HEALTH AND SPORT COMMITTEE

Wednesday 12 November 2008

Session 3

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HEALTH AND SPORT COMMITTEE
27th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Robert Jack (Society of Local Authority Chief Executives and Senior Managers)
John McCormick (Electoral Commissioner)
Andy O'Neill (Electoral Commission)
William Pollock (Association of Electoral Administrators)
Professor William Stevely CBE (Ayrshire and Arran NHS Board)
Professor Heather Tierney-Moore OBE (Lothian NHS Board)
Sandy Watson OBE (Tayside NHS Board)
Peter Williamson (Tayside NHS Board)
Dr Charles Winstanley (Lothian NHS Board)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 12 November 2008

[THE CONVENER *opened the meeting at 10:02*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning and welcome to the 27th meeting in 2008 of the Health and Sport Committee. Please ensure that mobile phones and BlackBerrys are switched off. No apologies have been received.

Item 1 on the agenda is a decision on taking business in private. The committee is invited to take in private item 4, which is a discussion on our approach to the mental health services inquiry. Holding the discussion in private would be in line with our usual practice. Are we agreed?

Members *indicated agreement*.

Health Boards (Membership and Elections) (Scotland) Bill: Stage 1

10:03

The Convener: Item 2 is oral evidence at stage 1 of the Health Boards (Membership and Elections) (Scotland) Bill.

Our first panel of witnesses represent national health service boards. I welcome to the committee Peter Williamson, director of health strategy at NHS Tayside; Sandy Watson OBE, chairman of NHS Tayside; Heather Tierney-Moore, director of nursing at NHS Lothian; Dr Charles Winstanley, chair of NHS Lothian; and Professor Bill Stevely CBE, chairman of NHS Ayrshire and Arran. We thank you for your submissions, which we have all had the opportunity to read. We will move straight to questions.

Mary Scanlon (Highlands and Islands) (Con): I expected to pick up great enthusiasm for direct elections to health boards in reading the submissions last night, but the opposite is the case. In fact, I began to get seriously worried by some of the submissions. NHS Lothian's submission states that the

"system has the potential to destabilise boards".

NHS Ayrshire and Arran's submission suggests that the bill would

"undermine the operation of a national NHS".

NHS Tayside has not only adopted a policy of non-co-operation with the pilot scheme but says that the scheme

"is likely to diminish the current source of strengths of Boards".

I am picking up from those submissions the suggestion that direct elections to health boards will be a negative rather than a positive development. Can panel members elaborate on the points that I have picked up from their submissions?

Professor William Stevely CBE (Ayrshire and Arran NHS Board): Although it is certainly the case that Ayrshire and Arran NHS Board has consistently taken the view that elections are not a good way forward, I am here today to try to ensure that the committee is aware of issues that it needs to take into account in taking the bill forward. I view my appearance before the committee as being a way to help to ensure that the provisions of the bill will minimise the problems that we have foreseen.

I am still concerned about the real potential for a national policy, or a policy that is agreed here in Edinburgh, to be opposed by a majority of a board

that has a majority of elected members. Such a situation would perhaps arise only occasionally, but I could easily paint a scenario that would illustrate how it could happen. Such a scenario would not be helpful to the future of the NHS.

The Convener: Can you paint that scenario for us?

Professor Stevely: If I may be forgiven, I will use a case that arises from our experience. I have no wish to concentrate on the matter itself, but I want to use it as an illustration.

Most members will be aware that, prior to the 2007 elections to the Scottish Parliament, NHS Ayrshire and Arran had made proposals that involved the closure of one of its accident and emergency units. The proposals aroused a great deal of hostility in the local community. It is therefore reasonable to suggest that, had there been elections to the health board at that time, it is probable that that view would have had a big influence on who was elected to the board. That may be seen as a good thing, but we should park that idea for now. The scenario would have been that a majority of people sitting round the board table had been elected on the basis that they opposed the decision.

Members will allow me to suggest that a not unreasonable scenario would be that the previous Administration had ended up in overall control after the parliamentary elections. One would therefore have a proposal that had met the Administration's prescription and that it had approved but which was now opposed by a majority of the board. That illustrates the tension that would have arisen.

The issue is not one that I am interested in at the moment, but that scenario would have left the majority of the board's members opposing the proposal and wanting to change it, with the Administration potentially saying that it wanted to maintain what had previously been done. That illustrates the potential for discontinuity that could disrupt the business of a board for a considerable period.

Sandy Watson OBE (Tayside NHS Board): I do not accept the tag of "non-co-operation" that Mary Scanlon attaches to NHS Tayside. As Professor Stevely is, we are here this morning not to challenge the direction of travel. We are here in a spirit of willingness to be involved in a discussion that might lead to enhancement of the bill. That is the key point for us.

In the foreword to "Better Health, Better Care", the Cabinet Secretary for Health and Wellbeing made it clear that she wants a more mutual NHS. The phrase that is used is

"involvement, representation and a voice that is heard."

In our view, this debate is about involvement and representation. NHS Tayside's view is that although the proposals that are currently before us would achieve representation, the question is whether they would achieve community engagement. We believe that we should explore that issue and add to the bill to ensure that community engagement is dealt with appropriately.

Dr Charles Winstanley (Lothian NHS Board): My colleagues have made some of the points that I wanted to make.

I emphasise that NHS Lothian sees the role of our board, especially its non-executive members, as governance and scrutiny of an entire system—a system that is very complicated. The lay members, apart from representing the public and patient interest, are selected because their backgrounds and professional skills can complement the board. The concern is that the proposals could lead to single-issue candidates. NHS Lothian has had recent experience of such a situation, which can destabilise the role of the board. Under the bill, narrow issues could become the entire focus of the board.

We think that there is a case for greater public involvement and we would welcome that. We find the idea of mutuality very exciting, but we already have wide and deep processes in place to enable us to hear the voices of all our communities. We would like later to suggest an additional part for a pilot, which would involve a different way of hearing from the community.

The Convener: I will leave that for the moment; other members may pick up on it. Mary Scanlon has a supplementary.

Mary Scanlon: Yes. It is worth putting on the record the final paragraph in the NHS Tayside submission, which states:

"the Board does not wish to engage in a pilot for directly elected Board members but would, if it is considered desirable, be prepared to look at extending Council representation on the Board".

I do not want anyone to think that I would put forward something that is inaccurate. I share some of those concerns. I will leave it at that.

The Convener: We will return to the matter, at which point Mary Scanlon can come back in.

Michael Matheson (Falkirk West) (SNP): Good morning. It would be helpful to the committee if each health board representative would spell out exactly whom they consulted when they decided on their responses to the policy proposal.

Dr Winstanley: I am happy to confirm that the board's position was a board meeting item. As usual, the meeting was held in public. It was an open and clear process.

Professor Stevely: I am happy to say the same: we simply repeated the view that the board had given previously and which—as it had been fully discussed by the board—represents the board's view. The process gave staff members the opportunity to contribute to the debate if they so wished.

Professor Heather Tierney-Moore OBE (Lothian NHS Board): We consulted widely through many of our patient involvement structures—patient councils, panels and so on. The view that the board ultimately took was supported by those people.

Michael Matheson: It would be helpful if the committee could see some of the evidence that you received from patient involvement groups that helped the board to formulate its view. Perhaps you will pass that to the committee.

In the case of two boards, only board members were consulted to any extent before the board came to a view on this policy intention.

Sandy Watson: That is also the view and position at NHS Tayside. The board was asked for comments for submission to the committee.

Michael Matheson: That is helpful.

I turn to the NHS Lothian submission. You said that the new system has the potential to destabilise boards. Will you spell out your evidence on that?

Dr Winstanley: I return to the point that I made earlier: my principal role is to ensure that the organisation's activities and programmes reflect Government policy. I am accountable to the cabinet secretary and my board members are accountable to me. I expect their activities and behaviours to be in line with the organisational direction of travel.

My concern is that directly elected members might consider their sole accountability and loyalty to be to those who elected them, which could make them out of step with Government policy and the board's agreed policy. Potentially, we could have two styles of director: those who work corporately and those who do not.

I repeat the point that I made earlier: although single issues are of concern, such valid concerns are only one part of the mosaic of our incredibly complex business. If single issues were to dominate board business and squeeze out debate on other issues, that could be destabilising.

Michael Matheson: That sounds more like opinion than evidence. You have presented no evidence on how that could destabilise boards.

Dr Winstanley: I can offer recent evidence. Our council members are welcome—the system works well—but at the moment the entire focus of one member from the council, who was elected on a single-issue ticket, is on that single issue. The situation provides an interesting illustration of what can happen when all debate is on a particular issue. The contribution of the board member tends to be limited to matters that relate to the single issue; the person is not part of discussions on other parts of our business. That is a practical example.

10:15

Michael Matheson: Has the situation destabilised your board?

Dr Winstanley: No, because we are a large board and there is only one single-issue member. However, if the bill were agreed to there would be far more.

Michael Matheson: NHS Lothian suggests in its submission that the inclusion of elected members on health boards would cause confusion. Why?

Dr Winstanley: Boundaries are an issue. Currently, we have an effective partnership with councils. We work closely with them on jointly funded projects and we have jointly funded posts. Members of the public can deal with us directly or talk to us via their council representatives, and the geographical alignment is clear.

There is potential for confusion. What would be the constituency of the directly elected members? How would that relate to council members, who might think that they already represented a geographical or territorial constituency? Who would represent whom?

Michael Matheson: In your submission you make five concluding points, the first of which is that the bill

"does not have widespread public acceptance".

On what basis do you make that assertion?

Professor Tierney-Moore: I think that our comment related to the report that came out following the consultation, in which different views were expressed by different sectors. There was support from some areas and less support from others.

Michael Matheson: Are you talking about the report on the consultation on the bill?

Professor Tierney-Moore: Yes.

Michael Matheson: Having read the report, how did you conclude that there is no "widespread public acceptance" of the bill?

Professor Tierney-Moore: That is our view—

Michael Matheson: It is your interpretation.

Professor Tierney-Moore: Yes.

Helen Eadie (Dunfermline East) (Lab): We talked about tension between policy that is determined at the centre and policy that is determined locally. I understand that in New Zealand a mechanism has been found to cope with that tension. Will the witnesses comment on how effectively that works and add to the information that we have about what happens in New Zealand?

The Convener: The witnesses might not have considered what happens in New Zealand.

Sandy Watson: I am not familiar with the situation in New Zealand, although I have read that the country seems to have cracked the issue in some respects, although we cannot always easily extrapolate.

What troubles the board at NHS Tayside is that because local government members plus elected members would be the majority, there would be the potential for clashes with Government policy at local level, regardless of which Government was in power. We must consider how the elected members would come to their positions. They would be elected by public ballot and might then be appointed by the cabinet secretary, but where would their loyalty lie in a crunch issue? Would it lie with the public via the ballot box or with the cabinet secretary? The issue is ultimately difficult to crack. Compliance would be a major problem.

Helen Eadie: In the submission from NHS Tayside, mention is made of mutuality, which we talked about. Mutuality means many things to many people. NHS Tayside states:

"For the Board, mutuality emphasises participation much more than representation."

In the circles in which I move, it means both participation and representation. Would you like to expand on your comments?

Sandy Watson: Mrs Eadie makes an important point. Tayside NHS Board concedes that representation may be part of the jigsaw of mutuality; our concern is that the bill includes only one piece of that jigsaw. We argue strongly that community engagement should be examined at the same time. I am aware that Mrs Eadie, like me, has a local government background. In local government, the issue was dealt with through legislation that gave councils a statutory duty in respect of best value and a statutory duty to facilitate the process of community planning. Perhaps something of that nature should be considered for the health service.

Helen Eadie: In the last paragraph on page 3 of its submission, Tayside NHS Board talks about the evaluation criteria—I am sorry that all my questions relate to Tayside. It suggests that the criteria for assessment and monitoring of pilot projects are not clear enough. Would members of the panel like to elaborate on their thinking in that regard? Tayside NHS Board has raised an important issue.

Sandy Watson: The issue is the point at which it is most appropriate that the evaluation criteria be fully articulated. In my view, that should be part of the process when the pilot starts—we must be clear at the outset about what we are trying to achieve. I am going on the statements of the Cabinet Secretary for Health and Wellbeing in the introduction to "Better Health, Better Care", which sets out the argument for mutuality. As I understand it, mutuality is essentially about there being public ownership of the direction of travel, so the evaluation criteria must ensure that public ownership is achieved. If, at the end of the day, we do not have public ownership of the direction of travel that is outlined in "Better Health, Better Care", it will not happen.

Helen Eadie: I have one brief final question. I understand that the cabinet secretary will have the power to sack everyone on the board—both elected members and council members. What is your view on that provision?

Professor Stevely: That power is spelled out in the bill. However, the bill must say what happens next if a large proportion of board members are elected. Simply proceeding to another election, at which the same people were elected, would lead to an even more unfortunate stand-off. Some thought needs to be given to how the power will work and what the follow-up procedure will be.

Ross Finnie (West of Scotland) (LD): I preface my remarks by commenting on some of your opening observations. You suggested that the purpose of this morning's meeting is simply to move the bill forward. I do not disagree entirely, but I point out, with due respect, that we are considering the bill at stage 1. Among other things, the committee must determine whether it approves of the principles of the bill. Although I do not want to get into a dispute on the matter, it is an important point.

Last week we heard from senior Government civil servants. We agreed that the bill is not about the line of accountability to the cabinet secretary but about engagement; you make the same point in your submissions. The public have expressed clear concerns about the legitimacy of the persons who would become non-executive members of boards. I know that this is almost impossible to do, but could we, for the moment, park the issue of qualifications and concentrate solely on where the members would come from and how they would get there? Rightly, one of the real issues in a body that is wholly and exclusively publicly funded is that there is a wish that a part of the legitimacy of those persons who serve as non-executive

directors ought to derive from a democratic process.

I have a difficulty with the position of NHS Ayrshire and Arran and NHS Lothian in that, although you state that there is greater engagement, that engagement is generally below board level. Furthermore, I feel that you are slightly dismissive of the extent to which democratically elected people might play a role in the process. That is not quite the position of NHS Tayside, which has said that one of its experiments might involve greater councillor involvement.

I accept that work is being done below board level, but what about at board level? I accept what you said about tension, which is why I favour greater councillor involvement. That is my personal view, but I am interested to hear your views.

Professor Tierney-Moore: Four elected councillors sit as full members of NHS Lothian's board: they have a stakeholder, non-executive director function. We would like to have at least one directly elected member from a defined constituency of people who are genuinely interested in and engaged with the functions of the health board, and we would spend time and effort to increase that constituency.

On direct elections, we should bear it in mind that broad sections of the population do not engage in such processes. Therefore, the section of the population that normally does so would be the only section that would do so in this context as well. You might argue that that would constitute a democratic process, but we would want to invest time, energy and resources in reaching out to sections of the population with whom we have difficulty engaging on health and health inequalities issues, and who are unlikely to engage in a normal democratic process.

Peter Williamson (Tayside NHS Board): The question of democratic elections to boards is important. We in NHS Tayside feel that, as you have already heard this morning, wedding those elections to the existing structure of the boards could make the operation of the board subject to certain risks—you could have a directly elected board, or the NHS board could be merged with the local authority. Our point was that, at present, boards are accountable to the Cabinet Secretary for Health and Wellbeing, whereas local authorities, obviously, are not. There would be appointed members as well as elected members. We have raised concerns about the idea of wedding the elected members to the current system and expecting that system to continue to operate as it has done up until now.

Dr Winstanley: On the point that Ross Finnie made about the sources of non-executive directors, it is worth making the point that the Office of the Commissioner for Public Appointments in Scotland is active in ensuring that the process is diverse and that applications will be encouraged from all sections of the community. Although boards will take a view on the necessary skill set, there are increasing efforts to ensure that non-executive directors come from all parts of society and are not perceived as being people who have a narrow range of business skills or who have been recycled from other boards.

10:30

Ross Finnie: I find all of those responses disappointing. I understand the tension of having two differently elected bodies. I am sorry that no one chose to comment on the submitted view that, because there are already elected members from councils on boards, representation is perfectly adequate. Your position seems to be, "We have councillors, one from each council, which is perfectly adequate. We don't need any more of these wretched elected people. We certainly don't want new, directly elected people. We are very happy with the composition of the board."

With all due respect, that is rather complacent, given that the Government wishes to make a serious difference. I am not a member of that Government, and I do not agree with the idea of directly elected boards, but you are not providing me with an alternative proposition that would lead to engagement greater than that provided by people whose legitimacy derived from the fact that they had been subject to an election in their local area.

Professor Stevely: As the bill stands, it is clear that there will be a majority of elected members. That is where I see some of the major tensions coming in. I have no great problem with increasing the number of people who arrive at the board via some electoral process, but you can get into difficulties when the majority of members have come from that route. For example, one issue that worries me is that elections will be across whole board areas. My view is that there ought to be wards that match local authority boundaries, as that would help to minimise some of the issues that I can see arising.

The Convener: Pardon me for interrupting, but that issue relates more to process, whereas today we are considering the principle of democratic representation. That is the nub of this argument.

Professor Stevely: Indeed, but the point that I am trying to make is that there is the potential for single-issue campaigners to be elected, and we

are trying to find ways of minimising the impact of that on boards.

In addition, it is not clear what the overall size of boards will be, since the number of appointed members is not defined, and it could be any number, including just one—namely, the chairman. That leads to issues around the size that boards must be if they are to function properly and the impact of those who are elected as opposed to those who are appointed ex officio.

The Convener: Professor Tierney-Moore, you mentioned having direct elections from a defined constituency rather than the public at large. I do not know what you meant by that.

Professor Tierney-Moore: The idea is a development of what has happened with foundation trusts in England. There, people are eligible to be a member of a board if they have, for example, a particular association with hospitals or a particular relationship with primary care. Our idea is that we would create an on-going dialogue with such people in a way that was meaningful to them, and they would become a constituency of people who had a relationship with the board rather than be involved simply at the point of election. They could be provided with information and allowed to become involved at a committee level, at management level and in all sorts of other ways, and they would have the ability to elect people from their constituency.

The Convener: Can I stop you there? Who would select those people? Who would make up the list?

Professor Tierney-Moore: You would make it open to everyone. No one would be denied the ability to vote—they would all be allowed to engage—but the board would have a responsibility to have an on-going relationship with them rather than an episodic, election-based relationship.

The Convener: I am sorry, but I do not understand that. I am trying to understand what plan B is. You suggest that we should have directly elected members of the board from a particular group of people, not just the public at large, and that they would be people who have associations with the health service. I am asking who would pick those people.

Professor Tierney-Moore: It would be for them to pick themselves. That would not be controlled by the board.

The Convener: Once they selected themselves, who would assess whether it was appropriate that they were in that constituency?

Professor Tierney-Moore: I am sorry, but we are talking at cross-purposes.

The Convener: Yes, we are.

Professor Tierney-Moore: The system would be a way of developing engagement with the health service on an on-going basis that would be open to all, defined by population.

The Convener: I am again taking assistance from Richard Simpson. Would people be on a register?

Professor Tierney-Moore: Yes. They would sign up to be associated with the board.

The Convener: And people on that register could be elected to be members of the board.

Professor Tierney-Moore: Yes.

The Convener: Right—I understand that.

Ross Finnie: Convener, could we allow Dr Winstanley and Sandy Watson to respond to my question?

Sandy Watson: I would very much welcome that, convener. Tayside NHS Board accepts entirely the desire for greater democratisation. As Mr Finnie pointed out, our submission indicates that our preference is to have more elected members from local government on our board. The three that we have already have made a superb contribution to the working of the board. I, personally, and the board would welcome having more elected members from local government. That would also deal with Professor Stevely's point about there being different local authority areas within health board areas. In our case, we have Angus Council, Dundee City Council and Perth and Kinross Council. Our suggestion would have the added financial advantage of not incurring the cost of running separate elections.

Ian McKee (Lothians) (SNP): I thank the witnesses for coming and for their interesting submissions. I want to clear up one aspect of the evidence. The Tayside NHS Board submission states:

"There are clearly parts of the community that seldom or ever sit round the Board table."

It refers specifically to age, ethnic background and socioeconomic status. However, the Lothian NHS Board submission states:

"NHS Lothian's non executive directors consider it important to re-emphasise their role in representing the public voice at Board level."

That is a slightly different focus. Do the NHS Lothian witnesses agree with their colleagues in NHS Tayside that the representation of non-executive directors is at present biased towards certain sectors of the community and leaves out other sectors?

Dr Winstanley: I support the Commissioner for Public Appointments in Scotland's assertion that there has not been a sufficiently diverse source of

non-executive directors. However, my fellow non-executive members of the board consider that they are there to represent the public and patient interest. They do that through an active programme of ambassadorial work, talking to community groups and getting out and visiting the community. They are not directly elected, but they see themselves as the representatives of the public.

Ian McKee: So they come from a skewed background, but they are responsible for representing people from backgrounds from which they do not come.

Dr Winstanley: We look for a geographical spread in our non-executive directors. We want to have people from all over the region that NHS Lothian serves. I am sure that you will agree that, in many areas of public life, people represent the interests of a group without having an identical profile. We select non-executive members who have the breadth of vision and compassion to be able to relate to people who have not had the same route in life.

Ian McKee: I move on to how the public have a voice at present. Several submissions mentioned the functions of public partnership fora. How do people get on to those fora?

Sandy Watson: We seek expressions of interest and people come on board against that back-cloth. They do a tremendous amount of excellent work, but they would be the first to confess that they are not the whole answer. By and large, their members are middle class and elderly. They have made strong pleas to NHS Tayside to cast the net much more widely.

I chair a community engagement strategy group in Tayside. We started by mapping all the existing forms of engagement, which was a salutary process. A tremendous amount is already happening. There are patient groups for stroke, diabetes, cancer and so on; general practice patient groups; voluntary organisations; carers and carer organisations; and community and neighbourhood groups—I could go on.

We are focusing particularly on how we can get young people and older people more involved—a strategy for older people will go to the board tomorrow—and how we can use social marketing to change the culture to give people ownership of the agenda. NHS Tayside sees that as the way to go. Our ideal ticket would be a combination of that kind of approach and increasing democratisation, about which I spoke in response to questions from Mr Finnie. We should make boards more representative by having a few more elected members from local government join them, without throwing out the good skill mix that exists on boards, which is in the public's interest.

Ian McKee: Does Tayside NHS Board appoint the members of PPFs?

Sandy Watson: No. Effectively, they appoint themselves by expressing an interest and coming together. I have attended meetings of patient partnership groups—which are not formally constituted—at which people have given us their views so that we can take them into account in our deliberations.

Professor Tierney-Moore: As Sandy Watson said, PPFs consist of people who have chosen to sign up, and they elect from among their members people who will have formal seats on our community health partnership sub-committee and so on. Although we are working hard to get diversity within those groups, the nature of the work, which involves people sitting on a committee to give their views, is such that it does not reach many people. Networking with other groups and having routes by which they can feed in their views, without necessarily being part of a formal committee structure, is important. That is why we favour a joint approach to engagement. PPFs are still at an early stage, although we can track specific examples of their influencing directly the work of the community health partnership and the university hospitals division. A great deal of development is needed to support them.

Ian McKee: One of your PPFs was dissolved recently. What was the mechanism for that?

Professor Tierney-Moore: The PPF was dissolved because of its inability to self-govern. The CHP had to intervene, with support from civil servants. We brought in someone to review the situation and independently to provide a way forward. The PPF has now re-formed. An independent chair has been elected to support its members through the process of re-engaging with one another and building a much broader base that will enable the PPF to function. It had become divided into factions and unable to self-govern.

Ian McKee: Who decided that the PPF was unable to self-govern?

Professor Tierney-Moore: The chair of the PPF, in discussion with the CHP.

The Convener: I think that we have exhausted that issue, unless one of the other witnesses wants to comment.

10:45

Professor Stevely: I simply add that it will be critical to evaluate the effectiveness of what is being done as mechanisms for engagement develop—we are actively considering new ways of engaging with people, to add to what we currently do—versus the effectiveness of pilots on the direct election of members.

Ian McKee: I do not know the circumstances of what Heather Tierney-Moore talked about, but I am concerned that one person's dysfunctional PPF might be another person's PPF that asked awkward questions that the board did not want to hear. I am interested in the mechanism whereby someone decides that a PPF is not functioning and should be dissolved.

Professor Tierney-Moore: The situation that I mentioned was brought to a head not by people challenging the board, asking difficult questions or wanting to make changes, which a number of our PPFs have done successfully—

The Convener: The question was about the process, not the particular circumstances. Who has the ultimate sanction to dissolve a PPF?

Professor Tierney-Moore: The specific issue was that the PPF wanted to review its constitution and potentially to agree a different membership of existing committees, but it could not agree on a new constitution, so—by its own actions—it could not function. It was not a question of a view being taken externally that the PPF was not functioning; the PPF could not agree a new constitution, so it could not elect a representative to sit on the CHP.

The Convener: It self-imploded, in other words, and the board did not instigate that.

Professor Tierney-Moore: Yes, exactly.

The Convener: Is that clear to Ian McKee?

Ian McKee: Yes.

Jackie Baillie (Dumbarton) (Lab): I want to establish information on boards' make-up. How many members does NHS Lothian have? I did not want to pick on you, but we considered that issue earlier.

Dr Winstanley: From memory, I think that our board has 26 members, of whom the majority are non-executive members. Our executive directors are easily outnumbered by stakeholder and lay non-executive members and council members.

Jackie Baillie: How many of the non-executive members are appointed by the Scottish ministers and how many are elected local authority members?

Dr Winstanley: Boards have a member for each council. In our case, we have four members, who are from the City of Edinburgh Council, East Lothian Council, West Lothian Council and Midlothian Council. We also have representatives of staff groups: the employee director, a representative from primary care and a representative of allied health professionals are the staff non-executive members. In addition, we have lay members, who are all of the same seniority.

Jackie Baillie: How many executive directors do you have? Forgive me for asking that, but I am scarred by my experience of NHS Argyll and Clyde, where—not to put too fine a point on it—a payroll vote was in operation.

Sandy Watson: In Tayside, six out of 22 board members are executive directors. As Dr Winstanley said, the other 16 include a representative of the area clinical forum, a representative of the area partnership forum, the employee director, a representative of the university—

The Convener: Sorry to interrupt. Are we talking about Tayside?

Sandy Watson: Yes.

Dr Winstanley: Lothian has six executive directors. The number is small.

Jackie Baillie: You suggested that perhaps one person could emerge from the partnership forum structures and work their way through various levels to reach the top of the pyramid. Is it reasonable to expect one person to take on the mantle of representing many people?

Professor Tierney-Moore: All the research on engaging with the public shows that having one representative is never a good idea and there should be at least two representatives, not least to ensure that people are supported and have the ability to speak. We are not far down the road in thinking this through, but we want to explore whether we might have someone who would focus on hospital provision and someone who would focus on primary care and public health. We could cut it in different ways, but one would not be the right number in the long term. That is more about having a starting point.

Jackie Baillie: Should the bill pilot alternative approaches rather than just one approach? I have a fair idea of NHS Tayside's preference, which is just to increase the number of local authority representatives on boards. Would the boards prefer to pilot the kind of approach that NHS Tayside has outlined? Would it be useful for the bill to propose piloting alternative approaches?

The Convener: I think that Richard Simpson has just deleted a question from his list.

Jackie Baillie: Excellent. I am saving you time, convener.

The Convener: I like to see you operating as a team. Who will answer Jackie Baillie's question?

Professor Stevely: There would be value in having more than one approach on a variety of issues, including this one. We could consider, for example, how one increases the representation of the public partnership forum and whether to have whole-area elections as opposed to ward

elections. One could try two or three different mechanisms and thoroughly evaluate them to assess which one gave the best outcome in terms of people's confidence in what we do, because that is what we are considering.

The Convener: All the witnesses should get the opportunity to answer on that one.

Dr Winstanley: I fully support testing more than one approach.

Sandy Watson: Likewise.

The Convener: So that is the view across the board.

Jackie Baillie: I suspect that my final question is about, dare I say it, the self-interest of boards. The costs in the financial memorandum have been updated, and it is now suggested that the total cost for Scotland-wide health board elections would be about £16 million, although there is debate about whether that would be sufficient. However, it is clear that, beyond the pilots, boards would be expected to absorb the costs of elections. What impact would that have? Could boards achieve the costs through efficiency savings without that impacting on front-line services?

Professor Stevely: We need a clearer idea of what the costs would be. However, as it stands, the costs that would fall to us, which do not take into account aspects such as expenses and returning officer costs, would be only about £200,000 per annum, if spread over the four years. While I am bound to say that that is significant, one cannot say that finding that amount of money would seriously hinder front-line services. However, it would be more of an issue if the amount was much larger than that. That is our initial estimate, which I think we provided to the committee in our submission.

Dr Winstanley: We estimated that the cost of elections, depending on turnout, would be between £0.25 million and £0.5 million. We have a budget of £1.4 billion, so we would be able to absorb that cost without causing serious disadvantage to patients, but the money would clearly need to come from current activities.

Professor Tierney-Moore: The amount of money that we want to spend on patient and public involvement generally and on work that links with learning from the patient experience is a significant resource. I have just put some figures together for the cost of taking that work forward effectively over the next few years. Lothian NHS Board wants to invest between £1 million and £1.5 million in that kind of activity. Clearly, anything that we spent on elections would make it more difficult for us to find the money to take that other work forward.

Peter Williamson: I echo that point. Lack of resources, for example the resources that are available for communication, holds back our engagement with people and impacts on the quality of that engagement. The committee should be aware that finding money for elections would require a trade-off with that other work. Whatever happens regarding elections to boards, further investment in engagement is required to move forward with a mutual NHS.

The Convener: I do not know whether Richard Simpson has any questions left.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Almost not. I began the morning with 10 questions, but my colleagues have whittled them down. However, I have a supplementary to Jackie Baillie's earlier question, which dealt with a fundamental aspect. If money is to be spent on direct elections, what current public involvement measures would boards have to drop, given that the money comes from the same pot? Have boards considered what they would drop if the bill goes ahead? I have a final, tiny question.

The Convener: I love the way that members always preface "question" with "tiny". It is a very elastic word on this committee.

Sandy Watson: The question is premature. Part of the process of the pilot is to work out exactly what the costs would be and how they might best be met. I would not like to commit myself at this stage to answering that question.

Professor Stevely: I take the same view. I expect that the costs of the pilot would be met centrally, which would allow us to see the real costs. Once the arrangements were rolled out, it would be legitimate to ask what needed to stop in order to fund the process.

The Convener: Dr Winstanley is nodding.

Dr Winstanley: I have nothing to add; I agree with both those points.

The Convener: Now for Dr Simpson's "tiny" question.

Dr Simpson: The fundamental point behind what the Government is trying to achieve through the bill is the belief that boards currently are not adequately accountable and public confidence has been shaken by some of the events of the past 18 months to two years. Have any of the witnesses considered whether the mechanism for selecting and appointing non-executive members might be changed to enhance their credibility as being representative of their communities?

Professor Stevely: As Charles Winstanley has indicated, the Commissioner for Public Appointments in Scotland is exercised about the matter. Board chairs have discussed it, and we

fully support moves to ensure that the people who come forward and are appointed to boards are more representative, for example in terms of gender and disability. I confess that one would go more along those lines, rather than specifically ask whether people are representative in another sense, if you follow me. Elections might bring forward people who are representative in a sense, but who do not reflect the variety of people they represent, as is all too obvious in some national legislatures, which are not particularly representative along the lines that I have mentioned. We need to think about those issues in relation to the confidence of the communities that we serve.

The Convener: Mary Scanlon is indicating that she wishes to ask a supplementary question, but I want to end this evidence session shortly.

Mary Scanlon: I have an important point—which has not been raised today, although it was raised last week—about the list of people who are prohibited from standing for boards, in particular NHS professionals. No one may stand if they give advice to health boards, which rules out many potentially excellent health board candidates. How do you feel about that? Would the career prospects of those who are currently employed by the NHS be affected if they stood for a health board?

What do you think about having no remuneration for elected members? What do you think about the proposal regarding 16-year-olds voting? I am trying to imagine the people who will stand for election. I appreciate that many people with experience of the NHS could greatly contribute to the working of boards. I am slightly concerned that, under the bill, they will be prohibited from doing so.

The Convener: That was a classic Mary Scanlon supplementary—in several pairts. The witnesses can deal with the bits that they want to answer. There is a sweeping-up exercise to be done—perhaps I should have done that.

Professor Stevely: We have an employee director on the board, which is valuable and should ensure that we tap into expertise on the board. That is my preferred approach. I do not believe that there should be a difference between elected and appointed members' remuneration. If we are asking people to do a significant amount of work and to devote time and energy to it, they need to be remunerated accordingly.

The Convener: Has the point about prohibited lists and people giving advice been answered?

Professor Stevely: There is a grey area around when someone is barred. I am not aware of that having been a real issue.

The Convener: We can raise—

Mary Scanlon: For clarification, convener—

The Convener: Just a minute, Mary. We can raise the matter with the minister, but does anybody else wish to pick up on the other points first, before we lose our thread?

11:00

Sandy Watson: We share Professor Stevely's view about the role of the employee director. If membership was open to NHS employees, we could find that declarations of interest would have to be made constantly.

I strongly favour a voting age of 16, but we need to consider eligibility in other elections and get some consistency. One of the things about community engagement that has impressed me most in recent years came up when I did interviews with young people about the dialogue youth initiative. I remember asking one young man, "What do you actually want out of this?" His answer has stuck with me ever since. He replied, "We want to be involved not just in rowing the boat but in steering it." I think that the young people of Scotland have a great contribution to make.

Dr Winstanley: I, too, take the view that all non-executive board members should be paid on the same basis. One cannot have two systems. The three staff representatives who are on the board already provide more than adequate representation. Interestingly, one member of my staff serves on a board elsewhere in the country. One approach could be to allow NHS staff to serve in the board area where they live, rather than where they work. I also welcome younger people becoming involved. As was said earlier, we tend to have an older cohort.

The Convener: We will stop at this point. We have another panel to hear from. I suspect that you are speaking to a marginally older cohort here, although I exempt Ms Baillie and Mr Matheson from that.

Thank you very much for your evidence this morning, which has been extremely helpful.

11:01

Meeting suspended.

11:09

On resuming—

The Convener: My notes said that I should allow a little time for changeover of witnesses—that can be defined as a tea break.

I welcome John McCormick, who is an electoral commissioner; Andy O'Neill, the head of the

Electoral Commission's Scotland office; Robert Jack, from the Society of Local Authority Chief Executives and Senior Managers; and William Pollock, the chair of the Scotland and Northern Ireland branch of the Association of Electoral Administrators. Thank you for your written submissions. You will comment not on policy, but on process.

Dr Simpson: I will get in first this time.

The Convener: I knew that you would say that—you were wounded last time because everyone took your questions. I hope that you do not have 10.

Dr Simpson: No, I have only two. I thought that if I did not get in first they would be picked off by someone else. The proposal to allow 16 and 17-year-olds to vote in health board elections is a relatively new provision; it does not apply to the two external elections that we have considered recently—elections to national park boards and elections to the Crofters Commission. Would you like to comment further on the issue? SOLACE suggests in its submission that having people of 15—presumably—on the public electoral register, with their date of birth, would raise child protection issues.

William Pollock (Association of Electoral Administrators): Electoral registration officers expressed concerns about the extension of the franchise to 16 and 17-year-olds because information on those electors would have to be included on the register, as you pointed out. As you know, all registers include attainers—people who will come of age during the period to which a register applies. At the moment, people can be 16 when their name first appears on a register, because it covers more than one year. In this case, 14 and 15-year-olds could end up on the register. That raises issues of child protection, because they are under 16. It may be possible for them to appear in a separate document that is not quite so publicly accessible. I know that EROs are considering that option, but a cost will be associated with any additional security measures that are implemented. The association supports reducing the age of majority in all elections, but we have expressed concerns about the extension of the franchise to people below the age of 18 only for elections to health boards.

The Convener: The issue is on the cusp between policy and process.

John McCormick (Electoral Commissioner): I will add a codicil to William Pollock's point. Having a closed register for attainers who are minors would raise issues of engagement with the electorate. Hopefully, those would be addressed.

Dr Simpson: My second question is about who would run the elections. At the moment, the health service has no skill in that area. Could the elections be run by someone else? Would boards have to appoint staff to run them?

Robert Jack (Society of Local Authority Chief Executives and Senior Managers): The bill and the draft regulations that have been published propose that the elections be run by local authorities, on behalf of boards. I understand that the returning officer for the most populous local authority area in a health board area would be the returning officer in board elections. That raises the question whether one returning officer would run the elections for a whole health board area or whether, if the area covered a number of local authorities, they would engage the assistance of other returning officers in that area. The current draft regulations envisage the appointment of one local authority returning officer for each election.

Dr Simpson: Is that a satisfactory way of proceeding?

Robert Jack: It would be an additional cost to local government, which is a concern.

Dr Simpson: Are we clear about whether the provision has been costed in the financial memorandum?

Robert Jack: I cannot answer that question.

11:15

Jackie Baillie: The integrity of any ballot is obviously important, so that we can trust in its outcome. In that context, what is your view of the suggestion that personal identifiers need not be used?

John McCormick: The Electoral Commission has a clear policy on personal identifiers, the use of which it favours, as a result of its experience in reporting on previous postal ballots. The principle that we abide by is that if an election takes place, regardless of what it is for, it should be robust and accepted by everyone who is involved. The principles that we follow—we would be happy to follow this up in a detailed submission, if the convener thinks that that would be useful—should apply to health board elections just as they apply to other elections, so that following such an election, everyone who is involved in it can accept the result. For postal votes, we favour the use of personal identifiers.

Andy O'Neill (Electoral Commission): From the Electoral Commission's point of view, if health board elections are run by the returning officers, they will be perceived by us and the electorate as statutory elections—they would become the fifth statutory election in Scotland—so they must be robust. Particularly in Scotland post 3 May 2007, we cannot afford to have elections that are seen as less than robust.

The Convener: Please do not take us back to that horrible night.

Andy O'Neill: We would certainly want a robust and consistent electoral administrative process.

Robert Jack: The previous exchanges contain an important point of principle, which is about the extent to which one should try to achieve a simple, uniform and robust electoral system that applies to all statutory elections. At the heart of our joint submission is a concern that if we pick and mix in order to get a particular proposal into law, we will cause confusion across the various electoral systems.

When it comes to the use of identifiers, we face a bit of a dilemma because the potential exists for conflict with the idea of an all-postal ballot. There is no doubt that running an all-postal ballot that involves the use of identifiers is a more costly and complicated process. Concerns have been raised about whether people might deselect themselves from the register rather than go through the identifier process. At the moment, only people who apply for an absent vote go through it.

If health board elections are run as the draft regulations appear to suggest, on the same basis as elections to national park boards, for which identifiers are not required—no declaration of identity is necessary—we will run into issues that are of concern to us all, which relate to the probity of the process and the prevention of fraud. There are conflicting objectives. The people who framed the bill think that an all-postal ballot is the best approach, but that inevitably means that one must compromise on the use of identifiers or, if one does not, one faces all the issues of introducing the use of identifiers for 100 per cent of the electorate. Our main point is about consistency across the electoral system and not introducing compromises for the sake of getting a particular proposal through.

Jackie Baillie: Thank you.

In an interesting submission, the Local Government Boundary Commission suggested that local authorities and health boards should have coterminous boundaries for the purposes of consistency and avoiding confusion, but the Government has said that it has no plans to make changes in that regard. Is that crucial or can the problem be overcome?

The Convener: I think that I saw a ball being passed along between the witnesses.

Robert Jack: There are wider issues at stake than simply those to do with elections—there is a significant community planning dimension. Local government has long argued that if it can be achieved, coterminosity assists the community planning process. Elections are just part of that. How easy or difficult that is to achieve without changing health board or local authority boundaries is a matter of debate.

Undoubtedly, one finds that the community planning process appears to work better in areas where the health board and local authority have, by and large, coterminous boundaries, than it does in areas where there is a multiplicity of authorities. Having worked in an area in which there are three authorities to the one health board, I remember that the public consultation around the introduction of community health partnerships and the debate about whether they would be based on the local authority area or the health board area was quite a tortuous process. Coterminosity is a good thing, but it is not necessarily easy to achieve.

Andy O'Neill: Coterminosity is a difficult issue in Scotland, because we do not have very much of it and it is difficult to achieve. Where you do not have coterminosity, we would emphasise that you have to ensure that the electorate know who they are electing and who represents them—you have to make more effort and spend more resource to achieve that.

Michael Matheson: What are your views on the timetable for the elections? Given that the Government proposes a postal ballot, does there need to be a more extended timetable from the opening of nominations to polling day, as opposed to the shorter period that we have for local government elections? Is there an issue around how long the timetable has to be?

John McCormick: We favour a longer period for the postal vote, which we hope will improve participation. There is an issue about allowing a period of seven days between the close of nominations and the beginning of the voting period. It might be a challenge to gather all the voter information and print the ballot papers in that time. We certainly think that it is worth taking the advice of the Royal Mail and those involved in the printing of ballot papers and getting information about whether everything that needs to be done can be done in seven days. That is a serious concern. However, in general, we welcome the longer period for people to take part in the election.

Michael Matheson: What should the timescale be?

John McCormick: That is a matter of judgment. If the measure is to be rolled out throughout the country, it is a matter of testing with the professionals the capacity for the printing of the documents and the delivery of them by the Royal Mail. In different elections in different parts of the United Kingdom in the past, the issue of printing—around which there was a learning curve for me—was challenging, because it put a weight on the

small number of people who are able to provide that service. We recommend that others who are involved in that professional area should give advice on whether the deadline could be met.

Andy O'Neill: I support what John McCormick said. The capacity issue is important, in relation to not just the publication and printing of the ballot papers but the information packs, which we understand from the election rules would go out to all the electorate in an all-postal vote. There are issues around the legal checking of the entries and such like. There are instances in the Greater London Authority elections and some of the mayoral elections in England in which the information packs that are sent to the electorate have included information from each candidate.

You have to look at each election individually and see how it will be structured before you look at capacity and what will need to be produced for issue on postal pack day, if you want to call it that. That is why we suggest that civil servants need to talk to the returning officers and the printing industry and Royal Mail, which offers the freepost service, to decide what is needed to produce and then set an appropriate timetable in regulations.

Robert Jack: I concur with the view that the longer period is preferable. The draft regulations suggest that candidate statements will be issued, so it follows that quite a lot of pack assembly will be required. There are issues about deadlines being met so that the complete pack is available. That detail has to be teased out.

If someone does not receive their material, will the returning officer be entitled to send out more? With regard to the time between sending out and return, problems occurred in the 2007 elections with people not receiving packs. There is an issue, therefore, about the timescale for people applying for replacement packs and their being sent out. It would be preferable to have a longer timescale for health board elections, if that was possible.

Mary Scanlon: A point was raised about the varying geographical size of health board areas. I represent the Highlands and Islands region, which consists of the three Highland constituencies, plus Argyll and Bute. Someone from, say, Coll or Tiree might stand for election to Highland NHS Board, which is based in Inverness. However, it would take them at least a day to get to Inverness, a day for the meeting and a day to return. Issues arise, therefore, around not only travelling and representation but equity because the elected person would be unpaid, while appointed members would be paid.

I want to roll those issues into one. For elections to the health board in the Highlands, would it be wiser to use parliamentary constituency boundaries than to use a health board boundary? I ask the witnesses to consider the equity issue, too.

The Convener: I wonder whether that is an appropriate question for the panel. In this session, I wanted the committee to consider electoral processes rather than the quality of representation.

Mary Scanlon: The Electoral Commission's written submission mentioned electoral areas.

The Convener: I raised the point because I was not sure about your question. However, feel free to ask it.

Mary Scanlon: The Electoral Commission has concerns about a health board area being the only electoral ward. If the witnesses do not want to talk about equity, that is fine. However, given that the issue of electoral areas was raised in the written submission, I think that the question is legitimate.

The Convener: I agree that questions about the electoral process are relevant, so the witnesses can answer those.

Andy O'Neill: I can comment on a matter that is related to the electoral process, but not specifically about it. The candidate expenses limit is set at £250 in the draft regulations, and we wondered whether that was high enough. We assume that the regulations mean that a candidate would not have to pay for the elector's information pack. However, we did some mathematics and if, say, a councillor stood as a candidate for the whole Western Isles, their total expenses would be approximately £7,000. Would £250 be enough to campaign in the Western Isles compared with doing so in an urban centre? I do not know. Of course, there is also the question of how much campaigning would be done. Again, I do not know the answer to that. However, we think that those aspects need to be looked at a little bit more.

Robert Jack: The comment to which Mrs Scanlon referred expresses concern about the proposed process for health board elections. There are questions around whether there should be a single transferable vote election over a whole health board area, and around how many places are to be filled and how large the electoral process would be. The issue is whether to break down the health board area into smaller subdivisions for an election. The point about remuneration is obviously not for this panel; it was raised during the previous witness session.

It seems to me that, whether or not the electoral ward is the whole health board area, someone who was elected to represent Coll or Tiree would still have to travel to and from health board meetings, so the travelling point is not germane to the point about electoral areas. Our point is that running a large election across a whole health

board area is a mighty undertaking. If the area were to be subdivided, by whatever methodology, into smaller wards, several elections would be undertaken. We feel that that would be more efficacious for the purpose.

Mary Scanlon: At last week's meeting, I made the point that, given that the population centre of the Highland NHS Board area is Inverness, it is more likely that someone from Inverness would stand as a candidate. For example, I live about two minutes from the health board's headquarters, so it would be easy for me to stand, should I wish to do so.

Voter fatigue was raised in the joint submission from the Society of Local Authority Chief Executives and Senior Managers in Scotland, the Society of Local Authority Lawyers and Administrators in Scotland, the Scotland and Northern Ireland branch of the Association of Electoral Administrators and the Scottish Assessors Association. Again, the issue is probably relevant to the Highlands because, as well as having all the other elections, that area has had elections for the Cairngorms National Park Authority, and it is proposed that crofting board and health board elections will be held there. What background information led to Mr Pollock making the point about voter fatigue in his submission?

11:30

William Pollock: Voter fatigue is highly subjective. Some electors are always enthusiastic and, as we well know, some are less than enthusiastic, irrespective of how few elections we hold. We have suggested that health board elections should take place when no other election is scheduled to take place. With the exception of a UK parliamentary election, we can usually predict the dates of elections, as they are scheduled well in advance.

Voters could become fatigued or tired and ask why they are voting and what it is all about. On top of that, non-statutory elections such as community council elections take place in some areas periodically. Other events might take place locally, too. People perceive all that just as something to vote on or something to do. If, as proposed, health board elections took place in one period for the whole of Scotland, whenever that happened to be, I expect that a national publicity campaign that was co-ordinated, supported or devised by the Electoral Commission would make people aware that the elections were taking place, as with any other election.

The Convener: I do not know whether John McCormick wants to say something or is just raising his eyebrows.

John McCormick: We in the Electoral Commission rather favour the democratic process and democratic participation, but Mrs Scanlon raises issues that the submissions cover when talking about what would happen if health board elections were combined with other elections. There are arguments for and against such a move. We hope that such arguments would be considered in the planning of health board elections.

The Convener: One might suggest holding local authority elections and health board elections at the same time. Would that resolve practical issues for returning officers and prevent voter fatigue? I am not suggesting that; I am simply asking a question.

Robert Jack: That would involve the problems of using different electoral systems, if health board elections used all-postal ballots, because local authority elections do not use all-postal ballots. Holding health board and local authority elections on the same day might have merit. If so, the elections should use the same system, which they would if the proposed all-postal requirement were departed from.

Conversely, we are considering separating two coincident elections—those for the Scottish Parliament and local government. However, the community planning dimension may provide more of an argument for holding health board and local government elections on the same day.

John McCormick: We are broadly in favour of decombination, but if policy makers felt for other reasons that elections should be combined, we hope that the important issues that arise from using two different election systems on one day, which can lead to voter confusion, would receive special examination and emphasis. In general, we favour separate elections on separate days for separate systems.

Helen Eadie: I am not being parochial, but I highlight that Fife Health Board is coterminous with Fife Council. I am not making a bid for the pilot, but people might consider that.

The Convener: You have undermined your own proposal by admitting your thoughts.

Helen Eadie: Your joint submission says that planning for the local government elections in 2012 needs to start no later than January 2009. You also say:

> "The prospect of this emergent legislation being pursued in isolation and adversely impacting on preparations for 2012 is one which should be avoided at all costs."

Would anyone like to expand on that? It strikes me as important to ensure that planning does not take place in isolation and that people take on board all

the issues. Would you have ample time to have pilot elections, should you go ahead with them?

The Convener: Where has the invisible ball stopped now?

John McCormick: I think that the matter is mentioned in our colleagues' submission, so I defer to them if they wish to speak first. I will take up the point afterwards.

William Pollock: If we had combined elections, that would have an impact on the timing of the pilots. We should consider the advice that was given to us in the Gould recommendation, which was that all election legislation should be in place at least six months before any election is held; that would impact on the electoral registration officers.

I return to a comment that I started with, although I realise that I might be straying into a policy issue: there would also be an impact on the 16 and 17-year-olds because if we were to combine a health board election with the local authority election in 2012, or whenever, it would be rather odd if 16 and 17-year-olds were able to vote in only one such election, which was combined with the local authority election at the same time on the same day. That would be bewildering and confusing, and would not put the interests of the voter first. That would have to be sorted out at some point before any combined election was put in place.

In relation to combined elections, we return to the point about boundaries and the possibility of administrative confusion as a result of current non-coterminous boundaries, although that can be overcome. However, there is a possibility that things would get a bit more muddied than if we had more easily recognisable and defined boundaries.

Helen Eadie: What about the timescale?

William Pollock: It is quite tight. Although 2012 seems a long way away, we will start planning next year for our next local authority elections. We might not even have any health board election pilots until 2010. Whatever review emerged from the pilots would have an impact and could cause us to adjust the regulations that apply to the election process. That might happen well into 2011 and then suddenly, in 2012, we could be running a combined election. We do not want a repeat of anything that happened in 2007.

Andy O'Neill: From the Electoral Commission's point of view, Helen Eadie makes a good point. Planning is very good and we should allow adequate time to achieve it. That is one of the things that we all know did not occur in the lead-up to 2007.

One of the points from the Gould recommendations that we have developed is the idea of establishing a national electoral management board for Scotland, which would be a voluntary coming together of all the returning and electoral registration officers to deliver planning that is best done at national level. I think that you referred to colleagues' responses about e-counting. On this side of the table, we all agree that if we go to e-counting in 2012—the assumed local government election date—we will need to start planning for it in January 2009 at the very latest. I agree that we need to plan, have more time, and do it nationally where appropriate.

John McCormick: I underline the point that there seems to be general acceptance of the six-month legislative window that is recommended in the Gould report. That proposal seems to be broadly accepted and is important in the context of health board elections.

The Convener: I thank you all very much for your evidence. We will consider item 3 in private.

11:38

Meeting continued in private until 12:34.

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