THE SCOTTISH OFFICE
Department of Health

The Scottish Health Service: Ready for the Future

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by Command of Her Majesty

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Foreword by the Prime Minister

The NHS was established in 1948 to improve and promote health and lift the burden of anxiety about ill-health which so affected previous generations. Since then, despite frequent debate about the development and scope of the NHS, it has proved to be an enduring institution which has earned a special place in our country. It touches all of us and we all have a stake in its future.

This Government is proud of its commitment to the NHS as a public service, promoting health and offering high-quality health care to everyone on the basis of need regardless of the ability to pay - an NHS which is true to its founding principles but which is adapting and developing to meet changing needs and rapid advances in technology and clinical practice.

This White Paper commits the Government to the future development of the Health Service in Scotland. It sets a clear direction for an NHS committed to meeting the needs of individual patients and to the development of services. The NHS is part of the fabric of this country, at the heart of every community, and in the hearts and minds of every person. This Government intends to ensure that a modern, effective, comprehensive NHS continues to be there when we need it.

John Major

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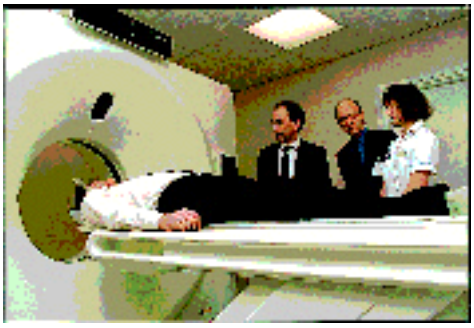
Introduction by the Secretary of State



In Scotland we have a Health Service of which we can be very proud. Over many years we have developed a distinctively Scottish approach to meet the health care needs of the Scottish people. We have done so by building on the founding principles of the NHS as they have applied throughout the UK for almost 50 years. We have established a service which is:

universal in its reach, available to everyone wherever they live

high quality, applying the highest professional standards and employing techniques based on the latest knowledge

available on the basis of clinical need, regardless of the ability to pay, and

patient-centred through its increasing focus on the experiences and needs of individual patients.

This paper sets out ways of continuing to improve the Health Service in response to the changing needs of patients and health service staff. I recently established a Health Service Policy Board with the aim to ensure that the views of those working in the NHS are heard, and that they have the opportunity to influence the future direction of the Service.

Levels of satisfaction among Health Service users are high. The Government's surveys reveal that more than 8 out of every 10 patients consider that the Health Service delivers an excellent service. Since success rarely makes the headlines, this Paper deliberately sets out the details of the achievements of the Service and our commitment to the £4.5 billion undertaking which is the Scottish Health Service. It is that commitment, the excellence of our Health Service staff, and our willingness to implement the necessary reforms which have made these successes possible.

The Government's reforms set out in *Working for Patients* are complete. We now have a structure targeted on better patient care which will serve our nation well into the 21st century. The direct management of health care services has largely passed from the Health Boards to the 47 NHS Trusts, and the internal market for health services is now the means by which standards are improved and services made more responsive to patients' wishes. In March 1996, the Shields Report set out the Roles and Responsibilities of Health Boards and described the key role they now play as commissioners of health care, working in close co-operation with general practitioners including GP fundholders, to give strategic direction to local health services. The creation of Trusts and GP fundholders has allowed major devolution of decision-making and has demonstrated the benefits which can flow when those in closest contact with patients have a proper say in the way services are organised and delivered. These substantial changes have been put in place while the Scottish Health Service has continued to deliver an expanded range of higher quality service.

We know, however, that there are aspects of the Service which can be made even better. These improvements can be grouped under 6 key themes:

- an emphasis on prevention;
- better information for the public;
- better access to services;
- greater responsiveness to patients' needs;
- effective continuity of care; and

- excellence in clinical and management practice.

This Paper sets out how the Government will help the Scottish Health Service to realise these aims. They are targeted on areas where we know that people want to see change and they are in keeping with our tradition of finding distinctively Scottish approaches to deal with our needs. I believe it is now right, therefore, to speak of the Scottish Health Service, since the NHS in Scotland has enough identity to warrant such a term, in much the same way as we speak of the Scottish legal system or the Scottish education system.

As the next millennium approaches, the Scottish Health Service is ideally placed to build upon its strong foundations. **The Government's commitment to the fundamental principles of a publicly funded Health Service free at the point of use is undiminished**, and its reforms have helped the Service to become more flexible and responsive to patients' needs. I am in no doubt that pursuit of this Paper's key themes should be, if pursued rigorously, as challenging an agenda as the original reforms. I am also sure that the work we are undertaking will mean that in another 50 years it will be possible to point to gains in health even more striking than those achieved by the Scottish Health Service since its inception some 50 years ago. Much will depend upon partnership between health and other agencies if maximum health benefits are to be realised, and this must be paralleled by partnership between the Government and the Health Service. The Government has created the framework and provided unprecedented levels of resources. It is confident that all those working in the Scottish Health Service will want to seize the opportunities that this Paper presents.

Michael Forsyth

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Setting the Scene

Introduction

1 The Government's reforms of the Health Service have brought greater freedoms and flexibilities to meet the changing pattern of patient needs, and have provided the Scottish Health Service with an effective foundation on which to build. The organisational structure is basically correct, and the need now is for organisational stability to realise further improvements in health care and in Scotland's health.

2 The Government's response to the priority which the public attaches to the Health Service means that The Scottish Office spends more on health than on any other single public service. In the last 10 years, NHS spending in Scotland has risen from £2.07 billion to over £4.5 billion - an increase in real terms of 28% since 1986-87. Whereas 10 years ago the Government was spending £646 for every man, woman and child in Scotland at today's prices, this year it will be spending £821. Expenditure per Scot has therefore grown in real terms at an average annual rate of 2.4% over the decade. The Government has recognised the particular health needs of Scotland by spending 23% more per head of population on health than England (see Figure 1).

Figure 1 - Real NHS Spending per head in England and Scotland

(To follow later)

3 The Government believes that the Scottish Health Service should continue to share in a growing economy. Its commitment to real terms increases in Health Service spending year by year is reflected in the Public Expenditure settlement for 1997-98. The Government looks to the Scottish Health Service to respond, as in the past, by striving for the highest standards of quality and by extracting maximum value from all of its resources.

4 Decisions on competing needs will remain difficult, but this has been the case since the NHS was founded. The Government does not accept that it should prescribe the range of treatments which the Scottish Health Service should or should not provide. No list of treatments could ever accommodate the range and complexity of cases which confront clinicians daily. There would be a real risk that decisions would be taken out of the hands of clinicians and placed in the hands of others who lack the necessary experience or expertise.

5 The health of Scottish people is improving, and the Scottish Health Service continues to deliver high quality services to increasing numbers of patients.

6 Over the 10 year period to 1995 the number of deaths from coronary heart disease, cerebrovascular disease (strokes), accidents, respiratory disease, and cancer have all declined. Annex 1 presents details of these trends, which reflect the dedication and skill of those working in the Scottish Health Service and associated agencies.

7 Numerous new treatments have been introduced in recent years, including the Scottish Heart and Liver Transplant Units which are achieving excellent results. The number of patients treated in Scotland's hospitals continues to increase, and the Health Service has responded flexibly and quickly to changes in clinical practice. Increases in the number of nurses, doctors and other clinical staff coupled

with more effective management have been crucial. Hours of work of junior doctors have been successfully reduced, and waiting times for treatment are now shorter than they have ever been. Annex 2 sets out further details of recent progress; it is a record of achievement in which the Scottish Health Service can take pride. It is a solid foundation on which to build a Health Service which is increasingly responsive to the needs of patients and staff alike.

Main Themes

8 The Government has identified 6 themes for the Scottish Health Service to pursue in order to realise these aims. They are targeted on areas where there is a public demand for improvement, and they should inform all the Service's strategies. They are:

- an emphasis on prevention
- better information for the public
- better access to services
- greater responsiveness to patients' needs
- effective continuity of care
- excellence in clinical and management practice.

They are to be given particular focus through the work in the priority areas of mental health, cancer and coronary heart disease/stroke which are discussed later in this Paper.

An Emphasis on Prevention

9 Although there have been improvements in Scotland's health, in particular more progress needs to be made on: smoking among young people, alcohol misuse and oral health of children. Despite the improvements in Scotland's health, people in England are living on average 2 years longer, and premature deaths in Scotland are 32% in excess of those in England.

10 Protecting Scotland's health calls for continued vigilance and responsiveness on the part of the Health Service, local councils and others who help combat the spread of disease and deal with health-threatening emergencies. This has been given particular emphasis by the recent *E-coli 0157* outbreak, and the Government is looking very carefully at the wider lessons to be learned from the reports by Professor Pennington's group.

Better Information for the Public

11 Knowledge about health and treatment helps people to use services effectively. People need good quality information about:

- how to stay healthy
- what to do when symptoms appear or when an emergency arises, to help them decide whether, when and how to seek help
- the implications of any illness that arises, so that they can take part in decisions about treatment and care.

12 Many people have a role to play in providing this information, including

Government, those working in the Scottish Health Service, the media, voluntary groups, social work services and schools. Co-ordination is needed to make the best of their contributions, and advantage must be taken of new technologies so that information can become more widely and easily available. It is important to ensure that information is accessible to members of ethnic minority communities and people with disabilities.

Better Access to Services

13 When the need to seek help arises, people want easy access to services. For most, the contact will be the family doctor and his or her clinical team, who will be able to meet the majority of their needs. For those who need specialist services, speedy access is equally important. Provision of optimal access requires a co-ordinated effort:

- to ensure patients have access to care *locally* whenever possible;
- to organise effective services which meet emergency needs, especially outside normal working hours;
- to minimise the time taken to admit patients who require urgent hospital treatment;
- to reduce the length of time which doctors and their patients wait to receive the results of diagnostic tests; and
- to ensure that waiting times for out-patient and in-patient treatment continue to shorten.

14 The growing trend to provide better treatment through clinical specialisation is leading to the concentration of some services, and this may mean that some patients have to travel further to benefit from that specialist treatment. But this trend must be balanced against the need for local access, which is highly valued. The Government believes that services should be provided locally unless there are strong clinical considerations to the contrary. Developments in clinical practice and technology are helping to achieve this aim of local treatment, with increasing numbers of consultants providing specialist clinics in GP surgeries and other community settings.

Greater Responsiveness to Patients' Needs

15 The Government's goal is to produce an integrated, high-quality service which is sensitive to the needs of patients. This does not mean imposing uniform service patterns or management solutions across Scotland. Indeed, *flexibility* in the way services are provided is essential because:

- the needs of individuals vary;
- the needs of communities vary. Some population groups suffer more illness than others, and some face particular difficulty in gaining access to services. Services in rural and remote areas may need to organise differently from those provided in urban or suburban areas; and
- services may be at different stages of development across Scotland, and priorities for change will vary accordingly.

Effective Continuity of Care

16 Many groups are involved in promoting health and caring for people. To be fully effective their work needs to be co-ordinated in a seamless Health Service in which:

- organisational boundaries do not get in the way of care for patients, but it is clear to patients who is responsible for their care at all times;
- the roles and responsibilities of those helping patients are clearly defined;
- multi-professional teams make the best use of the specialist skills and experience of their staff;
- all staff are trained to work in multi-professional teams, and there is support in working across organisational boundaries, such as those between health and social care; and
- planning and contracting for services supports practical working arrangements.

17 Working across the boundaries of health, social care, voluntary organisations and the independent sector can be difficult. Different funding mechanisms, different priorities, different boundaries, and different organisational cultures all contribute to this. Good working relationships, shared information, an understanding of other perspectives and a common commitment to patients and clients can all help to overcome the difficulties.

18 Developing an integrated Health Service also depends on effective working between the primary and secondary care sectors. As changing practice allows more treatment and care in the home or local community, the GP becomes ever more important as the co-ordinator of patient care.

19 Developments in communications and information technology will help to achieve integration and continuity, ensuring that the necessary information about patients and their care is readily accessible to those who need it but is safe from those who have no right to see it.

Excellence in Clinical and Management Practice.

20 Maintenance of the Scottish Health Service's reputation for excellence requires continued investment in research and development, as well as continuing professional education. To achieve this the Scottish Health Service needs:

- to stay at the leading edge of scientific research, working with colleagues to improve our understanding of the causes and effects of disease, and so bring about improvements in the prevention, diagnosis and treatment of illness and disability
- to evaluate new technologies and
- to work with health care professions to review their performance and enable them to bring the most effective practice into general use.

21 The professionalism of the workforce of the Scottish Health Service is not in doubt. Self-regulation sits comfortably alongside public accountability, ensuring a commitment to the health and well-being of patients, and to the development of the Scottish Health Service as a whole. The role of the statutory and regulatory bodies and the Royal Colleges in improving standards of practice, education and training remains invaluable, and there is a strong tradition of joint working between the Scottish Health Service, the universities and other academic bodies. Health Service

employers - principally Health Boards and NHS Trusts - have a key part to play in supporting this partnership and in providing direct training and development opportunities for all staff throughout their working lives.

22 Since it is the skills, knowledge and attitudes of staff which ultimately determine the patient's experience of the Health Service, the Government is committed to continuing education. This will ensure that these attitudes and values are passed on from one generation to the next.

23 As well as high level clinical skills, the delivery of high quality, responsive patient services also depends on a range of other qualities, including the ability

- to see things from the perspective of the patient or carer, and to be an effective communicator
- to work with patients and carers, ensuring that they can play a part in the decisions and choices affecting their treatment or care
- to understand and make the most of the whole health and social care system
- to work in teams, even where they cross organisational boundaries
- to identify health need and understand the opportunities for health promotion as well as treatment and care.

The Role of Information Management and Technology

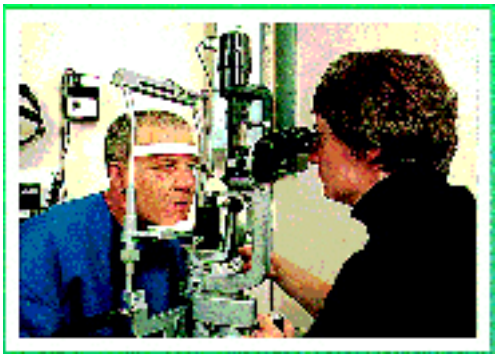
24 Progress can be made on all of these themes by making better use of modern Information Management and Technology (IM&T). The Paper has already described some of the possibilities, including easier access to information for patients and those who care for them, the opportunity to bring specialist care to the local surgery through telemedicine, and better co-ordination of care planning. In order to make the most of this new technology, a strategic framework has been drawn up for the Scottish Health Service for the next 5 years. It aims to get the right information, under the right safeguards, to the right place at the right time, smoothly and efficiently. Within this strategic framework, each part of the Scottish Health Service - Health Boards, Special Health Boards, Trusts, GPs and the Common Services Agency - will be asked to take forward their own proposals to exploit the potential offered by modern information management and technology.

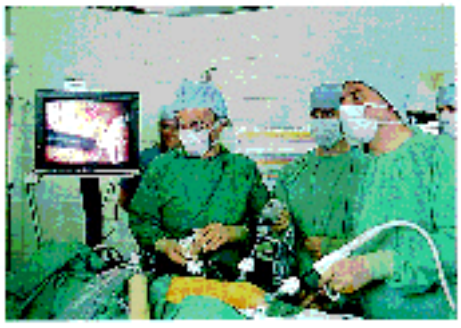
Conclusion

25 As the new millennium approaches, the Scottish Health Service is ideally placed to build upon these themes. The Government's commitment to the fundamental principles of a publicly funded Health Service free at the point of use is undiminished, and the Government's reforms have helped the Service to become more flexible and responsive to patients' needs than it has ever been. In the following section, the Government sets out work in progress and a number of new commitments and initiatives which will help to provide even better care for patients. They are grouped under a discussion of the Government's aims for: Health Service staff; improved quality; and service developments; and are designed to take forward the main themes of this White Paper.

Moving Ahead

Staffing Training & Development





Introduction

26 Scotland has a proud and internationally recognised tradition in the education and training of clinical staff. The provision of a well-educated and trained workforce is of paramount importance in ensuring a high standard of health care within the Scottish Health Service. Rapid advances in medicine have increased the need for continuing education if health care professionals are to keep up-to-date and retain appropriate skills throughout their professional lives. The Government's task is to ensure that a human resources strategy is in place which will cover recruitment, retention and retraining, and will help people to embrace change, build on the skills they have already acquired, and develop new ones.

27 The Paper now looks at each of the professions in turn, and the initiatives designed specifically for them. It starts with nurses, midwives and health visitors, since they represent the largest group working in the Scottish Health Service. The Government aims to ensure that nurses are supported in developing the scope of their practice and have every opportunity to realise their full potential.

Nursing, Midwifery and Health Visitor Education and Training

28 There have been significant recent changes in the arrangements for the training of nurses. Responsibility for the provision of pre-registration nursing and midwifery programmes now lies with the higher education sector, working very closely with the Scottish Health Service. Student nurses and midwives now have greater opportunities to learn within a multi-disciplinary environment, while retaining the benefits of early involvement in patient care.

29 The National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS) is responsible for ensuring that post registration education for nurses, midwives and health visitors meets the requirements of the United Kingdom Central Council (UKCC), the implementation of whose report on Post Registration Education and Practice (PREP) is now under way. To this end, the NBS has consulted employers to ensure that training standards are maintained while the needs of employers are met.

30 To build on these changes the Government has identified four areas for urgent action to enable the roles and responsibilities of nurses to be developed further:

- continuing and post registration education;
- recruitment and retention;
- shortages in specialist areas; and
- policy and practice development.

Continuing and Post Registration Education

31 The Government has already demonstrated its commitment to ensuring that nurses play their part in taking forward national priorities by strengthening the

knowledge base in cancer nursing. An additional 100,000 has been provided to help 38 nurses undertake post-graduate diplomas or degrees in cancer nursing in the academic year 1996-97. The Government now sets out three further initiatives.

Initiatives

Education and Training for Scottish Health Service Priority Areas

Provision of access to appropriate education and training to meet the needs of nurses working with patients suffering from cancer, cardiovascular disease and strokes, and with patients in the community who are suffering from mental illness.

100 nurses will be given the opportunity to obtain post registration education diplomas or degrees, so as to increase the cadre of highly skilled and knowledgeable nurses who can act as agents for change and as a resource for other nurses and managers.

Practice Nursing - Education and Training

Provision of additional training leading to a specialist practitioner qualification known as "community health care nurse (general practice)".

10% (approximately 100) of all current practice nurses will be helped to obtain a Practice Nurse Qualification which is recordable with the UKCC.

Nurse Prescribing in Primary Care

Implementation programme to introduce nurse prescribing across Scotland.

Nurse prescribing is an important development that can reduce the delay experienced by patients when obtaining a prescription and allow better use of GP time. It also extends the scope of nursing practice by enabling nurses to make decisions about patient care. The first step towards nurse prescribing in Scotland was taken in July 1996 when 2 demonstration sites were established to test the administrative arrangements needed. This initiative will be extended in 1997-98 to 250 additional district nurses and health visitors working in 25 general practices.

Recruitment and Retention

32 A key component of an effective human resources strategy is the retention of as many trained nurses as possible with appropriate support for those wishing to return to work. The Government has drawn up an initiative to provide new opportunities for 200 nurses a year.

Initiative

Retention of Nurses within the Scottish Health Service

To retain registered nurses currently working within the NHS.

This will be achieved by providing:

- Updating programmes for nurses qualified to work in a shortage area but not currently practising in that area e.g. children's nurses working with adult patients;
- Re-skilling programmes to enable registered nurses to work in new or different environments, such as the community;
- Programmes to allow nurses to move from a part of the register for which there is a reducing need, e.g. mental handicap, to those parts where there is a scarcity, such as paediatrics

These initiatives will provide new opportunities for some 200 nurses a year.

Shortages in specialist areas

33 Even with the best workforce planning, shortages may arise in certain areas. At present, these include intensive care, high dependency and theatre nursing. The following initiative will tackle the particular difficulties in these specialties.

Initiative

Education and Training for Specialist High Dependency Areas and Theatres

The development of education and training to provide the skill mix needed in specialist areas such as high dependency, neonatal and adult intensive therapy units and theatres.

This will involve 100 nurses being trained through existing courses to the level of competence required to work in ITU and Theatres.

Policy and Practice Development

34 The Government has funded a Nursing Research Initiative for Scotland, based at Glasgow Caledonian University. It believes it would now be timely to consider complementing this initiative with a Nursing Policy and Practice Development Unit and wishes to consider the best way of achieving this with Service and education providers.

Initiative

Nursing and Midwifery Policy and Practice Development Unit

A national resource centre to act as the focus for networking, sharing good practice and advice which will expand the contribution of nurses, midwives and health visitors to the provision of health care.

Professions Allied to Medicine (PAM)

35 The term 'Professions Allied to Medicine' is used to describe the following professions: Physiotherapy, Radiography, Occupational Therapy, Orthoptics, Chiropody and Dietetics. A vital role is also played by Medical Laboratory and Scientific Officers (MLSOs) and other professions such as speech and language therapy. The context in which PAM work has altered substantially over recent years with many changes in the organisation and delivery of patient care such as the shift from hospital to community care. The PAM have risen to the technological and clinical challenge by re-designing ways of working, while continuing to deliver high quality services. NHS Trusts employ the majority of PAM, but GPs are increasingly realising their value to Primary Care teams. Those working within NHS Trusts in Scotland have to be State Registered.

36 The responsibility for training in the Professions Allied to Medicine lies with the Higher Education Sector and is funded through the Scottish Higher Education Funding Council (SHEFC). In the past few years these professionals have moved from diploma to graduate status, and their initial qualification is by degree offered by universities and colleges with clinical training largely provided within the NHS.

37 As with nurses, the responsibility for identifying the post-registration training needed to meet service objectives rests with employers, working under guidelines issued by the regulatory body. In view of the changes taking place in health care, an independent review of the Professions Supplementary to Medicine Act 1960, which regulates the initial training and subsequent professional practice of these Professions, was commissioned by the UK Health Departments. The review concluded that new legislation and a "Council for the Health Professions" were required. Legislative proposals will be based on the broad principles established by the review and will be the subject of further consultation. The following initiative underlines the importance which the Government attaches to the role of PAM in tackling the Scottish Health Service priority areas:

Initiative

Education and Training for Scottish Health Service Priority Areas

Provision of access to appropriate education and training to meet the needs of Professions Allied to Medicine working with patients suffering from cancer, cardiovascular disease and strokes and with patients in the community suffering from mental illness.

25 individuals in the Professions Allied to Medicine to be given the opportunity of achieving post registration education diplomas or degrees in caring for patients with these illnesses.

Medical and Dental Education and Training

38 The Government believes that a consultant-based hospital service will provide the best quality service to patients. The number of consultants in Scotland has increased substantially in recent years (between 1990 and 1995 numbers have risen by over 12%), and the Government is committed to developing the consultant role. The intake of medical students to the four Scottish medical schools has risen significantly in recent years. Considerable progress has also been made in the revision of the undergraduate curricula of the medical schools, following the recommendations of the General Medical Council in *Tomorrow's Doctors* (1993). Within the Scottish Health Service the arrangements for the allocation of monies for the Additional Cost of Teaching (ACT) has been reviewed recently to take account of the increasing role of teaching in the community and of GPs. At the post-graduate level, the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) has been successfully established as a Special Health Board and has made a positive contribution to the provision of training for doctors and dentists. The scheme whereby the Council provides 100% of the basic salary costs of all training grade doctors is proving a considerable success. Within hospital medicine the introduction of the new Specialist Registrar grade which replaces the grades of Registrar and Senior Registrar is well advanced. Those doctors who have successfully completed a specialist training programme will be awarded the Certificate of Completion of Specialist Training (CCST) and included on the Specialist Register maintained by the General Medical Council. These changes are intended to deliver the

better structured, more streamlined training called for in the Calman Report (1993).

39 Post-graduate education and training for general practice is well established and Scotland is at the forefront of improving the quality and flexibility of training. For example, specialist registrar posts have been created on a part-time basis, and in August 1996 12 2-year fellowships in general practice were introduced to assist the development of higher professional training.

40 Doctors have a professional obligation to maintain their specialist knowledge and skills and NHS Trusts as their employers have a responsibility to help them do so. Although continuing medical education is a UK issue in which the relevant Royal Colleges have a key role, the Government would like to see proposals which match the educational strategies developed by Trusts as part of their need to deliver patient services. The Government looks forward to receiving the Royal Colleges' advice on this subject.

41 Continuing education for GPs poses a particular challenge and was a key issue identified in the consultation process *Primary Care: The Way Ahead*. Options for improvements include personal learning plans and where this is on offer, 70% of GPs have agreed to participate. Proposals for practice-based continuing education should be a key element in the formation of practice development plans. Although the number of general practitioners has risen from 3,757 in 1990-91 to 3,890 in 1995-96, a 4% increase, there are currently some concerns about maintaining their future supply. The development of a Primary Care-centred Scottish Health Service will require an adequate supply of vocationally trained doctors for general practice, and the Government remains committed to working with the profession to tackle this issue.

42 The Government is committed to support general professional training in dentistry and the development of specialist dental practices. The Government will consult on amendments to the Dentist Act to enable pilots to test alternative skill mixes in dental teams. It will also review the 'Keep in Touch Scheme' for dentists.

Managers

43 Management plays an essential part in the effective delivery of health services. However, in a patient-focused service, any resources which are not applied directly to health care must be subjected to close scrutiny. The Government considers it imperative that spending on management and administration should be subject to the same periodic and rigorous scrutiny as any other overhead cost, and must be shown to deliver benefits to patients.

44 Continuing education and development is as important for managers as it is for other professions in the Health Service. A range of development programmes is now available for Chief Executives, Executive Directors and their successors.

45 The Government welcomes the trend in recent years which has led to an increasing number of clinical professionals occupying key management positions in the Scottish Health Service. The Government wishes to help sustain this trend by supporting initiatives which bring senior management and clinicians together in management and organisational development programmes.

Work of carers, the voluntary sector and volunteers

46 The Government acknowledges the vital contribution which carers make to the delivery of services to patients and their need for support from the statutory sector. It supported the Carers (Recognition and Services) Act 1995 through Parliament. The Act gives carers who provide substantial amounts of care on a regular basis the right to request an assessment of their own needs. Local authorities must consider the results of this assessment when determining the services to be provided to those being cared for.

47 There is also a rich tradition of voluntary effort elsewhere in the health and social care sectors, which is distinguished by the imaginative response it finds to individual needs. The diversity of voluntary contributions is reflected through examples such as:

- the voluntary hospices for adults and the children's hospice;
- well-known national organisations such as the WRVS, which provide practical services to patients and their families;
- local hospital-based initiatives which greet visitors, provide befriending services and run voluntary car schemes;
- schemes such as day centres for the elderly and assistance for carers;

- advocacy initiatives;
- public health projects such as tackling alcohol and drug abuse; and
- voluntary outreach schemes such as the St Andrew's Ambulance Service and the Red Cross.

48 The Government's 1994 publication *Working Together: The Scottish Office, Volunteers and Voluntary Organisations* acknowledges the important role and contribution of voluntary organisations and volunteering interests, which complement the work of Health Service staff. The Government is also committed to consulting voluntary organisations on significant policy developments, monitoring the effect of policies on the sector and actively pursuing policies which benefit the sector and draw on its strengths.

49 In the summer of 1995 guidance was issued by the Government which encourages local authorities to develop strategies for working with the voluntary sector and volunteers. Similar guidance will be issued shortly to health bodies, updating the guidance issued in 1986.

50 The Government supports the work of voluntary organisations through schemes of grants. A total of 1 million a year is allocated to national voluntary organisations under section 16B of the National Health Service (Scotland) Act 1978. A further 7.6m is made available under section 10 of the Social Work (Scotland) Act 1980 to voluntary organisations providing social care.

51 The Government wishes to support the work undertaken by the voluntary sector with two further initiatives, one related to palliative care, the other exploring the scope for involving volunteers in Primary Care.

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Initiatives

Hospices as Resource Centres

The introduction of a pilot scheme to enable adult voluntary hospices, as key providers of specialist palliative care, to develop services which would extend and improve the local provision of palliative care.
The hospice would serve as a ready source of information and offer prompt access to practical help for primary health care teams, social work departments, registered nursing homes and community hospitals.. Among the services provided would be: accredited courses in palliative care, a library for the use of local health professionals, carers' support and bereavement service, 24-hour telephone advice service, specialist palliative care advice to nursing homes and short-term equipment loans. The initiative will be taken forward by pilots in two adult voluntary hospices, chosen in conjunction with the Scottish Partnership Agency for Palliative and Cancer Care.

Volunteering Strategy

A project, to be undertaken by Volunteer Development Scotland (VDS), to develop a strategy for volunteering in the Scottish Health Service.
Its main components will be:

a 3-year programme to provide fresh impetus to the development of volunteering (including employment of a full-time Development Officer by VDS, possibly on secondment from the Health Service)

a 2-year action research project to explore the scope for involving volunteers in Primary Care.

Outcomes & Quality

Managing for Quality: Evidence-based Health Care

52 Securing the highest quality care for patients is a key objective. Working together to achieve it is the responsibility of everybody in the Scottish Health Service and involves using all the resources available to maximum effect. Emphasis on quality should be at the centre of all discussions about what the Scottish Health Service does and how it goes about it.

53 Some aspects of quality are relatively easy to determine and measure, whereas others are more difficult and necessarily involve the use of judgement. How, for example, does a clinical team assess the value of an extra day in hospital for a patient who is recuperating against the value of admitting another patient waiting for an operation?

54 The information available to the Scottish Health Service is much better than it used to be, and Health Boards and GPs increasingly have data which can inform decisions about priorities. But there are dangers in basing decisions only on those factors which are easy to measure and ignoring the more difficult judgemental factors. The Scottish Health Service must seek the best value solution, rather than simply the least cost solution, and this inevitably involves the difficult issue of quality assessment.

55 To help address these matters, increasing effort has been devoted recently to the collection of evidence about effectiveness. The Government welcomes this trend and is committed to encouraging the further development of evidence-based health care in Scotland. One way forward is the agreed programme of work to help collate the production of evidence on the clinical effectiveness and cost-effectiveness of care by focusing on a number of important topics each year. Most of the programme supports the three clinical priority areas, but it also includes topics which have potential for the

immediate improvement of health as well as clinical care.

Research and Development

56 A total of £40m is invested annually by the Government on research in Scottish hospitals and universities. Considerable additional funding is also awarded by the Medical Research Council, charities and other sources to Scottish researchers, who have a distinguished record of innovation in medicine and health care. This is reflected in Scotland's rich provision of Medical and Dental Schools and University Departments of Nursing. The skills and expertise they sustain are recognised internationally. Many clinicians fulfil multiple roles: caring for patients, teaching students and conducting research. Excellent basic and applied medical research is conducted in Scotland and this allows new ideas to be developed, carried into practice, and incorporated into the training of future health professionals.

57 The Chief Scientist Office of The Scottish Office Department of Health is responsible for funding research which is relevant to the health needs of the Scottish population. Reflecting this approach, four specific research initiatives have been launched in recent months to stimulate additional work on:

- **Mental Health** - focusing particularly on community care;
- **Nutrition** - developing themes in the Diet Action Plan by targeting approaches which will affect dietary habits, obesity and effective weight management;
- **Cardiovascular and Cerebrovascular Disease** - focusing on research to underpin disease prevention and improve rehabilitation;
- **Primary Care** - stimulating the further development of research by those working in Primary Care, and encouraging innovative practice.

The Nursing Research Initiative in Scotland is also making a significant contribution by supporting clinical nurses who are undertaking research or implementing its findings.

Advice on Clinical Services

58 Everyone wants to be treated with the best that modern health care can offer. The Government has over the years devoted considerable effort and resources to working with health professionals and managers to provide guidance on best practice in the delivery of clinical services. The creation of the Clinical Resource and Audit Group (CRAG) in 1989 has provided a focus for this work, in particular in the field of clinical audit, clinical guidelines and outcome indicators. The National Professional Advisory Committees continue to be an additional important source of advice and information about all types of clinical services both for the Department and the Service.

Clinical Guidelines

59 Medicine is fast-moving and new treatments are being developed all the time. In Scotland, the Government has striven to ensure that knowledge about the most effective practice is available to all clinical staff. It has encouraged the development of clinical guidelines and good practice statements through the work of the Scottish Intercollegiate Guideline Network (SIGN), a collaborative venture undertaken by the Scottish Royal Colleges and other health professionals, and the CRAGworking group on mental illness.

The validated guidelines produced by SIGN have the potential to help patients in very direct ways and are intended for local implementation through protocols. For example, the SIGN guideline on the treatment of venous thrombosis - the most important preventable cause of death in hospitalised patients - collates the most up to date evidence to enable doctors to provide the most effective treatment to their patients.

Clinical Audit and Outcome Indicators

60 It is essential to evaluate the impact of good practice and clinical guidelines. In Scotland there is a long-standing tradition of doctors auditing their clinical practice. Surgical audit in Lothian has just celebrated its fiftieth anniversary and attests the strength of the tradition. These efforts have been encouraged by systematic programmes of clinical audit at local and national level, and the Health Service now spends some £6.5m a year in Scotland on these activities, all of which are supported by the professions at large and by the Scottish Royal Colleges. Scottish nurses have been identifying nursing care standards for many years; more recently, this has been supported by the Scottish Nursing Audit Project. There is scope for extending the role of audit in community pharmacy and in Primary Care dentistry.

61 In 1992, The Scottish Office Department of Health began a programme of work to develop outcome indicators, and has now published a series of reports, the latest of which, by the Clinical Outcomes Working Group of CRAG, was issued in August 1996. It contains 15 outcome indicators covering obstetric or gynaecological services, cancer survival rates, and emergency re-admission rates after common surgical operations. A separate CRAG initiative has seen the development of a patient-derived outcome scale in acute psychiatry. The scale is basic, simple, applicable virtually everywhere and commands the enthusiasm of patients and carers.

62 The significance of all of this work is that it allows critical review of performance by clinicians and has led to important changes in the organisation of services. The Government is committed to maintaining the momentum to develop and refine clinical outcome indicators, so the attention of clinicians and managers will remain focused on variations in outcome as a means of improving patient care. As new clinical guidelines are developed, a greater number of outcome indicators will become available.

Quality Control and Contracting

63 Within the Scottish Health Service numerous other initiatives to promote clinical and service quality have been undertaken. By the end of 1996, 13 Trusts and the State Hospital had obtained the Charter Mark Award and 9 others had been commended; others have secured recognition through the British Standards Institute and other external independent accreditation of their services such as the King's Fund Organisational Audit and Clinical Pathology Accreditation. Many of these initiatives complement the long-standing and respected inspection role of the Scottish Health Advisory Service (SHAS) in relation to services for the elderly, the mentally ill and those who have learning difficulties. The Government wishes to encourage these initiatives, but is considering the merits of a more standardised approach to quality assurance, one which will give confidence to patients and ensure that the efforts of purchasers and providers are targeted effectively on improving the quality of services to patients.

64 Professor Sir Robert Shields' Report *Commissioning Better Health* (1996), which described the new roles and responsibilities of Health Boards, recommended that the onus for maintaining a high quality environment for patients should in future fall more directly on providers, and should be tracked by them in a more focused way, with greater

external peer review of the way in which all services are provided. The primary responsibility of Health Boards in this area should relate to the monitoring of clinical outcomes and the questioning of clinical practice where it deviates from overall standards, using data from clinical audit to ensure that practice evolves in line with research. The Government will ensure that these recommendations are pursued.

65 Additionally, in recognition of the importance it attaches to high-quality and responsive health services, the Government now sets out a series of further initiatives designed to enhance patient involvement, improve collaborative working between different parts of the Health Service, and extend the implementation of clinical effectiveness initiatives into Primary Care.

Initiatives

Patient Involvement

Two complementary initiatives, one to promote local initiatives for enhanced patient involvement in Primary Care, the other to identify innovative ways of disseminating information on health and health services.
The focus on a Primary Care-centred Health Service must be complemented by greater patient input to primary care development. These projects would involve providing patients with more information about services and specific clinical conditions; supporting patients in developing greater confidence in their dealings with health professionals; and exploring different mechanisms for securing effective patient participation in practice planning. The Government wishes to discuss how best to take this initiative forward with the Scottish Consumer Council and the Scottish Association of Health Councils.

Designed Healthcare: a better experience for patients

A major effort to improve the experience of patients by minimising delays by reviewing each stage in the process of care.
Five demonstration projects will develop, implement and evaluate redesigned services beginning and ending with the patient in their home. Building on the example of the successful one-stop clinic for breast cancer at the Western General Hospital in Edinburgh, proposals will be sought from partnerships of Health Boards, General Practitioners and NHS Trusts to provide redesigned care in:

- Breast Cancer
- Coronary Heart Disease
- Severe Mental Illness
- Stroke

Clinical Effectiveness and Primary Care

Pilot schemes in two areas to improve the implementation of clinical effectiveness measures in Primary Care.
Clinical effectiveness work has concentrated on secondary care, but should equally be pursued within Primary Care. There is currently a variety of systems and funding for various aspects of clinical effectiveness - research, guidelines, education and audit - in Primary Care. There is a need for better co-ordination of these initiatives and a more widespread adoption of them.

Accreditation Arrangements for GPs providing Secondary Care Services in Primary Care

The provision of guidance on criteria for the accreditation of GPs intending to provide services currently carried out in hospitals.
As general practices take on more services which have traditionally been provided in hospitals, it is important that patients are assured that these services are provided in a safe and cost effective manner. The Government will work with the professions to establish criteria to accredit GPs and to issue guidance to the service for implementation in 1997.

Services

66 This part of the Paper describes the Governmentís approach to the 3 national priority services and outlines the more general improvements it wishes to pursue in primary, community and acute care services.

67 The Government has selected mental health, coronary heart disease/stroke and cancer as priority services for development because these are the conditions which affect the greatest numbers of our populace. There is also a growing body of evidence about how these services should be developed if health improvements are to be secured.

Mental Health

68 Systematic epidemiological information about the prevalence and incidence of psychiatric disorders in Scotland suggests that in any month 18% of women and 11% of men will have clinically significant neurotic symptoms. Another estimate is that around 10% of the population in a year will be diagnosed by their GP as having a mental health problem.

69 Government policy is that comprehensive mental health services should be available throughout Scotland, delivered wherever possible in peopleís homes or in homely settings in the community. Progress continues to be made in realising this policy, helped by the resources the Government has provided, for example through the Mental Illness Specific Grantt and by resource transfer from the Health Service to local authorities and others. But more remains to be done before it can be said with confidence that we have modern mental health services. There are some groups whose needs present particular challenges, such as children and adolescents, people suffering from schizophrenic illness and mentally disordered offenders; and too little emphasis has been placed on preventing mental illness. Progress in any of these areas involves collaboration between a large number of organisations and individuals. Health, social work, housing interests in both the public and independent sectors are among those with a key role, and it is essential to ensure that users and carers are involved from an early stage. The Government has therefore produced a strategic *Framework for Mental Health Services in Scotland*. Its purpose is to:

ï ï help local purchasers and providers, in consultation with service users and carers, to assess progress and agree local priorities for action to improve services, taking account of our growing knowledge of the clinical effectiveness and cost-effectiveness of services; and

ï establish a yardstick by which The Scottish Office can assess local strategies and action plans, and monitor progress.

70 The framework has been the subject of extensive consultation with the Scottish Health Service and others. To assist this process and consider the responses to the consultation, the Government has established a Mental Health Reference Group composed of those with current experience of using, planning, commissioning and providing such services. The Government is now establishing a £3 million Mental Health Development Fund and a Mental Health

Development Centre to give added momentum to the improvement of mental health services.

Initiatives

Mental Health Development Fund

Local agencies, in partnership, will be invited to bid for pump-priming funding for initiatives to develop community mental health services linked to local strategies.

Scottish Development Centre for Mental Health Services

Support for a development centre to promote and assist the implementation of new mental health services in Scotland by providing advice and support to agencies in the field. It will also provide training and undertake developmental and evaluative research.

The aim of both initiatives is to assist the Health Service, local authorities and other agencies to develop community-based services which meet the needs of people with mental health problems, within the parameters of Government policy of cautious but committed implementation of care in the community.

Coronary Heart Disease (CHD) and Stroke

71 CHD currently affects about 500,000 people in Scotland. At the beginning of 1996, The Scottish Office Department of Health published a major comprehensive policy review of CHD, which aims to obtain the greatest possible improvement in health by reviewing the balance between prevention, treatment and rehabilitation. Some two-thirds of deaths from CHD occur in the community, and most are sudden. In half these cases, where there has been no previous diagnosis of CHD, scope for effective treatment is limited. Population-based prevention initiatives must therefore be pursued, especially since other priority areas such as cancer and stroke will benefit from a reduction in common risk factors such as smoking and high blood pressure. Small population changes in risk factors potentially translate into major reductions in the subsequent incidence of CHD.

72 For those with established CHD, increasingly effective medical and surgical treatment is available. New drugs are helping to reduce CHD risk factors and modern surgery can be especially effective in relieving the pain and disability suffered by those with angina. As with all health care, access to these services should follow a careful local needs assessment and be guided by the development of clinical guidelines for the selection of appropriate patients, so that resources are targeted on those with the greatest capacity to benefit. Effective rehabilitation of those who have had a heart attack is also important and could halve the number of patients requiring cardiac bypass surgery. Substantial expansion of rehabilitation could be undertaken without requiring high levels of additional resources.

73 With respect to stroke, the National Medical Advisory Committee has produced a report on clinical management, and the Clinical Standards Advisory Group is currently undertaking research on the clinical effectiveness of services for patients suffering from this sudden and severe illness. SIGN has in hand guidelines on various aspects of stroke treatment and a Guidance Note for purchasers is in preparation. The Government will consider whether further action on stroke is

necessary once these documents have been finalised.

74 Implementation of all of the changes implied by these reviews will require Health Boards to prepare a comprehensive CHD/stroke strategy for their area and the Government will be reviewing their progress in 1997. The Government believes the most effective way of increasing health gain and reducing variations within and between Boards is to review the balance between health promotion, treatment and rehabilitation, to reflect local needs and circumstances and to invest further in those services which are known to be cost-effective.

Cancer Services

75 Cancer is now the main cause of death in Scotland. The report on Commissioning Cancer Services in Scotland by a sub-committee of the Scottish Cancer Co-ordinating and Advisory Committee (SCCAC) was issued to the Health Service in July 1996. This report endorsed the general aim of the Calman/Hine Report for England and Wales to establish a new structure for cancer services, based on a network of expertise in Cancer Units and Cancer Centres, with the aim of ensuring that the benefits of specialised care are available to all patients.

76 A planning framework for cancer services was also issued to the Health Service in July 1996. Health Boards have now prepared their plans in the light of this guidance, and implementation is a priority for 1997-98, starting with the configuration of Cancer Units. A rolling programme is envisaged, the first priority being to define the configuration of cancer services for cancers of the breast, large bowel and lung. The Government has commissioned a further report on the primary and palliative care aspects of cancer services. This examines the arrangements which need to be in place to ensure that the services for primary and palliative care are integrated effectively into the overall system of care and treatment for patients with cancer. The Government is currently considering the responses to the consultation on that report and will publish guidance later this year.

Screening programmes and genetic testing

77 Although more effective treatments for cancer continue to be developed, the need for early detection of the disease remains vital. It is for this reason that the Government remains committed to the development of screening programmes. Currently, the **Scottish Breast Screening Programme** (SBSP) invites women aged 50-64 to come for screening every 3 years, and women aged over 64 can attend on request. The main aim of the Programme, which costs £4.5m a year, is to reduce mortality from breast cancer in the women screened by 25% by the year 2000. In the period 1992-93 to 1994-95, 69% of women in Scotland accepted their invitation to attend screening. Attendance for 1995-96 has risen to over 75%. Women attending screening who need further assessment are offered an appointment within 8 weeks of the initial screen, and 95% are seen within 5 weeks.

78 There has been considerable public pressure recently to extend the age of invitation for screening to 69 years. UK demonstration projects have now been set up to generate further evidence on the benefits of doing so. In Scotland, the SBSP has responded by undertaking a pilot study in Inverness involving women aged 65-69.

79 The **Scottish Cervical Screening Programme** of 3-yearly cervical screening (smear tests) of all women between 20 and

60 is now well-established, allowing the identification of changes which may mean that a woman is at risk of developing invasive cancer. Early treatment of these lesions results in the permanent removal of the affected areas and prevents the development of malignancy. Latest figures indicate that 83% of eligible women in Scotland have been screened in the last 3½ years. The total number of smears examined runs at about 500,000 per year, 79% of them from women aged 20 - 49. During 1995, guidance was issued to the Service on three aspects of cervical screening: fail-safe procedures for dealing with abnormal smear results, quality control in laboratories and management and purchasing arrangements.

80 Scientific advance is bringing new possibilities to the identification of people at risk of developing cancer. The growing ability to map individualsí genetic makeup, allowing predictions about susceptibility to disease to be made at birth and even before, has resulted in a growing demand for **genetic screening**. Advances in this field have far-reaching consequences for health care provision and need careful consideration. SCCAC set up a working group to assess the need for cancer genetic services in Scotland, and further work is now being done on the implications of the groupís recommendations. The emphasis will be on carefully planned pilot studies rather than wholesale population screening. This work and its implications will be supervised by UK bodies such as the Screening Committee and the Advisory Committee on Genetic Testing. Meantime, the Scottish Health Service is in a very strong position to make a major contribution to research in this area through the Governmentís support of bodies such as the Scottish Molecular Genetic Consortium.

Development of Primary Care

81 Primary Care has always been the first and most frequent point of contact patients have with the Health Service; and it is in the GP surgery that the majority of patientsí health needs are identified. In addition advances in medicine and technology have significantly altered thinking about the boundaries between secondary and Primary Care and offer real opportunities to deliver a wider range of health services outwith hospitals. It is therefore essential as the Scottish Health Service moves forward, that we have a fully developed Primary Care system in which:

ï services are accessible and provided as close to patientsí homes as possible; and

ï patient care is properly planned and well co-ordinated between the Primary and secondary Care sectors.

82 In this patient-focused Primary Care-centred service, a broader range of services will be available locally with access to a network of specialist support services on which they can call.

83 Some significant developments have already taken place to widen the range of services offered within Primary Care, such as child health surveillance, chronic disease management and minor surgery, and in the ways in which GPs have, through their purchasing role, secured improvements in specialist services (e.g. diagnostic services, more locally-delivered outpatient services, shorter waiting times). There has also been a growing emphasis on the promotion of good health and the prevention of disease, including high levels of immunisation and screening for cervical cancer.

84 Introduced in 1993/94, the Primary Care Development Fund (currently £3.6m per annum) has supported some 600 local initiatives and helped the expansion of Primary Care services by enabling GPs and others to implement their own ideas. Increasingly, practices are working together, not just to influence and purchase specialist services for their patients, but also the delivery of local services. The organisation of out-of-hours care is a case in point. With the support of Government funding, practices have established new services such as Primary Care centres where patients can be given advice or treatment at night and at weekends. The Government will maintain its support of these developments.

85 One practical step the Government has taken recently to encourage more staff, including nurses, to choose a career in Primary Care, is to enable practice staff to join the NHS pension scheme. This change, which takes effect next September, removes a long-standing anomaly affecting Scotlandís 1,500 practice nurses and other staff employed in GP practices who, until now, have had to make their own pension arrangements.

86 An important component of the Governmentís plans for Primary Care is the continued development of GP fundholding, which puts more decision-making about health care in the hands of GPs. Between 1991 and 1996 the proportion of the population covered by GP fundholding practices increased from 2% to 43%. There are now 194 practices in the Primary Care Purchasing Initiative. A further 23 practices are taking part in 7 Total Purchasing Pilots, which allow practices, working with the local Health Board, to purchase the full range of services for their patients. The pilots are subject to national evaluation. Although the proportion of Hospital and Community Health Services (HCHS) funding directly spent by fundholders is still quite small (3.7% in 1995/96), their influence has been significant in securing improvements for all patients, and in giving GPs

the flexibility to expand services within their practice. In a number of areas, practices (fundholding and non-fundholding) have been working together to plan what is needed in a specific locality to inform and influence the local Health Board and NHS Trusts. Increasingly, funds are being devolved to local level to give these local groups more direct influence over the services their patients need.

87 Consultation on the discussion paper *Primary Care - The Way Ahead* (issued in August 1996) revealed widespread agreement that the overall direction of these policies is correct, but that there is a need to tackle a number of issues. A recurrent and underlying message from the consultation is that local arrangements have to be tailored to meet local needs. This means that more local flexibility is needed than exists in some of the current arrangements for Primary Care. The Government has responded by setting out in the White Paper *Choice and Opportunity* proposals for a new legislative framework which will enable the testing of different approaches to the provision of general medical and general dental services. Examples include practice- based contracts instead of the national contract which has existed up until now; a salaried option for GPs and dentists (either within partnerships or with other bodies such as NHS Trusts); and a single budget for general medical services, other hospital and community health services and prescribing, with the practice responsible for providing or purchasing services within that budget. It will also enable additional services to be secured from community pharmacists and optometrists.

88 Many of the other important issues identified through the consultation are common to all parts of the UK, and in relation to England have been discussed in the White Paper *Primary Care - Delivering the Future*. Where appropriate, these will be addressed on a UK basis, but a specific *Agenda for Action in Primary Care in Scotland* will be published later this month. It will set out in more detail a programme within the broad themes identified in the consultation exercise, under the general headings Quality of Service, Enhancing Organisational Capacity, Strengthening Relationships, Involving Patients and Carers and Resources and Infrastructure.

89 This is a substantial programme of action which will be discussed with the professions involved. The specific initiatives which follow, and those elsewhere in this Paper relevant to Primary Care, are the first step in implementing parts of that programme.

Initiatives

Primary Care Team Development

To help Health Boards establish team development programmes for Primary Care professionals.
As the role of Primary Care and the range of professional skills extend, there is a need to support the development of the Primary Care team. While this has been happening in some areas, there is a need for a more concerted and consistent effort.

Efficient and Effective Use of Medicines in Primary Care

To help GPs and pharmacists implement effective prescribing practice.
With the growth in the drugs bill, it is essential that GPs look closely at the medicines which they prescribe to ensure effectiveness and cost efficiency. There has been an encouraging and growing pattern of GPs, pharmacists, nurses and health visitors working together (supported by prescribing advisers) to address such areas as repeat prescribing, medication monitoring and dosage adjustment, advice on drug selection and formulary development. The target is for 10% of all practices to be working on specific areas with pharmacy input by the end of 1997-98.

New Ways For Primary Care to Provide and Purchase Services

Pilot schemes to test ways of delivering Primary Care services, and extending fundholding.
The White Paper *Choice and Opportunity* and the proposed Primary Care legislation open up opportunities for new approaches to service delivery and purchasing from a Primary Care perspective. Proposals for pilots under this enabling legislation will be sought from the Service. Criteria for pilots are being drawn up. Proposals should identify the service problems to be addressed and the benefits which would come from the new arrangements. The Government also wants to build on existing work by introducing a further model of local purchasing where GPs in cohesive local groups come together and take responsibility for purchasing hospital and community services for their patients. The group should have the opportunity to use any savings released by efficient and effective prescribing for additional patient services.

Primary Care Premises

To improve standards of Primary Care premises including health centres through the review of funding mechanisms.
As the range of services and the number of professional and support staff increase within primary care, pressure on premises grows. The Government wishes to promote higher standards for Primary Care premises, including health centres, and improved funding arrangements. This will be done in consultation with representatives of the profession, who have strongly supported the need to devise a package of measures to meet a variety of local requirements. Revisions will require amendment to the Statement of Fees and Allowances, on which the Government will consult in the near future (in parallel with a similar process in England).

Developing Community Hospitals

6 pilot projects related to the development of community hospitals as providers of a broader range of local health services, as well as health resource centres for local people.
Most people want care delivered as close to home as possible. Increasing skills of Primary Care professionals and recent technological advances are creating new opportunities to deliver more health care in a local setting. In many parts of Scotland, there are networks of community hospitals which have the potential to provide a broader range of local health services and act as health resource centres for local populations. It is important to realise the potential of these hospitals for the future. More detailed proposals will be worked up with the Association of GP/Community Hospitals in Scotland, Health Boards and NHS Trusts for implementation, on a pilot basis, in 6 locations.

Communication Infrastructure

The introduction of electronic links to GP practices during 1997.
Information exchange is needed between primary care professionals and between Primary Care and other parts of the system. Putting the essential equipment into GP practices will facilitate access to the Scottish Health Service network and support electronic links between practices and with specialist services in NHS Trusts and Health Boards. It will also reduce paperwork and bureaucracy and allow practices to use the new GPASS to improve the information they need in their day-to-day work.

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Care in the Community

90 Care in the Community is an important policy which complements the development of Primary Care. The aim is to ensure that those who need continuing health and social care should be able to live in their own home, or at least in a homely setting, wherever possible. This is what most people want. It requires co-operation at the strategic, operational and service provision levels between health, social work and housing interests and also requires a shift in resources and provision from long-term hospital care to community care. Since the community care reforms came into full effect in 1993, considerable progress has been made. Joint working is now well established and jointly agreed strategic plans which will shift the balance of care are either being developed or implemented across the whole of Scotland.

91 Since these substantial changes need to be carefully managed, the Government has concluded that the policy should be pursued with enthusiasm but tempered with sensible caution. The Government wishes to ensure that:

- individuals are involved in decisions about their care;
- there is no reduction in existing provision until replacement services, facilities and accommodation are in place in the community, with the related funding;
- every patient discharged from long-stay NHS care should have an agreed care plan; and
- joint working is effective.

92 Guidance (issued on 6 March 1996) defines the responsibilities of the Scottish Health Service to provide continuing health care. It emphasises that where the consultant in charge (or the GP in some community hospitals) in consultation with the multi-disciplinary team decides that a patient needs continuing in-patient care, that care should be arranged and funded by the Scottish Health Service. The Guidance also introduced from 1 April 1996 an appeal mechanism allowing a 2-stage review of clinical decisions recommending a discharge from hospital to an alternative model of care.

93 To assist with the process of service change, **Bridging Finance** is available for the double-running costs of the Health Service that have arisen from supporting patients who have transferred to community care while long-stay hospital services have to be maintained. In most cases Health Boards, NHS Trusts and local authorities can provide such bridging finance from their own resources. However the Scottish Health Service operates a bridging finance scheme which can contribute to these costs, especially for larger and more complex schemes. £18 million is available in 1997-98 under the scheme. Its continued availability allows patients to transfer to more appropriate care and support in homely surroundings much sooner than would otherwise be possible.

94 As responsibility for some aspects of care moves from the Health Service to local authorities as a result of Care in the Community, Government policy in Scotland recognises the need for resources to transfer as well, and formal arrangements were introduced in 1992. A measure of the joint understanding among local partners which has been achieved is the significant recurring resources that are now transferring each year from the Health Service mainly to local authorities. £80 million is expected to transfer in 1996/97. Health Board General Managers remain directly accountable for all sums transferred under these arrangements, and are required to ensure that the funds are used for the purpose agreed and at the level of spend negotiated.

Breaking down barriers between health and social care

95 The Government now judges that it would be desirable to move further to break down the organisational boundaries between health and social care, as these can be confusing to patients and can hinder the co-ordinated provision of care. Either the GP or the Social Work Department can be the key to the services needed, and in consequence there can be confusion and uncertainty about who to turn to in particular cases. This is especially so in more complex cases where the need for assistance is greatest. This confusion is not confined to the public. It occurs amongst those responsible for providing the services. It follows that one of the main ways of making the system more responsive to public needs is to help to remove some of the confusion about existing organisational arrangements.

96 A considerable amount of work is already being undertaken to improve co-operation between health and social care, but the Government has drawn up two initiatives to respond to the repeated pleas from those who work within the Service for

greater local flexibility to meet local needs, particularly across the health/social care interface.

Initiatives

Local Care Partnerships

Funding of 6 pilot sites to promote the local integration of health and social care.
These would encourage local decision-making through the devolution of funding and accountability, and team working across all the professional groups. Pilots, which would operate within the existing legislative framework, would be jointly managed locally on behalf of the statutory health and local authorities, with genuine community involvement. The pilot sites will be selected on the basis of interest from local areas, where joint working is well established. Health Boards, Trusts, GPs and local authorities will be invited to submit initial proposals.

Community Care Advice Number

The establishment of a single local contact telephone point for all community services, including health and social work services.
Health Boards will be invited to consider with local authorities the possibility of establishing a shared single phone number for community care users and their carers who need urgent access to support or advice on health, housing and social work issues.
In the first phase of the initiative, Boards and local authorities would review:

- the means of creating a single contact point of this type;
- the benefits to users and carers;
- the efficiencies which could be gained; and
- the potential resource implications, including training requirements.

Acute Hospital Services

97 The development of Primary Care and community care services has implications for hospital services. Changes in clinical practice mean that more patients can be treated by their GP or as outpatients without the need for hospital admission. Not only is this more convenient for patients, it also helps the Scottish Health Service to offer treatment to more people. Those patients who do need admission also find that changes in clinical practice mean that they now stay for shorter periods than in the past. The growth in day case surgery has been dramatic. Nearly 60% of all elective patients are now treated as day cases, a practice which is much more convenient for most people. Other changes include the increasing specialisation of some branches of medicine when it is clear that better outcomes can be achieved if services are concentrated in specialist hands. This trend has to be balanced with the value placed on local access. The current changes in hospital cancer services illustrate the search for an appropriate balance between these forces. It is increasingly clear, however, that careful consideration needs to be given to the organisation of other acute hospital services if the changing needs of patients are to be accommodated and the full value of new treatments is to be realised.

Doctors' and Dentists' Hours

98 There are also a number of important changes taking place in the staffing of our hospitals. The Government is committed to work with the profession to implement the recommendations of the Calman Report on higher specialist training in medicine and of the Mouatt Report on higher specialist training in dentistry. At the same time, the Government has been determined to reduce junior doctors' and dentists' hours of work. At 31 March 1993 3,171 junior doctors were contracted to work for more than 72 hours a week. By 30 September 1996 that number had reduced to 129. Further improvements in contracted hours are

expected. The reduction in junior doctors' hours, along with improvements in their living and working conditions and the appointment of more staff, means that they are fresher and fitter for work, with consequent improvements in the quality of care offered to patients.

Review of Acute Hospital Services

99 In combination, these influences have been potent forces for change in the acute hospital services throughout Scotland. At the same time acute hospitals have been treating more patients than ever before. In part, this has been due to the successful reduction in waiting times for elective treatment, but more recently there has been a remarkable growth in the number of emergency cases referred to hospital. Currently, the number of emergency admissions to Scotland's acute hospitals is increasing annually by almost 4%, the biggest increases occurring during the winter months when respiratory illness is more common. In January 1996 the Government judged that these trends and pressures required a review of acute hospital planning assumptions. The findings of the review were published in July 1996, and more detailed guidance on the management of emergency admissions was published in the autumn of the same year.

100 One of the conclusions of the review was that further consideration needs to be given to the influences which are changing the organisation of acute hospital services so as to ensure they are well planned and co-ordinated and complement other strategies. The Government has concluded that this further work should now be undertaken, drawing on the experience obtained during the review of cancer services which has proved an excellent model.

Initiative

Review of Acute Hospital Services

The examination of the role of acute hospital services within the overall network of clinical services in Scotland.
The terms of the review, which is to be led by the Chief Medical Officer, are to examine
the role of acute hospital services in the network of clinical services in Scotland, taking account of

- evidence on clinical effectiveness and outcomes;
- patient convenience;
- medical technologies;
- trends in demand;
- the development of primary and community care services;
- relationships between services such as obstetrics and paediatrics;
- training needs of the clinical workforce; and
- research and development activity.

The review is to be conducted over the next 12 months and its report will be published.

Capital Spending

101 The future development of our hospital services will continue to require capital investment, and in 1997/98 the Government will spend nearly £144m of public sector capital to maintain and update services, including the redevelopment of acute services by Dundee Teaching Hospitals NHS Trust at Ninewells, laboratory refurbishment at Raigmore Hospital NHS Trust, renovations at Crosshouse Hospital by North Ayrshire and Arran NHS Trust and the provision of operating theatres for day surgery cases at Yorkhill NHS Trust.

102 But the principal source of this funding is the Government's **Private Finance Initiative** (PFI), which entails securing private sector involvement in the financing and provision of premises and support services for Scottish Health Service clinicians. At present, at least 15 PFI health contracts have been signed, covering care beds, medical analysis equipment, waste disposal, accommodation for the elderly (for Edinburgh Healthcare NHS Trust) and an information systems project (at Law Hospital NHS Trust). There are also other smaller projects developed on the same principles which fall within the delegated limits of NHS Trusts and Health Boards. A further 3 projects have been approved and are proceeding to contract;

and a further 4 projects have completed final business cases. An additional 11 projects have been or soon will be advertised in the Official Journal of the European Community, with several more at an earlier planning stage. After some initial teething problems, the way forward for PFI in health looks assured. During the next 3 years it is expected that over £500m of private money will be invested in health projects through the PFI. These projects demonstrate the benefits which flow from the Government's policy of encouraging the public and private sectors to work together.

Conclusion

103 In this part of the Paper the Government has described the initiatives which will carry forward the themes set out earlier. This is not an agenda of change for the sake of change. It is a focused programme which builds on a number of existing policies and trends. It will enable staff in the Scottish Health Service to deliver more responsive services to patients, to do so wherever possible in the patient's own home or local surgery, and to ensure that the quality of services continues to improve.

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Annex 1

Scotland's Health Record

1 This Annex summarises trends in Scotland's health record and identifies a number of recent health improvements and initiatives which have been undertaken.

2 A special study carried out for the Chief Medical Officer's Annual Report in 1995 revealed substantial reductions in mortality (standardised for age) from most of the main causes of death over the preceding 10-year period. This was particularly the case for coronary heart disease, cerebrovascular disease (strokes), accidents and respiratory disorders such as bronchitis, emphysema and asthma. The impressive reductions (between 15% and 35%) in mortality were generally greater in males, with the result that life expectancy at birth in males increased by 2.0 years, with an increase of 1.3 years for females. A baby boy now has a life expectancy of 72 years, a baby girl of 77 years. Each year sees an improvement of about 2 months in life expectancy at birth. The number of non-smokers in the population has increased from 60% to 70%. Rates for neonatal mortality (deaths in the first 28 days of life) and infant mortality (deaths in the first year of life) are at their lowest level ever.

3 A number of ***health targets*** were set by the Government in its Policy Statements *Health Education in Scotland* (1991) and *Scotland's Health: A Challenge To Us All* (1992). For **Coronary Heart Disease**, the target is to reduce mortality in people under the age of 65 by 40% between 1986 and 2000. This implies that mortality from CHD in people under 65 should fall to about 46 deaths per 100,000 of the population by 2000. The mortality rate fell from 94.6 per 100,000 in 1986 to 59.7 per 100,000 in 1995. The trend line suggests that if this rate of improvement continues it should be possible to achieve the target for 2000. (Figure 2)

Figure 2
Coronary Heart Disease Mortality Rates per 100,000 Population Under 65, 1986-95

(To follow later)

4 For **Cancer**, the target is to reduce mortality in people under the age of 65 by 15% in the years between 1986 and 2000. The mortality rate for people in this age group fell from 103.7 per 100,000 in 1986 to 92.7 per 100,000 in 1995. The trend line suggests that the target mortality rate of 88 per 100,000 should be achievable if the rate of improvement in the last decade continues. (Figure 3)

Figure 3
Cancer Mortality Rates per 100,000 Population Under 65 1986-95

(To follow later)

5 The national target to reduce **smoking rates** to 32% among adults aged 25-65 was reached in 1994, some 6 years ahead of target.

Figure 4
Prevelance of Cigarette Smoking

(To follow later)

6 For **dental and oral health** the national target is that less than 10% of 45 - 54 year olds should be without their own teeth. In 1988, the figure for those in this age group without their own teeth was 33%, but by 1993, it had fallen to 15%.

7 The Scottish Joint Breastfeeding Initiative and the National Audit of Infant Feeding have contributed to work to achieve Scotland's target for ***breastfeeding***. There is evidence that breastfeeding not only improves the child's health prospects but also helps the mother by reducing, for example, the risk of her developing breast cancer.

8 ***Immunisation*** has a major role to play in the fight against childhood diseases. By the age of 2, over 94% of all children are immunised against diphtheria, whooping cough, tetanus, haemophilus influenzae b, polio, mumps, measles and rubella. The Government's emphasis on prevention is reflected in the increasing immunisation programmes over the last decade, for example the introduction in 1992 of the haemophilus influenzae vaccine and the successful mass immunisation campaign in Scottish schools in 1994-95 against measles and rubella. The latter was followed in October 1996 by a second dose of mumps, measles and rubella vaccine for pre-school children. These initiatives represent major steps towards the elimination of epidemics of these diseases.

9 Immunisation and the prevention of infectious diseases will continue to be at the forefront of the Government's work in the public health field. The Scottish Microbiology Reference Laboratories play a key role in this area. The recent *E-coli 0157* outbreak in Lanarkshire illustrates the important role of the reference laboratory system in identifying the sources of outbreaks and minimising further spread. All 10 centrally-funded reference laboratories have recently been reviewed against rigorous entry criteria. To improve the collection and collation of data, all Scottish microbiology laboratories, including reference laboratories, will be linked to the Scottish Centre for Infection and Environmental Health (SCIEH) by computer. In response to concern over the increasing emergence of drug-resistant strains of micro-organisms, the Government has agreed fund to a reference laboratory for multi-resistant staphylococcus aureus (MRSA), outbreaks of which can be life-threatening. The laboratory will also be able to undertake early detection of drug-resistant strains of tuberculosis.

10 Scotland now has one of the lowest prevalence rates for ***HIV/AIDS*** in Europe and that is a tribute to the success of the measures that the Government and the Service have taken, through health education and other initiatives such as needle exchange schemes, to prevent HIV infection and AIDS. In the absence of a cure or vaccine, it is vital that the Government maintains its prevention efforts, and resources will continue to be made available for this purpose.

11 These are important achievements, but the Government is committed to tackling a number of new and growing health problems, and in particular the problem of ***drugs misuse***. The Government's Drugs Task Force report set out a practical and effective strategy to tackle drug dealing, reduce the health risk to misusers, and, above all, enable young Scots to resist illegal drugs. This has been backed up by Drug Action Teams, who pull the key players together in concerted action in line with local strategic plans. All of the teams have a strong Health Service contribution. There was, for example, significant Scottish Health Service input to the Guidelines for Good Practice at Dance Events produced by the Scottish Drugs Forum. The Government has commissioned and will shortly issue a practical manual with specific advice for GPs regarding substitute prescribing, with its proven benefits to health, crime prevention and reduction of drug misuse. Major funding from the Chief Scientist Office (£1.5m currently) and the Central Research Unit of The Scottish Office continues to underpin research into the problem of

drug misuse, supporting such valuable initiatives as the Centre for Drug Misuse Research at Glasgow University. Services offered to help drug misusers - including needle exchanges and substitute prescribing measures - limit its direct damage. They also hinder the spread of serious threats to health like HIV/AIDS and hepatitis, and help to reduce drug-related crime.

12 The Health Education Board for Scotland (HEBS) and the Health Service generally help young people to grasp the facts and think again about drugs, through their health promotion work. This vital area has been strengthened this year by the all-party Scotland Against Drugs Campaign which is working towards a shift in youth culture away from drugs, and the new Scottish Drugs Challenge Fund which, with a substantial commitment from the private sector, aims to boost local communities in their efforts to counter drugs misuse.

13 The Scottish Health Service is also addressing an older and still powerful problem in Scottish life - ***alcohol misuse***. Working with other agencies through alcohol misuse co-ordinating committees, local health services help to prevent and treat drink problems that - unless tackled - may harm health, feed violent crime and damage the well-being of families and businesses. The Government continues to fund Alcohol Officers in each Health Board area so as to provide administrative support for alcohol misuse co-ordinating committees. Less satisfactory have been the failure to achieve the targeted reduction in the number of men drinking alcohol to excess, and the probability that the proportion of women drinking excessively may actually have increased.

14 The incidence of ***smoking*** amongst young people also gives cause for concern. ***Health education*** will continue to be an essential component of the Government's strategy for improving health. HEBS was established in 1991 and has played a significant role in leading health education at national level. For example, the Board's highly successful Smokebusters campaign has attracted over 300,000 calls, resulting in a substantial number of smokers giving up the habit.

15 *Eating for Health: A Diet Action Plan for Scotland* has been widely welcomed as a unique approach to Scotland's dietary shortcomings. The Plan is a blueprint for action over the next decade, establishing a structure within which everyone with an influence on what we eat - food producers and processors, the Scottish Health Service, local authorities, schools, caterers, retailers, the media and consumers themselves - can work together bring about dietary improvement in Scotland. Over £1m is being made available in this and the next 2 years to fund initiatives to help implement the Plan. The Government's funding for the national project officer is already helping to ensure that attention is paid to the special problems in low income communities where the health benefits from changes in diet are potentially large.

16 ***Exercise*** is also crucial to good health. HEBS, working closely with bodies such as the Scottish Sports Council, will continue to emphasise the importance of exercise in the drive to better health. The successful HEBS self-help guide *Hassle-Free Exercise* was made available through a special telephone Helpline.

17 The promotion of good health and the prevention of disease are high on the Government's agenda. Healthier lifestyles, based on choice and individual decision, are the key to sustained improvement in our health record. Comprehensive changes in habits which have developed over generations cannot be achieved overnight. But it is clear that the process of change has begun already and within the framework set out in its Policy Statements, the Government will work to maintain and increase this momentum. Key strategic documents, such as the Government's *Oral Health Strategy for Scotland* (1995) and *Towards a Non-Smoking Scotland* (HEBS, 1995), have emphasised the importance of a concerted approach.

18 Scotland's health problems are being tackled with dedication by Scottish Health Service staff. New challenges to public health continue to emerge and constant vigilance is essential. The Health Service cannot deal with these problems alone and its mission has to be shared with others. The many ways in which the public can play a crucial role include participation in vaccination and screening programmes, and making healthy choices for themselves and their families, in response to campaigns such as those designed to improve diet, encourage breast feeding, promote the intake of folic acid in pregnancy, boost exercise, cut smoking, moderate drinking and avoid drug misuse.

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Annex 2

Scottish Health Service Activity and Performance

1 This Annex summarises some of the improvements which have been made in the Scottish Health Service, and highlights recent trends in Health Service activity and performance.

New Treatments and Equipment

2 There are numerous examples of new treatments which have been introduced in recent years. The Scottish Heart and Liver Transplant Units have been established at an annual cost of £3.3 million, and both have achieved excellent results from the outset. Other developments include lithotripsy, a broader range of anti-cancer treatments such as bone marrow transplantation, brain injury rehabilitation, cochlear implants, recombinant factor VIII, viricidal combination therapy for HIV/AIDS, ablation of the endometrium (replacing hysterectomy), screening for and eradication of *Helicobacter pylori* and screen laser treatment ophthalmology. New developments in anaesthesia and perioperative care have allowed treatment to be extended to a greater range of patients, for example in the field of joint replacement and revision. All of these developments have benefited from the continuing improvements in the services offered by Scotland's Blood Transfusion Service. One of the great health care advances of the 1990s has been minimal access therapy. As emphasised by Scottish leaders in the field, it is important that surgeons have adequate training to acquire these new skills. The Minimal Access Therapy Training Unit for Scotland (MATTUS) has therefore been funded jointly by The Scottish Office and the Wolfson Foundation.

3 Considerable investment in equipment such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scanners has brought great benefits to patients; for example, patients with stroke can now get a CT scan more promptly. New applications have been found for ultrasound, which was pioneered in Glasgow 40 years ago. The Government will continue to ensure that the Scottish Health Service keeps pace with developments in medical technology and treatment so as to ensure that the most up-to-date care is provided.

Increase in Activity

4 The number of patients treated (as inpatients or day cases) has increased by around 2.5% a year since the 1980s. In the last few years, the rate of growth has accelerated to 5.2% a year. This represents an extra 50,000 people treated every year (see Figure 5). Most of the increase in activity is accounted for by the rise in day cases, which now represent over half of elective hospital admissions. The main advantage to patients is the continuing and dramatic reduction in waiting times.

Figure 5
Impatient and Day Cases in Acute Specialities

(To follow later)

Emergency Admissions

5 An important feature of the growth in demand in the acute sector has been the rise in the number of emergency hospital admissions (Figure 6).

Figure 6

Acute Emergency Admissions

(To follow later)

6 During the 1980s, such admissions increased by 2.8% a year, but since the early 1990s this rate of growth has accelerated to 3.9% a year. Emergency admissions account for an increasing share of the inpatient workload in acute hospitals; between 1979-80 and 1995-96 this share rose from 52% to 62%. It is a tribute to the responsiveness of the Scottish Health Service that it has been able to accommodate these pressures.

7 Speed of access to services is often crucial. The Scottish Ambulance Service has improved its responsiveness particularly through the move to double-staffed vehicles, the equipping of all front-line ambulances with defibrillators, improvements in its helicopter and fixed-wing services and the training of increasing numbers of paramedics. The Scottish Health Service maintains a state of constant readiness which enables it to mount rapid responses to major emergencies.

Staff Numbers

8 One of the main benefits of the Government's commitment to the Scottish Health Service is the continuing increase in the number of staff providing front line direct patient care.

- Numbers of qualified nurses have risen by over 35% since 1979 and hospital doctors and dentists by around 25%
- Numbers of GPs have risen from 3,757 in 1990-91 to 3,890 in 1995-96, a 4% increase
- Numbers working in the Professions Allied to Medicine have increased by over 80% since 1979
- There has been a rise of over 40% in ambulance staff since 1979
- Scientific and technical staff have increased by more than 40% since 1979
- The number of practice nurses increased sevenfold to 813 during the period 1982-95, reflecting the shift in the provision of care from hospital to community
- Between 1991 and 1995 the number of community psychiatric nurses rose by 25% to 477.

Patient's Charter Guarantees

9 The Government's promotion of the Patient's Charter has been the catalyst for significant improvements in patients' experience of the Scottish Health Service. The most important improvement has been in waiting times, given that waiting for diagnosis or treatment can be very stressful. The Scottish Health Service has responded impressively, and waiting times are now shorter than they have ever been.

- More than half of those needing to come into hospital are admitted immediately
- For those needing out-patient appointments, three-quarters now receive them within 9 weeks of being referred by their GP
- Three-quarters of patients who need admission after seeing a consultant in an out-patient clinic are offered it within one month
- The majority of patients now receive a guarantee from their Health Board on the length of time they can expect to wait and these times continue to reduce
- In March 1994, 1,745 patients on waiting lists had waited over 12 months. By March 1997, no patients with guarantees will have been waiting over 12 months.

The Government is committed to ensuring that waiting times continue to improve. From April this year it guarantees that no-

one will spend more than 12 months on a waiting list for in-patient treatment.

10 The Government Charter White Paper published on 19 September 1996 to mark the 5th anniversary of the Citizens' Charter re-inforced existing commitments and contained a number of new ones, including:

- All patients will have a named nurse, midwife or health visitor by June 1997
- All patients will receive written information about services before an arranged or planned admission to hospital or attendance at a clinic
- All patients have a right to be told before an arranged or planned admission to hospital whether care is to be provided in single or mixed sex accommodation.

Health Boards and Trusts have also been asked to update and republish local health charters. This is part of a distinctively Scottish approach emphasising local action, which experience has shown to be the most effective route of implementing improvements to patient care.

11 Effective handling of patients' complaints is an important part of a responsive Service. For this reason, the Government welcomed the recommendations of the Wilson Committee and has moved speedily to implement them. The Government has introduced improvements in the system for dealing with complaints. From April 1996, a new simplified procedure for complaints about any of the services provided by the Scottish Health Service has been in place. It aims to resolve complaints quickly and effectively, and to be fair to both complainants and staff. The work of the Mental Welfare Commission for Scotland exemplifies this approach for a particularly vulnerable section of the community.

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Annex 3

Key Documents referred to in the White Paper

Working for Patients (Cm 555) HMSO (1989)

Patient's Charter HMSO, Edinburgh (1991)

Health Education in Scotland HMSO, Edinburgh (1991)

Scotland's Health: A Challenge To Us All HMSO, Edinburgh (1992)

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Primary Care: The Way Ahead Scottish Office Department of Health (SODoH) (1996)

Commissioning Better Health ('the Shields Report') SODoH (1996)

Framework for Mental Health Services in Scotland Consultation Document, SODoH (1996)

Coronary Heart Disease in Scotland: Report of a Policy Review HMSO, Edinburgh (1996)

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