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(Letter only)

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Prime Minister

STOCKTAKING REVIEW OF THE HEALTH SERVICE IN SCOTLAND

Your Private Secretary's letter of 5 ~~October~~ May indicated that my Stocktaking Booklet on the Scottish Health Service should be held back until the NHS review discussions are further advanced. While this causes me no immediate difficulty, my foreword to the booklet expressly describes it as setting the scene for the proposals which will emerge from the wide-ranging review which we are currently undertaking. It does not of course anticipate them.

Inevitably, the White Paper which will describe the results of the review will be couched primarily in GB terms; and it will therefore be particularly helpful to have on the record an up-to-date statement of the position we have reached in Scotland and our broad objectives for the future. I hope therefore, that when we meet on 17 October, it will be possible to agree that the booklet should be published and settle on an appropriate date for that.

I am copying this letter to Kenneth Clarke, Peter Walker, Tom King and John Major, and to Sir Robin Butler. Copies also go to Messrs Woolley and Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

MR

MALCOLM RIFKIND

Scottish Office
11 October 1988

EML285F1

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NAT. HEALTH: Expenditure Pts.

THE SCOTTISH HEALTH SERVICE

FOREWORD

by the Rt Hon
Malcolm Rifkind, QC, MP,
Secretary of State for Scotland

1988 marks the fortieth anniversary of the National Health Service. This booklet takes stock of the Health Service in Scotland in the 1980s. We can all take pride in its achievements.

A high priority of the Health Service during the 1980s has been to prevent ill health — success in achieving that can only be judged many years from now — and to improve the quality of life for those who are elderly, handicapped or mentally ill, whether they are in hospital or in the community.

The acute hospital services have been developing rapidly. New ways of treating people, new equipment, new drugs mean that more patients than ever before can be given effective help. We are doing this more efficiently. Since the beginning of the 1980s the number of patients treated is up by 14%, while the number of beds in acute hospitals has decreased by 10%.

At my request Health Boards are balancing the ever increasing demand for more and better treatment for those who are acutely ill against the pressing need to improve care in the community and care in hospital for those top priority groups who need long-term help. Health Boards must continue to increase the share of their resources devoted to the priority categories although this will not be easy, nor achievable in every area every year.

We are committed to providing better care for patients. We are committed also to increasing efficiency and improving value for money. There is no conflict between these two objectives. That is why we have tackled competitive tendering for support services. Money saved goes to improve patient care — whether the tender is awarded in-house or to private contractors.

Since 1979 54 hospital projects have been completed providing 6,230 beds. Improvements also involve giving up facilities which are no longer required and which have served their purpose. Closures understandably attract opposition but bold decisions have to be taken to reduce inefficiency and release resources to develop services in other ways.

The length of time people have to wait for consultation or treatment is a source of concern and reduction of waiting times is a high priority. The

number of people on waiting lists for inpatient treatment fell by 5% from 1987 to 1988. A special allocation of £3.6 million was made in December 1987 for measures to reduce waiting lists and waiting times. For 1988-89 £3 million has been allocated to specific Health Board projects which will provide treatment for an additional 8,500 inpatients (12½% of the total on the waiting list) and 3,700 day cases (27% of the waiting list), and 30,000 more outpatients will be seen.

We want to give patients more information and more choice in their treatment. General medical practitioners need to know about waiting times so that they can discuss with patients their preferences — some may, for example, be willing to be referred to a more distant hospital if they can be treated more quickly there. Patients also need more information about the services their GPs provide, and we shall encourage GPs to provide their own practice leaflets.

But we need to address the challenges which still face us. Some of these are

- the death rate from many preventable diseases is higher, and people die at younger ages, in Scotland than in the rest of Great Britain. For lung cancer the death rate is a fifth higher for men and nearly a third higher for women
- too many people who are mentally ill or handicapped still live in large, old hospitals, when they could have a fuller life in their own homes or in hostels with support from the community
- the need for places in nursing homes and residential homes and for long-term care in hospital, for old people with dementia, is growing fast
- elderly people place big demands on both the general medical services and the acute hospital services and their numbers are increasing.

This booklet is published at a time of change for the Health Service in Scotland. We published a White Paper "Promoting Better Health" last year. Future arrangements for the organisation and management of schemes for the care in the community of the elderly, the handicapped, and others who need long-term support, are being looked at now. Ideas are being examined to make the Health Service an instrument of greater efficiency; and we mean to increase patient choice. Scotland has a small but expanding private sector: in planning their services, Health Boards should regard private facilities, as well as those they run themselves, as part of their local health resources.

The Government are undertaking a wide ranging review of the National Health Service as a whole, with particular reference to the hospital service; and our proposals will be announced in due course.

This report sets the scene for those proposals.

MALCOLM RIFKIND

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TEN OBJECTIVES

The Government's objectives for the Health Service in Scotland are

1 to achieve the most positive impact on the health of Scotland within available resources through a judicious mix of prevention and treatment

2 to promote good health and prevent ill health through education, screening, immunisation and preventive treatment

3 to reduce the incidence of those diseases and conditions where Scotland has high rates or create the conditions where these will fall in future

4 to take steps to ascertain customers' needs and perceptions and to take account of these in developing services

5 to deliver services for patients efficiently and effectively, achieving value for money and a high quality of care

6 to seek to measure the impact of services through performance indicators and appropriate measurements of quality of care

7 to promote closer coordination between Health Boards and local authorities in planning and delivering services including the development of community care, particularly for the elderly, mentally ill, mentally and physically handicapped and younger physically disabled

8 to improve management and planning through the provision of better management information

9 to give new emphasis to staff training and development in support of the aims of quality of care, value for money, and measurement of outcome

10 to respond flexibly to new demands such as technological and medical advance, AIDS, and drug misuse.

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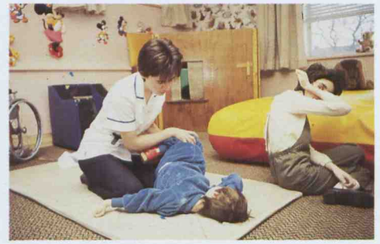
ACHIEVEMENTS

STAFF

Running the Health Service depends on a very large number of skilled and committed staff. Health Boards are major employers, and the total number of their employees, and of family doctors, dentists and others who provide primary care services in the community, is now over 150,000.



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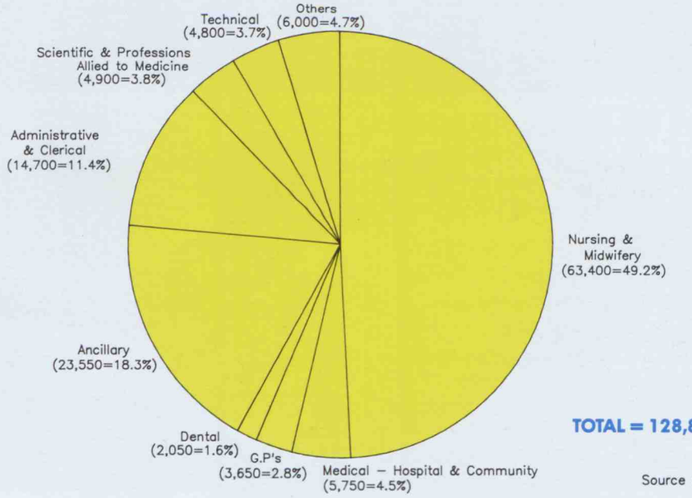
NHS EMPLOYEES

Whole Time Equivalent – as at 30 September 1987



TOTAL = 128,800

Source : ISD

Between 1980 and 1987 the total number of staff employed in the Scottish Health Service (expressed as a whole time equivalent) increased by 4.4%. The growth in staff directly engaged in patient care was significantly higher than that. For example, the number of consultants rose by 9.2%. The number of nursing staff rose overall by 8.2% and the number of qualified nurses by 25.3%.

In the family practitioner services, the number of doctors rose by 15%, and the number of dentists by nearly 20%.

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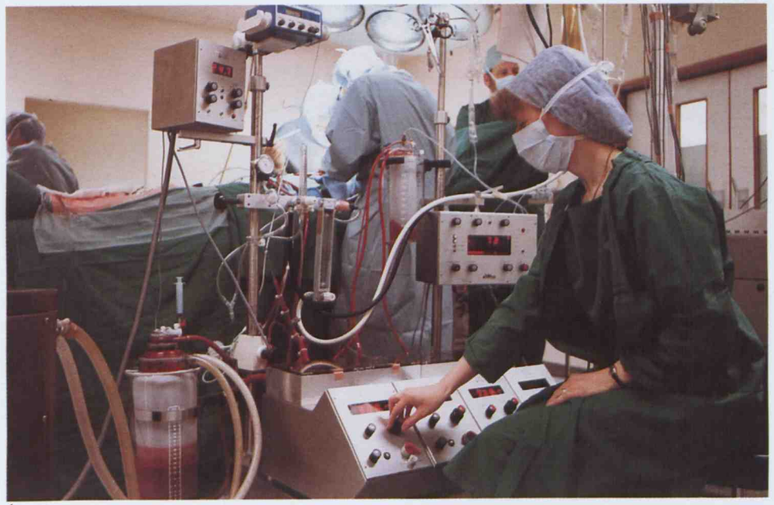
OUTPUT, OUTCOME, AND MEDICAL ADVANCE

A growing workforce along with improvements in individual productivity has meant an increased number of patients being treated in Scottish

hospitals: 14% more inpatients — 107,000 more people — were treated in 1987-88 compared with 1979-80; day cases nearly doubled to 160,000 and there were 435,000 more out-patient attendances — 5.7 million in all.

New therapeutic techniques are opening up new fields of treatment. They are making it possible to treat a wider range of conditions and of patients, with a greater expectation of success. This is demonstrated in the field of renal dialysis and kidney transplantation. Between 1970 and 1987 the number of Scottish patients receiving dialysis rose from 87 to 734 while the number of kidney transplant operations rose from 21 to 102. In the 6 years to 1986 operations to replace joints increased by 50% to 6,950 of which 4,700 were partial or total hip replacements and the number of cataract operations nearly doubled to 10,500.

National centres have been established for bone marrow transplantation and for lithotripsy, a process which avoids the need for operations for kidney stones. By 1984 the target of 2,000 open heart operations each year, which was set earlier in the decade, had been achieved. The Government have now agreed to



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provide financial support for a further 450 operations a year at Edinburgh and Aberdeen. A national centre for spinal injuries is planned.

Between 1980 and 1987 in the community the average GP's list size decreased from 1,831 patients to 1,626 while the number of prescriptions dispensed by chemists increased by 12% to 38 million. 14,000 more people over the age of 65 received home visits from district nurses who made nearly 4 million calls to people in this age group in 1987.

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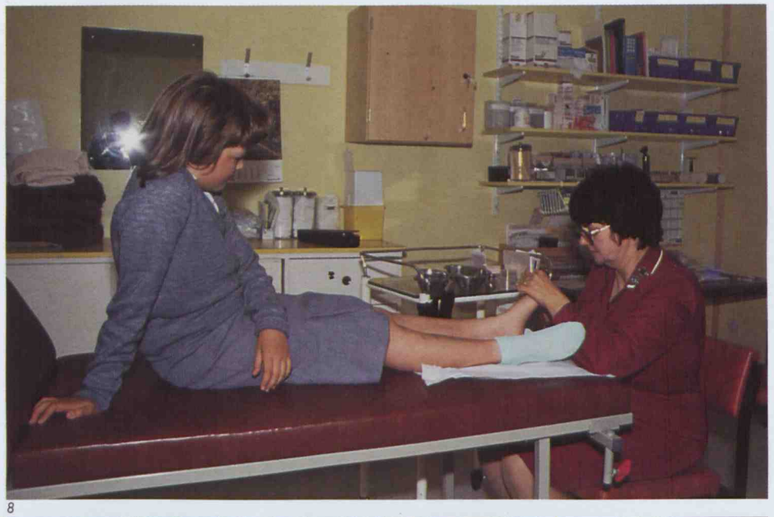

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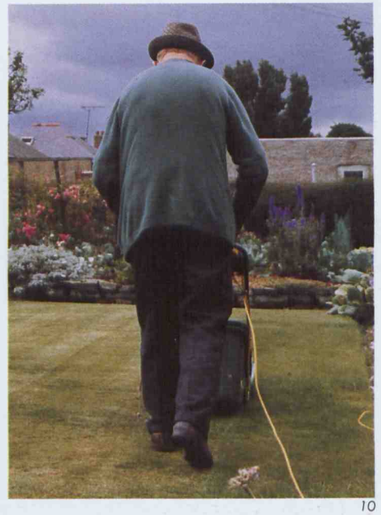

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The chiropody service expanded by 20% and the number of people carried by ambulance increased by 8% to over 2 million.

Improved health care has contributed to longer life expectancy and Scottish men can now, for the first time, expect to live a full 70 years. At the other end of the age scale stillbirths have decreased and perinatal and infant mortality rates have fallen. The infant mortality rate, which is considered by some authorities to be the best single measure of the overall well-being of a

population, fell from 12.1 per 1,000 live births in 1980 to 8.5 in 1987 – a fall of 30%.

FINANCE

Total expenditure on the Health Service in Scotland rose during the 1980s from £1,053 million in 1979-80 to a planned £2,543 million in 1988-89, an increase of over 140% in money terms and over 31% in real terms. Within these totals, expenditure on family practitioner services in particular (family doctors, dentists, pharmacists and opticians) rose by 45% in real terms.

In order to reduce waiting lists £3.6 million was allocated in December 1987, and in August 1988 a further £3 million was allocated to Health Boards for specific projects to reduce waiting times.

In the current year the Health Service building programme is expected to amount to £126 million. Fifty four hospital projects providing 6,230 beds and nearly 500 day places have been completed since 1979. In the pipeline are 32 developments with a cash value of nearly £300 million which will provide 4,050 beds.

In real terms average pay for staff increased in the last ten years by 33% for doctors, by 44% for nurses and by 34% for paramedical staff, such as occupational therapists and physiotherapists.

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THE CHALLENGE

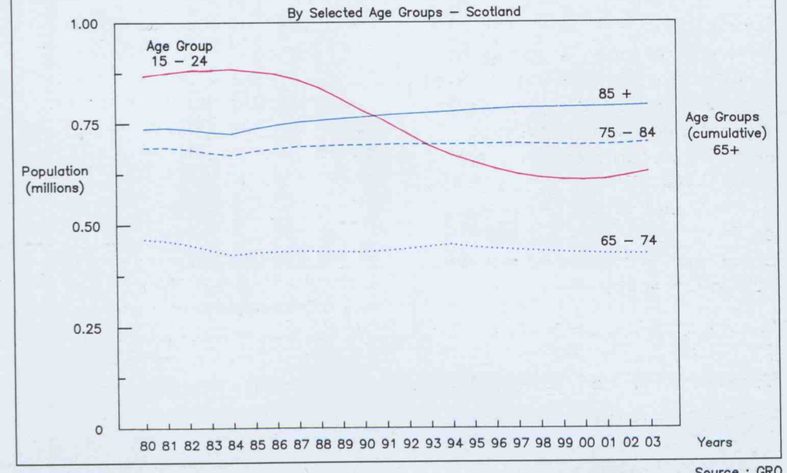
In spite of the striking progress highlighted in the previous section, Scotland still has higher death rates than England and most other developed countries at all ages and for most major causes. The excesses are particularly pronounced for the younger age groups and for cancer, heart disease and strokes. For example, overall death rates for men in the 25-64 age group are 23% higher in Scotland than the average for Great Britain. Greater Glasgow shows a 44% excess.

CHANGES IN THE POPULATION

Although the total population of Scotland is changing only very slowly, the age-structure shows much more change, with rapid growth in the elderly population in comparison with the population of working age and below. These changes, which have been in evidence over the past decade, are expected to continue for the rest of the century. There were fewer than 47,000 men and women in the 85+ age group in Scotland in 1980. This had increased to almost 57,000 by 1986 and is projected to reach a figure of almost 90,000 by 1996, a further 58% increase. This section of the population places very heavy demands on the Health Service.

Population Estimates 1980–1985 & Projections 1986–2003

By Selected Age Groups – Scotland



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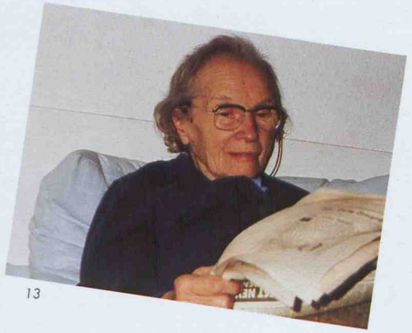

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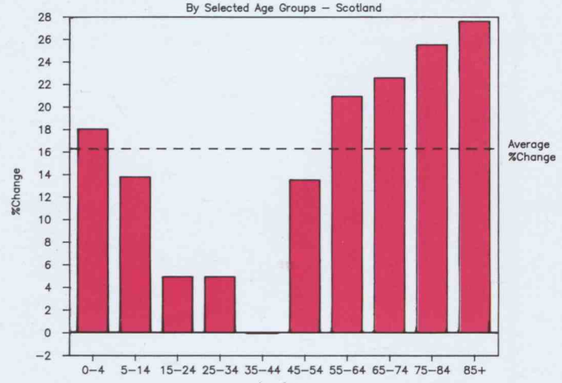
While the increase in the elderly population is expected to place growing demands on the health service over the next few years, the number of 18 year olds, who form the bulk of the recruits to the caring professions, will fall by about 30%.

Source : ISD

Inpatient Discharge Rates* : Percentage Change 1980–1986

By Selected Age Groups – Scotland



*From the acute specialties excluding obstetrics, mental illness, mental handicap and geriatric medicine

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INCREASED PUBLIC AWARENESS

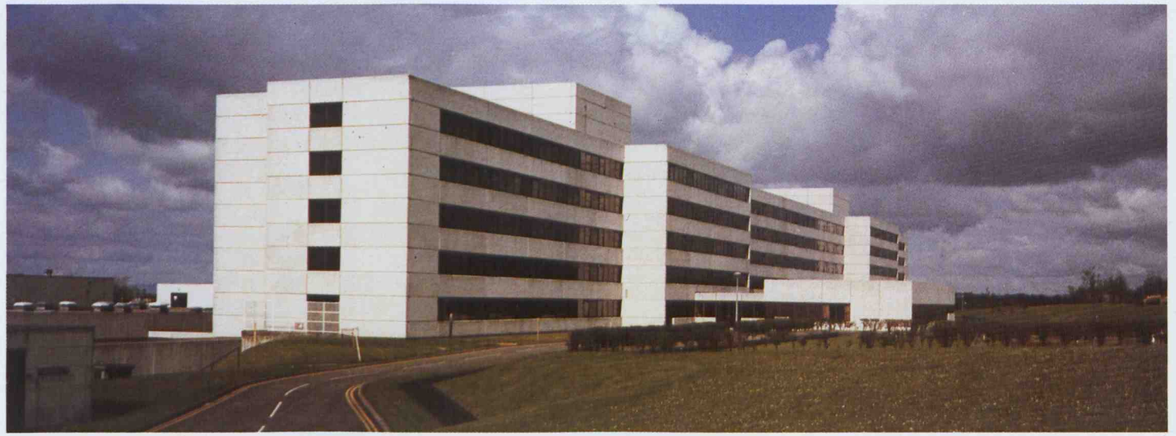
The general public are now much more aware of advances in medical science and are better informed about the possibilities for the treatment of illness. The Government welcome this and intend to encourage participation by patients in decisions that affect them, and greater awareness by Health Boards and their staff of their "customers'" expectations.

DISEASES BROUGHT ABOUT BY LIFESTYLE

What the Government and the health professions do will not succeed unless the general public also accept responsibility for maintaining their own good health. Smoking tobacco, in any quantity, misuse of alcohol and an unhealthy diet cause a variety of diseases. On average over 800 beds in Scottish hospitals are occupied every day by patients suffering from the three main diseases generally accepted as being associated with tobacco smoking. Mortality rates from smoking-related diseases for people aged 45 to 74 in Scotland are higher than in England, Wales, Northern Ireland and many other developed countries. Smoking among young women is a particular cause of concern. The death rate for lung cancer in women is rising, and in 1985 deaths from this cause exceeded those from breast cancer for the first time.

About 600 beds are occupied on any one day by patients whose principal diagnosis is related to misuse of alcohol.

Together the beds constantly in use for both of these groups of diseases are equivalent to two modern general hospitals.



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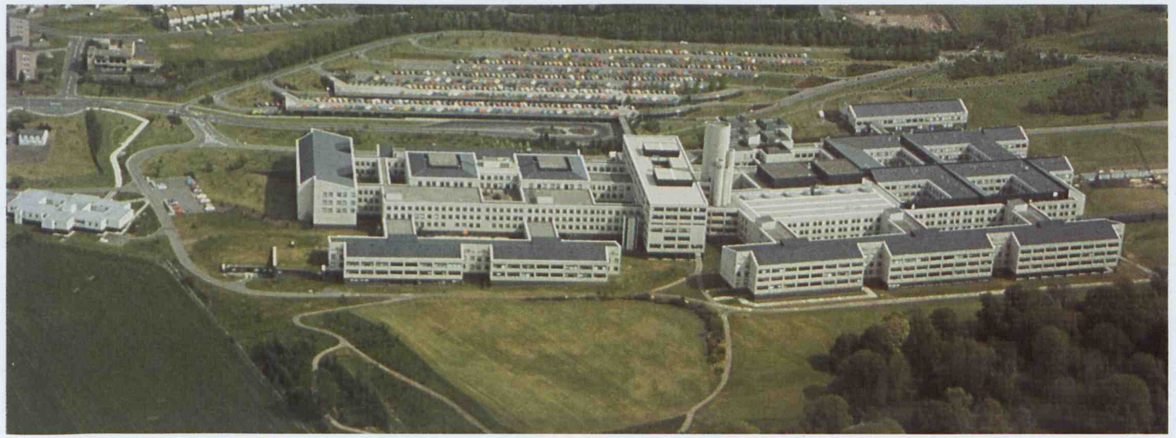

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AIDS

Human Immuno-Deficiency Virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS) are a new, and potentially very serious, challenge. At present, knowledge of the prevalence of HIV infection, the risks of its transmission in particular circumstances, and the time lag between infection and the development of the symptoms of AIDS is incomplete. So forecasts of the impact of the disease on the Health Service are difficult to make and are surrounded by uncertainty. The latest figures suggest that the number of new cases of AIDS in Scotland will rise from 85 in 1988 to 406 in 1991 and that bed requirements will rise from 19 to 155. These projections will need to be revised as more information becomes available. AIDS has the potential to be the most rapidly growing health care problem in Scotland over the next few years.

THE LARGE LONG-STAY HOSPITALS

In proportion to population Scotland has 60% more hospital beds of all kinds than England. The difference is particularly marked in mental illness and mental handicap hospitals where large institutions remain in use — and will remain for a number of years. Nearly a third of the 7,000 hospital patients with mental handicap in Scotland still live in the two largest hospitals. The number of residents in these two hospitals has been reduced by strenuous efforts to rehabilitate patients and place them in suitable accommodation in the community, and by reducing the number of new admissions, particularly of younger patients. The hospital buildings are being upgraded and made more comfortable.

In mental illness hospitals and psychiatric units in other hospitals, the number of long-stay patients is falling slowly. An increasing proportion of the long-stay group are elderly people, and many suffer from dementia. The buildings available for them are often unsuitable, with lack of ground floor sleeping accommodation a particular problem. The remote location of many big old hospitals makes visiting difficult for friends and relatives.

In the next sections of this booklet we set out ways of meeting these challenges.

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THE PRIORITIES

Priorities for the Health Service in Scotland were set out in the SHAPE report ("Scottish Health Authorities Priorities for the Eighties") produced by the Scottish Health Service Planning Council in 1980. These priorities have been reviewed and restated in the SHARPEN report ("Scottish Health Authorities Review of Priorities for the Eighties and Nineties") received from the Planning Council earlier this year. The revised priorities, endorsed by the Government, are

- **Services for old people** with dementia, in hospitals and in the community.
- **Care in the community** with particular reference to:

  services for elderly people

  services for people with a mental handicap

  services for people who are mentally ill.
- **Health education**, prevention of ill health, and health promotion.
- **Services for the younger physically disabled.**

Within the acute hospital sector, priority should be given to services which help old people maintain their independence. Among these are

- **ophthalmology**
- **orthopaedic surgery**
- **urology and renal services**
- **vascular surgery.**

These are the recommended priorities at national level. At local level Health Boards have to take account of the present state of their services, particular local needs, and the speed at which they can move towards national priorities. They will vary in their rate of progress.

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OLD PEOPLE

The SHAPE report recommended that 40 hospital beds should be provided for each 1,000 people over 75 years of age in the population. By 1984 38 beds per 1,000 had already been reached. Nevertheless, even taking into account places in local authority and privately run homes, Scotland has fewer places than England in residential care for the elderly.

One in 4 persons over the age of 80 may suffer from some degree of dementia. This is a clear top priority at national level, and will be a major local priority for most Health Boards.

CARE IN THE COMMUNITY

The Government endorse the principles

- that health services for elderly people, for people with a mental handicap and for those who are mentally ill should be designed to enable them to stay in their own homes and to lead as full a life as possible for as long as possible
- that only those who require continuing medical or nursing care should be admitted to hospital

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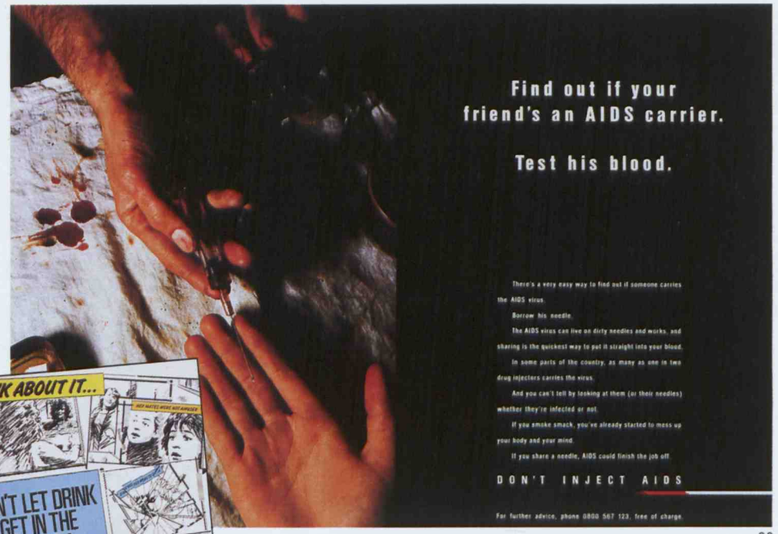
- and that quality of life for those in hospital is more easily achieved in smaller, local units than in very large, impersonal institutions.

It will take time before the present large, long-stay hospitals can be replaced. People at present living in these hospitals will not be discharged until there is proper support for them in the community. This requires cooperation among Health Boards, local authorities, voluntary bodies, housing associations serving specialist needs, and the private sector. The Government are considering how to improve cooperation between Health Boards and local authorities in this area.

HEALTH EDUCATION, PREVENTION OF ILL HEALTH, AND HEALTH PROMOTION

To alter the personal behaviour patterns that contribute to Scotland's poor record for illness and disablement is a long-term task, but a very important one. Health Boards have to develop their sources of information about the comparative health of people in their areas, and define more closely the groups to whom their services should be directed and on whom health promotion campaigns should be targeted.

The Scottish Health Education Group (SHEG) has been given the task of promoting health education



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programmes at national level and of assisting Health Boards and education authorities with their own health education projects. The Government's objective is to persuade members of the public to look positively at their own health and to adopt a healthier life style — summed up by the theme "Be All You Can Be". Current targets are

- **smoking** This is the greatest single cause of preventable ill health and premature death in Scotland. Health education programmes have particularly emphasised the dangers of smoking to young people.
- **alcohol misuse** A coordinated approach at national and local level is necessary to promote informed and sensible attitudes to the use of alcohol and to encourage moderation and a responsible attitude to drinking.
- **diet** An unhealthy diet is one of the prime causes of heart disease. SHEG's booklet "Eat To Your Heart's Content" contains advice on the sort of diet which would help to reduce the risk of coronary heart disease.
- **drug misuse** A sustained programme of public and professional education is essential for the prevention and discouragement of drug misuse. The urgent need to contain the spread of HIV infection through intravenous drug misuse means that a higher priority than ever must be attached to preventing young people becoming involved with drugs.
- **AIDS** There is no vaccine against HIV infection and no cure for AIDS. The principal weapon in the battle is public education. Over £20 million has already been spent on the Government's public education campaign, and its effects are being carefully monitored. General levels of awareness and understanding have greatly improved during the campaign.

Immunisation and **screening** are other weapons in the fight to prevent disease, or to detect it in the earlier, treatable stages. Neither is compulsory — the aim is to increase participation by education and persuasion. The Government's objective is to increase the uptake of immunisation to 90% or higher for measles, whooping cough, diphtheria, tetanus and polio, and to 95% of 14 year old schoolgirls for rubella (german measles). The introduction of a combined mumps, measles and rubella vaccine from 1 October 1988 should lead to a significantly higher proportion of children being protected against measles and to the virtual elimination of rubella among children.

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Health Boards have been asked to establish a computerised call and recall system by the end of 1988 which will ensure that all women in the age range 20 to 60 receive an invitation to attend for a smear test for cervical cancer by 1993, and are recalled for further tests at 5 yearly intervals. A comprehensive breast cancer screening programme for women aged between 50 and 64, with recall at 3 yearly intervals, will be established by 1991.

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SERVICES FOR THE YOUNGER PHYSICALLY DISABLED

About 16,000 very severely handicapped people in Scotland require special care, and about 400 younger physically disabled people are accommodated inappropriately in hospital units not specially intended for their needs. This is a group particularly in need of attention. A report from the Planning Council giving advice to Health Boards will be issued shortly.

MULTIPLE DEPRIVATION

The SHAPE and SHARPEN reports drew attention to the needs of households experiencing multiple deprivation. There are still major differences in the general health and well-being of different sections in the community, and Health Boards will be aware of particular localities, where the uptake of health services is low, which should be targeted for improvement.

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BALANCING PRIORITIES

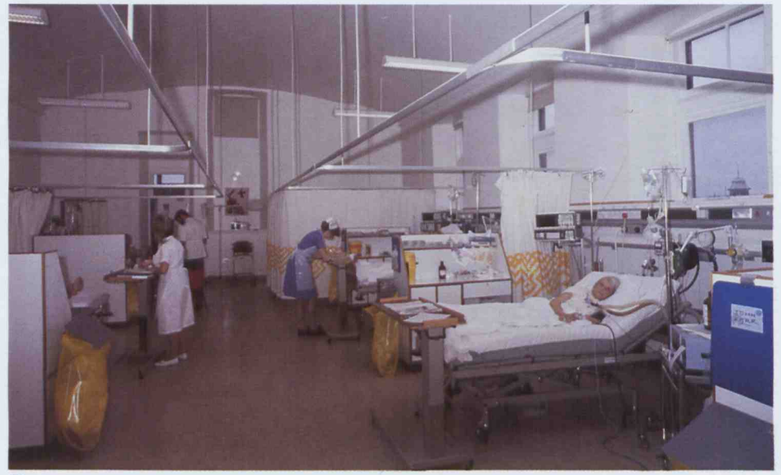
BALANCE BETWEEN ACUTE AND LONG STAY

There is a fundamental tension in the Health Service between the acute services provided in the general hospitals and the priority services described in the previous section. The SHAPE report recommended that the resources applied in acute hospital services should be restrained or even cut back to release resources for the long-stay, domiciliary and preventive programmes to which SHAPE attached highest priority.

The acute hospital services face increasingly heavy demands from

- the rising proportion of elderly people in the population
- medical advances making possible an extended range of treatments for increasing numbers of patients
- higher expectations on the part of the public in general.

The Planning Council now recommends, and the Government accept, that the acute services must at least be maintained in real terms. To achieve this and to make progress with the main priority services will mean difficult decisions for Health Boards.



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Within the acute hospital services, priority should be given to services that make a particular contribution to maintaining good health and independent living for elderly people. But the balance between acute and long-stay services, and within the acute services, will vary according to local needs. The change from a highly centralised hospital service to a more dispersed system of district general hospitals will continue to influence heavily the spending patterns of a number of Boards.

The Government believe that within the acute services there is considerable scope for rationalisation and for increased efficiency in the use of resources of all kinds and for increased value for money in terms of the quantity and quality of patient care.

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BALANCE BETWEEN HOSPITAL AND COMMUNITY CARE IN THE LONG-STAY SECTOR

The Scottish tradition of hospital inpatient care still strongly influences the balance of health care services for people who must depend on them for long periods. Increasingly the emphasis is on reducing the numbers of residents in the long-stay sector. This can be done both by more effective treatment, to the point where hospital care is no longer required, and by avoiding unnecessary admissions. For this to succeed an adequate range of alternative facilities must be provided. Health Board services for the priority groups outwith hospitals include respite care and day care and community nursing services. The Health Service also contributes through support finance arrangements, to the development of community care

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services provided by local authorities and voluntary bodies. The balance of care is shifting as a result of changes in attitudes, in professional thinking, and in standards of care and treatment. Where long-term medical and nursing care is necessary, smaller, more homely, local services are better than large institutions.

All this will take time to achieve. Many Health Boards are making impressive progress. Some however are faced with the problem of maintaining old hospitals which for many years will continue to be home for many patients. Staffing levels have been increased but, particularly in mental handicap hospitals, still fall short of the ideal. Where trained staff are in short supply patients' activities may be restricted and they may lose, or never succeed in acquiring the skills for daily living. Health Boards have to balance the need to build up services in the community against the need to improve the quality of life for patients remaining in hospital. For some Boards improving the accommodation in long-stay hospitals will have to remain a priority because many patients will need continued hospital care.

The Government have not set specific national targets for a reduction in

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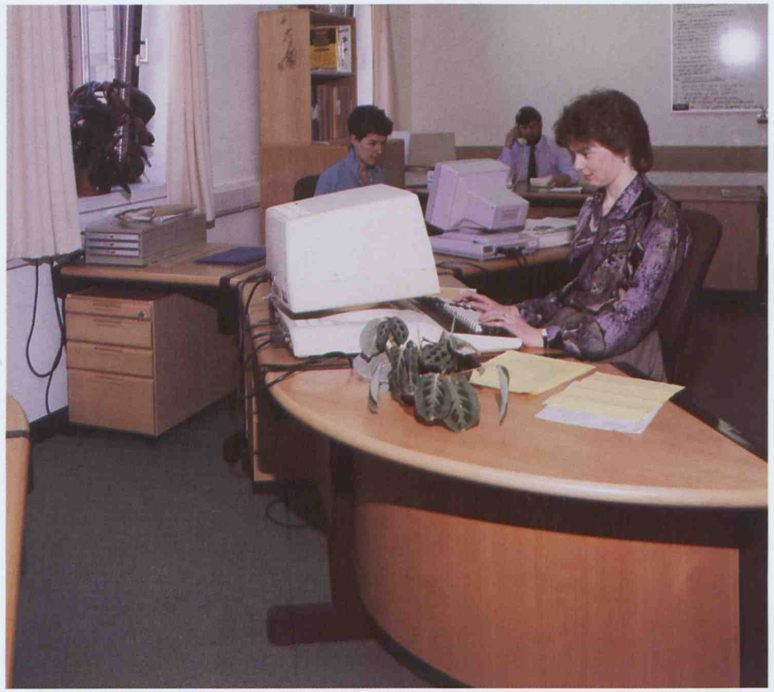
long-stay hospital places because the interests of individual patients must come first. But there is merit in setting specific objectives where these can be appropriately set and properly controlled. At Lennox Castle Hospital and the Royal Scottish National Hospital specific targets have been set for reducing the number of patients. Close co-operation is vital with social work departments, housing authorities and the private and voluntary sectors to ensure that the needs of the people concerned will be fully met when they leave hospital.

STRATEGIC PLANNING AND THE MONITORING OF CHANGE

The Government have encouraged Health Boards to develop a strategic planning system to ensure that they regularly reassess their services and decide on future objectives for the development of local health services. The Government review these plans to monitor the extent to which they deliver national priorities. The second round of meetings with Boards was completed in mid-1988 and indicated that Health Boards have achieved a



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perceptible shift within the hospital and community health budget in favour of the priority services. A third round of strategic plans and review meetings is now being planned.

Regular meetings will be held with each Board both to look back at their previous year's performance, with appropriate performance indicators, and to look forward at the coming year, setting a number of targets for achievement. These meetings will act as a spur to improve performance and

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help pass on information about good practice, thereby increasing the efficiency of the service.

Managers in the health service, including clinical managers, command resources on a grand scale — £2.5 billion in a year in Scotland — so it is highly important for them to have adequate management information. "Resource management" is the shorthand for the process and the systems which will supply the information which managers need to make better decisions on allocating resources of time and staff, supplies and accommodation. This information will not be confined to costs — a clinician for example will want clinical information to help in allocating the time of the clinical team. The Government look forward to the introduction by Boards of resource management activities in all major Scottish hospitals by 1992.

PRIMARY HEALTH CARE SERVICES

The way ahead for the primary care services has been charted in the Government's White Paper "Promoting Better Health" published in November 1987. These services are the first point of contact when advice or treatment is needed, and general medical and dental practitioners are the gatekeepers to specialist hospital services. The family practitioner services account in Scotland for nearly £500 million of public expenditure every year. The Government's objectives for these services are

- to make services more responsive to the needs of the consumer
- to raise standards of care
- to promote health and prevent illness
- to give patients the widest range of choice in obtaining high quality primary care services
- to improve value for money
- to enable clearer priorities to be set for family practitioner services in relation to the rest of the NHS.

Scotland is well placed in this respect since Health Boards are responsible for the administration of the family practitioner services as well as the hospital and community services.

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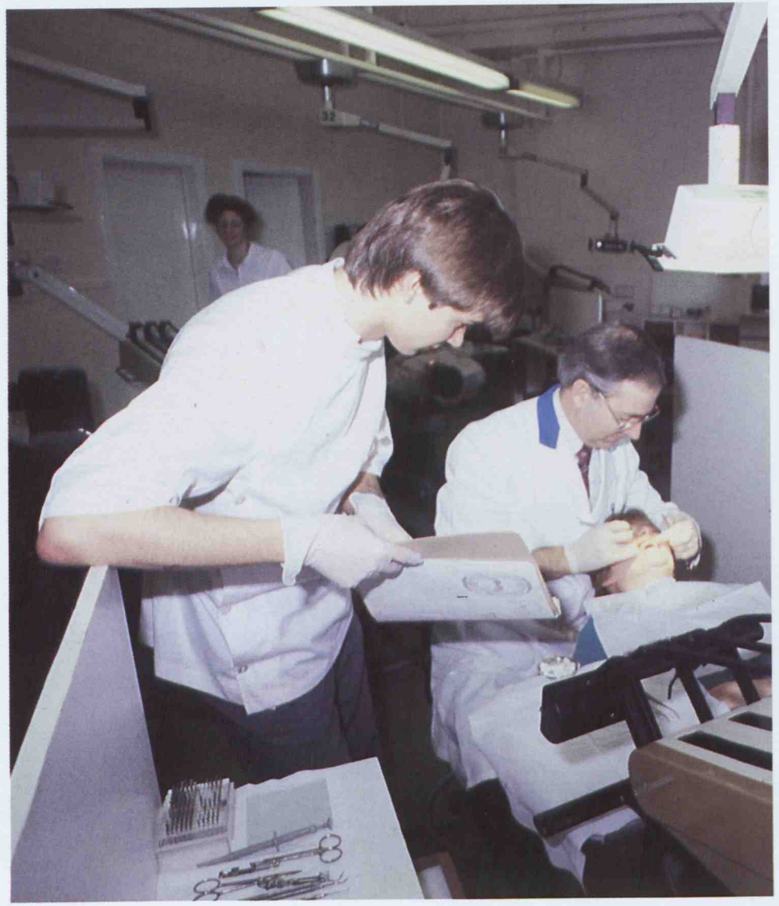
GENERAL MEDICAL SERVICES

Consultations are in progress between the Health Departments in Great Britain and the medical profession on the implementation of the proposals in the White Paper which affect general medical practitioners' terms and conditions of service. In Scotland there are particular problems in relation to doctors in isolated rural areas who may suffer from professional and social isolation and the stress of being constantly on call. In the course of these consultations the Government will examine the scope for measures to assist these doctors.

In all areas the need for better information for the public about the services provided by general medical practitioners is recognised. The Government will explore with Health Boards the best way to provide fuller information about practices in their areas and to make it more widely available locally. Practices will also be encouraged to produce their own practice leaflets.



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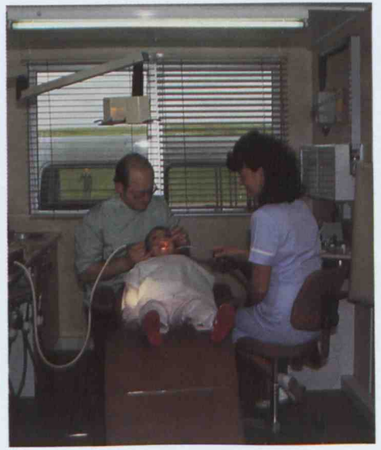
DENTAL SERVICES

Dental health in Scotland has been improving – for 5 year old children it has imporved by 20% since 1982. Dentists are no longer doing so many simple procedures. But demand is increasing for the more sophisticated treatments that are now possible. There is growing demand too from the increased numbers of older people who now keep their own teeth for much longer.

The Community Dental Service will spend more time on monitoring dental health and providing care for particular groups.



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COMMUNITY PHARMACY

The wider role proposed for pharmacists in the White Paper "Promoting Better Health" includes

- providing pharmaceutical supervision of the supply and safekeeping of medicines in certain residential homes
- maintaining records of medicines used by patients who are elderly or confused and are on long-term medication
- playing a greater role in the promotion of health education material.

Longer term changes may follow, including

- discussion with the profession on ways of delegating work to suitably qualified technicians under professional supervision
- investigation of the scope for making better use of the pharmacist's skills, particularly in providing advice and information on medicines and health matters to clients.

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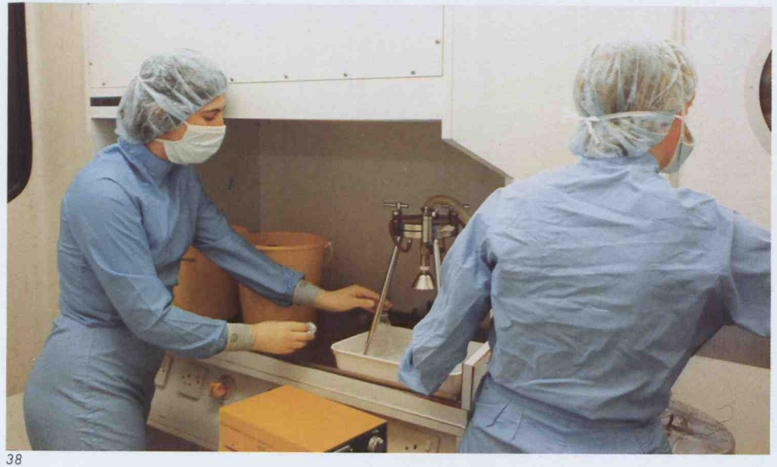

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AREAS OF CHANGE

NURSING SERVICES

Almost half of all staff in the NHS in Scotland are nursing staff, and they account for about 40% of total revenue expenditure. About 55% are qualified staff, 15% are in training and 30% are unqualified auxiliaries/ assistants. About 90% of all nursing staff are employed in the hospital services with the remaining 10% working in the community nursing services.

The key staff are those involved in direct clinical care. But while nursing is a practice discipline, practitioners require the support of management to facilitate that practice; of education to prepare practitioners and maintain their development throughout their careers; and of research to provide knowledge which will underpin practice.

The Government have given their approval to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's "Project 2000" proposals for reforming nurse education. The existing contribution of student nurses to the workforce will be reduced so that they are treated as supernumerary over most of their training. New curricula will enable nurses after qualification to be deployed flexibly between hospital and community. To enable the NHS to remain adequately staffed during the 1990s, when the number of school leavers available for recruitment will be about 30% fewer, access to the new training must be as wide as possible. That is why we are giving consideration to issues such as retention of qualified staff, recruitment of mature people, part-time courses, job-sharing and flexible working hours.

HOSPITAL DOCTORS

Scotland has too many hospital doctors in training grades compared to those who have reached career grades (like hospital consultants). Measures to improve our hospital medical staffing structure and to involve consultants more directly in the treatment of patients have been proposed in two recent reports. These are being implemented in Scotland through improved counselling and training of young doctors, and a reduction in training posts, matched by an increase in career posts.

CLINICAL PHARMACY IN HOSPITALS

The most significant development in hospital pharmacy has been the introduction of clinical pharmacy — the involvement of pharmacists at ward level in supplying physicians with information on pharmaceutical and therapeutic aspects of drug treatments, advising on the formulation of medicines and dosages, and assisting in therapeutic drug monitoring. Such an extension of the role of the hospital pharmacist will make demands on time and resources and will, in many cases, require supplementary education and training. The potential benefits are substantial.

SCOTTISH AMBULANCE SERVICE

The Scottish Ambulance Service is going through rapid changes to improve its management, efficiency and cost effectiveness. The service has been divided into two tiers, one for accident and emergency calls and the other for routine patient transport. More specialised vehicles are now being introduced to meet the different needs of the two tiers. Particular attention has been given to bringing

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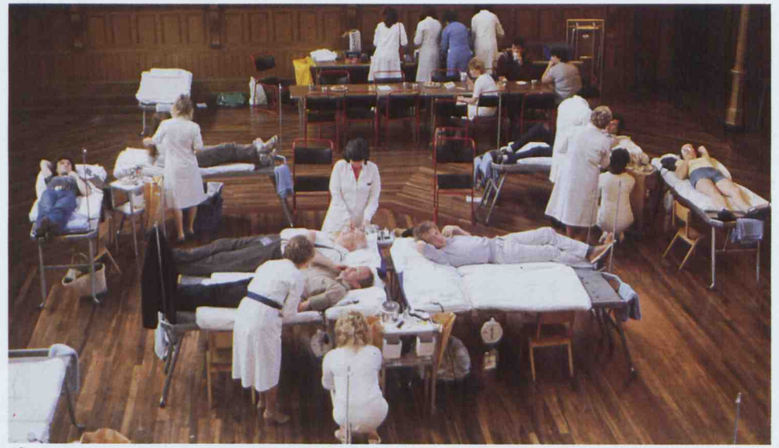
patients to the growing number of day hospitals, to maximise the time which patients can spend at the hospital, and to increasing the number of emergency calls which are answered by ambulances crewed by two staff.

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

As a result of the efforts of the Scottish National Blood Transfusion Service, Scotland has since 1983 been one of the few countries in the world which is self-sufficient in blood and all normally required blood products. This high quality of service can be maintained only if the Service continues to develop and to change to meet new requirements. Further efforts are needed to meet increasing demand for blood and blood products and to ensure that the volunteer donor programme, which is essential for a continued supply of safe blood, is fully maintained.



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VALUE FOR MONEY

To cope with the increasing demands on health services and to improve and develop these services Health Boards need to make the most efficient use of their resources. Action to improve efficiency can be of two types: it may release cash for patient services by providing support services for less cost or it may deploy clinical and related resources more efficiently so that more patients can be treated.

EFFICIENCY SAVINGS

Since 1985-86 Boards have been expected to produce a percentage of their revenue from efficiency savings. Domestic, catering and laundry/linen services have been identified as areas where significant savings can be achieved. By rationalising these internal services Boards had made savings of nearly £22 million (14% of the costs of these services) by the end of March 1988. Because of the greater savings that could be achieved Boards were instructed in December 1987 to push ahead with competitive tendering for domestic and catering services. This exercise is still in progress and the savings arising from contracts let so far are very substantial. Boards are now planning further tendering programmes as soon as the current round is complete. By March 1989 Health Boards will have made efficiency savings of £88 million in the last four years. Money released in this way is retained by Boards and put towards improved patient care.

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SALE OF SURPLUS LAND

Property which Health Boards no longer need is a valuable source of income. Up to 1984-85 Boards were raising less than £2 million a year from the sale of land, including hospitals which were being replaced. Since then Boards have identified further surpluses and have been able to offer more of their houses to sitting tenants. As a result the Health Service is now generating additional income of more than £8 million a year.

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SCOTMEG

The Scottish Health Management Efficiency Group (SCOTMEG) was established in 1985 to undertake a national programme of efficiency reviews and to monitor the progress of Health Boards and the Common Services Agency in implementing its recommendations. During its first three years of operation the Group will have produced 18 Action Plans covering such areas as linen services, income generation, uniforms policy, supplies, catering, domestic services, telecommunications and energy management and conservation. The Group estimates that annual revenue savings of £30-£35 million can be achieved if the recommendations in its Action Plans are fully implemented.

Working closely with Ministers SCOTMEG has started on the second round of its efficiency programme, studying new topics, including areas of clinical activity, and monitoring Boards' achievements in those areas where Action Plans have been issued. SCOTMEG has also organised a national staff suggestion competition aimed at encouraging staff commitment to obtaining better value for money and at generating practical suggestions on how to achieve this. It will also be issuing regular efficiency newsletters to publicise projects that have been successfully implemented.

CRUG

The Clinical Resource Use Group (CRUG) was established in 1987 by the Planning Council to identify and disseminate examples of good practice in resource use in the clinical field. CRUG investigates specific clinical topics in order to identify the effective use of resources. Guidance has been issued on the management of endoscopy services and diabetes, and enquiries are in hand on day surgery and protocols for laboratory and X-ray work. Collaborative ventures with SCOTMEG are being mounted, for example on management of outpatient services.

WORKING TOGETHER

Improvement in patient care depends on team work, involving many statutory and voluntary agencies. We want to encourage that process.

JOINT PLANNING

Effective joint planning is not easy because of the different constitutional position of Health Boards and local authorities, differences in the type and level of accountability and in sources of funding, and unfamiliarity of the concept and practice. Nevertheless progress is being made towards a more closely integrated approach to care in the community which is producing improved services in many areas. The contribution made by the voluntary sector is increasingly recognised and the involvement of voluntary bodies in the planning of local services should be encouraged.

HEALTH BOARDS AND UNIVERSITIES

The Health Service and the universities work closely together in the undergraduate and postgraduate education of doctors and dentists, in medical research, and in the provision of specialist hospital services. Health Boards and medical and dental schools must discuss and plan together the organisation and funding of activities and services on which they all depend.

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CO-OPERATION WITH THE PRIVATE SECTOR

If the most effective use of resources is to be made, all sectors involved in health care must collaborate. Scotland's private sector makes a large and growing contribution to the care of the elderly and has acute facilities which have been used to the benefit of NHS patients, for instance, to reduce waiting lists for surgery. Health Boards should be aware of private facilities available locally and should consider their use, wherever they offer advantages to patients and good value for money.

The forty years of the Health Service have seen a massive expansion of services and developments beyond the dreams of its founding fathers. In medical technology the frontiers of the possible are constantly being extended, while advances in the use of drugs and therapies mean that patients can be treated more effectively and more quickly.

The vast sums being spent on the Health Service in Scotland — £2.5 billion in 1988-89 — make it essential to look for efficiency and value for money. The health service is above all a personal service of caring and it depends on the efforts of staff dedicated to the needs of individual patients. We are all grateful to those who work in it.

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ILLUSTRATIONS

Cover Royal Hospital for Sick Children, Edinburgh

1 The Rt Hon Malcolm Rifkind QC MP, Secretary of State for Scotland

2 Royal Hospital for Sick Children, Edinburgh

3 Third Year Student Nurse and Resident, Royal Scottish National Hospital, Larbert

4 Physiotherapist, Royal Scottish National Hospital, Larbert

5 Radiographer, Falkirk and District Royal Infirmary

6 Open Heart Surgery, Glasgow Royal Infirmary

7 Health Visitor on Home Visit, Glasgow

8 Special Care Baby Unit, Falkirk and District Royal Infirmary

9 School Health Clinic, Forth Valley Health Board

10 Elderly Gentleman at Home, Edinburgh

11 Borders General Hospital, Melrose

12 Gilbert Bain Hospital, Lerwick

13 Elderly Lady at Home, Edinburgh

14 Health Education and Prevention: National Campaign against Smoking

15 Crosshouse Hospital, Kilmarnock

16 Ninewells Hospital, Dundee

17 Kirklands Hospital, Bothwell

18 Astley Ainslie Hospital, Edinburgh: The Balfour Pavilion

19 Elderly Lady at Home, Edinburgh

Health Promotion Campaigns—

20 'Live Better Longer', Ayrshire & Arran Health Board

21 'Walkaboutabit', Greater Glasgow Health Board

Health Education and Prevention: National Campaigns—

22 alcohol

23 AIDS

24 immunisation

25 Craigroyston Health Centre, Edinburgh

26 Young Residents at Work, Royal Scottish National Hospital, Larbert

27 Royal Infirmary of Edinburgh

28/29 Occupational Therapy, Astley Ainslie Day Hospital, Edinburgh

30 Young Residents at Play, Royal Scottish National Hospital, Larbert

31 Computer Suite, Borders General Hospital

32 Occupational Therapy, Astley Ainslie Day Hospital, Edinburgh

33 General Practitioners' Surgery, Leith

34 Dunblane Health Centre

35 Dental Hospital, Edinburgh

36 Mobile Dental Service, Forth Valley Health Board

37/38 Hospital Pharmacy, Preparation of Intravenous Feeding, Ninewells Hospital, Dundee

39 Scottish Ambulance Service

40 Community Blood Donor Session, Paisley Town Hall

41 Processing Blood Products, Scottish National Blood Transfusion Service, Edinburgh

42 Planned Replacement— Thomas Clouston Clinic, Royal Edinburgh Hospital

43 Income Generation— Shopping Complex, Glasgow Royal Infirmary

44 Tea Room, City Hospital, Edinburgh, manned by volunteers from local churches

45 Lamb's House, Edinburgh and Leith Old Peoples' Welfare Council, Leith

46 Members of Staff, Stirling Royal Infirmary

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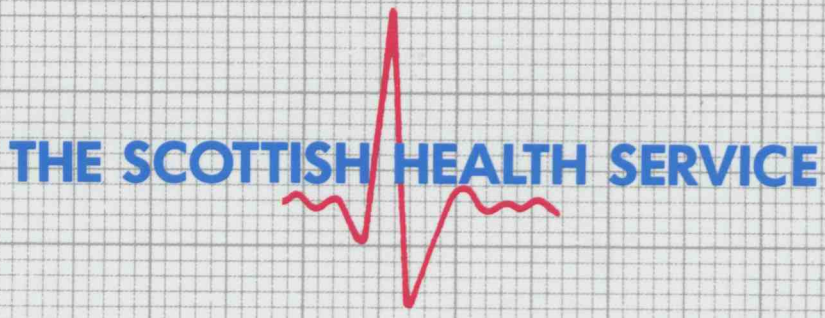

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