Rebuilding our
National Health Service

Guidance to NHS Chairs and Chief Executives
for implementing Our National Health
A plan for action, a plan for change

May 2001

Scottish Executive Health Department
Rebuilding our *National Health Service*

Scottish Executive Health Department, May 2001
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Introduction

Trevor Jones, Chief Executive NHSScotland

This change programme – *Rebuilding our National Health Service* – is intended to provide guidance for all those who are concerned with detailed implementation, on the ground, of the policies set out in *Our National Health: A plan for action, a plan for change* – the Scottish Health Plan.

It is above all a practical document, which aims both to map out the way ahead and to put down markers for how we must all continue to work together – in the widest sense – in the months and years to come.

This change programme focuses on a key element of *Our National Health*: a vision of national standards matched by unified, local systems of care in every part of Scotland. It’s a huge step for NHSScotland, but one which I am convinced will succeed – driven forward by the enthusiasm, energy and determination of NHS staff in all parts of the Service.

I should like to reassure you that the changes announced in this programme are not about structural upheaval – the vast majority of NHSScotland staff will continue to work for the same bodies with largely the same responsibilities. Fundamentally, it is a question of cultural shift, of changing behaviour patterns. It is about encouraging new attitudes towards how we plan and work together in a single NHSScotland – replacing a market-driven mentality with a genuine partnership philosophy.

Our new process of accountability will be inclusive, transparent and fair. For the first time, it will consider all aspects of NHS performance. The new Performance Assessment Framework will place equal weight on the quality of clinical and service delivery, financial management and public involvement. And the performance of the local NHS system will be assessed independently from a patient and public perspective. Responsibility for clear, coherent and managed action to involve patients and the public at all levels in the NHS is now mainstream and real.
Indeed, involving people must become the natural way to work – not a marginal activity of short-term projects and one-off exercises. It is about establishing a long-term partnership with the public – a partnership that will require continual encouragement if it is to lead to real and sustainable changes in service delivery.

For unless local NHS systems are directly accountable to the public for delivering change, the momentum of modernisation will be lost. In the near future, we will publish complementary change programmes to address the key priority areas of public involvement and service modernisation.

*Rebuilding our National Health Service* marks a first step along the road to delivering real change on the ground: I hope that you find it a practical guide to the changes which will take place over the coming months.

Trevor Jones
Chief Executive, NHSScotland
1. Rebuilding our National Health Service

Aim

1.1 This change programme expands on the changes announced in Section 3 of *Our National Health: A plan for action, a plan for change* – the Scottish Health Plan. The Plan gives a commitment to:

⇒ rebuilding a truly National Health Service through changes in governance and accountability

1.2 This programme describes how these changes will be taken forward over the coming months. The overall aims are to:

- clarify responsibility;
- increase accountability;
- streamline bureaucracy;
- improve planning across NHSScotland; and
- integrate decision making across local NHS systems.

1.3 Working within the existing legal and structural framework, implementation of these changes will:

- promote closer working and greater collaboration among health and health care services in Scotland;
- ensure that the system as a whole is held to account more effectively; and
- encourage greater effectiveness through continuous improvement.

1.4 *Our National Health*, the Scottish Health Plan, includes a commitment to issue three change programmes early in 2001. The present programme covers changes to NHS governance, performance and accountability, finance and planning. Two further change programmes will be produced shortly, covering:

- increasing public and patient involvement in the NHS; and
- developing mechanisms with the NHS to support major service change and modernisation.
1.5 In addition, the LHCC Best Practice Group was tasked last year to present proposals for strengthening the influence of LHCCs. Its final report has been completed and we shall shortly announce the next steps in their development.

1.6 Together, the three change programmes and the proposals for the development of LHCCs will provide a detailed framework for the implementation of Our National Health.

Background to the changes

1.7 The NHS is one of our most important public services. It provides quality care 24 hours a day, 365 days of the year, often under difficult circumstances. Substantial investment is producing better services, but too often bureaucracy stands in the way of further improvement. Many problems which manifest themselves in poor patient experience find their roots in fractured planning systems and flawed decision-making processes.

1.8 The 1997, the White Paper Designed to Care set about dismantling the internal market. It achieved a degree of integration and greatly reduced the number of local NHS organisations. However, experience has shown that local decision-making structures in the NHS are still too complex, too fragmented and over-layered. Each Health Board and NHS Trust is monitored and held to account separately, and has separate plans and planning mechanisms. Where effective collaboration does take place, it is often in spite of – rather than because of – the system.

1.9 In May 2000, Susan Deacon MSP, the Minister for Health and Community Care, commissioned work to review the roles, functions and accountability of the different parts of the NHS system: Health Boards, NHS Trusts and the Scottish Executive Health Department itself. The results of that review informed the development of the changes announced in the Scottish Health Plan and described in more detail in this change programme.
1.10 Staff who are involved in the delivery of front-line patient care want stability, not further disruption. The changes set out in the Scottish Health Plan aim to strike a careful balance: they focus on the need to change culture and behaviours within the NHS system, rather than on wholesale structural change in the Service. This will provide stability at local level – specifically, in the vital role NHS Trusts play as providers of services and as employers – while achieving significant changes in the way the NHS is governed.

1.11 All of the changes described here will be implemented in parallel with a high level and longer term review of NHS management and decision-making structures also announced in the Scottish Health Plan and described elsewhere in this programme.

**Principal themes of this change programme**

1.12 This change programme has five principal themes:

**New governance arrangements**

1.13 Building on the commitment in the Scottish Health Plan to establish 15 new NHS Boards, Section 2 of this change programme describes the role and composition of these new NHS Boards and how they will be established.

**New performance and accountability arrangements**

1.14 Section 3 describes work to develop a new Performance Assessment Framework for NHSScotland, which will underpin the new governance arrangements. The Framework will provide clearer, more objective and broad-based measures against which to assess the performance of all NHS organisations, with a new and more systematic accountability review process for holding the system to account, locally and at Scottish level.

**Changes to the financial framework**

1.15 Section 4 describes work to revise the financial framework for NHSScotland organisations and support more collaborative relationships, which will enable local NHS systems to plan more effectively.
**New planning arrangements**

1.16 Section 5 previews the introduction of a single Local Health Plan within each NHS Board area, to replace the separate Health Improvement Programmes and Trust Implementation Plans. Closer involvement of NHS Boards in the community planning process, alongside Local Authorities and others, will ensure more effective joint working on health improvement and a more consistent and cohesive approach to planning health care services.

**The Scottish Executive Health Department**

1.17 The final section of the programme describes the role and functions of the Scottish Executive Health Department and how it will support the NHS in improving health and health care for the people of Scotland.

**Implementation and timing**

**New governance arrangements**

1.18 The new NHS governance arrangements described in this change programme will be in place throughout Scotland by 30 September 2001, by which time all 15 new unified NHS Boards will be formally established. Until the new Boards are in place, all NHS organisations will retain their existing responsibilities and accountabilities.

1.19 The process of selecting Chairs for the new NHS Boards is already under way and, once appointed, they will have responsibility for establishing an appropriate mechanism for steering the change process in their area, working closely with their Chief Executive and with Trust Chairs and Chief Executives. This may include the formation of an implementation steering group or similar forum. Chairs will need to work closely with other partners in the local NHS system, with public, private and voluntary sector stakeholders and with their local communities.
**New performance and accountability arrangements**

1.20 The key elements of the new performance and accountability arrangements will be in place by 30 September 2001. This will include:

- the Performance Assessment Framework for newly established NHS Boards;
- details of the new accountability review process, which will be used to support reviews of NHS performance during 2001-02; and
- a programme of establishing and implementing further NHS service standards.

**Changes to the financial framework**

1.21 The timetable for the changes to the financial framework described in this programme is as follows:

- some initial changes will be introduced for 2001-02; and
- more substantive changes will be announced during 2001 and implemented, where possible, from April 2002.

**New planning arrangements**

1.22 The first new Local Health Plans will be drawn up in the course of 2001-02 covering the period 2002-03 and onwards.

1.23 Work is under way to prepare detailed guidance on changes to the NHSScotland planning process, covering links with community planning, Local Health Plans and regional and national planning. This will be published by late summer 2001.
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Key milestones
2. New governance arrangements in NHSScotland

Aim

➔ in each of the 15 NHS Health Board areas there will be a single unified NHS Board
➔ in the 12 mainland NHS Health Board areas, these new unified NHS Boards will replace the separate board structures of the existing NHS Health Boards and NHS Trusts

2.1 Currently, NHSScotland is divided into 15 Health Board areas, including 12 mainland Health Boards and 3 Island Health Boards. Within the mainland Health Board areas, there are 28 NHS Trusts. Each of these bodies is currently governed by a full board of executive and non-executive members.

2.2 The changes announced in Our National Health and described here do not require primary legislation and can therefore be implemented relatively quickly. To achieve this, we will use powers set out in secondary legislation (Orders and Regulations created by Statutory Instrument) to change the composition and membership of Health Boards and establish new unified NHS Boards which better reflect the different NHS organisations within the local NHS system. These new unified NHS Boards will cover the same geographical areas as the existing Health Boards.

Island Boards

2.3 Particular considerations relating to the Island Boards, which have no NHS Trusts, are discussed in paragraph 2.32 below. It will be important to ensure that in future the role and composition of Island Boards reflect the changes being made in the governance of mainland Boards.
**Special Health Boards and other NHS organisations**

2.4 The governance of Special Health Boards and other NHS organisations does not fall within the scope of this paper. However, alongside the introduction of unified NHS Boards, the Scottish Health Plan includes the following commitment:

- we will ensure that the work of the Special Health Boards (such as the Health Education Board for Scotland and the Health Technology Board for Scotland) and other national bodies (like the Common Services Agency) is properly co-ordinated and aligned to national policies and priorities

2.5 This commitment will be taken forward through separate pieces of work. However, as with the Island Boards, the intention will be to ensure that the spirit of the changes set out in this paper is reflected in any changes in the governance of Special Health Boards, whilst recognising their distinctive nature.

**Role and functions of the unified NHS Board**

2.6 The overall purpose of the unified NHS Board is to ensure the efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes.

2.7 The role of the unified NHS Board will be:

- to improve and protect the health of local people;
- to improve health services for local people;
- to focus clearly on health outcomes and people’s experience of their local NHS system;
- to promote integrated health and community planning by working closely with other local organisations; and
- to provide a single focus of accountability for the performance of the local NHS system.
2.8 The functions of the unified NHS Board will comprise:

- **strategy development** – to develop a single Local Health Plan for each NHS Board area which addresses the health priorities and health care needs of the resident population, and within which all aspects of NHS activity in relation to health improvement, acute services and primary care will be specified;

- **resource allocation** to address local priorities – funds will flow to the NHS Board, which will be responsible for deciding how these resources are deployed locally to meet its strategic objectives;

- **implementation** of the Local Health Plan; and

- **performance management** of the local NHS system, including risk management.

2.9 Membership of the unified NHS Board will carry with it collective responsibility for the discharge of these functions. **All** members of the NHS Board will be expected to bring an impartial judgement to bear on issues of strategy, performance management, key appointments and accountability, upwards to Scottish Ministers and outwards to the local community. Members will provide independence of thought and action in reflecting the public interest.

2.10 The creation of unified NHS Boards is not intended to result in more centralised decision making. On the contrary, the goal is Boards which empower those in the front line to plan and deliver services, but in the context of clear strategic direction and rigorous performance management.

2.11 As part of their strategy development function, NHS Boards will be expected to work with Primary Care Trusts to develop primary care services and, in particular, to strengthen the role of LHCCs in the management and delivery of services provided in the community, including health improvement and health promotion activities. Accountability review mechanisms at NHS Board level must take account of the extent to which delegation to LHCCs has been maximised.

2.12 The diagram illustrates the relationship between the component parts of the local NHS system and the role and functions of the unified NHS Board:
NHS Board

**Purpose**
- efficient, effective and accountable governance of the local NHS system
- strategic leadership and direction

**Overall Objectives**
- improve health of local people
- improve health services for local people
- focus on health outcomes and patients’ experience of the local NHS system
- promote integrated health and community planning
- promote single focus of accountability for performance of local NHS system

**Key Functions**
- strategy development
- resource allocations
- implementation of Local Health Plan
- performance management
Accountability within local NHS systems

2.13 NHS Boards will be strategic bodies, accountable to the Scottish Executive Health Department and to Ministers for:
   - the designated functions of the NHS Board; and
   - the performance of the local NHS system.

2.14 NHS Boards will not concern themselves with day to day operational matters, except where they have a material impact on the overall performance of their local NHS system. See also paragraphs 2.18 and 2.19 below.

2.15 All members of NHS Boards will share collective responsibility for the overall performance of their local NHS system, including the performance of its separate component parts.

2.16 The component parts of local NHS systems, including NHS Trusts, will retain their existing operational responsibilities for health improvement, acute services and primary care.

2.17 The direct operational responsibilities of Chief Executives and Directors of the existing Health Boards and NHS Trusts will be largely unaffected by the establishment of the new unified NHS Boards. For example:

   - Chief Executives will retain their “accountable officer” status. They will remain directly answerable to the Scottish Parliament for the propriety and regularity of financial transactions under their control and for the economical, efficient and effective use of resources;

   - Chief Executives will remain accountable to their respective NHS Board/Trust for the delivery of quality/clinical governance in each component part of the NHS system.
2.18 A distinction between strategic and operational matters may not always be either clear or desirable. Care will need to be taken, therefore, to ensure that the agendas of NHS Boards are structured so as to enable them to concentrate on issues which are of material importance for their local NHS system as a whole: in general, these will be the functions described in paragraph 2.8 above.

2.19 However, where operational deficiencies are deep-rooted and severe, they could impact on the overall performance of the local NHS system. In such cases, concerted action at NHS Board level may be necessary, both to achieve fully acceptable performance and to maintain public confidence in the local NHS. NHS Boards should ensure they have systems in place to spot problems early and, where necessary, co-ordinate appropriate solutions right across their local NHS system, underpinned by the new Performance Assessment Framework described in section 3 of this programme.

Public involvement in the business of NHS Boards and Trusts

2.20 NHS Boards will be public bodies, and as such they must be seen to be publicly accountable. The forthcoming change programme on patient and public involvement will set out how we intend to strengthen the patient’s voice and the role of local communities in decisions about the design and delivery of services.

2.21 People want to be reassured that the NHS is learning from people’s experience, listening to their views and delivering the care and support they need in an efficient and effective way. Patients and the public are no longer willing simply to trust the NHS to do this: they wish to be engaged in a new, more open and accountable process which demonstrates clearly that this is happening. This approach must translate into the individual patient experience. In turn, professionals must continue to foster a better dialogue with patients about decisions affecting their care.
2.22 NHS Boards must therefore focus clearly on people’s experience of their local NHS system. They must have mechanisms in place to ensure that:
- there is effective liaison with patients and their representative groups;
- complaints are addressed appropriately;
- patient feedback is captured and acted upon;
- the patient voice is heard.

2.23 It is essential that NHS organisations continue to make full use of the existing mechanisms for securing public involvement in local decision making. For example, NHS Boards must continue to draw on the expertise and experience of Local Health Councils. An important way in which this can be achieved is by ensuring that a representative of the Local Health Council attends all meetings of the NHS Board.

2.24 NHS Boards will continue to hold all their meetings in open session, in accordance with the demands of openness in public decision making.

2.25 The same requirements continue to apply to NHS Trusts: meetings of the full Trust management team will be held in public. Additionally, NHS Trusts will continue to have responsibility for ensuring that Local Health Councils are fully involved in assessing the design and quality of services delivered locally.
Operational components of local NHS systems

2.26 On the basis of the existing configuration of services in most areas, each local NHS system comprises three operational components:
- health improvement;
- acute services; and
- primary care.

2.27 The main focus of NHS health improvement activities currently rests with the existing Health Boards. Health Boards will continue to exist in law, although they will be known as NHS Boards, and their primary responsibility will remain to improve the health of their local population. Consequently, the role and function of those who currently work in the existing Health Boards will remain substantially unchanged: they will continue to take a central role in planning across their local NHS system.

2.28 In most cases, acute services and primary care are currently the responsibility of separate NHS Trusts. However, the Island Boards operate as single entities with no Trusts; and West Lothian Healthcare NHS Trust and Yorkhill NHS Trust operate as integrated Trusts, providing primary and secondary care.

2.29 The Scottish Health Plan does not imply any immediate change in the existing configuration of NHS Trusts within each NHS Board area. However, it does signal that in future, NHS Boards will have greater flexibility to achieve better integration and rationalisation of functions and service delivery arrangements.

2.30 Subject to proper consultation, the Scottish Executive Health Department would be willing to consider proposals from NHS Boards to alter the configuration of Trusts within their local areas to achieve better integration. Key criteria for assessing any such proposals are likely to involve demonstrable service benefits for patients and/or closer integration between health and social services.
Subject to any future changes in the configuration of local services proposed by NHS Boards, acute services and primary care will continue to be provided through NHS Trusts. Each component of the local NHS system will continue to have a Chief Executive and an executive management team as deemed necessary to fulfil its operational responsibilities.

Island Boards

The position of the Island Boards is different from mainland Boards, since there are no separate NHS Trusts. Acute service and primary care will continue, as at present, to be integral parts of the Island Board structure. It will, however, be necessary to review and, if necessary, change the configuration and membership of the Island NHS Boards to ensure that they are consistent with the new governance arrangements for mainland NHS Boards. The overall timescale for appointments to the Island Boards will be the same as for mainland NHS Boards.

Membership of the unified NHS Board

A board of governance

The NHS Board is to be a board of governance. It is not a management board or a representative body. Its membership will be conditioned by the functions of the Board, as set out in paragraph 2.8 above.

Members of NHS Boards will be selected on the basis of their position – such as a Trust Chair or Chief Executive – or the particular expertise which will enable them to contribute to the decision-making process at a strategic level.

The NHS Board will have collective responsibility for the performance of the local NHS system as a whole. The membership of the NHS Board must therefore reflect the partnership approach which is essential to improving health and health care.
**Public appointments**

2.36 All seats on NHS Boards will continue to be public appointments, made by the Scottish Ministers, in accordance with the guidelines laid down by the Commissioner for Public Appointments.

- we will launch a recruitment campaign early in 2001 to encourage people to be part of local decision making in the NHS

2.37 The process of selecting Chairs and members for NHS Boards began in March 2001 with an advertising campaign for 13 of the 15 Chairs. (Chairs have already been appointed in Fife and Tayside.) Interviews will take place in May, June and July.

2.38 New Chairs are being appointed initially to the existing Health Boards, where they will serve until the establishment of NHS Boards. NHS Boards will be established formally on 30 September 2001. However, in the case of Fife and Tayside, where new Chairs are already in place, there may be scope for them to move more quickly, once all the key board appointments are in place.

2.39 The appointment of Chairs will inform the selection and appointment of other board members. Similarly, existing members of NHS bodies are free to apply to be members of the new NHS Boards. In making appointments, Ministers will be keen to ensure that there is sufficient continuity within local NHS systems to enable the new NHS Boards to be established and effective quickly. See also paragraphs 2.121 to 2.123 and the development support planned to support these changes.

**The office of Chair of the NHS Board**

2.40 The changes announced in Our National Health will be achieved by amending the existing legislation governing Health Boards. Consequently, the office of Chair of the existing Health Board will become the office of Chair of the NHS Board. This applies to the office itself and not necessarily to the individual currently holding the position of Health Board Chair.
2.41 The NHS Board Chair will have dual responsibility:
- for the overall governance of the NHS Board generally; and
- specifically, for the health improvement activities of the NHS Board.

2.42 NHS Board Chairs will play a pivotal leadership role. They will lead in implementing the agenda set out in the Scottish Health Plan, and described here, to drive forward the changes needed to improve planning and decision making locally.

**Members from within the local NHS System**

> Chairs and Chief Executives of NHS Trusts will sit on the new unified NHS Boards and be held jointly accountable for the performance of the local health system

2.43 Trust Chairs already sit on the existing Health Boards. In future, they will be members of the new NHS Boards, but their role will change to reflect the new governance arrangements. In particular, as members of the NHS Board, their role will be to reinforce the corporate governance of the local NHS system as a whole.

2.44 To emphasise the importance of bringing together the different components of the local NHS system, Chief Executives of all the local NHS Trusts will join their Chairs as full members of the new NHS Boards.

**Chief Executives**

2.45 All Chief Executives within local NHS systems will sit on their local NHS Board. The new collective responsibility of Board and Trust Chief Executives – by virtue of their membership of the NHS Board – represents the most important driver in the process of cultural change. Their corporate role as members of the same NHS Board is intended to promote shared decision making and better collaborative working across the local NHS system.

2.46 The Chief Executive of the existing Health Board will continue to have direct responsibility for the health improvement component of the local NHS system.
2.47 In addition to operational responsibility for health improvement, the Board Chief Executive will support the Chair of the NHS Board in convening the governing body, co-ordinating the agenda and ensuring the smooth conduct of business of the unified NHS Board. This is consistent with the strategic planning function which Board Chief Executives currently exercise across their local NHS system.

2.48 There will be no direct line management relationship between the Board Chief Executive and Trust Chief Executives. Each will retain their existing operational responsibilities, and all will be collectively accountable to the NHS Board for the overall performance of their local NHS system.

2.49 Although all members of NHS Boards will be collectively accountable for the financial performance of their local NHS system as a whole, Trust Chief Executives will retain their “accountable officer” status and will thus be directly answerable to the Scottish Parliament for the finances of their own areas of operational responsibility.

2.50 As at present, the Board Chief Executive will be the “accountable officer” in respect of the total funds allocated to the local NHS system.

2.51 The lines of accountability implied by “accountable officer” status are set out in the *Memorandum to National Health Service Accountable Officers*, issued by the Scottish Executive Health Department in July 2000, following enactment of the Public Finance and Accountability (Scotland) Act 2000. In summary, Accountable Officers have personal responsibility for the propriety and regularity of the public finances of their organisations.
2.52 Chief Executives must ensure that the Board or Trust’s consideration of policy proposals relating to expenditure or income takes account of all relevant financial considerations, including propriety, regularity and value for money. Significantly, the specific duties of Accountable Officers must be combined with those implied by board membership: NHS Boards and Trusts are also responsible to the Scottish Parliament in respect of their policies, actions and conduct.

**Director of Public Health**

2.53 Directors of Public Health have close working relationships with Local Authorities and other health bodies. Their knowledge, skills and relationships will be invaluable to the NHS Board as a public health organisation if it is to discharge its health improvement responsibilities effectively. Directors of Public Health will therefore be members of NHS Boards.

**Board Finance Director**

- in future, the new NHS Boards will be accountable for the financial performance of the whole local NHS system

2.54 NHS Boards will assume the central role in allocating funds to the component parts of the local NHS system and will be held accountable for the financial performance of the system as a whole. The Health Board Finance Director will therefore become a member of each NHS Board. In addition to their existing responsibilities, Board Finance Directors will be responsible for reporting high level financial performance of their local NHS system.

2.55 As with Chief Executives, there will be no direct line management relationship between the Board Finance Director and Trust Finance Directors. The role of Finance Directors of NHS Trusts will continue as before: they will report to their Chief Executive on the financial performance of the Trust. Increasingly, they will also provide financial data to the NHS Board for inclusion in joint financial reports covering the whole NHS Board area.
**Staff partnership and the NHS Board**

➔ we reaffirm the principle of partnership working, that all NHS staff in Scotland must have the opportunity to be involved and engaged in the decision-making process.

2.56 The whole concept of the NHS Board is based on partnership: partnership between component parts of local NHS systems, partnership between the NHS and local communities, and partnership between the NHS and the staff who work in it.

2.57 The Scottish Partnership Forum (SPF) has led the way in the development of partnership working at national level and the NHS has made a good start in building partnerships locally. The establishment of NHS Boards provides an opportunity to build on progress to date.

➔ each of the new unified NHS Boards will have a partnership forum which must be fully involved in the development of Local Health Plans.

2.58 In partnership with the SPF, we will issue guidance on the role of area partnership forums and their relationship with the SPF and partnership forums at an operational level. This guidance, and the further work described elsewhere in this programme to develop the new Performance Assessment Framework for NHSScotland, will explain how:

➔ local staff partnership forums will be directly involved in assessing the performance of NHS Boards as employers, as part of the new accountability arrangements.

2.59 The Scottish Health Plan proposed that:

➔ there should be staff membership on the new NHS Boards, nominated by the local Staff Partnership Forums.

2.60 However, the establishment of Area Partnership Forums in each NHS Board area provides an opportunity to go further.
2.61 To reinforce the importance of partnership working and the role of partnership forums in the decision-making process, the Staff Side Chair of each Area Partnership Forum will, subject to Ministerial approval, be invited to sit on the NHS Board for their area.

2.62 In addition to the collective responsibilities shared by all members of NHS Boards (and described in the Annex to this document), the Chair of the Area Partnership Forum will have a key role in:

- providing a staff perspective on strategy development and service delivery issues considered by the NHS Board;
- acting as a focal point for staff from across the local NHS system who wish to contribute to the business of the NHS Board;
- explaining the work of the NHS Board and promoting opportunities for staff to be involved in decision-making locally;
- reflecting the views of local partnership forums on the performance of employers within the local NHS system in discharging their Staff Governance responsibilities; and
- championing partnership working and providing a vital link between the NHS Board and the area partnership forum.

2.63 If they are to make an effective contribution to the work of NHS Boards generally, the Chairs of Area Partnership Forums will need both induction training in the role of a board member, and practical support to enable them to carry out their role. As board members, they will have the opportunity to take part in a programme of induction and organisational development to be offered by the Strategic Change Unit. We will discuss with the SPF what additional development support might be needed.
Similarly, we will discuss with the SPF what guidance, if any, should be issued centrally about the practical support to be provided for Chairs of Area Partnership Forums in their role as board members. As a minimum, they will need protected time to enable them to carry out their roles, access to secretarial support and suitable mechanisms to enable them to communicate with staff.

The Chair of the Area Partnership Forum will be entitled to claim the same level of remuneration and expenses payable to other board members appointed in a personal capacity. This will be paid in addition to their salaries as employees.

**Local Authority members of the NHS Board**

- in their local areas Local Authorities should have a strong voice on the new NHS Boards

Health improvement cannot be delivered by NHSScotland in isolation. NHS Boards and Local Authorities must work closely together across a range of health and community planning issues. We intend to reinforce this partnership by further promoting greater integration of planning and decision making between local government and the NHS and other partners.

Some Health Boards already have members who are also elected Local Authority members. In future, this will be the norm across NHSScotland. The presence of elected representatives on NHS Boards is intended to:

- improve communications between the NHS and Local Authorities; and
- support closer partnership working, consistent with the principles of community planning.

More specifically, Local Authority members of NHS Boards will play a vital role in helping to strengthen collaboration between NHSScotland and Local Authorities – not just in planning but across a range of activities, including service delivery and community care.
2.69 The presence of Local Authority members on NHS Boards should help ensure that the Local Health Plan for each NHS Board area is consistent with the components of the community planning process in each Local Authority area. It will not, however, be the Local Authority member’s function to provide the primary link to the community planning process. Senior representatives of the NHS Board will be members of community planning partnerships in their own right. See also paragraphs 5.2 to 5.4 below.

2.70 Local Authority members will have a key role in facilitating interaction and co-operation between the Local Authority and local NHS systems and with wider communities. This interaction and co-operation is crucial to the shared objective of improving health.

2.71 As full members of NHS Boards, Local Authority members will be bound by the need for collective responsibility and the specific responsibilities outlined in the Annex to this document. In this context, they will also be expected to participate fully in the committee structures of the local NHS system.

2.72 It is vital that Local Authority members of NHS Boards enjoy the full confidence of their authorities, and are able to commit to decisions on health and health service matters which could affect their local communities. We propose therefore to invite Local Authorities to nominate either:

- their Leader; or
- their Deputy Leader; or
- the senior member of the Local Authority with designated responsibility for public health-related issues

To be appointed, by the Minister, as members of their principal NHS Board. See also paragraph 2.77 below.

2.73 Scotland currently has 32 Local Authorities, and the intention is to achieve their efficient and effective participation in the work of the 15 new unified NHS Boards.
2.74 In some areas, this will be straightforward, for example where the boundaries of the new NHS Board and of the Local Authority are co-terminous. In circumstances where the NHS Board area covers a number of council areas and/or where a Local Authority covers more than one NHS Board area, the situation becomes more complicated.

2.75 If each NHS Board were to have only one Local Authority member, by implication more than half of Scotland’s Local Authorities would not have a seat on any NHS Board. This could give rise to particular difficulties in NHS Board areas covering two or more council areas.

2.76 On the other hand, if every Local Authority had one seat on each NHS Board in its council area, this could result in disproportionate representation on some NHS Boards and unwieldy Board structures.

2.77 On balance, it seems preferable for each Local Authority to have one seat on its principal NHS Board. This offers the major advantage of ensuring that all Local Authorities have seats on NHS Boards. Where Local Authorities straddle more than one NHS Board area, membership should be on the NHS Board which covers the greatest proportion of the Local Authority’s resident population.

2.78 It is recognised, however, that particular geographical constraints may exist in certain areas. In such circumstances, the number of Local Authority members on the NHS Board may have to vary from the norm in order to ensure that particular local communities have a voice on the Board.

2.79 Accordingly, variations in the arrangements proposed in paragraph 2.77 above may be considered in exceptional circumstances and subject to prior Ministerial approval. Any such variations must be proposed in the first instance by the new NHS Board Chair.
**University Medical School members of the NHS Board**

2.80 At present, those Health Boards which have a University Medical School within their area have an additional seat for a member from the University. This is felt to have proved valuable. The participation of the University member facilitates strategic planning for both the NHS Board and the Medical School and reflects the degree of influence which medical education has on service delivery – and *vice versa*.

2.81 This practice will continue in those new NHS Board areas which include University Medical Schools. Nominations will be sought from the Universities in line with the guidelines issued by the Commissioner for Public Appointments.

**Clinical and other professional input to the NHS Board**

2.82 It is essential that NHS Boards are able to draw on professional skills and expertise from across the local NHS system as a whole for advice on clinical and other professional matters. Trusts, and where appropriate NHS Boards, will retain their own Medical and Nursing Director posts. These Directors will have an important contribution to make to the work of the NHS Board. This will undoubtedly include attendance at meetings of the NHS Board, as necessary.

2.83 The establishment of NHS Boards provides an opportunity to examine and refocus local clinical advisory mechanisms. NHS Boards will also be expected to harness and access the range of expertise which exists in Area Professional Committees. There is substantial scope to strengthen the role of these committees in underpinning the design and delivery of quality services. These committees already have a duty to advise existing Health Boards on clinical and other professional matters and may be consulted by the Board at its discretion.
2.84 Currently, provision exists for six Professional Advisory Committees at Health Board level covering:
- medical;
- dental;
- nursing and midwifery;
- pharmacy;
- ophthalmology; and
- the professions allied to medicine.

2.85 At present, the role, functions and effectiveness of these committees varies significantly from area to area. In preparation for the establishment of NHS Boards, each Health Board will be required to carry out a major overhaul of its Area Professional Committees, in order to ensure that efficient and effective mechanisms are in place which promote the involvement of clinicians from across the local NHS system in the decision-making process.

2.86 In addition, a new multi-professional committee will be established for LHCCs in each NHS Board area, to be known as the LHCC Professional Committee. These new committees will play a key role in demonstrating the potential of LHCCs to deliver enhanced services through flexible, multi-disciplinary working.

2.87 The Chairs of the Professional Committees in each NHS Board area will be invited to form a new multi-professional Area Clinical Forum. The Chair of the Area Clinical Forum will be a full member of the NHS Board. Further detailed work will be done, in partnership with professional, academic and staff representative bodies, to develop the role and terms of reference of the Area Clinical Forum.

2.88 As part of the new accountability review process (described in paragraphs 3.25 to 3.37 below), NHS Boards will have a duty to demonstrate that they have involved the relevant Professional Committees appropriately in strategy and service development issues.
2.89 At a national level, we propose to strengthen the role of nurses and midwives in policy development by establishing a new national **Nursing and Midwifery Forum**, bringing together professional, academic and staff representative leaders, to advise Ministers and the Scottish Executive Health Department on, for example:

- implementation of *Our National Health* as it relates to nursing and midwifery issues;
- implementation of the *Strategy for Nursing and Midwifery for Scotland*;
- implementation of the *Public Health Nursing Review*; and
- developing nursing and midwifery leadership in Scotland.

2.90 Further detailed work will be done, in partnership with professional, academic and staff representative bodies, to develop the role, terms of reference and membership of the new Nursing and Midwifery Forum and how it should relate to the existing advisory machinery. The working assumption is that Ministers would wish to meet with the new Forum from time to time.

**Additional members of the NHS Board**

2.91 It is important that the total number of members of NHS Boards is sufficient to ensure that Boards can carry out the functions required of them. These functions will include providing an adequate degree of scrutiny over all the component parts of their local NHS system, including membership of committees.

2.92 In addition to the membership discussed above, NHS Boards will therefore have the discretion to seek the appointment of up to two additional members. The exact number is to be decided locally. The number of members of the NHS Board needs to reflect a balance between the desire for inclusiveness and the need to ensure that the NHS Board is of a manageable size, consistent with the effective discharge of business. This balance may vary in different areas.
**Directors of existing Health Boards**

2.93 At present, not all Directors of Health Boards are appointed to the governing board of the Health Board. The only Directors who are appointed to the governing board on the basis of their position are Chief Executives. Other Directors, including the Directors of Public Health and Finance Directors, are appointed to the board as members following recommendation from the Chair.

2.94 A small number of Directors, who are currently appointed members of the board, may not be appointed to the NHS Board. However, this will not materially affect the level and importance of their contribution to the work of the new NHS Board. Their status and areas of operational expertise and responsibility will be undiminished.
**The size of the NHS Board**

2.95 Based on the proposals discussed in this paper, the following tables illustrate the likely composition of a typical NHS Board (with two Trusts), and a large NHS Board (with four Trusts):

<table>
<thead>
<tr>
<th>Typical unified NHS Board (with 2 Trusts and covering 2 Local Authority areas)</th>
<th>up to 15 Members</th>
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</thead>
<tbody>
<tr>
<td>Board Chair</td>
<td></td>
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<tr>
<td>2 Trust Chairs</td>
<td></td>
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<tr>
<td>2 Local Authority Members</td>
<td></td>
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<tr>
<td>Staff Side Chair of the Area Partnership Forum</td>
<td></td>
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<tr>
<td>Chair of the Area Clinical Forum</td>
<td></td>
</tr>
<tr>
<td>University Medical School Member (<em>where appropriate</em>) (up to) 2 additional members</td>
<td></td>
</tr>
<tr>
<td>Board Chief Executive</td>
<td></td>
</tr>
<tr>
<td>2 Trust Chief Executives</td>
<td></td>
</tr>
<tr>
<td>Director of Public Health</td>
<td></td>
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<tr>
<td>Finance Director</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Large unified NHS Board (with 4 Trusts and covering 4 Local Authority areas)</th>
<th>up to 21 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Chair</td>
<td></td>
</tr>
<tr>
<td>4 Trust Chairs</td>
<td></td>
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<tr>
<td>4 Local Authority Members</td>
<td></td>
</tr>
<tr>
<td>Staff Side Chair of the Area Partnership Forum</td>
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</tbody>
</table>
Management of NHS Trusts

The legal status of NHS Trusts

- NHS Trusts will retain their existing operational and legal responsibilities within the local health system but with streamlined management arrangements and fewer non-executive directors

2.96 NHS Trusts will continue to exist in law. They will remain as legal entities within the local NHS system and retain their existing operational autonomy – in particular, their responsibilities as employers. The vast majority of NHS staff will therefore continue to be employed by Trusts.

Non-executive members of Trust management teams

2.97 In future, NHS Trusts will concentrate on delivering their operational responsibilities within the local NHS system: this will primarily be the responsibility of the Trust’s executive management. In the light of this change of emphasis and the new governance and accountability arrangements which will be discharged through the NHS Board, the number of non-executive directors of NHS Trusts will be reduced to the minimum required by law.

2.98 Primary legislation currently requires that each NHS Trust must have no fewer than three non-executives: the Chair plus two others.

2.99 The Chair of the Trust will sit alongside the NHS Board Chair as a member of the NHS Board. The role of Trust Chairs will change from protecting the sole interests of their own particular organisations to ensuring that their Trust management teams work together with other partners in the local NHS system to promote better local planning and decision making.

2.100 The two other Trust non-executives will co-ordinate and serve on the Trust’s committees. Where appropriate, they may also be asked to serve on committees in other parts of the local NHS system, including committees of the NHS Board, as discussed more fully in paragraphs 2.113 and 2.114 below.
2.101 In future, non-executive directors of NHS Trusts will have a vital role to play in ensuring their executive teams recognise that they are part of a unified local NHS system. As ambassadors for the local NHS system, Trust non-executives will also be in a unique position to help the Trust and the NHS Board focus on people’s experience of their local health services.

The Trust executive team

2.102 Primary legislation stipulates that NHS Trusts shall have “executive directors who are employees of the Trust” and that the number of executive directors for each Trust is to be specified in the Trust Establishment Order. Each of the Trust Establishment Orders currently provides that the Trust concerned shall have five Executive Directors.

2.103 The role of the executive team will therefore remain substantially unchanged. This reflects the Trust’s continued focus as a key operational component of the local NHS system. No changes are currently proposed in the number or designation of Trust Executive Directors.

Meetings of the full Trust management team

2.104 The full Trust management team will thus comprise: the Chair; two non-executives; and five Executive Directors.

2.105 In accordance with the need for openness in public decision making, meetings of the full Trust management team will continue to be held in public, in the same way as current Trust Board meetings.
 Committees within the local NHS system

2.106 Primary legislation does not prescribe any board committees, either at Health Board or Trust level. Three committees are currently determined by Direction: Audit, Remuneration and Clinical Governance, and guidance prescribes an Ethics Committee. Additionally, certain primary care matters are laid down in Regulation: e.g. discipline and pharmacy practices committees.

2.107 However, there is evidence which suggests that, in some areas, the number of board committees of Health Boards and Trusts has grown substantially in recent years.

2.108 The new unified structure will provide considerable scope for rationalising the number of committees which exist within each local NHS system. As part of the process of establishing new unified structures, all NHS Boards will be expected to review the committee structures in their Board areas, in order to determine what is essential to discharge the business of the local NHS system as a whole.

2.109 The presumption should be that, subject to limited exceptions, separate committees in different parts of the local NHS system which share identical remits should be combined. One advantage of a system-wide approach to committees should be that it ensures consistency of treatment, fairness and equity across the system, as well as ensuring that knowledge and good practice is shared as efficiently as possible.

2.110 In principle, the following standing committees should exist at unified NHS Board level:
   - Clinical Governance;
   - Audit;
   - Staff Governance;
   - Ethics; and
   - Discipline (for primary care contractors).
2.111 Apart from the prescribed committees, it will be for NHS Boards to judge the type and composition of committees necessary to fulfil their responsibilities.

2.112 The above arrangements do not prevent NHS Trusts from retaining committees locally, subject to the outcome of the review proposed in paragraph 2.108 above. In particular, Primary Care Trusts are currently required to have a Pharmacy Practices Committee.

2.113 Membership of committees (of NHS Boards and Trusts) should be populated from across the whole local NHS system, drawing upon the pool of experience and expertise that exists in each area. All members of NHS Boards and Trusts will be expected to play a full part in the work of committees across the local NHS system.

2.114 Regulations already permit non-board members to be co-opted onto the committees of Health Boards and NHS Trusts. This provision permits trustees of NHS Trusts to serve on NHS Board committees and vice versa. It also allows members of the executive team and others with relevant interests and expertise to serve on key committees across the local NHS system.

**Clinical Governance Committees**

2.115 The Clinical Governance Committee of the NHS Board will have two key roles:

- **systems assurance** – to ensure that clinical governance mechanisms are in place and effective throughout the local NHS system; and

- **public health governance** – to ensure that the principles and standards of clinical governance are applied to the health improvement activities of the NHS Board.
2.116 However, the main focus of clinical governance activities will remain at Trust level. Trusts will therefore need to retain their own Clinical Governance Committees to fulfil the detailed systems assurance role which is required. NHS professionals who serve as members of Clinical Governance Committees will continue to play a vital part in their operation.

**Audit Committees**

2.117 Particular considerations apply to the Audit Committee. There is a continuing requirement, in keeping with best practice in the public sector, for separate Audit Committees for each legal entity within the local NHS system. However, these committees may be separate only in name, as it is possible, under existing Regulations, for committees to co-opt members as necessary.

2.118 The Audit Committee in each component part of the local NHS system should have common membership drawn from across the NHS system. We envisage that this will include at least one non-executive representative from each legal entity concerned. In order to preserve their independence from operational management, Audit Committees should not have executive membership.

**Staff Governance Committees**

2.119 NHS Boards will be expected to convene Staff Governance Committees to underpin the establishment of staff governance as an integral part of the performance management of NHS organisations. These committees will have an important role in ensuring consistency of policy and equity of treatment of staff across the local NHS system, including remuneration issues, where they are not already covered by existing arrangements at national level. This role will assume particular importance in the light of the new system-wide approach to performance management.
2.120 Parallel work is currently under way with the Scottish Partnership Forum and the Scottish Personnel Group to take forward the development of a Staff Governance Standard. Particular consideration will be given to the role and membership of Staff Governance Committees and other mechanisms needed locally to support NHS organisations in discharging their responsibilities as good employers.

**Ethics Committees**

2.121 Health Boards are currently required to have a Research Ethics Committee, covering the whole Board area. Its principal function is to provide independent advice as to whether a given piece of research is ethical, and whether the dignity, rights, safety and wellbeing of individual research subjects are adequately protected. Each NHS Board will continue to have such a committee.
Supporting change

2.122 Early implementation of the changes set out in this programme will be a challenging task for everyone concerned. The overarching objective is to develop systems, relationships and behaviours which promote partnership and collaboration across the NHS system. The development agenda for new NHS Board members will be particularly important: cultural and behavioural factors will be just as significant as the composition of the Board in creating the conditions for change.

2.123 The Strategic Change Unit (SCU) will build on its existing programme of activities and introduce a formal, structured organisational development programme to support the establishment of NHS Boards.

2.124 This programme will be delivered in two stages:

- **from now until October 2001:** a preparatory phase will focus on the development needs of Chairs and NHS Board members. These programmes will have a core content but will be customised to meet individual and local circumstances. For new NHS Board Chairs, there will be a formal, structured programme of induction, which will build on current SCU work focusing on the needs of Chairs. Development support will be provided for all Board members as they are appointed. There will be a concurrent programme of development for Trust management teams both within individual organisations and on a collective basis;

- **from October 2001 onwards:** ongoing support will be provided to meet the organisational development needs of each NHS Board area.
In the longer term

we will commission a high level review of the management and decision-making structures of the NHS in Scotland

2.125 Implementation of the changes set out in Our National Health will significantly improve the planning and performance of the NHS throughout Scotland. Nevertheless, Ministers recognise that there remain issues about the configuration and number of different health organisations proportionate to the size of Scotland. There is also an ongoing need to reflect on and develop the style of management appropriate for a post-devolution and post-internal market NHSScotland.

2.126 These are important issues which merit a great deal of consideration across a wide range of organisations and people, including the Scottish Parliament. We intend therefore to take the opportunity to review, in depth, the future management and decision-making structures of NHSScotland. In doing so, we recognise that changes in the structures of NHSScotland and the legislation which governs them may prove to be necessary in the longer term.

2.127 The review will cover issues such as:

- the numbers of different health organisations;
- the configuration of NHS Boards and Trusts;
- the scope for further integrating the work of NHSScotland, Local Authorities, and other agencies in improving health and providing health and social care;
- the style of management appropriate for NHSScotland in the future;
- any consequent need for changes to primary and secondary legislation.

2.128 The review will take into account successful models of health care which exist elsewhere.
2.129 Any proposals for major structural change must be the product of full and considered discussion, debate and consultation. It is anticipated that this work could take two or three years to complete.

2.130 Ministers will announce details of the scope, remit and membership of the review later this year.
3. New performance and accountability arrangements for NHSScotland

Aim

3.1 The new performance and accountability arrangements announced in Our National Health comprise:

- the new Performance Assessment Framework (PAF);
- the development of further national standards for NHS performance; and
- a revised accountability review process.

Together, these measures will enable the Scottish Executive to hold NHSScotland to account for its performance – systematically, reliably and effectively.

3.2 In future, the arrangements in place to hold NHSScotland to account will:

- be fair, objective, and evidence-based;
- address issues of importance to patients and the public;
- look at quality of care and outcomes as well as efficiency and value for money; and
- encourage continuous improvement through benchmarking and sharing good practice.

3.3 The new regime is underpinned by the following broader objectives:

- to encourage collaboration and joint working between health and other key partner organisations locally;
- to place patients and the public at the centre of planning and delivery of care;
- to stimulate public interest in and understanding of the performance of NHSScotland; and
- to promote consistent standards of performance across Scotland.
3.4 Key challenges include ensuring that:
- performance of health bodies is assessed across the full range of their responsibilities – and not only in terms of efficiency and meeting financial targets;
- the new unified NHS Boards engage constructively with NHS Trusts and other NHS bodies in their area to operate joint accountability arrangements in support of a single corporate agenda; and
- there is clear accountability for services delivered jointly by the NHS and other agencies, such as Local Authorities.

3.5 *Our National Health* makes clear that the new accountability arrangements must:
- be **open and transparent**;
- involve **independent assessment**;
- include **evidence-based clinical and service standards**;
- inform the publication of an **annual report** by each **NHS Board**.

3.6 At present, performance assessment arrangements for NHSScotland are perceived as fragmented, lacking in clarity, not sufficiently connected to priorities. There is also a perception that the current approach does not involve local communities sufficiently, does not actively promote consistency across the country and gives insufficient weight to important areas of NHS performance such as quality of patient care, public health measures and equity of access to health care – concentrating instead on indicators of financial performance and efficiency.

3.7 Prime responsibility for performance management of local NHS systems will lie with the new NHS Boards, as set out in paragraph 2.8 above. However, it is also vital that there is a consistent approach to NHS performance management across Scotland.
3.8 The new PAF will therefore support self-assessment by NHS Trusts, and performance management by the new NHS Boards. By incorporating explicit indicators of performance, standards of care, service delivery and efficiency which reflect national priorities and agreements, the PAF will help to ensure that priorities at both national and local level are managed effectively.

3.9 NHS Boards will be required to report to their local communities on the performance of their local NHS. It will be for NHS Boards to decide how best to do this, in consultation with community representatives and key partners. Performance in relation to health improvement will also be reported on collectively by community planning partnerships. The Executive will expect publication of a clear statement of performance as measured by the PAF, on at least an annual basis, including a report on compliance with national and local standards.

3.10 The role of the Scottish Executive will include:
- maintaining the PAF, in consultation with NHSScotland bodies and other stakeholders;
- encouraging effective local performance management;
- analysing national performance information;
- monitoring progress against agreed national targets; and
- assessing performance through accountability reviews with NHS Boards.

3.11 The Executive will also expand the range of published comparative data on the performance of NHSScotland bodies and key measures will be drawn together into a new NHSScotland annual report. Through the accountability review process and the annual planning round, the Executive will agree clear targets and action plans for development and improvement in the performance of each NHS Board area.
The Performance Assessment Framework

we will introduce a new comprehensive performance management framework for the NHS in Scotland which will assess health improvement, clinical outcomes and standards of service alongside good financial management

3.12 The purpose of the framework will be to support a broad-based assessment of the performance of NHS bodies.

3.13 To help provide focus, measures, standards and indicators of performance will be grouped under the following broad headings:

- health improvement and reducing inequalities;
- fair access to healthcare services;
- clinical governance, quality and effectiveness of healthcare;
- the patient's experience, including service quality;
- involving the public and communities;
- staff governance;
- organisational and financial performance and efficiency.

3.14 The framework – and the indicators, measures and standards which it comprises – will develop and change in response to emerging priorities and as new measures of performance become available. Work is well advanced to gather currently available standards, measures and indicators of performance. These will form the core content of the framework, providing a consistent set of measures for all NHS bodies across Scotland.

3.15 It will be very important to keep the elements of the PAF under review to ensure that it is working well and stays focused on the key issues. However, to provide consistent support for improving performance, it will also be necessary for the PAF to be stable – changing only when it needs to. And measures of performance must be carefully chosen to avoid perverse incentives.
3.16 Key characteristics of the framework will include the following:

- measures and indicators of performance will cover each of the fields listed in paragraph 3.13 above, and further work will be undertaken where necessary to fill gaps in coverage and help provide a balanced, comprehensive view of performance across each NHS Board area;

- measures should reflect national priorities and must be used consistently across the Service to aid comparison and benchmarking;

- wherever available, the framework will include standards of clinical performance and other aspects of service quality, based on good practice and involving independent assessment of compliance. Development, implementation and monitoring of performance against these standards will be based, where practical, on the methodology of the Clinical Standards Board for Scotland (CSBS);

- measures will reflect key aspects of the National Services Frameworks, setting out what care patients can expect in the clinical priority areas of cancer, coronary heart disease and stroke, mental health, and other areas as outlined in Our National Health.

3.17 Within the fields of activity listed above, the selection of measures should provide coverage of different settings, client groups, responsible health organisations and health policy priorities. Each measure or standard will include an indication of the settings and client groups to which it relates. In this way, it will be possible to select and present all measures which provide an indication of performance in relation to, say, children as a client group or primary care as a setting.

3.18 The PAF will support performance management and accountability processes at local and national level. This will in turn foster consistent standards and performance across NHSScotland and will help to focus attention on national and local priorities. For local performance management purposes, NHS Boards will be free to include measures and indicators of progress towards locally-set targets alongside the core framework, which will consist of a uniform set of Scotland-wide measures.
3.19 We will issue detailed proposals for standards, measures and indicators in the next few weeks. A subset of core measures within the PAF, for which data is already available, is currently being used by the Executive to track NHS performance in preparation for NHS Boards’ coming on stream, and to help iron out operational issues with the full PAF.

3.20 On the basis of these proposals, we will work with key stakeholders to produce a comprehensive and detailed framework, which will be available for use by NHS Boards by 30 September 2001.

Developing standards

3.21 *Our National Health* states that NHSScotland will develop consistent standards of service across the NHS. Much work is being undertaken, principally by the Clinical Standards Board (CSBS), to develop clinical standards; and a programme of development is under way also in relation to other aspects of service quality. The Executive is discussing the programme for developing and implementing these standards with the CSBS and others with an interest.

3.22 As well as developing new standards, the Executive is committed to working with existing organisations which review and report on the performance of NHS bodies. These include Audit Scotland, the CSBS, the Royal Colleges, the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS), the Scottish Health Advisory Service (SHAS) and others. The Executive’s aim is to promote continuing coherence and as far as possible to avoid overlap.
3.23 In addition, we have commissioned or are commissioning work on standards on hospital cleanliness and hygiene, decontamination and infection control, hospital catering services and staff governance.

3.24 In line with commitments in *Our National Health* to involve people in health service planning and delivery, the Executive will work with Local Health Councils, the Scottish Consumer Council and other key stakeholders to put in place effective mechanisms to involve patients in the setting and monitoring of standards.

**Accountability reviews**

- we will replace the current, fragmented accountability arrangements with a new accountability review process
- Chairs and Chief Executives will sit on the new unified NHS Boards and be held jointly accountable for the performance of the local health system
- local staff partnership forums will be directly involved in assessing the performance of NHS Boards as employers, as part of the new accountability arrangements

3.25 Formal accountability reviews will be held at least annually between the Scottish Executive Health Department and the new NHS Boards. The basis for the reviews will be provided by the PAF, including independent assessments of performance by, for example, local partnership forums.

3.26 The purpose of the reviews will be to reach a shared view between the NHS Board and the Executive of the level of performance reached by each local NHS system, across a range of areas of activity, on the basis of measures and indicators recorded in the PAF, of published reviews by bodies such as CSBS, and of progress against objectives and actions set out in published Local Health Plans and community plans.
3.27 Where strong performance is identified, the reviews will explore ways of reinforcing this. Where performance is identified as needing strengthening, the reviews will explore and agree necessary action. In this way, NHS Boards and Special Health Boards will be held formally to account annually by the Executive. The reviews will also provide an opportunity to consider forward plans and to probe future challenges and opportunities.

3.28 Key features of the accountability review process will include:
- sharing of assessments and other information between the NHS Board and the Executive beforehand so that attention is concentrated on the substance and not the detail;
- comparison of performance with previous periods to show trends; comparison of performance with plans; and comparison with achievements of other NHS Boards and with Scottish averages to enable objective, well-supported assessments of strong and less strong performance to be reached;
- review of independent assessments of performance (including peer review and assessment by key local stakeholders) against accepted and published standards;
- discussion of ideas for change and innovation put forward by the NHS Boards;
- agreement of programme of action for future to address national and local priorities, and set appropriate targets.

3.29 By drawing on assessments of performance derived from the PAF, the accountability reviews will be as far as possible objective and evidence-based. They will concentrate on actual performance in the period past and the factors bearing on it.
3.30 The outputs from each accountability review will be an overall assessment of performance of the local NHS system; a letter from the Scottish Executive to the Chair of the NHS Board conveying this assessment and setting out in general terms the action which has been agreed to reinforce good performance and to strengthen weaker performance; and an agreed action plan listing key points for attention by the local NHS system and a timescale for doing so. The intention is that the letter will be made public by the NHS Board.

3.31 The Executive will use its assessment of the overall performance of a local NHS system as a guide when considering a range of health management issues. It will be important to use this assessment sensitively. For example, it would not be appropriate to withhold health funding which would benefit the public in an area because of weak performance by the NHS bodies concerned. At the same time, NHS bodies should have clear incentives to maintain and improve performance. Effective input by the NHS Boards, and strong local accountability arrangements, have a key role to play here.

3.32 Possible incentives for strong performance available to the Executive might include varying the amount of detailed justification required from NHS bodies in seeking approval from the Health Department for capital schemes; the choice of location of innovative projects or pilot schemes to be funded by the Health Department; and the frequency with which performance monitoring and accountability review meetings take place.

3.33 The Executive also expects staff governance committees at local level to take account of the overall assessed performance of the relevant NHS organisations in making decisions about senior managers’ eligibility for performance bonuses (although not for pay progression).
3.34 It will be for NHS Boards and Trusts to decide how to use the PAF and the accountability review process at local level to reinforce and provide incentives for effective performance and to help develop plans and set priorities for the local NHS system.

**Publishing the results of the accountability review process**

3.35 The assessments of performance based on the PAF will be open and transparent. NHS Boards will publish in their annual reports performance information relating to all significant aspects of their work, including the results of independent assessments. They will also publish the Department’s overall assessment letter, as noted above.

3.36 We will issue guidance on what minimum performance information is to be included in NHS annual reports, to aid clarity and to assist inter-area comparison. NHS Boards will also show in their reports their objectives for future years, and will be expected to report achievements against these in future.

3.37 Effective local accountability arrangements go wider than annual reporting. NHS Boards will work with their local communities to improve further their approach to communicating with local people and other stakeholders. They will be expected to report on health improvement actions jointly with Local Authorities and other partners through the community planning process.
Other measures to support good performance

3.38 Innovations and new ways of working must be developed and shared in the NHS throughout Scotland – prompt dissemination of best practice must become the norm. Retention of information confers no advantage – we must share our work and our success stories.

3.39 The development of the PAF and of accountability reviews will augment but does not replace work already under way across the NHS to identify and support good performance. The Service must consistently pursue a culture of continuous improvement, and NHS Boards and senior managers must act to reinforce this. The PAF and the accountability review processes will provide a stimulus, but effective action rests at local level.

3.40 Benchmarking is an effective means of self-assessing comparative performance and of sharing good practice. NHS bodies in Scotland are already closely involved in a number of benchmarking activities. These and other initiatives will help to create a climate for continuous improvement, thus underpinning the objectives of the PAF and the revised accountability review process.

3.41 Other continuing work to help support good performance includes:
- the ongoing CSBS programmes of clinical and non-clinical standard setting, self-assessment and peer review;
- clinical outcomes and clinical audit work sponsored by CRAG;
- the work of Audit Scotland, at national and local level, on efficiency and effectiveness; accreditation reviews by professional bodies;
- externally-validated standards such as Investors in People and EFQM accreditation; and
- the work of researchers and others on NHS performance issues.

All of these have a part to play in supporting continuous improvement in NHS bodies in Scotland. The PAF and accountability review processes will be developed in the light of them.
Next steps

3.42 Full implementation of the proposed changes to the performance and accountability arrangements will be phased as follows:

- in the next few weeks, we will publish a draft Performance and Accountability Framework, which – together with this change programme – will form the basis for a structured dialogue with NHS and other stakeholders in the period to July 2001. The results of this dialogue will be incorporated in the PAF and in the proposals for the accountability review process;

- by 30 September 2001, we will work with NHSScotland to ensure that the new performance assessment and accountability review arrangements are clearly defined, are understood, and include relevant service standards under development by the Clinical Standards Board for Scotland and others;

- the key elements of the new performance and accountability arrangements will be in place by 30 September 2001. This will include:
  - the Performance Assessment Framework for newly established NHS Boards;
  - details of the new accountability review process, which will be used to support reviews of NHS performance during 2001-02;
  - a programme of establishing and implementing further NHS service standards.
4. The revised financial framework

Aim

4.1 Existing financial systems in NHSScotland are complex and – particularly in relation to NHS Trusts – derive from the requirements of the internal market. These are now inappropriate for a patient focused, partnership based, NHSScotland. The changes to the financial systems as set out in the Scottish Health Plan aim to simplify the way money flows in the local NHS system allowing greater flexibility for financial planning over the longer term.

4.2 The new system will form an integral part of the revised accountability and governance arrangements and the revised performance management framework. The aim is to develop a whole system approach to financial management, accountability and planning which maximises the return on additional investment and provides a better system for the planning and delivery of specialist services.

Outline of the changes

- we will review existing financial systems to ensure that resources flow and are managed in a way that is effective, efficient and accountable. The review will provide initial proposals for change by March 2001.

4.3 The Scottish Health Plan stated that initial proposals for change would be put forward in spring 2001. Given the complexities of the financial system, a number of the proposed changes being considered require further detailed review and examination to ensure that they operate effectively in practice.
Financial targets

4.4 Health Boards and NHS Trusts currently have different financial targets. Health Boards have a target to stay within their cash limit (on the introduction of resource budgeting they will also need to work within their resource limit). Trusts have to achieve three financial targets, break even taking one year with another, meet their external financing limit (EFL) and achieve a 6% return on net relevant assets. Only the break-even target is set out in statute but each has been treated as being equally important within the current financial regime.

4.5 Achieving financial targets is important, but insisting on their being met precisely every year may lead to sub-optimal decisions. It is felt that greater flexibility around the targets will facilitate better financial planning over the longer term and ensure that the NHS system obtains best value for money with the resources available to it.

Cash control

4.6 Good financial discipline continues to be of prime importance in the NHS and in line with other public sector organisations the management of cash continues to be a high priority. The need to manage within the external financing limit will therefore remain at least in the short term. We are considering alternative methods of strengthening control of cash and capital within the financial regime.

4.7 The requirement to break even taking one year with another is set out in statute and therefore must also remain as a target. In any case it is a sound and easy to understand measure. The retention of cash controls and the break even target will provide good indications of strong financial management in the NHS, one demonstrating the control of cash, and the other demonstrating the control of income and expenditure.
6% return

4.8 The requirement to achieve a 6% return on net assets is one part of Trusts’ capital charges and is intended to represent the cost of using capital. This concept is difficult to understand and is often seen as a charge on Trusts which is diverting resources away from patient care. Capital charges are currently being introduced across the public sector as part of the resource accounting and budgeting initiative. This is intended to improve the management of capital assets across the public sector. The return on assets is therefore another financial management tool. However its profile as a key financial target is misleading and the requirement to achieve it exactly each year may hinder long term financial planning.

4.9 Consideration is therefore being given to allowing greater flexibility over the requirement to achieve a 6% return. Trusts will still be required to plan, and include within costs, a 6% return. However, the primary target will be that the Trust should break even, taking one year with another. This is defined as having a cumulative surplus on the income and expenditure account. That will, in itself, normally result in Trusts’ also meeting the 6% rate of return. However, we are considering what further safeguards may be necessary to protect the Scottish Executive’s budget. In any case, Trusts will be required to state the rate of return actually achieved and explain any significant deviations from 6% in a note to their accounts.

A whole system approach

➔ In future, the new NHS Boards will be accountable for the financial performance of the whole local NHS system

4.10 Health Boards and Trusts currently report their financial position regularly to their own Boards and submit separate monitoring information to the Scottish Executive.
Financial planning

4.11 Sound financial planning across the whole of a local NHS must underlie, and complement, the Local Health Plans which are to underpin the new NHS Boards’ planning procedures and which are described elsewhere in this change programme.

4.12 Each NHS Board will be required to submit annually a five year financial plan showing how available resources will be used to support NHS activity in the area while maintaining firm financial control and achieving financial targets.

4.13 The Scottish Executive Health Department will provide as firm an indication as possible of the resources to be allocated to each NHS Board for the forward 3 years. Financial plans should be based on that information over that period. For the latter 2 years of the 5 year plan a range of assumptions should be considered for the size of any increased allocation.

4.14 In the interim, the Scottish Executive will require a copy of the joint financial plan to be submitted with the normal monitoring returns.

Reporting and monitoring

4.15 To facilitate the joint reporting which is within the whole system approach, changes to the reporting and monitoring arrangements are required. Health Boards and Trusts in an area will be expected to produce a joint financial report on a regular basis throughout the year.

4.16 Initially, this will be reported at the Health Board meetings until the NHS Boards are formally established. The key elements of this report should be:
- current and projected income and expenditure position;
- current and projected cash position;
- level and plans for the use of any reserves; and
- supporting narrative setting out key issues and corrective actions as required.
4.17 The monitoring arrangements by the Scottish Executive for Boards and Trusts will remain separate for the financial year 2001-02. This will allow further consideration to be given to the format and content of future monitoring information to be submitted to the Executive and to allow appropriate systems amendments to be made.

**Consolidation of reporting**

4.18 In relation to financial information, there are a number of issues which require further consideration. These relate primarily to the consolidation of financial information between all the organisations covered by the NHS Board, the format this should take and the frequency with which consolidated information should be compiled.

4.19 Consolidated financial information will provide a single focus for accountability and performance of the local health system. Consolidation will require consistency between NHS Board and Trust financial regimes and further work needs to be done on the changes required, in particular how balance sheets are structured. Consideration will also be given to the current arrangements of accounting for capital including the methodology for revaluation.

4.20 In terms of financial reporting at the year end, it is recommended that Health Board areas produce a joint annual report and this report contains, as a minimum summary financial information for each NHS body. Where possible, this information should be consolidated. The ability to include consolidated information for 2000-01 may be constrained if there are different auditors for each of the NHS organisations in the area. It is intended that, for future years, consolidated financial information will be required in the annual report. Further consideration will also be given to the production of consolidated annual accounts for the unified NHS Board.
Three-year financial management

We will enable NHS Boards to manage their finances over a three year cycle and to simplify the way money moves round the system to ensure it reflects what patient care needs

4.21 NHS Boards will be given firm allocations for the first year, and guaranteed minimum allocations for the next two years. This will allow the adjustments necessary to move towards implementing Fair Shares for All to be made when relevant information is available. In turn, this will allow the local NHS system to plan and develop services over a three-year timeframe.

4.22 As part of the discussions about the longer term changes to be made to the financial regime, we intend to increase the flexibility allowed on the achievement of financial targets and the timescales over which financial targets should be met, subject to appropriate safeguards being in place.

4.23 Significant strategic change in NHS Board areas means that achievement of a financial target in each and every year may be detrimental to this change process. In order to facilitate change and maximise the return on the additional investment being made in NHSScotland we will consider allowing achievement of financial targets over an extended timescale and will need to consider how shortfalls are managed across the whole system.

4.24 In order to simplify the financial framework consideration will be given to those areas where cashflows appear inappropriate or over-bureaucratic. In particular we will look at capital charges and how these flow within the system. We will look at the Common Services Agency and the cash and accountability arrangements in relation to Primary Care Trusts and the current Health Boards, reviewing and building on the arrangements which were put in place in April 1999.
Funding of specialist services

we will simplify the funding of those specialist hospital services provided to more than one NHS Board area

4.25 Defining “specialist services” is important and once determined will clear the way to consider the commissioning arrangements. However, it is important also to consider this matter in the wider context of the Plan’s other commitments. These include streamlining the current financial regime, and developing a framework for integrated national, regional and local planning.

4.26 The first task is to define specialist services for this purpose. We plan to adopt a wide definition. We will work with NHS Boards, Trusts and the National Services Division of the Common Services Agency to develop proposals for how to commission these services.

4.27 Current arrangements vary considerably across Scotland, with the West of Scotland furthest advanced. We will build on the successful models already in place, and spread good practice throughout Scotland.

4.28 The issues which a Commissioning Framework will cover, will include:
- regional or, when appropriate, national agreement on funding high cost/low volume activity;
- regional or national agreement on funding treatment provided at only a small number of locations;
- the establishment of regional or national risk management pools;
- simplified funding flows for regional agreements – perhaps channelling all the funds for some services through a single NHS Board;
- agreed rules on the pace of change for dis-investment;
- simplified arrangements for funding Scottish patients treated in England.
The work will be taken forward on the following timetable.
- initial formation of regional consortia by or before September 2001;
- agreement on formal structure and future agenda for each consortium by mid-January 2002; and
- implementation of any proposed supra-regional and/or regional financial risk pooling arrangements from April 2002.

Other issues

Unified budget

We are considering a move towards including family health service resources together with hospital and community health and GP prescribing resources in a single budget. The potential advantages of this change include the increased flexibility it would give to NHS Boards in allocating resources and, over time, changing the pattern of resource allocation in their area.

Much of the expenditure on family health services is fairly readily predictable, depending as it does on the number of primary care practitioners operating in an area. Nevertheless, the unification of the budget would need to be handled carefully and over a reasonable period of time, especially since substantial movement is required to achieve the appropriate share of general medical services resources in each NHS Board area, as identified in the Arbuthnott Report *Fair Shares for All*.

Capital

The capital resources allocated to the Health Programme currently fall into three main groups. First, a “formula allocation” is issued to each NHS Trust to be used for lower value capital developments and the purchase of items of equipment. The bulk of the resources available are held in a central pool and allocated for specific large scale building or equipment projects. The third source of funding for capital is public private partnerships.
4.33 We plan to reform the capital planning and funding arrangements in Scotland. We will:
- increase the formula allocation in the year from April 2001 so that NHSScotland is properly funded to maintain and replace buildings and equipment;
- maintain strict controls over capital to revenue transfers;
- publish clear criteria by autumn 2001 for identifying projects to be funded from the capital pool;
- consider by summer 2002 how to distribute more capital to NHS Boards for them to use to meet local priorities.
5. New planning arrangements

Aim

➔ in each NHS Board area, the existing separate Health Improvement Programmes and NHS Trust Implementation Plans should be replaced by a single comprehensive document – a Local Health Plan

5.1 Our National Health signalled several changes to planning arrangements in Scotland, with the overall objective of promoting collaborative planning and encouraging effective joint working.

Joint health improvement plans as part of community planning

5.2 There will be changes in the way public health and health improvement activity is planned. NHS Boards will work with Local Authorities, and other partners within community planning partnerships, to develop joint local health improvement plans for each Local Authority area. These will be key chapters in community plans. Overall responsibility for agreeing the local health improvement plans will lie with community planning partnerships.

5.3 These plans will set out objectives, strategies and actions for each organisation to improve the health of the local population. There will be local arrangements for reviewing and reporting on progress against the plans in the context of reporting on community plan achievements generally.

5.4 In this way, the organisations which can are best placed to tackle public health and health improvement issues at local level will be brought together to plan, execute and review actions. Local joint planning, collaborative action – for example, jointly funded posts between Local Authorities and NHS Boards – and reporting to communities on progress will help to increase further the effectiveness of public health and health improvement actions and to promote understanding of and support for this agenda among communities across Scotland.
Local Health Plans

5.5 Each NHS Board will draw up a single Local Health Plan for its area. The Plan will include NHS action points from the joint local health improvement plans drawn up for each Local Authority area in which the NHS Board operates.

5.6 The Local Health Plan will also include health care plans covering primary, community, secondary and tertiary services provided by NHS bodies in the Board area. The Plans will replace the former Health Improvement Programmes and Trust Implementation Plans, but not necessarily in the same form or to the same level of detail. The Local Health Plan will set out a clear financial strategy which demonstrates that the actions and developments proposed are affordable.

5.7 Preparing Local Health Plans will promote integration between primary, community and secondary health care. It should also lead NHS Boards to review the regional dimension of health care and the scope for sharing resources with planning partners, including neighbouring NHS systems. The plans should also set out how the resources and priorities of other local organisations, including Local Authorities and the voluntary sector, will be drawn together to care effectively for particular client groups such as the elderly and those with learning disability.

5.8 The aim of Local Health Plans is to ensure a co-ordinated, joint approach to planning and delivering the health agenda, and should provide a sharp focus on the actions for which the NHS is responsible, including public health/health improvement and health care services. This will translate into better informed and more rigorous planning, and consequently more effective and responsive services.
Regional and national service planning

5.9 A more systematic approach will be developed to planning health care services which are best provided on a regional or national basis.

5.10 Regional planning already takes place between Health Boards; and the National Services Directorate of the Common Services Agency supports a programme of specialist acute services which are available to patients throughout Scotland.

5.11 Developments in health care generally, and increased specialisation in some acute services, implies changes in the number and extent of services which are best provided regionally and nationally. More effective planning of these services will link with improvements in financial flows between NHS Boards. More systematic regional and national service planning will help ensure that services are provided at the most appropriate level, and that NHS Boards and patients are clear about what that level is.

Next steps

5.12 By September 2001, we intend to produce guidance on health improvement planning for community planning partnerships, including Local Authorities, NHS Boards and their planning partners, on developing, delivering and accounting for results from local joint health improvement plans within the community planning framework. This will include guidance on the frequency with which joint health improvement plans should be revisited.

5.13 By October 2001, we will also provide guidance on drawing up Local Health Plans, so that Local Health Plans in respect of 2002-03 and beyond can be drawn up on the basis of the guidance.

5.14 Work on regional and national planning of acute services will be led by the Health Department, drawing on advice from those who commission, provide and use regional and national services.
6. Role and functions of the Scottish Executive Health Department

Aim

6.1 The overall aim of the Scottish Executive is to “improve the well being of Scotland and its people”.

6.2 Specifically, the Scottish Executive Health Department’s purpose is to work with NHSScotland to improve health and health services for the people of Scotland.

6.3 Improving health is a long-term commitment and part of the Executive’s commitment to achieving social justice. Many services and agencies must work together to improve health and to empower individuals and communities to build better health.

Role

6.4 In achieving its purpose, the Health Department’s role is:

- to improve, protect and monitor the health of the people of Scotland, implementing policies which address inequalities in health, prevent disease, prolong life and promote and protect health;
- to develop and deliver modern, person-centred, primary care and community care services, in which high-quality, integrated services are delivered close to patients’ homes and ensuring that there is support and protection for those members of society who are in greatest need;
- to provide modern, high quality, responsive hospital and specialist services, working in partnership with patients to provide services designed from the patient’s perspective, harnessing new technology to improve services for patients and ensuring that patients’ rights are respected and protected.
Functions

6.5 The Scottish Executive Health Department is an integrated body, responsible for both the executive leadership of NHSScotland and the development and implementation of health and community care policy.

6.6 The functions of the Health Department include:

- **strategy development**
  - developing health and community care policy, in dialogue with key stakeholder groups;
  - working together with other government departments and agencies to achieve cross-cutting policy objectives, in particular social justice;

- **resource allocation**
  - securing and allocating appropriate, timely and sufficient resources for all NHSScotland organisations and other bodies sponsored by the Health Department;
  - exercising financial propriety and regularity and ensuring the economical, efficient and effective use of resources;

- **implementation**
  - guiding and monitoring the implementation of policy;
  - providing strategic national leadership and direction for NHSScotland;
  - co-ordinating and developing effective management and leadership across all NHSScotland organisations;
  - issuing guidance to NHS Boards on organisation and management issues;
  - establishing a framework for the planning and delivery of health services and disseminating this to NHS Boards through annual priorities and planning guidance;
• encouraging collaboration and joint working between health and other key partner organisations;
• facilitating the local implementation of national strategy by means of programmes such as National Services Frameworks, Managed Clinical Networks and the Remote and Rural Areas Initiative;

- performance management
• promoting consistent standards of performance across all NHSScotland organisations;
• monitoring and holding to account NHSScotland organisations, including NHS Boards, for their performance, by means of the new Performance and Accountability Framework and Accountability Review process;

- supporting Scottish Ministers and accounting to Parliament and the public
• providing objective and impartial advice and support for Scottish Ministers;
• providing assistance to Parliamentary Committees in their scrutiny functions, in particular, the Health and Community Care Committee;
• representing Scottish interests at United Kingdom level on matters which impact on health and community care;
• providing timely, relevant and accurate information to the public on health and community care matters in accordance with the demands of open government.

Accountability
6.7 The Health Department is accountable for the exercise of its functions to the Scottish Ministers, and in particular, the Minister and Deputy Minister for Health and Community Care, who, in turn, are accountable to the Scottish Parliament.

6.8 The Department is also under the obligation to explain its policies and provide information to the public.
6.9 The Head of the Health Department is also Chief Executive of NHSScotland. As Chief Executive and “accountable officer”, the Head of Department is directly answerable to the Scottish Parliament for financial propriety and regularity and for the economical, efficient and effective use of the resources allocated to the Department and to NHSScotland.

6.10 The Head of the Health Department and Chief Executive of NHSScotland is supported by the Health Department Board. The key functions and responsibilities of the Board are:

- performance management of NHSScotland;
- co-ordination of the development of strategic health policies; and
- management of the Scottish Executive Health Department.

The Health Department and NHSScotland

6.11 The Health Department is committed to developing closer working relationships with all NHSScotland organisations. This applies generally to improving the quality and efficiency of communications, as well as to specific matters such as the allocation of financial resources and the way the Service is held to account.

6.12 New performance and accountability arrangements, in particular, will redefine the relationship between the Department and NHSScotland. How this will work in practice is set out in some detail in the section of this programme which deals with the new accountability review process (see paragraphs 3.25 to 3.37 above).

6.13 In addition, revised planning processes at national and regional level will demand significant interaction between the Health Department and NHS organisations (see paragraphs 5.10 and 5.11 above). Medium-term financial planning at NHS Board level will be simplified by increased availability of advance information from the Health Department on financial allocations (see paragraph 4.16).
6.14 Increasingly, too, priorities are being set and policies mapped out only once the Department has fully involved the Service in discussions at an appropriate level. Modern policymaking is not an isolated activity: it is an inclusive process which must involve all key stakeholder groups. There is a sensitive balance to be struck between national priorities, which are set by the Executive, and responsibility for implementation, which lies at local level.

6.15 In order to cement the relationship between the Department and the Service, and to improve the way the NHS communicates – both internally and outwards to patients and communities – *Our National Health* includes a commitment to developing a joint communications programme for the Health Department and NHSScotland, which we shall be working on over the coming months:

- we will develop a communications programme for the Scottish Executive Health Department and the NHS in Scotland. The new NHS Boards will be expected to put in place effective communications arrangements for the local health system
Annex: Role of members of NHS Boards

“ As a member of an NHS Board, you will be expected to:

- participate fully in the governance of the local NHS system;
- contribute to strategic leadership and planning within the local NHS system;
- work with the Chair and other members of the NHS Board to discharge the functions of the NHS Board, which will comprise:
  - strategy development – to develop a single Local Health Plan which addresses the health priorities and health care needs of the resident population;
  - resource allocation to address local priorities – funds will flow to the NHS Board, which will be responsible for deciding how these resources are deployed locally to meet its strategic objectives;
  - implementation of the Local Health Plan; and
  - performance management of the local NHS system;
- accept collective responsibility, with the Chair and other members of the NHS Board, for decisions of the Board.
- work with and fully represent the Board’s activities, in an honest and positive way, to:
  - the local community;
  - local authorities;
  - elected community representatives;
  - all other interested parties;
- actively work with other NHS Boards, Acute and University NHS Trusts, Primary Care NHS Trusts, Local Health Care Co-operatives and other local service providers to ensure an integrated approach to providing health and community care services, and health improvement schemes;
- put into action the Scottish Executive’s policies and priorities as set out in the Programme for Government, for example, as they relate to health and healthcare, social inclusion and community development. In particular, you will work with all stakeholders in the local NHS system and nationally to implement the actions set out in Our National Health: A plan for action, a plan for change – the Scottish Health Plan (SEHD, December 2000);
- work with all health organisations and the Scottish Executive Health Department to make sure there is a corporate approach to implementing government health policy;
- develop an effective working relationship with other NHS Board members and staff within the local NHS system to implement the decisions of the Board;
- participate in training and development opportunities designed to help you perform effectively as a member of the NHS Board;
- adhere to the Standards of Conduct, Accountability and Openness of NHSScotland
- help ensure that organisational values and aims are clearly explained, understood and applied throughout the whole organisation;
- participate in, and potentially chair, committees of the NHS Board and the local NHS system, such as audit and clinical governance;
- be accountable to Scottish Ministers, through the Minister for Health and Community Care, for the decisions of the NHS Board and the overall performance of the local NHS system.

**Your opportunities**

As a member, you will:
- be able to contribute to the development of Scotland’s health service, which people depend on 24 hours a day, 365 days a year, and which is one of the best in the world;
- be able to help improve the health of the people in your community;
- be able to plan and deliver high quality healthcare for the people in your community;
- get support and training from both the Scottish Executive and the organisation to help you in your role;
- have the opportunity to contribute to the development of health policy at a national level by working with the Scottish Executive Health Department and the Minister for Health and Community Care.

**Time commitment**

As a member, you will probably need to spend around 8 hours a week on Board business, sometimes this may be in the evenings or at weekends.”