



SCOTTISH GOVERNMENT CONSULTATION – LOCAL HEALTHCARE BILL

**A response from the
Scottish Council for Voluntary Organisations**

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About SCVO

The Scottish Council for Voluntary Organisations is the national body representing the interests of the voluntary sector in Scotland. It does so through its policy committee which is elected from its membership of around 1300 Scottish voluntary organisations. SCVO's mission is to advance the values and shared interests of the voluntary sector to provide them with information and assistance; to improve their effectiveness and efficiency and to represent their views to Government and other public bodies. Further details about SCVO can be found at www.scvo.org.uk.

Introduction

SCVO welcomes the opportunity to respond to this consultation. The Consultation focuses mainly on the Government's commitment to introduce a Local Healthcare Bill to provide for direct elections to Scotland's fourteen territorial health boards. The seven special health boards such as NHSQIS (Quality Improvement) and the Scottish Ambulance Service are not covered by the proposals.

Most of the £10bn annual budget of NHS Scotland is allocated to the health boards to provide health care and related services for their area. The members of health boards are currently appointed by Scottish Ministers. They are a combination of NHS professionals including executive members and other stakeholders, lay members including the Chair and Depute Chair, and nominated local Councillors.

The Bill

1. The Government intends that a Local Healthcare Bill should address concerns about the role patients and the public play in decisions about how NHS board service are planned and delivered.
2. The consultation invites comments on two broad options for strengthening the role of public and patients. Option 1 is adapting existing structures and practice within the existing framework of wholly appointed boards. Option 2 is the introduction of direct public elections to boards.

SCVO's Approach

3. SCVO's approach to the issue of direct elections to health boards is influenced by four considerations.

First, that responsibility for the use of one third of the total Scottish public budget should be subject to the direct democratic accountability of the public for whose benefit the money is applied.

Second, that in a well educated and informed society with rising expectations of public services the current system of wholly appointed boards creates a legitimacy gap which is increasingly being filled by local campaigns of protest able to exercise a power of veto. This system of health board prerogative confronting a de facto power of public veto is inefficient and wasteful. Public preferences need to be embedded in health board decision-taking from the start.

Third, that the question of what is the best governance structure for Scotland's health Services cannot be fully answered by piecemeal improvements to the existing structures, or by direct elections, or by some combination of the two. SCVO believes that the growing importance of public health improvement and the associated need to integrate health and social care and other local government functions such as education, housing and community development justifies a closer alignment of primary health care and social care planning and provision. The options for achieving this should be reviewed against the experience of Community Health Partnerships and of directly elected health board members (if introduced) and the track record of other options.

Fourth, SCVO notes that the proportion of health board budgets allocated to the voluntary sector remains tiny despite an impressive growth of rhetoric in support of the sector's role in health provision and recognition of its potential to increase its contribution. SCVO supports direct elections to health boards on democratic grounds and because it believes that it will increase the effectiveness of decision taking. But it also dares to hope that opening up health boards to new representatives directly from the community will improve the chances of the voluntary sector's role and potential being better appreciated and supported.

4. **Option 1** – Existing structures and practice include a legal obligation on NHS boards to encourage public involvement. The Scottish Health Council which is a committee of NHSQIS is under a duty to support and monitor NHS' performance in promoting public involvement. The Council promotes national standards for public involvement, advice on best practice and reports publicly on health boards' performance.
5. Among other measures introduced are the establishment of Public Partnership Forums to involve the public and communities of interest including voluntary groups in the work of Community Health Partnerships and their parent health boards. The Annual Review process between boards and Ministers has been opened up to local people and organisations. Despite such measures the consultation paper notes continued concern that NHS boards are not giving sufficient weight to local opinion as revealed in the public campaigns of opposition to the closures of A and E services at Ayr and Monklands which led to the setting up of independent scrutiny panels. (These panels have subsequently supported the local campaigns.) The Government is also consulting separately on the future of independent scrutiny.
6. The paper asks a series of questions on the options for adapting existing structures and process. **A selection of key questions from the consultation paper are given below with consultation paper numbers and SCVO's response.**

SECTION 1 – Making Things Better

Question 1 - Could the extension of independent scrutiny help achieve better involvement of local communities?

Only indirectly by increasing the incentive for communities to protest. The scrutiny panels would presumably continue to be appointed by Ministers. Public involvement is at its most effective when it is embedded in the decision taking process.

Question 3 - Would the appointment of more lay members be helpful?

Increasing the proportion of lay members by Ministerial appointment would go only some way towards meeting the need. If lay members are to be credible in their role as champions of public opinion they need to be directly accountable to the public.

Question 5 – Could role of the Scottish Health Council be extended?

The drawback here is that the Health Council is a committee of an appointed board NHSQIS. Its lack of democratic legitimacy inevitably limits its public credibility.

One option worth considering is to emulate English practice by re-founding NHSQIS as a statutorily independent body on the model of the independent Healthcare Commission. However while this would introduce independent scrutiny of health provision to Scotland it would not reduce the 'legitimacy gap' between health boards and their publics.

Question 6 - Could Public Partnership Forums encourage greater public engagement?

CHPs and their Partnership Forums are still young institutions whose effectiveness remains to be tested. One option would be to introduce direct election of community members to the Forums alongside the stakeholder representation which in almost all cases now includes the voluntary sector.

However CHPs are funded by and accountable to their boards and are focused on the co-ordination of local delivery. This operational bias justifies their largely stakeholder representation. The problem of the legitimacy gap in health board planning has to be tackled at source.

Question 7 – Could local Community Planning Partnerships help improve public engagement with NHS planning?

Only to a limited extent. The experience of voluntary sector and community representation on CPPs is at best mixed. CPPs are dominated by public sector agencies which retain institutional discretion as to how much funding they allocate to agreed priorities. In any case health boards do not – and could not- delegate major spending decisions on health priorities to what are essentially unaccountable bodies.

SECTION 2 – Direct Election.

Question 9 – What eligibility criteria should candidates have to satisfy?

Only territorial residence and an age threshold of eighteen.

Questions 10, 12 & 13 - What other special requirements should be met – eg equality/diversity, exclusion of political party candidates.

None specifically for the directly elected members. The expectation would be that candidates would be elected from among people who have made a name as local health campaigners with varying backgrounds and affiliations. As political parties are voluntary associations of citizens it would be unacceptable to prohibit them from presenting candidates. Assuming that initially at least no more than half of health board seats would be filled by direct election Ministers would retain a power to appoint people with minority backgrounds such as people with disabilities or people from minority ethnic backgrounds.

Question 15 - Frequency of elections

To ensure maximum effectiveness directly elected members should be elected every four years.

Question 16 - Should directly elected members form a majority of the board?

For as long as health boards retain responsibility for both primary/community health and acute services directly elected members should probably not constitute a majority. As explained in the Introduction SCVO believes that direct election is not the only or even the best option for improving the governance of the health service. It believes that there is a steadily strengthening case for more closely aligning primary care with social care and other community based services provided by local Councils. Community Health Partnerships are one possible way of achieving this though it is too early to judge their effectiveness. They should be kept under review to be considered alongside other more radical options.

Question 17 - Should the division of existing representation between lay members, stakeholder members and executive members remain in place?

At least initially provision for the representation of non-elected lay members by appointment should be retained on the grounds presented immediately above. However the direct election on a local basis of lay members would mean that the role of appointed Councillors would become superfluous. Their role of providing public representation would be assumed by the directly elected members. The board should retain a mix of stakeholder representatives including health staff and senior local Council officials in an advisory, not executive, role.

Question 19 - Should NHS board areas be divided into local electoral wards?

Yes, given the size of most health board areas.

Question 22 - Electoral system

The most appropriate form of voting system would be the Single Transferable Vote. This would allow individual voters the power to limit political party domination of the system and encourage non-party affiliated local health champions to put themselves forward for election.

Question 24 - Should elected Board members be remunerated?

Yes, modestly at not more than the current £7,500 paid to appointed lay members.

Question 30 - Should boards continue to follow nationally set policies and priorities?

The current balance between national priority setting and Government accountability on one hand and local board discretion on the other should be maintained but subject to periodic review.