

NHS Quality Improvement Scotland

Response to Scottish Government consultation: Local Healthcare Bill

Introduction

NHS Quality Improvement Scotland (NHS QIS) welcomes the opportunity to respond to the Local Healthcare Bill consultation.

Our response focuses on section 1, which seeks views on how current mechanisms / processes for public and community involvement with NHS Boards might be improved, and the questions listed in the consultation paper are addressed below.

In relation to section 2, we note that the proposals for direct elections to NHS Boards do not extend to Special Health Boards, but have made a general comment at the end of this paper.

Section 1 NHS QIS response to 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?**

By encouraging the submission of 'alternative evidence-based perspectives from community and patient groups', the independent scrutiny of service change proposals has the potential to engage and involve local communities, as well as ensuring that proposals are considered independently and without undue influence of vested interests.

However, NHS QIS' response to the Independent Scrutiny consultation noted that greater clarity is required on a number of areas relating to the operation of scrutiny panels and how such processes would work. The consultation did not, for example, explain how panels would encourage the submission of alternative perspectives, and so it is difficult to establish the extent to which the proposals would help to achieve this aim.

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

We recognise that making public consultation as effective as possible is an area which has traditionally been challenging for health boards. Additional advice and guidance should be targeted at ensuring broad public involvement at an early stage in the planning process, to ensure the credibility of subsequent decision-making. This,

however, needs to be supported by public information and education on NHS consultation and decision-making processes, to enhance the wider understanding of the many considerations, not just public preference, that need to be taken into account in making decisions on service change.

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?

The proposed appointment of more lay members to NHS Boards for this purpose raises a number of questions and concerns.

Which patients or other groups would they represent? Who would they be reporting back to and how? It would not be appropriate for members to represent one particular interest above others, yet it is unclear how individual lay members would be able to represent a wide enough range of patient or other interests.

In addition, as noted in our response to the Independent Scrutiny consultation, the definition of lay requires greater clarity. There is merit in having members who are not currently employed by the NHS or involved in delivering services. We strongly believe, however, that members should be appointed for their expertise and transferable experience of how the health service works, and be personally responsible for their contributions - not as representatives with a potential lobbying role. The appointment system should be open and independent, ensure a balance of expertise and include adequate training to support the non-Executives in their role of constructively challenging the performance and decisions of Executive members. These features will help to provide the necessary degree of public assurance in relation to the management of NHS Boards.

To meet the challenges which may arise in relation to special interest groups, it may also be useful for Boards to make greater use of independent external advice from clinicians outwith the NHS Board in question or specialist groups.

4) 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?

We do not believe that adding more local authority councillors to the membership of Boards would help achieve this aim. As outlined under question 3, the primary rationale for appointment of members should be expertise. In addition, adding more local authority councillors has the potential to heighten conflicts of interest. Instead, local authorities should continue to be involved through Community Health Care Partnerships and the existing joint planning mechanisms.

In relation to the scrutiny of public and community engagement, the Scottish Health Council already has responsibility for ensuring that Boards deliver their Patient Focus and Public Involvement responsibilities. A local authority role in this area has the potential to overlap with that of the Council.

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?

The Scottish Health Council has been in existence for only 3 years and in that time has made a very encouraging start, with scope for further development of its existing role.

We welcome the Government's intention to review the operation of the Scottish Health Council, including an examination of whether the governance arrangements currently in place support achievement of the complementary aims of NHS QIS and the Council.

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

Community Health Partnerships are perhaps one of the most appropriate mechanisms for effective public engagement, benefiting from local experience and reflecting community structures. They operate at a level at which it is likely to be easier to engage and have a useful dialogue with the public than the much broader territorial Board areas.

We note that Public Partnership Forums associated with CHPs are at varying stages in their development and effectiveness and would suggest that more time, resourcing and a consistent approach would help these to bed in.

We would note, however, that members of the public involved in these Forums do not have a 'constituency' and are, technically, representing only themselves. Consideration should be given to the variety of methods of engagement and ways to encourage feedback and involvement from across the community.

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

As outlined under question 6, above, local levels of involvement are likely to be more effective and of greater benefit than at NHS Board level. The NHS should make use of existing planning partnerships rather than duplicate these.

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

There are a number of initiatives that need to be seen as working effectively before anything new is introduced. For example, Better Together: the Patient Experience Programme has the potential to make a significant contribution. It is important that the approach taken to implementing this and other initiatives is consistent and co-ordinated. For public involvement to be as effective as possible, it must also be properly resourced and also be seen as having sufficient influence to make it worthwhile.

Section 2
NHS QIS statement in response

We welcome the emphasis on greater patient, carer and community involvement in the delivery of local health services. It is important that this makes a real input rather than being tokenistic and is appropriately resourced. In any alteration to the NHS Board appointment system, it will be important to ensure that the range of expertise and experience required by Boards to plan and manage services effectively is sought and retained, that the interests of vulnerable and 'hard to reach' groups are not compromised, and that there is no detriment to the additional regional and national perspectives that need to be brought to bear on issues.

Not only would we question whether these would be advanced through direct elections, we would also express concern that direct elections bring with them the risks of Boards of governance becoming party political, and of legitimized lobbying, with one special interest being promoted above others. There are also potential difficulties around building and maintaining useful relationships with such broad constituencies and in having additional accountabilities to non-elected members.

As we have stated elsewhere in this response, expertise and experience should be the primary factors in appointments to NHS Boards.

David R Steel
Chief Executive

April 2008