

# “Getting into Shape”

A Discussion Paper to inform the debate about how the NHS in Scotland should respond to the challenges presented by the UK Government’s Comprehensive Spending Review

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February 2011

## **Executive Summary and Propositions**

**The NHS in Scotland is almost unrecognisable from that of a decade earlier and better than it has ever been.** Through leadership and effective management, involving partnership working with clinicians, staff side colleagues, communities, individual patients and their carers, Scotland's NHS has delivered dramatic reductions in waiting times for treatment, including a much more responsive service for people with cancer, coronary heart disease and stroke. New technologies are beginning to transform the ways some services are delivered and patients and staff are benefitting from a greatly improved quality of facilities in new and refurbished hospitals and community health centres. Although much of the media attention focuses on acute hospital care, primary care, mental health and learning disability care have all been transformed in the same time period. All of these developments and more, together with better integrated working across the NHS and with social work and housing have improved the patient's experience and contributed to an overall improvement in Scotland's health and wellbeing.

**Yet more action is needed** to address health inequalities and to deliver the most effective care and treatment in these financially challenging times. Amongst the challenges which the Government and the Service need to address in order to deliver the further changes that are required, include:-

- The demands on services from an ageing population, with an increasing number and complex mix of chronic diseases, versus the public health goals and ambitions for lifestyle changes and anticipatory care to combat the adverse effects of smoking, alcohol abuse and obesity
- A population which, as it ages, demands more of the public services, versus a smaller proportion of the population of working age to staff and support these services
- The best patient outcomes and clinical success of specialised services organised to provide 'critical mass', versus the public's wish for wider and more local access
- The media's fascination with exceptional cases requiring hospital care, with the potential to skew resources away from the more routine and commoner conditions faced by many more people
- Recognition that efforts to deliver conventional efficiency measures need to be redoubled, but these are not going to be enough to address the challenges, versus public and political communities which are resistant to service change
- A timeframe of affordability requiring early action, versus established policies and processes for service change which have traditionally been very slow

To continue to make a positive difference in people's lives, the NHS must become leaner and more efficient and, in some cases, must recognise the need for more fundamental service change, driven by the new financial reality faced by all public services. This new reality should be guided by shared values, reflecting the ambition of continuing health improvement and satisfaction with healthcare services, and

delivered in ways which encourage innovation. In publishing 'The Healthcare Quality Strategy for NHS Scotland' earlier this year, the Government set NHS Scotland the **aim to become a world leader in healthcare quality** and to do so by aligning three quality ambitions:-

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services. Partnerships which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- No avoidable injury or harm from the healthcare they receive, and that they are cared for in an appropriate, clean and safe environment at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, with no wasteful or harmful variation.

**We believe that quality improvement is still achievable when times are hard, so long as the criteria are clear and the right choices are made.** The challenges posed by this new financial reality and the leadership choices which they generate, make even more essential a new framework for determining which changes to pursue:-

1. New Government policies, quality initiatives, new developments and efficiency measures which both improve healthcare quality and reduce costs, or which are quality neutral but reduce costs must be pursued.
2. New policies, initiatives, developments and efficiency measures which are cost neutral but improve quality should be considered.
3. New policies, initiatives and developments which are not affordable within the current and future resource assumptions should not be pursued either by central imposition or locally. Equally, efficiency savings which reduce quality to an unacceptable level and do not add value should not be pursued.

Year on year the NHS in Scotland has delivered efficiency savings which, in the past year alone, amounted to >£200M. More such efficiencies can and must be delivered, but **as Audit Scotland acknowledged, there is a limit on the extent to which 'salami slicing' can continue before services are affected.** Balancing the books in the next few years will be much more difficult and will not be achieved by traditional efficiency savings alone. It is essential that the changes to service that will be required are delivered timeously and in ways which maintain and enhance the quality and effectiveness of patient care. This will be all the more important for the future, given the workforce changes envisaged, as well as the Government's stated intention to cut the number of Senior Managers in the NHS in Scotland by 25% over the four year period.

**The Senior Management of the NHS in Scotland are positive about responding to the challenge.** They have already begun to refocus their efforts to reflect the scale of the tasks ahead and are looking for support from Government demonstrating integrated thinking, is leaner and faster in facilitating change in order to deliver the

propositions in this paper, and which regards management as an asset rather than merely a soft target for efficiency savings.

## **Propositions**

1. Quality improvement is still achievable when times are hard, so long as the criteria are clear and the right choices are made :-

- New Government policies, quality initiatives, new developments and efficiency measures which both improve healthcare quality and reduce costs, or which are quality neutral but reduce costs must be pursued.
- New policies, initiatives, developments and efficiency measures which are cost neutral but improve quality should be considered.
- New policies, initiatives and developments which are not affordable within the current and future resource assumptions should not be pursued either by central imposition or locally. Equally, efficiency savings which reduce quality to an unacceptable level and do not add value should not be pursued.

2. All Health Boards should work together (with the support of the Government and Regional Planning Groups) to deliver greater efficiencies and, where appropriate, specific proposals to reconfigure hospital services where it is demonstrated that to do so:-

- would lead to better clinical outcomes for patients
- would make at-risk services more robust and sustainable
- would make more efficient use of specialist staff, equipment, facilities and estate without significant impact on speed of access to patient services

3. The Scottish Government should lead specific proposals, with the support of Health Boards and Regional Planning Groups, to reconfigure highly specialised services. Examples of these would be transplantation and neurosciences.

4. The specialist Health Board now responsible for telehealth development, with Government support, should lead proposals to adopt proven technologies on a system-wide basis in support of service quality improvement and efficiency gain.

5. The Scottish Government should review urgently, through consultation and engagement with the public and healthcare professionals, their strategy for reducing waiting times, with a view to developing a sustainable equilibrium for the future. This should be part of a wider move towards reducing narrow performance 'targets' and increasing accountability for proven interventions and health outcomes.

6. Government should also revisit their strategy on health screening (e.g. aortic aneurysm screening) to ensure public health/clinical priority, cost-effectiveness and affordability.

7. All Health Boards should work together to achieve a formal consensus to undertake benchmarking and to share services, that this should be the 'default' position and that any Board wishing to 'opt-out' would have to demonstrate an agreed rationale.

8. More is needed to achieve shared outcomes with other public services. It is proposed that formal consensus is pursued between all Health Boards, all Local Authorities and other relevant public services, recognising their different governance arrangements. This should include the possibility of strengthening Community Health Partnerships and extending the pooling of budgets, specifically to deliver shared outcomes for people requiring health and social care.

9. In the meantime and until formal agreements are active, opportunistic 'buddying-up' should continue to be pursued (e.g. NHS24/SAS Medical Director, NHS Lanarkshire and Forth Valley Public Health rota)

10. The governance arrangements of Health Boards and related Public Bodies across Scotland should be reviewed quickly and improvements managed in ways which minimise distraction and uncertainty, and deliver real and identifiable savings in the costs of governance. This should not distract Boards from pursuing efficiencies through shared services and may well reflect such reconfigurations.

11. Partnership between managers, policy makers, staff, trade unions and the professions is a valuable asset of which NHS Scotland should be rightly proud. This should be the basis for engagement at National as well as local level, to secure the flexibilities which (as Scottish Government has acknowledged) may be necessary to sustain the policy of no compulsory redundancies.

12. The NHS should make full use of relationships with education providers and workforce planning expertise to model scenarios and plan workforce numbers to ensure that recruitment levels match the needs of the service in the short term as well as in the medium to longer term.

13. While Health Boards continue to pursue efficiency improvements across their services, focussing on those requiring small scale changes, Boards should publish outline plans for larger scale change quickly, so that consultation can begin without unnecessary delay.

14. Health Boards should be given more discretion around local service change through a proper, and streamlined consultation process. Processes for consulting and decision-making on major service change with national significance, should also be reviewed to speed up the process.

## Scale of the Challenge

The impact of the UK Government's Comprehensive Spending Review on Health will see a real terms reduction in Scotland's Departmental Expenditure Limits of 11.3% for the 4 years 2011-12 to 2014-15 and a reduction in Capital of 36.5% over the same period. The fall in actual spending from 2010-11 to 2011-12 is £1.3bn.

The Scottish Government, in their November budget statement announced a 2.7% overall increase in revenue budgets (before inflation, with the 'real terms' increase being less) and a decrease in capital funding of >20% for 2011/12 for Health and Wellbeing (including the 'Barnett consequentials'). In recognition of the pressures on the health and social care system in a challenging fiscal climate, the Scottish Government has ringfenced £70 million in 2011-12 within the NHS Budget to a Change Fund for NHS Boards and partner local authorities to redesign services to support the delivery of new approaches to improved quality and outcomes and reduce demand on acute services.

Notwithstanding the cash increase in NHS funding, issues such as the ageing population, new technology and the cost of drugs mean that the NHS will still face considerable budget pressures. The Government has said that the NHS will be 'protected', although there are different views about what this means. Evidence has shown that demographic pressures (an ageing population driving increasing demand for services) and drug inflation require 4% uplift year on year to stand still. **This means that the NHS is likely to be facing real terms cuts of around 2% next year over and above the new 3% efficiency savings target imposed by Government across the Public Sector.** These pressures mean that the NHS will not only need to deliver maximum value through a focus on increased efficiency, but to protect the quality of care, will also have to deliver changes in the way services are delivered.

The Scottish Government has announced draft budgets for one year (2011/12). Health Boards have to address the immediate challenge of delivering more for less, at the same time as having to plan how to deliver and sustain services in the longer term. **It is important therefore, that this paper informs early debate around the financial position beyond next year.**

The Scottish Government's November budget statement made clear that the real terms reduction in public sector budgets for Scotland in 2011-12 means that cash reductions in pay bills across all public sector organisations will be required. It was pleasing to note, however, a level of additional support for lower paid staff.

McKinsey&Co (*Achieving World Class Productivity in the NHS 2009/10 – 2013/14*, DoH) referred to opportunities to improve the performance of the NHS in England through driving significant cost efficiencies, ensuring compliance with standards and shifting care into more cost-effective settings, e.g. reducing variation in clinical and non-clinical productivity, optimising spend by ensuring compliance with standards through care pathways, reconfiguring local health economies to shift acute care to primary/community/home care and optimising the use of the estate. While there are

differences in Scotland and some progress already in these areas, much of what was identified is worthy of closer attention and just as appropriate North of the Border.

For the NHS in Scotland, all of this will mean changes to the way the NHS operates on an unprecedented scale. Savings of this magnitude will not be achieved solely by efficiency measures or by driving up productivity, nor without impact on the current patterns of service delivery. **Changes need to be realistic, reflecting political and wider public interests, and they need to be delivered quickly.** Health Boards have already begun to identify where changes could be made, but there are real concerns that current procedures for consultation and scrutiny around service change are lengthy and convoluted; new ways will have to be found for sufficient headway to be made to ensure the Service meets next year's (2011/12) expenditure limits, while recognising the continuing importance of consultation, engagement and scrutiny.

At a time when Councils across Scotland are publishing their change programmes for next year, it has been wrongly assumed in some quarters that Health Boards will manage the new financial regimes without the need for significant change. **Senior NHS managers are calling for open debate on how the Service addresses the challenges,** in ways which properly inform the public conversation.

## Cost Drivers

Since most of the costs of NHS care and treatment relate to older people and the proportion of older people in Scotland is rising, so NHS costs rise accordingly. Also, the Scottish Medicines Consortium estimates that the costs of drugs, including those about to come on stream which Health Boards and GPs will be expected to offer to patients, could rise by around 10% per annum.

There are also a number of elements relating to the organisation of the NHS in Scotland which drive costs and which, because of current policy constraints and cultural belief, are not readily amenable to rapid change. These include:-

- Pattern, configuration and efficiency of hospital services and size of estate
- A persistent, public (and media) view that the NHS is all about hospitals and that the most effective clinical care has to be hospital-based
- Workforce levels and productivity, employment agreements and terms and conditions of employment
- Government targets, some of which (e.g. waiting time targets) risk delivering diminishing returns for increasing costs

It is extremely important that every opportunity is taken to emphasise that the vast bulk of patient and carer contact with the NHS is not with acute hospital services and that the most effective response to patients' needs is increasingly being met at home or in primary and community care. This model of care and treatment is not only in the best interests of patients, but must be supported by appropriate resource shift and the reconfiguration of those specialist services which have to remain hospital-based.

## Delivering and Sustaining High Quality Services

Some of the improvements in patient care being delivered today were unimaginable 10 years ago, e.g. treatment within two months for every urgent patient with cancer, >90% of patients for all conditions from referral to treatment within 18 weeks from seeing their GP, day surgery now the norm for >80% of all elective procedures, >40% of accident and emergency attendances appropriately treated in local minor injury units, chemotherapy for some cancer patients is now being administered at home and by nurses rather than in specialist in-patient units.

Overall, more and more services are now provided to a high standard to patients in their own home (in person and over the phone), in their local pharmacy, in GP surgeries and in local clinics and hospitals, often for diagnosis or treatment previously unavailable or only accessible in distant hospitals. GPs and local teams provide care and treatments previously only delivered by hospitals. The pattern of much of the present day healthcare (and the focus of increased joint working across public services) is delivering more intensive monitoring, communication, support and treatment to people at home, which is the norm, rather than respond to a health crisis only when someone is admitted to a hospital.

Inpatient care in hospitals has become the exception rather than the norm, providing for the few rather than the many. It is increasingly specialised and, in almost all cases, short-term. The pattern and networks of hospitals need to be redesigned to reflect this smaller but increasingly specialist role within the widening range of healthcare services available to communities and individuals. However, communities tend to resist changes to local hospitals, even when their role has changed and the quality and outcomes expected of new specialist services are unable to be replicated or sustained at such a local level. Against this background, **much more can and needs to be done to create a pattern of services which balances the achievable in terms of maximum patient safety and optimum productivity with the desirable in terms of convenience to patients.**

In the past decade or so, the major studies which have involved patients, the public and extensive professional advice (e.g. Carter 1998, Kerr 2005, McKinsey&Co. 2009) have all pointed to the need for further development of community and home-based care, but also for opportunities to be taken to redesign the pattern and modes of delivery of hospital and health services across Scotland which will deliver improvements in patient safety and will make services more sustainable for the future. They argue that this would improve the efficiency of the use of health service resources, their quality and patient safety and would accelerate the change in relationship between the Service and its users to one reflecting real mutuality.

Specialist medical staff have concerns about sustaining some particular hospital services which, through relatively low demand, shortage of specialists or changing, evidence-based practice, have insufficient 'critical mass' to meet the highest standards of quality and patient safety. Such services often have difficulties recruiting the best qualified staff, thus compounding the service deficits and putting

added strain on the staff who are there. This is not a new problem, but it is less visible at times when communities' ambitions for an ever-increasing range of local services can more easily be satisfied within a different political and financial climate. **Taking opportunities to reconfigure specialist hospital services to drive up the quality of services to patients should be seen as an ambition worthy of Government and public support** and, at the same time, would lead to a more sustainable estate where fixed costs are freed up to pay for improved patient safety. Many managers and clinicians believe that organ transplantation, neurosciences, specialist paediatric, specialist emergency services and laboratory services are among those that should be reorganised on fewer sites, to ensure the most appropriate balance between clinical service quality i.e. the best treatment outcomes, patient convenience and the most efficient use of scarce resources.

**Studies continue to be published, yet services on the ground in many parts of Scotland still do not reflect this model of service provision and repeated review of some very specialist services (e.g. paediatrics) struggle to achieve consensus over the most effective service configuration.** This continues to cause concerns in relation to quality standards and sustainability.

Much could also now be achieved through the more extensive and systematic use of telehealth, telemedicine and technologies in areas of proven benefit, both in terms of patient quality (e.g. home monitoring of long term conditions patients, home chemotherapy, remote specialist consultation/multi-professional review, increasing use of NHS24 for 'doing things once for Scotland') and process efficiency (e.g. patients' self check-in at OPDs, digitalisation of paper records). Health Boards believe that significant efficiency gains are achievable through the adoption of proven technologies and must therefore be accelerated, while recognising constraints on capital resources.

**Propositions.....**

All Health Boards should work together to deliver specific proposals, with the support of the Government and Regional Planning Groups, to reconfigure hospital services where it is demonstrated that to do so:-

- would lead to better clinical outcomes for patients
- would make at-risk services more robust and sustainable
- would make more efficient use of specialist staff, equipment, facilities and estate without significant impact on speed of access to patient services

The Scottish Government should lead specific proposals, with the support of Health Boards and Regional Planning Groups, to reconfigure highly specialised services. Examples would be transplantation, neurosciences and specialist paediatrics. *\*see below*

The specialist Health Board now responsible for telehealth development, with Government support, should lead proposals to adopt proven technologies on a system-wide basis in support of service quality improvement and efficiency gain.

## Government Targets

There has been considerable investment over the past decade aimed at shifting the balance of care away from an over-reliance on inpatient hospital services (which are expensive and not without risk) and into the community, where the vast majority of patient contact takes place. This must continue and will be supported by a number of developments including the Governments change fund and more effective joint working between the NHS and other public and voluntary services.

At the same time huge sums of money continue to be invested in hospital services, aimed at bringing down patient waiting times for diagnosis and treatment. This has been successful with many waiting times which were previously measured in years now being measured in weeks or days. However, this needs urgent review in terms of relative affordability. Similar targets have been discontinued in England, and some Senior Managers in Scotland now believe that to achieve universal access from referral to treatment within 18weeks, regardless of clinical need, will take massive investment for marginal benefits, when clinical prioritisation already ensures that those in pain or at highest risk are treated quickly.

At a time when there needs to be proper consideration of areas for disinvestment, any continuing investment in targets should demonstrate cost effectiveness. In this regard, there are real concerns about some screening programmes which are expensive, yet are neither clinically required nor clear about where value is added to the health of the population overall. An example of this is aortic aneurysm screening, where the full costs of implementation and consequent surgery are significantly in excess of normal economic limits.

Whilst recognising the Government's direct responsibilities for and duties towards the NHS, many believe that the time has come for them to shift away from the detailed management of Health Boards through a set of defined and relatively narrow 'targets' and to move towards health outcomes aimed at wider objectives of improving the population's health.

### **Proposition.....**

The Scottish Government should review urgently, through consultation and engagement with the public and healthcare professionals, their strategy for reducing waiting times, with a view to developing a sustainable equilibrium for the future. This should be part of a wider move towards reducing narrow performance 'targets' and increasing accountability for proven interventions and health outcomes, where these can be accurately measured.

Government should also revisit their strategy on health screening, to ensure public health/clinical priority, cost-effectiveness and affordability.

There is a continuing requirement to drive increasing efficiency, even although these measures, in themselves, are only part of a much wider programme of change required across the NHS in Scotland. This section deals with a number of areas where the cost of overheads should be minimised to protect and develop frontline patient care.

In the short term, Health Boards need to revisit opportunities to share non-frontline services including finance, human resources, public health, planning and estate management functions as a way of reducing costs and increasing quality and efficiency. Aiming to turn these services into 'best of class', should minimise waste and inefficiency and free up resources for frontline care.

Sharing such services with Local Councils and other public services is also a sensible aim and there could be early gains (e.g. co-location of premises, joint procurement, or transport provision). Building on successes in various parts of Scotland where Community Health Partnerships are delivering more cohesive local services (e.g. to older people, those with mental health problems and others with complex long term conditions) more shared outcomes are required and ways must be found to remove barriers to pooling budgets. This is a challenge which Government are seeking to recognise within the Change Fund announced in the November budget. However, harmonising different cultures and staff's terms and conditions of employment will not be achieved quickly.

Some commentators and politicians seem to believe that simply changing the configuration and structure of health services will make a significant contribution to meeting the challenges facing the NHS over the next few years. Certainly, the cost of governance is substantial. In addition to the 32 Local Authorities, there are 8 independently-governed and managed Special Health Boards in Scotland carrying out a wide range of specialist national functions and the population of the 14 Territorial Health Boards range at the extremes from 1 Board of governance for >1,200,000 population to 3 Boards of governance for <80,000 between them. Many Senior Managers, however, believe that the debate, while inevitably having to address the number of Health Boards, should also concentrate on the development of corporate governance arrangements for all public services in a country of 5M people. Strengthening Community Health Partnerships and improving the governance arrangements of Health Boards and other public bodies across Scotland could save money and there are advantages to be gained through co-terminosity of public service boundaries, which could justify the very real costs of change.

Kerr (2005) said that "..... the current organisation and infrastructure of both health and social care - with health still split into acute and primary sectors and social care managed as a traditionally separate entity - is far from ideal for the necessary development of the whole-systems approach essential for the good care of older people, both individually and at a population level."

The introduction of unified NHS Boards and the development of Community Health Partnerships have undoubtedly provided a better context for flexible and innovative

models of organisational integration, but more is needed to ensure that the organisations responsible for delivering healthcare in Scotland are as efficient as they can be and agile enough to embrace the changes needed to meet the coming challenges. **The important principle must be to ensure that organisational boundaries do not impede the delivery of appropriate, safe & efficient care to patients.**

Concerns have been raised about the risk of organisational upheaval distracting Boards from delivering 'business as usual' as well as the wider change agenda. However, if the present configuration and governance arrangements are to be made more efficient, it is the task of Government to clearly lay out the way forward and then for managers, through their own personal commitment and leadership, to do what is required to improve the efficiency of the governance arrangements.

### **Propositions.....**

It is proposed that all Health Boards work together to achieve a formal consensus to undertake benchmarking and to share services, that this should be the 'default' position and that any Board wishing to 'opt-out' would have to demonstrate an agreed rationale.

It is further proposed that such formal consensus is also pursued between all Health Boards, all Local Authorities and other relevant public services. This should include the possibility of strengthening Community Health Partnerships and extending the pooling of budgets.

In the meantime and until formal agreements are active, opportunistic 'buddying-up' should continue to be pursued (e.g. NHS24/SAS Medical Director, NHS Lanarkshire and Forth Valley Public Health rota)

The governance arrangements of Health Boards and related Public Bodies across Scotland should be reviewed quickly and improvements managed in ways which minimise distraction and uncertainty, and deliver real and identifiable savings in the costs of governance. This should not distract Boards from pursuing efficiencies through shared services and may well reflect such reconfigurations.

## Developing a Workforce with the Right Skills in the Right Place

As a consequence of the changes outlined in this discussion paper, there is a need to refocus, retrain and alter some sections of the NHS workforce and to do so sympathetically (using existing tools such as Career Framework and KSF), supporting some people into new roles across the service and supporting others into roles

outside the service. If, as some believe, the NHS in Scotland will require a smaller workforce, then it is all the more important that the workforce is appropriately educated and trained and has the right skills to meet the demands of the future.

It has always been difficult to match the numbers of doctors, nurses and other health professionals in training with the likely availability of jobs. However, it is evident that there are currently too many doctors and nurses being trained and guaranteed NHS posts, compared with the number of jobs likely to be available in the foreseeable future. This mismatch is unsustainable in the new financial climate and emphasises the need for a review of Government guarantees as well as more realistic and integrated workforce planning together with better alignment between training bodies and the Service.

Setting aside the money that goes directly to primary care contractors and GP prescribing, the NHS spends most of its money (around 70% in most Health Boards) on employing staff and therefore changes to improve service quality and efficiency and/or reduce costs will affect the location, type and number of jobs across the Service. Freezing recruitment and taking advantage of natural turnover (e.g. leavers, retirements) can create unacceptable distortions and, given the general slowdown in the economy, will not, in themselves, be sufficient to deliver the workforce in terms of numbers, skills or deployment required of the NHS in Scotland in the future.

Experience shows that much can be achieved through dynamic planning and strong partnership working with staff and trade unions, and the Government has already signalled in its budget statement the need for negotiations between local staff and management on securing flexibilities which lead to the avoidance of compulsory redundancies. It remains to be seen whether these will be sufficient to deliver the workforce changes and reductions necessary to meet the quality aspirations and bridge the gap in funding over the four years in question.

**Propositions.....**

Partnership between managers, policy makers, staff, trade unions and the professions is a valuable asset of which NHS Scotland should be rightly proud. This should be the basis for engagement at National as well as local level, to secure the flexibilities which (as Scottish Government has acknowledged) may be necessary to sustain the policy of no compulsory redundancies.

The NHS should make full use of relationships with education providers and workforce planning expertise to model scenarios and plan workforce numbers to ensure that recruitment levels match the needs of the service, in both the short and medium term.

## Timescales

Much work can and must be done within every Health Board to deliver more efficient services, and benchmarking is helping to set the highest standards at which Boards are expected to operate. Small scale changes can deliver much and often quite quickly.

When it comes to more complex, or larger scale change programmes, however, any constraints which prevent Health Boards from conducting open consultation are increasing the risk that tighter financial spending limits in the coming year will not be achieved. The scale of real terms reduction also means that programmes need to reflect deliverables over a sustained period of at least four years.

The principles around public consultation and engagement are well established and have developed significantly in recent years. Health Boards have learned the benefits and many have extended their relationship with patients, carers and the wider public, viewing the networks and processes of public engagement as an integral part of service planning. However, there are concerns that **the formal public consultation and independent scrutiny process in cases of service change is too long** and is in marked contrast to the processes employed by Councils, which are often more tightly managed and delivered more quickly.

### **Proposition.....**

While Health Boards continue to pursue efficiency improvements across their services, focussing on those requiring small scale changes, Boards should publish outline plans for larger scale change quickly, so that consultation can begin without unnecessary delay.

Health Boards should be given more discretion around local service change through a proper, but streamlined consultation process. Processes for consulting and decision-making on major service change with national significance, should also be reviewed to speed up the process.

## Conclusion

The challenges facing Scotland's public services are unprecedented and it is essential that the response to these challenges strengthens, rather than weakens the conditions necessary to continue to improve the health of the people of Scotland.

Healthcare leaders and managers across Scotland are committed to working with fellow health professionals, with the public, and with the Government to deliver high quality patient care and to improving the lives of the people of Scotland, and will strive to find and deliver the conditions which will ensure the continuing success of our National Health Service.

### References:

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- 'Scotland's Spending Plans and Draft Budget 2011-12', Scottish Government, 2010
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