Designed to care : renewing the National Health Service in Scotland / the Scottish Office, Department of Health.

THE SCOTTISH OFFICE
Department of Health

designed TO CARE

Renewing the National Health Service in Scotland

THE SCOTTISH OFFICE
DEPARTMENT OF HEALTH

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Renewing the National Health Service in Scotland

Presented to Parliament by the Secretary of State for Scotland by Command of Her Majesty
December 1997

Cm 3811 EDINBURGH: THE STATIONERY OFFICE
£6.80

Acknowledgements

Cover Photographs

Clockwise from top left:

- Ultrasound examination at Whinpark Medical Centre, Sighthill;
- Hospital care at Edinburgh Sick Children's NHS Trust;
- Stroke rehabilitation at the Western General Hospitals NHS Trust;
- Care of the elderly at Ferryfield House, Edinburgh Healthcare NHS Trust

Thanks to those who agreed to participate in the photographs and to the management of each of the services involved.

Photographs by Paul Watt, Creative Photography.

ISBN 0 10 138112 3

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Preface by the Prime Minister

Creating the NHS was the greatest act of modernisation ever achieved by a Labour Government. It banished the fear of becoming ill that had for years blighted the lives of millions of people. But I know that one of the main reasons people elected a new Labour Government on May 1 was their concern that the NHS was failing them and their families. In my contract with the people of Britain I promised that we would rebuild the NHS. We have already made a start. The Government is putting an extra £124 million into the health service in Scotland during the course of this year and next. More money is going into improving family doctor and hospital services. The NHS will get better every year so that it once again delivers dependable, high quality care - based on need not ability to pay.

This White Paper marks a turning point for the NHS in Scotland. It replaces the internal market. We are saving £100 million of red tape and putting that money into frontline patient care in Scotland. For the first time the need to ensure that high quality care is spread throughout the service will be taken seriously. Nationwide standards of care will be guaranteed. There will be easier and swifter access to the NHS when you need it. Our approach combines efficiency and quality with a belief in fairness and partnership.

As we approach the fiftieth anniversary of the NHS in Scotland, it is time to reflect on its huge achievements. But in a changing world, no organisation however great, can stand still. The NHS needs to modernise in order to meet the demands of today's public. *Designed to Care* begins the process of modernisation in Scotland. The NHS in Scotland will start to provide new and better services to the public. For example, a nurse-led help line to provide local information round the clock. New technology that links GPs' surgeries to any specialist centre in the country.

In short, I want the NHS in Scotland to take a big step forward and become a modern and dependable service that is once more the envy of the world.

Of course we must get the funding right. The Government have already put large extra sums into the NHS and will raise spending in real terms every year. But with that money comes a responsibility within the service to change. To produce better care. Care when you need it. Care of uniformly high standards.

It is a big challenge but I am confident that with the support of the public, the dedication of NHS staff and the backing of the Government we can again create an NHS in Scotland that is *Designed to Care*, an NHS that is truly a beacon to the world.

Tony Blair

Foreword by the Secretary of State

The Government were elected on a manifesto which committed us to a fundamental aim: to restore the National Health Service as a public service working co-operatively for patients, not a commercial business driven by competition. This White Paper, *Designed to Care*, sets out our vision for the NHS in Scotland and explains how we will fulfil the manifesto commitment.

We will ensure that the NHS remains true to the historic principle that if you are ill or injured there will be a national health service there to help, with access based on need and need alone, not on your ability to pay, or on who your GP happens to be, or on where you live. We will do this through our commitment to raise spending on the NHS in real terms every year, and put that money towards better patient care.

Our objective is a patient-centred health service. We will harness new technologies to improve the reliability and effectiveness of patient care. Our commitment to clinical effectiveness is designed to ensure that wherever patients make use of the services of the NHS they receive the highest quality care. We will create a seamless service which gives patients continuity of care from GP through hospital to rehabilitation.

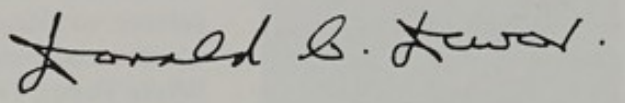
The White Paper sets out clearly the system which will replace the internal market in healthcare. We are not advocating a return to top-down management. The strategic role and the service role are distinct functions, and will remain so. Health Improvement Programmes, which we introduced in August, are designed to promote an overview of the health needs of our communities. They are the common agenda that will act as a catalyst for co-operation and collaboration amongst all those concerned with health care.

In recent years GPs have gained opportunities on behalf of their patients. We support this. But the cost under the internal market has been fragmentation, a burgeoning of bureaucracy and the potential development of a two-tier service. The White Paper honours our commitment to retain the central role for primary care while removing the disadvantages of the previous system. We will do this by giving strong organisational support to primary care through the creation of Primary Care Trusts, which will allow GPs and other health professionals to take the lead in combining locally to organise health services for all the patients in their area.

Trusts will retain their autonomy over day-to-day operational activity. The White Paper re-focuses Trusts on improving the design of services to patients by giving clinicians and those who use these services a bigger say in their management. We are committed to fewer Trusts, and the health service is already discussing locally

how to achieve this. We do not intend to impose an inflexible blueprint, and will leave plenty of scope to respond to local needs and circumstances.

Designed to Care is an important step in fulfilling our manifesto commitments, and does so without creating a disruptive 'big bang'. It sets out solutions suited to Scottish needs and lays the foundations for the work of the Scottish Parliament in continuing to improve the health of the people of Scotland. The NHS in Scotland has served the people of Scotland well for nearly 50 years. I believe the proposals in this paper will enable it to prosper well into the next century.



Section 1

The Government's Vision

1. The Government's vision is a National Health Service for the people of Scotland that offers them the treatment they need, where they want it, and when: a modern, "designed" health service putting patients first. We want a seamless health service centred on primary care, designed to ensure that patients receive care quickly and with certainty. This White Paper sets out how we will achieve these objectives.

2. The Government will ensure that the NHS remains true to its historic ideals, free at the point of use, funded through general taxation and available to all on the basis of need. This Government were elected with a clear mandate for change - a mandate to change the NHS for the better. We will deliver the commitments which won us the support of the Scottish people, and do so in ways which recognise the distinctive needs of Scotland. These have been long reflected in the structure and organisation of our health services, and we shall build on them. To do so is entirely in keeping with the traditions of the past, but also acknowledges that the creation of a Scottish Parliament is intended to ensure that in the future Scottish solutions are found to suit Scottish circumstances.

3. The NHS has stood the test of time for 50 years. In designing our proposals to renew and modernise the NHS in Scotland, the Government intend to lay the foundations for a service which is fit for the next 50 years. The speed of change in scientific knowledge and medical technologies, and the potential offered by modern information and communication systems require the NHS to be ready to embrace change. Instead of lurching from one major reorganisation to another, we need to embrace evolutionary changes, paced and researched, building on what we have.

4. It is sometimes argued that the NHS cannot cope with the pressures it now faces and the challenge posed by the pace of change. The Government reject that view. We will enable the NHS in Scotland to meet the pressures of the future and continue to provide a comprehensive range and quality of health care services through our commitment to annual real increases in resources for the NHS in Scotland, together with its capacity to find newer and more efficient ways of delivering services. In addition, the NHS in Scotland is well-equipped to make medical decisions based on patient need. Our medical culture is based on clinical judgements in which we distinguish between competing demands on the basis of need. As a result, we have a system which reduces unnecessary investigation and treatment. The Government are committed to enhancing this culture. We must root out inefficient and ineffective clinical procedures, subject new drugs and therapies to painstaking analysis in terms of their clinical and cost-effectiveness, eliminate inefficiencies that result from bureaucracy and address the differences in the availability of health care which re-inforce inequalities.

5. Our vision is to build on the strengths we have in the NHS in Scotland and to tackle some of the existing shortcomings which are of concern to patients and

NHS staff alike. We want an NHS concentrated on improving health and reducing health inequalities. Scotland is at, or close to the bottom of, the international health league table in the key areas of coronary heart disease and cancer, and people in other European nations enjoy a significantly longer life expectancy than the people of Scotland. While the NHS must continue to target these key areas, real improvements in public health will only be effected by tackling the variations in health status between social groups and between different parts of Scotland. We will publish a Green Paper aimed at establishing a collaborative approach between the NHS and the agencies whose decisions on housing, unemployment and poverty directly affect Scotland's health.

6. We want a service which is designed from the patient's viewpoint, which delivers clinically-effective care and which does so quickly and reliably in high-quality facilities. We want a world class health service, available throughout Scotland when people need it. In our renewed NHS, a wider range of information on health, health services and treatment will be available to patients. They will have local access to teams of health care professionals working together, able to obtain specialist expertise when needed, because family doctors and hospital staff are part of a network of integrated clinical services which deliver seamless care.

7. We believe our vision is shared by staff in the NHS in Scotland. We intend to create a health service where staff are free to concentrate on the task to which they are most committed - the delivery of high quality care.

8. To deliver this vision, the Government have concluded that a partnership approach based on co-operation, not competition, is the way ahead for Scotland's Health Service. A market-style NHS has failed patients; it set doctor against doctor, and developed two-tierism allied to bureaucracy, although to a lesser extent in Scotland than elsewhere. We will retain the benefits of devolved management and retain distinctive roles for Health Boards and Trusts in a patient-focused service built on partnership. Our approach will bring people together to meet the needs of patients by developing 4 main partnerships:

- a **partnership** between the Government and the people of Scotland, reflected in the Government's pledge to continue with annual real increases in NHS funding;
- a **partnership** between patients and the professionals who care for them, by giving both a bigger say in the design and management of the NHS in Scotland;
- a **partnership** between different parts of the NHS in Scotland to promote the integration of care and provide patients with a seamless service;
- a **partnership** between the NHS in Scotland and other organisations whose work can help improve health and the quality of services to patients.

9. There have always been differences in the way the NHS is organised in the different parts of the UK to take account of different needs. But sometimes, changes have been made in Scotland to reflect changes in England rather than in response to specifically Scottish needs. The NHS will continue to provide a common service throughout the United Kingdom, but the advent of the Scottish Parliament will mean a Scottish NHS more finely tuned and more rapidly responsive to Scottish needs.

10. The NHS in Scotland will be one of the main responsibilities of the Scottish

Parliament. It will be for the Scottish Parliament to decide the details of its relationship with health bodies, including funding arrangements. Devolution provides an opportunity to build on the strengths of the NHS in Scotland, as well as on the Scottish tradition of community responsibility for those needing care. For example, services can be organised to take account of the range of differing needs, from those of major cities to those of remote and island communities. The new system outlined in this White Paper lays the foundations for the work of the Scottish Parliament in improving the health of the Scottish people now and for future generations.

11. The Government believe the proposals in this Paper will result in an NHS in Scotland designed to put patients first, better equipped to take advantage of new technology to improve clinical effectiveness and the reliability of clinical care, and better able to develop distinctive solutions to Scotland's health needs and to provide better value for money. It will keep faith with its founding ideals by delivering comprehensive services to promote good health, rapid diagnosis and treatment for those who are ill, and care for those with continuing needs, and it will be funded through general taxation so that nobody need worry about the cost of being ill.

Section 2

Better Services for Patients

12. The objective of a National Health Service designed for patients is to provide better services for them in ways that are responsive to their needs and wishes. Good quality health care delivered consistently and to a high standard must be a key objective of the NHS in Scotland. It is a shared responsibility of everyone working in the NHS, and covers all aspects of health care including the effectiveness of clinical practice, the environment in which it is delivered, and responsiveness to the needs of patients.

13. Essential to achieving this objective is:

- improving reliability and co-ordination of care through use of new technology;
- improving clinical effectiveness by ensuring that performance meets agreed standards and that these standards are driven upwards;
- promoting the adoption of more effective care based on evidence;
- involving patients to a greater extent in decisions about their own care and treatment;
- providing patients with more information about their health and about the options for treatment when they are ill.

14. Our starting point is that every aspect of the planning and delivery of services should be designed from the perspective of patients. There is encouraging evidence of the benefits that flow when services are designed from this perspective, for example in breaking down organisational barriers and improving communication among different groups of staff involved in an individual patient's care, and in speeding up the processes of diagnosis and treatment. Such approaches can also enable staff to provide services to patients in the way they would wish, ensuring privacy and dignity are respected, and, despite the streamlining of care, again ensuring that time remains to treat patients individually and with humanity. The Government therefore expect all parts of the NHS to give priority at the highest level to the examination of services from the perspective of patients and to making changes designed to improve their experience of the NHS. This will be a key test of organisational performance.

Co-ordination and Reliability of Care

15. Information technology opens up new possibilities for improving the reliability of care by enabling its more effective co-ordination. Co-ordination of care can be improved through telemedicine, by enabling consultation with hospital specialists to take place in the GP's surgery. There are already examples in Scotland of the use of telecommunications to support patient care directly by reducing or eliminating the need for patients and clinicians to travel. Without leaving their GP's surgery, a clinic, or sometimes even their own homes, patients can be examined over video links by specialists based at any hospital which is also connected to the NHS telecommunications network. This can also carry the

output of diagnostic machinery, such as radiological images. Co-ordination of care can also be improved through speeding up the processes of transferring records, transmitting test results and making appointments.

16. To the patient, the NHS is a single entity geared to providing a co-ordinated and comprehensive care service. Patients expect to move from general practice to hospital, ward to ward, and hospital to community with ease. Information related to them should move with equal ease, but it does not always do so. As a result, patients can become by default the means of transporting information. The Government wish to change this. A safe flow of information about patients between GPs, hospitals, and other healthcare professionals is needed, and new technology is enabling them to share it, under professionally agreed safeguards. We intend to accelerate this process.

17. One of the first steps is to use the same number to identify patients wherever they are treated, and the Community Health Index number creates this opportunity. This unique patient identifier gives the NHS the means by which we can securely bring together the right information about a patient at the right time and place. Over the next two years we will ensure that all Health Service systems are able to use this number. We will continue to work with healthcare professionals through their Royal Colleges to define the key sets of information which need to be communicated. As well as referral and discharge letters, key information items are being specified for particular conditions and diseases so as to help ensure best clinical practice. The computer systems which will deliver this information are also important. They will first and foremost be designed for use by healthcare professionals in carrying out their clinical tasks. For example, ordering blood tests by electronic links is quicker and more reliable than filling in forms; and getting the results back on that same screen is not only just as useful, but quicker. To achieve these links, the whole of the NHS in Scotland will be linked to secure health service telecommunications systems over the coming year to ensure there are no obstacles in the way of assembling the right information.

18. For all these reasons, the major emphasis will rightly be on clinical care information. But accurate management information is also needed to help make sure services are delivered efficiently and performance targets met. This information should be a by-product of information collected for patient care purposes, and the NHS should be relieved of the need to supply variations on the same data to its many different users.

19. The Government's objective is to use technology to promote a seamless pattern of care. With this in mind we have decided to fund a number of demonstration projects focusing on two issues of current concern to patients:

- **the establishment of one-stop clinics where all tests are carried out in a single visit, and results and diagnosis, where possible, are available the same day. We will set a timetable to ensure that this practice becomes widespread within the NHS in Scotland;**
- **during 1998 we will electronically link up every GP surgery in Scotland. By the year 2002 patients will know the date of hospital appointments when they leave the surgery.**

Clinical Effectiveness

20. The effectiveness of clinical care and treatment has always been and will remain central to the quality of health care. Considerable effort and resources in Scotland are being devoted to the provision of guidance on best practice in the delivery of clinical services. The development of clinical guidelines and good practice statements provides clinical staff with information, based on available evidence, about most effective practice. Their impact is evaluated through clinical audit and the development of clinical outcome indicators which allow critical reviews of performance.

21. Scotland leads the United Kingdom in its work on clinical effectiveness. The creation of the Clinical Resource and Audit Group (CRAG) in 1989, under the chairmanship of the Chief Medical Officer, has provided a focus for this work and has resulted in:

- the development of systematic programmes of clinical audit at local and national levels accounting for some £6.5m a year;
- the creation of the Scottish Intercollegiate Guidelines Network (SIGN), a collaborative venture undertaken by the Scottish Royal Colleges and other health professionals, which is producing a series of clinical guidelines, 18 of which have been published to date;
- the publication of reports on clinical outcome indicators which facilitate critical review of performance by clinicians. Since 1993, 31 indicators have been published.

22. Working alongside CRAG, a number of other agencies also contribute to work on clinical effectiveness: the Chief Scientist Office funds a major research and development programme; the Scottish Health Purchasing Information Centre (SHPIC) produces advice on the cost-effectiveness of different treatments; and the Scottish Needs Assessment Programme (SNAP) provides a public health perspective to the health needs of people in Scotland. All these efforts have been directed towards the further development in Scotland of health care based on the evidence. Working closely with the professions, we intend to build upon this record of substantial achievement. A review of the role of CRAG, led by the Chief Medical Officer, is close to completion and has as its major objectives:

- development of a stronger strategic direction for the clinical effectiveness programme;
- promotion of a more integrated and co-ordinated approach; and
- the establishment of a mechanism for ensuring an appropriate proportion of its resources are devoted to nationally-determined priority areas.

Effective implementation is vital so as to ensure that the results of these efforts are applied in improving clinical practice and the quality of care for patients, which must be continuously monitored.

23. The NHS in Scotland already invests a great deal of time and effort in monitoring the quality of service provision to ensure and improve standards of care. Many hospitals and departments have achieved accreditation under schemes such as the King's Fund Organisational Audit, ISO 9000 and Investors in People; increasing numbers of laboratories are accredited by Clinical Pathology Accreditation (CPA); and both the breast and cervical screening programmes have well-established quality assurance arrangements in place.

24. But the work as yet remains uncoordinated. A review of all this activity has therefore been commissioned as part of the Acute Services Review (paragraph 50), which is examining existing methods of quality assurance and accreditation with particular emphasis on mechanisms to assure the quality of clinical services. Our intention is to build a nationally organised process of quality assurance which involves those closest to patient care in the systematic and continuous review of service quality. We believe that such an approach, which may include external review of services, will give added confidence to patients and NHS staff that service quality is the focus of management attention, and complements our approach to clinical governance (paragraph 68) and our intention to publish a range of clinical indicators (paragraph 55).

25. In primary care, the Regional Dental Officer Service has an important quality assurance role in dentistry. For General Medical Practice, the Royal College of General Practitioners has introduced Fellowship by Assessment and has recently launched the Quality Practice Award which has been developed and piloted in Scotland. This award, which covers all aspects of general practice including clinical care provides objective criteria against which practices can assess the quality of care they are offering to patients. The Government wish to encourage such approaches.

More effective care

26. A key aspect of more effective care is providing accurate information for doctors on the clinical and cost-effectiveness of new drugs and treatments. The further development and prescription of more effective medicines will continue to bring great benefits to patients. However, prescribing costs represent one of the major areas of expenditure for the NHS in Scotland and it is important to ensure that our resources are targeted appropriately, that every patient in Scotland has the same access to effective medicines and treatments, and that resources are not squandered inappropriately on treatments which will not provide effective and significant health gain. At Health Board level, expenditure on Family Health Services drugs will be combined with other budgets within a cash-limited total, allowing for the first time much greater flexibility in the use of resources and incentives for all GPs to develop their prescribing patterns.

27. To drive forward our commitment to safe, cost-effective developments, the Government intend to take a new initiative by supporting the setting up of a Scottish Health Technology Assessment Centre. The Centre will evaluate and provide advice to the NHS on the cost-effectiveness of all innovations in health care including new drugs. It will draw on appropriate professional expertise to prepare this advice.

Patient Involvement

28. Central to a designed health care system is involving patients more in decisions about their own care and where possible allowing them to exercise choice, in consultation with their GP or the consultant to whom they have been referred. The desire of patients to become more active participants in decisions about their own care reflects similar developments in many other services, reflecting wider changes in society. In the NHS, however, there is a special relationship built on trust between clinicians and their patients at times of anxiety and vulnerability. This makes it particularly important that clinicians are able to communicate effectively with patients and their relatives, and the Government welcome the increasing attention paid to the acquisition of these skills in professional training. Some patients have particular needs and require additional

help to express their concerns, and the Government have recognised the need to develop independent advocacy for them. A guide to good practice was issued in September 1997 in order to assist Health Boards in extending the services already available.

29. The Patient's Charter has played a part in providing a framework to focus the attention of the NHS on these issues. In Scotland, close involvement of staff in developing and implementing local standards within this national framework has resulted in significant progress in recent years. However, greater effort needs to be devoted to ensuring that local Charters are targeted on the quality and success of treatment, that they deal with the issues which concern patients most, and that standards rise steadily. For this reason, the Government intend to issue a new national Charter which will balance the rights and responsibilities of patients and set a framework for continuing local development of standards, an approach which has worked well in Scotland.

30. When things go wrong, it is important that people are able to complain and that their concerns are handled quickly and fairly. A new complaints procedure came into effect in April 1996 and an evaluation of these arrangements will start in 1998. The Government will look carefully at the conclusions of that evaluation in order to decide whether further changes are required.

Patient Information

31. Patients will be able to become more involved in the decisions about their care if they are also better informed. Access to improved information will promote greater personal responsibility for health and enable patients to use health services more effectively. The public is entitled to accessible and useful information about:

- how to stay healthy;
- particular conditions or illnesses, including the options for treatment (for example, the effectiveness of particular interventions, any side-effects, choices as to where to be treated);
- the services available, such as waiting times, admission arrangements, practice in relation to length of stay, visiting arrangements and entitlement to travelling expenses.

32. More information is available than ever before on matters such as these, not only as a result of the efforts of the NHS but also from a wide range of voluntary organisations and the media; and access to such information is increasingly possible through electronic means such as the Internet. In spite of this, patients still report that they have not been given adequate information, or that it was not provided in a way that they could easily understand and remember. This is not surprising, for even well-informed patients can feel at a disadvantage when dealing, at a time of anxiety, with issues as complex as health care.

33. The Government believe that the public is entitled to as much information as possible about all aspects of the NHS and that this information should:

- be up-to-date, accurate and intelligible to its target audience; and
- reflect local circumstances, including local protocols regarding the treatment of particular conditions.

For our part, we will by 1999 extend the NHS Helpline to provide local information on health and social care services. The public will be able to ring the Helpline and receive local health information from trained nurses.

34. The Government will therefore require the NHS to continue to make progress in this area, exploiting to the full the use of IT. In particular, it should:

- promote a continuing emphasis on informing the public about standards of care and performance against those standards;
- provide patients, on discharge from hospital, with summary information about the treatment they have received, drugs they are to take, and any follow-up consultations with their GP or at the hospital; and
- ensure access to information by children, elderly people, people with physical and learning disabilities, members of ethnic minority communities and others who find this difficult.

35. It is important that patients are involved in these information initiatives. The Government will take advantage of the growing availability of the Internet to extend the information available to the public on diseases, health promotion, and useful facts about all aspects of NHS services, in particular by using The Scottish Office web site (http://www.scotland.gov.uk). We also aim to ensure that each Health Board, Trust, and national support organisation has its own web site linked with **S**cottish **H**ealth **O**n the **W**eb (http://www.show.scot.nhs.uk). SIGN guidelines will also be appearing on the Internet, and this type of patient access should be very helpful in promoting the uptake of these guidelines by the profession at large.

Responsiveness to the public

36. Services need to be responsive not just to the needs of individual patients but also to the preferences of the public at large. To redesign services from the perspective of patients - and to reflect this in all aspects of health service planning - requires finding out what patients and communities want; and consulting them over proposals for change.

37. As statutory bodies, Local Health Councils have been part of the NHS structure since 1974. In the new NHS based on openness and partnership, Local Health Councils will be able to work co-operatively with their Health Board and agree how the Health Council's activity can be focused to achieve the greatest health gain for the people it serves. In addition, the Government wish to encourage other means of ensuring public involvement in the planning of services; and to require Health Boards to undertake thorough and imaginative consultation on their Health Improvement Programme (see paragraphs 52 and 58 and Annex A).

38. Already the NHS is making use of various means to tap the views of the communities they serve. User surveys both to obtain general feedback and to gauge reactions to particular proposals are well-established. Increasingly too Boards and Trusts are experimenting with new techniques such as focus groups, citizen's juries and survey methods which are targeted on the less tangible aspects of service provision. Building on this experience, the Government look to the National Health Service to step up its efforts to find better ways of involving patients and the public effectively. In each Health Board and NHS Trust, a designated member of the executive team will be given responsibility for making this happen; and progress will be a key feature of The Scottish Office Management Executive's performance management of Boards and Trusts.

39. Particular challenges lie in the field of primary care, and discussions are taking place with consumer organisations about the possibility of an initiative to

support patients in developing greater confidence in their dealings with primary healthcare professionals and to explore different mechanisms for securing effective patient participation in practice planning.

40. For its part, the Government will continue to involve lay members in a wide range of committees and working groups and to support them in making an effective contribution. The Government are also committed to extending support for the voluntary sector which makes such a valuable contribution to the NHS. Appointments of non-executive members of Health Boards and Trusts will include people from both of these sectors with the aim of making these bodies more responsive to the community they serve.

Openness

41. Underpinning all these developments is greater openness. The Code of Practice on Openness in the NHS in Scotland, issued in 1995, set out basic principles underlying public access to information about the NHS in Scotland. The Government have already taken its provisions a stage further by requesting all Trusts to hold their meetings in public. It looks to all parts of the NHS - including Health Boards, Trusts and GPs - to adopt the spirit as well as the letter of the Code, not only responding positively to all requests for information (unless they fall within the specified exempt categories) but also looking for new opportunities to reduce secrecy and to share information with patients and the public. Our decision earlier this year to remove "gagging clauses" from contracts of employment is an important step to ensure that matters of public concern are not hidden from public scrutiny.

Conclusion

42. At some time in our lives, every one of us will be a patient. Although the rest of this White Paper is about the nuts and bolts of the renewed NHS in Scotland, we must never lose sight of what that will mean for the patient. Our vision is of a patient making no more than a short trip to discuss their health with their family doctor, a consultation which will take place in premises with a welcoming atmosphere, where the most up-to-date technology is literally at the doctor's fingertips. If more than reassurance is needed, as much as possible will be done for the patient in these familiar surroundings. If more specialist advice is needed, we intend that the patient will leave the surgery certain of what is going to happen next, and where and when it will happen. That is what we mean by seamless care designed for the patient's benefit. We believe these are the concerns of patients. They are at the heart of our vision which the new arrangements in the rest of this White Paper are designed to achieve.

Section 3:

Replacing the Internal Market

44. In developing proposals for the replacement of the internal market, the Government have sought the views of those working in the NHS in Scotland, and have listened carefully to the criticisms of the existing arrangements. A consistent theme to emerge is the need for new arrangements which can deliver significantly better services for patients, by improving clinical links between parts of the National Health Service, and wholeheartedly pursuing the development of first rate primary care and hospital services. There will be no 'big bang'; we want to build on what we have. At the same time, solutions need to be flexible enough to respond sensitively to local needs rather than imposing an inflexible blueprint on them. The Government believe that the arrangements set out in this White Paper will achieve these goals.

45. The model which the Government will introduce to replace the internal market has a number of distinct aims. First and foremost, it is intended to improve clinical relationships within the NHS in Scotland, and to clarify the accountabilities of its different parts. In turn, this should help to promote the partnership and co-operation which are so fundamental to the effective delivery of health care services and which are an integral part of the Health Improvement Programmes already being developed in the NHS in Scotland.

46. The Government made clear in our manifesto that we had no intention of turning the clock back to a time when the NHS was run by a crude command and control system. It is widely accepted that such an approach undermines devolved decision-making, and so would run counter to the Government's whole approach. That approach is geared to ensuring a focus on patient care so that those who deliver services locally can respond to changing circumstances and changing patient needs quickly. Such responsiveness cannot be achieved if matters continually have to be referred upwards. The Government have therefore retained distinctive roles for those who are to be responsible for the development and implementation of strategy and for those who deliver services directly to patients: the strategic role and the service role.

47. One of the adverse features of the internal market was the scale of the bureaucracy and the associated costs to which it gave rise. The Government have already taken steps to reduce bureaucracy and achieve savings through the elimination of unnecessary duplication of support and other services. The Government's intentions emphasise the role of clinicians and patients in the design of services, and encourage the integration of service delivery in a seamless pattern across the interface between primary, secondary and tertiary care.

48. The Government have decided that the existing system must be reformed as soon as possible, in order to tackle these issues. We will do so by retaining some features of the existing system while replacing those which have been shown to work against the best interests of patients. It is an approach which is evolutionary and incremental, and an approach based on the belief that people achieve more by working together in partnership.

49. A start has already been made. The Priorities and Planning Guidance issued in August 1997 set out the framework for planning which the Government wish the National Health Service in Scotland to adopt. A number of further changes are in train on the management of human resources and financial services, designed to achieve greater consistency in service organisation across the country. These proposals, which have come forward from the NHS, are intended to achieve greater efficiency in the organisation of these important support services, as well as to eliminate waste and duplication. Later in the White Paper we set out further proposals intended to ensure that wherever people work within the NHS in Scotland they are treated fairly and equitably in accordance with principles established at national level.

50. Soon after taking office, the Government announced their intention of taking forward a review of acute health services in Scotland. The Acute Services Review is being led by the Chief Medical Officer and is expected to report in Spring 1998. More than 250 people across the NHS in Scotland and beyond are directly involved in the work of the Review, which is necessary if the NHS in Scotland is to be able to respond to the challenges of the next century. The Review is being conducted in accordance with the Government's commitment to openness. Everyone with an interest in the future of these services has been encouraged to become involved. Those conducting the review have been asked to frame their proposals in the context of a development plan for the next 5-10 years.

51. In September the Government also launched their *Framework for Mental Health Services in Scotland* which is intended to promote the development of local, comprehensive mental health services and pave the way for the replacement of services currently provided in outmoded institutions. By fostering a framework of collaborative organisations seeking to improve the pattern of service in the best interests of patients, the changes which are now set out will make it easier for these policy initiatives to be implemented speedily.

Key Features of the New Arrangements

52. The internal market led to a focus on the short term, with too much emphasis on an annual contracting round. Service developments need to take place over a longer time frame. Our Health Improvement Programmes are designed to promote a longer-term perspective on health and the elimination of the bureaucracy associated with contracting. Annex A sets out the current arrangements for Health Improvement Programmes.

53. Our modernised Health Service should lead to management savings of around £100 million over the lifetime of the Parliament. In summary, the roles of each part of the NHS in developing and implementing the Health Improvement Programme are:

- **Health Boards** have the lead role in its development and will retain their existing responsibilities in relation to public health protection, health improvement, needs assessment, service strategy and performance management, and will be given a small number of new powers to ensure that local strategies can be implemented. To discharge these responsibilities, Health Boards will also need to liaise closely with local authorities.
- **NHS Trusts** will be retained, re-focused on improving the quality of service to patients by giving clinicians who work in the hospitals, along with those who use their services, a bigger say in their management. The

number of Trusts operating within the NHS in Scotland will be reduced, though detailed proposals for their configuration will be the subject of public consultation in the light of the principles set out in this paper. There will be two main types of Trust: Acute Hospital Trusts and Primary Care Trusts.

- **Primary care** will be given strong organisational form through the creation of Primary Care Trusts. They will be responsible for all primary health care and will typically comprise community hospitals and mental health services as well as networks of general practices in Local Health Care Co-operatives. These Co-operatives will replace the standard GP fundholding system, which will be brought to an end. Joint Investment Funds (JIF) will be established to encourage co-ordination of services at the interface between primary and secondary care. Primary Care Trusts will also need to work closely with those responsible for social work services and housing.
- At the **national level**, the Government intend the Management Executive to tackle nation-wide NHS policy and planning matters and ensure greater consistency in the implementation of policy. Within The Scottish Office Department of Health the Management Executive, working in collaboration with the Public Health Policy Unit (PHPU), will make sure that the NHS contributes to broader Government policies in health and social affairs.

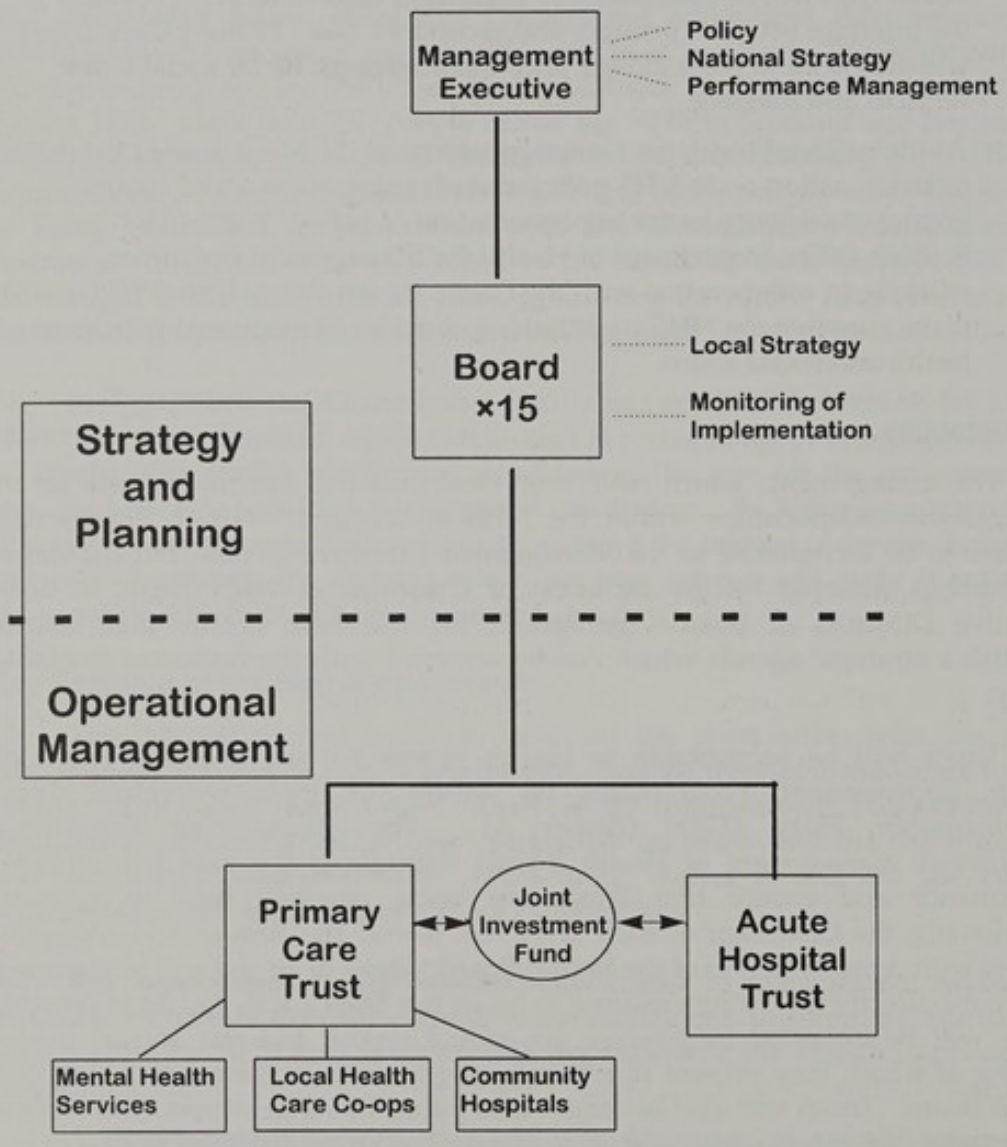
Accountability

54. The arrangements which have been described will establish a new set of accountability relationships within the NHS in Scotland. Health Boards will continue to be accountable to the Management Executive as now, but the cross-membership achieved by the inclusion of Chairmen of NHS Trusts as non-executive Directors of Boards (paragraph 67) will help ensure that Boards establish a strategic agenda which can be achieved with the resources available locally.

55. Trusts will be accountable to Health Boards for the implementation of Health Improvement Programmes by means of their individual Trust Implementation Plans (TIPs) (Annex A). The Management Executive's performance management of Health Boards throughout the year will monitor performance and ensure that Trusts are being properly held to account. Additionally, the Chairman of each Trust will attend the annual Accountability Review with representatives of the Health Board, where he or she will be expected to account directly for matters relating to his or her Trust's activity. As at present, Trusts will be expected to produce an annual report, but the annual public meeting at which they present it will in future be held in conjunction with the Health Board. Trusts will also be required to publish a range of specified clinical performance indicators which will be aggregated on an annual basis as part of the Annual Report on the NHS in Scotland. The Government see the development of these indicators as an important aspect of Trusts' accountability to the general public.

56. The particular circumstances faced by the three Island Health Boards have led the Government to conclude that they should continue to have responsibility for strategy and operational management through their directly-managed units. The Island Boards are expected to adopt the general principles and approach set out in this Paper, and should therefore review their existing internal management arrangements to ensure they can support the Government's proposals.

Figure 1
THE NEW STRUCTURE



Section 4:

Roles and Responsibilities of Health Boards

57. The Shields Report, published in March 1996, set out the main roles and responsibilities of Health Boards in the context of the internal market. With the abolition of the internal market, some of the detail of the Shields Report requires reconsideration. But the Government retain the view that the principal role of Health Boards remains the protection and improvement of the health of their resident populations. In more detail, Boards should focus on:

- health protection
- health improvement and health promotion
- needs assessment
- service development
- resource allocation
- resource utilisation
- performance management of Trusts' implementation of Health Improvement Programmes

and to do so with the underlying aim of promoting equity.

58. The main vehicle through which Boards are expected to ensure the discharge of these responsibilities is the Health Improvement Programme. Boards must put in place arrangements to ensure that the development of the Health Improvement Programme is a genuinely co-operative process in which local Trusts, GPs and others participate actively. Because Health Improvement Programmes are so important to the future pattern of local services, they are to be the subject of consultation. Boards will succeed in fulfilling these responsibilities only if they are able to provide responsive leadership to other organisations with an interest in health. This extends beyond the NHS to colleagues working in local authorities, voluntary organisations and the wider community.

59. The changes which are set out in this White Paper are considerable, and as part of the incremental approach designed to minimise upheaval, the Government have concluded that the existing Health Boards and their membership structure should be retained but with stronger community representation. Boards will therefore be able to lead the implementation of the changes and preserve a local identity in the development of services.

60. In developing Health Improvement Programmes, the NHS in Scotland will need to take full account of its relations with local authorities. The Government will give further consideration to the benefits of minor changes to some Health Board boundaries to align them with those of local authorities. The effective

delivery of health care often depends on the active co-operation of other agencies, particularly local authority social work departments. There has been much debate about where the boundary between NHS care and social work led care should rest. Whatever the structure, some boundary will inevitably exist. The important principle must be that the patient's care comes first. The patient should not perceive the boundary as interfering with the care he or she receives. To achieve this, the NHS in Scotland and local authorities need to develop close working relationships. The Government intend to consult on this.

61. To enable Boards to discharge these responsibilities, the Government have concluded that they must be given new powers to ensure effective implementation of strategies which have been developed through close working with others. Specifically, Boards will be given the responsibility of ensuring that Trusts implement the proposals set out in Health Improvement Programmes. This will be achieved through Trust Implementation Plans, which will be agreed between the Trust and its Health Board and will set out what the Trust is committed to do to help implement the Health Improvement Programme. In particular, they will set out:

- the changes in the pattern of service which are to be achieved;
- the resources which the Board intends to make available; and
- the expected level of service to be delivered.

62. Performance against these agreements will be the subject of regular monitoring by the Health Board. The Trust's performance in achieving its Trust Implementation Plan will be made available to the public each year.

63. Health Boards will not be responsible for operational matters. These will remain the responsibility of Trusts, but Boards will be given powers of approval in relation to capital planning, property and senior medical posts. The Government's intention is that Health Boards should be able to ensure that the strategic direction which has been agreed and set out in Health Improvement Programmes can be implemented, and not frustrated by Trusts' developing and pursuing alternative strategies through their estate management and employment responsibilities.

64. Since 1995, the Scottish Ambulance Service has been the only Scotland-wide NHS Trust, delivering all of our accident and emergency services and non-emergency Patient Transport Services (PTS). As a result it has had to negotiate annual service contracts with all 15 Health Boards and, in relation to PTS, with all 46 hospital Trusts. This has been a considerable bureaucratic burden. The Government have therefore decided to make the Scottish Ambulance Service a Special Health Board and will give further consideration to the funding and performance management arrangements for the Service. The three existing Special Health Boards - the State Hospitals Board for Scotland, the Health Education Board for Scotland and the Scottish Council for Postgraduate Medical and Dental Education - will continue, and the position of the Mental Welfare Commission for Scotland will remain unchanged.

Section 5:

Roles and Responsibilities of Trusts

65. A Trust's prime responsibility is the provision of patient care of the highest quality. To do this it must skilfully design, as well as deliver, the patient services agreed between it and the Health Board. The Trust should seek to provide integrated services which have clear health gain objectives, are clinically effective, have minimal waiting times, and have integral quality standards. In order to achieve this, Trust management must focus on improving the delivery of health care, and not let administrative processes become ends in themselves, rather than the supporting means. Among other things, this requires that clinical staff are central to the management of hospital, community and primary care services and are able to lead the development of clinical services.

66. Trusts will be responsible for all operational matters and managed by teams concentrating on the delivery of clinical services. Trusts' management teams will be able to take decisions relating to the local management of health services without undue interference from others, and will be responsible for the effective and efficient discharge of day-to-day operational activity. They will work within current national and strategic frameworks and in particular in line with the Health Improvement Programme developed with their Health Board. Trusts will continue as separate legal bodies, with power of employment, and will be required to work with each other to ensure that support services are organised cost-effectively and provide value for money.

67. This approach requires reform of existing arrangements for Trust Boards. Trusts will in future be managed by a Trust Team led by a part-time non-executive Chairman appointed by the Secretary of State. The Chairman will also act *ex officio* as a non-executive of the host Health Board. Supporting the Chairman will be a Team of up to 5 executives, including the Trust's Chief Executive. In addition, up to 5 non-executive trustees will be appointed to work as integral members of the management team. The existing Health Appointments Advisory Committee (HAAC) will continue to provide advice to Ministers on possible candidates who will be sought from areas including the NHS in Scotland, the voluntary sector, local government, and, in the case of Trusts with medical schools, from the universities.

68. The Government's new emphasis on the quality of services to patients must be reflected in the responsibilities and management of Trusts. The Government will amend Trusts' statutory duties to make explicit their responsibility for quality of care. This will need to be taken every bit as seriously as the existing financial responsibilities. Trust Chief Executives will carry ultimate accountability for the quality of care provided by their Trust, in the same way as they are already accountable for their Trust's proper use of resources. Trust Chief Executives will

be expected to ensure there are suitable local arrangements to give them, and the Trust board, the assurance they need that this duty is being met. The intention is to build on existing patterns of professional self-regulation and corporate governance principles, but offer a framework for extending this more systematically into the local clinical community, and ensure the internal 'clinical governance' of the Trust.

69. Control of the estate, comprising land and property, will be retained by Trusts, but Health Boards will be responsible for monitoring its utilisation to ensure consistency with Health Improvement Programmes and locally agreed estates strategies. The Government will have power to ensure that the estate is managed in ways which are consistent with strategic plans.

Types of Trust

70. Two principal types of Trust are envisaged. First, Primary Care Trusts (PCT) will be responsible for primary, community and mental health services within the geographical boundary of individual Health Boards. Second, Acute Hospital Trusts (AHT) will be responsible for a defined set of acute hospital services within the geographical boundary of individual Health Boards. Whilst these are the preferred forms for Trusts, the Government recognise that there will be particular circumstances where this will have to be varied to best serve the needs of the local population.

Primary Care Trusts

71. Developing primary care is at the heart of the Government's commitment to the NHS in Scotland and is essential to the development of an effective and efficient system of care. Our family doctor system is the envy of the world, but if the primary care sector is to realise its potential, it must be supported by the development of a robust organisational structure.

72. Primary care depends on the contribution of a wide range of professionals working together. GPs and the general practice team need to work closely with community nurses, midwives and therapists to offer comprehensive and appropriate support to their patients. Community pharmacists, dentists and ophthalmic opticians provide essential services, and access to their skills and professional expertise can greatly enhance the effectiveness of the team.

73. The NHS has been well served since its inception by the independent contractor status of general medical and dental practitioners, community pharmacists and opticians. The Government have no plans to change that status. It is however important in the interests of good patient care that the Family Health Service practitioners are involved in the design of that care and that the contribution they make is advanced and supported within a cohesive framework.

74. General Medical Practitioners and their teams are increasingly aware of the advantages of working together to plan and deliver new services in different ways. Out-of-hours schemes, primary care purchasing groups and locality arrangements are all examples of such collaborative working. In particular, practices are forming alliances, creating the foundations for new primary care organisations, which will overcome the artificial boundaries which have existed between community trusts and primary care.

75. Recognising the emergence of these new collaborative working methods and the benefits they bring to patients and practitioners alike, primary and

community health services will be brought together under a single unifying structure in the form of Primary Care Trusts. The establishment of these Primary Care Trusts will build on the strengths of general practice and give a voice to community nursing and other primary care professionals managing and delivering care to their local communities. In this way primary care will be able to pool resources, work across organisational boundaries, and develop shared aims and objectives which will underpin the drive towards better quality of care for patients.

76. In placing the emphasis on the primary care development role of Primary Care Trusts, the Government also recognise that these Trusts will have substantial responsibilities for the management of some hospital services, and in particular a range of local services for people with learning disabilities, people with a mental illness, and frail elderly people. Primary Care Trusts will need to ensure that they are able to structure themselves so that the needs of patients using these services are met appropriately.

77. Government policy envisages continued progress in the transition from institutional care to a comprehensive range of services provided either in patients' own homes or in homely settings in the community. The successful implementation of this transition depends in part on the creation of effective primary and community health services, and more effective working between health and other agencies, notably housing and social work. The Government have already announced a Local Care Partnership initiative to help find new ways of breaking down boundaries between health and social care, and plan to publish a discussion paper on the relationship between these services. Primary Care Trusts will have a key role in leading the implementation of these policies and can do so through their other responsibilities to develop extended teams of primary care professionals working in partnership.

78. The configuration of services within Primary Care Trusts must take into account natural groups which reflect local circumstances, in line with the Government's commitment to devolved decision-making. PCTs serving urban areas will be responsible for large patient populations requiring an extensive range of community and primary care services. Those covering rural areas scattered across several small centres of population may include elements of acute care provided within community hospital settings in addition to the primary and community services provided through general practice.

79. The new roles of the PCTs will be:

- to provide support to general practice in delivering integrated primary care services;
- to formulate primary care policy and to direct the future development of services within an agreed framework of organisational and financial accountability;
- to work in partnership with Health Boards, Acute Hospital Trusts and others to develop Health Improvement Programmes, to implement local health strategies, through Local Health Care Co-operatives, and to deliver their Trust Implementation Plan;
- to engage primary and secondary care clinicians in forming agreements on the design and delivery of clinical services reinforced through the allocation of ***Joint Investment Funds*** (paragraph 91);

- to stimulate improvements in quality and standards of clinical care;
- to address inequalities in health provision and support the development of local initiatives, which address local health needs; and
- to develop the role of community pharmacists, dentists and ophthalmic opticians in providing high quality care to patients as part of the primary care team.

80. PCTs will reduce the bureaucracy associated with fundholding and allow individual practices to concentrate on providing high quality primary care, freeing them from the distractions of managing an individual fund. It is envisaged that primary care clinicians will play a key role in directing and managing these new organisations, creating a strong sense of ownership within the general practice community. The internal organisation of the Trust will reflect the formation of Local Health Care Co-operatives. These will be voluntary organisation of GPs which will strengthen and support practices in delivering care to their local communities.

81. The objectives of Local Health Care Co-operatives will be to:

- provide services to their patients within an identified level of resources, including expenditure on prescribing;
- work with the support of public health medicine to develop plans which reflect the clinical priorities for the area, whilst taking into account specific health needs of the registered patient population covered by the Co-operative;
- support the development of population-wide approaches to health improvement and disease prevention which require lifestyle and behavioural change;
- improve the quality and standards of clinical care within practices and to support clinical and professional development through education, training, research and audit; and
- support the development of extended primary care teams which are formed around the practice structure, and promote the development of clinical expertise and the emergence of specialisms within primary care.

82. The funding of primary care under PCTs reflects the move away from the individual practice model towards a collective arrangement managed through the Local Health Care Co-operatives. Co-operatives will have the right to hold a budget for primary and community health services, if they wish. The extent of these budget-holding powers will be reviewed by the Government in the light of experience. The fundholding management allowance will be re-directed to support the work of the new Co-operatives, which will require access to specialist expertise providing a range of skills and support across the practices. These arrangements are designed to empower all GPs, working collectively, to ensure that they have flexibility to invest in services which optimise the health gain to their local communities.

Acute Hospital Trusts

83. Acute hospital services in Scotland face a number of pressures from rising demand, both for emergency and elective admissions. Acute hospitals in Scotland have managed to keep pace with these pressures by developing innovative

approaches to care and by seeking and securing increases in productivity and efficiency. As a result the acute sector now treats record numbers of patients; those admitted from waiting lists are admitted sooner than in the past; and the overall efficiency of acute services has increased. This is a significant record of achievement by the NHS in Scotland.

84. At the same time the acute hospital sector faces a number of issues which are affecting the way in which care is organised and delivered. Medicine is becoming increasingly specialised. As technological developments create an ever expanding range of therapies, difficult issues emerge about the extent to which the specialist skills needed to utilise these therapies can be provided throughout Scotland. The development of "care networks" is one of the ways in which these difficulties can be overcome, and has been the central feature of plans for cancer services which the NHS in Scotland has been developing and implementing. The objective in these plans is to make expertise available where it can provide the greatest benefit to those patients with specialised needs, and at the same time link cancer centres to services provided more locally, which meet the needs of the majority of patients. In this way the aim is to try and balance considerations of local access with the need to make the best use of scarce specialist skills. These trends to establish effective networks of clinical care in the acute sector are likely to intensify.

85. In addition to their main role in delivering patient care, acute hospitals in Scotland play a vital role in the education and training of health service staff, and in the pursuit of clinical and related research. Scotland has a long and internationally recognised reputation in these fields. The Government are committed to ensuring that this continues to be the case and wish to work closely with the universities and other interests to make certain that Scotland's proud tradition in education and research is maintained.

86. With these considerations in mind the Government have concluded that there are currently too many Acute Hospital Trusts in Scotland, which the internal market expected to compete amongst themselves. By reducing the number of separate organisations the Government believe the opportunity will be created for clinical networks to be strengthened, for more effective strategic planning to take place, and for greater efficiency to be secured through elimination of duplication and wasteful competition.

87. The Government intend that in most Health Board areas there should be one Acute Hospital Trust. For practical purposes, notably in Glasgow and Lothian, this may not be feasible. In consequence, the Government do not have a fixed view of the number of Acute Hospital Trusts which should emerge, but expect there to be significantly fewer than is currently the case. In developing proposals for the new configuration of Acute Hospital Trusts the following criteria should be applied:

- the ability to respond positively to change in clinical practice and technological development;
- improved opportunities for patient choice and access to the benefits of specialised services at a local level;
- adequate management competence and structures to ensure effective organisational development and high quality service delivery;
- increased ability to recruit and retain clinical and other staff, to offer enhanced education and training provision and to address the workforce challenges facing the NHS in Scotland;

- improved arrangements to ensure that patients receive the best possible co-ordinated care throughout any acute illness;
- improved ability to maximise the utilisation of scarce resources including capital assets and human resources; and
- reduced management cost overheads.

88. The longer-term future structure of acute hospital services in Scotland will also be influenced significantly by the outcome of the Acute Services Review which is expected to report in May 1998. In developing its proposals for Acute Hospital Trusts, the Government have been primarily concerned to create arrangements which will assist implementation of the conclusions of the Review, bearing in mind that the Review has been asked to identify planning principles to guide the development of acute services over the next 5 to 10 years.

89. It is the Government's intention that the new configuration of Acute Hospital Trusts should be identified and put in place as quickly as possible, consistent with the need for careful planning and appropriate consultation.

Collaboration between Trusts

90. The development of an integrated delivery system requires GPs and their extended primary care teams to work with secondary care clinicians to design clinical services around the needs of their patients. The main purpose of this dialogue is to evaluate and test, within a clinical framework, those elements of care which are best provided in hospital and which elements can be delivered through the primary care team.

91. In order to support these improvements, each Health Board will establish a **Joint Investment Fund.** The objective is to increase responsiveness without attendant bureaucracy. These Joint Investment Funds will allow changes in the clinical settings in which care is to be delivered and priorities for quality improvement to be agreed. The size of Joint Investment Funds will be for local determination by Health Boards and Trusts in the light of the Health Improvement Programme (see also paragraph 107).

Section 6:
The National Strategic Framework

92. The Government intend to retain the Management Executive within The Scottish Office Department of Health as the "Head Office" of the NHS in Scotland. As well as its role in supporting Ministers, the Management Executive will have 5 other key responsibilities.

Developing Health Service Policy

93. This is a well-established feature of the Management Executive's role. Hitherto, the Department has worked very closely with colleagues in the Department of Health in London. The Government intend that co-operation will continue between England and Scotland following devolution, but the Management Executive will enhance its own policy-making role so that it can provide full support to the Scottish Executive and the Scottish Parliament.

Setting National Strategic Direction

94. The annual Priorities and Planning Guidance is the principal document setting out the strategic direction for the NHS in Scotland. The Management Executive will continue to produce this Guidance, supplemented by more detailed strategic statements on specific services such as cancer and mental health; and on the inter-relation of services in the light of the work of the Acute Services Review. But the Management Executive will also be expected to take a key role in facilitating the implementation of strategy, where it is evident that improvements in health require a nationally co-ordinated programme.

Handling Issues affecting several Health Boards

95. Between those issues which can only be addressed at a national level, and those which are of concern at the local level, there are a number of health planning matters which straddle existing Health Board boundaries. The Management Executive will take a more active role in helping Health Boards to work together to address these regional planning concerns.

96. The Government also intend that the Common Services Agency should continue to provide a range of services for the NHS throughout Scotland. The range and nature of those services will be reviewed in the light of the changes set out in this White Paper.

Managing the Performance of the NHS

97. In recent years the process of holding the NHS to account for its delivery of Ministerial objectives has focused on the work of Health Boards. This will continue, but Chairmen of Trusts will in future be expected to attend the annual Accountability Review meetings, and Trusts will be expected to account for their performance to the public by publishing a broader range of indicators of clinical performance.

Promoting Leadership

98. In such a diverse organisation as the National Health Service in Scotland it is necessary that services are effectively managed and led. The Government believe that the Chief Executive and the chief professional officers in the Management Executive have a vital role in fostering local leadership so that the changes set out in this White Paper are implemented effectively.

Section 7:
Financial Flows and Resource Issues

99. This section describes the mechanisms which will replace contracts so as to ensure more equitable and effective use of resources. This section also describes how a single stream of funds will operate, and, among a range of other financial issues, the ways in which the NHS in Scotland can use its resources to provide better health care.

The Consequences of Abolishing Contracts

100. An essential requirement is to move away from wasteful competition and secrecy to open discussions between Health Boards and Trusts to allow them to share relevant information and agree service strategies. More openness is one of the key changes which is required to drive change. Mutually supportive objectives and actions must be agreed by each organisation over the coming period to deliver health services and improve the health of the population. The extent to which the programmes serve the greater good of the population and secure health gain will be the key criterion by which Boards and Trusts will be held accountable. The principal agenda for Trusts will be the implementation of relevant Health Improvement Programmes and the subsequent Trust Implementation Plans. This will be reflected in funding mechanisms. The emphasis is on the need to focus on health gain and improved outcomes for local populations. Health Improvement Programmes may propose changes in the health bodies which provide services. Under the internal market loss of services could threaten the viability of a Trust. There must now be collective ownership of any such problems and a plan for dealing with them before the change is made.

101. When issuing the Priorities and Planning Guidance, the Government anticipated the abolition of contracts. Mechanisms must be put in place which will ensure that high quality patient services are delivered. Health bodies must be properly accountable to the public for their actions.

Equitable Distribution of Resources

102. The Government have already announced a review of the arrangements for distributing resources to Health Boards for hospital and community health services (HCHS) and Family Health Services (FHS) to ensure the distribution reflects local population needs and operates as fairly as possible. The review is wide ranging and covers not only the distribution of Health Board general allocations (which currently enable Boards to secure health services for their resident population) but also how funds for FHS, including the drugs bill, are distributed. The review will, therefore, examine the methods for allocating the resources available to the NHS in Scotland including both primary and secondary care. We will move towards a distribution of funds in the future which is more objective and needs based with the aim of promoting equitable access to health care. This will ensure equal access to resources for people with equal needs. It will also seek to incorporate a range of allocations for special purposes which are currently issued separately.

103. The programme of work to be carried out will be drawn up by the end of 1997. Elements of the work will be completed over the coming year and the NHS in Scotland will be fully involved in the review and will be consulted about the various elements of the programme of work as the results become available.

Flow of Hospital and Community Health Services Funds

104. At the moment Health Boards are given annual allocations to meet the cost of HCHS based on the weighted capitation formula, commonly known as the SHARE (Scottish Health Authorities Revenue Equalisation) formula, which was introduced in the 1970s. Most parts of Scotland now get their fair share of resources based on the existing formula. The Review of the SHARE formula will inevitably lead to a need to redistribute funds and this will, as in the past, be done on the basis of an equitable redistribution over the coming years with the key aim of avoiding turbulence.

105. The Government are committed to improving further the arrangements for funding Health Boards for both primary and secondary care, so as to better reflect relative health needs of the population served. There are clear advantages in enabling local flexibility across drugs budgets and HCHS funds, both for more cost-effective care and to promote better overall value within the total resources available for health care. The Government have decided it is right to create a single stream of funds covering both HCHS and GP prescribing to be allocated to Health Boards and through them to Primary Care Trusts. This new arrangement will take effect from 1 April 1999.

106. The Health Improvement Programme and the Trust Implementation Plan will set out the range and quality of services that each Trust is to provide and the funds to be allocated to do so. The signing off of the Trust Implementation Plan by the Health Board will represent its agreement to allocate the funds required, and for the immediately following year will determine the Trust's budget. As is normal for any organisation, the budget may be reviewed later in the year, informed by higher or lower activity levels than expected, but this will not be in any sense a financial reward or penalty on a Trust. The performance of senior staff in a Trust will be judged by their success in providing patients with the agreed range and quality of services within the agreed budget. If Trusts secure savings from their management efforts, they will be permitted to retain them for re-investment in the development of services within the Trust, consistent with the Health Improvement Programme.

107. Acute Hospital Trusts and Primary Care Trusts will set up joint planning and budgeting arrangements to cover the interfaces between primary, secondary and tertiary care. As well as the direct budgets for the Acute Hospital and Primary Care Trusts, the Health Board will establish a Joint Investment Fund for these interface plans. Discussions about the use of this Fund will be led by the Primary Care Trust. The intention behind these proposals is to ensure that the design of services across primary and secondary care reflects appropriately the contribution the sectors can make, and that care is effectively planned, managed, and resourced at the operational level, consistent with the strategy agreed in the Health Improvement Programme.

108. Where a Trust delivers services for two or more Health Boards, its host Health Board will lead in planning the service requirements, involving the other Boards who will contribute to the Trust's budget according to the costs of treating their patients. There will always be some patients who fall outside the plans and

budgets which support them, typically where a small number of patients require very expensive treatment or where a patient is taken ill away from home. Most of these treatments should be taken into account in Trust Implementation Plans rather than through individual patient invoices. Health Boards will introduce a simplified system of funding to meet the costs of patients given treatment away from their home area.

Capital

109. The demand for capital investment in the NHS takes a number of forms, including the building of new hospitals, the redevelopment of existing facilities, investment in equipment to keep pace with medical developments and improve service quality, and investment in existing estate to ensure it is maintained to a high standard. The Private Finance Initiative will continue to play an important role in providing new hospitals for Scotland, but attempts to apply it to all capital projects, whether appropriate or not, were misguided. Both private and public sector capital have a role to play.

110. The majority of public capital is allocated by The Scottish Office for particular projects. Such allocation in the future must be set in the context of a clear capital plan for the NHS in Scotland. In formulating this strategic capital plan, the merits of all project proposals emerging from the HIP process will be measured against clear criteria, the most important being benefits for patients. This approach is not intended to second guess Health Improvement Programmes, but is simply a means of prioritising public capital resources across Scotland as a whole. In addition, financial viability and appropriateness for private finance will be taken into account.

111. The remainder of public capital is presently allocated to NHS Trusts on a formula basis, to cover areas such as property improvement and equipment replacement. NHS Trusts presently make their own decisions on priorities within their allocation. There is some evidence that competition between NHS Trusts has led to this capital not always being used in a way that is to the overall benefit of the NHS. This will stop in the future. All capital spending must be in line with HIPs. Further, the formula used to allocate this proportion of capital has reflected the existing NHS estate rather than any assessment of patient needs.

112. In future, a formula will be used to allocate this capital to Health Board areas on the basis of need. Health Boards will then allocate capital to Trusts before the start of the financial year. The role of Health Boards is strategic rather than becoming involved in the detail. Individual investments by Trusts of a significant size must be cleared by the Health Board to ensure consistency with the Health Improvement Programme.

113. With the increasing shift to community care, many large institutions are becoming empty. The NHS in Scotland must be more vigorous in disposing of surplus estate and re-investing the proceeds towards improving patient care. While such receipts will normally be re-invested in the Health Board area in which they arise, this may not necessarily be within the same Trust.

Capital Charges

114. The present system of capital charges brings out the use made of fixed assets when costing services. This will be reviewed to ensure greater consistency with the system of resource accounting and budgeting which is being introduced across Government.

Benchmarking and Performance Management

115. Health services should be provided efficiently and effectively. Benchmarking and performance measures have a key role to play in achieving this goal and will help:

- inform the process of setting priorities, objectives and targets;
- enable monitoring of progress against objectives and targets;
- promote the use of best practice; and
- improve the accountability of the service to patients and to the wider public.

116. The Government believe the main areas in which performance measures are relevant are:

- *the clinical effectiveness of services*: for instance, the extent to which services achieve reductions in mortality, morbidity and disability;
- *the quality of services*: for example, waiting times for outpatient appointments and for diagnosis and treatment;
- *the efficiency of services*: the costs incurred in delivering services, and the use made of staffing, beds and other resources;
- *access to services*: the availability of services in different areas of the country;
- *inequalities in health*: differences in morbidity and mortality between socio-economic groups; and
- *the appropriateness of services*: the type of services provided for patients - for example, the use made of day cases.

117. Significant progress has been made in recent years in improving the range and quality of information available for assessing comparative performance. The Government see continuing progress in this area as central to their aim of achieving improvements in services for patients and intend to review the information currently available for benchmarking and performance management in the NHS in Scotland. We will consult on proposals for improving the range of information which can be used to make comparisons between the quality and efficiency of services provided in different Health Boards and Trusts, who will be required to publish them and account for their performance.

Section 8:
Teamwork

118. The internal market has resulted in unnecessary fragmentation of policy and practice in the management of NHS staff. Not only has this created inconsistency in employment practice, it has also created duplication and bureaucracy. It has left staff feeling insecure and has undermined the nature of the 'NHS family', so vital to the team work and cohesion needed in the delivery of patient care.

119. The themes of partnership and co-operation set out in this White Paper apply equally to the recruitment, management and development of our workforce. Partnership in this context is about involvement, trust and openness, as well as fairness. In order to recruit and retain staff we need to develop a meaningful and practical partnership with them. To achieve this, we need effective employment practices, along with a commitment to training and development across the entire workforce, underpinned by a modern, consistent industrial relations practice delivered within the framework of a national strategy for human resources in the NHS in Scotland.

120. In developing such an approach, the Government will emphasise the balance between rights and responsibilities. Staff have the right to be involved and consulted in decisions which affect their job, how they work and the way service is delivered. Their responsibility is to work together to deliver a service which is effective and represents value for money.

121. Nurses, midwives, health visitors and the professions allied to medicine have long since taken the lead in providing effective and flexible solutions to changing patient needs, medical advances and shifts in the pattern of service delivery. They have expanded their scope for professional practice by developing in-depth specialist knowledge and skills in, for example, caring for patients with diabetes, glaucoma and mental illness. In primary care, the development of the nurse practitioner role has been key to changes in how patients with chronic problems are managed and cared for.

122. The Government value this commitment and wish to support and encourage future initiatives which will make the most of the contribution of nurses, midwives and health visitors to the provision of clinical services and will support the establishment in Scotland as soon as possible of a Nursing and Midwifery Practice Development Unit. The Unit will concentrate on the development and promotion of clinical excellence, and encourage networking and the sharing of good practice throughout the NHS in Scotland. The Unit will complement the Nursing Research Initiative already established in Scotland.

123. As the central theme of a human resources strategy, the Government intend to continue to invest in education, training and development. This will ensure that NHS staff are appropriately trained and well qualified both in the interests of the NHS and for their personal development in acquiring lifelong skills. A comprehensive training and development strategy will be produced which underpins the key strategic objectives of the NHS in Scotland. It will tackle a range of issues including:

- recognition of the value of lifelong learning and Government's wider policies for education and training;
- equal and easy access to training and development opportunities for all staff;
- promotion of a competency approach underpinned by national occupational standards and support of Government training programmes such as modern apprenticeships;
- commitment and support to the developments in undergraduate and Postgraduate education in medicine. The Government will examine the opportunities to further develop the role of the Scottish Council for Postgraduate Medical and Dental Education; and
- a commitment to the framework of Continuing Medical Education and Professional Development, a vital component in the maintenance of standards and competency of all clinical staff.

124. The relationship between employer and employee is vital to our success. The removal of gagging clauses from contracts of employment is a clear signal of the new culture the Government are determined to create in the work place. To do so, the Government have a number of priorities:

- The Government are committed to working closely with the medical profession on further improvement in the hours, conditions and quality of training for all grades of junior doctors. In addition, there will be closer working with the professions in solving complex and difficult manpower issues. Greater emphasis will be placed on the support of research and practice in the development of a flexible workforce, in a rapidly changing clinical environment.
- Since the NHS is one of the largest employers in Scotland, with a workforce in which over 70% are women, we are conscious of our responsibility to support and develop working conditions that recognise the needs of the modern family. We will work with NHS staff to develop effective employment practices. We will seek to reduce the barriers between staff groups and enhance personal responsibility and leadership. The Management Executive will promote equal opportunities in their widest sense as part of the human resources strategy for the NHS in Scotland to ensure that managers recognise and incorporate best practice with the aim of promoting the development of all staff and eliminating discrimination.
- The NHS in Scotland provides employment for over 130,000 people who work in hospitals, health centres and patients' homes. The Government will require all NHS employers to develop specific proposals to enhance the health, safety and security of staff. This will include the provision of access to an effective and comprehensive Occupational Health Service.
- Staff also should be given access to health promoting activities in the workplace, consistent with the Government's aim of improving the health of Scotland. The Government will therefore support the development of health promoting programmes for staff in their place of work.
- Exploratory talks have already commenced on the future of pay and conditions of NHS staff. Any system will need to balance the need to be flexible with a requirement to maintain a system of core pay and conditions of service across the NHS. Any system must have the confidence of staff and be seen to be fair.

- The Government are aware that the changes proposed in this document will have significant impact. It will affect not only the number of senior managers in the system but also the skills required of them. With this in mind, the Development Group in Scotland is under review and the report of this review will be available in April 1998, dealing with the way forward in management development and succession planning for the NHS. In addition, and following consultation with interested parties, the Management Executive will take the lead in developing clear plans to support the managerial workforce through this period of transition.

125. Many people work in the NHS who are not directly engaged in clinical care but who nevertheless make an important contribution to the quality of patient care. They are generally referred to as working in 'support services'. The Government believe that these members of staff need to be regarded as an integral part of the patient care team. Trusts will be required to assess systematically the value and quality of their support services, and to explore innovative ways of developing them, in consultation with staff and their representatives. The options which emerge must demonstrate a clear commitment to investment in the people who work in the NHS in Scotland. The Government will establish a steering group to support, identify and disseminate best practice in the management of support services and pilot a variety of partnerships for their development.

The Way Ahead

126. All NHS staff will continue to face enormous challenges as we constantly find new and better ways of delivering services to the population. The pace of change means that staff need to be given the support, skills and reward in order to sustain and build on their existing commitment. A practical human resources strategy is intended to assist in the more effective use of the existing resources we commit to manpower, training and education. It is also intended to give staff confidence that they are valued in ways which are meaningful, practical and realistic.

Section 9:
Implementation

127. Subject to the availability of Parliamentary time for the necessary legislation, our Implementation Plan is as follows:

• First Health Improvement Programmes completed	March 1998
• Boards consult on preferred configurations of Trusts	March 1998
• All GPs in Scotland linked electronically	March 1998
• First Trust Implementation Plans published	April 1998
• Human Resources Strategy for NHS in Scotland published	April 1998
• Acute Services Review reports, including recommendations on quality assurance	May 1998
• List of key performance indicators published	July 1998
• Report of Review of Resource Allocation published	December 1998
• Scottish Health Technology Assessment Centre established	December 1998
• Fundholding ends	March 1999
• First Primary Care Trusts established	April 1999
• Reconfiguration of Acute Hospital Trusts completed	April 1999
• Unified funding stream for drugs and HCHS implemented	April 1999

Annex A
Health Improvement Programmes (HIPs)

1. Patients look to all those involved in the National Health Service - Health Boards, NHS Trusts, primary care practitioners and others - to work together to provide them with effective care, delivered efficiently, and to put their interests first. To help achieve these aims Health Boards, Trusts and General Practitioners are working together to produce a Health Improvement Programme for the people of each Health Board area. Health Boards are leading the preparation of these Programmes, but with the active engagement of Trusts and General Practitioners. Clinicians are involved in the development of these Programmes. All parties involved will be committed to the successful implementation of the Programmes. Health Board and Trust Chairmen are expected to take personal responsibility for ensuring that the Programmes are agreed.

2. The necessary first steps in the preparation of Health Improvement Programmes are open discussions between Health Boards and Trusts to share and agree all relevant information in the light of existing service strategies including financial baselines. Having agreed the baseline information, these discussions will identify the mutually supportive objectives and action to be taken by each organisation over the coming years to improve the health of the population. The extent to which the Programmes serve the greater good of the population and secure health gain is a key criterion by which Boards and Trusts will be held accountable. The principal agenda for Trusts is the implementation of relevant Health Improvement Programmes. Collaboration and co-operation will help to improve quality. It is important to emphasise the need to focus on health gain and improved outcomes for local populations.

3. Health Improvement Programmes should:

- build on existing Health Board service and financial plans and Trust plans;
- cover a period of 5 years;
- include firm plans for the forthcoming year 1998/99 and provisional plans for later years which should nevertheless be as firm as possible; and
- be open to public scrutiny, recognising the role of the Local Health Council.

4. Each Health Improvement Programme should set out:

- proposals to protect the public health, including emergency planning;
- proposals to promote health;
- proposals to analyse and tackle health inequalities;
- service changes and developments, including those involving primary care;
- a rolling programme for the implementation of evidence-based clinical guidelines and clinically effective practice, to be monitored through clinical audit;

- resource assumptions including locally generated efficiencies;
- human resource strategies;
- how efficiency in the use of existing assets will be maximised; proposed capital investments; and changes in the National Health Service's estate; and
- Information Management and Technology strategies.

5. Health Boards which secure a significant level of service from Trusts outwith their areas should involve these Trusts as appropriate in preparing Health Improvement Programmes. Health Boards should also involve the Scottish Ambulance Service in discussions. Health Improvement Programmes will be prepared annually, rolling forward the previous year's 5 year Programme to firm up plans for the following year and to include a new Year 5. Health Boards will continue to agree annual Corporate Contracts with the Management Executive.

6. NHS Trusts should prepare an Implementation Plan consistent with the Health Improvement Programme. These should be agreed with the host Health Board to ensure they support delivery of Health Improvement Programmes and that resource assumptions are consistent. For Trusts which deliver a significant level of service to people from more than one Health Board area it will be appropriate to discuss their Implementation Plans with each of the relevant Health Boards.

7. Health Improvement Programmes are described in the Priorities and Planning Guidance, which provides the overall policy context for the planning and delivery of health services, and targets the NHS in Scotland on the most important national priorities. It sets out, amongst other things, the Service's clinical priorities. These are:

- mental health;
- coronary heart disease and stroke; and
- cancer.

These clinical priorities are kept under review and may therefore be subject to change over time.

Annex B

Primary Care Trusts

A. Resource Allocation

1. The Health Board's allocation from The Scottish Office Department of Health will comprise its weighted capitation share of resources for HCHS, Prescribing, GMS and other practitioner related costs; and any specific funding requirements (Figure 2).

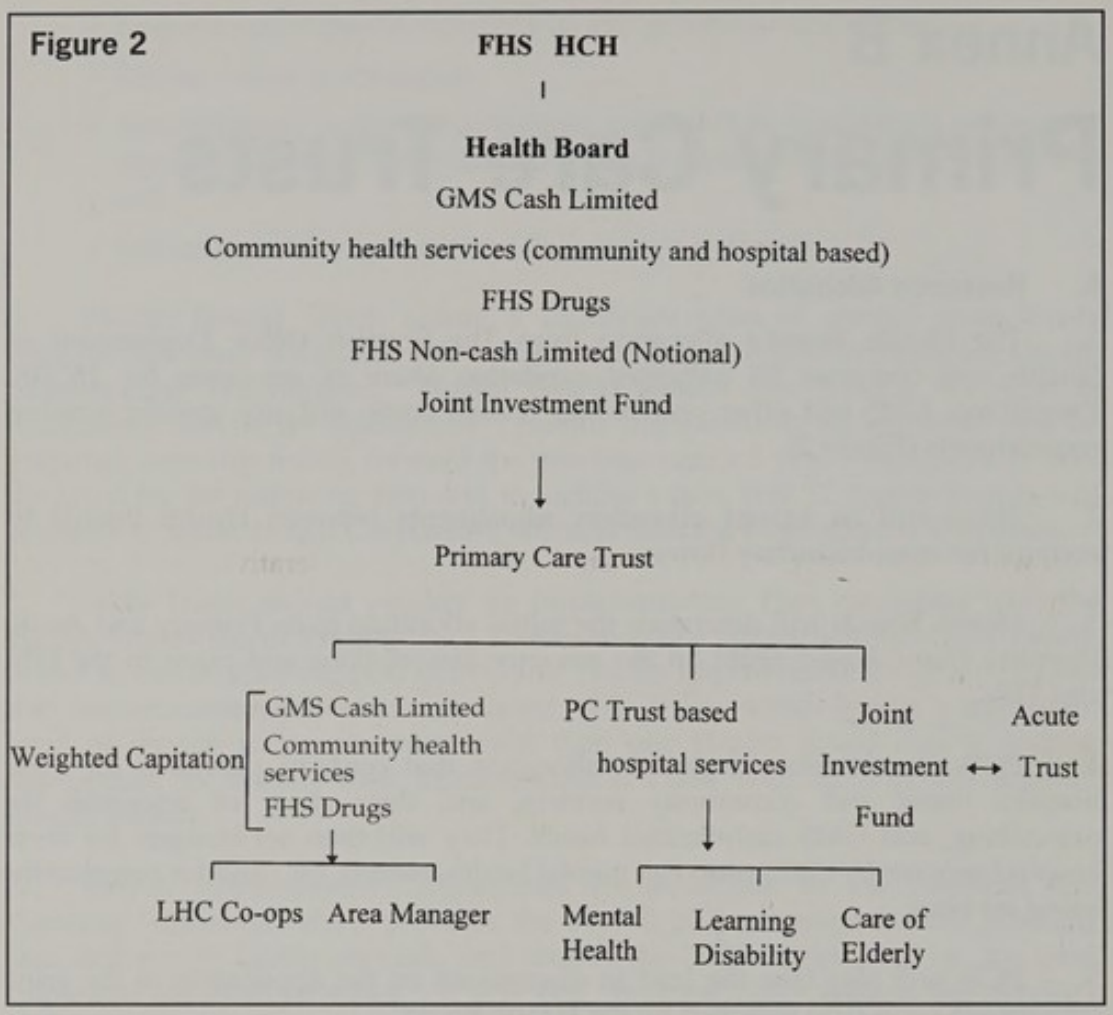
2. There will be agreed allocation adjustments between Health Boards to account for cross-boundary flows.

3. Health Boards will determine the initial allocation to its Primary and Acute Hospital Trusts, based again on the resource assumptions and plans in the HIP and TIPs.

4. PCTs can therefore expect an allocation that contains provision for their hospital based and community services, and their share of resources for prescribing, and GMS cash-limited funds. They will then set budgets for their hospital services by care group e.g. mental health, elderly, etc.; and for community based services.

5. PCTs will also take the lead in discussions on the application of the Joint Investment Fund (JIF) allocated by the Health Board.

Figure 2



B. Local Health Care Co-operatives

6. Co-operatives will cover natural communities. Their size will vary according to geography in the range 25,000 - 150,000.

7. Co-operatives will be an operational unit within the PCT responsible for managing and delivering integrated services across a defined area. The Co-operatives will be separate management entities but an integral part of the PCT.

8. The Co-operative structure will allow GPs to develop extended primary care teams which encompass district nursing, health visiting, midwives, community psychiatric nurses and professions allied to medicine within a multi-practice framework. Practices will be able to provide a wider range of services for their patients and will have access to specialist support e.g. public health, health promotion. Co-operatives will manage their own staff although contracts of employment will normally be held by the PCT.

9. GPs who do not wish to join a Co-operative will be allocated a notional budget for prescribing and their share of cash-limited General Medical Services. Community Services will be provided for them either by the Co-operative where there is one covering the majority of the area or by the area manager.

10. In areas where there is no Co-operative, transitional arrangements will allow existing GP fundholders to continue to hold a budget for community based services.

11. To allow for the development of different models to suit local circumstances, the Trust will allocate the Co-operative a budget that comprises some or all of the following:

- an agreed level of resources for community based clinical and PAM services based on weighted capitation;
- GMS cash-limited, which over time will move to a weighted capitation base;
- prescribing costs, which over time will move to a weighted capitation base;
- community hospital budget;
- an appropriate share of the JIF.

12. Whilst they will be responsible for managing and operating their budget, cash will be administered by the Trust, to whom the Co-operatives are financially accountable.

13. The Co-operative will be able to vire between individual budget heads, but as part of the PCT will be expected to contain expenditure within its overall allocated budget.

14. Co-operatives will be required to present regular financial and performance data to the Trust as well as an annual report that covers both financial and service information.

15. Expenditure by the Co-operatives will be accounted for separately by the Trust and consolidated in its annual account. Thus a Co-operative will be subject to audit examination by the Trust's statutory auditor - to whatever level the latter considers appropriate.

Printed in the UK for The Stationery Office Limited on behalf of the Controller of the Her Majesty's Stationery Office
CC No 075612, Dd 293199, 11/97 J32375

The Stationery Office

Published by The Stationery Office Ltd and available from:

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ISBN 0-10-138112-3

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