# HEALTH COMMITTEE

Tuesday 9 December 2003
(*Afternoon*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

# CONTENTS

## Tuesday 9 December 2003


| | Col. |
|---|---|
| **SUBORDINATE LEGISLATION** | 405 |
| Food (Brazil Nuts) (Emergency Control) (Scotland) Amendment Regulations 2003 (SSI 2003/558) | 405 |
| **NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL: STAGE 1** | 406 |


## HEALTH COMMITTEE
**16th Meeting 2003, Session 2**

**CONVENER**

*Christine Grahame (South of Scotland) (SNP)

**DEPUTY CONVENER**

*Janis Hughes (Glasgow Rutherglen) (Lab)

**COMMITTEE MEMBERS**

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

**COMMITTEE SUBSTITUTES**

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

**THE FOLLOWING ALSO ATTENDED:**

**THE FOLLOWING GAVE EVIDENCE:**

Danny Crawford (Unison)
Jim Devine (Unison)
George Irving (Ayrshire and Arran NHS Board)
Wai-yin Hatton (Ayrshire and Arran NHS Board)
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)

**CLERK TO THE COMMITTEE**

Jennifer Smart

**SENIOR ASSISTANT CLERK**

Graeme Elliot

**ASSISTANT CLERK**

Hannah Reeve

**LOCATION**

Committee Room 1

# Scottish Parliament

## Health Committee

*Tuesday 9 December 2003*

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:05*]

## Subordinate Legislation

### Food (Brazil Nuts) (Emergency Control) (Scotland) Amendment Regulations 2003 (SSI 2003/558)

**The Convener (Christine Grahame):** I convene this 16th meeting of the Health Committee. I ask members to ensure that all mobile phones and pagers are switched off. Agenda item 1 is subordinate legislation. The Subordinate Legislation Committee had no comments to make on the Food (Brazil Nuts) (Emergency Control) (Scotland) Amendment Regulations 2003, no members' comments have been received and no motion to annul has been lodged. Do members agree to make no recommendation on the amendment regulations?

**Members** *indicated agreement*.

## National Health Service Reform (Scotland) Bill: Stage 1

14:06

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

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

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

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

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

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

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

be acknowledged. The bill affords a good opportunity to pull together those various strands.

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

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

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

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

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

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

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

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

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

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

14:15

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

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

Our other concern was that patient involvement cannot be done at no cost. If we are serious about empowering people to participate in new

structures and take up the role that is proposed for them, we must invest in ensuring that they are properly resourced to engage in participation.

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

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

**Hilary Robertson:** The Scottish NHS Confederation's view of community health partnerships—on which we have been working with our members to try to elicit a bit more detail about how they would work, what they would look like and what they would do—is that they are about more than community and social care or primary and community care: they should also include secondary care. From the health point of view, it is important that the partnerships aid joint working and the integration of secondary and primary care.

**The Convener:** Should anything on community health partnerships be added to the bill? Also, COSLA's submission talks about guidance being

"re-drafted to avoid duplication of existing structures"

and suggests that we

"Re-draft CHP guidance".

What is happening with that? I do not know what that guidance is, and we are talking about operational duplication.

**Alexis Jay:** We are concerned about the draft guidance that the Scottish Executive issued on community health partnerships. It was put out for consultation and I believe that there was a vast number of responses. We did not feel that the draft guidance was specific enough about the Executive's vision and what its intention was for community health partnerships. There was concern that there was potential overlap with the joint future agenda that was not clarified by the guidance. We hope that the final guidance will fuse together the different strands that are currently running in parallel.

**The Convener:** I understand that the final guidance is coming out early next year. Is that correct?

**Alexis Jay:** Perhaps. I am afraid that I would not know.

**The Convener:** I am being advised about that.

**Hilary Robertson:** I will make a point about public partnership forums, which will be part of community health partnerships. We envisage there being two distinct elements to the system. The public partnership forums will be about the continuing involvement of patients and the public, whereas community planning is more about consultation. We see those as two slightly different elements of the system.

**The Convener:** I do not think that you commented on whether anything about community health partnerships should be added to the face of the bill. We are talking about guidance and regulations, but should the matter be included in the primary legislation?

**Councillor Thomas:** I am not sure exactly what you mean when you use the term "the face of the bill".

**The Convener:** I mean in the primary legislation.

**Councillor Thomas:** As I see it, the community health partnership—and beyond that the community health and social care partnership—is the one key vehicle for ensuring that all the principles that everybody signed up to in respect of the joint future agenda can be delivered at all the various levels within the health sector and local authorities. If adding a clear reference to that in the primary legislation would give a high-level commitment to that work, it would be useful.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** The Scottish NHS Confederation's submission accepts that the minister should be able to intervene where serious failures occur, but calls for more clarity on what intervention will mean. Should the definition of intervention and the circumstances in which the powers of intervention would be used be included in the bill or in regulations?

**Hilary Robertson:** It would be helpful to say in the bill what intervention means and, if possible, what the circumstances are in which it would occur. It is difficult to know from the provisions in

the bill how such intervention might work—some clarity about that would be helpful.

**Christine Lenihan (Scottish NHS Confederation):** Scottish NHS Confederation members understand that, rightly, responsibility lies with health boards. There should be strong local management, particularly through the performance assessment framework, which is the accountability mechanism, and the powers of intervention should be a last resort. At the same time, there needs to be a link to the indicators on the performance assessment framework to determine when use of the powers of intervention might be required in a supportive way rather than as a last resort.

**Mr McNeil:** Would regulations remove the flexibility for there to be ministerial intervention in a variety of circumstances?

**Christine Lenihan:** No, not necessarily. However, it is important to retain flexibility where the responsibility and accountability is located, which is in the local health system and through the very comprehensive assessment framework that is in place. The detail that our members might like to see is about what circumstances might trigger an intervention, who might trigger the intervention and where responsibility for the costs of the intervention might lie.

**Mr McNeil:** So regulations would suffice.

**Christine Lenihan:** We are not of that view. Our members are of the view that the definition of the powers of intervention should be enshrined in the bill.

**Kate Maclean (Dundee West) (Lab):** Do you not think that enshrining a statement of when and how powers of intervention are to be used in the bill would be very prescriptive and would lead to a lack of flexibility? If the detail in the bill is too prescriptive, the primary legislation might have to be changed in the future to allow intervention in circumstances that none of us can imagine now. We can consult on regulations and change them much more easily than we can change primary legislation—that can be a reason for including a matter in primary legislation, but in this case it might be better to retain some flexibility to deal with situations that might arise in the future.

**Hilary Robertson:** We concede that point, but it is important that there should be clear understanding of what is meant by intervention. That will depend on the wording in the bill; it would be helpful if there were a clearer definition of intervention in the bill, although perhaps the detail about how such intervention would be triggered and who would intervene should be in the regulations.

**The Convener:** That could be done without listing the circumstances.

**Mr Davidson:** I think that the witnesses from the Scottish NHS Confederation are making the point that if accountability is the factor that is behind this section of the bill, it must be defined. I presume that if such a definition were to be included in the bill, you would also welcome a provision to allow a health board to call on the minister to intervene at an early stage, rather than wait until the end of another accountancy period—if there was a problem with financial flow, for example. Is that the kind of flexibility—on the back of a definition—that you would like there to be?

**Hilary Robertson:** We agree that it is important that boards should be able to ask for support; that should be clearly recognised.

Intervention should be a last resort, but it must be timely. If there are indications that intervention is required, that intervention should be supportive and take place before the stage is reached at which the system is in complete crisis and probably beyond being able to make a speedy recovery. That is the key point. It would be better to put the explanations in regulations, which could be consulted on.

**Mr Davidson:** In the first session of Parliament, the Scottish NHS Confederation gave evidence to the Audit Committee, of which I was a member. It was clear that the confederation was looking to future legislation to tidy up the two-way process around difficulties that arise in the health service. I think that your main point today is that you would like accountability—and how people would step into that accountability process—to be defined in the bill.

**Christine Lenihan:** Yes, that is right. We do not take issue with the fact that there is already a comprehensive accountability framework in place and we agree that ministers should have powers of intervention. However, there needs to be clarity about the triggers for and timing of intervention and about whether intervention—albeit a last resort—would be a late last resort. There should always be flexibility to allow those who are accountable for local delivery to be responsible for that, but at the same time, our members would like to explore the possibility of there being a series of triggers for intervention and much clearer understanding about when and why powers of intervention would be used. Invariably, the use of those powers would have to be linked to the information that is in the performance assessment framework.

**Mr Davidson:** Perhaps it would be appropriate for the confederation to send the committee a short document that explains exactly what clarification is required.

**Christine Lenihan:** We would be happy to do that.

**The Convener:** That would be helpful.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** I would like to pursue the point, because I am now a little more confused than I was. We are talking about the requirement for flexibility, but surely to put triggers in the bill would have the opposite effect. Section 4 amends the National Health Service (Scotland) Act 1978 to include a new section 78A, on powers of intervention in case of service failure. The new section 78A(1)(b) states that the powers apply where

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

(i) to provide the service, or

(ii) to provide it to a standard which they"—

that is, the Scottish ministers—

"regard as acceptable."

It strikes me that the Parliament would be giving a tremendous amount of flexibility and power to the Scottish ministers where there was or was likely to be, in their opinion, service failure or failure in the standard to which service is provided. You seem to advocate that we should include triggers in the bill, but would that not narrow it down in certain circumstances?

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.

**Hilary Robertson:** We are not disagreeing with the flexibility that the ministers will have. We are saying simply that, from the boards' perspective, it would be helpful to understand better what the intervention might consist of. The bill mentions the ministers' power where they consider intervention necessary or likely to be necessary. It would be helpful to the boards, who would be the recipients of that intervention, if there was more clarity about what it would actually involve.

**Mr McNeil:** A preference was stated in the written evidence from the Scottish NHS Confederation that intervention should be defined in the bill. That is not what you are saying now. You are saying that, on consideration, it should probably be done through regulations.

**Hilary Robertson:** Our written submission states that we would like a definition of intervention to be included either in the bill or in the regulations.

**Mr McNeil:** Your submission says that intervention should be defined

"either in regulations or, preferably, in the legislation itself".

**Hilary Robertson:** Yes. We accept the point.

**The Convener:** On a point of information, it would be useful for the clerks to provide a note; these are amendments to existing statute, and it would be interesting to see where they slot into the National Health Service (Scotland) Act 1978, because that act might contain things that expand on the issue. The bill is not a stand-alone bill and should not be considered in a vacuum, so I ask the clerks to make that information available.

Are members content to move on?

**Shona Robison (Dundee East) (SNP):** I will move on to the issue of health councils. I do not think that either organisation referred specifically to health councils, although you referred to public involvement. Will the national health council that is proposed by the Executive be more or less independent than the current local health councils?

**Christine Lenihan:** The confederation supports a strong and effective independent voice for patients. It might not be appropriate for us to comment, as NHS boards are the organisations against which complaints would be made. NHS Quality Improvement Scotland has shown its capacity for independence in principle, but patient representation will be demonstrated as the process evolves. We strongly support the principle that an independent organisation should represent patients' voices effectively.

**Shona Robison:** Do local health councils provide an effective patient voice?

**Hilary Robertson:** I am sure that individual boards would be better able to answer for their areas, but local health councils seem to perform a useful and valued function. Our concern is about patients' and the public's perceptions of the new arrangements. As professionals, we and our members have confidence that the new arrangements will provide the required degree of independence, but the public and patients might not have the same perception. We would like that to be kept under review.

We would be confident that NHS Quality Improvement Scotland would be the appropriate place to locate the Scottish health council, and Quality Improvement Scotland has shown its independence, but it would be helpful to test the water and gather opinions from the public and patients to find out whether they share our view.

**Shona Robison:** It is a bit unclear who will provide hands-on assistance locally. Local advisory councils are proposed, but there is talk about commissioning services to provide the advice and practical hands-on assistance that patients and the public receive at the moment. Do you have a view on whether that will work, and from whom services should be commissioned?

**Hilary Robertson:** No.

**Shona Robison:** That is fair enough. You do not have to have a view.

**Christine Lenihan:** I am not sure whether I can answer the question directly, but I can offer the information that is emerging that many of our members are, with the philosophy of consultation, exploring new ways to engage and communicate with the public—whether or not they are patients—as individuals rather than on a representative or group basis, as has often happened in the past. The NHS has a tremendous commitment to such engagement. The philosophy behind representing patients' views through Quality Improvement Scotland or any other mechanism is the same; everyone is committed to finding ways to involve patients and members of the public as individuals in current and future care.

**Shona Robison:** Does COSLA have a view on health councils and the changes?

**Councillor Thomas:** Since October 2001, local authorities and health boards have had closer working arrangements. Health boards are benefiting from local authorities' experience of tried and tested methods of consulting service users and carers in social work, and from the various consultative structures that we have long had for developing measures such as community care plans and children's services plans. That expertise is being used in planning health service matters and consulting patients on them.

We value the local health council structures. Local authorities' experience can help those bodies to consult more widely, whether on an individual or representative basis. All the local structures that councils have, and are developing, can be used to reach citizens and to discuss not only council services, but health service issues. We are doing that in Edinburgh.

**Shona Robison:** Obviously, we all welcome the duty to involve the public's being placed on health boards, but how do we avoid that effort's becoming tokenistic? There is huge public cynicism, and for good reason: some consultation has been very poor. What needs to be done to make the duty to involve the public mean something? How do we convince the public that the involvement is genuine and not merely a nice idea?

**Hilary Robertson:** There are quite a number of examples around Scotland of NHS boards' finding new ways of involving people—ways that go well beyond what would be considered to be traditional consultation exercises—boards are learning from experience. In a number of parts of the country, before they actually need them, people are being asked how they would like services to be configured or provided. While they are well—that is, before they become patients—people are being asked what they want from the health service, how the service might be provided, and what would be particularly important to them. That is a relatively new approach. Examples from around the country are being shared, but it is fair to say that there is a lot of learning to be done about how to involve members of the public meaningfully, rather than tokenistically.

A challenge is to involve people in ways that do not focus on the usual suspects—if I may use that term—or on people who have a particular interest or represent a particular group. The challenge is to speak directly to the members of that group and to the people who use the services. NHS boards have been addressing that challenge willingly and enthusiastically. A lot of good practice has been shared and there is still much to be done—it is not an easy job—but I emphasise that health boards

are tackling the challenge and that they are enthusiastic about doing so.

**Christine Lenihan:** A view is emerging from our members that traditional consultation, which is necessarily issue-specific, may not be the only way forward. Hilary Robertson describes a continuous, meaningful and thoughtful engagement with individual members of the public; that is how members of the public will have a much more fruitful and effective influence on health boards' plans.

**Councillor Thomas:** We need more effective consultation mechanisms, but we also need more effective feedback mechanisms. From their constituency case work, committee members will know the highly personal issues that can be raised in consultations. Quite often we cannot do everything; we cannot shape our services exactly as every individual would want us to. However, we need to be better at going back to people to explain why we have made certain decisions. We may need a better balance between trying to shape services to meet local community needs and trying to make services as universal as possible.

**Mr Davidson:** There is a view that NHS QIS looks at the delivery of patient care from a technical perspective. The health councils have said that they do not wish to be part of another organisation; they wish to stand alone as a new national body in a national framework. Do the health councils have a point when they say that they consider scrutiny differently from NHS QIS? The approach of NHS QIS is very technical and has the patients' perspective. Is that approach reasonable? I put that question to COSLA first and then to the Scottish NHS Confederation.

14:45

**Alexis Jay:** I am not sure that we are entirely qualified to answer that question from the patients' perspective. However, we would certainly promote such an approach and hope that councils would take it with their own services. What the consumer, customer or client—whatever you want to call them—thinks of the service is entirely valid and should form part of any process for developing services. We must hear that voice.

**Christine Lenihan:** I pointed out earlier that NHS QIS has already demonstrated its ability to be independent in setting standards—we might be able to link such an approach to the establishment of standards for quality in patient care. Indeed, those standards are rapidly being established. The confederation sees no reason why, in that respect, the independence of patient representation could not be replicated along the same lines, although perhaps not using exactly the same mechanism.

**Mr Davidson:** In other words, you would not object if the proposed new health council operated outwith NHS QIS.

**Christine Lenihan:** Our membership has no issue with Quality Improvement Scotland's early demonstration of its capacity to be independent. Of course, we did not refer to that in our brief written submission because the Scottish NHS Confederation represents the bodies against which complaints would be made. As a result, we did not feel that it was appropriate to elaborate on that matter.

**The Convener:** Do you agree that, quite apart from the substantive question whether there would be a conflict of interest in that respect, there might be the perception of such a conflict?

**Christine Lenihan:** Possibly.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** I want you to confirm your views on the importance of contact within all the services as well as the importance of an independent voice outwith them. It would be good if everyone who worked in the system had the time to feed back problems that were highlighted by any one person and to marry that information with what might be happening outwith the system in the local health council. After all, I get the impression that an awful lot of patients have to contact outside bodies because they have problems with feeding into a system that should exist—indeed, does exist—in the best services. I am beginning to think that when a patient complains to a nurse or doctor, the nurse or doctor is too busy to feed it up into the system. As I said, perhaps many problems could be defused if people within our services had more time to listen to and act on them. Do you feel that your systems are robust enough to comply with that?

**Hilary Robertson:** If I have understood your question correctly, I think that the situation that you described should be covered by the health boards' complaints procedures, which have been consulted on recently. Of course people want sufficient time to listen to patients' views; I have no doubt that staff within all our member organisations strive to do so. I expect that, where a problem has been identified and a complaint has been made, the complaints procedure that has been reviewed recently would kick in.

Forgive me if I misunderstood your question.

**Dr Turner:** I would have thought that, in a good organisation, very few general complaints would require to be dealt with under the full complaints procedure. However, improving the situation within the system would probably even be of help to the independent voice outwith it. We should be listening to people and correcting things as we go along. I find that, whatever the system, people feel

that they are not listened to, especially when they are in hospital or are dealing with a particular department. The problem should be sorted out there and then, before it becomes a complaint.

**Hilary Robertson:** That comment brings us back to the continuing involvement of the public and patients in the system. I am sure that everyone would agree that, however well we listen to people, our ability to listen could always be improved.

**Dr Turner:** The problem is that we very much need support from outwith the system because such support is currently lacking within organisations. Perhaps you do not agree with that.

**Christine Lenihan:** The principle of emphasising public and patient involvement as a continuing process rather than as a response to particular decision-making processes is part of that. As Hilary Robertson said, the complaints procedures, which have recently been reviewed and which operate in all NHS boards, are another part. Underlying Dr Turner's question is a question about the point of the commitment to listen to individuals. NHS bodies are committed to doing that and Hilary Robertson mentioned some existing examples, such as NHS Shetland 100.

**The Convener:** Rather than list good examples of public involvement now, perhaps you would write to the committee on that issue. It would be useful for the committee to have those examples in written form.

**Christine Lenihan:** We would be pleased to do that.

**Mr McNeil:** The Scottish NHS Confederation welcomes the inclusion of formal duties on NHS boards to involve and consult the public on the development of services and to engage with patients. Who would not welcome that? We may be sent a list of good examples, but all too often, we read about poor examples. I accept that public involvement goes across the board and does not focus only on clinical or maternity services reviews. You mentioned additional finances. For the fun of it, will you say whether we get good value for the money 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 what the councils are doing and the authority that the bill gives to health boards.

**Alexis Jay:** That will depend on what the guidance eventually says about the role of councils. It appears to be absolutely appropriate that health improvement is located within community health partnerships. Of course, it will depend on how the structural arrangements work out, but I am confident that we could find ways through that. I know that health improvement staff across the board have some concerns. For example, one or two have said that they might not particularly like being managed by GPs and would prefer a wider scope in which to operate themselves. That is the kind of detail that needs to be worked out, but the development of health improvement through the proposals in the bill and its location in CHPs absolutely complements the relationship with councils. I am sure that we could work closely and co-operatively in ensuring that that is carried through.

**Hilary Robertson:** The Scottish NHS Confederation also sees the two duties as being complementary. It is clearly not just for the health service to try to improve health; it is important that the functions of other bodies are also taken into account and that the health improvement focus straddles all the appropriate departments, functions and bodies.

**Mr Davidson:** I would like to broaden the scope of the question to include money, which is the root of all evil, as we know. You have both made pretty strong remarks about the lack of money for consultation, but what about money for health promotion itself? Do you feel that there is enough clarity in the bill about funding and mixed funding? For example, there might be funding from the education department in a council to promote life-improvement education, while the health board might already have allocated money to that, although it might not be listed under the same budget heading.

15:00

We have to look at cross-boundary working on mixed budgets. We have already had disputes over care, in which a health board has a patient whose care needs are being assessed, and a council has a patient or resident whose care needs are being assessed, so there are two sets of appraisals. Does the bill need to look more closely at health improvement and at how budget definitions are organised, especially given that you both said there is no extra money for consultation?

**Alexis Jay:** Quite honestly, I do not know the direct answer to that question. We hear about the negative examples, but we have lots of good examples of aligned budgets. Many partnerships work closely and have aligned budgets. My council has funded health promotion activities in partnership with two health boards with which we have boundaries. Lots of good things are going on, and organisations are working together, but health promotion and health improvement are not well funded on the ground. We tend to scratch around a bit, looking for funding to back up new initiatives and for areas that we wish to promote. However, I could not be specific about how that should be presented in the bill.

**Mr Davidson:** Would you like to write to us with COSLA's view?

**Alexis Jay:** Yes.

**Hilary Robertson:** I have one small point. There is plenty of scope for joint working. Perhaps it would be helpful to apply the joint future model to health improvement. We note that the bill places a

duty on health boards to promote health improvement, which includes giving them powers to provide financial assistance to any person. We interpret that to mean any body or organisation. That will encourage joint working between the health service and other partners, such as local authorities and any other relevant partner. We support that. More money is always welcome, of course.

**Mr Davidson:** Your understanding is, however, that such measures will come out of current funding.

**Hilary Robertson:** Yes.

**Mr Davidson:** We are talking about reprioritisation.

**Hilary Robertson:** Yes.

**Mr Davidson:** Are you appealing for more money?

**Hilary Robertson:** No. We are simply recognising—

**Mr Davidson:** We have the evidence, convener. She said, "No."

**The Convener:** In summary, the financial memorandum states that

"Overall additional expenditure as a result of the above provisions"—

which is all the provisions in the bill—

"will be zero".

It also states:

"As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure".

That is not the case, is it?

**Christine Lenihan:** If we are talking about the summary, we know that some of the structural changes—which is where we started our discussion—are not incurring the costs that might have been thought necessary before they were started. There are examples of single systems that are very advanced in their planning, which have management structures in place, and which are actually releasing efficiency savings that are being deployed within various health systems for other priorities. It is too early to say what will be required in terms of CHPs, but it seems unlikely that in the early days of their development there will be no need for resources from elsewhere in the system. However, on an on-going basis, that has yet to be determined.

**The Convener:** I am trying to work out whether that was a yes or a no.

**Christine Lenihan:** It is work in progress. Our evidence is that single-system working is releasing funds back into the system to be spent on other priorities. That is as much as the Scottish NHS Confederation can say at this stage.

**The Convener:** I recall evidence from last week that conflicts with that, which was that savings of £19 million would be made at some point following restructuring, but the money just disappeared and was never accounted for. I will have to look back at last week's *Official Report* to see what it was. Does COSLA feel the same? Financial memoranda are important in all bills.

**Councillor Thomas:** We have already given evidence to the Finance Committee on that point. We have been clear that it is difficult for us to see how the measures can be cost neutral. The changes that we are seeking to engage and involve local communities, patients and service users will add to the cost, but it will be money well spent.

**The Convener:** That concludes our questions. Thank you all very much. If, on reflection, you feel that we have missed something, we would be content for you to write to the committee.

I will press on and welcome the next set of witnesses. While they are taking their chairs, I inform the committee that the videoconference with witnesses from Orkney will be on 6 January next year.

I will wait until you are all sitting comfortably. Some people will understand that reference from "Music with Mother" or "Listen with Mother"—I am rambling—it was "Listen with Mother".

From Ayrshire and Arran NHS Board, I welcome George Irving, chairman, and Wai-yin Hatton, chief executive. I also welcome, from Dumfries and Galloway NHS Board, Malcolm Wright, chief executive, and John Ross CBE, chairman.

I ask the witnesses from Dumfries and Galloway to outline for the committee their experience of working within a national health service system that, like my area in the Borders, no longer has NHS trusts. Is that structural change necessary to improve services, and should it be rolled out throughout Scotland?

**John Ross CBE (Dumfries and Galloway NHS Board):** When the unified board was set up in October 2001, the chief executive and I had a long discussion about where the major challenges for Dumfries and Galloway would be, not in the next week or month, but 10 or 15 years ahead. We quickly identified for the board that the big challenge would be the demographic change in the population of Dumfries and Galloway: a 26 per cent increase in over-65s, a 26 per cent decrease in those aged 19 and below and an 11 per cent decrease in the working-age population. We realised at that stage that the status quo—a health

board and two trusts—was not an option and that we needed to think radically about how we would start to modernise services in Dumfries and Galloway if we were to cope with the challenges of the next 10 to 15 years. That was the basis of the decision, to which we came quickly, to have an integrated health care system in Dumfries and Galloway that would result in the dissolution of the two trusts.

**The Convener:** That is a practical example.

**Malcolm Wright (Dumfries and Galloway NHS Board):** After the discussion that the chairman and I had, we had a process of engagement and consultation. It took 14 months from our taking the initial idea to the NHS board and the minister giving us approval to explore different models to put in place a completely integrated structure.

When we undertook consultation with the public, the local authority and our staff, it was interesting to note that nobody was of the view that having three statutory organisations to run health services in a place the size of Dumfries and Galloway was sensible. We have a population of 147,000 and a staff of 4,200, and everyone was of the view that we could organise services better.

When we examined how patient care was managed, we came to the view that we should design our structures and processes to support the flow of patients through the NHS system. Therefore, we have set up a number of groupings that span primary care, secondary care and, in a number of instances, tertiary care, on a specialty-by-specialty basis. There are about eight or nine local groups for cancer, learning disabilities, mental health or children's services in which primary-care practitioners and secondary-care clinicians come together with the public and staff to plan services on a regional basis and to determine how they will be run.

In a number of those services, close working with the local authority has been very helpful. 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 community planning boundaries. 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. Local government is rightly sensitive about the introduction of CHPs. In an addendum to the National Health Service Reform (Scotland) Bill, or in some form of regulation, it would be advisable at least to refer to the local government legislation. That would be a tactical move, because we are heavily dependent on our local authority partners.

The issue of the involvement of general practitioners was always going to be difficult. We are fortunate that all our GPs have opted in, but they could equally well opt out. Health service personnel have a statutory duty, but GPs do not. That was also a weakness of the LHCCs.

The concern has been expressed that we should not let CHPs become dominated by clinicians or general practitioners. We welcome CHPs very much and we are geared up for them—I think that we will implement them quickly—but we make some cautionary comments.

15:30

**John Ross:** I concur with George Irving. In Dumfries and Galloway, we were a bit concerned that minimum population figures were initially assigned to community health partnerships. We have four LHCCs, and as our population is 150,000, those LHCCs are small. However, as my chief executive said, those LHCCs' boundaries are 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 national minimum standards, and targets that are agreed locally with community involvement. It is not about saying that if Danny Crawford is in Glasgow and I am in Edinburgh, he will get a better service. There is a need for a minimum level of service. That is part of the earlier debate that you had about involvement.

**The Convener:** Does Danny Crawford wish to add to that?

**Danny Crawford (Unison):** No.

**Mr Davidson:** On the front page of your submission, you comment that you seek

"common conditions of service across all NHS Health Boards."

but you have not qualified that in relation to qualifications or responsibility. Does that mean that Unison is against anything other than a uniformly applied core arrangement? Are you in favour of flexibility to allow health boards in which there is a key shortage to attract staff to an expensive housing area or to somewhere that does not have the normal facilities that we might expect in the central belt?

**Jim Devine:** One of the problems that trusts created was that they had the right to determine local pay bargaining, the consequence of which is that we have staff working alongside one another on different terms and conditions. The differences are often minor, but they exist. For example, if you were on a trust contract, your annual leave entitlement would be less than mine would be if I had worked for the past 20 years in the national health service.

In the comment that you quoted, we are saying that, before we introduce agenda for change and get back to standardising the care that we want throughout Scotland, we need to get back to standardised terms and conditions. We need to have the baseline; if we do not have the baseline, we cannot introduce agenda for change, because, if terms and conditions are not standardised, we cannot introduce a pay modernisation system. It is frustrating enough to work on a joint future project or in an LHCC beside somebody who is on different terms and conditions, but I am sure that you can appreciate how much more frustrating it is to work in Stobhill hospital in north Glasgow alongside a colleague who is on different terms and conditions.

To be fair, we have sat down with the Scottish Executive and negotiated the low-pay deal, which has meant a standardisation of terms and conditions for ancillary staff, administrative and clerical staff and many nursing staff. As part of that agreement, we have a commitment to standardisation of terms and conditions by, I think, October 2004.

In the paragraph of our submission that you quoted, we make a point about associated employee status. That is very important, because we will not get the flexibility that we want in the delivery of care throughout Scotland if we have a Scottish strategy but do not introduce associated employee status. If Janis Hughes worked for Greater Glasgow NHS Board and left to go to, for example, Lothian NHS Board, she could lose a lot of her conditions of service. Doctors, on the other hand, have associated employee status, so they can move throughout Scotland and carry their conditions of service with them. That is not the case for nurses, porters, domestic staff or administrative and clerical staff. Although it might be argued that, because associated employee status concerns employment legislation, it is not a devolved matter, the advice that we have from our

lawyers is that there is something in the National Health Service and Community Care Act 1990 that would allow the Scottish Parliament to introduce associated employee status.

**Mr Davidson:** It would be helpful if Unison could draw up a note to clarify its reference to that act.

**The Convener:** It would be. I was not aware of what happens when staff move about.

**Kate Maclean:** There have been problems with staff moving to the care commission from local authorities and health boards and having different conditions and pay—that has caused some bad feeling. Do you want the bill to be delayed until the situation can be clarified and something can be firmed up on common conditions? From a previous life, I remember harmonisation, which came before single status, which the employer and employee sides have failed to implement. Single status has been around and agreed for years, and I do not think that we have reached the stage at which it will finally be implemented. If we had to delay the bill—which, in other aspects, would be an improvement—we would probably have to delay it for a long time to get agreement on conditions.

**Jim Devine:** Unison would not want the bill to be delayed, because it sends out a lot of positive messages. When I worked in the Scottish health service, staff were employed by the Scottish health service. I hope that we go back to that system, because that would send out a powerful message.

When the number of trusts went from 47 to 27, there was a 25 per cent reduction in the number of senior managers who worked in the Scottish health service. That money was diverted somewhere; I am sure that it went into patient care services. In the earlier evidence, you heard the arguments from the NHS boards in favour of a single system, but there are many other arguments. For example, purchasing policies among the four trusts in Glasgow are all over the place—one trust buys beds here and the other buys beds there. When the trusts come together, the purchasing policy will be improved. Simple matters such as that are one of the advantages of the system and would provide savings.

**Mike Rumbles:** I appreciate that you support a Scotland-wide human resources strategy for terms and conditions, but how relaxed are you about having different terms and conditions north and south of the border?

16:15

**Jim Devine:** The union supports national pay bargaining and, to be frank, we would be daft to throw that system away. We have recruitment and retention problems in Scotland, but there are greater problems elsewhere. For example, the vacancy level for nurses in Scotland is about 1.8 per cent, whereas London hospitals have a vacancy level of 30 to 35 per cent. That situation allows us to tap into the benefits of national bargaining. However, the other side is that we should have the right to tweak the machine in Scotland, which we have done. For example, through the low-pay deal, ancillary staff members now earn £5.35 an hour; that rate is not great, but it is different from the rate south of the border of £4.62 an hour. If you were to say that I want to have my cake and eat it, you would be quite right.

**Mike Rumbles:** I want to pursue the issue because it is of interest to me. In your job as a negotiator you want to get the best terms for your members, but if the Scottish Executive could give enhanced terms and conditions to your members in Scotland, would it be a difficulty that those conditions would not apply south of the border?

**Jim Devine:** No. We have already negotiated different conditions. That has caused me personal difficulties with my national officers, but it is not a difficulty for our members. If the Health Committee wants to give us a 10 per cent pay increase, we will happily accept that.

**The Convener:** Now I know why you are a negotiator.

**Mr McNeil:** My question is a little less exciting, but it is about a major issue. Unison's evidence states:

"we need to move the debate on health away from hospitals and illness and onto prevention and healthy living."

I am sure that everyone would agree that that is taken as read. Do you accept that the proposed duty on ministers and health boards to promote health improvement at least starts us on that journey?

**Jim Devine:** Yes. The important role of local authorities in promoting health improvement, which was mentioned in earlier evidence, must be considered. There have been great initiatives, such as the free entry into swimming baths in Glasgow. Health care must be considered in its broadest sense. When I worked in primary care psychiatry, I saw no one who had already been seen by a psychiatrist, but I was involved in taking people off medication. We held surgeries in a local leisure centre, which made people feel comfortable about access to the service. A few weeks ago, Greater Glasgow NHS Board had nurses in bookies' shops. Such initiatives are to be welcomed because we must get the message out.

A few weeks ago, I made a speech about an ethical health policy, although as I am Robin Cook's election agent, it is probably dangerous to

talk about that. We need to consider broader partnerships with local authorities and other bodies. We advocate banning smoking in public places. Our trade union believes that it is not acceptable for people, in effect, to kill other people while they are going about their work. That is a major health and safety issue. It is absolutely daft that people can walk into an NHS hospital, where health is supposed to be promoted, and see at the front door a vending machine that sells junk food. Simple strategies that can be implemented are to be welcomed.

**The Convener:** Do hospitals make money from those vending machines?

**Jim Devine:** I suspect that they do.

**The Convener:** That is why hospitals have them.

**Mr McNeil:** That is a simple point, but the problem is that a shop outside the hospital could sell the same items in abundance. Do you agree that although such initiatives can be debated and considered, they are complementary to overall health provision and would not necessarily reduce demand for health services or the need to provide acute services?

**Jim Devine:** I know where Duncan McNeil is trying to take me. It is interesting to read reports about the situation in Finland 15 years ago, when it had a greater problem with coronary heart disease in particular, and the situation there now. A community-based Government-driven campaign has been undertaken in Finland on healthy living, healthy lifestyles and healthy eating, and now it is being said that the demand on acute services is less. It would be wrong to pretend that implementing the strategy now would produce gains within five years. Healthy living will affect the next generation.

**Mr McNeil:** Jim Devine will be aware that such campaigns started in Finland not to improve health, but to address famine and hunger, and they have been undertaken for some time.

**The Convener:** I am conscious of the time, and the piper playing outside the building is annoying me enormously. As a Scot nat, I should not say that, but he is. We will move on.

**Helen Eadie:** Earlier, we discussed public involvement. Your submission says that Unison

"welcomes the Scottish Executive's pledge to involve staff and trade unions in all the stages of the planning process for establishing the new Scottish Health Council."

Does Unison share the concerns of other organisations about the independence of a national health council that will be part of NHS Quality Improvement Scotland?

**Jim Devine:** Convener, may I hand over to my colleague? We are a double act today.

**The Convener:** Certainly—just leap in. I do not think that your man needs to be told that.

**Danny Crawford:** The short answer is yes. Unison has concerns about that matter. Unison welcomes the establishment of a Scottish health council and welcomes patient focus and public involvement in the NHS, but it feels that the changes that will be introduced with the Scottish health council mean that the body should be independent.

I realise that no organisation is completely independent and that obtaining independence might be difficult. We understand that the Scottish Executive considered several options. One was a non-departmental public body, another was a special health board and another was a link with NHS QIS. The white paper said that the Scottish health council should be linked to Quality Improvement Scotland. When the NHS's chief executive launched the white paper, he said that the health council should be an arm's-length organisation. Most recently, the minister said that the organisation should not be under the thumb of Quality Improvement Scotland.

What has yet to be worked out is how the Scottish health council will sit with Quality Improvement Scotland, if it is to do so. Unison's position is that it would be better if the health council were as independent as possible, to represent patients' interests in the NHS.

**Helen Eadie:** Shona Robison said that local health councils provide the complaints route into the health service. Will you comment on that?

**Danny Crawford:** Unison has concerns about that issue. We understand that the proposal is that the Scottish health council's local offices would not provide the support that local health councils have provided to individuals who want assistance to make complaints through the complaints procedure or who want to know their rights.

We understand that NHS boards are to commission so-called independent bodies to provide such assistance. That might work well, but all the feedback that we have had—and we heard this view today as well—is that the system whereby the local offices of health councils provide support and advice works well. There may be one or two places where things are not done in quite the same way. In Dumfries and Galloway, for example, an advocacy service is provided for users of local government services as well. Historically, by and large, health councils have helped with complaints. They have done reasonably well; we are certainly not aware of any complaints about the way in which they have performed that function.

In England, the complaints procedure has been reorganised and concerns have been raised that

the new system is more bureaucratic and more costly. We would not want that to happen here. The system seems to work well and we are not sure why it would need to be changed.

**Dr Turner:** There is a duty to involve the public and it has been said that that will not involve significant additional resources. Will public involvement be improved in health service planning?

**Jim Devine:** It would be wrong to say that consulting will not cost. One practical example of that was the introduction of the patients charter. Any member of staff who works in an accident and emergency department will tell you that everybody who walks in the door knows all about their rights as a patient. We are not against the charter. However, when it was launched, there were videos, television adverts and letters, and people were told, on their appointment cards, about their rights as patients. It would be wrong to pretend that all that had no cost. If we want to communicate, to involve people and to make a mark, that will cost money.

**Danny Crawford:** Consultation will have an associated cost. That said, Unison's position is that the NHS should be open, transparent and accountable. Making NHS boards the primary body responsible for public involvement is logical and appropriate. It will be the NHS boards that are hauled before this committee or the Public Petitions Committee to justify how they went about a consultation exercise.

In Glasgow, an issue arose to do with a secure care unit. The reporter who came back—an MSP at the time—said that the board had consulted beyond what it had to do. However, the point was that the amount of consultation that it had to do was not an amount that the public felt was appropriate. I do not think that the Scottish Parliament felt that it was appropriate either.

A step change is required to improve the way in which the health service engages with and consults the public. It is right and proper that the NHS board has that responsibility. That said, it does not have to be the only body with that responsibility. There should be a local independent body that comments not only on the appropriateness of how consultation is done, but on the particular issue.

**Mike Rumbles:** I asked the witnesses from Ayrshire and Arran NHS Board about improving the governance of NHS employees. Should the Executive introduce amendments to the bill to place a duty on health boards to ensure that they have systems in place for monitoring and improving the governance of NHS employees?

**Jim Devine:** I totally agree with the comments that those witnesses made. In the Scottish health service, we have a unique form of industrial relations. We work in partnership, and we sit down with management, to get away from the confrontation that went on for many years. We work on the practicalities of the development of services and the provision of care. The most valuable resource in the provision of care is the staff. They want to feel part of the team and to feel valued. As the witnesses from Ayrshire and Arran said, if you are to have clinical governance—if the chief executive was making an assessment—staff governance should be there as well. That has been pushed by all the trade unions and professional bodies in Scotland.

16:30

**Mr Davidson:** I want to pursue the issue of the governance of NHS employees. What are Unison's views on access to continuing professional development?

**Jim Devine:** We are very supportive of that, but it comes with a price. Over the past 15 years, the work load for health service workers has more than doubled, because of an increase in the throughput of patients. The difficulties that we all have are in getting people off wards and departments so that they can have a clear career structure. The new pay mechanism, agenda for change, makes development and the knowledge and skills framework a crucial part of people's grading. Increasingly, people will want training and development and a clear strategy for that will be needed.

Under agenda for change, one hour's work on processing a form will be the equivalent of 14 years in capacity for the Scottish health service. Managers will have to sit down with people and conduct an assessment of their situation. They will have to conduct a development review and consider people's development and training needs. That work will have to be funded. Every hour of the process is the equivalent of 14 or 15 years of work, so there are major implications for health service capacity next year.

**Mr Davidson:** Do you agree that if staff have a higher skill base they will be able to take on more care, as well as more technical care?

**Jim Devine:** We are very supportive of the developing role of nurses and other staff. Tragically, my mum died during the summer, so I spent time in a hospital ward for about six weeks. Increasingly, all grades and disciplines of staff are taking on developing roles, compared with those that they had when I worked in the NHS. Nursing assistants take blood, while senior staff nurses run wards and departments. In Glasgow, there is talk of some nursing staff performing minor operations. We are supportive of such initiatives, but people

must be given the necessary training. Members will not be surprised to hear a trade union official say that not only do people need to be given training, but they need to be paid the going rate.

**Mr Davidson:** That will add to the difficulties that you have with the financial memorandum.

**Jim Devine:** I have a practical suggestion for the committee. Whenever the Scottish Executive makes an announcement on health, it should put a price tag on that. There are serious difficulties with morale, especially among senior managers, who on a daily basis confront members of the public who point out that, according to Gordon Brown and Jack McConnell, record amounts of money are being spent on health. If a manager cannot deliver the service when that is being said, who is lying? Is it the manager or, dare I say it, is it you, the politicians? Whenever an announcement is made, the Executive should indicate clearly the cost of the service.

**Mr Davidson:** I agree.

**The Convener:** As part of the package, should there be direct elections to NHS boards, on the basis that those would provide democratic accountability and transparency?

**Jim Devine:** That is an interesting question and I am not trying to duck it. Until six months ago, I would have said that there should not be direct elections to boards.

**The Convener:** You cannot now say no—in your submission you say that you are for direct elections.

**Jim Devine:** I know. I have attended the past three meetings of Greater Glasgow NHS Board, at which the closure of Yorkhill hospital was discussed. It is very interesting that the elected councillors were the people who were most nervous about making a hard decision. There may be a lesson there.

**The Convener:** I do not know what the lesson is, but you have hedged your bets cleverly. That concludes this evidence-taking session.

**Danny Crawford:** I do not want to prolong the discussion, but I would like to make a point about the statutory rights and responsibilities that currently lie with local health councils. My understanding of the position is the same as Shona Robison's. The changes that will take place will mean that those rights and responsibilities will no longer lie with anyone. That is a very important point. The rights include the right to visit facilities and the right to get information from and make comment to NHS boards. Health councils also represent people. People representing patients' interests and the public interest attend and have speaking rights at meetings of NHS boards. Hopefully, those rights will not be lost when the changes take place. We do not want the baby to be thrown out with the bath water. There ought to be change, but certain good aspects of the current system should be retained.

**The Convener:** If you have any other thoughts about issues that we have not asked about, please write to let us know after the meeting.

*Meeting closed at 16:35.*

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

**Friday 19 December 2003**

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

*Single copies: £5*
*Meetings of the Parliament annual subscriptions: £350.00*

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

*Single copies: £3.75*
*Special issue price: £5*
*Annual subscriptions: £150.00*

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

*Single copies: £3.75*
*Annual subscriptions: £150.00*

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

**The Stationery Office Bookshop**
**71 Lothian Road**
**Edinburgh EH3 9AZ**
**0870 606 5566 Fax 0870 606 5588**

**The Stationery Office Bookshops at:**
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

**The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:**

**Telephone orders and inquiries**
**0870 606 5566**

**Fax orders**
**0870 606 5588**

**The Scottish Parliament Shop**
**George IV Bridge**
**EH99 1SP**
**Telephone orders 0131 348 5412**

**RNID Typetalk calls welcome on**
**18001 0131 348 5412**
**Textphone 0131 348 3415**

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

**Accredited Agents**
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178