HEALTH COMMITTEE

Tuesday 16 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.

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HEALTH COMMITTEE
17th 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 GAVE EVIDENCE:

Dr Kate Adamson (Scottish Association of Health Councils)
Martyn Evans (Scottish Consumer Council)
Liz Macdonald (Scottish Consumer Council)
Mr Warwick Shaw (Association of Local Health Care Cooperatives)
John Wright(Scottish Association of Health Councils)

CLERK TO THE COMMITTEE
Jennifer Smart

SENIOR ASSISTANT CLERK
Graeme Elliot

ASSISTANT CLERK
Hannah Reeve

LOCATION
Committee Room 2

Scottish Parliament

Health Committee

Tuesday 16 December 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:00*]

Item in Private

The Convener (Christine Grahame): I welcome members to the 17th meeting this session of the Health Committee. Item 1 on the agenda is to consider whether to take item 4, on a bid for a civic participation event, in private.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): In the spirit of openness and transparency, we should do as much business as possible in public session. I hope that the committee will go along with that.

Mr David Davidson (North East Scotland) (Con): The issue does not need to be discussed in private. We will not exactly be changing our minds about anything. We will be having an open discussion and, because we are talking about a public engagement, it is right that the public should be able to be involved.

The Convener: Do any members want the item to be discussed in private?

Members: No.

The Convener: We will therefore take agenda item 4 in public.

Subordinate Legislation

Collagen and Gelatine (Intra-Community Trade) (Scotland) (No 2) Regulations 2003 (SSI 2003/568)

Regulation of Care (Applications and Provision of Advice) (Scotland) Amendment (No 2) Order 2003 (SSI 2003/570)

Regulation of Care (Excepted Services) (Scotland) Amendment Regulations 2003 (SSI 2003/571)

Regulation of Care (Requirements as to Care Services) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/572)

Regulation of Care (Fees) (Scotland) Amendment Order 2003 (SSI 2003/573)

National Assistance (Assessment of Resources) Amendment (No 4) (Scotland) Regulations 2003 (SSI 2003/577)

Food Labelling Amendment (Scotland) Regulations 2003 (SSI 2003/578)

14:01

The Convener: Members are asked to consider seven statutory instruments that are subject to the negative procedure. The Subordinate Legislation Committee has made no comments on the instruments. No comments have been received from members and no motions to annul have been lodged. Do members agree that the committee does not wish to make any recommendations in relation to the instruments?

Members *indicated agreement*.

National Health Service Reform (Scotland) Bill: Stage 1

14:02

The Convener: Item 3 on the agenda is on the National Health Service Reform (Scotland) Bill. I direct members to papers HC/S2/03/17/2, HC/S2/03/17/3 and HC/S2/03/17/4, which are the written submissions from our witnesses. I thank the witnesses for their submissions; it is helpful to have them before we take oral evidence.

I welcome Martyn Evans, director of the Scottish Consumer Council, and Liz Macdonald, the council's policy manager. I also welcome John Wright, director of the Scottish Association of Health Councils, and Dr Kate Adamson, the convener of the association. If you want to speak in answer to a question, you should indicate or gesture in some manner. If anyone else wants to make a point, they should just come in, because I might not think to ask directly.

Mike Rumbles: The first question to our witnesses is straightforward and basic. Do you think that the changes to the structure of the national health service that are proposed in the bill will improve service delivery? Will the bill succeed in that aim?

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

The Convener: As I say, other witnesses should just feel free to comment.

Dr Kate Adamson (Scottish Association of Health Councils): Provided that the transfer between primary and secondary care is genuine and seamless, there will be huge advantages for the public and patients, from community care up to specialist services. The bill will be extremely beneficial if its provisions and the important cultural change that it envisions are implemented.

Mr Davidson: In its written evidence, the Scottish Association of Health Councils says that one risk of the new structures could be greater centralisation and less openness. Why do you think that?

John Wright (Scottish Association of Health Councils): Although we welcome in general the abolition of trusts, one of their advantages has been that they operate geographically at a more local level. We do not wish to see a return to the old-style health boards, which were less open and less accessible to members of the public. However, we are concerned that that might happen.

Mr Davidson: Is that because primary care and acute services will be subsumed into one board and will not be dealt with separately, as they are now?

John Wright: Yes.

Mr Davidson: How could that be remedied in the bill?

John Wright: I do not have any suggestions on how that could be remedied in the bill. That will depend on the way in which boards conduct their business and meetings—how those meetings are structured, how the public are made aware of the meetings and what the agenda items are.

Dr Adamson: It will also depend on the individual structures in the 15 areas. In some areas, the specialist acute services will be in association with the community health partnerships, whereas in other areas there is talk about operating divisions. It is critical that the proposed systems are studied so that they are effective.

Liz Macdonald (Scottish Consumer Council): It is also worth noting that the package is balanced. Although one could say that things will be more centralised at board level, there should—if the proposals work as I understand they are intended to work—be greater devolution of influence to a local level in the community health partnerships, which will be able to plan services for local communities based on local needs. There is a balance between the two developments.

Mr Davidson: Is that well enough covered in the bill?

Martyn Evans: There is a tension, but we cannot say how we would improve the bill in that respect, because that is not the issue. The policy intention is clear. It is about trying to balance the twin tracks of national standards and local control, which, although difficult to do, is the right approach to take. The more local control over service delivery there is, the more responsive the service will be in urban and rural Scotland. However, local control should be taken alongside an ambition to have national standards to end postcode prescribing and to end the situation where, if one is lucky enough to live in a particular area, one will get more and, if one is unlucky enough to live in another area, one will get less. There is a tension, but we could not amend the bill to deal with it.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In your written evidence, you support many of the principles of the bill. You say that one of the challenges is the nature and culture of the NHS.

Can you identify some of the barriers that will prevent us from applying the principles of the bill?

Martyn Evans: There are barriers, but we do not believe that they will prevent the principles of the bill from being applied. From our point of view, the clearest principle is the duty on health boards to involve and engage the public in a whole range of areas. That is a different way of working from the old managerial and professional way. From a consumer point of view, we do not say that the interest of service users should dominate; we just say that that interest should be balanced with and brought to the table alongside professional, managerial and financial interests.

The great challenge is in making that a reality within all the complex arrangements of service delivery and service planning within the NHS. We see those tensions played out most weeks in the press with regard to service change. The NHS is up to the challenges, but we do not think that the structure alone will deliver the improvements that we were asked about. However, that is one of the areas that require more work and more support, which the bill will bring.

Mr McNeil: Have you any ideas that you can bring to the table about how engagement and public involvement can be improved?

Martyn Evans: There are two mechanisms by which to do that. The first is the Scottish Executive's current structure whereby a team helps NHS boards to deliver their required involvement with the public. The second is that the new Scottish health council will be able to develop the capacity of patients to find their own voice and to promote their own interests, although we are doubtful about whether the investment that is going into the health council will be sufficient to support its ambitious community development programme. I think that an amount of roughly £2 million is going into that area.

The Convener: I do not want to stray into the issue of the health councils, as we will come to them later. I ask members to stick to the generality.

Mr McNeil: Okay.

The Convener: I wonder whether our witnesses would comment on evidence that we received last week. My recollection is that the view was taken that integration might be easier in rural areas than in large conurbations, especially in respect of culture change and personnel. In practice, the process can already be seen in the Borders. I got the impression that the changes will be hard enough to achieve in rural areas and that they will be a bigger challenge in urban areas.

Dr Adamson: In rural areas, there tends to be more coterminosity with the local authority area. That is an important issue. In urban areas, a local authority might have to deal with two health boards, which can create tensions.

Martyn Evans: We agree that boundary issues are key. I understand that your previous witnesses talked about the fact that boundaries are different in different delivery areas. The big challenge for the whole public sector is to try to deliver coherent services where there are different boundaries. Indeed, where boundaries are different, different structures will have to be developed. We cannot plan for coterminous boundaries; we simply have to address the issue. However, those difficulties will be less in some of our rural communities. We do not doubt that, within the structure, rural services will be able to respond well to the challenges that they face.

Helen Eadie (Dunfermline East) (Lab): My question, which I invite any panel member to answer, is about the establishment of the community health partnerships. Given that the community health partnerships are expected to evolve from the local health care co-operatives, will practice be improved by giving them a statutory basis when much of the detail of how they will work will be subject to guidance, regulations and local variations?

The Convener: Dr Adamson has taken a very deep breath. I do not know what is coming next.

Dr Adamson: As I am on the community health partnership development group, I definitely took a deep breath. The LHCCs are comparatively new and have developed at different rates across Scotland. The fact that both the good and the bad from the LHCCs could be taken through to the community health partnerships, instead of only the good, is a problem. It really is a brave new world.

Liz Macdonald: As some of the committee's previous discussions have shown, there seems to be continuing confusion about the nature of the community health partnerships. The bill might not be clear enough in that respect. Our understanding is that the community health partnerships will be bodies within the NHS that are expected to work in partnership with other agencies. However, the term "community health partnership" creates the impression that the CHP is in itself a partnership body. There is a need for more clarity in the bill, guidance or regulations about the governance and management structures of the CHPs.

Helen Eadie: You have pre-empted my other question, which was to ask whether anything should be added to the bill in respect of CHPs.

14:15

Martyn Evans: Because of the way in which language is used, "community" and "partnership"

can mean a lot of different things to different people. When CHPs are described, sometimes they clearly come across as NHS organisations and sometimes they come across as partnership organisations with other bodies that are outside the NHS. We think that the governance arrangements should be crystal clear, although we have not decided whether they should be set out in the bill. We certainly think that the committee should consider whether the bill would be improved if it contained clear governance arrangements for those organisations that are not clear about the services for which they are responsible.

Dr Adamson: There is definitely a governance issue. We must remember that local authorities, which will be part of the CHPs, have by definition different governance arrangements from health boards. That issue really needs to be considered.

Helen Eadie: If the witnesses form a view on the matter at some stage, it would be helpful if they could let us have it in writing.

The Convener: I am a little confused, as I thought that CHPs went across different disciplines. Paragraph 19 of the policy memorandum says:

"The evolution into CHPs, which will have a key role in the overall planning of services in an area and co-ordinating the delivery of enhanced community based services, requires a more formal arrangement underpinned by legislation."

Perhaps a definition is needed in the bill.

At our meeting last week, a witness from Ayrshire and Arran NHS Board said:

"The CHPs are a different animal altogether. The LHCCs are very much in the NHS family, but the CHPs, which involve health and social care, are quite different."—[*Official Report*, *Health Committee*, 9 December 2003; c 432.]

I have got it into my head that social work, housing and health would be part of the CHPs. Is that not correct?

Martyn Evans: We understood that CHPs would be NHS organisations that engage in partnership work with organisations that are outside the NHS. If we are confused about the matter—and we are saying that some of that confusion is caused by the language that the consultation paper uses—perhaps the governance arrangements would make the structure much clearer. We would have to press the Executive on what the policy intention is.

Liz Macdonald: Our view on what a CHP is is based on the recent consultation document, on the basis of which guidance for CHPs will be developed. In the document, the CHP is described as a "key NHS partner".

The Convener: So it is an NHS animal.

Dr Adamson: It is an NHS animal. We hope that the guidance will be available at the beginning of February, after the next meeting of the development group. That will be an important time, when we will be interested in commenting on the guidance that comes out.

The Convener: It is interesting that the submission from the Scottish Consumer Council says:

"the new terminology may create confusion".

It has done that for me.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The terminology creates confusion for me, too. I was speaking to some general practitioners, who will be heavily involved in community health partnerships, and they do not understand the system either. The definition must be clear. I have not been able to speak to anybody who has a clear idea of what is ahead.

The Convener: We can put that question to the minister.

Dr Adamson: There is some ambivalence on the matter. Although the development group will provide guidance, some areas have already considered local governance and establishment criteria. In my area—Highland—for example, that information exists in draft form and is waiting to run, but some areas have not yet reached the same level of development.

The Convener: We will seek clarification from the minister.

Shona Robison (Dundee East) (SNP): What are the witnesses' general views of the proposals to dissolve the health council structure as we know it?

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

Martyn Evans: We welcome the national body. We welcome its independence from service providers, as the current health councils are not independent, in our view. We welcome the threefold function of the body, which comprises assessment, development and feedback, as is described in the papers accompanying the bill.

Dr Adamson: I have a problem over the independence issue, which I believe to be extremely important.

Shona Robison: We will obviously explore that issue a bit more shortly.

In its evidence, the Royal College of Nursing Scotland said that it was not necessary to get rid of health councils altogether and that the structure of the councils could be reformed, particularly with regard to their independence. The RCN said that getting rid of the health councils was a bit like throwing the baby out with the bath water. We could have a national body, but we could also maintain the current functions of local health councils. What do you think about that view?

Martyn Evans: I will deal with the matter of independence first and come back to the other issues. I was talking about independence from service providers. It is important to stress that, as the current health councils are not independent of the service providers—they are appointed and paid for by the service providers and their staff are on secondment from the service providers. We welcome the proposed Scottish health council, for which those things will not be true. As a consumer organisation, we do not think that the current state of affairs is satisfactory. However, there is a further question, which you will no doubt press us on, about the independence of the Scottish health council.

Liz Macdonald: On the abolition of the local health councils, I would say that, despite the fact that the Scottish health council is clearly to be a national body, there will still be local offices with local advisory groups. In that sense there will be a continuing presence of a form of local health council. We will have to wait and see how the local offices and local advisory councils develop their roles.

Shona Robison: There seems to be a lack of clarity around the various functions involved.

Liz Macdonald: Yes, although I think that that is a separate issue.

Martyn Evans: One of the functions that the local bodies may lose is complaints handling, which is done by some but not all of them. We are also concerned about how voice will be given to excluded and disadvantaged service providers. That is an important issue. There is also the matter of the visits that are currently possible.

I will address each of those points quickly. We believe that the complaints function is better handled by professional complaints bodies that are properly funded and have national service standards. That would be a step forward from the current ad hoc arrangements, whereby some health councils handle complaints and some do not. We want more clarity on and investment in that function.

At the moment, visits represent an important function, but they are undertaken by a very small number of people out of a very large organisation—after all, the NHS is the largest organisation in Scotland. In any one area, 10 or 12 people are visiting. We envisage a duty on NHS boards to involve the public in future, with the process of visits to be undertaken more extensively by patient and user groups, supported by the Scottish health council. We see that function not as being lost, but as being transferred from local health councils to patient groups, which will be more effective.

Shona Robison: How do we ensure that that happens?

Martyn Evans: As I said before, we are worried about the financial capacity of the Scottish health council to deliver that aspect of its work and to build on it. The committee has received evidence about how the voluntary sector can respond as far as visits are concerned. As for how we ensure that the visits function is maintained, my view is that more investment should be put into the Scottish health council for that purpose.

Shona Robison: If those questions are not answered, is there a danger that, in doing away with bodies that already carry out that function, we will be taking a leap in the dark and just hoping that things will be okay and that public and patient involvement will happen? We need to ensure that that function is a little more definite.

Martyn Evans: That definiteness will come from the assessment role of NHS Quality Improvement Scotland and the Scottish health council, which will assess local service delivery to see whether patient involvement and visits are being encouraged. Our view is that the uncertainty can be resolved through that mechanism. If there is uncertainty, it is up to NHS QIS and the Scottish health council, through their assessment functions, to ask why visits are not being allowed, why patient groups are not being encouraged to come in and why long-term patients organisations are not getting support to engage in that way. There is potential for a step change so that that important assessment role—which we agree the local health councils are carrying out well at present—is undertaken more extensively and effectively. Change and improvement will be better assessed through the NHS QIS and Scottish health council route.

Shona Robison: One of my colleagues will return to the finances later.

The Convener: We will move on to David Davidson's question.

Mr Davidson: I have no wish to be accused of leading witnesses, but both organisations mention the following issue in their evidence. Do you think that if the national health council is part of NHS QIS, there is a risk that it will be unable to act independently? If so, do you think that the bill should say something about that, in the form of a

definition or whatever? Should the council be set up as an independent body and, if so, what kind of body should it be?

Dr Adamson: We think that independence is important. We are involved in a lot of discussion and negotiation with the Scottish Executive and NHS QIS and we are running a project to consider the future of the Scottish health council. If it is within NHS QIS, we will need many safeguards because the health council must have an independent voice. I must stress that that independent voice should always be evidence based—that is an important point, which must be covered in the organisation. We must have definite safeguards in governance rules and so on, so that the situation is maintained if the minister and the chairperson and chief executive of NHS QIS all change.

Mr Davidson: You are saying that you want that to be defined in statute.

Dr Adamson: It is essential that the existence of the Scottish health council be included in statute. Our understanding is that it is probably not legally possible to put it in primary legislation, but it could be in a statutory instrument. There is a question about whether it could be a statutory organisation if it were part of another organisation, such as NHS QIS, and we are seeking advice on that.

Martyn Evans: This is one of the most challenging issues. It is about objective and subjective independence. Objectively, NHS QIS is clearly an independent organisation. We have seen how it operates and how it has built up credibility as an independent organisation; it has involved patients and members of the public in its service standards. However, the public perception of NHS QIS is different; it is perceived to be part of the NHS because it has NHS in its title.

We believe that there should be additional safeguards, not about the objective side of it, as we believe that QIS is an independent organisation and that the minister is committed to the independence of the Scottish health council. The safeguards that we would like are: a memorandum of understanding between the QIS board and the Scottish health council; a council for the Scottish health council; a directorate answerable to the council; a budget; and research capacity.

To answer Mr Davidson's question directly, the one bit that we think should be in the bill is the requirement to have a memorandum of understanding between the board of QIS and the entity called the Scottish health council. The bill does not have to define that memorandum, but the requirement must be there to ensure that something is put down on paper that sets out the rather complex relationship that is envisaged.

14:30

The Convener: I take it that you want the bill to say, "There shall be a memorandum of understanding." Where would that be put? Would it be in regulations or guidance?

Martyn Evans: The content of the memorandum would be for negotiation between the board of QIS and what we suggest should be the non-executive council of the Scottish health council. The memorandum would be a way of working that the two parties had agreed and its content would not be laid out in statute. The statute could say, "There shall be a memorandum". We have not put this in our evidence, but we have discussed the matter and we have heard what your witnesses have said. We think that a statutory basis for a memorandum may be helpful in dealing with the perceived lack of independence by giving the relationship some robustness.

The worry that people have is that somehow, behind closed doors, the voice and interests of the Scottish health council would be subsumed by the wider voice and interests of QIS. We have said to you here, and in our written evidence, that we believe that QIS is the right place for the Scottish health council to go; if the council was, like Caesar's wife, above suspicion, that would help.

Mr Davidson: I take it, therefore, that you would not want NHS anywhere in the organisation's name. Do you think that there is a potential stigma in being involved with NHS QIS?

Martyn Evans: The word stigma is too strong. It would be difficult to explain why an independent organisation was within an organisation called NHS QIS. It is not that we in any way doubt the independence of NHS QIS; we are just saying that, in explaining that, it would be difficult to get over the hurdle of the organisation having NHS in its title.

Dr Adamson: We have produced a side of A4 on our views on independence. The committee may like a copy.

The Convener: Oh, yes. Absolutely. If you submit that to us, we will have that as another public paper.

Mike Rumbles: I would like to pursue independence further. It is perhaps the one area in which the committee may decide to make recommendations to change the bill, depending on your evidence, as well as on other evidence that we have before us.

At the moment, the health councils are not perceived to be independent. Martyn Evans has just made the point that the Scottish health council would be independent, but that there is a problem of perception among the general public concerning

the proposals, as the council may not be considered to be independent. We also have written evidence from the Scottish Association of Health Councils that states:

"We consider the independence of the new Scottish Health Council, to act and speak in the best interests of patients to be of paramount importance"—

I do not see how its independence could be more important than that—

"and believe that this can best be achieved by establishing the Scottish Health Council as a statutory independent body in its own right with its own board of governance".

There seems to be a clear option of recommending to the Executive that it should go down that route, away from what it has suggested. However, I do not think that the committee would want to do that unless there was very strong evidence from everybody who had come before us that that would be best. We are getting that strong evidence from the health councils, but you are hedging your bets. Are you saying that it is not necessary for the committee to recommend a change to the bill as regards independence?

Martyn Evans: No, we are not saying that. I hope that we are not hedging our bets on this. The subjective view of independence would not be addressed if another special health board were created, because that also would be perceived to be part of the NHS. How could we get over that problem? In addition, if it were to be an independent organisation, its budget, at £2 million, is very modest. A lot of money would have to be spent on internal processes, so it would not be as efficient.

Also, the Scottish health council would have to build its independence and credibility. QIS has, in my experience, built that credibility of being independent within the NHS itself and in a wider policy field. I do not know whether it has had much impact in the public field, but it has had an impact in the wider policy field.

We would say that building on the safeguards within the structure of QIS is the best way forward, because putting the Scottish health council into a larger organisation gives you economies of scale, and the benefits of hitting the ground running and of the real independence that we believe is there.

Mike Rumbles: I would like to press you on one point. You asked, "Why create another health board?" That is what the proposal would mean, as far as you are concerned, but it would not have to be a health board. In fact, it would not necessarily have to be part of the NHS. If we think outside the box, we could think about health councils not actually being part of the National Health Service in Scotland. Do you see what I am getting at?

Martyn Evans: I do see that, but I was just responding to the proposal.

If the national health council were a wider body, perceived as part of the NHS, that part of our concern might not be there, but our other concerns would be. With only £2 million, a very small organisation would have to build its credibility. There is therefore a more pragmatic question to answer, and I would say, based on my experience of running small organisations, that such organisations can be efficient and effective. However, they can be more efficient and more effective by being part of a larger organisation, as the Scottish Consumer Council is.

The Convener: Before I bring in Shona Robison, I would just like to pick up on what you said about money. Martyn Evans referred to the £2 million mentioned in the explanatory notes, which state that the funding for the Scottish health council would be

"The £2,108,000 currently allocated to local health councils".

Martyn Evans raised that figure, but the evidence from the Scottish Association of Health Councils states:

"This will therefore require additional funding for the new Scottish Health Council, over and above the existing provision."

Does the Scottish Association of Health Councils think that we will need more than £2 million for the Scottish health council, and does the Scottish Consumer Council think that we need more than £2 million? The financial memorandum says that there will be

"no net additional expenditure arising from the Bill",

and that that is considered an accurate assessment. Could we clear up that point about the funding?

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

We are talking about a fundamentally different type of organisation—a national organisation with local offices working on the same core functions to national standards. In such an organisation, there needs to be considerable investment in the training and development of staff and local members, and that is something that the existing

health council structure has not been funded to do. Establishing the new Scottish health council, as currently proposed, will involve significant additional costs over and above the £2.1 million, if we are to have an organisation that can hit the ground running and, most important, be effective for patients.

The Convener: Are you saying that more than £600,000 will be needed?

John Wright: I am saying that the £600,000 is basically—

The Convener: I understand that. I am asking how much more you are talking about.

John Wright: I cannot say how much more would be needed, but there would need to be training and development for staff so that there could be competent managers in the organisation. As a different type of organisation, the Scottish health council will need to invest in development and training for both staff and members.

Martyn Evans: We agree with John Wright that the in-kind contribution must be recognised and specified clearly, because the health boards make an important in-kind contribution.

On the financial memorandum saying that there will be no change in the £2.1 million that is available, if we were to go into the system without making any change, we would be asking the Scottish health council to achieve a significant step change in the culture of service delivery with the same level of resources that has been available in the past. We do not think that that level of resources is sufficient to meet the challenge. In our view, that challenge is about bringing the patient interest to the table alongside the well-organised professional interest that previous witnesses have mentioned and the well-organised financial and managerial interests within the NHS. The proposed sum is a very modest amount of money for bringing the patient interest up to the same level of understanding and influence that the professional and funding interests have.

We do not believe that the Scottish health council will necessarily cost any more money than the amount that is proposed, but we do not think that it will be able to do the job unless more money is put into it—that is slightly different from what John Wright is saying. It is not inevitable that the health council will cost more money, but it will not succeed unless there is an investment of more than £2 million.

The Convener: It will be useful to put that point to the minister.

Shona Robison: I want to respond to two of the points that have been made. I want to pick up Martyn Evans on what he said about independence. You seemed to imply that the fact that the health council would not be big enough or well enough resourced to stand alone was driving your thinking on where it should be located. Should not the question of where the health council should be located in order for it to be as independent as possible be a matter of principle? Should resourcing not be left aside when considering that principle? If resources were not an issue, would that change your view on where the health council should be located?

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

All that I can do is respond to the alternative proposal of which I am aware, which is that there could be an NHS special health board. We say that there is no doubt that such a board would also be objectively independent, but the perception would remain the same—because the board would be an NHS board—and, in addition, there would be practical issues, although I accept that they would not be matters of principle.

We share the view of our colleagues—we think that it is absolutely vital that the health council is an independent organisation.

Shona Robison: My second question is for the Scottish Association of Health Councils. You have heard what the Scottish Consumer Council has said about safeguards. In your evidence, you said that, if you do not get the structure that you want,

"additional safeguards will be required"

as a fallback. Are the safeguards that the Consumer Council was outlining the same kind of safeguards that you are in favour of or do you have other safeguards in mind? If so, can you let us know what those other safeguards are, either today, or subsequently in writing?

John Wright: As I recall, the points that Martyn Evans made about safeguards are similar to those that we would make. We have been trying to work up proposals in a bit more detail, by considering issues such as the relationship between the health council and the board of NHS QIS and how accountability would work within that organisation. We have tried to work out the issue in a bit more detail and I would be happy to share our information on what we think that the safeguards for the health council's independence within NHS QIS would be.

The Convener: Please do. As you appreciate, some parts of the bill are more important than others and that key issue will have to be explored thoroughly by the committee.

Janis Hughes (Glasgow Rutherglen) (Lab): I refer to the written submission from the Association of Health Councils. You say that you are

"concerned that many of the existing functions carried out by Health Councils could simply disappear, unless alternative delivery mechanisms are identified".

Will you tell us what functions you are concerned might be lost under the proposal? What mechanisms could address those omissions?

14:45

Dr Adamson: We feel that it is extremely important to ensure that the public and patient voice is heard, although we are not suggesting that the Scottish health council necessarily has to be that voice.

The health boards have a duty to involve the public. However, there is a definite problem relating to the three to four-year interim development period, in which the health boards will have to develop new systems. We are currently considering various transition arrangements. We are also concerned about the arrangement whereby the public goes to a health board for information and the health board replies to their concerns. We have to ensure that the public's voice is heard and that the health boards do not give them the information as a way of avoiding problems. The public must get independent information as well as information from the boards.

Janis Hughes: Do you think that the bill goes far enough in relation to public involvement and the duty that will be on boards to involve the public? Might there, therefore, be a role for health councils to play that might not be in the new proposals?

Dr Adamson: There is definitely a role in ensuring that this process is adequate. The role of the Scottish health council will be to assess whether it is adequate. However, there has to be a robust mechanism by which any problems can be flagged up.

Janis Hughes: What would you suggest as a robust mechanism? What should there be in the bill to address the elements that you think might be lost?

Dr Adamson: We are considering that at the moment. We are not experts in legislation so we have to take advice from people as regards the mechanisms that can be used.

The Convener: You can write to us with suggestions later on. You do not have to use statutory language; all we need is a steer.

John Wright: We do not want a situation in which we are hoping that everything will be all right on the night. There are clearly-defined functions that health councils currently carry out. Should the decision be to transfer some of those functions to another organisation, we would like to ensure that, in the planning process for the establishment of the national health council, consideration is given to how those functions will be transferred and that it is ensured that the organisation that is taking those functions on board is capable of doing so. Those functions and services that are currently available to the public should not fall down a hole or suddenly become unavailable. The transition has to be planned extremely carefully.

Dr Adamson: We are well aware that MSPs send people to the health councils to access information. We are concerned about the possibility of a void opening up in this area while the area of public involvement with the boards is developed.

Liz Macdonald: You asked about what sort of robust process would be needed. In a way, that brings us back to QIS, because that has developed ways of coming up with standards and then going out and checking whether those standards have been met. Part of the strength of the health council's being associated with QIS is that it will buy into that robust process that is being developed in the context of public involvement.

Martyn Evans: I want to add something about functions being lost or not carried over. We have given our view about complaints and complaint handling and about the right of access in order to monitor services and I now want to agree with what Kate Adamson said about patient voice.

We agree with the policy direction that states that the Scottish health council will allow patients to find their own voice and to represent their own interests in all their diversity. Our concern is for those patients who are unable to do that for themselves: perhaps the very young; teenagers in particular; or perhaps homeless people seeking dental appointments, or whatever. We are talking about people at the margins who are disadvantaged. The Scottish health council must have a clear equalities strategy and it must be able to give a voice to some of those people. It is our experience that such people cannot easily be helped to find their voice because of the nature of their circumstances and how they engage with the NHS.

Although we broadly approve of building a capacity to enable people to say how they find the

services, there are key groups in our society who will not be able to have a voice. We do not suggest that that should be covered by the bill; equalities statements are part of safeguarding a voice for the voiceless. That voice is not necessarily a national one, but a voice that says to the local service provider, "In your area, this is a failure," or, "This is a concern that we have about our local office of the Scottish health council."

I agree strongly with what Kate Adamson said about voice.

Mr McNeil: It is natural at a time of change that one focuses on what one might lose and on what one is losing. We have heard from the Scottish Consumer Council that it believes that it was time for a review of the health councils, that all was not perfect, that there were weaknesses in the system and that this is an opportunity for progress. Will you take the opportunity to identify some of the weaknesses that you perceive in the system? Can you tell us what we can improve through the review, rather than dwelling on what we might lose?

John Wright: I make it clear that we agree with and are supportive of the need for health councils to reform, as Dr Adamson said earlier. The basic principle is that we are talking about fundamental and structural reform of the health service, of which the health councils are part. With the changes that are taking place in the NHS, we recognise that health councils need to reform and respond to that change. We agree with the principle that the board should be responsible for public involvement. We are positive from that point of view.

We see this as an opportunity to improve what health councils do because it is not about what is good or bad for health councils; it is about being able to deliver outcomes for patients. That will be determined by the powers, the remit, the role and the responsibilities that are given to health councils. The separation from service providers, which you have already talked about, is a positive step.

I do not want to be totally negative and say that everything about being involved in NHS QIS is bad because that organisation has, as we have said, demonstrated its ability to act independently. It has powers to intervene and it has powers to bring about change in the NHS. Having those powers vested in the Scottish health council and giving it teeth to deliver will give significant advantages over the current set-up. Currently, health councils can go along to boards and point out issues, and the boards can simply pat them on the head and say, "Thanks very much, but we're not going to do anything about it." From the powers and responsibilities that will be given to the Scottish health council will flow the opportunity to deliver change for patients and to ensure that the patients are involved in the planning and delivery of the NHS and that they will be able to communicate their voice. There are many positive points there. Our concern is that the organisation is created in the right environment, with the appropriate powers and remit to be able to deliver, and that it not only has independence but is perceived to be independent.

The Convener: We see a slight difference in views between the two groups.

I ask Duncan McNeil whether he wants to proceed with a question on the complaints procedure before we move on to questions from David Davidson.

Mr McNeil: Yes, that might be helpful. I return to the concerns about the complaints system, which was mentioned both in your written evidence and earlier this morning, when we heard evidence of concerns over the lack of investment and focus. Will you say more about your concerns about the complaints service and whether you believe that giving the boards responsibility to establish such a service will be an improvement on the current set-up? Did you say earlier that not every board has a complaints system in place?

Martyn Evans: One of the weaknesses of the current system is that not every health council has a mechanism for dealing with complaints, so the pattern of service delivery throughout Scotland is variable. The extent of support depends on the individual board, so the system is not coherent. The new NHS complaints procedure that is coming through will cut out the middle level: it is about local service provision and resolution at the local level. The evidence that we took in our preconsultation work showed that few people knew about the role of local health councils. Other organisations that provide advice and assistance are well known; name recognition of some of them is around 90 per cent.

To be consistent, we must invest in a complaints support service throughout Scotland. The Scottish health council should have a role in defining who should take up the services locally and in monitoring how well they are provided. We welcome the greater focus on consistency throughout Scotland and we hope that there will be proper funding of support services for people who make complaints about the NHS. The evidence that we took showed that a significant number of people just want to be dealt with locally and reasonably quickly, rather than go through the existing escalating procedure, which takes a significant amount of time.

Mr McNeil: Does Kate Adamson want to say anything about that? There was quite a challenge there in relation to your perception of the number

of MSPs and other people who use the procedure. I do not use it; many of us use a direct route. The challenge from the Scottish Consumer Council was that it should not necessarily be the health councils that provide the support and that citizens advice bureaux or local advice groups with name recognition and accreditation should do that work.

Dr Adamson: Work is being done on the mechanisms under which complaints are dealt with and on whether health boards will have to deal with complaints or whether they will commission services. The extremely important point that Martyn Evans made is that adequate training and capacity must be built into the handling of complaints; health boards cannot take on that work without making considerable investment.

Martyn Evans: I do not want my criticisms of the system to be taken as criticisms of health council members or staff. The councils' impact has been dramatic over the past 30 years; our criticism is of the structure and the method of service delivery. We have talked about the improvement that the proposals might bring. I say that in case I overstepped the mark in making my criticisms.

Mr Davidson: I go back to something that Liz Macdonald said about NHS QIS and its image, which rang a bell. It really comes down to what NHS QIS does. Many people see it as an organisation that audits and can intervene in professional delivery as opposed to one that deals with patient involvement. John Wright said clearly that the health councils welcome the ability of NHS QIS to step in to intervene. Does that mean that health councils have a separate role in putting a case to NHS QIS as an independent body to intervene from a patient perspective in something that might not be to do with professional standards but which might be to do with outcomes and accessibility? I challenge you both on that question again. John Wright made himself very clear, but where does the Scottish Consumer Council believe that the difference lies?

15:00

Liz Macdonald: I am not sure that I understand your point.

Mr Davidson: John Wright said that the health councils welcome the fact that NHS QIS has the power to intervene on delivery, and that NHS QIS is perceived as being more professional. Is there a role for the health councils to act as an independent body on behalf of patients and to take a case to NHS QIS?

Liz Macdonald: If there is an established system for setting standards and monitoring them, there would be no need for ad hoc approaches, which seems to be what you are suggesting.

Mr Davidson: That is how the system operates at the moment.

Martyn Evans: The system does not operate that effectively at the moment. NHS QIS has a system of doing routine and regular reviews and writing those up in the expectation that there will be improvement. It has powers to intervene in service failure and it is grappling with how it undertakes those powers. There is no reason why the Scottish health council could not support a voluntary organisation that wanted NHS QIS to take action on a perceived service failure in a particular location. If the memorandum of agreement that we have suggested is drawn up, there is no reason why the Scottish health council should not use internal mechanisms to ask the QIS board to intervene in a perceived service failure. There is also no reason why the current structure would preclude your suggestion.

Liz Macdonald was saying that the current quality assurance system is a routine system—it is not a system for exceptional circumstances—and it is understood that service failure will be exceptional. There is a mechanism for dealing with service failures and if we suggested that the memorandum of agreement might be put into statute, we would be looking for that memorandum to have a route to service failure intervention. That would be a strong indicator of independence from the QIS board. NHS QIS would still have to decide whether to intervene on service failure but the Scottish health council could make such a proposal. In an open and transparent organisation, it would be known that such a proposal had been made and what the evidence for it was.

Dr Adamson: A close relationship with QIS is viewed as being extremely valuable; it will be the important relationship. There will be an advantage in that the Scottish health council will not necessarily have to go back to the boss organisation, as it has to have a voice in areas where problems are perceived to exist. The council will benefit from QIS's experience in setting standards and considering outcomes, but it must be able to comment on those in its own right, especially where public involvement is concerned.

Dr Turner: Public involvement is very important. Given that the duty to involve the public will not be accompanied by significant additional resources, will it improve public involvement in health service planning?

Martyn Evans: We think that it will. As we said at the beginning, we are talking about a culture change. That might involve some investment in training but the major impact will be on service provision in public services for patients, in that their feedback will be respected and encouraged and their interests will be taken care of when service delivery and future services are planned.

I hope that we are not being naive when we say that we hope that the duty will improve NHS services in Scotland. It will make a major difference. The structures proposed in the bill, such as the capacity-building support that the Scottish health council will give, will be of major importance, and the statutory duty to involve the public and patients will also be of great importance. We are very optimistic about the changes that could take place in the NHS as a result of the bill.

The Convener: Do I detect dissent among the panel?

Dr Adamson: We are extremely concerned about the fact that public involvement by health boards is to be cost neutral. Unless that money is ring fenced, the problem that we have already of public involvement being considered not that important will definitely continue, and front-line services will be considered important as far as funding is concerned. There will be a conflict, unless the boards' duty of public involvement is covered in another way.

Dr Turner: That is an important issue. The Scottish NHS Confederation said that the proposal would cost quite a lot of money because, to use its phrase,

"Genuine, meaningful, continuous public involvement is not cheap".

I agree with that. The feedback from patients is that public involvement is fine but people already want to be involved and there is nobody to listen to them. That is the main thing. There are not enough nurses on the wards and there is not enough time in surgeries, and when people try to relate to people in the NHS, they find that the people in the NHS do not seem to have the time to listen. Even if there were more staff to answer questions, a cost would be involved. Enormous costs could be involved in public involvement.

Dr Adamson: We support that attitude.

Martyn Evans: Our experience is that it does not cost public services huge amounts of money to focus on their service recipients. After all, that should be the nature of what their business is about. There is a difference between getting the views of the public service user and providing the time, to which Dr Turner referred, for a general practitioner to spend with a particular patient. The issues are different. It can be argued quite legitimately that, for clinical and medical reasons, GPs and others need more time to see their patients. However, our evidence is that a large organisation such as the NHS—it is the largest organisation in Scotland—does not need significant extra funding to focus on its service users. It needs a culture change to reassess how it spends its money but we do not think that it needs large amounts of extra money over and above what it currently receives.

Mike Rumbles: On that point, I think that the issue is one of perception. I note that Dr Kate Adamson said that more money would not be provided for the bill. However, my understanding from the evidence that we have received from previous witnesses is that the Executive has said not that there will be no more money but that the bill will not add any further costs. For instance, Dumfries and Galloway NHS Board—which is a small health board in comparison with others—said in evidence that it saved £500,000 through service reorganisation. That is quite a substantial sum of money. The bill will make changes from the top and if those savings were replicated elsewhere, that could make moneys available. As far as I understand it, the Executive is saying that people will be able to redirect such moneys to public involvement among other things. Do you not share that perception of the situation?

Dr Adamson: We have read the evidence that Dumfries and Galloway NHS Board gave, but £500,000 on the board's turnover is not quite as good as it might sound at first hearing. We are talking about savings that will be made over quite some time but money will be required immediately to fund public involvement. Although the proposals may be cost neutral over time, there is definitely an issue over the initial cost.

Mike Rumbles: I want to pursue that point. You said, fairly, that the £500,000 is insignificant compared to the board's turnover. However, the funding of health councils is £2 million Scotland-wide, is it not? If the 15 health boards each saved £500,000, that would amount to a total of £7.5 million. Surely that is a substantial sum to save. I am sure that the actual savings would be a lot more, would they not?

Dr Adamson: The health councils will continue with assessments and other functions, so the £2 million will not go to the boards for public involvement. Public involvement is a new process.

Mike Rumbles: You seem to misunderstand my point. You said in response to my question that £500,000 is not a particularly large sum in proportion to the turnover of Dumfries and Galloway NHS Board. I then used another comparative example: the £2 million for health councils Scotland-wide. I am not saying that that sum would go to public involvement—I understand that it will not. However, the point that I am trying to make is that we do not know how much money will be freed up through the savings process; it could be several million pounds. It seems to me that if Dumfries and Galloway NHS Board can make savings of £500,000, there will be generally a substantial sum of money that should be directed to public involvement. I was questioning your point that more money should be allocated.

Dr Adamson: I am talking about allocating more money during the set-up period rather than in five years' time. I believe that that is an extremely important point. Dumfries and Galloway NHS Board said in its evidence that it could not guarantee that its saving would be mirrored in other areas.

The Convener: Three members want to ask supplementary questions. I ask them to be brief, so that we can move on. I am mindful that another witness is waiting.

Mr McNeil: I will be very brief. We have had a lot of evidence, including that from Dumfries and Galloway NHS Board, but I do not think that in any of that evidence anyone has described the cost of public involvement as being enormous amounts of money. We need to clarify that no one has given us such information; in fact, it is contrary to all the evidence that we have taken. What is your definition of enormous amounts of money?

Dr Adamson: It was not my intention to imply that enormous amounts of money would be involved. I want to ensure that the process of and the mechanisms for public involvement are covered. The Scottish Association of Health Councils has been considering the developing frameworks for public involvement that the boards are producing and the development of performance assessment. Our perception is that health boards are producing those things at different speeds. The frameworks are in operation, because the boards must produce them, but we do not have total confidence in the processes that they are undertaking.

Mr McNeil: That could be more to do with the culture than with the financial constraints.

Dr Adamson: It could be.

Dr Turner: My understanding—I wonder whether it is yours—is that public involvement is to take place throughout the whole health service and not just in the public's interaction with health councils. Time is money in every other form of employment and business. Therefore, if the culture has to change and people have to find more time to interact with patients and relatives to feed back to health councils and consumer councils, an amount of money will be involved that has not yet been prescribed. We have no idea yet what that amount will be.

Dr Adamson: A lot of the public involvement has been on the part of lay people giving their time voluntarily. If employees of health boards are required to be involved, by definition there will be a cost.

15:15

Liz Macdonald: A lot of the talk has been along the lines that public involvement is something new that has not happened before, but it would be a mistake to think that. We have been working on public involvement in the health service for many years. Public involvement is going on, and there are lots of examples of good practice. We are not talking about a step change in funding; we are talking about the introduction of a statutory duty as another driver to push people down a road that a lot of people are already on.

Helen Eadie: When I first came to the Scottish Parliament the guidelines on public involvement had not been changed since 1947. That was a contentious issue in my area in Fife. I ask each witness to define public involvement for me, because I am aware that there are many examples of best practice.

The Convener: I ask the witnesses to be brief.

Martyn Evans: I will distinguish between service-user involvement and public involvement, because they get mixed up. Public involvement is often about service planning. It is about the whole range of people who may not currently use a service, but who have an interest in how that service is developed. That public involvement is basically a citizenship issue. It is about engaging with citizens who have the interests of young people and others at heart. Engaging the public as citizens in service planning is a complex matter. We see that when hospitals have to be closed or reorganised.

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

We make that distinction, but we are much more interested in service-user involvement, only because we are the Scottish Consumer Council, and that is our locus. However, we understand the public-policy issues around public involvement, because we believe that better decisions are made about huge allocations of money and time. Involving citizens in big strategic decisions is a modern way of working, and it is a better way of working in a democracy.

The Convener: I will take one definition only from each organisation.

Dr Adamson: I support Martyn Evans's comments: there are the service users and there are the public. The service user often has their own interests; the public have a broader perception, but perhaps they do not understand the issues. It is essential that both groups are involved, and disadvantaged people must be enabled.

The Convener: I thank the witnesses. We will have a five-minute adjournment until 25 past 3.

15:18

Meeting suspended.

15:26

On resuming—

The Convener: I welcome Mr Warwick Shaw, chair of the Association of Local Health Care Cooperatives, a gentleman whom I met before in his work in the Scottish Borders. I will start off with a general question. Do you think that the change to the structure of the NHS as proposed in the bill is necessary or appropriate? That is quite a soft ball for you. Do you think that it will improve service delivery? That is a more difficult question.

Mr Warwick Shaw (Association of Local Health Care Cooperatives): I am speaking both as the chair of the association and as someone with a background in the NHS in the Borders. I think that the move to a single structure in the NHS in the Borders has been very valuable. It has enabled many improvements to begin, although I would not necessarily say that they have all been realised.

The Convener: I ask you to move the microphone a little closer to you.

Mr Shaw: Certainly, and I will move a bit closer to it as well.

The Convener: Thank you.

Mr Shaw: The reorganisation is an important one, and it offers many opportunities to improve services and the way in which they are delivered. That applies both to the public, who are the users of the service, and to the professionals, who deliver it.

Dr Turner: Do you think that the bill should explicitly state that community health partnerships should evolve from LHCCs? If so, why do you think that that would be beneficial?

Mr Shaw: I will answer the second part of the question first. When LHCCs evolved, as a result of a couple of phrases in the 1997 white paper, "Designed to Care", the guidance was broad and was very much an outline. It enabled front-line clinicians to feel far more involved than they had been in decisions on investment and on how services were shaped, and in how their lives were affected. The various reviews of LHCCs, the best-practice group and the primary care modernisation group have all identified that. There is a tremendous range of LHCCs, some of which have made a significant difference to the way in which services are provided. I am not suggesting that either big LHCCs or small LHCCs are the answer. It is not purely a question of size, although I think that we used that phrase in our evidence. It is much more an issue of attitude—I am perhaps phrasing that in a slightly different way than was done previously.

The Convener: If things have evolved in the way that you describe, what in fact is a community health partnership, or CHP—as one might work in the Borders, for example? I know that you are not here to give evidence on that, but if you have one in the Borders, you might as well tell us about it.

15:30

Mr Shaw: We do not actually have a community health partnership in the Borders; there is a unified NHS board. Many of the characteristics of a community health partnership are displayed in one of the LHCCs, but it has been set up as an LHCC, not a community health partnership, and therefore has fewer responsibilities and a slim infrastructure, as do most LHCCs.

What is a community health partnership? The association was invited to become part of the drafting process with the Scottish Executive Health Department, and we spent quite some time batting around what a community health partnership is. The summary of the consultation process contains quite a good description of what would be in a community health partnership, but that is rather different from what a community health partnership might do. Not only would there be services and staff within a community health partnership, the community health partnership would exercise influence over other areas, both within health services and within the local authority. I agree that community health partnership is not necessarily a tremendously helpful name to describe what is probably fundamentally an NHS body, albeit one with necessarily extremely strong links with the local authority partners.

Dr Turner: Can you give an example of something that is working well at LHCC level that would probably work well in a community health partnership with the local authority?

Mr Shaw: An example of that is the integration of the primary health care team at a level above the primary health care team—not just the general practitioners who work in a practice, who always work in close partnership, but the district nursing staff, the health visiting staff, community midwives, the local social worker and the local community practice nurse. All those people who work within a defined geographic area have always been able to work closely if there was the will for that locally. LHCCs have made that far more likely to be the case by allowing such joint working to take place

at the planning level for those local primary care teams.

Dr Turner: That certainly happened in some areas before the creation of community health partnerships. All those people worked together in a geographical area. In connection with the local authority, would there be more involvement with social work and housing services?

Mr Shaw: Certainly.

Dr Turner: That is what I was wondering. Do you have any examples of that happening at the moment?

Mr Shaw: There are examples around Scotland, but things have evolved differently in different areas. In your constituency, there is a well-developed discharge team, which involves good co-operation between the local authority and the LHCC.

Dr Turner: Yes, that is right.

Mr Shaw: That is also the case elsewhere.

Mr McNeil: It is important to examine the relationships between local authorities and LHCCs. Some of the more developed LHCCs take an integrated approach, but that is not uniform throughout the country. What are the strengths and weaknesses of LHCCs? What are the best examples? Where are the weaknesses? Can the formation of community health partnerships be expected to improve those relationships or does the committee need to do something to ensure that that happens?

Mr Shaw: In most cases, the areas where LHCCs have worked better are those where there is already an element of coterminosity and one LHCC does not have to try to deal with two local authorities—or vice versa—or something more complex. The community health partnership is specified as being coterminous with a local authority or some obvious part thereof. If coterminosity is one of the key elements in the success of integrating local authorities and LHCC services, we can assume that CHPs will be better able to develop services jointly if coterminosity is rolled out across the CHP model.

Janis Hughes: I have a follow-on question. How much emphasis do you place on the importance of coterminosity? Particularly given the way in which things stand in the central belt at the moment, coterminosity will be quite difficult to achieve. I know that the issue has been raised with the Executive and that it is looking at it in the context of the consultation on CHPs. How important is it to keep the CHPs coterminous with the areas that they are to serve?

Mr Shaw: It would be useful, but it is not vital. Coterminosity makes things simpler and, if one can make things simpler, they are probably more likely to succeed.

Janis Hughes: Would it be better to have a smaller CHP and keep it coterminous than to go for a bigger group with no coterminosity?

Mr Shaw: There are advantages to both. If a community health partnership is too small, it will not be possible to achieve an economy of scale in infrastructure. If it is too large and it covers too big an area, the complexity of the infrastructure means that it will have to work far harder in order to engage with all the appropriate partners.

Janis Hughes: You alluded to the fact that one of the benefits of LHCCs is that they can react to local needs. LHCCs are composed of groups of health professionals who work together in their local area. Will the statutory basis that is proposed for the community health partnerships mean that they will be more bureaucratic? If so, will they lose some of their ability to react to local needs?

Mr Shaw: Most of the members of the Association of Local Health Care Cooperatives steering committee would be concerned if CHPs were to become what we would characterise as traditional NHS organisations—by that I mean if CHPs became relatively bureaucratic and procedure and governance driven, as opposed to how we characterise ourselves, which is as slim organisations that concentrate on trying to do something. We rely on the NHS infrastructure around us to provide the governance framework within which we operate.

Janis Hughes: Is there anything that could be added to the bill that would help the CHPs to avoid that bureaucratic quagmire?

Mr Shaw: Community health partnerships need to exist as part of an NHS body and not as statutory, independent bodies in their own right. As we move away from the trust model, there is a danger that we could almost recreate them.

The Convener: From reading proposed new section 4A of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the bill, I think that there can be more than one community health partnership in a board area. Is that correct?

Mr Shaw: Yes.

The Convener: I think that I was getting the wrong idea that there would be one community health partnership in a board area. I can see that, if the health board covers a big area, it might have two or three CHPs in its area. If CHPs were set up on an area basis, could that deal with the difficulties of coterminosity?

Mr Shaw: There will be one community health partnership in only a very few health board areas.

If that were to happen, it would almost be as if we had one structure sitting on top of another structure, which would not be terribly helpful. In many areas, the coterminosity of a community health partnership in a health board area will be with the sub-divisions of a local authority and not the entire local authority. One example is Ayrshire and Arran NHS Board, which is considering having three community health partnerships. I think that Argyll and Clyde NHS Board is considering having four.

The Convener: Is that because not all the local authority area is in the NHS board area?

Mr Shaw: That is right. However, there is a need to try to retain a more local focus. We do not want to have a community health partnership with a million patients in it.

The Convener: I was thinking that way, but I have just realised that I was thinking wrongly, which is a bad sign.

Mr Davidson: I turn to the practice outcomes, because the delivery of health care is what the bill is supposed to be about. As CHPs are supposed to evolve from LHCCs, do you think that practice will improve? CHPs will be given a statutory basis, but much will be laid down by regulation, by guidance and by local variations.

Mr Shaw: By defining what a community health partnership's responsibilities are, one gives a level of legitimacy if there is a different view at the health board level in each area. One of the reasons why LHCCs are at different stages of development around Scotland is the level of the support that they were given by local health boards and the level of freedom that those boards were prepared to delegate.

Mr Davidson: In other words, the new sense of freedom comes with responsibility.

Mr Shaw: Yes. Where the freedom was given, the responsibility was returned.

Mr Davidson: On CHPs, do you think that an addition should be made to the bill to enshrine flexibility in devolved management? The minister talks about that principle, but are you content that there is enough in the bill to demonstrate it?

Mr Shaw: There is the opportunity in the bill for that to take place, but if it were defined, that would probably be rather welcomed by the steering committee of the Association of Local Health Care Cooperatives.

Shona Robison: The financial memorandum to the bill states that the community health partnerships will not require any "overall additional expenditure". Do you agree?

Mr Shaw: Given that the bill is in the context of a significant reorganisation of every local NHS system, there will certainly be possibilities to redeploy staff and transfer resources that might be freed up from the unified system into community health partnerships. You should also bear it in mind that most CHPs will be an amalgamation of several LHCCs, so some management and administrative effort will be available. Whether that is at the right level and with the right skills is a different question. I am almost falling into the civil service trap of weasel words—

The Convener: Heaven forfend.

Mr Shaw: I think that it is possible that additional expenditure will not be required, but goodwill, imagination and a willingness to transfer good staff, rather than spare staff, will be needed.

Shona Robison: Let us see whether we can get you out of the civil service trap. Under infrastructure, your evidence says:

"LHCCs have been established on a relative shoestring … It is important that CHP establishments are sufficient to handle the workload."

Given that CHPs will involve several LHCCs, as you mentioned, CHPs will presumably involve several shoestrings. To me, that reflects a concern that community health partnerships might not be adequately resourced—that comes from your written evidence, but also from what you said about ensuring that CHPs have the right personnel. Your evidence goes on to say:

"As NHS systems re-organise the opportunity to redeploy high quality staff within emerging CHPs should not be ignored or lost."

Of course, staff cost money; they are not free. Do you think that we need to ensure that there are adequate resources for CHPs? If so, how do we do that?

Mr Shaw: My association's steering committee would certainly agree with you, but it would also agree that one has to be realistic. NHS financial systems are already under some strain, and it would not be helpful to suggest that sums should be ring fenced for yet another style of organisation. It may well be helpful to the development of community health partnerships, but not to the overall NHS systems. I really think that we need to avoid trying to favour one group over another. Our evidence reflects the fact that there are two sides to the argument. There will be additional demands for an appropriate infrastructure for community health partnerships evolving from LHCCs, but that does not necessarily require investment from outside the existing envelope.

15:45

Shona Robison: So we run them on a shoestring as well.

Mr Shaw: As you yourself suggested, several shoestrings coming together can be plaited into a relatively substantial rope.

The Convener: A man of metaphors.

Mr Shaw: Hopefully not one who will hang himself. [*Laughter.*]

The Convener: He has thrown that rope to you. Clutch it, Shona.

Shona Robison: That is an interesting response. I am interested in what you are saying about balancing. We know that there are significant pressures on the NHS, and the Audit Scotland report makes interesting reading. However, we are also told—and we all agree—that what can be done in primary care should be done, so there will be an expectation that CHPs will deliver an awful lot more than LHCCs delivered. As we know, the success of LHCCs was very patchy across Scotland. I agree that it is a balancing act, but we also have huge expectations. Is there a danger that expectations of what can be delivered will be high and that, if we do not put in the necessary resources, those expectations could be dashed?

Mr Shaw: There is a difference between making resources available to a community health partnership and investing those resources in the management capacity and infrastructure of a community health partnership. Not an awful lot of managers actually treat people or provide services to individuals—some do, because they are also clinicians—but that is what we should be about. Rather than design our own empire, we should design something that is sufficient to meet the financial, organisational, planning and governance requirements. We should not just build an empire because we can.

Shona Robison: So we should keep bureaucracy to a minimum.

Mr Shaw: Yes. When LHCCs began, they were funded on a transfer of the old fund-holding manager allowance of £3 a head. I do not know whether that is well known to committee members, but that is pretty much what most LHCCs run on. Many of the larger ones manage to invest quite a lot of that in services and front-line staff rather than in their own organisation and infrastructure. Maybe we are our own worst enemies, as we have not provided ourselves with the infrastructure that there might have been money to provide, because we took a decision that it should be invested in services.

Shona Robison: That is interesting.

The Convener: In your written evidence you say:

"A key feature of CHPs will be the relationship with Local Authority partners."

You go on to say:

"Despite the best efforts within Joint Future work there remain some obstacles to joint working, and one that is often mentioned are the differing terms and conditions of service between the systems for similar work."

I do not know whether "some obstacles" is civil service speak, but I would like you to develop that point, because it has been raised before. If you are asking people to co-operate, they may be pretty hostile to one another if they are getting a lot less pay and their conditions are not so good.

Mr Shaw: One can be magnanimous if one is earning a lot more pay, but I do take your point.

The Convener: It is a serious point.

Mr Shaw: One of the oft-quoted examples is occupational therapy, where people with exactly the same professional qualification work on either side of the local authority-NHS boundary and are paid entirely differently.

The Convener: How much of a difference is there between people at the same level doing the same job? Thousands?

Mr Shaw: Not many thousands but a couple of thousands. It obviously depends on the grade as well. There are also differences between the terms and conditions of some care assistants in local authorities and those of health care assistants in NHS systems. Those differences generally favour those on the NHS side, not necessarily in hourly pay but in the continuity of employment.

The Convener: I do not want to spend too much time on this, but I want to flag it up because I think that what counts is the relationship between people at the coalface. We can have all the structures in the world in place, but the system will not work if there is hostility between people who are doing the same job because one of them is being paid a few thousand pounds less than the other.

Mr Shaw: Yes, and that is not something that can be resolved at a local level.

The Convener: You are right. We should bear that in mind.

Mr Davidson: Paragraph 9 of your submission says:

"CHPs must have delegated authority and flexibility in order to deliver the roles outlined … above. This must include appropriate budgets".

Given that you have to come to some arrangement with the local authorities, which have their own budgets, do you think that there has to be better definition of how you use combined budgets on the basis that, in many cases, patients are assessed twice, by two different set-ups?

Mr Shaw: Yes, I do. That falls under what we term "governance and accountability" in our submission.

There are various drivers, performance assessment frameworks and so on and QIS and the social work inspectorate use entirely different systems. There will be entirely different deliverables for the NHS and the social work elements of community health partnerships. That will definitely present us with a challenge.

Mr Davidson: Does your association have any particular thoughts to share with us in relation to that problem, if you see it as a problem?

Mr Shaw: We have at least 15 or 20 different thoughts. It depends on the area from which the representative comes. Each area has specific issues and some work well while others do not. As a rule, we feel slightly at variance with the joint future drive that aligned budgets are safer than pooled budgets.

Mr Davidson: Convener, could we ask Mr Shaw to send us something from his committee on that area? The area is complex and I know that some of the local authorities are already concerned about who will drive the process because, obviously, the CHPs will be health organisations.

The Convener: Are you happy to do that after taking advice from the representatives?

Mr Shaw: We will have a go.

Mr McNeil: On public involvement, your submission says:

"LHCCs have all involved the public, but to varying degrees. A specific responsibility and appropriate funding will enable this to be taken forward in a very meaningful way."

When there is a specific responsibility to involve the public, how will you do it better?

Mr Shaw: The level of public involvement has been immensely varied. Some LHCCs have an occasional chat with a member of the public, others have members of the public sitting on their boards and others embark on quite elaborate public involvement exercises. The more elaborate the exercise to involve the public, the greater the commitment and the expense. Most LHCCs will have tended to invest the money in services, as I said before, rather than in public involvement, which has not been a specific LHCC responsibility but has tended to reside at trust or health board level. As trusts disappear, public partnership forums are formed and the responsibility is given to LHCCs, there will be a structure in which public involvement must take place. There is an enthusiasm in LHCCs to do that work and involve the public more closely in the planning of the service. At this point I should say that I am grateful to the Scottish Consumer Council for drawing such a clear distinction between public and service user.

The Convener: That was helpful.

Mr McNeil: Your submission says that appropriate funding will enable the public to be involved in a meaningful way. However, the Scottish Consumer Council suggested that the problem was more cultural than financial.

Mr Shaw: That is a fair point. At the moment, however, LHCCs have no responsibility for public involvement and therefore not all of them dedicate any money to public involvement. In the future, LHCCs will have that responsibility and they will need to identify funds so that they can involve the public in a more meaningful way.

Mr McNeil: Have you done any work on how you would respond to that?

Mr Shaw: To be honest, we have not. We are waiting to see what the shape of public partnership fora might be. Many of us have made use of the local health council structures, but they are going to move on.

The Convener: That is tactful—we will also move on. Thank you for giving evidence, Mr Shaw. I hope that you found the experience as interesting as the committee has done.

Workforce Planning
Civic Participation Event

15:54

The Convener: We move on to agenda item 4. I refer members to the buff-coloured—or peachy—committee paper HC/S2/03/17/5. Members have had a chance to read the paper, so I want to confirm whether or not they want to take the course of action that is outlined in the report. The report is not yet on the website, but it will be—I know that that is exciting for members. I will spend 10 minutes taking members' views.

Janis Hughes: I was interested to read that the participation services people think that

"most value would be derived from the event if it only involved health service stakeholders."

I think that everybody to whom it was suggested we speak was a health service stakeholder—technically, we are all health service stakeholders—so I do not understand what the participation services officers mean by that comment. They might mean that we should include only health service professionals or employees, but the paper goes on to mention

"public and patient group representatives",

so the event would involve people other than those whom I think participation services mean by "stakeholders." I am not quite clear about that.

The Convener: Are there any other comments? We are discussing this item in formal session.

Mr McNeil: I am not against the committee's organising a civic participation event, but we are being steered away from this one and I think that we need more time. Should we take the participation services people's advice that the event would not be ideal for wider participation? The paper goes on to suggest that we might want to organise an event around the Regulation of Care (Scotland) Act 2001. I am happy to be directed by such papers, but this one does not help me to make up my mind.

The Convener: We do not have to run just one civic participation event; we could run two. A perfect time to have another civic participation event would be when we come to our post-legislative scrutiny of the Community Care and Health (Scotland) Act 2002.

The Health Committee should run more such events, because the issues that we consider are so huge and involve everybody: people might not be involved with the law frequently, but nearly everyone is involved with the health service at some point. We could discuss running an event such as that which Duncan McNeil suggested.

The clerk has passed to me a note about what participation services meant by public involvement at the proposed event. It was suggested that the general public could attend an open meeting, although it would be service professionals who were engaged in the meeting. I do not know whether that takes us anywhere.

Janis Hughes: I was concerned about the participation services officers' comments that

"most value would be derived from the event if it only involved health service stakeholders."

I feel strongly that patients—and the public in general, who are all potential patients—are health service stakeholders.

The Convener: I will ask the clerk, Jennifer Clark—sorry, Jennifer Smart; I definitely need the recess—for clarification.

Jennifer Smart (Clerk): Perhaps it would be helpful if I explained what the participation services officers meant. They think that there would be great value in the event, but have reservations about how to structure it to get the best value from it if there is to be a totally open invitation to interested members of the public. The suggestion was not meant to exclude people; we were considering from where we could get best input on the subject matter.

Participation services felt that we could have another event on the regulation of care—there is no problem with our having two events—that would perhaps better lend itself to people's coming to add personal experiences of the situation before and after the Regulation of Care (Scotland) Act 2001 was passed. The event that we are considering is perhaps slightly more focused on work-force planning—people might feel that they have had unhappy experiences of that. It is up to members, but the idea was that the second event would be structured in such a way that the committee would hear input from the public on the outcomes. People would be able to say whether they agreed with the outcomes and there would be an open session in which they could say what they would like the outcomes to be. People would not be excluded.

16:00

Mr Davidson: As far as the away day is concerned, I do not recollect agreeing to anything other than the principle that we should hold public participation events, because they have a valuable role and are a necessary part of the committee's work. However, the section on page 1 of the paper on what the inquiry is about is quite technical. The most important issue for me, at the first stage anyway, is that we get as much information as possible to allow us to examine what the Executive is doing and to go through all the bullet

points on page 1 of the paper. They are quite technical and tend to be a wee bit away from the focus of a lot of the people who might come to a public event.

I have no objection to holding an event at the second stage, when we have something to put before people for their confirmation or argument. However, we cannot muddle up the two types of event. We are doing a technical job on the inquiry into work-force planning, although what we do with it might go to the public.

Mike Rumbles: I could not disagree more with what has just been said. The whole point of the inquiry is to consider how work-force planning meets the needs and demands of patients—in other words, the general public. We are all patients and this is about public participation. We have just spent two hours grilling witnesses on public participation, but the first thing that we are going to do is say, "We're not having the public here—the inquiry's too technical. We don't want to involve the public, because they won't understand." That sort of approach is completely alien to what we are trying to achieve and I am flabbergasted that it is even being suggested.

Helen Eadie: I hate to do this to Mike Rumbles or anyone else on my team, but I have to say that I see where David Davidson is coming from. He is acknowledging that there is an appropriate time to involve the public; he is not dismissing the idea of the public's being involved. Among the crucial issues that have been raised with my local board—Fife NHS Board—is barriers to getting professionals; the shortage of skilled people has been the driving force behind the acute services reviews and the development of trusts in the past few years.

I do not want to pre-empt the discussion, but it is known that the royal colleges have restricted entry to medical services in the past few years. If we want to get to the heart of the matter, I would like to hear what they have to say. I am told that of the 16 royal colleges only three are in Scotland; the rest come under Westminster's remit. I want the colleges to give evidence, either at a public participation event or during an evidence-taking session. I certainly want us to hear from the public at the two stages. First we should have technical input, then wider public involvement at a later stage. That would be reasonable. When professionals give us advice, we can ignore it. We are paid to make a judgment and my judgment is that we should accept the advice that we have had from the professionals.

Mr Davidson: I thank Helen Eadie for clarifying my position. At no time did I say that the public should be excluded; rather, I said that the process had to be staged, as Helen Eadie kindly described. I do not understand why Mike Rumbles thinks that I am against public input on the subject, because that is not the case—it is a matter of time and place.

The Convener: When the Justice 1 Committee held such an event, the public were present at the morning session, even though it was fairly technical. We could perhaps tweak the proposed arrangement for our event. The paper suggests that we could

"hold a morning session with invited professionals."

I am not necessarily saying that we should use the same structure as the Justice 1 Committee's event, but a lot of group work took place in the morning, in which—although it was technically oriented—ordinary members of the public were involved, so the public could be involved in the morning at our event. As the paper suggests, the afternoon session will have much more input from the public. I agree with Mike Rumbles that it is not proper that there should be a Red sea between the professionals and the public. I suggest that what happens in the morning will be more skewed towards the professionals, although the public could be there. The counterbalance will be the public's involvement in the afternoon session.

When members see the planning for such events, they will realise that the public's involvement is highly interactive rather than passive. In my first experience of a public participation event, I was surprised that the set-up worked; I had been sceptical about whether it would. I will let Mike Rumbles come back in after Shona Robison and Jean Turner.

Shona Robison: I think that Mike Rumbles is getting himself overexcited about something that is not being suggested; I know that that is not like him.

The Convener: That is a tautology, I think.

Shona Robison: We are all in favour of public participation and we all want to be on Helen Eadie's team. The question is about the best way of organising the event to ensure that the public get something out of it. There is a real danger that if the event is too vague, broad and unstructured, the public will come along but not get much out of it.

We need to focus more on the structure and on what type of information members of the public will get; I cannot visualise how that will work. I can see the general idea, but I do not know what kind of experience the members of the public who come along will have. It would be helpful to have a bit more information on that because, as well as wanting the public to have a positive experience, we want to get something out of the event. After all, we are holding the event not only because it is the right thing to do, but because we want to hear

the public's views on specific issues in the inquiry; we do not want general information about people's experiences. We must thrash out some more detail.

The Convener: If we decide to proceed with the event and submit a bid for money, part of the issue might be resolved when we commission contracts from various parties. That will enable us to consider proposals for the structure of the event and to take a view on which course we want to follow. It is the job of those parties to structure the event and make it work. I agree that we do not want a cosmetic event; that would be pointless.

I was very impressed by the event that the Justice 1 Committee ran, which was highly structured. The public, who had had interaction with professionals in the work groups in the morning, had an awful lot to say. I do not know whether our event would go along those lines. At the bidding stage, we would have specific proposals in different bids.

Do you have something to add, Duncan?

Mr McNeil: I agree that we will get the focus that is missing at the moment when we consider specific proposals. We all agree that there needs to be a high level of public involvement, particularly because the event will be the launch of a major inquiry, rather than the beginning or the end of it. Whoever brings the event together needs to understand that we want to use it to launch nine months to a year of work. That aspect is missing from the paper; we are getting too involved in the detail.

Dr Turner: The convener's idea was a good one. It would be nice for people who use the service to hear what the managers think about what they provide, given all the changes, and how they see the situation. Staff could be questioned as well as participants—whether patients or carers.

Moreover, now that the new community health partnerships are being introduced, it would be interesting to hear people's perceptions of the information that management has provided about them and how the new situation will affect people. I think that there is much to be gained from the exercise, because the public will feel that their existence is at least being acknowledged.

Mike Rumbles: Our whole approach to this is wrong. As I said earlier, we have to remember that the whole point of this exercise is to

"review all workforce planning for all professionals within the health service and how this is being developed to meet the needs and demands of patients".

From colleagues' comments, it seems to me that we are approaching the matter from entirely the wrong direction. During this afternoon's session, people have been making comments such as "We need evidence from the professionals" and "Let's hear the managers". Well, I am sorry—we should not start off any examination of how to

"meet the needs and demands of patients"

at the other end of the spectrum. Of course everyone must be involved. However, if our aim is to achieve what we say we want to achieve, it is only common sense to start by asking simple and basic questions; for example, we should ask what are the needs and demands of patients. We should ask the public those questions and not rely on professional and managerial input. In any case, I find it strange that members' reaction has been "Well, the public can be there, too". I would like us—

Shona Robison: That is not what we are saying.

Mike Rumbles: I have just been listening to what has been said.

I would like us to be able to launch this programme, but I am not having a civic participation event in order to do so. Instead, we should go around the country, listen to what the general public has to say and then get input from professionals, managers and the like. If we are to meet the objective that we have set ourselves—which is

"to meet the needs and demands of patients"—

we should, for goodness' sake, find out what those needs and demands are. That is only common sense to me.

The Convener: As the only member who has taken part in a civic participation event, I should point out that such events are not evidence-taking sessions. The event could be structured along the lines that are suggested in the first bullet point on page 2, which says:

"between 50 and 80 people would be an appropriate number of invitees who could work in small groups on different aspects of the remit and bring forward suggestions and possible solutions".

It is not the case that we would on the one hand have experts and on the other the public, who would be told to listen and then make their contributions. Everyone will work in groups on various issues and come back to present views on them. I do not want to pre-empt anything, but there was, in the civic participation event that I attended, more technical input in the morning session and it was not closed to members of the public. Other material—including anecdotal evidence—emerged from the interaction between groups in the afternoon. We are all full of such anecdotes and have ideas about what is wrong with the health service, the justice system and so on. However, I

found that those views were tempered by sharing ideas during the morning session.

I certainly do not want an event at which we allow experts to give evidence, but patronise the public by telling them that they will get to say something in the afternoon. The event would be much more interactive during the morning session, with views raised and decisions made in the afternoon session. If we decide to bid for money for the event, we will be able to consider the various structures that the consultants will suggest. If we do not like the options and find that they are very close to the picture that Mike Rumbles has painted, we will not proceed with the event. I would certainly share Mike's views if that were to be the case. However, I do not think that the event will take that form—certainly no committee member wants that. Perhaps we are jumping extra fences; perhaps we should simply consider this broad paper and ask the clerks to bring something back to us. I feel that we all have views on the matter, but I am trying to bring the discussion to an end. I ask the clerk to say something about what she could bring back to the committee.

Jennifer Smart: Today, we hope to get from the committee an idea about progressing the bid. After all, we have talked about the proposal only in principle so we really need to take it to the bidding stage, which will happen in January. That will allow us to go out to consultation. Once the bids are in, we will receive details about how to structure the event; we will have a much clearer idea of things. Indeed, as we go through the process, we can develop a programme of what we want, which we can discuss in committee before we take things to the bidding stage.

The Convener: Are members content to take things to that stage?

Shona Robison: I am content to do so. However, I want to put on record that I object to Mike Rumbles's trying somehow to portray himself as the public champion. [*Interruption.*] Excuse me, I am speaking. He is trying to portray himself as a public champion while saying that the rest of us do not want any public involvement in the event, although no one around the table has said such a thing. We all want the public's maximum involvement in the event. However, we want it to happen in a way that ensures that the public gets something out of it. If we are going to have a successful event, we need to listen to what people are saying, rather than hear something different. After all, committee members all want the same thing.

The Convener: Yes. I think—

Mike Rumbles: Convener—

The Convener: No, Mike. I am ruling—

Mike Rumbles: Convener—

The Convener: No, Mike, I am sorry. I am in the chair and I am bringing this discussion to an end.

Mike Rumbles: Convener—

The Convener: Mike, I have ruled—

Mike Rumbles: I want to respond to those comments. I think that that was a personal attack in the chamber.

The Convener: I have ruled—

Mike Rumbles: You are not convening the meeting appropriately—

The Convener: I have ruled.

Mike Rumbles: —by not allowing me to respond to a personal attack by Shona Robison—

The Convener: I am sorry. Please turn off the microphones.

Meeting closed at 16:16.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178