NATIONAL HEALTH SERVICE REFORM (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the National Health Service Reform (Scotland) Bill introduced in the Scottish Parliament on 26 June 2003. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament’s Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 6–EN.

POLICY OBJECTIVES OF THE BILL - BACKGROUND

2. This Bill builds on the Executive’s policies on reform of health care, set out in detail in Scotland’s Health White Paper Partnership for Care1 (published in February 2003), and on the priorities for improving public services set out in the Partnership Agreement2.

3. The Executive will continue to increase investment in health services, with the health budget rising by over 5% a year in real terms from its current base of £6.7 billion. Partnership for Care and the Partnership Agreement made clear that this investment must be matched by reforms to deliver improved health and better integrated health services that are more responsive to the needs of patients and communities. These intentions are backed up by commitments to legislate to abolish NHS Trusts, establish community health partnerships, ensure co-operation in delivering regional service, increase public involvement and promote health improvement. All of this will be underpinned by new powers for the Scottish Ministers to intervene in the case of service failure, as a last resort, to ensure that health care is delivered to acceptable standards.

POLICY OBJECTIVES OF THE BILL - SPECIFICS

Dissolution of National Health Service Trusts

Policy objective

4. The Executive’s policy objective in relation to NHS Trusts is to abolish them. The abolition of NHS Trusts forms an important part of the Executive’s aim of reshaping the NHS to ensure that patients’ interests are put first and that services are planned and provided in an efficient and integrated way, through collaboration within and among NHS bodies. This process

began with the White Paper *Designed to Care*\(^3\) in 1997, which announced the merger of some NHS Trusts and the dismantling of the NHS internal market. These changes were implemented in the period 1998-99.

5. The White Paper *Our National Health: a plan for action, a plan for change*\(^4\) carried the process further by announcing the intention to introduce unified Health Boards with overall responsibility for the governance and performance management of services provided by NHS Trusts in their area. These unified Health Boards would have wider representation to reflect community, staff and clinical and other professional interests. NHS Trusts were to retain their existing operational and legal responsibilities within the local health system, but with streamlined management arrangements and fewer non-executive directors. *Rebuilding our National Health Service*\(^5\) set out in more detail the Executive’s plans for governance arrangements for Boards and Trusts. These plans were implemented and unified Health Boards were established by October 2001.

6. *Partnership for Care* sets out the Executive’s intentions for health and healthcare policy, with an emphasis on integration of healthcare services and delegation of responsibility and decision-making to local level, as near as possible to where services are delivered to patients. The White Paper explained that this approach had organisational consequences, including the dissolution of NHS Trusts. It states that “[the Executive] will therefore continue dissolving Trusts, as is already happening in the Borders and Dumfries and Galloway, and we will legislate to remove the powers relating to NHS Trusts.”\(^6\)

7. The Health Department issued guidance to Health Boards on single system working in 2003\(^7\). This guidance aimed to help Health Boards bring forward practical proposals as soon as possible for the dissolution of remaining NHS Trusts as separate legal entities. This included guidance on the transfer of NHS Trust functions, staff and assets to the new operating divisions of Health Boards.

8. Powers already exist for the Scottish Ministers to dissolve NHS Trusts by subordinate legislation where an application is made by the Trust for dissolution. These were exercised to dissolve the four Trusts in Borders and Dumfries and Galloway. It is expected that these powers will be used to complete the dissolution process, and also to transfer assets, liabilities and rights from NHS Trusts to Health Boards. Ministers also have powers to dissolve NHS Trusts at their own initiative if it appears to them to be in the interests of the health service. Once all Trusts have been dissolved, statutory references to them will be removed. This requires new primary legislation, which the Executive proposes should be enacted through the Bill.

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Alternative approaches

9. The Executive expects that the remaining NHS Trusts will be dissolved voluntarily, using existing powers; but there is no alternative to primary legislation to achieve the stated policy intention of removing the powers relating or referring to NHS Trusts.

Consultation

10. The proposals for the abolition of NHS Trusts in Partnership for Care, and reflected in the Partnership Agreement, have been widely welcomed. A wide-ranging exercise was undertaken in 2002-03 across the NHS and among local authority and other partners under the title “Review of Management and Decision Making in NHSScotland”. This was led by the Chief Executive of the NHS in Scotland and overseen by a group chaired by the Minister for Health and Community Care. The Review’s conclusions informed the preparation of Partnership for Care. When an application is made by an NHS Trust for dissolution under existing legislation, consultation must be undertaken by the relevant Health Board. Consultations have been or are being held in Borders, Dumfries and Galloway and Argyll and Clyde Health Board areas.

Community health partnerships

Policy objective

11. The Executive’s policy is that care should be delivered as close to home as possible consistent with the provision of safe and effective healthcare, and that staff at the frontline should have the opportunity and resources to support the delivery of that objective. The White Paper Partnership for Care\(^8\) emphasises that the vast majority of health care is delivered by community based professionals and that these staff also have an expanding role in health improvement.

12. Partnership for Care proposes the development of community health partnerships (CHPs) as a key building block in the modernisation of services, with a vital role in partnership, service integration and redesign. It states that legislation would be brought forward “to require Health Boards to devolve appropriate resources and responsibility for decision making to frontline staff and ensure that CHPs provide an effective basis for the delivery of local healthcare services. The Partnership Agreement reaffirms the commitment “to legislate for NHS reforms and establish Community Health Partnerships”.

13. CHPs are intended to evolve from local health care co-operatives (LHCCs). LHCCs were established following the 1997 White Paper Designed to Care. They are not bodies created by statute but are voluntary associations of primary health care professionals who come together, along with other partner agencies such as local authorities, to consider the planning and delivery of NHS services. LHCCs are supported through the operational management arrangements of NHS Trusts or Health Boards, and so enabled to contribute to the planning and delivery of NHS services to meet the assessed needs of local communities. NHS Trusts/Health Boards involve LHCCs in decisions about the services that are to be delivered locally and the resources required to do so.

\(^8\) Scottish Executive, Partnership for Care (2003) chapter 5
14. It is recognised that, while LHCCs have made good progress in developing into responsive and inclusive organisations, this has not been consistent across Scotland. The policy intention is to see CHPs, as successors to LHCCs, having a more consistent and strengthened role in service planning and delivery, with better accountability to local communities.

15. The enhanced role envisaged for CHPs includes the intention for them to:
- ensure patients and communities, and a broad range of healthcare professionals, are fully involved in the planning and review of services;
- establish a substantive partnership with local authority services;
- have greater responsibility and influence in the deployment of resources by Health Boards;
- play a more influential role in service redesign locally;
- act as a focus for integrating health services, both primary and specialist, at local level; and
- play a pivotal role in delivering health improvement for their local communities.

16. Health Boards are required to review the organisation and operation of their existing LHCCs with these objectives in mind. This will also include the development of a local public partnership forum (PPF) for each CHP to support effective dialogue with local communities. Boards are also required to work with local authority partners to produce plans aimed at ensuring more effective working with social care in appropriate locality arrangements. It is intended that CHPs will have greater capacity (than LHCCs) to play an effective role in the planning and management of local health services and be better matched with local authority counterparts.

17. In order to implement these objectives, the Bill makes provision requiring Health Boards to submit for approval by the Scottish Ministers schemes for the establishment of CHPs, which would cover the whole Health Board area. Boards would be required to include within their scheme:
- the number of CHPs;
- the membership of CHPs;
- the delegated functions of CHPs and their role in the overall planning of services for the area;
- the associated financial arrangements; and
- arrangements for the involvement of the public and patients.

18. It is not intended that CHPs should become independent bodies separate from Health Boards, but that they should have a statutory function within Boards, thereby providing those involved in the provision of community based care a greater say in the design and delivery of services.
Alternative approaches

19. The current non-statutory arrangements for LHCCs have operated satisfactorily in that they have fostered the development of informal organisations which have become increasingly important in the delivery of local services. However, this has not been consistent across Scotland, and there are widely differing arrangements for devolution of responsibility and resources. The evolution into CHPs, which will have a key role in the overall planning of services in an area and co-ordinating the delivery of enhanced community based services, requires a more formal arrangement underpinned by legislation. The requirement for Health Boards to submit local schemes for approval by the Scottish Ministers will ensure that CHPs reflect the needs and priorities of local communities. The Scottish Ministers may specify minimum criteria for these schemes of delegation, in order to ensure that CHPs have the delegated powers and resources to deliver the intentions in Partnership for Care and the Partnership Agreement.

Consultation

20. The proposals for CHPs in Partnership for Care have been widely welcomed. These build on the recommendations of the review report of the LHCC Best Practice Group, Connecting Communities with the NHS9, published in April 2001 and of the report of the Primary Care Modernisation Group, Making the Connections10, published in March 2002. There was extensive consultation before the publication of both these reports. In addition, the Review of Management and Decision Making in the NHS undertaken in the latter half of 2002 had a sub-group dedicated to the consideration of LHCC development, and its proposals mirror closely the creation of, and more formal role for, CHPs.

Duty of co-operation: regional planning and managed clinical networks

Policy objective

21. Some types of health services, particularly, but not only, hospital-based services, are becoming more specialised and concentrated. To deliver such services successfully often requires highly developed skills and major investment in equipment and training. Some of these services can be offered most practically and economically to the whole population of Scotland from a small number of sites. Collaboration between Health Boards is necessary for successful planning and delivery of such services. Even where a service is not particularly specialised, there may be advantages in clinicians in neighbouring Board areas working together to share skills and resources in managed clinical networks. In addition, other aspects of health services such as workforce planning and training are considered to work best when tackled collaboratively, across Health Board boundaries – sometimes regionally and sometimes at a Scottish level.

22. The change programme Rebuilding our National Health Service11, issued by the Health Department in May 2001, described the need for a more systematic approach to planning health

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care services which are best provided on a regional or national basis. This was followed up in March 2002 by a Health Department letter\(^ {12}\) that provided guidance on arrangements for regional planning of services.

23. Managed clinical networks have been established for the development of cancer services, based on 3 regional networks, and further regional managed clinical networks are emerging as part of the process of addressing the challenge of redesigning health services which include a significant tertiary element (i.e. based on one of the 4 teaching hospital centres). In September 2002 the Department issued a Health Department letter promoting the development of managed clinical networks in NHSScotland\(^ {13}\).

24. The White Paper *Partnership for Care*\(^ {14}\) described the Executive’s current policy on regional planning as a means of ensuring the sustainability and clinical quality of healthcare services for people in all parts of Scotland. The White Paper states that “Each NHS Board will have a formal duty to participate in regional planning groups and cross-Board managed clinical networks.” Steps are now being taken to appoint regional co-ordinators and the Department has also moved to establish a network of regional workforce co-ordinators (for workforce planning and implementation of the pay modernisation). The regional planning groups are considering a wider range of appropriate issues and are strengthening their links with other Boards in their area.

25. To implement the undertaking in “Partnership for Care”, the Executive proposes that Health Boards should be given a new statutory duty to co-operate with each other, the Common Services Agency and all Special Health Boards including the Scottish Ambulance Service and NHS24, with a view to securing and advancing the health of the people of Scotland. The Bill carries through this intention by imposing an appropriate duty on the Boards. It also makes clear that they may take action, including spending money and employing staff, to provide services that will benefit people throughout Scotland as well as in the Board’s own area. This will support the Boards’ participation in managed clinical networks that are set up to serve a wider population than that of a single Board. However, Boards’ prime responsibility will continue to be to ensure the provision of adequate healthcare services in their areas.

**Alternative approaches**

26. The current administrative arrangements to support regional planning and joint delivery of services operate satisfactorily, but as more services develop along regional lines, for example through managed clinical networks, more formal duties are necessary to ensure that Health Boards recognise responsibilities in relation to service delivery which may extend outwith their area. The Executive believes that this power is necessary to ensure that managed clinical networks and other regional and national initiatives can be satisfactorily developed and operated.


Consultation

27. Since the White Paper was published in February 2003, the Health Department has received no representations against imposing a formal duty on Health Boards to participate in regional planning.

Powers of intervention in case of service failure

Policy objective

28. The Executive’s policy is that the NHS should offer high quality care to all users of the service, no matter where they live in Scotland or what their circumstances are. To help reinforce this policy, the Executive has established a framework for setting clinical and other standards and for reviewing the performance of NHS bodies against these. These standards and the review process are the responsibility of NHS Quality Improvement Scotland.

29. The aim of NHS Quality Improvement Scotland is to contribute to the highest quality of patient care in NHSScotland by promoting best practice and ensuring effective clinical governance. One of its functions will be to carry out investigations and inquiries into serious service failures. The Executive is considering with NHS Quality Improvement Scotland the processes that need to be put in place to carry out this function, and the powers that need to be delegated for them to undertake inquiries. Information about current and proposed standards, and about the results of performance reviews, can be found on the NHSQIS web site\(^\text{15}\).

30. In addition, the Executive, on behalf of patients, has set clear targets for the NHS, particularly for waiting times for elective treatment. It has also introduced a performance assessment framework\(^\text{16}\) to gather and present systematic information about the performance of NHS bodies as part of the process of objective setting, monitoring and accountability between the Executive and the NHS.

31. The Executive believes it is important that if any part of the NHS consistently fails to achieve agreed quality standards or shows a marked decline in delivering an acceptable quality of care, support and guidance should be given to help improve performance. The Executive already has arrangements for escalating intervention under which recovery plans can be agreed with NHS bodies and monitored regularly. If performance improvement is not achieved by these means, further support in the form of additional management or professional staff can be brought in with agreement with the Board. The Board itself has the power - as the body responsible for performance overall and as the employer of Board staff - to make changes to the senior management team if it considers this to be necessary to improve performance.

32. If these steps fail to turn round performance, the Scottish Ministers can decide to give a direction to a Health Board. Directions may be general, or may relate to a specific area or matter. If for any reason a Board failed to comply with a direction, under existing legislation Ministers could choose to hold an inquiry and – if justified – hold the Board to be in default. It

\(^\text{15}\) [http://www.nhshealthquality.org](http://www.nhshealthquality.org)

\(^\text{16}\) Scottish Executive, Performance Assessment Framework (2002)

would also be open to Ministers to terminate the appointment of the Chair or other Board members. These are very much powers of last resort and have rarely, if ever, been used.

33. The Executive believes that Ministers should be able to act in a targeted, timely and effective way where performance has failed, is failing, or seems likely to fail, to secure health services of an acceptable standard. The Executive considers that to declare a Board to be in default, and to remove Board members, while these actions could become necessary in extreme cases, may be too blunt and slow to rectify the delivery of a particular service. The Executive also believes that the power of direction may not be effective in cases where a particular service is in severe difficulties and a Board is not able, or not willing, to resolve these at its own hand.

34. The Partnership Agreement published on 16 May 2003 said: “We will work with health staff and Health Boards to improve the quality and consistency of care through national standards, inspection and support. Where the steps of development, inspection and support do not secure the improvement needed, we will extend Ministerial powers to intervene, as a last resort, to direct the Health Board to take the specified action to secure the quality of healthcare required.”

35. On the basis of an internal review of powers of intervention, and in line with the commitments in Partnership for Care and in the Partnership Agreement, the Executive believes that Ministers’ existing powers to give directions to Health Boards should be extended to enable Ministers, where a service is not being delivered to a standard which they consider to be acceptable, to transfer responsibility for providing specified services that are failing to a body or persons other than the relevant Health Board for a given period. This would enable Ministers to require that a failing service be managed by another Health Board or by an expert team specially constituted for the purpose until performance had been turned round. Such teams would need to have experience of the NHS, so as to be able to work within the broader framework of financial systems, staff agreements and clinical standards applying to health services.

36. The Bill therefore makes provision for Ministers to be empowered to act in this way, where Ministers consider it necessary; and where Ministers consider that a body or person responsible under the National Health Service (Scotland) Act 1978 for providing services has failed, is failing or is likely to fail to provide a service, or provide it to an acceptable standard. The test of necessity will require Ministers to have explored other means for restoring the service or quality of service, including in extreme cases the option of issuing a direction to the Board under section 2(5) of the 1978 Act.

Alternative approaches

37. The need for effective powers to enable Ministers to secure the provision of health services of an acceptable standard cannot be met satisfactorily by the existing power to give directions to Health Boards, and requires an extension of existing powers of last resort, as proposed in the Partnership Agreement. Such a capability for Ministers to act in relation to a particular failing service, to restore services to an acceptable standard, requires primary legislation.
Consultation

38. Since the White Paper and the Partnership Agreement were published, the Health Department has received no representations against taking such a power. The consultation paper on setting up NHS Quality Improvement Scotland, *A Quality and Standards Board for Health in Scotland*\(^{17}\), discussed the issue of the power to investigate serious service failure in clinical service delivery.

Public involvement in the NHS and dissolution of local health councils (LHCs)

Policy objective

39. The Executive’s policy objective in relation to public involvement is to ensure that the primary responsibility for involving people in the planning and redesign of health services rests with Health Boards, rather than giving the responsibility for representing the public to an outside body. It is proposed therefore to impose a duty to secure public involvement on Health Boards and Special Health Boards, and to abolish local health councils and to replace them with a new public involvement structure. This forms an important part of the Executive’s aim of reshaping the NHS to ensure that patients’ interests are put first and that modernised structures are in place to ensure public involvement in the design and delivery of care. The White Paper *Our National Health: a plan for action, a plan for change* recognised the often excellent work of local health councils but noted that “Health Councils themselves are keen to modernise and reform. They have since worked with us to devise modern public involvement structures which will support patients and communities and have direct influence on local NHS decision-making; influence which will lead to real changes on the ground.”

40. In December 2001, the Health Department published the policy framework document *Patient Focus and Public Involvement*\(^{18}\). This placed a requirement upon the NHS to engage more directly with the public, with implications for the role of health councils. This was complemented by Health Department letter (2002)\(^{19}\), which offered guidance on consultation and public involvement in service change. This guidance is currently being refined to reflect the recent experiences of public consultation. *Patient Focus and Public Involvement* reiterated concerns around the current local health council structure. It included a commitment to consulting on a new structure for public involvement that would revolve around the core functions of assessment, development and providing feedback. This included the creation of a new national body (the Scottish Health Council), which would have a strong local presence.

41. *Partnership for Care* sets out the Executive’s intentions with regard to public involvement. It notes that “we have asked NHS Boards to develop sustainable frameworks for public involvement…the new Scottish Health Council will in future monitor the performance and effectiveness of Boards in relation to public involvement, and will report regularly on the results. This will ensure that there is external scrutiny and quality assurance of what Boards are doing to involve the public.” This is reflected in the Partnership Agreement, which commits the


Executive to ensuring “public involvement in health reorganisation plans by obliging Health Boards to consult stakeholders more effectively”.

42. The powers to create local health councils were established in section 7 of the 1978 Act. Our intention is that the Bill will repeal section 7 and will instead require Health Boards and Special Health Boards to involve the public directly in considering the planning, development and operation of health services. It is proposed that the Scottish Health Council be created as part of NHS Quality Improvement Scotland reflecting the close link that needs to exist between quality and involvement. The role of the Scottish Health Council will be to provide leadership in securing greater public involvement in NHSScotland; to support the development of good practice in public involvement; and to ensure that quality improvement is driven by the needs of patients and service users.

43. Key to the effectiveness of the Scottish Health Council will be the establishment of local advisory councils, composed of interested members of the public, in each Health Board area. The advisory councils’ role will be to keep the Scottish Health Council aware of local issues and concerns and to advise it of local views on the extent and quality of the involvement activities of their local health services. The Advisory Councils will be expected to develop good links with the local voluntary sector and patient groups to promote communication and partnership between all those with an interest in public involvement.

Alternative approaches

44. It has been agreed that a modernised structure for public involvement is required and that the Scottish Health Council will be established, as part of NHS Quality Improvement Scotland, with a local presence. There is no alternative to primary legislation to achieve the stated policy intention of removing statutory references to local health councils and to create the new duty on Health Boards to secure public involvement.

Consultation

45. Proposals for a New Public Involvement Structure for NHSScotland\(^{20}\) was issued on 4 March 2003 following an extensive pre-consultation exercise with key stakeholders. This consultation period will expire on 9 June 2003 and the conclusions will inform the content of any guidance issued by Ministers on how the NHS should implement the new duty of public involvement. As noted above, the Executive approach to public involvement was set out in Partnership for Care, published in February, and reflected in the Partnership Agreement.

Health improvement

Policy objective

46. Partnership for Care signalled the Executive’s intention to raise the profile of health improvement and to “bring forward legislation to back up this commitment and ensure that Health Improvement is a priority for NHS Boards and Community Planning partners”\(^{21}\). The


thrust of health improvement policy in the Partnership Agreement develops consistently with the terms of the White Paper, notably the commitment to promote health improvement through joint health improvement plans and through community planning. This is reflected in the Partnership Agreement, which commits the Executive to taking “strong action to promote good health”.

47. The Executive believes that the Scottish Ministers should have a specific duty to promote health improvement. It is also the Executive’s view that Health Boards should also have a specific duty in relation to promoting health improvement. The intention is to enhance Ministers’ and Health Boards’ capacity to act, other than through the NHS or voluntary bodies as at present, and to provide an opportunity for specific links to the community planning agenda.

48. The Ministerial duty of health improvement set out in section 1 of the 1978 Act provides Ministers with a duty to secure health improvement through the health service. Specifying a clear Ministerial power to promote health improvement (at their own hand) would enable Ministers to provide clear national leadership, as referred to in Partnership for Care, and would provide a more secure statutory basis for a wider range of actions which Ministers might wish to take themselves.

49. In particular, Ministers currently have power to provide funds for health improvement only to voluntary organisations or via the NHS. A power for Ministers to allocate funding directly in support of health improvement would allow greater opportunities to direct how monies for health improvement are spent, by local authorities and other bodies.

50. In relation to local authorities, section 20 of the Local Government in Scotland Act 2003 created a new discretionary power which enables local authorities to do anything they consider is likely to promote or improve the well-being of their area and/or persons in it. Draft statutory guidance to local authorities relating to the power to advance well-being is currently out for consultation. The draft guidance includes health improvement as an example of activity for which the power may be used.

51. Section 15 of the Act lays a duty on local authorities to initiate, maintain and facilitate the community planning process. It is a duty of a local authority to invite and take suitable action to encourage all other public bodies and community bodies to participate in the community planning process. NHS Boards are amongst the major “other public bodies” involved in community planning and are required by the Act to participate in community planning. Local authorities take the lead role in community planning and this, together with their powers to advance well being, will ensure that they are active in promoting health improvement.

Alternative approaches

52. The only way that legislation could be improved to make health improvement a priority for Health Boards is to provide a clear duty to the Scottish Ministers to promote the improvement of the health of the people of Scotland. This is over and above Ministers’ existing obligation to improve the health of the people of Scotland through the National Health Service.

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53. In making health improvement a priority for community planning partners, the Scottish Ministers will not disturb existing legislation on community planning. The statutory guidance on the new power of well-being in the Local Government in Scotland Act 2003 embraces the need for health improvement. This, coupled with the new duty on Health Boards, will make health improvement a priority for Health Boards and community planning partners. The community planning process will ensure that they work together to deliver an improvement in the health of the people of Scotland.

Consultation

54. Since the White Paper was published in February 2003, the Health Department has received no representations against bringing forward legislation to back up the commitment that health improvement should be a priority for NHS Boards.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

55. The Bill’s provisions are not discriminatory on the basis of gender, race, disability, marital status, religion or sexual orientation.

Human rights

56. The Executive is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights. As the Bill provisions in the main relate to the organisation of the functions of the National Health Service in Scotland, the Executive does not consider that the Bill provisions impact on human rights.

Island communities

57. The Bill, by laying a duty on Health Boards to co-operate with each other in relation to regional and cross-boundary services, is intended to promote the development of managed clinical networks. One aim of such networks is to sustain, as far as is consistent with clinical quality and safety, health services that are located as close as possible to the communities they serve, including communities in rural, sparsely populated and island areas.

Local government

58. The Executive is satisfied that the Bill will not have a direct impact on local government. The lead on implementing the legislation will fall to the Scottish Ministers and to Health Boards, who will receive support and guidance from the Executive. The intention is that the creation of community health partnerships will facilitate greater co-operation between health care professionals and local authorities in the delivery of community based health care services. Similarly, the new duty on the Scottish Ministers and on Health Boards to promote the improvement of the physical and mental health of the people of Scotland will be taken forward in liaison with local government. This is consistent with the Joint Futures agenda and the Executive’s commitment to community planning.
Sustainable development

59. *Meeting the Needs.....* describes how building a national effort to improve health, reducing inequalities in health, and making the NHS a “national health service”, and not a national illness service, is an integral part of sustainable development. The underpinning principles of social justice and taking individual and collective responsibility for actions that allow others to make best use of finite resources today and tomorrow run throughout this Bill.

60. Through placing a greater emphasis on health improvement the Executive is working to encourage people to take better care of themselves. Furthermore, the Executive is reforming the NHS in this Bill to improve access and ensure that the most effective use of resources is secured through better planning, both at a regional level, through managed clinical networks, and at a local level, through community health partnerships.

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This document relates to the NHS Reform (Scotland) Bill (SP Bill 6) as introduced in the Scottish Parliament on 26 June 2003

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