act.

After debate, the motion was agreed to ((DT) by division: For 73, Against 44, Abstentions 0).
National Health Service Reform (Scotland) Bill: Stage 1

The Presiding Officer (Mr George Reid): The next item of business is a debate on motion S2M-215, in the name of Malcolm Chisholm, on the general principles of the National Health Service Reform (Scotland) Bill, and on one amendment to that motion.

14:37

The Minister for Health and Community Care (Malcolm Chisholm): The National Health Service Reform (Scotland) Bill contains the legislative changes that are necessary to realise the vision that is set out in the white paper “Partnership for Care” and in the partnership agreement. It is a vision of a health service with a culture of caring that is to be developed and fostered by a new partnership between patients, staff and Government. It is a vision of a health service fit for the 21st century, in which patients are the key drivers of change and front-line staff are the leaders of the change process.

The Scottish Executive is spending £7.2 billion on health this year and the figure is planned to rise to £8.7 billion by 2005-06. That investment must be matched by patient-centred reforms that deliver improved health and more integrated health services.

The Health Committee took evidence from a wide range of interests and I thank it for its report. I very much welcome its endorsement of the bill’s general principles, subject to the reservations that it has expressed.

I will now deal with the bill’s provisions. The first of the reforms that I have included in the bill is the final step in the dissolution of national health service trusts. Trusts were set up as a key feature of the internal market and, although they have lost much of their original purpose, they are still a hindrance to the single-system integrated working that we believe is best for Scotland.

Patient-centred services of the highest quality cannot be delivered by a market-style NHS in which trusts compete with one another, but they can be delivered by NHS staff working together as part of the same organisation. That is why we are moving towards single-system working.

Mr Brian Monteith (Mid Scotland and Fife) (Con): The minister suggests that patient-centred care can be provided only by a centralised system. Does he acknowledge that opticians, which are not centralised and are generally free from direction, provide patient-centred care?
Malcolm Chisholm: I agree with the second point, but the leap from a single system to centralisation is enormous. I have been trying to tell the Conservative party for months that we support a single system that is decentralised—that is exactly what I will go on to describe.

In removing the powers to establish trusts, we wish to establish single-system working in a decentralised context with the delegation of decision making and responsibility to the point of patient care. That is where community health partnerships are so crucial. Community health partnerships will build on the achievements of the most innovative local health care co-operatives. They will help to make the planning and delivery of health care more responsive to the needs of local populations and to develop more services in community settings. They will also be a key vehicle for integration.

On the one hand, CHPs will act as a focus for the integration of primary and specialist services. That will bring about a shift in the balance of care to enhance local community-based services with improved access for local people. On the other hand, CHPs will be able to progress the joint future agenda locally through substantive partnerships with local authorities. If CHP boundaries are coterminous with local authority administrative boundaries, the potential for further integration becomes greater.

CHP committees will comprise representatives from front-line staff and key partners such as local authorities, the voluntary sector and the public. They will have greater responsibility and influence in the deployment of all resources by health boards and they will play a more influential role in service redesign locally. We will ensure that schemes of establishment are focused on health service and health improvement outcomes. We will also ensure that the health boards prepare robust development plans to support the evaluation of CHPs.

Bruce Crawford (Mid Scotland and Fife) (SNP): On coterminous boundaries, we must ensure that we get the best fit and the best efficiencies. Will there be a shift in health board boundaries to meet council boundaries or, vice versa, will councils be restructured to meet health board boundaries?

Malcolm Chisholm: We do not have any such proposals at the moment. We want to ensure that, as CHPs are set up, they are coterminous as far as possible with local authority boundaries. It may be that one CHP will have representatives from two NHS boards but not from two local authorities. That is the best approach at present.

It is vital that the CHPs involve their communities when planning and delivering services, as they cannot provide effective services unless they know what their communities need. Each CHP will be required to support effective community involvement through public partnership forums that will ensure that the CHP engages effectively with its local community. That should build on good existing local approaches and on the work of local user and carer groups. The forums will be involved directly in the decisions that are taken by each CHP on the planning and delivery of services.

Mr John Swinney (North Tayside) (SNP): I agree entirely with what the minister said about the importance of community involvement and locality. However, some of what he said does not sit comfortably with the feelings of many communities in Scotland about the way in which decisions are taken to reconfigure services, especially when the outcome fundamentally reduces access to those services at the local level. How will he ensure that the rhetoric that he uses in Parliament is much more closely reflected in the reality that some of us see on the ground in the communities that we represent?

Malcolm Chisholm: We have seen several excellent examples of good public involvement in the part of Scotland that John Swinney represents. I will visit NHS Tayside on Friday. The public partnership forums that have been set up in that area are a good example of better engagement with local communities.

I will now deal with public involvement more generally. Underpinning the obligations of the CHPs to involve the public will be a statutory duty that requires all health boards and special health boards to involve and consult the public on the planning, development and delivery of health services. It is essential to our vision of a modern health service that patient focus and public involvement are fully integrated with day-to-day management and delivery.

Bill Butler (Glasgow Anniesland) (Lab): Will the minister give way?

Mr Duncan McNeil (Greenock and Inverclyde) (Lab) rose—

Malcolm Chisholm: I will give way to Bill Butler and then I think that I will have to get on.

Bill Butler: The minister will be aware of my proposed member’s bill, which would provide for direct elections for a majority of places on health boards. Does he recall the words of his colleague the Deputy Minister for Health and Community Care in a debate on the national health service last year? The deputy minister said:

“The Executive will seriously consider the proposal alongside its own radical agenda”.—[Official Report, 18 June 2003; c 853.]
Have ministers reflected on the proposal? What will the Executive do formally to assist?

Malcolm Chisholm: I will report back to Bill Butler on the issue. Obviously, there would have to be a wide public consultation on his important bill. I will look into the matter in respect of any help that we can give.

The new Scottish health council, which featured quite a bit in the Health Committee’s report, will be a major step forward in supporting patient focus and public involvement in the NHS. We wish to see the Scottish health council created as part of NHS Quality Improvement Scotland, which reviews and reports on standards in the NHS independently of the Government. That is because we see achieving a real patient focus as inseparable from improving the quality of our health services, the starting point for improving quality being the experience of every patient who passes through the health care system.

I know that there are concerns about the future structure of public involvement and the independence of the Scottish health council, but I say again that we are committed to creating a Scottish health council that acts independently, brings professionalism and expertise to the patient focus and public involvement agenda and builds on the strong local roots and commitment of the health council movement. Detailed arrangements to secure those objectives are being developed in partnership with the Scottish Association of Health Councils. I shall write to the Health Committee about that before stage 2.

The duty that I have just mentioned requires boards to involve and consult the people to whom they provide services. A key role of the Scottish health council and its local advisory councils will be to ensure that the boards do that job properly. They will therefore be a key driver for the improved public involvement that we all want.

If the public are not receiving services, or are receiving poor-quality services, it is important that Scottish ministers have appropriate powers to intervene to ensure that those services are brought back up to the required standards. That is why I have included a power in the bill that is flexible enough to cope with a wide range of issues, yet can be used only as a last resort by virtue of the necessity test. That legal test will ensure that the new power will be available only where intervention is more than just desirable, useful or expedient.

The Scottish ministers can use many indicators to decide whether an intervention is necessary, including lengthening waiting times, information from the performance assessment framework, clinical standards not being met and persistent complaints from patients. I do not expect that ministers will use the new power often, but in the event of a serious failure, or where a serious failure is likely, patients would expect ministers to be able to step in quickly to ensure that the problems are addressed.

The bill also includes a new duty on boards to co-operate to advance the health of the people of Scotland. If we are to maximise the level of service that we can provide to all communities throughout Scotland, we need NHS boards to work collaboratively with other boards to share skills and resources to provide a better service. To do otherwise is simply not sustainable.

As some health services become more specialised and complex, we need more regional planning to ensure that the services are delivered successfully and to the highest possible level of care. Health board chief executives are working up a proposed regional planning framework that will allow for a co-ordinated approach to regional planning. I shall scrutinise that and ensure that we have much more effective arrangements than we had in the past.

Health improvement also features in the bill, as the NHS should be a service about health, not just about illness. The duty in the bill makes it clear that it is a responsibility of Scottish ministers and health boards to promote health improvement; the bill provides them with powers to enable them to do just that. I recognise that boards alone cannot improve health, so the powers will enable them and Scottish ministers to work with, and give financial assistance to, other organisations, including local authorities, in promoting health improvement.

In “Partnership for Care”, we said that none of the reforms will happen without staff. A key role for the Government, as I said in the debate last week on the NHS work force, is to support, value and empower staff to lead the change process in partnership with patients. I have already set out how we propose to empower front-line staff by devolving decision making to them. We also wish to value and support them. That is why we have a staff governance standard, which reflects our fundamental belief that staff should be well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently, and provided with an improved and safe working environment.

At stage 2, I will lodge an amendment to ensure that systems are in place to make a reality of staff governance. That will be achieved through compliance with the staff governance framework, which has been agreed by a partnership of the Executive, the NHS, trade unions and professional bodies.
Section 1 of the National Health Service (Scotland) Act 1978 requires Scottish ministers to promote a comprehensive and integrated health service designed to secure improvement in the health of the people of Scotland. It is important that the health service improves the health of all the people of Scotland, irrespective of gender, race, disability, age, sexuality, beliefs and opinions. That is why we will lodge an amendment at stage 2 to require boards to promote equal opportunities when undertaking their functions.

I know that some members have questioned the statement in the financial memorandum that no additional expenditure will be associated with the bill. I remind members that there has been an uplift of 7.8 per cent in the resources provided to boards in 2003-04 to manage and provide services. Moreover, an additional £173 million will be spent on health improvement over the next three years under the “Building a Better Scotland” programme and money has been invested in supporting the delivery of the patient focus and public involvement programme.

Boards have a great deal of capacity to manage change. Some boards have already dissolved trusts and demonstrated savings, for example. The change from LHCCs to CHPs is evolutionary. The move to regional planning will require a redistribution rather than an augmentation of resources. The reforms should result in more efficient use of resources and can be managed in the record sums that are being provided to boards to manage and provide services. I am determined, therefore, that no additional management costs will be associated with the bill.

The bill has been broadly supported by a variety of organisations. It represents an important step towards the vision set out in “Partnership for Care” and the partnership agreement. I hope that members will give their support to the principles of the bill and reject the unnecessary amendment in the name of Shona Robison.

I move,

That the Parliament agrees to the general principles of the National Health Service Reform (Scotland) Bill.

14:51

Shona Robison (Dundee East) (SNP): I begin by thanking those who gave evidence to the Health Committee and the clerks who, as ever, did a great deal of hard work to enable us to get to this stage 1 debate. I welcome the bill’s principles, which have been the thrust of SNP policy for some time—it has taken the Executive approximately five years to catch up, but better late than never.

The SNP has been keen for a long time to abolish trusts because we want to remove the artificial barriers that exist between primary and secondary care and that have hindered the delivery of an integrated system across Scotland. It is important to simplify the system for the public, patients and staff. There is too much bureaucracy in the NHS, but we are slowly getting rid of it, which is to be welcomed.

Structural changes alone will not cure the ills of the health service. We need to address more fundamental issues and to build capacity in the NHS to respond to the needs of the Scottish public. That does not mean that the bill is not necessary, however.

Phil Gallie (South of Scotland) (Con): When Shona Robison spoke of a reduction in staff, I presume that she was referring to administrative staff. However, how will the centralisation of the health boards and the division of primary care and acute trusts help to retain staff? Will she estimate how many jobs will be saved?

Shona Robison: I hope that there will be cost savings as a result of the reduction in bureaucracy—I would be concerned if that were not the case. The bill seeks to simplify bureaucracy and to deliver a better service. As the trusts have no role in that regard, their abolition is long overdue.

The bill deals with other important matters, such as regional working. The severe lack of co-operation across Scottish health board boundaries and the lack of regional planning have been highlighted by the debacle in maternity services in Glasgow and the west of Scotland. I know that Stewart Maxwell will have more to say on that in his speech. We have to ensure that such a debacle does not happen again.

Community health partnerships are another important development. Such partnerships have great potential, but we need to know more about the Executive’s thinking on how they will operate and what they will do. I do not think that all is clear on that front.

It is fair to say that LHCCs have been something of a mixed bag. Some of them work well; some not so well. The difference is that community health partnerships are to be statutory bodies, unlike the LHCCs, which are voluntary. CHPs must be dynamic organisations that can respond to local needs. I do not believe that that will be a cheap option. The NHS Confederation in Scotland, the body that represents the managers to whom the minister referred, is raising concerns about that. It has stated:

“The creation of new bodies almost inevitably has additional costs attached … and Ministers should be aware of this.”

Where is the money to meet those additional costs to come from if not from the Minister for Health and Community Care? Is it to come from other
budgets? If so, from which budgets? We need to know that.

Public involvement is an important element of the bill. As John Swinney highlighted, there has been widespread dissatisfaction about the quality of public involvement in many areas. Many members of the public feel that public consultation is a sham and a game played by those in power to get the result that they wanted in the first place. If we are to change that perception, we need to ensure that the bill’s provisions, as well as other measures, bring about change and that health boards consult the public properly on the planning and development of services. Crucially, there must be changes in the way in which health boards take decisions once they have listened to the public. The jury is currently out on that.

The Executive’s assertion that public involvement can be entirely achieved without any additional resources is a matter of concern. The financial memorandum states that the public involvement duty will involve “no additional expenditure” by health boards. The NHS Confederation, which represents managers—those who know the financial constraints in the health service—stated:

“continuous public involvement is not cheap, as NHS organisations have found through experience”.

If the experience of managers is that public consultation is not cheap, either we will end up having public consultation on the cheap, which will not work and will not deliver the change required, or, yet again, other budgets will have to be used to fund adequate public consultation. Either way, the situation is not acceptable.

Mr McNeil: Will the member take an intervention?

Shona Robison: I am a bit tight on time, otherwise, I would do—I am sorry about that.

I have no problems with the new Scottish health council monitoring how well health boards engage with the public—that is all well and good. However, I have concerns about the independence of the health council, as it is located within NHS Quality Improvement Scotland, which is an NHS body. There is a strong argument that that does not send out a message to the public that the Scottish health council will be truly independent and able to protect their interests. There are arguments for a different structure to be established so as to guarantee the new council’s independence. I would urge the minister, even at this late stage, to reconsider the matter.

There are further concerns about the abolition of the local health councils, which have carried out an important advocacy role in their communities. The local advisory committees, we are told, will not take on that role, although they may have to if no one else can fulfil it. That is extremely confusing—the role should be taken on by one body or the other. Local health councils have fulfilled an important role in directly assisting the public to take up issues with the local health boards. The loss of that important advocacy role is a retrograde step and I urge the minister to reconsider the proposal.

The bill also covers health improvement, which is important, and powers of intervention, which are welcome, although concerns have been raised about them. I agree that the bill must be clear about what “intervention” means and under what circumstances the powers will be used. If the bill is not clear on that point, situations could arise in which there is a lack of clarity about when the powers should be used. The financing of intervention is also a crucial issue. If a financial problem is being investigated and the health board has to pay for the costs of the intervention, is that not a double whammy for our already financially stretched health boards? The minister must consider that issue.

The focus of my amendment is the independence of the Scottish health council and the lack of detail in the financial memorandum. We cannot have a situation where additional responsibilities are put on health boards, which are already strapped for cash—there are already strapped for cash—they are trying to meet junior doctors’ working hours and are facing additional costs—without funding those new duties fully. The money has to come from somewhere; if it is not coming directly from the minister, it will have to come from other budgets, as NHS managers and other organisations are telling the Executive. The Executive must have another look at the financial memorandum and come back with something a bit more realistic.

I move amendment S2M-215.1, to insert at end:

“but, in so doing, believes that there must be safeguards in place to ensure the independence of the proposed new Scottish Health Council and is concerned about the lack of detail in the Financial Memorandum regarding potential additional costs arising from the Bill.”

15:01

Mr David Davidson (North East Scotland) (Con): As a matter of principle, we are opposed fundamentally to the National Health Service Reform (Scotland) Bill, which is designed to centralise even more power in the hands of the minister. Once again, devolution starts and ends with the Executive. At this stage we have no desire to amend the bill, because we oppose it and we do not want an amended version of it to proceed.

Unlike the Labour party’s Airborne brigade sitting on my left, we will stick to our manifesto
pledges of 1999 and 2003 to abolish health boards.

**Mike Rumbles** (West Aberdeenshire and Kincardine) (LD): Will the member take an intervention?

**Mr Davidson**: I will take an intervention from Mr Rumbles later. He should remind me, in case I forget him.

Health boards are well past their sell-by date, as we have been saying for the past few years. Even health board officials agree that the development of managed clinical networks covering several current health board areas will provide a strategic overview and the networking requirements of the future.

We want localised health care delivery to respond to what the patient needs, not what the Minister for Health and Community Care calls for. We want to see a system that will provide patient choice, in which people will be free to make financial and clinical decisions to suit the community and in which patients will be served through independent, not-for-profit organisations that are better able to respond to local needs. One size does not fit all in Scotland.

**Bruce Crawford**: Will the member give us a bit more explanation of the not-for-profit trusts? Is he talking about companies limited by guarantee?

**Mr Davidson**: We are talking about a new form of public service that is simple and has been understood in Westminster—in fact, John Reid has adopted some of our proposals. It is not a case of buying shares and floating a trust on the stock market.

**Bruce Crawford**: Is the member confirming that he would support the principle of not-for-profit trusts being companies limited by guarantee?

**Mr Davidson**: Absolutely. I have no problem with that. We do not need any more comfort zones and boards hiding behind the targets set by the minister. We need there to be real incentives for the people who deliver health care to deliver the best possible care to the maximum number of patients on the basis of the best value for money.

Foundation hospitals are accepted in England, and Scottish Labour MPs believe that they are the correct way forward. That view is apparently shared by the Co-operative Party, of which I believe there are members in the chamber. Brian Wilson has been quoted as saying that

"The NHS should always be responsive to local need",

and Nigel Griffiths, an Edinburgh MP, has stated that he would not object to the Edinburgh royal infirmary becoming a foundation hospital. The risk of not adopting foundation trusts in Scotland is that we will lose key staff, not just because of the money but because of the opportunity that such trusts provide of allowing people to concentrate on professional practice rather than ticking boxes for the minister.

I have stated regularly in the chamber that we do not wish to privatise the NHS but to add capacity through better partnerships with the independent sector. John Reid, that wonderful Scottish MP, has gone some way towards that—he has not gone far—by setting up 60 or so diagnostic treatment centres throughout England, all delivered by independent companies that are run by foreign doctors and designed to reduce waiting times by increasing throughput with no dilution of standards. Why cannot Scotland receive the same treatment?

We will not support the financial resolution, not only for the same reasons but because of our disbelief in the minister’s claims about cost neutrality. The bill is undeliverable without cuts in service, and the minister has just said that the boards have had the money; they will have to pay for the reforms out of what they have got. The only solution to that problem is to cut the costs, the staffing or the throughput. There is no arguing with what the minister said today. However, Audit Scotland is concerned about a lack of transparency if trusts go, and committees of the Parliament are not convinced that the move is correct.

Local health councils are to be merged into a national organisation. Existing health councils agree with that move—they want a national body—but they and I believe fundamentally that the new Scottish health council must not only be independent, but must be seen to be independent. I therefore cannot support its being placed within NHS Quality Improvement Scotland, where management will be confused. Having “NHS” in the title will create the wrong impression, and I do not believe that the minister has addressed the costs of setting up the new organisation.

Community health partnerships are supposed to be coterminous with local councils. Sticking to the principle of a patient-centred system, if that is the case, why can we not merge the social care budget with the primary care budget, combine the staff and do away with dual assessments? That would simplify the system and focus on patient need. I saw such a system in the Falkland Islands just over a week ago.

**Bristow Muldoon** (Livingston) (Lab): If Mr Davidson had taken the shorter journey to West Lothian, he would be aware that West Lothian Council and a local trust are already deep in negotiations about the pooling of social care and health budgets.
Mr Davidson: I take it from Mr Muldoon’s intervention that that is now official Labour policy, which I welcome.

The management boards of the new CHPs must include representatives of the main primary care professions, but there must also be clear input from communities in the boards and in local management. The communities that the CHPs serve must have a clear voice and must be able to get it across.

Malcolm Chisholm: I assure David Davidson that primary care professionals, including those from his profession of pharmacy, will be represented. I have already spoken about the public partnership forums. The CHPs are an example of power being given to front-line staff and of the involvement of local communities. Of course, CHPs completely disprove the nonsense that Mr Davidson and Brian Monteith have spoken about centralisation under the bill.

Mr Davidson: The minister has not yet provided much detail about how the CHPs will be set up and managed. The evidence that the Health Committee took certainly gave the impression that many professionals are concerned about their opportunity to have an input. Perhaps the minister will come back with more details.

To date, the minister has failed to convince anyone that sufficient funding is in place for the CHPs. He has failed to say how they will be structured and manned and to whom they will be accountable. Will the CHPs be accountable to the minister, to the health boards—if he keeps them—or to the communities that they will seek to serve?

Government has a major role in health care: it should fund it and seek ways in which to introduce new funding schemes and capacity. Government also has a role in supporting the educational needs of staff at all levels and it should set standards and ensure that audits are carried out. Given the vast sums that are spent in Scotland, the Government should also begin to seek value for money. Most important, it should ensure patient choice. Our patient passport would give patients the right to access care wherever it can be delivered appropriately and timeously within the NHS. If care is not available, the passport would allow patients to seek it in other sectors while taking some of the NHS tariff with them. Surprisingly, in England under new Labour, if patients go to one of the new independent sector diagnostic treatment centres, they can take the whole fee with them. Why can we not have that system here?

We believe that the issue is not about narrow political ideology, but about real reform that frees up our excellent professionals to respond to patients’ needs, wherever they live. This flawed bill will not do that; the detail is thin and its basis is wrong. The bill will merely entrench the inequalities in our health service, which we are determined to eradicate.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The bill sets out to abolish NHS trusts and to ensure that patients’ interests are put first and that services are planned efficiently through collaboration with and among NHS bodies. In addition, the bill will establish community health partnerships, develop managed clinical networks and place a duty on ministers and health boards to promote health improvement. Most important, the bill will impose a duty on health boards to encourage public involvement.

As the Health Committee’s stage 1 report on the bill makes clear, we are “satisfied that this Bill should improve health service delivery.”

The last sentence of the committee’s report is in paragraph 75, which states: “the Committee recommends that the Parliament approves the general principles of the Bill.”

David Davidson, who is the Scottish Conservative party’s health spokesperson and a member of the committee, supported that position. The report is a unanimous report by the Health Committee. David Davidson argued in favour of the bill in the committee, but he has just talked about the bill being flawed. He took one position in the committee and has taken an entirely different position in the chamber.

Mr Davidson: The committee took evidence and produced a report that is based on that evidence. We tried to reach a conclusion that was based on the evidence that we took, so that the bill could move forward. I remain opposed in principle to the removal of trusts, although I said clearly that I am happy to see them change into foundation trusts. It is for Mr Rumbles to decide whether what I have said has been reported in a different way and misunderstood. However, in simple terms, there are many things in the bill that I worked as a committee member to try to clarify, but we have not received clarity.

The Presiding Officer: Mr Rumbles will have another couple of minutes.

Mike Rumbles: Thank you, Presiding Officer—that was a long intervention.

It is interesting that David Davidson has said twice in two weeks that he has been misreported. We cannot get away from the fact that, as the Scottish Conservative party’s representative on the Health Committee, he has supported the bill.
As I said, he supported the committee’s unanimous recommendation:

“the Committee recommends that the Parliament approves the general principles of the Bill.”

The motion that is before members simply states:

“That the Parliament agrees to the general principles of the National Health Service Reform (Scotland) Bill.”

That is not exactly greatly different from what we put in the committee’s report. For David Davidson come to the chamber and realise that—oops—he has made a mistake is just not on.

Carolyn Leckie (Central Scotland) (SSP): Will the member take an intervention?

Mike Rumbles: No—I have just taken one.

Carolyn Leckie: My intervention is different.

Mike Rumbles: I want to return to the committee’s report.

Two areas of concern were highlighted in the evidence to the committee. The first focused on the public perception of the independence of the new Scottish health council and the second focused on the lack of detail in the financial memorandum that accompanies the bill. Indeed, those two issues are highlighted in the SNP’s amendment.

I will deal first with the Scottish health council. It is absolutely true that, although the committee was not convinced that the Scottish health council should necessarily be part of NHS Quality Improvement Scotland, the committee did not come to a view as to where the council should lie in the great scheme of things.

I found the Scottish Consumer Council’s evidence convincing. It said:

“In objective terms, we have no worry about its independence as part of NHS QIS, but we have significant concerns about how that would be perceived.”—[Official Report, Health Committee, 9 December 2003; c 426.]

Therefore, the issue, in effect, relates to perception. I am glad to see that, in the minister’s response to the committee’s report, he has assured us that the convener, the vice-convener and the director of the Scottish Association of Health Councils are members of the steering group that will set up the new arrangements. I am confident that the issue of the perceived lack of independence in the new arrangements will be successfully tackled.

I turn to the second issue—the lack of detail that was produced by the Executive in the financial memorandum that accompanies the bill. The committee report states:

“The Committee has concerns that it has not been given a breakdown of costs for the creation of the new bodies and therefore cannot make a fully informed comment.”

That is absolutely true and self-evident. However, that does not mean that we believe that the initiatives in the bill are underfunded. From the evidence that we received, I believe that the opposite may be the case.

Shona Robison: Will the member give way?

Mike Rumbles: The member should listen to the point that I am going to make first.

Dumfries and Galloway NHS Board, one of the smallest of the 15 health boards, has already gone down the road of integration. In its evidence, it said:

“We have made local and recurring savings in excess of £500,000 … We also took the view that we did not need three chief executives or three directors of finance and so on. We started with a blank sheet of paper and redesigned everything.”—[Official Report, Health Committee, 9 December 2003; c 426.]

I commend Dumfries and Galloway NHS Board for its clear evidence to the committee. That evidence was reinforced by written evidence from NHS Borders, which stated that management cost savings have been reinvested in patient care, although it did not give a figure.

Shona Robison: I bring to Mike Rumbles’s attention the other paragraph in the committee report that deals with that issue. It says—

Mike Rumbles: Which paragraph?

Shona Robison: It is paragraph62. It says:

“The Committee would not wish to see the initial phase of change compromised in any way due to a lack of funding.”

That raises the committee’s question about the potential lack of funding for the bill. Given the comments of the NHS Confederation—the managers who know—and its concern about the lack of funding, does not Mike Rumbles recognise that there is a potential shortfall?

Mike Rumbles: I recognise clearly what was stated in paragraph 62 of the committee’s report. I have it in front of me and was about to quote from it. On the strength of the evidence that we have received, I am convinced that there are real and substantial savings to be made in this whole process. Although those savings may not be available everywhere, I support the committee’s view that additional funding should be made available

“where it has been clearly demonstrated by Health Boards that the obligations imposed by this legislation have resulted in additional expenditure which could only be met by cuts in front line services.”

However, I will believe that when I see it, as the evidence does not indicate that that would be the case.

There are significant savings to be made by ending the duplication of the unnecessary
management systems with which the NHS was saddled by previous Conservative Administrations. Unfortunately, I have to return to the Conservative position, which ducks and dives all over the place. Conservative members say that they are supportive of the Health Committee's unanimous position in favour of the bill. However, David Davidson has referred to patient passports, and every time that we hear about patient passports, they are presented as some sort of gift that the Scottish Executive or the Government would be able to give to create freedom of choice for individuals throughout the country. For many of my constituents who live in rural Scotland, there is no choice of hospital; therefore, the idea of patient passports is a non-starter.

In addition, what the Conservatives fail to emphasise about their so-called patient passports is the fact that a patient would have to dip into their savings book for several thousand pounds before their choice would be subsidised by the Scottish Conservatives' plan. That money would have to be available in the first place, as there is no way that the Conservatives could afford it otherwise.

Mr Monteith: I thank the member for giving way, despite the fact that I was constantly heckling him about Airborne. Can he tell me whether all the operations that patients in his constituency require are delivered in his constituency or whether people have to travel outside his constituency to a variety of other hospitals that are chosen by clinicians?

Mike Rumbles: Brian Monteith makes a ridiculous point. In the north-east, there is only the Aberdeen royal infirmary and very few people can go to other hospitals. I do not suppose that the Conservatives are advocating that people should travel hundreds of miles away from their relatives, friends and loved ones to have their operations.

This is a very good bill indeed. It was supported by all members of the Health Committee, including David Davidson. It is a shame that he has suddenly realised that he should backtrack on the Conservative position, which has been going on for approximately two years, we are not really thinking about the patients but about the management structure that cannot cope because it does not have the capacity. How on earth are we going to improve such situations?

If the bill can improve the patient's journey, I am for it—we should all work towards improving that. There have been far too many changes in the NHS, which makes it hard to keep morale up. There has been change after change, and this new change is the greatest that there has been since the inception of the health service. I would like all of us in the chamber to work together for the good of the patient.

A gentleman in my constituency has been incontinent for more than a year. It is appalling for the trust to tell me—it did not tell him—that it does not undertake the highly specialised surgery required; it is expecting his consultant to report back to say whether the procedure is clinically
I am for anything that will improve communication between consultants, patients and—if they would get their act together—health boards. If the bill helps us to do something better for the patient, I am 100 per cent behind it and will vote for it.

I would love the minister and his deputy to reassure me that patients will be listened to. Public involvement is extremely important. I am an MSP because people truly do not feel as if they have been involved. They have attended expensive meetings for so-called consultation, but at the end of the day, all they want is their bread-and-butter services, such as medicine, general surgery and help when they have their heart attacks, to be near to where they live. They do not want to know that the working time directive means that there are not enough doctors to provide a service near to where they live.

There is nothing wrong with specialisation and centralisation for specialised services, such as neurosurgery or maternity and paediatrics in cases such as the Queen Mother’s hospital and Yorkhill children’s hospital. Those are specialist units in the same way as a cardiothoracic unit is a specialist unit.

People should be able to get their heart attacks, hernias or hip replacements dealt with. There are people in my constituency who are paying to have their hip replacements done in the private sector, but they should not have to use their hard-earned savings to pay for that. The private sector does not train nurses or doctors; it steals them from the NHS.

I would like the NHS to be improved. If the bill helps to do that and if the minister and his deputy can assure me that they will find the money to provide the doctors, nurses and all the other paramedical services to make the NHS work, I am 100 per cent behind them.

We must remember that we are here not just to talk about the NHS but to ensure that patients are seen when they are sick and when they are at their most vulnerable. Quite often, patients are afraid to complain about inefficient services because they fear that they will receive an unfavourable response.

At the moment, I am for the bill.

The Deputy Presiding Officer (Trish Godman): I call Kate Maclean. [Interuption.] I call Kate Maclean.

15:26

Kate Maclean (Dundee West) (Lab): In our debates on the NHS, it is always reassuring when the Tories oppose what we are doing. It is hardly surprising that the Tories do not like the bill because it puts patients first, it respects the role of staff in the planning and delivery of services and it abolishes the last bastions of the internal market that was set up when the Tories were in power. Therefore, I am delighted that the Tories are opposing the bill.

As a member of both the Health Committee and the Finance Committee, I have been fortunate to have read and heard a significant amount of written and oral evidence that will, I hope, shape the way that the bill ends up. The Health Committee’s stage 1 report details the several concerns that were raised, which I thank the minister for attempting to clarify during stage 1 and in a recent letter to the convener of the Health Committee. I certainly found it useful to have some of the outstanding issues clarified.

I particularly welcome the minister’s commitment to allow the Health Committee to comment on the draft regulations and statutory guidance on the operation of community health partnerships. In principle, CHPs are a good thing, as they should ensure that services are delivered in a way that puts patients at the heart of the service. An important feature is that CHPs will enable all the agencies to work together, which has often not happened very well in the past. CHPs will also ensure that services are planned by the people who deliver them.

Some of those who gave evidence raised concerns, which have been raised again this afternoon, about the membership, governance and geographic boundaries of CHPs. However, most of those concerns have been addressed by the minister during stage 1 or will be covered in the regulations and guidance, into which the Health Committee will now have some input.

I had some concerns about the powers of intervention, although I whole-heartedly agree with the need for the Scottish ministers to have such powers for exceptional circumstances. The intervention that took place in the health board in my area was welcome as it has resulted in services being delivered in a very different way. However, I still think that the bill, the explanatory notes and the minister’s evidence to the Health Committee are unclear about what “intervention” means and about the circumstances in which the powers of intervention would be used. I realise that it would be impossible to provide an exhaustive list of circumstances, but I would feel more comfortable about agreeing to the Scottish ministers having such wide-ranging powers if I was clearer about what the powers were and when they would be used.

I am also concerned about the estimated cost of intervention that Shona Robison mentioned. I have some sympathy with the SNP amendment,
although Shona Robison will hardly be surprised to learn that I will not support it. I will not support the SNP amendment because it says that

“there must be safeguards in place to ensure the independence of the proposed new Scottish Health Council”.

I am reassured by the commitment that the minister gave in his letter to Christine Grahame, in which he said that the steering group that is setting up the new Scottish health council and the local advisory councils will consider management issues and how to safeguard the health council’s independence. I think that the Health Committee will want to monitor the issue, but I am reassured by the minister’s commitment.

I agree with the concerns raised in the SNP amendment about the additional costs that might arise from the bill. Indeed, I completely disagree with Mike Rumbles on that matter. He is being very unrealistic if, on the evidence of a small health board that has coterminous boundaries with a local authority, he believes that having unified health boards will lead to savings and that that situation will necessarily be replicated elsewhere in Scotland. Notwithstanding that, I will not support the SNP amendment.

In the Finance Committee—and, I think, in the Health Committee—I raised concerns that the costs of intervention had been significantly underestimated. Indeed, it is not that the costs have been underestimated; it is that we just do not know what the costs will be. The Scottish Executive’s estimate, which was in the region of £85,000, was based on its intervention in Tayside Health Board some time ago. In his summing-up, will the minister tell us why that figure was plucked out of the air and used as an estimate, rather than the figure of £300,000, which was the cost of the more recent intervention in NHS Argyll and Clyde?

Unusually, I find myself agreeing again with Shona Robison on the issue of intervention. In most cases, the Scottish ministers will intervene because financial problems in health boards have led to the discovery of operational problems. As a result, I find it very strange that a health board will have to pick up the tab for intervention, especially as that figure has not been worked out sensibly.

Despite those comments, the legislation is very welcome and could potentially bring the NHS in Scotland up to date as a dynamic and efficient service for the people whom we represent. The minister has already shown great willingness to take on board the issues that were raised during stage 1. I hope that he will address issues that members in the chamber and in various committees have raised and ensure that what the Executive delivers through this legislation makes a positive difference to health services in Scotland.

15:32

Rob Gibson (Highlands and Islands) (SNP): I hope that the reform will bring welcome stability to the structure of the NHS. After all, the many changes over the years have led people to lose heart in the NHS’s claim that it puts patients at the core of its activities. From the Conservatives’ comments about foundation hospitals, I do not really believe that they are interested one bit in patients. Because of our general communitarian spirit in Scotland, we believe that we can create a public structure that will put patients at its heart and that will in due course give them the confidence to feel that they can receive treatment where they need it.

The creation of CHPs will mean some centralisation, because in some of the remote places in the area that I represent local health care co-operatives were bedding in and working quite well. The islands have a separate set-up, because they are small enough to be coterminous with local authority boundaries; however, in the Highland Council area, that slight centralisation will require some staff regrading. Indeed, that might well be the case in some other health board areas and CHPs elsewhere. Some retraining will be required, so extra costs will be incurred. That is a small example of how aspects of the changes that cannot yet be quantified will test the system. I will return later to finance.

I agree with Unison that front-line staff and people who deliver the services will have much more of a say within the proposed structure. However, like Unison, I would prefer trade unions to be more formally involved at health board and CHP levels; I would be interested to hear the minister’s comments on that.

On health promotion, I should point out that we already have a structure for a sickness service. However, I wonder whether the minister hopes to have an overarching brief for the Government’s approach to the matter. Health boards are being given responsibilities in health promotion, but NHS Scotland must provide benchmarks and targets for other departments, whether in food production or in the various means by which we ensure that the population has a healthy life. Health promotion is an exciting area and I welcome its potential. However, it must cut across other departments and the health service must take a strong lead. When the minister winds up, I hope to hear a bit about that.

On regional working, the managed clinical networks about which we hear so much tend to think about patients being moved to where the specialisms are. I will be interested in how the new structures in the health service will create contracts that take the specialists to where the patients are. A members’ business debate on
maternity services is coming up next week, which I hope to lead.

Mr Keith Raffan (Mid Scotland and Fife) (LD): Will the member give way?

Rob Gibson: Excuse me; I will finish my point.

The patients rather than the professionals are expected to travel to many central points.

Mr Raffan: I thank Rob Gibson for giving way. I have seen how managed clinical networks work in Tayside and Fife and Mr Gibson’s point about specialists is not accurate—certainly not in my experience of the health boards in my region—because they do travel. Does he agree that with the developing information technology within the NHS, distance and travel are becoming irrelevant anyway?

Rob Gibson: I recommend that Keith Raffan attend the debate about maternity services in Caithness.

I was surprised to hear Mike Rumbles dismissing the Conservatives by saying that we should not expect people to travel hundreds of miles. That is precisely what is happening to people in the north of Scotland who need treatment. That is why we hope that the managed clinical networks will take a different approach from that of merely moving patients.

On public involvement, the proposed Scottish health council that will replace the existing structure seems to me to be a form of centralisation, but one which could be powerful. I am surprised that it has not so far been suggested that local involvement could happen through elections and that the national committee could also be elected. We want more active citizens, so let us see whether the minister has ideas about having a directly elected Scottish health council.

As far as finances are concerned, the geography of Scotland will not change. We have accumulated debts in various parts of the health service, so we are not starting with a blank sheet. The proposed reforms can create stability in organisation, but there will have to be generosity from the Government and, indeed, extra cash if we are ever to provide the practitioners who will help patients through the managed clinical networks.

I very much welcome the bill, but I have concerns about the finance arrangements—those arrangements have not been clearly stated—and I have questions about the accountability and democracy of the proposed Scottish health council. I reserve my judgment on those issues and will wait to see what happens. I support Shona Robison’s remarks.

I crave members’ indulgence; I must now leave the chamber to attend to a constituency matter.

15:38

Eleanor Scott (Highlands and Islands) (Green): First, I say for the record that until last May’s elections I was a doctor in the NHS and that I am still a member of the British Medical Association.

I generally welcome the bill’s provisions, which will make NHS structures more logical and more functional. I hope that the new structures will ultimately make staff happier because low staff morale in the NHS is one of the biggest problems in recruitment and retention. I, too, support Shona Robison’s amendment and will say why as I go through my speech.

I welcome the opportunity that the bill gives to streamline NHS management, but I agree with one of the evidence givers to the committee—I cannot remember who—who said that people who work in the NHS have no appetite for major upheaval. Dr Jean Turner and other members referred to a history of changes, which has had a definite effect on staff morale; there is concern at ground level about the impact of another change in management structure. There is sometimes a perception that a change in the management structure means that it is one step removed from the patients. However, I know from experience that being in the front line of patient contact while being managed by somebody who is demoralised and insecure and who does not know whether their job will be there after the next reorganisation is not good for anybody. It is important that the change is effected relatively seamlessly.

I understand that the bill is intended to be cost neutral, but I doubt that that will be the case in the short term. There is always a transitional cost whenever there is change.

Mr McNeil: Eleanor Scott has mentioned uncertainty about finance a couple of times. Does she agree that the evidence shows that the people who have moved to a single board—in the Borders and in Ayrshire and Arran—have said that, in their experience, the process was not costly and could actually create savings?

Eleanor Scott: As I was saying, there will be savings in the medium term, because bureaucracy will be cut down, and I think that there will ultimately be savings. However, change always brings a transitional cost, because there are always people whose jobs have to be protected and there are always redundancy payments to be made. That has to be factored in. I do not think that change ever comes cheap.

Phil Gallie: Will Eleanor Scott take an intervention on Ayrshire and Arran NHS Board?

Eleanor Scott: I have no expertise on Ayrshire and Arran, so I do not particularly want to take
another intervention, if Mr Gallie does not mind. I come from the Highlands, so if members want to make interventions about Highland NHS Board, that is fine.

I hope that the Scottish Executive is ready for any investment that might be needed in the initial phase of change. It was noted in evidence to the committee that there has sometimes in the past been underinvestment in change, so that the change has not delivered as much as had been hoped. I note that local health care co-operatives, which we can now refer to as a kind of ancestor of community health partnerships, have lasted for only four or five years. However, they did make achievements—in inter-practice and community working, for example—during the years when they existed; care should be taken that that expertise is not lost. I agree that the community health partnerships should be better and that they should lead to better working with local authorities—with social work departments, for example.

I note in passing the democratic deficit that Bill Butler identified in his proposal that there be directly elected health boards. One wonders whether the logical end point would not therefore be to have health care delivery as a local authority function. I am not suggesting that as an amendment to the bill, but it is something that could perhaps be considered in the future.

I agree that the NHS must ensure public involvement, but I am not absolutely convinced that the new structures will in themselves deliver that at local, regional or national level. I wait with interest to see whether that happens. In that regard, I have some concerns about the numerous functions of NHS Quality Improvement Scotland that were identified by some witnesses who gave evidence and I am also concerned by the fact that the public are unlikely to view it—or the new pan-Scotland health council—as an independent body. There is a bit of selling to be done on that matter.

The provision for health boards’ working together is welcome. The acute services review envisaged for Scotland an NHS without boundaries; I hope that the collaboration between health boards will be a move towards that and that it will be done on a planned and strategic basis, with one board undertaking to provide a specific specialist centralised service so that that service is provided in one centre and not everywhere. That would allow economies of scale and the development of expertise. I would hate to see the item-of-service and payments-per-patient approaches across health board working. I do not think that that is what the bill envisages—I hope that it is not. That transition will require a smooth transfer of resources between boards.

I note that the bill gives powers to ministers to intervene on health boards in the event of service failure. I do not disagree with that, but I would like to turn that on its head and ask how sympathetically the minister would view and treat a health board that came to him to warn of an incipient failure due to funding shortages.

Finally, I would like to cite a point that the BMA made in its written evidence. It said that

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

and—dare I add it?—transport policy, just as equal opportunities and human rights must now be factored in. That would be a helpful step in mainstreaming health improvement, which is a major thrust towards the delivery of the health care that we want in Scotland.

15:44

Mary Scanlon (Highlands and Islands) (Con):

I was pleased to be asked to speak in this debate on national health service reform, until I read the bill, that is—all six pages of it. A unified health board has already happened in the Borders without the bill, so I have to ask the minister what kind of an NHS we have that the Parliament has to legislate to place a duty on health boards to cooperate with other health boards. If the patient’s needs came first, the health boards would have to talk to each other.

Consider the section of the bill on powers of intervention when there is service failure: what is acceptable and unacceptable? Are financial deficits as boards struggle to make ends meet acceptable? Will the long wait from GP referral to seeing a consultant or for a magnetic resonance imaging—MRI—scan be included in performance assessment?

I looked to the section that is entitled, “Duty to promote health improvement” in part 2 of the bill. The Western Isles NHS Board is certainly promoting health improvement, but that is exactly what boards are meant to have been doing for years.

Part 3 of the bill is even more exciting. It states:

“The Scottish Ministers may by order made by statutory instrument make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.”

I think that the people of Scotland will all rest well in their beds tonight, given that they have received those assurances from the Minister for Health and Community Care.

Of course, the three island authorities already have unified boards. I will show how impressed...
Orkney NHS Board was by the bill by quoting from its submission to the Health Committee. When it was asked whether it supported the general principles of the Bill, the board’s response was that one member of the board did. The board’s submission also states:

“We don’t have a LHCC in Orkney and I do not know what kind of animal a CHP will be. I do not know where it sits in relation to the Joint Future Agenda.”

It seems that the LHCCs have passed NHS Orkney by and that just as it was getting to grips with the joint future agenda, LHCCs have now been passed by for CHPs.

When Orkney NHS Board was asked about the quality of the consultation, it stated that five weeks was not enough—particularly given the active and highly regarded work that is done by the local health councils. The submission states that NHS Orkney

“would prefer that we have power to choose the way we spend the funds, as Scottish Executive directives don’t always fit Orkney’s situation”.

At least we can depend on Orcadians to tell us how it is.

Again, on what constitutes an acceptable service, would NHS Orkney’s cash-saving measure to cut the number of patients who go to Aberdeen for treatment because it does not have enough money be regarded as acceptable, or would that be a service failure? Perhaps the minister could tell us which cuts will be regarded as acceptable when the level of activity exceeds the financial allocation. I quote from a statement issued by NHS Orkney:

“Clinically urgent cases should continue to be dealt with where the Consultant feels that postponement of treatment would significantly impact on his/her patient’s health.”

We have had telemedicine for some years; now telepathic medicine is being applied from Aberdeen to Orkney. Those actions have been taken with no consultation of patients or GPs.

When the money comes through for the next financial year, there will already be a waiting list in Orkney left over from this year. I hope that the minister will now review the financial allocations to the three island authorities—Orkney NHS Board, Shetland NHS Board and the Western Isles NHS Board.

The policy memorandum states that the Executive’s policy is that care should be delivered as close to home as possible; in Caithness, people would like their babies to be delivered as close to home as possible and in Applecross and Lochinver, on the west coast of Scotland, people would like an out-of-hours service that is closer to their homes than the east coast.

Western Isles NHS Board, which faces a £600,000 overspend, now has the pleasure of intervention by the man from the ministry. I understand that he has proposed that the Western Isles should have four medical directors—three more than Lothian NHS Board has, although the Western Isles has a fraction of the Lothians’ population. Much more could be said about the Western Isles, but given the current problems with staff suspensions and so on it would be unwise to discuss the matter further.

Will the minister include registered practitioners of complementary medicine in the CHPs so that they are fully included in the delivery of health care and will he also ensure that the professions that are allied to medicine are included? As I said last week, the health service is not just about doctors and nurses.

I want to come back to a point on local authority accountability that Unison made in its submission to the Health Committee. I am pleased that Unison highlighted this point: if partnership is to work, the performance of social work must be monitored and evaluated. If the performance of social work is included, the proposals that are being discussed today will, I hope, help to meet the expectations that are being raised.

15:50

Mr Keith Raffan (Mid Scotland and Fife) (LD): I welcome the principles on which the bill is based. The bill puts the treatment of patients first; or, to use the words of Dr Jean Turner, it will “improve the patient’s journey”, which is NHS jargon, but I like it. As the minister said, that means increasing the integration of primary and specialist services and removing the artificial barrier between the services that trusts represent.

I hope that the minister will agree that another artificial barrier is put up by the boundaries of the NHS boards. I welcome the emphasis that he placed on regional planning and on the boards collaborating with one another. As we move towards greater specialisation and, indeed, sub-specialisation, such collaboration will be inevitable.

In my region, that is very important; the region is covered by three health boards—Tayside NHS Board, Fife NHS Board and Forth Valley NHS Board. Only one—Tayside—has a teaching hospital. As the minister rightly said a couple of weeks ago in response to a question of mine at question time, extra strains are put on boards that do not have a teaching hospital. It makes it much harder to run them. Consultant vacancies invariably take longer to fill in boards in which there is no teaching hospital, which has a knock-on effect on waiting lists and waiting times.

Earlier, I intervened on Rob Gibson. Where managed clinical networks exist—I would like them to develop further—they can ignore health service boundaries. Tayside’s managed clinical
network on diabetes is very effective. Specialists go from Ninewells hospital into Fife to hold clinics; patients do not necessarily have to go up to Ninewells. That is integrating primary and specialist care effectively. We want those networks to develop.

I agree with Dr Turner about financial disputes; I have seen at first hand at health board meetings with MSPs disputes between different health boards over who should pay for what. An example of that concerns patients from north Fife who tend to go to Dundee to use services at Ninewells hospital, who should pay for health services that are used by Fife patients in Tayside. We have to sort out such problems, which can consume too much of management's energy and time.

As the minister said, CHPs, growing naturally as they do out of LHCCs, focus on local delivery. We all want the NHS to be much less of a national illness service, so there should be greater emphasis on primary care and on reducing hospital admissions.

A year or so ago, I spent a day at the Bellyeoman surgery in Dunfermline. I sat with one of the specialist nurses there—Nicky Credland—as she saw patients. She saw a young boy who had asthma and was able to spend 30 to 45 minutes with him going through the different inhalers that he could use to see which would be most effective. Then—again with the patient’s agreement—I sat in as the nurse talked at length to a middle-aged man who had recently been diagnosed as having diabetes. She gave him advice on diet, showed him different types of food and advised which he should eat and which he should not eat. She has time do that, whereas a GP does not.

I have seen the statistics, and the specialist nurse service at the Bellyeoman surgery has greatly reduced the need for hospital admissions. With the likely doubling of the incidence of diabetes over the next seven years, and with an aging population suffering from chronic diseases, I want an increase in specialist services especially for people with chronic diseases; for example, advice on arthritis or on stopping smoking or whatever. I want to see anything that will take pressure off GPs and acute services.

Public involvement is, of course, very important. I hope that we can learn lessons from the health boards’ consultations during the acute services review—not all of which were very happy. It is important that public involvement is balanced, representative and genuine and I welcome the moves towards that in the bill.

I also agree that the minister must have a clear power of intervention; I do not believe that that is contrary to devolved health service management. The minister’s predecessor sent a task force into Tayside, which proved to be highly effective in combination—I like to think—with the work of the Parliament’s Audit Committee, which also undertook an inquiry into the NHS in Tayside. That helped to set Tayside back on the right track. It is important that the minister has that power of intervention from the centre; the crucial thing is the timing of its use, which is a matter of judgment rather than something that can be set down in legislation.

It is important that the structure of the NHS keep pace with the development and integration of services. I have no doubt that the structures will continue to change and evolve as the integration of primary and specialist services continues and—I hope—accelerates. As all parties have occasionally pronounced, ultimately we will have to examine the number of health boards, but that is an issue for another day. The important thing is that structures are changed and are allowed to evolve as and when they should; they should be flexible, because their purpose is to serve the health service.
groups in greater Glasgow. Many of those interventions were effective, but they survived on a hand-to-mouth basis; funding—which was the result of partnership between the health board and the local authority—was renewable every two or three years. There needs to be a solid strand of continuing funding and a commitment that health improvement measures will be implemented and will last for a considerable time.

Another important element in the bill is health boards’ duty to co-operate. I accept what members have said about the importance of managed clinical networks, which are obviously valuable, but it is crucial that health boards co-operate with one another, not just in service delivery, but in planning. Health board boundaries are of necessity artificial—they are constructed on the map and they do not necessarily make sense when one looks at the map in the context of patterns of travel and use, for example.

We can continue with the existing health board boundaries, provided that they do not become barriers to sensible planning—there are instances in which that has happened. In pursuing the duty of health boards to co-operate, I hope that the minister will ensure that strategic planning is properly co-ordinated, that resources and ideas are transferred effectively and that there is a working out across health board boundaries of the best ways in which to deliver services, rather than each health board deciding for itself in a vacuum.

It is important that that regional planning is also linked to national planning. As can be seen from the minister’s welcome intervention in taking over the Health Care International (Scotland) Ltd hospital and making it the national waiting times centre, national planning can be particularly effective in dealing with issues such as those that, for example, Jean Turner mentioned, including hip replacements, and with the issue of the cardiothoracic unit that we are consulting on with a view to taking it into HCI. Real and effective change can be delivered through co-ordinated regional and national planning—through people working out the best ways in which to work. Although HCI is making an excellent contribution already, it could do more. The one thing that I would hate to happen is for the vested interests of existing health boards and the ways in which money is transferred to be allowed to restrict the growth of the service that it is clear HCI can deliver.

I have some sympathy for some of the issues that Shona Robison raises in her amendment to the motion. For example, there is an issue about the advocacy role of health councils and how that is to be protected. There is also the issue of independence. As an ex-member of Greater Glasgow Health Board, I am well aware of the excellent work that was done by the greater Glasgow health council in contributing patient ideas and patient perceptions to the work of the board. I would hate to see that conduit of information and expertise lost. We need to watch that issue carefully.

I am a bit less convinced by Shona Robison’s approach to the financial issues. That is largely because her party has to start from a position of the £2.1 billion that would be sacrificed if Scotland were to go down the constitutional route that the SNP favours. Of course, the deficit would be added to if the SNP got its way in relation to business taxes. Some SNP members advocate changes that are in line with the Conservatives’ proposals, whereas others want to take different approaches. We have to be honest about the issue—we have to say that there is only so much money and we have to decide how best to deal with it.

There is a real issue of honesty in relation to consultation. Although I want to see better consultation, I do not want spent on consultation huge amounts of money that should be spent on patients. The real issue is to get the plans right first time and to consult efficiently and effectively. That is the way to improve the service to patients. As other members said, that is the most vital thing for us to do.

The final issue that I want to raise is the cost of intervention. I accept that ministers cannot necessarily cost intervention accurately before they have identified the problem that they want to resolve. However, the Finance Committee is clear that the evidence that we heard suggests that the cost of interventions will be more than was estimated in the financial memorandum for the bill. If the minister is going to use the power to intervene, he needs to draw up a pattern that shows how much an intervention will cost and how much can be delivered on that basis.

16:03

Ms Sandra White (Glasgow) (SNP): Des McNulty was doing so well, but as always, he spoiled what was a good contribution at the end. I point out to him that if Scotland was independent, the health service would not be in the situation that it is in today.

I give a sincere welcome to the bill. As Shona Robison and other members said, the bill is long overdue. I will not rehearse all of the problems that we have had with the health boards, consultations and so on. Instead, I want to concentrate on two specific areas. The first is the duty on health boards to co-operate in the planning and provision of services. My colleague Stewart Maxwell will elaborate on that issue in his contribution. The other area that I want to cover is the duty to encourage public involvement, which has caused
such a lot of consternation not only in Glasgow but in other areas of the country. The reason why I cite those two areas for attention is that it was the lack of proper co-operation and public involvement that caused such a furore and such concern in the review of maternity services in Glasgow and the health board’s recommendation to close the Queen Mother’s hospital.

This morning, a petition was submitted to the Public Petitions Committee on behalf of six eminent medical practitioners. They called for some of the things that I think are included in the bill, but I ask the minister to clarify that when he sums up. The petitioners called for a legal framework for consultation, for guidelines and for an independent process for the selection of expert witnesses when a national review of services is to take place, whether or not that is a maternity services review. If those are included in the bill, that is most welcome. If they are not, perhaps the minister will lodge amendments at stage 2.

The minister said in his opening speech that the bill is very much needed. One of the key aims of the bill is to enhance the powers of ministers, in particular to intervene in areas where there are service failures. That point was raised by Kate Maclean. The powers that ministers will have are of concern.

I will elaborate on that a little bit. I have considered the issue from a different angle, through consultation, legal advice and the Scottish Parliament information centre. If it is found that health boards have not complied with the legislation, for example with section 5, on public involvement, will they be guilty under section 44(2) of the Criminal Law (Consolidation) (Scotland) Act 1995 of not following through an act of Parliament? I would like the minister to think about that. If he cannot give me an answer in summing up, he can give me an answer later.

I seek clarification because we all know that health boards have a duty to consult, but the bill will make the duty to encourage public involvement legally binding. If they do not do that, they will be guilty of committing a criminal act under the Criminal Law (Consolidation) (Scotland) Act 1995, because the duty is in the legislation. I would like verification of that important point.

I sought advice on that point when the health board’s maternity review was on-going in Glasgow and was given lots of good legal advice by officials and SPiCe. Because the duty to consult is only a duty, boards are not guilty of committing a criminal act for not carrying it out. However, if the duty is in legislation of the Scottish Parliament, they could be guilty of committing a criminal act. Would they be guilty of committing such a criminal act? Is the point that ministers have enhanced powers and can intervene?

Like other members, I am worried about the lack of detail in the financial memorandum. Perhaps we will see savings in the long term, but in the beginning, during the transition period, there will be costs. I ask the minister to look favourably on Shona Robison’s amendment, and particularly the part about the financial memorandum, because it is not only me and my party who have raised concerns, but members from all parties.

The Deputy Presiding Officer (Murray Tosh): I call Carolyn Leckie, to be followed by Bristow Muldoon. I give notice that Bristow Muldoon and the others who speak in the open debate will have their time reduced to five minutes, with my apologies.

16:08

Carolyn Leckie (Central Scotland) (SSP): I welcome the abolition of trusts. It is no surprise that the Tories oppose it, although it is unusual for them to oppose NHS legislation from this Executive. However, I regret the phased approach that is being taken to the abolition of trusts, having been through the reorganisations as a result of trust mergers. The abolition of trusts and the direct control of health boards should have happened sooner, and the pain of reorganisation should have been avoided.

I will concentrate on the context in which any NHS legislation should be set, which is that of reversing our abominable health record. That should be the goal of any legislation. The duty in the bill to promote health improvement must be placed in perspective. People in the worst health areas are also poor. They earn only 65 per cent of what people in the best health areas earn. More than half of the million people in the United Kingdom who are worst off in health terms live in Scotland. If someone is poor, their risk of contracting coronary heart disease is more than doubled, their risk of contracting lung cancer is more than tripled, their life expectancy is reduced by up to 12 years and they have increased rates of suicide. Legislation without resources and radical economic and redistributive measures will mean that the achievement of health equality is a pipe dream. We must bear that in mind. Promotion, persuasion and propaganda will not improve the drastic health statistics of Scotland. Let us not pretend otherwise.

I want to discuss some specific aspects of the bill. I share the concerns that have been expressed about the absence of allocated resources to fund the bill. The costs relate not only to unifying health boards; some of the other measures will have cost implications. We need to bear in mind the fact that no savings were achieved through the reduction of trusts and trust mergers. When one considers the multitude of
pressures caused by other legislation, the working time directive, consultant and GP contracts and so on, it is clear that the idea that this bill can be implemented without additional funding is preposterous.

The 1997 document, “Designed to Care: Renewing the National Health Service in Scotland”, promised “a National Health Service for the people of Scotland that offers them the treatment they need, where they want it, and when”.

Has that promise translated to reality? It is unlikely that it has, particularly when one considers the loss of confidence in consultations by health boards, for example in maternity services, or the gap in the provision of out-of-hours GP cover. The bill gives us an opportunity to pursue meaningful consultation—that is the difference. We should be concerned not with hundreds of glossy leaflets or numerous roadshows, but with people’s ability to affect consultation and to change outcomes if they feel disengaged from health boards.

At this morning’s meeting of the Public Petitions Committee, Sandra White spoke to a petition relating to maternity services. I do not wish to get into the details of the petition, but I am glad that Sandra White did so. I urge the minister to consider the content of the petition when it arrives on his desk. I ask him to take evidence from the petitioners, as their suggestions could improve the bill at stage 2.

Phil Gallie: Carolyn Leckie referred to a 1997 document. The minister spoke of the great consultation processes under the new system. Is Carolyn Leckie aware that consultation about paediatric ward services in two hospitals in Ayrshire has been on-going for the past eight or nine months?

The Deputy Presiding Officer: I ask Mr Gallie to come to the point.

Phil Gallie: Does she agree that a decision will be taken to close one of the units, regardless of the outcome of the consultation?

Carolyn Leckie: Will the Deputy Presiding Officer give me more time?

The Deputy Presiding Officer: It was a self-inflicted wound.

Carolyn Leckie: Phil Gallie’s intervention was opportune and the problem he mentioned is not untypical of those faced across Scotland.

The SSP supports direct democracy and accountability of health boards. It believes that that is the only way to empower the public’s opinion and to prevent health boards from making bad decisions.

The proposed community health partnerships have been opposed. I share Unison’s concern that there is no guarantee that geographical inequality will not spring up. I would appreciate a comment from the minister in that regard. I am unhappy about the composition of such partnerships, particularly the fact that trade unions are to be excluded from them. Why is business being included when trade unions and the public are being excluded?

While health councils are imperfect, at least they are statutory. The new proposals are neither statutory nor independent. I hope that that can be amended at stage 2.

The minister said that regional planning arrangements will be much more effective than has been the case in the past. If he acknowledges that regional planning has been ineffective until now, does he not consider that maternity services and hospitals should be given a stay of execution from centralisation and closure until effective regional planning, including full public consultation, is implemented across regions and across the country?

I am glad that staff governance is being implemented, but serious consideration should be given to Unison’s demand that the terms and conditions of staff be harmonised. There should be direct employment by health boards and accrued terms and conditions should be protected so that staff can transfer without losing them.

The bill does not provide for a sufficiently democratic or accountable structure. I have a number of other criticisms of it, but it can be improved and I hope that it will be.

16:14

Bristow Muldoon (Livingston) (Lab): I welcome the general principles of the bill and I hope that members from all parties—with the possible exception of the Tories—will back it at stage 1 today. The bill marks the completion of reforms to remove marketisation from the health service, which started off with “Designed to Care” back in 1997, and which have been rolling back the agenda of marketisation that the last Tory Government introduced.

Like my colleague, Kate Maclean, I am very much encouraged by the Tories’ attitude in opposing the bill. If they oppose it, there must be quite a bit of merit in it. Their continuing hostility to the national health service and its founding principles shows what a threat to the NHS the re-election of a Tory Government would be.

One area of the bill that I strongly welcome, and which lies at its heart, is the establishment of the new community health partnerships, which will build on existing strong local partnerships. In my intervention on Mr Davidson, I referred to a strong and growing partnership in West Lothian where, as the minister knows, detailed discussions are
taking place between the health board and the local council on ways to bring budgets together and to enhance the delivery of services, particularly for elderly people.

That builds on a strong existing relationship, which has already had some successes over recent years, including the establishment of the Strathbrock partnership centre in Broxburn, which brings together enhanced GP services—with more primary care facilities being provided—and has social care staff working in partnership with the primary care staff. A partnership between the health service in West Lothian and West Lothian Council gave rise to the opening of a new GP practice in south Livingston, which will address problems of population growth in that area. Therefore, strong partnerships between local authorities and the health service already exist, and I believe that the creation of new community health partnerships, and the emphasis on their being, where practical, coterminous with the local authority area, will prove to be a strength of the eventual act.

On unified health boards, Rob Gibson, and later Carolyn Leckie, spoke about the role of the trade unions and staff. I think that the current Government has done more than any previous Government to try to involve staff in decisions in the national health service. The well-known Unison representative in my area—and a national representative—Eddie Egan, is employee director of Lothian NHS Board. He is right at the heart of many of the key decisions that affect health in the Lothians.

Carolyn Leckie: Does the member agree that, if trade union involvement in democracy is to be genuine, employee directors should be accountable to their members and not to the Scottish Executive, as is currently the case?

Bristow Muldoon: Anyone who has ever known or met Eddie Egan will know that he is 100 per cent committed to the national health service and to delivering the service to the people. I do not think that he would ever take a decision on the health board that would compromise that commitment.

Carolyn Leckie in particular addressed some of the pressures that face the unified health boards, which include the European working time directive and changes in how medical staff are trained. I would like a clear message to be sent out to the health boards that such pressures are not to be used as a reason to centralise acute services. Of course, where there is a strong clinical case to do so, highly specialised acute services will be provided at only a small number of sites, but we must ensure that the public receive their health service as locally as possible. That is good clinical practice and ensures access.

Health improvement is one of the most critical areas for Scotland. We must recognise that many countries that are poorer than Scotland have better health than Scotland. Largely, the situation comes down to personal behaviour and choice about alcohol consumption, the use of tobacco, diet and exercise. The role of health boards and local authorities, working together, can be vital in helping to develop the health improvement agenda and creating a healthier Scotland.

I believe that the National Health Service Reform (Scotland) Bill completes the process of ending the marketisation of the NHS that the Tories started. It will enable the NHS to enhance the local delivery of health services, particularly through primary health care facilities. We must ensure that there is no centralisation of acute health services.

It is clear that, with the exception of the Tories, every member and every party fully supports the NHS. I call on every member to express that support by expressing their support for the bill today.

16:20

Mr Brian Monteith (Mid Scotland and Fife) (Con): I am pleased to rise as a Tory. Before devolution, one of the concerns that many people expressed about Labour's proposals was the potential that they offered not for real devolution of power to the people but for the centralisation of power, not in the Parliament but among Government ministers and their departments. I believe that the National Health Service Reform (Scotland) Bill is yet more proof—as if it were needed—that those fears were well founded.

One of the first acts of the Parliament was to abolish self-governing status for Scotland's schools, which was a symbol—albeit a small one—of what was to come. Since then we have seen moves towards a national transport authority, an all-encompassing cultural quango and ever more ring fencing of local authority spending. We have seen the merger of trusts—an action that led directly to the rationalisation of hospitals—and now we see their abolition. Those moves, together with the bill, are all about centralisation. There is no other word for it.

What we know—as would anyone who cared to turn over the stone—is that, within the Scottish Executive Health Department over the past few years, an almighty private debate has gone on among civil servants, advisers and ministers about whether to devolve decision making in the NHS further down to the trusts or to centralise it in the boards. As we know, the centralisers won. Sam Galbraith ultimately triumphed and got his wish—he wanted to centralise power in the boards for no
other reason than that the Tories brought in the trusts. That was evidenced by a number of unguarded comments today.

Let us agree on some facts. The trusts are being replaced by divisions run by the health boards.

Malcolm Chisholm: I repeat to Brian Monteith that the decentralisers won, which is why we are setting up community health partnerships. That must be done within a framework of national standards and with a power to intervene as a last resort.

Mr Monteith: The minister might not like the words of Tony Blair, but he clearly likes the words of Eric Blair, because that intervention was nothing less than double speak. The bill abolishes NHS trusts but replaces them with operating divisions under health boards. It extends ministerial powers to intervene and establishes 50 community health partnerships, developed from the 80 local health care co-operatives. To me, that is nothing less than centralisation.

What is being discarded is not great swathes of bureaucrats, but the independence of thought and action that the trusts enjoyed. That independence allowed trusts to respond to local or sectoral needs and demands. What the bill proposes can only be called centralisation.

No savings are promised, just greater direction from the centre disguised by euphemisms such as guidance, co-ordination and—Labour’s favourite word—strategy.

Mike Rumbles: Will the member give way?

Mr Monteith: I will possibly give way later.

No savings are promised, for none is expected. Indeed, we can expect costs to rise. That is why the minister has taken the precaution of presenting a financial memorandum to authorise additional costs, which he fears will arise.

I have no doubt that everyone in the chamber wants to see top-class, world-beating public services in Scotland. Unlike the Prime Minister, Bristow Muldoon and Rob Gibson, I do not challenge the motives of members of other parties or question their good intentions. Where I differ is in questioning the belief that market systems cannot be utilised to provide better public services. They can, even in health care.

The NHS has prospered for more years under the Tories than under Labour. When I look at the spectacles that members in the chamber are wearing, do I see NHS spectacles or frames? No, I do not; I see designer frames. Devolving power down to the lowest level can liberate our NHS and make it more responsive to patients’ needs. That is the direction in which we should be going.

16:24

Mr Stewart Maxwell (West of Scotland) (SNP):
I assure Brian Monteith that this is not an unguarded comment: I completely and wholeheartedly welcome the abolition of the NHS trusts. We are long past the time when they should have gone.

I am sorry that Des McNulty has left the chamber because I want to mention the rather silly point that he made about debt in Scotland. The UK debt is many billions of times more than the supposed and inaccurate figures that were given out about Scottish debt. If debt is to be the criterion for independence and for good public services, the UK fails the test in spades. Perhaps Des McNulty should think twice before he goes down such silly roads.

The real problem with the NHS structure is the discrepancies and lack of co-operation that exist between health boards. That is why I welcome the formalisation of the duty of co-operation in section 3, which could prove to be an important step in improving and equalising service delivery throughout the country. Perhaps when the deputy minister sums up, he will explain what will happen if health boards fail to abide by section 3, given that many boards are failing to co-operate at present, although a duty to do so does not exist in legislation. If the bill becomes an act and section 3 is approved, what will happen if health boards fail to abide by it?

I will give three examples that shine a light on the lunacy of the current situation, in which different decisions are taken in different but often neighbouring health board areas. The examples are maternity services, postcode prescribing and drug rehabilitation services and prescribing.

Other members have mentioned the first example. The situation with maternity services in Glasgow and the west of Scotland is, frankly, woeful. Neighbouring health boards appear to have taken no cognisance of each other in taking decisions about maternity services provision. The west of Scotland has lost consultant-led services at the Vale of Leven hospital in Dunbartonshire and the Rankin maternity unit in Greenock. When those moves were first mooted, it was stated that mothers-to-be could travel to Paisley to have their babies, if they so wished. However, when it was pointed out that the natural transport corridors for people who live north of the River Clyde and from the Vale of Leven hospital area are up the north side of the river to Glasgow rather than across it—there are no decent public transport links between Dunbartonshire and Renfrewshire—it was suggested that patients could choose Glasgow as the place to have their babies.
Within weeks of the comments by Argyll and Clyde NHS Board, Greater Glasgow NHS Board announced its plans to close the Queen Mother’s hospital, which is north of the river, and, in effect, to remove that choice from women in the Dunbartonshire and Argyll areas. If the Queen Mother’s hospital is closed, the services will be transferred to the Southern general hospital, which is south of the River Clyde. The lack of joined-up thinking between the two boards is not only a problem of administration; it has a detrimental impact on ordinary patients’ lives and on their day-to-day experience of the health service in one of the most crucial areas—giving birth to their children.

The second example is the issue that is commonly called postcode prescribing. I will cite the example of a couple who came to see me at a surgery, which highlights the different policies in the health board areas of Argyll and Clyde and Glasgow. The minister will be aware of the issue because I have written to him about it—it is about differences in fertility treatment between Glasgow and Argyll and Clyde. The man in question had cancer, which I am glad to say was treated and cleared up, but, unfortunately, the treatment made him infertile. The man then sought the infertility treatment that would allow his family to grow, but Argyll and Clyde NHS Board said that it would not pay for the treatment and, worse than that, that it would not pay for the drugs. The family then found out that if they had lived a couple of miles up the road in the Glasgow area, Greater Glasgow NHS Board would have paid for the drugs, although it would not have paid for the infertility treatment. That is a cost of £1,000 to patients in Argyll and Clyde that does not exist for those in Glasgow.

My third example is about methadone prescribing. Unfortunately, a boy died in the Barrhead area of East Renfrewshire because no tests were taken before he was prescribed methadone. The fatal accident inquiry has just been completed. If the boy had lived in Glasgow, tests would have been carried out; it would have been discovered that he did not have heroin in his system; he probably would not have been prescribed methadone, which was inappropriate; and the outcome would have been different. In fact, the boy had Valium in his system, which is potentially lethal when combined with methadone, as many members will be aware. That lack of testing means that, in certain areas, people can be prescribed methadone at the same time as they are taking drugs that should not be mixed with methadone.

In conclusion, the three examples that I have cited show the importance of co-operation among health boards and why we must end the inconsistent service delivery throughout Scotland. I hope that section 3 of the bill will end such problems, inconsistencies and discrepancies and that the bill is strong enough. If it is not, I hope that stage 2 amendments will be lodged to ensure that postcode prescribing and differences are ended and problems are sorted out.

16:30

Mike Rumbles: This has been a good debate and members have made interesting speeches. I would like to focus on half a dozen of those contributions.

Jean Turner said that the bill is about improving the patient’s journey. I could not agree more—that is what the bill is about. The patient must be the focus of everything that the national health service and the Parliament do. Jean Turner made it clear that she supported the general principles of the bill in the committee and that she will support its general principles at decision time.

Unfortunately, Rob Gibson is not in the chamber—I understand that he has been called away. He called for extra cash and talked about uncertainty, which my Labour colleagues have highlighted. The point was made that that ignores the evidence that has been given to us by NHS boards that have gone through the process—Dumfries and Galloway NHS Board and Borders NHS Board.

Carolyn Leckie: Will the member take an intervention?

Mike Rumbles: No—I must press on.

Eleanor Scott made an interesting speech. I was a bit agog when she ventured to suggest that health provision in Scotland could become a function of local authorities. I met a group of local authority leaders last night over dinner and I am sure that they would really welcome such an initiative. I assume that Eleanor Scott was not being serious.

Helen Eadie (Dunfermline East) (Lab): Is the member aware that, in Denmark, a function of local authorities is to manage health budgets and to provide the service?

Mike Rumbles: I thank the member for intervening. I was not aware of that, but I am now.

Mary Scanlon made fun of NHS Orkney’s supposed opposition to the bill. My colleague Duncan McNeil said to Steve Conway of NHS Orkney by videolink:

“you say in your evidence that you generally support the bill.”

Steve Conway replied:

“The bill is about making better use of the resources that are available.”—[Official Report, Health Committee, 6 January 2004; c 499.]
Des McNulty took the opportunity to raise, among quite a few issues, the Arbuthnott formula and he talked about Arbuthnott plus. I have real difficulties with what he said and will respond on three points. First, it is absolutely and fundamentally right that we have a progressive and clearly redistributive taxation system and it is right that those who can afford to pay more should do so. Many such people are constituents of mine in north-east Scotland, in West Aberdeenshire and Kincardine. I recognise that people in the north-east are better off than people elsewhere in Scotland. The taxation system is the process through which we can redistribute.

Secondly, the Arbuthnott formula makes the big mistake of considering only deprivation indices between health boards. There are areas of deprivation throughout Scotland and we should focus on how we should tackle that problem rather than on the relationship between health boards as if deprivation appears in one health board area but does not appear in another health board area. That issue needs to be tackled throughout Scotland.

Thirdly, I will take NHS Grampian as an example. NHS Grampian is responsible for 10 per cent of Scotland’s national health service activity, but receives only 9 per cent of the record resources that are being allocated by the Scottish Executive. For such reasons, we must have a review of the Arbuthnott formula. I suppose that at least I agree with Des McNulty on that matter, although we obviously have opposite reasons for thinking that there should be a review.

The pièce de résistance of the debate was David Davidson’s speech, to which I must return. I would like to know how the Tories can support the abolition of NHS trusts in committee and sign up to a unanimously agreed report in favour of the general principles of the bill, yet, in this afternoon’s debate on that report and the motion, the same Tory spokesperson can state clearly that they are against the bill in principle.

That is no way in which to conduct business in the committees of the Parliament. We all compromise in an attempt to reach agreement if we can. The most honest approach would have been to make it clear to all colleagues on the committee that the bill would be opposed in principle by the Conservatives—an honourable position—instead of giving the pretence of support to try to mould the committee’s report, as may have occurred. That practice would be unacceptable and would undermine the work of the committee. A more likely explanation—there is only one other explanation that I can think of—is that, when the rest of the Tory group found out what their health spokesman was up to, they forced him to change his mind. I do not believe that David Davidson is dishonourable. I think that it is likely that that happened at the Tory group meeting yesterday or the day before.

The bill sets out to abolish NHS trusts and seeks to ensure that the patient’s interests are put first and that services are planned efficiently and effectively throughout the national health service. It is a good bill and I urge members to support it at decision time.

16:36

Mrs Nanette Milne (North East Scotland) (Con): Members have heard from David Davidson why we will not support the motion. I emphasise that I did not work in the health service for more than 20 years without believing in it.

Although the general principles of the bill are aimed at achieving a more streamlined and unified NHS, the resulting organisation will still be centrally driven, as Brian Monteith said, with the Executive empowering the new health boards to run the service via operations divisions derived from the abolished trusts and with community health partnerships representing the primary care sector and associated health professionals. The intention is to focus more on the patient and to increase input from the patient; however, the structure will still be top down and driven from the centre. As David Davidson said, that concept is fundamentally at odds with our thinking, which unequivocally puts the patient at the heart of the service—a patient who is empowered to get appropriate treatment whenever and wherever it is needed.

Budgets that were progressively devolved to local levels through GPs would allow GPs to take responsibility for all their patients’ care, including health-related social services, and would bring the budget for health and social care within the health service. That would allow social and nursing care to be commissioned from the most appropriate source in either the public or the private sector and would significantly reduce the problem of delayed discharge from secondary to primary care.

The gradual introduction of foundation status for hospitals in the public sector, together with the introduction of a patient passport, would eventually enable GPs to commission all care and would allow hospitals to plan on their own behalf in response to local demand. Alongside that, the role of health boards would be progressively reduced, bringing the service ever closer to the patient.

The Labour Party at Westminster has come close to adopting our approach by setting up foundation hospitals. Indeed, it has gone further by planning independent diagnostic treatment centres for south of the border, which will allow many more patients to receive appropriate and timely secondary care in new centres that are staffed...
from outwith the NHS. That care will follow referral by the NHS and will be paid for by the NHS. The centres will help to overcome the lack of capacity in the health service and will work in the best interests of patients. The new system was approved by Labour MPs at Westminster, many of whom represent Scottish constituencies. If such a system is reckoned by Scottish Labour MPs to be good for English patients, should not the Executive consider following their example for the benefit of patients up in Scotland?

Mike Rumbles: Will the member take an intervention on that point?

Mrs Milne: I am not going to take interventions.

That is all that I will say about our views. Members know where we are coming from and why we oppose the bill in principle.

There is a lot of concern in all quarters about the detail of the bill, even among those who think that it will go a long way towards improving the NHS in Scotland. I am not a member of the Health Committee, but I have read the committee’s report from cover to cover, including all the evidence that is appended to it. Almost every piece of evidence in that document contains caveats. Many witnesses said that the proposed structural changes, in order to be effective, would have to be accompanied by a culture change, with hearts and minds showing willingness to co-operate across boundaries, whether those are geographical, between health boards and local authorities, or between different professions in the NHS.

There are particularly widespread concerns about the composition and role of the proposed community health partnerships; about the independence of the new Scottish health council if it is placed, as planned, within NHS QIS; about the meaningful involvement of patients in planning and developing the service; and about the powers of ministerial intervention when the system shows signs of failure and who would bear the cost of such intervention. There is also widespread concern about how the proposed changes will be financed; few seem to agree with the Executive that the bill will be financially neutral.

I have heard those concerns voiced by members throughout the chamber this afternoon—by Shona Robison, Jean Turner, Rob Gibson, Eleanor Scott, Mary Scanlon, Des McNulty, Sandra White, Carolyn Leckie and even Kate Maclean. In fact, such concerns have been voiced by almost every member who has spoken in today’s debate.

I am particularly concerned about the composition and size of the proposed community health partnerships. Despite the minister’s reassuring words, associated health professionals seem to fear that GPs and nurses will dominate the CHPs; almost every associated professional organisation is clamouring for representation on the CHP boards. I worry that that could result in large, unwieldy organisations, along with dilution of the essential primary care input and loss of the goodwill that will be required for the proper functioning of the partnerships. It is crucial that the CHPs are dynamic and that they work effectively, as Shona Robison said.

Co-operation with local authority services will be vital. Although coterminous boundaries will help with that, unified health and social budgets will be necessary for long-term success in the area. That is being planned in some authorities, as we have heard.

In the event that the motion is agreed to today, the statutory guidance and regulations in relation to the operation of CHPs will be all-important. I am glad that the Health Committee will have the opportunity to scrutinise the guidance and regulations and to comment on them before they are introduced. It is clear that there is a long way to go and that there are many issues to be resolved before the bill finally becomes law. Assuming that the bill continues through the parliamentary process, we will take our full part in scrutinising the detail at stages 2 and 3. However, for the reasons that I have given, we will not support it at stage 1.

16:42

Stewart Stevenson (Banff and Buchan) (SNP): We welcome the ending of the NHS trusts and the burden that they have placed on the organisation of the NHS over a period of time. We welcome the move towards integrated working and the assurance that goes with it that a single system does not imply a centralised system. Of course, those assurances will go for nought if the implementation drops short of that and we will remain alert and watch carefully as the implementation of the proposals evolves.

The minister, in his response to the various committees’ investigations of the bill to date, has made encouraging signs of flexibility. For example, he has shown that he is prepared to amend the bill at stage 2 on local staff governance. I will return shortly to the apparent lack of flexibility on finance.

The Executive has turned its mind with great energy to consultation across many of its policy areas. There are clear signs—in the consultation on this bill, as in many others—that although the process allows the public and special interest groups to make their points, the Executive’s specific responses are not always so clear. Not all points that are made in response to a consultation can be accepted, because consultations bring out points that conflict with each other; that is a fact of life. However, there is considerable scope for improving the feedback to consultees.
Bill Butler made a point about direct elections to health boards. I have enormous sympathy with that idea and I know that my colleagues feel the same.

I give the minister early warning that if he is not able to indicate, in his summing-up, a preparedness to take away and re-present the financial memorandum in the light of the comments that have been made today, it is likely that we will be unable to support the motion on the financial resolution come decision time. Nonetheless, we will support the substantive motion on the bill and I look forward to doing that.

Like Kate Maclean, I was extremely reassured to hear the Tories’ concerns about the bill and similarly felt that we must be on the right track. Of course, the Tories have mentioned the money that will be required for the bill. However, I recall John Scott telling me in a previous debate that he did not care how much it would cost to decommission nuclear power stations, so the Tories’ interest in money is somewhat selective. I will return to that issue. Kate Maclean also broke with tradition by putting Mike Rumbles in his place over some of his remarks.

Eleanor Scott made an excellent contribution to the debate by making the point about health improvement that the British Medical Association raised in its evidence to the Health Committee. The BMA wants the health improvement strategy to be taken further, so that all policy decisions take account of health. Rural areas in particular cannot be developed if they do not have health provision. Without health provision, the development policies simply will not work.

My colleague John Swinney made an important point about consultation. Tayside’s three public partnership groups count for nought if local services are cut in the face of considered and considerable input from local communities. The minister might care to ponder whether there is any value in consultation that leads to no change.

Carolyn Leckie, quite rightly, echoed Unison’s point about the need to ensure that the trade unions and staff are fully involved in the process. Indeed, Unison’s written submission incorporated the Munich declaration, which highlighted the need for authorities across Europe to strengthen nursing and midwifery by

“Ensuring a nursing and midwifery contribution to decision-making at all levels of policy development and implementation”.

Let us hope that there is considerable scope for that in the way forward that the Executive has chosen.

If we do not get the staff on board, we will not be able to deliver for patients or for the public purse. Staff must end up in a position in which they are given individual freedom to make decisions that are in the interests of the service and in the interests of patients. Health service staff want to help patients. That is the fuel in their tank. That is the engine that drives them.

Let me turn to finance—I see that the Tories nearly woke up at the mention of that word. Paragraph 33 of the stage 1 report states:

“The Health Committee endorses the view of the Finance Committee insofar as we believe the cost of intervention has been considerably underestimated”.

We should hear more about that. Paragraph 62 states:

“The Committee would not wish to see the initial phase of change compromised in any way due to a lack of funding ... The Committee seeks further reassurance from the Minister”.

I hope that the minister will be able to give us that reassurance.

I also highlight paragraph 65. Mr Rumbles signed up to that paragraph in its entirety, so I note his comments about the Tory member of the committee. Paragraph 65 states:

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

The financial memorandum, which was considered by the Finance Committee, sums up the many changes that the bill will make to the NHS. The Finance Committee’s report on the financial memorandum stated that

“it was regrettable that further information could not be provided” about the costs of the bill, so there is clearly an issue about costs. On the costs of using the powers of intervention, Argyll and Clyde NHS Board thought that the cost per intervention would be £200,000, whereas the Executive says that it would be £85,000. Quite a lot of work is obviously needed on the costs associated with the bill. That is why the Finance Committee said that the work that the Executive had done did not provide adequate information about costs.

Even the Subordinate Legislation Committee, from which we seldom hear very much, had quite a lot to say about the powers that the Scottish ministers will retain for themselves. That committee expressed some concern and unease about the four significant powers that ministers will retain.

I must respond to Brian Monteith, who referred to Eric Blair. Brian Monteith is certainly not a Winston Smith, but far less is he a Winston Churchill. He has neither the gravitas, the dedication nor the insight.

It is 40 years since I worked in the health service. I do not want a health service that is driven by an economic model in which the purchase of health care by money, however
obtained, delivers dividends to people who provide it. All of us, apart from the Tories, want a health service that is driven by people’s health needs and which delivers a dividend of good health and protection from illness to all people in our society, whatever their condition.

16:50

The Deputy Minister for Health and Community Care (Mr Tom McCabe): I have listened with interest to this afternoon’s debate and, in my closing remarks, I will do my best to address at least some of the issues that have been raised. As Malcolm Chisholm said earlier, the bill contains some important provisions that are necessary for building a strong NHS, whose strength lies in close co-operation and collaboration among staff, patients and Government. For that reason, the bill has generally received wide support from many organisations that represent NHS, staff and patient interests.

I will begin by addressing the issue of public involvement. Shona Robison set out her concerns about the need for safeguards to the independence of the Scottish health council. We are already in discussion with the Scottish Association of Health Councils and other bodies on how best to achieve that. The council needs to be able to act independently if it is to command respect and credibility in its quality assurance and monitoring role. After all, its whole approach will be based on evidence and the ability to report openly what it finds. Those are key criteria of independence.

The Scottish health council does not need to be isolated in order to act independently. Although I know that some would like the Scottish health council to be a completely separate organisation, we think that there are alternatives. For example, establishing the Scottish health council as a unique and distinct part of NHS QIS has a number of advantages. First, it will help to contribute to the wider quality agenda. It will also offer the council the clout and profile that NHS QIS has to address deficiencies when standards fall short of what is expected. Boards will know what is expected of them and what the standards are. We are developing guidance on how boards can involve the public and will make that available to the Health Committee shortly. We seek to create a Scottish health council that will strengthen quality and public involvement and that will clearly express its own views and findings. Although it will fit within NHS QIS, it will have its own distinctive identity and ways of doing things.

Members also raised concerns that local advisory councils will not represent patients’ views, although I know that some have been reassured by what they have heard. I hope that, as we have made clear today, the new structure will encourage patients to speak for themselves and, where they cannot do so, will provide independent advocacy services to support them. Local advisory councils will do everything they can to ensure that patients can represent themselves, which will include ensuring that advocacy services are available for all those who require them.

I want boards to involve the public directly, either individually through patient groups and interest groups or through the public partnership forums that will be set up to inform the provision of health services in the community. Health boards must think laterally; they must consider how to work with others and how to establish constant engagement with the people whom they serve. Where health boards fail to involve the public appropriately, local advisory councils will take action to ensure that the patient’s voice is heard, understood and acted on. It is important that health boards hear the views of patients at first hand and that the local advisory councils’ functions support that.

In response to Sandra White’s point about section 44 of the Criminal Law (Consolidation) (Scotland) Act 1995, I must point out that that particular section applies to a person who “knowingly or willingly” gives false information in a statutory declaration. It does not stipulate that there should be criminal sanctions for a breach of a statutory duty. As a result, I can tell the chamber that we have no intention of criminalising health boards.

Several members, including Shona Robison and Kate Maclean, referred to the powers of intervention in the bill and said that the bill should include examples of when the power would be used. It would be extremely difficult to try to set out in legislation all the instances when ministers could intervene. Indeed, there would be a serious risk that we would miss a particular instance, which might have serious consequences. I stress that intervention is a last resort. It would be preceded by an escalating intervention protocol, which would seek resolution long before intervention became an option. Of course, at the same time, I stress that we see the power of intervention as a necessary part of our good governance strategy.

Several members mentioned community health partnerships. Much of the detail on community health partnerships will be contained in the guidance and regulations, on which we will be consulting shortly. That will ensure that responsibility is devolved and that front-line staff are able to take decisions on the best way to deliver care to patients and carers in their local communities.
Local authorities will have a strong role in community health partnerships; where services are provided in partnership as part of the joint future agenda, local authorities will have an equal say on how those services are to be provided. Local authorities and health boards need to have the courage to delegate management and financial responsibility for functions to CHPs. Producing better results through CHPs will require all partners to take the initiative and to share some risks in the search for solutions to problems. After all, all of us—politicians and professionals alike—came into public life to make things better, not to defend internal structures. The challenge is to be courageous enough to share power in the greater interest of those whom we serve.

Several members, including Shona Robison, David Davidson, Kate Maclean and Carolyn Leckie, mentioned the costs of the bill.

Carolyn Leckie: Will the minister take an intervention?

Mr McCabe: Sure.

Carolyn Leckie: Thank you very much—there’s a wee surprise. On costs, three of the commitments in the staff governance standard are that all staff will be “appropriately trained … treated fairly and consistently” and “provided with an improved and safe working environment”.

If that will not require additional resources, is the minister prepared to say that all that is being delivered within the current resource?

Mr McCabe: I will give my comments on the cost of the bill during the next few minutes.

Members have suggested that the bill is not cost neutral and that many things, including those mentioned by Carolyn Leckie, cannot be done. Let me give some examples. We have seen the dissolution of two trusts already. The evidence that we have from the two health boards that dissolved their trusts at the beginning of last year—NHS Borders and NHS Dumfries and Galloway—is that savings have been made. However, moving to single-system working is not about cutting costs. It is about improving health care for patients through greater co-operation and collaboration.

Shona Robison: Will the member take an intervention?

Mr McCabe: If savings can be made, I expect them to be reinvested in front-line services. [Interruption.] Presiding Officer, I have some difficulty in hearing requests for information.

The Deputy Presiding Officer: I think that the minister is giving way to Shona Robison. I ask members to calm down the level of conversation, so that we can all hear what is going on.

Shona Robison: We all hope that savings will be made and that the money will be reinvested in services, but is it not the case that it will take some time for that money to come through? The up-front costs of establishing community health partnerships and the Scottish health council, and of ensuring public involvement, will be immediate. Where will those funds come from?

Mr McCabe: Of course, health boards have considerable funds available to them. The funds that have been made available to them have increased greatly year on year. It is not the case that there will be immediate poverty in boards and we think that the changes will generate savings. I cited some examples where trusts have already been dissolved and we think that savings have been generated. There is no reason to suggest that the same savings cannot be generated throughout Scotland.

Phil Gallie: Will the minister give way on that point?

Mr McCabe: No, I will not. I need to get on.

Creating CHPs is about redesigning existing resources to ensure more effective use of them. NHS boards are able to manage that change and many of them have already done a lot of work in anticipation of the change. Reorganisation will not—I repeat, not—be done at the expense of funding for front-line services.

The Executive has always recognised that the exact costs of intervention will depend on the size and the nature of the intervention; the figure in the financial memorandum is, of course, indicative. However, it is important to remember that, as well as improving services, any intervention is likely to save money in the long run, as it will prevent money from being wasted on ineffective services and poor planning.

Again, some members have commented that additional funding will be required to increase public involvement. We accept that if boards are to put much more effort into information, communication and involvement, that will have a cost. However, that is integral to providing a patient-focused service and will lead to more effective expenditure on health services generally. Of course, it is an evolving situation. As we embrace meaningful engagement with our communities, we will always be open to discussions about what the costs and benefits are. We also expect boards to work with other partners locally, through the CHPs and the community planning structures, so that we have a joined-up approach to delivering local services and to sharing the costs of community involvement.

Members have also asked how the new duty of health improvement is to be funded. The important point to make in that regard is that it is not about...
creating new costs but about making it easier for boards and ministers to spend existing money more effectively on promoting health improvement. We already expend large sums of money in the promotion of health improvement. Examples of that include the extra resources of £173 million announced in “Building a Better Scotland”, and that is on top of the £134 million already being spent between 2003 and 2006. Malcolm Chisholm recently announced pilot areas to study unmet need. We are clearly looking forward to seeing the outcomes of that study and to being guided in our future expenditure decisions by those pilots.

It is simply not possible in the time available to address all the points that have been raised. At stage 2, there will obviously be a further opportunity for more detailed scrutiny of the bill and we look forward to working with the committee, and indeed the entire Parliament, on refining the bill. However, I believe that there is broad agreement, both inside and outside the chamber, that the general principles of the bill are sound, and I hope that members will support the bill. Our view of Shona Robison’s amendment is that it is unnecessary, so I urge members to reject it.

National Health Service Reform (Scotland) Bill: Financial Resolution

The Presiding Officer (Mr George Reid): The next item of business is consideration of a financial resolution. I ask Malcolm Chisholm to move motion S2M-227, on the financial resolution in respect of the National Health Service Reform (Scotland) Bill.

Motion moved,

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the National Health Service Reform (Scotland) Bill, agrees to any increase in expenditure of the Scottish Ministers payable out of the Scottish Consolidated Fund in consequence of the Act.—[Malcolm Chisholm.]

17:02

Shona Robison (Dundee East) (SNP): The SNP will have to oppose the financial resolution, given that ministers have not taken the opportunity to agree to revisit the issue. The reasons for our opposition were given in my speech. There is no funding for the establishment of community health partnerships, despite the reservations expressed by the NHS Confederation in Scotland and by others. No money will be received to ensure that public involvement is done properly. The costs of the powers of intervention will be pushed on to health boards, and there will be no resources to ensure that the Scottish health council is established.

It is not just the SNP and other members, including some on the Executive’s own benches, who are raising concerns about the costs of the bill. Influential and important organisations such as the NHS Confederation in Scotland, which represents managers in the health service, are also concerned. It is just not good enough to say that costs can be met from within savings, because those savings will not be seen immediately and yet there are immediate costs from the bill.

The Deputy Minister for Health and Community Care said—and I hope that I am quoting him accurately—that there will be no immediate poverty in health boards. He should tell that to the health boards and to the patients who see cuts to local services across Scotland, and to the MSPs who sit at health board meetings listening to the financial savings that are having to be made and implemented over the next few years because resources are being stretched to meet the new responsibilities, particularly those of junior doctors’ working hours and the rise in drugs budgets. All the resources are being stretched to meet those new responsibilities, so any new responsibility that
the Executive puts on to health boards that is not fully funded will, yet again, put further pressure on budgets so that those resources will have to be met from patient services. That is not good enough. Legislation that is made in the Parliament should receive funding to ensure that it can be implemented without the funding having to come out of money in the health budget that is designated for other services.

I urge members to follow their consciences, to listen to members such as Kate Maclean and to support our amendment to the motion on the bill. I ask the Executive to go away and think again about the financial resolution.

17:05

Mr David Davidson (North East Scotland) (Con): The Conservatives are against the financial memorandum because the Minister for Health and Community Care said clearly at the beginning of the debate on the bill that he expected any cost to be met out of the increased funding that is already in the system. In the financial memorandum, the minister did not identify, as he should have done, what the costs are likely to be and who will bear them. The principle that has operated in this Parliament over the past five years has been that every financial memorandum should have clarity and be robust. This financial memorandum is neither clear nor robust; I will not go through the litany of problems.

There is a marginal administrative saving over the first two years, which could average as much as £1 million per health board, but that is a drop in the ocean compared to the up-front costs that will be suffered by health boards throughout Scotland if the financial memorandum goes through.

17:06

The Minister for Health and Community Care (Malcolm Chisholm): I am not surprised that, once again, the only substantive contribution that the SNP can make to a health debate is to call for more resources. That is the SNP’s answer to all the issues in the health service.

In response to the Conservatives, I point out that we acknowledged in the financial memorandum that there would be some additional costs. However, we also said that there would be some savings. We need a financial resolution in the Parliament to cover the former but, as Tom McCabe said in his winding-up speech, there have already been savings in NHS Borders and NHS Dumfries and Galloway, where trusts were abolished earlier than elsewhere. There have been savings of £500,000 in one year in NHS Dumfries and Galloway and the same kind of amount has been saved in NHS Borders, although over a slightly longer period. It is a case of there being some costs and some savings.

The key issue is the more effective use of existing resources: the £173 million extra that is already going into health improvement; the sum of more than £2 million that already supports the health council movement; and the £1 million that is supporting managed clinical networks, which will help to improve regional planning.

Shona Robison started by talking about community health partnerships. One of the key issues in respect of CHPs is the delegation of existing resources to the front line; it is about using the resources that are in the system. Management costs are also in the system already in the local health care co-operatives and in the primary care trusts; it is a matter of using the resources more effectively.

Let us not forget that although there are, of course, pressures in the health system, we have record resources in health. Those can be used more effectively and that is what the bill is all about.
Decision Time

17:12

The Presiding Officer (Mr George Reid):
There are five questions to be put as a result of today’s business. The first question is, that amendment S2M-215.1, in the name of Shona Robison, which seeks to amend motion S2M-215, in the name of Malcolm Chisholm, on the general principles of the National Health Service Reform (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR
Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Ewing, Mrs Margaret (Moray) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Ingram, Mr Adam (South of Scotland) (SNP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
McEwen, Mr Michael (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (SNP)
McGrigor, Mr Jackie (Highlands and Islands) (Con)
McLeitch, David (Edinburgh Pentlands) (Con)
McMahon, Mr Michelle (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Montheith, Mr Brian (Mid Scotland and Fife) (Con)
Morrison, Mr Alasdair (Western Isles) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Mundell, David (South of Scotland) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peatie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Caithness and Shin Croyston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Tosh, Murray (West of Scotland) (Con)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST
Aitken, Bill (Glasgow) (Con)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brookbank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Davidson, Mr David (North East Scotland) (Con)

Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Eddie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Claydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)

Amendment disagreed to.
The Presiding Officer: The second question is, that motion S2M-215, in the name of Malcolm Chisholm, on the general principles of the National Health Service Reform (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For
Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Bränkin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Mrs Margaret (Moray) (SNP)
Fergusson, Patricia (Glasgow Maryhill) (Lab)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Godman, Trish (Central Scotland) (SNP)
Gorrie, Donald (South of Scotland) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (LD)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Campbell (West of Scotland) (SNP)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan ( Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West ABERDEENShire and Kincardine) (LD)
Russel, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinney, Mr John (NORTH Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST
Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Muno (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Montelth, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Tosh, Murray (West of Scotland) (Con)

ABSTENTIONS
Byrne, Ms Rosemary (South of Scotland) (SSP)
Curran, Frances (West of Scotland) (SSP)
Fox, Colin (Lothians) (SSP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)

The Presiding Officer: The result of the division is: For 94, Against 17, Abstentions 5.

Motion agreed to.

That the Parliament agrees to the general principles of the National Health Service Reform (Scotland) Bill.

The Presiding Officer: The third question is, that motion S2M-227, in the name of Andy Kerr, on the financial resolution in respect of the
National Health Service Reform (Scotland) Bill, be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**FOR**

Alexander, Ms Wendy (Paisley North) (Lab)  
Baillie, Jackie (Dumbarton) (Lab)  
Baird, Shiona (North East Scotland) (Green)  
Baker, Richard (North East Scotland) (Lab)  
Ballance, Chris (South of Scotland) (Green)  
Ballard, Mark (Lothians) (Green)  
Barrie, Scott (Dunfermline West) (Lab)  
Boyack, Sarah (Edinburgh Central) (Lab)  
Brankin, Rhona (Midlothian) (Lab)  
Brown, Robert (Glasm​o​w) (LD)  
Butler, Bill (Glasgow Anniesland) (Lab)  
Canavan, Dennis (Falkirk West) (Ind)  
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)  
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)  
Curran, Ms Margaret (Glasgow Baillieston) (Lab)  
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)  
Eadie, Helen (Dunfermline East) (Lab)  
Ferguson, Patricia (Glasgow Maryhill) (Lab)  
Gillon, Karen (Clydesdale) (Lab)  
Glen, Marilyn (North East Scotland) (Lab)  
Godman, Trish (West Renfrewshire) (Lab)  
Gorrie, Donald (Central Scotland) (LD)  
Harvie, Patrick (Glasgow) (Green)  
Henry, Hugh (Paisley South) (Lab)  
Home Robertson, Mr John (East Lothian) (Lab)  
Hughes, Janis (Glasgow Rutherglen) (Lab)  
Jackson, Dr Sylvia (Stirling) (Lab)  
Murray, Dr Elaine (Dumfries) (Lab)  
Munro, John Farquhar (Ross, Skye and Inverness West) (Lab)  
Pearson, James (Caithness) (Lab)  
Peattie, Cathy (Falkirk) (Lab)  
Peacock, Peter (Highlands and Islands) (Lab)  
Peat, Dr Jim (Highlands and Islands) (Lab)  
Plumridge, Naomi (East Kilbride) (Lab)  
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)  
Radcliffe, Nora (Gordon) (LD)  
Raffan, Mr Keith (Mid Scotland and Fife) (LD)  
Robson, Euan ( Roxburgh and Berwickshire) (LD)  
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)  
Russell, Mr Mark (Mid Scotland and Fife) (Green)  
Scott, Eleanor (Highlands and Islands) (Green)  
Scott, Tavish (Shetland) (LD)  
Smith, Elaine (Coatbridge and Chryston) (Lab)  
Smith, Iain (North East Fife) (LD)  
Smith, Margaret (Edinburgh West) (LD)  
Stephen, Nic (Aberdeen South) (LD)  
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)  
Wallace, Mr Jim (Orkney) (LD)  
Watson, Mike (Glasgow Cathcart) (Lab)  
Whitefield, Karen (Airdrie and Shotts) (Lab)  
Wilson, Allan (Cunninghame North) (Lab)

**AGAINST**

Adam, Brian (Aberdeen North) (SNP)  
Aitken, Bill (Glasgow) (Con)  
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)  
Byrne, Ms Rosemary (South of Scotland) (SSP)  
Crawford, Bruce (Mid Scotland and Fife) (SNP)  
Cunningham, Roseanna (Perth) (SNP)  
Curran, Frances (West of Scotland) (SSP)  
Davidson, Mr David (North East Scotland) (Con)  
Douglas-Hamilton, Lord James (Lothians) (Con)  
Ewing, Mrs Margaret (Moray) (SNP)  
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)  
Fox, Colin (Lothians) (SNP)  
Fraser, Murdo (Mid Scotland and Fife) (Con)  
Gallie, Phil (South of Scotland) (Con)  
Gibson, Rob (Highlands and Islands) (SNP)  
Grahame, Christine (South of Scotland) (SNP)  
Ingram, Mr Adam (South of Scotland) (SNP)  
Johnstone, Alex (North East Scotland) (Con)  
Kane, Rosie (Glasgow) (SSP)  
Leckie, Carolyn (Central Scotland) (SSP)  
Lochhead, Richard (North East Scotland) (SNP)  
MacAskill, Mr Kenny (Lothians) (SNP)  
Martin, Campbell (West of Scotland) (SNP)  
Marwick, Tricia (Mid Scotland and Fife) (SNP)  
Mather, Jim (Highlands and Islands) (SNP)  
Matheson, Michael (Central Scotland) (SNP)  
Maxwell, Mr Stewart (West of Scotland) (SNP)  
McFee, Mr Bruce (West of Scotland) (SNP)  
McGrigor, Mr Jamie (Highlands and Islands) (Con)  
McLachlan, Dr George (Argyll and Bute) (Lab)  
Mcleish, Alex (Edinburgh Pentlands) (Con)  
Milne, Mrs Nanette (North East Scotland) (Con)  
Mitchell, Margaret (Central Scotland) (Con)  
Monteith, Ms Karen (Mid Scotland and Fife) (Con)  
Morgan, Alasdair (South of Scotland) (SNP)  
Mundell, David (South of Scotland) (Con)  
Robison, Shona (Dundee East) (SNP)  
Scanlon, Mary (Highlands and Islands) (Con)  
Scott, John (Ayr) (Con)  
Stevenson, Stewart (Banff and Buchan) (SNP)  
Sturgeon, Nicola (Glasclo​w) (SNP)  
Swiny, Mr John (North Tayside) (SNP)  
Tosh, Murray (West of Scotland) (Con)  
Welsh, Mr Andrew (Angus) (SNP)  
White, Ms Sandra (Glasgow) (SNP)

**The Presiding Officer:** The result of the division is: For 73, Against 44, Abstentions 0.  

**Motion agreed to.**

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the National Health Service Reform (Scotland) Bill, agrees to any increase in expenditure of the Scottish Ministers payable out of the Scottish Consolidated Fund in consequence of the Act.
National Health Service Reform (Scotland) Bill

Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 1 to 9  Schedules 1 and 2
Section 10  Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Malcolm Chisholm

1 In section 1, page 1, line 10, at end insert—

<( ) In section 82 of the 1978 Act, after subsection (2A) insert—

“(2B) All endowments and property held in trust transferred to a Health Board by an order under paragraph 26 of Schedule 7A (whenever made) are held by the Health Board free of any trust existing immediately before the transfer (hereafter in this section referred to in relation to any such endowment or property as “the original trust”); but all such endowments and property shall be held by the Health Board on trust for such purposes relating to services provided under this Act, or to the functions of the Board with respect to research, as the Board may think fit.”

( ) Until the coming into force of subsection (1) so far as repealing Schedule 7A to the 1978 Act, paragraph 26 of that Schedule has effect with the insertion after sub-paragraph (1) of the following sub-paragraph—

“(1A) For the avoidance of doubt, the reference to “property, rights and liabilities” in sub-paragraph (1) includes endowments and property held in trust.”>

Mr David Davidson

54 Leave out section 1

Section 2

Malcolm Chisholm

2 In section 2, page 1, line 15, leave out from <, within> to end of line 16 and insert <establish, in accordance with a scheme under section 4B approved by the Scottish Ministers (an “approved scheme”)>
Malcolm Chisholm

4 In section 2, page 1, line 19, at end insert—

<(1A) Community health partnerships shall be established as committees or sub-committees of a Health Board.

(1B) Where the area or district of a community health partnership includes all or part of the areas of two or more Health Boards, the community health partnership (a “joint community health partnership”) shall be established jointly by those Boards in accordance with their approved schemes.

(1C) Joint community health partnerships shall be established as joint committees of the Health Boards by which they are established.>

Malcolm Chisholm

5 In section 2, page 1, line 20, leave out <general function> and insert <functions>

Malcolm Chisholm

6 In section 2, page 1, line 20, leave out <is> and insert <are—

(a)> 

Malcolm Chisholm

7 In section 2, page 1, line 21, after <of> insert—

<i> such of>

Malcolm Chisholm

8 In section 2, page 1, line 23, leave out from <under> to end of line and insert <as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

(ii) such other of those services as its Health Board may specify, with a view to improving those services,

5

(b) to provide, or secure the provision of—

(i) such of the services which it is the function of its Health Board to provide, or secure the provision of, as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

10

(ii) such other of those services as its Health Board may specify, and

(c) to exercise such other functions of its Health Board—

(i) as may be prescribed by regulations under section 4B(5),

(ii) as may be specified in the approved scheme,

(iii) as the Health Board may delegate to it.

15 (2A) In this section, references to the Health Board of a joint community health partnership are to each of the Health Boards by which it was established.
4B Community health partnerships: further provision

(1) Every Health Board shall, within such period as the Scottish Ministers may specify, prepare and submit to them a scheme for the establishment of one or more community health partnerships in pursuance of section 4A(1).

(1A) In preparing a scheme under subsection (1) or (4) a Health Board shall—

(a) have regard to—

(i) any guidance issued under subsection (7),

(ii) community planning under section 15(1) of the Local Government in Scotland Act 2003 (asp 1) so far as relating to the area of the Board,

(b) consult—

(i) each local authority whose area includes all or part of the area or district of a community health partnership proposed by the scheme, and

(ii) any other person whom the Health Board think fit, and

(c) encourage the involvement of local authorities and other persons consulted under paragraph (b) in the preparation of the scheme.

Mr David Davidson

8B As an amendment to amendment 8, line 10, after <specify,> insert—

( ) to co-operate with local authorities to secure the provision of health-related services, and>

Mr Duncan McNeil

8A As an amendment to amendment 8, line 14, at end insert—

<(d) subject to subsection (2ZA), to prepare and publish annual plans explaining how it intends to exercise the functions referred to in paragraphs (a), (b) and (c) above over the 12 month period before publication of the next plan,

(e) to take reasonable steps to promote awareness of any annual plan published under paragraph (d) above within the district or area that the partnership covers, and

(f) to provide a copy of such a plan to any person resident in that district or area who requests the plan, in such format as that person may reasonably request.

(2ZA)An annual plan prepared under subsection (1)(d) above may not be published until it has been approved by the Scottish Ministers and any amendments to it proposed by the Scottish Ministers have been made.>
<(2A) At least one member of a community health partnership must be a representative of a local health council covering the same, or part of the same, district or area as the partnership.>

Mr David Davidson

56 In section 2, page 1, line 23, at end insert—

<(2B) At least one member of a community health partnership must be a representative of a voluntary health organisation working within the district or area of the partnership.>

Mr David Davidson

39 In section 2, page 1, line 24, leave out from beginning to end of line 8 on page 2

Malcolm Chisholm

9 In section 2, page 2, line 3, at end insert <or in pursuance of subsection (3A).>

(3A) Where the Scottish Ministers refuse to approve a scheme, they must return it to the Health Board and may direct the Board to resubmit the scheme with—

(a) such modifications (if any) as the direction may specify, and
(b) any further modifications which the Board consider appropriate,

by such time as the direction may specify.>

Malcolm Chisholm

10 In section 2, page 2, leave out lines 10 and 11

Mr David Davidson

57 In section 2, page 2, line 12, at beginning insert <without prejudice to sections 4A(2A) and (2B).>

Malcolm Chisholm

11 In section 2, page 2, line 12, leave out <status, membership, procedures, staffing and expenses> and insert <membership>

Malcolm Chisholm

12 In section 2, page 2, line 17, at end insert—

<(da) the application in relation to joint community health partnerships, with such modifications as may be specified, of the provisions of this Act, and any provision made under this Act, so far as applying in relation to community health partnerships,>

Malcolm Chisholm

13 In section 2, page 2, leave out lines 20 to 37
Malcolm Chisholm

14 In section 2, page 2, line 37, at end insert—

<(7) The Scottish Ministers may, after consulting such persons as they think fit, issue guidance about community health partnerships and shall publish such guidance.

(8) For the purposes of establishing a joint community health partnership in pursuance of section 4A(1B), any power to appoint committees conferred on Health Boards by virtue of this Act shall include power for two or more Health Boards jointly to appoint joint committees.

(9) Nothing in section 4A or this section affects the extent of any power under this Act so far as relating to committees or sub-committees of Health Boards.”>

After section 2

Malcolm Chisholm

15 After section 2, insert—

<Duty in relation to governance of staff

After section 12H of the 1978 Act insert—

“12HA Duty in relation to governance of staff

It shall be the duty of every Health Board and Special Health Board and of the Agency to put and keep in place arrangements for the purposes of—

(a) improving the management of the officers employed by it; and

(b) monitoring such management.”>

Shona Robison

Supported by: Dr Jean Turner

15A As an amendment to amendment 15, line 8, at end insert <; and

(c) workforce planning.”>

Malcolm Chisholm

16 After section 2, insert—

<Equal opportunities

Equal opportunities

After section 2C of the 1978 Act insert—

“2D Equal opportunities

(1) Health Boards, Special Health Boards and the Agency must discharge the functions conferred on them by, under or by virtue of this Act in a manner that encourages equal opportunities and in particular the observance of the equal opportunity requirements.
(2) In this section “equal opportunities” and “equal opportunity requirements” have the same meaning as in Section L2 (equal opportunities) of Part II of Schedule 5 to the Scotland Act 1998 (c.46).”

Mr Duncan McNeil

36 After section 2, insert—

<Waiting times

Duty of Health Boards etc. to monitor waiting times

In section 12H (duty of quality) of the 1978 Act—

(a) in subsection (1), leave out “purpose of” and insert “purposes of—

(a) monitoring whether it is adhering to guidance on waiting times issued by the Scottish Ministers, and

(b)”

(b) in subsection (3) at end insert—

““guidance on waiting times” means guidance issued by the Scottish Ministers as to the recommended maximum time any individual should ordinarily have to wait to receive any particular form of health care which the Board or Agency provides to individuals once the Board or Agency become aware or the individual’s medical condition; and such guidance shall be issued by way of regulations.”

Mr David Davidson

40* After section 2, insert—

<NHS foundation trusts

After section 12G of the 1978 Act insert—

“12GA NHS foundation trusts—

(1) The Scottish Ministers shall, within one year of the appointed day in terms of section 10(1), publish a scheme by way of regulations—

(a) allowing any NHS hospital, or group of hospitals, to apply to become an NHS foundation trust; and

(b) setting out the grounds on which the Scottish Ministers may allow or refuse such applications.

(2) In this section “NHS foundation trust” means a hospital, or group of hospitals, operating on a not for profit basis, with—

(a) the status of a body corporate,

(b) a board of management composed of health professionals and lay persons, and

(c) the power to—

(i) acquire and dispose of land and other property and retain the proceeds of such disposals,
(ii) employ staff and determine the remuneration, conditions and allowances of such staff,
(iii) enter into contracts, and
(iv) borrow sums in sterling.”>

Section 3

Mr Duncan McNeil
37 In section 3, page 3, line 6, after <to> insert—

<( ) ensuring that any guidance on waiting times issued by the Scottish Ministers under section 12H is met across Scotland, and
( )>

Malcolm Chisholm
17 In section 3, page 3, line 8, leave out from beginning to <Board> in line 10 and insert—

<(2) In pursuance of subsection (1) a Health Board may—
(a) undertake to provide, or secure the provision of, services as respects the area of another Health Board, and the other Health Board may enter into arrangements with the first Health Board for that purpose,
(b) undertake with one or more other Health Boards to provide, or secure the provision of, services jointly as respects their areas.
(2A) A Health Board undertaking to provide, or secure the provision of, services under subsection (2)>

Mr David Davidson
41 In section 3, page 3, line 12, at end insert <including arrangements for the payment of remuneration and expenses and any other costs reasonably incurred in relation to the provision of such services.>

Malcolm Chisholm
18 In section 3, page 3, line 15, leave out from first <for> to <(2)> in line 17 and insert <as respects their area.
( ) This section>

Section 4

Mr Duncan McNeil
38 In section 4, page 3, line 29, at end insert <, or

(iii) to provide the service within the relevant recommended waiting time as provided for in guidance issued under section 12H.
(1B) In coming to a view under subsection (1)(b) above, the Scottish Ministers must have regard to any written representation made by an individual that the body or person has so failed, is so failing or is likely so to fail, and offering reasons.

(1C) If the Scottish Ministers decide, having received a written representation under section (1B) above, not to make a direction under subsection (2) below, they must—

(a) inform the individual who made the representation of their decision in writing; and

(b) in so doing give reasons for the decision.>

Malcolm Chisholm

19 In section 4, page 4, line 4, at end insert <, or

( ) any other person who the Scottish Ministers consider has appropriate experience or expertise.

5 A body or person appointed by a direction given under subsection (2) to perform functions of a body or person referred to in subsection (1) is referred to in this section as an “appointed person”.

10 An appointed person must comply with a direction given under subsection (2).

( ) The remuneration and expenses of, and any other costs reasonably incurred by, an appointed person in performing the functions specified in the direction shall, unless otherwise specified in the direction, be paid by the body or person referred to in subsection (1).

15 Anything done or omitted by an appointed person in performing the functions specified in the direction is to be regarded as done or omitted by the body or person referred to in subsection (1).

( ) A person dealing with an appointed person in good faith and for value is not concerned to inquire whether the appointed person is acting within the powers conferred by virtue of the direction.

( ) The Scottish Ministers may vary or withdraw a direction given under subsection (2).>

Mr David Davidson

19A As an amendment to amendment 19, line 10, leave out from <body> to end of line 11 and insert <Scottish Ministers.>

Mr David Davidson

42 In section 4, page 4, line 4, at end insert—

<(... The Scottish Ministers must prepare guidance as to the circumstances in which they may consider it necessary to make a direction under subsection (2), and may, from time to time, revise such guidance.

( ) Any such guidance or revised guidance must be published, and a copy laid before the Scottish Parliament.>
Before section 5

Shona Robison
Supported by: Dr Jean Turner

43 Before section 5, insert—

<Membership of Health Boards

In paragraph 2 of Schedule 1 to the 1978 Act,

(a) after “and” insert—

“(a) in the case of a Health Board other than a Special Health Board, such number of other members as the Scottish Ministers think fit—

(i) no more than half of whom may be appointed by the Scottish Ministers,

(ii) the remainder to be determined by way of regular elections to the Board, to be held no less frequently than every four years for each Board, and

(b) in the case of a Special Health Board,”

(b) at end insert—

“(2) The persons entitled to vote as electors at an election for membership of a Health Board are those who on the day of the poll—

(a) would be entitled to vote as electors at a local government election in an electoral area falling wholly or partly within the area covered by the Board, and

(b) are registered in the register of local government electors at an address within the area covered by the Board.

(3) Where a poll is taking place for membership of two or more Health Boards on the same day a person is not entitled to vote as elector in more than one Board area on that day.

(4) The Scottish Ministers may by regulations make further provision as to the conduct of elections for the return of Health Board members.”>

Mr David Davidson

58 Before section 5, insert—

<Membership of Health Boards: local authority members

After paragraph 2 of Schedule 1 to the 1978 Act, insert—

“2ZA The Scottish Ministers shall ensure, when appointing members of a local authority as members of a Health Board, that, so far as is possible, the members appointed reflect the party balance of political parties represented on the local authority of which they are members.”>
Section 5

Malcolm Chisholm

20 In section 5, page 4, line 12, leave out <Health Board and Special Health Board> and insert <body to which this section applies>

Malcolm Chisholm

21 In section 5, page 4, line 13, leave out <services for which they are> and insert <health services for which it is>

Malcolm Chisholm

22 In section 5, page 4, line 17, leave out <of the Health Board or Special Health Board> and insert <to be made by the body significantly>

Malcolm Chisholm

23 In section 5, page 4, line 19, at end insert—

<(  ) This section applies to—

(a) Health Boards,
(b) Special Health Boards, and
(c) the Agency.>

Malcolm Chisholm

24 In section 5, page 4, line 20, leave out from first <Health> to end of line 23 and insert <body is responsible for health services if they are health services—

( ) which it is the function of the body to provide, or secure the provision of, and

( ) which are provided, or to be provided, to individuals by—

(i) the body, or
(ii) another person on the body’s behalf, at the body’s direction or in accordance with an agreement made by the body with that other person.>

After section 5

Mr David Davidson

45 After section 5, insert—

<Scottish Health Council

After section 4 of the 1978 Act insert—

“4C Scottish Health Council

(1) There shall be a body to be known as the Scottish Health Council, which shall be funded by the Scottish Ministers.
(2) In this section “Scottish Health Council” means an independent body with—
   (a) a board of management composed of one member from each local health council, and
   (b) the power to—
      (i) acquire and dispose of land and other property,
      (ii) employ staff and determine the remuneration, conditions and allowances of such staff,
      (iii) enter into contracts,
      (iv) with the consent of the Scottish Ministers, borrow sums in sterling by way of overdraft for the purpose of meeting a temporary excess of expenditure over sums otherwise available to meet that expenditure,
      (v) obtain information from Health Boards and Special Health Boards, and
      (vi) visit any establishment administered by a Health Board, Special Health Board or the Agency where services are being provided.

(3) The general duties of the Scottish Health Council shall be to—
   (a) co-ordinate the work of the local health councils on a national basis,
   (b) monitor the performance of Health Boards and Special Health Boards, and
   (c) liaise with the Scottish Executive Health Department on matters concerning the work of local health councils.”>

Section 6

Shona Robison
Supported by: Dr Jean Turner

46 Leave out section 6

Section 7

Malcolm Chisholm

25 In section 7, page 5, line 10, after <Board> insert <and Special Health Board and of the Agency>

Malcolm Chisholm

26 In section 7, page 5, line 12, after <Board> insert <, a Special Health Board or the Agency>

Malcolm Chisholm

27 In section 7, page 5, line 19, at end insert <, a Special Health Board or the Agency>

Malcolm Chisholm

28 In section 7, page 5, line 20, after <Board> insert <or Special Health Board>
Malcolm Chisholm
29 In section 7, page 5, line 22, leave out from first <the> to end of line 23 and insert—

<( ) the Health Board by the order under section 2(1)(a) which constituted the Board, or
( ) the Special Health Board by the order under section 2(1)(b) which constituted the Board,
as the case may be.”>

After section 7

Mr David Davidson
47 After section 7, insert—

<Dissolution of NHS Health Scotland>
(1) The body known as NHS Health Scotland is dissolved.
(2) Any property and rights of or held by NHS Health Scotland are transferred to, and vested in, the Scottish Ministers.
(3) The Scottish Ministers shall by regulation arrange for the transfer of such property and rights to local health care partnerships.>

Section 9

Malcolm Chisholm
30 In section 9, page 6, line 2, after <contains> insert <minor amendments and>

Schedule 1

Malcolm Chisholm
31 In schedule 1, page 7, line 5, at end insert—

<( ) In section 2C(4) (co-operation in discharging of functions to provide primary medical services), for “section” substitute “sections 12I and”>

Malcolm Chisholm
32 In schedule 1, page 7, line 9, at end insert—

<( ) In section 79 (acquisition, use and disposal of land and moveable property), after subsection (2) insert—
“(2A) For the avoidance of doubt, the power to use heritable property conferred by subsection (1), and the power to dispose of land conferred by subsection (1A), include power to let the property or, as the case may be, land.”>

Malcolm Chisholm
33 In schedule 1, page 7, line 19, at end insert—
In section 1 (power of NHS trusts to enter into agreements) of the National Health Service (Private Finance) Act 1997 (c.56)—

(a) in subsection (1), for “National Health Service trust” substitute “Health Board, a Special Health Board and the Common Services Agency for the Scottish Health Service (“the Agency”) to enter into contracts”,

(b) in each of subsections (3)(a) and (5), for “trust” substitute “Board or, as the case may be, the Agency”,

(c) in each of subsections (4) and (6), for “National Health Service trust” substitute “Health Board, a Special Health Board or the Agency”.

Malcolm Chisholm

In schedule 1, page 7, line 19, at end insert—

In section 77(1) (interpretation) of the Regulation of Care (Scotland) Act 2001, for the definition of “health body” substitute—

““health body” means a Health Board or Special Health Board constituted by order under section 2 of the National Health Service (Scotland) Act 1978 (c.29);”

Schedule 2

Shona Robison
Supported by: Dr Jean Turner

In schedule 2, page 7, leave out <Section 7.>

In schedule 2, page 8, leave out line 19

Shona Robison
Supported by: Dr Jean Turner

In schedule 2, page 8, line 25, leave out from first <subsection> to end of line 28 and insert <and in subsections (3) to (7), the words “, NHS trust” in each place where they occur.>

Shona Robison
Supported by: Dr Jean Turner

In schedule 2, page 9, line 11, leave out <“local health council”,”>
Shona Robison
Supported by: Dr Jean Turner

53 In schedule 2, page 9, line 16, leave out <29(3) and (4)(a)> insert <29(4)(a)>

Malcolm Chisholm

35 In schedule 2, page 9, line 23, at end insert—

<National Health Service (Residual Liabilities) Act 1996 (c.15) Section 2(2)(b).>
Groupings of Amendments for Stage 2

Organisation and operation of NHS: dissolution of NHS trusts
1, 54, 30, 32, 33, 34, 35

Community health partnerships
2, 3, 4, 5, 6, 7, 8, 8B, 8A, 10, 11, 12, 13, 14

Community health partnerships: membership
55, 56, 57

Community health partnerships: powers of the Scottish Ministers etc.
39, 9

Staff governance
15, 15A

Equal opportunities
16

Waiting times
36, 37, 38

NHS foundation trusts
40

Health Boards: duty to co-operate
17, 41, 18, 31

Powers of intervention
19, 19A, 42

Membership of Health Boards
43, 58

Public involvement: general
20, 21, 22, 23, 24

Public involvement: Scottish Health Council
45

Public involvement: local health councils
46, 48, 49, 50, 51, 52, 53

Promotion of health improvement
25, 26, 27, 28, 29
Promotion of health improvement: dissolution of NHS Health Scotland

47
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

9th Meeting, 2004 (Session 2)

Tuesday 23 March 2004

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

Also present: Karen Gillon

Apologies: Duncan McNeil

National Health Service Reform (Scotland) Bill: The Committee considered the Bill at Stage 2.

Relevant to amendments considered under this agenda item, Helen Eadie declared that she is a member of the Scottish Co-operative Party

The following amendments were agreed to (without division): 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15A, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35.

The following amendments were agreed to (by division)—

1 (For 8, Against 1, Abstentions 0)
9 (For 8, Against 1, Abstentions 0)

The following amendments were disagreed to (by division)—

54 (For 1, Against 8, Abstentions 0)
55 (For 4, Against 5, Abstentions 0)
56 (For 3, Against 5, Abstentions 0)
39 (For 1, Against 8, Abstentions 0)
40 (For 1, Against 8, Abstentions 0)
41 (For 1, Against 8, Abstentions 0)
45 (For 3, Against 6, Abstentions 0)
46 (For 4, Against 5, Abstentions 0)
47 (For 1, Against 8, Abstentions 0)

Amendments 36, 19, 19A and 43 were moved and, with the agreement of the Committee, withdrawn.

The remaining amendments were not moved.
Section 1 was agreed to as amended.
Section 2 was agreed to as amended.

Sections 3, 5, 7 and 9 and schedules 1 and 2 were agreed to as amended.

Sections 4, 6, 8 and 10 and the long title were agreed to without amendment.

The Committee completed Stage 2 consideration of the Bill.
National Health Service Reform (Scotland) Bill: Stage 2

14:03

The Convener: Item 2 is stage 2 consideration of the National Health Service Reform (Scotland) Bill. I welcome the minister and his team. I will give the minister a moment to get his papers sorted. In fact, I need to get my papers sorted. While the minister was sorting out his papers, I have managed to get mine all muddled.

Section 1—Dissolution of National Health Service trusts: modification of enactments

The Convener: Amendment 1 is grouped with amendments 54, 30, 32, 33, 34 and 35.

The Minister for Health and Community Care (Malcolm Chisholm): I will deal first with the Executive amendments in the group, which are amendments 1, 30 and 32 to 35. They are minor technical amendments, which reflect the fact that national health service trusts are dissolving and that references to NHS trusts are to be removed from the statute book.

Amendment 1 will help to ensure the smooth handover of NHS trust property to boards. The amendment relates to the property of NHS trusts that is subject to endowment or trust terms. The amendment will ensure that all endowments and other property that is currently subject to a trust will be transferred to health boards free of the original trust and endowment terms. The original objects of the trust or endowment will be preserved by operation of existing provision in section 82 of the National Health Service Act 1978, which requires that the board shall ensure as far as is reasonably practicable that the original trust or endowment purposes are observed.

Amendment 30 is a minor amendment to section 9, on the modification of enactments, and seeks to expand schedule 1 to the bill to include minor as well as consequential amendments. Amendment 32 seeks to clarify that the powers of Scottish ministers to use and dispose of land includes the power to lease land. That power will be conferred on health boards. Amendment 33 seeks to replace the current statutory reference to NHS trusts in the NHS (Private Finance) Act 1997 with a reference to health boards, special health boards and the Common Services Agency, to ensure that existing contractual obligations of NHS trusts are not disturbed.

Amendments 34 and 35 seek to add an additional consequential amendment to schedule 1 and an additional repeal to schedule 2. The repeal will remove a reference to “National Health
I will give David Davidson the acute sector and patients as entities, the minister Care (Scotland) Act 2001 by removing the phrase "National Health Service Trust". Amendment 54 is unnecessary and I am not clear what David Davidson expects to achieve with it. Scottish ministers already have the powers to dissolve trusts by subordinate legislation when a trust makes an application for dissolution. Indeed, trusts have already been dissolved in Dumfries and Galloway and the Borders and the order that dissolves the remaining trusts was laid before Parliament on 10 March. Those who gave evidence during stage 1 consideration of the bill overwhelmingly supported the abolition of trusts. 

Trusts will cease to exist on 1 April. Amendment 54 will not change that; all it will do is to leave on the statute book references to bodies that no longer exist. I fail to see how that will improve the health care of the people of Scotland. Accordingly, I invite David Davidson not to move amendment 54.

I move amendment 1.

The Convener: Before I call David Davidson to speak to amendment 54 and the rest of the amendments in the group, I should point out that I omitted to say that we had received apologies from Duncan McNeil and to welcome to the meeting Karen Gillon, who will move Duncan's amendments. We hope that the committee substitute, Paul Martin, will join the meeting later to vote on those amendments.

Mr David Davidson (North East Scotland) (Con): On the minister’s points about amendment 54, over the past three years he has regularly referred to devolving power and decision making to front-line health service operatives. However, with this bill, he is seeking to do the very opposite and to hold all the power himself.

It is becoming more apparent that boards will no longer be the strategic bodies of the future. Indeed, with the development of managed clinical networks, which cover a much larger area than standard health boards, there is an opportunity for them to become strategic bodies in the health boards’ place. Separating the regional strategy from service delivery, which is the responsibility of trusts or, in some cases, operational divisions, would result in far more local autonomy to deliver services locally in the interests of local people. It would also remove the minister from any involvement at the front end of things—indeed, I believe that that is Liberal Democrat policy in Westminster.

If we want to retain the primary care sector, the acute sector and patients as entities, the minister can also retain the power to intervene in crises, but he does not need to become involved in management. After all, in the European system, there is a national agreement on standards between ministers and those who provide capacity regardless of the sector. That system is based on a non-prescriptive approach and leaves staff and patients to become involved in designing the service locally.

I and many health board chief executives believe that health boards are also likely to go. I move amendment 54, because it seeks to provide an opportunity to maintain trusts while long-term strategic movements in the NHS settle down. Obviously, if the amendment is agreed to, I will need to lodge consequential amendments. I have not troubled the clerks to produce them but they can be delivered readily.

The Convener: Thank you. You do not have to move amendment 54 at this point. I welcome Paul Martin to the committee. He is the formal substitute for Duncan McNeil and therefore has voting rights.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): In one way, the fact that David Davidson has lodged amendment 54 is surprising, but, in another way, it is not surprising. I am thinking of our debate on our report at the end of stage 1. Throughout stage 1, he fully supported the heart of the bill. In that sense, I am surprised.

The Convener: I will give David Davidson the right of reply to that.

Mr Davidson: Thank you, convener. I will keep it brief.

I recognise the fact that five boards among our current health boards do not have trusts. They chose to do things that way. I would prefer there to be choice at local level. The boards were not forced to withdraw the trusts; in fact, some of the boards wanted to move towards having co-ordinated health boards.

Amendment 54 would allow the minister the opportunity to talk about possible future changes in the health board structure, about the future role of managed clinical networks, about choice, and
about whether he believes that keeping strategy separate from delivery is a good thing for the future of the health service. He has the opportunity to put his views on the public record.

Malcolm Chisholm: David Davidson is confusing different issues. He presents the preservation of trusts in terms of devolving power and decision making, encouraging managed clinical networks and ensuring more autonomy at local level. I support all those objectives, but they are quite separate from the existence or otherwise of trusts. Managed clinical networks are a good example; they are a particularly Scottish model of care and are consistent with the general model of care that we are trying to promote. Our model is different from the English model, and the same debate, although with some differences, will take place on David Davidson’s amendment on foundation trusts.

We are trying to create a more integrated way of working in Scotland—single-system working, with the different parts of the health system working together collaboratively. That is precisely what managed clinical networks are. We do not want the fragmented system that has been one of the hallmarks of trusts in Scotland.

I do not know how many times I have to say this to David Davidson, but just because we want single-system working does not mean that we want centralisation. The biggest part of the bill and the biggest number of amendments relate to community health partnerships, which are a more appropriate level to which to devolve power than are the traditional trusts, which, as we know, are very large organisations in Scotland. This same territory will be covered in debates on future amendments but I wanted to make a brief opening statement at this point.

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeen and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 54 disagreed to.

The Convener: The question is, that section 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeen and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Section 1, as amended, agreed to.

Section 2—Community health partnerships

14:15

The Convener: Amendment 2, in the name of the minister, is grouped with amendments 3 to 8, 8B, 8A and 10 to 14.

Malcolm Chisholm: I will explain why the largest number of amendments is to section 2, as I said in my previous comments. Since the bill was introduced, we have had extensive consultation on community health partnerships, and the Executive amendments are largely the product of that exercise. We have also sought to address issues that committee members raised at stage 1, such as CHPs that cross health board boundaries, which Janis Hughes picked up on.

Amendment 2 will change the initial duty to submit a scheme of establishment into a duty to
establish CHPs in accordance with an approved scheme. An approved scheme is a scheme of establishment that the Scottish ministers have approved.

Amendment 3 will make a minor change to recognise that CHPs may cover the area of more than one health board.

Amendment 4 will define CHPs’ status. It explains that CHPs must be established as committees or sub-committees of boards. It will also allow boards to establish a joint CHP when a CHP’s area includes more than one health board area. Joint CHPs must be established as joint committees of the health boards that establish them.

Amendments 5 and 6 are technical amendments to recognise that CHPs will have more than one function.

Amendments 7 and 8 will make it clear that CHPs have three functions. First, they will coordinate the planning, development and provision of services. Secondly, they will provide or secure the provision of services. Thirdly, they will exercise functions of their boards. However, that will apply only to services and functions that have been prescribed in regulations, included in the approved scheme of establishment or specified by the health board.

Amendment 8 will also move the initial duty to submit a scheme of establishment for CHPs to a new section, which will be proposed new section 4B of the 1978 act. Section 4B(1A) will require boards, in preparing their schemes, to have regard to statutory guidance and to the community planning process and to consult and encourage the involvement of local authorities and other persons that they think fit.

Amendment 10 will remove the regulation-making power to prescribe the number of CHPs that are to be established in each health board’s area. That was considered to be too prescriptive. Boards should be able to determine the number of CHPs for their areas, having regard to the statutory guidance.

Amendment 11 will remove the regulation-making powers on CHPs’ status, procedures, staff and expenses. The status of CHPs will be prescribed in the bill. As CHPs are committees of boards, they will be subject to the same regulations about procedures—the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302)—as are other committees that boards establish. A regulation-making power on staff and expenses was considered unlikely to be needed.

Amendment 12 will add a new regulation-making power to apply to CHP joint committees the provisions in the 1978 act on single committees of health boards.

Amendment 13 will remove the illustrative list at new section 4A(6) of the 1978 act, which was considered to be far too detailed. For example, it is unnecessary to prescribe how CHPs will consult their parent boards and it is inappropriate to detail the reports that CHPs will produce.

Amendment 14 will add three new subsections to proposed new section 4B. New subsection (7) will say:

“The Scottish Ministers may, after consulting such persons as they think fit, issue guidance about community health partnerships and shall publish such guidance.”

That is the statutory guidance to which boards will have regard when producing their schemes of establishment. New subsection (8) will allow health boards to appoint joint committees for the purpose of CHPs. Section 2(11) of the 1978 act allows the Scottish ministers to establish joint committees for the areas of two or more health boards but, at present, health boards cannot do that. New subsection (9) will ensure that any provision on CHP committees in proposed new sections 4A and 4B will not affect other powers that relate to board committees more generally.

I appreciate the sentiment behind amendment 8B, but it is unnecessary for three reasons. First, the Executive has already lodged amendments to ensure that the role of local authorities is properly recognised and that they are properly involved in the exercise of the CHPs’ functions. They include provisions that state that, when drawing up the scheme of establishment, health boards should have regard to statutory guidance, which includes many references to working with local authorities to secure the provision of health-related services, and to the community planning process, which local authorities lead and which considers the provision of public services across a local authority area. The provisions also state that health boards shall consult local authorities and that they shall encourage the involvement of local authorities. The draft CHP regulations also require there to be a member or an officer of the local authority on the CHP committee. Those provisions will ensure that CHPs are co-operating with local authorities.

Secondly, the amendment would place on CHPs a replica of the duty that is imposed on boards in section 13 of the 1978 act. The need is not to increase the number of duties but to ensure that the duties that are imposed will achieve the necessary outcomes. We think that the Executive amendments do that. As a consequence of them, CHPs will, in effect, be performing duties similar to those imposed on their parent board under section 13 of the 1978 act.
Thirdly, the suggested amendment is not about a function of CHPs but is a description of how CHPs should exercise their functions. It does not fit well in a section that is intended to describe a CHP’s functions. Since the bill already meets David Davidson’s objectives, I encourage him not to move his amendment.

Amendment 8A relates to the production of annual plans. As I said in relation to amendment 13, it is overly prescriptive to be included in the bill and relates to an ancillary matter rather than CHPs’ core functions. As part of its business planning arrangements, a CHP will draw up plans for how it proposes to provide the services and exercise the functions delegated to it by the health board. At the moment, there is no requirement to make such plans publicly available. However, I propose to amend the statutory guidance to require such plans to be prepared by the CHP, involving the public and other stakeholders as necessary, and to ensure that those plans are made publicly available if requested. However, I do not think that it is necessary for those provisions to be included in the bill or, crucially, for the annual plans from every CHP in Scotland to come to me for approval. That would be too prescriptive and centralist and I would encourage whoever might move the amendment not to do so.

The Executive amendments represent the outcome of our extensive consultation.

I move amendment 2.

Mr Davidson: The minister has detected that amendment 8B is intended to be supportive of the role that is played locally by local authorities and the health boards, sometimes separately and sometimes jointly. It would include in the bill an opportunity to merge local authority budgets and staff who deliver medical care to create a single management operation with single patient assessment and contact, which would minimise bureaucracy and save money. The model would be similar to one that Bristow Muldoon talked about in a recent debate and I know that some local authorities are seeking to work on that basis. The amendment would encourage closer working between the two systems, because there have been far too many cases of individuals dropping between the two systems, because there have been far too many cases of individuals dropping out and stage 3.

On amendment 8A, I appreciate the principle of publishing a plan, which could be done through libraries and so on, but I find the proposed method of doing so far too bureaucratic and costly and likely to divert resources away from where they should be going without ensuring that the information that Mr McNeill, who lodged the amendment, wishes to be made available would be seen. My original comments on amendment 8B show that the minister and I are not approaching intervention from the same angle. We might discuss that later on today. The principle of publishing a plan is a good one, but the method suggested is onerous and I cannot support it.

Karen Gillon (Clydesdale) (Lab): New section 4A(2) of the 1978 act states:

“The general function of a community health partnership is to co-ordinate … the planning, development and provision of the services which it is the function of its Health Board to provide, or secure the provision of”.

Amendment 8A seeks to give community health partnerships a duty to make the public aware of what they are entitled to.

The new section 4A(2)(d) of the 1978 act that amendment 8A proposes would require the drawing up of an annual plan to explain how the functions to which the minister’s amendment 8 refers would be exercised. Proposed new paragraph (e) would require steps to be taken to promote public awareness of the annual plan and paragraph (f) would allow for that plan to be provided in other forms, such as Braille or audio tape, if that was in the interests of the person seeking it. Proposed new section 4A(2ZA) would give the minister the final say on the content of any annual plan.

I appreciate what is being said and I listened carefully to the minister’s opening comments. I understand that he does not want those measures to be in the bill because he believes that they are too prescriptive. There is an opportunity for dialogue with the minister on how the matter can be resolved and I would be minded not to move the amendment if that could take place between now and stage 3.

Shona Robison (Dundee East) (SNP): The intention behind amendment 8A is sound because we would want the public to be aware that the plans exist. The minister should persuade us that CHPs will be proactive in ensuring that that happens. The minister said that the plans would be publicly available if requested, but I am concerned that people would have to know of their existence before they could request them. I would be more comfortable if I knew that CHPs were going to be obliged to ensure that, as far as possible, the public are made aware of the existence of the plans and are encouraged to look at them. I hope that that will be done. I am quite
relaxed about whether the measure is included in the bill or in the regulations and guidance. I do not have any strong views on that, as long as the principle is established.

Janis Hughes (Glasgow Rutherglen) (Lab): I, too, accept the spirit of Duncan McNeil’s proposals. At stage 1, we discussed the service that will be provided and how it might be changed somewhere along the line. If we think about other recent legislation, we see that that can be detrimental to the service that is provided locally. Duncan McNeil seems to want to tell people about the good things that can be provided. By doing that through a CHP publication, we would show people the benefits that can be available. As Shona Robison said, if people do not know about the plans, they will not ask for them. Therefore, the intention behind amendment 8A is to be welcomed, and it would be helpful if we could have dialogue on the proposals at some point in the future.

I have a specific question about amendment 4. The minister is aware of my views on coterminosity in CHPs where that is possible, although I accept that it is not possible in every case. Does the minister have a view on the minimum population required for a CHP to be viable in an area? I am thinking of instances in which a community health partnership might span two health board areas and have a population of 100,000, whereas a population of 50,000 would allow CHPs to remain coterminous with each health board. I wonder whether the minister has a view on that and whether he can explain, if he thinks that the higher number is preferable, why it is preferable and what the benefits would be.

14:30

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I have been thinking about information for patients. It is a good idea that patients should know what their community health partnership does, but primarily they will be in contact with their general practice. General practices are required to keep up to date leaflets that say everything that they can do for patients and also what they cannot do and where patients can find help. A plan for each practice is also required.

I sympathise with what has been said and with Duncan McNeil’s amendment 8A. I wonder whether the two things could be tied up to make what practices do more public. There is a requirement for information on the health board and practices are required to have a yearly business plan. Patients being informed through the community health partnership as well as at practice level would be a good idea.

Malcolm Chisholm: There are three lots of issues to which to respond. I will deal with the issues that Karen Gillon raised first. I am entirely happy with her suggestion that there should be further discussion. Obviously, I have made a proposal that has not yet been implemented, so it is clear that it is modifiable. Indeed, we would welcome comments from committee members on anything in the statutory guidance, now that they have it.

I repeat what I said: I propose to amend the statutory guidance to require such plans to be prepared by the CHP, involving the public and other stakeholders as necessary, and to ensure that those plans are made publicly available if requested. I am entirely happy to consider the wording of that last part, as there does not seem to be any obvious reason why they should not be more routinely available—I think that Jean Turner made that point, too. I would certainly be happy to discuss the matter with Karen Gillon, Duncan McNeil or anybody else who wishes to discuss it and I look forward to what Health Committee members have to say if they are going to respond more generally to the statutory guidance.

On the issue that Janis Hughes raised relating to amendment 4, the statutory guidance that the committee has received talks about a minimum number of 50,000. That is another area in which we have shifted from the original idea that the matter would be in the regulations to its being in statutory guidance. Some members might accuse me of being too centralist; others might accuse me of being the opposite and of not being prescriptive enough. There is a balance to be struck. We are trying to be as flexible as possible about the numbers for CHPs, but we have indicated in the statutory guidance that a minimum number of 50,000 seems reasonable given the ambitions that we have for CHPs.

That leads me to David Davidson’s amendment 8B. I suppose that he went way beyond the wording of his amendment in talking about joint or pooled budgets. The reality is that we have already legislated for that through the Community Care and Health (Scotland) Act 2002. There have already been significant developments in that direction and that is not what we are talking about in the bill.

David Davidson’s amendment says that CHPs should co-operate to secure the provision of services. My point is that that is already a requirement on health boards under the 1978 act. There is a strong focus on the joint future agenda in many places in the statutory guidance for CHPs; the language in relation to working with local authorities has been strengthened in the second version of that guidance; and there is also the requirement for representation of local authorities on community health partnerships in the regulations. Indeed, the issue is covered in the
parts of the bill to which I referred in relation to local authorities’ involvement in various ways in the schemes of establishment.

I would argue that we have more than addressed the need for CHPs to co-operate to secure the provision of services, and I do not believe that such a provision should be in section 2, which is about the CHPs’ functions rather than about how they should be performed.

Kate Maclean (Dundee West) (Lab): You covered what amendment 8A’s proposed new paragraph (d) seeks to do by saying that you will produce statutory guidance to require CHPs to produce annual plans. I believe that that will also cover the provision in amendment 8A’s proposed new paragraph (e). However, will Executive amendment 16 cover what amendment 8A’s proposed new paragraph (f) seeks in relation to equal opportunities and the production of CHP annual plans?

Malcolm Chisholm: I would not like to give a snap judgment on that. Obviously, what paragraph (f) seeks should happen. I believe that amendment 16 covers it in general terms.

Kate Maclean: Amendments 16 refers to the fact that “Health Boards, Special Health Boards and the Agency must discharge the functions conferred on them”.

Malcolm Chisholm: I believe that amendment 16 covers the equal opportunities aspect in general terms. Obviously, I support that objective.

I am glad that Kate Maclean revisited amendment 8A. I welcome discussion on it, but the fundamental reason why I am opposed to it—I am sure that David Davidson will be pleased to hear this—is that I do not believe that it is appropriate that I, as minister, should approve the annual plan of every CHP in Scotland.

The Convener: I am sensing an interesting agreement on that point.

Kate Maclean: Just to clarify, amendment 8A’s proposed new paragraph (f) seeks “to provide a copy of such a plan to any person” in accessible formats. I presume that amendment 16 covers that provision.

Malcolm Chisholm: I support such a provision and I believe that amendment 16 covers it in general terms.

Amendment 2 agreed to.

Amendments 3 to 7 moved—[Malcolm Chisholm]—and agreed to.

Amendment 8 moved—[Malcolm Chisholm].

Amendments 8B and 8A not moved.

Amendment 8 agreed to.

The Convener: Amendment 55, in the name of David Davidson, is grouped with amendments 56 and 57.

Mr Davidson: Amendment 55 seeks to put at least one local health council representative on each CHP to provide patient-based input and monitoring of plans before the plans are confirmed. That would satisfy some of the demands for democracy in the pooling together of the CHPs’ plans about delivery and so on. The provision would tie in the local health councils to being round the table when the plans are being developed. Consideration of such provision is a natural progression; that can also be said of another amendment that I have lodged, which will be debated later.

I turn to amendment 56. We are all aware that the voluntary sector in Scotland delivers annually the equivalent of £6 billion-worth of centrally supplied services. I do not have an accurate figure for the health sector, but it is certainly into the billions. We are becoming more and more dependent on the voluntary sector. Examples such as the Macmillan nurses show that there are services for which the charity sector provides part or all of the funding. I feel that, for the purposes of local co-ordination of services, it is important not only for the role of the voluntary health sector to be recognised, but for a local member, appointed from that sector, to be present at the table to demonstrate what is available and what cooperation can be achieved. That person could be part of the dialogue at the planning stage in the delivery of local services.

Amendment 57 is a consequential amendment.

I move amendment 55.

Shona Robison: I am sympathetic towards amendment 56. Often, we do not give due recognition to the role of the voluntary sector, and there is a strong argument for its important role being duly recognised in the bill to ensure that the hand of the voluntary health sector is strengthened in the community health partnership. Without the voluntary sector, the community health partnership will not work as it should do, so I sympathise with the intention of amendment 56.

Mike Rumbles: When I first saw amendment 56, I thought, “This looks good.” When I read the amendment in detail, however, I had problems with it. David Davidson has lodged the amendments in the group with the intention of identifying individuals on the community health partnerships, yet nowhere else in the bill do we identify individuals. The approach that David Davidson’s amendments propose is quite prescriptive. If we were to agree to the amendments, we would be dictating to people
from the voluntary sector that they should be on a community health partnership. I do not think that it would be appropriate to do that, considering that we have not done so in any other case.

**Dr Turner:** In some ways, I understand what Mike Rumbles is saying. If we were to prescribe, in one case, who should be on a community health partnership, we would have to do that in every case. However, in the two examples that have been given, the health council works very much with the patients and the Macmillan and Marie Curie nurses are almost like an amoeba that has been invaginated into the health service. Those are voluntary sector services but they are paid for in part by health boards, so most people think that they are the NHS. There might be a case for naming those two groups in particular; I do not know how other members feel about that. I imagine that a community health partnership would have as many people on it as possible within an area, but it may not always happen that way, just as it did not always happen with the local health care co-operatives.

**Malcolm Chisholm:** I shall say something about the local health council proposal and the voluntary sector proposal, but first I would like to explain that the regulations that members have received prescribe certain people who ought to be on community health partnerships. As usual, a balance must be struck. Is the list too prescriptive or not? My view is that we ought to prescribe who has to be on a community health partnership, not least so that we can ensure that the CHP is a diverse body and, as I shall explain later, that it is a decentralised body.

The regulations include an extensive list of people who will have to be on the community health partnership. For example, there will have to be a nurse, as well as a doctor and a pharmacist. As I shall explain, there will have to be somebody from the voluntary sector and somebody—at least one person, if not more—who represents patients. My fundamental point about amendments 55, 56 and 57 is that it makes no sense to list two of the required members in the bill and the other members—whatever considerable number of them we are talking about—in the regulations. That would be an incoherent and nonsensical way in which to proceed. The members should be, and will be, listed in regulations, but they should not be included in the bill.

14:45

I will deal with the particularity of amendments 55, 56 and 57. In the first instance, it is well known that our policy is to replace health councils with a new structure that will require health boards to involve the public directly; Executive amendments on that will be forthcoming. Under our proposals, public involvement will be monitored and quality assured by the Scottish health council and its local advisory councils. It is obvious that we cannot accept amendment 55, which refers to local health councils, when the councils will be dissolved by another part of the bill.

As I have indicated, regulation 3(1)(i) of the draft CHP regulations requires there to be a member of the public partnership forum on the CHP. That member’s function will be to represent the interests of the public on the CHP, although the CHP will still have to engage the public directly. I repeat that a minimum of one person is required but, clearly, more can be placed on the CHP. Public partnership forums will bring together existing local groups, networks of patient groups, voluntary organisations, interested individuals and others, with the key role of considering specific issues and informing CHPs.

Regulation 3(1)(j) of the draft CHP regulations states that a CHP must contain a member of the local voluntary sector. Regulation 3(2) requires the CHP members to “either live, be employed, or perform services in the area of the community health partnership.”

David Davidson’s objective has already been achieved by means of the regulations, which are binding, therefore we should not separate out and include in the bill one category of CHP member, while the rest are stipulated in regulations. In view of that, I urge David Davidson to withdraw amendment 55 and not to move amendments 56 and 57.

**The Convener:** The minister has called the amendments not competent and “incoherent”, so I look forward to David Davidson’s winding up.

**Malcolm Chisholm:** I did not say that they were not competent.

**Mr Davidson:** Were you inviting me to speak, convener?

**The Convener:** Yes.

**Mr Davidson:** It sounded more like a statement.

I will deal first with the comments from Shona Robison and Jean Turner. They understand where I am coming from, and they agree that it is important, as far as the voluntary health sector is concerned, that due recognition is given. I lodged amendment 56 so that Scotland could, through the Parliament, recognise officially the role of voluntary health organisations in delivering vast amounts of care and support that are not being delivered through the Scottish Executive budget for health and community care. It is appropriate that such organisations are recognised in that way.

With regard to what the minister said about amendment 55, on local health councils, there is
an issue about later discussions. Neither committee members nor the minister have any control over how things will be dealt with, because of the timing of these discussions. That is part and parcel of later amendments, approval of which will be sought from the committee. On that basis, I am inclined to press amendments 55, 56 and 57.

I understand what Mike Rumbles was saying. There are proposed regulations, which have not yet been put to the Parliament for approval, in which there is an outline list of certain people who must, as a minimum, be part of a CHP. In other words, the list is prescribed. Unless I misunderstood the minister’s point, he has just said that he will seek to extend that list, but we have not seen the colour of that.

Malcolm Chisholm: I did not say that.
Mr Davidson: I will let the minister in.

The Convener: That is for the convener to decide. If you finish your points, I will let the minister back in.

Mr Davidson: I am against too much local prescription, but amendment 55 is linked to a later amendment and on that basis I will press it. On amendment 56, it is a matter of principle that we publicly declare our support for the voluntary health sector and recognise where it is coming from. Amendment 57 is consequential.

Malcolm Chisholm: I do not understand what David Davidson said. Perhaps I did not make myself clear earlier. The regulations are perfectly explicit about membership of the CHP—there will be a member of the local voluntary sector and at least one member of the public, a doctor, a nurse, a pharmacist and various other people. That is explicit in the regulations.

Mr Davidson: When the minister refers to the voluntary sector, does he mean the voluntary health sector? Perhaps he could clarify that.

Malcolm Chisholm: The regulations refer to the local voluntary sector. The assumption is that that will be health related. If the committee has concerns about that, we will welcome your comments—it is our purpose to seek such comments.

The Convener: The question is, that amendment 55 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 55 disagreed to.

Amendment 56 moved—[Mr David Davidson].

The Convener: The question is, that amendment 56 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 56 disagreed to.

Amendment 39, in the name of David Davidson, is grouped with amendment 9. If amendment 39 is agreed to, amendment 9 will be pre-empted.

Mr Davidson: The minister already has the power of intervention, therefore he need only have notification that community health partnerships have drawn up a scheme of establishment. The minister does not need to approve such schemes, which is why I lodged amendment 39. The minister with responsibility for local government has schemes laid before him by local authorities for their community councils, but those schemes are not submitted for the minister’s approval. There is, therefore, a precedent for what I propose.

This is a matter of the local design of services, to which the minister has alluded several times this afternoon. If people look back at the Official Report at a later date, they will find that to be the case. The minister does not think that certain things are prescriptive, but he thinks that other things are. I believe that the proposals on ministerial powers in relation to community health partnerships are very prescriptive. The minister has talked at length about those proposals this afternoon, but there is no requirement for him to be involved at some of the planning levels.

The minister has the power of intervention as far as health delivery is concerned, therefore he should not be involved in the mechanisms as long as a scheme has been lodged—and I believe that
there is an onus on CHPs to lodge a scheme with ministers. If that scheme does not deliver what it is supposed to deliver, the minister may intervene anyway, given the powers that he has. That would present an opportunity for negotiation and discussion, rather than its being for the minister to agree individual local schemes. The provision that will enable the minister to do that flies in the face of the comments that he has made today.

I move amendment 39.

Malcolm Chisholm: The purpose of sections 2(3) and 2(4) is to ensure delegation of authority and resources to front-line staff. The best way of achieving that is for health boards to submit schemes of establishment to the Scottish ministers, so that we can ensure that it happens.

David Davidson and his party are concerned—as they keep telling us—about the move to single-system working resulting in centralisation within boards. The purpose of sections 2(3) and 2(4) is to ensure that that does not happen and that we have the decentralisation and delegation of authority and budgets that community health partnerships are all about.

As with the dissolution of trusts and the move to operating divisions, we will require boards to demonstrate to us that they are devolving adequate functions and resources so that front-line staff have an input into the decisions that are made on the delivery of services. That is entirely consistent with the objectives that are outlined in “Partnership for Care: Scotland’s Health White Paper”. There must be a way of ensuring that boards are complying with the regulations and having regard to the statutory guidance that will be issued. The best way to achieve that is for the Scottish ministers to check the schemes of establishment to ensure that the policy and benefits of a single system that does not centralise power in health boards are being delivered.

As I have said in many of our debates this afternoon, a balance needs to be struck. It is not right that I should have to approve the detailed annual plans of every community health partnership in Scotland, but it is important that we ensure that, within our local health systems, the delegation and decentralisation that I want, and which David Davidson claims to want, take place.

Amendment 9 will make additional provision so that, if boards do not get approval for their schemes of establishment, they will have to resubmit them to ministers to take into consideration points that the Scottish ministers had made and any other points that boards think are appropriate.

I encourage the committee to reject amendment 39 and support amendment 9.

Mr Davidson: What the minister has just said demonstrates that he has no trust in community health partnerships and their boards, despite the obligations that the bill lays on them. If the minister truly wants to stand back and be responsible for overall standards of delivery of care, he should allow the boards their heads within the rules. The rules will be in the guidance and are in various parts of the bill. The boards have duties laid upon them to provide care and they should be left utterly free to decide how best to do that in their localities. That comes back to local planning, not central control over alleged local planning.

I rest my case and press amendment 39.

The Convener: The question is, that amendment 39 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 39 disagreed to.

Amendment 9 moved—[Malcolm Chisholm].

The Convener: The question is, that amendment 9 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (SNP)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 8, Against 1, Abstentions 0.

Amendment 9 agreed to.

Amendment 10 moved—[Malcolm Chisholm]—and agreed to.

Amendment 57 not moved.
Amendments 11 to 14 moved—[Malcolm Chisholm]—and agreed to.

Section 2, as amended, agreed to.

The Convener: As David Davidson is about to object, I will take the opportunity to admit to a procedural hiccup. It is not procedurally correct to have divisions on sections; we simply ask whether sections are agreed to. The division on section 1 was my mistake. We will record David Davidson’s dissent.

After Section 2

The Convener: Amendment 15, in the name of the minister, is grouped with amendment 15A.

Malcolm Chisholm: In November, I wrote to you, convener, to inform you that we would amend the bill to include a provision on staff governance. A draft section was published for consultation on 17 November 2003. In addition to a written consultation, my officials delivered a national consultation event and three regional consultation events. They also offered to hold individual events in each NHS board and special health board in order to hear the views of staff and NHS employees. The outcome of that consultation exercise was published on the Scottish Executive’s website.

15:00

Amendment 15 will put staff governance on an equal footing with clinical and financial governance, by which I mean the arrangements that are in place to ensure good clinical and financial management, which are underpinned by legislation. The amendment has been welcomed by all the people who attended the consultation events and it was welcomed in the written responses to the consultation document. It will require health boards, special health boards and the Common Services Agency to put in place arrangements for improving management of their staff and to monitor those arrangements.

The committee will be aware that trade unions, professional bodies and NHS employees have been working together for some time to promote better management of staff in the NHS. They have produced the staff governance standard, which outlines what employers are required to deliver and what staff are entitled to. The document should assist boards and the CSA in discharging the new duty. I hope that the committee will add its support for those arrangements and the amendment.

I am prepared—indeed I am keen—to support amendment 15A in the name of Shona Robison, which is supported by Jean Turner. It seeks to add work force planning to the list of things that health boards, special health boards and the CSA should have in place.

The Convener: You have made a woman happy.

Malcolm Chisholm: Our view is that the matter was already covered by amendment 19, but I do not oppose putting it beyond doubt. The document entitled, “Working for Health: the Workforce Development Action Plan for NHS Scotland” outlines the arrangements that must be put in place at local, regional and national levels to support work force development. That has not happened in the past, but it must happen in the future, and I am entirely happy for that to be in the bill.

I move amendment 15.

Shona Robison: I am recovering from the shock of the minister’s supporting amendment 15A.

I welcome amendment 15 because it responds to concerns about staff governance that were raised at stage 1. The purpose of amendment 15A is to place on health boards an explicit duty—in respect of work force planning—to ensure that such planning is given the prominence that it deserves in securing improvements in management of officers that the boards employ. Given the problem of health-professional shortages, which has been highlighted by several professional bodies and trade unions, it is time to give statutory force to work force planning in NHS Scotland. The evidence from the Royal College of Nursing Scotland, which stated that an explicit duty for work force planning would support improved delivery of a vital aspect of staff governance, is particularly persuasive. I am happy that the minister has decided to accept my amendment.

I move amendment 15A.

Mr Davidson: I agree with the comments that have been made on amendment 15; evidence exists to support it. I will support amendment 15A, but I would broaden it because it raises several questions that minister might respond to, including lack of staff capacity, which is a major problem in the health service in Scotland, and difficulties in attracting and retaining staff. Amendment 15A assumes that staff capacity and work force planning are major concerns that must be the responsibility of good management, but it also assumes certain freedoms that I do not see, and it assumes that there will be adequate resources. That brings into question—yet again—the issues around next year’s review of the Arbuthnott formula. I would like to hear the minister’s comments on the freedoms and resources that will be available to conduct that valuable exercise.
Amendment 15A agreed to.

The Convener: The minister might wish to comment on amendment 15, as amended.

Malcolm Chisholm: How long have you got? David Davidson raised a lot of major issues. The general issue of work force planning was covered in the debate that we had in the chamber two or three weeks ago; I do not think that I need to repeat all the points that I made.

Workplace planning is a major issue for us. It is something that has been sadly lacking in the past, which explains some of the difficulties that we have; in particular, the shortage of specialists. The problem will now be tackled at local, regional and national levels.

David Davidson invited a debate about resources in the health service, which is not appropriate to the amendment. Members can read my speech from the recent debate, but I repeat that there are extra resources and staff. However, we are determined to achieve more. I will press amendment 15, as amended.

Amendment 15, as amended, agreed to.

The Convener: Amendment 16, in the name of the minister, is in a group on its own.

Malcolm Chisholm: Amendment 16 will provide a legal underpinning to existing policy that encourages health boards, special health boards and the CSA to discharge their functions in a manner that encourages equal opportunities. It will also require them to observe equal opportunity requirements in current legislation. The measure has been discussed with the NHS, patient bodies and equality bodies and has been widely welcomed and supported. When I wrote to the committee in November to inform members of our intention to amend the bill to include staff governance, I also mentioned that I would lodge amendment 16 on equal opportunities.

I move amendment 16.

Amendment 16 agreed to.

Amendment 36, in the name of Duncan McNeil, is grouped with amendments 37 and 38.

Karen Gillon: For members of the public, waiting times are a key indicator of their experience of the health service. We all have experience of frustrated constituents who feel that they have not received the service that they should have when they believed that they would have an operation or treatment within a specified time.

Minimum waiting times for key treatments are set by the Executive; health boards have a duty to comply with those set times. They also have a duty to make their customers and patients aware of their right to treatment. If boards do not comply with the minimum waiting times guidance we, as patients, can make representations to ask the minister to intervene and to provide the treatment from another source.

Openness and transparency are key if the public are to trust the waiting times guarantee. The article in today's The Herald, which suggests that people are for spurious reasons moved to other lists to meet targets does little to develop that trust. If the article is accurate, it simply underlines why we need a more robust mechanism to monitor and evaluate what is happening in relation to waiting times.

Amendment 36 would place a duty on health boards to monitor their adherence to guidance on waiting times that has been issued by ministers. That is not too onerous a task for boards and it is one that we should ask them to undertake.

Amendment 37 seeks to ensure active cooperation throughout Scotland—not simply on a board-by-board basis—so that any spare capacity can be used effectively to allow people to have their operations carried out in a timeous manner. It will also ensure that the waiting times guarantee does not have the potential to become a postcode lottery.

Amendment 38 would allow patients in a final arbitration position to make representations to the minister and it would allow the minister to take a view on intervention when waiting times guidance was not being met. If we as politicians set guarantees for minimum waiting times, we have to be prepared to take action if those guarantees are not met. The amendments would provide a helpful way in which to do that. I would welcome comments from members and the minister.

I move amendment 36.

Mike Rumbles: Perhaps Karen Gillon will clarify this when she sums up, but if such targets were written into law, what would happen if they were not met?

Mr Davidson: I wanted partly to ask the same question. If the waiting times targets that the minister has published are not met, there is a duty on NHS Quality Improvement Scotland to become involved, and the minister and his department can intervene. Therefore, I wonder whether amendment 36 is a bit top-heavy. However, I have sympathy with the general view that patients should have a right to know that they will be treated on time.

Amendment 37 would require inter-board action to maximise the use of spare capacity in any part of the health service. I would welcome such a move because it would give patients choice.
Unfortunately, the amendment would not empower patients and their clinicians—for example, GPs and consultants—to trigger that movement to allow the patient to be treated in another health board area that had available capacity.

Dr Turner: I see why people want to keep faith with the patient and keep faith with waiting times, but I think that doctors would generally find the proposal very restrictive. I will give an example. Two people might be diagnosed as having arthritis of the hip and be in need of hip replacements, but the person who came on to the list second might deteriorate faster than the other. If doctors had to stick to waiting times directives, they would be required to treat the first patient first while the other patient’s condition continued to deteriorate. Requiring people to stick to waiting times would be difficult.

I agree, for example, that if a patient is in agony and their hip replacement cannot be carried out within their own health board area, they should be able to go anywhere in Scotland for the operation. I have sympathy with the amendments, but I think that people would be further tied down with waiting times by them. I would be scared that patients in need would have to wait longer.

Shona Robison: Amendment 36 is an interesting amendment, which I was pleased to see had been lodged by Duncan McNeil. Health boards would certainly find it challenging to meet a duty on local waiting times. As Mike Rumbles pointed out, the consequences of their failing to do so would, I presume, be ministerial intervention or intervention by the Health Department. However, one would like to think that that would happen anyway if health boards failed to meet their waiting times targets. Perhaps the minister will comment on that.

When Karen Gillon spoke to the amendments, she made reference to the way in which people have been moved from one list to another in order to massage waiting times figures, as is alluded to in today’s edition of The Herald. However, I am not sure that the proposed duty to monitor waiting times would necessarily stop that. Perhaps we should impose a duty on health boards not to move patients between lists. I will be interested to hear the minister’s response to this interesting group of amendments.

Malcolm Chisholm: I believe that the amendments are not necessary and may well be counterproductive.

On amendment 36, the duty in section 12H of the 1978 act already requires boards to have arrangements for monitoring and improving the quality of health care, which includes arrangements for monitoring and reducing waiting times. Boards already have systems in place to monitor whether they are adhering to the Health Department’s guidance on waiting times and they make regular submissions to the department’s waiting times unit on how they are performing against the waiting times targets. That happens already, so amendment 36 is clearly unnecessary.

We are delivering on the waiting times guarantees, which kicked in at the end of last year, but I am not convinced that to give them a statutory basis would be a good idea. Although our firm guarantees go beyond what existed in the past and, indeed, beyond what applies in the rest of the UK, turning them into a legal duty could be counterproductive by creating a downward pressure on targets because of the threat of legal challenges against boards. Such an approach would also seriously distort the power of intervention that is proposed in amendment 38. I take it that Duncan McNeil is invoking the sanction in that respect.

15:15

Amendment 38 is contrary to the principles that the power of intervention should be used as a last resort and restricted to systemic service failure, rather than to individual breaches of waiting times. I agree that if a board is systematically failing to meet waiting times targets it might be necessary to use the power of intervention as a last resort. However, that would happen anyway because the whole service would be failing to meet acceptable standards.

It is not appropriate to consider using the power to transfer the function from the board to an intervention team every time somebody claims that they have not been treated within the waiting times guarantee, or claims that it is likely that in future they will not treated within the guarantee. That might involve ministers in pre-emptive use of the power in individual cases, which could interfere with a board’s operation. As drafted, the provisions in section 4 will allow for intervention only when it is absolutely necessary either to provide a service or to restore a service to an acceptable standard. As a result, I encourage members to reject amendment 38.

That said, with reference to the article in The Herald, the board in Glasgow and I would want to know about any complaints that individuals might have. The article itself gave no specific examples, but patients who have complaints should certainly come forward and tell us about them.

On amendment 37, the current wording of the duty of co-operation requires boards to co-operate in order to secure and advance the health of the people of Scotland. Such a duty includes co-operating on reducing waiting times and thereby advancing the health of the people of Scotland.
Boards will continue to co-operate with the Golden Jubilee hospital on reducing waiting times and to work with other health boards to ensure that there is a national effort to reduce such times. As a result, amendment 37 is unnecessary.

**Karen Gillon:** First, I want to deal with some of the minister’s points. His response to amendment 38 trivialises the issue slightly. I am aware of cases in which patients have been given appointments 18 months after they have seen the consultant. That does not meet the waiting times guarantee. When such issues are brought to a health board’s attention, it simply says that they are mistakes. If that is the case, the board should introduce more robust procedures to ensure that such “mistakes” do not happen.

I certainly do not believe that the intention behind amendment 38 is to allow every individual who does not receive an appointment within the first week of seeing a consultant to complain to the minister. The procedure would be far more robust than that and would, in effect, represent a court of last appeal. That said, I am prepared to accept that the amendment would not do what is intended. I will have another look at that.

The minister suggested that the proposal in amendment 37 goes way beyond the guarantee by turning it into a legal duty. However, if the guarantee has no real status, what is the point of it? We must examine what it means to offer patients guarantees, and we must examine the status of any guarantee that is not honoured. What rights do patients have when politicians raise their expectations but cannot deliver on them? We need to answer such serious questions. If amendments 36, 37 and 38 are not the right way of doing that, my colleague Duncan McNeill and I will be happy to enter into discussions on the matter. However, the point is that, if we set something up as a guarantee, we need to be able to back it up with some clout.

That brings us back to Mike Rumbles’s very serious question about what will happen if boards consistently do not meet the waiting times guarantee. The answer is that if Parliament or ministers have given such guarantees, there will have to be ministerial intervention. As for Dr Jean Turner’s comments, I do not think that the amendments seek to remove the need for clinical priority patients to be seen within nine months—after all, someone whose condition is deteriorating very quickly will need to be seen before someone who is not.

I have listened to what has been said and I seek the committee’s agreement to withdraw amendment 36 and to come back with it at stage 3.

*Amendment 36, by agreement, withdrawn.*

**The Convener:** Amendment 40, in the name of David Davidson, is in a group on its own.

**Mr Davidson:** Members of the committee will know about the benefits that have come from the English scheme, which was totally supported by many Labour Party MPs who represent Scottish seats. Such schemes have many advantages. Amendment 40 seeks to allow

“any NHS hospital, or group of hospitals”—

because some hospitals operate as groups across different premises—

“to apply to become an NHS foundation trust”.

The rest of the amendment is there for members to read.

Foundation trusts allow development and allow focus on responsiveness to patient needs. They aid specialisation. The committee has just agreed to the amended amendment 15 and, as was covered in our discussion, England and Wales must allow scope to deal with patients’ needs on a staff-capacity basis. Amendment 40 would allow hospitals the freedom to recruit and retain staff—particularly specialists—on a realistic basis. To be frank, few hospital groups do not have specialisation shortages, be they shortages at consultant level or at the level of specialist nurses or nurse consultants. The shortages cut right across the specialist skills in the NHS.

The focus should be on turning the health service round and making it patient centred. It should not just be a mechanism for delivery on a standardised prescriptive basis throughout Scotland. We need to free up centres: centres in England have proved that they can reduce waiting lists and waiting times and that they can, by agreement, develop regional specialisation to deliver specialist care. That assists the smaller hospitals and neighbouring health boards.

In Scotland, there is a huge shortage of specialist skills. We need to skill-up more doctors to become consultants. That seems to be the difficulty. If it does not happen, we cannot train the next generation. Hospital units in England provide specialisation and the opportunity for continuing training and development. Hospitals are allowed the freedom to go into the marketplace to attract staff by whatever means they consider appropriate, although obviously those means have to be legal. If we could do the same, we would not have the great shortages that we have.

I am not sure why the minister has set his heart against foundation trusts. Many Scots realise that over-intervention from the centre does not incentivise people to deliver more care. If we consider foreign models, we see that the health service attends to delivery, but the minister stands by to deal with resources and standards. That is
appropriate because that is what the public are looking for.

Since the whole issue of foundation trusts arose south of the border, I have not heard a serious argument from the minister, or even from the First Minister, about why we cannot have foundation hospitals or allow hospitals the opportunity to apply for foundation status. I cannot see how it is right to restrict hospitals’ ability to deliver as they see fit. We have agreed to the amended amendment 15 and we have to give the health service the tools to do the job.

I move amendment 40.

Mike Rumbles: I oppose amendment 40. It is completely illogical. We are in the business of abolishing trusts and yet the amendment seeks to establish foundation trust hospital status. That is completely bonkers. It is completely alien to what we are doing in the bill.

My second reason for opposing the amendment is that it is driven by Conservative ideology. David Davidson raised that issue. He is perfectly entitled to pursue Conservative ideology but doing so in this forum is a waste of time. It does not chime with the Scottish people. To meet the needs of the Scottish people, we must have a different solution from the solution down south.

I am focused on what we are doing north of the border. I find it particularly difficult to grapple with the amendment given that David Davidson is a north-east regional MSP, because establishing foundation hospitals in competition with each other to serve the population of Grampian would be completely irrelevant. David Davidson knows that very well, yet he still pursues the issue. For many people in rural Scotland, there is no choice, and I am convinced that the reform of the NHS in Scotland that the minister has put before us is the right solution. It is certainly the right solution for rural Scotland and I oppose David Davidson’s ideologically driven amendment 40.

The Convener: Heaven forefend that we should be driven by ideology.

Shona Robison: If we were being honest, we would say that it is Conservative and new Labour ideology, but I will move on.

On several occasions, I have put on record my opposition to foundation hospitals on a point of principle. Without going over old ground, I want to deal with one specific issue that David Davidson raised: his argument that foundation hospitals would somehow address specialist staff shortages across Scotland. It is important that we understand that David Davidson talked about shortages across Scotland. Of course, foundation hospitals would not address those shortages, because they would only make staff shift within Scotland, between competing hospitals that are paying different rates.

Surely, we want to attract more specialist staff to Scotland, and the only way to do that is on a Scotland-wide basis. I argue that that might require offering enhanced terms and conditions for some specialities, otherwise all that will happen is that the problem will shift from one hospital to another within Scotland, but I have never understood the concept of using internal competition as a mechanism to address staff shortages. We are talking about the Scottish national health service, so surely we want to address the problems throughout the service and not just allow the survival of the fittest at the expense of the weakest, which would not address the problem in any way.

Dr Turner: I am absolutely opposed to anything that would bring us back to fundholding and non-fundholding, which was dreadful for the patient. The only people who I remember thought fundholding was a good idea were doctors who managed to get an easy life. They certainly put their patients first, but that was at the expense of the others. I could not go along with it.

I cannot understand why anyone would think that foundation hospitals are a better idea, because one hospital gets built up at the expense of others. How long would the others take to creep up to the standard of the fundholding hospitals?

There would be a shift of people. When NHS 24 was started, it was evident that many experienced nurses left coronary care and general practice and went into the higher paying jobs in NHS 24. That was good for them, and no one blamed them for it, but practices in Scotland must retain their staff and I do not think that David Davidson’s idea is the way in which to go about it.

We must also consider the education and training of doctors and nurses. As I have said before, the private sector does not train nurses or doctors; we in the NHS train our doctors and nurses. Specialised units that do certain procedures can steal a certain number—probably quite a lot—of people who have had that training, so I am against David Davidson’s proposal. I am afraid that I do not support amendment 40.

Helen Eadie (Dunfermline East) (Lab): I draw members’ attention to the register of interests. I am a member of the Co-operative party.

Although it is interesting to hear what David Davidson said about trusts, when the Tories first set them up, there are those of us who pushed for a mutual model, which is distinct from the model for foundation hospitals that he talks about. It is perverse that he is now suggesting that we should move to a form of mutualism, given that his party threw that out when it first set up the trusts all
those years ago. For that reason, I will not be supporting amendment 40.

It is also interesting that David Davidson mentions shortages. Shortages are driving a lot of the change in the health service, but they cannot be resolved by foundation trusts. As other members have said, foundation trusts would mean that we would end up with leap-frogging across the country, so they are not an appropriate solution for Scotland. Foundation trusts might be appropriate for other parts of the country, but they would not resolve the specific problems that we face in Scotland. David Davidson might feel that they are the solution, but I do not think that that belief is realistic. It does not chime with the views of the professionals or members of the public, neither of which want to move in that direction. They want a strong health service. Above all, they want us to strengthen it—that is what they are calling for us to do.

15:30

The Convener: I somehow think that the minister is going to complete the rout.

Malcolm Chisholm: I was certainly intrigued by David Davidson’s speech, which told us—more than once—about the advantages that have come from foundation hospitals in England. The fact is that there are no foundation hospitals in England, although I accept that there will be some next week. I will follow what happens in England with great interest, to find out whether there are any lessons that we can learn from them or from any other health initiative there, but we must find ways forward that meet the needs, systems and health structures of Scotland.

As Mike Rumbles pointed out, it is completely illogical to abolish trusts in the bill’s first section and then set up foundation hospitals at a subsequent point. As members know, not one person—as far as I am aware—who came before the Health Committee called for foundation hospitals, and I am not aware that they are being called for to any great extent in the health service.

The fundamental reason why we will not have foundation hospitals in Scotland is that we have our own reform agenda, which is based on the principle of single-system working within a decentralised context. I believe that that is the most patient-centred approach, because patients see one system. It is unfortunate that, in the past, patients have often bumped into the barriers between the different parts of the health system. In Scotland, we want a reform agenda that is based on a single health system. That is the fundamental reason why we will not have foundation hospitals here. People can point to all the other arguments about foundation hospitals, but the main point is that we want to improve the whole health care system, not just isolated entities within it.

We want a single system that brings together primary, acute and social care. We want a system in which, rather than compete with one another, health care professionals co-operate and collaborate. In Scotland, I believe that that is best achieved through developments such as the introduction of community health partnerships, rather than by following the English approach, although it might well suit English circumstances. Apart from anything else, England is starting from a different place. We have already taken steps down the path of modernisation and the bill moves us further down that path.

Mr Davidson: I make the point that we are talking about NHS foundation trusts, not about privatising. I do not think that that has been understood by all members at the table and it should be made clear.

Mike Rumbles said that the proposal was alien and illogical. That might be his view, but the fact is that the best practice that he mentioned is not operating. He well knows that the north-east is experiencing extreme difficulty in employing specialist staff at all levels. Many specialist staff are going to England because of foundation trusts, and not just because of pay rates. Helen Eadie spoke about that. The issue is not all about pay rates; much of it is about the environment within which someone is able to operate and develop.

Staff might also move because of attractions to an area. Mike Rumbles knows very well that, in the oil industry, people from abroad had to be persuaded to bring their skills to the north-east economy. That welcome development was achieved partly by selling the area, partly through conditions and partly through pay.

We have no choice about competition—a point that Mike Rumbles mentioned—because competition within the health service already exists. I have spoken to people who, for the sake of argument, would rather work in a hospital on the outskirts of Glasgow than in Raigmore hospital in Inverness. If, quite apart from their professional working conditions, people’s terms and conditions are not appropriately attractive, they will not go to work there.

The proposal in amendment 40 is a mechanism by which real focus can be given to identifying what patients are looking for. My experience in the Parliament is that many people would be happy to go to another area for treatment if that meant that they could get the correct and appropriate treatment earlier to relieve their pain and discomfort. Not everybody wants to do that and it should be the patient’s choice. They might have reasons for not wanting to go elsewhere for
treatment, such as wanting to stay near a loved one or a dependent.

Shona Robison commented on shortages. There is a drift to England and there is no argument about that. The medical schools, deans and department heads in hospitals tell us that. The issue is not only pay; competition is already there.

Jean Turner talked about fundholding GPs. The proposal for NHS foundation trusts is a different exercise. There is already a duty of education and training within the hospital system. No one is trying to dilute that, but if hospitals can attract quality key consultant staff, they will attract those who wish to be trained there and to get experience. Ultimately, that is to the good of the patient.

Helen Eadie mentioned the Co-operative party, which is, of course, supportive of foundation hospitals south of the border; it is for her to tell me what her party’s policy is north of the border. The proposal in the amendment is not a privatisation exercise.

The minister talks about the health service already moving in the appropriate direction. I point out to him that I also lodged an amendment to section 1. My approach is logical—Mike Rumbles mentioned that it was illogical—as amendment 40 links back to that amendment 54. The minister talks about a single system working with local management. He talks about local management, but it is not there. He talks about there being a single system for the patient, but under the proposal for foundation trusts, the patient would go to the clinician—be that a GP or an out-patient consultant—and would take advice. If the advice was, “I can get you that specialist care at Raigmore hospital because it is offering the care. You live in Aberdeen, but there is a waiting list in Aberdeen,” so be it.

That brings us back to rural areas. Rural people often have to travel for specialist treatment anyway. We cannot support every hospital in Scotland having expertise in all fields. Hospitals have specialities—some are generalist and some provide special care. The proposal in the amendment offers an opportunity in areas such as Grampian for multisite hospitals to work together to the benefit of not only the local community but the regional community. The model can work. It is not about putting money into private shareholders’ pockets; it is about the opposite of that. It is an opportunity to modernise the system at a stroke and, if their boards wish to move in that direction, to use some of the fine hospitals that we have in Scotland. My amendment would give them that opportunity.

The only ideology that I will come out with is that the proposal is all about choice in a modern society. The convener will recall that, on Friday, we attended a meeting sponsored by the Scottish Executive. We heard about the benefits of the approach in hospital systems throughout Europe. Many of the benefits that were talked about were modelled exactly on the NHS foundation trust model—albeit that the bodies were privatised and operated as contractors to the health service, and we are not talking about that in this instance.

The Convener: It is very naughty to draw me in with your amendment by association. I have kept silent throughout and I remain silent. Will David Davidson press or withdraw amendment 40?

Mr Davidson: I press it.

The Convener: The question is, that amendment 40 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)
AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 40 disagreed to.

Section 3—Health Boards: duty of cooperation

Amendment 37 not moved.

The Convener: Before I proceed any further, I should say that I would like to press on until half past four. However, I am in the committee’s hands. Are members content that we try to get through stage 2?

Members indicated agreement.

The Convener: Members are content that we will try to get through stage 2 today. Amendment 17 is in the name of the minister. I did not ask the minister whether he is content to continue, which was a bit discourteous. Can I take it that he also consents?

Members indicated agreement.

The Convener: Members are content that we will try to get through stage 2 today. Amendment 17 is in the name of the minister. I did not ask the minister whether he is content to continue, which was a bit discourteous. Can I take it that he also consents?

Malcolm Chisholm: I am in your hands, convener.

The Convener: I will take that as agreement.

Amendment 17, in the name of the minister, is grouped with amendments 41, 18 and 31.
Malcolm Chisholm: Amendments 17, 18 and 31 are Executive amendments that relate to the new duty of co-operation and which clarify what powers boards will have in pursuit of that duty. Amendment 17 will make new subsection (2) clearer by making provision for two different types of activity in pursuance of the duty of co-operation. The first is where a board undertakes to provide or secure the provision of services for residents of another health board area. In that situation, amendment 17’s provisions will give the health board that intends to arrange for its residents to receive services from another health board the powers it needs to enter into such arrangements. The second type of activity is where two or more boards come together to provide services jointly across their areas. Of course, that was the original policy intention at stage 1. Amendment 17 aims to express more clearly the powers available to boards to give effect to that intention.

The last part of amendment 17 provides for the powers that are available to a board that undertakes to provide services to residents of another board area—that is the first type of activity that I described—and to all boards that participate in the second type of activity, which is jointly arranged services, so that such boards may enter into arrangements with other boards or the Common Services Agency. For services that are subject to the agreements, those boards will have the same powers as they have with respect to services in their own areas.

Amendment 18 is a minor drafting amendment that is required because of amendment 17. Amendment 17 adds an additional subsection to the new section proposed by section 3. Therefore, it becomes necessary to provide that the provisions in section 3 do not restrict health boards’ other powers to co-operate.

Amendment 31 adds a minor consequential amendment that arises from that duty. The Primary Medical Services (Scotland) Act 2004 introduced a function of co-operation in relation to primary medical services. It is necessary to ensure that that new duty, which is targeted at primary medical services, does not restrict the wider duty that section 3 provides for. Amendment 31 will achieve that result.

On amendment 41, I have just explained that the Executive considers it necessary to clarify what power boards will have in pursuing the duty of co-operation. Executive amendments 17 and 18 will provide for a board that undertakes to provide services to residents of another board area to have the same powers as it has in relation to its own residents. Health boards also have the option of entering into an arrangement or NHS contract under section 17A of the 1978 act. Therefore, I invite David Davidson not to move amendment 41.

I move amendment 17.

The Convener: I invite David Davidson to speak to amendment 41 and the other amendments in the group.

Mr Davidson: In simple terms, I seek to include amendment 41’s provision in the bill to deal with a problem. For a start, health boards tell us that, with all the new burdens of having to look after other boards’ patients without clear movement of resource allocation to them to do that, they believe that they will face difficulty. Personally, I believe that payment should follow patients and that they have a right to receive care from wherever it is delivered in the health service, regardless of boundaries and titles. However, there is another problem because, under the Arbuthnott formula, it could be argued that a patient who lives in Lothian or Grampian might not have the same tariff ability to take money with them to another hospital or board area for treatment as someone in Glasgow, where there might be a larger amount. Health boards seek to address such problems. Amendment 41 seeks to make it clear that, when a health board offers care to a patient from another health board area, it automatically has the right to have the resource follow the patient to pay for the treatment.

The Convener: As no other member wishes to speak to the amendments, I invite the minister to wind up.

15:45

Malcolm Chisholm: I have made the points that I wanted to make. However, the clear movement of resources is part of what is covered by Executive amendments 17, 18 and 31. In addition, the chief executives of health boards are working on a framework for regional planning that will cover the nuts and bolts. I accept that the resources must follow when a patient is treated in another area; however, I flag up my concern about David Davidson’s understanding of the Arbuthnott formula. I am sure that Paul Martin and others would agree with me on that point. Glasgow has more money, relatively, because it has greater health needs, relatively.

Amendment 17 agreed to.

Amendment 41 moved—[Mr David Davidson].

The Convener: The question is, that amendment 41 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Davidson, Mr David (North East Scotland) (Con)
AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 41 disagreed to.

Amendment 18 moved—[Malcolm Chisholm]—and agreed to.

Section 3, as amended, agreed to.

Section 4—Powers of intervention in case of service failure

Amendment 38 not moved.

The Convener: Amendment 19, in the name of the minister, is grouped with amendments 19A and 42.

Malcolm Chisholm: I will speak to amendment 19 and explain why I do not propose to press it at this time. Since the amendment was lodged, we have received a number of representations. It has not been possible to take a firm view of those representations before today and, therefore, my intention is to consider them further and return to the issue at stage 3. In the light of that, I hope that David Davidson will not move amendment 19A.

On amendment 42, I can understand why committee members are keen for ministers to give an indication of when an intervention would take place. However, that is simply not practical. As I have said before, there could be many circumstances in which Scottish ministers might wish to intervene and it would be unrealistic to try to record all of those circumstances.

We are all agreed that Scottish ministers should not intervene lightly, which is why the duty is subject to a necessity test that would allow for intervention only when it is more than simply desirable or expedient. Perhaps the amendment is intended to ensure that boards are not taken by surprise by an intervention. However, the idea that a board would not know when a ministerial intervention was likely to take place is totally unrealistic, given that there would be many steps to go through before this last-resort measure was taken. A protocol covering that already exists.

The escalating intervention protocol means that there would be meetings between officials from the Health Department and the board, with the department providing help, advice and support with a view to resolving problems within a short, focused timescale. Those meetings between officials could lead to the production of a recovery plan, which would be closely monitored by the department.

Where performance continues to be poor, the department will discuss with the NHS board how management might be strengthened and will take the necessary action. If performance continues to be poor, the department might send in a task force, with the agreement of the board, to assist with the management. As that step would take place with the agreement of the board, the necessity test in the bill would not be met.

In addition to the support and action described above, the department might recommend to ministers that they should invite the chair and the non-executive members of an NHS board to consider their position. Ministerial action can also be taken in certain circumstances to remove the chair and/or members of an NHS board.

All those measures would be considered before resorting to the power, which is likely to be needed only where no other options exist or it is reasonable for ministers to take the view that other options would not achieve the objective of remediating failing services.

I note that the amendment suggests that the guidance should cover circumstances that might result in an intervention, which means that there could be circumstances that are not covered in the guidance. If the guidance is not to be comprehensive, I am not sure what its value would be. Therefore, I encourage members to reject amendment 42.

I move amendment 19.

The Convener: Mr Davidson, as the minister has moved amendment 19, you have a choice. You may either move amendment 19A and speak to it or not move it and not speak to it. If you want, you can move the amendment, air the arguments, and then seek leave to withdraw it.

Mr Davidson: I will do that and quickly speak about the points that the minister made.

It is important that the minister put on the record today his reasons—although he did not explain them fully—for the changes that he seeks and his comments on the areas that he intends to change at stage 3.

The purpose of amendment 19A is simple. Boards, which seem to be in some discomfort about the costs of intervention, might be in such a precarious financial position that they would be able to pay for an intervention only by not delivering some other service. The minister says that he will intervene in a very responsible way, so I hope that he will be equally responsible in giving financial support to a board that is in that situation.
I hear what the minister says in relation to amendment 42. He indicated that he will publish guidance, some of which is already in the public domain and I think that he is also talking about refining the guidance. The minister commented on the removal of chairs, but of course those chairs are appointed at his behest and to deliver his policies—as they regularly tell me. I would not have thought that any new powers were needed to remove chairs who were not delivering to his expectation.

Many board members have expressed great concern that they do not know in advance how the rules of engagement under the escalating intervention protocol will work to their satisfaction. I hope that the minister will assure me that before stage 3 he will clarify exactly what he means by “escalating intervention protocol”, because currently many people who work in the health service seem to be quite unclear about that. I did not lodge amendment 42 to be pernickety, but did so to ensure that the procedures would be clearly stated in the bill.

I move amendment 19A.

Malcolm Chisholm: I certainly referred to the escalating intervention protocol, but that was all. I was a little confused by what David Davidson said first, because I thought that he was assuming that I was talking about guidance that was separate from the protocol. The word “protocol” is more appropriate in this context as “guidance” does not correctly reflect what is being sought.

The protocol was issued some months ago. A copy has been sent to the committee and further information can certainly be provided. If problems are arising because NHS boards do not understand the protocol, we can deal with that. I am surprised to hear that that is the case, but obviously if members have information about that I will want to ensure that there is more clarity in the minds of any individuals who have doubts about the protocol. That is the correct way to proceed; it would not be at all appropriate to put the protocol in the bill. I accept that at stage 3 we can be more explicit in giving detailed information about the protocol’s content, but I remind members that a copy of the protocol has been sent to the Health Committee.

Amendments 19A and 19, by agreement, withdrawn.

The Convener: David, do you want to move amendment 42, which has already been debated with amendment 19?

Mr Davidson: I do not think that the minister quite understood the second subsection in amendment 42, which says:

“Any such guidance or revised guidance must be published, and a copy laid before the Scottish Parliament.”

If I understand the minister correctly, he seems to want to satisfy that demand. On that basis, I will not move amendment 42.

Amendment 42 not moved.

Section 4 agreed to.

Before section 5

The Convener: Amendment 43, in the name of Shona Robison, is grouped with amendment 58.

Shona Robison: Amendment 43 would address a general concern among the public that they are very dislocated—I suppose that that is the right word—from the decisions that health boards make.

Time and again in the committee, in the chamber and in our constituencies, we have heard about decisions that are made that fly in the face of public opinion, which has led to the public feeling disempowered and cynical about moves to consult and involve them. Health boards have often consulted, but they have ended up coming to the original decision that they set out with, which has led in no small way to people being cynical about the whole process.

Clearly, public involvement is an important part of the bill, with the duty on health boards to involve the public, but it is time to go further than that and take a radical approach by putting power back in the hands of the public by giving them a direct say over the health decisions in their areas. We have to take public involvement to its logical conclusion, and allow the public to sit on health boards. I propose that half the members of health boards should be elected members of the public, in order to democratise the health board system.

I have some sympathy for the intention behind amendment 58, in the name of David Davidson. Where local authority representatives sit on health boards, there is an argument that they should reflect the political make-up of the local authority. Apart from anything else, that would bring various opinions to the table, so I have sympathy for what he is trying to achieve. Some people may argue that local authority representation on health boards is the democratic input into health boards, and there is an element of truth in that, but it is no substitute for the direct voice of the public, which unfortunately has been all too lacking in our health board structure.

I move amendment 43.

Mr Davidson: I understand Shona Robison’s principle that there should be patient and public input to the running of boards. That is one of the reasons why I wanted local health council members to be represented on CHPs, as they are already part of a system. However, the proposal in amendment 43 would be costly and would set a
and it was my amendment that persuaded the involved in was the National Parks (Scotland) Bill, supported by Jean Turner. The first bill that I was 43, which is in the name of Shona Robison and is with the arguments that are behind amendment amendment, for the following reasons.

On amendment 58, local authority members are currently on health boards to represent their local communities. COSLA guidelines state that the d’Hondt principle should be followed, but those guidelines are not statutory and do not appear in regulations. In the main they are ignored, despite the fact that there are councils in Scotland where control was determined by tossing a coin or cutting a deck of cards. I want to put in the bill a measure on party balance. I would have thought that people who understand local government schemes well and who talk regularly in the Parliament about democracy and proportional representation should apply the principle of proportion to local authority representation on health boards.

16:00

Mike Rumbles: I have a great deal of sympathy with the arguments that are behind amendment 43, which is in the name of Shona Robison and is supported by Jean Turner. The first bill that I was involved in was the National Parks (Scotland) Bill, and it was my amendment that persuaded the Executive to change its mind about 20 per cent local representation on national park authorities through direct elections. I start from that perspective, but I am minded not to support the amendment, for the following reasons.

Democratic accountability is important, and that is why I am sympathetic to Shona’s and Jean’s position. However, I think that we can have democratic accountability in one of two ways, but not in both ways. We can go down the ministerial intervention route, which is the route that the committee and the Parliament have taken. The minister is democratically accountable and is given powers to intervene to ensure that our health boards are doing what they are supposed to be doing.

 Alternatively, we can go down the directly elected route and require 50 per cent of the members of a health board to be directly elected, as amendment 43 suggests—as I said, I have some sympathy with that route. However, we cannot take both routes, because we would set ourselves up for a huge conflict between the democratically expressed wishes of the people through their elected representatives on health boards and a ministerial decision to intervene and overturn the decisions of those representatives. There would be a tussle between powers of intervention and direct elections.

At stage 1, I flagged up my concern about the powers of intervention. The committee is giving the minister a huge power of intervention. Section 4 states that Scottish ministers may issue certain instructions

“where they consider it necessary”— not where anyone else considers it necessary. The word “necessary” is far too powerful. I thought about lodging an amendment to address that point, but I did not do so because I thought that we were proceeding down the route of ministerial intervention rather than the route of directly elected individuals. If we were starting from scratch and we wanted to go down the route of directly elected individuals, I would be supportive, but we decided not to do that. The two routes are mutually exclusive and therefore, with regret, I do not support amendment 43.

Helen Eadie: I will vote against amendments 43 and 58. I am not against the principle of directly elected representatives to health boards—I am a signatory to Bill Butler’s proposed member’s bill on that subject, so I support that notion—but amendment 43 suggests that half of the board members should be appointed by the minister and half should be elected by the public. For me, the jury is out on whether the entire board should be elected by the public or whether it should be half and half. In the Parliament, we have always tried to adhere to the fundamental point that we should consult and take evidence on proposals that we intend to sign up to. The committee has not heard any evidence on what form of election would be appropriate for membership of health boards.

In amendment 58, David Davidson suggests that the composition of health boards should reflect the balance of political parties. Again, the jury is out on the issue, but I would want to look at some Scandinavian examples and consider how health services are run in those countries. In Denmark, local authorities run health services but do not necessarily follow that prescription. I want to hear and consider the evidence rather than make a snap judgment about an amendment that has been slipped in today. That is why I will not support amendments 43 and 58, although I like the principle of having directly elected health board members.

Dr Turner: It would take an awful lot of time and thought to put the proposal into practice, but it is evident that the Government wants public involvement. It is also evident that the public feel uninvolved and powerless to make changes. Campaign groups all over Scotland are trying to defend NHS services close to their communities
and to sustain their communities. We have problems in Glasgow, too.

The public would like to think that the Government would consider the proposal. Since about 1990, I have attended many meetings at which people have said that it would be great to have elected board members, as that would mean that some of the messes that we get into would not happen. Perhaps that would happen and perhaps it would not, but at least the public would feel a little better and would feel that they were trying to make changes.

Doctors, the public and MSPs wish that many board members were elected—I have heard MSPs from all parties say that. If we had had elected members, the mess that we have got into in Glasgow might have been avoided. Perhaps the concept of directly electing 50 per cent is too big to take on board, but almost 50 per cent would be needed to shift what has happened in Glasgow.

Amendment 58 concerns the balance of parties. When people attend health board meetings—as I have—at which they cannot open their mouths and they are dying for an elected representative from a council to speak, but he sits there never opening his mouth, that makes them feel that they are not being taken care of. I support amendments 43 and 58.

Paul Martin (Glasgow Springburn) (Lab): My comments are similar to Helen Eadie’s. I fully support Bill Butler’s proposed member’s bill and I would like the minister to describe progress on that. I have always thought that 100 per cent of board members should be directly elected, but various views are held on that issue. It is okay to have 100 per cent directly elected representation in housing associations and other organisations in our communities that spend millions, yet quangos have different constitutional settlements.

We must have a comprehensive approach. Agreeing to the amendments today would not allow us to make progress on that. An effective consultation exercise about representation and consultation must be undertaken. After that, we can consider progress on Bill Butler’s proposed member’s bill.

Malcolm Chisholm: The amendments raise a fundamental issue about the balance between national and local accountability in a national health service. As the debate continues, that is the key issue that must be explored. I support more local involvement. The point at issue may be how that is best achieved.

On the one hand, the creation of the 15 unified NHS boards in September 2001 extended the range of key stakeholders, which includes local authority councillors. The role of local authority members on an NHS board was set out in “Rebuilding Our National Health Service”, which was published in May 2001. The current practice is that each local authority nominates one of its councillors to be a member of the health board. As Minister for Health and Community Care, I formally appoint them to the board, subject to the usual statutory criteria. The formal presence of elected councillors as full members on each board is intended specifically to strengthen local accountability, responsiveness to community issues and joint working between health boards and local authorities.

As each local authority has one member on the health board that covers the local authority area, I find it difficult to see how amendment 58 would work. How will we apportion one person into a number of different political parties? Surely the important point is that the local authority member on a health board enjoys the confidence of that local authority, which is consistent with the guidance that has been issued on the matter.

More generally, the Executive is working to improve patient and public involvement throughout the NHS, as evidenced by other sections of the bill. For example, community health partnerships will include at least one member of the public partnership forum, who will represent the interests of the public. The public partnership forum member will be linked into a large virtual forum of interest groups and will be genuinely representative of the public. The new duty of public involvement in the bill will ensure that boards consult the public on plans and decisions that significantly affect the operation of services and that they involve the public far more than was the case in the past under the narrow concept of consultation. I want to create ways in which every interested member of the public can influence what happens in their board area.

Beyond general public involvement is the specific patient involvement agenda and patient experience agenda, both of which seek to bring about a far more patient-focused service than has existed in the past. I will not go into the details of that issue because it was discussed in June 2003 in the first health debate that we held in this session of Parliament. Our approach is based on an increasingly strong patient focus and the public involvement agenda, although I accept that we still have a long way to go.

Moreover, as Helen Eadie and Paul Martin pointed out, this is the wrong time at which to be legislating on elected members for health boards, given that Bill Butler is seeking to introduce a member’s bill on the issue. Were that bill to be introduced, a wide public consultation on the proposals would have to take place. I am not persuaded that we should legislate in advance of such a consultation exercise. There is a general
issue about major amendments. We are proud of our pre-legislative scrutiny in Scotland. The appropriate way forward on the matter is through Bill Butler's proposed bill. I hope that the committee will wait to see the outcome of the consultation on that proposal before considering whether—and if so, how—we should proceed with legislation on this important matter.

I therefore recommend that the committee reject amendments 43 and 58.

Shona Robison: I thank everyone for their comments. The discussion was useful.

David Davidson seemed to be against my proposal on the ground of cost, which is a tenuous argument because the election process would not have to be costly, given that it could fit in with local authority elections. It might well fit in nicely with the proposed new system of proportional representation for local elections. A proportional representation system could deal with the issue of by-elections. I am sure that systems could be introduced to minimise cost and deal with his concerns. He shows a slight lack of consistency, given that the Conservatives support the direct election of the chairs of police boards. One would think that if something was good for the goose, it would also be good for the gander, but maybe not.

Mike Rumbles raised an important point: there is a debate about democratic accountability and whether that is achieved by, as he put it, ministerial intervention or direct elections. However, I do not agree that the two are mutually exclusive. Local authorities are elected, but they also have duties placed on them by ministers—they operate within the parameters that ministers set. The same situation would exist with directly elected health boards. Ministers could set the parameters within which health boards operate.

Helen Eadie and Paul Martin made some useful comments about the need for consultation. I accept that there are various forms of direct elections and that we have to decide how far to go—should it be all members or 50 per cent of them? We should take further evidence on the issue. I thank Jean Turner for her support. I was hoping that she would name the local authority rep who sat schtum, but unfortunately she did not.

The minister talked about major amendments being lodged without consultation. I hope that that means that we will no longer see the Executive lodging major amendments at the last minute without consultation. It is useful that that is now on the record.

I am persuaded by the arguments that were made on the need for further consultation. Given that the bill is about health service reform and also about public involvement, I thought that it was important to put down a marker today. I hope that Bill Butler's proposed bill to establish direct elections to national health service boards will be progressed. His bill would secure an important principle, which the public supports. On that basis, I seek leave to withdraw amendment 43.

Amendment 43, by agreement, withdrawn.

The Convener: Amendment 58, in the name of David Davidson, was debated with amendment 43. Do you wish to move amendment 58?

Mr Davidson: Am I allowed to respond before I make a decision on that?

The Convener: I beg your pardon. Please forgive me. I meant to invite you to do so.

Mr Davidson: That is very kind of you, convener. We are obviously getting tired.

I want to address one or two of the points that were raised, the first of which is Helen Eadie’s comment about the Danish model. The difference between Denmark and here is that the local members in Denmark are elected to deliver a service. The issue is not whether I believe in PR. In Scotland, members are only appointed from an elected body by the minister and all councillors are elected to represent areas. The situation is not the same here. I am led to believe that, in some health board areas, more than one member comes up from the local authority—however, I am open to being advised otherwise by the minister.

Helen Eadie also referred to the election of police board chairs. I suppose that that suggestion would take us to the principle that, instead of the minister appointing the chairmen of the health boards, those posts are also put up for election. If that were to happen, it would represent a real democratic shift.

I listened to what the minister had to say about how the Executive is dealing with the consultation on Bill Butler’s bill. By the sounds of it, his bill will be allowed to proceed to the chamber. On that basis, I accept the minister’s premise that it would be best for us to discuss the issue at that time, as we will have seen the results of the consultation.

Amendment 58 not moved.

The Convener: That is fine. I am mindful of the time. If we were to extend the meeting by 15 minutes—at the very latest to 4.45 pm—we could finish stage 2. What does the committee feel about doing so?

Mike Rumbles: Go for it.

Shona Robison: Yes, go for it.
The Convener: I hear, “Go for it.” Would the extension to 4.45 pm be a problem for any member?

Mr Davidson: I will have to rejig something, but I will slip out and make a telephone call. I am happy to go with the committee view.

The Convener: That is very kind of you. I will try to pick a time at which you can slip out without missing an opportunity.

Section 5—Public involvement

The Convener: Amendment 20, in the name of the minister, is grouped with amendments 21 to 24.

Malcolm Chisholm: This group of amendments refines the duty of public involvement and extends it to the Common Services Agency. As a consequence of extending the duty to the agency, it is necessary to define more narrowly the services that are subject to the duty. That is because some of the agency’s services and some of the services that are provided by special health boards result in services being provided to other NHS bodies. The policy intention is to ensure that the focus of the duty remains firmly on consulting and involving the public on the provision of health services.

The purpose of amendment 22 is to ensure that only decisions that will significantly affect the operation of the service should be subject to the new duty. Without amendment 22, there is doubt as to whether the duty applies merely to trivial operational decisions. Amendment 22 avoids that doubt.

I move amendment 20.

Janis Hughes: I welcome amendment 22 in particular. At stage 1, I raised a concern about the provisions in the bill that relate to consulting on decisions made by the health board. I thought then that the bill’s requirement that boards should consult on decisions sounded as though a decision had already been made, which might mean that there was no room to change those decisions. I welcome the minister’s amendment 22, which changes the wording to “decisions to be made”. That reflects the concerns that were raised by the committee at stage 1.

The Convener: As no member wishes to speak in opposition, I take it that the minister will waive his right to wind up.

Malcolm Chisholm: Yes.

Amendment 20 agreed to.

Amendments 21 to 24 moved—[Malcolm Chisholm]—and agreed to.

Section 5, as amended, agreed to.

After section 5

The Convener: Amendment 45, in the name of David Davidson, is in a group on its own.

Mr Davidson: Amendment 45 would provide for the proposed new Scottish health council to be set up as a statutory body under the bill. The council should be set up as an independent organisation funded by the minister and not as part of NHS QIS or any other organisation. Amendment 45 might pre-empt Shona Robison’s amendment 46—

The Convener: It will not.

Mr Davidson: That is fine.

There has been a lot of discussion about the Scottish health council. An independent body is currently meeting to consider the role of such a national organisation. A lot of effort has been put into the matter and we have taken evidence on it, yet the council does not appear in the bill. I find that strange. On that basis, I want the bill to provide for the formation and funding of the council, along with the powers and duties that it will have.

I move amendment 45.

Shona Robison: I have a lot of sympathy with the amendment. I am puzzled as to why the establishment of the Scottish health council is not covered in the bill. Issues have been raised throughout the evidence-taking sessions about the independence of the council. Without going over all the old ground, I believe that amendment 45 would go some way towards establishing that independence. Just as important, it would put the formation of the Scottish health council on a statutory footing in the bill, where it should be.

Malcolm Chisholm: As members know, we have proposed that the Scottish health council should be established as a body with a distinct role and status in NHS Quality Improvement Scotland. That is because we regard patient focus and public involvement as being essential parts of securing quality in the NHS. Improving quality has to be about developing services that are more focused on patient experience and about meeting what patients want through, for example, service redesign, managed clinical networks and other initiatives. The review and inspection functions of NHS QIS will also be strengthened by the ability to draw directly on the expertise and patient networks of the proposed Scottish health council.

NHS QIS is the body at the heart of improving quality in the NHS. It operates separately from ministers and other boards. The standards on diabetes that were issued this morning are the most recent good example of its work.

I have written to the committee to set out our proposals for ensuring the independence of the
Scottish health council in NHS QIS, but I will reiterate them now. First, the council will be created through legislation, albeit through regulations, as a committee of the board of NHS QIS. Similarly, NHS QIS was created not by primary legislation, but by regulations. Ministers will appoint the chair through the public appointments process. Up to three members will be appointed from the local advisory councils, to ensure strong local links. Other members will be appointed, through the open public appointments process, by NHS QIS.

That is a better way forward than the one that David Davidson proposes in his amendment, which would create an organisation that lacked independence. Effectively, the system proposed in the amendment replicates the existing system, in which the Scottish Association of Health Councils, a non-statutory body, has a membership made up from local health councils throughout Scotland. Members of the body proposed in the amendment would not be appointed through the normal, open public appointments process for health bodies. They would come from local health councils, which are appointed by health boards. That is not the best way forward for a truly independent body. Accordingly, I invite David Davidson to withdraw the amendment.

Mr Davidson: On the NHS QIS point, during one of the evidence sessions Helen Eadie asked a pertinent question about the independence of the management structure. The minister has still not addressed that point fully. The issue is the public's perception of independence. The minister refers to the appointments system that is used for local health councils. Most local health councils go down the route of advertising posts and then interviewing people. Apart from perhaps a nominal comment at the end of the process, the health board tends not to be very involved, unless that model occurs in areas that I have not come across.

I lodged the amendment because of the issue of perception and to put the Scottish health council on the face of the bill, which would make it different from NHS QIS. I do not want the health council to be a committee of another organisation that has NHS in its name. A Scottish health council has the great capacity to develop—the fine print can follow. However, the minister must always remember—as I am sure he does—that doing things by regulation means that he has total control and that, at any time in future, any other minister can come along and do whatever he or she sees fit; no one else will have any say in the matter. If the organisation is provided for in the bill, the Parliament will, in future, have an opportunity to debate potential changes. Some of those changes may be to the good—I would not preclude that—but it is important that the new organisation be provided for in the bill and that it is seen to be independent.

The Convener: The question is, that amendment 45 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 3, Against 6, Abstentions 0.

Amendment 45 disagreed to.

Section 6—Dissolution of local health councils

The Convener: Amendment 46, in the name of Shona Robison, is grouped with amendments 48 to 53.

Shona Robison: I will be brief, much to the relief of folk round the table. Throughout the evidence-taking process, I have expressed concern about the loss of the role that local health councils perform at the moment, particularly their advocacy role. I accept that some councils have performed that role better than others, but the role is nevertheless important and is not being given to the Scottish health council or to the local advisory councils. I have looked through the evidence again and I do not understand why the establishment of the Scottish health council, with its particular role, should lead directly to the dissolution of the local health councils as we know them. Why are the two mutually exclusive? They would carry out different functions. In the absence of a replacement for a body to fulfil that advocacy role, it would be a retrograde step to do away with local health councils. The purpose of amendment 46 is to retain the local health councils and their specific role, as the Scottish health council will have a quite different and distinct role as a national body.

I move amendment 46.

The Convener: Have you spoken to the other amendments in the group?

Shona Robison: They are consequential to amendment 46.
The Convener: I will put members in sequence—Jean Turner then David Davidson.

Dr Turner: There has been a great deal of change in the health service and the bill will make a fantastic difference, which many of the patients do not really understand; even many of the doctors, who are all toying with it at the moment, probably do not fully understand it. Given that there is so much change, it would have been a kindness to the patients and the public to keep the local health councils in place.

It is true that, as Shona Robison says, the health councils might have served their communities in different ways. Some might have thought that they were part of the health board—occasionally, I thought that, too. In relation to the acute services review in Glasgow, it seemed that the local health council was going along with the health board, but then it took on board the fact that there were problems. It began by considering the issue of trolley waits and ended up accepting that there was a capacity problem within greater Glasgow, which everyone else was worried about.

I think that the health councils have a great role to play at the interface between the public and the health service; they can be the patients’ advocates in the health service. The health councils also have representatives on health boards. I am a little confused about what the Scottish health council that takes over will do and about how we will look after the public in the change. That is why I support amendment 46.

Mr Davidson: I have seen both good and poor health councils. The reason why some health councils are poor is that their role is not always understood fully at local board level. Generally, however, the health councils have done excellent work over the years. They enter, in a stylish manner, into premises in which NHS care is delivered and they produce some excellent reports. Their current method of working is a credit to them and the individuals who serve on them.

A system in which all the health councils were linked into a national health council with a slightly different role would be far better than the current system. All the local health councils except the one in Lothian are involved in the Scottish Association of Health Councils. I believe that they have done a good job, which I think could be improved by various aspects of the bill. Getting rid of them would be a bit like throwing the baby out with the bathwater. We do not know in what way the advisory councils will be better than what we have already. I suspect that they will not have the same teeth or perform to the same level as the local health councils. I support Shona Robison’s proposal to delete section 6.

Malcolm Chisholm: The amendments in this group seek to preserve the existing structure and functions of local health councils. I am happy to acknowledge that much good work has come out of local health councils, but the time has come to build on that good work and take it in a new direction. That is what I want to achieve. The status quo is simply not good enough.

Our approach is to develop new arrangements for advancing patient focus and public involvement. The provisions in the bill for a new duty of public involvement and for dissolving local health councils are designed to support and underpin that. We wish to put greater responsibility on NHS boards to communicate with and involve patients and the public and to encourage patients and community and voluntary organisations to represent their views directly to boards. We want to involve the public directly in the planning and design of health services and not have their views filtered through an outside body. The Scottish health council will monitor and quality assure that process, which will do more to help to achieve a more responsive and patient-focused NHS than keeping the present system would.

However, we will not disregard existing interests and expertise. Current members of local health councils will have an opportunity to be represented on local advisory councils, which will be the local presence of the Scottish health council. In many cases, those people will be the ideal candidates to fulfil that role and I hope that many of them will choose to do so. They have played a valuable role up to now and can do more in the future in their revised role. The approach that we are proposing will be far more valuable than keeping the status quo. Accordingly, I invite the committee to reject the amendments.

Shona Robison: I do not accept that, as the minister suggested, the status quo would remain if we rejected the amendments, because the bill will establish the Scottish health council and all that goes with it in terms of monitoring public involvement. I believe that we should maintain local health councils’ discrete role in relation to advocacy, in particular, which is not about filtering views but about harnessing views and helping them to be expressed. I wish to press amendment 46.

The Convener: The question is, that amendment 46 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For
Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 46 disagreed to.

Section 6 agreed to.

Section 7—Duty to promote health improvement

The Convener: Amendment 25, in the name of the minister, is grouped with amendments 26 to 29.

Malcolm Chisholm: Amendment 25 extends the duty on NHS boards to promote health improvement to include the special health boards and the Common Services Agency. Special health boards were not originally included in the bill, because the commitment that was made in the white paper “Partnership for Care” referred only to NHS boards. We considered whether it would be appropriate to extend the duty to include special health boards and the Common Services Agency and, after consultation with those bodies, we concluded that opportunities exist for them to promote health improvement when they perform their functions. Therefore, we think it appropriate and consistent to extend the duty to those bodies.

I move amendment 25.

Amendment 25 agreed to.

Amendments 26 to 29 moved—[Malcolm Chisholm]—and agreed to.

Section 7, as amended, agreed to.

After section 7

The Convener: Amendment 47, in the name of David Davidson, is in a group on its own.

Mr Davidson: In lodging amendment 47, I seek to move on from the past. NHS Health Scotland is past its sell-by date. The minister regularly talks about the new duties and responsibilities on health boards and community health partnerships to promote public health. As most of that work could be done locally, the minister should transfer the duties, responsibilities and resources of NHS Health Scotland to local community health partnerships. If we are to get the message about health care across, it is best to do so through local activities.

There will be occasions on which the minister might, under his own auspices, promote a particular campaign on an advisory basis—he has the powers and the resources to do that and I do not argue that he should not have those powers or choose when to use them. However, NHS Health Scotland is no longer required, because the minister has sought to transfer powers and responsibilities to health boards and to CHPs. We have an opportunity to cut a lot of centralised bureaucracy and cost and to put resources into the local community health care systems, where they would be best placed.

I move amendment 47.

Malcolm Chisholm: I believe in increasing local delivery of health improvement, but the abolition of NHS Health Scotland is not the corollary of that. The body plays a vital role in delivering action to improve the health of the people of Scotland. In the light of Scotland’s poor health record, it is more important than ever to promote health improvement, which is the core function of NHS Health Scotland.

NHS Health Scotland carries out important national functions. One of those functions is to develop research and use the evidence gained from it to inform our policy development and national and local practice to support health improvement actions. For example, it recently launched the constituency profiles, which provide the most comprehensive picture of Scotland’s health ever produced. In addition, the Health Education Board for Scotland, one of the two bodies that were brought together when NHS Health Scotland was formed in April 2003, was responsible for work such as the Stinx campaign, which was targeted at teenagers, as well as the successful blue sticks—“This tastes bogging”—campaign. [Laughter.] We can provide that for the official reporters.

I agree that it is important that the health improvement activities are undertaken at a local level. That is one reason for giving health boards a duty to promote health improvement, which is a prime responsibility of the new community health partnerships. However, it is also important that we have a special health board with a national remit that can support local initiatives and health boards as well as co-ordinate national initiatives. I strongly urge members to reject the amendment.

Mr Davidson: I suppose that we should not talk about chips and health promotion at the same time.

The minister and the Executive have a lot of money and spend a lot of money on advertising. I have already referred to the powers that the minister has. He talks about the need for a body to produce statistical evidence. However, I have always been under the impression that that was the job of the information and statistics division, which is within the minister’s department. I know
that the ISD is unable to answer questions relating to information that is not held centrally, but I argue that such information should be held centrally.

I am trying to divide appropriately between the minister, the health boards and the community health partnerships the responsibilities and the necessary resources. If they are given the new powers, health boards are likely to struggle to cope with the new demands without the necessary resources. My amendment provides an opportunity to facilitate a different model. It does not prevent the minister and the Health Department from running national campaigns but it would allow better use of resources at a local level. I wish to press the amendment.

The Convener: The question is, that amendment 47 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Davidson, Mr David (North East Scotland) (Con)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 47 disagreed to.

Section 10 agreed to.

Long title agreed to.

The Convener: That concludes stage 2 consideration of the National Health Service Reform (Scotland) Bill. Thank you for your forbearance.

Meeting closed at 16:44.
National Health Service Reform (Scotland) Bill
[AS AMENDED AT STAGE 2]

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National Health Service Reform (Scotland) Bill

[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

PART I

ORGANISATION AND OPERATION OF NATIONAL HEALTH SERVICE

Organisation

1 Dissolution of National Health Service trusts: modification of enactments

(1) In the National Health Service (Scotland) Act 1978 (c.29) (referred to in this Act as “the 1978 Act”), section 12A and Schedule 7A (establishment, functions, dissolution etc. of National Health Service trusts) are repealed.

(2) In section 82 of the 1978 Act, after subsection (2A) insert—

“(2B) All endowments and property held in trust transferred to a Health Board by an order under paragraph 26 of Schedule 7A (whenever made) are held by the Health Board free of any trust existing immediately before the transfer (hereafter in this section referred to in relation to any such endowment or property as “the original trust”); but all such endowments and property shall be held by the Health Board on trust for such purposes relating to services provided under this Act, or to the functions of the Board with respect to research, as the Board may think fit.”

(3) Until the coming into force of subsection (1) so far as repealing Schedule 7A to the 1978 Act, paragraph 26 of that Schedule has effect with the insertion after sub-paragraph (1) of the following sub-paragraph—

“(1A) For the avoidance of doubt, the reference to “property, rights and liabilities” in sub-paragraph (1) includes endowments and property held in trust.”

2 Community health partnerships

After section 4 of the 1978 Act insert—
4A Community health partnerships

(1) Every Health Board shall establish, in accordance with a scheme under section 4B approved by the Scottish Ministers (an “approved scheme”)—

(a) a community health partnership for the area of the Board, or

(b) two or more community health partnerships for districts which, taken together, include the whole area of the Board.

(1A) Community health partnerships shall be established as committees or subcommittees of a Health Board.

(1B) Where the area or district of a community health partnership includes all or part of the areas of two or more Health Boards, the community health partnership (a “joint community health partnership”) shall be established jointly by those Boards in accordance with their approved schemes.

(1C) Joint community health partnerships shall be established as joint committees of the Health Boards by which they are established.

(2) The functions of a community health partnership are—

(a) to co-ordinate, for its area or district, the planning, development and provision of—

   (i) such of the services which it is the function of its Health Board to provide, or secure the provision of, as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

   (ii) such other of those services as its Health Board may specify, with a view to improving those services,

(b) to provide, or secure the provision of—

   (i) such of the services which it is the function of its Health Board to provide, or secure the provision of, as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

   (ii) such other of those services as its Health Board may specify, and

(c) to exercise such other functions of its Health Board—

   (i) as may be prescribed by regulations under section 4B(5),

   (ii) as may be specified in the approved scheme,

   (iii) as the Health Board may delegate to it.

(2A) In this section, references to the Health Board of a joint community health partnership are to each of the Health Boards by which it was established.

4B Community health partnerships: further provision

(1) Every Health Board shall, within such period as the Scottish Ministers may specify, prepare and submit to them a scheme for the establishment of one or more community health partnerships in pursuance of section 4A(1).

(1A) In preparing a scheme under subsection (1) or (4) a Health Board shall—
(a) have regard to—
   (i) any guidance issued under subsection (7),
   (ii) community planning under section 15(1) of the Local Government in Scotland Act 2003 (asp 1) so far as relating to the area of the Board,
(b) consult—
   (i) each local authority whose area includes all or part of the area or district of a community health partnership proposed by the scheme, and
   (ii) any other person whom the Health Board think fit, and
(c) encourage the involvement of local authorities and other persons consulted under paragraph (b) in the preparation of the scheme.

(3) The Scottish Ministers may—
(a) approve (with or without modifications), or
(b) refuse to approve,
   a scheme submitted to them under subsection (1) or (4) or in pursuance of subsection (3A).

(3A) Where the Scottish Ministers refuse to approve a scheme, they must return it to the Health Board and may direct the Board to resubmit the scheme with—
(a) such modifications (if any) as the direction may specify, and
(b) any further modifications which the Board consider appropriate,
   by such time as the direction may specify.

(4) A Health Board—
(a) may, at any time,
(b) if so directed by the Scottish Ministers, must, within such period as they may specify,
   submit to the Scottish Ministers a new scheme under this section.

(5) Regulations may make provision in relation to—
(b) the membership of a community health partnership,
(c) the form and content of, and the procedure in relation to, schemes under this section,
(d) the functions of a community health partnership and the exercise of those functions,
(da) the application in relation to joint community health partnerships, with such modifications as may be specified, of the provisions of this Act, and any provision made under this Act, so far as applying in relation to community health partnerships,
(e) such other matters with respect to community health partnerships as the Scottish Ministers think fit.
(7) The Scottish Ministers may, after consulting such persons as they think fit, issue guidance about community health partnerships and shall publish such guidance.

(8) For the purposes of establishing a joint community health partnership in pursuance of section 4A(1B), any power to appoint committees conferred on Health Boards by virtue of this Act shall include power for two or more Health Boards jointly to appoint joint committees.

(9) Nothing in section 4A or this section affects the extent of any power under this Act so far as relating to committees or sub-committees of Health Boards.”

2A Duty in relation to governance of staff

After section 12H of the 1978 Act insert—

“12HA Duty in relation to governance of staff

It shall be the duty of every Health Board and Special Health Board and of the Agency to put and keep in place arrangements for the purposes of—

(a) improving the management of the officers employed by it;

(b) monitoring such management; and

(c) workforce planning.”

2B Equal opportunities

After section 2C of the 1978 Act insert—

“2D Equal opportunities

(1) Health Boards, Special Health Boards and the Agency must discharge the functions conferred on them by, under or by virtue of this Act in a manner that encourages equal opportunities and in particular the observance of the equal opportunity requirements.

(2) In this section “equal opportunities” and “equal opportunity requirements” have the same meaning as in Section L2 (equal opportunities) of Part II of Schedule 5 to the Scotland Act 1998 (c.46).”

3 Health Boards: duty of co-operation

Before section 13 of the 1978 Act insert—

“12I Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency

(1) In exercising their functions in relation to the planning and provision of services which it is their function to provide, or secure the provision of, under or by virtue of this Act, Health Boards shall co-operate with one another, and with Special Health Boards and the Agency, with a view to securing and advancing the health of the people of Scotland.

(2) In pursuance of subsection (1) a Health Board may—
(a) undertake to provide, or secure the provision of, services as respects the area of another Health Board, and the other Health Board may enter into arrangements with the first Health Board for that purpose,

(b) undertake with one or more other Health Boards to provide, or secure the provision of, services jointly as respects their areas.

(2A) A Health Board undertaking to provide, or secure the provision of, services under subsection (2) may—

(a) enter into arrangements with another Health Board, a Special Health Board or the Agency in relation to the provision of such services,

(b) do anything in relation to the provision of such services which they could do for the purpose of providing, or securing the provision of, such services as respects their area.

(3) This section is without prejudice to any other power which a Health Board may have.”

Powers of intervention

4 Powers of intervention in case of service failure

After section 78 of the 1978 Act insert—

“78A Powers in case of service failure

(1) This section applies where—

(a) it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and

(b) the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

(i) to provide the service, or

(ii) to provide it to a standard which they regard as acceptable.

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

(a) a body falling within subsection (4), or

(b) one or more persons falling within subsection (5).

(3) In subsection (2), “specified” means specified in the direction.

(4) A body falls within this subsection if it is—

(a) a Health Board,

(b) a Special Health Board, or

(c) the Agency.

(5) A person falls within this subsection if the person is—

(a) an employee of a Health Board, a Special Health Board or the Agency,
(b) a member of the staff of the Scottish Administration.

78B Relationship of sections 77, 78 and 78A

The powers conferred by each of sections 77, 78 and 78A are without prejudice to the powers conferred by the other two sections.”

Public involvement

5 Public involvement

After section 2A of the 1978 Act (inserted by section 7(2)) insert—

“2B Duty to encourage public involvement

(1) It is the duty of every body to which this section applies to take action with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are involved in, and consulted on—

(a) the planning and development, and

(b) decisions to be made by the body significantly affecting the operation,

of those services.

(1A) This section applies to—

(a) Health Boards,

(b) Special Health Boards, and

(c) the Agency.

(2) For the purposes of subsection (1) a body is responsible for health services if they are health services—

(a) which it is the function of the body to provide, or secure the provision of, and

(b) which are provided, or to be provided, to individuals by—

(i) the body, or

(ii) another person on the body’s behalf, at the body’s direction or in accordance with an agreement made by the body with that other person.”

6 Dissolution of local health councils

(1) Local health councils established by virtue of section 7 of the 1978 Act are dissolved on such date as the Scottish Ministers may by order made by statutory instrument specify.

(2) A statutory instrument containing an order under subsection (1) is subject to annulment in pursuance of a resolution of the Scottish Parliament.
PART 2

PROMOTION OF HEALTH IMPROVEMENT

7 Duty to promote health improvement

(1) After section 1 of the 1978 Act insert—

“1A Duty of the Scottish Ministers to promote health improvement

(1) It is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland.

(2) The Scottish Ministers may do anything which they consider is likely to assist in discharging that duty including, in particular—

(a) giving financial assistance to any person,

(b) entering into arrangements or agreements with any person,

(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to section 1 and any other provision of this Act conferring or imposing functions on the Scottish Ministers.”

(2) After section 2 of that Act insert—

“2A Duty of Health Board, Special Health Board and the Agency to promote health improvement

(1) It is the duty of every Health Board and Special Health Board and of the Agency to promote the improvement of the physical and mental health of the people of Scotland.

(2) A Health Board, a Special Health Board or the Agency may do anything which they consider is likely to assist in discharging that duty including, in particular—

(a) giving financial assistance to any person,

(b) entering into arrangements or agreements with any person,

(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to any other provision of this Act conferring or imposing functions on a Health Board, a Special Health Board or the Agency.

(4) Anything done by a Health Board or Special Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on—

(a) the Health Board by the order under section 2(1)(a) which constituted the Board, or

(b) the Special Health Board by the order under section 2(1)(b) which constituted the Board,

as the case may be.”
PART 3
SUPPLEMENTARY

8 Ancillary provision

(1) The Scottish Ministers may by order made by statutory instrument make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—
   (a) make different provision for different purposes,
   (b) modify any enactment, instrument or document.

(3) A statutory instrument containing an order under this section (except where subsection (4) applies) is subject to annulment in pursuance of a resolution of the Parliament.

(4) No order under this section containing provisions which add to, replace or omit any part of the text of an Act is to be made unless a draft of the statutory instrument containing the order has been laid before, and approved by resolution of, the Parliament.

9 Modification of enactments

(1) Schedule 1 contains minor amendments and amendments consequential on the provisions of this Act.

(2) The enactments specified in column 1 of schedule 2 are repealed to the extent specified in column 2.

10 Commencement and short title

(1) The provisions of this Act, except section 8 and this section, come into force on such day as the Scottish Ministers may by order made by statutory instrument appoint.

(2) Different days may be appointed under this section for different purposes.

(3) This Act may be cited as the National Health Service Reform (Scotland) Act 2004.
SCHEDULE 1
(introduced by section 9)

MINOR AND CONSEQUENTIAL AMENDMENTS

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

1 (1) The 1978 Act is amended as follows.

(1A) In section 2C(4) (co-operation in discharging of functions to provide primary medical services), for “section” substitute “sections 12I and”.

(2) In section 12H(1) (duty of quality), for “, Special Health Board and NHS trust” substitute “and Special Health Board”.

(3) In section 75A (remission and repayment of charges and payment of travelling expenses), in subsection (2), for “, (c) or (d)” substitute “or (c)”.

(3A) In section 79 (acquisition, use and disposal of land and moveable property), after subsection (2) insert—

“(2A) For the avoidance of doubt, the power to use heritable property conferred by subsection (1), and the power to dispose of land conferred by subsection (1A), include power to let the property or, as the case may be, land.”

(4) In section 86 (accounts), in each of subsections (3) and (4), for “to (c)” substitute “and (b)”.

(5) In section 102 (State hospitals), in subsection (4)(b), for “, the Agency or an NHS trust” substitute “or the Agency” and for “, Agency or trust” substitute “or Agency”.

(6) In section 105 (orders, regulations and directions), in subsection (4)(b), for the words from “12A(1)” to the end substitute “or 70(2)”.

(7) In Schedule 1 (Health Boards), in paragraph 8A, for “, the Agency or an NHS trust” substitute “or the Agency”.

(8) In Schedule 5 (Common Services Agency), in paragraph 8A, for “, a Health Board or an NHS trust” substitute “or a Health Board”.

National Health Service (Private Finance) Act 1997 (c.56)

1A In section 1 (power of NHS trusts to enter into agreements) of the National Health Service (Private Finance) Act 1997 (c.56)—

(a) in subsection (1), for “National Health Service trust” substitute “Health Board, a Special Health Board and the Common Services Agency for the Scottish Health Service (“the Agency”) to enter into contracts”,

(b) in each of subsections (3)(a) and (5), for “trust” substitute “Board or, as the case may be, the Agency”,

(c) in each of subsections (4) and (6), for “National Health Service trust” substitute “Health Board, a Special Health Board or the Agency”.

Regulation of Care (Scotland) Act 2001 (asp 8)

1B In section 77(1) (interpretation) of the Regulation of Care (Scotland) Act 2001, for the definition of “health body” substitute—
““health body” means a Health Board or Special Health Board constituted by order under section 2 of the National Health Service (Scotland) Act 1978 (c.29);”

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

2 (1) The Public Appointments and Public Bodies etc. (Scotland) Act 2003 is amended as follows.

(2) In section 7 (investment and borrowing), in subsection (7), for “to (6)” substitute “or (4)”.

(3) In section 9 (directions in relation to endowments), for the words “, and paragraph 6(1) of Schedule 7A to, the 1978 Act (which confer” substitute “the 1978 Act (which confers”.

SCHEDULE 2
(introduced by section 9)

REPEALS

<table>
<thead>
<tr>
<th>Enactment</th>
<th>Extent of repeal</th>
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</table>
| National Health Service (Scotland) Act 1978 (c.29) | Section 7. In section 8(1), the words “and any NHS trusts in the area or combined areas” and “, any such NHS trust”.
| | In section 9, in subsection (5), the words “and, where the Secretary of State so directs, an NHS trust”; and in subsection (7), the words “or, where the Secretary of State so directs, NHS trusts”.
| | In section 10(4), the words “the NHS trusts”, “or of the NHS trusts” and “or NHS trusts”.
| | Sections 12AA to 12C. Sections 12D to 12G. In section 13, the words “NHS trusts,”. Section 17A(2)(e). In section 17D, subsection (1)(a); and in subsection (2), paragraph (a) of the definition of “NHS employee”.
<p>| | In section 27(1)(b), the words “or by an NHS trust”. Section 35A. Section 73(c). |</p>
<table>
<thead>
<tr>
<th>Enactment</th>
<th>Extent of repeal</th>
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<tbody>
<tr>
<td>Section 74(c) and the preceding “or”.</td>
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<td>Section 75A(1)(d) and the preceding “and”.</td>
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<td>Section 77(1)(aa).</td>
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<td>In section 82(2A), the words “or 6(2)”.</td>
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<td>Section 83(2).</td>
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<tr>
<td>In section 84, in subsection (1), the words “or an NHS trust” and “or NHS trust”; in subsection (2), the words “or NHS trust” and “or NHS trusts”; and in subsection (3), the words “or an NHS trust”.</td>
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<tr>
<td>In section 84A, in subsection (1), the words “or NHS trust”; subsection (2); and in subsections (3) to (7), the words “NHS trust or local health council”, “NHS trust or council” and “NHS trust or the council” in each place where they occur.</td>
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<td>Section 85AA(7).</td>
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<td>Section 85(1)(f).</td>
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<td>In section 85A(4)(a), the words “or a local health council”.</td>
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<td>In section 85B, subsection (2)(d); and, in each of subsections (3)(a) and (4)(b), the words “or NHS trust”.</td>
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<td>In section 86, subsection (1)(c) and the preceding “and”; and subsection (1B).</td>
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<td>In section 101, the words “, an NHS trust”.</td>
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<td>Section 105(1A).</td>
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<td>In section 108, in the definition of “health service hospital”, the words “or vested in an NHS trust”; and the definitions of “local health council”, “National Health Service trust” and “operational date”.</td>
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<td>Schedule 7B.</td>
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<td>Enactment</td>
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<tr>
<td>Health Services Act 1980 (c.53)</td>
<td>In Schedule 6, paragraph 1.</td>
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<td>National Health Service and Community Care Act 1990 (c.19)</td>
<td>Section 29(3) and (4)(a) and (c).</td>
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<td>Sections 31 to 33.</td>
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<td>Schedule 6.</td>
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<td>In Schedule 9, in paragraph 19, sub-paragraphs (4), (7)(a)(ii), (11) to (14), (16), (17), (19), (21) and (22)(b) and (d).</td>
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<tr>
<td>Health Authorities Act 1995 (c.17)</td>
<td>In Schedule 1, paragraph 102(7).</td>
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<td>National Health Service (Residual Liabilities) Act 1996 (c.15)</td>
<td>Section 2(2)(b).</td>
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<td>National Health Service (Primary Care) Act 1997 (c.46)</td>
<td>Section 1(7).</td>
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<td>In section 3, subsection (2)(a); and in subsection (3), paragraph (a) of the definition of “NHS employee”.</td>
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<td>Health Act 1999 (c.8)</td>
<td>Sections 46 to 49.</td>
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<td>Sections 53 to 55.</td>
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<td>In Schedule 4, paragraphs 44, 45, 62 and 63.</td>
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<tr>
<td>Public Finance and Accountability (Scotland) Act 2000 (asp 1)</td>
<td>In schedule 1, paragraph 2.</td>
</tr>
<tr>
<td>Abolition of Feudal Tenure etc. (Scotland) Act 2000 (asp 5)</td>
<td>In section 18C, in subsection (1), the words “a National Health Service trust or”, “in either case” and “the trust or as the case may be”; and in subsection (3), the words “the trust or as the case may be” and “the trust or, as the case may be,”.</td>
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<tr>
<td>Community Care and Health (Scotland) Act 2002 (asp 5)</td>
<td>In section 22(1), in the definition of “NHS body”, paragraph (c).</td>
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<td>Scottish Public Services Ombudsman Act 2002 (asp 11)</td>
<td>In schedule 2, paragraph 4(c).</td>
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<td>Enactment</td>
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<td>Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)</td>
<td><strong>Section 6.</strong></td>
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<td>In section 5, in subsection (3), the words “and NHS trusts”; in subsection (5), the words from “(except” to “trust)”; and subsection (6).</td>
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<td><strong>Section 10.</strong></td>
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<td>In section 7, subsection (3)(b) and the preceding “or”; and subsections (5) and (6).</td>
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<td>In section 8, in each of subsections (1) and (2), the words “and NHS trusts”; and subsection (3)(b) and the preceding “and”.</td>
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<td>In section 9, the words “and NHS trusts” and the words “or trust” in both places where they occur.</td>
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<td><strong>Section 10(1) and (3).</strong></td>
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<td>In schedule 2, the entry “any National Health Service trust”.</td>
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<tr>
<td>Title Conditions (Scotland) Act 2003 (asp 9)</td>
<td><strong>Section 20.</strong></td>
</tr>
<tr>
<td></td>
<td>In section 46, in subsection (1), the words “a National Health Service trust, or of”; in subsection (2), the words “the trust or” in both places where those words occur, and the words “its or”; and in subsection (3), the words “the trust or” and “as the case may be”.</td>
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National Health Service Reform (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

Introduced by: Malcolm Chisholm
On: 26 June 2003
Supported by: Mr Tom McCabe
Bill type: Executive Bill
Present:

Dr Sylvia Jackson (Convener) Gordon Jackson (Deputy Convener)
Stewart Maxwell Christine May
Alasdair Morgan Mike Pringle
Murray Tosh

Delegated powers scrutiny: The Committee considered the delegated powers in the following Bill—

the National Health Service Reform (Scotland) Bill as amended at Stage 2

and agreed the terms of its report.
Delegated Powers Scrutiny

National Health Service Reform (Scotland) Bill: as amended at Stage 2

The Convener (Dr Sylvia Jackson): I welcome members to the 14th meeting of the Subordinate Legislation Committee this year. I have received no apologies.

Item 1 is delegated powers scrutiny of the National Health Service Reform (Scotland) Bill as amended at stage 2. A number of changes have been made to the bill, which introduce or amend delegated powers. The first of them concerns community health partnerships. A new regulation-making power has been added at new section 4B(5)(da) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the amended bill. As our legal advice indicates, the big question is why the new power is needed for joint community health partnerships. The provisions in any case appear at new section 4A(1B) of the 1978 act, also as inserted by section 2 of the amended bill.

Alasdair Morgan (South of Scotland) (SNP): I am not quite sure whether that is a big question, but you are right to point out that the provisions in new section 4B(5)(da) of the 1978 act do not seem necessary in view of the provisions already in place under new section 4A(1B). Some explanation should be sought, in case that needlessly complicates things for the future.

The Convener: Is that agreed?

Members indicated agreement.

The Convener: The second point is also on section 2 and community health partnerships. There were Executive amendments to do with the number of such partnerships. It has been suggested that the provisions are unduly prescriptive, that there should be more flexibility, and that those provisions should be moved over to guidance. Are we agreed on that?

Members indicated agreement.
SUBORDINATE LEGISLATION COMMITTEE

EXTRACT FROM THE MINUTES

15th Meeting, 2004 (Session 2)

Tuesday 4th May, 2004

Present:

Dr Sylvia Jackson (Convener)    Murray Tosh
Stewart Maxwell                Christine May
Alasdair Morgan                Mike Pringle

Delegated powers scrutiny: The Committee considered the delegated powers in the following Bill—

the National Health Service Reform (Scotland) Bill as amended at Stage 2

and agreed the terms of its report.
Delegated Powers Scrutiny

The Convener (Dr Sylvia Jackson): I welcome colleagues to the 15th meeting in 2004 of the Subordinate Legislation Committee. At the moment, I have no apologies, so I assume that our two missing members—Murray Tosh and Gordon Jackson—will arrive.

National Health Service Reform (Scotland) Bill: as amended at Stage 2

The Convener: Item 1 is delegated powers scrutiny of the National Health Service Reform (Scotland) Bill as amended at stage 2. Our report on that will be produced tomorrow morning.

Murray Tosh has arrived, so we now have one of our two missing members.

The committee will remember that we asked two questions on new section 4B(5)(da), which the bill will insert into the National Health Service (Scotland) Act 1978. The answers that we have received from the Executive have led our legal adviser to feel that the use of delegated powers to amend the 1978 act is a quick fix and is not helpful drafting in health legislation, which is already a complicated area. What are members’ views on the matter?

Alasdair Morgan (South of Scotland) (SNP): No further action is required, convener.

The Convener: Are we all agreed that we have gone as far as we can?

Members indicated agreement.

Christine May (Central Fife) (Lab): It must be fixed.

The Convener: Yes, it must be fixed.

Emergency Workers (Scotland) Bill: Stage 1

The Convener: Item 2 is delegated powers scrutiny of the Emergency Workers (Scotland) Bill at stage 1. Committee members have received the bill and associated information.

The bill, which is part of the antisocial behaviour agenda, creates a new offence of assaulting or impeding persons who provide emergency services. The bill also contains powers to make delegated legislation in section 6, which concerns powers to modify. However, paragraph 6 of the memorandum on the bill that the Executive has submitted to the committee mentions that, in addition to introducing the power to add a person to, or remove them from, the list of emergency workers covered by the bill,

“Section 6(1) also allows the Scottish ministers to make provision connected with modification as they think fit.”

Our legal advice suggests that it is possible that that further power might be used to adjust the penalties contained in section 4, for example, which would be a significant and possibly controversial change. The delegated powers are simply subject to annulment, and the question is whether that is sufficient, particularly for the further power.

Alasdair Morgan: The provisions to alter the bill are far too widely drawn to be subject to the negative procedure, and we need to write to the Executive on that point.

The Convener: Should we be a bit more specific on the point that arises from paragraph 6 in the Executive’s memorandum to us?

Christine May: We should, because if the Executive were to confine ministers’ powers to modify the bill to making changes to the list of emergency workers alone, that might— I use the word “might” advisedly—be sufficient to allay the committee’s fears. We have time to ask the Executive whether it would be prepared to amend the bill to restrict the powers to modification of the list only, after which we could examine the provisions and determine whether that restriction and the associated scrutiny powers were sufficient.

The Convener: Is that agreed?

Members indicated agreement.

Murray Tosh (West of Scotland) (Con): As the legal briefing points out, the exercise of Henry VIII powers is ordinarily subject to the affirmative procedure rather than the negative procedure. I recall that, several meetings ago, we agreed to let something go on the basis that it did not seem terribly significant. However, at some stage, perhaps we should have a paper on the matter that we could discuss in isolation from any statutory instruments, so that we do not make decisions on the basis of the importance of provisions, because that could be the thin end of a substantial wedge. We should at least consider the principle that we should always ask for the affirmative procedure to be used for Henry VIII
powers. It may be that, if we consider the matter, we will decide that that is an extreme view to take, but I would not mind having that discussion at some stage.

**The Convener:** That is a good point. We could perhaps go further than having that debate ourselves; we could have it at our next meeting with the Executive. Is that what you mean?

**Murray Tosh:** Absolutely.

**The Convener:** Do the clerks have a note of the wording that Christine May suggested?

**Alasdair Rankin (Clerk):** Yes, I have taken a note of that point.

**The Convener:** Are we agreed on what we will say about section 6?

**Members** indicated agreement.

**The Convener:** No points arise on section 7, which concerns the short title and commencement.
Subordinate Legislation Committee

Remit and membership

Remit:

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:
Gordon Jackson QC (Deputy Convener)
Sylvia Jackson (Convener)
Stewart Maxwell
Christine May
Alasdair Morgan
Mike Pringle
Murray Tosh

Committee Clerks:
Alasdair Rankin
Joanne Clinton
Bruce Adamson
The Committee reports to the Parliament as follows—

1. At its meetings on 27th April and 4th May the Committee considered the inserted or substantially amended delegated powers provisions in the National Health Service Reform (Scotland) Bill as amended at Stage 2. The Committee reports to the Parliament on such provisions under Rule 9.7.9 of Standing Orders.
Subordinate Legislation Committee, 19th Report 2004 (Session 2)

National Health Service Reform (Scotland) Bill
As Amended at Stage 2

Report of the Subordinate Legislation Committee


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

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

Report

Introduction
3. A number of changes to the above Bill that introduce new delegated powers or amend existing powers were made at Stage 2. It has therefore again been referred to the Committee for consideration of those changes\(^1\). The Executive has supplied the customary Memorandum for the assistance of the Committee in its consideration of those changes which is reproduced at Appendix 1 of this report. Having considered the following sections with the assistance of the Executive’s memorandum, the Committee approves them without further comment: Section 2, inserted sections 4A(5)(a) and 4A(5)(b).

\(^1\) The Committee’s Stage 1 report is incorporated into the Stage 1 report of the lead committee. See Health Committee 3rd Report 2004 (Session 2), SP Paper 90, published on 6th February 2004 and available on the Parliament’s website at: http://www.scottish.parliament.uk/health/reports/her04-03-02.htm#4
Delegated powers

Section 2
Inserted section 4B: Community health partnerships

Introduction
4. A new regulation-making power has been added at section 4B(5)(da) of the National Health Service (Scotland) Act 1978 (“the Act”) as inserted by section 2 of the amended Bill.

5. As provided for under 4A(1B) of the Act, as inserted by section 2 of the amended Bill, joint community health partnerships are community health partnerships where the area of the partnership includes all or part of the areas of two or more Health Boards.

6. Further background to the new provisions is set out in the Memorandum.

7. The main purpose of the new power in section 4B(5)(da) is to enable appropriate modifications to be made by regulations made by statutory instrument (subject to annulment) to provisions of the Act and subordinate legislation made under it, which apply to community health partnerships so that they will work in relation to joint community health partnerships.

Report
8. The drafting of this provision did not seem entirely clear to the Committee and it had some difficulty in understanding how exactly it will be used. New section 4A already contains its own express amendments to cover joint community health partnerships and while it may be necessary to make adaptations to new sections 4B(1) to (4) it was not clear to the Committee how the power would operate in relation to section 4(5) or why the power to apply and modify provisions of subordinate legislation under the Bill is needed if it is possible to apply the parent provision itself.

9. In principle, the delegated power seemed reasonable to the Committee and the subject matter appropriate to subordinate legislation. However, the Committee asked, if only in the interests of ensuring that the drafting of any resulting subordinate legislation in exercise of the power is not made needlessly complicated because of the drafting of the enabling power, for some further clarification of the drafting of the relevant provision, new section 4B(5)(da), to be inserted into the 1978 Act by the Bill. In particular, the Committee asked how it was intended that the power would be used and how the power will operate in relation to section 4B(5).

10. In its reply, reproduced at Appendix 2, the Executive provided a full explanation of how it envisages the power will be used and further justification for the taking of delegated powers.

11. Despite the further background supplied by the Executive, the new enabling power as drafted also seems to the Committee to have the potential to lead to some complicated drafting when, and if, it is exercised. However, the Committee
accepts that there will be a need for some adaptation of existing legislation to take account of the substantive changes to which reference is made and the new powers appear workable. The Committee therefore approves the powers without further comment.

12. There are no further delegated powers provisions in the Bill of concern to the Committee.
Appendix 1

SUPPLEMENTARY MEMORANDUM TO THE SUBORDINATE LEGISLATION COMMITTEE
BY THE SCOTTISH EXECUTIVE

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

Purpose
1. This supplementary memorandum has been prepared by the Scottish Executive to explain the changes made at Stage 2 to the powers in the NHS Reform (Scotland) Bill to make subordinate legislation. The Subordinate Legislation Committee last scrutinised the delegated powers at its Stage 1 consideration of the NHS Reform (Scotland) Bill on the 4 November 2003. This supplementary memorandum should be read in conjunction with the original memorandum prepared for the Committee and the Bill, both as introduced (“the Bill as introduced”) and as amended at Stage 2 (“the amended Bill”).

2. This Memorandum is split into 3 parts as follows:-

Part I New Subordinate Legislative Powers
Part II Changes to Subordinate Legislative Powers
Part III Changes to illustrative lists

PART I NEW SUBORDINATE LEGISLATIVE POWERS

Section 2: Community Health Partnerships

Power conferred on: the Scottish Ministers
Power exercisable by: Regulations made by Statutory Instrument
Parliamentary procedure: Negative Resolution of the Scottish Parliament
(section 105(2) of the National Health Service (Scotland) Act 1978)

3. At Stage 2 a new regulation making power was added at section 4B(5)(da) of the National Health Service (Scotland) Act 1978 (“the Act”) as inserted by section 2 of the amended Bill. The purpose of this new regulation making power is to allow for the provisions on community health partnerships to apply to joint community health partnerships.

4. During the course of Stage 1, it became clear that it would be necessary to allow Health Boards to set up joint community health partnerships. As provided for under 4A(1B) of the Act, as inserted by section 2 of the amended Bill, joint community health partnerships are community health partnerships where the area of the partnership includes all or part of the areas of two or more Health Boards. The introduction of joint community health partnerships necessitated additional amendments at Stage 2. These are – (1) Section 4A(1C) of the Act, as inserted by section 2 of the amended Bill, which requires that joint community health...
partnerships shall be established as joint committees of the Health Boards by which they are established, and (2) - Section 4B(8) of the Act, as inserted by section 2 of the amended Bill, which extends the power of Health Boards to appoint committees under Regulation 10(1) of the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 to include the power for two or more Health Boards to jointly appoint joint committees.

5. The main purpose of the new power in section 4B(5)(da) is to enable appropriate modifications to be made to provisions of the Act and subordinate legislation made under it which apply to community health partnerships so that they will work in relation to joint community health partnerships.

PART II    CHANGES TO SUBORDINATE LEGISLATIVE POWERS

Section 2: Community Health Partnerships

6. Following the consultation exercise on community health partnerships, a number of Executive amendments were made to the subordinate legislative powers in section 4A of the Act, as inserted by section 2 of the Bill as introduced.

7. The first of these was to remove the regulation making power at section 4A(5)(a) of the Act, as inserted by section 2 of the Bill as introduced. This power allowed for regulations to be made to prescribe the number of community health partnerships to be established for the area of a Health Board. Responses to the consultation considered this to be too prescriptive and it was, therefore, decided that Health Boards should have the flexibility to determine the number of community health partnerships, although they will have to have regard to Scottish Executive guidance on this matter.

8. Section 4A(5)(b) of the Act, as inserted by section 2 of the Bill as introduced, enabled the power to make Regulations to include provision on the status, membership, procedures, staffing and expenses of a community health partnership. At Stage 2 this particular power was changed and it now extends only to the making of Regulations as to membership of community health partnerships. The status of community health partnerships as committees, sub-committees or joint committees of Health Boards is now prescribed on the face of the amended Bill at sections 4A(1A) and 4A(1C) of the Act, as inserted by section 2 of the amended Bill. Regulation making powers for committee procedures and expenses already exist in Schedule 1 to the Act and the regulation making powers in the Bill as introduced are now considered to be unnecessary duplication. Since community health partnerships are committees of Health Boards they will be supported by officers of the Health Board and so it was no longer necessary to have a regulation making power specifically for them.
PART III  CHANGES TO ILLUSTRATIVE LISTS

Section 2: Community Health Partnerships

9. The illustrative list at section 4A(6) of the Act, as inserted by section 2 of the Bill as introduced, has been removed. There are two main reasons for this.

10. Firstly, some of the items in the illustrative list are now covered on the face of the amended Bill. Section 4A(6)(a) of the Act, as inserted by section 2 of the Bill as introduced, allowed for regulations to specify particular functions of a Health Board that are to be exercised by a community health partnership. The specification of functions by Regulations is now achieved through sections 4A(2)(a)(i), 4A(2)(b)(i) and 4A(2)(c)(i) of the Act, as inserted by section 2 of the amended Bill. Section 4B(1A) of the Act, as inserted by section 2 of the amended Bill, now requires Health Boards to have regard to statutory guidance and community planning, as well as to consult and involve local authorities and other persons that Health Boards think fit when preparing the schemes of establishment. Furthermore, the duty of public involvement in section 5 of the Bill requires Boards to consult and involve the public when planning, developing and making significant decisions about a service. It is intended that community health partnerships will also exercise this function and the statutory guidance provides advice to support this. Therefore, section 4A(6)(e) of the Act, as inserted by section 2 of the Bill as introduced, regarding public involvement in the exercise of a community health partnership’s functions is no longer required.

11. Secondly, the illustrative list was considered to be too prescriptive. The amended Bill now states that community health partnerships will be sub-committees, committees or joint committees of the Health Board. It is not appropriate to prescribe in regulations how one part of the Board should consult and report to another part of the Board. This is considered to be too centralist and bureaucratic. Therefore sections 4A(6)(c) and 4A(6)(d) of the Act, as inserted by section 2 of the Bill as introduced, on the consulting and reporting requirements between community health partnerships and Health Boards were no longer appropriate.

12. The amended Bill now allows for Scottish Ministers to issue guidance about community health partnerships under section 4B(7) of the Act, as inserted by section 2 of the amended Bill, which Health Boards must have regard to when drawing up their schemes of establishment. It was considered that statutory guidance was a more appropriate means to describe the various matters that a community health partnership should consider when planning, developing and providing services. Covering this in regulations was considered to be too prescriptive and controlling and, therefore, section 4A(6)(b) of the Act, as inserted by section 2 of the Bill as introduced, was removed. Community health partnerships are expected to evolve as time progresses and the guidance may be continually updated to reflect additional matters that community health partnerships may have to consider as they develop.

13. Therefore, following the consultation on community health partnerships and a review of the subordinate legislation making powers for community health
partnership it was considered not to be necessary to illustrate what regulations would be made in pursuance of section 4A(5)(d) of the Act, as inserted by section 2 of the Bill as introduced, since they were now either prescribed on the face of the Bill or required the additional flexibility given by inclusion in statutory guidance rather than in regulations.

Scottish Executive Health Department

20 April 2004
Appendix 2

NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL AS AMENDED AT STAGE 2

On 27th April, 2004 the Committee asked the Scottish Executive to provide further explanation in relation to section 4B(5)(da) to be inserted into the National Health Service (Scotland) Act 1978 (“the Act”) by the National Health Service Reform (Scotland) Bill (“the Bill”). The Committee raised in particular the following points:

1. the Executive’s approach to the drafting of section 4B(5)(da);
2. how the power will be used;
3. how the power will operate in relation to section 4B(5); and
4. why a power to apply and modify subordinate legislation is needed if it possible to apply the parent provision itself.

The Scottish Executive Health Department responds as follows –

The Executive’s approach to drafting section 4B(5)(da)

Community Health Partnerships (CHPs) are to be established as committees or sub-committees of a health board under section 4A(1A). Therefore any provision of the 1978 Act or any subordinate legislation made under the Act which applies to all committees of Health Boards will apply to CHPs.

An example is paragraph 11(b) and (c) of Schedule 1 to the National Health Service (Scotland) Act 1978 (“the 1978 Act”) which provides that Scottish Ministers may make Regulations as to the delegation of functions to committees or sub-committees and the procedure of committees and subcommittees. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302) have been made in exercise of those powers. These regulations have general application to all Health Boards. As CHPs are to be committees or sub-committees, these Regulations will apply to them.

Section 4B(5)(da) can be used to modify any provision of the 1978 Act or any subordinate legislation made under the Act which relates to CHPs so that the provisions can be properly applied to joint CHPs. As the provisions referred to above apply to all committees, they apply to CHPs and they therefore need to be properly applied to joint CHPs. In our view, the powers in paragraph 11 of Schedule 1 to the 1978 Act do not in themselves allow Regulations to be made which would cover joint committees of 2 or more Health Boards.

The relevance of these other provisions of the 1978 Act which are not contained in proposed sections 4A or 4B (or made under powers conferred by those sections) to CHPs and the fact that these provisions will not work for joint CHPs without
modification is the main reason for the drafting approach taken in section 4B(5)(da).

The power provided by section 4B(5)(da) is similar to the power to modify the 1978 Act provided by section 2(11) of the Act in relation to joint committees of Health Boards set up by order made by the Scottish Ministers.

**How the power in section 4B(5)(da) will be used**

It is intended that the power will be used to modify provisions of the 1978 Act (such as paragraph 11 of Schedule 1) and Regulations made under the Act so that they will work in relation to joint CHPs. An example would be to modify references in the 1978 Act to “Health Board” so that it includes 2 or more Health Boards acting jointly; or modification of references to “committee” or “sub-committee” so that they will include joint committees for the purposes of proposed section 4A(1C) of the 1978 Act.

Note that section 4B(5)(da) can only be used to modify provisions so far as they relate to joint CHPs. It has no effect on the application of provisions of the 1978 Act to other committees or sub-committees of Health Boards.

**How the power will operate in relation to section 4B(5)**

The power in proposed section 4B(5)(da) would enable, for example, references in the other paragraphs of section 4B(5) to “community health partnerships” to be modified so as to include joint community health partnerships.

**Why is a power to apply and modify subordinate legislation needed if it possible to apply the parent provision**

The Executive considers that such a power is expedient. As drafted, the other powers in section 4B(5) could not be used in relation to joint CHPs. Paragraph (da) allows those powers to be used in relation to joint CHPs. The alternative would be to refer to “community health partnerships or joint community health partnerships” in each paragraph of section 4B(5). However, paragraph (da) would still be required to modify other provisions in the 1978 Act as alluded to above.

We hope that this is of assistance.

**Scottish Executive Health Department**

29th April, 2004
Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 10
Schedules 1 and 2
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 2

Malcolm Chisholm
1 In section 2, page 2, line 23, leave out <with a view to improving those services> and insert—
<with a view to improving those services>

Mr Duncan McNeil
6 In section 2, page 2, line 30, after <specify,> insert—
<( ) to take all reasonable steps to provide information, in such formats as
may be reasonably requested, to those who reside within its area about—
(i) the health services to which they are entitled,
(ii) the timescales within which such services will be provided, and
(iii) any alternative sources of treatment which they are entitled to
access in the event that such a service cannot be delivered within
such a timescale,>

Section 2B

Malcolm Chisholm
2 In section 2B, page 4, line 22, leave out from second <the> to <Act> in line 23 and insert <their
functions>

After section 2B

Mr Duncan McNeil
9 After section 2B, insert—
<Waiting times
Duty of Health Boards etc. to monitor waiting times
In section 12H (duty of quality) of the 1978 Act—
(a) in subsection (1), leave out “purpose of” and insert “purposes of—
(a) monitoring whether it is adhering to guidance on waiting times issued by the Scottish Ministers, and

(b)”,

(b) in subsection (3) at end insert—

““guidance on waiting times” means guidance issued by the Scottish Ministers as to the recommended maximum time any individual should ordinarily have to wait to receive any particular form of health care which the Board or Agency provides to individuals once the Board or Agency become aware of the individual’s medical condition; and such guidance shall be issued by way of regulations.”

Section 3

Mr Duncan McNeil

10 In section 3, page 4, line 37, after <to> insert—

<(   ) ensuring that any guidance on waiting times issued by the Scottish Ministers under section 12H is met across Scotland, and

(   )>

Mr David Davidson

21 In section 3, page 5, line 12, at end insert—

<(2B) Where a medical practitioner after consultation with an individual, considers—

(a) that the individual is, for medical reasons, in need of particular goods or services, and

(b) that the Health Board whose function it is to provide health care for the individual is unable to provide such goods or services within an appropriate time (having regard to the seriousness or urgency of the patient’s medical condition),

the practitioner may ask the Health Board in writing to take the action referred to in subsection (2C).

(2C) That action is to co-operate with any other Health Board or Special Health Board to secure the provision of such goods or services within such time as is set out in the written communication from the practitioner.

(2D) A Health Board receiving a written communication of the type referred to in subsection (2B) must—

(a) take the action referred to in subsection (2C), and

(b) make arrangements for the payment of remuneration and any expenses reasonably incurred by the other Board in securing or providing such goods or services.>
After section 3

Mr David Davidson

22* After section 3, insert—

<National tariff system for NHS treatment

National tariff system for NHS treatment

After section 17J of the 1978 Act, insert—

“17J National tariff system for NHS treatment

Ministers shall by regulations provide for—

(a) the setting of tariffs (expressed as a monetary value) for any generic NHS treatment, the same value being assigned to any such treatment regardless of which Health Board or Special Health Board would provide it,

(b) a system permitting any individual (“the individual”) in need of treatment which has been assigned a tariff to receive that treatment from—

(i) a Health Board other than the Health Board (“the individual’s Health Board”) whose function it is to provide health care for the individual,

(ii) a Special Health Board,

(iii) a private health care provider, or

(iv) a voluntary or not-for-profit health care provider,

provided that a general practitioner who has consulted the individual has confirmed in writing to the individual’s Health Board that the individual is in need of such treatment,

(c) the individual’s Health Board, under appropriate circumstances to—

(i) secure the provision of such treatment for the individual by any health care provider fitting within the description set out in paragraphs (b)(i) to (iv) above, and

(ii) pay all or part of the tariff to the provider of the treatment,

(d) general practitioners’ responsibilities to include advising any of their patients on—

(i) waiting times for treatment (including whether different health care providers have different waiting times), and

(ii) whether different health care providers are likely to provide different outcomes on treatment.”>
Section 4

Mr Duncan McNeil

11 In section 4, page 5, line 25, at end insert <, or

   (iii) to provide the service within the relevant recommended waiting
time as provided for in guidance issued under section 12H.>

Malcolm Chisholm

3 In section 4, page 6, line 1, at end insert <, or

   ( ) an employee of a local authority.

   ( ) A body or person appointed by a direction given under subsection (2) to
perform functions of a body or person referred to in subsection (1) is referred
to in this section as an “appointed person”.

   ( ) An appointed person must comply with a direction given under subsection (2).

   ( ) The remuneration and expenses of, and any other costs reasonably incurred by,
an appointed person in performing the functions specified in the direction shall,
unless otherwise specified in the direction, be paid by the body or person
referred to in subsection (1).

   ( ) Anything done or omitted by an appointed person in performing the functions
specified in the direction is to be regarded as done or omitted by the body or
person referred to in subsection (1).

   ( ) A person dealing with an appointed person in good faith and for value is not
concerned to inquire whether the appointed person is acting within the powers
conferred by virtue of the direction.

   ( ) The Scottish Ministers may vary or withdraw a direction given under
subsection (2).>

Before section 5

Shona Robison
Supported by: Carolyn Leckie

12 Before section 5, insert—

<Membership of Health Boards

In paragraph 2 of Schedule 1 to the 1978 Act,

   (a) after “and” insert—

   “(a) in the case of a Health Board other than a Special Health Board, such
number of other members as the Scottish Ministers think fit—

   (i) no more than half of whom may be appointed by the Scottish
Ministers,
(ii) the remainder to be determined by way of regular elections to the Board, to be held no less frequently than every four years for each Board, and

(b) in the case of a Special Health Board,”

(b) at end insert—

“(2) The persons entitled to vote as electors at an election for membership of a Health Board are those who on the day of the poll—

(a) would be entitled to vote as electors at a local government election in an electoral area falling wholly or partly within the area covered by the Board, and

(b) are registered in the register of local government electors at an address within the area covered by the Board.

(3) Where a poll is taking place for membership of two or more Health Boards on the same day a person is not entitled to vote as elector in more than one Board area on that day.

(4) The Scottish Ministers may by regulations make further provision as to the conduct of elections for the return of Health Board members.”>

After section 5

Mr David Davidson

13 After section 5, insert—

<Scottish Health Council

After section 4 of the 1978 Act insert—

“4C Scottish Health Council

(1) There shall be a body to be known as the Scottish Health Council, which shall be funded by the Scottish Ministers.

(2) In this section “Scottish Health Council” means an independent body with—

(a) a board of management composed of one member from each local health council, and

(b) the power to—

(i) acquire and dispose of land and other property,

(ii) employ staff and determine the remuneration, conditions and allowances of such staff,

(iii) enter into contracts,

(iv) with the consent of the Scottish Ministers, borrow sums in sterling by way of overdraft for the purpose of meeting a temporary excess of expenditure over sums otherwise available to meet that expenditure,

(v) obtain information from Health Boards and Special Health Boards, and
(vi) visit any establishment administered by a Health Board, Special Health Board or the Agency where services are being provided.

(3) The general duties of the Scottish Health Council shall be to—

(a) co-ordinate the work of the local health councils on a national basis,
(b) monitor the performance of Health Boards and Special Health Boards, and
(c) liaise with the Scottish Executive Health Department on matters concerning the work of local health councils.”

Section 6

Shona Robison
Supported by: Carolyn Leckie
14 Leave out section 6

Schedule 1

Malcolm Chisholm
4 In schedule 1, page 9, line 5, at end insert—
<( ) In section 2 (constitution of Health Boards and Special Health Boards)—
(a) in subsection (1)(a), after “shall”, where it second occurs, insert “, without prejudice to subsection (1B),”,
(b) in subsection (1B), for “(1)(b)” substitute “(1)”>

Schedule 2

Shona Robison
Supported by: Carolyn Leckie
15 In schedule 2, page 10, line 16, leave out <Section 7.>

Shona Robison
Supported by: Carolyn Leckie
16 In schedule 2, page 11, leave out line 6

Shona Robison
Supported by: Carolyn Leckie
17 In schedule 2, page 11, line 12, leave out from <subsection> to end of line 15 and insert <and in subsections (3) to (7), the words “, NHS trust” in each place where they occur.>

Shona Robison
Supported by: Carolyn Leckie
18 In schedule 2, page 11, leave out lines 17 to 19
Shona Robison
Supported by: Carolyn Leckie

19 In schedule 2, page 11, line 29, leave out "local health council".

Shona Robison
Supported by: Carolyn Leckie

20 In schedule 2, page 12, line 3, leave out <29(3) and (4)(a)> and insert <29(4)(a)>

Malcolm Chisholm

5 In schedule 2, page 13, line 21, at end insert—

<Mental Health (Care and Treatment) Section 3(3)(d) and (e).> (Scotland) Act 2003 (asp 13)
National Health Service Reform (Scotland) Bill

Groupings of Amendments for Stage 3

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: Community health partnerships
1, 6

Group 2: Equal opportunities
2, 5

Debate to end no later than 25 minutes after proceedings begin

Group 3: Waiting times/duty to provide goods and services/national tariffs
9, 10, 21, 22, 11

Group 4: Powers of intervention in case of service failure
3

Debate to end no later than 1 hour after proceedings begin

Group 5: Membership of Health Boards
12

Group 6: Health Councils
13, 14, 15, 16, 17, 18, 19, 20

Group 7: Naming of Health Boards and Special Health Boards
4

Debate to end no later than 1 hour, 50 minutes after proceedings begin
Note: (DT) signifies a decision taken at Decision Time.

**Business Motion:** Tavish Scott, on behalf of the Parliamentary Bureau, moved S2M-1275—That the Parliament agrees that, during the Stage 3 proceedings of the National Health Service Reform (Scotland) Bill, debate on each part of those proceedings shall be brought to a conclusion by the time-limits indicated (each time-limit being calculated from when Stage 3 begins and excluding any periods when other business is under consideration or when the meeting of the Parliament is suspended or otherwise not in progress):

- Groups 1 and 2 – no later than 25 minutes
- Groups 3 and 4 – no later than 1 hour
- Groups 5, 6 and 7 – no later than 1 hour 50 minutes
- Motion to pass the Bill – no later than 2 hours 30 minutes

The motion was agreed to.

**National Health Service Reform (Scotland) Bill - Stage 3:** The Bill was considered at Stage 3.

The following amendments were agreed to without division: 1, 2, 3, 4, 5

The following amendments were disagreed to (by division)—

- 6 (For 38, Against 57, Abstentions 5)
- 21 (For 15, Against 89, Abstentions 0)
- 22 (For 16, Against 88, Abstentions 0)
- 13 (For 48, Against 61, Abstentions 0)
- 14 (For 43, Against 61, Abstentions 0)

The following amendments were moved and, with the agreement of the Parliament, withdrawn: 9, 12

Other amendments were not moved.

**National Health Service Reform (Scotland) Bill – Stage 3:** The Minister for Health and Community Care (Malcolm Chisholm) moved S2M-1095—That the Parliament agrees that the National Health Service Reform (Scotland) Bill be passed.

Shona Robison moved amendment S2M-1095.1 to motion S2M-1095—

Insert at end—
“but, in so doing, remains concerned about the lack of detail in the Financial Memorandum regarding potential additional costs arising from the Bill.”

After debate, the amendment was disagreed to ((DT) by division: For 37, Against 78, Abstentions 0).

The motion was then agreed to ((DT) by division: For 99, Against 16, Abstentions 1).
Scottish Parliament

Thursday 6 May 2004

[THE PRESIDING OFFICER opened the meeting at
09:30]

Business Motion

The Presiding Officer (Mr George Reid): Good morning. The first item of business is consideration of business motion S2M-1275, in the name of Patricia Ferguson, on behalf of the Parliamentary Bureau, setting out a timetable for the stage 3 consideration of the National Health Service Reform (Scotland) Bill.

Motion moved,

That the Parliament agrees that, during the Stage 3 proceedings of the National Health Service Reform (Scotland) Bill, debate on each part of those proceedings shall be brought to a conclusion by the time-limits indicated (each time-limit being calculated from when Stage 3 begins and excluding any periods when other business is under consideration or when the meeting of the Parliament is suspended or otherwise not in progress):

Groups 1 and 2 – no later than 25 minutes
Groups 3 and 4 – no later than 1 hour
Groups 5, 6 and 7 – no later than 1 hour 50 minutes
Motion to pass the Bill – no later than 2 hours 30 minutes.—[Tavish Scott.]

Motion agreed to.

National Health Service Reform (Scotland) Bill: Stage 3

09:31

The Presiding Officer (Mr George Reid): We now move on to the stage 3 proceedings for the National Health Service Reform (Scotland) Bill. As members know, they should have the bill as amended at stage 2—that is, SP Bill 6A; the marshalled list, which contains all amendments that have been selected for debate; and the groupings.

I will allow a voting period of two minutes for the first division this morning. Thereafter, I will allow a voting period of one minute for the first division after a debate on a group. The voting period for all other divisions will be 30 seconds.

Section 2—Community health partnerships

The Presiding Officer: Amendment 1, in the name of Malcolm Chisholm, is grouped with amendment 6.

The Minister for Health and Community Care (Malcolm Chisholm): Amendment 1 is a minor technical amendment, or perhaps I should say a very minor technical amendment, as the words that it deletes are reinserted, albeit in a different place.

The error that amendment 1 corrects occurred in the printing of the marshalled list of amendments at stage 2. The amendment affects subsection (2)(a) of proposed new section 4A of the National Health Service (Scotland) Act 1978. That paragraph provides for the general community health partnership function of co-ordinating the planning, development and provision of certain services. In turn, the relevant services are set out in subparagraphs. The effect of the error is that the words

“with a view to improving those services”

are currently attached to subsection (2)(a)(ii), although the intention is that they should apply to all the functions that subsection (2)(a) covers. Amendment 1 ensures that the bill reflects the original policy intention.

I can appreciate what Duncan McNeil is trying to do with amendment 6, and I pay tribute to all the work that he has done on patient information. It is clearly very important that patients and the public should know about the services that they can expect the national health service to deliver and the targets that we have set for the provision of those services. We are committed to ensuring that that information is made available at national and local levels so that patients are comprehensively informed.
We consulted last year on the document “Patient Rights and Responsibilities: A draft for consultation”, which sets out what patients can expect from the NHS, and we are currently working with the Scottish Consumer Council to finalise the document. It will be produced as a national document that states what the NHS is committed to deliver to the people of Scotland. We will require each health board to publish a local version of the document, which will show how those rights and responsibilities will be delivered locally. We are already working on, and are committed to, ensuring that patients have information on the services that they can expect to receive. When that local information is issued, we will ensure that it gives the full information that is necessary to inform the public of their rights as well as specific local services and provision that are available. We will also ensure that NHS boards disseminate that information widely in different forms so that it is available to the largest possible number of people locally.

Amendment 6 is not the best way to achieve what we are determined to do, and there are a number of reasons for that. For example, it covers all health services, whereas CHPs’ remit will not extend to all health services. If any such duty were to be placed on a body, it would need to be placed on NHS boards, and, as I have already stated, we shall require boards to provide information.

We are committed to reducing waiting times in general and specific waiting times in some key areas of treatment, such as heart surgery. We fully agree that the public need to know which services are subject to waiting times guarantees and how they can ensure that their health board can fulfil those guarantees. The purpose of having a guarantee is to impose a requirement on NHS boards to ensure that the guarantee is fulfilled. If a board cannot itself offer treatment to fulfil a guarantee, it is required to arrange and fund treatment through another health board or through an alternative public or private provider in the United Kingdom or elsewhere. That reflects our absolute commitment to ensuring that guarantees are fulfilled.

If patients have any difficulty in obtaining access to treatment that should be available under a waiting times guarantee, that will be followed up in the first instance with their local health boards and then with the national waiting times unit in the Health Department, which is working with the NHS in Scotland to reduce delays for patients through more efficient use of capacity within and outwith the NHS and to help to ensure that waiting times guarantee commitments are fulfilled. The national waiting times unit will then ensure that a provider that is able to offer treatment is identified and that the necessary arrangements for treatment are completed through the local health board.

I am happy to provide the assurance that the commitments to waiting times guarantees will be set out in the patient information documents that we will issue nationally and locally and that that will include information on what patients should do if they feel that they are not receiving treatment within the guaranteed waiting times. Duncan McNeil might say that that has not happened yet, but I remind members that the guarantees started only this January, and I give another guarantee that the information that I have described will be disseminated nationally and locally in the near future. That is the most effective way to ensure that patients know which treatments are subject to targets and the rights that they have to ensure that those targets are hit.

I move amendment 1.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I will make some brief statements of fact. The more socially disadvantaged and less well-educated members of our communities have the poorest health and shortest life expectancy. Our constituents, especially the more socially disadvantaged and less well educated, are not conversant with their rights to NHS treatment. It is not possible for somebody to exercise a right if they do not know that it exists, and a right that cannot be exercised is no right at all.

Amendment 6 seeks to put right that situation by placing a statutory duty on community health partnerships to take active steps to make the public aware of what they are entitled to, the timescale within which that should be provided and which alternative sources of treatment they can access in the event that the service cannot be delivered within the timescales. The amendment would also place a duty on CHPs to ensure that access to that information is as wide as possible. It would require that the information be made available in a range of formats—for example, Braille and languages other than English.

With amendment 6, I am determined to improve the health record of our most deprived communities and to close the opportunity gap, and so I am sure that I can count on Executive support for such a modest move.

Mr David Davidson (North East Scotland) (Con): I accept the minister’s explanation of amendment 1 and I have great sympathy with what Duncan McNeil is trying to do with amendment 6. It is important that we stress at the beginning of the debate that the patient should be at the centre of the health service, not added on to it. We should do anything that we can to provide patients with the right information. We hear a lot of groups talking about patient empowerment, and I have great sympathy with what Duncan McNeil has said, so I do not understand why the minister wants to produce expensive, glossy documents for
national distribution given that when people have difficulties, they seek local health care in their communities. I beg the minister to change his mind about Duncan McNeill’s amendment 6, which I will certainly support.

Karen Gillon (Clydesdale) (Lab): I am generally sympathetic to Duncan McNeill’s amendment 6, because it is essential that patients should know what they are entitled to. I welcome the minister’s comments, which are a step forward from the position at stage 2, but I would like more information from him about what he proposes and how he will ensure that that will reach the targets—the kind of people about whom Duncan McNeil is talking—and will not be just another glossy pamphlet that reaches only those who already know their entitlement, stand up for their rights and ensure that they get their treatment within the waiting times guarantees. How will he ensure that the people whom we are trying to target—those who have the worst health records and who might not read a glossy pamphlet—know what they are entitled to, what they should do to obtain that entitlement and the steps that they can take if a health board stands in the way of their accessing the health care that we in the Labour Party were committed to in our manifesto and are beginning to deliver?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I support Duncan McNeil’s amendment 6. General practitioners are used to giving patients information and to making patient leaflets that are updated with changes and contain maps. GPs’ staff also help them to convey information.

Glossy leaflets are not enough. They are often found lying around health centres, where people may walk on them. They are just waste paper to gather at the edges of fences.

The Health Department frequently employs much cash to convey information to the public. Sometimes, £85,000 is not considered too much to spend on one publication.

Providing information is health boards’ responsibility, as they are supposed to interact with the public and communicate information. If they are to place more responsibility on general practitioners, they must think about the money and time that will be spent on producing materials, such as posters and leaflets, in addition to postage and staff costs.

Given the new regulations that will mean that not all practices have to provide the same service, it is essential that patients have knowledge. A patient’s own general practice is a good place of contact. Greater use of health visitors would also enable information to circulate in the community.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Duncan McNeil’s objective is good and perfectly achievable. The only question is whether it should appear in the bill. We are establishing community health partnerships by giving them aims and objectives and specifying the practices that they must undertake. Duncan McNeil is arguing for good practice—it is good practice that patients should receive such information. However, I am not convinced that it is necessary to put that in legislation and I urge him not to move amendment 6, because it would not be helpful to make such provision when we have not yet established the CHPs.

Shona Robison (Dundee East) (SNP): I support Duncan McNeil’s amendment 6, which is reasonable. I remind members that it says that “all reasonable steps” should be taken “to provide information, in such formats as may be reasonably requested … about … the health services to which” people “are entitled … the timescales within which such services will be provided, and … any alternative sources of treatment which they are entitled to access in the event that such a service cannot be delivered within such a timescale”.

I do not understand why the minister is reluctant to accept the amendment. People should be fully informed and should receive information in a format that they understand. That is not too much to ask from our health service.

In answer to Mike Rumbles’s question, the reason for putting the provision in the bill is simple: it would state from the start the principle of what we expect from the new bodies that are being established. That would send out the right message about what we expect from community health partnerships. I hope that the minister will reflect on that and accept Duncan McNeil’s amendment.

Malcolm Chisholm: I agree with almost everything that has been said, but I do not draw the conclusion that it is therefore appropriate to put in the bill a duty on community health partnerships, which are new bodies that will already have massive responsibilities and challenges.

My fundamental point is the same as that which Jean Turner made. She said that she supported Duncan McNeil’s amendment 6 but that providing information was the health boards’ responsibility, which is the fundamental point that I made. Community health partnerships are committees of boards, so they will obviously have a key role to play, but the fundamental duty is on health boards. As I described in detail, we shall ensure that boards fulfil that responsibility.
I agree entirely with Duncan McNeil that people cannot exercise rights if they do not know that those rights exist. That is precisely why we are working with the Scottish Consumer Council on finalising a statement of patient rights and responsibilities. I assure him that that will be available in a range of formats.

Of course I agree with David Davidson that patients should be at the centre of the health service, but I am again astounded that he should imply that we think otherwise. As he thinks in stereotypes about the Executive's health policy and does not pay attention to what we are doing, he talked about national distribution and blotted out all my remarks about the information that would be available locally. The thrust of what I said was that information would be in local formats.

I agree with Karen Gillon that it is essential that patients should know their rights. She asked how we would ensure that the target was hit. To do that, we will not only produce the new document to which I referred, but ensure that boards disseminate that information, as I outlined. The reality is that the way in which we will ensure that that happens will not be fundamentally different from the way in which Duncan McNeil's amendment would be enforced. If his amendment were agreed to, we would have to ensure that community health partnerships provided information, just as we will ensure that boards fulfil that responsibility. In many cases, boards will act through community health partnerships to do that.

I dealt with Jean Turner's comments and I thank her for saying that providing information is the health boards' responsibility. I do not disagree with Shona Robison that all reasonable steps should be taken to provide information. I certainly agree that that should be done—I might even want to state it more strongly than that.

I implore members to accept that the primary responsibility must be on the health boards. Community health partnerships could be the most exciting part of the bill. They have enormous challenges. To place on them alone the duty to provide information, which would have quite a lot of ramifications, and to do so without consultation—although a massive consultation document on the partnerships was issued—would be received extremely negatively by those who are involved in the partnerships. It is not that they do not want to be part of fulfilling the responsibility, but I repeat that the primary responsibility rests with health boards. We shall ensure that they discharge it.

Amendment 1 agreed to.

Amendment 6 moved—[Mr Duncan McNeil].

The Presiding Officer: The question is, that amendment 6 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR
Aitken, Bill (Glasgow) (Con)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Muldoon, Bristow (Livingston) (Lab)
Neill, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, John (Ayr) (Con)
Stevenson, Stewart (Banff and Buchan) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Alexander, Ms Wendy (Paisley North) (Lab)
Bailie, Jackie (Dumbarton) (Lab)
Barrie, Scott (Dunfermline West) (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)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Bailleston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Fergusson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Glen, Marlyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)

Kerr, Mr Andy (East Kilbride) (Lab)  
Lamont, Johann (Glasgow Pollok) (Lab)  
Lyon, George (Argyll and Bute) (LD)  
Macdonald, Lewis (Aberdeen Central) (Lab)  
Macintosh, Mr Kenneth (Eastwood) (Lab)  
Maclean, Kate (Dundee West) (Lab)  
Macmillan, Maureen (Highlands and Islands) (Lab)  
Martin, Paul (Glasgow Springburn) (Lab)  
May, Christine (Central Fife) (Lab)  
McAveety, Mr Frank (Glasgow Shettleston) (Lab)  
McCabe, Mr Tom (Hamilton South) (Lab)  
McMahon, Michael (Hamilton North and Bellshill) (Lab)  
McNulty, Des (Clydebank and Milngavie) (Lab)  
Morison, Mr Alasdair (Western Isles) (Lab)  
Mulligan, Mrs Mary (Linlithgow) (Lab)  
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)  
Murray, Dr Elaine (Dumfries) (Lab)  
Oldfather, Irene (Cunninghame South) (Lab)  
Peattie, Cathy (Falkirk East) (Lab)  
Pringle, Mike (Edinburgh South) (LD)  
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)  
Radcliffe, Nora (Gordon) (LD)  
Raffan, Mr Keith (Mid Scotland and Fife) (LD)  
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)  
Scott, Tavish (Shetland) (LD)  
Smith, Elaine (Coatbridge and Chryston) (Lab)  
Smith, Iain (North East Fife) (LD)  
Smith, Margaret (Edinburgh West) (LD)  
Stephen, Nicol (Aberdeen South) (LD)  
Stone, Mr Jamie (Gairness, Sutherland and Easter Ross) (LD)  
Wallace, Mr Jim (Orkney) (LD)  
Watson, Mike (Glasgow Cathcart) (Lab)  
Whitefield, Karen (Airdrie and Shotts) (Lab)  
Wilson, Allan (Cunninghame North) (Lab)  

ABSTENTIONS  
Byrne, Ms Rosemary (South of Scotland) (SSP)  
Fox, Colin (Lothians) (SSP)  
Kane, Rosie (Glasgow) (SSP)  
Leckie, Carolyn (Central Scotland) (SSP)  
Sheridan, Tommy (Glasgow) (SSP)  

The Presiding Officer: The result of the division is: For 38, Against 57, Abstentions 5.  

Amendment 6 disagreed to.  

Section 2B—Equal opportunities  

The Presiding Officer: Group 2 is on equal opportunities. Amendment 2, in the name of Malcolm Chisholm, is grouped with amendment 5.  

The Deputy Minister for Health and Community Care (Mr Tom McCabe): At stage 2, the Executive lodged an amendment to provide a legal underpinning to the existing policy of encouraging health boards, special health boards and the Common Services Agency to discharge their functions in a manner that encourages equal opportunities. The duty, as introduced at stage 2, will require those bodies to encourage equal opportunities and to observe equal opportunities requirements that are contained in existing legislation pertaining to equal opportunities. The duty applies to the functions of those bodies that arise from the National Health Service (Scotland) Act 1978.  

The amendments extend the duty to promote equal opportunities to all health board, special health board and Common Services Agency functions, not only those that are listed in the 1978 act. Amendment 2 will extend the range of functions to which the duty to promote equal opportunities applies. Amendment 5 is a consequence of amendment 2 and will repeal the duty to promote equal opportunities in the Mental Health (Care and Treatment) (Scotland) Act 2003. That is required in order to avoid unnecessary and potentially confusing duplication.  

The issue has been discussed in the NHS, patient bodies and equality bodies and the measures are widely welcomed and supported.  

I move amendment 2.  

Amendment 2 agreed to.  

After section 2B  

The Presiding Officer: Group 3 is on waiting times, the duty to provide goods and services and national tariffs. Amendment 9, in the name of Duncan McNeil, is grouped with amendments 10, 21, 22 and 11. There will be a slight pause until Mr McNeil is ready.  

Mr McNeil: I apologise for the delay, Presiding Officer.  

The partnership agreement pledges that the interests of the patient “will always come first”. Sadly, I am not sure whether our communities agree that that happens. When health bosses sit down to consider the most controversial issue that faces the national health service in Scotland—service redesign—they have certain legally binding obligations. There are, for example, the European working time regulations and the new consultant contract. In fact, there is some sort of statutory protection for everyone’s interests, except those of the patient. The interests of the patient get a look in only when the four corners of the debate, as defined by law, are agreed, and that cannot be correct.  

Amendments 9, 10 and 11 seek to redress the balance and give patients’ interests parity with professionals’ interests. Amendment 9 would give ministers the right, through regulations, to set legally binding guarantees for patients on maximum waiting times for certain services. Amendment 10 would give health boards, in partnership, a duty to ensure adherence to those waiting times guarantees throughout Scotland, and amendment 11 would mean that the powers of intervention in the bill would apply to bodies that, or persons who, do not comply with the waiting time regulations. I do not pretend that the amendments in themselves will put patients at the heart of the national health service, or even the decision-making process—they would simply give
patients’ interests the same status as those of the professionals.

I know from our discussions on the matter that the minister argues that what we currently have is better than what the amendments would deliver and that making maximum waiting times legally enforceable would lead to less ambitious targets being set. However, I do not follow that logic. If we really are already delivering on our tough targets, does the sanction for failure make a great deal of difference? If health boards are not meeting the guarantees, however, the option of recourse to the legal system would put the power to take action in the hands of the patient rather than in the hands of the bureaucrats at the national waiting times unit.

On the other hand, boards may have been relying on the public’s lack of knowledge in order to meet their targets and they would be under real pressure if more patients knew their rights—as amendment 6 would have ensured—and were better able to exercise them. Whatever the case, I cannot see how what is proposed would be detrimental to the people whom I was elected to represent.

I move amendments 9 and 10.

The Presiding Officer: For the purposes of the Official Report, I advise that, for procedural reasons, although Mr McNeil has spoken to amendments 10 and 11, he can move only amendment 9.

Mr McNeil: Yes. I am sorry.

Mr Davidson: Throughout the discussion on regulations, the minister talked a lot about the duties of boards. However, we hear time and again about individuals who cannot get treatment locally at an appropriate stage and about their clinical advisers—whether they are out-patient consultants or GPs—wanting them to receive, on time, treatment that is suitable and which meets the needs of their particular case. In other words, a clinical decision is involved. If the local health board cannot supply a service at a time that the physician recommends, the system should be allowed to change to ensure that the health board facilitates the patient being taken to another health board area—or another source—to receive treatment.

The Minister for Health and Community Care already said at stage 2 that he will put a duty of care on boards to look after other boards’ patients. Quite a mix-up is involved in the fund flows and in the understanding of the matter out there. With amendment 21, I seek to put clear reasons in the bill for that approach and to give support to patients in their patient journey, to which the minister frequently refers.

One issue that health boards have raised time and again is that when they have co-operated with another health board, they often get their own operation into financial difficulties—whether through the Arbuthnott formula or something else. They find that they must pay for treatment that has been provided by another board, although the funds do not necessarily follow. To avoid any connivance, in a sense, whereby a board thinks that it can get a service cheaper elsewhere, amendment 22 seeks to set up a national tariff system for NHS treatments that would be set in place by regulation and which could be updated quite simply in the same way that, in pharmaceutical supply, the drug tariff is updated on a weekly to monthly basis.

We must ensure that money timeously follows the patient and does not cause any hold-up in or damage to the system. We should have a national health service, and patients should have the right to transfer within that service. If, as the minister has said, the health service cannot supply a service, the patient should be able to obtain it elsewhere, whether in the independent sector, the voluntary sector or the not-for-profit sector.

All that I seek to do is to put in the bill the rights of patients to have their treatment at the appropriate time wherever their clinicians think that they should have it and wherever it can be dealt with accurately, properly and safely. I want funding to follow the patient. The patient is the core of the health service and every patient journey must have such rights attached to it.

Mr McNeil’s proposals are unnecessary. I do not want yet more administrative effort and duties to be placed on health boards when they should be seeking to provide the best possible service at the earliest possible opportunity. The proposals would simply mean a cumbersome administrative exercise.

I move amendments 21 and 22.

The Presiding Officer: Mr Davidson can only speak to amendments 21 and 22; the opportunity to move or not to move them will come later.

Shona Robison: I support amendment 9, in the name of Duncan McNeil. We should be prepared to take the step that he proposes for a number of reasons, the most important of which is that, currently, a number of health boards are under considerable financial pressure. We are concerned that that could lead to an erosion of the waiting times guarantee. We know that health boards are under pressure and that, in some areas, waiting times will be impacted on. Giving patients the right to recourse if health boards fail to meet the waiting times guarantee would prevent that from happening.
Duncan McNeil made a strong case when he spoke about the patients' interests being protected in the same way that others' are. At present, the public and patients feel that the health service is not always run in their interests and that is a perception that we all want to change.

Accepting amendment 9 would send out a strong message to health boards that failure to fulfil their duty to patients would empower the patient to use the law to get what they should be getting from the health board in their area. I am happy to support Duncan McNeil's amendment 9.

10:00

Mike Rumbles: I will not comment on the dispute between Duncan McNeil and the minister about Duncan McNeil's amendments; I will stick strictly to David Davidson's amendments.

David Davidson gives the appearance of being the patients' champion in the national health service, but he is the champion of the private patient. Liberal Democrats believe that it is healthy to have an alternative to the state-provided health service, but we believe vehemently that the public health service should not be used to subsidise private health care. Amendment 22 would be a passport out of the national health service.

David Davidson has lodged a substantial amendment that strikes at the very principles of the national health service and at the principles of the bill. He did not lodge the amendment at stage 2 in committee—in fact, David Davidson signed up to the Health Committee's stage 1 report. It was only when that report was debated in the chamber at stage 1 that David Davidson turned about to oppose it.

It is disappointing that amendment 22 has been lodged in such a way because the point of the process of passing laws in the Scottish Parliament, which is so different from the process in Westminster, is that we involve the public. We involve everybody in the consultation process and take evidence as we go through the process. Lodging amendment 22 at the last possible moment represents Conservative party political principles—it is not appropriate at this stage. I do not question David Davidson's right to do that—he is perfectly entitled to lodge amendments in that way—but it is a little disingenuous of him to pose as the champion of the patient when he is the champion of the private patient.

Carolyn Leckie (Central Scotland) (SSP): I do not disagree that Duncan McNeil has the patient's interests at heart. He spoke about reorganisations in health boards and their lack of accountability, but his amendments do not address that point.

The experience of medical secretaries, for example, is that the management of waiting times distorts clinical priorities and wastes their time in some areas because it takes them away from being able to deliver patient care. Legislating on the matter would be a simplification of the delivery of health care and would risk distorting clinical priorities.

I support Shona Robison's proposed measures to keep health councils and thereby the democratic accountability of health boards. I hope that Duncan McNeil will support those measures because they would provide a way of holding health boards to account for organisations that the public do not support.

I concur with Mike Rumbles on David Davidson's amendments. Instead of allowing the bill to abolish the internal market and trusts, amendment 22 would have the effect of making the internal market that wee bit bigger and it would offer up opportunities for the proliferation of the private sector. David Davidson's amendments are a bit sneaky—I say well done for trying, but we will not support them.

Karen Gillon: I will not support David Davidson's amendments. It is good to have somebody like David Davidson in the Scottish Parliament because it reminds me of why I am in the Labour Party, why the Tories are the Tories and why we must do everything that we can to prevent them from getting into power at the next general election.

I support Duncan McNeil's amendments. If the waiting times guarantee is to be meaningful, it must be enforceable. I am interested to know why the minister opposed those amendments and why he does not think that a patient should have the right to enforce the guarantee if it is not met by the health board. That was a key plank of our manifesto and many people voted for us on that basis, so I would be grateful to know why they should not have that right.

There will be pressures on health boards and, in my area, we have been made aware of a couple of pressures in relation to how the consultant contract will impact on elective surgery. I would be grateful to know from the minister how we can continue to meet those guarantees without giving patients the right to recourse when we fail to meet them.

Christine Grahame (South of Scotland) (SNP): I rise in support of Duncan McNeil's amendments and against David Davidson's amendments. Many of the arguments have already been made; I simply endorse Duncan McNeil's amendments. We are not dealing with a simple matter of providing information—it is also about having equality throughout Scotland. The key is that we want to embody the waiting times guarantee in regulations to make it legally
enforceable. That is what the minister does not want to face—he does not want to deal with litigation based on the regulations. However, it is important to have them because there is no point in having a waiting times guarantee if it is just a piece of paper that one can do nothing about.

Much has been said about David Davidson’s amendments. I say more kindly than Miss Leckie, with whom I agree entirely, that the amendments represent an unsubtle attempt to take us incrementally down the road of Tory privatisation. We know that some health services have already been purchased outside the NHS, but the Scottish National Party does not want to see that increase—we would like to see a return to a much more public service. David Davidson’s amendments are unsubtle and will be rejected by the Scottish National Party.

Dr Turner: I have the joy of being an independent member and I do not feel obliged to vote one way or the other on the amendments—I agree with them all. I agree with Duncan McNeil because what he said was important.

I know what happens to patients and when I looked at David Davidson’s amendments, I thought about the passports that everybody is afraid of. I hate to think that the national health service would ever be privatised, but I tell members that, in Glasgow, there are three different prices for orthopaedic operations. There is a price for the health board, there is a different price for the Golden Jubilee hospital, which might be the cheapest, and there is another price for the private sector. So many people out there are in desperate need of a hip replacement operation to keep them mobile that, as I have said before in the chamber, they have had to spend their hard-earned savings on having perhaps two hip replacements. They receive no tax rebate although they have paid into the national health service, which cannot provide.

One of my constituents would love to go anywhere in Scotland to have his hip replaced, but he has not been able to have that sorted out. I had a patient at the Glasgow royal infirmary, but when his consultant was transferred to the Golden Jubilee hospital, the whole waiting list did not move with that orthopaedic surgeon to the new hospital. My patient was deprived of having his operation in time. I should have said “constituent” rather than “patient”—I still forget that I am no longer a general practitioner. That poor chap would dearly have loved to go private because there was no other way for him to have his operation in time. He would have scraped up the money—his family would have provided the finances—but he was not fit to have his operation done in the private sector. We should remember that it is not always easy to choose to use the private sector. It might be imperative to stay in the NHS and in an NHS general hospital because of one’s other medical conditions.

I read David Davidson’s amendments carefully and, if he has some ulterior motive, I am sorry about that. I agree with what he says, however, because I would like equality and I would like patients to have their treatment now.

Far too many people are having to wait. For example, I know someone who has to wait 72 weeks for her first orthopaedic appointment in an NHS hospital. The NHS is not working. The waiting times are dreadful. In fact, consultants do not know the real extent of the waiting lists; instead, they are given what they are told is their waiting list, although they know that the rest of their list is sitting in some other part of the hospital. As a result, any suggestions on how we can keep an eye on waiting times would be valuable. Targets are another matter: I would ban them. In any case, I agree with all the members who have spoken.

I remind members—

The Presiding Officer: Briefly, please.

Dr Turner: I will be very brief. I remind members that people in the outer Hebrides are able to receive physiotherapy the next day, the day after that or the next week whereas people in Glasgow have to wait 13 weeks for the same treatment. As patients within the health service do not have an equal opportunity, I support all the amendments that have been lodged in this group. Lucky me.

John Swinburne (Central Scotland) (SSCUP): In many cases, we are talking about pain. Someone who is in pain will take any steps to alleviate it. I am a great supporter of and believer in the NHS. As the service already allows consultants to carry out private work, I do not see that there is a great deal of difference between David Davidson’s proposals and the Executive’s position.

I do not believe in private medicine, but neither do I believe in private pain. I was forced to have an operation privately, because I could not suffer the pain of my arthritic hips for another year. My heart goes out to anyone who is still waiting in that queue for treatment.

I support the amendments lodged by Duncan McNeil and David Davidson. As Jean Turner said, they are both right, and consensus on this matter would help everyone.

Malcolm Chisholm: I appreciate the intention behind amendments 9, 10 and 11 and assure Duncan McNeil and Karen Gillon that the patient guarantees will be met. That said, I am not convinced that those three amendments will
achieve the desired outcome or be in patients’ interests.

To date, we have made some good progress in working with health boards to reduce waiting times and to ensure that the guarantee is delivered. I should remind members that the guarantee itself kicked in only this year. I accept Dr Jean Turner’s comments about out-patient waiting times, which were left for too long in Scotland. However, we are very much making up for that now by introducing a major programme of work on reducing out-patient waits. Indeed, I am speaking tomorrow at a major out-patient event for one of the areas affected—ear, nose and throat—and will announce some money and ensure that action is taken to reduce those waits.

Progress has been helped by the work of the centre for change and innovation and the waiting times unit and by making available the resources of the Golden Jubilee national hospital to NHS patients across Scotland. I believe that that collaborative approach has achieved results and is more constructive than the legal approach that is proposed in amendments 9, 10 and 11. As I pointed out in relation to amendment 6, steps are being taken to ensure that patients are well aware of the waiting time guarantees, what the waiting times are; and what they should do if they feel that the guarantee has not been met in their case.

I have three general objections to the idea of enshrining maximum waiting times in primary legislation.

10:15

Christine Grahame: Will the minister give way?

Malcolm Chisholm: I will take an intervention after I make my three points.

First, creating legal duties in relation to services that are subject to a waiting times guarantee—including elective surgery such as hernia repairs and cataract removal—would give rise to a perverse situation in which those services could become a priority over other more clinically urgent services, such as emergency services, that are not enshrined in legislation in such a way. Indeed, I think that Carolyn Leckie made the same point. It would mean that boards would be under express legal duties in relation to services covered by the waiting times guarantee, but not under similar duties for other services such as emergency care.

Secondly, as waiting times are integral to the quality of the services provided, I do not think that it is appropriate to single out in legislation the particular issue of waiting times from other crucial aspects of quality.

Thirdly, our firm guarantees already go beyond what applies in the rest of the UK. Turning those guarantees into a legal duty could be counterproductive in creating pressure to soften targets and guarantees as a result of the potential for expensive legal challenges against boards. Even if Duncan McNeil does not accept that, I hope that he thinks it reasonable to give the guarantees some time to prove themselves. After all, as I have said, they were introduced only in January.

Christine Grahame: I think that the minister has already answered my question. However, for the sake of clarity, is he saying that the waiting times guarantee is not legally enforceable and that, if it were not met in my case, I could not take him, his department or any board to court?

Malcolm Chisholm: That is a statement of fact. However, I have already assured members that the guarantees will be met and there are many ways of ensuring that that happens short of putting them in primary legislation. I certainly think that many staff members and patients would be horrified at the idea that someone in such a situation should be taken to court. My point is that, if we push this provision beyond a guarantee, we will create a perverse situation in which minor elective procedures, which would then be legally binding, would have to be put before emergency care, which would not be. Such a situation would be neither clinically acceptable nor in patients’ interests.

The other duties set out in amendments 9 and 10 do not add anything to the current arrangements. As the duty in section 12H of the National Health Service (Scotland) Act 1978 currently requires arrangements for monitoring and improving the quality of health care to be in place, it already applies to waiting times because that aspect of a service is an integral part of the service’s quality. As a result, systems already exist for monitoring and reducing waiting times. For example, boards make regular submissions to the department’s waiting times unit on how they are performing against the waiting times targets. Given that the 1978 act contains such an equivalent duty, amendment 9 is therefore unnecessary.

Amendment 10 seeks to affect the duty of co-operation. However, as currently drafted, the bill already requires boards to “co-operate ... with a view to securing and advancing the health of the people of Scotland”. That wording already covers co-operation to reduce waiting times as that itself would advance “the health of the people of Scotland”.

Boards will continue to co-operate with the Golden Jubilee hospital on reducing waiting times and will also work with other health boards in a national effort to reduce them.
On amendment 11, I agree that if a board is systematically failing to meet waiting times targets it might be necessary as a last resort to use the new power of intervention. That is partly a response to Christine Grahame’s earlier point. Such boards would clearly be failing to provide the service to a standard that Scottish ministers find acceptable.

That does not mean that I support amendment 11. It is unnecessary because, as drafted, the power of intervention already allows ministers to intervene when an adequate service is not being provided. I have said before that we will not be able to prescribe every circumstance in which Scottish ministers should intervene and waiting times should not be singled out over and above other issues such as quality. That matter will no doubt arise when we discuss the next group of amendments.

Moving on to David Davidson’s amendments, I have to say that amendment 21 is quite unusual in how it takes the good aspects of the current service and makes them worse. At present, a patient has a consultation with a medical practitioner, who then decides on the treatment that the patient needs. Taking into account the seriousness or urgency of the patient’s condition and the availability of services, the medical practitioner will then consider where the patient can receive that treatment and make a referral for specialist services on that basis.

The national waiting times database has been available to all GPs since December 2002 and to the public since October 2003. It is designed to help and support patient choice and to inform decision making for the patient, the primary care practitioner and hospital services. If the patient and general practitioner want a referral to a clinic in another board area, that can already happen.

Mr Davidson: The minister mentioned patient choice. I am trying to ensure that such choice can be delivered on the ground and that there are clearer duties in that respect. It should not simply be put into the melting pot of waiting times. Recently, a constituent of mine had a lump in her breast and was panic stricken. She went to her general practitioner and he asked for an immediate investigation, but the health board said that it did not have the capacity to do that within two months. She went for private treatment. She did not have health insurance but she and her family scraped the money together. Is it not right that, if a health board cannot provide the service, a patient can be referred elsewhere? We are certainly not proposing the privatisation of the health service, but if the health service fails, there should be provision for other services to provide the treatment. It is concern for the treatment of the patient that lies behind amendments 21 and 22.

Malcolm Chisholm: The reality is that, under the arrangements that I have just described, that constituent could have been referred to another board if the waiting time had been shorter there. The problem with amendment 21 is that it would seriously distort priorities at health board level because decisions on the timing of treatment would rest solely with individual medical practitioners, as stated in the proposed new subsection (2C). If anyone is thinking of supporting amendment 21, I ask them to read the proposed subsection (2C) within it, which makes it clear that a letter from a GP would supersede not only the targets and the waiting times guarantee but clinical priority as well.

Amendment 21 says that a medical practitioner could insist on the precise time of treatment. That could lead to a scenario in which a GP demanded that a minor surgical procedure be performed quickly, with the result that a far more serious operation had to wait longer. Different practitioners would make different professional judgments in situations that might seem similar to us. However, amendment 21 would place a legal duty on a health board to do whatever an individual doctor said that it must do. The board would have to ensure that a service was provided to the individual patient by a date dictated by the doctor. The health board would not be able to consider the disruption to other treatment, to consider wider priorities, or to consider other strategic matters. I fail to see how that would be good for patients or the NHS.

I turn now to amendment 22. The tariff idea is interesting. David Davidson has lifted it from Labour in England—albeit with a deadly Tory twist. The idea of having a uniform cost for a particular treatment is one in which I am interested. I have asked my department to give it detailed consideration. However, it would be quite wrong to agree to amendment 22 on the hoof without such detailed consideration and without consultation. For example, one of the downsides to the idea may be that treatments cost different amounts in different hospitals for quite legitimate reasons. It may well be that small hospitals would lose out under such a system.

The Tories support this idea as a Trojan horse for their unfair and divisive patient passport, whereby each patient would automatically receive a tariff—or “part of the tariff”, to use the very words of the proposed section 17J(c)(ii) in amendment 22—in order that those who can afford it can supplement their own private payment and access health care on the basis of income rather than on the basis of clinical priority.

The Presiding Officer: Minister, we have only nine minutes in which to get through both this
group of amendments and the next group, before the knife falls at 10:31.

**Malcolm Chisholm:** That is utterly unacceptable and is—[**Laughter.**]

I mean, David Davidson's amendment 22 is utterly unacceptable. [**Laughter.**] No, actually, I meant that the Tory twist was utterly unacceptable. [**Laughter.**] In itself, that twist is sufficient reason to reject amendment 22.

**The Presiding Officer:** Mr McNeil, do you wish to wind up briefly?

**Mr McNeil:** No. I have heard what the minister said and I am happy with that.

**The Presiding Officer:** Are you pressing amendment 9?

**Mr McNeil:** No, I am not.

**Amendment 9, by agreement, withdrawn.**

**Section 3—Health Boards: duty of co-operation**

**Amendment 10 not moved.**

**Amendment 21 moved—[Mr David Davidson].**

**The Presiding Officer:** The question is, that amendment 21 be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**For**

Aitken, Bill (Glasgow) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Montefth, Mr Brian (Mid Scotland and Fife) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

**Against**

Alexander, Ms Wendy (Paisley North) (Lab)
Bailie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brandin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis ( Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Grahaime, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
Lyons, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Mathur, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
(MacNeil, Paul (Edinburgh East) (Lab)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Russell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Sheridan, Tommy (Glasgow) (SSP)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross)

The Presiding Officer: Mr McNeil, do you wish to wind up briefly?

Mr McNeil: No. I have heard what the minister said and I am happy with that.

The Presiding Officer: Are you pressing amendment 9?

Mr McNeil: No, I am not.

Amendment 9, by agreement, withdrawn.

Section 3—Health Boards: duty of co-operation

Amendment 10 not moved.

Amendment 21 moved—[Mr David Davidson].

The Presiding Officer: The question is, that amendment 21 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.
The Presiding Officer: The result of the division is: For 15, Against 89, Abstentions 0.

Amendment 21 disagreed to.

After section 3

Amendment 22 moved—[Mr David Davidson].

The Presiding Officer: The question is, that amendment 22 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Aitken, Bill (Glasgow) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ferguson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

Against

Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrisson, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Sheridan, Tommy (Glasgow) (SSP)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (SNP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)
The Presiding Officer: Amendment 3, in the name of Malcolm Chisholm, is in a group on its own.

Mr McCabe: Amendment 3 serves two main purposes. The first relates to the range of individuals who may be included within an intervention team that is to be sent into a health board to bring a failing service back to an acceptable standard. The bill currently restricts the individuals who are eligible for an intervention team to employees from health boards, special health boards, the Common Services Agency and the Scottish Executive. It is considered that local authority employees could usefully be added to this list, thereby broadening the pool of expertise and experience that Scottish Ministers could draw from. The first part of the amendment gives effect to that policy.

The second reason for amendment 3 is to clarify that the actings of the appointed person are to be treated as actings of the relevant body that is subject to the intervention. As I said during stage 1, the general principle to which we are working is that boards that are responsible for a failing service should be responsible for the costs of intervention to remedy the failure. The alternative would be for costs to fall on the entire Scottish NHS budget and therefore on boards as a whole. We believe that it would be wrong to penalise other boards for the costs of correcting the failings of one board.

However, the amendment also enables Scottish ministers to assist with the costs of the intervention if they choose to do so. For example, if ministers were to take the view that the costs were such that, if the board was to meet them, it would result in a material reduction in services in that board area, they could decide that it would be appropriate for the Executive to contribute to, or bear, the costs of remediying the failure. The effect of doing so would, of course, be to spread the costs across the whole of Scotland.

Amendment 3 also makes it clear that third parties do not have to distinguish between acts of the relevant board and those of the appointed person in the unlikely event that they suffer any loss during the course of an intervention.

I hope that I have provided the necessary clarification that the Health Committee requested at stage 1.

I move amendment 3.

The Deputy Presiding Officer (Murray Tosh): We have very little time. I call Shona Robison.

10:30

Shona Robison: The minister will be aware that there have been concerns about who meets the costs of interventions. The Health Committee had a lot to say about that because we are talking about health boards that are already under severe financial stress. I am pleased that the minister has said that, when the costs would lead to a material reduction in services, the Executive could help to meet those costs. That is to be welcomed. However, we require a bit more information about what would constitute a material reduction in services. At what level would that be measured? How would it be assessed whether services had been reduced to that extent? It would be helpful to have more information on that.

The Deputy Presiding Officer: I apologise to the two members whom I cannot call.

Mr McCabe: It is clear that the Executive would want to take action to ensure that there was a comprehensive assessment of the situation in any area. The criterion is that, regardless of what has occasioned the failure of a service within a board, whatever actions we take should not have a detrimental effect on the other services within that area. The Scottish Executive, aided and abetted by the officials who serve us, would conduct a comprehensive assessment to ensure that we did not take any action that would have further detrimental effects on the people who depended on the services in that area.

Amendment 3 agreed to.

Before section 5

The Deputy Presiding Officer: Group 5 is on the membership of health boards. Amendment 12, in the name of Shona Robison, is in a group on its own.

Shona Robison: Amendment 12 is necessary because we cannot have a debate on NHS reform without talking about one of the most important reforms that could and should take place in the health service, which is to redress the balance by tackling the lack of public say in and power over the decisions that are made locally about people’s health services. We know from all our patches that the public in constituencies throughout Scotland feel dislocated from the decisions that are made by health boards. In Caithness, the west of Scotland, Glasgow or wherever, there are feelings of disempowerment and a sense that the health boards will do what they want to do in spite of the public’s opposition.

If we are to address that concern, the public will be able to regain their trust in health boards only if they are given a direct say in the decisions that health boards make. In my opinion, the only way in which to do that is to have direct elections for at least half the places on health boards. I am aware that Bill Butler has made a proposal for a bill on the subject and I look forward to hearing about
what is happening on that front and what the timescales are for the bill's introduction. We cannot afford to wait for such change for ever. The time is now right to send out a signal to the public that we recognise their disillusionment with the decisions that have been made and so we are prepared to take real action to address the imbalance of power.

I move amendment 12.

**Mr Davidson:** We will not be supporting amendment 12, for the reasons that I stated during stage 2 consideration. The proposal has a huge cost implication and we have far too many elections in Scotland as it is. Frankly, the introduction of elections for health boards would open up the boards to the risk of being taken over by single-issue campaign groups, which could bring nothing but disruption to the running of the boards.

We must seek ways of incorporating health patients' views to a greater extent in the health system. I felt that local health councils played a valuable role in that regard, before the bill came along. There is a big skills gap among the general public about how health boards are run. It is one thing to talk about patients' input and getting their voices heard—I have some sympathy with what Shona Robison said about the needs of communities in relation to consultation on changes such as the centralisation of maternity services—but I do not believe that having an electoral process, which could be repeated time and again during a session of Parliament, to deal with a single issue would be in the interests of the health service's efficiency.

**Mike Rumbles:** I do not think that Shona Robison seriously expects the Parliament to support her amendments today. I will make the same comment that I made on David Davidson's amendments 21 and 22, which I said would change the NHS's entire principles.

Shona Robison has already referred to Bill Butler's proposal for a member's bill. I am sympathetic towards the principle behind amendment 12, which also lies behind Bill Butler's proposed bill. However, there are two ways of ensuring health boards' accountability to patients and the public. The first is through ministerial powers of intervention and the other is through direct elections. I am sympathetic towards direct elections because, when the National Parks (Scotland) Bill was considered by the Rural Affairs Committee in the first parliamentary session, I lodged 15 amendments on the subject. They were successful—the Parliament agreed to them—and 20 per cent of all the members of the national parks boards are now directly elected by the people within the national park boundaries. That is a good thing and, from speaking to the people who are involved, I believe that the system works extremely well.

I am supportive of the principle, but I return to the point that I have just made. There are two public accountability options—direct elections and ministerial intervention. Although I am supportive of the Executive's decision to go down the route of ministerial intervention, it presents me with a difficulty. How compatible with direct elections is giving the minister powers to intervene to ensure the public interest, if that means that the people who are directly elected are then subject to ministerial intervention? That is the crux of the matter. Members of all parties who want health boards to have more public accountability face a real dilemma.

On amendment 12 specifically, I do not think that now is the moment for the Parliament to take on board Shona Robison's proposal without a thorough investigation. We must give due attention to Bill Butler's proposed bill.

**Janis Hughes (Glasgow Rutherglen) (Lab):** I support the spirit of amendment 12, which is the same as an amendment that Shona Robison lodged at stage 2. I accept that the proposal forms an important part of reform of the NHS and links in with a number of other areas that are dealt with in the bill, such as consultation.

I fully agree that the public should have a say, through consultation, in how services are delivered in their area, but I also believe that they should have a say on the question of direct elections to health boards. That is why I think that it is premature to lodge such an amendment. Mention has already been made of making policy on the hoof and I think that that is what we would be doing by including in the bill provision for direct elections to health boards.

I have given my support to Bill Butler's proposed member's bill and I think that the way forward is through full consultation, which I understand will be happening in the near future. Through such consultation, we should give the public the opportunity to comment on how they view direct elections to health boards. For that reason, I will oppose amendment 12.

**Carolyn Leckie:** I support amendment 12, having lodged a similar amendment. It is unfortunate that such a measure was not contained in the consultation on the bill, as that would have provided the opportunity for it to be discussed fully. I, too, would like there to be a lot more debate about the composition of, and elections to, health boards. I have already indicated my support for Bill Butler's proposed bill.

I will explain why direct elections to health boards are necessary. Up and down the country—from Wick to the Borders and from the Highlands
and Islands to Glasgow—there is a lack of confidence in the democracy and accountability of health boards. That is a constant theme in the petitions that are submitted to the Public Petitions Committee. Nearly every reorganisation results in the public being up in arms and reaching conclusions that are the opposite of those reached by the health board. That is unacceptable; the situation is untenable.

Let us consider what is happening now. The issue is not just the public’s inability to hold health boards democratically to account; it is the composition of boards. By my reckoning, 41 appointees to NHS boards are ex-Labour candidates or councillors, nine are Liberal Democrats, nine are independent, four are members of the Scottish National Party and four are Tories. That represents a clear imbalance if we consider the proportion of the population that is made up by activists of or candidates for the Labour Party and other parties. Two thirds of the appointees who have disclosed political affiliations are members of the parties of the Scottish Executive and only seven appointees—less than 10 per cent—have affiliations with non-Executive parties. There might be even more appointees with Labour affiliations, because only people who have stood as candidates in the past five years are required to disclose their party background. For example, Bill Speirs, the general secretary of the Scottish Trades Union Congress, is an appointee who does not have to declare his Labour Party affiliations, so he is not included in the figures that I have given.

If we are to address the public’s suspicions, there must be greater openness and transparency, direct accountability and direct democracy. A secret report—although it is not secret, because we all know about it—expresses great suspicion about accountability, the number of quangos, the performance of the Scottish Parliament and so on. We could restore public confidence and deal with the quango issue by introducing direct elections to health boards. Quangos could be turned into democratically and publicly accountable bodies if we replaced the appointed members of NHS boards with directly elected members who would be answerable to local communities, rather than to the political party in which they are active.

**Bill Butler (Glasgow Anniesland) (Lab):**
Shona Robison mentioned me in dispatches, so I will place a few matters on the record.

It is my intention to issue before the summer recess a consultation paper on my proposal for a member’s bill on direct elections to health boards. I give my word on that to Parliament. I sincerely believe that that is the appropriate approach to what would be a far-reaching reform with profound ramifications. To tack on to the bill an amendment, without consultation, would not be an appropriate way of introducing a much-needed reform, as I think that the Health Committee decided at stage 2.

If the results of the consultation are positive, as I think they will be, I hope that the ministerial team will give my proposal a fair wind. I will be interested to hear what ministers say about that later in the debate.

**Mr McCabe:** I was surprised that Shona Robison lodged amendment 12, after a similar amendment was withdrawn at stage 2. I understood that at that stage she thought that further consultation was needed and that Bill Butler’s proposal offered an appropriate approach. I do not think that much has materially changed since stage 2, but we must consider the amendment nevertheless.

Bill Butler has indicated that he has every intention of introducing his member’s bill and that there will be an opportunity for proper consultation on the proposals that his bill contains. I am not persuaded that we should legislate in advance of such a consultation and I hope that members want to wait for the outcome of the consultation before they consider whether and how to take forward legislation on such an important issue.

We should remember that the Executive has already taken steps to increase the public accountability of health boards throughout Scotland. The creation of 15 unified NHS boards in September 2001 extended the range of key stakeholders by including local authority councillors. The formal presence of elected councillors as full members of boards was specifically intended to strengthen local accountability, responsiveness to community issues and joint working between health boards and local authorities.

The Executive is also working to improve patient and public involvement throughout the NHS. That is demonstrated by other provisions in the bill. Community health partnerships, for example, will include at least one member of the public partnership forum, who will represent the public’s interests. The new duty of public involvement will ensure that boards consult the public on plans and decisions that significantly affect the operation of services. We want to create mechanisms that allow interested members of the public to influence what happens in their health board area and I believe that we are doing that.

This is not the time to introduce the provisions in amendment 12 and I urge members to reject it.

**Shona Robison:** I will be brief. I thought that it was important to keep the issue of direct elections to health boards on the agenda, so I lodged amendment 12 as a probing amendment, to find
out what was happening about Bill Butler’s proposed member’s bill. I am grateful to Bill Butler for his commitment to proceed with the consultation before the summer recess and I look forward to that process. I am sure that there will be a large response from people throughout Scotland and we will certainly encourage people to respond. Given Bill Butler’s commitment, I will seek to withdraw amendment 12.

Amendment 12, by agreement, withdrawn.

After section 5

10:45

The Deputy Presiding Officer: Group 6 is on health councils. Amendment 13, in the name of David Davidson, is grouped with amendments 14 to 20.

Mr Davidson: The Health Committee took a lot of evidence about the proposed new Scottish health council and discussed the matter fully. I find it strange that although the Executive has spun the fact that the council is to be established and will be an important body, the bill does not refer to it. That is staggering given that the minister has regularly stated in public that the health council represents a vital part of the modernisation of one aspect of health care in Scotland.

Amendment 13 would include the Scottish health council in the bill and would reinforce the fact that the council should be an independent body and not merely a department of NHS Quality Improvement Scotland or a body that is subject to joint management. The Scottish health council should stand alone.

Local health councils are keen to be linked into a proper national body—neither they nor I object to that proposal—but they want that body to be truly independent. In the past, they worked closely with but were funded by the health boards. However, the Scottish health council should be a truly independent body that considers NHS performance from the point of view of patients and staff and visits the different health establishments in which local health councils have been active and welcome in the past. Currently, one or two local councils do not have the resources or the manning to enable them to be efficient. Amendment 13 would clarify the position. I think that the minister is sympathetic to that aspect of the matter and I ask him to accept that the Scottish health council should be covered in the bill. It is vital that we give the public confidence that independent bodies are there for them and that they can turn to such bodies to investigate any failure in the system. NHS QIS measures quality standards in health service performance on a technical basis; it does not consider that aspect.

Dennis Canavan (Falkirk West) (Ind): I have some sympathy for the member’s position, but amendment 13 states:

“The general duties of the Scottish Health Council shall be to … co-ordinate the work of the local health councils on a national basis”.

However, local health councils will be dissolved under section 6. I do not see the point of coordinating the work of bodies that will be dissolved.

Mr Davidson: The minister seeks to set up local advisory councils. The local health councils want those to come together in a national body that would support and help them. If the bill is passed, local advisory councils will replace local health councils, as the discussions in the Health Committee acknowledged.

I am sympathetic to Shona Robison’s amendment 14 and I will listen carefully to what she says. If amendment 13 is not agreed to, we might support amendment 14.

I move amendment 13.

The Deputy Presiding Officer: I call Christine Grahame, to be followed by Carolyn Leckie.

Christine Grahame: I support amendment 13—

The Deputy Presiding Officer: I beg your pardon. I made an error; I should have first called Shona Robison to speak to the amendments in her name.

Shona Robison: I seek the retention of local health councils, but that does not mean that I do not recognise the importance of the new national body, the Scottish health council. The two are not mutually exclusive—they have distinct roles. I will say a bit about the independence of the Scottish health council in a minute.

Throughout the passage of the bill, I have expressed concern about the dissolution of local health councils and the loss of their important role, particularly their advocacy work. The councils help some of our most vulnerable people to complain or to find their way round the health service. People have given years of service to their local health council, but the local expertise that has been built up is, unfortunately, in danger of being lost. I have spoken to a number of people who have been involved in local health councils, and they are disappointed and feel that they have been cast aside because their services are no longer required. Although the intention is to try to involve some of those people in the new local advisory councils, those councils will not have the same role, and so a number of people will choose not to be involved.

As I have said throughout the process, I cannot understand why the establishment of the Scottish
health council should lead directly to the dissolution of local health councils. It is unfortunate that the Executive has linked those two measures. The Scottish health council and local health councils would have distinct roles. I urge members not to throw the baby out with the bath water and to retain the role of local health councils.

I share David Davidson’s concerns about the independence of the new Scottish health council. It would be unfortunate if the message that the public received was that the council was not fully independent or able fully to protect their interests. It is difficult to argue that the council will be independent when it is to be located within NHS Quality Improvement Scotland, which is an NHS body. There are arguments for establishing a different structure to guarantee the new council’s independence. I am happy to support David Davidson’s amendment 13 to achieve that end.

The Deputy Presiding Officer: Since I started Christine Grahame, I will allow her to finish.

Christine Grahame: My colleague has addressed David Davidson’s amendment 13. It is important that the new Scottish health council is put on a statutory basis for the reasons that David Davidson expressed. In evidence to the Health Committee, a recurring theme was the strongly expressed concerns about the independence of such an organisation. The Executive appears to be going for a symbiotic relationship with NHS QI/S, but the evidence to the committee shows that there is a strongly perceived conflict of interest, if not an actual one, in relation to the proposal.

Dennis Canavan is right. Mr Davidson’s amendment 13 states:

“The general duties of the Scottish Health Council shall be to … co-ordinate the work of the local health councils on a national basis.”

Mr Davidson is trapped by his amendment: he has no option but to support Ms Robison’s amendment 14.

Carolyn Leckie: I concur with that point and I hope that Mr Davidson will support amendment 14.

I want to place the debate in context. I hoped that the Executive would listen to the views of organisations such as the Transport and General Workers Union, Unison and the Royal College of Nursing on the proposed abolition of local health councils, which is a serious assault on the independence of the system. A non-statutory body that is located within NHS QI/S will be nowhere near a replacement for the rigorous work of local health councils, whose work could be improved further, because there is always room for improvement.

I support David Davidson’s amendment 13, which would create a national body to oversee the work of the local health councils—I presume that he supports amendment 14. Amendment 13 would not introduce enough democracy, but it is better than nothing. To give a wee bit of political history, in England, proposals that were similar to the Executive’s were at first removed because of opposition by the Tories, Labour back benchers and the Liberal Democrats, but Tony Blair, in his no-reverse-gear mode, insisted on reintroducing them. I hoped that that attitude would not be reflected in the Executive’s bill, but unfortunately it is. However, it is never too late—we should stick up for health councils today.

I seek clarification on the policy and intentions of the Lib Dems. When Nora Radcliffe was the health spokesperson for the Lib Dems, she had a members’ business debate on 4 October 2000 to celebrate the success of local health councils. I understand that it is published Liberal Democrat policy to support health councils and to oppose their abolition. Perhaps the Lib Dems will let us know what they are doing. We have an opportunity to reach a consensus through which we could retain health councils and introduce an independent national health council.

Mike Rumbles: I am delighted to respond to Carolyn Leckie. I cannot help thinking that if the Executive had proposed another quango, Carolyn Leckie, Shona Robison and David Davidson would have argued how terrible that was. As the Health Committee realised, a number of different options could have been chosen.

What has been missing from the debate so far is a focus on the bill, rather than the amendments. The problem is solved in section 5, which for the first time will introduce in legislation a duty to encourage public involvement. Section 5 states:

“It is the duty of every body to which this section applies” to consult the public, not only on “planning and development” but, importantly, on “decisions to be made”. As the Health Committee knows, people throughout Scotland are dissatisfied with the public involvement and consultation processes of the 15 health boards in Scotland. I am pleased that the Executive is taking action through the bill to ensure that we have real consultations, not consultations after decisions have been made. The bill turns round the situation by talking about “decisions to be made”.

Shona Robison: We all agree about the importance of public involvement, but we are talking about the abolition of local health councils and the independence of the new Scottish health council. As Carolyn Leckie said, the previous incumbent of Mike Rumbles’s post as health spokesperson had strong views on the retention of
local health councils. What is his view on their abolition?

**Mike Rumbles:** Thank you very much for that. I am trying to put across the point that the National Health Service Reform (Scotland) Bill will radically change public involvement in the health service in Scotland. I hope that SNP members will support the bill at decision time. They would be mad not to accept that the Labour Party and the Liberal Democrats are radically changing the situation, which has moved on in the past four years.

The key issue is the duty to involve the public. As the Liberal Democrat spokesperson on health and community care, I am satisfied that we have the right approach and that the bill will introduce significant changes in public involvement. Therefore I am relatively relaxed about not creating another so-called independent, non-accountable body, which is what David Davidson would like. It is not at all necessary. The whole raison d'être has changed, so placing the Scottish health council within NHS QIS is perfectly acceptable.

11:00

**Dr Turner:** The beauty of debate is that one is able to change one’s mind. Bills go through fairly quickly; as a new member of Parliament, I have found that the process can be difficult, because there is so much to take on board and one changes one’s mind many times. I have always felt that it would be a great pity to dissolve the local health councils. Many changes happen in the health service and the most disadvantaged are always penalised. It would have been a great idea to leave the Scottish health council in the bill. In committee, I was persuaded in the end by the minister’s assurance that the intention was that the Scottish health council would be independent, under the NHS QIS banner. On reflection, and on reading what has been said in the past, I think that such an important body should have been included in the bill. I go along with everything that has been said.

Mr Davidson said something that made me stop and think. If the Scottish health council comes under NHS QIS but is not included in the bill, it will be subject to regulations. If everybody’s intentions are honourable at present, everything will go well. However, if people change, regulations could change, and the whole idea, as it is set up at the moment, might change. Since I am independent, I will vote for amendments 13 and 14. I would have loved it if the Scottish health council had been included in the bill. Throughout the evidence, people’s fear that the Scottish health council would not be independent was a constant theme. In the light of the public’s mistrust of health boards and the Government, it was a mistake not to put the Scottish health council in the bill.

**Malcolm Chisholm:** I will explain why amendment 13 and amendments 14 to 20 should be rejected, just as they were rejected by the Health Committee. Amendment 13 seeks to establish the Scottish health council as a separate, independent body—or, should I say, a supposedly independent body; as Dennis Canavan rightly pointed out, the amendment would ensure that a Scottish health council would be composed of local health council representatives. The key point is that local health councils are appointed by local health boards. David Davidson, Shona Robison and Carolyn Leckie should all remember that point when they applaud the independence of local health councils.

The Executive has proposed that the Scottish health council should be established as a body with its own distinct role and status within NHS Quality Improvement Scotland. That is because the Executive regards patient focus and public involvement as an essential part of securing quality in the NHS. As I say repeatedly, the experience of every patient is the starting point for improving quality in health. In the Executive’s view, improving quality should be about developing services that are more focused on patient experience and meeting what patients want through service redesign, managed clinical networks and other initiatives. The review and monitoring functions of NHS QIS will be strengthened by that body being able to draw directly on the expertise and patient networks of the Scottish health council. NHS QIS is at the heart of improving quality in the NHS. It operates separately from ministers and other boards. I am sure that anyone who knows the chair, Naren Patel, will understand what I mean when I say that.

I have written to the Health Committee setting out the Executive’s proposals for ensuring the independence of the Scottish health council within NHS QIS, and I reiterate those proposals now. The council will be created through regulations as a committee of the board of NHS QIS. The chair will be appointed through the public appointments process. Members will be appointed through an open process by NHS QIS, and up to three members will be appointed from the local advisory councils to ensure strong local links.

Establishment of the Scottish health council through regulations will mean that there is parliamentary involvement in the process. The Scottish health council cannot be created by primary legislation, because NHS QIS was not created by primary legislation. Establishment through regulations will also mean that there will be a clear, legislative basis for the Scottish health council’s work. It will ensure that the council’s continuing existence is not just a matter for ministers and the Health Department, and that the
council cannot be changed or abolished without parliamentary approval. The council’s local advisory structure will mean that it is not a remote or centralising body. By creating a Scottish health council, we will be able to bring more professionalism and expertise to patient focus and public involvement in Scotland. At the same time, the existence of the local advisory councils will mean that there is local input from patients and the public, thus ensuring that the health boards communicate with and listen to patients and local people.

On community health partnerships, there will be the new public partnership forums, which will be important in ensuring that there is strong communication and engagement with the public and, crucially, feedback on key issues and policies.

**Christine Grahame:** The minister said that the Scottish health council could not be included in primary legislation because NHS QIS is not included in primary legislation. I do not understand the rationale for that, because amendment 13 makes no reference to NHS QIS. With respect, the argument is not logical.

**Malcolm Chisholm:** Christine Grahame may not agree with the argument, but the Scottish health council will be set up as a part of NHS QIS and it is not possible to have a part of a body in primary legislation when the body itself is not in primary legislation.

**Shona Robison’s amendments 14 to 20,** which are almost identical to those that the Health Committee rejected at stage 2, seek to preserve the status quo. A lot of good work has come out of local health councils—I pay tribute to all the people who have been involved in that—but everybody accepts that that work has been uneven. It is time to build on that good work and to move on. Preserving the status quo would be inadequate for the better public involvement that we want. Mike Rumbles got straight to the heart of the debate when he said that the new structure is all about ensuring better public involvement and better patient focus.

The bill’s provisions for a new duty of public involvement and for dissolving local health councils are designed to support and underpin patient focus and public involvement. The Executive wishes to put greater responsibility on NHS boards to communicate with and involve patients and the public, and to encourage patients and community and voluntary organisations to represent their views directly to boards, rather than to have local health councils substituting, as it were, for the public and for those groups. I want to involve the public directly in the planning and design of health services, and not to have their views filtered through an outside body. The Scottish health council will monitor and quality assure that process, and that will do more to help to achieve a more responsive and patient-focused NHS than would be the case if we kept the current system.

I know of the dissatisfaction among members about the way in which public involvement has been facilitated in the past. The Scottish health council’s new role will be crucial to guaranteeing better public involvement. For example, all the service change proposals that come to me for approval at present, partly on the ground that there has been good public involvement, will all be considered by the Scottish health council. The council will report on that, and it will give annual reports on the extent to which boards are improving their work on public involvement. That is crucial to an objective that all members share.

From listening to Shona Robison today, and at stage 2, I know that she wants to maintain local health councils’ discrete role in relation to advocacy. The Executive sees local advisory councils as having an important role in ensuring that health boards hear, understand and act upon the views, concerns and experiences of patients, carers, patients, organisations and communities. That is a wider role than advocacy in the traditional sense, which is about supporting individuals and helping them to speak for themselves in their relationship with health services. When a local advisory council feels that the patient’s viewpoint is not being adequately considered, or when there is not an appropriate patient support group, the local advisory councils will be able to put forward the views of patients and ensure that appropriate action is taken. I made that point at stage 2, and I have written directly to Greater Glasgow Health Council on the matter.

We want to encourage health boards to engage much more directly with patients and with local opinion; at the same time, we will ensure that strong feedback arrangements are in place where the patient’s voice, for whatever reason, is not being properly expressed or heard.

We are not disregarding existing interests and expertise. Those people who are currently on local health councils will have an opportunity to be represented on the local advisory councils. They will be the local presence of the Scottish health council; in many cases, those who are currently on local health councils will be the ideal people to fulfil that role and I hope that many of them will choose to do so. They have played a valuable role so far, and they can do more in their new roles in the future. That would have far more value than staying where we are. Accordingly, I encourage members to follow the example of the Health
Committee and reject the amendments in this group.

Mr Davidson: In fact, it was the whipped ranks of the partnership parties in the Health Committee that voted down my amendment at stage 2, not the committee at large—although we have to accept the numbers game.

Mike Rumbles: Will the member take an intervention?

Mr Davidson: No, not at this time. I will come to Mr Rumbles eventually.

This has been an interesting debate, but I do not think that the minister has grasped the significance of my amendment 13. I do not think that he understands the public’s worry about the matter or the perception about having a health council that is not regulated, other than through ministers’ directions. That is an example of the minister’s desire to control all aspects of health in Scotland from his desk. The public are getting very concerned about that centralising approach.

I appreciate the support that I have had on this matter from the other side of the chamber, particularly the points that were made by Shona Robison and Carolyn Leckie. It is important to have a statutory body that can be clearly identified by all members of Scottish society and which acts not just at the behest of the minister, but in a clear, independent manner.

I thought that I heard Mr Rumbles talking about public involvement, and I think that the minister got round to speaking about that, too. What is wrong with public involvement? This is about how we deliver our public services, for goodness’ sake. If the public do not have a right to say something, what rights do they have left? If NHS QIS is not enshrined in primary legislation, that is a fact of life. That is why we need to include the Scottish health council in primary legislation, as a distinctly separate, independent body, which is perceived to be independent and to act in the best interests of the patients. That is what the health service is there to do.

Once again, we have seen a Liberal Democrat squirm out of policy commitments from the past, just because there has been a new agreement. I find that very strange, and I think that the Liberal Democrats should be more honest about that.

Mike Rumbles: Will the member take an intervention?

Mr Davidson: In a moment.

Mike Rumbles: He will not do so, will he?

Mr Davidson: I am just trying to warm him up, Presiding Officer.

I refer to some of Jean Turner’s comments. As a former practising medic in the community, she understands very well the public perception of the situation. Her route to Parliament demonstrated the public’s desire for input.

In the interests of democracy, I will allow Mr Rumbles to intervene.

Mike Rumbles: I would have preferred it if the intervention had come from Nora Radcliffe, because she could have put Mr Davidson right on some facts. My point is that our policy has not veered one iota in four years. Is it not rather odd to suggest that committee members from an Executive party should be willing to vote against a policy that they are advocating?

Mr Davidson: That says it all, really.

I beg the minister to reconsider the Executive’s position on this matter. The proposal in amendment 13 would be an important step forward. If the minister believes in democratic input, as I think he does, deep down, he should get away from wanting to do everything by regulation. He should have some courage and include the new body, the Scottish health council, in the bill, so that it can actively work for patient care throughout Scotland and build on the good work that has been done. Everybody who is involved seeks a properly resourced national body that is independent enough to work where it wishes in the NHS.

11:15

The Deputy Presiding Officer: The question is, that amendment 13 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Aitken, Bill (Glasgow) (Con)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Curran, Frances (West of Scotland) (SSP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fox, Colin (Lothians) (SSP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Grahaume, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Martin, Campbell (West of Scotland) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, John (Ayr) (Con)
Sheridan, Tommy (Glasgow) (SSP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

AGAINST
Alexander, Ms Wendy (Paisley North) (Lab)
Baillie, Jackie (Dumfarton) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Maryhill) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gillan, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, Mr John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Lyne, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peatlie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddael, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, lain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

The Deputy Presiding Officer: The result of the division is: For 48, Against 61, Abstentions 0.

Amendment 13 disagreed to.

Section 6—Dissolution of local health councils

Amendment 14 moved—[Shona Robison].

The Deputy Presiding Officer: The question is, that amendment 14 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Aitken, Bill (Glasgow) (Con)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Curran, Frances (West of Scotland) (SSP)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Alex (Galloway and Upper Nithsdale) (Con)
Fox, Colin (Lothians) (SSP)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Johnstone, Alex (North East Scotland) (Con)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Martin, Campbell (West of Scotland) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewar (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scanlon, Mary (Highlands and Islands) (Con)
...
The result of the division is: For 43, Against 61, Abstentions 0.

Amendment 14 disagreed to.

Schedule 1

MINOR AND CONSEQUENTIAL AMENDMENTS

Amendment 4 is a minor amendment to schedule 1. It removes the existing requirement under the National Health Service (Scotland) Act 1978 that the formal names of health boards should contain the words "Health Board". Under the 1978 act, ministers have a power to name health boards and special health boards by order but, by stipulating that the words "Health Board" appear in all health boards' formal titles, the act limits ministers' discretion on names. The order that names the various health boards does so according to their geographical location, followed by the words "Health Board"; for example, we have Grampian Health Board and Lothian Health Board. Since 1999, the NHS brand has been developed across the health service in Scotland. Following representations from health boards, I agree that their official names should reflect their names under the NHS brand and their responsibilities for delivering the full range of NHS services, following the dissolution of the trusts. Amendment 4 allows for the updating of health boards' names to reflect that branding, as has already been done for the special health boards with national coverage. The obligation to use the formulation “Health Board” will be removed. Members will know from their own areas that boards might already be using their new names; for example, NHS Highland and NHS Lothian are doing so. We want to make that possible as far as the legal use of such titles is concerned. I hope that members will support the proposal.

I move amendment 4.

Amendment 4 agreed to.

Schedule 2

REPEALS

Amendments 15 to 20 not moved.

Amendment 5 moved—[Malcolm Chisholm]—and agreed to.
National Health Service Reform (Scotland) Bill

The Deputy Presiding Officer (Trish Godman): The next item of business is a debate on motion S2M-1095, in the name of Malcolm Chisholm, that the National Health Service Reform (Scotland) Bill be passed, and one amendment to that motion.

11:20

The Minister for Health and Community Care (Malcolm Chisholm): The passage through Parliament of the National Health Service Reform (Scotland) Bill has been assisted by a great many people and I would like to thank those who have been involved in its progress. That includes the broad range of groups that have taken the time to give evidence to the committees and have represented the views of the national health service, staff, local authorities and the public. I am grateful to the members of the Health Committee, the Finance Committee and the Subordinate Legislation Committee who have debated and scrutinised the bill. Finally, I thank the clerks of those committees and my officials.

The National Health Service Reform (Scotland) Bill contains an important series of measures that will accelerate the development of NHS Scotland into a modern service that responds to and involves patients, that cares for its staff, is free to innovate and is not hindered by bureaucracy.

Having a patient-centred NHS means giving patients and the wider public a voice and an ability to express their views directly to the NHS rather than through a handful of individuals. That is why the bill will make it a legal requirement for health boards to take action to ensure that the public are directly involved in the planning and development of health services, as well as in significant decisions that affect those services. That is not a meaningless duty, but one that will be backed up by a robust public involvement structure that is able to act independently and ensure that health boards perform their duty of public involvement properly.

The key objectives of the bill are to make the planning and delivery of health care more responsive to the needs of local populations; to develop more services in primary care settings; and to break down the traditional barriers between social care, primary care and specialist health services. That is why we are establishing community health partnerships as a key part of our distinctive Scottish health reform agenda. Those partnerships will enable local health care professionals, local authorities, the voluntary sector and communities to work together to improve the health of their local area. They will deliver services to the community in the community where it is safe and sustainable to do so.

The NHS needs to respond to the needs of a diverse Scottish society. That is why the bill also places a duty on the NHS to encourage equal opportunities and I am pleased that the Parliament has agreed to extend that duty to all functions, not just those that are contained in the principal National Health Service (Scotland) Act 1978.

Staff are the core of the NHS and must be properly managed. The bill imposes a duty in relation to the governance of staff that will require boards to have in place arrangements for improving the management of staff and for workforce planning.

The bill will provide boards with the freedom to innovate through the duty to co-operate. While we will try to deliver as many services as close to the patient as possible, there are some services that can be delivered safely and sustainably only from highly skilled and specially resourced centres. I want boards to look beyond their boundaries more and to work together to ensure that there is greater and more effective regional planning.

The NHS needs to be able to operate free from unnecessary bureaucracy and barriers. That is why I have dissolved the trusts and will remove the power to create trusts. Primary and secondary care need to be more joined up and that is best achieved through single-system working. Single-system working will allow front-line staff to work together more effectively and, through the schemes of delegation, will empower staff to take decisions on the provision of health care.

When things go wrong, it is important to have effective means of intervening to correct service failure. The health service is a massive and diverse organisation. It would be impossible to prescribe every scenario in which an intervention might take place. However, it is important that intervention takes place only as a last resort and the measure that is contained in the bill will achieve that.

For too long, the NHS has been seen as a reactive health organisation that responds when people are suffering or injured. The NHS, with its partners, needs to be more proactive in promoting health and the new duty of health improvement will achieve that. It will also give boards the powers that they need to do that.

Tom McCabe will cover the details of Shona Robison’s amendment to the motion in his speech and, while I look forward to hearing what Shona will say, I fear that I have heard it all before. The NHS is receiving unprecedented levels of funding and the costs of the bill can and will be absorbed
by that. It is certainly not right that more of the finite resources that are available should be spent on administrative costs rather than front-line services. The costs associated with the bill are not significant. The bill is about reforming and redesigning existing methods and practice to make them more appropriate for the national health service of the new century.

I am pleased that the Parliament supported the general principles of the bill at stage 1. The bill was improved at stage 2 to include some important new features and I hope that the Scottish Parliament will now approve the bill, which will allow the NHS to develop and continue to be a source of national pride.

I move,

That the Parliament agrees that the National Health Service Reform (Scotland) Bill be passed.

11:26

Shona Robison (Dundee East) (SNP): I thank all those who gave evidence during the passage of the bill. I also thank the Health Committee clerks, who did a great deal of work in getting us to the stage 3 debate.

I welcome the main thrust of the bill. As I have said throughout the process, the Scottish National Party has been keen for a long time to abolish trusts, because we want to remove the artificial barriers that exist between primary and secondary care and which have hindered the delivery of an integrated system of health care across Scotland, and because we want to simplify the system and get rid of the bureaucracy in the NHS that has been a major barrier to change and progress.

However, structural changes alone will not be enough. As I said when I spoke about my amendment 12, on direct elections, we have not seen enough of the real reform that is needed if the public are to be empowered. However, that will have to wait for another day. We need to address the fundamental issues in the NHS, such as capacity and financing, which I will deal with later.

As the minister said, the bill has many positive aspects, such as regional working and community health partnerships, which must be dynamic organisations responding to local needs. I do not believe that they represent in any way a cheap option, as was suggested by some during the evidence-taking sessions. I agree with the NHS Confederation in Scotland, which said:

The creation of new bodies almost inevitably has additional costs attached ..., and Ministers should be aware of this.

Public involvement is another important element of the bill and we all support the idea. However, as I have said, we need to have real public involvement through direct elections. As the NHS Confederation in Scotland said,

continuous public involvement is not cheap, as NHS organisations have found through experience.

We have had a debate around the independence of the Scottish health council and the abolition of local health councils. My concern about those two aspects remains and, although I will support the motion, I want that concern to be on the record.

On finance, I was interested to hear the minister say that he has heard it all before. I think that he is going to hear even more about the issue. I am sure that he is aware that, according to senior civil servants, three health boards are in dire financial straits at the moment and seven others could go either way. The minister will hear a lot more about the financial problems that are facing health boards. Legislators have a responsibility not to make the situation even worse by passing legislation without ensuring that the resources will follow.

Health boards will have to find the money from somewhere to fund the public involvement elements of the bill—such as community health partnerships—the powers of intervention, the duty of co-operation and the duty to promote health. I do not believe that there will be no overall additional expenditure as a result of those provisions, and I do not think that many health boards will believe it. The money will have to come from somewhere, but from where? Given that all the new responsibilities will have to be funded, the money will inevitably have to come from services and patient care. Surely we all want to avoid that situation.

The purpose of my amendment is to say that we remain concerned that the financial provisions in the bill are inadequate; I hope that members who share those concerns will support the amendment.

I move amendment S2M-1095.1, to insert at end:

“but, in so doing, remains concerned about the lack of detail in the Financial Memorandum regarding potential additional costs arising from the Bill.”

11:31

Mr David Davidson (North East Scotland) (Con): I join Shona Robison in thanking the clerks and those who gave evidence to the Health Committee; we were well supported during the scrutiny of the bill.

I am, once again, afraid that we have come back to a situation in which the minister runs everything from his desk and all is controlled from the centre. Today, he has—[Interruption;] I heard that. For the record, Tom McCabe said, “If only.” That is the
ideology of the ministerial team and probably of the Executive and those in the chamber who support it.

I regret the passing of the trusts, because they were a change in bringing forward health care in Scotland. Obviously, they were due for review but, as I have said before, I would have got rid of the health boards, if anything. In fact, many health board chiefs are beginning to think that there will be rapid moves either to amalgamate boards or to examine the roll-out of the managed clinical networks, which are strategic bodies that examine health care in the wider regional aspect, so I suspect that the changes that are made by ministers will not end here.

I do not, from what the minister has said, understand why the opportunity that exists in other parts of the country to use foundation trusts—such trusts are mutual bodies, so they do not represent privatisation—is to be denied in Scotland, where hospitals want to work in that way. I always thought that the minister was keen on public-private partnerships, but that gets spun into the idea that the only good job is a job that is done in the public sector. That is a load of nonsense—the health service was founded on a public-private partnership and many of the professionals who operate in our health service come from the private or voluntary sectors.

Shona Robison mentioned funding, and the minister said that an increasing amount of money is pouring into the health service, but we are not getting an increasing amount of outcomes from all that money. Since the Scottish Executive came to power, the growth in the number of administrative staff has far exceeded the increase in staff who deliver care in the health service. People might be fed up with my talking about the patient journey, but the patient should be the centre of the health service. The patient is what the service is all about, and we should facilitate patients receiving good care at the right time. That should be based not on a general practitioner saying, "This is my patient," as the minister thinks, but on a clinical need. People will have to be consulted not on a general practitioner saying, "This is my patient," but on a clinical need.

In a situation in which there are so many points of failure, we must allow the patient to move and we must ensure that health boards that are in trouble do not have to fund care for other health boards without additional funding being offered. That is the basis of the comments that I made earlier today.

There are aspects of the bill that will lead to improvement. There are many good things about the community health partnerships and I welcome the fact that the voluntary sector—which provides an enormous amount of unpaid support in health care in Scotland—will be represented on them. However, it is also important to ask when we are going to deal with local authorities and health boards working together on patient care, where they have shared responsibility. I still do not understand why the minister refuses to move to a situation in which the budgets are simply brought together and the local authority staff who work on delivering medical care move to the health board. We would then have single patient assessment, a single budget and single management of every case. The twin-track approach is not working in some areas, and I know that one or two councils are looking to take the joint future agenda down the route that I mentioned. There was an opportunity to do that in the bill, but the minister failed to take it.

Once again, we reach the end of passage of a bill that is riven with Scottish socialist tendencies, although there have been flashes of understanding from the socialists in some respects. I say to the minister that I do not think he will survive the journey for long because, to be quite frank, the people of Scotland expect delivery of health care and not just another big bill.

11:35

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The bill will fundamentally reform the organisation and management of the NHS in Scotland. It will abolish the last traces of the Tories’ discredited internal market by dissolving the NHS trusts. The reforms will also devolve decision making and resources to front-line staff through the establishment of community health partnerships. The bill will also give ministers greater powers to intervene when the health service is deemed to be failing. The principle that prevention is better than cure is an obvious one, and the bill places a duty on health boards and ministers to promote health improvement, which is a long-standing Liberal Democrat commitment. Community health partnerships will delegate existing resources to the front line.

One of the biggest improvements that the bill will introduce is the duty to encourage public involvement; I am pleased that I managed to say something about that while the bill was being amended. The bill will make a remarkable difference in addressing the problems that people throughout Scotland face with so-called public consultation. People will have to be consulted not only on planning and development, but on decisions

“to be made”—

those three words are extremely important—

"by the body significantly affecting the operation, of those services".

That is a radical improvement, and I am pleased
that it will be enshrined in law, assuming that we pass the bill at decision time.

The Lib Dems will not support the SNP amendment, which says that we should be "concerned about the lack of detail in the Financial Memorandum regarding potential additional costs arising from the Bill."

As Shona Robison will recall, evidence was given on the issue by one of the smallest health boards in Scotland and it told us about what it had saved by streamlining its organisation. Throughout Scotland, that saving should run into millions, so I will not support Shona Robison's amendment.

I turn to the Conservatives' contribution to the debate. People are often turned off politics, and they say—mistakenly, of course—"You lot are all the same." I take this opportunity to thank the Conservatives publicly for tackling that issue as far as health is concerned, because they are indeed being different. They are championing the cause of the private patient at the expense of our national health service. In Parliament, there are real differences between what the Executive parties offer and the ideological approach that is taken by the Conservatives. We are in favour of reforming and improving the national health service in Scotland but—it seems to me—the Conservatives are interested in undermining it in favour of private practice.

Mr Davidson: Mike Rumbles is missing this point: if there is health service failure, does not the patient have the right to go elsewhere? We should make the health service as efficient and as well managed as possible. We are not in favour of privatising the health service. We need to give to choice to the patient, and if care can be delivered by other sources, why should it be denied them?

The Deputy Presiding Officer: Mr Rumbles, you must wind up now.

Mike Rumbles: I want to respond to David Davidson. He is quite right to say that patients have rights when the service fails, and that is why the power of ministerial intervention is included in the bill. However, the problem will not be solved by his proposal to undermine the national health service by taking public money away from the public health service and giving it to a private health service. We must have a thriving public health service—in which that money makes a difference—and a separate private health service. We cannot subsidise one at the expense of the other. I obviously have to end at that point.

11:40

Janis Hughes (Glasgow Ruchetglen) (Lab): I thank the clerks and other Parliament staff who have helped in the process of bringing the bill to this stage and I thank those who gave evidence as part of that process.

The National Health Service Reform (Scotland) Bill contains much that is to be welcomed, so I am pleased to be able to support it. One of the main principles that underpins the bill is the removal of unnecessary barriers and bureaucracy from the national health service. The bill will devolve more power so that services can be delivered in communities. The NHS should not be a one-size-fits-all service.

The bill will facilitate much more local decision making. In part, that will be achieved by the creation of community health partnerships. CHPs—which will replace the current local health care co-operatives—will require the establishment of joint working with local authorities and other partnership agencies as part of the community planning process. They will have budgetary control and dedicated staff to allow the development of services that best meet local needs in communities and that can be integrated with social care and other local services.

Another important aspect of the bill concerns public involvement in decisions that affect service development and delivery. We have already heard much about public involvement today. In recent years there have throughout Scotland been major changes in the way health care is delivered. For many reasons—too many to go into today—change is necessary, but it is often not without pain, and consultation methods have varied greatly among health boards. Although the Executive has produced guidelines in the form of policy documents, those have not always led to meaningful consultation. The bill will enshrine the need to secure the public's involvement in the planning and development of their health services.

In addition, the bill will place a duty on health boards to co-operate with other health boards and other agencies in planning and providing services. In recent months, there has been much criticism of the lack of regional planning of services. Health boards have taken in isolation decisions that have had effects on neighbouring boards. Although I welcome the measures in the bill, I would like further guidance from the Executive on the consultation process. I hope that the minister can give some assurances on that when he sums up.

One aspect of the bill that I welcome particularly is the promotion of health improvement. As I have said before in the chamber, health improvement has for too long been the Cinderella of the health service. Often, it is the first area to be targeted when money is short. The bill will impose a duty on ministers and health boards to promote improvement of the physical and mental health of the Scottish public. I very much welcome that and I hope that we will in the near future see more
details on how that will be done, especially on how boards will work with key partners, such as those in the voluntary sector.

During the Health Committee’s evidence-taking meetings on the bill, the British Medical Association, the Royal College of Nursing, Ayrshire and Arran Primary Care NHS Trust and others highlighted the fact that staff governance had been omitted from the bill. The Health Committee raised that issue with the minister at stage 1. I am pleased that the minister took our comments on board and that the duty for staff governance will, after today, be enshrined in legislation.

In conclusion, the bill contains much that is to be welcomed. It brings together a number of recent health care policy developments, such as the joint future agenda, “Designed to Care” and “Partnership for Care”. It also addresses a number of concerns that we have had about issues such as consultation and regional planning. I believe that the bill will do much to improve our health service and I will be pleased to support it today.

11:44

Christine Grahame (South of Scotland) (SNP): In the interests of brevity, I will speak only in support of the SNP amendment.

As my colleague Shona Robison pointed out, the budgets of three health boards are currently in extremis and the budgets of another seven are on the cusp of being so. From the evidence that the Health Committee received on the budget, we are aware that the increase in expenditure for Greater Glasgow NHS Board will cover only inflation, the increased staffing costs arising from the new contracts and the costs of complying with European directives. Therefore, any clinical initiatives that the minister wishes to prioritise will require cuts in other clinical services. Another example of such a situation is provided by Argyll and Clyde NHS Board. The Auditor General’s report states:

“The auditor considers that NHS Argyll and Clyde’s cumulative deficit could reach £60-70 million by 2007/08 and may be irrecoverable.”

That is the background against which the Scottish National Party challenges the assertions in the financial memorandum to the bill. Our position is corroborated and supported by the Finance Committee’s report. The financial memorandum pretty much states that the major changes—which we support—to the structure of the NHS will be cost neutral. Paragraph 41 of the financial memorandum states:

“The Executive is of the view that there will be no impact on other aspects of public expenditure, including local authorities, or on the costs of the voluntary or private sectors or individuals, as a result of the provisions in the Bill.”

Perhaps the minister should address that point when he sums up.

My comments on the financial memorandum are based mainly on the Finance Committee’s report, which makes very interesting reading. The report from that secondary committee provided our committee with important and helpful support for our findings. Indeed, I associate myself with the remarks that the deputy convener and my other colleagues on the Health Committee have made about the evidence that was given by witnesses and about the hard work of the clerks.

Paragraph 13 of the Finance Committee’s report makes an important point:

“The Committee questioned whether the Scottish Executive could have provided a clearer financial assessment of the costs and savings associated with abolishing NHS Trusts, especially in the initial phases, rather than assuming that they would offset each other.”

At paragraph 17, the report states:

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

When members introduce members’ bills in the Parliament, they need to ensure that their financial memoranda are correct: it seems to me that there is one rule for members’ bills and another for Executive bills, because it is still not clear that those questions have been answered.

Paragraph 29 of the Finance Committee’s report deals with the costs of intervention. The minister said that he would address that issue perhaps by spreading the cost across health boards, but that still does not answer all the questions that the Finance Committee report asks. Paragraph 29 states:

“The Committee remains unconvinced that the estimated average cost”—

not liability—

“associated with the power on intervention is reasonable based on the evidence it received.”

The Health Committee also pointed out that no assessment has been made of the cost implications of the recommendations that a health board will have to implement following an intervention. Will those costs be paid by the health board in question or will they be spread throughout Scotland? What are the cost implications?

Finally, paragraph 43 of the Finance Committee report deals with public consultation, on which the minister has given us some undertakings. The report states:
“The Committee would recommend that the Health Committee further pursue whether the funding provided at present is adequate for carrying out public consultation as detailed in the Bill.”

The health boards that were mentioned are quite small health boards, but other health boards cover large areas and have major deficits. My party is not convinced that the bill is financially neutral.

11:48

Carolyn Leckie (Central Scotland) (SSP): The Executive is either burying its head in the sand or wilfully under-resourcing the NHS. To suggest that the bill has no financial implications and that NHS boards will be able to absorb the changes flies in the face of the evidence. That is why I will support the amendment in the name of Shona Robison.

Let me quote from a letter that was recently issued to a division of one NHS board. The letter ably demonstrates the sort of pressures that boards face and the drastic measures that they are considering in order to bring themselves into financial balance.

Under the heading “Benchmarking acute services and identifying potential to reduce capacity”, the letter suggests that the division will have to review its

“homeopathic service … All ‘standalone’ rehabilitation hospitals … Dermatology inpatient beds”

and

“Conversions to five day wards”.

It will also have to

“Reduce continuing care beds”

and

“Close beds to reflect reduced cross boundary flow”.

On prescribing, the letter states that the division will have to

“Restrict introduction of new drugs”

and implement an

“Aggressive cost reduction programme”.

On pay, it says that the division will have to

“Manage introduction of Agenda for Change within funding available”.

That means tinkering with the agenda for change, which was supposed to be an independent evaluation of people’s roles.

The recommendations go on. The division will have to

“Reduce agency cost …Identify potential for reduced and reshaped workforce”

—which means job losses—and

“Identify potential to reduce mental health beds”.

I could go on. The letter contains 14 separate recommendations for cuts and many of the recommendations are broken down into further subsections. That letter describes reality.

Although we will support the bill, we have serious reservations about the impact that it will have on costs to NHS boards and the ensuing impacts on services to patients. I remain concerned about a number of the details. The jury is still out and continuous scrutiny will be required.

I will not repeat all the points that were made earlier in relation to the amendments on health councils. There is a serious lack of democracy and accountability in the provision of health services, which the bill does not address in any way. The bill deals with delivery of health and social care, which was previously part of the joint future agenda, but it does not address unequal terms and conditions, roles, responsibilities and training. The question of accountability of staff—who their employer is and how their status is monitored—is also not addressed. There are difficult issues on the ground.

There will not be enough trade union and clinical input into the composition of community health partnerships and the BMA has told us that there will not be enough input from GPs, for example. However, there will be an increase in the participation and influence of private business. I have deep concerns about that.

The bill provided us with an opportunity to introduce national collective bargaining for NHS staff in Scotland. That opportunity has been missed, which is unfortunate.

I challenge the Executive to be realistic about, to justify and to indicate what it will do about the current financial situation. It should justify the introduction of legislation that will place a burden on NHS boards, which workers must deliver and boards must manage. Where will the funding come from? The reality is that services are being cut left, right and centre.

11:52

Mrs Nanette Milne (North East Scotland) (Con): The problem with the NHS in Scotland today is not funding, but that it is driven from the centre and has constantly to respond to centrally set priorities and targets, each of which puts more pressure on the system and results in more administrative costs, harassed staff and frustrated patients waiting to access the system.

The National Health Service Reform (Scotland) Bill was a golden opportunity to put things right—to turn the system around and truly to devolve decision making in the health service from politicians to professionals and patients. If there
were a focus on the needs of the patient and funding went with the patient, choice would open up for them and the service would soon respond. Sadly, that opportunity has been lost.

The removal of NHS trusts apparently involves the removal of a layer of bureaucracy, but we see it as a move away from the patient towards centralisation because—essentially—the trusts have been subsumed as operating divisions of health boards, which are one step further away from patients.

There is merit in much of the bill, but we still have many concerns about it. The development of managed clinical networks deriving from regional co-operation between health boards is a step in the right direction, but it falls far short of our proposals to allow patients the option of receiving their treatment from any NHS provider or from the voluntary, not-for-profit and independent sectors if they choose, based on a national tariff system that would define set costs for specific procedures, as explained by David Davidson.

I will respond to the criticisms of our policies. As I have said often in the chamber, I am and always have been a passionate believer in the NHS. My family has more reason than many to be grateful to it, following my son's successful liver transplant 12 years ago. However, as Jean Turner did, I point out that many private patients are only private patients because they cannot timeously get the treatment that they need from the public service. I know many elderly people who are by no means wealthy and who have given their life savings to procure the treatment that they need. There is no reason why those people, who have contributed to the NHS all their lives through taxation, should not take a part of the cost of their treatment with them, which would free up space in the service for those who are still waiting to gain access to it.

The development of local health care co-operatives into community health partnerships has merit and will give local stakeholders and front-line staff a role in decision making on the delivery of local health care services, which must be in the interests of the patient. However, there is still much work to be done on the statutory guidance for CHPs—on their remit, role, membership, number and cost. It is extremely important that the Health Committee has the opportunity prior to their introduction to scrutinise the guidance and regulations relating to the operation of CHPs.

The duty on health boards to ensure public involvement is a positive step but, as the BMA stated, if the proposed Scottish health council and CHPs together are to engage the public and encourage them to play a meaningful role in community planning, it is essential that that work receive appropriate funding. We still have doubts about whether the proposed Scottish health council can be truly independent as part of NHS Quality Improvement Scotland and we do not agree with the proposal.

We also have serious concerns about the cost of the provisions in the bill, particularly in relation to intervention, CHPs and the Scottish health council.

Christine Grahame: Will the member take an intervention?

The Deputy Presiding Officer: The member is winding up.

Mrs Milne: We question the Executive’s claim that the bill will be cost neutral. It is a particular concern that health boards could incur the costs of intervention at the very time when they are facing serious financial difficulties.

We see merit in some of the proposals in the bill but we have serious concerns about others. Above all, we see the bill as a missed opportunity for true reform of the NHS in Scotland—to put the patient and health professionals at the very core of the service. Sadly we cannot, therefore, give the bill our support.

11:56

The Deputy Minister for Health and Community Care (Mr Tom McCabe): This has been an important debate for the future of the NHS in Scotland. I express my thanks to those who have been involved in the passage of the bill.

The bill that we are being asked to pass today will update the principal act that governs the national health service—the National Health Service (Scotland) Act 1978. It will ensure that the right legislative framework is in place to enable the NHS to move forward, to modernise and to adapt to the needs of a 21st century health service.

However, the founding principles—that health services should be free to all at the point of delivery and that health professionals should be able to work together without barriers to deliver the best possible care—remain as valid today as they were in 1948. Those principles are widely shared by the people of Scotland and by many of the people who gave evidence on the bill.

It is disappointing, though not surprising, that the Conservatives have fundamentally misunderstood what the bill is about. The bill is about decentralising as much as possible down to front-line staff. It is remarkable that David Davidson and his colleagues harp on about centralisation when, week after week, they ask for specific funding for particular conditions or for their pet project of the month. Week after week, they ask for central direction from the Executive, but in this debate they have harped on about their claim that the bill is about centralisation. It is not. The bill is about
health boards becoming single bodies and about community health partnerships delivering services locally with local authorities and other partners and pursuing safe, sustainable services. It is about our being able to take action to ensure that local and regional services are provided to an adequate standard. That is the reform agenda that is right for Scotland and which will provide high-quality health services right across the country.

As members know only too well, the Government is injecting record amounts of money into the national health service, but the money pot is not bottomless. Tough choices need to be made, especially in relation to specialised services, and the public need to be meaningfully involved in those decisions. In some cases, the status quo is not an option if we are to continue to provide safe high-quality services. No one group can opt out of making choices—not the Executive, not health boards and not the public. The duty of public involvement is just that—a duty to involve the public in decisions. It is not a duty to avoid making decisions.

As the Health Committee recommended in its stage 1 report, safeguards will be put in place to ensure that the proposed Scottish health council and its local advisory councils are able to act at arm's length from the bodies that they monitor. That will be achieved through the regulations that will establish the health council—regulations that the Health Committee will be able to scrutinise.

The National Health Service Reform (Scotland) Bill will also address the balance in the NHS between health treatment and health improvement. That is important to our vision of what a health service should be—a service that actively promotes health improvement, rather than just a service to which people turn when their health is failing. A focus on health improvement will lead to a healthier population, which is better for the NHS and better for our country.

Finally, I want to address Shona Robison’s concerns about the financial memorandum that accompanied the bill. As Malcolm Chisholm said in the short debate on the financial resolution at stage 1, it is no surprise that the SNP’s only substantive contribution is—yet again—to call for more resources.

The bill that we pass today will lead to some additional costs. That has always been clear, but there will be additional savings which, together with the redistribution and better management of resources, will more than make up for the additional costs.

Mr McCabe: Okay.

I will give the example of the dissolution of trusts. We know that Dumfries and Galloway NHS Board saved £500,000 in one year after its move to single-system working and that Borders NHS Board saved a similar amount, albeit over a longer time. However, the move to single-system working is not about cutting costs; it is about improving health care for patients through greater cooperation and collaboration. If savings can be made, I expect them to be reinvested in the front line.

The new duty of health improvement is designed to make it easier for boards and ministers to spend existing money more effectively on promoting health improvement. We already spend large sums of money on promotion of health improvement. Examples include the extra £173 million that was announced in “Building a Better Scotland”, on top of the £134 million that is already being spent between 2003 and 2006.

As Malcolm Chisholm said in his opening speech, we have seen record levels of investment in the NHS in Scotland. Those resources can and must be used more effectively and that is what the bill is all about. I urge members to reject the SNP amendment.

Today, we are being asked to pass an important bill that will reform the NHS so that it continues to deliver quality health services to the people of Scotland. To do that we need to reduce bureaucracy, increase collaboration, delegate functions that can be delivered locally to community health partnerships, support staff and intervene effectively when necessary. The bill will achieve that and more. I strongly urge every member to support it.
Decision Time

17:01

The Presiding Officer (Mr George Reid):
There are nine questions to be put as a result of today’s business.

The first question is, that amendment S2M-1095.1, in the name of Shona Robison, which seeks to amend motion S2M-1095, in the name of Malcolm Chisholm, that the National Health Service Reform (Scotland) Bill be passed, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

FOR
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Byrne, Ms Rosemary (South of Scotland) (SSP)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
MacDonald, Margo (Lothians) (Ind)
Martin, Campbell (West of Scotland) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Sheridan, Tommy (Glasgow) (SSP)
Stevenson, Stewart (Banff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

AGAINST
Aitken, Bill (Glasgow) (Con)
Baillie, Jackie (Dumbarton) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
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**The Presiding Officer:** The result of the division is: For 37, Against 78, Abstentions 0.

**Amendment disagreed to.**

**The Presiding Officer:** The second question is, that motion S2M-1095, in the name of Malcolm Chisholm, that the National Health Service Reform (Scotland) Bill be passed, be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**For**
- Ballie, Jackie (Dumarton) (Lab)
- Baird, Shiona (North East Scotland) (Green)
- Ballance, Chris (South of Scotland) (Green)
- Ballard, Mark (Lothians) (Green)
- Barrie, Scott (Dunfermline West) (Lab)
- Boyack, Sarah (Edinburgh Central) (Lab)
- Brankin, Rhona (Midlothian) (Lab)
- Brown, Robert (Glasgow) (LD)
- Butler, Bill (Glasgow Anniesland) (Lab)
- Byrne, Ms Rosemary (South of Scotland) (SSP)
- Canavan, Dennis (Falkirk West) (Ind)
- Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
- Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
- Crawford, Bruce (Mid Scotland and Fife) (SNP)
- Cunningham, Roseanna (Perth) (SNP)
- Curran, Frances (West of Scotland) (SSP)
- Curran, Ms Margaret (Glasgow Baillieston) (Lab)
- Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
- Eadie, Helen (Dunfermline East) (Lab)
- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Ewing, Mrs Margaret (Moray) (SNP)
- Fabiani, Linda (Central Scotland) (SNP)
- Ferguson, Patricia (Glasgow Maryhill) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Fox, Colin (Lothians) (SSP)
- Gibson, Rob (Highlands and Islands) (SNP)
- Gillon, Karen (Clydesdale) (Lab)
- Glen, Marilyn (North East Scotland) (Lab)
- Godman, Trish (West Renfrewshire) (Lab)
- Gorrie, Donald (Central Scotland) (LD)
- Grahame, Christine (South of Scotland) (SNP)
- Harper, Robin (Lothians) (Green)
- Harvie, Patrick (Glasgow) (Green)
- Henry, Hugh (Paisley South) (Lab)
- Home Robertson, Mr John (East Lothian) (Lab)
- Hughes, Janis (Glasgow Rutherglen) (Lab)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Mr Adam (South of Scotland) (SNP)
- Jackson, Dr Sylvia (Stirling) (Lab)
- Jackson, Gordon (Glasgow Govan) (Lab)
- Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
- Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
- Kane, Rosie (Glasgow) (SSP)
- Kerr, Mr Andy (East Kilbride) (Lab)
- Lamont, Johann (Glasgow Pollok) (Lab)
- Leckie, Carolyn (Central Scotland) (SSP)
- Lochhead, Richard (North East Scotland) (SNP)
- Lyon, George (Argyll and Bute) (LD)
- MacAskill, Mr Kenny (Lothians) (SNP)
- MacDonald, Lewis (Aberdeen Central) (Lab)
- MacDonald, Margo (Lothians) (SNP)
- Maclean, Kate (Dundee West) (Lab)
- Macmillan, Maureen (Highlands and Islands) (Lab)
- Martin, Campbell (West of Scotland) (SNP)
That the Parliament agrees that the National Health Service Reform (Scotland) Bill be passed.

Martin, Paul (Glasgow Springburn) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Belshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
Morrison, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pingleton, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Raffan, Mr Keith (Mid Scotland and Fife) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Sheridan, Tommy (Glasgow) (SSP)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Stephen, Nicoll (Aberdeen South) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST
Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Scott, John (Ayr) (Con)
Tosh, Murray (West of Scotland) (Con)

ABSTENTIONS
Swinburne, John (Central Scotland) (SSCUP)

The Presiding Officer: The result of the division is: For 99, Against 16, Abstentions 1.

Motion agreed to.
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2 Community health partnerships
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2B Equal opportunities

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7 Duty to promote health improvement

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8 Ancillary provision
9 Modification of enactments
10 Commencement and short title

Schedule 1—Minor and consequential amendments
Schedule 2—Repeals
National Health Service Reform (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

PART 1

ORGANISATION AND OPERATION OF NATIONAL HEALTH SERVICE

Organisation

1 Dissolution of National Health Service trusts: modification of enactments

(1) In the National Health Service (Scotland) Act 1978 (c.29) (referred to in this Act as “the 1978 Act”), section 12A and Schedule 7A (establishment, functions, dissolution etc. of National Health Service trusts) are repealed.

(2) In section 82 of the 1978 Act, after subsection (2A) insert—

“(2B) All endowments and property held in trust transferred to a Health Board by an order under paragraph 26 of Schedule 7A (whenever made) are held by the Health Board free of any trust existing immediately before the transfer (hereafter in this section referred to in relation to any such endowment or property as “the original trust”); but all such endowments and property shall be held by the Health Board on trust for such purposes relating to services provided under this Act, or to the functions of the Board with respect to research, as the Board may think fit.”

(3) Until the coming into force of subsection (1) so far as repealing Schedule 7A to the 1978 Act, paragraph 26 of that Schedule has effect with the insertion after sub-paragraph (1) of the following sub-paragraph—

“(1A) For the avoidance of doubt, the reference to “property, rights and liabilities” in sub-paragraph (1) includes endowments and property held in trust.”

2 Community health partnerships

After section 4 of the 1978 Act insert—
“Community health partnerships

4A Community health partnerships

(1) Every Health Board shall establish, in accordance with a scheme under section 4B approved by the Scottish Ministers (an “approved scheme”)—

(a) a community health partnership for the area of the Board, or

(b) two or more community health partnerships for districts which, taken together, include the whole area of the Board.

(1A) Community health partnerships shall be established as committees or sub-committees of a Health Board.

(1B) Where the area or district of a community health partnership includes all or part of the areas of two or more Health Boards, the community health partnership (a “joint community health partnership”) shall be established jointly by those Boards in accordance with their approved schemes.

(1C) Joint community health partnerships shall be established as joint committees of the Health Boards by which they are established.

(2) The functions of a community health partnership are—

(a) to co-ordinate, for its area or district, the planning, development and provision of—

(i) such of the services which it is the function of its Health Board to provide, or secure the provision of, as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

(ii) such other of those services as its Health Board may specify, with a view to improving those services,

(b) to provide, or secure the provision of—

(i) such of the services which it is the function of its Health Board to provide, or secure the provision of, as may be prescribed by regulations under section 4B(5) or specified in the approved scheme, and

(ii) such other of those services as its Health Board may specify, and

(c) to exercise such other functions of its Health Board—

(i) as may be prescribed by regulations under section 4B(5),

(ii) as may be specified in the approved scheme,

(iii) as the Health Board may delegate to it.

(2A) In this section, references to the Health Board of a joint community health partnership are to each of the Health Boards by which it was established.

4B Community health partnerships: further provision

(1) Every Health Board shall, within such period as the Scottish Ministers may specify, prepare and submit to them a scheme for the establishment of one or more community health partnerships in pursuance of section 4A(1).

(1A) In preparing a scheme under subsection (1) or (4) a Health Board shall—
(a) have regard to—
   (i) any guidance issued under subsection (7),
   (ii) community planning under section 15(1) of the Local Government in Scotland Act 2003 (asp 1) so far as relating to the area of the Board,

(b) consult—
   (i) each local authority whose area includes all or part of the area or district of a community health partnership proposed by the scheme, and
   (ii) any other person whom the Health Board think fit, and

(c) encourage the involvement of local authorities and other persons consulted under paragraph (b) in the preparation of the scheme.

(3) The Scottish Ministers may—
   (a) approve (with or without modifications), or
   (b) refuse to approve,

   a scheme submitted to them under subsection (1) or (4) or in pursuance of subsection (3A).

(3A) Where the Scottish Ministers refuse to approve a scheme, they must return it to the Health Board and may direct the Board to resubmit the scheme with—

   (a) such modifications (if any) as the direction may specify, and
   (b) any further modifications which the Board consider appropriate,

   by such time as the direction may specify.

(4) A Health Board—

   (a) may, at any time,
   (b) if so directed by the Scottish Ministers, must, within such period as they may specify,

   submit to the Scottish Ministers a new scheme under this section.

(5) Regulations may make provision in relation to—

   (b) the membership of a community health partnership,
   (c) the form and content of, and the procedure in relation to, schemes under this section,
   (d) the functions of a community health partnership and the exercise of those functions,
   (da) the application in relation to joint community health partnerships, with such modifications as may be specified, of the provisions of this Act, and any provision made under this Act, so far as applying in relation to community health partnerships,
   (e) such other matters with respect to community health partnerships as the Scottish Ministers think fit.
(7) The Scottish Ministers may, after consulting such persons as they think fit, issue guidance about community health partnerships and shall publish such guidance.

(8) For the purposes of establishing a joint community health partnership in pursuance of section 4A(1B), any power to appoint committees conferred on Health Boards by virtue of this Act shall include power for two or more Health Boards jointly to appoint joint committees.

(9) Nothing in section 4A or this section affects the extent of any power under this Act so far as relating to committees or sub-committees of Health Boards.”

10  **2A Duty in relation to governance of staff**

After section 12H of the 1978 Act insert—

“12HA Duty in relation to governance of staff

It shall be the duty of every Health Board and Special Health Board and of the Agency to put and keep in place arrangements for the purposes of—

(a) improving the management of the officers employed by it;

(b) monitoring such management; and

(c) workforce planning.”

20  **2B Equal opportunities**

After section 2C of the 1978 Act insert—

“2D Equal opportunities

(1) Health Boards, Special Health Boards and the Agency must discharge their functions in a manner that encourages equal opportunities and in particular the observance of the equal opportunity requirements.

(2) In this section “equal opportunities” and “equal opportunity requirements” have the same meaning as in Section L2 (equal opportunities) of Part II of Schedule 5 to the Scotland Act 1998 (c.46).”

30  **3 Health Boards: duty of co-operation**

Before section 13 of the 1978 Act insert—

“12I Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency

(1) In exercising their functions in relation to the planning and provision of services which it is their function to provide, or secure the provision of, under or by virtue of this Act, Health Boards shall co-operate with one another, and with Special Health Boards and the Agency, with a view to securing and advancing the health of the people of Scotland.

(2) In pursuance of subsection (1) a Health Board may—
(a) undertake to provide, or secure the provision of, services as respects the area of another Health Board, and the other Health Board may enter into arrangements with the first Health Board for that purpose,

(b) undertake with one or more other Health Boards to provide, or secure the provision of, services jointly as respects their areas.

(2A) A Health Board undertaking to provide, or secure the provision of, services under subsection (2) may—

(a) enter into arrangements with another Health Board, a Special Health Board or the Agency in relation to the provision of such services,

(b) do anything in relation to the provision of such services which they could do for the purpose of providing, or securing the provision of, such services as respects their area.

(3) This section is without prejudice to any other power which a Health Board may have.”

Powers of intervention

4 Powers of intervention in case of service failure

After section 78 of the 1978 Act insert—

“78A Powers in case of service failure

(1) This section applies where—

(a) it is a function of a body or person under or by virtue of this Act to provide, or secure the provision of, a service, and

(b) the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail—

(i) to provide the service, or

(ii) to provide it to a standard which they regard as acceptable.

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

(a) a body falling within subsection (4), or

(b) one or more persons falling within subsection (5).

(3) In subsection (2), “specified” means specified in the direction.

(4) A body falls within this subsection if it is—

(a) a Health Board,

(b) a Special Health Board, or

(c) the Agency.

(5) A person falls within this subsection if the person is—

(a) an employee of a Health Board, a Special Health Board or the Agency,
(b) a member of the staff of the Scottish Administration, or
(c) an employee of a local authority.

(6) A body or person appointed by a direction given under subsection (2) to perform functions of a body or person referred to in subsection (1) is referred to in this section as an “appointed person”.

(7) An appointed person must comply with a direction given under subsection (2).

(8) The remuneration and expenses of, and any other costs reasonably incurred by, an appointed person in performing the functions specified in the direction shall, unless otherwise specified in the direction, be paid by the body or person referred to in subsection (1).

(9) Anything done or omitted by an appointed person in performing the functions specified in the direction is to be regarded as done or omitted by the body or person referred to in subsection (1).

(10) A person dealing with an appointed person in good faith and for value is not concerned to inquire whether the appointed person is acting within the powers conferred by virtue of the direction.

(11) The Scottish Ministers may vary or withdraw a direction given under subsection (2).

78B Relationship of sections 77, 78 and 78A

The powers conferred by each of sections 77, 78 and 78A are without prejudice to the powers conferred by the other two sections.”

Public involvement

After section 2A of the 1978 Act (inserted by section 7(2)) insert—

“2B Duty to encourage public involvement

(1) It is the duty of every body to which this section applies to take action with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are involved in, and consulted on—

(a) the planning and development, and

(b) decisions to be made by the body significantly affecting the operation, of those services.

(1A) This section applies to—

(a) Health Boards,

(b) Special Health Boards, and

(c) the Agency.

(2) For the purposes of subsection (1) a body is responsible for health services if they are health services—
Part 2—Promotion of health improvement

6 Dissolution of local health councils

(1) Local health councils established by virtue of section 7 of the 1978 Act are dissolved on such date as the Scottish Ministers may by order made by statutory instrument specify.

(2) A statutory instrument containing an order under subsection (1) is subject to annulment in pursuance of a resolution of the Scottish Parliament.

PART 2

PROMOTION OF HEALTH IMPROVEMENT

7 Duty to promote health improvement

(1) After section 1 of the 1978 Act insert—

"1A Duty of the Scottish Ministers to promote health improvement

(1) It is the duty of the Scottish Ministers to promote the improvement of the physical and mental health of the people of Scotland.

(2) The Scottish Ministers may do anything which they consider is likely to assist in discharging that duty including, in particular—

(a) giving financial assistance to any person,

(b) entering into arrangements or agreements with any person,

(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to section 1 and any other provision of this Act conferring or imposing functions on the Scottish Ministers."

(2) After section 2 of that Act insert—

"2A Duty of Health Board, Special Health Board and the Agency to promote health improvement

(1) It is the duty of every Health Board and Special Health Board and of the Agency to promote the improvement of the physical and mental health of the people of Scotland.

(2) A Health Board, a Special Health Board or the Agency may do anything which they consider is likely to assist in discharging that duty including, in particular—

(a) giving financial assistance to any person,

(b) entering into arrangements or agreements with any person,
(c) co-operating with, or facilitating or co-ordinating the activities of, any person.

(3) Subsections (1) and (2) are without prejudice to any other provision of this Act conferring or imposing functions on a Health Board, a Special Health Board or the Agency.

(4) Anything done by a Health Board or Special Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on—

(a) the Health Board by the order under section 2(1)(a) which constituted the Board, or

(b) the Special Health Board by the order under section 2(1)(b) which constituted the Board,

as the case may be.”

PART 3
SUPPLEMENTARY

8 Ancillary provision

(1) The Scottish Ministers may by order made by statutory instrument make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—

(a) make different provision for different purposes,

(b) modify any enactment, instrument or document.

(3) A statutory instrument containing an order under this section (except where subsection (4) applies) is subject to annulment in pursuance of a resolution of the Parliament.

(4) No order under this section containing provisions which add to, replace or omit any part of the text of an Act is to be made unless a draft of the statutory instrument containing the order has been laid before, and approved by resolution of, the Parliament.

9 Modification of enactments

(1) Schedule 1 contains minor amendments and amendments consequential on the provisions of this Act.

(2) The enactments specified in column 1 of schedule 2 are repealed to the extent specified in column 2.

10 Commencement and short title

(1) The provisions of this Act, except section 8 and this section, come into force on such day as the Scottish Ministers may by order made by statutory instrument appoint.

(2) Different days may be appointed under this section for different purposes.

(3) This Act may be cited as the National Health Service Reform (Scotland) Act 2004.
SCHEDULE 1
(introduced by section 9)

MINOR AND CONSEQUENTIAL AMENDMENTS

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

1 (1) The 1978 Act is amended as follows.

(1ZA) In section 2 (constitution of Health Boards and Special Health Boards)—
   (a) in subsection (1)(a), after “shall”, where it second occurs, insert “, without prejudiice to subsection (1B),”;
   (b) in subsection (1B), for “(1)(b)” substitute “(1)”.

(1A) In section 2C(4) (co-operation in discharging of functions to provide primary medical services), for “section” substitute “sections 12I and”.

(2) In section 12H(1) (duty of quality), for “, Special Health Board and NHS trust” substitute “and Special Health Board”.

(3) In section 75A (remission and repayment of charges andpayment of travelling expenses), in subsection (2), for “, (c) or (d)” substitute “or (c)”.

(3A) In section 79 (acquisition, use and disposal of land and moveable property), after subsection (2) insert—
   “(2A) For the avoidance of doubt, the power to use heritable property conferred by subsection (1), and the power to dispose of land conferred by subsection (1A), include power to let the property or, as the case may be, land.”

(4) In section 86 (accounts), in each of subsections (3) and (4), for “to (c)” substitute “and (b)”.

(5) In section 102 (State hospitals), in subsection (4)(b), for “, the Agency or an NHS trust” substitute “or the Agency” and for “, Agency or trust” substitute “or Agency”.

(6) In section 105 (orders, regulations and directions), in subsection (4)(b), for the words from “12A(1)” to the end substitute “or 70(2)”.

(7) In Schedule 1 (Health Boards), in paragraph 8A, for “, the Agency or an NHS trust” substitute “or the Agency”.

(8) In Schedule 5 (Common Services Agency), in paragraph 8A, for “, a Health Board or an NHS trust” substitute “or a Health Board”.

National Health Service (Private Finance) Act 1997 (c.56)

1A In section 1 (power of NHS trusts to enter into agreements) of the National Health Service (Private Finance) Act 1997 (c.56)—
   (a) in subsection (1), for “National Health Service trust” substitute “Health Board, a Special Health Board and the Common Services Agency for the Scottish Health Service (“the Agency”) to enter into contracts”,
   (b) in each of subsections (3)(a) and (5), for “trust” substitute “Board or, as the case may be, the Agency”,
   (c) in each of subsections (4) and (6), for “National Health Service trust” substitute “Health Board, a Special Health Board or the Agency”.

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Regulation of Care (Scotland) Act 2001 (asp 8)

1B In section 77(1) (interpretation) of the Regulation of Care (Scotland) Act 2001, for the definition of “health body” substitute—

““health body” means a Health Board or Special Health Board constituted by order under section 2 of the National Health Service (Scotland) Act 1978 (c.29);”

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

2 (1) The Public Appointments and Public Bodies etc. (Scotland) Act 2003 is amended as follows.

(2) In section 7 (investment and borrowing), in subsection (7), for “to (6)” substitute “or (4)”.

(3) In section 9 (directions in relation to endowments), for the words “, and paragraph 6(1) of Schedule 7A to, the 1978 Act (which confer” substitute “the 1978 Act (which confers”.

SCHEDULE 2
(introduced by section 9)

REPEALS

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<th>Enactment</th>
<th>Extent of repeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Service (Scotland) Act 1978 (c.29)</td>
<td>Section 7.</td>
</tr>
</tbody>
</table>
| In section 8(1), the words “and any NHS trusts in the area or combined areas” and “, any such NHS trust”.

In section 9, in subsection (5), the words “and, where the Secretary of State so directs, an NHS trust”; and in subsection (7), the words “or, where the Secretary of State so directs, NHS trusts”.

In section 10(4), the words “the NHS trusts”, “or of the NHS trusts” and “or NHS trusts”.

Sections 12AA to 12C.

Sections 12D to 12G.

In section 13, the words “NHS trusts,”.

Section 17A(2)(e).

In section 17D, subsection (1)(a); and in subsection (2), paragraph (a) of the definition of “NHS employee”.

In section 27(1)(b), the words “or by an NHS trust”.

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<table>
<thead>
<tr>
<th>Enactment</th>
<th>Extent of repeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 35A.</td>
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<tr>
<td>Section 73(c).</td>
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<tr>
<td>Section 74(c) and the preceding “or”.</td>
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<td>Section 75A(1)(d) and the preceding “and”.</td>
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<td>Section 77(1)(aa).</td>
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<td>In section 82(2A), the words “or 6(2)”.</td>
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<tr>
<td>Section 83(2).</td>
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<tr>
<td>In section 84, in subsection (1), the words “or an NHS trust” and “or NHS trust”; in subsection (2), the words “or NHS trust” and “or NHS trusts”; and in subsection (3), the words “or an NHS trust”.</td>
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<tr>
<td>In section 84A, in subsection (1), the words “or NHS trust”; subsection (2); and in subsections (3) to (7), the words “, NHS trust or local health council”, “NHS trust or council” and “NHS trust or the council” in each place where they occur.</td>
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<tr>
<td>Section 85AA(7).</td>
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<td>Section 85(1)(f).</td>
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<td>In section 85A(4)(a), the words “or a local health council”.</td>
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<td>In section 85B, subsection (2)(d); and, in each of subsections (3)(a) and (4)(b), the words “or NHS trust”.</td>
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<td>In section 86, subsection (1)(c) and the preceding “and”; and subsection (1B).</td>
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<td>In section 101, the words “, an NHS trust”.</td>
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<tr>
<td>Section 105(1A).</td>
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<tr>
<td>In section 108, in the definition of “health service hospital”, the words “or vested in an NHS trust”; and the definitions of “local health council”, “National Health Service trust” and “operational date”.</td>
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<tr>
<td>Schedule 7B.</td>
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<td>Enactment</td>
<td>Extent of repeal</td>
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<tr>
<td>Health Services Act 1980 (c.53)</td>
<td>In Schedule 6, paragraph 1.</td>
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<tr>
<td>National Health Service and Community Care Act 1990 (c.19)</td>
<td>Section 29(3) and (4)(a) and (c).</td>
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<td>Sections 31 to 33.</td>
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<td>Schedule 6.</td>
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<td>In Schedule 9, in paragraph 19, sub-paragraphs (4), (7)(a)(ii), (11) to (14), (16), (17), (19), (21) and (22)(b) and (d).</td>
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<tr>
<td>Health Authorities Act 1995 (c.17)</td>
<td>In Schedule 1, paragraph 102(7).</td>
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<tr>
<td>National Health Service (Residual Liabilities) Act 1996 (c.15)</td>
<td>Section 2(2)(b).</td>
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<td>National Health Service (Primary Care) Act 1997 (c.46)</td>
<td>Section 1(7).</td>
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<td>In section 3, subsection (2)(a); and in subsection (3), paragraph (a) of the definition of “NHS employee”.</td>
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<tr>
<td>Health Act 1999 (c.8)</td>
<td>Sections 46 to 49.</td>
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<td>Sections 53 to 55.</td>
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<td>In Schedule 4, paragraphs 44, 45, 62 and 63.</td>
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<tr>
<td>Public Finance and Accountability (Scotland) Act 2000 (asp 1)</td>
<td>In schedule 1, paragraph 2.</td>
</tr>
<tr>
<td>Abolition of Feudal Tenure etc. (Scotland) Act 2000 (asp 5)</td>
<td>In section 18C, in subsection (1), the words “a National Health Service trust or”, “in either case” and “the trust or as the case may be”; and in subsection (3), the words “the trust or as the case may be” and “the trust or, as the case may be,”.</td>
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<tr>
<td>Community Care and Health (Scotland) Act 2002 (asp 5)</td>
<td>In section 22(1), in the definition of “NHS body”, paragraph (c).</td>
</tr>
<tr>
<td>Scottish Public Services Ombudsman Act 2002 (asp 11)</td>
<td>In schedule 2, paragraph 4(c).</td>
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<tr>
<td>Enactment</td>
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<tr>
<td>Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 4)</td>
<td>In section 5, in subsection (3), the words “and NHS trusts”; in subsection (5), the words from “(except” to “trust)”; and subsection (6).</td>
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<td>Section 6.</td>
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<td>In section 7, subsection (3)(b) and the preceding “or”; and subsections (5) and (6).</td>
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<td>In section 8, in each of subsections (1) and (2), the words “and NHS trusts”; and subsection (3)(b) and the preceding “and”.</td>
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<td>In section 9, the words “and NHS trusts” and the words “or trust” in both places where they occur.</td>
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<td>Section 10(1) and (3).</td>
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<td></td>
<td>In schedule 2, the entry “any National Health Service trust”.</td>
</tr>
<tr>
<td>Title Conditions (Scotland) Act 2003 (asp 9)</td>
<td>In section 46, in subsection (1), the words “a National Health Service trust, or of”; in subsection (2), the words “the trust or” in both places where those words occur, and the words “its or”; and in subsection (3), the words “the trust or” and “as the case may be”.</td>
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<tr>
<td>Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)</td>
<td>Section 3(3)(d) and (e).</td>
</tr>
</tbody>
</table>
National Health Service Reform (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to make provision in relation to the organisation and operation of the National Health Service and the promotion of health improvement; and for connected purposes.

Introduced by: Malcolm Chisholm
On: 26 June 2003
Supported by: Mr Tom McCabe
Bill type: Executive Bill