

Howwood Community Council response to Local Healthcare Bill consultation
Agreed at meeting on 11.3.2008

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We agree to our response being made public, and to receiving further, related,
requests for information and opinions.

The consultation then considers two key areas: (A) public, etc. involvement in
decision making and priority setting in the local area; and (B) directly electing some
or all of the board membership.

A

Q1. Do you think the current proposals for independent scrutiny of service change
proposals help achieve the aim of better engaging and involving local communities?

A1. We see no evidence of it doing so and there have been many changes recently in
our area, in the former Argyll & Clyde.

Q2. How could additional guidance to NHS Boards on making public consultation as
effective as possible help achieve this aim?

A2. Guidance on how to consult the local community may help, and a requirement on
Health Boards to consult relevant Community Councils would be welcome. Current
arrangements and guidance seem to result in poorly advertised, poorly managed
“engagement” sessions, lacking adequate information and context, providing no
feedback and displaying little or no evidence of effect.

Q3. 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?

A3. Current Board membership is meant to be representative, so additional board
members would only improve improve community involvement and consultation if
board members were required to engage with those whose healthcare they are
managing. This does not occur currently and it is unlikely that a couple of additional
board members alone would make it happen.

Q4. In particular, would adding more local authority councillors (one councillor 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?

A4. LAs have more experience and awareness of consultation and other democratic
processes than health boards, but increasing LA Cllr membership on health boards
could improve public consultation only indirectly. Why increase this membership
only to ask those individuals to consult more widely when the entire health planning,
strategy and development system needs more engagement with and consultation of
the public. The community planning system purports to engage local communities
and includes some health considerations through Community Health (and Care)
Partnerships, but the overall view of community planning from outwith local
authorities themselves is overwhelmingly negative. Community Planning in
Renfrewshire is scarce, tokenistic and non-inclusive.

Q5. 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?

A5. The Scottish Health Council makes no link to local communities except an occasional newsletter; the former local health councils were in more contact but had less voice to convey local views. The role could be enhanced to better reflect public opinions and views, but this again would be indirect; it would be a useful addition if adequately resourced and managed, especially in scrutinising services, but it should not short cut direct health board consultation with communities.

Q6. How could the Public Partnership Forums associated with Community Health Partnerships encourage greater public engagement?

A6. They could identify themselves to their communities, which has not happened so far, and they could and should engage actively with Community Councils in particular, as local, democratic, statutory, community-based representative groups. Our only contact with the local PPF was a request to nominate a potential representative. There has been no feedback on that, let alone notification of membership, let alone still any exchange of healthcare information or consultation.

Q7. How could local Community Planning Partnerships best ensure improved public engagement with NHS planning?

A7. Community Planning Partnerships are ineffective and fail to engage properly with communities. They should be abandoned, so that money saved could be used to consult directly with Community Councils. See no. 4 above.

Q8. What other measures could be introduced to increase effective engagement and involvement of the public with the NHS in Scotland?

A8. Government could direct Health Boards and CHPs to consult directly with community councils.

B

Q9. what eligibility criteria should candidates meet (e.g., should they be resident in the Board area? Should there be any other qualifications?)

A9. Their eligibility could be similar to that for for LA Cllrs. They ought to reside in their board area.

Q10. how could equality and diversity of candidates be promoted?

A10. As for LA Cllrs.

Q11. 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?

A11. Yes.

Q12. is there a case for excluding candidates standing as a representative of a political party?

A12. There is a risk that party politics influence health board decisions, but that could be managed by limiting the proportion of elected members. Excluding those who are members of political parties is unlikely to be lawful or to succeed in limiting political influence. They should have to declare that political interest though, as per no. 11

above.

Q13. in what circumstances might someone be disqualified from seeking election?

A13. This could be analogous to LA Cllr rules also. Elected members of other elements of national or European parliaments should be excluded due to potential conflicts of interest.

Q14. who should be allowed to vote in the election? Should the same rules as apply to local authority elections be followed?

A14. Yes the same rules should apply, but the elections may be better to be held separately from LA and parliamentary elections, especially if by a different system.

Q15. 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?

A15. Yes, if they use STV as LA elections do, they might sensibly be held at the same time in fact. Efforts should be made to avoid voter confusion.

Q16. should directly elected members form a majority of the members on a Board?

A16. We are not sure on this. Initially they should make up one person less than 50% of the board, but if the system works well, this could increase in future.

Q17. should the existing categories of appointed Board members (lay members, stakeholder members and executive members) remain in place?

A17. Yes, executives need to, and stakeholders such as staff partnership also need to. LA Cllrs are less clear cut – they have a role in CH(C)P Committees which manage joint services – so they could remain on health boards but reduce their number to allow directly rather than indirectly elected board membership to increase without making boards too populous which could diminish function.

Q18. Among the appointed, stakeholder, members on NHS Boards are local authority Councillors. What should their role be if directly elected members sit on Boards?

A18. As per no. 17 above.

Q19. Should NHS Board areas be divided up into electoral wards?

A19. Not small ones, but there should perhaps be a multimember superward system established on LA area boundaries – as many boards cover more than one LA area. The number of members should reflect the relative population proportions per LA area.

Q20. 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?

A20. It could be but that is already the case now, and with an adequate code of conduct (equivalent to that for LA Cllrs) and good meeting management, this issue should be manageable. In addition, Boards are accountable to Parliament.

Q21. 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?

A21. Elected members not making a majority on the board and an adequate code of

conduct, adequately enforced, should suffice.

Q22. Would you favour a simple, first past the post voting system, a proportional representation approach or another type of system?

A22. Single transferable vote gives the best overall representation of the electors' preferences, and is used for LAs now.

Q23. how should voters be allowed to cast their votes? By postal ballot or at a polling station? Or either, depending on the voter choice?

A23. Either, as for other elections.

Q24. should directly elected Board members be remunerated? If so, at what rate, the same as appointed members currently receive?

A24. Yes, yes, the same. Their work and responsibilities will be equivalent.

Q25. Are pilots a good idea?

A25. In theory, yes, but in practice, no. They would need to be very prolonged to produce any valid information, and they may not be generalisable for a variety of reasons, such as geographical or sociological differences between the pilot area and other areas.

Q26. how many pilots should there be?

A26. Best to avoid pilots.

Q27. how should pilot areas be selected?

A27. Best to avoid pilots.

Q28. how long should pilots run for?

A28. Best to avoid pilots.

Q29. what criteria should be used to assess and evaluate the pilots?

A29. This question is at the heart of why pilots are unlikely to be of use. Avoid them!

Q30. 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?

A30. Both! Some issues require a national approach and some services will be provided by one board for a wider area or region. Some national standards and guidance are likely to be necessary still also, in particular to ensure a minimum standard for the range of services provided. Some issues are reserved and have UK wide guidance (such as regulation of healthcare workers). But local areas vary in geography, in social issues, and in their views on health issues, so many strategic and implementation issues should be taken as locally as possible. This may mean some areas' service provision differs from other areas' and sometimes that may cause complaint, but it is not necessarily wrong. Also if there was true engagement and consultation with local communities in setting priorities for services, the local variations might benefit from some sense of local "ownership." It is inevitable that finite funding and potentially infinite spending require health service rationing; major rationing decisions should be debated and decided openly, publicly and locally, as

much as possible.

Q31. 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?

A31. Key issues may need to be, but there needs to be flexibility so that changes in evidence and so forth do not give rise to the need for primary legislative change; enabling legislation and secondary legislation thereafter on core issues may suffice, allowing local flexibility on other issues.

Q32. 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?

A32. Code of conduct and something like the Standards Commission may be more appropriate than ministers in dealing with these issues, but ministerially appoint ex officio executive board members could probably be "fired" by ministers as their overall employers if their conduct warrants it.

Q33. should NHS resources be used to support direct elections? What do you think would be a reasonable amount to spend on elections?

A33. Election expenses should come from central funds and elections should be organised as others are by the appropriate returning officer system. We have no idea what a reasonable cost would be; but perhaps coupling health board elections to LA elections (and sticking to the same STV system) would bring some economies of scale.

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