THE SCOTTISH OFFICE

NHS
MEL(1993)38

National Health Service in Scotland Management Executive

St. Andrew's House
Edinburgh EH1 3DG

25 March 1993

Addressees

For Action:
General Managers,
Health Boards

Chief Executives
NHS Trusts

For Information:
General Manager,
Common Services Agency

General Manager,
State Hospital

General Manager,
Health Education Board
for Scotland.

To be copied to:
Unit General Managers
and Fundholding GPs
for action and to all
other GPs for
information

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Dear Colleague

THE NEW NHS - OPENNESS

Summary

1. At the Contracting and Regulation Seminar at Erskine Bridge in September 1992 the Management Executive undertook to issue a circular on the sharing of information and openness in contracting.

2. The attached paper sets out a framework for those involved in contracting.

Action

3. It is important that all parties involved in the contracting process should adopt the framework of openness set out in the attached paper particularly with respect to the requirements of paragraph 9.

4. Please copy this letter to Unit General Managers and Fundholding GPs for action and all other GPs for information.

Yours sincerely

M H COLLIER
Director of Finance

RAH00415.023

Recycled

THE NEW NHS - OPENNESS

Background

1. The new NHS is dependent upon multiple purchasers and providers respectively being able to plan services, allocate resources, negotiate contracts and monitor and review outcome. It is axiomatic that this should be carried out in as well informed way as possible and that there is, therefore, a fundamental need for openness of conduct and transparency of transaction. Purchasers and providers should be acting in mutually supportive ways by promoting the exchange of relevant information and not restricting access for any other reasons than those set out in this circular.

2. Accountability for the achievement of health service goals passes through Health Boards to the Management Executive (ME) and the ME hold the NHS Trusts accountable for their managerial and financial obligations. Regulation of the NHS is also the responsibility of the ME. This calls for open exchanges between purchasers, providers and the ME.

3. The NHS is in the public sector with clear accountabilities to the public both as individuals and collectively. The means are required of ensuring that patients and the community at large are kept informed of what is happening and proposed in the NHS and to equipping them to participate better in the promotion of improvements.

4. Already, considerable guidance has been issued which emphasises the need to maintain an open approach in the service.

- The Procedural Manual on Contracting.
- Publication of
  - Local Health Strategies
  - NHS Trust Business Plans
  - Contracts
  - Annual Reports
  - ECR and contractual tariffs.

- The encouragement in the widest involvement of General Practitioners, Consultant, Medical and other professional staff.

Central guidance will be kept under review to ensure that it is fostering openness.

5. The NHS also has a tradition of maintaining national information, research, and statistics in the public domain. This will continue as these are developed to meet the needs of the new service eg the review of the Scottish Health Service Cost Book.

6. Although this circular sets out some ground rules for access to information its main purpose is to promote a general climate of openness in the NHS in Scotland.

Purchasers and Providers

7. The Procedural Manual on contracting made reference to contracting being part of a long-term relationship between purchasers and providers. Both parties need a shared vision of the future. Longer term objectives need to be discussed in open honest debate to inform Local Health Strategies and Trust Business Plans as well as the contracting process. Where change in service provision is required realistic notice should be given. It is expected generally that where significant changes in staffing levels are required a minimum of 6 months' notice is appropriate from purchasers including GP Fundholders. In some instances a longer period of notice may be required. It is important that purchasers and providers work as partners and avoid conduct which is too short term in approach.

8. The quality of financial information to support planning and contracting varies between Boards and Trusts although advances are being made continually. It is important that "product definition" and cost allocation methods are consistent across Scotland so that differences in price are driven by case mix and efficiency rather than being obscured by differences in pricing methods. To assist this, costing guidance has already been issued (Section 6.7 of the Procedural Manual on contracting and NHS (Finance) Circular No (1990)1), however, a national costing

project in 2 development sites in Scotland has now been established. This is due to complete its work by Spring 1995 but will report periodically on progress and generate guidance and requirements in the meantime as appropriate. It is important that local costing development work should not be delayed during the life of this project.

9. To inform the contracting process, purchasers and providers will need to exchange information on activity, outcome, quality, costs and costing methodology. There should be a general presumption in favour of openness of information between the parties. Only the following categories of information should not be made available.

9.1 Information relating to individual patients or members of staff. The guidance on safeguarding the confidentiality of personal data associated with contracts issued in MEL(1992)42 on 7 August 1992 must be observed.

9.2 Information not reasonably available other than at disproportionate cost.

9.3 Information specifically classified as sensitive or confidential by the Management Executive.

10. The purchaser/provider contracting regime has introduced an element of competition into the service. This brings with it dangers of increased secrecy as competitors seek to keep information from each other. Moreover, contract negotiators may perceive advantages in a lack of frankness with the other side. This is short term in outlook and is damaging to long-term relationships. Mature and long-term relationships must be fostered in the NHS and competition should be on the basis of an accurate understanding of quality and cost not on the ability to obscure and equivocate.

11. A literal interpretation of the exclusions outlined in para 9 could lead to the conclusion that everyone has the right of access to everything subject to the stated exceptions. The purpose of this circular is indeed to encourage openness and to facilitate this, yet, there is an expectation that information will only be sought where it is relevant to the business

in hand and to the role of the body seeking it, and to the improvement of the services provided. The demand for information simply for its own sake is not acceptable practice. Purchasers or providers who are called upon to supply information have the right to question its relevance and are entitled to recover the cost through the contracting process.

12. There is a distinction between information needed to support contracting and that required to manage a directly managed unit (DMU). Boards will require a regular flow of management performance information from their DMUs. This, of course, would be inappropriate in respect of NHS Trusts. Boards and NHSTs should agree between themselves what contract monitoring information is required. However, Trusts should not refuse to let their purchasers have management type information on an ad hoc basis simply for reasons of principle if the sharing of this will assist their joint working.

13. It is clearly in the interests of purchasers that their providers are kept in the picture about their plans and intentions, indeed joint planning between purchasers and their main providers is to be encouraged. Purchasers should not withhold information from providers as a matter of principle but should be prepared to meet providers' requests if it aids their planning and improved services and use of resources.

14. Purchasers will be concerned to reassure themselves that contract prices, capital bids and costs are reasonable and justified. Equally providers should not be disadvantaged in the negotiating process by being denied access to purchasing capacities, costs and related information concerning Health Boards.

15. General Practitioner Fundholders are important purchasers and the same climate of openness described in this circular should apply to them also. Thus the notice period referred to in paragraph 7 and the publication of contracts referred to in paragraph 4 equally apply to GP Fundholders. GP Fundholders and Health Boards should work closely together to develop a shared vision with the aim of achieving compatible purchasing strategies. By working together on aspects such as quality monitoring duplication of effort can also be avoided.

16. Much of what the NHS does is medically led. It is vital that doctors whether hospital and community consultants or General Practitioners are fully involved in planning, contracting and monitoring and review of services. The routing of patients to units is determined by GPs' preferences and Health Board planning. It requires an interactive approach with GPs assisting Health Boards by sharing information about their insights into needs assessment, their referral preferences, and their judgement on the services they receive from providers. Boards should communicate to GPs their priorities, plans and intentions with a view to ongoing discussion. This requires new ways of communication which have to be achieved without placing a disproportionate administrative burden on the time of individual GPs.

17. Consultant medical staff are at the heart of what is provided by NHS Trusts and DMUs. They are able to advise on medical practice and new developments in particular. They also have to lead the delivery of contracted services. Their involvement in unit planning and contracting is essential to the achievement of better services to patients with the appropriate two-way sharing of information, including the results of medical audit. This does involve doctors setting aside time to play their full part yet managers and medical staff between them should endeavour to ensure that this does not lead to the benefits to patient care being reduced. Purchasers will also wish to have access to consultant's advice on the assessment of need.

18. A key principle of the Patient's Charter is increased openness of information for the general public. Again therefore the expectation should be that both purchasers and providers will routinely keep the public informed as to their plans and progress, and that any confidentiality of information should be a (temporary) exception and not the norm. This means not just making information available, but ensuring that it is disseminated in a format and in language appropriate to the general public. Local health councils are a useful source of advice on accessible language and styling, and more generally on how best to keep the public informed.

Management Executive - Accountability Monitoring and Regulation

19. Three significant aspects of the role of the Management Executive are to

- secure the accountability of Health Boards for the achievement of the goals of the NHS;

- secure the accountability of NHS Trusts for their managerial and financial obligations;

- regulate the interaction of purchasers and providers.

20. There is already a framework established relating to the accountability of Health Boards and NHS Trusts eg Health Board Accountability Review meetings, strategy and plan approvals, monitoring returns and the manual on NHS Trust Business Planning. The role of regulation although established in part eg the Procedural Manual on Contracting, disputes procedure, closure procedures and changes of use, is still being developed.

21. Underpinning these roles, however, is a requirement for openness. It is incumbent upon the ME to communicate national policies and requirements clearly and openly and as far as possible to involve the service in the development of national strategies. The creation of "Framework for Action" and the Joint Working network are examples of this. The ME will continue to pursue ways of promoting an open approach.

22. A reciprocal approach is required of the service through the dialogue with the centre, at Accountability Reviews and via monitoring and review returns.

23. The Management Executive will ensure that purchasers and providers share equally in the advice and guidance which issues from the centre and are equal partners in the preparation of additional or revised guidance; and that consumer organisations are also kept in touch with such developments.

24. The objective for the service and the ME should be "no surprise" underlining the climate of openness, integrity and transparency.