

PARTNERSHIP FOR CARE

SCOTLAND'S HEALTH WHITE PAPER



COMMUNITIES



ACCESS



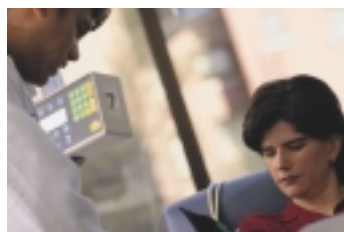
PATIENTS



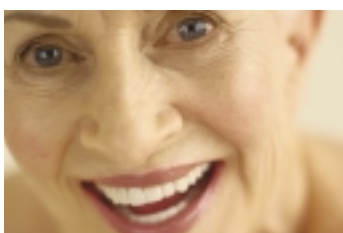
STAFF



INCLUSION



QUALITY



SCOTTISH EXECUTIVE

Working together for a healthy, caring Scotland

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MINISTERIAL FOREWORD



At the heart of my vision for the future of the health service is a culture of care that is developed and fostered by a new partnership between patients, staff and Government.

Patients are at the centre, key drivers of change and a fundamental source of the definition of quality. We recognise the diversity of the patients we serve and want a responsive service. In the new culture we are seeking to create we must listen to patients and respond to patients in order to develop the patient-centred services we have talked about for so long.

None of this will happen, however, without staff. That is why a key role for Government is to support, value and empower staff to lead the change process in partnership with patients. That means staff together. One of the historic problems of the health service has been the split between primary care and secondary care and between health and social care. Patients see one system and we must create the care without barriers that they want.

Within a new framework of national standards and inspection I want to give frontline staff the resources and the tools and the freedom to innovate and find better ways of delivering care. I also want to see more diagnosis, care, and treatment delivered within new Community Health Partnerships whenever that is appropriate and clinically safe.

All of this demands significant investment. We have already increased Scotland's health budget from £4.6 billion to £6.7 billion over the course of this Parliament. This will continue to rise by over 5% per year in real terms. National Insurance will increase by 1% in April – the Scottish Executive will use this extra money to fund a sustained increase in health spending.

Scottish taxpayers and patients will rightly expect to see service improvements as a result of their investment. We need to meet their expectations and match investment with reform.

Some of these exciting reforms are outlined in this White Paper. It signals a direction of travel and a way of going forward together. It also takes a broad view of health and recognises we will never make the progress we want without addressing the broad determinants of health within our society. These reforms will require legislation.

I look forward to receiving your views and once again thank the thousands of staff without whom this journey would never take place.

A handwritten signature in black ink, reading 'Malcolm Chisholm'.

Malcolm Chisholm, MSP

Minister for Health and Community Care

CHAPTER **ONE**

INTRODUCTION



1. This Health White Paper is about the promotion of health in the broadest possible sense and the creation of a health service that is fit for the 21st century. It builds on *Our National Health: A plan for action, a plan for change*,¹ published two years ago, but moves on to develop certain key issues. In particular, it sees patients and national standards as key drivers of change in the health service and frontline staff as leaders of the change process; it outlines ways in which the redesign, integration and quality of services can be systematically progressed; and it seeks a step change in our approach to health improvement as an essential complement to the modernised, patient-focused services of the 21st century.
2. We describe the kind of action we believe is required in order to achieve an improvement in Scotland's health. This cannot be done by the Health Department or the health service alone so we are working in new ways across the Scottish Executive. Partnership at national and local level with Local Authorities, the voluntary sector and local communities is also crucial.
3. Scotland's health is improving but remains poor compared to the rest of Europe, with an unacceptable health gap between the richest and the poorest communities. Action to close that gap pervades the health improvement strategy, which we outline in Chapter 2.
4. Looking at services from a patient's point of view underpins everything that we are seeking to do in the health service. Patients are concerned about the quality of care; treatment at the right time and in the right place; being treated with dignity and respect; having their say in decision-making; having their feedback taken into account; and getting clear explanations at every stage. All this amounts to a massive culture change in the health service compared to the first fifty years of its history.

¹ <http://www.scotland.gov.uk/library3/health/onh-01.asp>

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5. In Chapter 3 we describe this culture change and how we intend to bring it about, building on some of the excellent work that is already taking place. We start from the assumption that patients must be seen as partners in their own healthcare. The health service must engage with patients, their carers and families, and listen to them in order to be more responsive to their needs. The Health Service must recognise the diversity of the population it serves. This is at the heart of improving quality and redesigning services from a patient's point of view.
 6. The drive to define national standards for healthcare is still a relatively new feature of the health service and is now being taken forward in a more integrated way by NHS Quality Improvement Scotland.² National standards are being set, performance is being independently inspected and the findings are being reported publicly for the first time. This will be backed up by effective intervention by the Executive, where necessary, to ensure that standards are met. Standards must include clinically-driven waiting times and critical patient issues such as cleaning in hospitals and infection control. Scotland is a pioneer in some of this work through the development of clinical guidelines and evidence-based care. The challenge now is to stay ahead and to build patients and their carers into the process in a more central way. We describe this broad quality and standards agenda in Chapter 4.
 7. Our model of a modern health service in Scotland lays strong emphasis on partnership, integration and redesign. Chapter 5 describes how those principles will manifest themselves. It foresees a central role for primary care teams in new Community Health Partnerships, working with hospital services – for example in Managed Clinical Networks – and in new relationships at community level between NHSScotland and Local Authorities. Instead of the fragmentation of the market, which characterised the health service for much of the 1990s, we are seeking to bridge the gap between primary and secondary care and between health and social care. In this way, we will enable health and social care professionals to look at the whole picture of care from a patient's point of view. We believe this is essential for achieving shifts in the balance of care and for developing the new models of care that meet patients' needs.
 8. If patients and national standards are the key drivers of change, then the key agents for delivering that change are frontline staff, especially clinicians. Staff are the health service and it is only through supporting and empowering them that services can be improved in ways that patients need. Central to this are healthcare teams working together and learning from each other in new ways.

² <http://www.nhshealthquality.org/>

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9. In this White Paper we explicitly reject a command and control management approach, whether from St Andrew's House or local NHS Board headquarters. Instead we describe ways in which the centre can support staff by giving them the tools and the freedom to redesign services and lead change, in partnership with patients. The centre also has a vital role, neglected in the past, in workforce planning and in ensuring that workforce development is at the heart of health policy. All of this is described in Chapter 6.
10. In creating a healthcare system fit for the 21st century we are not interested in change for change's sake and are inclined to distrust structural change as a distraction from the key issues and challenges. The new emphasis on integration, and on clinicians and patients working together to find better ways of doing things, will nevertheless have organisational implications. We describe these in Chapter 7; they are a consequence of our new approach rather than the starting point for it.
11. Everyone has a part to play if we are to raise standards of health in Scotland. In the final Chapter we concentrate on these roles and responsibilities: of the Executive, of managers; of health service staff including clinicians; and of the wider public. In particular, we make a clear commitment as a Scottish Executive to lead the new agenda in a supportive, facilitating and empowering manner, working alongside patients and healthcare teams to create a modernised health service fit for the 21st century.

CHAPTER TWO

HEALTH IMPROVEMENT

- 
- A new approach to improve health in Scotland and to reduce health inequalities
 - A sustained effort to tackle the lifestyles and circumstances which damage health
 - New actions focused on early years; teenage transition; the workplace; and in communities
 - Legislation to secure the place of Health Improvement in Community Planning

1. The challenge of improving health in Scotland – both physical and mental – will not be easy. Our approach links health with other areas of public policy, recognising the central role of Community Planning and focusing action in ways that are relevant to peoples' everyday lives.
2. Scotland's health is improving but the scale of the challenge is still daunting. Scotland's death rates are among the highest in the world for cancer and coronary heart disease. Life expectancy is consistently lower than in other European Union countries. We have rising rates of suicide, particularly among young men, and rising numbers of young people, in particular girls in their early teens, being treated for self-harm. This reflects a complex interaction of different factors relating to life choices, life styles and life circumstances.
3. Our objective is to improve Scotland's health and reduce the health inequalities within our society. Poor health is strongly linked to deprivation and inequality. Our commitment to improving health in Scotland is integral to closing the opportunity gap and the programmes which are described more fully in the *Health Improvement Challenge*,³ which will be published to accompany this White Paper, will be pursued with a particular focus on the social groups most at risk. We will bring forward legislation to back up this commitment and ensure that Health Improvement is a priority for NHS Boards and Community Planning partners.

³ <http://www.scotland.gov.uk/library3/health/hahg-02.asp>

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4. NHS Boards will also step up their efforts to reduce health inequalities, for example by working with both statutory and voluntary sectors to implement Health and Homelessness Action Plans. In addition we are developing, for the first time, Health Inequality Indicators and will work towards a target for reducing health inequalities, which we will set in consultation with Local Authorities and NHS partners.
 5. Action to promote good mental health will be an essential component of our approach to improving health in Scotland. We will continue to work to remove the stigma attached to mental illness, reduce the rate of suicides and achieve greater public understanding of mental wellbeing. A national group chaired by the Minister for Health and Community Care will continue to take forward this work which supports wider Scottish Executive plans on mental health improvement and social justice.
 6. Health improvement has often been seen as a task for the Director of Public Health and health promotion departments in the NHS. This is no longer acceptable. Promoting Scotland's health needs support and leadership from:
 - Ministers and Departments across the Scottish Executive;
 - Local Authorities;
 - employers;
 - professionals in health, education and social inclusion;
 - local community leaders;
 - Trade Unions; and
 - representative groups in the voluntary sector.
 7. The Executive's new, cross-government approach to health improvement will help deliver this leadership and support. It draws on a wide understanding of the contributors to health improvement across the Executive's portfolios – in education, housing, the environment and in employment – to ensure a coherent approach to tackling those life circumstances and life choices that impact on our health as individuals. At a local level we are committed to working with Community Planning partners to ensure effective delivery in communities. Only by putting health improvement onto everyone's agenda can we join together the various initiatives and achieve an impact which will be more than the sum of its parts.

Making Progress

8. We have already made a start. For example, we have three health improvement Demonstration Projects,⁴ an Active Primary School programme, 44 Healthy Living Centres focused on reducing health inequalities, a Health Promoting Schools Unit, an Eating for Health⁵ programme including a telephone advice line, and a range of projects funded from the Health Improvement Fund.⁶ We have established a direction of travel. We intend now to raise the pace.

Changing Culture

9. Looking ahead, we still need to promote fundamental change in public attitudes among individuals and families, within businesses, in local communities, and the NHS. There will be no quick fix. If we are to raise standards of health, then the people of Scotland need to be motivated and their interest sustained over the long term to make a difference. Health improvement actions will need to involve the public in all its diversity and that will need highly effective and varied communications.

10. Clarity and consistency of message must be sustained across a broad spectrum of actions and settings. Communications on specific topics will be visibly drawn into the health improvement programme by a co-ordinated healthy living identity, to link activities in diverse areas such as education, health and social justice with initiatives on mental wellbeing, smoking, alcohol, diet and physical activity.

‘Focus on Four’

11. The integrated and focused approach, set out more fully in the *Health Improvement Challenge*, will incorporate four broad areas of particular attention: Early years; Teenage Transition; Workplace; and Communities.
12. There is clear evidence of the importance of a child’s **early years** on their subsequent health and standard of living. The Executive will develop an integrated approach for Early Years, including an enhanced focus on health improvement. Actions will include:
 - an integrated programme of measures by early 2003 to be reflected in plans developed by Community Planning partnerships and NHSScotland;

⁴ <http://www.show.scot.nhs.uk/demonstrationprojects/>

⁵ <http://www.healthylivingscotland.gov.uk/>

⁶ <http://www.scotland.gov.uk/library3/health/shif-00.asp>

- challenging professionals, health workers, local organisations, and NHS Boards to ensure measures for health improvement in a child's early years are designed to benefit the most vulnerable and disadvantaged families and children; and
- linking with the education service in programmes such as Sure Start⁷ to focus health resources on those children and families who need the most support.

13. The **teenage transition** is a time of great change, impressionability, and conflicting pressures on young people. Across the Executive we will develop and build on existing programmes that integrate topic specific action (smoking, drugs, sexual health, alcohol, healthy eating, physical activity and mental wellbeing) alongside promoting personal skills and emotional intelligence. This work will link with the Schools Improvement Framework under the National Priorities in Education,⁸ but will also go beyond the school environment. Actions will include:

- active health service involvement and support for the roll out of the New Community Schools programme⁹ across the whole of Scotland by 2007;

- implementation of an Executive-wide policy with funding to improve the quality of school meals including the adoption of nutritional standards;
- enabling all schools to become Health Promoting Schools by 2007 through the Health Promoting Schools Unit; and
- refocusing the school nursing service to support an integrated approach to improving the health and potential of children and young people through a new Scottish Framework for Nursing in Schools.

14. A broad view of 'health' in the **workplace** takes us beyond the widespread belief that this is principally about preventing accidents and injuries. Employment and training opportunities bring emotional and social benefits, quite apart from their impact on a person's economic wellbeing, and so can have a powerful impact on the way we feel and the choices we make. Actions will include:

- support for small and medium-sized enterprises in dealing with drug and alcohol problems amongst employees;
- increasing the number of non-smoking workplaces to protect employees from passive smoking;

⁷ <http://www.surestart.gov.uk/new/default.htm>

⁸ <http://www.nationalpriorities.org.uk/NPFP.html>

⁹ <http://www.scotland.gov.uk/education/newcommunityschools/default.htm>

- expanding the coverage of *Scotland's Health at Work*¹⁰ scheme; and
- encouraging employers to examine the business case for offering their employees health-improving opportunities such as smoking cessation services and exercise facilities.

15. Communities which are active in promoting good health can benefit all who live there. Support for community-led health improvement initiatives will be closely linked to the development of Joint Health Improvement Plans (JHIPs) with Community Planning partnerships, and will be targeted at disadvantaged groups in both urban and rural settings. Actions will include:

- optimising the potential of alcohol and drug action teams, Healthy Living Centres and other community-based initiatives;
- building voluntary sector and community-based capacity to deliver health improvement through community action;
- supporting local people to take a lead in developing local solutions for local community problems; and

- integrating programmes on fuel poverty with JHIPs to ensure a reduction in the number of households in fuel poverty.

Accelerating the Pace of Reform and Change

16. Ministers and the Scottish Executive will work with the people of Scotland to achieve a decisive difference in Scotland's health and wellbeing. We have already moved to strengthen the national delivery and support for health improvement by bringing together the Health Education Board for Scotland and the Public Health Institute of Scotland into a single organisation – NHS Health Scotland.

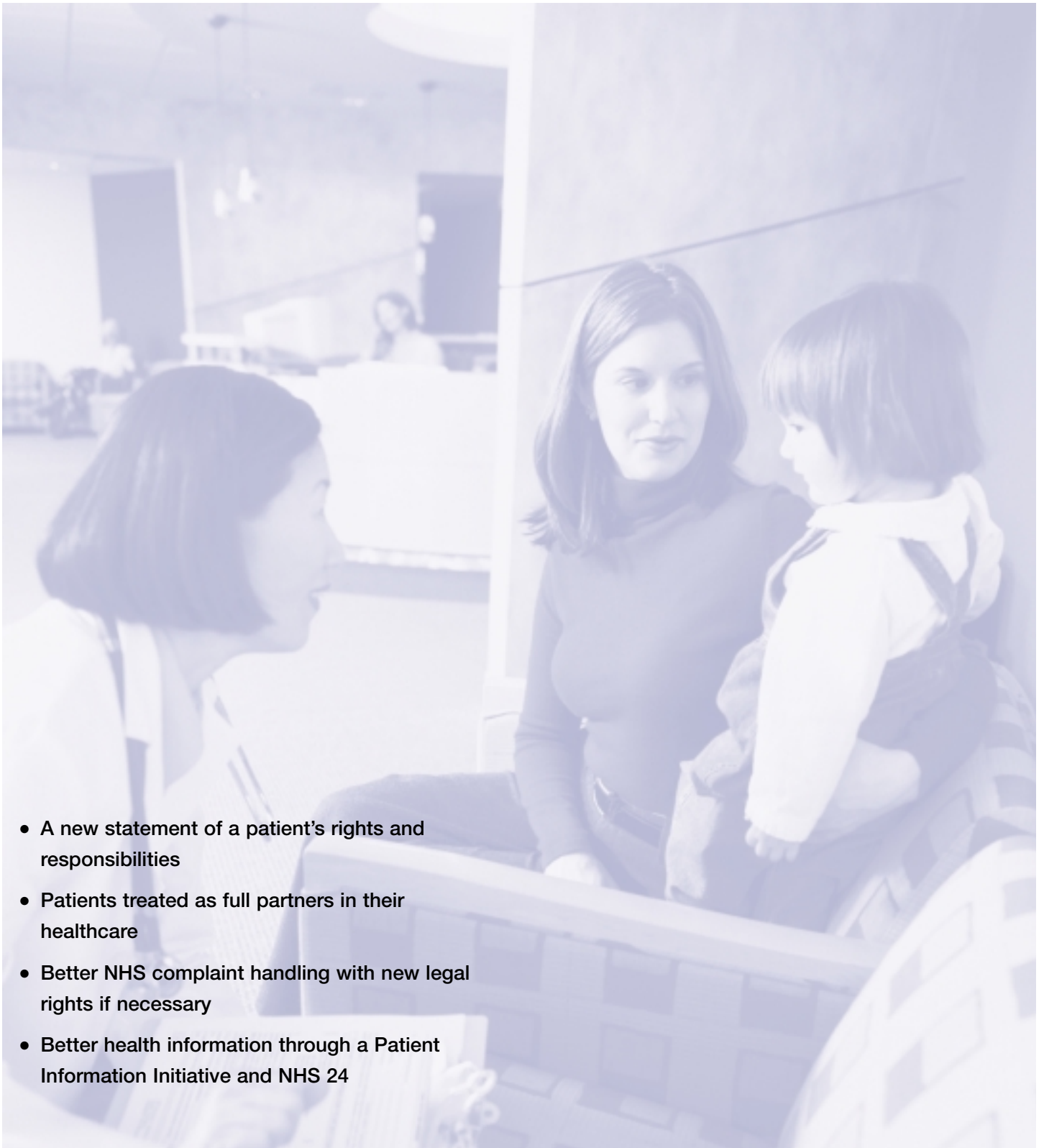
17. In broad terms our proposed approach to improve health throughout Scotland will involve close collaboration with other agencies – Local Authorities, voluntary bodies, employers and Trade Unions and will:

- empower the people of Scotland by supporting more people to care about their own health and that of their families; and
- help people to understand the issues, listen to their needs and give them the kind of support they need, underpinned by clear consistent messages.

¹⁰ <http://www.shaw.uk.com/>

CHAPTER **THREE**

LISTENING TO PATIENTS



- A new statement of a patient's rights and responsibilities
- Patients treated as full partners in their healthcare
- Better NHS complaint handling with new legal rights if necessary
- Better health information through a Patient Information Initiative and NHS 24

1. We are committed to creating a patient-centred National Health Service – based firmly on the ideals of a public healthcare service which is accessible to all and free at the point of delivery. Those fundamental values that shaped the NHS over fifty years ago should still guide us in modernising health services today.
2. The NHS was set up in an age when people had different expectations, treatment possibilities were more limited and scientific progress was slower. People now expect to be involved in deciding about their own healthcare as responsible partners in care. They wish to be treated with dignity and respect, to be treated as individuals and not as cases, and to have the right care in the right place at the right time. Meeting people's changing expectations while encouraging greater personal responsibility is a key theme of the White Paper.
3. Understanding the wants and needs of patients whether children, adults or older people will lead to more effective and high quality healthcare, and must be a core activity of the health service. It means developing a genuinely responsive health service by seeking input and feedback from patients as a key part of developing services and improving quality.

4. For example, in Tayside 136 patients/parents and healthcare users volunteered to talk openly about their day to day experience of being in hospital. Clinical leaders undertaking the Royal College of Nursing Leadership Programme learnt about the difficulties patients had with practical issues such as safety, knowledge, fear of dying, loss of dignity and independence, cleanliness, privacy, the importance of humour in the wards and most importantly kindness. The stories helped nurses act on the issues that concern patients, sharing these insights with the team and problem solving together.

Taking the Patient's Point of View

5. At its best the NHS delivers the highest standards of patient-focused care but we know that for many reasons this does not always happen. We are committed to a new culture of patient focus and individual care in the NHS. However, this will not happen overnight. It will take a great deal of investment and hard work to enable health staff to deliver the new focus we are looking for. But it is an essential foundation for the modern health service we are determined to create in Scotland.

6. Our commitment is to a NHS which is dedicated to serving each patient. We want to see a health service where there is:

- **participation** by patients, carers and local communities. This should mean that their views are actively sought, listened to and acted on; and treated with the same priority as clinical standards and financial performance;
- **empowerment** of individuals and communities, to enable them to increase control over and improve their health; and
- **partnership** between clinicians, professionals, patients and carers in understanding a person's condition and making decisions about the right treatment and care.

7. Many people who come into contact with the service already rely on care given by an informal carer. These carers are crucially important to the person they look after but they can still find themselves marginalised by health service professionals. The vital role of carers as major care providers must be recognised at all levels in the NHS and staff must work closely with carers as partners in providing care.
8. Sometimes the views and experience of patients can be expressed effectively through voluntary organisations. The health service does recognise the valuable role of the voluntary sector, not just as advocate, but in providing a range of services for patients and carers. We are supporting Voluntary Health Scotland and will continue to encourage NHS Boards to engage closely with the voluntary sector.
9. Achieving a real focus on patients will require a high level of communication skills from health organisations and staff. It will also require staff to be aware of the diverse needs of patients. The provision of training in communication and involvement skills will be a high priority for our new NHS training organisation, NHS Education for Scotland.¹¹ We expect to see the principles of a patient-focused approach built into induction programmes; pre-qualification professional training; continuous personal development and professional training; and leadership development. NHS Education for Scotland will support NHS organisations to achieve this objective and this task will be a major element of its own strategy.
10. An effective patient focus needs high quality information. There is a large volume of health information already available to individuals through publications, voluntary patient support organisations and the Internet, as well as from the NHS. Much of this is valuable but not all is high quality or readily accessible.

¹¹ <http://www.nes.scot.nhs.uk/>

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11. Our Patient Information Initiative will be designed to offer a quality assurance process for patient information, and to widen the range of information available and improve access to it. NHS Boards will also work with Local Authorities to develop Carer Information Strategies to ensure that staff across NHSScotland support carers by telling them about their right to ask for an assessment of their own needs, and helping them to access sources of support from their Local Authority, voluntary bodies or elsewhere.
12. NHS 24¹² will provide the people of Scotland with 24-hour access to health information and advice over the telephone, and will have an important role to play in collecting and communicating patient information. We will review with NHS 24 how they can support the Patient Information Initiative. Clinical guidelines and standards can also be an important way of communicating information to patients and NHS Quality Improvement Scotland will ensure that its publications are accessible to patients and carers.
13. An increasing proportion of NHS patients are older people and the service needs to ensure that it adapts and plans to meet this changing pattern of need. At the same time it needs to ensure that whatever the individual circumstances of people's lives, including age, gender, ethnicity, disability, religion, sexual orientation, mental health, economic or other circumstances, they have access to the right health services for their needs. This is central to our commitment to social justice and the need to bridge the opportunity gap for all.
14. We have been working to ensure that the needs of ethnic minorities and refugees in Scotland are being effectively met, by implementing *Fair for All*.¹³ We believe there is also a need for a more coherent approach within NHSScotland to meeting the needs of disabled people. In this European Year of Disabled People¹⁴ we will extend the principles set out in *Fair for All* across the NHS to ensure that our health services recognise and respond sensitively to the individual needs, background and circumstances of people's lives.

¹² <http://www.nhs24.com/>

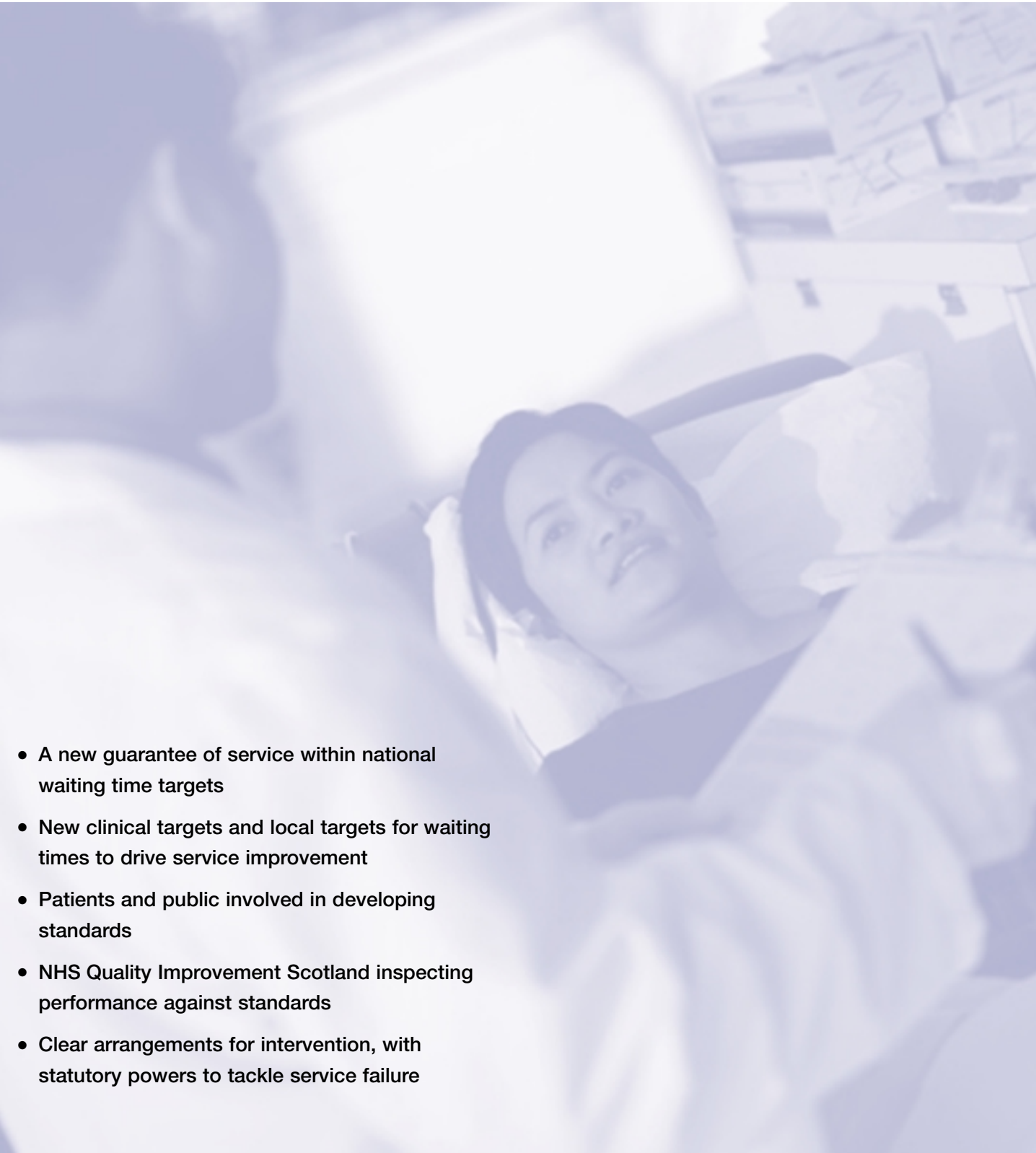
¹³ <http://www.scotland.gov.uk/library3/society/ffar-00.asp>

¹⁴ <http://www.disability.gov.uk/euro/euro.html>

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15. A focus on patients must mean a willingness to learn from situations where things have gone wrong or a patient has not received the level of service or care he or she expected. We are therefore developing a new complaints process for NHSScotland. This is designed to strengthen the response to complaints, increasing the focus on handling complaints, quickly and ensuring that there is a positive and constructive response to patients and the public. This will be a priority for senior management in all health organisations and needs to be reflected in the attitudes and behaviour of staff at all levels.
16. A failure to deal with complaints effectively, or to respond to the recommendations arising from investigation of a complaint, could constitute a service failure, triggering an investigation by NHS Quality Improvement Scotland and possible Executive intervention. If these new arrangements do not lead to significant improvements in complaints performance, we will take all necessary steps including legislation.
17. Achieving a genuine partnership with patients will not be easy. It will depend on changes in culture and behaviours on both sides but success will help to transform our health services. It is central to the quality agenda which is described in the next Chapter.

CHAPTER **FOUR**

QUALITY, NATIONAL STANDARDS AND INSPECTION

- 
- A new guarantee of service within national waiting time targets
 - New clinical targets and local targets for waiting times to drive service improvement
 - Patients and public involved in developing standards
 - NHS Quality Improvement Scotland inspecting performance against standards
 - Clear arrangements for intervention, with statutory powers to tackle service failure

1. The starting point for improving quality must be the experience of every patient who passes through the healthcare system. But more is required. Patients and the public expect the NHS to provide safe, high quality care and treatment – and they expect this to be available consistently across Scotland. Safety and clinical quality are fundamental aspects of the way clinicians plan and give care. Improvements in quality are constantly being made through improvements in technology, knowledge and experience and patient feedback is an essential part of the process. We will continue to support this work, ensuring that quality assurance systems are in place, and that frontline staff are helped to deliver high quality care. We will ensure rigorous and independent monitoring and inspection, with robust arrangements to investigate and tackle serious service failure.
2. We want the public to feel confident that health services are as safe and effective as possible, and to know where this assurance comes from and who gives it. That is why in January we set up a new body – NHS Quality Improvement Scotland – to focus on improving the quality of clinical care. This new organisation will link more closely the work programmes of all of the partners in this important field including the Scottish Inter-Collegiate Guidelines Network.¹⁵

¹⁵ <http://www.show.scot.nhs.uk/sign/about/introduction.html>

3. NHS Quality Improvement Scotland will provide clear, authoritative advice on effective clinical practice, set national standards and inspect and publish reports on performance. NHS Quality Improvement Scotland inspections will be entirely independent of government and of NHSScotland. It has the skills, access, resources and power necessary to identify areas of weakness and ensure that NHSScotland is improving quality where that is necessary. It also has a tough new remit to investigate serious service failures and make clear recommendations for remedial action. Ministers will request NHS Quality Improvement Scotland to investigate hospital or other services where they consider that is necessary. NHS Quality Improvement Scotland may also intervene itself, for example in response to public concern.
4. The Executive will intervene where necessary to correct significant service failures. If there are serious concerns about patient safety and service quality or persistent failure to deliver against national targets, including waiting times, then we will require NHS Boards to make immediate changes to remedy these, working with Boards to provide support, strengthen management and make other necessary changes. The Executive has arrangements for escalating intervention to address service failures within the NHS. We will review our

powers of intervention and bring forward legislation, if necessary, to ensure that we have in place effective mechanisms for the delivery of national standards and priorities.

5. Audit Scotland¹⁶ has an important role in relation to the efficiency and effectiveness of NHS organisations, independently of NHSScotland and government. Its financial audit of NHS organisations is complemented by its performance audits of aspects of the service provided by NHSScotland. Efficiency and effectiveness are vital to make sure that the extra resources flowing into the NHS achieve improved services for patients. There is a close working relationship between Audit Scotland and NHS Quality Improvement Scotland to achieve rigorous standards of inspection and monitoring. This will help to ensure patient confidence in the quality and safety of healthcare provision.
6. NHS Quality Improvement Scotland will also work alongside the Scottish Commission for the Regulation of Care¹⁷ which will modernise and standardise the regulation of care services. National Care Standards have been developed to provide a benchmark for this regulation.

¹⁶ <http://www.audit-scotland.gov.uk/>

¹⁷ <http://www.carecommission.com/>

7. Patients have a central role in every aspect of the work of NHS Quality Improvement Scotland including the development of standards and the monitoring and review of compliance. The NHS will have to persuade patients' representatives that their services are up to standard. In particular, we propose that the new Scottish Health Council – which will provide a new, far sharper focus for patient and public involvement in NHSScotland – will be an integral part of NHS Quality Improvement Scotland. This will ensure the patient's viewpoint is right at the heart of determining standards of healthcare and service, and of inspecting performance.
8. To support our overall approach to improving clinical quality we will continue to invest in research to underpin health improvement and better health services, within a new research strategy¹⁸ focused on the clinical priorities of cancer, cardiovascular disease, mental health and public health. Through this investment we will strengthen the evidence base for tackling Scotland's major health problems and health inequalities.

Clean Hospitals

9. The public expects Scottish hospitals to be clean and that patients will be protected from acquiring infections in hospital. We asked the Clinical Standards Board for Scotland – a predecessor body of NHS Quality in Scotland – to produce service standards for hospital cleaning and infection control. Hard-hitting reports have recently been published showing that although progress is being made, much more needs to be done in individual hospitals. NHS Quality Improvement Scotland and the Health Department will ensure that individual action plans are implemented and the necessary changes made.
10. To help achieve the standards the public expects, NHS Quality Improvement Scotland has set national standards on infection control and we are, for example, developing a new educational programme for 3500 infection control link nurses to help encourage the development of skills and expertise within the NHS. A task force headed by the Chief Medical Officer is implementing our Healthcare Associated Infection action plan, including the key conclusions from *The Watt Group Report*,¹⁹ but all hospital staff, including managers, clinicians, and domestic services and catering staff are responsible for ensuring standards are met.

¹⁸ <http://www.show.scot.nhs.uk/cso/>

¹⁹ <http://www.scotland.gov.uk/library5/health/twgr-00.asp>

Service Standards and Waiting Times

11. Patients expect to wait less as a result of the extra money going into the NHS. We agree. We will ensure that the Service makes a substantial and sustained improvement in waiting times for outpatient appointments and hospital treatment. For too long the service has suffered from bursts of clinical activity to respond to waiting time pressures, which have not resulted in sustained service improvements and have sometimes distorted clinical priorities. Patients need to be confident that their diagnosis and treatment is well-planned, reliable and available within reasonable timescales. Equally clinicians want to offer patients the fastest and most reliable service appropriate to their individual clinical need.
12. This requires actions at a number of levels and over different timescales – waiting times will not be solved overnight. We must take actions that tackle the roots of the problems as well as alleviate the symptoms.
13. To address the root causes of delays each NHS Board must take a ‘whole system’ approach to service redesign to reduce waiting times. This will ensure that patient expectations are taken fully into account and that the reasons for bottlenecks and duplication of activity are removed. In designing better healthcare, health professionals will be increasingly aligned to a particular service and less to a particular institution, as they harness the benefits from working more consciously as part of a clinical network, sharing expertise and good practice to reduce waiting for patients.
14. Reducing waiting times also requires much quicker access to clinical information, which can speed up decision-making. New arrangements such as the introduction of contact centres for each hospital, and the introduction of new hospital appointment systems, will make it easier for patients and healthcare professionals to book appointments for consultations.
15. There will be increased national support to the health service from the Health Department which will promote understanding of the issues that lead to delays in assessment and treatment, and support the spread of service improvement approaches. It will do this by:
 - sharing examples of good practice with hospitals and NHS Boards;
 - supporting staff in redesigning services to reduce delays and waiting times for treatment;
 - launching a new national programme of service improvement and redesign;
 - providing leadership from the National Waiting Times Unit for capacity planning;
 - expanding the waiting times database to ensure that patients and clinicians are given maximum flexibility in deciding how, where and when to access healthcare;

- ensuring that the Golden Jubilee National Hospital acts as a support to NHS Boards by contributing appropriately to reducing waiting for outpatient, in-patient and diagnostic services; and
 - booking spare capacity in the private sector to reduce the misery for those waiting longest. We will continue to do this where this will complement and not detract from NHS Boards' corporate responsibility to develop sustainable local solutions to long waits.
- second, setting condition-specific waiting targets which cover the most urgent clinical conditions will continue to be set by NHS Quality Improvement Scotland. These will build on the existing Coronary Heart Disease and Cancer targets; and
 - third, requiring each NHS Board to set challenging local targets for their inpatient, daycare, and outpatient services. They will demonstrate the progress which each Board is expected to make in reaching and then exceeding our National Guarantees.

16. Because of these actions, we will be able to make progress in relation to targets and guarantees and will hold Boards accountable for their performance by:

- first, setting National Guarantees. We will give patients a guarantee that our national targets will be met. These will be monitored to ensure that patients have prompt access to services. If a patient is not treated by their local NHS within the National Guarantee, we will give them the right to be treated elsewhere. This may be in the National Golden Jubilee Hospital, elsewhere in the NHS, in the private sector, or in exceptional circumstances elsewhere in Europe;

17. We will move faster to deliver improvements in outpatient waiting. The current target of 26 weeks maximum wait by 2006 will be brought forward by a year so that it is achieved in 2005. We will improve the management of outpatient waiting times by recording for the first time the number of referrals received for a service, and the waiting time for patients who have not been seen at a clinic. This will enable hospitals to plan services that have the capacity to provide outpatient appointments within agreed targets and within clinical priorities.

18. We are also determined to end delayed discharge. This 'bed blocking' happens where patients, mostly elderly, have to stay on in hospital simply because more appropriate care is not available in the community. We are investing an extra £30 million a year to enable Local Authority and NHS partnerships to tackle delayed discharges. Partnerships must deliver on their targets to receive additional resources. If they fail, support teams will help ensure patients receive the care they need.
19. NHS Boards and Local Authorities are keen to learn from each other's experiences of tackling delayed discharge. The Executive is supporting this through a Good Practice Resource and National Learning and Sharing Network which provides partners in health, social work and housing with information on what works and what does not.

Incentives for Good Performance

20. We have described how the Health Department and NHS Quality Improvement Scotland will intervene where performance becomes unsatisfactory, and how waiting times guarantees for patients will provide strong incentives for NHS Boards to deliver maximum waits for treatment. We will also provide incentives for good and improving performance. NHS staff are strongly motivated to provide clinically excellent services which respond to patients' needs. However, we need to focus the efforts of everyone in the NHS – Boards, clinical staff and managers – on achieving progress on key priorities which mean most to patients and the public. The Scottish Executive Health Department set 12 priorities for the NHS for 2003-04 – far fewer than before. The Service is focusing on these. But we need to bring other parts of the performance and incentive framework into line.

21. The Performance Assessment Framework (PAF) includes 60 quantitative measures of NHS performance and a further 30 qualitative measures to provide a set of published indicators on which the public can judge performance. The Framework provides valuable, high quality broad-based information which provides an important basis for the Executive's system of escalating intervention. This system builds on the annual Accountability Review meetings, which are crucial to improving NHS Boards' performance. We will also work with Boards to develop a new Performance Incentive Framework in 2003 that will help provide incentives for good or improving performance.

22. Against that background, we will:

- keep NHSScotland focused on no more than 12 priorities each year;
- publish a core set of key performance indicators relating to the NHS priorities and drawn from the PAF;
- develop a new Performance Incentive Framework;
- agree with NHS Board Chairs how senior managers' pay progression and bonuses can best be linked to performance on the NHS priorities as part of their annual appraisal in a way that is felt to be fair and reinforces motivation.

CHAPTER **FIVE**

PARTNERSHIP, INTEGRATION AND REDESIGN

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- Redesigned services, to meet national standards and deliver quicker treatment
 - Legislation to create new Community Health Partnerships matched better with Social Work services and with stronger roots in the community
 - New ways to involve health professionals in redesigning services
 - A challenge to NHS Boards to improve public involvement in service redesign
 - New Scottish Health Council to help the public engage with the Health Service
 - Additional funding for service innovation
 - Support from the Centre for Change and Innovation

1. As the NHS modernises services it must keep its eye sharply focused on the changing demand for health services. By 2021, the number of older people (over 75) will increase by around 27%, while the number of young people is expected to fall by around 20%. These changes are already happening, and the impact can be seen in the rise of emergency admission of older people. Within Scotland the pattern of falling population will be unevenly felt. The specific challenge that NHSScotland faces, particularly in primary care, to provide a range of health services for our remote, rural and island communities, will not be made any easier.
2. Just as the overall population ages, so the proportion of the population of working age will decline. The health and caring services will face particular pressures in trying to recruit the staff they need to look after increasing numbers of older people. These changes are also likely to affect the number of people acting as informal carers, and the pattern of care they provide.
3. But there is a more urgent challenge for the health service workforce. The New Deal contract for junior doctors and European employment regulations²⁰ will increasingly limit the hours worked by doctors in training and others. This will be of real benefit to staff and patients. However, it also has profound implications for the delivery of health services, especially in the hospital sector, where staff groups, including doctors in training, have contributed to out-of-hours cover.

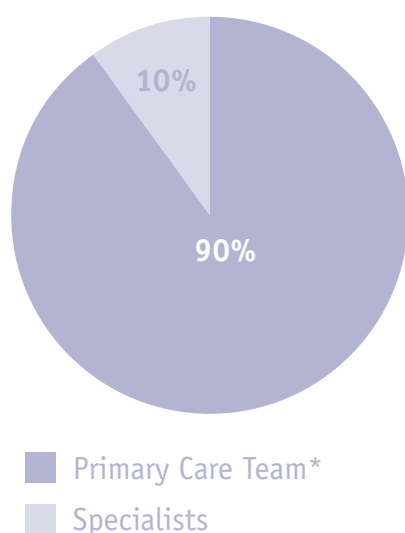
²⁰ <http://europa.eu.int/scadplus/leg/en/cha/c10405.htm>

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4. NHS organisations must be aligned with the nature and scale of change required. Healthcare improvement will best be delivered when the different parts of the health system work in partnership as teams of professionals and with patients. We believe that this approach is most likely to come up with integrated solutions in line with the wants and need of patients.
 5. We now require a major programme of service redesign across Scotland. This means looking at the pathway of care from a patient's point of view and making it smoother, more accessible, less complicated and less subject to delays. Sometimes it may involve changes in hospital arrangements. For example, over 300 one-stop clinics have been established to provide a number of tests and procedures at one rather than several hospital visits. At other times it will result in treatment being carried out in primary care rather than a hospital setting, or by a different member of the healthcare team than previously.
 6. A wider range of services will be provided in community settings. Diagnostic and outpatient services are already provided in local health centres so that people wait less for specialist opinions or decisions about their care or treatment. More clinics will be held for the management of chronic disease and direct access clinics will be developed for services such as physiotherapy. More specialist treatment will be available in community facilities, sometimes from a General Practitioner (GP) who has acquired specialist expertise and sometimes from a traditional specialist who is based to a greater extent in the community.
 7. Certain health services, however, which require a concentration of specialist skills, may have to be located in designated centres if they are to be sustainable over the long term. Such change will have to be managed with full public consultation, so that people understand the reasons for the change. This process is already under way, for example in acute maternity services.
 8. Within such facilities, patients will be confident that professional staff are working with well-defined protocols, consistent with national standards, and subject to independent inspection and performance review. Within such centres, staff will have the necessary range of supporting facilities.
 9. Changes in service delivery will require clinicians and managers to make best use of resources. The speed of change will depend on the level of new investment in hospitals and community health centres, in information systems and also on building the capacity and skills of the NHS workforce.
 10. Our focus is on developing services within local communities and strengthening partnerships with Local Authority services. We will achieve this through a massive programme of service redesign, sometimes working across NHS Board boundaries, through partnership working at all levels, and by empowering staff locally to make change happen.

HEALTH SERVICES IN THE COMMUNITY

11. For most people contact with the NHS begins and ends in primary care. The professionals who provide these services are in every community: GPs, nurses, health visitors, community pharmacists, optometrists, dentists, physiotherapists, occupational therapists, podiatrists and speech and language therapists and dieticians. They manage 90% of patient contacts with the health service, co-ordinating diagnosis, treatment and care and ensuring that more of these services are provided as close to home as possible. They also have an expanding role in improving health, by helping patients to take more responsibility for actively managing their own health.

Contact with NHS Care



*GPs, Nurses, Dentists, Health Visitors,
Pharmacists, Optometrists

Support for Primary Care

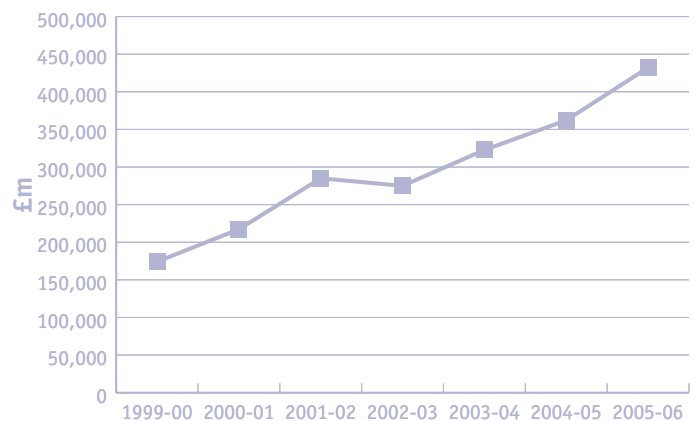
12. Radical service improvements can happen when people at the frontline are given the opportunity, skills and resources to do a better job. This requires:
- the right number and mix of staff with the right education, training and skills;
 - premises which are flexible enough to support a broad range of community services and a better environment for care teams;
 - clinical and care information systems which support the primary care team; and
 - quicker access to a wider range of services.
13. Patients and communities need to recognise that many NHS services will be provided locally by an increasingly wide range of skilled staff working together as a team. Such teams will be less confined to particular buildings and will work across communities and care settings so that patients can access services at a range of locations from a range of professional staff. This multi-disciplinary and multi-partner approach is particularly critical for the provision of local, integrated mental health services.

14. Professionals are continually extending the scope of their practice and also developing areas of special interest as they work together to deliver improvements to patient care. We will continue to invest in staff development and clinical leadership to encourage and support such improvements. For example:

- GPs with special expertise provide additional services in specific clinical areas;
- pharmacists and nurses have supplementary prescribing rights;
- Allied Health Professionals are working more in the community to support rehabilitation;
- hygienists, therapists and other members of the Dental team are making full use of their skills;
- optometrists in the community provide more extensive services for those with diabetes and cataracts; and
- community nurses can access Local Authority equipment.

15. All primary care premises need to be modern, accessible and welcoming to patients. £51 million has already been allocated to support over 100 community projects to improve premises and we will continue to use the Modernisation Programme to develop new premises. In many cases this will mean multi-agency community resource centres which provide easier public access to a wider range of integrated services. We will also promote the use of local pharmacies as walk-in centres where people can receive health advice and services.

SEHD Total Capital Budget Allocations



16. For example, the Dalmellington Area Centre is a 'one stop shop' that integrates community services and promotes better services and advice for the 11,000 population of Doon Valley, all provided from premises befitting the delivery of primary care services in the 21st century. It is an excellent example of good working practices between a NHS Board, Local Authority, and other partner organisations including Strathclyde Police and the Princess Royal Trust for Carers.

Access

17. We are investing in NHS 24 to provide 24-hour access to health advice and information about healthcare services by telephone from trained health professionals. This new service is already available to almost one-third of the population of Scotland and will be rolled out across Scotland by 2004. Its key objective is to get patients to the right point of care at the right time and to simplify contact with

the NHS. NHS 24 will offer an integrated out-of-hours service with GPs, which means that patients need only make one telephone call and NHS 24 will arrange for them to be seen by a GP if necessary.

18. Patients often complain about the time they have to wait to see a GP or other member of the primary care team. Our target is that by April 2004 no one will have to wait longer than 48 hours to access the appropriate member of the primary care team. We are providing support for this by establishing a Primary Care Collaborative which focuses on improving access. Primary care teams will come together to share experience about different ways of improving access, and to test out what works for them. This approach will also be appropriate for other areas such as diabetes and cancer services.

Developing Community Health Partnerships

19. The key building blocks for primary care services are the Local Health Care Co-operatives (LHCCs). LHCCs have made good progress in developing into responsive and inclusive organisations which are now the main focus for planning the development of community health services. But this is not the end of the road. We want to see a more consistent and strengthened role for LHCCs at the heart of a decentralised but integrated healthcare system. We therefore expect to see LHCCs evolve into Community Health Partnerships to reflect their new and enhanced role in service planning and delivery. In particular these Partnerships will:

- ensure patients, and a broad range of healthcare professionals, are fully involved;

- establish a substantive partnership with Local Authority services;
- have greater responsibility and influence in the deployment of resources by NHS Boards;
- play a central role in service redesign locally;
- act as a focus for integrating health services, both primary and specialist, at local level; and
- play a pivotal role in delivering health improvement for their local communities.

20. As a first step NHS Boards will review the organisation and operation of their existing LHCCs by early 2004 with these objectives in mind. This review should ensure that Community Health Partnerships maintain an effective dialogue with their local communities, which we envisage will be achieved through the development of a local Public Partnership Forum for each Community Health Partnership. If necessary, we will bring forward legislation to require NHS Boards to devolve appropriate resources and responsibility for decision-making to frontline staff and ensure that Community Health Partnerships provide an effective basis for the delivery of local healthcare services.

21. Boards will also work with Local Authority partners to produce plans aimed at ensuring more effective working with social care in appropriate locality arrangements within the same timescale.

22. Primary care is pivotal to the NHS. It is the right place to promote good health and to manage illness, particularly chronic diseases, such as diabetes, asthma and heart disease. Primary Care is particularly well placed to meet these challenges, as one of its strengths is the ability to provide a generic and holistic approach to care, which is so vital when a patient presents with more than one condition. When people need more specialist care, Managed Clinical Networks will support primary care practitioners to work with others to provide the best possible integrated care to their patients.

23. By working in partnership within the NHS and with other agencies, primary care is uniquely placed to influence and promote system-wide seamless care. It has enormous strengths on which to build in providing convenient, accessible and high-quality care to people in their own communities. If it can be done in primary care it should be done in primary care.



PARTNERSHIP WITH SOCIAL CARE

24. As more people receive their care in the community they will rely increasingly on joint responses from the NHS and local partners. The development of LHCCs and the Joint Future²¹ agenda have provided real opportunities to improve care in Scotland; and Community Planning provides a local focus for NHS Boards and Local Authorities to improve the health and wellbeing of communities. The commitment by the NHS and Local Authorities to joint working has never been greater and was endorsed by the Joint Summit of Ministers and leaders from NHSScotland and Local Authorities.

25. There is evidence that significant progress in developing more person-centred and integrated care in the community has been made, and the Community Care and Health Act 2002²² takes joint working to new levels by enabling local partners to delegate functions and to pool budgets. In those areas where the greatest advances have been made, there are clear benefits – particularly in services provided to older people:

- faster and better assessment of their needs (down from several weeks to a few days);
- better access to more integrated services (through professionals accessing each others' services);

- more comprehensive care packages (though information sharing across boundaries and a single shared assessment); and
- better and more detailed information about services (through new developments such as information on equipment on the Web).

26. NHS Boards and Local Authorities will be required to make significant further progress, including the extension of joint resourcing and joint management from older people's services to the rest of community care from April 2004.

27. We are strongly committed to learning what works from Joint Future as we take forward our work on developing better integrated services for children through implementation of the Action Plan 'For Scotland's Children'. The National Child Health Support Group will support the NHS in joining up with partners in Local Authorities and the voluntary sector to promote a combined and integrated Child Health Service which is responsive and evidence-based.

²¹ <http://www.scotland.gov.uk/health/jointfutureunit/>

²² <http://www.scotland.gov.uk/health/cc&hact/Default.asp>

28. NHS Boards should work with Local Authorities to review jointly how service planning and delivery can be better designed to meet community needs including:

- maximising co-terminosity of service provision and organisational boundaries;
- targeting funding at integrated services – a major focus for new capital development should be on community infrastructure, including modernised integrated community resource centres and joint information systems; and
- empowering those who provide care – NHS Boards and Local Authorities should jointly develop clear schemes and processes for the delegation of responsibility, accountability and resources.

29. Joint working is particularly important in improving mental health services. Within this broad framework, networks of mental health service professionals can address the problems of patients or service users as they move from one service provider, or partner organisation to the next. Such care networks can improve the patient's pathway of care and promote the better use of the shared resources. To drive this network approach, we invite NHS Boards, Local Authorities and other partner organisations to work together to redesign the way mental healthcare is delivered. To complement the care network approach we will work with local Joint Future partners to extend joint management and joint resourcing to mental health services from April 2004.

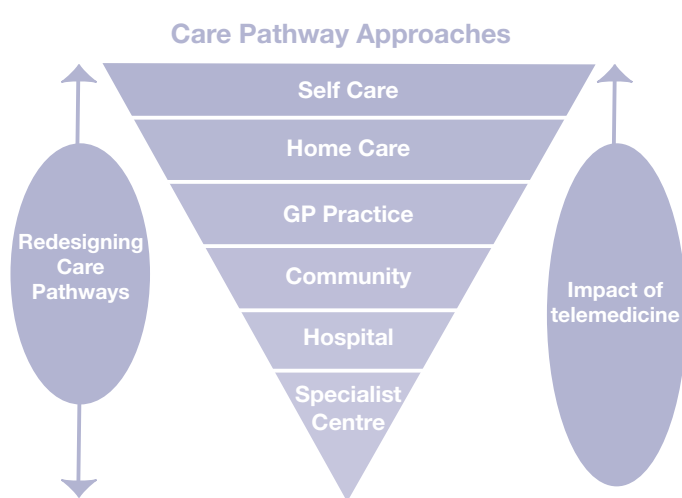
30. NHS Boards should work with Local Authorities to develop their Local Partnership Agreements to include targeted plans by early 2004 to:

- reduce bureaucracy and duplication;
- develop a network of modern, sustainable and integrated community services focused on natural localities;
- integrate community-based services and specialist healthcare services through clinical and care networks; and
- develop organisations to support the necessary changes in service delivery.

INTEGRATED HEALTHCARE

31. Patients expect to move from one part of the health service to another quickly and easily. They expect each part of the service to work with a shared understanding of their needs, and with common, high standards of service. Integration involves a greater emphasis on systems of care rather than separate institutions, with management arrangements and budgets increasingly focused on them.

32. To achieve this the NHS needs to bridge the divide between services delivered in primary care and those delivered by specialist services, usually in hospitals. If patients are to receive integrated healthcare, then multi-professional teams need to work together to redesign the patient's pathway of care.



Managed Clinical Networks

33. One important way of developing integrated services is through Managed Clinical Networks (MCNs). They are linked groups of health professionals and organisations from primary, secondary and tertiary care, working together in a co-ordinated manner, unconstrained by professional and NHS Board boundaries, to ensure equitable provision of high quality, clinically effective services throughout Scotland.

34. Key objectives of MCNs are to:

- involve patients and their carers;
- set and demonstrate evidence-based standards of service;
- ensure that patients are managed in the right setting at the right time;
- ensure that appropriate management is available to sort out difficulties arising in the care of individuals and the network as a whole;
- underpin the network with an information infrastructure that informs service planning and redesign; and
- regularly report on the network performance to the public.

35. Networks already exist: cardiac services in Dumfries and Galloway; diabetes in Tayside; regional cancer services; and the national MCN for cleft lip and palate (Cleftsis). National Demonstration Networks in Lanarkshire for vascular services and neurology with particular reference to stroke are being evaluated. MCNs are also being developed for multiple sclerosis, epilepsy, asthma, and a wide range of other conditions.

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36. MCNs have already proved that they can produce benefits for patients. The cancer MCNs have shown that patients welcome the development of clearly defined pathways of care, which reduce delays and duplications and tackle bottlenecks. They also lead to clearer information for patients and carers.
37. MCNs also offer benefits to health professionals by giving them:
- a leading role in the shaping of services;
 - a wider range of professional contacts;
 - a greater understanding of the role their colleagues play in the patient's journey;
 - a chance to extend their professional roles within a supported context so that patient safety is not compromised; and
 - new tools, such as data collection and quality assurance system, which help to achieve continuous quality improvement.
38. We wish to see MCNs developed more widely but this will only happen where they can deliver clear benefits for patients. NHS Boards will be required to support this development by:
- undertaking a systematic assessment of the MCN developments in their area; and
 - working through the new regional planning machinery to agree the most appropriate geographical coverage of future networks.
39. We will consult NHS Boards, the Royal Colleges, NHS Education for Scotland, and other professional organisations on how to best promote the clinical leadership required by MCNs, considering what incentives might be made available to Lead Clinicians of MCNs. NHS Boards will be expected to identify resources for clinical sessions devoted to Network development, to complement Departmental funding already available for Network Managers.

Regional Planning

40. No single NHS Board can provide the full range of modern health services. We need to strike the right balance between the provision of highly specialised treatment centres and the need to provide services closer to people's homes where it is possible and safe. We also have to address the issues facing remote, rural and island communities and the challenges of providing services in areas of urban deprivation. This requires better planning and co-operation at regional and national level.
41. For example the three Regional Cancer Advisory Groups are based on partnership working and collaboration and have established links with regional planning groups. Their aim is to secure better access to services, quicker diagnosis and reduced waiting times for treatment – and continuous quality improvements in services in line with NHS Quality Improvement Scotland clinical standards.
42. Each NHS Board will have a formal duty to participate in regional planning groups and cross-Board Managed Clinical Networks. The existing three regional planning groups will be supported by a full-time co-ordinator, working closely with the new regional workforce co-ordinators, with NHS Board planning staff, MCNs, and with others planning regional services, such as the Scottish Cardiac Intervention Network. We will also expect regional planning groups to put in place open, structured and transparent public involvement strategies.

43. A key task for regional planning groups will be to consider the sustainability of services. Where specialist services cannot be delivered by individual NHS Boards they will plan for the continuing availability of clinical expertise at a regional level, taking account of clinical standards and the availability of experienced staff. Their plans will identify the best way to configure acute hospital and other services at a regional level in order to provide the best service possible to the people of the area.

Acute Services

44. Over time, service redesign will have a major impact on the configuration of services. For example, more acute services will be delivered in hospitals on a day-case basis, in ambulatory care and diagnostic centres. New intermediate care and rehabilitation services will be required particularly for older people and we will need to sustain and develop our Community Hospitals.
45. For example, as birth rates fall, changes will take place in paediatric and maternity services. More care will be provided in the community. However, to get the best and safest clinical services, some inpatient and other specialist clinical care will be concentrated in fewer centres. Implementing such change will require continued investment in the infrastructure of NHSScotland and also in the training and professional development of the health service workforce.

46. In Lothian, Glasgow and Tayside we have taken the first steps for new diagnostic and treatment centres at a local level. These will speed up the patient's journey, bring down waiting times and deliver better healthcare. We are determined to see these facilities develop right across Scotland and NHS Boards will make their development a priority.

47. The emphasis will continue to be on reducing the need for people to stay in hospital. Reducing pressure on hospital beds will help with the increasing number of people with chronic illnesses, including the elderly and frail, who require hospital care urgently, especially in winter. Service redesign is essential to ensure that we can provide that emergency care, without disruption for people who are waiting for operations and other treatment. Working with Local Authorities to reduce delays in discharge, and working with primary care staff to provide better alternatives to hospital admission will be crucial.

48. Any change that takes place must take into account patient safety, the best clinical standards and the availability of the right clinical staff. It is not possible to provide emergency and elective care for every condition in every hospital or NHS Board area. Trying to do too much in too many places creates staffing difficulties, and complaints about standards of care. Some acute services can best be delivered locally, some on a regional level and some at a national level. It may be feasible to provide some services locally during core daytime hours, and on a regional level at other times. If patients need specialist clinicians and other services overnight, this may not be possible on every hospital site. NHS Boards, regional planners and the Scottish Executive will review what kind of service is appropriate at each level. This will result in a reduction in waiting and cancelled elective procedures, and more effective supply of specialist staff for NHSScotland as a whole.

49. NHSScotland must work with the public, staff and patients to demonstrate that the changes in hospital provision are in order to improve care for patients. The changes are to make sure that the highest clinical standards are achieved and that staff are available in the right place, at the right time, with the right skills to provide the care that is needed. Making this happen is a great challenge for leaders in acute services and in NHS Boards.

PUBLIC INVOLVEMENT

50. The public should be involved at an early stage in discussions about the changing pattern of healthcare services. The Service has not always handled such consultations with local communities well, and it must learn to engage the public far more effectively in future.
51. Traditional forms of consultation on options for change or service development are no longer enough. If the public feel that health providers are consulting them only after they have developed a preferred option, then involvement is too late. People must be involved earlier so that their views are available at the formative stage of any new proposals.
52. We need to develop genuine public involvement in the NHS if we are to have a service in which patients are confident that their needs are being met. Of course this will sometimes mean difficult decisions.
53. What is important is that all decisions are taken in an open, honest and informed way, and that the public are involved in the choices and decisions which need to be made. This means seeking public views from the earliest stages, defining issues clearly, exploring possible options, and examining these in an open way with good evidence. It means using modern methods of communication and involvement to ensure that the widest range of individuals and communities affected by changes are reached. It also means feedback to those consulted.
54. The Scottish Consumer Council has helped us consult widely inside and outside the NHS on the best ways to involve local communities and the public. We will issue final guidance reflecting that consultation and publish proposals to strengthen public involvement structures and establish a Scottish Health Council in the NHS.
55. The Scottish Health Council will be set up as part of NHS Quality Improvement Scotland reflecting the close link that needs to exist between quality and involvement. Its role will be to provide leadership in securing greater public involvement in NHSScotland; to support the development of good practice in public involvement; and to ensure that quality improvement is driven by the needs of patients and service users.
56. We have asked NHS Boards to develop sustainable frameworks for public involvement which take account of the local Public Partnership Forums which we envisage for each Community Health Partnership and of the need to involve patients in the work of Managed Clinical Networks. The new Scottish Health Council will in future monitor the performance and effectiveness of Boards in relation to public involvement, and will report regularly on the results. This will ensure that there is external scrutiny and quality assurance of what Boards are doing to involve the public.

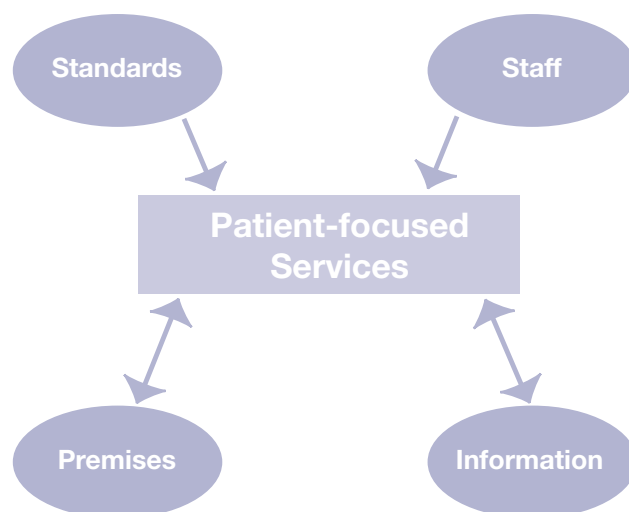
SUPPORT FOR SERVICE REDESIGN

57. Strengthening the delivery of community health services and ensuring they are fully integrated with more specialised care will require a significant commitment to redesign. We believe that this will be driven by an increased focus on the needs of patients and the framework of national standards for healthcare, but also by empowering staff to initiate change locally in response to these demands.
58. We expect NHS Boards to co-ordinate redesign activity by putting in place service redesign programmes. These programmes should ensure that sufficient staff time is freed up to concentrate on redesign and be supported by development programmes for staff to enhance their knowledge, skills and ability to lead service change. This includes ensuring that staff have access to examples of best practice both locally and nationally.

Change and Innovation

59. We will require NHS Boards to develop Change and Innovation Plans that are specific, prioritised and resourced to support local redesign activity. Plans must:
- demonstrate active participation by patients and leadership by clinicians;
 - challenge traditional boundaries of service delivery;
 - develop sustainable services; and
 - ensure information systems support changing patterns of care.

Taking the Patient's Point of View



60. We expect local plans to address service improvements in key priority areas by:
- developing community health services through Community Health Partnerships; and
 - increasing integration of primary care and specialist care, and in particular strengthening MCNs.

61. We will distribute a Change and Innovation Fund to NHS Boards where we are satisfied that local Change and Innovation Plans will deliver these objectives. Progress in implementing these Plans will be reviewed as part of the annual Accountability Review process.

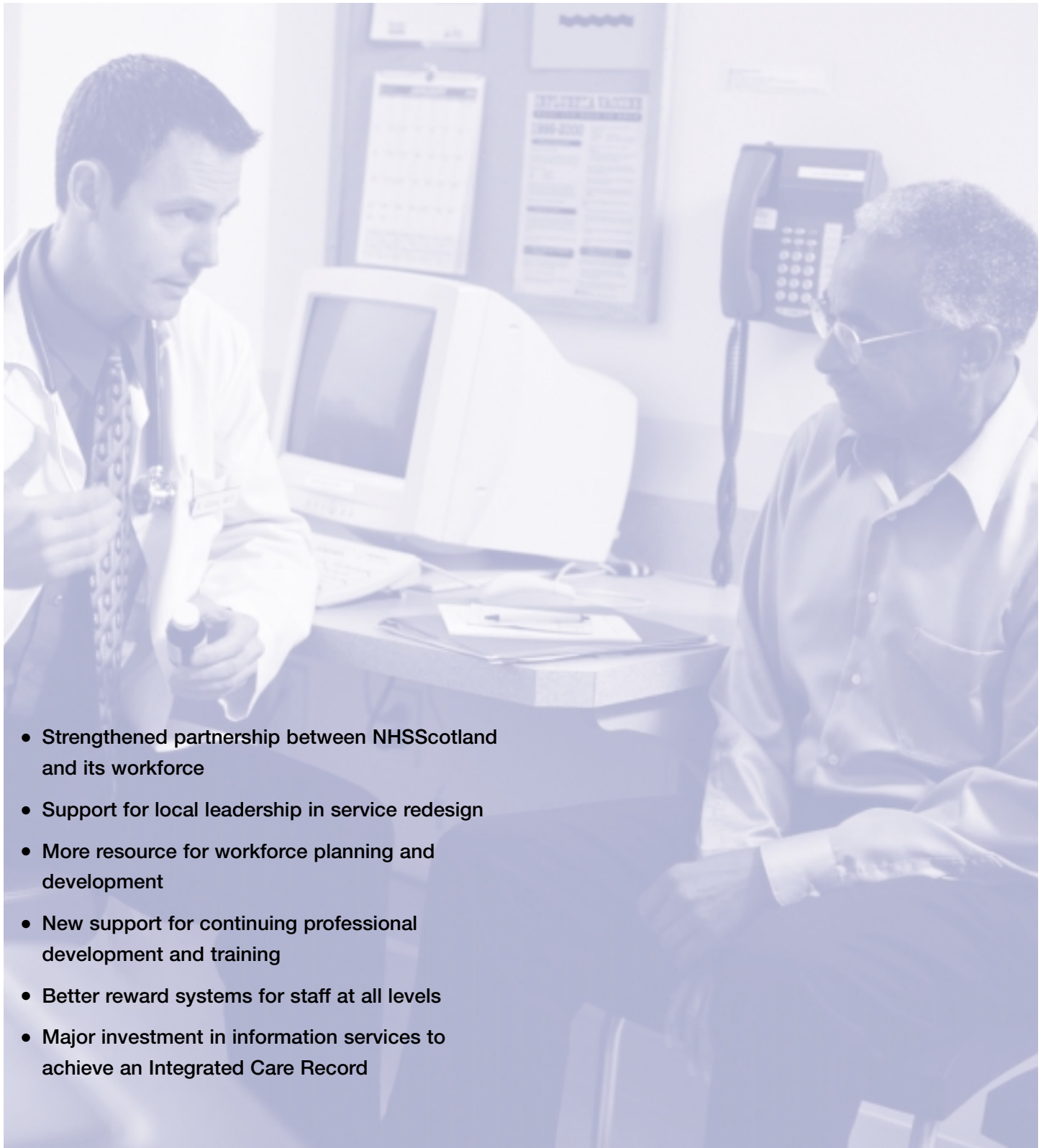
62. We will also strengthen clinical involvement in service redesign by requiring all NHS Boards to establish a Service Redesign Committee. These Committees will link to the Area Clinical Forum, where the leadership of health professionals come together within each NHS Board area, and include members drawn from each Community Health Partnership, in order to ensure strong clinical input to the development and delivery of Change and Innovation Plans.

Support for Change and Innovation

63. We will also provide national support for service redesign through the work of the newly created Centre for Change and Innovation (CCI). The CCI will provide practical support and expertise to help NHSScotland improve the way in which care is provided for patients. It will do this by:
- supporting service improvement in national priority areas such as mental health, cancer, coronary heart disease and stroke and chronic diseases such as diabetes;
 - using well tried techniques such as ‘collaboratives’ to help staff develop solutions to their own problems;
 - developing a database of national and international good practice in clinical and service design;
 - providing expert support for NHSScotland to help address local service problems;
 - tackling national initiatives such as outpatient appointments, access to primary care and mental health services;
 - creating networks to develop improvements in clinical practice; and
 - encouraging flexible and innovative ways of working and supporting the professions and other people in the development of different roles.

CHAPTER **SIX**

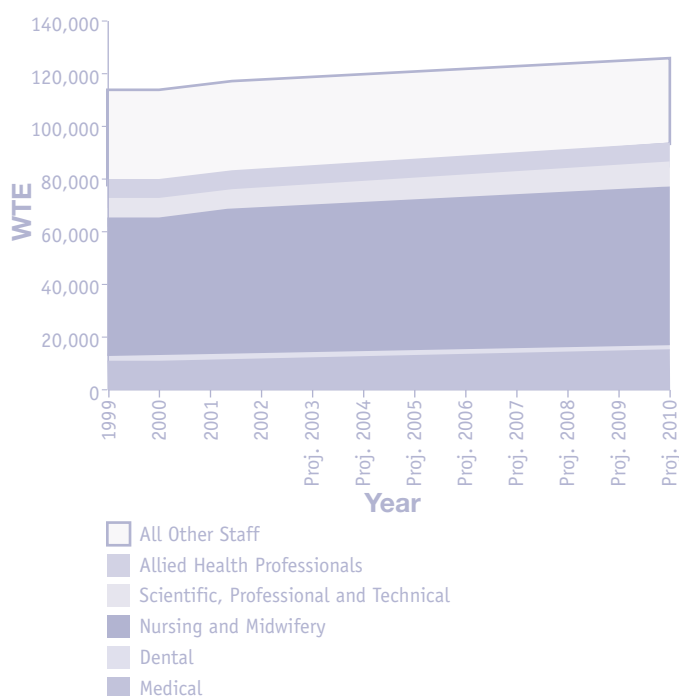
EMPOWERING AND EQUIPPING STAFF



- Strengthened partnership between NHSScotland and its workforce
- Support for local leadership in service redesign
- More resource for workforce planning and development
- New support for continuing professional development and training
- Better reward systems for staff at all levels
- Major investment in information services to achieve an Integrated Care Record

1. If we are serious about improving health and healthcare, then we have to be serious about supporting, valuing and empowering the staff who deliver care. The key to change is giving healthcare teams support to solve old problems in new ways. This means giving staff the opportunity and incentive to design and deliver integrated services around the needs of their patients. It also means investing in staff, freeing them to do things better and equipping them with the tools they need to do the job.
2. Evidence suggests that staff initiate and lead service improvement if they are fully involved and understand the context for change. Where staff have to work differently they will be directly involved in driving the change process. We must get the size and shape of the workforce right, promote flexibility and team working and encourage new ways of working, with appropriate training and development support.

NHSScotland Staff



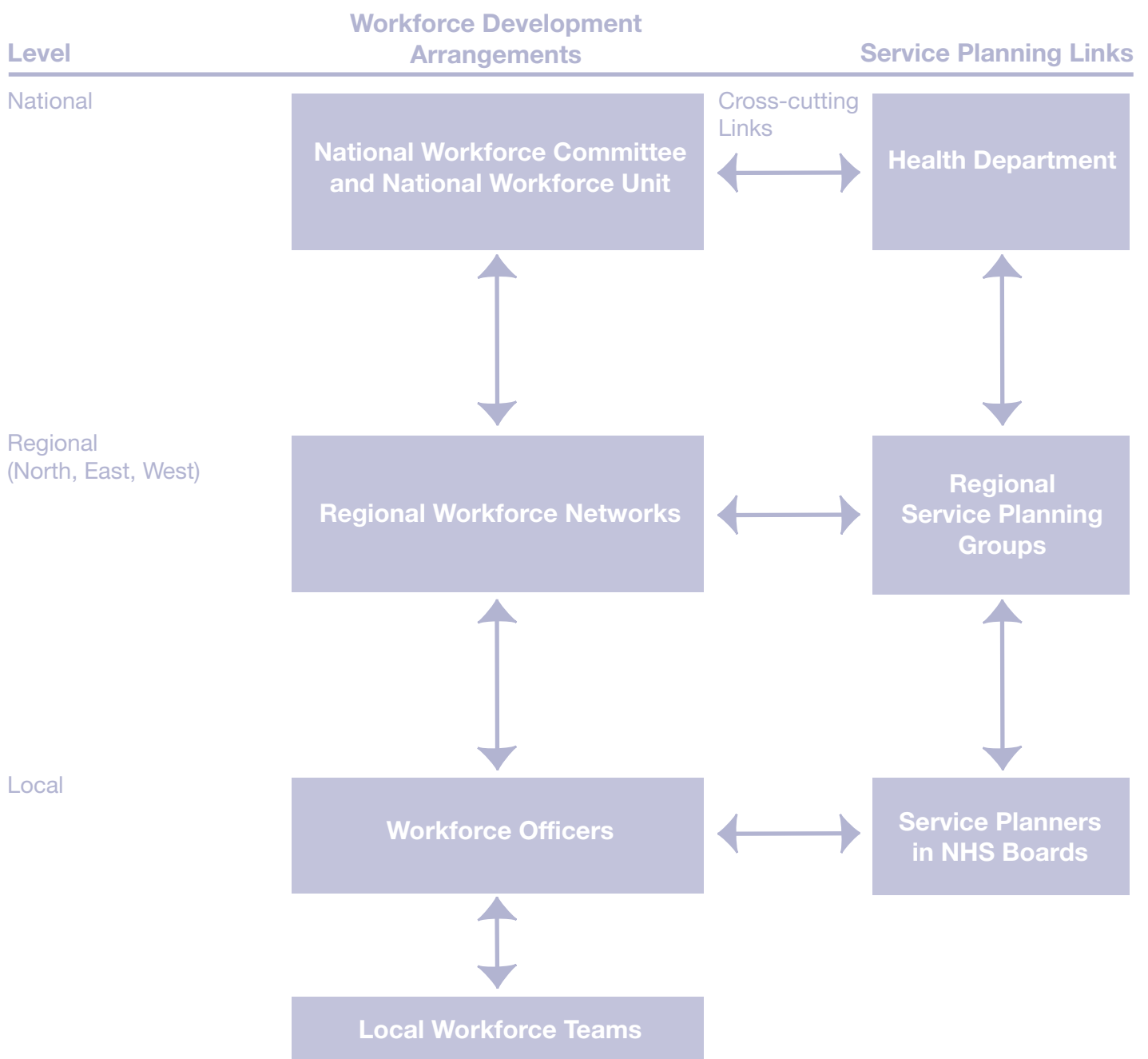
Workforce Planning and Development

- Failure to get the shape of the workforce right in the past has resulted in shortages in certain specialities today. We are already developing a more strategic and coherent approach to workforce planning for NHSScotland, making sure we have the right people with the right skills in the right place at the right time. This means taking a holistic approach which integrates workforce planning, service planning, redesign, education and training, recruitment and retention, role development, modernised pay systems and the impact of applying safe limits to working hours.

- Our approach to workforce planning and development, outlined in *Working for Health: The Workforce Development Action Plan for NHSScotland*²³ will enable us to plan how many doctors, nurses, pharmacists, Allied Health Professionals and ancillary staff are required to deliver responsive and sustainable services 3, 5 and 10 years into the future.
- Young people with mental health problems will be the first to benefit from our new national approach to integrated workforce development. Our first priority will be mental health workers for child and adolescent services. This initiative will identify core competencies for staff, provide new opportunities for joint training and enable staff in partner organisations to combine more effectively in multi-disciplinary teams to provide improved, sustainable services.
- To build capacity to develop the workforce at **local, regional and national** level we will:
 - support the development of expertise in workforce planning and development in each **NHS Board area**, making it a central strand of redesign;
 - appoint **Regional Workforce Co-ordinators** for the North, East and West of Scotland to work closely with those responsible for regional service planning; and
 - provide overall direction and leadership for workforce development through a **National Workforce Committee**.

²³ <http://www.scotland.gov.uk/library5/health/wfh-00.asp>

Workforce Development – Key Accountabilities/Relationships



7. These initiatives build on the measures we are already taking to improve recruitment and retention for nurses and midwives, through the Facing the Future initiative, and for Allied Health Professionals and the medical workforce. We are:
- providing extra investment to provide new posts;
 - funding schemes that encourage skilled professionals to return to NHSScotland;
 - making careers more attractive and engaging with staff to develop initiatives which will motivate and reward them and encourage them to stay;
 - supporting local recruitment with regional and national campaigns; and
 - promoting diversity in employment.
8. It is critical that we get the shape of the medical workforce right in the future. We are committed to developing a new structure for postgraduate medical training, geared to meet current pressures and changing demands.

Learning, Development and Careers

9. We are committed to creating a culture of lifelong learning within the NHS and to the promotion of learning organisations across the NHS. NHS Education for Scotland will work in partnership with NHS Boards and staff organisations to bring together strategies for learning and development for all staff groups, delivering multi-disciplinary and team-based development programmes.

10. We will build on the success of our *Learning Together*²⁴ strategy by:
- establishing NHSScotland as an exemplary employer for workplace learning;
 - confirming the role of appraisal and personal development plans in supporting quality improvement and change;
 - developing an entitlement for all staff to continuous professional development; and
 - reviewing arrangements for health-related educational and development funding.
11. We are taking a co-ordinated look at skills, careers and recruitment through a multi-agency group, looking at:
- new methods of providing career support for the personal and professional development of staff;
 - setting up a register of skills for staff which will provide them with greater access to learning and development and an electronic means of recording their development; and
 - increasing access to learning activities through the development of a co-ordinated database.
12. We will co-ordinate the activities of responsible agencies including NHS Education for Scotland, NHS Quality Improvement Scotland and regulatory and professional bodies to ensure that the people

²⁴ <http://www.scotland.gov.uk/learningtogether/leto-00.htm>

who provide services are appropriately trained and skilled. NHS Quality Improvement Scotland and NHS Education for Scotland will also ensure that new ways of working and emerging new roles will promote the highest standards of care.

Flexibility

13. Care in the 21st century will depend on flexible teams providing services that patients need, irrespective of organisational boundaries. Staff are the best people to develop these new roles and there is already much good practice to build on. Diagnostic testing and extended prescribing roles for pharmacists and nurses, technician-led pre-admission clinics, clinical decision-making by paramedics and other clinical staff are just the beginning.
14. For example, radiography teams are using their expertise more effectively and flexibly to ensure patients receive care as quickly as possible with more job satisfaction for practitioners. Radiographers undertake ultrasound and barium investigations in many areas and therapy radiographers in some cancer centres provide and monitor treatment for patients receiving palliative radiotherapy.
15. Flexibility is about the NHS providing the care that patients need, at the time and in the place that they need it. It is also about staff finding work they want to do while maintaining a fair work life balance. The Centre for Change and Innovation is already leading new work on providing flexible working conditions

for nurses. The principles underpinning this work will provide a platform for initiatives for all staff groups. Every NHS Board will, as part of their programme of change and innovation, set out their plans for staff flexibility and the development of new roles.

Partnership and Employment Practice

16. High quality services and good employment practice go hand in hand. So partnership between staff and employers, involving Trade Unions and professional organisations, is essential to the continual improvement of public service. This partnership commitment will be driven forward at national level through the Scottish Partnership Forum and Human Resources Forum, launched earlier this year to make sure staff have a voice at the highest level.
17. We will also strengthen partnership working by investing further in a national Partnership Support Unit. This brings together expertise from the unions and professional organisations, NHSScotland and other partners. It will help local health systems work more effectively and support staff governance in practice.
18. We will build on the Partnership Information Network Guidelines, which are a good example of staff partnership at work, producing guidance on good practice in the workplace, from family-friendly policies to safety at work.

19. We will also actively support collaboration between NHS employers, trade unions and professional organisations to forge a consistent set of national employment, learning and careers standards for everyone in NHSScotland.

Staff Health

20. Staff need to feel that their own health at work is protected. Under the leadership of the Human Resources Forum we will invest in a network of one-stop centres at NHS workplaces, develop a fast-track rehabilitation service for health workers and encourage a campaign to reduce work-related ill-health. The existing *Staff Governance Standard*²⁵ will be extended to include a commitment to improving the wellbeing of all staff providing NHS health services whether permanent, temporary, agency or from the private sector.

Leadership and Management

21. Leadership is not the preserve of a small group of people in senior positions but needs to be nurtured at all levels of the service. Delivery of improved services depends on effective leadership at all levels of the NHS. In particular, clinicians, working as part of multi-professional teams, are at the heart of service development. We recognise that clinical leaders require the support and time to be fully involved in service redesign and we are committed to finding better ways of recognising the key leadership role of clinicians from all professional

backgrounds. This includes investment in development programmes that cross clinical boundaries and consideration of supplementary financial rewards for clinicians who play a lead role in service redesign. In particular we will give priority to the support needs of clinicians leading the development of Community Health Partnerships, Managed Clinical Networks and Care Networks.

22. Leadership more generally will be strengthened by the creation of a National Framework for Leadership Standards to support staff and a supporting Code of Practice, which will clearly set out the leadership standards and behaviours.

Pay, Reward and Motivation

23. We are working to introduce major new systems of remuneration covering most of the 136,000 health workforce. If agreed by staff, these will amount to the most comprehensive change ever in NHS pay.
24. We are in discussion with the profession on the terms and conditions of a new **contract for consultants** which, if agreed, will build better relationships between managers and clinicians and allow consultants to plan their work in a way which recognises their own needs and makes best use of their contribution to clinical care.

²⁵ <http://www.show.scot.nhs.uk/sehd/publications/dc20020208sgss.pdf>

25. We have played a full part in negotiations on a UK-wide contract for the delivery of **general medical services** by GP practices. If agreed by the profession, this will transform the way in which services are delivered in the community by focusing on the practice team rather than the individual GP, and supporting more effective care pathways between primary and secondary care. It will also deliver more effective management of GP workloads and provide a clearer focus on the achievement of outcomes through the provision of quality care to patients.
 26. There are also plans to introduce a new pay system, **Agenda for Change**, for the majority of NHS staff including nurses, Allied Health Professionals, healthcare scientists, ancillary, clerical, administrative and managerial staff. If agreed, for the first time life-long learning will be embedded in pay arrangements for these staff, rewarding them for the development of knowledge and skills, allowing them the flexibility and freedom to design jobs that are more rewarding, and providing them with the opportunity to develop new roles that can respond more effectively to patients' needs.
 27. We are in the initial stages of negotiating a new contract for **community pharmacists**. The focus will be on the contribution pharmacists make to health improvement, chronic disease management and community pharmacy-led treatment of minor illness. This will be underpinned by a quality framework and will ensure community pharmacy is recognised as an integral part of the wider primary care team.
 28. We will also take forward, in discussion with the **dentistry profession**, proposals for changes to the system for rewarding primary care dentistry in order to promote prevention, improve access to services and improve recruitment and retention.
 29. These new pay systems will of course only be implemented with the agreement of staff.
- ### Equipping Staff
30. Staff need to have the tools to do their job. So we are investing heavily, not only in NHS staff themselves, but also in modernising the infrastructure of NHSScotland and above all in the information systems and communications technology necessary to deliver redesigned healthcare.
 31. NHS staff need access to the right information at the right time, if they are to meet patients' needs. We urgently require an e-Health culture to be established, driven by clinical leaders.

32. This means both getting the foundations in place, and systematically building sophisticated information and communication systems. By the foundations, we mean personal computers, network connections and training for staff to use these tools as part of their job. Steadily increasing investment in these basics has been made over the past three years and this will continue.

33. Our goal is to deliver an Integrated Care Record jointly managed by patients and professional NHS staff with in-built security of access governed by patient consent. Integrated Care Records will take time to reach, but each step in their development will bring immediate benefits to patients, carers and healthcare professionals by enabling:

- greater patient involvement in their own care;
- service redesign and the shift in the balance of care provided in different settings;
- quicker exchange of information between professionals;
- quicker access to patient records (with built-in patient confidentiality); and
- continuous improvement by providing routine monitoring of quality standards.

Clinical Information Systems

34. When people move within or between care settings, we must ensure that the right information such as clinical letters and laboratory test results are transferred quickly and securely. Our priority is to speed up this process by establishing agreed data sets and codes to be used in all exchanges so that information is correctly interpreted by everyone who shares it. Standardisation of definitions and integration between data sets will be clinically-driven in future to ensure that NHSScotland's information systems support national clinical priorities. Scotland's diabetes specialists are already working closely on the Scottish Clinical Information Diabetes Collaboration, an initiative which has already defined shared information for diabetes care and is now starting to roll out electronic patient record systems across NHSScotland GP and hospital diabetes services.

35. We will improve the co-ordination of children's care services, through an electronic Integrated Children's Services Record, developed in partnership with Local Authority and other relevant agencies. The benefit for children will come from better communication between professionals involved in their care. This key project will be Scottish Executive-wide. In due course, it should be possible to issue a 'smartcard' containing key health information in easily accessible electronic form which patients could use to unlock their information rapidly and securely when required. We plan to explore the possible use of such 'care cards' in

consultation with patient groups and professionals, and we will explore the use of the Citizen's Smartcard under development through Scottish Executive 21st Century Government as the secure key to enable safe access to this record.

36. Information and communication systems must also be used to reduce pressures on staff who waste time looking for information. NHSScotland information systems must offer support for:

- Accident & Emergency departments;
- online access to laboratory tests;
- electronic prescribing systems integrated with other clinical information systems;
- on-line instant retrieval and transmission of clinical images such as X-rays and ultrasound across Scotland;
- primary care and shared communication with other parts of the NHS; and
- community pharmacy systems linked to other NHS practitioners (e-Pharmacy).

37. National procurement is already under way to establish electronic patient record systems for Accident & Emergency departments which will be linked to existing hospital systems and to partner services such as GP Out of Hours, NHS 24 and Scottish Ambulance Services. We have also established a secure way of linking NHS and Local Authority telecommunications networks and three local NHS and Social Work partnerships use this, with patient consent, to share the patient/client record with practitioners in each agency.

38. To achieve this, clinicians will take a lead role in the selection and use of systems. NHS Boards will be required to appoint a clinician as Director of Clinical Information to drive forward this e-Health culture.

39. A Ministerially chaired e-Health Programme Board will draw together clinicians and other stakeholders to co-ordinate this work. A Clinical Information Steering Group, led by the Chief Medical Officer, will be responsible for agreeing common definitions and standards across NHSScotland in partnership with NHS Quality Improvement Scotland and other relevant organisations. Consideration will be given at every stage to clinical coding and UK data sharing requirements.

40. These actions will support the redesign of health services:

- patients, carers and staff will find consistent information systems across NHSScotland;
- patients will benefit from consistent interpretation of shared information as a result of agreed data sets and coding systems;
- patients will be involved in decisions about the use of their personal health information;
- clinical communications will use a single broadband telecommunications network, with a common e-mail directory and access to the Internet wherever it is needed; and
- e-Health funds and information support staff will be organised in a way that supports operational systems critical to the care process.

CHAPTER **SEVEN**

ORGANISING FOR REFORM

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- **Abolition of NHS Trusts**
 - **A requirement on NHS Boards to devolve authority and involve clinicians in service redesign**
 - **Cost-effective support services**

1. To support the development of integrated, decentralised healthcare services that meet the needs of individual patients and local communities, we need to remove unnecessary organisational and legal barriers. By devolving management authority to the front line, we will strengthen delivery by empowering NHS staff to plan and deliver improved healthcare services within a framework of clear strategic direction and rigorous performance management.
2. There are too many separate statutory NHSScotland organisations planning and providing health services. Often they work well together but sometimes they do not. This situation is confusing both for patients and staff and for the wider community. It reinforces institutional, professional and service delivery barriers and inhibits co-operation.
3. This needs to change. The public, patients and staff expect the NHS at local level to be a single organisation with a common set of aims and values and clear lines of accountability. We will therefore continue dissolving Trusts, as is already happening in Borders and Dumfries & Galloway, and we will legislate to remove the powers relating to NHS Trusts. We will require NHS Boards to bring forward proposals, by April 2004 at the latest, to dissolve the remaining Trusts. We will also place a duty on NHS Boards to implement decentralised approaches that devolve responsibility to frontline staff.

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4. Proposals should minimise disruption for patients and staff. They should also support improved local service delivery and better performance by:
 - ensuring that patients' everyday experience of care drives the design and development of services;
 - supporting the development of Community Health Partnerships and building on the achievements of the Joint Future agenda in a way which engages with Community Planning partners;
 - devolving duties, responsibilities and decision-making powers to staff who are directly involved in delivering healthcare; and
 - supporting local leadership by delegating financial and management authority and encouraging locally responsive approaches to service provision.
 5. NHS Boards must concentrate on strategic leadership and performance management across the entire local NHS system. This will require well-defined operating divisions, with specific delegated authority to act without constant reference to the Board, backed up by clear, formal schemes of accountability. The introduction of single NHS organisations in each area will strengthen corporate working and provide clear strategic direction but must not result in greater central control over operational matters.
 6. We need to recognise the important role of managers in working with clinicians to enable service change and clinical reform. Managers will have a critical role to play: they need the freedom to deliver. With the disappearance of Trusts, leaders of operating divisions will develop cross-system leadership roles to integrate, redesign and improve patient-centred services. There must be devolution of real management authority to local level and, crucially, to clinical staff: decentralisation of decision-making must not stop at operating division level.
 7. We will extend NHS Board membership to strengthen clinical expertise and ensure that service delivery in local communities has a strong voice at Board level. We will therefore take immediate steps to secure the appointment of a Medical Director and the Chair of the LHCC Professional Committee to each NHS Board: these new appointments will play a key role in the transition to Community Health Partnerships.
 8. The new duty on NHS Boards to put in place devolved systems of decision-making carries with it a responsibility to ensure that local services are provided as efficiently and effectively as possible within the resources available. NHS Boards must put in place a framework of controls which enables risk to be assessed and managed, and swift action to be taken where services do not meet the high standards of quality set for NHSScotland. The Scottish Executive will maintain oversight of service delivery to ensure that national standards and priorities are met and will intervene if necessary in the event of failure by NHS Boards.

Shared Services

9. As well as providing integrated clinical services, we need to ensure our support services (including information management and technology, finance, procurement, estates and human resources) are aligned to clinical needs. This is currently inhibited by the legacy of the internal market, which means that there are currently around 50 semi-autonomous organisations providing a diversity of support services to NHSScotland.
10. We will consider the right size for transactional administrative processes and base our decisions on a robust business case. Our approach will be incremental, based on the Best Value principles of continuous improvement and evidence-based change. It will be focused on service benefits and the risks will be carefully managed. We want to free up the skills and experience of professionals to concentrate on activities that add real value to staff and patients. By streamlining aspects of our support services we will provide greater clarity for system users and a better focus for investment. It will also open up the possibility of much closer co-operation and links with our public sector partners in future, particularly as part of the Joint Future agenda.
11. A more corporate national approach to support services will not, however, require new central organisations. We will ensure that where we can achieve clear service benefits from a more co-ordinated approach nationally, regionally or locally, then changes will be taken forward by joint stakeholder consortia, working in a new relationship with the Common Services Agency²⁶ for NHSScotland.
12. As a first step, we will:
 - consult with NHS Boards, trade unions and staff organisations and public sector partners, including the Convention of Scottish Local Authorities (CoSLA), on the possibility of **closer co-operation** in the provision of support services;
 - champion a new approach to strategic **procurement** by working with the six largest NHS Boards, which between them account for 50% of total NHSScotland procurement expenditure;
 - develop a national integrated **human resource** information system and an electronic staff record; and
 - work with the Property and Environment Forum²⁷ to co-ordinate the national **estate** strategy and clarify the respective roles of NHS Boards and the Forum.

²⁶ <http://www.show.scot.nhs.uk/csa/>

²⁷ <http://www.nhsis.co.uk/pef/guest/>

CHAPTER **EIGHT**

ROLES AND RESPONSIBILITIES



1. With this White Paper, we have set out a framework for the NHS. Organisationally, we are consolidating around 15 NHS Boards, with minimal structural change and a large degree of devolution and delegation to frontline staff. We envisage a deepening relationship between NHS Boards and Local Authorities, as the Joint Future agenda yields ever increasing examples of practical co-operation on the ground. In particular, Community Health Partnerships and Local Authority social work services need to evolve around distinct local communities.
2. We expect increasing co-operation among NHS Boards, based around a stronger system of regional planning for services and around Managed Clinical Networks to redesign health services. We want to see a system of national standards, independently inspected, with performance subject to public reporting. We expect to see a sharing of good practice and sharp action to check poor performance. But above all, we expect to see a greater involvement of patients and the public at every stage in the design, delivery and review of health services.

3. The Scottish Executive will:

- determine national objectives and policies for health protection, health improvement and health services, setting targets and offering guarantees on behalf of patients;
- provide a clear statutory and financial framework for NHSScotland;
- hold NHSScotland to account for its performance against national priorities and targets, and within the context of increased funding provided by the taxpayer; and
- intervene when serious problem or deficiencies in service arise which are not being resolved quickly enough at local level.

4. Within the centre of NHSScotland there must also be a capacity to:

- develop strategic plans with NHS Boards, setting clear criteria for success and measures of performance to implement national objectives and policies;
- initiate policy or service reviews that require attention at a regional level and support NHS Boards in carrying them out; and
- deliver certain national services for NHSScotland.

5. We will now place increased emphasis on:

- promoting a culture of patient focus and public involvement;
- joining up Executive policies which are relevant to improving health;
- planning and developing the workforce in far more effective ways; and
- setting clearer targets and monitoring NHS Board performance to ensure that services are delivered effectively.

6. What we reject however, is a command and control culture that assumes the Health Service can be transformed from either St Andrew's House or NHS Board headquarters. One of the key messages of this White Paper is that it is frontline staff and clinicians in particular who will lead the change process that will deliver improvements in performance for patients funded by increased public investment in the NHS. We are determined to support and empower them to deliver results in the interests of patients.

7. However, support and empowerment bring responsibilities. Clinicians must practise in accordance with agreed standards and within the limits of their professional competence, maintaining those standards by life-long learning and personal development. They must involve patients and be responsive to patients – for some, a culture change from the past. Clinicians must work with managers to ensure that services are provided efficiently and effectively.

8. One of the problems in the Health Service over many years has been distrust between clinicians and managers. The step changes in performance that patients – and we – want to see will require managers and clinicians to work together with mutual respect, since each has a vital role to play.
9. As we move beyond NHS Trusts as the key operational units, there will be an even more important role for operational management, ensuring the best possible service in matters that go beyond standards of clinical care. We value that role. Managers must work in partnership with clinicians and other staff to develop a culture that responds to patients and involves the wider public.
10. Because of their particular responsibilities, the performance of senior managers should be rigorously scrutinised by NHS Boards. The Scottish Executive will work in partnership with senior managers and will offer support and assistance where there are management difficulties. But where these are not being adequately addressed, the Health Department will act swiftly and fairly to ensure the interests of patients are protected.
11. Patients and the wider public have responsibilities too. In relation to health improvement, there is self-evidently a key element of personal responsibility. For the Health Service we have been working with the Scottish Consumer Council on developing a Statement of Entitlements and Responsibilities. Ensuring that appointments are kept is one obvious aspect of those responsibilities.
12. We are not interested, however, in a culture of blame but in a culture of improvement. As a Scottish Executive, we make a commitment at the end of this White Paper to lead the programme of change and improvement that we have outlined, recognising the central new role for patients and staff. We are determined to work in a renewed spirit of partnership with them to bring about the changes which are urgently required.

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