



SCOTTISH EXECUTIVE

Health Department
Trevor Jones, Head of Department and
Chief Executive, NHSScotland

Dear Colleague,

A framework for reform: devolved decision-making MOVING TOWARDS SINGLE-SYSTEM WORKING

Summary

1. [Partnership for Care: Scotland's Health White Paper](#) includes proposals for changes to the governance arrangements for local NHS systems which are intended to improve service organisation and delivery throughout NHSScotland.

Action

2. The attached guidance is intended to meet the following objectives:
- to help NHS Boards bring forward simple, practical proposals as soon as possible, but no later than April 2004, to dissolve the remaining NHS Trusts as separate legal entities and for their functions, staff and assets to be transferred intact to new Operating Divisions of NHS Boards;
 - to describe the new duty on NHS Boards to implement decentralised approaches to local decision-making that give real influence to frontline staff;
 - to ensure that all NHS Chief Executives have appropriate cross-system, regional or national leadership roles;
 - to confirm that NHS Boards have an explicit duty to participate in effective and pro-active regional and national service planning; and
 - to provide pragmatic guidance on limited changes in the membership of all NHS Boards.

Yours faithfully,

TREVOR JONES
Chief Executive of NHSScotland

7th March 2003

Addresses

For action

Chairs and Chief Executives,
NHS Boards and NHS Trusts

For information

Members of NHS Boards,
Chairs and Trustees of NHS Trusts

NHS Board Nurse Directors,
Directors of Public Health, Finance
and Human Resources

NHS Trust Medical Directors,
Directors of Nursing, Finance and
Human Resources

Members of the Scottish Partnership
Forum
Members of the Human Resources
Forum

Chief Executives, Local Authorities

Chief Officers, Local Health Councils
and SAHC

Enquiries to:

Dick Manson
Director of Projects
Room 1N.03
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 5035

dick.manson@scotland.gsi.gov.uk

**A framework for reform:
devolved decision-making
MOVING TOWARDS SINGLE-SYSTEM WORKING
March 2003**

TABLE OF CONTENTS

	Page number
1. Introduction	1
2. Current roles of local NHS organisations	2
3. Moving to unitary NHS organisations:	3
NHS Boards – key principles for change	5
Devolution of powers – schemes of delegation	6
Scope for additional developments	7
4. A repositioning of NHS management:	8
A new duty of regional (and national) planning	8
Support for clinical leadership	9
The role of NHS Chief Executives in single-system working	10
Relationships among NHS Chief Executives	11
ANNEXES:	
A: Changes to membership of NHS Boards:	12
Appointment of Chairs of LHCC Professional Committees to NHS Boards	14
Appointment of Medical Directors to NHS Boards	15
Replacement of Trust Chair positions	16
Additional lay member positions on NHS Boards	16
Overall size of NHS Boards	17
B: Divisional Management Teams:	18
Current appointments of Trust Chairs and trustees	18
Chair of the Divisional Management Team	18
Divisional Clinical Governance Committees	19
Other former Trust committees	19
C: Brief summary of legal steps to Trust dissolution	20
Dissolution of Trusts	20
Transfer of staff, movable property, rights and liabilities to NHS Boards	20
Transfer of heritable property to Scottish Ministers	20

1. Introduction

1. *Partnership for Care: Scotland's Health White Paper*¹ includes proposals for changes to the governance arrangements for local NHS systems which are intended to improve service organisation and delivery throughout NHSScotland. Organisational barriers in local NHS systems will be removed as far as possible, and clear duties are now placed on NHS Boards to enhance corporacy, partnership and clarity of direction both within and beyond each NHS Board area. As LHCCs evolve into Community Health Partnerships, the most important challenge for local NHS systems will be to ensure that decision-making power is devolved as close as possible to those in the front line of patient care.

2. This guidance is therefore intended to meet the following objectives:

- to help NHS Boards bring forward simple, practical proposals as soon as possible, but no later than April 2004, to dissolve the remaining NHS Trusts as separate legal entities and for their functions, staff and assets to be transferred intact to new Operating Divisions of NHS Boards;
- to describe the new duty on NHS Boards to implement decentralised approaches to local decision-making that give real influence to frontline staff;
- to ensure that all NHS Chief Executives have appropriate cross-system, regional or national leadership roles;
- to confirm that NHS Boards have an explicit duty to participate in effective and pro-active regional and national service planning; and
- to provide pragmatic guidance on limited changes in the membership of all NHS Boards.

3. The public and Ministers expect the NHS at local level to be a single organisation with shared aims, a common set of values and clear lines of accountability. Unnecessary organisational boundaries can undermine the unity of purpose and effort of the local NHS system and hinder the drive for better health and improved healthcare services.

4. At their best, however, Trusts have embodied some significant advantages that need to be retained in any new configuration. These include:

- the separation of system-wide strategic planning and performance management functions and operational responsibilities for service delivery;
- the creation of an environment where innovation and change can flourish; and
- the delegation of power and responsibility closer to the point of patient care.

¹ *Partnership for Care: Scotland's Health White Paper*, SEHD, February 2003:
<http://www.scotland.gov.uk/library5/health/pfcs-00.asp>

5. The main thrust of the White Paper is about improving the health of the people of Scotland and reforming healthcare services: NHS Boards will continue to play a key role in providing leadership and support for reform.

6. Priority needs to be given to:

- devolving real decision-making power as close to the front line as possible;
- ensuring that healthcare professionals work much more closely together so that patients experience a co-ordinated health service;
- investing in the infrastructure of NHSScotland – in staff, in buildings and in information technology to bring benefits for an integrated health service tasked with meeting national standards;
- working across the boundaries of NHS Boards, whether through Managed Clinical Networks, other clinical or care networks or regional planning processes; and
- working with other key stakeholders, including local authorities, the wider public sector and voluntary groups.

7. **In this context, major structural upheaval is unnecessary and would cause unwelcome disruption to healthcare services.**

2. Current roles of local NHS organisations

8. The purpose and functions of **NHS Boards**, as set out in paragraphs 2.6 to 2.12 of *Rebuilding Our National Health Service*,² include:

- efficient, effective and accountable governance (within a framework of prudent and effective controls which enable risk to be assessed and managed);
- strategic leadership and direction for the system as a whole;
- strategy development, including the Local Health Plan;
- resource allocation to address local priorities;
- implementation of the Local Health Plan; and
- performance management of the entire local NHS system.

9. **NHS Trusts** are responsible for implementing the strategic plans of the NHS Board by organising and providing healthcare services, under the direction of Trust Management Teams. As members of the NHS Board, Trust Chairs and Chief Executives share collective responsibility for the performance of the local NHS system. Trusts are, however, separate public bodies in their own right, and their formal accountability is to Ministers and Parliament, rather than to NHS Boards.

² *Rebuilding our National Health Service*, SEHD, May 2001:
<http://www.scotland.gov.uk/library3/health/ronh-00.asp>

3. Moving to unitary NHS organisations

10. The White Paper proposals are not change for change's sake: indeed, structural change is a distraction from the key issues and challenges faced by NHSScotland. They are the next steps in a direction set out in *Designed to Care* and taken forward in *Our National Health: A plan for action, a plan for change*, and they aim to consolidate around 15 NHS Boards, with minimal structural change and a large degree of devolution and delegation to frontline staff. The key themes underlying the proposals are corporacy, integration, decentralisation, service redesign and patient focus. Of central importance is the recognition that evolutionary change is both helpful and necessary to enable the NHS to continue to modernise and to empower front-line staff to meet the challenges they face.

11. Those NHS Boards which still operate with Trusts should therefore bring forward simple, practical proposals to enable the Trusts in their areas to be dissolved and for their functions, staff and assets to transfer intact to new Operating Divisions of the NHS Board. **Proposals should be submitted to the Scottish Executive Health Department as soon as possible, but no later than April 2004.**

12. This gradual approach is essential to allow NHS leaders to concentrate on supporting improvements in patient care, to deliver:

- **improved health and reduced health inequalities;**
- **shorter in-patient and out-patient waiting;**
- **cleaner hospitals and reduced risk of infection;**
- **clinical service reform and redesign;**
- **sustainable services, through better regional and workforce planning;**
- **more widely developed Managed Clinical Networks;**
- **more responsive and inclusive community health services.**

13. In future, the respective roles of the different components of local NHS systems should be as follows, once Trusts have been dissolved:

- the strategic planning, governance and performance management role of **NHS Boards** will continue unchanged, and the operational management role currently undertaken by NHS Trusts will transfer to Operating Divisions of the unified NHS system;
- **Operating Divisions** will form part of a single statutory organisation, but, like Trusts, they will have the ability to take operational decisions and manage the delivery of healthcare services within the governance framework of the NHS Board but without continual reference to the central board of governance.

14. Within the new Operating Divisions, there must be devolution of real management authority to local level: those in the front line must be empowered to plan and deliver services within a framework of clear strategic direction and rigorous performance management. **Decentralisation of the decision-making process must not stop at Operating Division level.**

15. Dissolution of Trusts can be achieved using existing legislation and **will have no substantive impact on the employment of staff**, since the obligations of the employer will transfer directly to the respective NHS Board.

16. Local stakeholders must be fully involved in local decisions, in keeping with the priority that we attach to involving front-line staff, patients, carers and partner agencies and communities in leading change across NHSScotland. This principle will apply to the statutory consultation period preceding the dissolution of Trusts.

17. **Proposals for change should be as simple and practical as possible.** Successful proposals will reflect the key principles set out overleaf:

NHS Boards – key principles for single-system working

NHS Boards should retain their focus as **boards of governance**, embodying:

- a **corporate, inclusive approach** to collective decision-making,
- based on the principles of **partnership working** and **devolution of powers** to the front line of patient care.

NHS Boards should support **local leadership**, by:

- delegating **financial and management authority** as far as possible; and
- encouraging **locally responsive approaches** to service provision.

As **integral parts** of local NHS systems, well-defined **Operating Divisions** should have:

- **specific, delegated authority** to act within a defined remit without constant reference to the NHS Board;
- this must be backed up by clear, formal **schemes of accountability**;

Proposals should recognise the **complex interaction** between:

- **clinicians and other staff** who work directly with patients; and
- **common services** which support them in that task.

Responsibility and decision-making should be **devolved** to staff who are **directly involved** in delivering healthcare.

The design and development of services should be firmly grounded in the patient's **everyday experience of care** at **locality level**.

NHS Boards should continue to develop **sustainable frameworks** for **patient focus** and **public involvement**.

NHS Boards should build on the achievements of:

- **Local Health Care Co-operatives** as they evolve into **Community Health Partnerships**; and
- the **Joint Future** initiative

in a way which:

- engages with **Community Planning** partners; and
- **maximises population alignment** between LHCCs / Community Health Partnerships and social care.

Health services should be delivered **locally as far as possible**, but always consistent with providing **safe, sustainable** and **efficient** services to patients.

To achieve this, NHS Boards should: **promote, resource** and **actively manage** the development of:

- **Managed Clinical Networks** and other clinical and care networks;
- both **within** and **beyond** their local boundaries.

Devolution of powers – schemes of delegation from NHS Boards to and within Operating Divisions

18. The Health White Paper announced a new duty on NHS Boards to put in place devolved systems of decision-making. This duty carries with it a responsibility to ensure that local services are provided as efficiently and effectively as possible within the resources available.

19. Upon the dissolution of the remaining NHS Trusts, NHS Boards should therefore exercise their existing statutory powers of delegation³ to devolve duties and responsibilities for service delivery to new Operating Divisions. This should be achieved by converting the current Trust Management Teams into a committee or committees of the NHS Board – here referred to as ‘Divisional Management Teams’.

20. Divisional Management Teams will act in broadly the same way as the current Trust Management Teams, and their role and responsibilities will be similar, but with a stronger operational bias.

21. Duties to deliver services to a defined standard on behalf of NHS Boards will be devolved to Operating Divisions under robust schemes of delegation. As with other committees of the NHS Board, these should take the form of standing orders. Once their operating framework is established, Operating Divisions will be empowered to act directly in the name of the NHS Board – without the need to revert to the Board for approval to proceed or commit the Board to a particular course of action.

22. The devolution of powers direct from NHS Boards to Operating Divisions is intended to ensure that Divisional Management Teams are just as flexible as the Trust Management Teams they replace. Additionally, these new arrangements should ensure that NHS Boards preserve their status as strategic boards of governance and do not become unnecessarily involved in day-to-day management issues. Further details will be made available in due course if required.

23. In turn, Divisional Management Teams must delegate budgetary and decision-making powers to the appropriate level within their local NHS system, consistent with the key principles for single-system working set out above: decentralisation must not stop at Operating Division level.

24. Schemes of delegation should be designed to achieve the following core objectives:

- adequate segregation of duties;
- the necessary operational autonomy; and
- appropriate internal control.

³ cf. Regulation 10(1) of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (SSI2001/302): “A Board may, and if so directed by the Scottish Ministers shall, appoint committees for such purposes as the Board may determine, subject to such restrictions or conditions as the Board may think fit, or as the Scottish Ministers may direct.”

25. In particular, schemes of delegation, which may take the form of standing orders, should:

- clearly differentiate the separate functions of Operating Divisions and the system-wide responsibilities of NHS Boards;
- put in place mechanisms to devolve duties and responsibility for service delivery as close to the patient as possible;
- strengthen corporate working and provide clear strategic direction;
- but they should not result in a greater degree of unnecessary central control over operational matters.

Scope for additional developments

26. There may be some circumstances in which different organisational arrangements for managing services are required to address particular local conditions. For example, following extensive reviews of local decision-making structures, NHS Borders and NHS Dumfries & Galloway concluded that their population size did not warrant two separate operational units in each area. Likewise, NHS Argyll & Clyde concluded that its current Trust configurations did not represent the best way to organise services to meet local needs.

27. Such factors will not necessarily apply in other parts of Scotland. Nevertheless, NHS Boards retain the flexibility to determine the appropriate organisational structures to deliver local health services. Consequently, NHS Boards may consider developing arrangements that use the skills and talents of their existing leaders in different ways, provided there is agreement and where benefits can be demonstrated. Where this is the case, NHS Boards should develop proposals in partnership with the respective Trusts / Operating Divisions and their management teams.

28. It is, however, crucial that an appropriate balance should be maintained between the need to avoid the disruption frequently associated with organisational change and the overriding aim of securing tangible benefits for patients.

29. Any such proposals will require the prior approval of the Health Department before submission to Ministers.

4. A repositioning of NHSScotland management

30. The White Paper aims to bring about a fundamental repositioning of NHSScotland management to reflect its value and critical importance in working with clinicians to enable service change and clinical reform. The role performed by NHSScotland executives and senior managers in the planning and delivery of services will remain critical.

31. In particular, the removal of the artificial legal barriers between Trusts will enable Divisional Chief Executives to develop cross-system leadership roles in the drive to integrate, redesign and develop patient-centred services. These will differ according to local needs but will generally include the following:

- **pursuing the redesign agenda, developing more sustainable and patient-focused solutions for hospital services, which will enable clinicians and patients to lead service redesign;**
- **maximising the development of LHCCs and giving them more influence in the local NHS system as they evolve into Community Health Partnerships;**
- **developing Managed Clinical Networks and other clinical and care networks, and ensuring that they are adequately resourced to bridge organisational boundaries in the system wherever they occur;**
- **in the context of NHS Boards' new duty to play a full part in regional planning, improving responsiveness to local, regional and national service priorities, developing more effective service delivery plans; and**
- **achieving the 'best fit' possible with other services provided locally, including those provided by partner agencies such as local authorities.**

32. **NHS Boards will be expected to ensure that all Chief Executives have appropriate cross-system, regional or national leadership roles.**

A new duty of regional (and national) planning

33. Leadership in regional (and national) service and workforce planning is an essential component of the NHSScotland reform agenda. With developments in healthcare generally, increased specialisation in some acute services and the legislation on hours of work of doctors and other professionals, urgent and sustained progress needs to be made in planning and implementing services that need to be provided for populations greater than those of individual NHS Boards.

34. The functions of NHS Boards, as set out in paragraphs 2.7 and 2.8 of *Rebuilding Our National Health Service*, are now expanded to include an explicit duty to participate in effective and pro-active regional planning, in accordance with HDL(2002)10.⁴ In turn, NHS Boards are expected to place a clear, formal duty on each of the Chief Executives and other executive managers in their area to lead and participate fully in effective regional planning and cross-Board working.

35. All Chief Executives in each NHS Board area should therefore play co-ordinated leadership roles in promoting the urgent development of cross-Board services. Chief Executives should also ensure other members of their management teams play complementary leadership roles in supporting:

- co-ordinated, pro-active regional workforce plans;
- sustainable, cross-Board solutions for specialist service provision; and
- the further development of Managed Clinical Networks and other clinical and care networks.

36. Executives with key clinical leadership roles, such as Directors of Public Health, Directors of Nursing and Medical Directors, have particular roles to play in ensuring that the regional planning agenda is taken forward pro-actively and that it keeps pace with immediate and future service demands. Similarly, Directors of Finance have a particular role in ensuring that the financial planning and resource allocation framework facilitates rather than inhibits regional service planning and implementation.

Support for clinical leadership

37. All Chief Executives and other key executives must play major leadership roles in developing, nurturing and supporting clinical leadership. This will enable Managed Clinical Networks and other clinical and care networks:

- to develop an increasingly influential role in local NHS systems and beyond;
- to fulfil their potential to improve and integrate care pathways; and
- most importantly, to improve the patient's experience of care.

38. A key thrust of the White Paper is the need to promote the involvement of clinicians in planning and implementing improved services for patients through service redesign. As a key part of this process, all NHS Boards will be required to establish a Service Redesign Committee.

39. Service Redesign Committees should include a broad range of local clinical leaders, including Directors of Nursing and Medical Directors, and they should establish close links with the Area Clinical Forum and the LHCC Professional Committee. In addition, Committees should include members drawn from each LHCC or Community Health Partnership in the NHS Board area, and consideration should be given to involving lay members.

⁴ *NHSScotland: Guidance on regional planning for health care services*, HDL(2002)10, SEHD, March 2002: http://www.show.scot.nhs.uk/sehd/mels/HDL2002_10.pdf

40. To support clinical redesign at local level, each NHS Board will be required to develop a Change and Innovation Plan. Additional funding will be made available to support the implementation of these plans, and Service Redesign Committees will make a key contribution to their development and delivery. **Further details will be made available in due course.**

41. Just as there is a need for NHS Boards to devolve decision-making to front-line clinicians, clinical staff need to be more involved in the work of NHS Boards. This will strengthen clinical expertise, ensure that service delivery in local communities has a strong voice at NHS Board level and assist in the drive to devolve decision-making and promote clinical involvement in service redesign.

42. Accordingly, we intend to strengthen NHS Board membership by securing the appointments of additional senior clinicians on all NHS Boards, as both executive and non-executive members:

- a new position of NHS Board Medical Director will be created to sit alongside the Nurse Director as a full member of each NHS Board;
- the Chair of the LHCC Professional Committee will be appointed as a full member of each NHS Board. Established in 2001, LHCC Professional Committees have a broad remit to strengthen the influence of primary care across the whole local NHS system and provide an improved focus for the development of integrated working between health and social care.

43. Taken together, these additional appointments will:

- strengthen clinical involvement in decision-making;
- assist in the drive towards greater integration and service redesign;
- ensure that service delivery in local communities has a greater influence and profile at NHS Board level; and
- play a key role in the transition from LHCCs to Community Health Partnerships at locality level.

The role of NHS Chief Executives in single-system working

44. **NHS Board Chief Executives** are currently responsible for strategic leadership and governance of the NHS system; strategic planning and resource allocation; implementation of the strategic plan; and performance management of the whole system. That role will remain broadly unchanged. The only difference will be that instead of discharging their responsibility for implementation through separate statutory bodies, it will be discharged through Operating Divisions of the NHS Board.

45. The role of **Divisional Chief Executives** will match very closely the current role of Trust Chief Executives. Divisional Chief Executives will continue to be accountable for their budget, for the performance of their organisation and for leading and securing appropriate advice for their Divisional Management Team. They will work closely with the Chair of the Divisional Management Team, as they currently do with the Chair of the Trust Management Team.

46. Two changes are a direct consequence of the move to single NHS organisations:

- Divisional Chief Executives will not be appointed formally as Accountable Officers – this is in any case a consequence of the introduction of unified NHS Board accounts – but they will still have primary accountability for their budget, and they will still be liable to be summoned to give evidence to the Parliament;
- the Chief Executive of the NHS Board will have overall accountability for the performance management of the whole NHS system, and there will therefore be a direct line of accountability from Divisional Chief Executives to the NHS Board Chief Executive.

47. **These formal changes will not affect the status, authority or autonomy of Divisional Chief Executives.**

48. The other members of the former Trust executive team will fulfil the same roles as before but as part of the Divisional executive team and will continue to report to the Divisional Chief Executive.

Relationships among NHS Chief Executives

49. All Chief Executives in the NHS Board area must operate as a strong, unified team, providing leadership in agreed areas across the local NHS system, with specific operational results being delivered by Divisional Chief Executives and their executive teams. NHS Board Chief Executives carry ultimate responsibility for the performance management of the local NHS system.

50. The NHS Board Chief Executive will be responsible for performance assessment of Divisional Chief Executives in consultation with the Chair of the Divisional Management Team. In practice, NHS Board Chief Executives and the Chair of the respective Divisional Management Team will carry out the appraisal of the Divisional Chief Executives, which will be reviewed by the Chair of the NHS Board and the Remuneration Committee. The NHS Board Chair and the Remuneration Committee will be responsible for performance appraisal of the NHS Board Chief Executive.

51. Chief Executives must be able to carry the confidence of the wider NHS system, so a key part of the assessment of the effectiveness of the Chief Executive team as a whole should be ‘360-degree’ appraisal of each other against the agreed key behaviours for effective leadership. This will ensure a balanced leadership team that is able to work together effectively in an atmosphere of mutual support.

Changes to membership of NHS Boards

A1. Limited changes to the membership of NHS Boards are necessary in parallel with the dissolution of Trusts across Scotland. These changes are required to ensure NHS Boards have the appropriate level of non-executive input to discharge their responsibilities, but they are also intended to increase the influence of clinicians and other stakeholders on decision-making at NHS Board level, in line with the proposals set out in the White Paper.

A2. The establishment of fifteen new unified NHS Boards in September 2001 implemented one of the key proposals of the Scottish Health Plan, *Our National Health: A plan for action, a plan for change*:

*to forge effective links with patients, staff, local communities and excluded groups so that their needs and views are put at the heart of the design and delivery of local health services.*⁵

A3. NHS Boards are boards of governance, not representative bodies or management boards. Their membership is conditioned by the functions of the Board, which include:

- strategy development (including regional planning and cross-Board working alongside health promotion and health improvement);
- resource allocation;
- development and implementation of the Local Health Plan; and
- performance management of the local NHS system as a whole.

A4. All members of NHS Boards – executive and non-executive – enjoy equal status and share collective responsibility for the performance of the local NHS system as a whole. The membership of the NHS Board must therefore reflect the partnership approach which is essential to improving health and healthcare. NHS Boards are intended to bring together all stakeholders with an interest in improving local health and healthcare services: local communities, healthcare staff and the component parts of local NHS systems.

A5. *Rebuilding our National Health Service* described the role and composition of NHS Boards and provided guidance on how they were to be established. Since then, it has been supplemented by other guidance as follows:

- the development of LHCCs;⁶
- the establishment of Area Clinical Forums;⁷
- the appointment of Nurse Directors;⁸

⁵ *Our National Health: A plan for action, a plan for change*, SEHD, December 2000:
<http://www.scotland.gov.uk/library3/health/onh-00.asp>

⁶ *LHCC Development: the next steps*, SEHD, July 2001: http://www.show.scot.nhs.uk/lhcc/Latest_News.html

⁷ *The Role and Terms of Reference of the Area Clinical Forum*, SEHD, July 2001:
<http://www.show.scot.nhs.uk/nhspublicappointments/Area%20Clinical%20Forum%20240701.pdf>

⁸ *Appointment of Nurse Directors*, SEHD, April 2002:
<http://www.show.scot.nhs.uk/nhspublicappointments/standarddocs/NurseDirectorFinalGuidance220402.pdf>

A6. The current composition of a typical mainland NHS Board is as follows:

<p>Current NHS Board membership (<i>since June 2002</i>):</p> <p><i>Non-executive lay members:</i></p> <ul style="list-style-type: none"> - NHS Board Chair; - <i>(two to four) Trust Chairs;</i> - <i>(up to two) other lay members</i> <ul style="list-style-type: none"> – appointed by Ministers following open public competition, in accordance with the OCPA Code of Practice; <p><i>Non-executive stakeholder members:</i></p> <ul style="list-style-type: none"> - <i>(up to five) local authority member(s)</i> <ul style="list-style-type: none"> – a senior elected councillor is nominated by <u>each</u> of the local authorities covered by the NHS Board area; - Chair of the Area Partnership Forum ('employee director') <ul style="list-style-type: none"> – nominated by the local staff partnership forum(s); - Chair of the Area Clinical Forum <ul style="list-style-type: none"> – nominated by local clinicians and other professionals; - University Medical School member <ul style="list-style-type: none"> – nominated by the local teaching hospital (if any); <p><i>Executive members:</i></p> <ul style="list-style-type: none"> - NHS Board Chief Executive; - <i>(two to four) Trust Chief Executives;</i> - Nurse Director; - Director of Public Health; - NHS Board Director of Finance.
--

A7. In summary, the following changes are proposed to the membership of NHS Boards:

- creation of a new non-executive position for the **Chair of the LHCC Professional Committee;**
- creation of the new executive position of **NHS Board Medical Director;**
- transfer of Trust Chief Executive positions to **Divisional Chief Executive** positions;
- replacement of the **Trust Chair** positions by an equivalent number of **lay member** positions;
- **possibility** to create additional **lay member** positions on each NHS Board to compensate for the loss of **trustees** on Trust Management Teams – up to two such positions may be created for each Trust to be dissolved, **subject to the prior agreement of the Health Department.**

Appointment of Chairs of LHCC Professional Committees to NHS Boards

A8. In July 2001, guidance was issued on the role and remit of the new, multi-professional LHCC Professional Committee, to be established in each NHS Board area. These new committees are intended to play a key role in demonstrating the potential of LHCCs to deliver enhanced services through flexible, multi-disciplinary working.⁹

A9. The LHCC Professional Committee has a remit to strengthen the influence of primary care across the whole local NHS system and provide an improved focus for the development of integrated working between health and social care. In particular, it is charged with the following responsibilities:

- active involvement in the service design, redesign and development agenda for the local healthcare system;
- sharing in the task of advising the NHS Board on proposals and programmes which will improve the integration of services both within local healthcare systems and across health and social care;
- contributing to the NHS Board's development of the Local Health Plan and its strategic objectives;
- advising the NHS Board on service improvement through the development of multi-disciplinary working;
- advising the NHS Board on service developments within primary care and their workforce implications, and on achieving the right skill mix within the NHS Board area.

A10. *LHCC Development: the next steps* states that membership of the LHCC Professional Committee should include every LHCC in the NHS Board area, and there should be ensure balanced representation of all the professional groups which deliver community-based services within LHCCs. The Committee should operate flexibly, using subject specific small groups as required, and it has the power to co-opt appropriate additional members, including secondary care clinicians, local authority representatives, members of the public, patients, carers and voluntary agencies. It is up to local NHS systems to determine the most appropriate make-up of this Committee to ensure the effective delivery of its remit.

A11. The Chair of the LHCC Professional Committee currently sits on the Area Clinical Forum. In turn, the Chair of the Area Clinical Forum is a full member of the NHS Board. It is now proposed that the Chair of the LHCC Professional Committee should have automatic membership of the NHS Board. As a consequence, Chairs of LHCC Professional Committees will no longer be eligible to chair the Area Clinical Forum, although they will retain membership of the Forum.

A12. **This new appointment will apply to all fifteen NHS Boards. As Board members, Chairs of LHCC Professional Committees will be expected to play a key role in the transition from LHCCs to Local Health Partnerships.**

⁹ cf. paragraphs 9 and 14 to 16 of *LHCC Development: the next steps*.

Appointment of Medical Directors to NHS Boards

A13. A Medical Director will be appointed to a new position on each of the fifteen NHS Boards. The NHS Board Medical Director will be a local Divisional Medical Director appointed to serve as a full member of the NHS Board. These will be additional Ministerial appointments and not new employed posts. In common with all other executive members of NHS Boards, NHS Board Medical Directors will not be separately remunerated for their contribution to the NHS Board.

A14. Although NHS Board Medical Directors will be members of the NHS Board, their terms of employment will not be affected – just as Directors of Finance and Public Health remain employees of the NHS Board, even though they sit together as NHS Board members.

A15. The appointment of a Medical Director on all fifteen NHS Boards is intended to bring the following advantages:

- the appointment of a Medical Director as a full member of the NHS Board emphasises the importance that we attach to placing senior clinicians at the heart of local decision-making;
- the role of NHS Board Medical Director will complement the role of NHS Board Nurse Director, first introduced in June 2002.

A16. The pool of potential applicants eligible to be appointed as NHS Board Medical Directors will be limited to Medical Director(s) employed at Divisional (currently, Trust) level in each NHS Board area. In an NHS Board area with several Operating Divisions (Trusts), this implies the selection of one of the Medical Directors to serve as an executive member of the NHS Board. The aim should be to keep the selection and nomination process as simple as possible.

A17. The following process should be managed locally:

- a. the NHS Board Chair should invite all those local Divisional (Trust) Medical Directors eligible for appointment to submit an application;
- b. the NHS Board Chair should convene a small panel including a mix of Chairs and Chief Executives drawn from within the local NHS system to consider the applications;
- c. if there is more than one applicant for the proposed Board position, the panel should hold selection interviews;
- d. the panel will need to be satisfied that individual applicants demonstrate the ability to perform the role;
- e. the panel's decision should be informed by professional advice, which may appropriately be obtained from the Chief Medical Officer for Scotland;
- f. the role of the panel is to reach a decision on who the NHS Board Chair should nominate for appointment to the NHS Board;
- g. the NHS Board Chair should submit the preferred applicant for the Minister's consideration;
- h. the Minister will be invited to appoint the nominee submitted.

A18. As with the existing Nurse Director position, this additional seat on the NHS Board is intended to enhance the work of the Board and will in no way restrict the opportunities for clinical and professional input from other sources within the local NHS system.

A19. This appointment is not intended to destabilise existing local advisory mechanisms (such as the Area Clinical Forum). Nor will it undermine the role of other clinical leaders in local NHS systems, the level and importance of whose contribution will remain undiminished.

A20. This new appointment will apply to all fifteen NHS Boards.

Replacement of Trust Chair positions

A21. Those NHS Board positions held *ex officio* by Trust Chairs and which are not separately remunerated will cease automatically upon dissolution of Trusts. In order to maintain non-executive capacity in each local NHS system, an equivalent number of new lay member positions should be created on each NHS Board concerned. These new lay positions must be filled by open public competition, in accordance with the Code of Practice of the Office of the Commissioner for Public Appointments.¹⁰

A22. Those NHS Trust Chairs who have been newly appointed from November 2002 onwards to separately remunerated ‘dual’ positions on NHS Trusts and NHS Boards will continue as members of their local NHS Board, but their appointment as Trust Chairs will fall upon dissolution.

Additional lay member positions on NHS Boards

A23. We are prepared to consider applications from NHS Boards for the creation of additional lay member positions, where this is considered necessary to compensate for the reduction in overall non-executive capacity in each local NHS system following the loss of trustee positions on dissolution of Trusts.

A24. Chairs of NHS Boards should submit proposals for any additional lay members to the Chief Executive of NHSScotland in the first instance.

A25. Such proposals must be justified in terms of the overall size and balance of the NHS Board, as discussed further below. In accordance with this principle, a maximum of two additional lay member positions may be created for each Trust that is dissolved.

A26. Where possible, Chairs should consider the possibility of filling lay member vacancies gradually over a period: this will have the advantage of staggering terms of appointment, so that future vacancies do not all arise simultaneously. All new lay positions must be filled by open public competition, in accordance with the Code of Practice of the Office of the Commissioner for Public Appointments.

¹⁰ cf. <http://www.ocpa.gov.uk/index.htm>

Overall size of NHS Boards

A27. It is important that the total number of members of NHS Boards should be sufficient to ensure that Boards can carry out the functions required of them. These functions will include providing an adequate degree of scrutiny over all the component parts of their local NHS system, including membership of committees. The overall number of members of NHS Boards should reflect a balance between the desire for inclusiveness and the need to ensure that the Board is of a manageable size, consistent with the effective discharge of business. **This balance may vary in different areas.**

A28. Based on the proposals discussed in this paper, the following table illustrates the likely composition of a typical NHS Board following the dissolution of Trusts. For this purpose, it is assumed that there are currently two Trusts in the NHS Board area, that there is no University Medical School and that the area spans two local authorities:

Typical unified NHS Board (with two Operating Divisions)
Lay members – 5 to 9
NHS Board Chair
4 to 8 lay member positions, of whom: <ul style="list-style-type: none"> • 2 existing lay members; • replacement of 2 former Trust Chair positions; • 0 to 4 new lay members, compensating for the loss of 4 trustees.
Stakeholder members – 5
2 Local Authority members
‘employee director’ – Chair of the Area Partnership Forum
Chair of the Area Clinical Forum
<u>new</u> Chair of the LHCC Professional Committee
Executive members – 7
NHS Board Chief Executive
2 <u>new</u> Divisional Chief Executives (= Trust Chief Executives)
Director of Public Health
NHS Board Finance Director
NHS Board Nurse Director
<u>new</u> NHS Board Medical Director

A29. Currently, the same local NHS system will have:

- 9 lay members
(including 4 trustees appointed to the 2 Trust Management Teams);
- 4 stakeholder members; and
- 6 executive members.

Divisional Management Teams

B1. Trust Management Teams currently comprise a Chair; two non-executive trustees; and five Executive Directors.

B2. The current appointments of **Trust Chairs and trustees** will cease automatically upon dissolution of Trusts. This will also apply to unremunerated NHS Board positions held *ex officio* by Trust Chairs.

B3. The position of **executive members** of the former Trust Management Team is different, since they are employees of NHS bodies. When Trusts are dissolved, they will automatically transfer to **Divisional Management Teams** and they will become employees of the NHS Board, in common with all former Trust employees.

B4. Divisional Management Teams will be chaired by a non-executive member of the NHS Board. Meetings will no longer be required to be held in public, since they are not separate public bodies.

Current appointments of Trust Chairs and trustees

B5. Ministerial appointments of **lay non-executive members** of NHS bodies are made in accordance with the guidelines issued by the Office of the Commissioner for Public Appointments. Under OCPA rules, direct transfers will not be possible between NHS Trusts and NHS Boards, as the role of NHS Board members is substantively different from that of lay members of Trusts.

B6. The contribution of Trust Chairs and trustees has been greatly valued and their continued contribution until the dissolution of Trusts will be essential. Trust Chairs and trustees whose positions cease upon dissolution of NHS Trusts will be welcome to apply as candidates in open competitions for new lay member positions on their local NHS Board which will be created. This will generally also apply to Trust Chairs (or trustees) who are already serving their second term of appointment with the Trust, since a successful application to become a member of the NHS Board would constitute a new public appointment. The provisions regulating maximum terms of appointment are set at zero when appointments are made to different public bodies following open competition.

Chair of the Divisional Management Team

B7. The new Divisional Management Team will be chaired by a non-executive lay member of the NHS Board. As the Divisional Management Team will be, in formal terms, a committee of the NHS Board, its Chair will be appointed by the NHS Board (in the same manner as the Chair of the Audit Committee, for example) rather than directly by Ministers, as is currently the case for Trust Chairs.

B8. A substantial time commitment will be expected of the Chair of each Divisional Management Team. This will amount to at least two days per week, in addition to the one day per week which is expected of all lay members of NHS Boards. In recognition of this, additional remuneration should be paid by the NHS Board to the lay member who is appointed to chair each Divisional Management Team to reflect the additional time commitment.

Divisional Clinical Governance Committees

B9. Trusts' current responsibilities for clinical governance will continue to be discharged at Operating Division level. The responsibilities of Trust Clinical Governance Committees will therefore transfer to Divisional Clinical Governance Committees. In formal terms, such committees will be committees of the Divisional Management Team and, in consequence, sub-committees of the NHS Board.

B10. Membership of the Divisional Clinical Governance Committee will be similar to the current Trust Clinical Governance Committee. Accordingly, Divisional Clinical Governance Committees should be chaired by a non-executive member of the NHS Board. To preserve an appropriate degree of independence, the Chair of the Divisional Management Team should not chair the Divisional Clinical Governance Committee.

Other former Trust committees

B11. Some former Trust committees, such as the Audit Committee, will no longer be necessary following dissolution of Trusts. *Rebuilding our National Health Service* lays considerable emphasis on the general presumption that “*subject to limited exceptions, separate committees in different parts of the local NHS system which share identical remits should be combined.*” Paragraph 2.108 of *Rebuilding our National Health Service* is of particular relevance in this context:

The new unified structure will provide considerable scope for rationalising the number of committees which exist within each local NHS system. As part of the process of establishing new unified structures, all NHS Boards will be expected to review the committee structures in their Board areas, in order to determine what is essential to discharge the business of the local NHS system as a whole.

B12. Committees and sub-committees of the NHS Board should therefore be populated from across the whole local NHS system, drawing upon the pool of experience and expertise that exists in each area. **As before, all members of the NHS Board will be expected to play a full part in the work of committees across the local NHS system.**

Brief summary of legal steps to Trust dissolution

C1. There follows a brief summary of the legal steps to Trust dissolution. The text is not designed to be comprehensive. Further advice may be obtained from the Scottish Executive Health Department.

Dissolution of Trusts

C2. Scottish Ministers must give prior authorisation for dissolution of each Trust, upon formal application from the Chair of the Trust Management Team. Public consultation must then take place in relation to the dissolution of the Trusts and the transfer of staff, property, rights and liabilities, under the terms of The National Health Service Trusts (Consultation on Dissolution) (Scotland) Regulations 1993. Consultation will generally last three months. Once consultation is complete, the NHS Board must submit a report to the Minister within one month summarising the results of the consultation process.

C3. Subject to Ministerial approval, a dissolution order is then drafted in terms of paragraph 25 Part IV of Schedule 7A of the NHS (Scotland) Act 1978 which will be in the form of a Statutory Instrument signed by the Minister. Because of the terms of Section 105(4) of the 1978 Act, this is not subject to Parliamentary procedure. Such orders are prepared on behalf of Ministers by the Office of the Solicitor of the Scottish Executive (OSSE).

Transfer of staff, movable property, rights and liabilities to NHS Boards

C4. In addition to staff transfers, dissolution of Trusts necessitates the transfer, by order, of all movable property, rights and liabilities from Trusts to the respective NHS Board. Such transfers are provided for specifically under the National Health Service (Scotland) Act 1978 under paragraph 26(1) of Schedule 7A, Part IV “Dissolution”. The necessary orders are not Statutory Instruments and there is no Parliamentary procedure; they are prepared on behalf of Ministers by OSSE.

C5. It is important to emphasise that staff transfer orders will have no substantive impact on the employment of staff, since the obligations of the employer will transfer directly to the respective NHS Board. In formal terms, the dissolution of Trusts will follow the principles set out in the National Organisational Change Policy Document.

Transfer of heritable property to Scottish Ministers

C6. As legislation stands, it is not possible for NHS Boards to hold heritable property rather than Scottish Ministers, which means that the transfer of heritable assets must be made from the respective Trusts to Scottish Ministers. These aspects of Trust dissolution should be taken forward in conjunction with the Property & Capital Division of SEHD and the Central Legal Office.

C7. The fact that Scottish Ministers hold legal title to heritable property does not leave NHS Boards (or Special Health Boards) at any disadvantage compared with NHS Trusts. This is borne out by the standard accounting treatment, which is based on NHS Boards’ retaining all the advantages of economic ownership of the assets in their respective NHS Board areas (including, for example, the proceeds of sale of assets).