HEALTH COMMITTEE

Tuesday 23 March 2004
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
9th Meeting 2004, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

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

*attended

THE FOLLOWING ALSO ATTENDED:

Malcolm Chisholm (Minister for Health and Community Care)
Karen Gillon (Clydesdale) (Lab)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 3

Scottish Parliament

Health Committee

Tuesday 23 March 2004

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:02*]

Subordinate Legislation

Road Traffic (NHS Charges) Amendment (Scotland) Regulations 2004 (SSI 2004/76)

The Convener (Christine Grahame): Welcome to the ninth meeting this year of the Health Committee. Item 1 on the agenda is on subordinate legislation. We have a negative instrument before us, and I refer members to paper HC/S2/04/9/1. The Subordinate Legislation Committee has made no comments, no comments have been received from members of this committee and no motion to annul has been lodged. Is it the case that the committee wishes to make no recommendation in relation to the instrument?

Members *indicated agreement.*

National Health Service Reform (Scotland) Bill: Stage 2

14:03

The Convener: Item 2 is stage 2 consideration of the National Health Service Reform (Scotland) Bill. I welcome the minister and his team. I will give the minister a moment to get his papers sorted. In fact, I need to get my papers sorted. While the minister was sorting out his papers, I have managed to get mine all muddled.

Section 1—Dissolution of National Health Service trusts: modification of enactments

The Convener: Amendment 1 is grouped with amendments 54, 30, 32, 33, 34 and 35.

The Minister for Health and Community Care (Malcolm Chisholm): I will deal first with the Executive amendments in the group, which are amendments 1, 30 and 32 to 35. They are minor technical amendments, which reflect the fact that national health service trusts are dissolving and that references to NHS trusts are to be removed from the statute book.

Amendment 1 will help to ensure the smooth handover of NHS trust property to boards. The amendment relates to the property of NHS trusts that is subject to endowment or trust terms. The amendment will ensure that all endowments and other property that is currently subject to a trust will be transferred to health boards free of the original trust and endowment terms. The original objects of the trust or endowment will be preserved by operation of existing provision in section 82 of the National Health Service Act 1978, which requires that the board shall ensure as far as is reasonably practicable that the original trust or endowment purposes are observed.

Amendment 30 is a minor amendment to section 9, on the modification of enactments, and seeks to expand schedule 1 to the bill to include minor as well as consequential amendments. Amendment 32 seeks to clarify that the powers of Scottish ministers to use and dispose of land includes the power to lease land. That power will be conferred on health boards. Amendment 33 seeks to replace the current statutory reference to NHS trusts in the NHS (Private Finance) Act 1997 with a reference to health boards, special health boards and the Common Services Agency, to ensure that existing contractual obligations of NHS trusts are not disturbed.

Amendments 34 and 35 seek to add an additional consequential amendment to schedule 1 and an additional repeal to schedule 2. The repeal will remove a reference to “National Health

Service Trust" from the National Health Service (Residual Liabilities) Act 1996 and the consequential amendment seeks to amend the definition of "health body" in the Regulation of Care (Scotland) Act 2001 by removing the phrase "National Health Service Trust".

Amendment 54 is unnecessary and I am not clear what David Davidson expects to achieve with it. Scottish ministers already have the powers to dissolve trusts by subordinate legislation when a trust makes an application for dissolution. Indeed, trusts have already been dissolved in Dumfries and Galloway and the Borders and the order that dissolves the remaining trusts was laid before Parliament on 10 March. Those who gave evidence during stage 1 consideration of the bill overwhelmingly supported the abolition of trusts.

Trusts will cease to exist on 1 April. Amendment 54 will not change that; all it will do is to leave on the statute book references to bodies that no longer exist. I fail to see how that will improve the health care of the people of Scotland. Accordingly, I invite David Davidson not to move amendment 54.

I move amendment 1.

The Convener: Before I call David Davidson to speak to amendment 54 and the rest of the amendments in the group, I should point out that I omitted to say that we had received apologies from Duncan McNeil and to welcome to the meeting Karen Gillon, who will move Duncan's amendments. We hope that the committee substitute, Paul Martin, will join the meeting later to vote on those amendments.

Mr David Davidson (North East Scotland) (Con): On the minister's points about amendment 54, over the past three years he has regularly referred to devolving power and decision making to front-line health service operatives. However, with this bill, he is seeking to do the very opposite and to hold all the power himself.

It is becoming more apparent that boards will no longer be the strategic bodies of the future. Indeed, with the development of managed clinical networks, which cover a much larger area than standard health boards, there is an opportunity for them to become strategic bodies in the health boards' place. Separating the regional strategy from service delivery, which is the responsibility of trusts or, in some cases, operational divisions, would result in far more local autonomy to deliver services locally in the interests of local people. It would also remove the minister from any involvement at the front end of things—indeed, I believe that that is Liberal Democrat policy in Westminster.

If we want to retain the primary care sector, the acute sector and patients as entities, the minister can also retain the power to intervene in crises, but he does not need to become involved in management. After all, in the European system, there is a national agreement on standards between ministers and those who provide capacity regardless of the sector. That system is based on a non-prescriptive approach and leaves staff and patients to become involved in designing the service locally.

I and many health board chief executives believe that health boards are also likely to go. I move amendment 54, because it seeks to provide an opportunity to maintain trusts while long-term strategic movements in the NHS settle down. Obviously, if the amendment is agreed to, I will need to lodge consequential amendments. I have not troubled the clerks to produce them but they can be delivered readily.

The Convener: Thank you. You do not have to move amendment 54 at this point. I welcome Paul Martin to the committee. He is the formal substitute for Duncan McNeil and therefore has voting rights.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): In one way, the fact that David Davidson has lodged amendment 54 is surprising, but, in another way, it is not surprising. I am thinking of our debate on our report at the end of stage 1. Throughout stage 1, he fully supported the rest of the committee. We unanimously agreed our report. Under the heading "Provisions of the Bill … Organisation and operation of NHS", our report said:

"The abolition of NHS Trusts has been welcomed as a means of reducing NHS bureaucracy."

Among our conclusions, we said that

"the Committee recommends that the Parliament approves the general principles of the Bill."

At no time did David Davidson dissent, but suddenly we have an amendment that strikes at the heart of the bill. In that sense, I am surprised.

The Convener: I will give David Davidson the right of reply to that.

Mr Davidson: Thank you, convener. I will keep it brief.

I recognise the fact that five boards among our current health boards do not have trusts. They chose to do things that way. I would prefer there to be choice at local level. The boards were not forced to withdraw the trusts; in fact, some of the boards wanted to move towards having co-ordinated health boards.

Amendment 54 would allow the minister the opportunity to talk about possible future changes in the health board structure, about the future role of managed clinical networks, about choice, and

about whether he believes that keeping strategy separate from delivery is a good thing for the future of the health service. He has the opportunity to put his views on the public record.

Malcolm Chisholm: David Davidson is confusing different issues. He presents the preservation of trusts in terms of devolving power and decision making, encouraging managed clinical networks and ensuring more autonomy at local level. I support all those objectives, but they are quite separate from the existence or otherwise of trusts. Managed clinical networks are a good example; they are a particularly Scottish model of care and are consistent with the general model of care that we are trying to promote. Our model is different from the English model, and the same debate, although with some differences, will take place on David Davidson's amendment on foundation trusts.

We are trying to create a more integrated way of working in Scotland—single-system working, with the different parts of the health system working together collaboratively. That is precisely what managed clinical networks are. We do not want the fragmented system that has been one of the hallmarks of trusts in Scotland.

I do not know how many times I have to say this to David Davidson, but just because we want single-system working does not mean that we want centralisation. The biggest part of the bill and the biggest number of amendments relate to community health partnerships, which are a more appropriate level to which to devolve power than are the traditional trusts, which, as we know, are very large organisations in Scotland. This same territory will be covered in debates on future amendments but I wanted to make a brief opening statement at this point.

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 8, Against 1, Abstentions 0.

Amendment 1 agreed to.

Amendment 54 moved—[David Davidson].

The Convener: The question is, that amendment 54 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
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Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 54 disagreed to.

The Convener: The question is, that section 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 8, Against 1, Abstentions 0.

Section 1, as amended, agreed to.

Section 2—Community health partnerships

14:15

The Convener: Amendment 2, in the name of the minister, is grouped with amendments 3 to 8, 8B, 8A and 10 to 14.

Malcolm Chisholm: I will explain why the largest number of amendments is to section 2, as I said in my previous comments. Since the bill was introduced, we have had extensive consultation on community health partnerships, and the Executive amendments are largely the product of that exercise. We have also sought to address issues that committee members raised at stage 1, such as CHPs that cross health board boundaries, which Janis Hughes picked up on.

Amendment 2 will change the initial duty to submit a scheme of establishment into a duty to

establish CHPs in accordance with an approved scheme. An approved scheme is a scheme of establishment that the Scottish ministers have approved.

Amendment 3 will make a minor change to recognise that CHPs may cover the area of more than one health board.

Amendment 4 will define CHPs' status. It explains that CHPs must be established as committees or sub-committees of boards. It will also allow boards to establish a joint CHP when a CHP's area includes more than one health board area. Joint CHPs must be established as joint committees of the health boards that establish them.

Amendments 5 and 6 are technical amendments to recognise that CHPs will have more than one function.

Amendments 7 and 8 will make it clear that CHPs have three functions. First, they will co-ordinate the planning, development and provision of services. Secondly, they will provide or secure the provision of services. Thirdly, they will exercise functions of their boards. However, that will apply only to services and functions that have been prescribed in regulations, included in the approved scheme of establishment or specified by the health board.

Amendment 8 will also move the initial duty to submit a scheme of establishment for CHPs to a new section, which will be proposed new section 4B of the 1978 act. Section 4B(1A) will require boards, in preparing their schemes, to have regard to statutory guidance and to the community planning process and to consult and encourage the involvement of local authorities and other persons that they think fit.

Amendment 10 will remove the regulation-making power to prescribe the number of CHPs that are to be established in each health board's area. That was considered to be too prescriptive. Boards should be able to determine the number of CHPs for their areas, having regard to the statutory guidance.

Amendment 11 will remove the regulation-making powers on CHPs' status, procedures, staff and expenses. The status of CHPs will be prescribed in the bill. As CHPs are committees of boards, they will be subject to the same regulations about procedures—the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI 2001/302)—as are other committees that boards establish. A regulation-making power on staff and expenses was considered unlikely to be needed.

Amendment 12 will add a new regulation-making power to apply to CHP joint committees the provisions in the 1978 act on single committees of health boards.

Amendment 13 will remove the illustrative list at new section 4A(6) of the 1978 act, which was considered to be far too detailed. For example, it is unnecessary to prescribe how CHPs will consult their parent boards and it is inappropriate to detail the reports that CHPs will produce.

Amendment 14 will add three new subsections to proposed new section 4B. New subsection (7) will say:

"The Scottish Ministers may, after consulting such persons as they think fit, issue guidance about community health partnerships and shall publish such guidance."

That is the statutory guidance to which boards will have regard when producing their schemes of establishment. New subsection (8) will allow health boards to appoint joint committees for the purpose of CHPs. Section 2(11) of the 1978 act allows the Scottish ministers to establish joint committees for the areas of two or more health boards but, at present, health boards cannot do that. New subsection (9) will ensure that any provision on CHP committees in proposed new sections 4A and 4B will not affect other powers that relate to board committees more generally.

I appreciate the sentiment behind amendment 8B, but it is unnecessary for three reasons. First, the Executive has already lodged amendments to ensure that the role of local authorities is properly recognised and that they are properly involved in the exercise of the CHPs' functions. They include provisions that state that, when drawing up the scheme of establishment, health boards should have regard to statutory guidance, which includes many references to working with local authorities to secure the provision of health-related services, and to the community planning process, which local authorities lead and which considers the provision of public services across a local authority area. The provisions also state that health boards shall consult local authorities and that they shall encourage the involvement of local authorities. The draft CHP regulations also require there to be a member or an officer of the local authority on the CHP committee. Those provisions will ensure that CHPs are co-operating with local authorities.

Secondly, the amendment would place on CHPs a replica of the duty that is imposed on boards in section 13 of the 1978 act. The need is not to increase the number of duties but to ensure that the duties that are imposed will achieve the necessary outcomes. We think that the Executive amendments do that. As a consequence of them, CHPs will, in effect, be performing duties similar to those imposed on their parent board under section 13 of the 1978 act.

Thirdly, the suggested amendment is not about a function of CHPs but is a description of how CHPs should exercise their functions. It does not fit well in a section that is intended to describe a CHP's functions. Since the bill already meets David Davidson's objectives, I encourage him not to move his amendment.

Amendment 8A relates to the production of annual plans. As I said in relation to amendment 13, it is overly prescriptive to be included in the bill and relates to an ancillary matter rather than CHPs' core functions. As part of its business planning arrangements, a CHP will draw up plans for how it proposes to provide the services and exercise the functions delegated to it by the health board. At the moment, there is no requirement to make such plans publicly available. However, I propose to amend the statutory guidance to require such plans to be prepared by the CHP, involving the public and other stakeholders as necessary, and to ensure that those plans are made publicly available if requested. However, I do not think that it is necessary for those provisions to be included in the bill or, crucially, for the annual plans from every CHP in Scotland to come to me for approval. That would be too prescriptive and centralist and I would encourage whoever might move the amendment not to do so.

The Executive amendments represent the outcome of our extensive consultation.

I move amendment 2.

Mr Davidson: The minister has detected that amendment 8B is intended to be supportive of the role that is played locally by local authorities and the health boards, sometimes separately and sometimes jointly. It would include in the bill an opportunity to merge local authority budgets and staff who deliver medical care to create a single management operation with single patient assessment and contact, which would minimise bureaucracy and save money. The model would be similar to one that Bristow Muldoon talked about in a recent debate and I know that some local authorities are seeking to work on that basis. The amendment would encourage closer working between the two systems, because there have been far too many cases of individuals dropping between two different management systems or budgets.

If we are to spend money from the public purse, we should do so in a way that is as user-friendly as possible for patients and carers and which secures the skills of staff from both sectors under a single management and budgetary system. The amendment seeks to support the minister, clarify the situation and give an opportunity for departments and budgets to be merged at a future date.

On amendment 8A, I appreciate the principle of publishing a plan, which could be done through libraries and so on, but I find the proposed method of doing so far too bureaucratic and costly and likely to divert resources away from where they should be going without ensuring that the information that Mr McNeil, who lodged the amendment, wishes to be made available would be seen. My original comments on amendment 8B show that the minister and I are not approaching intervention from the same angle. We might discuss that later on today. The principle of publishing a plan is a good one, but the method suggested is onerous and I cannot support it.

Karen Gillon (Clydesdale) (Lab): New section 4A(2) of the 1978 act states:

"The general function of a community health partnership is to co-ordinate … the planning, development and provision of the services which it is the function of its Health Board to provide, or secure the provision of".

Amendment 8A seeks to give community health partnerships a duty to make the public aware of what they are entitled to.

The new section 4A(2)(d) of the 1978 act that amendment 8A proposes would require the drawing up of an annual plan to explain how the functions to which the minister's amendment 8 refers would be exercised. Proposed new paragraph (e) would require steps to be taken to promote public awareness of the annual plan and paragraph (f) would allow for that plan to be provided in other forms, such as Braille or audio tape, if that was in the interests of the person seeking it. Proposed new section 4A(2ZA) would give the minister the final say on the content of any annual plan.

I appreciate what is being said and I listened carefully to the minister's opening comments. I understand that he does not want those measures to be in the bill because he believes that they are too prescriptive. There is an opportunity for dialogue with the minister on how the matter can be resolved and I would be minded not to move the amendment if that could take place between now and stage 3.

Shona Robison (Dundee East) (SNP): The intention behind amendment 8A is sound because we would want the public to be aware that the plans exist. The minister should persuade us that CHPs will be proactive in ensuring that that happens. The minister said that the plans would be publicly available if requested, but I am concerned that people would have to know of their existence before they could request them. I would be more comfortable if I knew that CHPs were going to be obliged to ensure that, as far as possible, the public are made aware of the existence of the plans and are encouraged to look at them. I hope that that will be done. I am quite

relaxed about whether the measure is included in the bill or in the regulations and guidance. I do not have any strong views on that, as long as the principle is established.

Janis Hughes (Glasgow Rutherglen) (Lab): I, too, accept the spirit of Duncan McNeil's proposals. At stage 1, we discussed the service that will be provided and how it might be changed somewhere along the line. If we think about other recent legislation, we see that that can be detrimental to the service that is provided locally. Duncan McNeil seems to want to tell people about the good things that can be provided. By doing that through a CHP publication, we would show people the benefits that can be available. As Shona Robison said, if people do not know about the plans, they will not ask for them. Therefore, the intention behind amendment 8A is to be welcomed, and it would be helpful if we could have dialogue on the proposals at some point in the future.

I have a specific question about amendment 4. The minister is aware of my views on coterminosity in CHPs where that is possible, although I accept that it is not possible in every case. Does the minister have a view on the minimum population required for a CHP to be viable in an area? I am thinking of instances in which a community health partnership might span two health board areas and have a population of 100,000, whereas a population of 50,000 would allow CHPs to remain coterminous with each health board. I wonder whether the minister has a view on that and whether he can explain, if he thinks that the higher number is preferable, why it is preferable and what the benefits would be.

14:30

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I have been thinking about information for patients. It is a good idea that patients should know what their community health partnership does, but primarily they will be in contact with their general practice. General practices are required to keep up to date leaflets that say everything that they can do for patients and also what they cannot do and where patients can find help. A plan for each practice is also required.

I sympathise with what has been said and with Duncan McNeil's amendment 8A. I wonder whether the two things could be tied up to make what practices do more public. There is a requirement for information on the health board and practices are required to have a yearly business plan. Patients being informed through the community health partnership as well as at practice level would be a good idea.

Malcolm Chisholm: There are three lots of issues to which to respond. I will deal with the issues that Karen Gillon raised first. I am entirely happy with her suggestion that there should be further discussion. Obviously, I have made a proposal that has not yet been implemented, so it is clear that it is modifiable. Indeed, we would welcome comments from committee members on anything in the statutory guidance, now that they have it.

I repeat what I said: I propose to amend the statutory guidance to require such plans to be prepared by the CHP, involving the public and other stakeholders as necessary, and to ensure that those plans are made publicly available if requested. I am entirely happy to consider the wording of that last part, as there does not seem to be any obvious reason why they should not be more routinely available—I think that Jean Turner made that point, too. I would certainly be happy to discuss the matter with Karen Gillon, Duncan McNeil or anybody else who wishes to discuss it and I look forward to what Health Committee members have to say if they are going to respond more generally to the statutory guidance.

On the issue that Janis Hughes raised relating to amendment 4, the statutory guidance that the committee has received talks about a minimum number of 50,000. That is another area in which we have shifted from the original idea that the matter would be in the regulations to its being in statutory guidance. Some members might accuse me of being too centralist; others might accuse me of being the opposite and of not being prescriptive enough. There is a balance to be struck. We are trying to be as flexible as possible about the numbers for CHPs, but we have indicated in the statutory guidance that a minimum number of 50,000 seems reasonable given the ambitions that we have for CHPs.

That leads me to David Davidson's amendment 8B. I suppose that he went way beyond the wording of his amendment in talking about joint or pooled budgets. The reality is that we have already legislated for that through the Community Care and Health (Scotland) Act 2002. There have already been significant developments in that direction and that is not what we are talking about in the bill.

David Davidson's amendment says that CHPs should co-operate to secure the provision of services. My point is that that is already a requirement on health boards under the 1978 act. There is a strong focus on the joint future agenda in many places in the statutory guidance for CHPs; the language in relation to working with local authorities has been strengthened in the second version of that guidance; and there is also the requirement for representation of local authorities on community health partnerships in the regulations. Indeed, the issue is covered in the

parts of the bill to which I referred in relation to local authorities' involvement in various ways in the schemes of establishment.

I would argue that we have more than addressed the need for CHPs to co-operate to secure the provision of services, and I do not believe that such a provision should be in section 2, which is about the CHPs' functions rather than about how they should be performed.

Kate Maclean (Dundee West) (Lab): You covered what amendment 8A's proposed new paragraph (d) seeks to do by saying that you will produce statutory guidance to require CHPs to produce annual plans. I believe that that will also cover the provision in amendment 8A's proposed new paragraph (e). However, will Executive amendment 16 cover what amendment 8A's proposed new paragraph (f) seeks in relation to equal opportunities and the production of CHP annual plans?

Malcolm Chisholm: I would not like to give a snap judgment on that. Obviously, what paragraph (f) seeks should happen. I believe that amendment 16 covers it in general terms.

Kate Maclean: Amendments 16 refers to the fact that

"Health Boards, Special Health Boards and the Agency must discharge the functions conferred on them".

Malcolm Chisholm: I believe that amendment 16 covers the equal opportunities aspect in general terms. Obviously, I support that objective.

I am glad that Kate Maclean revisited amendment 8A. I welcome discussion on it, but the fundamental reason why I am opposed to it—I am sure that David Davidson will be pleased to hear this—is that I do not believe that it is appropriate that I, as minister, should approve the annual plan of every CHP in Scotland.

The Convener: I am sensing an interesting agreement on that point.

Kate Maclean: Just to clarify, amendment 8A's proposed new paragraph (f) seeks

"to provide a copy of such a plan to any person"

in accessible formats. I presume that amendment 16 covers that provision.

Malcolm Chisholm: I support such a provision and I believe that amendment 16 covers it in general terms.

Amendment 2 agreed to.

Amendments 3 to 7 moved—[Malcolm Chisholm]—and agreed to.

Amendment 8 moved—[Malcolm Chisholm].

Amendments 8B and 8A not moved.

Amendment 8 agreed to.

The Convener: Amendment 55, in the name of David Davidson, is grouped with amendments 56 and 57.

Mr Davidson: Amendment 55 seeks to put at least one local health council representative on each CHP to provide patient-based input and monitoring of plans before the plans are confirmed. That would satisfy some of the demands for democracy in the pooling together of the CHPs' plans about delivery and so on. The provision would tie in the local health councils to being round the table when the plans are being developed. Consideration of such provision is a natural progression; that can also be said of another amendment that I have lodged, which will be debated later.

I turn to amendment 56. We are all aware that the voluntary sector in Scotland delivers annually the equivalent of £6 billion-worth of centrally supplied services. I do not have an accurate figure for the health sector, but it is certainly into the billions. We are becoming more and more dependent on the voluntary sector. Examples such as the Macmillan nurses show that there are services for which the charity sector provides part or all of the funding. I feel that, for the purposes of local co-ordination of services, it is important not only for the role of the voluntary health sector to be recognised, but for a local member, appointed from that sector, to be present at the table to demonstrate what is available and what co-operation can be achieved. That person could be part of the dialogue at the planning stage in the delivery of local services.

Amendment 57 is a consequential amendment.

I move amendment 55.

Shona Robison: I am sympathetic towards amendment 56. Often, we do not give due recognition to the role of the voluntary sector, and there is a strong argument for its important role being duly recognised in the bill to ensure that the hand of the voluntary health sector is strengthened in the community health partnership. Without the voluntary sector, the community health partnership will not work as it should do, so I sympathise with the intention of amendment 56.

Mike Rumbles: When I first saw amendment 56, I thought, "This looks good." When I read the amendment in detail, however, I had problems with it. David Davidson has lodged the amendments in the group with the intention of identifying individuals on the community health partnerships, yet nowhere else in the bill do we identify individuals. The approach that David Davidson's amendments propose is quite prescriptive. If we were to agree to the amendments, we would be dictating to people

from the voluntary sector that they should be on a community health partnership. I do not think that it would be appropriate to do that, considering that we have not done so in any other case.

Dr Turner: In some ways, I understand what Mike Rumbles is saying. If we were to prescribe, in one case, who should be on a community health partnership, we would have to do that in every case. However, in the two examples that have been given, the health council works very much with the patients and the Macmillan and Marie Curie nurses are almost like an amoeba that has been invaginated into the health service. Those are voluntary sector services but they are paid for in part by health boards, so most people think that they are the NHS. There might be a case for naming those two groups in particular; I do not know how other members feel about that. I imagine that a community health partnership would have as many people on it as possible within an area, but it may not always happen that way, just as it did not always happen with the local health care co-operatives.

Malcolm Chisholm: I shall say something about the local health council proposal and the voluntary sector proposal, but first I would like to explain that the regulations that members have received prescribe certain people who ought to be on community health partnerships. As usual, a balance must be struck. Is the list too prescriptive or not? My view is that we ought to prescribe who has to be on a community health partnership, not least so that we can ensure that the CHP is a diverse body and, as I shall explain later, that it is a decentralised body.

The regulations include an extensive list of people who will have to be on the community health partnership. For example, there will have to be a nurse, as well as a doctor and a pharmacist. As I shall explain, there will have to be somebody from the voluntary sector and somebody—at least one person, if not more—who represents patients. My fundamental point about amendments 55, 56 and 57 is that it makes no sense to list two of the required members in the bill and the other members—whatever considerable number of them we are talking about—in the regulations. That would be an incoherent and nonsensical way in which to proceed. The members should be, and will be, listed in regulations, but they should not be included in the bill.

14:45

I will deal with the particularity of amendments 55, 56 and 57. In the first instance, it is well known that our policy is to replace health councils with a new structure that will require health boards to involve the public directly; Executive amendments on that will be forthcoming. Under our proposals, public involvement will be monitored and quality assured by the Scottish health council and its local advisory councils. It is obvious that we cannot accept amendment 55, which refers to local health councils, when the councils will be dissolved by another part of the bill.

As I have indicated, regulation 3(1)(i) of the draft CHP regulations requires there to be a member of the public partnership forum on the CHP. That member's function will be to represent the interests of the public on the CHP, although the CHP will still have to engage the public directly. I repeat that a minimum of one person is required but, clearly, more can be placed on the CHP. Public partnership forums will bring together existing local groups, networks of patient groups, voluntary organisations, interested individuals and others, with the key role of considering specific issues and informing CHPs.

Regulation 3(1)(j) of the draft CHP regulations states that a CHP must contain a member of the local voluntary sector. Regulation 3(2) requires the CHP members to

"either live, be employed, or perform services in the area of the community health partnership."

David Davidson's objective has already been achieved by means of the regulations, which are binding, therefore we should not separate out and include in the bill one category of CHP member, while the rest are stipulated in regulations. In view of that, I urge David Davidson to withdraw amendment 55 and not to move amendments 56 and 57.

The Convener: The minister has called the amendments not competent and "incoherent", so I look forward to David Davidson's winding up.

Malcolm Chisholm: I did not say that they were not competent.

Mr Davidson: Were you inviting me to speak, convener?

The Convener: Yes.

Mr Davidson: It sounded more like a statement.

I will deal first with the comments from Shona Robison and Jean Turner. They understand where I am coming from, and they agree that it is important, as far as the voluntary health sector is concerned, that due recognition is given. I lodged amendment 56 so that Scotland could, through the Parliament, recognise officially the role of voluntary health organisations in delivering vast amounts of care and support that are not being delivered through the Scottish Executive budget for health and community care. It is appropriate that such organisations are recognised in that way.

With regard to what the minister said about amendment 55, on local health councils, there is

an issue about later discussions. Neither committee members nor the minister have any control over how things will be dealt with, because of the timing of these discussions. That is part and parcel of later amendments, approval of which will be sought from the committee. On that basis, I am inclined to press amendments 55, 56 and 57.

I understand what Mike Rumbles was saying. There are proposed regulations, which have not yet been put to the Parliament for approval, in which there is an outline list of certain people who must, as a minimum, be part of a CHP. In other words, the list is prescribed. Unless I misunderstood the minister's point, he has just said that he will seek to extend that list, but we have not seen the colour of that.

Malcolm Chisholm: I did not say that.

Mr Davidson: I will let the minister in.

The Convener: That is for the convener to decide. If you finish your points, I will let the minister back in.

Mr Davidson: I am against too much local prescription, but amendment 55 is linked to a later amendment and on that basis I will press it. On amendment 56, it is a matter of principle that we publicly declare our support for the voluntary health sector and recognise where it is coming from. Amendment 57 is consequential.

Malcolm Chisholm: I do not understand what David Davidson said. Perhaps I did not make myself clear earlier. The regulations are perfectly explicit about membership of the CHP—there will be a member of the local voluntary sector and at least one member of the public, a doctor, a nurse, a pharmacist and various other people. That is explicit in the regulations.

Mr Davidson: When the minister refers to the voluntary sector, does he mean the voluntary health sector? Perhaps he could clarify that.

Malcolm Chisholm: The regulations refer to the local voluntary sector. The assumption is that that will be health related. If the committee has concerns about that, we will welcome your comments—it is our purpose to seek such comments.

The Convener: The question is, that amendment 55 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 55 disagreed to.

Amendment 56 moved—[Mr David Davidson].

The Convener: The question is, that amendment 56 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 56 disagreed to.

The Convener: Amendment 39, in the name of David Davidson, is grouped with amendment 9. If amendment 39 is agreed to, amendment 9 will be pre-empted.

Mr Davidson: The minister already has the power of intervention, therefore he need only have notification that community health partnerships have drawn up a scheme of establishment. The minister does not need to approve such schemes, which is why I lodged amendment 39. The minister with responsibility for local government has schemes laid before him by local authorities for their community councils, but those schemes are not submitted for the minister's approval. There is, therefore, a precedent for what I propose.

This is a matter of the local design of services, to which the minister has alluded several times this afternoon. If people look back at the *Official Report* at a later date, they will find that to be the case. The minister does not think that certain things are prescriptive, but he thinks that other things are. I believe that the proposals on ministerial powers in relation to community health partnerships are very prescriptive. The minister has talked at length about those proposals this afternoon, but there is no requirement for him to be involved at some of the planning levels.

The minister has the power of intervention as far as health delivery is concerned, therefore he should not be involved in the mechanisms as long as a scheme has been lodged—and I believe that

there is an onus on CHPs to lodge a scheme with ministers. If that scheme does not deliver what it is supposed to deliver, the minister may intervene anyway, given the powers that he has. That would present an opportunity for negotiation and discussion, rather than its being for the minister to agree individual local schemes. The provision that will enable the minister to do that flies in the face of the comments that he has made today.

I move amendment 39.

Malcolm Chisholm: The purpose of sections 2(3) and 2(4) is to ensure delegation of authority and resources to front-line staff. The best way of achieving that is for health boards to submit schemes of establishment to the Scottish ministers, so that we can ensure that it happens.

David Davidson and his party are concerned—as they keep telling us—about the move to single-system working resulting in centralisation within boards. The purpose of sections 2(3) and 2(4) is to ensure that that does not happen and that we have the decentralisation and delegation of authority and budgets that community health partnerships are all about.

As with the dissolution of trusts and the move to operating divisions, we will require boards to demonstrate to us that they are devolving adequate functions and resources so that front-line staff have an input into the decisions that are made on the delivery of services. That is entirely consistent with the objectives that are outlined in "Partnership for Care: Scotland's Health White Paper". There must be a way of ensuring that boards are complying with the regulations and having regard to the statutory guidance that will be issued. The best way to achieve that is for the Scottish ministers to check the schemes of establishment to ensure that the policy and benefits of a single system that does not centralise power in health boards are being delivered.

As I have said in many of our debates this afternoon, a balance needs to be struck. It is not right that I should have to approve the detailed annual plans of every community health partnership in Scotland, but it is important that we ensure that, within our local health systems, the delegation and decentralisation that I want, and which David Davidson claims to want, take place.

Amendment 9 will make additional provision so that, if boards do not get approval for their schemes of establishment, they will have to resubmit them to ministers to take into consideration points that the Scottish ministers had made and any other points that boards think are appropriate.

I encourage the committee to reject amendment 39 and support amendment 9.

Mr Davidson: What the minister has just said demonstrates that he has no trust in community health partnerships and their boards, despite the obligations that the bill lays on them. If the minister truly wants to stand back and be responsible for overall standards of delivery of care, he should allow the boards their heads within the rules. The rules will be in the guidance and are in various parts of the bill. The boards have duties laid upon them to provide care and they should be left utterly free to decide how best to do that in their localities. That comes back to local planning, not central control over alleged local planning.

I rest my case and press amendment 39.

The Convener: The question is, that amendment 39 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 39 disagreed to.

Amendment 9 moved—[Malcolm Chisholm].

The Convener: The question is, that amendment 9 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

The Convener: The result of the division is: For 8, Against 1, Abstentions 0.

Amendment 9 agreed to.

Amendment 10 moved—[Malcolm Chisholm]—and agreed to.

Amendment 57 not moved.

Amendments 11 to 14 moved—[Malcolm Chisholm]—and agreed to.

Section 2, as amended, agreed to.

The Convener: As David Davidson is about to object, I will take the opportunity to admit to a procedural hiccup. It is not procedurally correct to have divisions on sections; we simply ask whether sections are agreed to. The division on section 1 was my mistake. We will record David Davidson's dissent.

After Section 2

The Convener: Amendment 15, in the name of the minister, is grouped with amendment 15A.

Malcolm Chisholm: In November, I wrote to you, convener, to inform you that we would amend the bill to include a provision on staff governance. A draft section was published for consultation on 17 November 2003. In addition to a written consultation, my officials delivered a national consultation event and three regional consultation events. They also offered to hold individual events in each NHS board and special health board in order to hear the views of staff and NHS employees. The outcome of that consultation exercise was published on the Scottish Executive's website.

15:00

Amendment 15 will put staff governance on an equal footing with clinical and financial governance, by which I mean the arrangements that are in place to ensure good clinical and financial management, which are underpinned by legislation. The amendment has been welcomed by all the people who attended the consultation events and it was welcomed in the written responses to the consultation document. It will require health boards, special health boards and the Common Services Agency to put in place arrangements for improving management of their staff and to monitor those arrangements.

The committee will be aware that trade unions, professional bodies and NHS employees have been working together for some time to promote better management of staff in the NHS. They have produced the staff governance standard, which outlines what employers are required to deliver and what staff are entitled to. The document should assist boards and the CSA in discharging the new duty. I hope that the committee will add its support for those arrangements and the amendment.

I am prepared—indeed I am keen—to support amendment 15A in the name of Shona Robison, which is supported by Jean Turner. It seeks to add work force planning to the list of things that health boards, special health boards and the CSA should have in place.

The Convener: You have made a woman happy.

Malcolm Chisholm: Our view is that the matter was already covered by amendment 19, but I do not oppose putting it beyond doubt. The document entitled, "Working for Health: the Workforce Development Action Plan for NHS Scotland" outlines the arrangements that must be put in place at local, regional and national levels to support work force development. That has not happened in the past, but it must happen in the future, and I am entirely happy for that to be in the bill.

I move amendment 15.

Shona Robison: I am recovering from the shock of the minister's supporting amendment 15A.

I welcome amendment 15 because it responds to concerns about staff governance that were raised at stage 1. The purpose of amendment 15A is to place on health boards an explicit duty—in respect of work force planning—to ensure that such planning is given the prominence that it deserves in securing improvements in management of officers that the boards employ. Given the problem of health-professional shortages, which has been highlighted by several professional bodies and trade unions, it is time to give statutory force to work force planning in NHS Scotland. The evidence from the Royal College of Nursing Scotland, which stated that an explicit duty for work force planning would support improved delivery of a vital aspect of staff governance, is particularly persuasive. I am happy that the minister has decided to accept my amendment.

I move amendment 15A.

Mr Davidson: I agree with the comments that have been made on amendment 15; evidence exists to support it. I will support amendment 15A, but I would broaden it because it raises several questions that minister might respond to, including lack of staff capacity, which is a major problem in the health service in Scotland, and difficulties in attracting and retaining staff. Amendment 15A assumes that staff capacity and work force planning are major concerns that must be the responsibility of good management, but it also assumes certain freedoms that I do not see, and it assumes that there will be adequate resources. That brings into question—yet again—the issues around next year's review of the Arbuthnott formula. I would like to hear the minister's comments on the freedoms and resources that will be available to conduct that valuable exercise.

Amendment 15A agreed to.

The Convener: The minister might wish to comment on amendment 15, as amended.

Malcolm Chisholm: How long have you got? David Davidson raised a lot of major issues. The general issue of work force planning was covered in the debate that we had in the chamber two or three weeks ago; I do not think that I need to repeat all the points that I made.

Workplace planning is a major issue for us. It is something that has been sadly lacking in the past, which explains some of the difficulties that we have; in particular, the shortage of specialists. The problem will now be tackled at local, regional and national levels.

David Davidson invited a debate about resources in the health service, which is not appropriate to the amendment. Members can read my speech from the recent debate, but I repeat that there are extra resources and staff. However, we are determined to achieve more. I will press amendment 15, as amended.

Amendment 15, as amended, agreed to.

The Convener: Amendment 16, in the name of the minister, is in a group on its own.

Malcolm Chisholm: Amendment 16 will provide a legal underpinning to existing policy that encourages health boards, special health boards and the CSA to discharge their functions in a manner that encourages equal opportunities. It will also require them to observe equal opportunity requirements in current legislation. The measure has been discussed with the NHS, patient bodies and equality bodies and has been widely welcomed and supported. When I wrote to the committee in November to inform members of our intention to amend the bill to include staff governance, I also mentioned that I would lodge amendment 16 on equal opportunities.

I move amendment 16.

Amendment 16 agreed to.

The Convener: Amendment 36, in the name of Duncan McNeil, is grouped with amendments 37 and 38.

Karen Gillon: For members of the public, waiting times are a key indicator of their experience of the health service. We all have experience of frustrated constituents who feel that they have not received the service that they should have when they believed that they would have an operation or treatment within a specified time.

Minimum waiting times for key treatments are set by the Executive; health boards have a duty to comply with those set times. They also have a duty to make their customers and patients aware of their right to treatment. If boards do not comply with the minimum waiting times guidance we, as patients, can make representations to ask the minister to intervene and to provide the treatment from another source.

Openness and transparency are key if the public are to trust the waiting times guarantee. The article in today's *The Herald*, which suggests that people are for spurious reasons moved to other lists to meet targets does little to develop that trust. If the article is accurate, it simply underlines why we need a more robust mechanism to monitor and evaluate what is happening in relation to waiting times.

Amendment 36 would place a duty on health boards to monitor their adherence to guidance on waiting times that has been issued by ministers. That is not too onerous a task for boards and it is one that we should ask them to undertake.

Amendment 37 seeks to ensure active co-operation throughout Scotland—not simply on a board-by-board basis—so that any spare capacity can be used effectively to allow people to have their operations carried out in a timeous manner. It will also ensure that the waiting times guarantee does not have the potential to become a postcode lottery.

Amendment 38 would allow patients in a final arbitration position to make representations to the minister and it would allow the minister to take a view on intervention when waiting times guidance was not being met. If we as politicians set guarantees for minimum waiting times, we have to be prepared to take action if those guarantees are not met. The amendments would provide a helpful way in which to do that. I would welcome comments from members and the minister.

I move amendment 36.

Mike Rumbles: Perhaps Karen Gillon will clarify this when she sums up, but if such targets were written into law, what would happen if they were not met?

Mr Davidson: I wanted partly to ask the same question. If the waiting times targets that the minister has published are not met, there is a duty on NHS Quality Improvement Scotland to become involved, and the minister and his department can intervene. Therefore, I wonder whether amendment 36 is a bit top-heavy. However, I have sympathy with the general view that patients should have a right to know that they will be treated on time.

Amendment 37 would require inter-board action to maximise the use of spare capacity in any part of the health service. I would welcome such a move because it would give patients choice.

Unfortunately, the amendment would not empower patients and their clinicians—for example, GPs and consultants—to trigger that movement to allow the patient to be treated in another health board area that had available capacity.

Dr Turner: I see why people want to keep faith with the patient and keep faith with waiting times, but I think that doctors would generally find the proposal very restrictive. I will give an example. Two people might be diagnosed as having arthritis of the hip and be in need of hip replacements, but the person who came on to the list second might deteriorate faster than the other. If doctors had to stick to waiting times directives, they would be required to treat the first patient first while the other patient's condition continued to deteriorate. Requiring people to stick to waiting times would be difficult.

I agree, for example, that if a patient is in agony and their hip replacement cannot be carried out within their own health board area, they should be able to go anywhere in Scotland for the operation. I have sympathy with the amendments, but I think that people would be further tied down with waiting times by them. I would be scared that patients in need would have to wait longer.

Shona Robison: Amendment 36 is an interesting amendment, which I was pleased to see had been lodged by Duncan McNeil. Health boards would certainly find it challenging to meet a duty on local waiting times. As Mike Rumbles pointed out, the consequences of their failing to do so would, I presume, be ministerial intervention or intervention by the Health Department. However, one would like to think that that would happen anyway if health boards failed to meet their waiting times targets. Perhaps the minister will comment on that.

When Karen Gillon spoke to the amendments, she made reference to the way in which people have been moved from one list to another in order to massage waiting times figures, as is alluded to in today's edition of *The Herald*. However, I am not sure that the proposed duty to monitor waiting times would necessarily stop that. Perhaps we should impose a duty on health boards not to move patients between lists. I will be interested to hear the minister's response to this interesting group of amendments.

Malcolm Chisholm: I believe that the amendments are not necessary and may well be counterproductive.

On amendment 36, the duty in section 12H of the 1978 act already requires boards to have arrangements for monitoring and improving the quality of health care, which includes arrangements for monitoring and reducing waiting times. Boards already have systems in place to monitor whether they are adhering to the Health Department's guidance on waiting times and they make regular submissions to the department's waiting times unit on how they are performing against the waiting times targets. That happens already, so amendment 36 is clearly unnecessary.

We are delivering on the waiting times guarantees, which kicked in at the end of last year, but I am not convinced that to give them a statutory basis would be a good idea. Although our firm guarantees go beyond what existed in the past and, indeed, beyond what applies in the rest of the UK, turning them into a legal duty could be counterproductive by creating a downward pressure on targets because of the threat of legal challenges against boards. Such an approach would also seriously distort the power of intervention that is proposed in amendment 38. I take it that Duncan McNeil is invoking the sanction in that respect.

15:15

Amendment 38 is contrary to the principles that the power of intervention should be used as a last resort and restricted to systemic service failure, rather than to individual breaches of waiting times. I agree that if a board is systematically failing to meet waiting times targets it might be necessary to use the power of intervention as a last resort. However, that would happen anyway because the whole service would be failing to meet acceptable standards.

It is not appropriate to consider using the power to transfer the function from the board to an intervention team every time somebody claims that they have not been treated within the waiting times guarantee, or claims that it is likely that in future they will not treated within the guarantee. That might involve ministers in pre-emptive use of the power in individual cases, which could interfere with a board's operation. As drafted, the provisions in section 4 will allow for intervention only when it is absolutely necessary either to provide a service or to restore a service to an acceptable standard. As a result, I encourage members to reject amendment 38.

That said, with reference to the article in *The Herald*, the board in Glasgow and I would want to know about any complaints that individuals might have. The article itself gave no specific examples, but patients who have complaints should certainly come forward and tell us about them.

On amendment 37, the current wording of the duty of co-operation requires boards to co-operate in order to secure and advance the health of the people of Scotland. Such a duty includes co-operating on reducing waiting times and thereby advancing the health of the people of Scotland.

Boards will continue to co-operate with the Golden Jubilee hospital on reducing waiting times and to work with other health boards to ensure that there is a national effort to reduce such times. As a result, amendment 37 is unnecessary.

Karen Gillon: First, I want to deal with some of the minister's points. His response to amendment 38 trivialises the issue slightly. I am aware of cases in which patients have been given appointments 18 months after they have seen the consultant. That does not meet the waiting times guarantee. When such issues are brought to a health board's attention, it simply says that they are mistakes. If that is the case, the board should introduce more robust procedures to ensure that such "mistakes" do not happen.

I certainly do not believe that the intention behind amendment 38 is to allow every individual who does not receive an appointment within the first week of seeing a consultant to complain to the minister. The procedure would be far more robust than that and would, in effect, represent a court of last appeal. That said, I am prepared to accept that the amendment would not do what is intended. I will have another look at that.

The minister suggested that the proposal in amendment 37 goes way beyond the guarantee by turning it into a legal duty. However, if the guarantee has no real status, what is the point of it? We must examine what it means to offer patients guarantees, and we must examine the status of any guarantee that is not honoured. What rights do patients have when politicians raise their expectations but cannot deliver on them? We need to answer such serious questions. If amendments 36, 37 and 38 are not the right way of doing that, my colleague Duncan McNeil and I will be happy to enter into discussions on the matter. However, the point is that, if we set something up as a guarantee, we need to be able to back it up with some clout.

That brings us back to Mike Rumbles's very serious question about what will happen if boards consistently do not meet the waiting times guarantee. The answer is that if Parliament or ministers have given such guarantees, there will have to be ministerial intervention. As for Dr Jean Turner's comments, I do not think that the amendments seek to remove the need for clinical priority patients to be seen within nine months—after all, someone whose condition is deteriorating very quickly will need to be seen before someone who is not.

I have listened to what has been said and I seek the committee's agreement to withdraw amendment 36 and to come back with it at stage 3.

Amendment 36, by agreement, withdrawn.

The Convener: Amendment 40, in the name of David Davidson, is in a group on its own.

Mr Davidson: Members of the committee will know about the benefits that have come from the English scheme, which was totally supported by many Labour Party MPs who represent Scottish seats. Such schemes have many advantages. Amendment 40 seeks to allow

"any NHS hospital, or group of hospitals"—

because some hospitals operate as groups across different premises—

"to apply to become an NHS foundation trust".

The rest of the amendment is there for members to read.

Foundation trusts allow development and allow focus on responsiveness to patient needs. They aid specialisation. The committee has just agreed to the amended amendment 15 and, as was covered in our discussion, England and Wales must allow scope to deal with patients' needs on a staff-capacity basis. Amendment 40 would allow hospitals the freedom to recruit and retain staff—particularly specialists—on a realistic basis. To be frank, few hospital groups do not have specialisation shortages, be they shortages at consultant level or at the level of specialist nurses or nurse consultants. The shortages cut right across the specialist skills in the NHS.

The focus should be on turning the health service round and making it patient centred. It should not just be a mechanism for delivery on a standardised prescriptive basis throughout Scotland. We need to free up centres: centres in England have proved that they can reduce waiting lists and waiting times and that they can, by agreement, develop regional specialisation to deliver specialist care. That assists the smaller hospitals and neighbouring health boards.

In Scotland, there is a huge shortage of specialist skills. We need to skill-up more doctors to become consultants. That seems to be the difficulty. If it does not happen, we cannot train the next generation. Hospital units in England provide specialisation and the opportunity for continuing training and development. Hospitals are allowed the freedom to go into the marketplace to attract staff by whatever means they consider appropriate, although obviously those means have to be legal. If we could do the same, we would not have the great shortages that we have.

I am not sure why the minister has set his heart against foundation trusts. Many Scots realise that over-intervention from the centre does not incentivise people to deliver more care. If we consider foreign models, we see that the health service attends to delivery, but the minister stands by to deal with resources and standards. That is

appropriate because that is what the public are looking for.

Since the whole issue of foundation trusts arose south of the border, I have not heard a serious argument from the minister, or even from the First Minister, about why we cannot have foundation hospitals or allow hospitals the opportunity to apply for foundation status. I cannot see how it is right to restrict hospitals' ability to deliver as they see fit. We have agreed to the amended amendment 15 and we have to give the health service the tools to do the job.

I move amendment 40.

Mike Rumbles: I oppose amendment 40. It is completely illogical. We are in the business of abolishing trusts and yet the amendment seeks to establish foundation trust hospital status. That is completely bonkers. It is completely alien to what we are doing in the bill.

My second reason for opposing the amendment is that it is driven by Conservative ideology. David Davidson raised that issue. He is perfectly entitled to pursue Conservative ideology but doing so in this forum is a waste of time. It does not chime with the Scottish people. To meet the needs of the Scottish people, we must have a different solution from the solution down south.

I am focused on what we are doing north of the border. I find it particularly difficult to grapple with the amendment given that David Davidson is a north-east regional MSP, because establishing foundation hospitals in competition with each other to serve the population of Grampian would be completely irrelevant. David Davidson knows that very well, yet he still pursues the issue. For many people in rural Scotland, there is no choice, and I am convinced that the reform of the NHS in Scotland that the minister has put before us is the right solution. It is certainly the right solution for rural Scotland and I oppose David Davidson's ideologically driven amendment 40.

The Convener: Heaven forfend that we should be driven by ideology.

Shona Robison: If we were being honest, we would say that it is Conservative and new Labour ideology, but I will move on.

On several occasions, I have put on record my opposition to foundation hospitals on a point of principle. Without going over old ground, I want to deal with one specific issue that David Davidson raised: his argument that foundation hospitals would somehow address specialist staff shortages across Scotland. It is important that we understand that David Davidson talked about shortages across Scotland. Of course, foundation hospitals would not address those shortages, because they would only make staff shift within Scotland, between competing hospitals that are paying different rates.

Surely, we want to attract more specialist staff to Scotland, and the only way to do that is on a Scotland-wide basis. I argue that that might require offering enhanced terms and conditions for some specialties, otherwise all that will happen is that the problem will shift from one hospital to another within Scotland, but I have never understood the concept of using internal competition as a mechanism to address staff shortages. We are talking about the Scottish national health service, so surely we want to address the problems throughout the service and not just allow the survival of the fittest at the expense of the weakest, which would not address the problem in any way.

Dr Turner: I am absolutely opposed to anything that would bring us back to fundholding and non-fundholding, which was dreadful for the patient. The only people who I remember thought fundholding was a good idea were doctors who managed to get an easy life. They certainly put their patients first, but that was at the expense of the others. I could not go along with it.

I cannot understand why anyone would think that foundation hospitals are a better idea, because one hospital gets built up at the expense of others. How long would the others take to creep up to the standard of the fundholding hospitals?

There would be a shift of people. When NHS 24 was started, it was evident that many experienced nurses left coronary care and general practice and went into the higher paying jobs in NHS 24. That was good for them, and no one blamed them for it, but practices in Scotland must retain their staff and I do not think that David Davidson's idea is the way in which to go about it.

We must also consider the education and training of doctors and nurses. As I have said before, the private sector does not train nurses or doctors; we in the NHS train our doctors and nurses. Specialised units that do certain procedures can steal a certain number—probably quite a lot—of people who have had that training, so I am against David Davidson's proposal. I am afraid that I do not support amendment 40.

Helen Eadie (Dunfermline East) (Lab): I draw members' attention to the register of interests. I am a member of the Co-operative party.

Although it is interesting to hear what David Davidson said about trusts, when the Tories first set them up, there are those of us who pushed for a mutual model, which is distinct from the model for foundation hospitals that he talks about. It is perverse that he is now suggesting that we should move to a form of mutualism, given that his party threw that out when it first set up the trusts all

those years ago. For that reason, I will not be supporting amendment 40.

It is also interesting that David Davidson mentions shortages. Shortages are driving a lot of the change in the health service, but they cannot be resolved by foundation trusts. As other members have said, foundation trusts would mean that we would end up with leap-frogging across the country, so they are not an appropriate solution for Scotland. Foundation trusts might be appropriate for other parts of the country, but they would not resolve the specific problems that we face in Scotland. David Davidson might feel that they are the solution, but I do not think that that belief is realistic. It does not chime with the views of the professionals or members of the public, neither of which want to move in that direction. They want a strong health service. Above all, they want us to strengthen it—that is what they are calling for us to do.

15:30

The Convener: I somehow think that the minister is going to complete the rout.

Malcolm Chisholm: I was certainly intrigued by David Davidson's speech, which told us—more than once—about the advantages that have come from foundation hospitals in England. The fact is that there are no foundation hospitals in England, although I accept that there will be some next week. I will follow what happens in England with great interest, to find out whether there are any lessons that we can learn from them or from any other health initiative there, but we must find ways forward that meet the needs, systems and health structures of Scotland.

As Mike Rumbles pointed out, it is completely illogical to abolish trusts in the bill's first section and then set up foundation hospitals at a subsequent point. As members know, not one person—as far as I am aware—who came before the Health Committee called for foundation hospitals, and I am not aware that they are being called for to any great extent in the health service.

The fundamental reason why we will not have foundation hospitals in Scotland is that we have our own reform agenda, which is based on the principle of single-system working within a decentralised context. I believe that that is the most patient-centred approach, because patients see one system. It is unfortunate that, in the past, patients have often bumped into the barriers between the different parts of the health system. In Scotland, we want a reform agenda that is based on a single health system. That is the fundamental reason why we will not have foundation hospitals here. People can point to all the other arguments about foundation hospitals, but the main point is that we want to improve the whole health care system, not just isolated entities within it.

We want a single system that brings together primary, acute and social care. We want a system in which, rather than compete with one another, health care professionals co-operate and collaborate. In Scotland, I believe that that is best achieved through developments such as the introduction of community health partnerships, rather than by following the English approach, although it might well suit English circumstances. Apart from anything else, England is starting from a different place. We have already taken steps down the path of modernisation and the bill moves us further down that path.

Mr Davidson: I make the point that we are talking about NHS foundation trusts, not about privatising. I do not think that that has been understood by all members at the table and it should be made clear.

Mike Rumbles said that the proposal was alien and illogical. That might be his view, but the fact is that the best practice that he mentioned is not operating. He well knows that the north-east is experiencing extreme difficulty in employing specialist staff at all levels. Many specialist staff are going to England because of foundation trusts, and not just because of pay rates. Helen Eadie spoke about that. The issue is not all about pay rates; much of it is about the environment within which someone is able to operate and develop.

Staff might also move because of attractions to an area. Mike Rumbles knows very well that, in the oil industry, people from abroad had to be persuaded to bring their skills to the north-east economy. That welcome development was achieved partly by selling the area, partly through conditions and partly through pay.

We have no choice about competition—a point that Mike Rumbles mentioned—because competition within the health service already exists. I have spoken to people who, for the sake of argument, would rather work in a hospital on the outskirts of Glasgow than in Raigmore hospital in Inverness. If, quite apart from their professional working conditions, people's terms and conditions are not appropriately attractive, they will not go to work there.

The proposal in amendment 40 is a mechanism by which real focus can be given to identifying what patients are looking for. My experience in the Parliament is that many people would be happy to go to another area for treatment if that meant that they could get the correct and appropriate treatment earlier to relieve their pain and discomfort. Not everybody wants to do that and it should be the patient's choice. They might have reasons for not wanting to go elsewhere for

treatment, such as wanting to stay near a loved one or a dependent.

Shona Robison commented on shortages. There is a drift to England and there is no argument about that. The medical schools, deans and department heads in hospitals tell us that. The issue is not only pay; competition is already there.

Jean Turner talked about fundholding GPs. The proposal for NHS foundation trusts is a different exercise. There is already a duty of education and training within the hospital system. No one is trying to dilute that, but if hospitals can attract quality key consultant staff, they will attract those who wish to be trained there and to get experience. Ultimately, that is to the good of the patient.

Helen Eadie mentioned the Co-operative party, which is, of course, supportive of foundation hospitals south of the border; it is for her to tell me what her party's policy is north of the border. The proposal in the amendment is not a privatisation exercise.

The minister talks about the health service already moving in the appropriate direction. I point out to him that I also lodged an amendment to section 1. My approach is logical—Mike Rumbles mentioned that it was illogical—as amendment 40 links back to that amendment 54. The minister talks about a single system working with local management. He talks about local management, but it is not there. He talks about there being a single system for the patient, but under the proposal for foundation trusts, the patient would go to the clinician—be that a GP or an out-patient consultant—and would take advice. If the advice was, "I can get you that specialist care at Raigmore hospital because it is offering the care. You live in Aberdeen, but there is a waiting list in Aberdeen," so be it.

That brings us back to rural areas. Rural people often have to travel for specialist treatment anyway. We cannot support every hospital in Scotland having expertise in all fields. Hospitals have specialities—some are generalist and some provide special care. The proposal in the amendment offers an opportunity in areas such as Grampian for multisite hospitals to work together to the benefit of not only the local community but the regional community. The model can work. It is not about putting money into private shareholders' pockets; it is about the opposite of that. It is an opportunity to modernise the system at a stroke and, if their boards wish to move in that direction, to use some of the fine hospitals that we have in Scotland. My amendment would give them that opportunity.

The only ideology that I will come out with is that the proposal is all about choice in a modern society. The convener will recall that, on Friday, we attended a meeting sponsored by the Scottish Executive. We heard about the benefits of the approach in hospital systems throughout Europe. Many of the benefits that were talked about were modelled exactly on the NHS foundation trust model—albeit that the bodies were privatised and operated as contractors to the health service, and we are not talking about that in this instance.

The Convener: It is very naughty to draw me in with your amendment by association. I have kept silent throughout and I remain silent. Will David Davidson press or withdraw amendment 40?

Mr Davidson: I press it.

The Convener: The question is, that amendment 40 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 40 disagreed to.

Section 3—Health Boards: duty of co-operation

Amendment 37 not moved.

The Convener: Before I proceed any further, I should say that I would like to press on until half past four. However, I am in the committee's hands. Are members content that we try to get through stage 2?

Members *indicated agreement*.

The Convener: Members are content that we will try to get through stage 2 today. Amendment 17 is in the name of the minister. I did not ask the minister whether he is content to continue, which was a bit discourteous. Can I take it that he also consents?

Malcolm Chisholm: I am in your hands, convener.

The Convener: I will take that as agreement.

Amendment 17, in the name of the minister, is grouped with amendments 41, 18 and 31.

Malcolm Chisholm: Amendments 17, 18 and 31 are Executive amendments that relate to the new duty of co-operation and which clarify what powers boards will have in pursuit of that duty. Amendment 17 will make new subsection (2) clearer by making provision for two different types of activity in pursuance of the duty of co-operation. The first is where a board undertakes to provide or secure the provision of services for residents of another health board area. In that situation, amendment 17's provisions will give the health board that intends to arrange for its residents to receive services from another health board the powers it needs to enter into such arrangements. The second type of activity is where two or more boards come together to provide services jointly across their areas. Of course, that was the original policy intention at stage 1. Amendment 17 aims to express more clearly the powers available to boards to give effect to that intention.

The last part of amendment 17 provides for the powers that are available to a board that undertakes to provide services to residents of another board area—that is the first type of activity that I described—and to all boards that participate in the second type of activity, which is jointly arranged services, so that such boards may enter into arrangements with other boards or the Common Services Agency. For services that are subject to the agreements, those boards will have the same powers as they have with respect to services in their own areas.

Amendment 18 is a minor drafting amendment that is required because of amendment 17. Amendment 17 adds an additional subsection to the new section proposed by section 3. Therefore, it becomes necessary to provide that the provisions in section 3 do not restrict health boards' other powers to co-operate.

Amendment 31 adds a minor consequential amendment that arises from that duty. The Primary Medical Services (Scotland) Act 2004 introduced a function of co-operation in relation to primary medical services. It is necessary to ensure that that new duty, which is targeted at primary medical services, does not restrict the wider duty that section 3 provides for. Amendment 31 will achieve that result.

On amendment 41, I have just explained that the Executive considers it necessary to clarify what power boards will have in performing the duty of co-operation. Executive amendments 17 and 18 will provide for a board that undertakes to provide services to residents of another board area to have the same powers as it has in relation to its own residents. Health boards also have the option of entering into an arrangement or NHS contract under section 17A of the 1978 act. Therefore, I invite David Davidson not to move amendment 41.

I move amendment 17.

The Convener: I invite David Davidson to speak to amendment 41 and the other amendments in the group.

Mr Davidson: In simple terms, I seek to include amendment 41's provision in the bill to deal with a problem. For a start, health boards tell us that, with all the new burdens of having to look after other boards' patients without clear movement of resource allocation to them to do that, they believe that they will face difficulty. Personally, I believe that payment should follow patients and that they have a right to receive care from wherever it is delivered in the health service, regardless of boundaries and titles. However, there is another problem because, under the Arbuthnott formula, it could be argued that a patient who lives in Lothian or Grampian might not have the same tariff ability to take money with them to another hospital or board area for treatment as someone in Glasgow, where there might be a larger amount. Health boards seek to address such problems. Amendment 41 seeks to make it clear that, when a health board offers care to a patient from another health board area, it automatically has the right to have the resource follow the patient to pay for the treatment.

The Convener: As no other member wishes to speak to the amendments, I invite the minister to wind up.

15:45

Malcolm Chisholm: I have made the points that I wanted to make. However, the clear movement of resources is part of what is covered by Executive amendments 17, 18 and 31. In addition, the chief executives of health boards are working on a framework for regional planning that will cover the nuts and bolts. I accept that the resources must follow when a patient is treated in another area; however, I flag up my concern about David Davidson's understanding of the Arbuthnott formula. I am sure that Paul Martin and others would agree with me on that point. Glasgow has more money, relatively, because it has greater health needs, relatively.

Amendment 17 agreed to.

Amendment 41 moved—[Mr David Davidson].

The Convener: The question is, that amendment 41 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 41 disagreed to.

Amendment 18 moved—[Malcolm Chisholm]—and agreed to.

Section 3, as amended, agreed to.

Section 4—Powers of intervention in case of service failure

Amendment 38 not moved.

The Convener: Amendment 19, in the name of the minister, is grouped with amendments 19A and 42.

Malcolm Chisholm: I will speak to amendment 19 and explain why I do not propose to press it at this time. Since the amendment was lodged, we have received a number of representations. It has not been possible to take a firm view of those representations before today and, therefore, my intention is to consider them further and return to the issue at stage 3. In the light of that, I hope that David Davidson will not move amendment 19A.

On amendment 42, I can understand why committee members are keen for ministers to give an indication of when an intervention would take place. However, that is simply not practical. As I have said before, there could be many circumstances in which Scottish ministers might wish to intervene and it would be unrealistic to try to record all of those circumstances.

We are all agreed that Scottish ministers should not intervene lightly, which is why the duty is subject to a necessity test that would allow for intervention only when it is more than simply desirable or expedient. Perhaps the amendment is intended to ensure that boards are not taken by surprise by an intervention. However, the idea that a board would not know when a ministerial intervention was likely to take place is totally unrealistic, given that there would be many steps to go through before this last-resort measure was taken. A protocol covering that already exists.

The escalating intervention protocol means that there would be meetings between officials from the Health Department and the board, with the department providing help, advice and support with a view to resolving problems within a short, focused timescale. Those meetings between officials could lead to the production of a recovery plan, which would be closely monitored by the department.

Where performance continues to be poor, the department will discuss with the NHS board how management might be strengthened and will take the necessary action. If performance continues to be poor, the department might send in a task force, with the agreement of the board, to assist with the management. As that step would take place with the agreement of the board, the necessity test in the bill would not be met.

In addition to the support and action described above, the department might recommend to ministers that they should invite the chair and the non-executive members of an NHS board to consider their position. Ministerial action can also be taken in certain circumstances to remove the chair and/or members of an NHS board.

All those measures would be considered before resorting to the power, which is likely to be needed only where no other options exist or it is reasonable for ministers to take the view that other options would not achieve the objective of remedying failing services.

I note that the amendment suggests that the guidance should cover circumstances that might result in an intervention, which means that there could be circumstances that are not covered in the guidance. If the guidance is not to be comprehensive, I am not sure what its value would be. Therefore, I encourage members to reject amendment 42.

I move amendment 19.

The Convener: Mr Davidson, as the minister has moved amendment 19, you have a choice. You may either move amendment 19A and speak to it or not move it and not speak to it. If you want, you can move the amendment, air the arguments, and then seek leave to withdraw it.

Mr Davidson: I will do that and quickly speak about the points that the minister made.

It is important that the minister put on the record today his reasons—although he did not explain them fully—for the changes that he seeks and his comments on the areas that he intends to change at stage 3.

The purpose of amendment 19A is simple. Boards, which seem to be in some discomfort about the costs of intervention, might be in such a precarious financial position that they would be able to pay for an intervention only by not delivering some other service. The minister says that he will intervene in a very responsible way, so I hope that he will be equally responsible in giving financial support to a board that is in that situation.

I hear what the minister says in relation to amendment 42. He indicated that he will publish guidance, some of which is already in the public domain and I think that he is also talking about refining the guidance. The minister commented on the removal of chairs, but of course those chairs are appointed at his behest and to deliver his policies—as they regularly tell me. I would not have thought that any new powers were needed to remove chairs who were not delivering to his expectation.

Many board members have expressed great concern that they do not know in advance how the rules of engagement under the escalating intervention protocol will work to their satisfaction. I hope that the minister will assure me that before stage 3 he will clarify exactly what he means by "escalating intervention protocol", because currently many people who work in the health service seem to be quite unclear about that. I did not lodge amendment 42 to be pernickety, but did so to ensure that the procedures would be clearly stated in the bill.

I move amendment 19A.

Malcolm Chisholm: I certainly referred to the escalating intervention protocol, but that was all. I was a little confused by what David Davidson said first, because I thought that he was assuming that I was talking about guidance that was separate from the protocol. The word "protocol" is more appropriate in this context as "guidance" does not correctly reflect what is being sought.

The protocol was issued some months ago. A copy has been sent to the committee and further information can certainly be provided. If problems are arising because NHS boards do not understand the protocol, we can deal with that. I am surprised to hear that that is the case, but obviously if members have information about that I will want to ensure that there is more clarity in the minds of any individuals who have doubts about the protocol. That is the correct way to proceed; it would not be at all appropriate to put the protocol in the bill. I accept that at stage 3 we can be more explicit in giving detailed information about the protocol's content, but I remind members that a copy of the protocol has been sent to the Health Committee.

Amendments 19A and 19, by agreement, withdrawn.

The Convener: David, do you want to move amendment 42, which has already been debated with amendment 19?

Mr Davidson: I do not think that the minister quite understood the second subsection in amendment 42, which says:

"Any such guidance or revised guidance must be published, and a copy laid before the Scottish Parliament."

If I understand the minister correctly, he seems to want to satisfy that demand. On that basis, I will not move amendment 42.

Amendment 42 not moved.

Section 4 agreed to.

Before section 5

The Convener: Amendment 43, in the name of Shona Robison, is grouped with amendment 58.

Shona Robison: Amendment 43 would address a general concern among the public that they are very dislocated—I suppose that that is the right word—from the decisions that health boards make.

Time and again in the committee, in the chamber and in our constituencies, we have heard about decisions that are made that fly in the face of public opinion, which has led to the public feeling disempowered and cynical about moves to consult and involve them. Health boards have often consulted, but they have ended up coming to the original decision that they set out with, which has led in no small way to people being cynical about the whole process.

Clearly, public involvement is an important part of the bill, with the duty on health boards to involve the public, but it is time to go further than that and take a radical approach by putting power back in the hands of the public by giving them a direct say over the health decisions in their areas. We have to take public involvement to its logical conclusion, and allow the public to sit on health boards. I propose that half the members of health boards should be elected members of the public, in order to democratise the health board system.

I have some sympathy for the intention behind amendment 58, in the name of David Davidson. Where local authority representatives sit on health boards, there is an argument that they should reflect the political make-up of the local authority. Apart from anything else, that would bring various opinions to the table, so I have sympathy for what he is trying to achieve. Some people may argue that local authority representation on health boards is the democratic input into health boards, and there is an element of truth in that, but it is no substitute for the direct voice of the public, which unfortunately has been all too lacking in our health board structure.

I move amendment 43.

Mr Davidson: I understand Shona Robison's principle that there should be patient and public input to the running of boards. That is one of the reasons why I wanted local health council members to be represented on CHPs, as they are already part of a system. However, the proposal in amendment 43 would be costly and would set a

precedent for other bodies, such as fire boards and police boards. Every time somebody moved off one of those boards, there would be a by-election, which would be an expensive exercise involving the local authority and a properly conducted ballot. That could happen on a quarterly basis. We already have an awful lot of elections in Scotland. The mechanism is far too costly and bureaucratic. For those reasons, I cannot support amendment 43.

On amendment 58, local authority members are currently on health boards to represent their local communities. COSLA guidelines state that the d'Hondt principle should be followed, but those guidelines are not statutory and do not appear in regulations. In the main they are ignored, despite the fact that there are councils in Scotland where control was determined by tossing a coin or cutting a deck of cards. I want to put in the bill a measure on party balance. I would have thought that people who understand local government schemes well and who talk regularly in the Parliament about democracy and proportional representation should apply the principle of proportion to local authority representation on health boards.

16:00

Mike Rumbles: I have a great deal of sympathy with the arguments that are behind amendment 43, which is in the name of Shona Robison and is supported by Jean Turner. The first bill that I was involved in was the National Parks (Scotland) Bill, and it was my amendment that persuaded the Executive to change its mind about 20 per cent local representation on national park authorities through direct elections. I start from that perspective, but I am minded not to support the amendment, for the following reasons.

Democratic accountability is important, and that is why I am sympathetic to Shona's and Jean's position. However, I think that we can have democratic accountability in one of two ways, but not in both ways. We can go down the ministerial intervention route, which is the route that the committee and the Parliament have taken. The minister is democratically accountable and is given powers to intervene to ensure that our health boards are doing what they are supposed to be doing.

Alternatively, we can go down the directly elected route and require 50 per cent of the members of a health board to be directly elected, as amendment 43 suggests—as I said, I have some sympathy with that route. However, we cannot take both routes, because we would set ourselves up for a huge conflict between the democratically expressed wishes of the people through their elected representatives on health boards and a ministerial decision to intervene and overturn the decisions of those representatives. There would be a tussle between powers of intervention and direct elections.

At stage 1, I flagged up my concern about the powers of intervention. The committee is giving the minister a huge power of intervention. Section 4 states that Scottish ministers may issue certain instructions

"where they consider it necessary"—

not where anyone else considers it necessary. The word "necessary" is far too powerful. I thought about lodging an amendment to address that point, but I did not do so because I thought that we were proceeding down the route of ministerial intervention rather than the route of directly elected individuals. If we were starting from scratch and we wanted to go down the route of directly elected individuals, I would be supportive, but we decided not to do that. The two routes are mutually exclusive and therefore, with regret, I do not support amendment 43.

Helen Eadie: I will vote against amendments 43 and 58. I am not against the principle of directly elected representatives to health boards—I am a signatory to Bill Butler's proposed member's bill on that subject, so I support that notion—but amendment 43 suggests that half of the board members should be appointed by the minister and half should be elected by the public. For me, the jury is out on whether the entire board should be elected by the public or whether it should be half and half. In the Parliament, we have always tried to adhere to the fundamental point that we should consult and take evidence on proposals that we intend to sign up to. The committee has not heard any evidence on what form of election would be appropriate for membership of health boards.

In amendment 58, David Davidson suggests that the composition of health boards should reflect the balance of political parties. Again, the jury is out on the issue, but I would want to look at some Scandinavian examples and consider how health services are run in those countries. In Denmark, local authorities run health services but do not necessarily follow that prescription. I want to hear and consider the evidence rather than make a snap judgment about an amendment that has been slipped in today. That is why I will not support amendments 43 and 58, although I like the principle of having directly elected health board members.

Dr Turner: It would take an awful lot of time and thought to put the proposal into practice, but it is evident that the Government wants public involvement. It is also evident that the public feel uninvolved and powerless to make changes. Campaign groups all over Scotland are trying to defend NHS services close to their communities

and to sustain their communities. We have problems in Glasgow, too.

The public would like to think that the Government would consider the proposal. Since about 1990, I have attended many meetings at which people have said that it would be great to have elected board members, as that would mean that some of the messes that we get into would not happen. Perhaps that would happen and perhaps it would not, but at least the public would feel a little better and would feel that they were trying to make changes.

Doctors, the public and MSPs wish that many board members were elected—I have heard MSPs from all parties say that. If we had had elected members, the mess that we have got into in Glasgow might have been avoided. Perhaps the concept of directly electing 50 per cent is too big to take on board, but almost 50 per cent would be needed to shift what has happened in Glasgow.

Amendment 58 concerns the balance of parties. When people attend health board meetings—as I have—at which they cannot open their mouths and they are dying for an elected representative from a council to speak, but he sits there never opening his mouth, that makes them feel that they are not being taken care of. I support amendments 43 and 58.

Paul Martin (Glasgow Springburn) (Lab): My comments are similar to Helen Eadie's. I fully support Bill Butler's proposed member's bill and I would like the minister to describe progress on that. I have always thought that 100 per cent of board members should be directly elected, but various views are held on that issue. It is okay to have 100 per cent directly elected representation in housing associations and other organisations in our communities that spend millions, yet quangos have different constitutional settlements.

We must have a comprehensive approach. Agreeing to the amendments today would not allow us to make progress on that. An effective consultation exercise about representation and consultation must be undertaken. After that, we can consider progress on Bill Butler's proposed member's bill.

Malcolm Chisholm: The amendments raise a fundamental issue about the balance between national and local accountability in a national health service. As the debate continues, that is the key issue that must be explored. I support more local involvement. The point at issue may be how that is best achieved.

On the one hand, the creation of the 15 unified NHS boards in September 2001 extended the range of key stakeholders, which includes local authority councillors. The role of local authority members on an NHS board was set out in "Rebuilding Our National Health Service", which was published in May 2001. The current practice is that each local authority nominates one of its councillors to be a member of the health board. As Minister for Health and Community Care, I formally appoint them to the board, subject to the usual statutory criteria. The formal presence of elected councillors as full members on each board is intended specifically to strengthen local accountability, responsiveness to community issues and joint working between health boards and local authorities.

As each local authority has one member on the health board that covers the local authority area, I find it difficult to see how amendment 58 would work. How will we apportion one person into a number of different political parties? Surely the important point is that the local authority member on a health board enjoys the confidence of that local authority, which is consistent with the guidance that has been issued on the matter.

More generally, the Executive is working to improve patient and public involvement throughout the NHS, as evidenced by other sections of the bill. For example, community health partnerships will include at least one member of the public partnership forum, who will represent the interests of the public. The public partnership forum member will be linked into a large virtual forum of interest groups and will be genuinely representative of the public. The new duty of public involvement in the bill will ensure that boards consult the public on plans and decisions that significantly affect the operation of services and that they involve the public far more than was the case in the past under the narrow concept of consultation. I want to create ways in which every interested member of the public can influence what happens in their board area.

Beyond general public involvement is the specific patient involvement agenda and patient experience agenda, both of which seek to bring about a far more patient-focused service than has existed in the past. I will not go into the details of that issue because it was discussed in June 2003 in the first health debate that we held in this session of Parliament. Our approach is based on an increasingly strong patient focus and the public involvement agenda, although I accept that we still have a long way to go.

Moreover, as Helen Eadie and Paul Martin pointed out, this is the wrong time at which to be legislating on elected members for health boards, given that Bill Butler is seeking to introduce a member's bill on the issue. Were that bill to be introduced, a wide public consultation on the proposals would have to take place. I am not persuaded that we should legislate in advance of such a consultation exercise. There is a general

issue about major amendments. We are proud of our pre-legislative scrutiny in Scotland. The appropriate way forward on the matter is through Bill Butler's proposed bill. I hope that the committee will wait to see the outcome of the consultation on that proposal before considering whether—and if so, how—we should proceed with legislation on this important matter.

I therefore recommend that the committee reject amendments 43 and 58.

Shona Robison: I thank everyone for their comments. The discussion was useful.

David Davidson seemed to be against my proposal on the ground of cost, which is a tenuous argument because the election process would not have to be costly, given that it could fit in with local authority elections. It might well fit in nicely with the proposed new system of proportional representation for local elections. A proportional representation system could deal with the issue of by-elections. I am sure that systems could be introduced to minimise cost and deal with his concerns. He shows a slight lack of consistency, given that the Conservatives support the direct election of the chairs of police boards. One would think that if something was good for the goose, it would also be good for the gander, but maybe not.

Mike Rumbles raised an important point: there is a debate about democratic accountability and whether that is achieved by, as he put it, ministerial intervention or direct elections. However, I do not agree that the two are mutually exclusive. Local authorities are elected, but they also have duties placed on them by ministers—they operate within the parameters that ministers set. The same situation would exist with directly elected health boards. Ministers could set the parameters within which health boards operate.

Helen Eadie and Paul Martin made some useful comments about the need for consultation. I accept that there are various forms of direct elections and that we have to decide how far to go—should it be all members or 50 per cent of them? We should take further evidence on the issue. I thank Jean Turner for her support. I was hoping that she would name the local authority rep who sat schtum, but unfortunately she did not.

16:15

The minister talked about major amendments being lodged without consultation. I hope that that means that we will no longer see the Executive lodging major amendments at the last minute without consultation. It is useful that that is now on the record.

I am persuaded by the arguments that were made on the need for further consultation. Given that the bill is about health service reform and also about public involvement, I thought that it was important to put down a marker today. I hope that Bill Butler's proposed bill to establish direct elections to national health service boards will be progressed. His bill would secure an important principle, which the public supports. On that basis, I seek leave to withdraw amendment 43.

Amendment 43, by agreement, withdrawn.

The Convener: Amendment 58, in the name of David Davidson, was debated with amendment 43. Do you wish to move amendment 58?

Mr Davidson: Am I allowed to respond before I make a decision on that?

The Convener: I beg your pardon. Please forgive me. I meant to invite you to do so.

Mr Davidson: That is very kind of you, convener. We are obviously getting tired.

I want to address one or two of the points that were raised, the first of which is Helen Eadie's comment about the Danish model. The difference between Denmark and here is that the local members in Denmark are elected to deliver a service. The issue is not whether I believe in PR. In Scotland, members are only appointed from an elected body by the minister and all councillors are elected to represent areas. The situation is not the same here. I am led to believe that, in some health board areas, more than one member comes up from the local authority—however, I am open to being advised otherwise by the minister.

Helen Eadie also referred to the election of police board chairs. I suppose that that suggestion would take us to the principle that, instead of the minister appointing the chairmen of the health boards, those posts are also put up for election. If that were to happen, it would represent a real democratic shift.

I listened to what the minister had to say about how the Executive is dealing with the consultation on Bill Butler's bill. By the sounds of it, his bill will be allowed to proceed to the chamber. On that basis, I accept the minister's premise that it would be best for us to discuss the issue at that time, as we will have seen the results of the consultation.

Amendment 58 not moved.

The Convener: That is fine. I am mindful of the time. If we were to extend the meeting by 15 minutes—at the very latest to 4.45 pm—we could finish stage 2. What does the committee feel about doing so?

Mike Rumbles: Go for it.

Shona Robison: Yes, go for it.

The Convener: I hear, "Go for it." Would the extension to 4.45 pm be a problem for any member?

Mr Davidson: I will have to rejig something, but I will slip out and make a telephone call. I am happy to go with the committee view.

The Convener: That is very kind of you. I will try to pick a time at which you can slip out without missing an opportunity.

Section 5—Public involvement

The Convener: Amendment 20, in the name of the minister, is grouped with amendments 21 to 24.

Malcolm Chisholm: This group of amendments refines the duty of public involvement and extends it to the Common Services Agency. As a consequence of extending the duty to the agency, it is necessary to define more narrowly the services that are subject to the duty. That is because some of the agency's services and some of the services that are provided by special health boards result in services being provided to other NHS bodies. The policy intention is to ensure that the focus of the duty remains firmly on consulting and involving the public on the provision of health services.

The purpose of amendment 22 is to ensure that only decisions that will significantly affect the operation of the service should be subject to the new duty. Without amendment 22, there is doubt as to whether the duty applies merely to trivial operational decisions. Amendment 22 avoids that doubt.

I move amendment 20.

Janis Hughes: I welcome amendment 22 in particular. At stage 1, I raised a concern about the provisions in the bill that relate to consulting on decisions made by the health board. I thought then that the bill's requirement that boards should consult on decisions sounded as though a decision had already been made, which might mean that there was no room to change those decisions. I welcome the minister's amendment 22, which changes the wording to "decisions to be made". That reflects the concerns that were raised by the committee at stage 1.

The Convener: As no member wishes to speak in opposition, I take it that the minister will waive his right to wind up.

Malcolm Chisholm: Yes.

Amendment 20 agreed to.

Amendments 21 to 24 moved—[Malcolm Chisholm]—and agreed to.

Section 5, as amended, agreed to.

After section 5

The Convener: Amendment 45, in the name of David Davidson, is in a group on its own.

Mr Davidson: Amendment 45 would provide for the proposed new Scottish health council to be set up as a statutory body under the bill. The council should be set up as an independent organisation funded by the minister and not as part of NHS QIS or any other organisation. Amendment 45 might pre-empt Shona Robison's amendment 46—

The Convener: It will not.

Mr Davidson: That is fine.

There has been a lot of discussion about the Scottish health council. An independent body is currently meeting to consider the role of such a national organisation. A lot of effort has been put into the matter and we have taken evidence on it, yet the council does not appear in the bill. I find that strange. On that basis, I want the bill to provide for the formation and funding of the council, along with the powers and duties that it will have.

I move amendment 45.

Shona Robison: I have a lot of sympathy with the amendment. I am puzzled as to why the establishment of the Scottish health council is not covered in the bill. Issues have been raised throughout the evidence-taking sessions about the independence of the council. Without going over all the old ground, I believe that amendment 45 would go some way towards establishing that independence. Just as important, it would put the formation of the Scottish health council on a statutory footing in the bill, where it should be.

Malcolm Chisholm: As members know, we have proposed that the Scottish health council should be established as a body with a distinct role and status in NHS Quality Improvement Scotland. That is because we regard patient focus and public involvement as being essential parts of securing quality in the NHS. Improving quality has to be about developing services that are more focused on patient experience and about meeting what patients want through, for example, service redesign, managed clinical networks and other initiatives. The review and inspection functions of NHS QIS will also be strengthened by the ability to draw directly on the expertise and patient networks of the proposed Scottish health council.

NHS QIS is the body at the heart of improving quality in the NHS. It operates separately from ministers and other boards. The standards on diabetes that were issued this morning are the most recent good example of its work.

I have written to the committee to set out our proposals for ensuring the independence of the

Scottish health council in NHS QIS, but I will reiterate them now. First, the council will be created through legislation, albeit through regulations, as a committee of the board of NHS QIS. Similarly, NHS QIS was created not by primary legislation, but by regulations. Ministers will appoint the chair through the public appointments process. Up to three members will be appointed from the local advisory councils, to ensure strong local links. Other members will be appointed, through the open public appointments process, by NHS QIS.

That is a better way forward than the one that David Davidson proposes in his amendment, which would create an organisation that lacked independence. Effectively, the system proposed in the amendment replicates the existing system, in which the Scottish Association of Health Councils, a non-statutory body, has a membership made up from local health councils throughout Scotland. Members of the body proposed in the amendment would not be appointed through the normal, open public appointments process for health bodies. They would come from local health councils, which are appointed by health boards. That is not the best way forward for a truly independent body. Accordingly, I invite David Davidson to withdraw the amendment.

Mr Davidson: On the NHS QIS point, during one of the evidence sessions Helen Eadie asked a pertinent question about the independence of the management structure. The minister has still not addressed that point fully. The issue is the public's perception of independence. The minister refers to the appointments system that is used for local health councils. Most local health councils go down the route of advertising posts and then interviewing people. Apart from perhaps a nominal comment at the end of the process, the health board tends not to be very involved, unless that model occurs in areas that I have not come across.

I lodged the amendment because of the issue of perception and to put the Scottish health council on the face of the bill, which would make it different from NHS QIS. I do not want the health council to be a committee of another organisation that has NHS in its name. A Scottish health council has the great capacity to develop—the fine print can follow. However, the minister must always remember—as I am sure he does—that doing things by regulation means that he has total control and that, at any time in future, any other minister can come along and do whatever he or she sees fit; no one else will have any say in the matter. If the organisation is provided for in the bill, the Parliament will, in future, have an opportunity to debate potential changes. Some of those changes may be to the good—I would not preclude that—but it is important that the new organisation be provided for in the bill and that it is seen to be independent.

The Convener: The question is, that amendment 45 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 3, Against 6, Abstentions 0.

Amendment 45 disagreed to.

Section 6—Dissolution of local health councils

The Convener: Amendment 46, in the name of Shona Robison, is grouped with amendments 48 to 53.

Shona Robison: I will be brief, much to the relief of folk round the table.

Throughout the evidence-taking process, I have expressed concern about the loss of the role that local health councils perform at the moment, particularly their advocacy role. I accept that some councils have performed that role better than others, but the role is nevertheless important and is not being given to the Scottish health council or to the local advisory councils. I have looked through the evidence again and I do not understand why the establishment of the Scottish health council, with its particular role, should lead directly to the dissolution of the local health councils as we know them. Why are the two mutually exclusive? They would carry out different functions. In the absence of a replacement for a body to fulfil that advocacy role, it would be a retrograde step to do away with local health councils. The purpose of amendment 46 is to retain the local health councils and their specific role, as the Scottish health council will have a quite different and distinct role as a national body.

I move amendment 46.

The Convener: Have you spoken to the other amendments in the group?

Shona Robison: They are consequential to amendment 46.

16:30

The Convener: I will put members in sequence—Jean Turner then David Davidson.

Dr Turner: There has been a great deal of change in the health service and the bill will make a fantastic difference, which many of the patients do not really understand; even many of the doctors, who are all toying with it at the moment, probably do not fully understand it. Given that there is so much change, it would have been a kindness to the patients and the public to keep the local health councils in place.

It is true that, as Shona Robison says, the health councils might have served their communities in different ways. Some might have thought that they were part of the health board—occasionally, I thought that, too. In relation to the acute services review in Glasgow, it seemed that the local health council was going along with the health board, but then it took on board the fact that there were problems. It began by considering the issue of trolley waits and ended up accepting that there was a capacity problem within greater Glasgow, which everyone else was worried about.

I think that the health councils have a great role to play at the interface between the public and the health service; they can be the patients' advocates in the health service. The health councils also have representatives on health boards. I am a little confused about what the Scottish health council that takes over will do and about how we will look after the public in the change. That is why I support amendment 46.

Mr Davidson: I have seen both good and poor health councils. The reason why some health councils are poor is that their role is not always understood fully at local board level. Generally, however, the health councils have done excellent work over the years. They enter, in a stylish manner, into premises in which NHS care is delivered and they produce some excellent reports. Their current method of working is a credit to them and the individuals who serve on them.

A system in which all the health councils were linked into a national health council with a slightly different role would be far better than the current system. All the local health councils except the one in Lothian are involved in the Scottish Association of Health Councils. I believe that they have done a good job, which I think could be improved by various aspects of the bill. Getting rid of them would be a bit like throwing the baby out with the bathwater. We do not know in what way the advisory councils will be better than what we have already. I suspect that they will not have the same teeth or perform to the same level as the local health councils. I support Shona Robison's proposal to delete section 6.

Malcolm Chisholm: The amendments in this group seek to preserve the existing structure and functions of local health councils. I am happy to acknowledge that much good work has come out of local health councils, but the time has come to build on that good work and take it in a new direction. That is what I want to achieve. The status quo is simply not good enough.

Our approach is to develop new arrangements for advancing patient focus and public involvement. The provisions in the bill for a new duty of public involvement and for dissolving local health councils are designed to support and underpin that. We wish to put greater responsibility on NHS boards to communicate with and involve patients and the public and to encourage patients and community and voluntary organisations to represent their views directly to boards. We want to involve the public directly in the planning and design of health services and not have their views filtered through an outside body. The Scottish health council will monitor and quality assure that process, which will do more to help to achieve a more responsive and patient-focused NHS than keeping the present system would.

However, we will not disregard existing interests and expertise. Current members of local health councils will have an opportunity to be represented on local advisory councils, which will be the local presence of the Scottish health council. In many cases, those people will be the ideal candidates to fulfil that role and I hope that many of them will choose to do so. They have played a valuable role up to now and can do more in the future in their revised role. The approach that we are proposing will be far more valuable than keeping the status quo. Accordingly, I invite the committee to reject the amendments.

Shona Robison: I do not accept that, as the minister suggested, the status quo would remain if we rejected the amendments, because the bill will establish the Scottish health council and all that goes with it in terms of monitoring public involvement. I believe that we should maintain local health councils' discrete role in relation to advocacy, in particular, which is not about filtering views but about harnessing views and helping them to be expressed. I wish to press amendment 46.

The Convener: The question is, that amendment 46 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)
Grahame, Christine (South of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 46 disagreed to.

Section 6 agreed to.

Section 7—Duty to promote health improvement

The Convener: Amendment 25, in the name of the minister, is grouped with amendments 26 to 29.

Malcolm Chisholm: Amendment 25 extends the duty on NHS boards to promote health improvement to include the special health boards and the Common Services Agency. Special health boards were not originally included in the bill, because the commitment that was made in the white paper "Partnership for Care" referred only to NHS boards. We considered whether it would be appropriate to extend the duty to include special health boards and the Common Services Agency and, after consultation with those bodies, we concluded that opportunities exist for them to promote health improvement when they perform their functions. Therefore, we think it appropriate and consistent to extend the duty to those bodies.

I move amendment 25.

Amendment 25 agreed to.

Amendments 26 to 29 moved—[Malcolm Chisholm]—and agreed to.

Section 7, as amended, agreed to.

After section 7

The Convener: Amendment 47, in the name of David Davidson, is in a group on its own.

Mr Davidson: In lodging amendment 47, I seek to move on from the past. NHS Health Scotland is past its sell-by date. The minister regularly talks about the new duties and responsibilities on health boards and community health partnerships to promote public health. As most of that work could be done locally, the minister should transfer the duties, responsibilities and resources of NHS Health Scotland to local community health partnerships. If we are to get the message about health care across, it is best to do so through local activities.

There will be occasions on which the minister might, under his own auspices, promote a particular campaign on an advisory basis—he has the powers and the resources to do that and I do not argue that he should not have those powers or choose when to use them. However, NHS Health Scotland is no longer required, because the minister has sought to transfer powers and responsibilities to health boards and to CHPs. We have an opportunity to cut a lot of centralised bureaucracy and cost and to put resources into the local community health care systems, where they would be best placed.

I move amendment 47.

Malcolm Chisholm: I believe in increasing local delivery of health improvement, but the abolition of NHS Health Scotland is not the corollary of that. The body plays a vital role in delivering action to improve the health of the people of Scotland. In the light of Scotland's poor health record, it is more important than ever to promote health improvement, which is the core function of NHS Health Scotland.

NHS Health Scotland carries out important national functions. One of those functions is to develop research and use the evidence gained from it to inform our policy development and national and local practice to support health improvement actions. For example, it recently launched the constituency profiles, which provide the most comprehensive picture of Scotland's health ever produced. In addition, the Health Education Board for Scotland, one of the two bodies that were brought together when NHS Health Scotland was formed in April 2003, was responsible for work such as the Stinx campaign, which was targeted at teenagers, as well as the successful blue sticks—"This tastes bogging"—campaign. [*Laughter.*] We can provide that for the official reporters.

I agree that it is important that the health improvement activities are undertaken at a local level. That is one reason for giving health boards a duty to promote health improvement, which is a prime responsibility of the new community health partnerships. However, it is also important that we have a special health board with a national remit that can support local initiatives and health boards as well as co-ordinate national initiatives. I strongly urge members to reject the amendment.

Mr Davidson: I suppose that we should not talk about chips and health promotion at the same time.

The minister and the Executive have a lot of money and spend a lot of money on advertising. I have already referred to the powers that the minister has. He talks about the need for a body to produce statistical evidence. However, I have always been under the impression that that was the job of the information and statistics division, which is within the minister's department. I know

that the ISD is unable to answer questions relating to information that is not held centrally, but I argue that such information should be held centrally.

I am trying to divide appropriately between the minister, the health boards and the community health partnerships the responsibilities and the necessary resources. If they are given the new powers, health boards are likely to struggle to cope with the new demands without the necessary resources. My amendment provides an opportunity to facilitate a different model. It does not prevent the minister and the Health Department from running national campaigns but it would allow better use of resources at a local level. I wish to press the amendment.

The Convener: The question is, that amendment 47 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Davidson, Mr David (North East Scotland) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 47 disagreed to.

Section 8 agreed to.

Section 9—Modification of enactments

Amendment 30 moved—[Malcolm Chisholm]—and agreed to.

Section 9, as amended, agreed to.

Schedule 1

CONSEQUENTIAL AMENDMENTS

Amendments 31 to 34 moved—[Malcolm Chisholm]—and agreed to.

Schedule 1, as amended, agreed to.

Schedule 2

REPEALS

Amendments 48 to 53 not moved.

Amendment 35 moved—[Malcolm Chisholm]—and agreed to.

Schedule 2, as amended, agreed to.

Section 10 agreed to.

Long title agreed to.

The Convener: That concludes stage 2 consideration of the National Health Service Reform (Scotland) Bill. Thank you for your forbearance.

Meeting closed at 16:44.

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