

THE NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

KATHLEEN ROBSON

The NHS Reform Bill is an Executive Bill introduced to Parliament by Malcolm Chisholm on 26 June 2003.

The primary aim of the Bill is to reform the organisation and management of the NHS in Scotland. The Bill seeks to abolish the last vestiges of the internal market by dissolving NHS Trusts and integrating the management of acute and primary care services into NHS Boards. The reforms also intend to devolve decision making and resources to frontline staff through the establishment of Community Health Partnerships.

The Bill also contains proposals to:

- place a duty of co-operation on Health Boards – and so promote the development of Managed Clinical Networks
- give Ministers greater powers to intervene where health services are deemed to be failing
- allow greater involvement of the public in service planning
- dissolve local health councils
- place a duty on Health Boards and Ministers to promote health improvement

This paper contains an outline of the background to the reforms and the current organisation of the NHS, the consultation process that took place, a detailed look at each section of the Bill as well as initial reactions and issues that have been raised in response to the proposals.

SPICe Briefings are compiled for the benefit of the Members of the Parliament and their personal staff. Authors are available to discuss the contents of these papers with MSPs and their staff who should contact Kathleen Robson on extension 85371 or email Kathleen.Robson@Scottish.Parliament.uk. Members of the public or external organisations may comment on this briefing by emailing us at spice.research@scottish.parliament.uk. However, researchers are unable to enter into personal discussion in relation to SPICe Briefing Papers.

Every effort is made to ensure that the information contained in SPICe briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.



SUMMARY OF KEY POINTS	3
INTRODUCTION & BACKGROUND	4
The Internal Market/Managed Competition	4
A Timeline of Reforms 1997-2003	4
Main Objectives of the Bill	5
THE BILL PROPOSALS	6
Organisation of the NHS in Scotland	6
Abolition of NHS Trusts.....	6
Background and Consultation	6
The Bill Proposals	7
Issues and Reactions	7
Establishment of Community Health Partnerships	7
Background and Consultation	7
The Bill Proposals	8
Issues and Reactions	8
Possible Future Structure of the NHS in Scotland	9
Operation of the NHS in Scotland	10
Duty of NHS Boards to Co-operate.....	10
Background and Consultation	10
The Bill Proposals	10
Issues and Reactions	10
Powers of Intervention	10
Background and Consultation	10
The Bill Proposals	11
Issues and Reactions	11
Public Involvement and the Dissolution of Local Health Councils	11
Background and Consultation	11
The Bill Proposals	12
Issues and Reactions	12
Promotion of Health Improvement	13
Background and Consultation	13
The Bill Proposals	13
Issues and Reactions	13
Financial Consequences	13
Abolition of Trusts and Establishment of Community Health Partnerships	14
Duty to Encourage Public Involvement	14
Duty to Promote Health Improvement.....	14
Other Issues	14
Staff Governance	14
Sources	16

SUMMARY OF KEY POINTS

The Bill:

- represents the latest in a series of health service reforms since 1997
- seeks to create a decentralised, integrated health care system
- seeks to remove the statutory powers of NHS Trusts and thereby remove the last vestiges of the internal market
- requires NHS Boards to establish Community Health Partnerships which will evolve from Local Health Care Co-operatives and bring together primary care professionals and planning partners
- aims to improve public involvement in health service development by imposing a duty on NHS Boards to encourage public involvement
- dissolves local health councils to make way for the establishment of a national health council within NHS Quality Improvement Scotland
- imposes a duty of co-operation on NHS Boards, in order to encourage the development of cross-regional planning and allow Boards to fund services for people outwith their own area
- seeks to enhance the powers of Ministers to intervene in areas where there are deemed to be service failures
- gives Ministers and NHS Boards a duty to promote health improvement to allow the health improvement agenda to be taken beyond the NHS and the voluntary sector

INTRODUCTION & BACKGROUND

The NHS Reform Bill ("the Bill) represents the latest in a series of reforms by the coalition Executive to transform the NHS in Scotland (NHSiS). Since 1997, there have been four health white papers and a review of acute services. The last white paper, [Partnership for Care](#) (Scottish Executive 2003a) presented the current proposals set out in the bill. The bill embodies changes that would complete the abolition of the internal market established in the 1990s by the Conservative government.

THE INTERNAL MARKET/MANAGED COMPETITION

The Conservative government introduced a quasi market that divided the NHS into purchasers (Health Boards and Fundholding General Practitioners) and providers (Primary Care Practitioners and Hospitals), while the NHS and Community Care Act 1990 allowed for the establishment of NHS Trusts as self-governing public corporations within the NHS. The aim of these reforms was to increase efficiency and improve quality by introducing an element of managed competition that allowed providers to compete with each other for the 'business' of purchasers. This led to criticisms of providers 'cream-skimming' which encouraged a two-tiered system of healthcare.

A TIMELINE OF REFORMS 1997-2003

In 1997, the new Labour government affirmed its commitment to ending the NHS internal market. In Scotland this was signalled by the publication of the white paper [Designed to Care: Renewing the National Health Service in Scotland](#) (Scottish Office 1997). The vision set out in *Designed to Care* was:

"...a National Health Service for the people of Scotland that offers them the treatment they need where they want it, and when: a modern "designed" health service putting patients first. We want a seamless health service centred on primary care, designed to ensure that patients receive care quickly and with certainty."
(Section 1, para 1)

A key characteristic of the reforms since 1997 has been the vision of an 'integrated' healthcare service as a means of improving quality and reducing costs. This is a policy objective witnessed worldwide and pursued through a variety of different models. In Scotland, initial policy changes aimed towards further integration by encouraging partnership among NHS bodies.

The internal market was dismantled by the Health Act 1999. This act ended GP fundholding and contracting for services and, despite being seen as a key component of the internal market, Trusts were retained as the organisations responsible for the operational management of healthcare services, although the number was halved. Two distinct types of Trust were established - Primary Care Trusts (PCTs) and Acute Hospital Trusts (AHTs). PCTs became responsible for general practitioner services, community hospitals and mental health services, while AHTs were responsible for providing clinical services for emergency admissions, planned admissions and medical specialities. Strategic management became the preserve of Health Boards and the purchaser/provider split was relabelled as the strategic/service divide. Instead of managed competition, Boards and Trusts were expected to work in partnership.

Local Health Care Co-operatives (LHCCs) were also established as a way of integrating care at a local level. LHCCs are groups of primary care professionals that voluntarily come together to plan and deliver services for their area.

The emphasis on commissioning and purchasing of services was replaced by the requirement for Health Boards to publish 5-year rolling Health Improvement Plans (HIPs) with Trusts implementing the parts relevant to them via a Trust Implementation Plan (TIP). Boards and Trusts were then held to account in the annual accountability review by assessing their performance against the plans.

Reforms were progressed further with the publication of [*Our National Health: A Plan for Action, a Plan for Change*](#) (Scottish Executive, 2000). The system of HIPs and TIPs was changed to have a single local health plan against which the performance of the entire local health system would be judged, thus providing a single point of accountability. Unified NHS Boards were created through changes to the membership and procedures of Health Boards, thus creating a place on the Board for Trust Chief Executives as well as local government and staff representatives. Although this was intended to simplify accountability mechanisms, the continual existence of the Trusts with independent legal status has meant the current configuration is seen as being unnecessarily bureaucratic (Scottish National Party 2002; Scottish Liberal Democrats 2003).

In addition, the success of LHCCs throughout Scotland has been recognised as patchy (LHCC Best Practice Group 2001) and there is a perception that care at the interface between acute and primary care is weak (NHS Scotland Forum 2002). The interface between health and social care has been strengthened in recent years through the Joint Future agenda (Joint Future Group 2000) but this has not been paralleled in acute and primary care. Efforts have been made to make primary and secondary care 'seamless', for example through Joint Investment Funds¹ (JIF) but this was a voluntary measure not taken up to any great extent and was subsequently discontinued by the health plan.

MAIN OBJECTIVES OF THE BILL

The Bill is significant in that it seeks to achieve a decentralised, integrated health care system through:

- ***changes to the system's structure and organisation*** – the dissolution of NHS Trusts, the so-called 'last vestiges' of the internal market and the integration of the management of primary and acute healthcare services within Health Boards
- ***the decentralisation of decision making and resources*** – through the formation of Community Health Partnerships with increased control over service development and devolved budgets
- ***increasing public involvement in NHS decision making*** – by giving NHS boards a statutory duty to consult the public, the creation of community health partnerships and the dissolution of local health councils to make way for a new national body to oversee public consultation.
- ***the development of regional planning and services*** – by placing a duty of co-operation on Health Boards, thereby encouraging the development of clinical networks.

The Bill also aims to give ministers greater powers to intervene where services are deemed to be failing, and impose a duty on Ministers and NHS Boards to promote health improvement.

¹ The Joint Investment Fund was a fund that was intended to facilitate cross-sector working in the NHS. It was not a separate fund of money, it was a pooled budget agreed between Primary Care and Acute Trusts for the redesign of services, the responsibility for which was held by Primary Care.

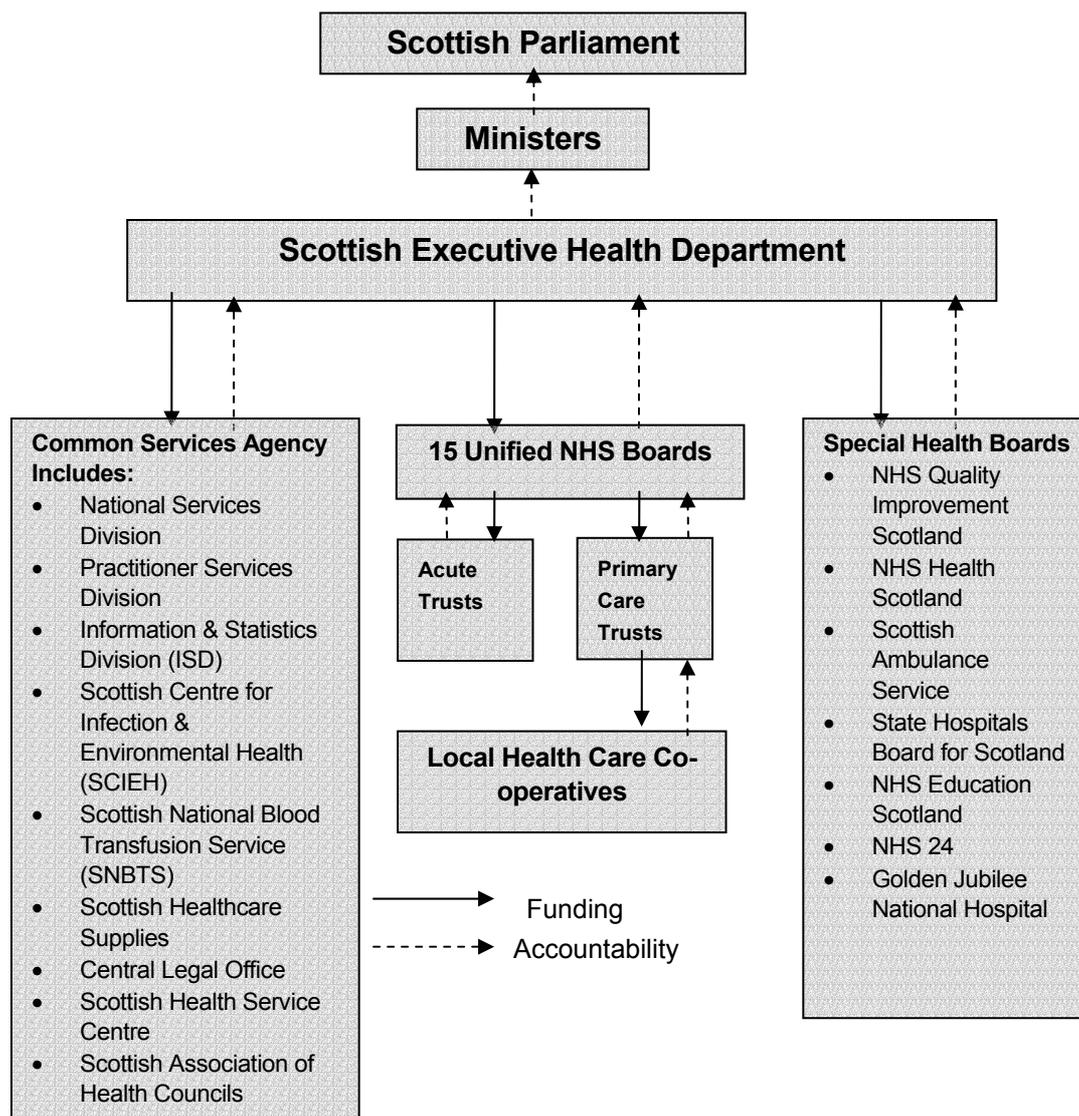
THE BILL PROPOSALS

ORGANISATION OF THE NHS IN SCOTLAND

Abolition of NHS Trusts

Background and Consultation

The following diagram outlines the current structure of the NHS in Scotland. For a more detailed background of the workings of the NHS in Scotland see a recent SPICe briefing (Robson 2003).



Although the diagram shows the accountability line of Trusts going upwards to NHS Boards, this reflects the reality of accountability review practices as opposed to statutory lines of accountability. As independent legal entities, Trusts are formally accountable to Ministers and to Parliament.

During 2002-03, the Scottish Executive Health Department conducted a "Review of Management and Decision Making in NHSScotland". The review established a number of sub-groups and had the involvement of over 100 clinicians, managers, local authority personnel and lay people. There was no final report of the review group, instead the conclusions fed directly into the formation of [Partnership for Care](#) (Scottish Executive 2003a).

providing research and information services to the Scottish Parliament

The Bill Proposals

Partnership for Care set out the Executive's intention to abolish NHS Trusts. NHS Trusts can already be dissolved via subordinate legislation, as has recently happened in the Borders and Dumfries and Galloway². The remaining trusts in Scotland are also expected to be dissolved in this way, as outlined in a recent [health department letter](#) to NHS Boards (Scottish Executive 2003b). Despite this power, primary legislation is needed to remove the statutory powers of NHS Trusts. The Bill proposes to do this by repealing section 12A and schedule 7A of the National Health Service (Scotland) Act 1978 ('the 1978 Act').

The Executive's guidance expects NHS Boards to bring forward proposals to dissolve NHS Trusts by April 2004. The proposals should include plans to transfer the functions, staff and assets of Trusts to operating divisions of NHS Boards. Trust Management Teams are expected to become a committee within the NHS Board called "Divisional Management Teams" with broadly the same role as the former teams but with more emphasis on operational matters.

Operating division powers to deliver services on behalf of NHS Boards will be defined through the development of committee standing orders. The divisional management teams must also develop proposals to devolve budgets and decision making lower down the NHS system.

When dissolving Trusts, NHS Boards are required by statute to consult with local stakeholders.

Issues and Reactions

The proposal to abolish NHS Trusts has been generally welcomed as a means of reducing NHS bureaucracy, simplifying management and integrating care. However, some have questioned whether bureaucracy will be reduced as operating divisions within NHS Boards will still require experienced senior management, and also whether there is a danger that the acute/primary care divide will be recreated within the operating divisions (British Medical Association 2003; Scottish Consumer Council 2003). It has been argued that structural change will not guarantee the policy aims of the bill and perhaps a cultural change is needed instead (Scottish Consumer Council 2003).

Establishment of Community Health Partnerships

Background and Consultation

The proposals outlined in the Bill build upon the reports of the LHCC Best Practice Group (2001) and the Primary Care Modernisation Group (2002).

LHCCs were defined in the white paper *Designed to Care* as "voluntary organisations of GPs which will strengthen and support practices in delivering care to their local communities" (Scottish Office 1997). LHCCs began operating in April 1999 and quickly gained support from the vast majority of GPs. In May 2000 the Best Practice Group was established and tasked with identifying good practice and making proposals for strengthening the role of LHCCs. This was in recognition of the belief that the primary care arena was best placed to meet the health needs of local communities, and that many LHCCs had moved beyond the vision outlined in *Designed to Care* but were constrained by the limited influence they had in the strategic planning of NHS Boards. The LHCC Best Practice Group report was published in April 2001 (LHCC Best Practice Group 2001). The conclusion of the group was:

² SSI 2003/189 "[The Borders and Dumfries and Galloway National Health Service Trusts \(Dissolution\) Order 2003](#)"
providing research and information services to the Scottish Parliament

“There is a clear imperative that cultures and ways of working of the unified boards ensure that LHCCs are directly engaged in strategic leadership across the whole health care system and have sufficient devolved autonomy and resources to work in partnership to plan services strategically and address local priorities at LHCC level.” (LHCC Best Practice Group 2001 p.71)

The Primary Care Modernisation Group was established in August 2001. The group undertook a written consultation exercise and conducted a number of stakeholder meetings across Scotland. The report outlined a number of frustrations and irritations experienced by staff together with subsequent actions for improvements. A key recommendation of the report was:

“In order to provide integrated care for patients, it must be a core responsibility of NHS Boards to establish local mechanisms which bring together LHCCs and the specialist sector to develop strong collaborative arrangements to tackle issues of joint interest.” (Primary Care Modernisation Group 2002 p.3)

Both reports fed into *Partnership for Care*, which pledged to develop Community Health Partnerships. The Scottish Executive has recently finished consulting on guidance to NHS Boards, on the finer details of how they will work ([Scottish Executive 2003c](#)).

The Bill Proposals

Section 2(1) of the Bill proposes to insert into section 4 of the 1978 Act, a requirement for Health Boards to produce a scheme to establish Community Health Partnerships (CHPs) for their area. CHPs are expected to evolve from the current LHCC structure but unlike LHCCs, they will have statutory underpinnings as opposed to being voluntary groupings. They will however, be considered part of the health board and not as independent statutory bodies. The Bill describes the function of a CHP as:

“...to co-ordinate, for its area or district, the planning, development and provision of the services which it is the function of its Health Board to provide, or secure the provision of, under or by the virtue of this Act, with a view to improving those services” (Section 2, Subsection 2)

The consultation on CHPs (Scottish Executive 2003c) proposed that schemes brought by NHS Boards should include proposals for the number of CHPs in the area, their membership, the functions delegated to them and the necessary financial arrangements, as well as the plans for involving patients and the public. CHPs will be expected to involve a wide range of healthcare professionals and to develop a ‘public partnership forum’ to engage with patients and communities. It is also expected that proposals should endeavour to maximise the alignment of CHP boundaries with local authority boundaries in order to aid joint working.

Section 2(3) gives Ministers the power to accept or reject a scheme and section 2(5) allows regulations to be made to provide the form and function of CHPs in a given health board. Regulations will be subject to negative resolution procedure.

Issues and Reactions

The general principle of devolving resources and decision making to frontline staff has been widely welcomed. In particular, local authorities have welcomed the establishment of CHPs - and the encouragement to maximise co-terminosity of their boundaries with those of councils - as an opportunity to bolster joint working and the community planning process (COSLA 2003; Association of Directors of Social Work 2003). Other groups see their establishment as providing greater opportunity for service users and the public to engage more with the health service (Disability Rights Commission 2003). However, many of the written submissions received by the Health Committee expressed concerns over the workings of CHPs, most of

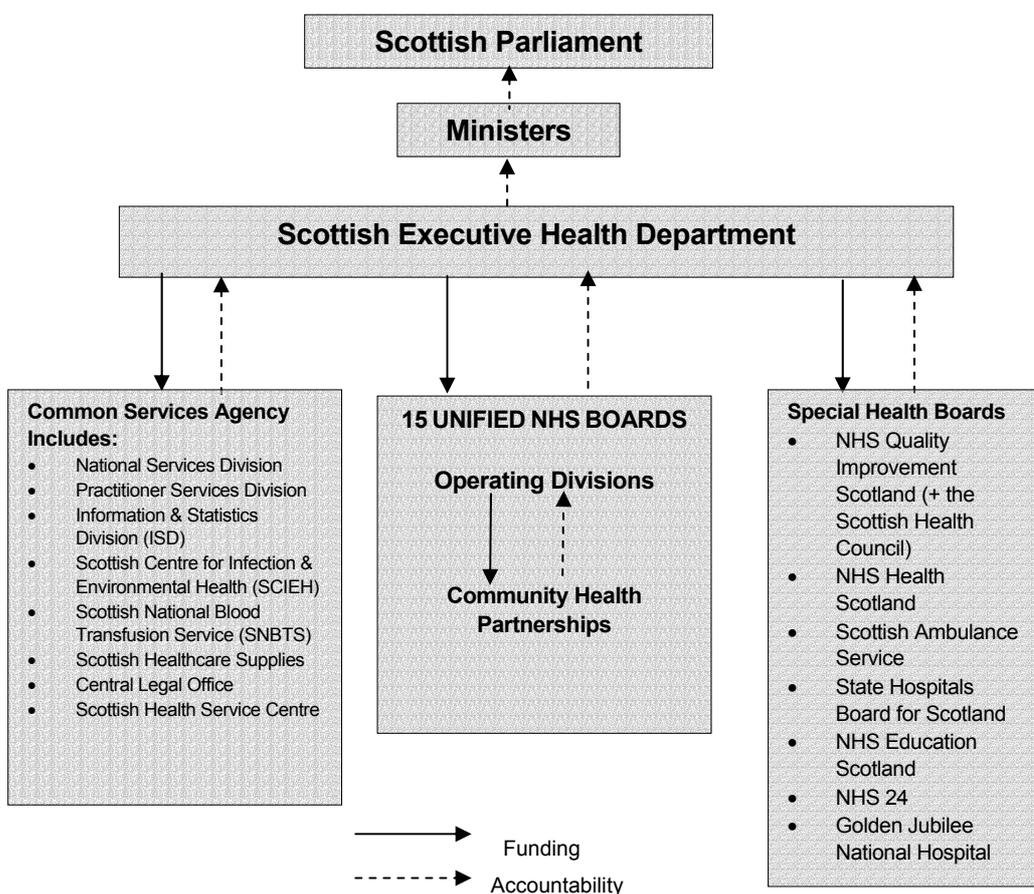
which stemmed from uncertainty as to what they will be like in reality. For example, one board member of NHS Orkney states:

“We don’t have an LHCC in Orkney and I do not know what kind of animal a CHP will be. I do not know where it sits in relation to Joint Future Agenda. Is there duplication or conflict here?” (NHS Orkney 2003)

Similar questions were raised in other submissions but cannot be answered until publication of the final guidance by the Scottish Executive.

One further concern voiced by COSLA relates to the lack of mention of local authorities on the face of the Bill. They feel that to mention local authorities would be symbolic of the Executive’s commitment to partnership working, and they feel that the lack of mention may imply that Health bodies have a lead in partnership working (COSLA 2003).

Possible Future Structure of the NHS in Scotland



The above diagram is one possible configuration of the new structure, but it is expected that some Board areas will deviate from this. For example, some may not create operating divisions at all, while among those who do, the numbers may differ.

OPERATION OF THE NHS IN SCOTLAND

Duty of NHS Boards to Co-operate

Background and Consultation

A number of health services in Scotland are provided on a national or supra-regional basis. Historically, this has been reserved to specialised tertiary services such as cancer care or transplant surgery, but this approach is increasingly being seen in other services. This is due to a number of influences affecting the sustainability of services, such as the increasing specialisation of staff and pressure to comply with EU working time directives.

[Rebuilding Our National Health Service](#) (Scottish Executive, 2001a) outlined a need for a more systematic approach to planning health services and in March 2002 a health department letter issued guidance on arrangements for the regional planning of services ([Scottish Executive 2002a](#)). There are currently three regional planning groups in Scotland covering the North, the South-East and the West of Scotland.

No specific consultation has been undertaken by the Scottish Executive on this aspect of the Bill, although the proposal was included in the white paper.

The Bill Proposals

Section 3 of the Bill proposes to place a duty on NHS Boards to co-operate with other Health Boards, Special Health Boards and the Common Services Agency in planning and providing services. This would allow Health Boards to enter into arrangements that will advance the health of anyone in Scotland, not just those who reside within their Board area.

Issues and Reactions

Some groups have welcomed the duty as they think it will improve the efficiency of patient care and/or encourage the model of service provision that they wish to see for their particular specialised area (Scottish Society for Rheumatology 2003; Royal College of Anaesthetists 2003). Others have raised questions as to what types of services should be considered on a cross-regional basis. The Scottish NHS Confederation has said:

“We would ask Ministers to ensure...that it is made clear in guidance which services are most appropriate and most likely to benefit from being organised on a cross-board co-operative basis” (Scottish NHS Confederation 2003 p.2)

A similar point was raised by the Association of Directors of Social Work in their written evidence to the Health Committee:

“We would like further clarification on these proposals and examination of what services this statutory duty would extend to” (Association of Directors of Social Work 2003 p.2)

Powers of Intervention

Background and Consultation

Ministers currently have what is called a 'power of direction' conferred upon them by section 2(5) of the 1978 Act.

At present the Executive has a policy of 'escalating intervention', with the power of direction being used as a last resort. If a part of the NHS is not achieving standards or meeting targets, the Executive will provide guidance and support with subsequent performance monitored for improvements. If this does not work the Board can agree to additional management support to be brought in to assist, but the Board is still responsible for the performance of the local NHS system. If this fails - or if they do not make changes that Ministers deem necessary - Ministers can choose to use the power of direction. If Boards do not comply with the direction, an inquiry can be held to assess whether or not the Board is in default. The ultimate sanction would be the removal of Board members.

The Bill Proposals

Despite a Minister's power to give directions, NHS Boards are ultimately responsible for carrying them out. Section 4 of the Bill proposes to give Ministers a clear power to intervene, with or without the approval or co-operation of the NHS Board. This would occur when a body charged by the 1978 Act with providing a service, has been deemed by Scottish Ministers as failing, having failed or likely to fail in either providing the service or providing the service to a standard they regard as acceptable. Section 4(2) gives Ministers the powers to transfer the responsibility and management of a service to another body. In the Bill appropriate bodies are outlined in Section 4(4) as:

- a Health Board
- a Special Health Board
- the Common Services Agency
- persons who are an employee of any of the above
- persons who are staff of the Scottish Administration (Scottish Executive Health Department)

Issues and Reactions

This proposed power has been welcomed by some as essential for protecting patient safety (Scottish Consumer Council 2003) while others view it as contrary to the principle of devolved health service management that the Bill aims to encourage (Scotsman 2003). Some written submissions to the Health Committee expressed a desire for greater clarity and guidance on when the power should be used and on the scope of any intervention (Scottish NHS Confederation 2003; British Medical Association 2003) The Scottish NHS Confederation has called for this to be defined in regulations so that NHS organisations know what to expect.

Public Involvement and the Dissolution of Local Health Councils

Background and Consultation

The NHSiS is guided on public involvement by the policy document [Patient Focus and Public Involvement](#) (Scottish Executive 2001b) which requires NHS Boards to:

“...take a pro-active and positive approach to public involvement on issues of potential service change...Involving the public should not be seen as something that has to be done at the end of a process, but something that is part of an integrated process of communication and discussion; where communities, patients, public and NHS staff have opportunities to influence decision making.”

This document was later followed by draft interim [guidance](#) (Scottish Executive 2002b). The Scottish Consumer Council and Scottish Health Feedback were commissioned to consult on the draft guidance. They published their [report](#) in September 2002 (Scottish Consumer Council 2002).

In addition to the guidance on public involvement, there are also 15 local health councils in Scotland, whose role is to represent patient's interests in the NHS. In 2003, the Executive set out its vision for patient/public involvement structures in the consultation document [A New Public Involvement Structure for NHSScotland; Patient Focus and Public Involvement](#) (Scottish Executive 2003d). The consultation ended at the beginning of June 2003.

The Scottish Executive proposes to replace the individual health councils with one national council, the 'Scottish Health Council' which would be independent of NHS Boards. It is envisaged that there will still be a local presence in the shape of local advisory councils which will feed local issues into the national body. The consultation paper set out the role of the national council across 3 areas:

- 1. Assessment** – The council will play a part in the accountability review process of NHS Boards, assessing how well consultation has been carried out with the public in each Board area.
- 2. Development** – The council will aim to promote the roll-out of good practice in public involvement in the NHS
- 3. Feedback** – The council will aim to provide patients and carers with opportunity and support to express their views

The new national council will not have a statutory basis but will be incorporated into [NHS Quality Improvement Scotland](#) (NHS QIS), a non-departmental public body. Although local health councils have a statutory basis, their independence has been questioned due to the fact that their members are appointed by the Health Boards.

The Bill Proposals

Section 5 of the Bill proposes to place a duty on Health Boards and Special Health Boards to secure the involvement of the public in the planning and development of health services. Also, section 6(1) proposes to dissolve local health councils, established by the 1978 Act (s7). The intention of these changes is to make public involvement an integral responsibility of the Health Boards, as opposed to that of an external body.

Issues and Reactions

It would appear that the proposal to place a duty on NHS Boards to secure the involvement of the public has been welcomed by respondents to the Health Committee's call for written evidence. The issue of Board consultation and accountability has received much attention in recent years in light of controversial decisions taken during service reviews.

The response to the dissolution of local health councils, on the other hand, has received a mixed response. Some have questioned just how independent the new council will be (Greater Glasgow Health Council 2003; Scottish Consumer Council 2003). Others have questioned the subsequent breadth of remit of NHS QIS. For example, in their written evidence to the committee, the Royal College of Physicians of Edinburgh stated:

"The College has previously expressed reservations to the Scottish Executive Health Department about the breadth of remit of NHS Quality Improvement Scotland, and remains concerned that Ministers should rely on a single Health Board for standard setting, routine assessment, public involvement and the investigation of serious service failures.

There is a risk that this body will be acting not only as judge and jury but will have written the "laws" too. The public and health professions may have greater confidence if ministerial investigations of problem areas are
providing research and information services to the Scottish Parliament

delivered through a vehicle independent of NHS Quality Improvement Scotland.” (Royal College of Physicians of Edinburgh 2003 p.1)

Other concerns relate to the greater centralisation of the role of health councils, with some seeing this as a lost mechanism for the public to influence the health agenda locally and arguing that public involvement should stem from local bodies (Disability Rights Commission 2003; NHS Orkney 2003; Scottish Society for Rheumatology 2003; Unison 2003).

PROMOTION OF HEALTH IMPROVEMENT

Background and Consultation

Partnership for Care outlined the Scottish Executive’s intentions to raise the profile of health improvement and bring forward legislation to ensure that health improvement is a priority for NHS Boards and their planning partners. Ministers have a duty to promote health improvement via the health service, yet it is recognised that the determinants of health involve every facet of the social and economic environment. The lead role of health improvement lies with public health and health promotion departments within Health Boards, although much of their work involves joint working with key partners, for example, local authorities.

This joint working has recently been developed further by the Local Government in Scotland Act 2003 (asp 1), which gives local authorities a power to promote well-being for the people of their area. Draft guidance to local authorities on the use of this power highlights health improvement as an example of how it can be used.

No specific consultation has been undertaken by the Scottish Executive on this aspect of the Bill, although the proposal was included in the white paper.

The Bill Proposals

Section 7 of the Bill proposes to give Ministers and Health Boards a duty to promote improvement to the physical and mental health of the Scottish public. This duty can be discharged through any means including providing funding to any person, or by entering into other arrangements, co-operating with, facilitating or co-ordinating the activities of any person.

Issues and Reactions

This duty is intended as a way of taking health promoting activity beyond the NHS and therefore recognising the wider determinants of health, for example by allowing Ministers or NHS Boards to allocate money to organisations outwith the NHS or the voluntary sector. The proposed duty has been well received with the only questions raised relating to a lack of detail within the Bill on what Ministers and Boards will be able to do (Scottish NHS Confederation 2003; Unison 2003).

FINANCIAL CONSEQUENCES

The cost of implementing the bill is outlined in paragraphs 30 to 42 of the [Explanatory Notes](#). The Financial Memorandum states:

“As many of these proposals involve formalising or reforming existing obligations, there is no net additional expenditure arising from the Bill” (Para 31)

The memorandum states that as the reforms will occur at the same time as increased funding in the NHS, no additional expenditure will be required. The Executive justifies this on the grounds

that, if enacted, the provisions of the Bill will have either no cost implications or can be funded by the reorganisation of existing resources.

Some have questioned the assumptions within the Financial Memorandum and argued that some of the provisions will have financial consequences for both the NHS and local authorities. These points are outlined below:

Abolition of Trusts and Establishment of Community Health Partnerships

The Royal College of Pathologists and the Royal College of Physicians of Edinburgh (2003) voice concern that another structural change will remove resources from patient services already at full capacity. This is reiterated by COSLA and the Association of Directors of Social Work (2003) who argue that change cannot be put into effect without some associated costs, as evidenced by the implementation of the Joint Future Agenda. COSLA also questioned how the Executive can conclude that the Bill is cost neutral when the finer details of CHPs have not yet been determined. The British Medical Association (2003) also pointed out that there was little evidence of any cost-savings when, in 1999, the number of Trusts in Scotland was reduced from 46 to 28.

Duty to Encourage Public Involvement

The financial estimate in relation to the duty to involve the public has been questioned in submissions received by the Health Committee (Royal College of Physicians 2003; Scottish NHS Confederation 2003). The financial memorandum says that the duty is not expected to lead to “any significant additional expenditure”. However, the Scottish NHS Confederation argue that,

“Genuine, meaningful, continuous public involvement is not cheap, as NHS organisations have found through experience—it may require the provision of training both for NHS staff and for communities, for example—and whilst the Confederation fully agrees that it is crucial, it should not have to come at the expense of other services. This may mean that the requirement in the legislation is backed by the provision of dedicated funds to advance the public engagement agenda.” (Scottish NHS Confederation 2003 p.2)

Duty to Promote Health Improvement

Both the Royal College of Physicians of Edinburgh (2003) and COSLA (2003) believe a duty on Ministers and Health Boards to promote health improvement will have financial implications. The explanatory notes outline that overall expenditure is not expected to increase but that the pattern of expenditure is expected to change.

OTHER ISSUES

Staff Governance

A number of bodies (The Royal College of Nursing 2003, BMA 2003, Ayrshire & Arran NHS Board 2003, NHS Orkney 2003) have highlighted the omission of staff governance from the Bill. Staff governance forms the third part of governance, alongside financial and clinical. In April 2002, the Scottish Partnership Forum of the Scottish Executive (2002c) published its [Staff Governance Standard for NHSScotland Employees](#). The standard outlined that NHSScotland staff are entitled to be:

- well informed
- appropriately trained

- involved in decisions which affect them
- treated fairly and consistently
- provided with an improved and safe working environment
- performance against the Staff Governance Standard will be assessed by the Scottish Partnership Forum and Local Partnership Forums and form an integral part of the new Performance and Accountability Framework

Written submissions to the Health Committee have specifically called for monitoring of the performance of NHS employers against the standard, and the power for ministers to intervene where employers are deemed to be failing.

SOURCES

Association of Directors of Social Work. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-18.htm>

Ayrshire & Arran NHS Board. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-21.pdf>

British Medical Association. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-19.htm>

CoSLA. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-00.htm>

Disability Rights Commission. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-10.htm>

Greater Glasgow Health Council. (2003) *Promoting Patient and Public Involvement in NHSScotland*. [Online] Available from: http://www.show.scot.nhs.uk/gghc/gghc.asp?section=National&id=issues/national/publicinvolvement_marapr03.htm [Accessed 1 October 2003]

Joint Future Group. (2000) *Report of the Joint Future Group*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library3/social/rjfg-00.asp>

LHCC Best Practice Group. (2001) *Connecting Communities with the NHS: Report of the LHCC Best Practice Group*. Edinburgh: Scottish Executive. Available at: <http://www.show.scot.nhs.uk/lhcc/Latest%20News%20Docs/bestpracticefinalreport.pdf>

National Health Service Reform (Scotland) Bill [as introduced] Session 2 (2003). SP Bill 06. Edinburgh: Scottish Parliament. Available at: <http://www.scottish.parliament.uk/bills/pdfs/b6s2.pdf>

National Health Service Reform (Scotland) Bill: Explanatory Notes (and other accompanying documents) Session 2 (2003). SP Bill 06-EN. Edinburgh: Scottish Parliament. Available at: <http://www.scottish.parliament.uk/bills/pdfs/b6s2en.pdf>

National Health Service Reform (Scotland) Bill: Policy Memorandum Session 2 (2003). SP Bill 06-PM. Edinburgh: Scottish Parliament. Available at: <http://www.scottish.parliament.uk/bills/pdfs/b6s2pm.pdf>

NHS Orkney. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-11.htm>

NHS Scotland Forum. (2002) *NHS Scotland Forum Meeting - 6th December 2002*. [Online] Available at: <http://www.clarkston.u-net.com/scotsec/nhssf021206.html> [Accessed 31 October 2003]

Primary Care Modernisation Group (2002) *Making the Connections*. Edinburgh: Scottish Executive. Available at: <http://www.show.scot.nhs.uk/sehd/publications/mcbp/mcbp.pdf>

Robson K (2003) *The National Health Service in Scotland*. SPICe Briefing 03/47. Edinburgh: Scottish Parliament. Available at: <http://www.scottish.parliament.uk/research/briefings-03/sb03-47.pdf>

Royal College of Anaesthetists. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-12.htm>

Royal College of Nursing (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-23.htm>

Royal College of Pathologists. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-13.htm>

Royal College of Physicians of Edinburgh. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-02.htm>

The Scotsman. (28 June 2003) *Chisholm Defends NHS Plan*. Available at: <http://www.news.scotsman.com/archive.cfm?id=704912003>

Scottish Consumer Council. (2002) *Consultation and Public Involvement in Service Change – Draft Interim Guidance for Consultation* Glasgow: Scottish Consumer Council. Available at: <http://www.scotconsumer.org.uk/rep02/Consultation%20and%20public%20involvement%20Full.pdf>

Scottish Consumer Council. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-04.htm>

Scottish Executive. (2000) *Our National Health: A plan for action, a plan for change*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library3/health/onh-00.asp>

Scottish Executive. (2001a) *Rebuilding Our National Health Service*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library3/health/ronh.pdf>

Scottish Executive. (2001b) *Patient Focus and Public Involvement*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library3/health/pfpi-00.asp>

Scottish Executive. (2002a) *NHS Scotland: Guidance on Regional Planning for Healthcare Services: HDL 2002/10*. Edinburgh: Scottish Executive. Available at: http://www.show.scot.nhs.uk/sehd/mels/HDL2002_10.pdf

Scottish Executive. (2002b) *Consultation and Public Involvement in Service Change – Draft Interim Guidance: HDL 2002/42*. Edinburgh: Scottish Executive. Available at: http://www.show.scot.nhs.uk/sehd/mels/HDL2002_42.pdf

Scottish Executive. (2002c) *Staff Governance Standard for NHSScotland Employees*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library5/health/sqss.pdf>

Scottish Executive. (2003a) *Partnership for Care: Scotland's Health White Paper*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library5/health/pfcs-00.asp>

Scottish Executive. (2003b) *A framework for reform: devolved decision making: moving towards single system working: HDL 2003/11*. Edinburgh: Scottish Executive. Available at: http://www.show.scot.nhs.uk/sehd/mels/HDL2003_11.pdf

Scottish Executive. (2003c) *Community Health Partnerships*. Edinburgh: Scottish Executive. Available at: <http://www.show.scot.nhs.uk/sehd/publications/DC20030718Partners.pdf>

Scottish Executive. (2003d) *A New Public Involvement Structure for NHSScotland: Patient Focus and Public Involvement*. Edinburgh: Scottish Executive. Available at: <http://www.scotland.gov.uk/library5/health/npis-00.asp>

Scottish Liberal Democrats. (2003) *Make the Difference: Fresh Thinking for Four More Years*. [Online]. Available at <http://www.scotlibdems.org.uk/manifestos/se2003/index.htm>

Scottish NHS Confederation. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-15.htm>

Scottish National Party. (2002) *Health Policy Paper* available at: <http://www.snp.org/scripts/getpdf.php?tablename=speeches&keyname=speechID&keyval=12>

Scottish Office. (1997) *Designed to Care: Renewing the National Health Service in Scotland*. Edinburgh: Stationery Office. Available at: <http://www.scotland.gov.uk/library/documents1/care-00.htm>

Scottish Office. (1999) *Towards a Healthier Scotland – A White Paper on Health*. Edinburgh: Stationery Office. Available at: <http://www.scotland.gov.uk/library/documents-w7/tahs-01.htm>

Scottish Society for Rheumatology. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-08.htm>

Unison. (2003) *Written Evidence to the Health Committee on the National Health Service Reform (Scotland) Bill*. Available at: <http://www.scottish.parliament.uk/health/evidence/hec03-04-17.htm>