

**Response to Consultation on the Local Healthcare Bill
South Edinburgh Public and Patient Forum – March 2008**

We welcome the opportunity to comment on the consultation paper “Local Healthcare Bill”.

- Since our Group is based in Lothian, we have based our responses on what might be applicable in Lothian. In general we welcome the emphasis on greater involvement for the general public in health matters. Our observations are that while we welcome the effort expended by health professionals on behalf of the public and more importantly patients, sometimes the priorities which are given to location of facilities or the priority accorded by the general public to certain conditions does not always accord with the views of health professionals who may be working from a different set of priorities. Redressing the balance by introducing sensible members from the patient/public base would help address those concerns – and it would also help health professionals to explain and influence the policies to be adopted more widely.

Following the issues on which you sought comment:-

Consultation Questions

SECTION 1

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 are broadly in favour of setting up independent scrutiny of service change proposals with the caveats already stated in our response to the consultation on independent scrutiny. I quote from our response already submitted to the Independent Scrutiny consultation –

“In general the group on behalf of which I am responding (South Edinburgh Public and Patient Forum) is wholly behind the principle of independent scrutiny of proposals to establish an accurate evidence base on which to consult about major NHS changes. How effective the preferred method of using an independent panel will be, we think will depend heavily on the true independence and skill of the panel members. The recently constituted Walker panel appeared to have a good mix of skills, with appropriately eminent members, and a satisfactory transparent outcome. We had a query about exactly how ‘major’ was to be defined – what an NHS Board sees as major may differ from what a patient sees as major.”

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

Any guidance will need to be clear and unambiguous and designed to reach patients/public/carers who have an interest in the subject matter being consulted upon. We see it as very important that any consultation reaches to those affected – so for example seeking views from local nurseries/baby and toddler groups and GP surgeries for consultations on affecting services for young children. We suggest consideration should be given to making the guidance statutory so that all Health Boards throughout Scotland adopt a similar approach.

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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?

We would like there to be a statutory definition of the word “lay”. For example would a retired or “not-working” professional (such as a doctor, nurse, pharmacist, social worker or NHS manager) be regarded as “lay”?

We think that there would be a difficulty if electing from a group with a specific function – simply because the elected person would have a natural (and expected) inclination to represent the group they know and understand well – and this in turn may preclude other just as important views and input. One of the most appropriate routes for election of a patient representative should be from the local PPF – where ideally there will be a breadth of experience and views and where that representative can put forward the views of the whole group rather than their individual view.

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?

No, as there is already local authority representation on the Board (which we would like to see continued), we see no need for further local authority councillors.

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 see little advantage in strengthening the role of the Scottish Health Council. Effective engagement and involvement does not benefit from a third party – it simply introduces more scope for misunderstanding. Although the Scottish Health Council is charged with “improving the way that people are involved in decisions about health services” local experience is that the Council are not prominent in making their role feature except on their own website – which tends to exclude a good proportion of the general public. As part of Quality Improvement Scotland, the Health Council is also not seen as truly independent.

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

The PPFs need a properly constituted role rather than to exist simply as a loose gathering of some interested patients and public. It is suggested that the PPFs could operate well along the lines of local Community Councils, with a dedicated minimum budget, and office bearers. This would allow them to act in partnership with their local CHP to involve people – on specific issues such as mental health or on general issues by advertising in GP surgeries, chemists, schools, or libraries etc. Involving appropriate people can best be done at “grass roots” level, rather than at the more elevated and for some intimidating level of CHP or Board.

The consensus in our group was that the PPFs should not be regarded as a loose cannon but as the wellspring of opinion that could propose concerns to CHP via CHP reps delegated from PPFs.

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

NHS planning needs to take account of local regeneration plans and one of the ways to do so is to engage with local neighbourhood partnerships. People at the level of the neighbourhood partnership are likely to know and be aware of local issues – including those relating to health and which may involve the NHS.

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

Each service in the NHS – for example Maternity services, or a GP practice – could bring together a local contact group to be a periodic sounding board for ideas. Recent patient experience from such groups would best inform decisions.

The Board should clearly have power to co-opt specialists from outwith its membership and form sub-committees for specialist tasks and investigations, to draw on any expertise required that the Board itself lacks.

SECTION 2

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

We submit that candidates should

- Be resident in the NHS Board area;
- Be able to devote the time required to contribute satisfactorily to the Board's work;
- Have some relevant experience of the health service, but **not** a current Health Board employee;
- Any lay members should be able and confident to put forward the view of the public/patients; and
- Be over 18 years of age.

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

Notice of elections should be posted in all the usual places – local newspapers, free newspaper sheets, GP surgeries, local pharmacists and Community Centres.

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?

Yes, and in addition any commercial interest should be declared as well as political or pressure group membership.

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

Yes, there are other avenues for political party membership if the local authority representatives are retained.

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

It would be appropriate to have at least the same stringent criteria as those imposed on being a member of the Community Health Partnership as detailed in Section 7 of the Community Health Partnerships (Scotland) Regulations 2004.

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

The same criteria as applied to local elections should be followed.

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?

We think that every 4 years is a sensible period – it establishes a link in the voter's mind that there is someone they can vote for to represent their views specifically in their local NHS and also it makes sense financially to run the 2 elections together.

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

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

There should be a small majority for the "lay" contingent of Board members. Roughly a 40/60 split may be appropriate – for example in Lothian 7 appointed members and 9 elected – which is 44%/56% split. The Lothian Board would consist of

- The Chair
- 4 local Councillors
- A University of Edinburgh medical school representative
- Director of Public Health
- and 9 elected representatives – see the answer to Q22

The other usual appointees, - an Employee Director - normally the Chair of the Area Partnership Forum nominated by the relevant NHS staff representative body; and the Chair of the Area Clinical Forum - a senior healthcare professional nominated by local clinicians should be co-opted and called as and when required to give the Board the benefit of their experience for specific agenda items. We see there being advantages to not having these members as part of the decision making process – to protect them against accusations of acting in the interests of their own group (employees or clinicians) for example.

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

The role of the local Councillors should be to represent the work between Councils and the local

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| Partnerships. |
| <p>19 Should NHS Board areas be divided up into electoral wards? NHS Board areas should be aligned with the wards used in the Scottish Parliamentary elections.</p> |
| <p>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?</p> <p>In theory this could present difficulties, but providing the Chair is fair and balanced and there is a clear mechanism to deal with misconduct then there should not be a problem. The emergence of Dr Jean Turner as an MSP representing the “Save Stobhill Hospital” campaign brought local strongly held patient views to the fore in the Scottish Parliament and made a difference to the outcome of how Stobhill was handled. It is not always wrong to take account of local views – often the general public have valid points to make.</p> |
| <p>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?</p> <p>In making a pre-election statement, any candidates with a particular agenda should be obvious to the electorate – and any particular agenda which emerges post-election may be grounds for disqualifying the member. However, should the electorate decide it wants a candidate to fight a particular issue such as for example a hospital closure, then that is democracy if the candidate is elected.</p> |
| <p>22. Would you favour a simple "first past the post" voting system, a proportional representation approach or another type of system?</p> <p>In general we would favour a proportional representation approach according to the population which the Board serves. For example in Lothian, Edinburgh has a population of 463,510; West Lothian, 165,700; East Lothian 92,830; and Midlothian 79,290. Taking representation at approx. 80,000 each, that would lead to 5 members for Edinburgh, 2 members for West Lothian, 1 each for East and Mid Lothian.</p> |
| <p>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?</p> <p>Either by postal ballot or at a polling station. The rules should be the same as other elections.</p> |
| <p>24. Should directly elected Board members be remunerated? If so, at what rate - the same as appointed members currently receive?</p> <p>Yes, at the same rate as appointed members currently receive plus receipted expenses.</p> |
| <p>25. Are pilots a good idea? Yes</p> |

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26. How many pilots should there be?

27. How should pilot areas be selected?

There should be at least 2 pilot areas, one urban and one rural, followed by a review.

28. How long should pilots run for?

For the full 4 years, to allow teething problems to be ironed out.

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

The criteria should conform to the standards of community engagement; the running of the pilot Boards should represent value for money; the Boards should be cost-effective and within budget.

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?

As far as possible national priorities and policies should be adhered to, but there may be circumstances in which local clinical priorities may have to be considered. For instance, cancer treatment centres obviously have to be sited in urban settings, but this should not rule out plans for domiciliary chemotherapy where appropriate.

The 4 teaching areas would probably have different requirements, and areas with perhaps unique specialist services would need to cater for different demands. Bed occupancy rates, and higher “bed costs” would have to be accepted in those areas. However, routine services such as dialysis should be available as near to patients as possible.

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?

Legally binding frameworks sound attractive but there is often a problem of definition with performance standards. A code of practice (adhering to best practice) may be a good starting point. There needs also to be some inbuilt flexibility for local situations.

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?

Yes, but only in defined prescribed circumstances such as serious misconduct, or persistent non-attendance or any of the reasons for disqualification as in response to 13.

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

Funding should come from central funds but it is difficult to say exactly what should be spent.