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Welcome!

I am pleased to extend a personal welcome to you as you join the Management Training Scheme. Already you have achieved a measure of success by being selected to join the Scheme. I know this will be a valuable learning experience for you, and I am sure you will gain a great deal of pleasure and benefit from it.

The NHS Scotland Management Training Scheme is an important part of our strategy to ensure the supply of future leaders and managers for the service. You are joining the Scheme at an exciting time. NHS Scotland is working with an agenda of service improvement unprecedented in its history. Our Quality Strategy sets out a direction for the future that is innovative and designed to meet the needs of the Scottish people.

I know that you are ready for this challenge and that the Scheme will support you well during the next two years. I would like to add my personal support to you and the Scheme. You are important to the future of the NHS. Amongst you are some future leaders, and I wish you every success as you embark on your NHS career.

Derek Feeley  
**Acting Director-General Health & Social Care and Chief Executive of NHS Scotland**

Can I offer you my personal congratulations on being successful through a very challenging recruitment process for the Management Training Scheme together with a warm welcome to NHS Scotland. I hope this will be the start of a long and enjoyable career for you as you help to lead the NHS in Scotland to an even stronger future.

NHS Scotland needs to develop today’s best talent to deliver tomorrow’s improved health services. It needs enthusiastic and challenging individuals who seek more than just a job. It is looking for people who want to develop the skills needed for a career in Scotland’s most highly regarded public service who recognise that excellence in leadership and management is vital to the delivery of excellence in healthcare.

I wish you every success both in your studies and your career in NHS Scotland.

John Matheson  
**Director of Health Finance and Information**  
**Scottish Government Health Directorate**
Introduction

I would like to add my own welcome to you and look forward to working with you during your time as a Trainee and later in the exciting leadership roles you will be fulfilling.

This Handbook is designed to be a resource for you and will contain most of the information you need while on the Scheme. Your contribution to the continuous improvement of the programme will be most welcome. I do hope you will engage with me in enabling this to happen for the benefit of the Scheme and yourself.

The Handbook is divided into a number of sections, each covering a certain aspect of the Scheme in Scotland:

Section 1 is about the education and the learning programme. The learning and development we have put in place provides a wide range of learning interventions that make up the programme.

Section 2 contains the competence framework underpinning the selection process and your continued leadership development. This is integral to the Scheme.

Section 3 outlines the arrangements for your placement monitoring and Trainee progress review with an NHS Board.

Section 4 has been provided by NHS Education for Scotland (your employer) and contains valuable information on your terms and conditions of employment.

Section 5 outlines the Scheme’s policies and guidelines (including guidance for the elective.)

Section 6 explains how you can access the information and library services based at the Scottish Health Service Centre.

Section 7 offers an overview of the Knowledge Network (KN) and the tools that it can offer in ordering some of the content that you will find useful in your career.

Section 8 will offer an overview of the funding and structure of the NHS in Scotland.

Elaine Lawther
NHS Scotland Scheme Manager
SECTION 1: Background to the NHS Scotland Management Training Scheme

Aim of the Scheme

The aim of the Scheme is to identify, recruit and develop a small number of graduate level people who have the potential to become top managers within NHS Scotland and so make a long term contribution to the public sector in Scotland.

The rationale for the Scheme in Scotland is to enable the NHS to secure future leadership capacity and capability by investing now in high calibre individuals who demonstrate the potential to develop into senior leadership roles.

The Objectives

The programme reflects the needs of NHS Scotland, its constituent organisations, and the individual Trainees. The overall framework will provide:

- A comprehensive insight into all aspects of health improvement and healthcare delivery with key partners.
- Management placements that will provide challenging opportunities to develop operational and strategic management and leadership competencies.
- An opportunity to provide a broader insight to health, healthcare, management and other related sectors.
- A masters level qualification, skill development and a personal development package to underpin experiential learning with academic knowledge.
- A comprehensive package of support, particularly through mentoring, action learning and coaching, plus good line management.
- This Scheme will be supported by local health systems. NHS Boards will host a Trainee for the duration of the programme and the Chief Executive of that Board will sponsor the Trainee.

The Steering Group

A steering group has been established since early 2005. Representatives from senior managers, alumni, clinical leaders and staff side are represented within it. The role of the steering group is to provide strategic direction and advice for the Scheme and support the Scheme Manager.
The Steering Group membership is as follows:-

- CHAIR: Fiona Mackenzie, CEO Forth Valley NHS Board
- Elaine Lawther, Management Training Scheme Manager
- Gavin Speers, Health Scotland, (alumni)
- Jonathan Best, Divisional Chief Executive, Yorkhill
- Fiona Mitchell, NHS Lothian
- Professor Elizabeth Ireland, Scottish Government & Stirling University
- Malcolm Wright; CEO National Education for Scotland
- Hazel Mackenzie – Head of Leadership NHS Scotland
- Partnership Representative
A comprehensive local and national induction to NHS Scotland. The purpose of the three-month orientation is to ensure Trainees gain an understanding of health and social care, its constituent parts and partners and how national policy is developed.

Stage 2 – Management post 1 (9 months) Year 1
An operational management post with real responsibility for people, services and resources. The level of responsibility will depend on the experience and maturity of the Trainee. Good line management is essential, as is regular contact with their mentor. A stretch experience in a supported environment with clear objectives and feedback.

Stage 3 – Elective (3 months maximum) Year 2
An opportunity to gain a broader view of health and social care delivery and management, and the role of other sectors and partner organisations in these services. Each Trainee will research a specific theme, such as “improving patient participation and public involvement”, “improving mental health services”, “the development of Community Health Partnerships” etc. The chosen theme will be sponsored by the host NHS Board and contribute to the Trainee’s masters dissertation. The work can be pursued through a number of ways, for example:
- Organisational visits to partner organisations or special health boards.
- Learning from best practice by visiting organisations across the UK.
- Short term placements with relevant partner organisations, clinical networks, etc who can offer relevant research opportunity to enhance the Trainee's learning on the chosen topic and which will offer added value to NHS Scotland.
- Project work in a remote and rural Board.

The elective theme will be developed by the Trainee and the host NHS Board in line with the dissertation guidelines, and with the support of the mentor, personal development adviser and Scheme Manager. This could be a specific topic within one or a number of organisations listed above.

**Stage 4 – Management Post 2 (9 months) Year 2**
A strategic management post to provide experience that offers greater exposure to political and strategic contexts, partnership working or service improvement issues.

**Post (deployment) Year 3**
Following the two year Scheme (subject to satisfactory performance) the local health system will be responsible for identifying a suitable 3rd Year position for a minimum of 12 months for their Trainee. This post will need to be agreed with the Scheme Manager, as it is essential that the position provides both personal stretch and support for the Trainee and is one that is consistent with a fast track approach to career development. It is important that investment in the Trainee is not lost to the system and that we think clearly about the best role for them as they leave the Scheme.

**Education**
To complement the practical placements, and as an integral part of the overall Scheme, Trainees will study for an MSc in Leadership & Healthcare Management at Stirling University. Trainees will also undertake master classes on specific topics and action learning sets, to be shared with an equal number of Financial Management Trainees and Specialist Doctors in training (known as Specialty Trainees or STs) recruited with the support of the Deaneries.
The Financial Management Training Scheme

In 2008 the Financial Management Training Scheme (FMTS) was re-established following consultation and discussion prompted by the strategy paper entitled “Are you Ready?”

Overview
Placements are dependent on the requirements of the host Board locally as well as the particular learning needs of the Trainee with them.

For each placement, the Trainee will receive a training plan which will provide details for the key areas for which training will be provided and will be based on criteria identified within the Scheme. The Training Plan will also indicate to whom the Trainee will report during the placement.

To complement the practical placements, Trainees will also undertake master classes on specific topics and action learning sets, to be shared with an equal number of General Management Trainees and Specialty Trainees recruited with the support of the Deaneries.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Stage 1</th>
<th>NHS Orientation</th>
<th>4 months</th>
<th>Aug – Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Financial Management Placement 1</td>
<td>9 months</td>
<td>Dec – Aug</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Stage 3</th>
<th>Audit &amp; Assurance</th>
<th>3 months</th>
<th>Sept – Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 4</td>
<td>Financial Management Placement 2</td>
<td>9 months</td>
<td>Dec – Aug</td>
<td></td>
</tr>
</tbody>
</table>

| Year 3               | Stage 5 | Financial Management Placement 3 | 12 months | Sept - Aug |

Stage 1 - Orientation (4 months) Year 1
You’ll experience a range of NHS services in your host Board and across Scotland. You will start your studies with CIPFA to progress your qualification and gain an understanding of health and social care, its constituent parts and partners and how national policy is developed.

Stage 2 – Placement 1 (9 months) Year 1
You’ll work in a real financial management post with a strong operational focus. You will gain an insight into how NHS finances are managed, and the contribution made
by effective performance management. This will be a stretch experience in a supported environment with clear objectives and feedback.

**Stage 3 – Elective, (2 months) Year 2**
Have the opportunity to develop your audit and assurance skills, working with both internal and external audit teams.

**Stage 4 – Placement 2 (9 months) Year 2**
You’ll develop your financial management post in your host Board, taking on more responsibility and getting an introduction to strategic management challenges.

**Stage 5 – Placement 3 (12 months) Year 3**
You’ll move into another financial management post in your host Board, taking on responsibility for people, resources and budgets.

**Education**
To complement the practical placements, and as an integral part of the overall Scheme, Trainees will study for their professional accountancy exams under CIPFA and through Kaplan Financial. Trainees will also undertake master classes on specific topics and action learning sets, to be shared with an equal number of Financial Management Trainees and Specialty Trainees recruited with the support of the Deaneries.
Research has shown that successful graduate schemes need to have in place structured support, direction and career management throughout the programme, together with credible and accountable management arrangements. To these ends, the Scheme consists of the following aspects of Trainee support and Scheme infrastructure. The Trainee will need support both as a Trainee and as a member of staff doing a real job within the organisation.

**Roles to support Trainees**

- Scheme Manager
- Line Manager
- Placement Co-ordinator
- Education team
- Mentor
- Fellow Trainees (past and present)
- Doctors (STs)
- Coach
Mentor/sponsor

The NHS Board who are hosting a Trainee will identify a senior manager (in many cases the Chief Executive) who will mentor the Trainee. This role is crucial in offering advice, support and credibility to the Trainee. The sponsor role is very much about “opening doors” and exposing the Trainee to valuable experiences such as Board meetings and introducing him or her to the strategic thinking of the organisation. An introduction to and exposure to senior managers is also important. The mentor role can provide support to career development, and be a sounding board for Trainee thinking on their performance and development within the Board.

Line Manager

Each management post will find the Trainee working to a Line Manager in the normal way. Research from other schemes tells us that this relationship is key to the perceived success of any placement with an NHS Board. Usual line management support, such as objective setting and appraisal, development opportunities and feedback, will apply. The Line Manager will provide direction and advice relevant to the management post and support the Trainee’s growing understanding of the operational and strategic issues.

Placement Co-ordinator

This is an individual based in the host NHS Board who provides important support to the Trainee’s placement. They will organise the orientation, the setting up of the management posts and liaise with the Scheme Manager at NHS Education for Scotland. They need to be familiar with the placement guidelines and will ensure that twice yearly progress reviews take place.

Scheme Management

The NHS National Leadership Unit is based in NHS Education for Scotland. The Scheme Manager is part of this unit. The Scheme Manager is responsible for the management of the entire MTS Scheme. This includes marketing, recruitment, placement and performance management, commissioning and delivery of appropriate education and learning interventions, support to Trainees and working with the Steering Group to shape the future direction of the Scheme.
The purpose of the programme is to contribute to the development of Trainees as managers and leaders, to ensure that they learn and develop in the following ways:-

- Knowledge of NHS Scotland, its values and strategic direction.
- Develop the skills and behaviours required of senior managers and leaders.
- Gain an awareness of how health services are delivered differently within the Home Countries, across Europe and globally.
- Develop their resilience and emotional intelligence as leaders.
- Learn alongside doctors to gain a greater understanding of the importance of multi-disciplinary approaches and a shared agenda for improving healthcare.

The Programme

The education and learning programme is made up of the following elements:-

- An MSc in collaborative leadership and health service management OR a professional accountancy qualification through CIPFA
- Financial and HR management modules
- Action learning sets with Specialty Trainees
- Personal coaching
- Skills workshops
- Attendance at specific master classes with clinical leaders on ‘Delivering the Future’
Financial Management

This workshop will cover the basics of budgeting and financial control systems. It will introduce you to a common financial vocabulary and ensure you have the skills needed to support the management of financial resources.

This course aims to get you to a level of competence that you are confident that you can meet the requirements of KSF Dimension G4 at Level 1.

- Monitors expenditure against agreed budgets to support effective financial management and consistent with legislation, policies and procedures
- Identifies any actual or potential deviations from budgets and reports these to the appropriate person
- Provides information to the relevant person on the current spend against budget

Human Resource Management

This will consist of two one day workshops (HR1 and HR2) delivered locally by an HR professional from within NHS Scotland. HR1 focuses on the role of HR and the practical support the function offers managers, the role of Line Managers in recruitment, performance management, etc. HR2 takes a more strategic approach and covers some of the principles underlying policy and practice in NHS Scotland, such as staff governance.

Skills Workshops, Action Learning, and Coaching Programme

Context

The proposal is based on a two year programme with each annual intake consisting of up to eight Trainees and a matching number of Specialty Trainees. The annual programme will commence in October each year and finish in August of year two.

There will be two groups of eight people, split equally between Trainees and Specialty Trainees. Activities will normally take place in Edinburgh at the Lister Postgraduate Institute.

Underlying Principles

- To identify the skill needs of Trainees and Specialty Trainees.
- To provide an integrated skills programme that will enhance managerial capabilities and develop leadership skills that will contribute to improving patient care.
- To utilise key speakers from within Scotland and beyond in a progressive dialogue with the participants.
- To understand how the Scottish health and care system works and what the key challenges are.
- To utilise coaching and action learning to help participants resolve (or prepare for) difficult issues, and to develop techniques for handling future situations.
- To integrate the programme with the Masters programme at Stirling University.
- To learn through exercises and role play underpinned by theory and good practice.
- To optimise reflective learning and encourage applied practice.

The programme is based around twelve development days (six master classes in each year). Half the time will be allocated to skills workshops, with the other half allocated to action learning. In addition there will be:

- Time during Induction Week to begin the process of understanding the Scottish health and care system.
- A two day Community Challenge in July/August of Year 1.
- Four one-to-one coaching sessions with each of the eight Trainees.

### Master Classes

The development days will be built around themed master classes:

1. Understanding Self; Understanding Others
2. Effective Team Working
3. Communication Skills
4. Decision Making
5. Managing Meetings
6. Managing Change
7. Managing Difficult People
8. Preparing for the Future
9. Project Management
10. Internal Consultancy

The key elements and learning objectives of the master classes are outlined below:

1. **Understanding Self: Understanding Others**

One half day workshop utilising psychometric and other tools to heighten self awareness, develop self management, and better understand relationships. This will include: understanding self; understanding others, and gaining insight into how we are perceived by others.
Key Elements
- Beliefs, values, and behaviours
- Emotional intelligence
- MBTI

2. **Effective Team Working**
One half day workshop examining how to optimise team effectiveness and individual performance within a team.

Key Elements
- Team building
- Team role preference
- Belbin
- Improving team performance

3. **Communication Skills**
Two half day workshops using role play and organisational case studies to develop a range of effective communication skills. The learning objectives will include: understanding barriers to effective communication; building rapport (NLP); body language; and the utilisation of different types of influencing.

Key Elements
- Influencing
- Styles audit
- Assertiveness
- Presentation skills

4. **Decision Making**
One half day workshop exploring the theory and practice of decision making, and examining how that can impact on service delivery

Key Elements
- Theory of decision making
- Good and bad practice

5. **Managing Meetings**
One half day workshop to develop effective chairing and meeting techniques, including good communication and influencing skills.

Key Elements
- Types of meetings
- Chairing and participant skills
- Influencing skills
- Making meetings effective
6. **Managing Change**
One half day workshop allowing participants to: develop practical tools and techniques for effective change; learn how to win hearts and minds in times of change; understand and manage their own response to change; and understand different stakeholder perspectives to change.

Key Elements
- Understanding change
- Reactions to change
- Theories of change
- Leading change

7. **Project Management**
One half day workshop examining project management tools and project management roles.

Key Elements
- Project management tools
- Effective project management
- Team roles

8. **Preparing for the Future**
Two half day workshops giving participants the opportunity to: reflect on their career options; understand public sector recruitment techniques; develop skills and techniques for the interview process; and consider appropriate personal development beyond the end of the programme.

Key Elements
- Career planning
- Assessment centres
- Interview skills
- Continuing personal development

9. **Managing Difficult People**
One half day workshop considering behaviour types, and how managers can use different tools and techniques to reach optimum solutions.

Key Elements
- Planning for difficult meetings
- Role play for managing difficult people
- Turning negatives into positives

10. **Internal Consultancy**
One half day workshop to help participants deliver change and organisational development, utilising internal resources.
Key Elements

- Workshop delivery: tips and techniques
- Becoming an Internal Champion
- Developing a training toolbox
- Effective public engagement
- Event facilitation

### Community Challenge

This two day challenge is a project normally based in the community, often with a charity, that is sourced and delivered by programme participants. Participants will be able to utilise skills in: project management; problem solving; team work; leadership; entrepreneurship; and partnership working. A review session will use reflected learning and relate this to the skills master classes.

### Action Learning

All participants join an action learning set which meets for half a day on twelve occasions in the two year programme. Both sets include Trainees and clinicians.

Action learning sets offer a safe opportunity for participants to learn and grow, using live issues to explore problem solving processes. As participants are from different professional backgrounds, the problems presented will generate different perspectives.

The sets focus on action based solutions derived from different approaches. They help individuals to experiment, evaluate options, and enhance self-awareness. Sponsoring organisations will benefit from motivated participants with an enhanced problem solving capability.

Further details will be contained in the Action Learning booklet.
Schedule

Each Development Day will normally consist of a half day skills workshop and a half day of action learning.

Year 1

Development Days

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
</tr>
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<tbody>
<tr>
<td>Understanding Self; Understanding Others</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Effective Team Working</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Communication Skills I</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Communication Skills II</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Project Management</td>
<td>Action Learning Set</td>
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Community Challenge

Year 2

Development Days

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
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</thead>
<tbody>
<tr>
<td>Managing Difficult People</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Preparing for the Future I</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Preparing for the Future II</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Managing Meetings</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Managing Change</td>
<td>Action Learning Set</td>
</tr>
<tr>
<td>Internal Consultancy</td>
<td>Action Learning Set</td>
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</tbody>
</table>
Coaching

One-to-one coaching is an important part of the Trainee learning process. It is a key component of leadership development and a valuable support for individuals. A skilled coach will help the Trainee work through issues and problems, and assist them in coming to their own conclusions, developing strategies and approaches that work for them.

Each Trainee will have 1.5 days of time with a coach which they can draw down from over the two years. It is totally confidential and what is discussed is not shared with the placement, the Scheme Manager or other Trainees.
SECTION 3: Personal Development Planning & Reviews

Competency Framework

There are two competency frameworks that apply to Management Trainees. These are the Leadership Competencies (page 24) and the Knowledge & Skills Framework (page 22).

These competence frameworks have been used to recruit NHS Scotland’s Management Trainees. They are also used to inform the Trainee Personal Development Plan & Review (PDP&R) and the design of their placement.

Placement design

The Competence Framework outlines the exposure and experience that a management Trainee needs to gain over the course of the Scheme. The Placement Co-ordinator, Trainee, and Scheme Manager will review the experience and competence gained in the first management post and assess what gaps there are. These will need to be addressed in the second management post and possibly the elective experience.

Personal Development Plan & Review

Trainees should review their assessment centre feedback against this competence framework. This will indicate some of the areas where they need to gain greater experience or develop more skill. The first placement will provide relevant experience and the Line Manager should provide feedback and guidance to the Trainee as the placement progresses.

We recommend the Trainee and the Line Manager using the competence framework as a focus for these conversations. The PDP should reflect formal and informal learning and take advantage of in house Board training, such as induction, recruitment and selection, etc. We would encourage the Trainee to take responsibility for their PDP as this is a good habit to get into early on in their development.

The competence framework, PDP and placement content will be discussed at regular progress reviews.
Agenda for Change is the single pay system in operation in the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and some very senior managers. The three core elements that make up Agenda for Change are job evaluation, terms and conditions and the Knowledge and Skills Framework (KSF). The NHS Knowledge and Skills Framework (the NHS KSF) defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff.

Every post in the NHS has a KSF outline, essentially an overview of the specific knowledge and skills required for that role. There are 30 dimensions in total with six of them called “core dimensions” which will apply to all staff. These should appear in all KSF outlines at the appropriate level (one to four). These core dimensions are:

- C1 Communication
- C2 Personal and People Development
- C3 Health, Safety and Security
- C4 Service Improvement
- C5 Quality
- C6 Equality and Diversity

In addition to the dimensions expected to apply to all jobs, there are some which are more suited to different areas. In broad categories, these cover Health & Wellbeing, Estates & Facilities, Information & Knowledge and General dimensions.

This diagram illustrates the KSF Development Review Process (From The NHS Knowledge and Skills Framework and the Development Review Process, 2004, p28.)

All Trainees will use their KSF outline as part of their development reviews and document progress reviews using e-KSF. This is an online tool developed in partnership with the Department of Health and is used across the UK.
## SERVICE EXCELLENCE

<table>
<thead>
<tr>
<th>COMPETENCE</th>
<th>TRAINEE – SELF-ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor /No experience</td>
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<tr>
<td>• Clearly identifies key issues</td>
<td></td>
</tr>
<tr>
<td>• Monitors progress against plans</td>
<td></td>
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<tr>
<td>• Articulates benefits of improved ways of working</td>
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<tr>
<td>• Provides clear justification for their proposal</td>
<td></td>
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<tr>
<td>• Shows the benefits and/or advantages of proposals</td>
<td></td>
</tr>
<tr>
<td>• Introduces new ideas or concepts not contained in the brief</td>
<td></td>
</tr>
<tr>
<td>• Recognises the bigger picture and long term strategic view</td>
<td></td>
</tr>
<tr>
<td>• Organises tasks effectively for self and others, planning and monitoring progress so that outputs are delivered to agreed timescales</td>
<td></td>
</tr>
</tbody>
</table>

### Achieving results

| • Demonstrates energy and enthusiasm to ensure that objectives are met despite difficulties | | | |
| • Identifies importance and urgency of tasks leading to prioritisation | | | |
| • Sets clear goals or objectives | | | |
| • Ensures activities are completed on time | | | |

### Leading Change

<p>| • Considers the impact of decisions on others | | | |
| • Seeks, welcomes and builds on ideas from others | | | |
| • Provides and sets direction for others | | | |</p>
<table>
<thead>
<tr>
<th><strong>FUTURE FOCUS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Makes firm recommendation on way forward</td>
</tr>
<tr>
<td>• Considers a range of options or solutions</td>
</tr>
<tr>
<td>• Evidence of making and owning decisions</td>
</tr>
<tr>
<td>• Offers people choices or alternatives</td>
</tr>
<tr>
<td>• Provides clear justification for proposals</td>
</tr>
<tr>
<td>• Shows the benefits and/or advantages of proposals</td>
</tr>
<tr>
<td>• Introduces new ideas or concepts</td>
</tr>
<tr>
<td>• Recognises the bigger picture and long term strategic view</td>
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<table>
<thead>
<tr>
<th><strong>DELIVERING GOVERNANCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Awareness of Scottish health agenda</td>
</tr>
<tr>
<td>• Commitment to quality and service excellence</td>
</tr>
<tr>
<td>• Recognises the importance of quality and builds standards into work</td>
</tr>
<tr>
<td>• Identifies pros and cons of different options and potential/risks</td>
</tr>
<tr>
<td>• Recognises the importance of establishing and maintaining relationships with organisations and individuals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TEAM WORKING</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Influences others to act</td>
</tr>
<tr>
<td>• Provides direction and champions high standards and change, winning the trust, commitment and co-operation of others</td>
</tr>
<tr>
<td>• Understands approaches to influencing others and their effectiveness</td>
</tr>
<tr>
<td>• Identifies key people they need to influence in a given situation</td>
</tr>
<tr>
<td>Works towards common understanding</td>
</tr>
<tr>
<td>• Seeks to understand other perspectives, find common ground and encourage meaningful dialogue</td>
</tr>
<tr>
<td><strong>PERSONAL QUALITIES AND INTERPERSONAL SKILLS</strong></td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>• Communicates clearly and concisely</td>
</tr>
<tr>
<td>• Builds on contribution of others</td>
</tr>
<tr>
<td>• Seeks clarification of ideas and summarises what others have said</td>
</tr>
<tr>
<td>• Influences others by use of persuasive argument</td>
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<table>
<thead>
<tr>
<th><strong>MANAGEMENT SKILLS</strong></th>
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<tbody>
<tr>
<td>Manages time effectively</td>
<td></td>
</tr>
<tr>
<td>Makes effective contributions in meetings</td>
<td></td>
</tr>
<tr>
<td>Chairs meetings effectively with due consideration to time, decision making and the contribution of others</td>
<td></td>
</tr>
<tr>
<td>Understanding of budget setting and monitoring process</td>
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<tr>
<td>Understands effective cost control</td>
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<tr>
<td>Knowledge of HR polices and procedures and when they should be employed</td>
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<tr>
<td>Ability to develop a business plan and undertake option appraisal cost/benefit analysis</td>
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</table>

**Guide to ranking (a message rather than a measure!)**

**Poor** – Does not meet competence or has had no experience to exhibit it.

**Proficient** – Meets competence on most occasions but may be not be able to assess when to adopt it or not entirely proficient as yet.

**Good** – Is skilled at this area and confident when to employ it.

**Excellent** – Fluent and expert in this area. High level of skill developed already.
The broad change context within which leaders in NHSScotland operate sets the scene for leadership development.

As outlined in section 2.0

The challenges of the leadership role (at all levels) comprise:

- **Service objectives**, i.e., what leaders are required to do – as set out in local Performance Management (PM) processes.
- **Role-specific knowledge and skills**, i.e., what leaders need to know to do their role – as set out in the Knowledge & Skills Framework (KSF) or Personal Development Plans for senior managers.

The leadership qualities and behaviours that are required to deliver the challenges facing leaders in NHSScotland, with personal qualities at the heart.

As outlined in section 3.0

The model for leadership development recognises that leadership development does not take place in isolation but is critically linked to other processes locally and nationally.

The model also provides scope for development approaches that concentrate on leadership development – enhancing collective leadership capability and leader development – enhancing the development of individual leaders.

The model sets out the strategic context in which leaders across NHSScotland operate.

The leadership role is defined and linked to local processes including performance management, personal development planning and application of the Knowledge and Skills Framework.

Excerpt from Delivering Quality Through Leadership
As a Trainee you will receive regular and timely feedback on your performance at your progress reviews. For this to be effective, there needs to be a clear understanding amongst all the parties involved: the Scheme Manager, Line Manager, Trainee and Mentor/Sponsor. The review process aims to ensure that you are clear about the following:

The objectives and targets you are working to
The level of performance and behaviour expected of you
That you receive feedback on this

And that:

You have the opportunity to give feedback on the management post and placement.
It is important that you take an active part in drawing up your objectives and PDP, with support from others. As a senior manager in the NHS, you will be expected to reflect on your performance and training and development needs and take a proactive role in these reviews.

Framework for review

The review will draw on the job description for the management post or elective proposal, the objectives set for the work to be undertaken and the leadership development framework. The Line Manager, Scheme Manager and Trainee will attend a meeting to review progress within the placement and to identify development needs with you. The mentor may or may not be present. The meeting will be chaired by the Scheme Manager.

Job description and Personal Development Plan (PDP) for first management post

The job description for the first management post must be available by November year 1 (during orientation) at the latest. A PDP should also be drawn up before the first management post, between you and the Line Manager. This should relate to the requirements of the first management post and the knowledge and skills framework for it. You will be able to share your assessment centre feedback as part of the development of this PDP. Good practice with development plans requires you to consider what skills you already have, what the job will require, thus highlighting any development areas you personally may have for the first management post.

The schedule of reviews is as follows:-
Review 1, Year 1 (February)

Purpose
- To review the Trainee’s experience during orientation, education provision and Scheme Manager support to date.
- To review progress in management post 1.
- Draw up a personal development plan (PDP) for the Trainee.
- Discuss elective plans and progress these as required.
- Ensure the Line Manager understands the requirements of the Scheme and the support they should provide to the Trainee.

Review 2, Year 1 (August)

Purpose
- To review Trainee experience and performance during the first management post against agreed objectives.
- Review PDP and progress against the leadership development framework.
- Finalise plans for elective.
- Review mentoring arrangements.
- Early plans for post in year 3.

Review 3, Year 2 (May/June)

Purpose:
This will be a broader review to encompass the Trainee experience on the two year Scheme and make plans for the 3rd year post that the NHS Board will offer the Trainee.
- Review performance in management post 2 against objectives.
- Review PDP and development across whole Scheme.
- Review the 3rd Year post job description.
- Discuss Trainee’s future career plans.
SECTION 4: Employment Information

This section of the handbook has been supplied by NHS Education for Scotland (NES) to provide you with:

- a guide to your terms and conditions of employment
- information on policies and procedures and
- answers to your FAQs relating to your employment.

This information is to act as a guide during your contract with NES. If you require any further information please contact your Scheme Manager or HR contact at NES, as follows:

<table>
<thead>
<tr>
<th>NHS Education for Scotland HR Department</th>
<th>2nd Floor Hanover Buildings</th>
<th>Rose Street</th>
<th>EDINBURGH</th>
<th>EH2 2NN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HR Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Burgess</td>
<td>Senior HR Officer</td>
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<td></td>
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<tr>
<td>NHS Education for Scotland</td>
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<td></td>
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<tr>
<td>2nd Floor Hanover Buildings</td>
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</tr>
<tr>
<td>66 Rose Street</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Edinburgh</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0131 220 8657</td>
<td><a href="mailto:caroline.burgess@nes.scot.nhs.uk">caroline.burgess@nes.scot.nhs.uk</a></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| **Payroll Support**                     |                             |             |           |         |
| HR Officer                              |                             |             |           |         |
| India Thom                              |                             |             |           |         |
| india.thom@nes.scot.nhs.uk              | 0131 220 8603               |             |           |         |

| **Payroll Liaison Officer**             |                             |             |           |         |
| Lynsey Macdonald                       |                             |             |           |         |
| lynsey.macdonald@nes.scot.nhs.uk        | 0131 220 8620               |             |           |         |

NHS Education for Scotland – [www.nes.scot.nhs.uk](http://www.nes.scot.nhs.uk)

NES is a Special Health Board and was created on 1st April 2002 through an amalgamation of the National Board for Nursing, Midwifery & Health Visiting for Scotland (NBS); the Post Qualification Education Board for Pharmacists (PQEB); and the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE).
NES help to provide better patient care by providing educational solutions for workforce development through designing, commissioning, quality assuring and, where appropriate, providing leading-edge learning, education and skills development for all health service employees within Scotland. NES is dedicated to ensuring that NHS Scotland staff teams are given the educational support to help them work together with maximum effectiveness for the benefit of patients.

NES is committed to making equality and diversity part of everything it does. We employ over 750 staff in a variety of employment/flexible working relationships, based across Scotland principally at our Central Offices in Edinburgh but also at locations in Glasgow, Dundee, Aberdeen and Inverness.

Your contract of employment is with NES who act as host employer for the NHS Scotland Management Training Scheme. Management Trainees will follow standard NES HR/Payroll policies, unless stated otherwise on the Contract of Employment. If you have any queries, please don’t hesitate to ask your Scheme Manager or the HR Team at NES.

**Pay and Expenses**

**Salary**

Salary is payable monthly in arrears through the NES payroll by Bank Credit Transfer on the last Thursday of every month. A payslip giving all details of the salary payment is issued individually to the nominated home address.

Trainees are on a national Trainee salary grade, which is reviewed annually. Please note that for the Trainee salary further information can be found in your contract of employment or by contacting HR.

**Payslip**

You will receive your payslip in the week you are being paid. It is important that you keep this in a safe place in case you need to refer to this at a later date. Your Basic Pay will be detailed along with any deductions for tax, NI and pension. Your cumulative salary, NI, tax and pension are also detailed.

If you have any queries on receiving your payslip please contact HR.

**Documentation**

Your P60 is issued at the end of the financial year. This is an important document and should not be destroyed. Duplicate P60s are not allowed to be issued, as per Inland Revenue rules. If you have any problems regarding your P60, contact your local Tax Office.
P45 – these should be given to your new employer on commencement of leaving.

When you complete the Scheme your final salary will be paid in the usual way, with payment for any outstanding annual leave if appropriate, and your payslip will be posted to your forwarding address. Your final payslip will include a P45 and any other relevant documents.

**Pension**

Unless you decide to opt out of the National Health Service Superannuation Scheme, your salary is superannuable. The normal retirement age for all NHS NES staff is 65. The Scheme is contracted out of State Earnings Related Pension Scheme (SERPS) and details of the Scheme should have been sent to you with your contract of employment.

**Expenses**

All expenses incurred by Trainees in relation to their education and development are expected to be claimed in line with NES policy.

e-Expenses is the preferred way of submitting expense claims. It is available only through a connection to the N3 network e.g. from an NHS Scotland server. Trainees just need to complete an Access Application Form and submit to the Scheme Manager. Trainees will then receive log in details & a guide to using the system. The address of the e-Expenses page is: [https://workforce.mhs.scot.nhs.uk/eyou/authentication/login.aspx](https://workforce.mhs.scot.nhs.uk/eyou/authentication/login.aspx)

If Trainees cannot access the NES Intranet then they would need to submit their claims on a paper claim form. If Trainees are claiming mileage a copy of their Certificate of Insurance, which must have Business use included, must be submitted and the Scheme Manager needs to confirm that they've had sight of a valid driving licence & MOT.

Trainees are entitled to:

- claim for reimbursement of actual expenses incurred in travelling in connection with the Management Training Scheme;
- reimbursement of expenses of up to maximum of £700 for electives (see Electives section of this Handbook).

Please contact the Scheme Manager if you have any queries regarding this.
All receipts must be attached by the Trainee when claiming expenses. Failure to attach receipts will result in non-payment of missing items.

HR Policies

Contract of Employment

Your contract of employment is with NHS Education for Scotland, who act as host employer for the Management Trainees.

Work Related/Personal Problems

Any problems relating to your work placement or of a personal nature should be discussed with your Line Manager (in your host Board) in the first instance. However, if you feel it inappropriate to seek their advice, or do not wish to do so, then you should contact your Scheme Manager or NES HR Team for advice and support.

Leaving the Scheme

Upon leaving the Scheme you will be invited to attend an exit interview with the Scheme Manager. In the event of resignation from the Scheme, a formal letter of resignation is required, addressed to your Scheme Manager.

Annual leave

The leave year runs from 1\textsuperscript{st} April to 31\textsuperscript{st} March and you are entitled to the following annual leave entitlements:

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>Annual Leave Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>On appointment</td>
<td>202.5 hours (27 days)</td>
</tr>
<tr>
<td>After 5 years service</td>
<td>217.5 hours (29 days)</td>
</tr>
<tr>
<td>After 10 years service</td>
<td>247.5 hours (33 days)</td>
</tr>
</tbody>
</table>

Annual leave entitlement is based on aggregated NHS Service.

In addition you will be entitled to 8 public holidays per leave year, pro rata for part-time staff.

During the year of entering or leaving NHS NES, annual leave will be in proportion to completed months of service. Annual leave should be booked in agreement with your Line Manager.
Sickness

In the event of absence from work due to sickness you must notify your Line Manager.

1. Trainees should fill out the appropriate form (either the form in this handbook or by connecting to the NES intranet) and press "submit" which will attach in an email.
2. They should email to their manager who can then electronically sign.
3. Once both parties have signed it can be submitted to CO.Absence@nes.scot.nhs.uk. Alternatively, it can be done in hard copy which can be posted to HR at Rose Street.

You should give the specific reason for absence. A broad description of the illness should be given, please note that ‘sick’ or ‘ill’ is not sufficient. You should also give the expected duration of absence and date of return. If you are unable to return on the day as indicated, you are required to follow the normal procedure by informing your Line Manager.

If absence occurs during a recognised Statutory or Public Holiday, there will be no reimbursement of the holiday. Discretion may be exercised to reimburse annual leave during which a period of sickness absence occurs, however, the actual period of sickness must be medically certificated before any reimbursement can be given.

Sickness Certification:

- 1 – 7 calendar days absent – complete a Return to Work and Self Certification Form (see example at the end of this section). An electronic version is available from NES HR. You will need to complete the relevant sections and then press "submit" which will put the attachment in an email. You then need to send it to your manager who can then electronically sign. Once both parties have signed please submit to CO.Absence@nes.scot.nhs.uk and cc in the Scheme Manager. Alternatively you can complete a hard copy which can be posted to HR at Rose Street.

- 8 calendar days or more – in addition to the above you must obtain Statement of Fitness for Work from your doctor to cover the period of your absence which is in excess of 7 calendar days. This should be sent directly to your Line Manager marked ‘Addressee Only’ on the 8th day of absence with any subsequent Statements of Fitness for Work (Fit Note) as soon as possible after your doctor’s appointment. It is the employee’s responsibility to ensure that the timing of their doctor’s appointment allows them to fulfil their responsibilities in terms of submitting a medical certificate. This must then be forwarded to NES HR.

- Failure to provide correct and valid certification may be classed as unauthorised absence and may result in a deduction in payment and disciplinary action being taken.
**Hospital In-Patients/Emergency Admissions**

If you have to go into hospital as an in-patient instead of submitting periodical medical certificates, you should submit a self-certificate on entry, and where the incapacity lasts for more than 7 calendar days, a medical certificate on discharge.

**Medical and Dental Appointments**

Staff who are on a flexi-time system are expected to arrange medical and dental appointments outside core times. However, in exceptional circumstances, and subject to management consent, credit can be given to staff who need time off during core times to attend a medical or dental appointment.

If the appointment is likely to overlap into core time, you should inform your Line Manager of your appointment and seek approval for time off work.

You will be entitled to receive sickness payments in accordance with both the Statutory Sick Pay Regulations and the Occupational Sick Pay provisions as contained in the Agenda for Change Terms and Conditions of Service Handbook Section 14, subject to observance of current local procedures for reporting sickness.

**Health and Safety**

Please refer to the NES Health and Safety policy which was given with your contract of employment.

**Frequently Asked Questions**

Q – My previous employer has given me a P45, what do I do with it?  
A – You should retain part 1A for your own record. Parts 2 and 3 should be sent to HR at NES.

Q – When does my salary increase?  
A – Your incremental date is the anniversary of your start date each year of the Scheme, in line with nationally agreed recommendations.

Q – How can I obtain further information about the NHS Scotland Pension Scheme?  
A – Further to the guide issued with your contract, you can obtain information from the Scottish Public Pensions Agency (SPPA) website: [http://www.sppa.gov.uk/nhs/home.htm](http://www.sppa.gov.uk/nhs/home.htm), contact them at 7 Tweedside Park, Tweedbank, Galashiels, TD1 3TE or telephone 01896 893000.
Q – What happens at the end of the Scheme?
A – As you are on a fixed term contract, there is no need to give notice, unless you intend leaving the Scheme early.

Q – What if I resign before the end of the Scheme? Will I be liable for any educational/professional fees?
A – Should an employee leave the NHS Scotland during the academic year on a voluntary basis or be dismissed, they may be required to refund all current associated financial assistance.
NHS Education for Scotland

NOTIFICATION OF INCAPACITY FOR WORK

SELF CERTIFICATION FORM

This certificate must be used for periods of incapacity of up to 7 calendar days (including weekends and public holidays, even if you would not normally work on these days.) The form must be completed on the day of return to work and forwarded to NES HR without delay.

Name: ..............................................................................................................

Post held: ...........................................................................................................

Department: ........................................................................................................

First day of incapacity: ...........................................................

Last day of incapacity: ..........................................................

No of work days absent: ..........................................................
(including part-days)

Please indicate when your department was informed of your absence: .................. (Date)

Reason for absence (please note ‘sick’ or ‘ill’ will not suffice):

..........................................................................................................................

..........................................................................................................................

..........................................................................................................................

..........................................................................................................................

Did you consult your doctor? YES / NO (delete as appropriate)

Return to work interview carried out? YES / NO (delete as appropriate)

NOTE: For periods of incapacity in excess of 7 calendar days, a doctor’s certificate is required. The certificate should be sent to the local HR Representative as soon as possible to avoid delay in the payments due.

Signature of Employee: .................................................. Date: ......................

Signature of Line Manager: .................................................. Date: ......................
This section outlines some guidance for everyone who has a role with the MTS. The first policy (NHS Scotland MTS Policy) is something everyone should make themselves familiar with.

The subsequent guidelines are specifically for Host Boards or for General Management Trainees. You should contact the Scheme Manager if you would like further clarification on any part of this.

### NHS Scotland Management Trainee Scheme Policy

1. **Introduction**

   1.1 The NHS Scotland Management Trainee Scheme exists to grow highly skilled professionals who have the potential to go on to achieve senior leadership positions to improve Healthcare. NHS Scotland aims to foster an organisation that promotes the proper conduct of public business, empowers, develops and supports staff, and delivers excellence and best value in the provision of its services.

   1.2 As part of the commitment to deliver work of the highest quality and to adopt the best professional standards and practices, NHS Scotland offers two versions of the Scheme (General and Financial), including financial support, under the terms detailed in this policy. The purpose of the Scheme is to support staff during the training period and to equip them with the necessary skills and experience to become effective professionals on qualification.

2. **Training Programme**

   2.1 The Scheme will provide training and development, which will offer practical work experience together with support for academic studies. Successful completion of the academic element of the Scheme will lead to an opportunity to transfer to an open-ended contract.

   2.2 A designated member of the National Leadership Unit (NLU) team will have a key role in the application of the Scheme, coordinating individual training plans, regularly reviewing progress and annually providing details of Trainee reviews to management. That person (referred to throughout as the Scheme Manager) will maintain contact with the colleges to ensure that
the academic progress of Trainees is taken into account in the assessment process. Progress made will also be monitored as part of the Personal Development Plan & Review (PDP&R) system with appropriate managers.

2.3 Trainee positions will be advertised internally and externally as required. Applicants must meet the minimum entry requirements:

- Possess a minimum of a 2:2 degree in any subject or
- Post graduate qualification (MBA, Masters, PhD)

2.4 The NHS Scotland supported qualification for Finance Trainees is membership of the Chartered Institute of Public Finance and Accountancy (CIPFA).

The NHS Scotland supported qualification for General Trainees is an MSc in Leadership & Healthcare Management.

2.5 NHS Scotland will meet the costs of course fees and associated fees, including registration, examination, professional membership and exemption fees. Travel and subsistence expenses will be met for education and learning events in accordance with NHS Scotland’s travel and subsistence policy.

Financial assistance will be granted on the basis of one attempt at each module of the professional examination. Any additional re-sits will be at the discretion of the Director of Finance/Chief Executive and Scheme Manager. These will only be granted in exceptional circumstances and will be undertaken in the Trainees’ own time and at their own expense.

A personal mentor will be appointed to each Trainee. The role of the mentor will be to provide guidance when necessary on training issues and be available to discuss any problem areas with regard to college or work based training. Issues which cannot be resolved by the Trainee’s mentor will be referred to the Scheme Manager.

Time off will be given for attendance on appropriate courses for course subjects during the normal working day for the period of hours corresponding with the duration of the session. This includes necessary time for travel between place of work and the study centre.

Study leave entitlements for FMTS are set out in Appendix 1 for Finance Trainees. Trainees will have reasonable access to computer equipment and other workplace facilities to assist in undertaking course work. Any loss or damage to equipment when not in the workplace will be paid for by
the Trainee. Trainees may wish to check that their house contents insurance covers such loss before taking equipment out of the office.

Time off will be given for attendance at examinations when they occur during the normal working day.

3. Work Experience & Personal Development

3.1 Trainees will be provided with an initial broad based training programme which will indicate the training placements planned during this timescale.

3.2 The Induction is designed to give a general, but comprehensive, introduction to the strategy and operations of NHS Scotland, including the facilities and support available to Trainees.

3.3 Placements will be agreed between the Scheme Manager and host Board and will take account of the resource needs of the teams and the work experience of the Trainee. The training programme will be flexible and may be amended in accordance with departmental work and resource priorities.

3.4 For each placement, the Trainee, Placement Co-ordinator and Line Manager will develop a Personal Development Plan & Review (PDP&R) which will provide details for the key areas for which training will be provided and will be based on criteria identified within the Scheme. The PDP&R will also indicate to whom the Trainee will report during the placement.

4. Assessment

4.1 All Trainees will be subject to continuous assessment including the NHS Scotland’s PDP&R. Trainees will be monitored and supervised throughout the programme and will have ample opportunity to discuss their progress.

4.2 Assessment will cover academic studies, proficiency in the workplace and personal competencies. Assessment will be based on the agreed competencies and skills, taking into account performance on work placements, personal effectiveness and approach to academic studies.

4.3 Failure to meet the academic standards set by the Professional Institute or the work experience criteria set by NHS Scotland may lead to a Trainee being required to leave the programme.

4.4 Finance Trainees are allowed one full re-sit per stage of the CIPFA qualification (one at Certificate, one at Diploma and one at FTPC stage).
The Trainee’s overall progress will be assessed at this time and the Trainee will remain on their salary point until examination success is achieved. If the re-sit is successful, a full assessment of progress in relation to other criteria of the Scheme will be made. If this is satisfactory, the Trainee will be recommended for progression within the Scheme. If examination success is not achieved, the Trainee’s position within the Scheme will be reviewed, taking into account any extenuating circumstances.

4.5 Trainees may achieve success in examinations, but fail to achieve the required progress within other defined progression criteria of the Scheme. Through continuous assessment, Trainees will be made aware of these areas and support will be given to assist with development. If satisfactory progress is not achieved to enable recommendations to be made for salary progression, the Trainee will remain at their salary point until such time as the Trainee achieves the required standard. If the required standard is not achieved, the Trainee’s position within the Scheme will be reviewed.

4.6 If the Trainee achieves examination success in their final year, but fails to achieve in other defined criteria of the Scheme, the Trainee will receive their salary increase in recognition of examination success but they will not be eligible to apply for a promoted open-ended post. The Trainee will continue to participate in the Scheme and the Scheme Manager will regularly review progress. If the required standard is not achieved, the Trainee’s position within the Scheme will be reviewed.

4.7 Where a Trainee is consistently not achieving satisfactory progress and/or does not satisfactorily complete the approved course of study and/or practical training he/she will be removed from the Scheme. In such circumstances, the Trainee may be subject to the Board’s disciplinary procedures.

5. Recruitment and Selection Process

5.1 Recruitment will be carried out centrally, reflecting the fact that Trainees are a corporate resource to the NHS in Scotland. The recruitment process will consist of a robust and objective assessment of the capability and potential of applicants, with a view to maximising success in professional examinations and achieving workplace-based competencies.

5.2 As an equal opportunities employer, NHS Scotland will ensure that the assessment process does not discriminate on the grounds of race, ethnic origin, gender, sexual orientation, disability or age.
6. **Contract of Employment**

6.1 Trainees recruited externally for the MTS will be employed on a fixed term training contract for the duration of the training programme.

6.2 Finance Trainees will be issued with a contract for 36 months. General Trainees will be issued with a contract for 24 months. There will be scope for an extension to cover exceptional circumstances. Any extension must be approved by the Scheme Manager and Director of Finance or Chief Executive of the host Board.

6.3 As the programme will involve placements in different parts of the organisation to ensure relevant work experience, all Trainees will be expected to be mobile. NHS Scotland will provide relevant financial assistance, where necessary, and will seek to consider the personal circumstances of the Trainee.

6.4 Trainees will enjoy the same conditions of service as staff on open-ended contracts in respect of basic annual leave, flexible working, maternity leave, access to pension membership and sickness benefit.

6.5 Exam failure or failure to achieve a satisfactory assessment in any other component of the programme or work environment may give rise to NHS Scotland withdrawing support and the Trainee’s contract of employment being terminated. Trainees will be given notice of contract termination.

6.6 In exceptional circumstances, a Trainee who has received excellent work assessments but is unable to gain the required academic passes may be offered an alternative post within the organisation provided a suitable vacancy exists.

6.7 Should an employee leave the NHS Scotland during the academic year on a voluntary basis or be dismissed, they will be required to refund all current associated financial assistance. The academic year being the 12 month period beginning on the date of commencement of the course.

6.8 NES recognises that individual circumstances vary and it is within the discretion of the Head of Organisational Development/Chief Executive to waive or decrease the level of repayment costs based on recommendations from the appropriate Functional Director/Line Manager.

6.9 NES will not require the repayment of financial assistance where an employee is required to leave the organisation on an involuntary basis arising for example through redundancy or relocation.
7. **Our Commitment to You**

7.1 Our Management Training Scheme is designed to equip you to become a fully qualified professional Accountant.

7.2 The Scheme is about more than the professional qualification. It will provide you with relevant practical experience that can be applied both to your studies and to the development of your career as a qualified professional with the NHS.

7.3 We will reward you for your success in the Scheme through accelerated salary progression.

7.4 We will pay your course and exam fees, student membership and expenses for materials, subsistence and travel.

7.5 We will provide you a high level of non-financial support in the form of a Scheme Manager, mentor and Placement Co-ordinator as well as time off for college/university and exam attendance.

8. **Trainee Responsibilities**

8.1 Trainees are responsible for managing their own learning and career, and for taking full advantage of the personal and professional development opportunities made available by NHS Scotland.

8.2 Trainees will be expected to make a personal commitment to pursue diligently all the requirements of their studies (including any associated institutes) and NHS Scotland.

8.3 Trainees will be expected to follow the required course of study including attendance at college in the form of block/day release and any other courses or workshops deemed appropriate. This includes action learning set and the wider development programme.

8.4 Financial Trainees will make themselves available for external examinations each year, at the time and place determined by the training provider.

8.5 Trainees will complete all course assignments, projects and reports to agreed timescales.

8.6 Trainees are expected to prepare for and endeavour to achieve success in their annual examinations or assessment.

8.7 Trainees should not absent themselves from college or courses without the prior consent of their Line Manager.
8.8 Each Trainee will provide constructive feedback on each placement. Finance Trainees will maintain and update their CPD log book, which will be countersigned by their Line Manager. The placement feedback will also provide evidence toward the assessment of competence in written work.

8.9 Trainees should seek advice from their Scheme Manager in the first instance on any matters arising from their course of study, placement, assignments, projects or reports.

8.10 Trainees will be expected to adopt a professional approach both when at work and when undertaking studies at college/university etc. Trainees must always bear in mind that they are a representative of NHS Scotland and their institute/tuition provider.

8.11 Trainees must be prepared to complete the whole Scheme, after which they will be expected to apply for vacant posts with the NHS.

9. Salary – Range and Progression

9.1 Trainees will have access to accelerated salary progression provided satisfactory progress is met on all academic requirements, practical work experience and demonstrated skills and competence.

9.2 Normally a review meeting with the Scheme Manager will be held within two weeks of the examination results being known. A decision will normally be communicated to the Trainee within a further two weeks.

9.3 The salary scale for Trainees is Agenda for Change band 6. Salary progression over the training period of the programme will allow for progression to designated scale points as set out below.

<table>
<thead>
<tr>
<th>Completion Stage</th>
<th>Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>On entry</td>
<td>65% of band 6 max</td>
</tr>
<tr>
<td>Completion of first stage</td>
<td>70% of band 6 max</td>
</tr>
<tr>
<td>Completion of second stage</td>
<td>75% of band 6 max</td>
</tr>
<tr>
<td>Completion of third stage</td>
<td>80% of band 6 max</td>
</tr>
</tbody>
</table>

9.4 In the event that the Trainee fails to meet the criteria for salary progression as set out above, they will be entitled to the normal annual increments but limited to the particular salary placement at the time.
10. **Promotion**

10.1 On completion of the Scheme, Trainees are eligible to apply for an open-ended established post. Pending appointment to a vacant post, normal incremental progression on the scale will apply.

10.2 NHS Scotland does not guarantee an appointment at the end of a Trainee contract although it is usual for successful Trainees to secure an open-ended position, subject to competent work performance, qualification and sufficient vacancies being available.

10.3 Promotion to an open-ended position is subject to a recommendation concerning work performance/suitability and may also be subject to competitive application using appropriate selection tools.
APPENDIX 1
STUDY LEAVE ENTITLEMENTS FOR FINANCIAL MANAGEMENT TRAINEES

First Sitting

<table>
<thead>
<tr>
<th>Number of Subjects</th>
<th>For each subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Leave</td>
<td>1 day</td>
</tr>
<tr>
<td>Pre-Exam Leave</td>
<td>1 day</td>
</tr>
<tr>
<td>Mock exam*</td>
<td>1 day</td>
</tr>
<tr>
<td>Course Time</td>
<td>According to agreed educational establishment timetable</td>
</tr>
<tr>
<td>Open Learning</td>
<td>2 days</td>
</tr>
</tbody>
</table>

* This will equate to up to 2 days study leave for each subject:
  ✓ Tuition phase mock = 1 day per module
  ✓ Revision phase mock = 1 day per module

Second Sitting

<table>
<thead>
<tr>
<th>Number of Subjects</th>
<th>For each subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Leave</td>
<td>1 day</td>
</tr>
<tr>
<td>Pre-Exam Leave</td>
<td>1 day</td>
</tr>
<tr>
<td>Course Time</td>
<td>According to agreed educational establishment timetable</td>
</tr>
</tbody>
</table>
For Host Boards

Becoming a Host Board: Placement Guidelines & Criteria

1. Introduction

This document outlines what NHS Boards will need to put in place to host a management Trainee and issues that will need to be considered. It provides the information you need to submit an expression of interest and details the stages involved. It sets out what is required at each stage of the Scheme and identifies the players and their roles. Thank you for your support and interest in the Scheme.

2. Process for expression of interest

Your expression of interest should be sent to Elaine Lawther, Scheme Manager at elaine.lawther@nes.scot.nhs.uk. The Scheme Steering Group will review these and get back to you as soon as possible with comments and suggestions. The final assessment centre will select up to eight successful candidates in late March and it is intended that they will start the Scheme at the beginning of September of the same year with a national induction. During April it is our intention to consider the allocation of placements and Trainees, following the results of the selection process.

Expressions of interest should take the form of a short document (two or three pages only) outlining the nature and purpose of the placement you can offer, the jobs you are proposing for that Trainee, the support processes and resources you will put in place. It should also outline your commitment to offering the Trainee a one-year 3rd Year post at the end of the two-year Scheme. You will need to identify the sponsor (usually the Chief Executive or a senior manager) and the Placement Co-ordinator.

3. Programme Outline

NHS Scotland offers up to eight places per year on its Management Training Scheme. Successful applicants will be offered a management training post with a host NHS Board for two years, followed by at least one year’s substantive employment with that organisation.
4. Education Provision

The Trainees undertake a Masters in Leadership & Healthcare Management, supported by action learning sets and a variety of events delivered within Scotland. The learning sets will be shared with Specialty Trainees.

Trainees are expected to attend all aspects of the learning and education programme. The timetable for the education programme is published in advance and each Trainee will know when they will be away from the host NHS Board. They will need broadband internet access to make best use of the e-learning component of the programme and it is expected that they will be able to access this from their place of work.

5. Placement Evaluation Criteria

We would expect to see the following aspects reflected in your expression of interest:

a) Management Posts

♦ Management posts that offer them the opportunity to have responsibility for people, services and resources. Real jobs - not projects.
♦ The placement as a whole needs to offer a range of experience - operational and strategic across a range of settings i.e. within acute, primary care, CHP, networks, - not to spend two years in one part of the organisation.
♦ Exposure to the strategic planning of the organisation as well as operational issues.
♦ The opportunity to present to the Board following key milestones in the placement, i.e. findings from elective, impressions after orientation etc.
♦ Sufficient exposure to inter-agency working and all aspects of the health and social care system (more than just orientation).
♦ Commitment to contribute to progress reviews and report to the MTS Steering Group.
♦ Commitment to offering a challenging 3rd Year post for one year following the Scheme (this might be collaboratively with a nearby Board).

b) Support

♦ Identify a sponsor who is the Chief Executive or a very senior manager within your organisation (please provide a short CV).
♦ Regular meetings with Chief Executive or senior manager acting as sponsor.
♦ Explicit support and permission for Trainees to attend ALL education provision as detailed in the programme of activity.
c) Access

♦ Access to work station, computer and broadband.
♦ Line management support, appraisal and development consistent with any other manager working within your organisation.
♦ Indicate who will be the Placement Co-ordinator and their skill set for the role (please provide a short CV).
♦ Shadowing senior managers and Chief Executive as appropriate.

We welcome expressions of interest both from individual NHS Boards or NHS Boards working collaboratively, perhaps utilising the Regional Planning links, if this leads to an innovative and well designed placement that meets the above criteria.

6. Structure of the Scheme

The following section is a more detailed outline of the intended structure of the placement and your role within it. The end of each section lists in italics the information you need to provide us with.

The two year placement (overview)

<table>
<thead>
<tr>
<th>Year 1</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>NHS Orientation</td>
<td>3 months</td>
<td>Sept – November</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Management Post 1 (operational role)</td>
<td>9 months</td>
<td>Dec – August</td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 3</td>
<td>Elective (possibly inter-agency)</td>
<td>3 months</td>
<td>Sept – Nov</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Management Post 2 (strategic)</td>
<td>9 months</td>
<td>Dec – Aug</td>
</tr>
</tbody>
</table>

| Year 3          | (Trainee has graduated from Scheme) 3rd Year post | One year (minimum) |

6.1 Stage 1: Orientation (First three months)

Purpose
The purpose of the orientation is to give Trainees the broadest overview of the health service possible; it is not primarily about learning management issues. It is an induction into NHS Scotland and your health and social care system. The orientation should focus on giving Trainees the opportunity to learn about the nature and pattern of health and health service delivery and the issues arising. Emphasis will be on both how the NHS operates as an entity and how the various components contribute to the improvement of health and delivery of health and social care. Trainees will also begin
to develop their knowledge and experience of the Service’s many and varied professional groups and functional departments. It is also essential that they begin to gain some knowledge and experience of your partner organisations, service challenges and strategic direction. The orientation is organised and provided by the host organisation, to give Trainees an introduction to health and social care as viewed through the eyes of the care givers, patients and partner organisations.

The recommended model of delivery is the concept of the ‘Patient Pathway’, whereby the Trainee shadows a patient’s experiences from entry into the NHS. The Trainee’s observations and experiences can therefore be linked to key issues affecting the delivery of care, for example, quality of care provided by multi-agency initiatives. One suggested route is to follow a patient’s progress through the system (patient to be consulted and consent to be obtained in advance). As well as the organisations and departments encountered by patients, orientation should also include experience of inter-agency working and partner organisations.

It is also useful towards the end of the orientation period for Trainees to meet with their Line Manager and the people they will be working with in the first placement.

The level of past experience that the Trainee brings should be taken into account in the final design of a suitably worthwhile and challenging programme.

*The expression of interest needs to outline the programme you propose for this stage, demonstrating the blend of opportunities and partners.*

### 6.2 Stage 2: Management Post 1 (nine months)

**Purpose**
The first placement must be a real job (not a project), where the Trainee can gain valuable experience in the management of services, people and resources with strong line management support and guidance. It is essentially an operational management role. Examples of the sort of role that a Trainee might undertake would be an operational role within a service area, clinical directorate or CHP. This should involve some responsibility for staff and might include experience in an area undergoing service improvement, such as waiting times. The Trainee also needs to understand the strategic context within which they are working, particularly early on in the Scheme where their role will be operational.

You will need to give some early thought to the elective project with the Trainee during this stage.

This is an opportunity to think creatively about how arrangements could be designed to support the development of another manager e.g. seconding a substantive manager to undertake a different piece of work within the organisation which will be
developmental and refresh them, and so creating a real opportunity for a Trainee to have an operational job.

*Your expression of interest needs to include a job description and a short CV for the Line Manager. Where will the Trainee be and what support will they be provided with? Will they have access to a work station and broadband?*

6.3 Stage 3: The Elective (maximum of three months)

**Purpose**
The work the Trainee undertakes during this stage of the placement will contribute to their dissertation for the masters (guidelines are provided from the Learning & Development Partnership.) Essentially it is an opportunity to work on a live project in a significant role. This might be a service improvement initiative or a review or scoping study. It might be the formulation of a business case for an investment on behalf of the organisation. We would welcome and, indeed, encourage innovative electives that exploit inter-agency working. The Trainee might well be based with a partner organisation for part of the elective, if not all of it. It is important that it is seen as a chance for them to gain wider experience in a different arena; both organisationally and with regard to the nature of the service. We would encourage Boards and Trainees to use this opportunity to spend time in a **Special Health Board** or a **remote Health Board** area.

Support and guidance for the dissertation will be provided by the education provision team.

*Please indicate your ideas at this stage – no firm elective project may be available as yet.*

6.4 Stage 4: Management Post 2 (nine months)

**Purpose**
The final part of the Scheme should expose Trainees to a more strategic role within the health and social care system. This might involve a planning or service improvement job, and may involve working across organisational boundaries, e.g. managed clinical networks. The level of responsibility and scope of the second placement should be greater than that of the first placement. It should be suitably challenging. It also needs to expose the Trainee to a different part of the organisation.

It is important to balance the content of each stage of the Scheme – first placement, elective, etc. so that the Trainee receives a rounded and comprehensive experience.

*Please provide an outline job description and short CV of proposed Line Manager.*
6.5 One year (minimum) 3rd Year role post Scheme

Following successful graduation from the Scheme, it is a requirement that the host organisation will act as the employer for the individual by offering a one-year post (minimum). The nature of this post will depend on the type of role you and the Trainee consider best suits their abilities and aspirations. It must, however, be validated by the Scheme Manager to ensure that it offers continued development at an appropriate level.

*It is not necessary to provide detailed information about what this post might be at this stage but you will need to confirm your commitment to there being one.*

7. Roles

The sponsor
This is usually the Chief Executive or a very senior manager within your organisation. Their role is to ensure that your organisation has set up the necessary support systems and processes as outlined in this document. He or she will also keep in contact with the Trainee and meet with them regularly. This may be informal but there will be a more formal progress review with the Scheme Manager, Line Manager and sponsor twice a year. The sponsor will also invite the Trainee to attend Board meetings or shadow them when appropriate and in particular, if it would be considered to be developmental so to do. They may also act as a mentor to the Trainee.

The sponsor needs to be committed to the Scheme and the Trainee. They need to have considerable experience of the NHS and be working strategically.

*Please provide a short CV for the sponsor and their experience in this area, and outline the practical steps that will be taken, i.e. how often they propose to meet with the Trainee, what access the Trainee will have to Board level events and exposure to strategic thinking of the organisation.*

The Placement Co-ordinator

This needs to be someone in your organisation who will take responsibility for designing the orientation and co-ordinating arrangements for the different job placements. They will need to ensure that the Trainee has a desk and computer (broadband access). The Placement Co-ordinator will be the point of contact for the Scheme Manager and arrange for progress reviews to take place. It is envisaged the Placement Co-ordinator may well be the person who prepares the expression of interest. Familiarisation with your organisation’s HR policies, information systems and health and safety procedures and should take place during the orientation period.
They need to have good organisational skills, access to a wide range of people within
the organisation and be committed to the Scheme.

*Please provide a short CV for the individual outlining their experience for the role and
the skill set they bring to it.*

**Line Manager**

The Line Manager for the first and second work placement and the elective may well
be different. Good line management is the key to a good Trainee experience. Line
managing a Trainee should not differ from good staff management practice with any
other member of staff. Trainees will need to develop objectives and a personal
development plan for each placement while on the Scheme. They should receive
feedback via the appraisal process. Access to in-house courses and information that
complement their education provision, should be offered where necessary.

*Please provide short CVs for each of the Line Managers for the two management
posts.*

**The Scheme Manager**

The Scheme Manager (Elaine Lawther) is based at the NHS Education for Scotland,
and works closely with the service to implement the NHS Scotland Management
Training Scheme. Elaine is responsible for the marketing, recruitment and running of
the Scheme. She works closely with NHS organisations on placements for Trainees.
She is also a resource for your organisation in support of the placement. The
Scheme Manager will monitor Trainee progress on the Scheme and will work closely
with you in order to do this.

**The Steering Group**

The Scheme has a steering group composed of a range of senior managers from the
NHS and leadership experts (some of them past Trainees). Their role is to provide a
stakeholder input and strategic direction for the Scheme. They will review all
expressions of interest for placements, although the Scheme management team will
be responsible for the evaluation outcome.

8. Additional information

**Salary and Expenses**

Any expenses incurred while on the Scheme, may be claimed back in line with the
NHS NES Travel and Subsistence Policy.
Working environment

It is important that the Trainee has a desk, a computer and access to broadband, plus any equipment or resources they will need to effectively execute the placement.

FINALLY…..

The Scheme cannot operate at all without the commitment and contribution of NHS Scotland and its staff. Thank you very much for taking the time and trouble to participate and support the Scheme by offering a placement. Your organisation, its staff and your services will benefit, as well as the Trainee. This short document provides information which we hope you will find useful. Its purpose is to enable you to put in place the processes and support necessary to ensure the placement is a success for the Trainee, the Scheme and your organisation. It is intended that this is a developmental process that we engage in together.
This is the individual who is based in the host NHS Board and who provides important administrative and management support to the Trainee’s placement. The role provides a lynch pin for the Scheme within the Board. The practical duties include organising the orientation, setting up the two management posts and liaise with the Scheme Manager. They need to be familiar with the placement guidelines and ensure that twice yearly progress reviews take place.

Much of the role will involve you in liaising with many different people in your board (especially when organising the orientation) to ensure that the placement works effectively. It is important that this role is not delegated to individuals who are too junior to have the credibility or connections to make things happen. You may wish to delegate some of the administrative work associated with this role, but it is important for it to be effectively managed by someone sufficiently senior in the organisation.

The placement must meet the criteria set out in the guidance and application document.

A progress review takes place twice a year with the Trainee, Scheme Manager, Line Manager and placement coordinator present. The purpose of this to ensure that the placement is working effectively for the Trainee and for the host organisation, to make plans for the next stage of the placement and to establish objectives for the Trainee and make any improvements that might be necessary to the way the placement is being conducted.

Each year a briefing event is held for Line Managers, placement co-coordinators and mentor/sponsors to come together to be updated on the Scheme and to share good practice with one another. You will be reminded by the Scheme Manager when these are due (refer to the Scheme Handbook for the schedule) and expected to ensure everyone can get together for 1.5 hours to conduct this review. It is usually held on health board premises.

As placement coordinator you will copy reports, progress reviews and any documents relating to the Scheme to the Line Manager and mentor/sponsor as required. You are also encouraged to take part in some of the recruitment and selection process running from January to the end of March each year.

Experience of over 5 years of the Scheme strongly indicates that the placement coordinator is essential to the smooth running of the placement. This is particularly so during the first few weeks of the orientation when the Trainee is new, perhaps “green” and certainly anxious to make a good impression but also very hungry to learn and see as much as they can of the health system of which they will be a part. So another aspect of the role is being there to respond to queries and questions during that time.
Line Manager Guidance

Each management post will find the Trainee working to a Line Manager in the normal way. Research from other schemes tells us that this relationship is key to the perceived success of any placement with an NHS Board. Usual line management support, such as objective setting and appraisal, development opportunities and feedback, will apply.

The Line Manager will provide direction and advice relevant to the management post and support the Trainee’s growing understanding of the operational and strategic issues. Trainee feedback is that they value the relationship with the Line Manager when it is supportive while providing direction and clarity on the role. The Trainees we recruit tend to be a mixture of graduates with work experience (some in-service) and new graduates. So you may have an individual who is very new to the world of work and the NHS or someone who brings other experience with them.

Whatever their background, the NHS is a complex and often impenetrable organisation. Part of your role will be to help the individual navigate through the job role making sense of how best to prioritise the work, focusing on what matters, learning how to manage people (sometimes difficult people) and relate to other managers within your area. They need stretching but not breaking. You will find this a rewarding line management responsibility. Thank you for contributing to the future.

A progress review takes place twice a year with the Trainee, Scheme Manager, Line Manager and placement coordinator present. The purpose of this to ensure that the placement is working effectively for the Trainee and for the host organisation, to make plans for the next stage of the placement and to establish objectives for the Trainee and make any improvements that might be necessary to the way the placement is being conducted.

The Trainee and Line Manager will assess the Trainee performance against the competence framework. The purpose of this is to provide feedback and monitor Trainee development but also to ensure that the overall two year design of placements will provide sufficient experience and coverage of the competences outlined.

The placement coordinator within your Board, who administers and organizes the Trainee’s placement, will copy you into reports, progress reviews and any documents relating to the Scheme that you will need to read.

Line Managers are also encouraged to take part in some of the recruitment and selection process running from January to the end of March each year.
During the 50 years of the Management Training Scheme in the UK, the mentor role has been present in one form or another. The mentor is part coach and part “sponsor” for the Trainee within the host board. It is essential that the mentor is senior (ideally the Chief Executive) enough to be able to act as an effective sponsor for the Trainee and to ensure they gain the exposure and experience they need.

The Trainee gets some coaching as a component of their education programme but this is inadequate in terms of amount. You as mentor within the organisation have a crucial role in helping the Trainee navigate through the politics and culture of your particular board. You will have been chosen because of your seniority, skill and willingness to nurture future leaders. You will also be keen to expose the Trainee to key events and people within the Board and beyond – perhaps shadowing senior managers, attending a Board meeting, partnership forum etc. You will have the organizational savvy to know what these events are and who the key players are.

The mentor also acts as a sounding board for the Trainee. He or she can bring to you work dilemmas and role challenges that they wish to discuss. The mentor should listen first to understand and then coach and sometimes advise the Trainee on the best course of action. You are both a guide and a sounding board.

A progress review takes place twice a year with the Trainee, Scheme Manager, Line Manager and placement coordinator present. The purpose of this to ensure that the placement is working effectively for the Trainee and for the host organisation, to make plans for the next stage of the placement and to establish objectives for the Trainee and make any improvements that might be necessary to the way the placement is being conducted.

The placement coordinator within your Board, who administers and organizes the Trainee’s placement, will copy you into reports, progress reviews and any documents relating to the Scheme that you will need to read.

You are also encouraged to take part in some of the recruitment and selection process running from January to the end of March each year.
1. Background

As part of the two plus one year structured programme on NHS Scotland’s General Management Training Scheme, Trainees undertake a two to three month “elective”. This provides an opportunity for Trainees to broaden their leadership and management experience in a different setting and learn transferable skills that can be brought back into the NHS. The elective is intended to be a positive learning experience that enhances and builds upon all elements of the MTS Scheme.

Trainees are encouraged to work with their host Health Board and Scheme Manager to set up their elective placement and project, as this is a unique opportunity for them to design a management or research experience for themselves. Trainees may spend their elective in partner healthcare organisations, special health boards, local or central government departments, and possibly voluntary organisations. Trainees may go abroad with the support of their Board and the Scheme. Electives may involve undertaking a management role, a project, a piece of research or period of study, and can provide an important comparative dimension in the Trainee’s experience of leadership and management and/or healthcare. It is important that the elective provides stretching personal development and learning for the Trainee and contributes positively by widening knowledge and sharing best practice within NHS Scotland and its partners.

Traditionally, the elective experience has been a demanding and very productive experience for Trainees, who learn and grow through both the organisational exposures and the personal demands involved in organising, planning and taking responsibility for their own elective. The Scheme Manager receives proposals from Boards during the year for electives, and will share these with you. However, it is important that the Trainee takes personal responsibility for the elective to ensure high levels of motivation.

2. Timing

The two year placement (overview)

<table>
<thead>
<tr>
<th>Year 1</th>
<th>NHS Orientation</th>
<th>3 months</th>
<th>Sept – November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Management Post 1 (operational role)</td>
<td>9 months</td>
<td>Dec – August</td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The elective period lasts three months maximum and almost always takes place at the start of year two of the MTS programme, that is between September and December. The elective involves Trainees in spending time in another organisation, gaining experience and insights into leadership and management in a different context.

Trainees may choose to spend their entire elective in one organisation or divide it between two organisations, but the whole elective period should last no longer than three months. In selecting their elective, Trainees are encouraged to ask first what they want to focus on – the location should be driven by this main consideration. Trainees will be supported in their choice if there is a strong case for them to visit place x or place y, in order to study best practice.

The Placement Guidance which went out to NHS organisations in Scotland articulated the purpose of the elective as follows:-

*The elective is an opportunity to work on a live project in a significant role. This might be a service improvement initiative or a review or scoping study. It might be the formulation of a business case for an investment on behalf of the organisation. We would welcome and, indeed, encourage innovative electives that exploit inter-agency working. The Trainee might well be based with a partner organisation for part of the elective, if not all of it. It is important that it is seen as a chance for them to gain wider experience in a different arena; both organisationally and with regard to the nature of the service. We would encourage Boards and Trainees to use this opportunity to spend time in a Special Health Board or a remote Health Board area.*

Trainees are encouraged and advised to take some annual leave between September and the end of December, and must be available to begin their second management post from early January at the latest.

**In summary the elective must meet the following criteria:**

- Offer the Trainee a stretching experience that will meet specific development needs identified in their PDP
- Focus on a specific service issue that will broaden the Trainees’ knowledge and experience
• Offer a real opportunity to share best practice not only in their host health board but across NHS Scotland on completion of the elective
• Be located in a partner organisation of the NHS, special health board, or public sector organisation
• Be a real piece of work that is sufficiently self-contained to run for 3 months
• The host for the elective must identify a lead person to support the Trainee and be the point of contact for Scheme Manager.
Deployment post Scheme is one of the main strategies for ensuring retention and continued enhancement of the management Trainee’s skills and competence. Boards therefore agreed to offer their Trainee a minimum of a one year’s substantive post at the end of the two year Scheme.

This guidance outlines the process to be adopted for this and the level of job recommended. There needs to be a common approach adopted by Boards to ensure transparency and fairness. However, it is also important that flexible and innovative approaches to deployment of Trainees are encouraged. The needs of the Board, the service and the career aspirations of the individual Trainee will need to be balanced. The third year post will, of course, be subject to satisfactory performance as a Trainee and in the host board as evidenced by regular performance reviews conducted with the Trainee, Placement Co-ordinator, Trainee and Line Manager.

1. **3rd Year level**

The Trainees are on a percentage of Agenda for Change Band 6 during the Scheme. It is therefore essential that the 3rd Year post is at least at this level, and preferably higher.

2. **Process**

We recommend that the Host Boards begin to think about the role to which they might recruit a Trainee at the end of the first year on the Scheme, rather than leaving it too late. This may not be possible in every case. The process for identifying a suitable role for your Trainee is as follows:

Boards will need to identify a suitable role in discussion with the Trainee and the Scheme Manager at the third review in year 2. A number of options may be possible.

**Option 1** Permanent post – if Boards and the Trainee wish to offer a permanent post then this will follow the usual competition rules for the Board. If Trainees are unsuccessful then option 2 and Boards have a suitable permanent vacancy, then the Trainee can be made aware of this opportunity and apply in open competition in accordance with the Board’s recruitment policy. If Trainees are unsuccessful then option 2 is available.

**Option 2** – a fixed term or temporary role within the Board. It may be that the Trainee wants further experience in a particular area, or that there simply are no permanent posts at an appropriate level.
**Option 3** – A role within another Board. The reasons for this might be that a Trainee wishes to work nearer home or that there is a specific job within another Board that they wish to apply for. These will be identified by discussion between the Scheme Manager, the board and the Trainee as part of their final review.
Health Management Library and Information Service

The Health Management Library is a free library and information service that is open to all staff working in the NHS and in social services in Scotland. The library’s main focus is on the non-clinical aspects of health and social care and holds resources to support healthcare planning, policy, management and service improvement of health and social care services.

The Library holds the latest literature in such areas as: -
Business Planning    Performance Management
Care Pathways        Primary Care
Clinical Governance   Public Health
Commissioning        Quality Improvement
Health Economics      Risk Management
Healthcare Planning   Screening Programmes
Health Policy         Service Modernisation
Human Resources       Social Care
Leadership           Telehealth and Telecare
Partnership Working   Workforce Planning

Services Available to all NHS Scotland MTS Trainees

- Literature Search Service: The team’s experienced information professionals can carry out customised expert literature searches for you. Information is sourced from the Library’s extensive database, from online databases such as HMIC, ASSIA, CINAHL and Emerald, and extensive web research. All literature search results are emailed or posted directly to you.

- Loan and Document Delivery Service: The library holds over 16,000 books, reports and policy documents. A full lending and electronic document delivery and photocopying service is available. If the Health Management Library does not hold an item that you need, our team will obtain it for you through our inter-library loan service. Wherever you work in NHS Scotland all items will be emailed or posted to you.

- Current Awareness Service: In order to keep up to date with fast moving healthcare issues, the Library produces a monthly current awareness bulletin. This bulletin provides details of new reports, journal articles, books and policy documents added to the Library stock. The bulletin will be emailed directly to you.
Training Materials: The Library holds a collection of DVD and video-based training programmes essential for the delivery of training, in areas such as change management, diversity, empowerment and teamwork.

Reference Enquiries: The team will endeavour to answer your reference and quick enquiries using the Library’s unique collection and expert knowledge of retrieving information.

Training: The Library offers tailored workshops for groups and individual training sessions on accessing management information.

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This section of the Handbook has been taken from the Healthcare Financial Management Association (HFMA) “INTRODUCTORY GUIDE TO NHS FINANCE IN SCOTLAND” (2005) with their prior permission. We have extracted the chapters that are still current to the service however, if you would like to understand more about the historical situation, please get in touch with the Scheme Manager for further information.

Although this section has been written for a Finance audience, the information may be of interest and of use to all management Trainees.

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Chapter One, Introduction

Purpose

The NHS in Scotland has for the past few years been undergoing a period of expansion and fundamental change. The NHS finance function has not been immune to these changes. Finance departments themselves have undergone structural change with the formation of new organisations all requiring financial services. The need for a simple, concise and up-to-date guide to NHS finance is therefore clear.

In 1998 the White Paper Designed to Care started a revolution in how health services would be provided in Scotland. This involved major structural changes that required radical new thinking about how financial services should be provided. NHS finance has therefore been faced with managing a service in a period of substantial change and significant expansion; whilst at the same time itself undergoing major upheaval.

The need to keep up-to-date with NHS finance has never been greater. The changes themselves inevitably spawned a new raft of specialist terminology and abbreviations, which this guide seeks to de-bug and explain.

The target audience for this Scottish Introductory Guide is diverse. Feedback from colleagues in the wider UK NHS suggests that many NHS finance directors regard the General Introductory Guide as essential reading for executive directors of other functions and non-executive directors, and this is expected to be the case for this Scottish version.

Finance students and new NHS finance staff are another group that traditionally use the Guide. Many aspects of NHS finance are unique to the service, and staff transferring in from the private sector can often feel a little confused or bemused by unfamiliar financial arrangements and language. Given the audience, the guide is not intended to provide in depth technical advice, although references listed at the end of each chapter give an indication of where to find out more.

To make it easier to get to grips with a particular aspect of NHS finance, each chapter of the guide treats its topic in a self-contained way.

Cross-references are included where they are helpful and sources of further advice and technical guidance are listed at the end of each chapter. Inevitably, given the decision to create self-contained chapters, there is some duplication.

The guide ends with a data file of key facts and figures and a glossary of terms and abbreviations. Website references are included so that readers can access updated information as it becomes available.
The Authors

This guide is produced by the Healthcare Financial Management Association's Scotland Branch Committee. Members of the committee are finance staff from across NHS Scotland (NHSS) who give up their time voluntarily to help improve financial management standards and control in the NHS, and to promote an understanding of NHS finance both inside and outside the finance department.
Chapter Two, Background to the NHS

Introduction

The NHS is a large and complex organisation - to understand its current structure and financing, it is helpful to know a bit about its history. Cynics would comment that the perpetual state of flux in the NHS results in a cyclical development pattern; others would claim that there have been significant changes in emphasis at different stages. However, what cannot be doubted is the fact that each development and initiative has contributed to the language and approach of the NHS finance function.

The Internal Market

Prior to 1998, the NHS operated a quasi-market, known as the internal market. The internal market introduced a number of features:

- An optional scheme to give general practitioners (GPs) the ability to hold budgets for the purchase of hospital services for their patients (GP fundholding)

- The separation of the provision of hospital/community services from the commissioning or purchasing function - the so-called purchaser/provider split. Hospitals were encouraged to apply for self-governing trust status, creating separate organisations which were devolved from health authorities

- Hospital services were costed for the first time, allowing the publication of prices and negotiation of contracts

- Trusts were encouraged to invest in and develop services and to compete with each other to win patient service contracts with purchasers.

The internal market was criticised for a number of reasons. Competition between providers led to winners and losers, which in turn led to overall increases in costs to the NHS (essentially, losing organisations had to be sustained to ensure that services could be maintained). The principle of patient-centred care was lost, as trusts competed to provide care where it was cheapest, not necessarily in locations that were convenient for the patient. Pricing of contracts remained difficult and contentious, and in a period of activity growth, sufficient funding was not available.

The relationship between costs and income became damaged, and one of the founding principles of the internal market, that 'money followed patients' was undermined. The market also led to an increase in bureaucracy as transaction costs soared. In 1997, plans were drafted to scrap the internal market.
Designed to Care

Starting with the 1998 White Paper, Designed to Care, the Scottish Government set about reorganising the way services are delivered and managed. At that time the NHS operated under quasi market-based principles with NHS organisations competing to provide healthcare in a system where funding was designed to ‘follow patients’.

Designed to Care proposed dismantling the internal market instead focusing on improving clinical relationships within NHS Scotland (NHSS), and promoting partnership and cooperation across NHS organisations and with local authorities. The Health Act 1999 provided the statutory powers to reduce the number of trusts, and establish primary care trusts (PCTs) to be responsible for primary, community and mental health services within health board areas.

Designed to Care and the following legislation reduced the number of NHS trusts from 47 to 28. Broadly this meant one PCT and one acute hospitals trust in each mainland health board area, with some variations owing to local circumstance - for example, in Island Health Board areas, trusts were not introduced and hospitals were 'directly managed units' (DMUs).

Designed to Care also introduced the concept of local healthcare cooperatives (LHCCs) that were designed as networks of general practices established to support agreements between primary and secondary care, and to improve local services. As a result of the introduction of LHCCs, GP fundholding was abolished.

Our National Health: A Plan for Action, a Plan for Change

The White Paper Our National Health: A Plan for Action, a Plan for Change, published in December 2000 further rationalised NHS systems in Scotland, removing the separate board structures of health boards and NHS trusts, replacing them with a single unified NHS board, responsible both for improving the health of their local populations and delivering the healthcare they require. NHS trusts retained their existing operational and legal responsibilities within the local health system, but with streamlined management arrangements. The White Paper also further reinforced the commitment to work in partnership with local authorities, and introduced joint resourcing and joint management of community care services as recommended by the Joint Future Unit of the Scottish Government Health Directorate (SGHD). From a financial viewpoint, the White Paper made further changes in that the new NHS boards became accountable for the financial performance of the whole local health system.

Partnership for Care

Published in February 2003, Partnership for Care abolished NHS trusts in Scotland as separate legal entities. Their functions, staff and assets were transferred to their
area NHS boards by April 2004. The Paper further encouraged the decentralisation of
decision making as far as possible to the front line, backed by devolution of
resources. In his budget speech of 2002, the Chancellor committed substantial
additional funds to the NHS for the medium term. The Scottish Parliament has upheld
this commitment, projecting an increase in funding from £6.7 billion to £8.7 billion
over the next three years.

New community health partnerships (CHPs) will be introduced to build on the
successes of LHCCs. These CHPs will:

- Have greater powers to ensure patient involvement
- Have a greater say in the distribution of NHS board resources
- Establish substantive partnerships with local authority services
- Play a central role in service redesign locally.

A revised financial framework is also being introduced following the dissolution of
NHS trusts, whereby a single set of financial reports will be produced for each NHS
Board area to a standard format on a resource accounting (accruals) basis. The
legislative backing for the above changes comes from the National Health Service
Reform (Scotland) Act 2004. The Act:

- Allows for the dissolution of NHS trusts and the establishment of community
  health partnerships (CHPs)
- Introduces a statutory duty for NHS boards to co-operate with each other with
  a view to enhancing the health of the nation (for example, through regional and
  national planning)
- Establishes powers of intervention on behalf of Scottish ministers in case of
  service failure
- Imposes on NHS boards duties to encourage public involvement and promote
  health improvement.

Other relevant legislation includes:
- National Health Service (Scotland) Act 1972 - this allowed for the
  establishment of area health boards and administration of the provision of
  healthcare
- National Health Service and Community Care Act 1990 - this allowed for the
  establishment of NHS trusts
- Health Act 1999 - this implemented the proposals of the White Paper Designed to Care
- Public Finance and Accountability (Scotland) Act 2000 - this sets out the rules for the Parliament's budgetary process
- Community Care and Health (Scotland) Act 2002 - this provides the legislative backing for improvements in care services

**Underlying Financial Issues**

Consecutive governments have sought to change NHS policy and emphasis. However, many features of the NHS have remained unchanged since its inception in 1948 - for example:

- The principle of the service remaining free at the point of delivery. The Wanless report, published in April 2002 concluded that the current method of funding the NHS through taxation is both fair and efficient. This independent assessment has been used by the current government to justify its continued approach to NHS funding
- The need to manage within overall resource limits determined by the government each year
- The need to match finite resources to what is essentially infinite demand for health services
- The expectation that continued efficiency savings can be made, often as a result of structural or technological advances
- Intense public and media interest in, and scrutiny of, the NHS.

**New or Changing Financial Issues**

While many of the fundamental principles that underpin the NHS remain the same there have been many changes in structural and policy terms over recent years with a particular emphasis on the need for the NHS to reform. Some of the major recent changes and challenges include:

- Devolution. NHSS is now accountable to the Scottish Parliament and not as previously to the Secretary of State for Scotland. Given that health is the largest devolved budget the Parliament has to manage, it is under intense scrutiny
- The introduction of NHS boards and dissolution of trusts altered the accountability arrangements within NHSS considerably. Previously health
boards reported on a cash basis while trusts reported on an accruals basis. Following the introduction of resource accounting and budgeting (RAB) for all government departments, the new NHS boards report on an accruals basis

- Clinical negligence. The costs of medical litigation continue to rise

- A new performance and accountability framework (PAF) and the effective delivery of corporate and clinical governance targets. The aim to reduce waiting times and improve health, combined with measures to curb management costs has placed great pressure on NHS financial resources. The development of the Scottish Health Advisory Service (SHAS), the Clinical Standards Board for Scotland (CSBS) and its successor watchdog, Quality Improvement Scotland (QIS) will further test these resources

- Agenda for Change. In response to a growing number of equal pay claims, the NHS has set about modernising its pay structures.

The basic principle of Agenda for Change is that all posts can be assessed against a single set of criteria, and then against a single pay scale. The new system for assessment is designed to encourage lifelong learning, with personal development rather than duration of service being rewarded. The evaluation of so many diverse jobs represents a considerable challenge for NHS organisations and brings with it a significant financial risk. Agenda for Change is to be implemented across the UK from October 2004

- Revised GP contracts. Allied to changes taking place for other professions under Agenda for Change, GPs have been offered revised terms of employment. Among other changes, from April 2004 GPs have had the right to negotiate with NHS boards to withdraw out-of-hours services. From December 2004 they will have a right to opt out from such services. NHS is rapidly seeking alternative arrangements for out-of-hours services - an example is the introduction of NHS 24. This links with a wider review of emergency care provision, with primary care organisations, the Scottish Ambulance Service and acute care providers of accident and emergency services combining to consider how better to provide services

- New consultant contract. A new contract for consultants has now been agreed across the UK. Although the contract does not introduce a ban on private work for some doctors, as originally envisaged, it does give the NHS first call on consultants' time for a session of four hours before they can undertake private work. The contract, backdated to April 2003, includes a substantial pay rise for consultants and the full cost of implementation is still being calculated

- National programme for IT. The government is investing unprecedented amounts of money in IT systems across the country that will make the transfer of information easier. The programme includes electronic patient records,
direct access appointments and linking other systems such as those used to monitor the quality framework set up under the new GP contract.

References and Further Reading

Designed to Care:
http://www.scotland.gov.uk/library/documents1/execsumm.htm

Our National Health:

Partnership for Care:
http://www.scotland.gov.uk/library5/health/pfcs-00.asp

National Health Service Reform (Scotland) Act 2004:

Wanless Report:

For further information on devolution, see the Scottish Parliament website:
www.scotland.gov.uk

HM Treasury guidance on the introduction of Resource Accounting and Budgeting:
http://www.hmtreasury.gov.uk/about/resourceaccounts/resourceaccounts_index.cfm

Agenda for Change:
http://www.show.scot.nhs.uk/SGHD/paymodernisation/afc.htm

New Consultant Contract:
http://www.show.scot.nhs.uk/SGHD/paymodernisation/ConsultantContract.htm

New GP Contract:
http://www.show.scot.nhs.uk/SGHD/paymodernisation/GMservicesContract.htm

National Programme for IT:
http://www.npfit.nhs.uk/default.asp
Chapter Four, The Scottish Government Health Directorate

Introduction

The Scottish Government Health Directorate (SGHD) is changing to meet the challenges of the future - working more corporately to provide effective leadership to the NHS and social care and a better service to ministers and the public as a leading department of state. The department has undergone some reform in recent years following devolution.

Background

The NHS was established under the National Health Service Act of 1946. This and other subsequent Acts of Parliament relating to the NHS set out the duty of the Secretary of State for Health to provide a comprehensive health service in England, and the UK Parliament holds the health secretary to account for the functioning of the NHS and the use of resources. Prior to devolution, the Secretary of State for Scotland assumed the above duty for Scotland.

Following devolution, the First Minister of the Scottish Parliament is responsible for providing health services, and the Scottish Parliament holds him to account. There is no direct accountability to the Secretary of State for Health. Parliamentary accountability and scrutiny require that managers in the NHS provide information to ministers to enable MSPs’ queries to be answered.

The Minister for Health

The SGHD has two ministers - the Minister for Health and Community Care and his deputy. The Minister for Health and Community Care has overall responsibility for the work of the SGHD and NHS Scotland (NHSS), including overall strategic responsibility for NHSS improvement, delivery and reform, finance and resources. The Minister works together with his deputy and the Head of the SGHD. The Head of the SGHD is also the Chief Executive of NHSS.

Parliamentary Scrutiny

The work of the SGHD is examined by the Scottish Parliament Health Committee on behalf of the Scottish Parliament. This is one of 16 cross-party committees overseeing individual government departments. These committees conduct inquiries and have the power to require the submission of written evidence and documents and to send for and examine witnesses. The members are appointed by the Parliament. The Committee has ten members, including a Convener and Deputy Convener.

The Health Committee is appointed by the Parliament to consider and report on matters relating to health policy and the National Health Service in Scotland and such
other matters as fall within the responsibility of the Minister for Health and Community Care.

Reports of the committee and the minutes of each committee meeting are available to the public, with the exception of those items the committees opts to hear in private session. Minutes of all parliamentary committees can be found on the Parliament's website - www.scottish.parliament.uk

The committee is supported in its work by a committee clerk and his staff. Other Parliamentary committees may scrutinise the SGHD and the health service, for example the Audit Committee or the Finance Committee. The Audit committee considers and reports on any accounts laid before the Parliament, or any report laid before the Auditor General for Scotland concerning financial control, auditing or accounting in relation to public expenditure. The Finance Committee may consider and report on any proposals relating to budgets or public expenditure, or tax-varying resolutions, or any matter relating to the expenditure of the Scottish Administration.

**The Role of the Scottish Government Health Directorate**

The SGHD supports Ministers in carrying out their ministerial responsibilities for health and community care services. The Directorate sets overall strategic aims and priorities on all health issues, including public health matters. It is also responsible for the provision of health services, a function which it discharges through NHSS including independent contractors such as general medical practitioners (GPs), dentists, pharmacists and opticians. This being the case, monitoring the performance of NHSS is a further important role. Finally, the SGHD issues guidance to NHSS on a wide range of issues - clinical, managerial, financial and governance related.

SGHD's work is far reaching - ranging from setting national standards on waiting times & emergency care to promoting healthier lifestyles and living. The head of the SGHD is also the chief executive of NHSS, and as 'accountable officer', is directly accountable to the Scottish Parliament for financial propriety and regularity, and for achieving best value from the resources allocated to the SGHD and NHSS.

The SGHD is responsible for health policy and the administration of the NHS in Scotland. The chief executive of the SGHD leads the central management of the NHS, is accountable to ministers for the efficiency and performance of the service, and heads a management executive which oversees the work of NHS boards responsible for planning health services for people in their area. The Public Health Policy Unit of the SGHD is responsible for promoting the health of the people of Scotland. The Directorate also has responsibility for the State Hospital, which cares for patients who require treatment under conditions of special security, and the Health Education Board for Scotland, which promotes positive attitudes to health and encourages healthy lifestyles.
The Directorate is also responsible for social work policy and in particular for community care and voluntary issues. The NHSS has around 132,000 staff, including more than 63,000 nurses, midwives and health visitors and over 8,500 doctors. There are also more than 7,000 family practitioners, including doctors, dentists, opticians and community pharmacists, who are independent contractors providing a range of services within the NHS in return for various fees and allowances.

SGHD Financial Performance Management and Accounting Team

The Financial Performance Management and Accounting Team sits within the Performance Management and Finance Directorate of the SGHD. It has responsibility for all financial issues in relation to the NHSS to ensure that it is efficient and effective and that it complements other policy initiatives. In addition it has a key role to provide advice and guidance on all financial issues affecting the service to both the NHS boards and to ministers. It has specific responsibility for:

- Co-ordinating the monitoring of the financial performance of all NHS boards and special health boards in Scotland. Providing regular information and explanations to the SGHD board
- Developing the financial accounting framework for the NHSS, including capital charges and capital accounting
- Providing advice and support at a strategic level on technical accounting issues
- Providing input on the financial aspects of business cases
- Co-ordinating the presentation of business cases to the Capital Investment Group
- Providing information and advice to ministers on the financial performance of the NHSS
- Development of specific policy areas such as costing, Euro development and finance staff development. It consists of four teams:
  - Technical accounting
  - East & North
  - West
  - Special health boards.

Other NHSS Bodies

The SGHD works with a variety of special health boards and other agencies, which have responsibility for particular business areas. These agencies are still part of the Directorate and are accountable to it. They are:
- National Waiting Times Centres Board - established in July 2002 following SGHD's purchase of the former HCI hospital at Clydebank for the NHS. The Centre's prime role is to increase the capacity and activity of NHS Scotland so as to help reduce the time people wait for treatment. It helps, in particular, by treating patients who have been waiting longest.

- NHS 24 - established in April 2001. NHS 24 provides a nurse-led advice, referral and health and healthcare information service through a network of contact centres, including an improved and more appropriate response to 999 callers who do not require the immediate despatch of an ambulance. The service is currently available in the Grampian and Greater Glasgow area and is expected to be available to the whole of Scotland by the end of 2004.

- NHS Education for Scotland - established in April 2002, bringing together the National Board for Nursing, Midwifery and Health Visiting for Scotland, the Post-Qualification Education Board for Health Service Pharmacists and the Scottish Council for Postgraduate Medical and Dental Education. NHS Education for Scotland promotes best practice in the education and lifelong learning of all NHSS staff through educational development, quality assurance of educational provision, facilitation of continuing professional development and the management of educational programmes.

- NHS Health Scotland - established in April 2003 bringing together the Health Education Board for Scotland and the Public Health Institute for Scotland to provide a national focus for health improvement in Scotland. NHS Health Scotland is responsible for delivering health improvement programmes to a wide variety of audiences and stakeholders working to improve Scotland's health, employing knowledge about health and its determinants in a way that influences policy and practice to improve health in Scotland. It is also expected to play a key role in the successful implementation of programmes of health improvement.

- NHS Quality Improvement Scotland - established in January 2003, bringing together the Clinical Standards Board for Scotland, the Clinical Resource and Audit Group, the Health Technology Board for Scotland, the Nursing and Midwifery Practice Development Unit and the Scottish Health Advisory Service. NHS Quality Improvement Scotland is expected to co-ordinate the work of Scotland's clinical effectiveness organisations through the development of a national strategy for improving the quality of patient care. It also advises NHSS on the clinical and cost effectiveness of new and existing health technologies.

- Scottish Ambulance Service - provides accident and emergency and non-emergency services to the people of Scotland from a total of 152 locations. Accident and emergency ambulance crews are trained in pre-hospital care and life-saving techniques and to respond to 999 calls and other requests for
emergency ambulances. The Patient Transport Service provides transport for people to, and from, hospitals, clinics and day centres who do not require an emergency service but whose medical condition still means there is a need for ambulance transport.

- State Hospitals Board for Scotland - provides secure psychiatric care to patients who, because of mental illness, have dangerous, violent or criminal propensities. At any one time, care is provided to some 250 patients (some 70% of whom suffer from schizophrenia and around half have multiple diagnosis) by 550 staff organised in multidisciplinary teams.

- NHS National Services Scotland (formerly the Common Services Agency - CSA) - supports NHSS through providing and coordinating national and regional services; including the Scottish National Blood Transfusion Service, Central Legal Office, Information and Statistics Division, National Services Division, Practitioner Services, Scottish Centre for Infection and Environmental Health, Scottish Healthcare Supplies and the Scottish Health Service Centre.

References and Further Reading

Department of Health Website:  
www.dh.gov.uk
NHS Website:  
www.nhs.uk
Scottish Government Health Department:  
www.show.scot.nhs.uk/SGHD/
Special Health Boards:  
http://www.show.scot.nhs.uk/organisations/orgindex.htm
Financial Performance & Management Accounting Team:  
http://www.show.scot.nhs.uk/SGHD/fpma/
Chapter Five, NHS Boards

Introduction

There are 15 NHS boards covering the whole of Scotland with population spans from 20,000 to 900,000 over widely differing areas. All NHS boards report to the head of the Scottish Government Health Directorate (SGHD).

NHS boards are responsible for planning and commissioning hospital and community health services for their resident populations. Until recently, the majority of healthcare in hospitals and the community service was provided by NHS trusts - self-governing bodies - whose boards, like those of health boards, were appointed by the First Minister for Scotland.

This all changed with the White Paper Our National Health: A Plan for Action, a Plan for Change, published in December 2000, which rationalised NHS systems in Scotland. The separate board structures of health boards and NHS trusts were removed and replaced with a single unified NHS board, responsible for both improving the health of their local populations and delivering the healthcare they require. NHS trusts retained their existing operational and legal responsibilities within the local health system, but their management arrangements were streamlined.

In February 2003, Partnership for Care abolished NHS trusts in Scotland as separate legal entities. Their functions, staff and assets transferred to their area NHS boards. Partnership for Care also encouraged the decentralisation of decision making as far as possible to the front line, backed by devolution of resources.

Role and Functions

NHS boards are required to provide strategic leadership and have overall responsibility for the efficient, effective and accountable performance of the local NHS.

The roles of the different components of local NHS systems, under the new unified board arrangement are as follows:

- NHS boards continue with their role in strategic planning, governance and performance management. The operational management role previously carried out by NHS trusts transfers to the operating divisions of the unified board

- Operating divisions are part of a single statutory organisation. However, like trusts, they have the ability to take operational decisions and manage the delivery of healthcare services within the governance framework of their NHS board. However, they must do so with continual reference to the central board of governance.
Operating divisions have management authority at local level with those in the front line empowered to plan and deliver services within a framework of clear strategic direction and rigorous performance management. It is considered vital to the management arrangements that devolution of decision-making does not stop at the operating division level.

The typical structure of NHS boards (assuming two operating divisions) is as follows:

### Lay Members – 5 to 9

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS board chair</td>
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<tr>
<td>Plus 4 to 8 lay member positions, of whom:</td>
<td></td>
</tr>
<tr>
<td>▪ 2 existing lay members</td>
<td></td>
</tr>
<tr>
<td>▪ Replacement of 2 former trust chair positions</td>
<td></td>
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<tr>
<td>▪ 0 to 4 new lay members, compensating for the loss of</td>
<td></td>
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<tr>
<td>▪ 4 trustees</td>
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### Stakeholder members – 5

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 local authority members</td>
<td></td>
</tr>
<tr>
<td>‘Employee Director’ – chair of area partnership forum</td>
<td></td>
</tr>
<tr>
<td>Chair of area clinical forum</td>
<td></td>
</tr>
<tr>
<td>New chair of the LHCC professional committee</td>
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</tbody>
</table>

### Executive members

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS board chief executive</td>
<td></td>
</tr>
<tr>
<td>2 new divisional chief executives</td>
<td></td>
</tr>
<tr>
<td>Director of public health</td>
<td></td>
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<tr>
<td>NHS board finance director</td>
<td></td>
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<tr>
<td>NHS board nurse director</td>
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<tr>
<td>New NHS board medical director</td>
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</tbody>
</table>

The key principles of NHS boards and operating divisions are that:

- NHS boards should retain their focus as boards of governance and take 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, backed up by clear, formal schemes of accountability
Organisations 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 grounded firmly 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 both the achievements of local health care cooperatives (LHCCs) as they evolve into community health partnerships and the joint future initiative in a way that engages with community planning partners and maximises population alignment between LHCCs/CHPs 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.

It is intended that NHS boards use their powers of delegation to devolve duties and responsibilities for service delivery to operating divisions. This is to ensure that they maintain their status and do not become unnecessarily involved in day-to-day management issues.

Divisional management teams will act in much the same way as the trust management teams that they replace, but with a stronger operational bias. These changes have had an impact on the management responsibilities and accountabilities within local NHS systems. In particular, there are two consequences of introducing a single NHS organisation:

- Divisional chief executives are not appointed formally as accountable officers - this results from the introduction of unified NHS board accounts - but they still have primary accountability for their budget, and remain liable to be summoned to give evidence to the Parliament.

- The chief executive of the NHS board has overall accountability for the performance management of the whole NHS system with divisional chief executives directly accountable to them.
Local and National NHS Plans

In Scotland planning is primarily the function of the NHS boards, although an overview is provided by the SGHD. The role of the NHS board is to:

- Improve and protect the health of local people
- Improve health services for local people
- Focus clearly on health outcomes and people’s experience of their local NHS system
- Promote integrated health and community planning by working closely with other local organisations
- Provide a single focus of accountability for the performance of the local NHS system.

The functions of the NHS board are:

- Strategic development through the local health plan
- Resource allocation and addressing local priorities
- Implementation of the local health plan (discharged through the operating divisions)
- Performance management of the local NHS system
- Preparation and implementation of the local health plan. This has replaced the health improvement and trust implementation plans.

The main difference is that the local health plan will result in greater collaboration between all NHS bodies in the NHS board area. Local authorities and staff will also have representatives on the NHS board as a means of promoting this collaborative and partnership approach. Each operational division is required to produce local operational plans to achieve the objectives of the local health plan. A performance and accountability framework has also been developed, which will take the reporting focus beyond purely finance-based performance indicators.

National Health Service Reform (Scotland) Act 2004

The NHS Reform (Scotland) Act was introduced primarily to establish Community Health Partnerships (CHPs) as the main vehicle for planning and providing local healthcare (see below). In addition to establishing CHPs, the Act also introduced a range of other measures applicable to NHS boards, each of which is discussed briefly below:

- Duty of cooperation. NHS boards are required to cooperate with each other and central agencies in relation to the planning and provision of services in order to secure and advance the health of the population. The purpose of this duty is to ensure that NHS board boundaries do not become a barrier to securing the effective planning of services, some of which may be best tackled at either a regional or national level.

- Powers of intervention - if Scottish ministers consider that a person or body whose function is to provide (or secure the provision of) healthcare, is failing in
that duty they may direct another body or person to perform that function. Each NHS board has clear performance objectives against which it is monitored through the performance and accountability framework (PAF). In addition, the establishment of NHS Quality Improvement Scotland (NHS QIS) ensures best clinical practice. One of the powers of QIS is to investigate serious service failures. Each NHS board also has the power to make changes to the senior management team if it considers this to be necessary to improve performance. Should ministers consider that these measures are failing, then they have the power to transfer the responsibilities of the board to another board or expert team until performance has improved.

- Public involvement - a further duty has been placed on NHS boards to ensure that patients and the public are involved in any decision that will affect the operation of health services. This duty has the potential to be onerous on NHS boards, and may affect the speed with which decisions are made in relation to service delivery.

- Promotion of health improvement - it is now a statutory duty of both ministers and NHS boards to promote health improvement. This allows NHS boards to provide resources, or enter into agreements with any person or body that will assist in discharging that duty. In effect, this gives NHS boards wider scope to transfer resources to non-NHS bodies in the pursuit of health improvement for their population.

### Community Health Partnerships (CHPs)

NHS boards have an obligation (under the NHS Reform (Scotland) Act 2004) to establish CHPs to bring together primary care professionals, planning partners and local authority partners for an area or district. The CHP will coordinate the planning, development and provision of community health services which are the responsibility of the NHS board.

CHPs will be established formally on 1 April 2005, and schemes of establishment will set out the:
- Services that the CHP will provide and is responsible for
- Delegated authority of the CHP
- Operating and financial arrangements of the CHP.

It is expected that CHPs will be the main vehicle for planning, coordinating and delivering local health services in each NHS board area, and the authority delegated to them must reflect this.

The SGHD has issued statutory guidance as to how CHPs will operate, what they are responsible for, which parties must be involved, and the authority they have.
References and Further Reading

Our National Health:
Partnership for Care:
http://www.scotland.gov.uk/library5/health/pfcs-00.asp
National Health Service Reform (Scotland) Act 2004:
NHS Quality Improvement Scotland:
http://www.nhshealthquality.org
Performance Assessment Framework:
CHP Statutory Guidance:
http://www.scotland.gov.uk/library5/health/chpg-00.asp
Chapter Six, Primary Care

Introduction

The first port of call for many people when they develop a health problem is their local general practitioner (GP) or local community pharmacist. They are often described as the frontline of the NHS - the part officially called 'primary care'. Many other health professionals work as part of this frontline team including nurses, health visitors, dentists, opticians and a range of specialist therapists. NHS 24 and NHS walk-in centres are also part of primary care. Most family doctors, dentists, opticians and pharmacists remain independent contractors - in other words, they are not NHS employees.

Partnership Working

NHS boards have a general responsibility to maximise partnership working for the benefit of patients. In recent years flexibilities have been introduced to allow pooling of budgets so that, for example, an NHS board and its local social services department can pool their resources for mental health and social care services. This can enable them to commission services through a joint pool so that services may be delivered more flexibly (see chapter 7). Closer working between health and local authorities is also being pursued in relation to children's services.

Primary Care Funding

Primary care payments are funded through the family health services (FHS) funding source. Prior to April 2004 this included a mix of non-cash-limited funds (from a national 'pot') and cash-limited resources (from NHS boards' unified budgets). Primary care includes a wide range of services provided principally by independent contractors - see below for more details.

Primary care or family health services funding amounted to over £1.6bn in 2003/04. Some 57% was spent on pharmaceutical services (including drugs and appliances), 32% was spent on GP services, 9% on dental services and 2% on ophthalmic services. The government has announced a huge increase in primary medical services as part of the introduction of the new GP contract - expenditure is due to rise by 33% between 2002/03 and 2005/06.

Ophthalmic Services

Payments are made to dispensing opticians, ophthalmic opticians and to ophthalmic medical practitioners for NHS tests (where a fee or reduced fee is payable by the recipient of the test) and similarly for the supply, repair or replacement of spectacles. Sometimes a fee is paid for home visits. The Practitioner Services Department of National Services Scotland (PSD) makes these payments monthly - most are not cash-limited and do not form part of the unified budget.
**Pharmaceutical Services**

Under the NHS (Pharmaceutical) Regulations 1992, payments are made to pharmacists and some doctors for supplying and dispensing certain drugs (net of prescription charges collected) and for items such as rota services, the supply and maintenance of oxygen concentrators and providing services to residential homes. In sparsely populated country areas, essential small pharmacy allowances may also be payable. Normally payments are made monthly by PSD. These remuneration payments do not come out of unified budgets.

For the supply and dispensing of drugs, payments are made according to calculations by the PSD. PSD receives details of all prescriptions dispensed in Scotland, and then calculates the amounts payable, allowing for the drug and container cost and a service fee. Costs of the drugs themselves are charged to a cash-limited budget held by the NHS board.

A new pharmacy contract similar to the new general medical services (GMS) contract is being considered to take effect from 1 April 2005 with a payment structure mirroring the headings of Minor Ailments Service, Chronic Medication Service, Acute Medication Service and Public Health Service as well as a range of locally negotiated services.

The rising cost of primary care prescribing is a significant cost pressure for NHS boards. Prescribing costs have always risen faster than general inflation as new, more effective and more expensive drugs become available. However, this has become even more pronounced in recent years with the introduction of national service frameworks, which have led to increased prescribing in areas such as coronary heart disease. But guidance from the National Institute for Clinical Excellence (NICE) and NHS QIS, which assesses the clinical- and cost-effectiveness of new drugs and technologies, is also driving both prescription volume and cost.

**General Dental Services**

PSD is also responsible for making payments to dental contractors, either under the Statement of Dental Remuneration or in accordance with NHS board approvals. There are also plans for a new dental contract.

**General Practitioners**

*Funding up to and including 2003/4*

General practitioners were paid either for providing general medical services (GMS) to patients under the terms of service set out in the National Health Service (General Medical Services) Regulations 1992 or through personal medical services (PMS) contracts. PMS pilots were set up under The NHS (Primary Care) Act 1997. Under GMS GPs received payments for services according to the terms outlined in the
Statement of Fees and Allowances (also known as the 'Red Book') and these were termed non-cash limited i.e. they were paid out of a national pot.

In addition they received funding from cash limited resources held by PCTs - part of their unified budgets. This funding included improvement grants and reimbursements for computer costs and employing practice staff as well as delivering certain 'rental' payments following improvements or extension of premises or the provision of new surgeries.

Under PMS GPs are paid contract sums to deliver a defined service. This gave NHS boards and providers, particularly GPs and nurses, freedom to develop innovative options for meeting primary care needs. Resources are allocated annually and become fixed or 'cash-limited' for that year.

**Funding from 2004/05**
The new GMS contract came into effect in April 2004 with the introduction of the Primary Medical Services (Scotland) Act 2004. It replaces the above system for GMS doctors. NHS boards receive a cash-limited sum for GMS services as part of their allocation. NHS boards allocate resources to practices in three main ways:

- A global sum to cover running costs and the provision of essential and additional services
- Enhanced service payments for practices which expand the services they provide
- Quality payments to reward standards.

The global sum will be calculated through a resource allocation formula based on the age and sex profile of a practice's population, additional needs, list turnover and remoteness and rurality. Practices that opt out of additional services will have their global sum reduced according to a tariff. A significant proportion of the new money will be available to reward practices for providing higher quality services. A new 'quality and outcomes framework' will set out a range of clinical and organisational standards by which allocations will be judged. To prepare practices for the quality and outcomes framework, NHS boards will make 'preparation payments' on a capitation basis in 2003/04 and 2004/05. To help practices meet the standards to which they aspire, NHS boards will also make monthly 'aspiration payments' to practices from 2004/05. Practices that succeed in meeting these standards will then receive 'achievement payments' from 2004/05. Aspiration and achievement payments will be made according to a points scheme.

Practices and other providers will be able to apply to NHS boards for additional funding to meet the costs of specialised services (for example, extended minor surgery) commissioned by the NHS board. Investment in enhanced services will be managed and monitored by NHS boards.

Practices that lose out under the new resource allocation formula will be protected by a minimum practice income guarantee (MPIG). The MPIG is calculated by comparing
income for essential and additional services under the new contract (the global sum) with the equivalent under the Red Book. Any shortfall under the new arrangements will be covered by the MPIG. There will also be separate funding streams for:

- **Premises.** Funding will form part of a single central fund from 2004/05. Each NHS board will then be allocated a sum based on a submission detailing it’s requirements and a percentage allocation will be made.

- **Information communications and technology (ICT).** Funding the purchase, maintenance, future upgrades and running costs of ICT within primary care will be the responsibility of NHS boards, rather than practices.

- **Seniority pay.** NHS boards will also receive and administer funding for improved seniority pay, golden hellos, maternity, paternity and adoptive and sick leave.

The funding for the new GP contract is being delivered to NHS boards in allocations that will be incorporated within enlarged unified budgets. The new arrangements mean that virtually all GP funding is now delivered from cash-limited funds, rather than the mix of cash-limited and non cash-limited funds that existed before.

PMS will continue alongside the new GMS contract and PMS practices will also be able to receive quality payments and be eligible for enhanced services (if these are not already in their PMS contract) plus the premises, ICT and seniority pay. PMS practices can opt to switch into the new GMS contract.

**Other Issues**

The radical changes introduced by restructuring unitary NHS boards have raised a number of issues that impact on their ability to maintain financial control and highlight risks that require careful management. These include:

- Developing new organisations and implementing organisational change while at the same time modernising local health services and doing things differently.
- Devising methods of involving health professionals and the public meaningfully in commissioning services and prioritising investments.
- Managing primary care budget expenditure where the budgets are the responsibility of the NHS board but the expenditure is incurred by independent contractors with no direct financial accountability to the NHS board.
- Particularly in rural areas, the impact of the NHS board’s obligation to provide GP services out of hours when the majority of local GPs have opted out of providing this service.
References and Further Reading

The NHS (Primary Care) Act 1997:

The Primary Medical Services (Scotland) Act 2004:
http://www.scotlandlegislation.hmso.gov.uk/legislation/scotland/acts2004/40001--b.htm#1

Pay modernisation information:
http://www.show.scot.nhs.uk/SGHD/paymodernisation/GMservicesContract.htm
Chapter Seven, Partnerships between the NHS and Local Authorities

Introduction

Increasingly, NHS organisations are working in partnership with local authorities to manage and deliver local services in which both parties have an interest. This includes services for children, the elderly, the disabled, the mentally ill and people with learning disabilities.

Greater integration and joint working between the NHS and local government has been possible since the introduction of the Community Care and Health (Scotland) Act 2002 - before then there were legal limitations on the powers of NHS bodies to enter into partnership agreements with local authorities.

A Joint Future Group was established in 1999 as a result of a desire on the part of the NHS, local authorities and politicians to improve joint working without the need to radically alter organisational structures. The group's report, Community Care: A Joint Future was published in December 2000 and its 19 key recommendations accepted by ministers in January 2001.

The Joint Future Unit of the Scottish Government (SG) was set up shortly thereafter to provide a strategic lead to the agenda. Initial guidance from the SE (CCD 7/2001) set out six key actions local partnerships need to implement in order to achieve improved joint working:

- Agreement on joint management arrangements
- Agreement on the resources (including staff, money, equipment and property) to be brought under joint management arrangements
- Agreement on outline joint development priorities with the associated organisational and HR development plan and targets for the medium term
- Agreement on joint governance and accountability arrangements
- Agreement on the joint performance management framework
- Agreement on the local partnership agreement (LPA) with targets, performance measures and governance and accountability arrangements.

In the first instance services for older people are subject to these arrangements, but joint working will in the future be extended to all the groups mentioned above.

The above actions were extremely challenging for all local partnerships, resulting in revised guidance in January 2002 in relation to older peoples services which set out the 'bottom line' that agencies should achieve in order to fully deliver joint resourcing and management:

- Scope the joint resourcing 'pot' for older peoples services and decide what resources to include at the outset
- Decide what single management arrangements to adopt and from when; what the management structure would be, and whether they will 'align' or 'pool' budgets
Give staff confidence in the new agenda, set up a joint staff forum, provide a statement of intent and a clear joint training and organisational development agenda

Prepare a project plan to implement the 'bottom line' by April 2002.

Within the joint futures agenda there are several distinct areas that this chapter will look at briefly:
- Joint resourcing
- Joint management
- Joint premises
- Single shared assessment.

**Joint Resourcing**

Under the joint futures agenda, agencies within each partnership have the option either to 'align' or 'pool' budgets, depending on what best suits local circumstances. Aligned budgets are a step towards fully integrated, pooled budgets with single management arrangements. However, at present there are no partnerships in Scotland that have opted for full pooled budgets.

**Aligned budgets**

Once the initial 'pot' is scoped (ie partners identify and agree what resources are to be brought under joint management arrangements), these resources (staff, money, property) may be included in the LPA and are then jointly managed to deliver services. This may happen either at Board or committee level, or through a group of senior managers. The individual funds are still held by each partner agency, and each agency must account for its contribution, but funds may be transferred between agencies.

The partnership at this stage does not constitute a separate legal entity, therefore each agency must retain separate auditors, standing financial instructions and schemes of delegation. This would not however preclude the appointment of a single manager by either partner to manage the aligned budget. This would be a joint appointment, but the person would be on the payroll of one or other agency.

**Pooled budgets**

The same scoping principles as above are applied, and resources are brought together and prioritised within the LPA. However, at this point resources are pooled and lose their original identity. A single manager may be appointed, and resources managed through a single ledger. Pooled budgeting allows for a more flexible use of resource, and only a single set of accounts, auditors and scheme of delegation is required. However, the fact that budgets are pooled does not infer the partnership is a separate legal entity, and the partnership cannot employ staff in its own right.
Instead, staff are 'hosted' by one of the partner agencies. Where either a pooled or aligned budget exists, the partners to the LPA will have written agreements setting out:

- The functions covered
- The aims agreed
- The funds that each partner will contribute
- Which partner will act as the 'host' (i.e. which organisation will manage the budget and take responsibility for the accounts and auditing).

Sections 13-14 of the Community Care and Health (Scotland) Act 2002 grant the power to both NHS bodies and local authorities to make payments to each other to fund expenditure incurred in relation to the services that the joint futures agenda covers.

**Corporate governance**

Local authorities and the NHS are subject to different governance regimes: although each receives significant levels of public funding, local authorities have a democratic mandate and are accountable to the local electorate whereas NHS boards are ultimately accountable through the Minister for Health to the Scottish Parliament. See the HFMA's Introductory Guide to Corporate Governance in the NHS for more about governance arrangements.

**Risk sharing and control**

Partnerships need to decide how they will share financial and other risks. So for example if the partnership overspends there will need to be agreement around how the overspend is financed and reported. Risk sharing agreements are often difficult to negotiate and require a degree of compromise from both partners. Partnerships also imply a loss of control over the service, as partners can no longer make unilateral changes to the service itself or to the level of funding.

**Financial framework**

The NHS and local government operate under different financial regimes. There are two key areas where this has an impact:

- VAT: local authorities are able to recover VAT on most items of expenditure whereas the NHS may not. Customs and Excise will not allow for the creation of partnerships to be used as a mechanism for avoiding VAT and, therefore, it may be necessary for the partnership to account for tax as if it were still two bodies

- Charges: local authorities have the power to charge clients for the services provided, whereas the NHS does not. The partnership agreement will have to be devised so that there is no loss of revenue.
Joint Management

Joint management is concerned with effective cooperation between agencies in relation to planning, commissioning and resourcing community care services. To ensure that there is effective management there needs to be:

- A high level joint board or committee - including NHS board members and elected members of local authorities
- A senior management group
- Either a new partnership body or single joint manager.

The LPA is central to the development of the management arrangements, and should detail how each element of management will operate in practice. The LPA should outline the arrangements that local partnerships have put in place to ensure that the proper joint governance and accountability arrangements are in place. These arrangements must ensure that clear statements about decision-making processes, operational and management arrangements, delegation of responsibilities, reporting lines to parent agencies and monitoring for joint services, are available to staff and managers.

The Joint Performance Information and Assessment Framework (JPIAF) assesses local partners' implementation of joint working arrangements, including joint services. It focused initially on how local authorities (both social work and housing) and NHS boards had implemented key parts of the joint future agenda. It now focuses more on joint outcomes and benefits for service users and carers (see NHS circular CCD 1/2003).

The JPIAF contains several performance indicators relating to joint resourcing, joint management and single shared assessment. Within the JPIAF is a Joint Resourcing Financial Framework (JRRF) which should detail 5 key areas:

- Financial management arrangements
- Financial protocols
- Strategic baseline
- Operational baseline
- Medium term financial plan.

Joint Premises

The commissioning of joint premises is a logical 'next step' in the development of the joint future agenda. In order to progress the matter, the SE set up a short life working group (SLWG) to identify ways of removing obstacles that inhibited integrated approaches to funding and managing joint premises.

The SLWG was constituted on a joint basis with contributions from the Health Department, NHS Scotland and COSLA. The group produced a report, including 22 recommendations, aimed at identifying and promoting solutions to progress joint
premises development in primary and community care, and investigating various models of delivery. After the report had been issued for comment and the responses collated, a sub-group was set up with the specific remit of examining recommendations relating to the introduction of legislation to allow local authorities, NHS boards and private sector providers to enter into joint venture agreements that would make available another vehicle to support joint premises development. The sub-group also took forward the recommendation to consult on such proposals as Local Improvement Finance Trusts (LIFT). LIFT was launched in 2001 in England and is a form of public-private partnership designed to help develop and improve primary care premises. Overall co-ordination and guidance is provided by Partnerships for Health, a joint venture between the Department of Health and Partnerships UK. At a local level, separate LIFTs are set up as limited companies with the purpose of co-locating related services, including local authority social services. See chapter 10 for more.

Single Shared Assessment

Single Shared Assessment (SSA) is an essential element of the joint future agenda and is intended to avoid duplication, clarify decision-making and deliver outcomes faster. The aim of SSA is that information related to the level of need of an individual is collected once and this information is then shared between agencies that can use it to provide the appropriate service. The SSA is a tool to ensure that service users are not subject to multiple assessments by different agencies - it must therefore capture information that each agency requires.

The main difficulties with SSA relate to:
- The design of the forms which capture the information - all agencies information needs must be satisfied
- Protocols surrounding information sharing
- Joint training of staff carrying out assessments.
- Progress with SSA is monitored through the JPIAF.

Other Issues

There are a number of other areas where NHS bodies and local authorities come into close contact. These include:
- Delayed discharges
- Development of community health partnerships (CHPs)
- Equipment and adaptations

Delayed discharges
Delayed discharges from hospitals (often referred to as 'bed blocking') are a widespread problem and the government is keen to see the NHS, local authorities and other local organisations (including housing organisations, primary care and the independent and voluntary sectors) working together to minimise the impact.
CHP development
The White Paper 'Partnership for Care' introduced CHPs to build on LHCCs. The new CHPs would have greater power to establish substantive partnerships with local authorities, and greater responsibility in the deployment of resources by NHS boards. It is expected that the CHPs will have a pivotal role in the development of the joint future agenda. (See Chapter 5 for further detail on CHPs)

Equipment and adaptations
The Joint Future Group recognised that enabling equipment and adaptations (for example, wheelchairs, handrails, hoists) play a significant role in the lives of disabled and older people, and that the organisation and management of these services was not always clear. The Strategy Forum - Equipment and Adaptations was set up to recommend ways to improve access to these services. The report of this group highlighted deficiencies and recommended that LPAs include specific information on the joint resourcing and management of equipment and adaptations.

References and Further Reading

SE Joint Future Unit: http://www.scotland.gov.uk/Topics/Health/care/17673/JPT100
Joint Premises: http://www.scotland.gov.uk/Topics/Health/care/17673/13312
NHS LIFT: http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHS LIFT/fs/en
Chapter Ten, Governance

Introduction

This chapter explains the concept of governance and looks at the need for and aims of the different elements that are found in NHSS. There are three main areas of governance that NHSS promotes:

- Corporate
- Clinical
- Staff

While differing in their scope, essentially all three have the same approach which includes matching the:

- Right people, to do…
- the right things, in…
- the right way, by…
- ensuring that effective systems are in place, including…
- checks and controls, and…
- appropriate internal/external reporting arrangements.

Corporate governance is concerned with all that an organisation does, not just its administrative and support functions - in the NHS this means that effective corporate governance is as much of a concern to a nurse or consultant as it is to an accountant or manager.

Clinical governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and 'safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'1. Addressing clinical governance issues is a major issue for NHS Boards, and is reflected in the fact that each board must establish a Clinical Governance Committee as a standing committee.

Staff governance is a system of corporate accountability for the fair and effective management of all staff. The establishment of a staff governance standard following the principles of Our National Health sets out the minimum standards that must be achieved by each NHSS employer in the management of staff.

As the purpose of this guide is to provide an aide to those with an interest in finance, this chapter focuses on 'corporate governance' issues. However, both clinical and staff governance are looked at briefly.

What is Corporate Governance?

Corporate governance is defined in the 1992 Cadbury Committee report as 'the system by which companies are directed and controlled'. In essence it is all about how an organisation is run - how it structures itself and how it is led. Organisational
culture is also a key factor - the principles of good corporate governance must permeate to all levels.

What this means in practice is that, on the structural side, corporate governance is concerned with the systems, processes and controls that are in place to provide a sound framework for clear and accountable decision making by senior managers across an organisation. In terms of leadership, corporate governance is to do with the responsibilities, behaviour and approach of senior managers and with the organisation’s underlying culture and values.

A specific impact of Cadbury’s recommendations in the NHS is that, since 1997/98 all annual accounts for NHS bodies have carried a statement of assurance on their systems of internal financial control. From 2001/2 all NHS boards have been required to publish an annual assurance statement called the 'statement on internal control' signed by the accountable officer (the chief executive) on behalf of the board. This statement is presented with the NHS bodies' annual accounts.

**Historical Development**

The NHS has been well aware of the importance of corporate governance for many years with a wide range of separate regulatory frameworks and ethical codes in operation for the different professions working in NHS Introductory bodies. The NHS has also been swift to learn from and respond to private sector developments - partly because as the governance structures of NHS bodies are similar to those of listed companies, the conclusions reached have a more direct application.

However, the focus on corporate governance has strengthened in recent years, largely as a result of a series of high profile cases that have referred to governance failings of various kinds - for example, the Bristol and Alder Hey inquiries, the Shipman crimes and and financial difficulties in NHS Tayside. Corporate governance underpins all activities and consists of a number of different elements. The HFMA’s Introductory Guide to Corporate Governance in the NHS identifies these as:

- Culture and values (for example, leadership style and codes of practice)
- Structures and processes (for example, statutory requirements, committee structures)
- Control frameworks (for example, risk management, audit, clinical governance, counter fraud and corruption).

As this guide's focus is finance, the remainder of this chapter looks at corporate governance from this narrower perspective. In particular it looks at:

- Risk management and assurance
- Controls assurance
- Statement of internal control
- The board’s role
- The accountable officer
The director of finance
Codes of conduct
Committees
Audit
Processes
Fraud and corruption.

Risk Management and Assurance

In the context of health, corporate governance is also concerned with the use of scarce resources to provide high quality clinical care in ‘an environment of care’. This linkage of resources to quality is an obvious, but radical step. It is no longer acceptable to settle for inadequate quality on the grounds that resources are insufficient. This relationship leads to difficult questions, such as: Can we afford to provide this service safely with existing resources? Should the service be centralised to create a critical mass of resources to enable quality thresholds to be reached?

Good corporate governance therefore includes implementing and maintaining effective risk management and organisational controls. Although not always overtly expressed, the financial management of the NHS concerns the management of risk - ensuring that resources are deployed to comply with health and safety legislation, securing sufficient medical cover for a particular specialty, or having a piece of medical equipment that improves diagnostic results. Recognising the interdependence of such elements, NHS bodies have set up committees that ensure a rigorous and methodical approach is taken. These include audit and clinical governance committees (both mandatory) and risk management committees (not essential but a good way of focussing effort in this area).

The application of an appropriate risk management model, the establishment of a process to identify risks, the setting of control standards (such as standing financial instructions) and the use of benchmarking are all risk management techniques. Together, they provide reassurance to board members, so enabling an assurance statement to be signed. NHS Scotland (NHSS) has a national risk management scheme - the clinical negligence and other risks indemnity scheme (CNORIS) - which has been developed to provide claims management and risk management arrangements.

The benefits of an effective approach to risk management and assurance include:
- Reduction in risk exposure through more effective targeting of resources to address key risk areas
- Improvements in economy, efficiency and effectiveness resulting from a reduction in the frequency and/or severity of incidents, complaints, Introductory claims, staff absence and other loss
- Demonstrable compliance with applicable laws and regulations
- Enhanced reputation and increased public confidence in the quality of NHS services.
Controls Assurance

A key element in the overall risk management and assurance framework for NHSS is the Performance Assessment Framework (PAF) – an approach that has been developed by the SGHD to meet the operational needs of NHSS. The PAF has 7 key areas against which organisations are measured:

- Health improvement and reducing inequalities
- Fair access to health services
- Clinical governance, quality and effectiveness of healthcare
- Patients’ experience
- Involving the public and communities
- Staff governance
- Organisational and financial performance and efficiency.

Each area has a range of qualitative and quantitative indicators against which NHSS organisations’ performance is assessed. This then provides evidence that all parts of the organisation are doing their ‘reasonable best’ to manage themselves in a way that enables them to meet their overall objectives with minimal risk to stakeholders (for example, patients and staff). The organisation's board is also informed about significant risks so that it can decide where best to direct limited resources to eliminate or reduce those risks.

Statement on Internal Control

The focus on risk management and assurance finds formal expression in the statement on internal control (SIC). Since 2001/02, NHS bodies have had to submit a SIC as part of their annual financial statements. Changes announced by the Treasury require an even more rigorous approach to the SIC from 2003/04 - accountable officers (see below) must now disclose the following in the SIC:

- Identification of how the risk management processes are maintained and developed to ensure continuing effectiveness
- Disclosure of significant internal control issues
- A description of the processes in place
- Documented evidence of the assessment of the effectiveness of the system of internal control and assurances that actions are or will be taken where appropriate to address issues arising.

The SIC must be signed off by the chief executive, as the accountable officer, on behalf of the board. Internal audit advises on the adequacy of the internal control system and both it and external audit formally report the completeness and adequacy of the SIC. The SIC is an extremely important statement that covers the whole of an organisation and is a board responsibility. Chief executives and boards will be held to account if they sign a statement that subsequent events show they did not understand or take seriously.
Board Controls - A Financial Focus

NHS boards are responsible for high standards of financial stewardship through effective planning, financial strategy, and financial control and through maximising value for money or obtaining 'best value'. They are assisted in these tasks through guidance, regulations, policies and procedures as discussed below.

Role of the Accountable Officer
The SGHD has formally given chief executives the status of accountable officers for their organisations, and they are sent a memorandum setting out their responsibilities. As accountable officers, chief executives must make sure their organisations operate effectively, economically and with probity; that they make good use of their resources, and they keep proper accounts. The role of the chief executive as accountable officer is therefore a key element in corporate governance, requiring the NHS body to act corporately to achieve goals and to account to the chief executive of the NHS for its success or failure.

Role of the Director of Finance
Finance directors of health bodies are automatically executive directors with a seat on the board. Their role includes:

- Corporate management - finance directors take part in setting the strategic direction of the organisation and drawing up its plans; present information to the board to show how their plans are being actioned; help to shape new initiatives by finding cost-effective solutions; and manage the finances in support of the corporate objectives
- Financial management - finance directors are responsible to the chief executive and board for formulating, monitoring and reviewing financial strategy, as an integral part of the business plan
- Public accountability and stewardship - finance directors have a special responsibility for preparing the annual financial statements and returns; for ensuring that the highest standards of conduct are maintained within their organisations and that there is probity in the use of public money
- Finance directorate management - finance directors need to lead the way in adopting the best possible standards of management in order to provide a finance function that is highly motivated, well trained, and dedicated to quality and excellent service.

More recently finance directors have taken on much wider responsibilities around estates and facilities, and information, communications and technology.

Codes of Conduct

Code of business conduct
On Board - a guide for board members of public bodies in Scotland was issued by the Scottish Government in 2000, following from the implementation of the Ethical Standards in Public Life (Scotland) Act 2000.
The Model Code of Conduct sets out the following principles that board members are expected to uphold in carrying out their duties:

- Public service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Honesty
- Accountability and stewardship
- Respect
- Openness.

**Code of conduct for NHS managers**
The Code of Conduct for NHS Managers issued in October 2002 sets out core standards of conduct expected of NHS managers to guide them and employing health bodies in the work they do and the decisions and choices they have to make. It also reassures the public that these important decisions are being taken against a background of professional standards and accountability.

**Committees**

To help the board discharge its duties effectively, a number of committees exist in NHS bodies - some of which are mandatory. Within the finance area, the key committees are:

- Terms of service and remuneration
- Audit committee.

Boards are also required to have separate clinical and staff governance committees - see later in this chapter.

**Terms of service and remuneration committees**
A key function of management is to appoint, appraise and reward its employees fairly and equitably. NHS boards carry out this function by establishing a remuneration and terms of service committee. This is a mandatory committee that reports to the board. The committee must comprise the organisation's chair and at least 2 other non-executive directors.

**Audit committees**
Audit committees are mandatory and provide an independent and objective review of the organisation's financial systems, its financial information and compliance with legislation. The audit committee is a sub-group of the board, comprising non-executives and excluding the chair of the NHS body.
**External Audit**

The public is entitled to expect that money raised by local or national taxation is properly accounted for. To provide an assurance that this is the case, there is a need, among other things, for a wide-ranging audit covering both financial aspects of corporate governance, value for money (VFM) and identifying areas where improvements may be possible – for example, increased efficiency in one place may lead to greater advantages elsewhere.

There is a continuing programme of VFM research at national level to identify good practice so the benefit can be shared more widely. One of the most effective tools is the use of comparative information that helps local managers to see areas where they could improve performance.

Audit Scotland is responsible for external audit, which it may delegate to private providers of audit services. In relation to the overall assurance framework, external audit must review and report on:

- Financial aspects of corporate governance arrangements as they relate to:
  1. the legality of transactions that might have significant financial consequences
  2. financial standing
  3. systems of internal financial control
  4. standards of financial conduct and the prevention and detection of fraud and corruption
- The annual accounts
- Arrangements to manage performance that relate to economy, efficiency and effectiveness in the use of resources.

The external auditor is also required to issue a management letter to board members at the conclusion of each year's audit. The letter acts as a brief for the board and brings together the major issues stemming from the audit or which the auditor wishes to raise. The auditor should issue such a letter by 31 December following the year of audit.

**Internal Audit**

All NHS bodies must have an internal audit service to provide an independent and objective opinion to the accountable officer, board and audit committee on the extent to which risk management, control and governance arrangements support the aims of the organisation.

The development of the 'managed audit' process has helped to define the scope of internal audit. This requires internal and external audit to agree a joint approach, enabling external audit to place reliance on internal audit, rather than duplicating their work.
Organisational Controls - a Financial Focus

Board reports, annual accounts and annual report Boards must ensure that they receive regular financial and other information in a succinct and efficient form so they can make informed decisions on spending. It is for the board to decide the form and content of the reports. NHS bodies must prepare accounts and have them independently audited. In addition, NHS boards must prepare annual reports, which must be presented to a public meeting by 30 September following the year-end. The annual report must be approved by the board and signed by the chair of the board. The chief executive, as accountable officer, and the director of finance must sign the audited accounts.

Standing financial instructions, standing orders and schemes of delegation All NHS bodies are required to have these documents written and approved by their boards. They detail rules and regulations that govern the administrative procedures of the board and of employees.

Other policies/procedures
For NHS bodies to run smoothly, many more policies and procedures (both financial and non-financial) are required; and these are usually pulled together in organisational policy and procedure manuals. These cover a wide variety of areas from banking procedures, use of credit cards to health and safety and equal opportunities policies.

Fraud and Corruption

The emphasis on dealing with fraud and corruption in the NHS has increased significantly over the last few years. As a result, NHSS now has a national Counter Fraud Service that investigates suspected cases of fraud in relation to Family Health Services (FHS) finance. FHS covers payments made to independent practitioners (GPs, pharmacists, dentists and opticians). The unit also checks claims made for patient exemptions by individual patients. Local checks were previously carried out by boards into patients who claimed to be exempt from FHS charges for treatment, however these checks did not satisfy the need for a consolidated national programme. A team was therefore set up to promote a national campaign of deterrence and to consolidate patient checking Scotland-wide, using technology to rationalise the process. The role Counter Fraud Services was extended in 2002 (see HDL (2002) 88) to take a lead role in the deterrence, detection and investigation of fraud, other irregularities and corruption within and against NHS Scotland.

Clinical Governance

Clinical governance makes quality of care an integral part of the NHSS governance framework.
NHS boards are obliged to establish structures and processes that put quality of care at the forefront of their operation. Responsibility for the delivery of clinical governance rests with the chief executive, who discharges this responsibility through the management structure of the NHS board. Whatever management structure the Board chooses to operate requires staff at all levels to be well informed about relevant clinical quality issues and to make decisions based on that information.

**Role of the clinical governance committee**

Each NHS board should have established a clinical governance committee with a reporting line direct to the board. The role of this committee is:

- To oversee rather than deliver clinical governance
- To observe and check on the clinical governance activity being delivered by management
- To assure the board that appropriate structures are in place for clinical governance to be effective; that these structures are operating effectively and that action is being taken to address any areas of concern.

In addition to the work of the local clinical governance committee, one of the national special health boards - NHS Quality Improvement Scotland (NHS QIS) - has a national role in setting standards, monitoring performance, and providing advice, guidance and support to NHSS on effective clinical practice and service improvements.

**Staff Governance**

Staff governance is the third component of the governance framework within which NHS boards are required to operate. The performance and accountability framework (PAF) for NHSS ensures that boards are equally accountable for how they behave as employers.

As well as meeting all legal obligations and implementing existing policies and agreements, organisations are expected to continuously improve in relation to the fair and effective management of staff.

There are 5 key standards that employers are required to deliver, entitling staff to be:

- Well informed
- Appropriately trained
- Involved in decisions which affect them
- Treated fairly and consistently
- Provided with an improved and safe working environment.

In achieving this, NHS boards must:

- Have an Employee Director who sits on the Board
- Have both a local and area partnership forum
- Establish a staff governance committee as a standing committee of the Board.
References and Further Reading

Introductory Guide to Corporate Governance in the NHS, HFMA, 2003 CNORIS:
http://www.cnoris.com/

On Board - A Guide for Board Members of Public Bodies in Scotland:
http://www.scotland.gov.uk/library5/social/obgbm-06.asp

Example NHS Board Member Code of Conduct:

Code of Conduct for NHS Managers:
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/Moder
nisingProfessionalRegulation/ConductCodeNHSStaff/fs/en

Audit Committee Handbook (May 2001), available from the publications pages of the
Department of Health's website:
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolic
yAndGuidance/fs/en

Counter Fraud Services:
http://www.show.scot.nhs.uk/fiu/index.htm

Clinical Governance
http://www.nhshealthquality.org/nhsqis/

Staff Governance Standard:
SECTION 9: Further Information

Useful Websites

1. Main Scottish Health Sites
   www.show.scot.nhs.uk
   Main health site for Scotland – has search engine and links

   www.show.scot.nhs.uk/SGHD
   Scottish Government Health Directorate website

   www.isdscotland.org
   Information and statistics division for Scotland – details of statistics and useful information on health issues

   Delivery for health – key document that sets out the service plan for service reform and modernisation in NHS Scotland


2. Acute Services Website
   www.show.scot.nhs.uk/waiting/
   Waiting times database and information for whole of Scotland

3. Mental health
   http://www.scotland.gov.uk/Topics/Health/health/mental-health/NationalProgramme

4. Better Health, Better Care
   http://www.scotland.gov.uk/Topics/Health/Action-Plan
   http://www.scotland.gov.uk/topics/health/NHS-Scotland/Delivery-improvement
   http://www.scotland.gov.uk/Publications/2009/01/20121026/0
   Force for Improvement – Workforce response to BHBC

5. Scottish patient Safety Alliance:
   http://www.patientsafetyalliance.scot.nhs.uk/
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