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SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

21 December 1988

Paul Gray Esq
Private Secretary
10 Downing Street
London SW1A 2AA

Dear Paul,

NHS REVIEW: WHITE PAPER: SCOTLAND

My Secretary of State has asked me to circulate the attached draft chapter (or section) on Scotland for inclusion in the draft White Paper to be considered on 22 December. I should note that, while he is satisfied with the content, Mr Rifkind intends that the style should be sharpened up in the next draft.

I am copying this letter and enclosure to the Private Secretaries to the Chancellor of the Exchequer, the Secretaries of State for Wales, for Northern Ireland, for Health, the Chief Secretary to the Treasury and the Minister of State (Department of Health); to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit; and to Richard Wilson in the Cabinet Office.

Yours sincerely,

David.

DAVID CRAWLEY
Private Secretary

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NHS REVIEW WHITE PAPER: DRAFT SCOTTISH CHAPTER (20 DECEMBER)

Introduction

1. Scotland enjoys high standards of health care. The proposals in this White Paper will build on these and on a proud tradition of medical and nursing education. Among the achievements published in "The Scottish Health Service" last November were longer life expectancy; fewer still-births; lower rates of peri-natal and infant mortality; more in-patient, day cases and out-patient attendances; increased numbers of patients receiving renal dialysis, kidney transplant operations, and operations to replace joints and treat cataracts. There has been progress too in reducing in-patient waiting lists, increasing care for the elderly in their homes, raising staff numbers and the level of the health service building programme. Total expenditure in the NHS in Scotland has risen 34% in real terms from £1053 million in 1979-80 to a planned £2683 million in 1989-90.

2. Since 1974 the integration within one organisation of all hospital, community and primary care services has been accepted as appropriate for Scotland, given the scale of the NHS and the distribution of population served by each health board. The wide support which this arrangement commands has been confirmed in the Primary Health Care White Paper (Cm 249). The Government will maintain it as the basis on which to introduce in Scotland the improvements set out in this White Paper.

3. The Government's priorities for the Scottish Health Service were recently set out in the Foreword to the Report "Scottish Health Authorities Review of Priorities for the Eighties and Nineties". These are the priorities to which this Review's proposals for improved delivery of services are addressed. They are:

> Services for old people with dementia, both in-patient care in hospitals and domiciliary care in the community;

Care in the community with particular reference to:-

services for elderly people
services for people with a mental handicap
services for poeple who are mentally ill

Health education, prevention of ill health and health promotion encouraging people to be better informed and to take responsibility for their own health and well-being; and

Services for the younger physically disabled

and better management

At the same time acute hospital services require sufficient resources to maintain their present high standards.

4. The means of achieving further improvements in the efficient delivery of health care set out in this White Paper apply fully to Scotland. Scotland will continue to have a high standard of medical care available to all regardless of income; the benefits of greater patient choice, modernised and improved buildings, and equipment; and a service which is responsive to the needs and wishes of individual patients. The necessary changes can be brought about only by giving staff a more satisfying measure of responsibility coupled with clearer accountability for the results they are expected to produce. This applies not only in hospitals but also in the community and family practitioner services which normally provide the first contact patients have with doctors and nurses.

Putting Patients First

5. Chapter 2 sets out the general objectives for better patient care which lie at the heart of this Review. Health boards have already been asked to shorten waiting lists and reduce the time people have to wait for hospital treatment. The funds available for this purpose have been increased over the past two years and up to £7 million will be available in 1989-90. Health Boards will be asked specifically to ensure that:

- services are planned and delivered with the aim of meeting the wishes of patients;

- patients are always treated as valued customers;

- hospitals and clinics provide appointment times that patients can rely on;

- a higher proportion of outpatients see the appropriate consultant on their first visit, rather than a junior doctor;

- attractive information leaflets are provided telling patients what they need to know when first admitted to hospital, including details of what amenities and extra facilities may be available at an extra charge.

Ministers will be considering further the best way to ensure that Boards seek and act on their "customers'" views in the light of a recent management consultants' report on this subject.

6. Responsiveness to the consumer was also a key element in the Primary Health Care White Paper whose detailed implementation is currently being discussed with the professions concerned. Scottish interests are fully represented in these discussions which will result in measures to give consumers more information about family doctors and services to help them exercise a more informed choice.

Central Management of the Health Service in Scotland

7. Following the successful introduction of general management at health board level, the Government's aim is to develop and strengthen the general manager's rôle. This will be done by delegating decision-making for operational matters to the maximum possible extent; with Ministers retaining full responsibility for strategic policy and for ensuring cost-effective use of public money. Delegation downward must be matched by accountability upward. General Managers are already formally accountable for the spending of their Boards. Building on existing monitoring of progress, the Government will introduce an Annual Round of Accountability Reviews and Target-Setting at which each health board will discuss with the Department the Board's performance over the past year and agree targets for the coming year.

8. The central management of the health service in Scotland will continue to rest with the Scottish Home and Health Department, reporting to the Minister for Education and Health and the Secretary of State. But the Government is considering ways of strengthening this central management and supervisory role.

9. The Scottish Health Service Policy Board will however be abolished. Recent experience has shown that the Board has not fulfilled its original purpose. The broad issues of policy can be dealt with more effectively by Ministers directly, seeking advice as necessary, through meetings with representatives of Health Boards and other bodies and through the work of the Scottish Health Service Planning Council.

10. The Government have, however, reviewed the Planning Council machinery for obtaining and disseminating advice on best practice for health service management and clinical care. Following consultation they have concluded that the Planning Council needs to be refashioned to tackle the changing needs of the Health Service. The Secretary of State has therefore decided to replace it with a statutory Advisory Council consisting of individuals who will provide a range of skills and experience and include representation from health service management, the professions, the universities, the private health sector, the staff and other related interests. It will advise the Secretary of State as requested, on the exercise of his Health functions. The Council will also, with his agreement, give advice on good practice to Health Boards, and those delivering health services. Further details of the composition of the new Council and of related advisory bodies for individual health professions will be announced and the necessary legislation prepared in due course.

Future of SHARE

11. Money for the current expenditure of the health service in Scotland, is distributed to the 15 health boards according to a Scottish Health Authorities Revenue Equalisation formula (SHARE). It measures the relative needs of the different areas by weightings for the age and sex structure of the population and its morbidity (as indicated by standardised mortality rates).

12. The Government intend to simplfy the SHARE formula by removing central adjustments for cross-boundary flows. In future "the money will follow the patient", so that wherever patients are examined, tested or treated the board where the patient resides will pay for the work done by the board where the work is carried out. SHARE allocations will continue to reflect relative needs, based on each board's population structure and morbidity, but without any element to take account of work imported or exported across the boundary between boards.

13. This arrangement will require prices to be set for a wide range of hospital and laboratory procedures. To begin with, an indicative tariff, based, for acute hospital procedures, upon the classification of such procedures into diagnosis-related groups (DRGs), may be set centrally but in due course it will be for providers to set their own prices along business lines. The Government will consult interested bodies during 1989 about what modifications to SHARE can be introduced in 1990-1991.

14. Considerable further investment in computers and information technology will be needed in nearly all units to produce patient-based, DRG-classified cost information accurately. Once an accurate information base is provided it may be possible to move away from the SHARE formula altogether and to reimburse providers entirely on the basis of work done rather than needs forecast.

Structure and Role of Health Boards

15. With the introduction of general management the rôle of health boards is changing and their membership should reflect, in size and composition, the kind of changes that are occurring. It will be appropriate for the General Manager to sit on the board alongside a number of external non-executive directors, under the Board's chairman. Such a board might be somewhat smaller than the present range of 14-22 members. The Government will be consulting interested bodies about the details of any such change.

16. Greater emphasis on the rôle of health boards in commissioning, contracting for, and purchasing services from providers (rather than, as now, supplying most services at their own hand) will make it particularly

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valuable to have non-executive directors on boards with business skills and experience.

17. The Government believe that the more active management of the family practitioner services originally proposed in the White Paper "Promoting Better Health" and developed in this White Paper can be carried forward in Scotland by the health boards retaining their responsibility for both the hospital and community health programme and the family practitioner services. The boards will, however, have to adjust their arrangements for managing these services to bring about the changes in accountability and consumer choice proposed in this White Paper.

Self-Governing Hospital Trusts

18. Chapter 4 has set out the Government's proposals for self-governing hospital trusts. The proposals are also relevant to Scotland's interests. In the absence of a regional tier in the Scottish health service, the Scottish Home and Health Department will take responsibility for guiding and supporting hospitals which meet the criteria and are interested towards achieving self-government. Some 30 Scottish hospitals might be regarded as potential candidates in the longer term. But subject to legislation, [two] Scottish major acute hospitals might attain self-governing status by [1992]. The Government will consult interested parties on the criteria for setting up a trust, on the responsibilities of trusts and on the arrangements for managing the process of transition.

Medical Audit

19. The proposals in chapter [ ] for medical audit are fundamental to the principles of the Review. Managers and practitioners need comprehensive and credible outcome data on the treatment of patients in order to assess what they are achieving. A pilot study into avoidable factors in anaesthetic and surgical deaths is proceeding in the Lothian Health Board area, but experience in Lothian over recent years demonstrates how clinicians, in cooperation with one another and with general management, can examine the effectiveness of clinical care and take steps to improve their own performance.

20. In the primary care sector the continuing development of the General Practice Administration System for Scotland (G-PASS) of micro-computer software, issued free to general practitioners, will supply better information about the outcomes of patients' treatment. The software is now in use by general practitioners in all areas. Over a third of practices in Scotland use it to assist with repeat prescribing, patient administration, morbidity recording, call-and-recall of patients for screening or inoculation, as well as audit and research. The next step is to extend G-PASS to all practitioners; and to make sure it fits in easily to the information systems being developed for the hospital service.

GP Practice Budgets

21. The rationale for general practitioners exercising a greater degree of financial responsibility for the total health care of their patients applies with equal force in Scotland. The opportunity of GP practice budgets as discussed in Chapter will therefore be available in Scotland. By virtue of their unified responsibility for family practitioner services as well as hospital services, Health Boards should be well placed to operate such a scheme but they will need adequate information systems for the purpose, as will the GPs. Scottish general practitioners opting for practice budgets will have to demonstrate to the Health Board their capability to manage them. There will be a right of appeal to the Secretary of State against rejection or withdrawal. Those practices which obtain budgets will have the same scope for flexibility between financial years as indicated in Chapter .

22. Taking the criteria indicated above in Chapter , about 60 practices in Scotland will be eligible to opt for GP budgets. This represents 5% of all practices, a lower proportion than in England since list sizes are smaller on average because of the more scattered population. Subject to suitable arrangements being devised with the Health Boards in whose areas they occur, the Government would like to see a number of group practices with GP practice budgets by 1992.

23. An essential ingredient both of clinical audit as applied to general practitioners and of GP budgets will be the feedback of information about prescribing practice and hospital referrals. Machinery already exists for

investigating alleged cases of excessive prescribing and the Government proposes to improve its effectiveness [and extend it to cover referrals as well]. Subject to consultation with the professions, it is proposed that responsibility for conducting these investigations should remain firmly with the appropriate general practitioner committee of the Health Board but consulting the Area Medical Committee for its view on each case rather than using that Committee as its agent for conducting the investigation. By this means a more obviously impartial judgement of each case should be obtained.

24. The emphasis in Chapter on the increased extent to which a general medical practitioner's income will be derived from capitation fees will be reflected in the remuneration of practitioners in Scotland to encourage them to offer a service which will attract patients to their list. The Government appreciates that there will be limitations on that process in the less populated areas, and will consider further the arrangements for these areas. [Fuller detail of how GP practice budgets would be expected to operate in Scottish circumstances will be set out in the discussion document which the Secretary of State will publish as part of the implementation of the Review.]

External Audit

25. The statutory audit of the health boards and other health authorities in Scotland is the responsibility of the Secretary of State. Hitherto the audit has been conducted entirely by the Scottish Office Audit Unit which is not part of the Scottish Home and Health Department but is answerable to the Secretary of State. Recently the audit of two of the health boards has been contracted out to commercial auditors. Both in-house and commercial auditors in the health care field are devoting an increasing proportion of their time to value for money audit in addition to their routine certification audit duties. The Secretary of State has reviewed these arrangements. While he has concluded that they are still appropriate for the present configuration of the health service in Scotland, he would welcome comments on the establishment of statutory audit arrangements which do not form an integral part of the Scottish Office.

The Private Sector

26. Scotland's growing private health sector has 7,000 beds. Most of them give nursing and convalescent care to frail elderly people. In fact, a third of Scotland's long-stay beds are in the private sector. Health Boards already draw on this resource - nearly [1,000] nursing home places are taken by National Health Service patients. Many other residents have their fees paid through Social Security funds. Good nursing homes offer the very elderly - a fast growing group - congenial surroundings, nursing care and a choice of location. The Government expect them to play a big part in our services for the very elderly and, with that in mind, have just made new regulations, to be backed shortly by guidelines of good practice, to promote standards of care.

27. More Scots are looking to the private sector for the diagnosis and treatment of their health problems. The Government want to make this an option for NHS patients too. Over the last year, private hospitals have worked closely with the NHS to tackle waiting lists for operations like hip surgery and this kind of cooperation should continue and expand. With the introduction of GP practice budgets, general practitioners in Scotland should be able to choose, if they wish, to buy operations for their NHS patients directly from private hospitals [or from self governing NHS hospitals]. The results should be shorter waiting lists for operations, and more choice for patients.

28. Medical procedures, like renal dialysis, could also benefit from private sector involvement, and Health Boards in Scotland are already looking at how private companies might help them to provide more, and more convenient, dialysis places.

Concluding Comment

29. [To be drafted]