Scottish Health Council
Response to Local Healthcare Bill

March 2008

The Scottish Health Council has been set up to help improve the way that people are involved in decisions about health services. As well as being a champion for patient and public involvement in NHS Scotland, the Scottish Health Council scrutinises local NHS Boards to ensure they are working with, and listening to, people in their community. We are pleased to offer the following comments on the Scottish Government consultation on the Local Healthcare Bill.

Consultation Questions

1. Do you think the current proposals for independent scrutiny of service change proposals help achieve the aim of better engaging and involving local communities?

We consider that the primary role of Independent Scrutiny is to provide assurance that options or proposals for major service change are evidence-based and satisfy a range of criteria, such as safety and sustainability, and to confirm that all viable options have been considered. Expertise in assessing clinical and financial aspects of the proposals is essential.

The role of assisting and assessing how effectively Boards engage and involve communities is the role and remit of the Scottish Health Council and it is important that a clear distinction exists between the two approaches.

2. How could additional guidance to NHS Boards on making public consultation as effective as possible help achieve this aim?

New draft guidance has recently been issued by the Scottish Government on consulting on major service change[1], which amongst other things gives a strong emphasis to the role of the Scottish Health Council in verifying that Boards have followed a robust public involvement process before proceeding to a formal consultation. Our analysis of consultations is that the options development stage is critical, and if Boards do not work properly in partnership with affected communities in developing proposals for change, the subsequent formal consultation lacks public credibility.

However the guidance has not yet been formally issued and should be tried out in practice before further guidance is introduced.
However, there may be a need to develop further guidance (or add more detail to existing guidance) relating specifically to the use of UK Treasury 'Green Book' options appraisal guidance, and how Boards are expected to use this in conjunction with the public involvement guidance.

[1] "Informing, engaging and consulting the public in developing health and community care services" Scottish Government October 2007. For day to day engagement Boards are expected to comply with the "National Standards for Community Engagement", developed by Communities Scotland, available at www.communitiesscotland.gov.uk/

3. Would the appointment of more lay members to NHS Boards – perhaps to directly represent patients or other groups – help achieve the aim? How might this be achieved?

More ‘lay’ members on Boards may achieve this aim, but there is a danger that members that are appointed to represent particular patient groups may have too narrow a focus on specific conditions and have difficulty in seeing the ‘bigger picture’. There is also the difficulty that attempting to ensure that a reasonable range of patient groups are represented (old/young/disabled/mental health/learning disabilities/minorities/long term conditions/maternity etc) would lead to Boards becoming cumbersome and unwieldy. If this option was to be explored further, it might be better to secure Board members from broader patient/public groups – e.g. the Public Partnership Forums.

4. In particular, would adding more local authority councillors (one councilor from each local authority whose area a Board serves is currently appointed to that Board) help achieve the aim? Could local authorities have a role in scrutinising public and community engagement?

Adding more local authority councillors may help achieve the aim, but once again care needs to be taken to avoid Boards becoming too cumbersome or unwieldy, particularly if there are also to be directly elected members of Boards. Local authorities are also represented on Community Health Partnerships which also ought to assist with the involvement and engagement agenda. For this reason however, it would be difficult for Local Authorities to have a role in scrutinising the public and community engagement by a Board, as they have representation in the governance of both the Boards and the Community Health Partnerships they would be scrutinising.

5. Should we develop further the role of the Scottish Health Council to bring about more effective engagement and involvement? If so, what additional responsibilities could the Council take on and what would the benefits be?

We welcome the statement in the draft guidelines “Informing, engaging and consulting the public in developing health and community care services” issued in October 2007, that:

“Boards should not move to the formal consultation stage until they have the Scottish Health Council’s confirmation that public involvement in the option development and appraisal process has been satisfactory.”

This effectively means that in our role we approve both the options development process/consultation proposals and also issue a final

approval at the end of the formal consultation, reporting on how well these consultation proposals have been implemented. However a very important stage is how the Board defines the problem to be tackled – quite often communities and Boards are at variance in their perception of the problem that needs to be solved. The Scottish Health Council considers that it could also play a useful role in approving the Board's public involvement in the definition of the problem – i.e. the problem that the option development and appraisal process is designed to address. If Boards have a continuing dialogue with their communities through mechanisms such as the Public Partnership Forums it should be possible to develop shared understandings of the problems and challenges facing NHS Boards.

The Scottish Health Council still encounters hostility and public suspicion because it was not established as an independent organisation, but as a committee of NHS Quality Improvement Scotland, and is seen as 'part of the system'. Communities have also expressed frustration that our role is limited to only commenting on the process followed by Boards and we were not able to provide a commentary on the views of the community. For these reasons the Council believes that the Scottish Health Council should be enshrined in statute as a separate organisation.

6. How could the Public Partnership Forums associated with Community Health Partnerships encourage greater public engagement?

Recent research commissioned by the Scottish Health Council concludes that Public Partnership Forums are making progress and the majority of members believed that they can or will make a difference to the health service. Although membership of the forums is, in the words of the report "at least as representative as existing democratic structures if not more so"[2] it also notes that public awareness of the new Forums is still low, and that equality and diversity issues still need to be addressed.

Although still 'early days' once fully established and supported across Scotland the Public Partnership Forums ought to provide an essential sounding board for Boards to establish if their engagement strategies are adequate, and a channel for the Community Health Partnerships and Boards to engage with local groups, community planning structures and the voluntary sector.

[2] "Public Partnership Forums: what direction and support is needed for the future?" February 2008 FMR Research. Available from the Scottish Health Council website www.scottishhealthcouncil.org

7. How could local Community Planning Partnerships best ensure improved public engagement with NHS planning?

Local Authorities facilitate Community Planning Partnerships, which are intended to involve (amongst others) NHS Boards, Enterprise Companies, Police Boards and Fire Boards, community and voluntary organisations, business and trade unions. It is therefore important not to 'reinvent the wheel' as the Community Planning Partnerships should be able to provide a very important route for Boards, Community Health Partnerships to engage with other stakeholders as well as the public.

8. What other measures could be introduced to increase effective engagement and involvement of the public with the NHS in Scotland?

Interactive techniques involving deliberation and discussion (e.g. citizen's juries, deliberative polling) have been used effectively in other parts of the public sector and could be more widely used in the Health Service.

Section 2

A new approach – this section asks for your views on changing the current framework so that NHS Boards have directly elected members with the aim of bringing about greater patient and community involvement in planning and delivering local health services.

General statement

The Scottish Health Council has doubts about the introduction of directly elected board members. We set out our concerns in our response to Better Health Better Care and these can be summarised as follows:

- **The risk of low turn out or shortage of candidates in some areas could lead to the election of members with less popular support than the existing Local Authority Members of Boards, who would presumably be removed to make room for them.**
- **Because not everyone would necessarily want to put themselves up for an electoral process, perhaps the most suitable people will not put themselves forward.**
- **There could be a detrimental affect on Regional Planning as directly elected Boards may be very focused on issues raised by local electorates, and preventing progress where decisions need to be made on a regional basis.**
- **The role and status of Public Partnership Forums could be affected, as there may be a perception that Public Partnership Forums (being comprised of volunteer members) are less legitimate than elected representatives and consequently have a reduced status and input.**
- **It is difficult to see how direct elections could simply be an add-on to existing structures. If we are to avoid unwieldy mechanisms with confused and confusing lines of accountability, there would need to be a rethink from first principles of the roles and relationships of elected Boards, Public Partnership Forums, Community Health Partnerships and independent scrutiny panels with a view to decluttering the landscape. The NHS suffers from almost constant organisational turmoil. It would be preferable to give these fledgling institutions a chance to become embedded and contribute effectively before throwing all the cards into the air again.**

9. What eligibility criteria should candidates meet (e.g., should they be resident in the Board area? Should there be any other qualifications?)

The most practical option would be for those people who live in the area served by the Board to be eligible for election although this will exclude those communities who rely on health services provided by other Boards.

10. How could equality and diversity of candidates be promoted?

This could be difficult if the elections are to be fair and open. If Board members are to be elected then they either have to be elected from geographical communities in which case it is difficult to ensure the promotion of equality and diversity (witness the make up of parliaments and assemblies across the UK) or members would be need to be elected from distinct non-geographical 'communities of interest'. The latter would pose a new set of challenges, including some very practical problems of how to define a 'community of interest' and what their entitlement would be in terms of members.

11. Should candidates have to submit profile statements and declare any interests and/or relevant qualifications / skills / experience, for example membership of a political party or a pressure group?

Full disclosure, in line with other public positions requirements, would be necessary.

12. Is there a case for excluding candidates standing as a representative of a political party?

It is difficult to see how a restriction in accepting candidates who represent a political party could be enforced. Scope would remain for candidates to put themselves forward for election without necessarily stating their political allegiance. Such a restriction could also be seen as unfair and discriminatory.

13. In what circumstances might someone be disqualified from seeking election?

Disqualifications similar to those in force for other local or parliamentary elections ought to apply.

14. Who should be allowed to vote in the election? Should the same rules as apply to local authority elections be followed?

Yes.

15. How often should elections be held, and when? Local authority elections are held every 4 years. Should elections to NHS Boards follow the same pattern?

Given the cost of holding elections and, to assist in ensuring a good turn-out there would be merit in holding the elections on the same day as local government elections. The lessons learned from the recent experience of multiple elections (i.e. the last Local Authority/Scottish Parliament elections) would need to be utilised.

To ensure continuity, elections to Boards would require to be staggered – with say half of elected positions contested at each election.

16. Should directly elected members form a majority of the members on a Board?

If the intention in having elected members onto Boards is to secure greater reflection of local population views on health matters there is no specific need to ensure that they are in the majority. However if the intention is that Boards should be democratically accountable to the communities they serve then a 100% of Board members would need to be elected, as is the case with Local Authorities, and the Scottish, UK and European Parliaments.

17. Should the existing categories of appointed Board members (lay members, stakeholder members and executive members) remain in place?

See our answer to 16 above.

18. Among the appointed "stakeholder" members on NHS Boards are local authority Councillors. What should there role be if directly elected members sit on Boards?

It would still be desirable for there to be a link at elected member level between the Board and the local authority, but their role on the Board would not sit easily if there were to be directly elected members.

19 Should NHS Board areas be divided up into electoral wards?

Yes - to protect rural and less populous communities from being 'outvoted'.

20. Would the emergence of groups or individuals with particular views be a difficulty or a potential threat to good governance and direction of the NHS in Scotland?

Yes – but difficult to see how this could be avoided if open and democratic elections are held.

21. Should safeguards be introduced to prevent unrepresentative / disproportionate representation of a political party or special interest group on a Board, and if so what form might such safeguards take?

See our previous answers – in practice it may difficult to avoid these problems.

22. Would you favour a simple "first past the post" voting system, a proportional representation approach or another type of system?

The same arguments for proportional representation for Local Authority elections would be valid for NHS Board elections.

23. How should voters be allowed to cast their votes? By postal ballot or at a polling station? Or either, depending on the voter's choice?

The same processes for voting should be available as in other elections.

24. Should directly elected Board members be remunerated? If so, at what rate – the same as appointed members currently receive?

Yes.

25. Are pilots a good idea?

Given the many obstacles and potential problems associated with this initiative, pilots seem sensible.

26. How many pilots should there be?

Three would be desirable – one urban, one rural, one city.

27. How should pilot areas be selected?

See our answer to 26.

28. How long should pilots run for?

One election cycle (four years).

29. What criteria should be used to assess and evaluate the pilots?

Criteria would need to be developed that measured public satisfaction with Board services, pre and post elected members. The Scottish Health Council could provide assistance with this.

30. Should NHS Boards continue to provide generally consistent levels of performance across Scotland and follow national policies and priorities? Or should elected NHS Boards have the freedom to exercise local discretion and flexibility?

National minimum standards, policies and priorities must be set and maintained although local discretion and flexibility should be permitted to achieve these. Beyond these levels, Boards should be best placed to recognise local priorities and should be free to exercise local discretion and flexibility over these. Without this, what is the point of elected members?

31. Should current guidance e.g. on governance, priorities and performance standards be set out in future in legally-binding form, to ensure that elected Boards comply with them? What would be the advantages and disadvantages of this?

The advantage is that this would help ensure compliance, the disadvantage is that at some point litigation is inevitable and Boards would then have to divert resources away from patient care to managing the legal process.

32. Ministers currently have powers to remove members. Should they be able to remove elected members? What sort of reasons might justify such a power being used?

This could only be justified on the same basis that members of other publicly elected bodies can be removed.

33. Should NHS resources be used to support direct elections? What do you think would be a reasonable amount to spend on elections?

No – additional resources would need to be made available from electoral funding sources since this is not a function of the NHS.

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