enlighten.scot

NHS 2048

Compendium

enlighten
Scotland's independent think tank

ENLIGHTEN

Enlighten, a charity registered in Scotland, is a public policy institute which works to promote increased economic prosperity, opportunity for all, and more effective public services. Enlighten is independent of political parties and any other organisations. It is funded by donations from private individuals, charitable trusts and corporate organisations. Its Director is Chris Deerin and Alison Payne is the Research Director. Both work closely with the Trustee Board, chaired by Lord Jack McConnell, which meets regularly to review the research and policy programme and carry out their legal responsibilities.

BOARD OF TRUSTEES

CONTENTS

Workforce

Governance and Leadership

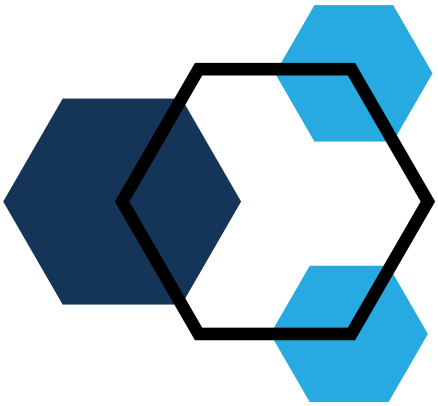
Resource Allocation and Shifting the Balance of Care

Rurality

Patient-Led Change

End of Life

Political Contributions



FOREWORD

Enlighten launched its NHS2048 programme – named for the centenary of the health service's founding – in November 2023. The intention was to highlight the many challenges facing Scotland's health, and to draw out ideas from across the sector and beyond as to how these problems can be addressed.

In the two-and-a-half years since, we have published over 70 contributions, with authors ranging from senior clinicians to those working in the private sector, from academics to political and third sector leaders. It has been an unprecedented flowering of thought leadership and innovation, and shows that the ideas are out there, if only there is the political will and courage to deliver them.

Given the difficult politics around health, it is hard to see any one party being in a position to commit to the radical change that is needed. Indeed, the mood among our contributors and at the various events we have held has been that cross-party collaboration is essential: decide on the nation's medium- and long-term priorities and agree a broad plan of action which successive governments (of whichever party) can follow. So far, unfortunately, the politicians have proved reluctant to work together in any meaningful way.

Without serious, collaborative reform, the challenges facing the health service, the social care system, and Scotland's health in general, will not be met. Let's hope that once the Holyrood election is over, our political leaders will rethink their intransigence, decide to put country before party, and get down to the hard work of tackling what is, as the polls tell us after all, the electorate's top priority.

Chris Deerin
Director

Overarching Reform

1. The NHS Is Not Sustainable in Its Present Form – Paul Gray

Originally published 15/11/2023

This article first appeared in The Herald **on 15 November 2023**

When the NHS was founded in 1948, we were told:

"*There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness*."

In 1948, the population of Scotland was around 5.1 million; now it is over 5.4 million – an increase of about 6%. And life expectancy for both women and men has increased by well over 10 years since 1948. But in 1948, 15 million prescriptions were issued in Scotland. By 2018, the 70th birthday of the NHS, that had risen to over 103 million – an increase of over 600%. And in 1948, there were just over 22,000 nurses and midwives in NHS Scotland; now there are around 60,000. So let us temper our aspirations of a return, by 2048, to the halcyon days of 1948. We probably want to hang on to minimally invasive surgery, MRI scanners and the Glasgow Coma Scale. They really were invented here, just like the Highlands and Islands Medical Service, which covered half of Scotland's land mass from 1913 onwards and offered a template for the NHS.

However, we are now at the point where it is widely recognised that the current approach to providing health and care services is not sustainable in its present form. It is not sustainable for the people it is intended to serve; it is not sustainable for the people providing the service; and it is not sustainable in terms of continually increasing demand on the resources available to fund it. This is not the same as saying that it is beyond repair, or that it is fundamentally unfit for purpose. But the need for change and development is obvious and the moment is not near, but now.

Change is possible; governance of health and care services now is very different from what it was in 1948, but does it reflect the current and foreseeable needs of the population? Development and innovation are possible; there have been some profound, life changing advances pioneered in Scotland, but are there some developments that are now more urgent than others? Expansion is also possible as the numbers quoted show; but is it inevitable, and should it be planned and managed, and is it always the right answer?

If we are all paying for the NHS, should we care about it? I suggest that we should, and that most do. And if we care about it, should we be willing to talk about it? I suggest that we should, and that many might agree. But if we want to talk about it, ought we to think about the terms of the debate? I suggest that we should, and I would like to invite you to do so as well.

If we seriously want to have viable health and care services in 2048, we need to talk soon and act quickly. And we need to avoid using the discussion to prove that everyone else was wrong and I was right. If I proposed that we reinstate the NHS as it was in 1948, with the same staffing, governance, funding, diagnostics and procedures, I would be laughed out of court. But the reason

for that is not that what was done in 1948 was wrong. It was right – for its time. It is just that a lot has changed since 1948, and we know things now that we did not know then.

So, my first proposition is that we should remember that change is hard and using it as a weapon to claim the moral high ground greatly reduces the likelihood of its success.

My second proposition is that development and innovation are needed, but they must be prioritised to the issues that are most fundamental and pressing.

And my third proposition is that expansion is not inevitable. If all we need is more of everything, we have three problems. The first is that more of everything is not available. The second is that more of everything is not affordable. And the third is that more of everything is not right.

Against that background, I want to make a final point. Change involves choice. Choice is difficult. Choice often means that some people get what they want, and others don't; or some people get something quickly, and others have to wait. But there is one choice that everyone contributing to this debate can make: do I want to make it possible for everyone to contribute, or would I prefer to hear only the voices with which I agree? Our actions will convey that choice much more clearly than our opening statements of intent. Nobody will dissent from the idea that the debate will be open and inclusive – but if I think that health and care services should be free at the point of delivery, will I jeer at people who suggest that we consider other options? If I think that we should have more involvement of the private sector in the NHS, will I call people who believe it should be entirely in public ownership naïve? The more that we can discuss difficult issues openly and respectfully and draw on evidence and analysis rather than opinion and oratorical skill, the more likely we are to do good. And who knows, we might surprise ourselves by hearing a different perspective and seeing things in a light we had not recognised hitherto.

I welcome Enlighten's willingness to host this debate. I believe that the manner in which we approach it will tell us a great deal about the likelihood of our reaching a successful outcome.

Professor Paul Gray was chief executive of NHS Scotland, 2013-19 and NHS Scotland Director of Primary and Community Care from 2005-2007.

2. Ideas to Stimulate a National Discussion – David Rowland

Originally published 12/12/2023

Introduction

We need our NHS now more than ever.

With more of us living longer and with increasing chronic conditions, we need a service that responds quickly, effectively, safely and in a way that helps individuals achieve their desired outcomes if we are to avoid worsening symptoms becoming acute exacerbations that result in debilitating and decompensating stays in hospital.

But we cannot look at NHS service provision in isolation.

Rather, given their symbiotic relationship, we must jointly consider what the future shape of NHS and Social Care services is. These services must be planned and delivered in a way where Social Care is seen and valued as an equal to NHS services, recognising the vital role it plays in supporting people to live well and independently at home, reducing the chance of admission to hospital and ensuring timely discharge when a hospital stay has been necessary.

In progressing this discussion and to plan effectively for a Health and Social Care system fit for the future, the following factors should be considered:

1. **What Health and Social Care Services should we provide and to who?**

The range of services provided by the NHS has grown exponentially since its inception and the level and complexity of Social Care at Home services has grown significantly since the introduction of Free Personal Care.

The current levels of provision are not sustainable. Nor is there scope for further growth and development in a sustainable way under the current system.

There is therefore a need to discuss openly and honestly what Health and Social Care services should be delivered in the future.

From an NHS perspective, General Medical Services as the source of the holistic assessment, advice and support necessary for condition management, as well as gateway to more specialist interventions when required, must be protected and properly funded as a core Health Service, free to all at the point of access.

Similarly, to ensure life and limb continue to be protected in emergency situations, Emergency Departments should continue to offer assessment, diagnosis and treatment, following an accident or where a person has a life-threatening condition, with onward transfer to a specialist emergency treatment facility where required. This too should be free to all at the point of access, as should emergency ambulance response, treatment and transfer to hospital where this is required. People who present to these services who have not experienced a significant injury from an accident or who have a life-threatening condition should no longer be given any treatment

within the Emergency Department and should be signposted to the service that can best meet their needs, where these exist.

There is also a strong argument, given the increasing incidence and prevalence, particularly among low income and disadvantaged individuals, to continue to provide a full range of appropriately resourced Mental Health services, free to all at the point of access.

There does, however, need to be a discussion about wider primary care services. Should General Dental Services and General Ophthalmic Services continue to operate in a mixed economy basis with assessments free to all at the point of contact and grades of treatment based on an individual's ability and willingness to pay? Or should there be means testing to ensure those on lower income can continue to access services as they do now, while those on higher incomes either pay as they go or enter an insurance-based arrangement to cover costs when they use services? Similarly, should we continue with free prescriptions for all and free access to consultative services offered under General Pharmaceutical Services through the Minor Ailments Service or should these too be means tested?

Turning to specialist out-patient, diagnostic, day-case and in-patient services, the current level of expectation and demand cannot be met and a discussion is required as to how we manage this. Work was done previously by the King's Fund, highlighting procedures of limited value – should these be removed from the range of services offered by the NHS? Alternatively, should we raise the thresholds for access to treatment, accepting that this may impact adversely on how people live their lives and contribute to society? Or, indeed going even further, should we consider not offering interventions where a condition is a result of a self-inflicted lifestyle choice, e.g. smoking, excessive alcohol consumption, excessive eating, abuse of illegal or prescription drugs, etc.? None of these choices feel in any way palatable but these are precisely the difficult type of discussion that is required if we are to safeguard the NHS capacity for those who need it most. There is, of course, also the question of whether access to out-patient, diagnostic, day-case and in-patient services should be means tested and free at the point of access for low-income families, while those who are better off make provision through an insurance scheme – we accept the need to insure our homes, our cars, our life and our travel, so why not our health? There may also be a case for contracting out some of the high volume, low complexity planned care work. While this could help reduce waiting times for certain services, there is a risk that altering the case mix within certain services could lead to increased pressure on NHS Staff who would be dealing with the more complex and challenging cases all day, every day, which could lead to burnout and higher staff turnover.

Linked to this is the ongoing introduction of new and expensive drugs and medicines, underpinned by evidence from clinical trials. While the evidence of the efficacy of such treatments may be strong, there is a need to consider the extent to which new drugs and medicines, along with those already available, simply offer symptom relief, which offer limited impact on life expectancy or quality of life, which offer increased life expectance but limited or no improvement in quality of life and which offer curative potential with or without improvement in quality of life. Based on this, discussion should be had with the public about the financial impact of providing such drugs and medicines, with an aim to determine a more rationale and sustainable approach to providing

those that offer greatest benefit to the most people, accepting that some of these decisions will prove to be difficult and highly unpopular with some groups.

In terms of social care, the disparity in the availability of provision across Scotland is significant. Similarly, the disparity in the assessment practice of practitioners is evident with some areas identifying the need for face-to-face social care packages that are double the size of the Scottish average. There is a need for standardisation and an approach that limits face-to-face care to those interventions that only professional care staff can offer. The days of having sufficient capacity to offer 'check-visits', medication prompts, shopping support, housekeeping support, etc are no more. There is a need to focus our limited social care capacity on the provision of personal care, and a discussion as to how the third sector, local communities and families can offer wider support. Linked to this, there is a need for an honest and open conversation about how sustainable Free Personal Care is, particularly in light of a dwindling workforce, increasing demand and expectation, rising costs of delivery and continued budget pressures.

2. **How do we promote and encourage individual responsibility for health and wellbeing?**

The NHS has for too long been seen as a panacea to all our health-related ills. It has become a paradoxical entity that is both treasured and valueless at the same time. People recoil from any hint of change, modernisation or transformation of the health service that may change their relationship with it while at the same time, having no sense of the costs they incur when they access it.

This is perhaps a result of one of its greatest traits – a service that is free to all at the point of access. But perhaps it is that trait that has resulted in a common belief that the NHS is there to support us regardless of what health needs we have. And this, has perhaps, for some, led to an abdication of personal responsibility for one's own health – for where is the incentive to change or adapt one's lifestyle to live a healthier life or to take the steps that can help better manage a known condition and avoid acute exacerbation, when you have grown up knowing that the NHS will respond to your needs and, without cost to you at point of access, generally get you back home and living your life again?

We therefore need an honest conversation about our population's health and the responsibility of every single citizen to take the steps they can in living the healthiest life they possibly can.

Similarly, with Social Care, the introduction of Free Personal Care has created an expectation that people will be supported at home with a four-times-per-day visiting service from trained, professional care staff fast becoming the norm. This combined with the comparatively low value we as a society place on the elderly, when compared to other societies across the world, means that some individuals and families abdicate responsibility and seek to take no role in meeting people's social care needs – even the non-personal care aspects. This is neither sustainable nor particularly healthy for us a society and the impact on older people's wellbeing cannot be underestimated. There is therefore a need for discussion on how we see and value older people as vibrant contributors to our society and how we develop strengths based approaches to helping them understand how their assets, their families, their friends and their communities can support them in living the life they want while helping them connect them with a wider range of supports

to help them achieve their desired outcomes. Such an approach would enable us to focus our limited professional social care resources on ensuring people's personal care needs can be met in an effective, efficient and timely way.

3. How do we fund Health and Social Care Services for the future?

There is no question that the post-2010 austerity action has impacted greatly on the resources available to support the delivery of Health and Social Care and there is now a need to either significantly increase the budget for both or change the funding model for us as citizens.

We will not be able to sustain Health and Social Care services without change to the funding model and while it is difficult to engage people in a discussion about this, it must lie at the heart of our planning for 2048 and beyond.

Given there are little or no savings left to take, any increase in capacity needs to be funded and there are three ways to do that.

First, to fund services we could introduce a new Health and Social Care tax. A proportionate tax levied on income from individuals and ring-fenced for the purposes of Health and Social Care, with complete transparency in terms of a set of accounts that shows how much is being raised and what it is being spent on nationally. This would have the added benefit of helping people understand the cost of these services and perhaps enhance the value they place on them.

Secondly, this levy could be made more proportionate by using the amount raised to fund General Medical Services, Mental Health Services and Emergency Services for all but only wider primary care services, planned care services and free personal care for low-income households, with higher earners required to make their own provision through an appropriate insurance system for health services and direct, personal payment of social care.

Thirdly, to raise capital funding to support new facilities or invest in new IT system development, windfall taxes should be raised on any excess profits (level to be determined) made by large utility companies, energy companies and pharmaceutical companies. This would provide the one-off funding required for investment.

Discussion around the merits of these and other funding options is vital to considering the future of Health and Social Care.

4. How do we create a vibrant, dynamic and committed workforce for the future?

We do not have enough trained staff in health and social care. Practitioners leave both the NHS and Social Care because the terms and conditions are poor relative to other sectors in Scotland and, for those with greater mobility, other health sectors across the world.

There is therefore a need to review and enhance the terms and conditions for staff. This has to include the rates of pay, the hours they work and, of course the conditions they experience in the workplace. If each day is a relentless, unfulfilling slog then even higher rates of pay and slightly shorter working weeks are not going to be appealing.

We should want a future workforce who are motivated to make a difference for the people they support, a workforce who want to help them achieve the life they want to lead and a workforce

who take pride in achieving that. More than that we should want a workforce who feel valued by those they support, but also by society as a whole.

For social care professionals in particular this is a massive issue. They are not held in the same regard as NHS staff. They experience much lower rates of pay than, for example Healthcare Support Workers, yet often carry much greater responsibility in terms of lone working, assessment and decision-making and, of course, administering medication. This needs to be addressed as a matter of urgency and we need to promote a career in care in the same way as we promote a career in nursing or any other health profession.

We therefore need a discussion about how we achieve this. It will take a change in how we portray Health and Social Care. Pick up any newspaper, log on to any news outlet, listen to any opposition politician and they are all quick to tell you how bad Health and Social Care is right now – who would want to come to work in an industry that is getting such a bad reputation; who would want to stay in it.

There is no question that Health and Social Care is under pressure – I would not be writing this if it wasn't. But the staff within those services do brilliant things every day. They change lives every day. They are there making the best of times better and they are there making the worst of times as bearable as they can. Our staff are to be celebrated but we only hear about the bad.

The discussion on how we promote careers in health and social care and how we value the services and cherish the workforce needs to be driven by how we de-politicise these services. Both have become the proverbial political football with those in government defending their policies and performance of service while setting unrealistic targets and goals and driving silo-based and at times contradictory service directives. While those in opposition attack and seek to highlight and make the most of any weaknesses for political gain. This needs to stop. We need to build a political consensus around what the professionals and the public tell us our Health and Social Care services should look like for 2048 and beyond. This needs to be managed and delivered on a cross-party basis, with appropriate but constructive challenge around those areas where improvement are needed.

5. What Health and Social Care Structures do we need for the future?

Scotland is a large geographical area but with a small population. Many of our more specialist services are not sustainable at current territorial health board levels due to limited staffing availability and budgetary challenge but more importantly insufficient population density to sustain skills and expertise.

We therefore need a new model of delivery where we agree what people can reasonably expect close to home – definitely General Medical Services and perhaps a 'rural DGH' offering immediate assessment and stabilisation of life-threatening conditions before transfer on to specialist sites; General Medical, Care of the Elderly and Rehabilitation / Repatriation for recovery from acute exacerbation; supported virtual out-patients; and a full range of diagnostics (reported remotely).

We also need to specify a new model of delivery that sees, as a norm, people traveling to regional centres for planned care, where capacity protected from unscheduled care activity, is maximised to reduce waiting times and from where people will be discharged at an earlier stage back to their

local DGH for recovery. Similarly, regional unscheduled care centres will be needed to provide the specialist interventions required before transfer back to a local DGH for recovery should become the norm.

This would require a very different Territorial Health Board structure and it is perhaps now time to move to the much talked about three-region model to plan and deliver these regional hubs, with local 'rural' DGHs being managed by a reformed Integration Joint Board structure that would ensure these services were planned and delivered in a way that is right for local needs and in a manner that interfaces seamlessly with the social care and community health delivery in the area.

These reformed Integration Joint Boards should be directly accountable to and funded by Scottish Ministers through the National Care Service. All responsibility for Social Care should be removed from local councils to avoid disparity of standards and to ensure application of budget is not swayed by conflicting local priorities.

6. What systems do we need for Health and Social Care services in the future?

For Health and Social Care services to operate effectively, safely and in a person-centred way, everyone involved in a person's care should have access to the information they need. Right now, there are a myriad of health systems and a myriad of social care systems that allow the flow of information to a greater or lesser degree.

This builds risk into the system, is frustrating for people providing care and support and exasperating for people accessing care and support as they have to tell their story time and time again.

We need to discuss what our information requirements are. We need to discuss how we want information to be shared in the future. And we need to use that to form a specification for our IT systems for the future. We need to move away from individual NHS Boards and Councils having the ability to specify and procure their own systems and move to an NHS and NCS procurement that is led by Scottish Ministers on a once for Scotland basis and rolled out consistently across all services.

Through the move to Vision for all GP Practices by 2026, we are seeing the first step towards this, and we need to build on that momentum.

It will take time, perhaps a decade or more, and it will be disruptive and painful, but the long-term benefits far outweigh the short-term disadvantages.

Similarly, when it comes to applying new technologies, there needs to be a once for Scotland approach to ensure equity and avoid waste and duplication. There are three key areas where discussion is required now to agree a national direction.

First, the use of Robotic Assisted Surgery, ensuring this is linked directly to service planning and the regionalisation of specialist services, as well as workforce planning and the training of our future surgical workforce.

Secondly, the implementation of Artificial Intelligence in Radiology to improve efficiency and effectiveness in the reading of images to support clinical decision-making.

Thirdly, Digital technologies to support independent living at home, deploying a pace and scale those technologies that can support the activities of daily living, those that can aid social interaction and those that can monitor changes in health and behaviour and escalate for early intervention to reduce the number and level of acute exacerbations.

Conclusion

There is no single or simple answer to how we create a more viable and sustainable Health and Social Care system for 2048 and beyond.

Rather, there is a need for an open, honest and challenging discussion with the public, with professionals and with politicians on how we radically transform our current arrangements into those that will be fit for the next hundred years.

Those discussions will need to cover the factors covered in this article, and indeed many others.

But there is a fundamental aspect that needs to be considered and that is the expectation of those who use these services. That expectation has grown exponentially over the years since 1948 – perhaps even more so than the range and capacity of services that are now offered.

At its inception, the NHS issued a leaflet to every household detailing what their new health service would offer and how they should use it. It may sound patronising and twee at this point in time but the truth is we have lost sight of this over time and whatever the design of our future Health and Social Care services looks like, we perhaps need to go back to that very direct, basic messaging to re-set expectations and people's relationship with these services.

David Rowland has a Masters in Public Policy and Management and a lifelong interest in, and passion for, excellence in health and social care.

3. More Questions than Answers and a Healthy Dose of Realism - Dr Andrew Evennett

Originally published 21/12/2023

So here we are, 75 years into the NHS's 100-year journey from inception to centenary, faced with the seemingly Herculean task of ensuring that it reaches that venerable milestone still free at the point of need and delivering a service which is effective, cost-efficient, sustainable and valued by all of its stakeholders.

Accordingly, we should acknowledge the size of this challenge and anticipate a process which will involve multiple steps, considerable sophistication, patience, diplomacy and attention to detail and foster a spirit of constructive cooperation.

I agree that at the beginning of this process it is correct to ask, "what are the key questions which we should be asking?".

To make lasting progress we need to set off together in the right direction.

Simplistically, one could imagine that to make an organisation or service work well requires an agreed vision and budget, an appropriately designed strategy, the creation of a suitable operational plan, a thorough governance framework, active stakeholder engagement, regular review and subsequent adaptation/evolution.

Yet the NHS has been doing all of this for years.

In fact the amount of political, academic, managerial, clinical and creative energy poured into the NHS has been colossal.

Over these 75 years some people have experienced interactions with the NHS which have been satisfactory, good, very good, excellent or extraordinary.

Unfortunately, others have had experiences which have been unsatisfactory, bad, very bad, dreadful or catastrophic.

The extensive systems of governance reporting and critical incident reviews have provided a vast amount of information about all of the above.

Also, during this time there have been very many strategic reviews, refreshed visions for healthcare, renewed clinical strategies and public engagement exercises and yet stakeholder dissatisfaction remains very high.

So, some of the ensuing questions may include:

- **Why is there still such a large gap between the intended and actual output/delivery of the NHS resulting in such a level of dissatisfaction?**
- **Fundamentally, does the NHS represent the correct paradigm for healthcare delivery or are we striving for the impossible?**

If Scotland is to have a mature, constructive debate aimed at building consensus around the future of health and care services, **how does one satisfactorily hear the representation and meet the needs of such a large and varied group of stakeholders (patients, public/ electorate, tax payers, NHS staff, indirectly contracted staff, government, parliament…), each with different hopes and expectations (access to excellent healthcare, value for money, good employment conditions, political ideals…) ?**

Linked to this is the challenge to encourage acknowledgement of vested interests to allow for the most productive dialogue.

Last year I asked several former medical colleagues from very different roles and backgrounds to give their opinion about what should be done to improve the NHS and received dramatically different responses.

When discussing what has/has not worked well thus far, clearly there is a need to be frank, open and specific yet also to avoid causing offence to those whose contributions have turned out to be less successful or even damaging.

- **How is this going to be facilitated in order to produce the most creative framework for effective change rather than promoting defensive, obstructive or negative behaviour?**

Organisational culture has the reputation of being able to confound even highly sophisticated organisational strategy, rendering it ineffective.

- **So what does a healthy organisational culture look like and how do we promote and develop this at all levels of the health and care service?**
- **How do we design a service which is able to adequately cater for constantly changing societal behaviour and subsequent requirements?**

The health and care sector workforce is suffering from considerable collective fatigue but also a high level of disillusionment.

- **How do we regain lost confidence in the short to medium term in order to completely overhaul the service in the medium to longer term?**
- **As we seek to design a service which functions well at a national level how do we also encourage and optimise local engagement and ownership?**
- **How do we decide how to divide the use of finite resources between relatively low cost/high impact health promotion and high cost dramatic intervention?**

Over the last 75 years technology has advanced at an incredible rate and undoubtedly will continue to do so even more over the next 25 years. Indeed, the development of Artificial Intelligence has been compared with that of nuclear energy, bringing both enormous opportunities as well as very real challenges.

- **How are we going to engage with science and technology to optimal effect?**

Moving on from suggested possible questions I would like to make a specific suggestion.

I have already mentioned the large number of strategic initiatives which have taken place during the life of the NHS.

In my opinion, by far the most outstanding of these has been that of Realistic Medicine, introduced by the Chief Medical Officer in 2016, conceptually relatively simple and yet profound in terms of its potential impact.

At its core is a framework for delivering dynamic, interactive healthcare capable of catering for the general and specific needs of both the population and the individual, changing as they do with time.

I would like to close this piece with the suggestion that as we proceed with the NHS 2048 project we could learn from Realistic Medicine:

We should strive to include realism in all our discussions. Saying or planning a thing does not mean it will happen or succeed.

We should aspire to develop an NHS which is dynamic and interactive at every level, able to evolve rapidly as required.

Dr Andrew Evennett is a retired GP. He was a member of the NHS Highland Board, chaired the Area Clinical Forum Chairs' Group for Scotland and served on many other health committees. He was actively involved in raising concerns about behaviour in NHS Highland and in the subsequent review processes.

4. The NHS in 2048 - Dr Ronald Culley

Originally published 05/03/2024

Across the entirety of its 75 years, the NHS has been a public service under pressure. It has had to contend with issues around increasing costs, government under-investment, a complex and under-pressure workforce, and the constant innovation of new drugs and medical technologies – and yet through it all, it has maintained its position as our most-prized institution. When the public is asked for a view, the response is pretty consistent – the NHS is sacred, give it the funding it needs, and don't footer with it.

That's all well and good, but there are clouds on the horizon. According to the Scottish Fiscal Commission, Scottish Government spending on the NHS will need to increase markedly across the next fifty years (increasing from 35% of Scottish Government spending in 2027-28 to 50% in 2072-73) if it is to keep pace with demographic change, new treatments and the increasing prevalence of long-term health conditions. As you might imagine, this is an unaffordable proposition: spending is projected to exceed available funding by an average of 1.7 per cent in each of those fifty years, creating an enormous black hole in the public finances. So, something has to give.

That outlook might be less troubling were the NHS not having to confront this difficult outlook from a position of instability. It has still to recover from the tumultuous impact of the Covid-19 pandemic, several Health Boards are in a state of financial distress, huge gaps have opened in the workforce, and with various high-profile public inquiries ongoing, NHS Scotland is not exactly in rude-health.

There are a few obvious opportunities which will undoubtedly be part of the remedy. Invest in public health, the upstream measures which prevent people from developing damaging (and expensive) health conditions. It means thinking differently about healthcare, developing a health-promoting environment and programmes designed to promote early intervention. We also need to invest in primary care, to make sure that people get what they need at first point of contact. That won't always be about healthcare or medicine – the public famously unpack a whole host of ailments and complaints on their GPs, many of which can't be sorted by a scribble on a prescription pad or a referral to a specialist.

Of course, these observations are hardly original and indeed much good work has already been done in these areas. The army of link workers that has been developed over the last five years is a case in point, key workers based in GP surgeries who support patients with the difficult non-medical issues which may be impacting on health (especially mental health): managing personal finance and social security, managing housing issues and so on. Unfortunately, with the foretold financial pressures beginning to mount, it is the very services we need to be investing in which are feeling the sharp end of funding cuts.

Even then, however, redirecting public spending upstream won't be enough. We need to think differently about how we provide healthcare, and about the culture of the organisations which provide it. Despite its best efforts, the NHS is a hulking, slow and (at times) unfeeling bureaucracy – and that's despite the fact that it has brilliant, empathic and committed clinicians and managers working within it. The way it is run in Scotland in 2024 isn't a million miles away from how it was

established in 1947[1]: a centrally-managed public sector monopoly, delivered under an ethos of command and control, pulled by politics towards short-term targets. It's a 20th Century institution struggling to come to terms with 21st Century needs.

Of course, many will defend the current system – the NHS *should* be directly accountable to Scottish Ministers to deliver national consistency. But that governance arrangement demonstrably fails to overcome postcode lotteries. For example, according to Public Health Scotland, there are nearly **eight** times as many people **per capita** getting knee operations in one Health Board area compared with another.[2] So a national system does not equal equality of output. Two Health Boards, with the same governance arrangements, the same national targets, the same 'once for Scotland' policies – yet huge variation in service outputs and patient experience.

That's not to say we should follow the NHS in England, which has flirted with internal markets and competition and private sector interests that have been far too commercial for our sensibilities. Not many in Scotland would look south of the border for inspiration. But at the same time, we can't allow our general nervousness about market-led healthcare to merely reinforce the status quo. The NHS in Scotland needs to be rethought and rewired. Might there be merit, for example, in extending the Self-Directed Support legislation to give patients more choice and control over their healthcare? If it's delivered free at the point of use, then what's the problem? Why is it that we think that's a good approach to supporting people to access social care to meet their long-term needs but not their healthcare?

We need to challenge the NHS as a public sector monolith by thinking of healthcare as a complex ecosystem consisting of a range of public and third sector bodies working in partnership in support of the public good. We need to break-out of the ideological prison we have built in Scotland which equates public service with the public sector. Indeed, some of the best public services we have are delivered in the third (not-for-profit) sector, rather than through public institutions. The highly respected Feeley Review notes that when it comes to community based services, quality is generally higher among third sector providers, when compared with the public and private sectors.[3] The idea of 'commissioning for the public good' may sound anodyne, but it could have a radical application, were it applied to the healthcare sector. It could mean expanding on partnerships between the NHS and our leading charities, for example. We already have some great, if isolated, cases to draw on. CHAS, which provides specialist hospice care for children, is unremittingly brilliant in the medical care and family support it provides. It is part-funded by the state, part funded by the charity itself (through fundraising and other income generating activities). Or again, the William Quarrier Scottish Epilepsy Centre represents one-of-a-kind in Scotland: a specialist hospital for the assessment and treatment of complex epilepsy delivered by a charity and funded by NHS Scotland.[4]

These models of delivery can benefit from the best of the NHS but also add the value of the third sector. Able to operate without the dead hand of bureaucracy, they have been able to exhibit innovation and fleet of foot that often eludes mainstream NHS services. Now we're not arguing that all healthcare provision should follow these models – far from it. I merely point out that when the NHS challenges its own out-dated operating model in favour of something a bit different, then little pools of possibility begin to grow. The NHS needs to be freed from its political straitjacket, to

become more autonomous, with accountability pushed down to the local level. Then, and only then, will we begin to see a brighter future take shape.

Dr Ronald Culley has been CEO of Quarriers since April 2020. He previously worked as Chief Officer of the Western Isles Health and Social Care Partnership.

1. [1] Section 12 of the 1947 Act, Part II Section 12 stipulates: 'Subject to the exercise of functions by Boards of Management, it shall be the duty of a Regional Board, subject to and in accordance with regulations and such directions as may be given by the Secretary of State, generally to administer on behalf of the Secretary of State the hospital and specialist services provided in their area'. This could easily describe the existing management and governance arrangements of the NHS in 2023.
2. [2] Public Health Scotland
3. [3] Page 42
4. [4] Placements are funded by the NHS and the clinical team is seconded from NHS Greater Glasgow and Clyde.

5. The NHS in Scotland: Public Expectations & Political Delivery – David Belfall

Originally published 18/04/2024

On 27 March 2024, the King's Fund and the Nuffield Trust published the results of the latest British Social Attitudes Survey, conducted in 2023, showing public attitudes towards the NHS and social care across Great Britain – England, Scotland, and Wales. Some of the most striking findings were as follows: –

- Overall satisfaction with the NHS was 24% – down from 70% in 2010.
- 52% were dissatisfied with the NHS – the highest proportion since these surveys began in 1983.
- 84% of respondents agreed that the NHS has a major or severe funding problem and 48% would support the government increasing taxes and spending more on the NHS.
- The 2 top priorities cited by survey respondents were making it easier to get a GP appointment (52%) and increasing the number of staff in the NHS (51%). Other priorities were improving waiting times for planned operations (47%) and in A&E (45%).
- Public satisfaction with GP services – historically the service with the highest level of public satisfaction – fell to 34 %, the lowest level recorded since these surveys began.
- Only 13% were satisfied with social care – the lowest level since these surveys began. 57% were dissatisfied.

Some limited comparative information is available for Scotland alone, which suggests that attitudes here do not vary widely from the rest of Britain. Thus, the level of dissatisfaction with both the NHS in Scotland and with social care is slightly higher in Scotland than in England but slightly lower than in Wales.

Unless I have missed something, the results of this important survey have not raised a ripple in Scotland. Is this because the results are as expected and not surprising? Nor do the political parties seem to have commented. Is this because they do not know how to react?

Certainly, none of the Scottish political parties are currently offering much to the public on improved NHS performance, nor are they conveying a true recognition of the scale of the problem and the time it will take to secure lasting improvements.

The Political Dimension

Ultimately, the person responsible for the NHS in Scotland is the Cabinet Secretary for Health. The NHS is both a massive, complex business and – not least because of the public resources it consumes – a political football. Few MSPs have any business experience, and fewer still have any significant experience of business management at senior level. They will however be acutely aware of the political dimension.

As Harold Wilson once said, a week is a long time in politics and few politicians have horizons which extend beyond the next election. Our political system does not readily accommodate long term issues – as the problem of developing and delivering the green agenda amply demonstrates.

Other long-term issues – including the NHS but also housing and drug misuse – fall into the same category.

Against this background, the post of Cabinet Secretary for Health, while undoubtedly regarded as important, poses challenges rather than opportunities for the aspiring Minister. He or she is much more likely to spend time trying to downplay or excuse failures and avoid brickbats rather than basking in the warm glow of public approval. Nor will he or she be able to shuffle off responsibility for operational matters to, for example an NHS Chief Executive, as Sir Ewan Brown suggests in his NHS 2048 blog. It would be a brave Cabinet Secretary indeed who responded to a Parliamentary Question or an approach from another MSP concerning a constituency case by saying that this was a matter for the NHS Chief Executive and he or she had no power to intervene.

The nature of the Cabinet Secretary's role – as currently viewed – also explains why (in response to one of Sir Ewan's other questions) his or her most senior official in recent years has been a civil servant. For such a position the Cabinet Secretary is looking for someone who will watch his or her back, and not create any waves – functions for which traditional civil servants are ideally placed and skilled. By comparison, introducing someone such as a businessman from the private sector would carry risks, since he or she will not be so closely attuned to the politics and the public mood, and might say or do something which departs from the approved script.

Major improvement is clearly needed in the performance of NHS Scotland. If this is to be delivered, an altogether different type of Cabinet Secretary is required. What is needed is a visionary figure who regards NHS improvement as his or her life's work and is able to convey to the Scottish public that he or she knows what needs to be done and is determined to deliver. He or she would need the unflinching support of the First Minister and a reasonable period in office (say 5 years). Further, that Cabinet Secretary would need to give at least as much attention to the business dimension as to the political dimension. In that respect he or she would need not only the support of an NHS Chief Executive with significant senior management experience (preferably in both the public and private sectors) but also the active involvement and support of a panel of senior business leaders. Judging from his NHS 48 blog, Alex Neil knows what is needed and might have been able to fulfil this role as redefined, but he has left the Holyrood scene. Who else, currently behind one of the Holyrood desks, might be able to do so?

Manpower

Public concern about the NHS centres heavily on the delays in obtaining a GP appointment, the delays in receiving specialist treatment, the delays at A&E (including the sight of queues of ambulances waiting to discharge their patients), and the delays in freeing hospital beds because of the shortage of appropriate care packages. As regards ambulances waiting outside A&E Departments – each with 2 paramedics per patient – it ought not to be beyond the wit of man to find some solution which is not so wasteful of manpower and resources. In all other respects, however, there is a clear need for more manpower, if performance is to improve. I shall focus on the need for more doctors, though I recognise that similar concerns arise in relation to other health professions.

It is clear – surely – that we have been training too few doctors for a very long time. The shortage of supply has been reduced for many years by importing doctors, especially from the Sub-

Continent – which in itself raises ethical issues. More recently it has been much exacerbated by many doctors moving to part time working, others moving abroad after qualification and others retiring early, not least because of a foolish decision about their pensions (now apparently reversed).

We need now to try to overcome this shortage, firstly by increasing the number of medical training places, and then by taking radical steps such as:

- offering those who gain places at medical schools a contract to pay all their university fees and living expenses during training in return for 10 years work in the Scottish NHS:
- offering double pay to those GPs who are prepared to work for more than 30 hours a week:
- providing an incentive for those doctors who are prepared to work on beyond retirement age.

I entirely appreciate that such steps would require substantial additional public funding – a topic to which I will return – and that the powerful medical unions will have views – but steps such as these are what we should now be considering.

As regards earlier discharge from hospital beds to appropriate care packages, this would also require substantial additional funding, plus funding for care packages to delay and prevent hospital admissions. As Alex Neil suggested in his contribution, this will cost hundreds of millions of pounds and will take time to set up, but we should be making a start now. To date the politicians have gone so far as to recognise the problem but have signally failed to come up with a deliverable solution.

Structure

In my view the scale of the challenge facing the NHS requires radical change to its structure at least for a 10-year period. The Cabinet Secretary needs to be at the centre of this. I would create a Scottish NHS Reform Task Force, consisting of no more than 15 members, chaired by the Cabinet Secretary, with cross-party representation if at all possible, and including the most senior figures from the health professions and also from the business world. The NHS is the National Health Service, and the Task Force should be unashamedly directive in its approach. Decentralisation, however desirable in principle, should be set aside for the duration of the Task Force's life.

The Task Force – in effect a supreme NHS authority – would need to be supported by local bodies, drawing in local expertise, but these would be explicitly delivery mechanisms. They would replace the regional health boards, have no more than 15 members each, and might number 4, as Sir Ewan Brown has suggested. The Task Force should also be supported by a Manpower Board given the importance of expanding the workforce.

After 10 years, and assuming that all goes well, the Task Force might then be replaced by a structure more on the lines Sir Ewan suggests. At that stage some decentralisation might then be possible.

Funding

Advances in medical sciences mean that, as a result of new and in some cases expensive forms of treatment, people are living longer, are taking up more of the time of health professionals and are

living long enough to need expensive care packages. All this means an increase in costs, which can only be borne by the state or by the individual.

Scots who have the means to pay – either directly or via an insurance scheme – already have access to a thriving private health care sector (though smaller than in England). It provides a means of bypassing NHS queues for access to specialist care or surgery. A private GP service is also beginning to emerge. The private health sector can be expected to grow further. Who could blame older people if, in their declining years, they decide to spend their resources on, for example, joint replacements or cataract removal, rather than enduring unconscionable waits for NHS treatment? To the extent to which the private health care sector expands health capacity in Scotland, it is to be welcomed – and indeed is being increasingly used by the NHS to reduce delays for some specific treatments. But its success is an index of the NHS's failures, and it provides, undeniably, a 2-tier service which benefits the well-off and disadvantages those less well placed.

There are those who would like to see the private health care sector grow further as a means of relieving the NHS and reducing the need for public funding. This may indeed be the outcome, incidental or deliberate, if we do not spend significantly more on the NHS. If the NHS's performance is not to decline still further, the inescapable fact is that substantial additional public funding is required. This can only be found by reducing other public spending programmes, or by raising the tax take. Given the state of the economy, it would be foolish to imagine that sufficient resources can be found – at least in the short term – to eliminate NHS delays at primary and secondary care levels, but it should surely be possible to find sufficient resources to reverse the current trend.

One option would be to establish a separate NHS levy, within the tax take, which would be spent only on the NHS, so that the public could be satisfied that it would not be used for other purposes. Of course, the Treasury and the Scottish Government Finance department would be outraged by any hypothecation of taxes in this way, but perhaps the time has come to challenge such orthodoxies?

Whether or not hypothecation is pursued, there is a hard choice to put to the Scottish electorate – to accept continuing and probably increasing delays in the NHS or pay more in taxes. Oh, and by the way, spending more on the NHS means spending less on X, Y and Z, and do not expect any quick changes in NHS performance until the necessary changes have been worked through.

Politicians are not noted for putting hard choices before the electorate, preferring to fudge issues and sugar pills wherever possible, but I believe that it is possible that a brave politician with the necessary force of personality, strength of commitment, political standing and widespread credibility could make the case for such an increase in public spending (and therefore taxes) with a reasonable chance of success, given the support which the Scottish public has always expressed for the NHS, and the widespread public recognition that more needs to be spent.

David Belfall was Director of Health Policy and Public Health at the Scottish Office (as it then was) for 3 years in the 1990s. He has since served for 5 years as a Non-Executive Director on a regional health boar

6. Managing Reform – Sir Ewan Brown

Originally published 14/08/2024

There is a consensus at Holyrood that the £19 billion NHS Scotland is out of control and in urgent need of reform. Quotes from senior politicians include:

SNP: "*Scotland's NHS is in need of fundamental reform. The health service must be overhauled*".

Labour: "*Across Scotland, our NHS is on life support".*

Conservatives – "*There is a crisis in our NHS*"

Recent reports by Audit Scotland have further confirmed this:

- "*Regional NHS boards are expected to deliver services well beyond the capacity of their budgets".*
- "*The Covid Recovery Plan was promised in 100 days. Achieving this meant that boards were not consulted. Yet they are the ones expected to deliver*".
- "*Patient safety and experience are being compromised due to overcrowding, lack of privacy, poor building conditions, and workforce issues.*"

What is needed?

- maintain high levels of clinical care and patient safety.
- align health provision with social care.
- preserve the principle of "*free at the point of delivery*"; but recognise that as demand cannot be capped, major decisions and actions will be needed on the supply side.
- ensure that NHS Scotland is a good employer with high levels of staff satisfaction.
- make better use of public funds and do more for less.
- imbed good governance and clear lines of accountability throughout the organisation.

How to get there?

A reform agenda should properly be led by politicians, ideally on a non-partisan basis. If this is not achievable, it should be led by the government of the day, supported by civil servants. However, since there seems to be little or no appetite from politicians to do other than speak in general terms about protecting and modernising the NHS, reducing waiting lists and improving overall healthcare delivery, proposals for reform may have to be initiated from out with the body politic.

The organisation that would seem best placed to initiate this is Scotland's national academy, the Royal Society of Edinburgh ("RSE"), with its 1,800 leading experts across the sciences, medicine, business, professions, and the public and third sectors.

If willing, the RSE could oversee the creation of limited-life Working Groups of, say 10-12 members each. The members could be a mix of RSE Fellows and others with specialist knowledge and expertise.

To embrace what would inevitably be a complex and broad reform agenda would require several Working Groups, each with a different remit. For example: -

Group A – undertake necessary research and data gathering, including mapping.

Group B – address long term policy issues.

Group C – address long term structural issues.

Group D – consider capital funding needs and make proposals.

Group E – identify short term practical fixes.

In addition to the Working Groups, there would need to be a small, highly respected panel co-ordinating their output. The panel's remit would be to receive regular progress reports from each Group and ensure that the emerging proposals and recommendations were broadly accordant.

Group A (comprising members with an intimate knowledge and experience of the sector) The Group's remit would recognise that the stakeholders of the NHS in Scotland, (which help to influence clinical and professional standards), include health and social care partnerships,

Integrated Joint Boards, local authorities, national clinical groups, Royal Colleges, local and national charities, Police Scotland, Universities, Unions and patient organisations.

To provide pertinent data that would assist in developing NHS reforms, the Group should: -

- map the constituent parts of the NHS in Scotland setting out who reports to who, and why.
- map the proposed National Care Service and its relationship to align with the NHS.
- map all significant NHS collaborators and other key stakeholders, ensuring that public services such as the Police (who are collaborators in the myriad partnerships that engage and surround the NHS, with their own governance, accountability, underlying values, and culture) are aligned
- take account of a possible shift of some health care services from hospitals to the community.
- Interrogate the key financial metrics for health and social care as well as the financial projections being used by government to inform policy decisions.

Group B (comprising "thinkers") to address major policy issues.

Given the growing divergence between demand and supply:-

consider the root causes of poor health and related long-term healthcare costs. What prevention measures would best help people live healthier lives by tackling obesity and harmful addictions.

Aim to increase life expectancy and reduce health inequalities.

- should dental and ophthalmic services continue to operate free to all at the point of contact?

- should free prescriptions be continued for all and free access to consultative services offered under General Pharmaceutical Services through the Minor Ailments Service?

- while the evidence of the efficacy of new and expensive drugs / treatments seems strong, is there a need to consider the extent to which some new drugs have limited impact on life expectancy and/or quality of life?
- are the days over of having sufficient capacity to offer 'check-visits', medication prompts, shopping support, housekeeping support, etc?
- given that a divide has been created because of the inequality of treatment between the NHS and social care, its workforce and its resourcing, should social care be a joint partner with the NHS in the embedding of social health and care in the community?
- could the use of home-based technology offer the prospect for shaping care to distinctive needs, and for radically reducing avoidable and unnecessary acute hospital admissions?
- should citizens be given a social care budget with the right to spend it in selecting the care support that best fits their needs and aspirations?
- consider re-casting the notion that the NHS is an arm of political delivery and promote it as a national service with strong values. How could lines of communication be strengthened across the whole of the NHS in Scotland?

Group C (comprising members with knowledge of the sector)

The Group's structural issues remit:-

whether it would be beneficial to create a real entity that is NHS Scotland, accountable to Scottish Ministers and at arms' length, confining Government to policy, monitoring, agreeing strategy and the business of creating, protecting health and preventing disease – and holding NHS Scotland to account?

- whether the roles of NHS chief executive and Director-General Health & Social Care should be split, leaving the civil service to focus on policy and strategic direction. If so, what qualities and experience would be needed in the chief executive?
- whether there is a need for a more contractual system where the responsibilities of NHS Scotland and the government / politicians are spelled out in detail?
- consider how leadership across the NHS could be strengthened by pushing decision-taking down to the lowest possible level.
- whether there is a need for a clear accountability framework defining the roles and responsibilities of each principal stakeholder, including mechanisms for performance evaluation and oversight? How could performance management be better aligned with long-term outcomes rather than short term metrics?
- how could patient and public involvement best be engaged – eg patient councils, advisory groups and participatory decision-making processes?
- how should hospitals and health centres be situated and used to deliver safe and sustainable healthcare whilst supporting reform? What activities should be done in what

settings, and could some activities be distributed differently within or between tertiary, acute and primary care to deliver more efficiently and effectively?
- Are there sufficient hospital beds to prevent ambulance queues and meet the needs of an ageing population?
- how best to value the NHS workforce to retain and attract talent?
- could some health care services be transferred from hospitals to the community.?
- can reform of the NHS be achieved without compulsory redundancies?
- how best to implement a culture of continuous improvement, encouraging innovation, learning, and adaptation to changing healthcare needs and priorities.
- If a key role of hospital management is to facilitate the work of consultants and other clinicians, is this working, or does it need a fundamental rethink?

Group D (comprising financial experts and working closely with Scottish Futures Trust).

The Group's remit: -

- working with Group A, map the level of capital spend that NHS Scotland proposes to commit in order to upgrade infrastructure (which is often outdated and inadequate to meet the needs of modern healthcare) and over what timescale.
- consider the needs and circumstances of rural communities.
- given that the high cost of finance terms (particularly PFIs) from previous capital projects inevitably sucks essential revenues from delivering front line services, what is the most cost-effective approach to funding that spend?

Group E (comprising "doers")

The group's short-term fix remit: -

- identify opportunities for greater collaboration and integration among boards, health and social care partnerships and other stakeholders to improve coordination and decision-making.
- replace the flawed Blueprint 2 governance guidance with a prescriptive governance code applicable across the whole organisation (ie not restricted to boards).
- given Audit Scotland's withering criticism that "*regional health boards are expected to deliver services well beyond the capacity of their budgets*", what are the pros and cons of regional boards?
- if regional boards are retained should their number be reduced from 14 to (say) 4 – Glasgow & Clydeside, Lothian, North of Scotland and South of Scotland?
- could the structure of NHS Scotland be further simplified by combining the 8 speciality boards into a single unit.
- review overall governance including whether the number of regional board members should be reduced from up to 28 to a maximum of (say) 15; propose more effective recruitment and development for chairs and non-executives; ensure that there is diversity of thought, experience and background on all boards; whether each regional health board

should include a member of staff who is not part of the senior management team; whether the remuneration of board members should be increased to reflect their responsibilities, replacing the daily rates element with fixed fees; strengthen whistleblowing to give concerned staff direct access to the non-executive members of boards.

- working with experienced consultants, review digitisation opportunities to investigate the application of artificial intelligence to do more for less; and consider how data analytics and performance indicators could best be used to monitor healthcare quality, identify areas for improvement, and inform decision-making at all levels

Where appropriate, Working Groups should consult with, and take advice from, the Royal Colleges, including GPs.

To reflect the urgent need for reform, a timetable of no more than 24 months would be set for publication of a set of proposals and recommendations. Hopefully, they would form a constructive platform for the government of the day to mould as it sees fit.

Sir Ewan Brown CBE FRSE has served on the boards of listed and private companies, universities and charities. He is the author of Corporate Ego, which describes the spectacular fall from grace of seven prestigious Scottish companies – Burmah Oil, Ivory & Sime, Lilley, HBOS, RBS, Johnston Press and Standard Life; and he identifies major failings in governance as the common cause. Ewan contends that governance in the public sector, and NHS Scotland in particular, is not fit for purpose.

7. The Future of the NHS in Scotland: A Vision for 2048 – Peter Cawston

Originally published 01/01/2025

As we approach the centenary of the National Health Service (NHS) in Scotland in 2048, it is crucial to envision its transformation into a system that champions equity, environmental sustainability, and community well-being. The challenges of health inequality and climate change present Scotland with a unique opportunity to lead by example, creating an NHS that is a global model for fairness, resilience, and sustainability.

In 2048, Scotland's NHS has become a cornerstone of a fair and sustainable society. The gap in life expectancy between rich and poor has dramatically narrowed, and communities across the nation enjoy equitable access to healthcare. This transformation is powered by Scotland's renewable energy revolution and a commitment to reducing carbon emissions across all sectors, including healthcare.

The NHS is no longer just a provider of health services but a key player in addressing the social determinants of health. From supporting local economies to empowering communities, the service has embraced its role as a catalyst for positive change.

Reimagining NHS Spaces and Practices

Sustainable and Accessible Facilities

By 2048, NHS Scotland's premises have become models of environmental sustainability and community integration. GP practices and primary care hubs feature energy-efficient designs, including natural ventilation, solar power, and living roofs. These buildings are set within vibrant green spaces—community gardens, wildflower meadows, and outdoor gyms—that double as spaces for health promotion and biodiversity.

Car-free access routes have become the norm, encouraging walking and cycling for both staff and patients. Inside, technology is seamlessly integrated to improve efficiency and reduce waste, ensuring that digital health services are accessible to everyone.

Community-Driven Care

Healthcare delivery is rooted in collaboration with local communities. GP teams are embedded in their neighbourhoods, attending community events, supporting local businesses, and fostering trust through personal engagement. This localised approach has strengthened the relationship between healthcare providers and the communities they serve, resulting in better outcomes and higher satisfaction. Communities are enabled in numerous ways to co-create the shape of services delivered in their locality.

Frontline healthcare is delivered through small teams, which have become the backbone of the NHS. Every patient in Scotland has a named GP and receives relational care and continuity with a trusted individual provider, who is supported by a small and known administrative and clinical team. This has radically reduced demand on health care, improved patient self-management and

reduced reliance on pharmaceuticals, technological interventions and specialists. Instead, patients and professionals are partners in developing tailored, personalised health care plans that are suited to their unique needs.

Empowering NHS Scotland's Workforce

Scotland's NHS workforce in 2048 is thriving, diverse, and well-supported. Roles across all levels—from clinical to administrative—are highly valued, with comprehensive training pathways ensuring inclusivity and career progression. This approach has addressed recruitment challenges and created opportunities for individuals from disadvantaged communities to join the healthcare sector.

Sustainability at the Core of NHS Scotland

Carbon-Neutral Healthcare

NHS Scotland has achieved its ambitious target of net-zero carbon emissions. Sustainability is now embedded in every aspect of healthcare delivery, from building design to prescribing practices. Measures such as the widespread adoption of low-emission inhalers and robust recycling programmes have significantly reduced the carbon footprint of healthcare services.

Prescriptions now include information about both financial and environmental costs, empowering clinicians and patients to make informed, sustainable choices. Social prescribing has become a cornerstone of care, offering alternatives to pharmaceuticals that address the root causes of health conditions.

Minimising Pharmaceutical Reliance

A holistic approach to healthcare has reduced over-reliance on pharmaceuticals. Community-led initiatives, such as peer support networks and physical activity programmes, play a significant role in addressing chronic conditions like obesity, mental health disorders, and diabetes.

Addressing Health Inequalities in Scotland

In 2048, NHS Scotland actively combats the root causes of health inequality. Localised action has been central to addressing social determinants of health, with healthcare services working in tandem with housing, welfare, and employment support organisations.

GP practices now offer integrated advice on energy-saving measures, mitigating fuel poverty, and supporting communities to adapt to climate challenges. Free public transport to all healthcare appointments, alongside active travel plans, ensures equitable access to services while promoting sustainability.

Technology in NHS Scotland

Scotland's NHS has embraced digital innovation to enhance care while maintaining its human touch. Universal electronic prescribing has reduced administrative burdens and improved patient safety. Virtual consultations are standard practice, supported by community-based digital literacy programmes to ensure that no one is left behind in the digital age. Technology is used to augment

human connections, allowing healthcare professionals to focus on delivering personalised and compassionate care.

Biodiversity and Greenspace in Healthcare

Scotland's health facilities now prioritise biodiversity and greenspace, recognising their therapeutic and environmental benefits. Urban orchards, wildflower meadows, and community gardens are commonplace, promoting biodiversity and serving as tranquil spaces for patients and staff alike.

Green prescriptions have become a standard part of care, encouraging patients to engage with nature through gardening, outdoor exercise, and eco-restoration projects. These initiatives not only enhance physical and mental health but also foster a sense of community and purpose.

A Catalyst for Broader Change

The transformation of NHS Scotland has had far-reaching impacts beyond healthcare. By supporting local procurement and renewable energy initiatives, the NHS has strengthened regional economies and contributed to Scotland's leadership in sustainability. Collaborations with community organisations have created green jobs and bolstered economic resilience, embedding health equity into Scotland's broader development strategy.

Conclusion: A Vision for Scotland's Future

If we do not envisage the future we want, then others will shape it for us. The NHS in Scotland remains a valued institution in 2024, but in its current form does not offer the shape of a health service that will be fit for purpose in 2048. The crises of climate change and widening inequalities along with the challenge of creating a sustainable service that can meet the needs of the population mean that we must engage now with the NHS of the future. This will require a far more mature and honest public debate about what purpose the NHS in Scotland serves, and in whose interests, than has hitherto often been the case.

This debate needs to engage with the reforms required to shift the centre of gravity and funding away from centralised, specialised, hospital-based services into community-based services. These will result in difficult trade-offs and balancing competing demands, including those of well entrenched interest groups. For example, care approaches such as realistic medicine, forward care planning and reduced reliance on pharmaceutical prescribing, currently in their infancy, will need to become integrated into all health consultations. This will require greater patient-centredness in medical practice, but also greater public understanding of the limits of medicine and the harms which excessive medicalisation causes.

Long term continuity of relational care with a trusted provider such as a GP is probably the single most cost-effective and evidence-based way in which a health service can maintain trust, reduce inefficiencies such as inappropriate tests and treatments, and improve patient satisfaction and practitioner retention. Restoring the proportion of NHS funding to levels previously invested in general practice would be necessary to enable this to happen. Somewhat ironically, a major step in reform towards the NHS of the future may be to restore a key element from the past, albeit in a modernised form.

The challenges in shaping the NHS of 2048 are not insurmountable, if we can look up beyond the day-to-day demands of perpetual crisis management and dysfunctional short termism. There is a profound democratic deficit in the NHS in Scotland, with communities having little say or influence at all levels, particularly those who are most vulnerable and impacted by the mismatch between care and need. Greater community control of the various levels of health-care service, reconfiguring procurement policies towards local suppliers and sustainable supply chains, investing in modern community premises rather than centralising services in hospitals, and integrating the information revolution and artificial intelligence with person-centred human care, are some of the steps on this journey which we need to be engaging with now. Above all we need the same belief that the founders of the NHS had in 1948 – that the future is ours to shape and that the NHS in Scotland can and will safeguard the well-being of future generations while contributing to a more just and resilient society.

Peter Cawston is a Deep End GP based in Glasgow who has advisory roles in health inequalities and clinical sustainability

This blog is based on a round table discussion held in 2022 in which a small group of Glasgow-based GPs and NHS Officers met to discuss the question: how can we transition to a just and sustainable General Practice? The workshop was kindly supported by the NHSGGC Community Wealth Building team and the Glasgow HSCP GP engagement fund

8. A Paradigm Shift is Needed - John Sturrock KC

Originally published 22/01/2025

To address fully the challenges in the provision of health care and social care in Scotland, I sense that we may need a paradigm shift. In other words, a fundamental change in our way of thinking about how we deliver health care and social care. To paraphrase Einstein, it may not be possible to solve our problems with the same thinking which was used when the NHS was established in the 1940s. Things have changed so much since then and we need to frame the discussion in terms of the circumstances which exist today.

As the OECD said, boldly, in a report a few years ago:

"We're beyond quick fixes to address the discontent of people. There is no returning to the past. Too many things are not working for too many people. The only way forward is not to patch up …, but to shake it up."

To achieve such a shift is not easy. It may mean examining some of the very foundations of how things are currently done and challenging some of the basic precepts upon which present thinking is based. That doesn't necessarily involve throwing everything out of the window. But it does mean having the courage to ask important – and possibly challenging – questions about what we have been doing and what we may take for granted, to look at things in a way we may perhaps not have done before.

We need to be aware of the 'danger of the single story', of assuming that there is only one way to view things. There may be multiple perspectives, each one having validity from the viewpoint of those observing or commentating. Perhaps only by considering many views, even if apparently outlandish, provocative and contrary to current ways of thinking, will we open up the possibility of really creative and innovative solutions.

Such an approach also requires humility, and an admission that we don't have or know all the answers. Humility takes real courage and can be the source of much wisdom. The leading economist, Sir John Kay, in his latest book 'The Corporation in the 21st Century', describes how leaders in large organisations can never have all the information needed to make decisions, nor can they anticipate what might happen in the future. We must therefore abandon the pretence of knowing the answer – *'the pretence of knowledge'* as he describes it. Perhaps only then can we embark properly on the process of exploring change.

If we do so, we might conclude, for example, that top-down solutions are unlikely to work and cannot be imposed, that centralised control and hierarchical management is not the way forward. The modern NHS is one of the most complex institutions we have yet devised. Things are arguably just too complex, volatile, radically uncertain and multi-faceted for a one-size-fits-all approach. That may mean enabling – and trusting – people in different settings and localities to make decisions, based on their own experiences and knowledge. Empowering them to make choices, with all the benefits that would bring. That carries the risk, of course, that some of these decisions and choices may turn out to be wrong. It's a balance. But we learn from what doesn't work as well as from what does.

John Kay writes that, in large organisations, it is not possible to issue peremptory instructions to subordinates. It is necessary, he says, to assemble and share the collective knowledge and experiences of many people in the organisation, resulting in what he describes as problem-solving 'collective intelligence', enabling better use of resources. In such an institution, relationships cannot be purely transactional; indeed, a transactional approach is both repellent and mistaken he says. Might this analysis apply to the provision of health care and social care in Scotland too? In particular, in order to adapt to a rapidly changing environment with rapidly evolving needs and technologies, might leaders and others need the freedom to do new things without central approval?

New thinking would require genuine collaboration in practice, not just talking about it. It could mean a shift from what some may see as a transactional, incentive-driven, reward/punishment model, in which individuals sometimes feel like heavily monitored cogs in a wheel, to one founded on strong, respectful relationships throughout the system, where skills and contributions are valued and affirmed. The stronger the relationships, the more resilient the system, as it was once put. Strong relationships are 'the catalyst for everything' as another describes it.

That may mean encouraging, prioritising and valuing in-person encounters, however informal, rather than relying on remote, distant communication. 'Room not Zoom' is a phrase one hears more and more although, of course they are not mutually exclusive. Creating safe spaces for real and sometimes difficult conversations may be as important as any other policy shift. The very recently published book 'Informality in Policymaking' emphasises just this point. And it might just make the really difficult stuff easier to do.

This approach aligns, it seems to me, with what John Kay describes when referring to Mihaly Csikszentmihalyi's idea of 'flow': "*the elation that comes from complete engagement in the successful performance of a difficult task*", emphasising the meaning and purpose that reflects the intrinsic motivation that drives so many to work in health care and social care. Let's re-engage those drivers.

New thinking might, therefore, entail a move from targets, possibly unachievable, to greater trust and empowerment, perhaps acknowledging the illusion of centralised competence and permitting fallibility and vulnerability in the quest for vision, innovation and creative leadership. Financial resources may be limited; imagination, ingenuity and ideas are not.

Fear cannot be the driver. We should encourage a culture of taking responsibility, not avoiding blame. Political point-scoring, hyperbolic language, personal attacks, the narcissism of small differences – all of these will tend to undermine, create defensiveness and mitigate against new thinking. There is a pressing need to take health and social care out of the party-political arena and approach it on a consensual basis. Finding a shared vision for the future and relegating small differences to the margins seems vital.

This need to transcend sectoral interests and support longer-term thinking and outcomes applies to other influential stake-holders also, not just politicians. Setting aside some well-established interests for the sake of the common good seems likely to be necessary. But there's the rub: how many of our politicians (and others) will feel that they have the latitude to work across boundaries? Of course, we must recognise the pressures politicians and others face and acknowledge that sacrificing short-term gains is really hard to do when so much of modern life

requires quick fixes and easy answers. Yet, somehow, we must create the environment to enable brave steps to be taken. The urgency of the situation demands no less.

Cooperation, connection and communication are key. We need to work together, enabling people within the system to thrive and feel valued and affirmed, recognising the inescapable network of mutuality, inter-dependence and reciprocity upon which a properly functioning health care and social care system surely depends. All of this is easy to say … achieving this may be a national imperative.

John Sturrock KC is Founder and Senior Mediator at Core Solutions and, in 2019, conducted a review for the Scottish Government into allegations of bullying and harassment in NHS Highland. This is a revised and expanded version of an article which appeared in print only in the Scottish edition of The Times on Monday 6 January 2025.

9. The Future of Health in Scotland – An Open Letter

Originally published 10/06/2025

This letter first appeared in The Scotsman on 10 June 2025

We are a diverse group of committed senior figures, with wide-ranging experience of the delivery of health care and social care in Scotland, who share a belief that the health of our people is central to the success of our nation, and that we need to re-imagine how health is created in Scotland.

The Current Situation

We recognise that many people are well served by the NHS in Scotland, and that thousands of dedicated and hard-working people ensure that compassionate and effective, sometimes life-saving, care is provided on a day-to-day basis. And yet, as has also been acknowledged, the current system of delivering health care and social care in Scotland is unsustainable, often stretched beyond capacity, overly complicated, difficult to navigate, often inefficient and is perceived as not always meeting the needs of people living in Scotland. The health of the nation is deteriorating and health inequalities are widening. Reform is urgent and critical.

A Vision

We understand that simply spending more money will not solve all of the problems we face. But a vision at the centre – of a whole ecosystem of health, a service of health care and social care for all and a culture that promotes equality and fairness and honours all who work in health and care and for a healthier nation – can make Scotland unique. And we recognise that reform of the NHS is only part of the picture and that wider issues require to be addressed, including the vital role of the third sector and local government. Health care is not the sole responsibility of the NHS. We need to look beyond the NHS to the broader determinants of health and prioritise prevention and health creation as a national imperative, while recognising the role of social care in its own right.

The Need for the Long View

We appreciate the enormous challenge that this presents to decision-makers, and the value therefore of safe and meaningful deliberation. We also recognise that it is not helpful to view the future health of the country and the problems currently facing our health care and social care systems as the responsibility of any one political party, government or individual minister.

In reality, the challenges to health and the crises in our NHS are caused by a combination of complex and inter-related factors which have arisen over many years, for which there are no quick or simple solutions. Transformation is beyond the capacity of any one political party, government or group of stakeholders, who should not be expected to carry that burden alone.

While there are urgent short-term needs requiring immediate attention and action, longer term change is essential and will make the biggest difference. We feel that the necessary consideration of what this will entail cannot be dependent on the needs of short-term party politics or conditioned by the next parliamentary election. We need a longer-term vision, shared by us all as a common responsibility, with a whole of Scotland commitment.

A Call for Cross-Party and Cross-Sectoral Working

We believe that there is potential for cross-party and cross-sectoral acceptance of common ground on certain issues, including what is and is not working well, which could then be discussed with the general public, openly and candidly, in the quest for effective, fair and sustainable long-term solutions. There are no easy answers, hard choices will need to be faced, and delivering the necessary reforms will take more than one electoral cycle.

We believe that, to achieve the necessary longer-term change, we will need politicians to be willing to work across parties and with all stakeholders, not least to ensure the consistent delivery of that change over several political cycles. We see evidence of such an approach in other countries, such as Denmark and Australia.

A Commitment to Work Together

We note that politicians and civic leaders in Scotland recently came together to discuss other important matters, expressing a commitment to working together, and have recognised that solutions will be manifold and complex, requiring a collective response, with a shared responsibility to map a way forward for Scotland. We believe that the current situation in health, health care and social care requires a similar collective approach.

We are committed to work together to support a Scotland-wide approach to reform of health, health care and social care. To help achieve this, we wish to encourage making space for fresh thinking and candid conversations about change with politicians and other stake-holders, conducted through respectful private, informal, Chatham House Rule exploration of the key issues, development of options and identification of possible ways forward. We take as our model the Edinburgh Conversations of the 1980s which did so much to ease tensions during the Cold War. What worked then could work again now in our approach to the nation's health.

A Shared Mission to Improve Scotland's Health

In short, ours is a plea for a shared mission, for the humility and courage to recognise that we require new ways of discussing, delivering and improving the nation's health and creating sustainable health care and social care systems for the future.

Dr David Caesar*, Emergency physician and *Associate Medical Director for Medicine*, *Dr Sarah Doyle, Chief Executive and Nurse Director, Queen's Nursing Institute Scotland* , *Professor Andrew Elder, President, Royal College of Physicians, Edinburgh*, *Professor Liz Grant, Assistant Principal (Global Health) & Director of the Global Health Academy, University of Edinburgh*, *Jane-Claire Judson, Chief Executive, Chest Heart & Stroke Scotland*, *Dr Elizabeth Kelly, Chair, Improving Wellbeing and Working Cultures Strategic Board* , *Dr Tamasin Knight, Consultant in Public Health Medicine* , *Dr Donald Macaskill, Chief Executive, Scottish Care
Dr Alastair MacGilchrist, Chair, Scottish Health Action on Alcohol Problems (SHAAP)*, *Tejesh Mistry, Chief Executive, Voluntary Health Scotland* , *Rami Okasha, Chief Executive, Children's, Hospices Across Scotland (CHAS)* , *Professor Stephen Turner, former chair, Academy of Medical, Royal Colleges and Faculties in Scotland*, *Charlotte Waite, National Director, British Dental Association, Scotlan

10. Trust, Morality and Efficiency: Renewing the NHS Social Contract – Alistair Veitch

Originally published 17/11/2025

Executive Summary

The UK's National Health Service is one of the most significant moral and social institutions in modern British life. Yet, in the twenty first century, it faces a crisis of sustainability: funding pressures, demographic change, workforce shortages, and declining public confidence. This short paper combines the moral insights of Adam Smith and the economic critique of Ludwig von Mises then extends them through the lens of the Nolan political cycle to explain how social mood and political stability intersect with healthcare policy. It argues that a renewed NHS social contract that balances moral duty, economic prudence, and political cohesion is essential to preserving both the NHS and the stability of the centre ground of British society.

Context

The NHS's founding ideal of care based on need, not based on the ability to pay, free at the point of service and accessible to all residents, embodies a moral principle consistent with Adam Smith's concept of sympathy. However, mounting pressures are threatening that principle as public expectations rise while service performance stagnates. Many taxpayers perceive they are paying more for fewer services, undermining trust in the institution's fairness. Without a renewed social contract that reinforces transparency, accountability, and shared responsibility, confidence in the NHS and, by extension, in the political centre may erode.

Adam Smith's Moral Framework

In The Theory of Moral Sentiments, Adam Smith wrote that the foundation of social life is built on sympathy, the human ability to understand and care for others. A just society, he argued, depends on prudence, justice, and benevolence, all guided by an inner sense of fairness, the impartial spectator. In this light, the NHS reflects a moral truth: a society shows its humanity in how it cares for the vulnerable. But Smith also warned that compassion must be guided by prudence. A system that wastes resources fails both morally and economically. I believe that he would therefore support healthcare that is universal yet efficient, accountable, and grounded in both public and personal responsibility.

Mises's Critique of Bureaucracy

Ludwig von Mises argued that bureaucracies cannot allocate resources efficiently because they lack market prices and feedback signals. They function through rules, hierarchy, and budgets, not profit and loss. While such organisation is necessary for justice or defence, it can hinder innovation and responsiveness in service delivery and importantly resource allocation. Applied to the NHS, I believe that Mises's analysis would warn against over-centralisation and bureaucratic inertia. I would further argue that if a bureaucratic structure were to remain he would call for managerial autonomy, transparent performance data, and competition of ideas without undermining the moral goal of universality.

Combining the Thinking of Smith and Mises through Modern Governance

Effective governance would provide a bridge between Smith's moral duty and Mises's efficiency. Utilising principles of decentralisation, performance measurement, and transparency would allow public institutions to behave with moral purpose while being disciplined by results. In the NHS, this means empowering local trusts, linking funding to outcomes, and engaging patients as partners rather than passive recipients. This model emphasises outcome-driven management, balancing compassion with accountability.

The Renewed Social Contract

Smith's moral economy and Mises's efficiency converge on a shared premise: institutions survive when trust, fairness, and responsibility align. A renewed NHS social contract should rest on three principles: universality, accountability, and shared responsibility. Universality affirms that everyone deserves care. Accountability ensures that public money delivers measurable value. Shared responsibility means that patients use services wisely and maintain personal health, while providers deliver care responsibly, efficiently, and ethically. This mutual commitment strengthens both the moral legitimacy and the long-term sustainability of the system.

Political Dynamics and the Social Political Context

The Nolan political cycle visualises how societies oscillate between centrist consensus and polarised extremes depending on social mood. In times of positive mood, cooperative politics dominates within the "Centrist inner diamond." When mood turns negative, often during fiscal strain or public disillusionment, societies shift toward the "Partisan outer diamond," where populist and authoritarian movements emerge. The NHS, as a moral and economic cornerstone, sits at the heart of this dynamic. When the population perceive declining returns, paying more taxes for fewer or lower-quality services, the NHS becomes a lightning rod for discontent. Such erosion of confidence can trigger broader political fragmentation. Without a consciously renewed and communicated NHS social contract to restore trust, the centrist common ground that underpins democratic stability may dissolve, giving way to ideological extremism or even worse civil unrest.

Policy Implications and Mechanisms

To prevent this fragmentation of society and reinforce both institutional and political stability, NHS reform must pursue moral and economic legitimacy simultaneously. Key mechanisms may include:

- Outcome-based funding within stable baseline budgets.
- Decentralised decision-making with transparent public reporting.
- Public engagement in governance through citizen panels and open data.
- Preventive education linking personal health with public minded responsibility.
- Local innovation supported by national learning networks.

These measures strengthen accountability while reaffirming the NHS as a shared civic achievement rather than a partisan battleground. They facilitate risk taking and sharing of successful ideas, rewarding success for all parties of the contract.

Conclusion

I believe that Adam Smith would view the NHS as an embodiment of moral sentiment while Mises would view it as an organisational challenge. Combined, they reveal a deeper truth: moral legitimacy and economic efficiency are inseparable. The NHS's future depends not only on managerial reform but on political and moral renewal. If policymakers fail to renew the social contract while people continue to pay more for less, the resulting erosion of confidence and trust could destabilise the political centre. Conversely, by uniting moral duty with prudent management, the NHS can remain the cornerstone of both social justice and political stability, preserving the common ground essential for national cohesion.

Alistair Veitch is the Managing Partner of Cairnstone Capital an Investment Firm based in Scotland

11. Three Measurement Failings in Healthcare – Neil Pettinger

Originally published 08/12/2025

Ambulances are delayed. GP appointments are delayed. Patients in emergency departments are delayed. Patients who need to move from one hospital ward to another are delayed. Patients who can only be discharged from hospital if there are social care arrangements put in place for them at home – these patients are also delayed. There are delays everywhere in our health and care system. And all these delays are caused by mismatches between demand and capacity. Mismatches which can be measured, using data. But the NHS isn't measuring these mismatches with enough rigour, despite having more data at its disposal than it knows what to do with. This is a measurement failure. But before we can work out how to remedy this failure, we need to get to grips with the underlying reasons why the NHS is failing in its duty of measurement.

The first failing is that the NHS focuses its measurement attention overwhelmingly on the 'front doors' of acute hospitals. This is because it's the front doors – the emergency departments – where the most visible performance target lives: the government-imposed standard that emergency department patients should be treated within four hours of their arrival. However, even though this target was introduced – twenty years ago – because it was a pretty accurate barometer of whole-system health, and even though most NHS managers know that in order to meet the four-hour target you have to fix things downstream of the emergency department, the measurement focus is still predominantly on the emergency department.

To make matters worse, on the rare occasions when attention does move away from the front door, it leapfrogs straight to the back door, missing out all the interior doors along the way. Those same NHS managers who know there's a cause-and-effect relationship between delayed discharges at the back door and breaches of the four-hour target at the front door will often go straight to that delayed discharges figure and interpret it as being the sole cause of all their problems. Now – to be fair – that is not an unreasonable conclusion to reach: there is indeed a cause-and-effect relationship here. But this back-door-to-front-door approach taken by managers has two problematic side-effects: first, it makes it easy for hospital managers to blame other agencies (health and social care partnerships, for example) or other factors ('big picture', 'beyond our control' phenomena like the ageing population, for example); second, it means they don't bother looking at any of the delays that might occur while patients are passing through the hospital system. The way the cause-and-effect chain reaction actuallyworks is that A (delays in the emergency department) is caused by B (no empty beds in the admitting wards), which in turn is caused by C (no empty beds in the specialty wards, either), which in turn is caused by D (not enough social care capacity). And even that is an oversimplification. But NHS managers often jump straight from A to D, missing out whole chunks of measurable activity and actions that are under their direct influence and control.

But it's not just that the NHS is focusing on the wrong parts of the system; it's also inhabiting the wrong time zone. Most of the demand and capacity measurement that takes place in a typical general hospital is 'here-and-now' measurement. "It's 8am on a Monday morning: how many patients are in the emergency department *now*? How many empty beds are there in the acute medical unit *now*? How many discharges can we expect before noon *today*?"

This is the NHS in 'reactive mitigation' mode. This is the NHS trying to alleviate its delay problems by tying its hands behind its back and unquestioningly accepting the status quo as a given. It looks at the patients who are currently in hospital and asks: "Can we do anything with these patients – most of whom are in any case close to completing their hospital stays – to discharge them a couple of hours sooner?" So the impact of interventions by bed managers, discharge coordinators and others is constrained by the fact that that they are only being brought to bear on the patients who are already here and who are on the verge of being discharged anyway.

The NHS doesn't measure or describe its coalfaces in ways that enable clinicians to move into a cooler, more reflective mode of thinking. It needs to move out of the 'here-and-now' time zone of reactive mitigation and move into the 'there-and-then' time zone that enables 'reflective improvement'. As things stand, the NHS doesn't provide clinicians with the data or measurement tools that allow them to look at last month's discharges and ask questions like: "Is there anything we could've done differently to any of those patient pathways? Can we change one or two of those generic pathways to either prevent a few admissions in the first place or to reduce the length of stay of the others?" Those are questions we'll never know the answer to because they're questions that are never asked.

And the reason why those questions are never asked is because of the political baggage carried by data and measurement in healthcare. This is the third failure of measurement. Clinicians often complain of data being weaponised against them by managers who use it for top-down performance management purposes rather than for bottom-up improvement purposes. This is an aspect of measurement and data that often gets overlooked – particularly by the data professionals themselves, who are usually so remote from either the clinical or managerial coalface that they don't sense these political overtones. Data is not a neutral, value-free commodity; when it's used in an organization, it comes pre-packaged with assumptions to do with authority, performance assessment and control. And if the NHS wants to *re*-package data with a different set of assumptions (for example: collaboration, service improvement and participation), it's going to be very difficult to make that switch – particularly if it's not even aware that the switch is needed. Data somehow needs to be un-moored from its top-down 'surveillance' connotations and reinvented so that it can be owned by the clinicians themselves and re-purposed for collaborative improvement. This is not a change of emphasis that the NHS will find easy to make.

All of these three measurement failings – the wrong doors, the wrong time zone, the wrong connotations – conspire to prevent the rigorous examination of cause-and-effect relationships in the health and care system that's needed. The focus on the hospital front door means emergency department performance isn't connected to the bed fullness in the next – and subsequent – staging posts. The focus on the 'here-and-now' means that there is no time or opportunity for reflection, for looking at what happened last month to see if anything might be changed in order to achieve more impactful, more sustainable improvements next month. And the top-down measurement culture means that data is too often viewed with suspicion and cynicism by clinical staff. There's no ownership. There's no buy-in. This all needs to change if we want to do something about all those delays.

Neil Pettinger is a freelance healthcare data analyst and trainer, specializing in patient flow. He lives in Edinburgh.

12. The Election is An Opportunity to Prioritise Working Together for the Long-Term Future of the NHS

Originally published 12/03/2026

The NHS is an organisation about which I care very deeply. I have worked continuously in the NHS in Scotland since 1992. I have never practiced in the private medicine sector. I believe fundamentally in the principle of a health service that is free to all at the point of care. In my NHS clinic, I see all too often people from different parts of the world – where private medicine is a feature – who have been subjected to needless, expensive investigations for no reason, other than that they are items of service that can be charged for by their respective healthcare service. These investigations often turn up 'incidental' findings that will not reduce the quality or length of life of that individual, but which catalyse even more investigation and sometimes unnecessary treatment.

The NHS in Scotland is not without its faults, but a basic and unshakeable tenet is that the investigations performed and the treatments offered are done so in the best interests of the patient, albeit in a cost-effective manner that is for the good of the whole of society.

Being such a passionate supporter of the NHS, it is a source of genuine and considerable pain to see the gradual decline in the service it provides. There is no doubt that in times of extreme need, the NHS will be there to provide some of the best and most innovative care in the world. However, the difficulties people have in seeing a GP, the long waiting times for elective surgery, diagnostic investigations and out-patient appointments are both distressing for patients and distressing for staff.

Elective waiting lists continue to face sustained pressure, with an estimated 504,949 ongoing waits for a new outpatient appointment as at 31 January 2026. Long waits of more than 52 weeks also persist, including 30,259 waits for an outpatient appointment, underscoring the scale of the challenge against the Scottish Government's pledge to eliminate waits longer than 12 months by March 2026.

Long waits in emergency departments and caring for patients in corridors have become normalised. Recruitment and retention of medical staff in some parts of Scotland is an enormous challenge, while rota gaps and sickness absence amongst the medical workforce are now commonplace. As people live longer, medicines become more expensive and the breadth of treatable conditions expands, the costs of healthcare will relentlessly rise and given the understandable constraints on government funding, it is plausible that the performance of our NHS will continue to decline.

The Scottish Parliament election on 7th May is pivotal for our NHS, and as we have indicated in our own "health manifesto", politicians from all parties must use this as an opportunity to be up-front and honest with the public about the challenges it faces as part of a long promised "national conversation". No one political party can claim to have all of the solutions. The national conversation could come in the form of a National Convention, which would include service users (the general public), the healthcare professions and politicians.

We therefore urge the next Scottish Government – whatever its complexion – to create a Convention before the end of 2026. The harsh reality is that we cannot fund all healthcare for everyone in Scotland, all of the time, without NHS reform. That reform can only be achieved with cross-party support in the next Scottish Parliament. Without such cross-party support the NHS is unlikely to survive in its current form.

Scotland does not have to look far to find examples of such political consensus. In November 2024, the Danish Government announced a political agreement on healthcare reform, backed by a broad coalition of the three governing parties (the Social Democratic Party, the Liberal Party, and the Moderates) and four additional parties from across the political spectrum.

The agreement included general practice reform; chronic care packages for COPD, diabetes, cardiovascular diseases, and patients with complex multimorbidity; a national agency to oversee digital health, data infrastructure and innovation projects; and a new national public health law.

Cross-party political agreement on NHS reform is possible. NHS staff are often told they must change their ways of working to improve quality of service. The same is now true of our politicians. Scotland's political parties must use the election as a chance to prioritise working together for the long-term future of the NHS. Ultimately, we need a plan for reform backed by investment. If the funding envelope available cannot be increased, the "free at the point of use" NHS founding principle is seriously at risk.

In our health manifesto for the election, we present some ideas for reform. For example, we call for action on delayed discharges, to reduce pressure on hospital bed capacity and ensure that people are getting care where they need it most; and a medical workforce plan designed to attract more people to study medicine and stay in Scotland to practice it. Furthermore, we want to see investment in, and integration of, adult social care; action to address the current negative trends around life expectancy and the persistent health inequalities in Scotland and to ensure that the NHS is part of the tech revolution while improving current IT systems to reduce technological barriers for our hard-working people.

Finally, it is worth noting that Scotland can take lessons from the Darzi report, published in September 2024, which outlined three strategic shifts towards futureproofing the NHS in England: from hospital to community, from analogue to digital and from sickness to prevention. The College agrees with this approach and we have consistently urged the NHS in Scotland to follow suit. Many of our policy recommendations are focused around these three ambitions, indicating how seriously we take them. Scotland's political parties should take them seriously, too. The Health and Social Care Renewal Framework, published by the Scottish Government in June 2025, is a step in the right direction towards following the Darzi 'three strategic shifts' and we are encouraging the Scottish Government – whatever its complexion after the election – to continue down this route.

Remarkable innovation is happening across Scotland's health and care sectors, led by talented and ambitious clinicians, academics and researchers. Our workforce can be empowered and they want to help lead change, but this can only happen if Scotland's political parties work together to match these ambitions.

Professor Mark Strachan is President of the Royal College of Physicians of Edinburgh

12. Prosperity as Health: Recentring Care to Guide Health System Reform – Tim Jackson

Originally published 31/03/2026

Health systems in advanced economies face persistent and intensifying challenges: high levels of chronic disease, early onset of multimorbidity, widening inequalities and sustained pressure on public health and social care services. Despite decades of stated commitment to prevention, early intervention and person-centred care, outcomes have not kept pace with ambition. Demand continues to rise, recovery remains fragile and reform cycles repeatedly return to the same operational priorities. Scotland provides a particularly clear example of these dynamics.

This paper argues that these difficulties are not primarily failures of evidence or delivery. Neither can they be solved by imposing productivity targets and efficiency measures on already overstretched health services. They reflect a deeper misalignment between how prosperity is understood and how health is produced. The paper analyses this misalignment, proposes an alternative vision of prosperity and offers a simple test designed to guide policy reform towards long-term success.

The terrain of health: how demand is produced over time

The rise in chronic disease and early-onset multimorbidity is not adequately explained by individual behaviour, genetics or clinical failure. It reflects the gradual erosion of the terrain of health: the set of material and social conditions in which people live, work and navigate physical, psychological and social wellbeing.

Nutrition, income security, housing quality, working conditions, social connection and time to rest all exert ongoing physiological effects on health. When adverse conditions repeatedly exceed tolerable limits, the cumulative strain becomes biologically embodied as chronic disease. Where disadvantage is continuous rather than episodic, this process begins earlier and progresses more rapidly. The result—visible in many countries and particularly clearly in Scotland—is the early onset of multiple long-term conditions and widening health inequalities. Rising pressures on health systems such as the National Health Service (NHS) are therefore not simply a sign of system failure. Nor can they be solved from within the healthcare system alone. They are the predictable outcome of environments that generate ill health faster than it can be prevented or reversed.

Prosperity as wealth: the systemic driver

The degradation of the terrain of health does not occur by accident. It is shaped by the dominant vision of prosperity embedded in contemporary society and pursued as a political priority. In modern economies, prosperity is typically defined in terms of wealth: growth in the GDP, productivity, profit and consumption. This framing shapes what is valued, what is measured and what attracts investment in the economy.

Systems organised around growth privilege speed, scale and throughput. They intensify work, compress time and treat stability and sufficiency as constraints rather than goals. Activities that sustain health over time—continuity, maintenance and relational care—deliver their benefits slowly and are poorly captured by short term performance metrics. As a result, they are systematically undervalued and repeatedly displaced when healthcare comes under pressure.

The same dynamic reshapes the conditions of everyday life. Insecure work, time scarcity, poor housing, fuel poverty and unhealthy food environments are not isolated policy failures. They are structural by-products of an economic model in which success is measured primarily by expansion and output. The impacts of these conditions are socially patterned, translating inequalities in access and resources into inequalities in health. This wealth-centred vision of prosperity therefore drives both sides of the problem. It generates the upstream conditions that produce chronic disease and it embeds institutional incentives that marginalise the forms of care and prevention capable of reducing future demand.

The demotion of care: why prevention remains structurally marginal

Care – understood as the work that sustains balance, supports recovery and enables people to live with long-term conditions—is essential to managing chronic disease. Prevention depends on the same qualities: continuity, coordination, stable investment and long-time horizons. Yet both care and prevention remain structurally marginal not only within the health system but across the economy.

There are both institutional and normative reasons for this failure. Care resists productivity gains, delivers its benefits slowly and is poorly captured using throughput-based measures. As such it struggles to survive in a culture where 'time is money' and success is defined by market outcomes. Beyond this structural constraint lie normative impediments. Care work is highly gendered. It is often marginalised or even denigrated in society. These features make it particularly vulnerable in systems which prioritise growth, efficiency and short-term performance. (*see T. Jackson The Care Economy*)

Despite a succession of strategic frameworks explicitly aimed at promoting person-led and community-centred health, the work of care remains peripheral in society and vulnerable to mission failure within healthcare reform. When operational pressure intensifies, care and prevention are squeezed in favour of interventions that generate immediate, measurable output. Recovery becomes the dominant priority, while the conditions required for sustaining health remain largely unchanged.

Prosperity as health: a different organising principle

A core proposition of this paper is to reframe prosperity as health rather than as wealth. This reframing transforms the governing dynamic of the economy. The pursuit of wealth is governed by a dynamic of accumulation and growth. The pursuit of health is governed by a dynamic of balance. When prosperity is understood as health, the focus of economic success shifts away The

pursuit of wealth is governed by a dynamic of accumulation and growth. The pursuit of health is governed by a dynamic of balance. from growth at all costs and is focussed instead on the capacity of individuals and populations to create, nurture and maintain wellbeing over time, to adapt to challenge and to recover from disruption.

In this framing, economic activity itself becomes a means to sustain the conditions under which balance can be achieved. Care is no longer a residual or discretionary activity. It is the essential infrastructure required to maintain the terrain of health: protecting continuity, enabling coordination and protecting the time required for recovery and adaptation. Prevention is not an optional add-on justified by downstream savings. It is essential to the maintenance of balance and the pursuit of prosperity.

This shift in perspective is foundational. But it does not necessarily imply an entirely new policy agenda. Many of the necessary elements are already present in current policy debates— including those in Scotland. **What is needed is a consistent way of judging whether reform choices reinforce the production of ill health or reduce it over time.** To support that task, this paper proposes a simple policy test.

The policy test: a decision discipline for reform

Does this intervention move institutions closer to prosperity understood as health —or does it merely cushion the costs of prosperity understood as wealth?

This test is not a scoring tool or a binary judgement. Measures that cushion the costs of ill health are often necessary, particularly in periods of acute operational pressure. But they do not, on their own, alter the future trajectory of demand. The purpose of the test is to distinguish between policies aimed solely at improving operational efficiency and interventions which progressively improve the terrain of health and thereby reduce the demand for healthcare services.

When applied to contemporary policy directions, the test reveals some clear patterns. Operational recovery is indispensable but largely leaves future demand unchanged. Policies that act directly on the environments in which health is produced—for example through the regulation of food systems or improvements in housing and energy efficiency —have a clear potential to reduce future harm and moderate demand over time.

Many of the reforms proposed in Scotland (and elsewhere)—such as primary care transformation, care integration, workforce changes and digital innovation—turn out to be conditional. Their impact depends on whether they strengthen continuity, coordination and sustained relationships or whether they are absorbed into a throughput-driven model of healthcare.

Policy directions aligned with prosperity as health

Viewed through this lens, re-centring care implies a clear realignment of priorities which needs to foreground several distinct policy directions.

- Care capacity is treated as essential infrastructure investment and is protected during periods of acute pressure.
- Performance frameworks value continuity, coordination and long-term outcomes alongside access and throughput.
- The working conditions of care roles across health and social care are continuously improved and supported.
- Time is recognised as a therapeutic resource, particularly for people with multiple long term conditions.
- Major drivers of avoidable demand—such as diet, exposure to environmental toxins and work-related stress—are systematically addressed upstream.
- False economies – which generate private gain at the expense of social costs and lock society into indefinite disease management – are avoided.
- Proven prevention and care models are promoted from pilots to permanence.
- Healthcare leadership is framed around stewardship of population health over time. The choice facing policy makers is therefore a strategic one.. to pursue prosperity in ways that generate ill health.. or organise reform around sustaining the conditions in which people can remain well.

Many of these elements are present in some form within recent policy debates around the world and in particular within the Scottish Government's Health and Social Care Service Renewal Framework (SRF). What is missing is a consistent way of identifying and prioritising these kinds of policies—particularly in the context of rising demand and limited public funding.

The choice ahead

Policymakers face no shortage of ambition or professional commitment when it comes to health system reform. The question is not whether to invest in health, but what kind of system those investments will entrench. Without deliberate protection for care, prevention and the conditions of health, public health systems will continue to face rising demand regardless of how efficiently they are managed.

It is impracticable—and unfair—to expect these challenges to be met entirely from within the healthcare service. The operational pressures on NHS staff, for example, are already unmanageable. Prosperity understood as health re-centres care and enables health service reform to move beyond the absorption of pressure towards the prevention and reduction of future harm. But it requires political and economic change to be viable.

The choice facing policymakers is therefore a strategic one. It is a choice between continuing to pursue prosperity in ways that generate ill health, which health services like the NHS must absorb at cost, or organising reform around sustaining the conditions in which people can remain well. Making that distinction explicit is the first step towards a health system—and a society—capable of supporting wellbeing over time.

Tim Jackson is an ecological economist, writer and former government advisor. He is Professor Emeritus at the University of Surrey and co-Director of the Centre for the Understanding of Sustainable Prosperity (CUSP). His books include *Prosperity without Gr*owth which was named as *UnHerd*'s economics book of the decade in 2019, *Post Growth – Life after Capitalism* which won the Eric Zencey prize for ecological economics in 2022 and most recently *The Care Economy* (2025, Polity).

This article is a policy summary of the full working paper which is available to download via the CUSP website. It has been simultaneously published as a CUSP working paper as well as commissioned as an input to Enlighten's NHS 2048 initiative. The author is grateful for comments and suggestions on various drafts from Linda Gessner, Bryan Jones, Jen Morgan, Alison Payne, Jonathon Porritt, John Sturrock and the participants at a workshop held at the University of Surrey in January 2026.

Social Care

14. Learning from social care: Citizen choice & budgetary control in NHS 2048 – Donald Macaskill

Originally published 21/11/2023

2048 is of course the 100th anniversary of the founding of the NHS but during this past years' 75th NHS celebrations you might have missed the other 75th birthday – that of modern social care. I don't think we even got a slice of the birthday cake!

Reform of the NHS in Scotland is urgent and necessary, and I cannot but agree with Paul Gray's summons to the robust and thoughtful decision-making of choice. There is a requirement both to think outside the box and to think the unthinkable in the exploration of necessary change.

However, any attempt to address the challenges and more importantly shape the potential of health provision in Scotland will be for naught unless the symbiotic relationship with social care is both recognised and prioritised.

My reading of the writings and speeches of Aneurin Bevan and the others who founded the NHS has always led me to the conclusion that they saw the role of community-based care and support (in the non-clinical sense) as intrinsic to the welfare and wellbeing of communities. He even extended some of this thinking to social housing portraying a model of social wellbeing which was ahead of its time with its recognition that good health was more than the absence of disease. Sadly, for many reasons we have lost that holistic vision which rooted wellbeing in community, as increasingly the NHS has become the National Hospital Service. A misplaced emphasis on acute and secondary healthcare has been at the expense (quite literally) of both primary and social care. Moving towards 2048 we urgently need to find afresh that balance and to re-discover the social dimension of health and care.

Social care is not about maintaining our population as they are, but rather it is about the enabling of citizens to thrive and flourish to the fulness of their lives regardless of age, disability, or circumstance. Social care is about independence, control, choice, and voice. These are not empty words but are themselves reflective of the social and communitarian dimension of social care which the Social Work (Scotland) Act of 1968 emphasises. It underscored the criticality of supporting people in community, as social and 'independent' beings with relationships which are as a significant for wellbeing as any medical procedure. An emphasis on 'choice' recognises the importance of avoiding a one size fits all approach to social care and instead enables a diversity of provision that fits the distinctive and peculiar needs of folk. And 'voice' is about giving real control and power to the citizen not playing lip service to engagement and involvement. The professional being on tap not on top. The system being there to serve rather than to become an end in itself.

The fact is the worlds of the NHS and social care in contemporary Scotland are vastly different and we ill-serve either by failing to recognise, celebrate and value that diversity. Yet over the decades what has happened is that we have negatively created a divide because of the inequality of treatment for social care, its workforce and its resourcing. Social care truly is the Cinderella service where it should be a joint partner with the NHS in the embedding of social health and care in the community.

I think there are two aspects of contemporary social care that might contribute to the shaping of the NHS in 2048 if we allow it.

The first is an emphasis upon preventative and autonomous care and support. Citizens are increasingly in control of so much of their lives through the digital and technological revolutions we are living through, accelerated by the potential of AI. The use of home-based technology (being careful to avoid social and access inequalities) offers us a real prospect for shaping care to distinctive needs, for radically reducing avoidable and unnecessary acute hospital admissions, for preventing the huge human and fiscal costs caused by frailty and falls, and for treating and supporting people for longer in their own homes or a homely setting. The NHS 2048 needs to be tied into this revolution of autonomy and prevention.

The second is the need to maximise fiscal autonomy on the part of citizens as they access health and care. Despite resistance and vested interest from some parts of the public sector the principles in practice of the Social Care (Self-directed Support) (Scotland) Act 2013 continue to champion the rights of citizens to be given a social care budget and to spend it in shaping and selecting the care support that best fits their needs and aspirations. Social care at its optimum treats the citizen as a grown up rather than the plaything of public sector parents too frightened of the loss of power to cut the fiscal and control apron-strings. But it requires real choice and real options and therefore a managed social care market that reflects the modernity of divergent requirements that people are increasingly demanding. Is it heresy to say that the NHS can learn some of the lessons which result when we authentically empower the patient through real choice including by offering greater financial control for their healthcare (and I am not saying removing the principle of 'free at the point of need')? We know that citizens who are given choice exercise that to the maturity of their health and to the benefit of the wider health economy – why don't we give choice, voice, control and budgets to our patients?

Let's be bold and imaginative because 25 years is simply not a long period of time and unless we do so we might not reach our joint NHS and social care 100th when hopefully there will be one cake shared amongst all.

Dr Donald Macaskill is the Chief Executive of Scottish Care.

15. “Growing old is not for wimps”: A Personal Reflection on Dementia in Scotland – Professor Frank Gunn-Moore

Originally published on 15/01/2026

“*Growing old is not for wimps*”. This is the comment my grandfather made to me when he learnt that my research was looking at Alzheimer’s disease. Subsequently, as I started to speak more openly about this research topic to the public, a member of the audience piped up: “*You know you are getting old, when every new sensation is a symptom*”. This gallus humour typifies the Scottish spirit, something that can seem to be so bleak can always be given a light-hearted response.

In this article and follow-on ones from colleagues, I have some good news: things are starting to change, as we enter a new era, as described in the Scientific American article ‘New Age of Alzheimer’s Scientific American‘. In this 84-page special edition, which has the likes of Bill Gates and the Davos Alzheimer’s Collaborative giving their thoughts, only one country is mentioned specifically, and that is Scotland (p72-74). This is because it was the first country to develop a national strategy where every person who has Alzheimer’s has a minimum of one year’s support from a named caregiver after diagnosis. But it also highlights how the Scottish community of academia, charities and government organisations are trying to work together, not in competition or in isolation.

Twenty five years ago, I created my own research group in St Andrews where I started to apply the biochemistry that I had previously learnt to try and understand and potentially treat Alzheimer’s disease, though using a different approach of combining biology, chemistry and physics. A lot has changed in the last 25 years and progress is being made on all fronts.

Dementia is the umbrella term, covering many different neurodegenerative diseases mainly affecting the elderly but also – as I recently found out – the young, termed “Childhood dementia” (Alzheimer Scotland). In the field, clinically there is a lot of discussion about the use of the “D” word, but it is a term, whether correct or not, that the population has heard about, including the prisoners I have taught in HMP Perth and Shotts. Twenty five years ago there was little mention of these diseases. When I was a new lecturer, I quickly came to realise that working on these diseases was about more than just raising funds and publishing papers – it was also the fact that it was affecting everyone. Indeed in 2008, 13 of us put our names to an open letter to the then Health Minister Alan Johnson saying that this was a group of diseases that could not be ignored.

Slowly new funds started to appear. David Cameron’s first initiative brought in some more funds, £50 million, but as I commented in my inaugural lecture, though welcome, this level of funding was the equivalent of paying for one new building in St Andrews (no one in it, just the building). However, then the Dementia Research Institutes came to the fore, so new research funding started to trickle in, and though still chronically unfunded there is movement in the right direction. It was helpful, too, that celebrities and famous people started to openly discuss their experiences. For example, I was in the audience when Terry Pratchett announced his diagnosis, and I played a small part in Sally Magnusson’s very personal best seller “Where Memories Go”.

A unique aspect to Scotland is its size and the interconnectedness of its Institutions. Exemplars of this in the academic world are the "pooling initiatives": discipline-led initiatives that seek to join up the universities' prowess. I was the Deputy Director of Scottish University Life Sciences Alliance (Home – SULSA, and recently and specifically mentioned in the new 2025 Scottish Government Life Sciences Strategy Growing a £25 billion industry – gov.scot) which helped in the formation of the European Lead Factory and the National Phenotypic Screening Centre. Helping each other like this is a unique Scottish trait, indeed the initial application for the highly successful Edinburgh Dementia Research Institute was supported by neuroscientists outside of Edinburgh: an approach that you don't find in other countries. In addition, Alzheimer's Scotland oversaw the formation of the Scottish Dementia Research Consortium (SDRC), bringing all dementia research under one roof. This is turn led to the Scottish Funding Council-funded Brain Health Alliance for Research Challenges (BRAIN HEALTH ARC). And from these endeavours have come funds to help in particular early career researchers such as the RS MacDonald Charitable Trust and the Scottish Funding Council-backed Scottish Neurological Research Funds, now in their fourth round.

Bringing people together is important and is an undervalued skill. The St Andrews Brain Health Summits, which attract major stakeholders from industry, government and charity funding agencies, academics, policy-makers and politicians, are another example of colleagues putting aside potential institutional biases and strategies to come together to tackle the big problems practically. These summits have led to new data challenges and even the launch of new companies such as Scottish Brain Sciences (Scottish Brain Sciences).

Scottish dementia research has blossomed, with many world class and leading groups in our institutions. But there are areas that desperately need help. It is a frustrating fact that many ideas within universities are not capitalised on, whether that be new drugs or new technologies. But ideas are coming forward. For example, a £10 million scheme to fund the "killer experiment" indicating biological efficacy that normal routes will not fund. This fund would lead to new companies and so to high-quality jobs; and possibly the development of a *Scottish Wealth Fund* which has been the backbone of many other countries. We need to reduce the bureaucracy and develop companies. We can do it, as successful companies have been built from scratch (for example Exscientia, a Dundee spinout was sold last year for $688 million, putting it into the "Soonicorn bracket"). I would also advocate the idea of a neuroscience industry pool (along the lines mentioned above). These steps could help build a world-leading community.

Clinical trials are also a priority for Scotland and the new £100 million Commercial Research Delivery Centres are wonderful to see (NHS Research Scotland), as are new business ventures such as Scottish Brain Sciences which boasts the fastest recruitment of participants ever recorded, and new drug trials underway that would not have occurred without a new approach.

However, for most of us who have had to personally deal directly with this disease with loved ones, the care aspect and how to deal and manage it, is the rawest. My mother's own diagnosis was met with her usual phlegmatic comment of "Well the best thing I can do is to remain calm". But my family were lucky as we had the contacts and financial ability to make my mother's last few months as comfortable as possible. The majority of Scots do not have this luxury. So what can we do in dementia care?

The first is to recognise the true scale of the challenge. The usual quote is that 90,000 people in Scotland have dementia. However, this is apparently based on non-Scottish data, and so the reality is that it is probably a significant underestimate as many cases are not recorded, and most people are being cared for by family and friends. It is estimated that to look after patients with advanced dementia will cost £100K per person, which even using the underestimated number, leads to an eye-watering bill of £9 billion per annum!

The community and government recognise that a new approach is required and so many of us from a wide number of different backgrounds of academia, governmental agencies, charities, entrepreneurs and hands-on experience are now working to solve this hardest of problems, and to develop practical ideas, not just strategies without actions.

I detect a willingness coming from all political spheres, as this is an issue that effects everyone. Following this article will be other like-minded colleagues who will provide their own perspective on the challenges and solutions. And Scotland is leading the charge. As quoted by the Global Alzheimer's Platform, we are the "Goldilocks country": not too big, not too small, just the right size. Many of us believe that we can use Scotland as the blueprint for other countries. That is a human and scientific prize worth fighting for.

Frank Gunn-Moore is Professor of Molecular Neurobiology at the University of St Andrews and is an academic and researcher in the field of neurodegeneration and dementia research.

16. The Inheritance No One Talks About: Women, Care, and the Cost of Dementia -Greg Stevenson

Originally published on 22/01/2026

My father's family comes from one of the small, picturesque fishing villages scattered along the East Neuk of Fife. Like many people researching their family tree, I expected to find familiar patterns: men inheriting land, women marrying out, property following the male line.

What I found surprised me.

Until well into the 20th century, it was often the daughters—not the sons—who inherited property. At first glance, this felt remarkably progressive. Women owning homes? Securing assets? In a conservative, coastal society? Fabulous, I thought.

Then I looked more closely.

The inheritance came with an expectation. The youngest daughter was typically responsible for caring for her ageing parents, often at significant personal cost. Marriage could become difficult or impossible. Paid work was limited. The house, then, was not a reward but compensation—a form of social security for a woman whose life choices had already been constrained by duty.

Viewed through that lens, the arrangement felt far less enlightened.

Which raises an uncomfortable question: how much has really changed?

A Gendered Burden of Health

Let's start with health.

Female health priorities have historically struggled for attention, funding, and urgency. That imbalance becomes even more stark when we consider dementia—a condition overwhelmingly associated with older age, and one that disproportionately affects women.

Women are more likely to develop dementia than men, and not simply because they live longer. Biological, hormonal, and genetic factors all play a role. Yet despite this, dementia research, diagnosis, and support systems remain under-resourced, and often poorly designed around women's lived realities.

Care: Still Women's Work

Then there is care.

Across the UK, unpaid caring remains heavily feminised. Wives care for husbands. Daughters care for parents. Sisters, nieces, and granddaughters step in where the state does not.

In heterosexual relationships, men are often older than their female partners and tend to experience serious illness earlier. When that happens, it is usually the woman who becomes the carer—often for years, sometimes until death. By the time her caring role ends, her own health may be compromised.

If there is no spouse, responsibility frequently falls to a daughter.

As care demands increase, something has to give. And more often than not, it's paid work. Women reduce their hours or leave employment altogether, commonly in their fifties—precisely the period when earnings and pension contributions should peak. Children have grown and demands on resources have reduced.

The Financial Fallout

The financial consequences are often profound.

Women already earn less than men on average. They already accumulate smaller workplace pensions. When caring forces them out of employment, that gap widens dramatically.

Those final 10 to 15 years of working life are often the most valuable for pension saving. Lose them, and private pension growth stalls. State pension entitlement can also be affected: currently, 35 qualifying years of National Insurance contributions are needed for a full state pension.

While carer's credits exist, many carers either don't qualify, aren't aware of them, or fall through the cracks of an overstretched system. In the midst of caring for someone with a neurodegenerative condition like dementia—physically exhausting, emotionally draining, and relentless—long-term financial planning is rarely front of mind. People get by in the here and now, often at the expense of their future security.

The result? Women who were already disadvantaged in salary and pensions are penalised again for fulfilling a role society quietly expects them to take on.

A Perfect Storm

This creates an almost perfect storm.

An ageing population means dementia rates continue to rise—around 90,000 people in Scotland alone are currently living with the condition, though as highlighted by the previous article "Growing old is not for wimps by Prof Frank Gunn-Moore, this is probably an under-estimate (Enlighten). Most will rely, at least in part, on unpaid support from family or friends. And we know that support is most likely to come from women.

Yet unpaid carers remain politically invisible. Welfare budgets are consistently scrutinised, and carers are rarely prioritised. Addressing this properly would require investment, not cuts—and it is far easier to look away.

The costs don't disappear, of course. They are simply shifted: onto women, onto families, onto communities, and ultimately back onto society when preventable poverty and ill health take hold.

Time to Re-Examine Our Assumptions

So why don't we do more?

Is it because dementia and caring affect women more than men? Or because women's unpaid labour has long been treated as an inexhaustible resource—natural, expected, and therefore invisible?

Just as the daughters of the East Neuk once "inherited" a house in exchange for lifelong care, modern women are still absorbing the costs of care in ways that rarely make it into policy decisions or public debate.

Because until we do, the real inheritance being passed down to women is not property or security—but responsibility, sacrifice, and long-term disadvantage.

After spending most of his career in senior roles within healthcare companies, Greg Stevenson is now a management consultant specialising in health policy and healthcare. On a personal level, he is supporting a close family member recently diagnosed with dementia on their post-diagnosis journey.

https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/unpaid-carers-nutshell

https://www.legalandgeneral.com/retirement/pensions/guides/gender-pension-gap

https://commonslibrary.parliament.uk/research-briefings/cdp-2025-0038

https://www.bma.org.uk/news-and-opinion/closing-the-gender-health-gap-the-importance-of-a-women-s-health-strategy

17. Scotland Needs Accessible and Deliverable Social Care – Katherine Crawford

Originally published on 05/02/2026

'Fix social care' and 'care reform' are familiar refrains to many of us, but what do they really mean to most people in Scotland? Unless you're one of around 175,000 people receiving or waiting for a care package or one of up to 800,000 unpaid carers supporting someone in need, it's likely the phrase means very little. But it should be important because the truth is that many, if not most, of us will need social care at some point in our lives.

I've worked in the third sector for over 20 years now. The rhetoric around health and social care reform trips off my tongue. But if you work as a carer, an adviser, care navigator/ advocate, or are a family member facing the intricacies of trying to support or access a meaningful care package, that rhetoric becomes fairly meaningless. A person's care needs are often profound and will be immediate. Every day's delay risks further depleting someone's quality of life.

As the Scottish charity for older people, Age Scotland is all too aware of how great the need for an accessible and deliverable social care system is. Every day older people, their families or carers download information guides on social care provision. Our helpline handles hundreds of calls from people desperately trying to find their way through a tangled system. At a time when things have reached breaking point, support is urgently needed and the callers are often plain exhausted.

Problems in the social care sector don't only impact the older person in need but also those who find themselves thrust without warning into the role of unpaid carer. This quote from a member of Age Scotland's Human Rights Working group, who is also an unpaid carer, illustrates the need for radical change:

"The key is not just adding services but transforming the system so that recognising and supporting unpaid carers becomes a default not an afterthought."

There is no shying away from the fact that unpaid carers, who might not even recognise themselves as carers, provide countless hours of support, day and night. That comes at a high personal cost. Carers Scotland's 2025 'Cost of Caring Report' found:

- 30% of unpaid carers said they had bad or very bad physical health
- 34% reported having bad or very bad mental health

At Age Scotland we often hear from people grateful for the most basic levels of support. They accept care packages which only attend to some of their needs and don't like to ask for more. This reflects the position we're in. People accept that the system can't fulfil all their needs and appreciate any support offered. Often they don't have the energy or knowledge to challenge the vastly complex system. It certainly isn't easy.

Another stumbling block is geography. Comparing data and insight from around Scotland's local authorities quickly throws up a substantive imbalance in how care is delivered

area to area, even town to town. Workforce challenges are exacerbated by the country's physical geography and Scottish society's ongoing struggle with health inequalities in areas of greatest socio-economic deprivation.

When it comes to social care the inconsistencies in accessibility and delivery mean people don't know what they can expect from it. It's harder to put into words than, say, our expectations of the NHS. We understand waiting lists, recognise a decent hospital infrastructure, know what we expect from an appointment with a dentist or doctor and if the reality doesn't meet our expectations we can challenge it more effectively. That understanding also keeps the NHS in the public spotlight and makes it a consistent political priority.

Compared to the transparency in the NHS, social care lurks in the shadows and, as we know only too well, it is not a political priority. Yes, it's talked about but quickly slides to the bottom of the pile when the spotlight moves elsewhere.

But why isn't social care being addressed more urgently? Those working within the system have been expressing frustration for years. Carers themselves want to provide high-quality social care. Local authorities, care organisations, some politicians and charities like ours have repeatedly flagged the problems that are crippling the sector. So what is stopping decision makers getting round a table to come up with a deliverable plan to fix social care?

My first role in the third sector was as a support worker, advocating for individual's rights. That was way back in 2004. Even then, my heart went out to the individuals and to the beleaguered social services staff who knew that they didn't have the capacity to provide the service that was needed. Nobody can say the current system fell apart overnight – or even in the lifetime of any particular government.

In 2024 I chaired a national conference on social care and was struck by the fact that ministers, care providers, individual activists, charities and people in receipt of care each had a shocking case study to share. In some cases a lack of funding and system complexity came together to deliver appalling standards of care. In others no care at all. There is no doubt everyone sharing the story felt true compassion and frustration. Yet, despite compelling evidence, our transformational reform agenda has stalled.

The failure to garner enough support to deliver the National Care Service Bill, heralded as the big bold move to put social care on an equal footing with healthcare, leaves a sour taste. But we can't let that derail the entire reform agenda. We need to be confident that we are holding true to our values of delivering equality and human rights. At Age Scotland we fundamentally believe that older people must be at the centre of thinking, planning and delivery. To succeed, a strategy to fix social care must come back to those fundamental principles around human rights and strategy creators must keep listening to those voices.

Looking again to the NHS, there have been great pieces of innovation in NHS services, such as the valuable Hospital at Home initiative, but it takes time to evaluate and embed. The Hospital at Home pilot in South Lanarkshire began in 2011 and it has taken 14 years to roll it out at scale across the country. To be blunt, the current social care system can't wait 14 years for improvement. The older people in need can't wait 14 weeks, and yet all too often they have no choice.

The urgency to fixing social care doesn't appear to be widely recognised. And that extends to our own actions when it comes to thinking about our own future social care requirements. All of us should be prepared for a time when we may no longer have capacity. Scotland's Power of Attorney (PoA) legislation enables people to plan in advance, delegating authority to people that they trust through a system that builds in protections.

However, the PoA application process is complicated and can be expensive for many. It's estimated that 83% of adults in Scotland have a welfare PoA but I would argue strongly that every single one of us should have both welfare and financial PoAs from the moment we reach adulthood. Evidence now shows that a lack of PoAs is causing issues around delayed discharge from hospital with 21% of delays being as a result of AWI (Adults with Incapacity) reasons in 2024/25. This is almost 150,000 people who are potentially unable to articulate their wishes around social care too.

There are so many damaging consequences to struggling on with a broken social care system, for older people, those living with dementia, people with long term health conditions and many others. As time goes by with no sign of improvement, the less faith people have and human misery is compounded.

I don't profess to have a magical solution to what feels like an intractable problem, but in a bid to advance the reform agenda, here's what we would like to see happen soon after the Scottish parliamentary election in May. We want the leaders of the political parties at Holyrood to get together and agree that social care must be a collective focus. We want them to plot out an agreed framework for what needs reform and, broadly, how that will be achieved. Stop hand wringing and work together on a bold plan in the best interests of the country.

Maybe once the party political bickering is set aside, leaders can sit down and create a truly transformational outcome for social care. Put human rights, dignity and personal choice at the heart of a reinvigorated and fully integrated social care system for older people now and for generations to come. It's a big ask but from my standpoint, it's the only option if we're ever going to make progress.

Katherine Crawford is Chief Executive Officer at Age Scotland

Prevention and Early Intervention

18. Royal College of Podiatry submission – Louise Slorance

Originally published on 19/12/2023

The Royal College of Podiatry is the professional body and trade union for podiatrists in the UK. The College represents qualified, regulated podiatrists across the UK and supports them to deliver high-quality foot and lower limb care, and to continue to develop their skills, both within the NHS and independent practice.

Prevention is a key focus for the podiatry profession. This emphasis enables podiatrists to provide patients with early interventions, enabling preventative care and treatment, keeping individuals independent, mobile and active. Effective prevention and early intervention may avoid people needing acute care and importantly ward space. Ultimately these types of preventative interventions increase the health and well-being of our population while reducing health spend in the medium and long term.

Currently strained NHS resources in Scotland are directed to immediate issues, acute care, seeking to address the crises of the day. Many of the crises faced are related to workforce issues, affecting all health and social care professions. While each profession's workforce crisis differ in their appearance, the result is the same – there are not enough staff to meet demand in the current structure.

While there is no magic money tree, there is also, no magic workforce tree and working smarter should form part of NHS reform. Smarter, does not mean harder. We have heard suggestions of 7-day weeks for clinics, but what we have not seen is any suggestion of spreading workloads, where advanced practitioner's hold the appropriate skills. Many of the smaller professions are not applying their maximal skillset due to existing structures of care. Utilising appropriately these full skillsets will allow for reduced pressure on other clinical staff and hospital beds in spite of ever-increasing demands on our health service.

Podiatric Surgery clinics provide a service example of how this can work in practice to the benefit of patients, staff and budgets. Changing service delivery from inpatient orthopaedic led foot surgery services to podiatric day case surgery within community hospital settings, has produced substantial improvements – reduced impatient admissions, increased bed allocations for other services and leaving this elective surgery unaffected by trauma emergencies. Furthermore, the majority of the surgeries will utilise regional anaesthetic techniques rather than general anaesthetics, reducing the need for anaesthetist involvement.

Furthermore, preventative care reduces demands and costs. In patients with diabetes, podiatrists actively reduce the risk of amputation through early intervention and prevention of associated diabetic foot ulcers. The cost of lower limb amputation is high not only for patients; amputation has a 5-year mortality rate of over 60%[1], but also for the health service. It is estimated that managing the diabetic foot, coupled with the cost of associated lower limb amputations, costs the NHS up to £1 billion annually[2].

While using the full skillset of our NHS podiatrists, it cannot be forgotten that another podiatry workforce exists, those in independent practice. Trained and regulated in an identical way to their NHS colleagues, private practitioners offer similar prevention and early intervention services. Over a number of years, due to NHS Podiatry services having to increase their access criteria, independent practitioners have become the sole option for some aspects of preventative podiatry care.

The COVID pandemic saw the NHS reduce and refocus services to allow for the substantial pressures bought on by the global virus. This saw NHS podiatrists only reviewing high risk patients, such as wounds, leaving individuals to self-care or seek alternative care. Since NHS podiatry services have opened up, they are seeing higher acuity and huge demand, leaving many services mainly seeing high risk patients.

While the previous paragraph suggests that reducing NHS podiatry services has a detrimental impact on patients, and in the longer-term healthcare budgets, it must be noted that this was done without notice and preparation. Further experiences suggest that educating patients and carers can improve self-care and, help ensure good foot and lower limb health.

CPR for feet[3] was developed by podiatrists for use by all health and social care staff. The resource educates staff on the overall need for appropriate foot checks, appropriate protection and appropriate referral. This wide-ranging workforce are now able to identify issues at an earlier stage and initiate appropriate referrals for early intervention, benefitting both the patients and our health services.

Overall, enabling the future sustainability of NHS Scotland will require a change in focus from reactive to preventative healthcare. This will necessitate open communication and substantial reallocation of resources. To target the limited resources in the best possible way for the future benefit of the population and the NHS, a full review of all existing health and care pathways must take place. Engagement with the entire health and social care workforce will identify opportunities to provide healthcare differently, and more effectively.

One final point remains, all those involved need to be open to fundamental change in the way services are delivered and trust the different experts in their fields.

Louise Slorance is Policy & Public Affairs Officer (Scotland) at the Royal College of Podiatry

[1] https://www.jfas.org/article/S1067-2516(20)30333-1/fulltext

[2] https://resolution.nhs.uk/2022/06/13/diabetes-and-lower-limb-complications-a-thematic-review-of-clinical-negligence-claims/

[3] https://learn.nes.nhs.scot/6801

19. Nutrition Matters to Reduce Scotland's Healthcare Burden – Dr Wayne Phimister

Originally published 27/12/2023

The growing field of lifestyle medicine, identified in the NHS strategic objectives, is a vital element in disease management. It reduces the financial load on the public purse but, more importantly, encourages practical health solutions for the individual, thus falling within the governmental framework statutorily designated to address personal health in Scotland.

The 2021 NHS Mission Statement is "*to provide care and services that we and our families would want to use*,**"** facilitating ease of access to information that informs them about their best health and well-being choices. The vision is **"***to enable people to live healthier and more independent lives through high quality seamless care***".**1

Therefore, citizens deserve professional practices that encourage and foster individual responsibility for their health, focusing on how one eats, drinks, exercises, sleeps, thinks, feels, acts and the supportive environment. Facilitating a personal journey back to health needs to be personalised to support individual efforts.

Hippocrates said, "*All disease begins in the gut*".2 The recent discovery of the human microbiome and its relationship to health starts in the gut and affects all parts of the body through the nervous system, endocrine system and immune system.3-8 Eating nutrient-dense and non-harmful food and beverages, optimal sleep quantity and quality, daily exercise and a supportive environment reduces gut stress, releasing the overtaxed immune system from fighting chronic inflammation and infection, thus returning the body, brain and mind to health.9-11 Targeting this key element for change supports the healing process for each citizen and NHS.

Background

NHS Education for Scotland (2021) says, "Our mission is to provide education that enables excellence in health and care for the people of Scotland".12

Public Health Scotland (Nov 2023) has recognised that 30% of health is determined by healthy behaviours, including access to healthy food, minimum unit pricing of alcohol, regulation of tobacco, supporting active lives and quality addiction services.13

The Targeting Health Inequalities paper (Aug 2023) by Strathclyde and Newcastle Universities, the Health Foundation and Health Equity North has identified consuming five or more fruits and vegetables per day as one of the four interim measurement metrics chosen to show a potential reduction in life expectancy, healthy life expectancy, obesity and infant mortality rate.14 I would add that a healthier diet also reduces poor mental health.

The current healthcare model needs to expand to encompass health and well-being at its core.15-16

A 25-Year Health Plan

Primary and secondary schools must educate each individual on how to be healthy in each pillar of health, namely diet, sleep, substance reduction, mental health and maintaining relationships, and provide physical education for all students.17

Universities need to prioritise research and educate on healthy living for future healthcare practitioners and leaders.

In particular, medical schools need to integrate teaching on lifestyle medicine so every doctor can educate their patients on making healthier choices to prevent and help treat disease. GPs should educate patients at each consultation on one health-improving behaviour. Consultants can add lifestyle advice on Ref Help to guide all GPs on what to do for each medical condition, e.g. reduce ultra-processed foods and drinks and increase nutrient-dense foods.18 Ref Help is an excellent consultant-led database in Lothian that directs GPs to treat and refer patients for optimal secondary care, which all health boards in Scotland should promote.

Health behaviours need to be tackled, like minimal unit pricing on alcohol, access to healthy food, regulation on tobacco, quality addiction services, and supporting active lives.15 Mental services must also expand with a culture of Realistic Medicine with compassion, intense listening, and colleague support, which needs to be in primary and secondary care, as the Chief Medical Officer of Scotland summarised in her 2017-2018 annual report.15,19

The Scottish Government should pursue the taxation of ultra-processed foods, the most likely cause of diet-associated disease.9,10 Diet is one of the top 6 causes of the global disease burden and is directly related to 3 other top 6 causes, namely hypertension, high body weight, and high cholesterol.20

The Scottish Government should consider integrating a personalised health plan, like the world-leading ZOE programme, run by Professor Tim Spector from Kings College London, for each adult and adolescent. This will educate and guide each person in individual food choices for health. It will also guide each person on lifestyle measures, such as exercise, sleep, alcohol and mental health strategies to be healthy. ZOE's main principles are to eat a flexible, non-restrictive diet low in ultra-processed foods and high in plant diversity to optimise sugar and fat blood levels with microbiome diversity.21,22

Artificial Intelligence (AI) can be used to personalise further health advice tailored to each person.

Goals of this Plan

- Reduced health inequalities with increased life expectancy, healthy life expectancy, reduced obesity and overweight, lower infant mortality rates and reduced suicide, depression and anxiety rates.
- Encouragement of patients' individualised responsibility for their health with a personalised health plan with AI guidance.
- GP retention with an increased sense of accomplishment.

- Shorter waitlists for consultants, investigations and surgeries and shorter wait times in A&E.
- Nurse retention and better remuneration through economic and accomplishment efficiencies.
- The Scottish Government demonstrates "Health is Back in the NHS", and Scotland champions NHS reform via this plan's optimisation and proof of concept.

Dr Wayne Phimister is a GP with 23 years of experience and a special interest in chronic pain and lifestyle medicine. He is a previous Assistant Professor of Family Medicine at the University of BC, Canada, and works as an NHS GP locum and private GP.

References

1. https://mission-statement.com/nhs
2. Lloyd, G. (1983) *Hippocratic Writings.* London: Penguin.
3. Asnicar F, 'Microbiome connections with host metabolism and habitual diet from 1,098 deeply phenotyped individuals', *NatureMedicine,* 2021 Feb; 27, 321–332. https://pubmed.ncbi.nlm.nih.gov/33432175/
4. Harland J, 'An update of the evidence relating to plant-based diets and cardiovascular disease, type 2 diabetes and overweight'. *Nutrition Bulletin*, 2016 Nov 15; 41(4), 323-338. https://onlinelibrary.wiley.com/doi/full/10.1111/nbu.12235
5. Kearns CE, 'Sugar Industry and Coronary Heart Disease Research. A Historical Analysis of Internal Industry Documents. *JAMA International Medicine*, 2016 Nov; 176(11), 1680-1685. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2548255
6. Gwak MG, 'Gut-Brain Connection: Microbiome, Gut Barrier, and Environmental Sensors', *Immune Network*, 2021 Jun 16;21(3):e20. https://pubmed.ncbi.nlm.nih.gov/34277110/
7. Guzel T, 'The Role of Serotonin Neurotransmission in Gastrointestinal Tract and Pharmacotherapy', *Molecules*, 2022 Mar 3;27(5):1680. https://pubmed.ncbi.nlm.nih.gov/35268781/
8. Wiertsema SP, 'The Interplay between the Gut Microbiome and the Immune System in the Context of Infectious Diseases throughout Life and the Role of Nutrition in Optimizing Treatment Strategies', *Nutrients*, 2021 Mar 9;13(3):886. https://pubmed.ncbi.nlm.nih.gov/33803407/
9. Elizabeth L, Machado P, Zinöcker M, Baker P, Lawrence M. 'Ultra-Processed Foods and Health Outcomes: A Narrative Review'. *Nutrients*. 2020 Jun 30;12(7):1955. https://pubmed.ncbi.nlm.nih.gov/32630022/
10. Sroar B, 'Ultra-processed foods and human health: What do we already know and what will further research tell us?' *The Lancet*, 2021 Feb 3;32:100747. https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00027-4/fulltext
11. Tsigos C, 'Stress: Endocrine Physiology and Pathophysiology', [Online] 2020 Oct 17. Available from: https://www.ncbi.nlm.nih.gov/books/NBK278995/
12. https://www.nes.scot.nhs.uk/about-us/what-we-do
13. https://publichealthscotland.scot/our-areas-of-work/public-health-approach-to-prevention/scotlands-public-health-challenges/
14. https://www.healthequitynorth.co.uk/app/uploads/TARGETING-HEALTH-INEQUALITIES-REPORT.pdf
15. https://publichealthscotland.scot/our-areas-of-work/public-health-approach-to-prevention/the-building-blocks-of-health/
16. https://carnegieuktrust.org.uk/publications/liuk2023/
17. https://bslm.org.uk
18. https://apps.nhslothian.scot/refhelp
19. https://www.gov.scot/publications/personalising-realistic-medicine-chief-medical-officer-scotland-annual-report-2017-2018
20. https://www.healthdata.org/research-analysis/gbd
21. https://podcasts.apple.com/gb/podcast/we-risked-it-all-does-zoe-work-heres-what-our-latest/id1611216298?i=1000635036853
22. Berry SE, 'Human postprandial responses to food and potential for precision nutrition', *Nature Medicine*, 2020 Jun;26(6):964-973. https://pubmed.ncbi.nlm.nih.gov/32528151/

20. Preventative Healthcare and Social Impact Investing – Ian Marr

Originally published 09/01/2024

Sir Elton John is a name we normally associate with 'Candle in Wind' and similar hits rather than with ground breaking innovation in health care. But the work of the Elton John Foundation has come to the attention of the UK Parliament with Sir Elton addressing MPs in November 2023.

The Foundation established an innovative, preventative health care service using social impact investment as the financing model.

The Zero HIV project was initiated in the London neighbourhoods of Southwark, Lewisham and Lambeth which have some of the highest rates of HIV in England. It was estimated that 1,000 local residents were unaware that they had HIV. The Zero HIV project financed an 'opt out' system of blood testing when people engaged with A & E departments, or other health care facilities, in order to facilitate early identification and treatment of HIV which is much better for the individual and much more cost effective for the health system. Between 2018 and 2021 the project tested 265,000 people and more than 460 Londoners with HIV entered treatment – over 200 people received a new diagnosis and entered care and over 250 who had stopped treatment returned to care.

By ensuring early treatment this project is estimated to have released £90m to the health care system – this is money which can be used at the discretion of health professionals to address emerging health needs in other areas. (£200,000 of costs are avoided each time someone living with HIV is engaged into care).

As a result of the effective impact of the Zero HIV project the HIV Action Plan in December 2021 announced £20m of funding for emergency department HIV testing in areas with very high incidence of HIV.

This is an example of preventative spending in practice – and it works! The fact that it worked stimulated wider systemic change shifting significant resources to further preventative spending which, in turn will create additional value and release additional funds to be used at the discretion of healthcare professionals.

Everyone agrees that we need to move to much greater use of preventative spending. The problem is that budgets are usually entirely consumed on firefighting activity. This firefighting activity is crucial and can't simply be abandoned in preference to preventative spend – no matter how effective that preventative spend is in the medium to longer term. So the key question is how do we actually move some budget to preventative spending in the real world and move beyond fine words about the importance of such spending.

Key to the impact of the Zero HIV project was the nature of the funding mechanism which made it possible. Essentially it used Social Impact Investment, the value of which is explored in more detail in Enlighten's 'Investing for Good' report.

In Social Impact Investment a service delivery organisation in the community agrees a set of mutually desirable outcomes with a public sector body. For example, a service which is being developed to support women experiencing substance dependency in Glasgow where the outcomes relate to individual women achieving a drug free lifestyle.

In Social Impact Investment, third party Investors provide the working capital to cover the cost of service delivery until the agreed outcomes are achieved. When these outcomes are achieved and evidenced **THEN** the public body pays for each outcome. The revenue generated from these outcomes is used to repay the investors who could be private individuals, philanthropic foundations or institutional investors.

This financial structure ensures that the public body only pays for outcomes that are definitely achieved, effectively providing a 100% guaranteed impact of the spending. This makes it much easier to justify preventative spending – the preventative impact is guaranteed before payment is made. The financial risk of non-completion of outcomes is carried by the investors. Crucially, this provides the missing bridge in funding which allows a preventative service to be created and delivered in advance of the payment for that service.

Social impact investment as a financing structure could be used in a wide range of preventative services – we have noted the opportunity to use in addressing Scotland's challenging relationship with drugs which bring misery to so many individuals, families and communities. It could also be used to create services supporting those young people who are experiencing poor mental health but whose diagnosis does not reach the tariff which would offer them access to NHS Child and Adolescent Mental Health Services – services which have been under consistent pressure in recent years. This financial structure has been used in a number of health care settings e.g.

- The End of Life Care Incubator in Waltham Forrest which reduces attendance at A & E departments and enables people to receive appropriate palliative care in their own homes
- The Ways to Wellness service in North East England which uses Social Prescribing to enhance the quality of life for people experiencing long term health conditions like COPD, Diabetes or Asthma and consequently reduces demand on healthcare systems.
- The Enhanced Dementia Care service in Hounslow which is designed to deliver integrated care plans and reduce non-elective admissions through effective preventative care

If we are serious about reforming elements of our health service and serious about implementing preventative healthcare, then we must find pragmatic ways to initiate preventative spending which go beyond laudable aspirations but rather create actual action – only then will we start to see real impact in the lives of real people in real communities. Social Impact Investment offers one tool to achieve the reforms which will create real change.

Ian Marr is the Chief Executive of The Growth Partnership

21. Foundations For Reform: System Wide and Preventative Approaches – Paul Johnston

Originally published 01/04/2024

I have enjoyed reading the important contributions that have been made so far to the Enlighten discussion on NHS 2048. They set out areas for change that have resonance, from the potential of innovation, technology and AI, the scope for greater citizen empowerment and the necessity of work on leadership and culture.

My own experience of public service leadership in areas such as policing convinces me that reform is possible – delivering better services for the public in a more sustainable manner. However, to be successful, reform must be built on strong foundations.

There are two building blocks that provide a firm underpinning for the reform of the NHS. The first requires health and social care to be seen in the broader context of what makes for health and wellbeing. And the second is an intensification of work to get upstream – preventing problems and promoting good health alongside the necessary focus on responding to ill-health.

Our health is shaped by a complex network of factors, including social and economic factors, health behaviours, health services, and the places that we live and work. None of these operates in isolation. Excellent health services will support improved health and wellbeing of our population as a whole – but cannot bear all the responsibility for this. Tackling poverty impacts on health, as does the availability of good work, high quality education and childcare, affordable housing, addressing climate change, and tackling racism.

Scotland's health challenges require collective focus and resolve. People in Scotland now die younger than in any other Western European country. People spend more of their lives in ill health. The gap in life expectancy between the poorest and the wealthiest is growing. We have seen great progress in the past but, at the moment, Scotland's health is getting worse.

There are further challenges facing us too. The Scottish Burden of Disease Study forecasts a 21% increase in disease by 2043, as our population continues to age. Two thirds of this will be due to a rise in the numbers of cancer cases, cardiovascular disease, and neurological conditions. All these present a significant challenge to the long-term sustainability of the health and social care system.

In my first year as Chief Executive of Public Health Scotland, I have seen clearly that change is possible. A collective focus on prevention, particularly primary prevention, can stop problems from happening in the first place and help reduce demand on public services, including our health and social care system. I am encouraged by the preventative interventions that are already receiving substantial investment in areas such as the Scottish Child Payment, the expansion of Early Learning and Childcare and vital work to keep The Promise.

Within public health, vaccination and screening are two of the best examples of prevention in action. We can draw on a range of examples where we have been bold and innovative in tackling Scotland's public health challenges through prevention.

These include:

- Taking a targeted approach to alcohol harm and the action that can help reverse current trends.
- Supporting new ways of tackling high levels of smoking, with tobacco still claiming more than 8,000 lives a year in Scotland.
- Trying new ways of working to reduce the number of people dying from drug use in Scotland.
- And not being afraid to approach existing issues with a fresh perspective to help policy makers and the public view issues in a different light, helping to aid our collective response to national issues.

There is a growing body of economic evidence that supports the case for investing in public health interventions and prevention. A debate on the future of the NHS must include a focus on how collectively our public services – including national and local government, the NHS, businesses, communities, and individuals can achieve that increased focus on prevention and reverse current population health trends.

At a time of resource pressure, encouraging investment in primary prevention is challenging but the case remains compelling. For example, the IPPR suggest that £2.3 billion of health boards' budgets in Scotland is being directed at responding to the impacts of poverty. The annual cost to the UK of obesity and overweight is estimated to be approx. £98 billion, with costs to the NHS of £19 billion. A concerted focus on these two areas alone has the potential to contribute significantly to reducing demand on our health system as well as having a positive social and economic impact.

An increased focus on prevention raises fundamental questions about how and where we invest already stretched resources and capacity where they will have the biggest impact. There are new ideas emerging which could, if adopted, fundamentally change our approach to delivering health care.

We must be bold and brave in the face of the health challenges we face. A focus on increasing prevention is increasingly gaining traction and it is important we look to shape these opportunities, particularly in reforming and modernising our public services.

Within Public Health Scotland we are using our evidence and insight to support decision makers in allocating resources in a way that will increasingly achieve upstream impact. Our vision is for a Scotland where everyone thrives. This involves preventing ill-health, promoting health and wellbeing, and tackling inequality.

We will play our part in securing a compelling and unifying vision for health and wellbeing in Scotland, built on the strong foundations of whole system reform and upstream interventions. Change is possible. Raising life expectancy, increasing wellbeing, and ensuring that our system of health and social care can support us all when we need it most is a mission that deserves a united focus across Scotland.

Paul Johnston is Chief Executive of Public Health Scotland

Find out more about Public Health Scotland's approach to prevention here.

22. Improving Children's Participation in Sport – A "Nice to Have" or a Serious Health Prevention Issue? – Claire Anderson

Originally published 24/07/2024

As we enjoy a summer packed with big sporting events, not least the Olympics in Paris, it is uncomfortable to find out many children have not returned to play sports at the same levels as pre Covid-19. Of course, compared to our European peers, these pre-Covid levels were nothing to write home about so to see a downward step is concerning on many levels. Seen through a health prism this is crying out to be seen as part of the wider health prevention agenda and debate.

Of course, children don't play sport because:

- **they think it will improve their life expectancy** (Scotland having the worst in western Europe[1]),
- **they think it might reduce their risk of developing coronary heart disease** (Scotland's biggest killer[2]),
- **it might help keep their BMI in a healthy range, helping to avoid type 2 diabetes in adulthood or even before** (a significant burden on Scotland's NHS[3]),
- **they think it will improve their mental health and wellbeing**. (In 2020, almost one-quarter of young people in Scotland experienced two or more psychological problems in a single week. About 1 in 10 children and young people between the ages of five and 16 had a mental illness that could be diagnosed clinically[4]).

Children play sport because it's fun. They get to play with family and friends, old and new. They enjoy the steps of achievement, a badge or belt or certificate. They love to win but are surprisingly resilient when they lose. They celebrate when their team does well, understanding a major life lesson, it takes a whole team to win, or to lose.

Additionally, they are adopting pastimes, skills and habits which they can carry into adulthood. These early learnt skills are more than just how to swim, paddle a kayak, swing a racket or throw a ball, these are skills which give children moving into different life stages, and perhaps new locations, the confidence to join like minded in clubs and societies, helping to establish and embed themselves in their local community.

Of course, many, if not all, of these clubs rely on hard working volunteers, the essential fabric which supports community sports and physical activity. Children and young people see, understand and ultimately become part of that community supporting structure. A virtuous circle.

Yet all the health benefits of sport and physical activity, and more, are true. So, the findings in a report published jointly by the Observatory for Sport in Scotland and The Data for Children Collaborative on 19th June 2024 are all the more concerning. It looks at the impact of Covid 19 on children's return to sport, or not.

The report identifies how many children have not returned to sport post Covid 19, a key factor being the pressure on local authority funding, something which has impacted the very backbone of Scottish leisure and sports services. There have been hundreds of facilities closed, swingeing cuts to staff and volunteers as local authorities battle to balance their books. Additionally, Covid19, and the isolation it imposed, has left some children with issues of anxiety and body confidence, barriers exacerbated by increasing participation costs. Of course, it is the children who come from the poorest socio-economic backgrounds who are the worst affected.

So, the challenge to our political leaders and policy makers is this: if children taking part in sport and physical activity isn't an important part of the health prevention agenda, then what is? Allowing children's participation levels to drop when the Scottish health stats are, at best, fairly alarming seems to be the equivalent of scoring a very public own goal.

There is a way forward mooted. The report calls for a Scottish Children's Sports Strategy (SCSS), one based on much better quality data than is currently available. An essential plank of a future SCSS has to be foundations of rock solid data, evidence and analysis.

A SCSS would bring a focus to a defined generational group with its own particular needs but from such a focus a broader sports strategy might flow, helping all ages and abilities. To be clear, this is not a call for top-down analysis and a "*ta dah*" solution, this is a call for the Scottish sports sector at its broadest to be central to the crafting of a SCSS.

It is something in its making that needs rigour, honesty and objective, independent oversight. It would need strong and credible leadership, so why not appoint an independent Tsar for Scottish Children's Sport? He or she could lead on the setting of a national framework, structured around local needs, capacity, and ambitions. Such a framework would be the scaffolding from which a meaningful SCSS could be built. Not only would such a strategy create something of true value, it could, if built, developed and nurtured in the right way, have genuine support from the many sports leaders and volunteers on whom so much day to day, and future delivery relies.

Implementation of such an approach, and of the inevitable change required would take commitment to funding and strong political leadership. Frankly, Scottish children deserve no less.

Any takers?

Claire Anderson is Co vice-Chair of The Observatory for Sport in Scotland

---

[1] Public health Scotland, April 2024. National Records of Scotland Report 2020-22, provisional figures Sept 2023.

[2] ScotPHO

[3] Diabetes UK estimate Scotland's NHS spends £875m pa on diabetes care, 55% on avoidable diabetes related complications.

[4] Children & Young Peoples' Commissioner Scotland.

23. Mental Health and Child Poverty – Can we do Better? – Alastair Noble

Originally published 23/10/2024

I think we need to take a step back and look at what we mean and diagnose as mental illness and what Mental Health /Wellness and Mindfulness actually mean.

As a GP with a long-term interest in mental health, we prioritised appointments of our many essential professionally trained staff to allow our community to benefit from correct treatment of those with mental illness. This was alongside and in tangent with all the other essential building blocks of a successful and sustainable community.

The Greeks worked out several thousand years ago the fascinating relationship between "a healthy mind and a healthy body."

We do not need any more research to show that healthy exercise, good education, good housing, healthy diet, sensible alcohol intake, not smoking, good jobs, good relationships all contribute to longer healthy lives.

The opposite is obviously true as well. Poverty is not just present in financial terms but as importantly in all other aspects of the opposites to all of the positives above.

We need to make sure we deliver both prongs of this delivery plan to achieve maximum community health and wealth, but also to target the correct treatment of mental illness.

We also must rigorously evaluate our differing delivery options and as always prioritise productivity and value for money.

It is worthwhile to consider what worked really well in our Nairn Model for Mental Illness. Firstly we decided that some of the biggest health gains we could deliver would come from improving the outcomes for patients with mental illness. Again, our well proven model of early and correct intervention with an integrated care team was known to work. Generally early, correct intervention was known to deliver better outcomes than late, often dramatic intervention.

Some very important examples – it was easier to stop young females from developing anorexia nervosa by early intervention and sensible discussion with them, and often their parents, than it was to try and treat established and often intractable anorexia nervosa in its late stages.

Similarly, the work of DRAMS (Drink Reasonably and Moderately Sensibly) shows positive benefits in early identification of too much drinking before it became addictive dependency.

So how did it all work? The team met every Wednesday morning to look at all referrals and allocate them to the most appropriate member of the team or even back to the GP.

Our psychiatrist was a psycho-geriatrician but in fact dealt with all our adult psychiatry. (I do wonder about all this hyper specialism). She was incredibly supportive of the whole team approach

and very much in “what do you think is wrong approach to the individual patient and more importantly what can you as the individual do to help yourself and get it sorted?”

We had excellent mental health nurses, social workers, psychologists, occupational therapists, and excellent links to health visitors, midwifes, district nurses, social workers as well as the practice team. This also applied out of hours, when again our local nurses and GPs were on call. The mental health team could leave clear instructions on the correct response to emergency calls.

The outcomes were very impressive – we went for weeks on end with no inpatients in the psychiatric hospital in Inverness. When our psychiatrist was on call at weekends and doing a ward round, she saw patients who she knew would have been better cared for in their own community with our team approach. We had numerous outside evaluations and my favourite quote from a patient with severe mental illness was simply “this is the best I have ever been”.

Patients who had been frequently readmitted before were coping well in their own community with their own families and friends.

So, as often in medicine the correct early diagnosis and sensible consistent treatment delivered better outcomes.

So, what is happening now?

We have a rather unbelievable 814 social prescribing voluntary groups listed for various causes on ALISS for Nairnshire alone. No wonder individuals are struggling to find the right help. We are also dribbling out large sums of money with no evaluation or long term follow up.

We must return some clarity and common sense to our locality based and outcome driven Model. The recent paper by Des McNulty highlighted how the spending is rising on an exponential curve, at the same time as we have more referrals, longer waiting lists and above all more children affected by poverty and mental health problems.

Nothing can be more damaging for a child than living in a home with undertreated mental illness. I include in that drug and alcohol addiction and many serious forms of abusive behaviour-even if that is not easily treatable or preventable. It helps the affected child if even you can let them know you know what is happening and are trying to get it sorted. Nothing is more damaging than for the child to think they are the cause or feeling responsible for not curing their parent’s problem.

So, to return to my central theme -we need to ensure we have the correct integrated local team to deal with Mental Illness. We also must use the same model for mental health that we use for physical health.

Nobody thinks you will get physically fit if you do not exercise and train.

Why then are we allowing so many mental health problems to avoid a similar fitness training program back to full mental health function.

The “healthy body, healthy mind“ thinking has always worked both ways. We need to prioritise both and aim for as many individuals as possible in all of our communities being as physically and mentally fit as possible.

Dr Alastair Noble worked as a GP in Nairn and was awarded an MBE for his work in integrating Health and Social Care in Nairnshire.

24. Early Intervention & Pastoral Care Key to Addressing Adverse Childhood Experiences – Rhona McLeman

Originally published 08/01/2025

From the moment of birth a million connections are made within a baby's brain every second; beginning to hard wire everything from how that wee person experiences the world to learning about relationships through the connections made with the faces that swim into focus. Early childhood is a time of exponential growth and developmental progress and as a Health Visitor, it is a privilege to walk alongside families as they experience all the joys and challenges this can bring.

Health Visiting is a unique profession, working in a strength-based, salutogenic (health-creating) way, we visit families in their homes, building trusting relationships and playing a significant role in providing support to overcome adversity. The role is complex and at its foundation is the quality of the connections which are formed with families; knowing when to offer containment, knowing how to empower and when to advocate. Health Visitors must work on suspending their nursing 'fixing' skills, instead walking alongside parents to reduce the barriers that prevent them being the best they can be. Of course not every family requires the same level of support and the power of Health Visiting comes in its universal proportionalism, the way in which our service is resourced and delivered as a universal service for all but with an intensity proportionate to the degree of need. Through this approach Health Visitors get to know the needs of their individual communities and the challenges of disrupting intergenerational trauma and preventing Adverse Childhood Experiences (ACEs) from occurring.

The link between adversity experienced in childhood and its impact on health in adulthood was first made in the late 1990s. Since then the knowledge base around ACEs has grown considerably. We know that ACEs are stressful and potentially traumatic experiences that occur in childhood or adolescence and that they influence a child's development making them more likely to engage in risk taking behaviours and experience increased physical and mental ill health in adulthood. Research tells us that there is a higher risk of experiencing ACEs if you are born into a family experiencing poverty. Compared with those with no ACEs, those with four or more ACEs are twelve times more likely to experience alcoholism, drug use, depression and suicide attempts. Strikingly, if we could prevent ACEs occurring in childhood it is estimated we could reduce the numbers of adults suffering with depression by as much as 44%.

In coproduction with colleagues across the local Health Visiting teams, we undertook a project to transform record keeping. As in many areas of health care, Health Visitors were documenting rich detail in patient's records about families' experiences and the challenges they faced however in a format that was uncollectable and therefore prevented any further analysis from occurring. We sought to change this and are now able to capture data and view it interactively through a dashboard that allows for analysis. Our early ACEs data provides evidence that the greatest adversity facing children in our communities is having a parent living with a mental health condition. For these children the impact can be wide ranging; from poor attachment affecting their own ability to form connections, to not managing within the classroom to being socially isolated

and lacking the opportunities to make friends. As a Health Visiting service, we plan to use our new found knowledge to inform our early intervention work in specific areas but also to work alongside our Public Health colleagues to consider how this new data can be best used to influence policy and direct funding.

The project described above is just one example of innovation within Health Visiting practice aimed at putting the focus firmly on early intervention and prevention of adversity and there are many more. Health Visitors often look creatively at the public health challenges within their communities and will work with people locally to find solutions. Undoubtedly, across the country there will be Health Visitors working hard on their own areas of service development in response to gaps encountered or issues raised, after all the Nursing and Midwifery Council Spheres of Practice for the profession indicate this a key area of our practice. What does not exist however is a specific professional and strategic lead at national level … a Chief Health Visitor.

Whilst we have a Chief Nursing Officer and a Chief Allied Health Professions Officer sitting within the Chief Nursing Officer Directorate at Scottish Government level the responsibility for oversight of early years and children sits under the Chief Midwifery Officer's remit. These senior roles are necessary and in many ways achieve their aims of providing policy advice to ministers and delivering strategic and professional leadership. However, in order to be effective in leading the kind of reform that will impact on reducing ACEs and intergenerational trauma through investment in early intervention across childhood and adolescence I would argue that a further specialist Chief Officer role is needed.

If we are serious about health and education reform, we must look towards a model which promotes and provides early invention in families where adversity exists. At present Health Visitors provide specialist pastoral support (care provided to ensure physical and emotional wellbeing) to parents until their child goes into Primary One. From this pivotal moment, forwards families must negotiate the challenges of parenthood without this intensive professional input. Many families have circles of support to call upon and due to their resilience weather the storms that parenting can sometimes bring. However, other families have little resilience promoting factors in their lives and have often needed regular Health Visiting support to keep them afloat. Every year from August onwards, we continue to have families who reach out for support after their child has started school. They know they have been discharged from our care but are accustomed to being able to 'check in' with a trusted professional for advice and support. These families have had home visits where the Health Visitor has had time to listen, to contain, to signpost and advocate for them allowing them to overcome some of the barriers and wider stressors affecting family life and without this, they begin to flounder.

In my experience, it is not that primary schools do not wish to provide this type of support to families most in need but the current system and resources available are not designed with this in mind. There is little in the way of home visits, which would allow education staff to understand the complex needs of vulnerable families. Nor is there the capacity for staff within schools to have time to focus on building relationships with parents to understand the barriers faced and then work alongside families to reduce these. The School Nursing Service, which could be well placed to provide pastoral care is currently a referral only service and it relies on these referrals to

highlight families otherwise they go unseen. The current capacity of School Nursing is such their work is dominated by supporting families who are experiencing the greatest adversity due to this there is little scope to focus on early intervention public health approaches which would go some way to alleviating adversity occurring. When pastoral care is more present again in secondary school for many families this comes as too little, too late. The work done in the early years has now lost momentum and the challenges facing some families have become insurmountable.

If we are serious about reducing health inequalities and adversity experienced in childhood I believe we must look to provide proportionate pastoral support to parents throughout childhood not just the early years. We must do this through reform that chooses to prioritise delivering models of care which promote and provide early intervention through strategic national focus on leadership in this area.

Rhona McLeman is Health Visitor and Queen's Nurse.

25. Alcohol and the Future of the NHS: Part of The Problem and Part of The Solution – Alastair MacGilchrist

Originally published 06/02/2025

There has been much said about how to deal with the challenges facing the NHS in Scotland. An oft-repeated mantra is that we need to focus more on prevention, as argued in a previous NHS2048 blog by Paul Johnston of Public Health Scotland. In many respects this is a 'no-brainer'. Of course preventing illness will reduce the disease burden and reduce the pressure on our beleaguered healthcare services. The argument is even more compelling when you appreciate just how much of that disease burden is preventable. Non-communicable diseases (NCDs) – including heart disease, cancer, diabetes, Alzheimer's, lung disease and liver disease – account for 83% of all deaths in Scotland, and an estimated 20% of NCDs are preventable. The key drivers are tobacco, alcohol and unhealthy foods. In this blog I will focus on alcohol, for 3 reasons: (1) Scotland has a particularly unhealthy relationship with alcohol; (2) the steps which can be taken to improve the situation are well-known and compelling; and last but not least, that being the case, (3) why have we not already taken these steps?

Alcohol kills over 1200 Scots per year. That is 3 times as many as when I entered the NHS in 1979! These are alcohol-specific deaths, i.e. those deaths which are due to alcohol alone, mostly liver disease. But that is not the whole story. When you also take account of the many diseases in which alcohol plays a part, such as heart disease, stroke and cancer (alcohol is proven to cause 7 types of cancer, including breast and bowel cancer) then the death toll rises 3-4 fold, i.e. around 4000 deaths in Scotland per year. Hospital admissions directly due to alcohol are running at around 30,000 per year, and that does not include the many thousands of alcohol-related attendances at our overcrowded A&E departments. So no-one should be in any doubt that alcohol harm is a major component of the current crisis facing our NHS.

We have known for decades what public health measures work to reduce alcohol harm. What the WHO describe as the 3 'best buys' can be thought as the 3As: reduce affordability, reduce the attractiveness and reduce availability. The single most important is affordability. The principal reason for that 3-fold increase in alcohol deaths is that alcohol is much cheaper in real terms than it used to be. That is why Scotland is to be applauded as the first country in the world to introduce a minimum unit price for alcohol (MUP), i.e. a floor price below which alcohol cannot be sold. The attractiveness of this measure is that it specifically targets the cheapest alcohol which is favoured by the heaviest drinkers who are at most risk of harm. And it is working: MUP is estimated to be saving around 150 lives per year, nearly all of these from deprived communities, making MUP a progressive measure which is reducing health inequalities. Of course the level at which MUP is set is crucial to its effectiveness. The level of 50p at its introduction in 2018 was actually the level proposed 6 years earlier, in 2012. You may remember that the policy was delayed by repeated unsuccessful legal challenges from the Scotch Whisky Association (SWA) – of which more later. So 50p in 2018, which equates to 65p in 2024 when it was uprated, is perhaps less effective than it might have been. The point is that regular uprating to keep pace with inflation is crucial to its continuing success.

And yet, despite MUP, the total number of alcohol deaths has been rising. This is the result of the Covid-19 pandemic which has had a major detrimental effect on our drinking behaviours: those already drinking more than they should have greatly increased their consumption.

So MUP alone is not the answer. We should be introducing regulation to restrict alcohol marketing and advertising to protect particularly the young – including a ban on advertising in public places and a ban on sports sponsorship; to separate the point of sale of alcohol in supermarkets; to enforce alcohol licensing regulations supposed to take account of health harm. We should be encouraging the UK government to increase alcohol duty at or above the rate of inflation; to ban alcohol advertising on all media outlets before the 9pm watershed and to introduce mandatory health warnings on all alcohol products akin to those for cigarettes. All of these measures in combination will reduce the toll of death and illness from alcohol.

That being so, why have such measures not been introduced long ago? The problem is not uncertainty regarding their effectiveness, nor is it a lack of support from the public. No, the reluctance of successive governments in Holyrood and Westminster to implement measures to reduce alcohol consumption and therefore alcohol harm is due principally to the power and influence of the alcohol industry. The track record of the alcohol industry is just like that of the tobacco industry and the unhealthy foods industry. They attempt to move responsibility for the harm their products cause away from the manufacturers and on to a minority of 'problematic' consumers. They intensely lobby policy makers with misinformation intended to deny the evidence for public health interventions, delay their implementation (as with the SWA and MUP), overstate the economic importance of alcohol and the supposed economic damage from public health measures, and instead argue for ineffective alternatives such as self-regulation and supposed consumer education.

Paul Johnston has argued, Scotland's health problems are growing and without preventative action to address unhealthy lifestyle and behavioural factors, our NHS, even with reform to improve the delivery of healthcare, will be unable to cope. In contrast, if the Scottish Government – which has previously been seen internationally as a beacon of hope for progressive alcohol policy – rediscover the political will to introduce evidence-based, effective public health measures, there is no reason why we cannot get the levels of alcohol harm in Scotland back down to those of a generation ago. Such progress could make a major contribution to the NHS successfully delivering healthcare in 2048.

PS How much is too much?

This blog makes the case for population level measures to reduce our alcohol healthcare burden to help our beleaguered NHS. Readers may also be interested in what they as individuals should do with regard to alcohol. Well, we should follow the Chief Medical Officers' guidance to drink not more than 14 units per week. That works out as a bottle and a half of wine, 6 pints of beer or half a 70cl bottle of spirits. These limits were chosen because that is the point at which the risk of alcohol being responsible for your death reaches 1% and rises rapidly with higher consumption. We are not talking here about that small minority of drinkers who unfortunately develop alcohol dependence, important as they are in terms of the major impact on their lives, their health and

their families. They will be drinking far more than 14 units. Most patients who develop liver disease are also drinking at substantially higher levels. But it is the more subtle, hidden risks such as heart disease, and particularly cancer which explain that 14 unit limit. Current evidence suggests the old story that a little alcohol is good for your heart is not, in fact, true. Alcohol is a class A carcinogen (something the public are unaware of, hence the need for mandatory health warnings) and the cancer risk rises with any alcohol at all. So from a health perspective, less is better and none is fine. For me, I am comfortable that the risk of continuing to drink but at less than 14 units per week is acceptably low, but that should be a personal, informed decision for each individual.

Dr Alastair MacGilchrist is a hepatologist (liver specialist) who worked from 1992 to 2022 at the Royal Infirmary of Edinburgh which houses the Scottish Liver Transplant Unit. He has been the hepatology specialty advisor to the Scottish Government, a non-executive director of UK Transplant, a council member of the Royal College of Physicians of Edinburgh and the president of the Scottish Society of Gastroenterology. Since 2021 he has chaired Scottish Health Action on Alcohol Problems (SHAAP). SHAAP, a partnership of the Medical Royal Colleges and Faculties in Scotland, provides the authoritative clinical voice on how to tackle Scotland's alcohol problem.

26. Why Movement Matters: The Imperative for a Changed Approach – Emma Anderson

Originally published 11/02/2025

When did you last move? It might seem an odd question and to many the answer is simple – to make a cup a tea, to answer the door, or just to stretch. However, to others it is not so simple. Some of you might find it harder to answer this question. There may be a whole range of reasons why you have not moved much at all, including anxiety, illness, due to health conditions or due to a lack of access to appropriate facilities. Barriers to moving can have a devastating impact on people's health and life chances. Yet, at a time of ever-increasing health inequalities, movement has never been more important and, while the recent Scottish Government announcements to cut waiting lists are welcome, still more needs to be done to put preventative healthcare front and centre of the reform agenda.

Movement for Health

Movement for Health is a coalition of national health organisations working on increasing physical activity levels to improve the social, physical, and mental health of people living with long term health conditions. We work with a range of academics and government agencies to promote and support physical activity provision and choices for people with health conditions. We regularly engage with the Scottish Government and representatives from all parties represented in the Scottish Parliament to advocate for greater prominence and investment to be given to realising our ambition. And we support health and social care professionals, leisure and physical activity providers, acting as a hub on relevant policy, tools and practise across Scotland.

The Imperative for Change

As the Scottish public health system struggles to cope with ever-increasing demand, movement can and should play a fundamental role. We hear a lot about the importance of preventative health from politicians and policy makers, yet the reality is that preventative healthcare is chronically underfunded and is not given the political nor clinical leadership it requires.

At present, the results of physical inactivity are putting public services under increasing strain, with the costs of meeting the increasing demand running into the billions. The World Health Organization estimates that, globally, the cost of physical inactivity to public health care systems between 2020 and 2030 will be about $300 billion, so approximately $27 billion per year, if levels of physical inactivity are not reduced.

In Scotland, around 3,000 preventable deaths are directly attributable to physical inactivity, with just over a half of the adult population being able to meet the recommended physical activity guidelines. Unsustainable pressures are set to continue as some 47% of the adult population in

Scotland are living with at least one long term health condition, with our most deprived communities being disproportionately impacted.

Movement matters

All movement matters. In order for people to be able to achieve the global physical activity guidelines of 150 aerobic minutes of movement per week and the essential strength and balance minimums, we need to engage using positive framing that suits the individual and their circumstances. Appreciating that minor movement is absolutely crucial to achieving those longer-term goals.

Some people will remain limited by conditions, so for them the guidelines are unachievable. Yet, what they can do matters, is valuable, has purpose and should be recognised and celebrated. Without starting with and celebrating minor movement, our society will not see the shift we need to become a moving nation.

A new public health framework, published by the Scottish Government, helps frame the implementation of physical activity, but only through a focus on movement and implementation through partnership and collaboration – and adequate finance – will the benefits of the framework be reaped. The First Minister's recent announcement on NHS reforms are welcome, but they don't go far enough to address the need to put physical activity and preventative health at the heart of the system.

The need for reform and partnership

This is why we believe that movement and physical activity should be placed at the centre of all efforts to alleviate public health pressures and tackling health inequalities. By refocusing on such preventative measures and making them a priority investment on an equal footing with clinical interventions, there could be as much as 1:14 return on investment, as evidence showed at our first national conference in June 2024. This will require a whole systems approach, pioneered by Public Health Scotland, with all sectors collaborating to promote movement for everyone within society. The third sector, community and local government organisations particularly have a key role to play in developing new referral pathways, including social prescribing, and ways to offer appropriate and available support in the individual's community.

Much can be achieved through partnership and sharing information. We need to keep sharing learnings, sharing good practice and examples across the community and across sectors. . The whole system approach promotes the concept that all sectors need to collaborate to promote movement for everyone within society. This encompasses a multidisciplinary method, which includes not just excellent physical activity programmes but modification of environments externally and internally.

Fundamentally though, there needs to be a step-change to our approach to social prescribing and patient referral pathways. NHS organisations and GPs and other primary care professionals are under increasing strain to cope with the levels of demand.

If Scotland is to address health inequalities and increase physical activity, the NHS and the way we prioritise preventative health must change. The third sector, community and local government organisations must play an increasing role in the future of our healthcare.

Movement is for everyone, movement is to be free, movement is to be seen.

Emma Anderson leads the Movement for Health coalition, the national programme, and the community of practice. For more information please visit their website and engage with their podcast Movement in Conversation: Movement for Health | We Move Together

27. PreHab and the Pipeline to Recovery – Charles Maasz

Originally published 20/02/2025

I am writing this in February with my sister Sharron very much in mind. Sharron knew homelessness, rough sleeping, alienation, adversity, violence and all of the pernicious ways in which this life can do harm to a vulnerable woman. Sharron would have celebrated her birthday in February with her three now adult children, were it not for the accumulative effects of poly-substance addiction and multiple complex needs. Every service available was engaged with, all supports exhausted. The race to the finish was not won by interventions or wonderful support workers but by one last session that tipped her over into God's eternity.

Chronic addiction is a consuming shadowy force that devours the host. Addiction will hollow us out, slowly at first. It rips the heart out of families and destroys communities. As the CEO of a 200 year old charity in the heart of Glasgow that specialises in destitution and life at the hard margins, as the director of a residential addiction rehab all coupled with my own lived experience, I've seen a bit. I've seen some approaches that work and much that doesn't.

In the last figures released (2023), Scotland recorded 1,172 drug misuse deaths. This marked a 12% increase from the previous year. Equating to an age-adjusted rate of 22.4 deaths per 100,000 people, up from 20.0 in 2022[1]. The death stats are horrendous but they represent the literal tip of the iceberg. Far too many families know the agony and helplessness of addiction hidden away behind closed doors and curtains. Not all of it is life endangering but all of it is life diminishing.

Despite all recent and historic drives to combat this crisis, addiction shows no sign of retreating. It is a paradox. We spend more on solutions and find only increase.

Scotland's drug death crisis is the worst in Europe. Despite extensive investment in harm reduction strategies, traditional approaches—such as Opioid Replacement Therapy (ORT) and community-based support—have struggled to significantly reduce fatalities and relapse rates. This calls for a radical shift in addiction recovery; one that prioritises relationship-based, structured interventions.

What follows are my thoughts on a new approach building on principles and models that are proven to be effective. The working name for this approach is 'PreHab' – a preparatory rehab facility. The Prehab Centre presents an innovative solution that fills a crucial gap in the addiction recovery pathway, offering stabilisation and preparation for long-term rehabilitation with its primary aim – to save lives.

Prehab: A Transformational Approach to the Drug Deaths Crisis

Scotland's drug mortality rate is 3.7 times higher than the UK average, with Greater Glasgow and other deprived areas disproportionately affected. Many individuals undergoing Methadone and other ORT routes remain trapped in cycles of addiction, unable to transition into residential rehabilitation due to strict entry requirements.

While ORT helps many individuals, it does not provide the structured, long-term support required for full recovery and ongoing sobriety. PreHab is a first stage of an abstinence based approach to recovery from addiction. Many established rehab facilities require individuals to be stabilised on low-dose ORT, fully detoxed or require a 'cold turkey' approach on entry. Without a structured environment to assist the transition from chronic levels of consumption, many never make it into long term or residential rehabilitation or if they do, they do not last the course and withdraw at an early stage.

Community addiction services, though valuable, often lack the structured intervention necessary for meaningful stabilisation. Without immediate access to a safe, wrap-around and supportive environment, those seeking recovery from addiction are highly vulnerable to relapse, increasing the risk of accidental overdose.

The Prehab Centre: A Bridge to Recovery

The Prehab Centre is designed to provide a vital link between the initial 'cry for help' and a full-time residential rehab, addressing the structural gaps that currently hinder recovery outcomes. How PreHab will help:

1. Immediate Intervention: When an individual expresses readiness for recovery, the Prehab Centre ensures they receive immediate support. This is crucial, as delays in accessing services can lead to lost motivation, isolation, despair and continued life threatening substance use.

2. A Safe, Structured Environment: Unlike community-based services, which require individuals to remain in high-risk environments, the Prehab Centre removes the individual from relapse triggers and places them in a controlled residential setting where they can focus on recovery.

3. Early exit from programmes: The PreHab recognises that for many new rehab residents the strong community frameworks, rules and discipline, and the mutual accountability found in many residential programmes represents too great a shock to the system. PreHab will offer the chance for residents to acclimatise and in so doing prevent many of the premature exits from full-time residential rehab programmes.

4. Personalised Stabilisation and Tapering Support: The programme will include gradual ORT and illicit drug use/alcohol reduction under medical supervision, ensuring individuals are physically prepared for rehab while minimising damaging withdrawal symptoms and associated risks.

5. Improved Graduation and Retention Statistics: A successful PreHab will improve referral processes into residential rehab programmes. Quality referrals ensure the right people are matched with the most suitable rehab programmes. Along with the culture-familiarisation and detox processes we expect to see rehab retention and graduation statistics improve along with improved post-graduation outcomes.

6. A Relationship-Based Approach: Many individuals battling addiction have experienced isolation, trauma, and fractured relationships. The Prehab Centre fosters strong, trust-based relationships between residents and staff, recognising that relational support is key to long-term recovery.

7. Faith-Based Holistic Care: Rooted in Christian values, the Prehab Centre offers holistic care that addresses not only physical recovery but also emotional and spiritual well-being. While faith is a core component, the programme is inclusive and welcomes all individuals seeking transformation.

The Strategic Model and Impact

Collaborative Development: The Prehab Centre concept was conceived in conversation with a coalition of leading Scottish recovery organisations – Glasgow City Mission, The Haven Kilmacolm, Street Connect, The Arch, and Bethany Christian Trust. The collaborative partnership has ensured input from a wide range of expert practitioners in all stages of the recovery journey, operational expertise, and post-rehab support networks. The working partnership has been led by Glasgow City Mission with active engagement from The Haven and Street Connect with Life Housing and Bethany offering informal support and collaboration.

A PreHab centre will be registered with the Care Inspectorate and adhere to all legal and healthcare regulations, ensuring it meets the highest standards of addiction recovery care.

The service design leads us to aim for a facility that will accommodate 18-22 residents at a time, with an 8-16 week structured programme. Situated in a semi-rural setting near Glasgow, it is believed that the centre will balance accessibility with the need to remove individuals from urban relapse triggers.

Pathways beyond PreHab: Residents will have options based on their progress through the PreHab phase of the journey:

- Entry into long-term residential rehabilitation (majority of cases).
- Transition into independent living with continued partnership support.
- Community reintegration with aftercare services.

Alignment with Government Policy and Financial Viability

Supporting Scotland's National Mission on Drug Deaths: The Scottish Government's national drug strategy emphasises expanding rehabilitation services and improving access to recovery pathways. The Prehab Centre directly addresses these priorities by offering a preparatory stage for rehab entry.

Financial and Social Return on Investment: Human Cost Savings: Each person supported through addiction recovery reduces the likelihood of future overdoses and drug-related harm.

Economic Benefits: According to Public Health England, every £1 invested in drug treatment yields £2.50 in social benefits. Assuming these figures to be a ballpark estimate, a 50% success rate at the Prehab Centre could be read as a £2.9 million annual saving—four times its projected operational cost.

Overcoming Barriers to Change

Breaking the Cycle of Dependency: Current models often leave individuals indefinitely dependent on medication and opioid replacements, failing to provide a clear path toward full recovery and sobriety. Prehab disrupts this cycle, giving individuals the structured support they need to move forward.

Addressing Resistance to Innovation: Traditional harm reduction approaches remain dominant in policy and funding decisions. While these have a place in addiction care, they must be complemented by transformative recovery solutions like Prehab.

Challenging the Stigma Around Abstinence-Based Recovery: In some policy and expert circles, abstinence-based models are viewed with degrees of scepticism. However, lived experience and long-term success rates within our already established networks demonstrate that full recovery, not just harm reduction, ought to be the ultimate goal of PreHab.

A Call to Action

Scotland's drug crisis demands urgent, innovative solutions. The Prehab Centre is not just another addiction service, nor is it a residential Rehab by another name—it is a game-changer, filling a critical gap in the recovery pathway. By offering immediate intervention, structured tapering support, and relationship-based care, Prehab provides individuals the chance of achieving the stability needed to embark on a successful rehab/recovery journey.

We urge policymakers, health & addiction specialists and agencies, investors, and community leaders to support this transformative initiative. With the right backing, a Prehab Centre can become the centre of a game-changing turning of the tide in Scotland's drug crisis; saving lives and restoring hope. PreHab could provide a game-changing template for a replicable service in an area of need that desperately needs new approaches.

I am strongly persuaded that we are unlikely to find a way out of this drug deaths crisis by adhering to existing modes and practices. Throwing resources at addiction cannot fill the voids that drive it. That is not to say money does not need spent, because it does. But if there is one thing addiction can burn through quicker than a fire in a dry forest it is resources, especially money. Addiction has an appetite that none can satisfy. Only radical inner change and corresponding shifts in perception can affect meaningful and long-lasting recovery from chronic life threatening addiction. The kinds of interior and perception shifts that are required do not come easy to most of us, especially perhaps for those caught in addiction. There are no 'silver bullets', no shortcuts, no cheat methods. The hard work that brings stabilisation and sobriety is best achieved within a supportive therapeutic community environment. We believe that the missing link in addiction recovery services is a PreHab.

Charles Maasz is the CEO of Glasgow City Mission

28. Rethinking Mental Health Support for Scotland's Kids – Fiona McFarlane

Originally published 14/05/2025

Child and Adolescent Mental Health Services (CAMHS) waiting lists are in and out of the news and becoming enough of an issue to repeatedly show up at First Minister's Questions. The debate, like so many public policy issues, is turning on whether the SNP can claim that they have delivered. They say they have, their opponents say they haven't.

Before we get into it, it is worth thinking about the Hawthorne effect. This principle tells us that the act of observing something changes the nature of it. And in the world of mental health waiting lists, that couldn't be truer. The focus on the service and the 18-week target has led to some pretty significant changes in how we respond to the mental health of our children.

The Scottish Government have been shouting from the rooftops that they're hitting their target of seeing children and young people within 18 weeks. That is genuinely good news, and a testament to the efforts of healthcare professionals who've been working to triage referrals and manage risks effectively. Let's not gloss over the realities of that success – being responsible for deciding which children need seen urgently and which can wait a while is difficult, risk laden, work. For many, that decision can be life changing, and lifesaving. But here's the catch: the success being lauded by the Scottish Government has also morphed the waiting list into something entirely different—one that leaves some children and families in the lurch.

The number of children on the waiting list, and how long they've been there, are statistics, and there are lots of ways to make statistics move up or down. In this case, the obvious assumption is that meeting the target means children are moving through the waiting list more quickly, more families are receiving support, and everyone is having their needs met. A supercharged system, well-resourced to meet demand. That may be the case for some. There is another answer though. You can meet targets without changing the speed or levels of support just by changing the criteria for the children you need to see.

And that brings us to the rub. Across Scotland, children and young people referred for ADHD and autism assessments aren't on the CAMHS waiting lists anymore (unless their risk is severe enough). They're sent down another route, which is significantly backed up. In some places the pathway has closed altogether. In this route, families are left waiting for months—sometimes years—for the assessments that often provide much-needed clarity and support. The 18-week target feels very far away for these families.

This issue comes at a time when we're all feeling the weight of rising distress amongst young people, which can be seen in increased rates of self-harm, anxiety, and school absenteeism. Teachers report far higher levels of dysregulation and school readiness. The statistics are alarming, and they reveal a deeper crisis brewing beneath the surface.

The Scottish Government are correct – the waiting list success is good and they are taking action. Right now, CAMHS is getting a hefty £123.5 million a year. On top of that, there is £16 million given to local authorities for school counselling, focused on secondary schools. These numbers are significant and are facilitating good, essential service provision, but they are addressing only part of the problem and being used to tell only part of the story.

You can see from the funding split that the focus has been on clearing those waitlists, addressing the most significant risk and driving more resources into diagnostics. This has worked for some. But even for those it has helped, the quickest way to move anyone through any system, which is what a focus on a target forces you to do, is to provide an outcome. In this case that outcome is a diagnosis.

For the Scottish Government's success stories, and indeed their strategy, this opens up another debate. While diagnosis is important, we risk it becoming our only focus. There is a debate going on about the rate of diagnosis and the risk of pathologising human behaviour and experience. We do know that while a diagnosis provides insight, understanding and a better sense of identity, it doesn't automatically open the floodgates to adequate support. We also know that, from a system perspective, diagnosis is the easier part. Sustainable, holistic, relationship-based support is harder, and lengthier, and more expensive.

Children and families can find that after a diagnosis they're still grappling with the same challenges day in and day out. This raises a pressing question for all of us: what are our public services and politicians doing to help support a mentally healthy childhood? For we might solve a diagnostic problem and yet not address the need or the experience. That question is one that is beyond the current CAMHS wait time and diagnostic debate, but one that we should also be expecting answers on from our public services and politicians. To balance the figures above, the Scottish Government spends £130million a year on Pupil Equity Funding, which can be used by schools to support broader wellbeing and attainment. Not much more than the cost of CAMHS.

So the questions we need to ask have to be broader than the focus on waitlists and diagnostics. What are we doing to **build resilient families**? Are we equipping families with the tools to better understand and cope with emotional challenges and mental health issues as they arise throughout childhood? Are we providing**support early** and setting up mental health and wellbeing services in primary schools for children, schools, teachers, and families to help us all handle big emotions? And are we **supporting purposeful activities** and fostering community initiatives that give kids a sense of belonging through sports, drama, or the arts?

It's difficult to understand the roots of the current mental health crisis – the impact of screens, inequality and poverty, and the post pandemic malaise are things that many discuss. But looking from the other end of the telescope, we do know the components of good mental health for children and young people. Strong relationships, supportive parenting, family financial stability, and a sense of community are the bedrock of positive wellbeing, and we can focus on these to make a change. Diagnosis can be incredibly important for many, but while we focus on that crisis, we can't forget to focus on creating an environment where children can truly flourish. We have to do both.

By shifting our gaze from counting waitlist numbers to genuinely supporting children and their families we might just see change and positive, healthy, happy futures for all children and their families.

Fiona McFarlane is Scotland Director for Place2Be, a children's mental health charity, and is former Head of Policy and Public Affairs at The Promise Scotland.

29. Our National Disease Service – Professor John Smyth

Originally published 19/06/2025

In its current form the NHS is not a "Health" service but a "Disease Service" – we use almost all or our resources for treating the ill, not maintaining the health of the population. The current arrangements are unsustainable and we need to change the model. A huge challenge but a necessity. I offer below my thoughts as to why we are in the present position and two major suggestions for the way forward.

What has gone wrong?

I believe that the major causes of our present unsatisfactory situation are due to two factors – a failure to recognise the amazing success of medical research over the past 50 years, and a failure to provide the manpower to deliver the health benefits resulting from that research. My justification for having an opinion on this is the fact that I have been a doctor for the past 55 years, and a professor of medicine for 46 of those. I was the first consultant medical oncologist to be appointed in Scotland and led the development of that speciality for many years. I am still active in research and believe that Cancer is a good model for considering the future of all forms of illness. One in two of us will experience cancer in our lifetimes so it will always be of importance to medical planning, but my comments are equally relevant to most other areas of health.

Medical research has literally transformed the potential outlook for people with cancer over the past decades. When I began my consultant career we had about 12 medicines for treating a limited number of cancers. Now we have > 250 medicines, can help almost everyone, and with the recent development of immunotherapy are actually curing some of these diseases, something that I could never have envisaged in years gone by.

Equally important have been the major advances in surgery and radiotherapy. In Edinburgh we were leaders in the concept of "multidisciplinary" care – patients being discussed at the planning stage by surgeons, physicians radiotherapists, clinical psychologists, nurses etc. All of this is time consuming and requires adequate funding.

The second and related reason for our current problems is the failure to plan for the manpower required to deliver these developments. We have fewer specialist cancer doctors per 100,000 people than almost any other country in the developed world, and one of the consequences of this is "burnout", with the consequence that some specialists seek early retirement, thus reducing the planned workforce even further.

What Should we do?

In thinking about solutions I believe that we should aim high in our ambition and seek solutions that if not "ideal" are at least a significant improvement on the present.

PREVENTION. Many of the causes of illness are preventable. Mental health is a huge problem that I will not comment on here in order to stick to the example of cancer, but we know many of the preventable causes of cancer and other major diseases. Nutrition/poor diet, obesity, tobacco, alcohol and drugs all contribute to ill health. We need to educate young people to better understand this but I fully recognise the challenge this presents and of course it overlaps with major societal issues such as poverty, social deprivation etc. But we should not ignore the value of prevention. People working in primary care clearly have a role in promoting the concept of prevention.

SCREENING. We need to improve the uptake pf screening to detect early signs of cancer. We do well with breast and colon screening and there are controversies about the value of screening for prostate and lung cancers. In the near future developments in genetic screening are going to offer the chance of identifying many more people who are at risk of developing cancer and these will need selective and more intense screening than the population at large. Hence more resources needed but the rewards will be significant later on.

TREATMENT. We need to dramatically improve the efficient use of hospital facilities and clinics. These should be focussed on the active management of patients not the "caretaking" problem of bed blocking because there is nowhere for patients to convalesce.

We should also improve communication between hospital and GPs so that the latter can help more with aftercare . Electronic record sharing is an important step towards this.

So how can we achieve this?

Health care planning is at present done by politicians. The inevitable consequence of this is that they have to be short-term minded and appeal to particular sections of the public who elected them. This has to change. I suggest that the responsibility for managing health care budgets and planning future developments should be undertaken by a new independent organisation. I suggest the formation of a Medical Commission comprised of 15-20 people representing a broad spectrum of appropriate expertise – medical, political (of all parties), economists, lawyers etc. who would serve for 5 years renewable once in order to allow long term planning – 10 years at least. Whatever monies are available this should surely give a greater allowance for making the very difficult decisions about priorities. But surely better than leaving it to politicians alone? And I would fund this differently.

Compulsory health insurance

I have been heavily involved with fellow oncologist in Europe throughout my career, and served as President of the European Society of Medical Oncology and the Federation of European Cancer Societies. For a decade I was Editor in Chief of the European Journal of cancer and responsible for founding the Cancer Drug development Forum, an association that seeks to speed up the process of introducing new medicines for patients. Most of the European countries provide health care through a mixture of state funded and private funding and I believe that the time has come for us

to consider such a dramatic move. The much spoken of term “free at the point of delivery” is nonsense since we pay for the NHS through income tax. The latter is means tested and the European models incorporate just such systems. We could have a setup where the state provides such things as Accident and Emergency services and obstetrics and possibly geriatrics. All the other services could be provided by a limited number of approved Private Health Companies to which the public would have to sign up. Exceptions would apply to those on low incomes or unemployed. Differential rates would be applied for people with chronic conditions – diabetes, hypertension etc. There are some excellent examples to review.

So, I hope that these ideas may be of interest and warrant discussion at least in part. I am convinced that the current setup is unsustainable and future research is only going to compound the problem. Serious change is needed.

Professor John Smyth FRCPE, FRCP,FRCSE,FRCR,FRSE is Emeritus Professor of medical Oncology

30. Scottish Health Ecosystem – Ben Thomson

Originally published 03/09/2025

1. Summary

There is a general recognition that the approach to sickness and health needs to adapt to reflect the change in the nature of disease, with a greater focus on the prevention and management of chronic, long-term conditions. There needs to be much greater emphasis on creating a strong Scottish Health Ecosystem that keeps people healthier and out of hospital to free up the NHS acute and chronic trauma services to be able to provide the standard of care its highly professional staff are capable of delivering.

There are c13,500 hospital beds in Scotland with approximately 1,000,000 inpatients and 4,000,000 outpatients per year. There are nearly 700,000 on Scottish hospital waiting lists. The average cost per day of a hospital bed is c£550 and average length of stay around 7 days so about £3bn per year. Any reduction in inpatients and outpatients will have a significant impact on freeing up hospital resources to manage waiting lists and create significant economic efficiencies.

The majority of hospital beds are for acute patients (33%) with the next largest being for dementia (18%). The ten most treated conditions in acute care are cardiovascular conditions, respiratory infections, traumatic injuries, UTI inflections, mental health crisis, diabetes management, orthopaedic injuries, gastrointestinal disorders, skin/burn injuries and neurological emergencies.

In order to reduce the requirement for hospital beds there are 3 broad areas

- Keeping people healthier so avoiding/delaying onset on chronic disease
- Early diagnostics to detect issues before they become acute or chronic
- Managing inpatients to reduce average length of stay

There are many aspects to improving each of these areas and some are easier to address than others. These aspects of health should all be pulled together to form a Scottish Health Ecosystem to reduce the requirement for acute care. As part of that Scottish Health Ecosystem testing has an important part to play in keeping people healthy, early diagnostics and getting inpatients back to health quicker as set out in this paper.

1. Keeping People Health

There are now more and more tests that can be used to focus on health areas such as hormones, cardiovascular, gastrointestinal, environmental toxins, food allergies and genetics to allow practitioners to monitor the day to day health of their patients. All the tests can be taken at home or through networks of phlebotomists in the UK and used by the practitioner to guide their patients' health needs.

Most healthcare practitioners using these tests for health are private sector regulated healthcare practitioners such as functional and private doctors, clinical specialists (such as

gastroenterologists) and nutritional therapists. At present primary care NHS is not focussed on health or health testing to keep patients healthy but rather their primary role is to identify clinical illness and then refer patients towards secondary care. Individuals are increasingly seek advice on addressing health problems such as fatigue, stress, weight and gut issues or simply to understand the areas they might be susceptible to and need to keep an eye on. However, getting access to testing through the public sector is often difficult and sporadic across the country. If we are to protect the secondary system then primary care healthcare practitioners need to be more focussed on health.

An example of an area of focus of keeping people healthy for instance is women's health as outlined below.

Women's Health – Example of Keeping People Healthy

The Scottish government's Women's Health Plan "aims to reduce avoidable health inequalities for women and girls across the course of their lives – from puberty to the later years – focussing on those areas that are stigmatised, disregarded or dismissed as 'women's problems'. By supporting health in women and girls we can expand their choices and opportunities to achieve their potential." Part of the plan is about improving women's knowledge in areas such as menstruation. Hormone testing however, which is central in looking at abnormal menstruation (heavy/painful periods), PMS, perimenopause, decreased sex drive, mood swings, fatigue, anxiety and depression, breast tenderness, endometriosis, fibroids, acne or hormonal weight gain, is not readily available in the NHS. The DUTCH Complete Hormone Test is used extensively by Functional Doctors to look for hormone imbalances. It would improve understanding of women's health if adopted into the NHS women's health program. There are also tests for detecting the microbes contributing to UTIs and vaginal infections important to assessing women's health. All these tests can be taken at home and could be prescribed to patients by a GP and available in pharmacists. The results would then be uploaded onto a platform allowing GPs to analyse the results to better support the patient.

2. **Early Diagnostics**

Early diagnosis is crucial in preventing chronic health conditions, as it allows for timely intervention before diseases progress to more severe stages. Among the top acute conditions, some are more easily identified than others, but early detection is particularly important for cardiovascular disease, diabetes, urinary tract infections (UTIs), cancers, neurodegenerative diseases and gastrointestinal infections. These conditions, if diagnosed early, can often be managed or treated effectively, reducing the risk of complications and long-term damage. If GPs were equipped to diagnose and prescribe treatments at the earliest stages, patients could benefit from more personalised care, preventing the progression of these illnesses into chronic, life-altering conditions. Early treatment also lessens the burden on healthcare systems, reducing hospital admissions and improving overall public health outcomes.

Cardiovascular Disease & Diabetes (Metabolic Syndrome) – Example of Early Diagnosis

Metabolic syndrome is a cluster of conditions that occur together which increases the risk of heart

disease, stroke, and type 2 diabetes and is on the rise in Scotland. Despite significant reductions in coronary heart disease (CHD) death rates over the past decade, heart and circulatory diseases cause nearly 29% of all deaths in Scotland. CHD is the leading cause of death in Scotland, affecting approximately 7% of men and 4% of women, making its treatment and prevention a national priority under Scotland's Heart Disease Action Plan. Diabetes, the most common metabolic disorder, poses an increasing health challenge for Scotland, with most registered cases being Type 2 Diabetes. Cost to the NHS in Scotland is £950m and the cost to the Scottish economy is estimated to be £2.5bn including the costs of lost jobs and disability benefits.

A Cardiometabolic Profile Test can evaluate risk factors for cardiovascular disease (CVD), metabolic factors related to metabolic syndrome, and type 2 diabetes. Along with traditional CVD risk factors currently assessed by doctors in the NHS, this test includes clinically sensitive atherogenic lipoprotein subspecies, key apolipoproteins, arterial inflammation, and lipoprotein-associated phospholipase activity, a sensitive marker for atherogenesis and arterial plaque instability. These markers are good early indicators of CVD. It also assesses cystatin C for kidney function and 1,5-anhydroglucitol (Glycomark®) for detecting hyperglycemic episodes, alongside adipokines related to insulin sensitivity and liver fat metabolism to give key insights into risk of developing Type 2 Diabetes. Early detection and then change of lifestyle/diet and medication before cardiometabolic conditions become chronic can significantly delay and reduce the need of acute care. These tests could be prescribed by GPs and purchased through pharmacists with access to phlebotomy services.

Urinary Tract Infections (UTIs) – Example of Early Diagnosis

An NHS report shows there were over 1.8 million hospital admissions in England involving UTIs between 2018-19 and 2022-23, the majority of which involved patients aged 65 and older (there is no comparable data in Scotland). The average stay for an acute inpatient with UTI is 4 days so the cost to the NHS is about £3bn over this period not to mention the discombobulating impact of UTI on an older person that can lead to other injuries. Much of this could be reduced by earlier detection of UTI especially in high-risk parts of the population such as the over 65s. The UroKey test is a highly accurate diagnostic tool for detecting bacteria and fungi in urine samples that may cause urinary tract infections, interstitial cystitis, and bladder infections. The test uses next-generation sequencing technology, which identifies over 57,000 potential pathogens with 99% accuracy. Studies show that culture methods, currently used in the NHS, may miss up to 50% of UTI cases and only a 30% chance of finding the dominant species driving the infection. Once known the UTI can be addressed early and most importantly with the right antibiotic for the particular bacteria. If this was available through nursing homes or GPs on prescription from pharmacists, it could prevent many of the hospital-related UTIs which use expensive acute beds as well as patient pain for what is often an avoidable condition.

3. **Managing Inpatients' Health**

Patients' health is important not just when healthy but also when suffering chronic illness and even in acute wards. There is strong evidence to support a good diet and hospital environment can aid quicker recovery and shorter stays in hospital. At present there is little testing for inpatients

outside those tests needed for clinical procedures. For instance dieticians in hospitals will rarely test an individual to see what nutrition is right for the patient's needs but rather prescribe a diet to match the clinical procedure.

Dieticians – Example of Managing Inpatients' Health

Nutritional healthcare practitioners in the UK belong broadly to two bodies – BANT (British Association of Nutritional Therapists) and BDA (British Dietetic Association). The former is mostly private sector practitioners where testing is a key part of a patient's treatment protocol. The latter is mostly public sector and is broadly focused on matching the correct diet with the medical procedure. Although this is a simplification – for example, dietitians do sometimes purchase tests – the vast majority of testing is conducted by nutritional therapists, not dietitians. However, there are certain tests that, if incorporated into a dietitian's diagnostic process, could significantly improve patient outcomes by better addressing individual needs. For instance, a simple SIBO Test could greatly enhance the understanding of a more personalised treatment plan to improve digestive and overall health. It is currently used by some gastroenterologists in the NHS and available in some parts of the country, but not all, and typically not by dieticians. A plan to incorporate SIBO testing into Scottish dieticians' analysis of symptoms would improve recovery outcomes for patients in hospital.

4. **Conclusion & Recommendations**

Like many countries, the UK is facing challenges in restructuring public health services to reduce the strain on acute and chronic care systems. Scotland has the potential to lead the way in developing new healthcare approaches, focusing on keeping people healthy and reducing hospital admissions. A key aspect of this strategy is the use of effective testing to maintain public health and prevent disease progression.

It is recommended

- To establish a Scottish Health Ecosystem directly under the Scottish Government, chaired by the Health Minister, bringing together the NHS, academics, SNIB, Scottish Enterprise, and others. The goal would be to create an integrated health system focused on keeping people healthier and reducing hospital admissions.
- That testing becomes a key part of the Scottish Health Ecosystem to better inform and educate practitioners and patients to stay healthy. GPs prescribing at-home tests could become important tools that provide valuable insights into a patient's health, enabling earlier diagnosis and more informed care.

Ben Thomson is a former Chair/Founder of Enlighten and currently Chair/Founder of Regenerus. Regenerus, based in Scotland is the largest provider of health tests to UK healthcare practitioners. It providers around 150 tests to over 5,000 practitioners in the UK backed by a clinical support team to advice practitioners about the test results and a data management platform that enables the practitioner to upload, manage and interpret the patients data.

31. Has a Change to Vaccination Delivery Placed Scotland's Most Vulnerable Children at Risk? – Ross Jaffrey

Originally published 26/10/2025

Across Scotland, a preventable crisis is quietly unfolding. Childhood vaccination rates are falling just as global outbreaks of once controlled diseases gain momentum, leaving our youngest children increasingly vulnerable. This threat has been amplified by recent political upheavals in the USA and UK where policy changes have slashed aid for international immunisation programmes, creating conditions where preventable diseases can flourish and spread across borders. Growing vaccine skepticism fuelled by rhetoric from the USA and compounded by post-pandemic vaccination fatigue is undermining public confidence in one of medicine's greatest achievements. The evidence for childhood immunisation remains unequivocal: these programmes have saved millions of lives and freed generations from the fear of devastating diseases. Yet today in Scotland, we are witnessing a troubling reversal. Vaccination uptake is plummeting in rural communities and areas of high deprivation, creating a stark health inequality that threatens to divide our nation's children into the protected and the vulnerable. Unless we move swiftly to restore confidence in vaccination and ensure equitable access across all communities, we risk allowing preventable suffering to take hold among Scotland's children. The time to act is now, before this widening gap in protection becomes a public health catastrophe we could have prevented.

Significant changes to the delivery of vaccination programmes occurred in Scotland following the introduction of the 2018 Scottish GP contract. Responsibility for much of the national childhood and seasonal vaccination programme was transferred from Primary Care (GP surgeries) to the Health Board–led Vaccination Transformation Programme (VTP), delivered primarily through large, centralised vaccination hubs. This transfer occurred between 2021 and 2023. This policy change blocked most GP practices in Scotland from ordering, storing, and administering vaccines, even when opportunities arose, a phenomenon I term "empty fridge syndrome". GP's are no longer able to directly intervene when a vaccine opportunity appears; we now refer a patient to the vaccine service, which may be located some distance from the practice. At the outset of this policy change, several primary care team members involved in community vaccine delivery warned that implementing it in certain locations could cause delays, reduce vaccine uptake, and result in harm.

For this discussion, I use measles, mumps, and rubella vaccine (MMR) uptake as the example, but a similar pattern is seen across most pre-school vaccinations. Since the introduction of VTP, the uptake gap – the difference in percentage of children taking the vaccine – between the least and most deprived children has widened. Source data from Public Health Scotland, published on 30th September 2025, demonstrated minor recovery in the least deprived groups, but not in the population groups living in areas of deprivation (SIMD 1and 2); in these groups, uptake is falling and this gap is widening. The VTP model of delivery may be influencing this health inequality for

families in more deprived areas, with the effect potentially greatest in remote towns, places without proximity to a major vaccine delivery hub.

Measles remains a rare disease in our country. Scotland reported 24 cases in 2024; a single case was reported in 2023. The potential for re-emergence of this virus within the community is a real and growing threat; 28 measles cases have been reported so far this year. The impact of measles should not be underestimated. England has reported 772 cases and 1 death in 2025. In 2024, the European region reported 127,350 cases of measles, with children under five accounting for 40% of all cases. The United States and Canada have also faced widespread outbreaks that strain local health services, sparking public fear and much finger pointing over accountability. While measles is often regarded as an unpleasant but self-limiting illness, it can be severe, particularly in young children, leading to long-term complications. There is no specific antiviral treatment for measles; management is generally supportive once the infection is contracted. Prevention remains the most effective strategy to mitigate harms caused by this disease. The MMR vaccine has been a key part of the UK immunisation programme since its introduction in 1988. It is safe and highly effective, providing over 95% protection against the disease with two doses. Achieving high levels of vaccination coverage is essential to protect communities through herd immunity, WHO recommend at least 95% uptake. Maintaining this level of coverage has proven to be a global challenge due to several factors: issues with access, vaccine availability, vaccine misinformation, and vaccine hesitancy. Scotland's rates should not be affected by the first two, but these may have influenced uptake in rural regions and within areas of deprivation following the change in delivery to VTP. The first childhood dose MMR uptake in 2024 for NHS-Scotland by 24 months was 92.8%, previously when GP practices delivered this part of the programme uptake remained above 94% (2013-2022). This slight decline in uptake nationally fails to fully unmask a significant and evolving problem in our most deprived areas, the largest drop-off in vaccine uptake is occurring in these population groups (SIMD 1 and 2). Prior to 2020, the largest gap between least and most deprived children for MMR-1 in children aged 6 was less than 1%, this is now 3.7%, equivalent to approximately 1300 children missing vaccination per year. Clearly, the pandemic had some impact from 2021 but trends are now recovering in the least deprived groups, but not in the most deprived groups. The steepest decline is evidenced in NHS-Highland, the board area I work in. MMR-1 uptake variance between the least deprived (97.8%) and most deprived (88.2%) is almost 10%, a 3-fold increase since the change in delivery system. For MMR-2, this gap becomes 17.1% (only 75.6% of children have both vaccines in SIMD 1). These trends are not unique to NHS-Highland. The MMR booster uptake in children aged 6 for NHS-Tayside demonstrate a similar trend with a 14.5% uptake gap between least and most deprived, NHS-Grampian evidences a 16.4% gap; historically, these health inequality gaps were never as stark. Primary schools in areas of deprivation are likely to be significantly more vulnerable to measles outbreaks because of this variance. Why is this happening and being permitted to continue?

The VTP was welcomed for easing pressure on GP appointments. In 2018, the BMA, together with the Scottish Government, negotiated the removal of vaccination from the national GP contract. However, many Highland GP, and others across Scotland, wanted to keep vaccinations within general practice. They feared the change would weaken the vital link between GP teams and the families they care for, and make vaccination services harder to access. For many young families, vaccination visits were their first contact with the GP practice. These appointments gave staff a

chance to spot other health needs early and support overall wellbeing. Administrative teams took pride in encouraging attendance, and time was set aside to discuss parents' concerns if hesitancy to attend occurred. Since the move to central vaccine hubs in larger towns, with fewer, smaller clinics in outlying areas, services feel less flexible and more impersonal. Travel can now be significant, adding costs for low-income families and hitting rural communities hardest. Many community clinics are not open five days a week and do not stock the full range of vaccines that practices once carried. Some vaccines are available only on specific days, and siblings of different ages often cannot be seen together. The current VTP setup makes it difficult for GPs to view a child's up-to-date vaccination record. A child's full immunisation history may no longer be held in one place, and it can be hard to access quickly. This data-sharing problem was known before the change and still hasn't been resolved. For such a critical service, that should not have happened.

Allow family doctors do what they do best: protect patients and utilise our highly skilled local Primary Care teams to help address the widening health inequality being observed in childhood vaccine uptake. Scotland's 5 year immunisation plan, published in November 2024, identified 4 key priorities: equitable access, make every contact count, strengthen capacity and capability, and to use a system wide approach. A main goal was to reduce inequalities. Unfortunately the data paints a different picture, without significant change to the current model many children in several regions will be let down despite a cohort of health professionals trying their best to prevent it. Family doctors have the expertise, trusted relationships, and systems to deliver it efficiently and equitably. Yet current policy prevents most GPs in Scotland from ordering, storing, and administering vaccines directly. Fridges in surgeries remain empty. This must change.

Vaccination remains available through the national VTP service. If your child is eligible and not yet vaccinated, please book with your local vaccination team now. Measles, and other vaccine-preventable illnesses, are real, immediate threats. We should not wait for a significant outbreak to act.

Dr Ross Jaffrey, GP based in Highland

REFERENCES

1. https://www.unicef.org/press-releases/european-region-reports-highest-number-measles-cases-more-25-years-unicef-whoeurope (published 13th March 2025)
2. Global immunisation funding shortfall/cuts https://www.gavi.org/news/media-room/world-leaders-recommit-immunisation-amid-global-funding-shortfall
3. Public Health Scotland: Immunisation and vaccine-preventable diseases quarterly report
4. April to June 2025 (Q2) https://publichealthscotland.scot/publications/immunisation-and-vaccine-preventable-diseases-quarterly-report/immunisation-and-vaccine-preventable-diseases-quarterly-report-april-to-june-2025-q2/results-and-commentary/pertussis/
5. GP contract Scotland 2018 https://www.gov.scot/publications/gms-contract-scotland/
6. https://publichealthscotland.scot/publications/childhood-immunisation-statistics-scotland/childhood-immunisation-statistics-scotland-quarter-and-year-ending-31-march-2025/

7. https://publichealthscotland.scot/population-health/health-protection/infectious-diseases/measles/data-and-surveillance/disease-surveillance
8. https://www.gov.uk/government/publications/measles-epidemiology-2023/confirmed-cases-of-measles-in-england-by-month-age-region-and-upper-tier-local-authority-2025
9. EU statistics: https://measles-rubella-monthly.ecdc.europa.eu/
10. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book
11. Di Pietrantonj C et al. Vaccines for measles, mumps, rubella, and varicella in children. Cochrane Database of Systematic Reviews 2021, Issue 11. Art. No.: CD004407. DOI: 10.1002/14651858.CD004407.pub5
12. https://publichealthscotland.scot/publications/scotlands-5-year-vaccination-and-immunisation-framework-and-delivery-plan/

32. Rebuilding Strength, Transforming Wellness: How Scotland Could Lead a Healthy Ageing Revolution – Clare Johnston

Originally published 29/10/2025

For too long, we've accepted ageing as a story of inevitable decline — a slow unravelling of strength, independence, and vitality.

We prepare ourselves for frailty as though it were a natural law, not a preventable condition.

But I know now that it is indeed preventable – and even reversible. I know because I've seen it with my own parents.

Over the past year, my 82-year-old mum, Rhoda, and my dad, Michael, 81, have rebuilt their muscle strength in a way that's transformed both their health, lifestyle and, in my mum's case, has restored her failing mobility.

Our discovery of this "fountain of youth" began with my own transformation — from journalist working in mainstream media for over 25 years to independent content creator focused on how to age well.

Seven years ago, I started *The Honest Channel* on YouTube, initially reviewing products. As I entered my late forties, what started as an interest in skincare developed into a fascination around the science of ageing — what truly helps us stay strong, vital, and independent for longer. Eventually it led me to muscle's door.

One conversation changed everything. I interviewed Dr Chris Reis, a strength coach and doctor of physical therapy based in Cincinnati, who had left clinical practice to teach older adults barbell-based strength training.

His clients' transformations — including 98-year-old Merce Hershey, who reversed bone loss through lifting — were both inspiring and eye-opening.

I couldn't stop thinking about my mum, who had osteoporosis and could no longer walk upright unaided. A scan had shown she'd lost around 80% of the muscle in her back. "It feels like the elastic's gone," she'd tell me. My dad, recovering from hernia surgery, was also beginning to lose confidence.

So, early in 2024, I bought a barbell rack and weights for my garage and asked my parents if they'd train with me. They didn't hesitate. For the first time in years, we felt hopeful.

Under Chris's online coaching, we started a simple, progressive strength programme built around the four core barbell lifts — the squat, bench press, overhead press and deadlift — which together strengthen every major muscle group.

They started by lifting very light, adding small increments of around 1kg (sometimes less) weekly. Each session takes around 90 minutes and they do this twice a week.

Twelve months on, the results are extraordinary. My dad now deadlifts over 90 kilograms — more than double his starting weight. My mum, who once struggled to walk unaided for 30 seconds, now squats with 20 kg on her back, deadlifts over 40kg, and walks unaided for six minutes at a time — a milestone we once feared impossible.

Building strength has taken away their fear of the future – the concern that they were losing their mobility and it would lead to a loss of safety and independence.

My dad sums it up simply: "When I turned 80, it felt like a downward path. But now I have no fear of the future, because I'm getting more, rather than less, capable in everyday life."

Now 52, I am the strongest I have ever been because of weight training.

We are sharing our strength journey on my YouTube channel through the series Rebuilding Mum and Dad. The series itself has been watched more than a million times, and clips have reached many more millions worldwide — one reel alone attracting over 8 million views on Instagram.

The response has been overwhelming, with countless people inspired to start lifting.

But a common question always echoes in my mind: How can I do what your parents have? Where can I access the coaching and the equipment?

The Science of Strength

Dozens of studies now confirm that muscle is one of the strongest predictors of healthspan and longevity.

Research published in the *Journal of Gerontology: Medical Sciences* found that people with low muscle strength are 50% more likely to die prematurely from all causes. Other studies show strong links between higher muscle mass and lower risk of frailty, falls, metabolic disease, cognitive decline, and even depression.

Sarcopenia — the age-related loss of muscle — begins in our 30s and accelerates in our 60s. But it is not inevitable. Strength training can reverse it. Crucially, this is not about bodybuilding or gyms full of machines: it's about functional strength — the ability to lift a shopping bag, get up from a chair, or climb the stairs without fear.

Under the right programme of progressive load, strength training is safe and transformative. The greater risk lies in doing nothing.

Why It Matters for Scotland

Scotland, like much of the developed world, faces a crisis in ageing and social care. One in five Scots is now over 65, and that number will rise sharply in the next decade.

That's only a problem if our ageing population is an unhealthy one – and it doesn't have to be that way.

Falls remain a leading cause of hospital admissions and mortality among over-75s, costing the NHS millions as well as being profoundly traumatic for patients and their families.

Meanwhile, muscle loss and frailty quietly erode independence and quality of life — long before any hospital admission.

My parents' experience shows what can happen when older adults are given the right tools, guidance, and encouragement. In a single year, they reversed years of decline, improved their confidence and mobility, and regained independence — without medication.

Imagine if this were scaled nationally. Accessible, evidence-based strength training for older adults could dramatically reduce falls, fractures, and dependence on long-term care.

It could save millions in healthcare costs while extending healthy, active years of life.

A National Healthy Ageing Strategy

We need to rethink what "healthy ageing" looks like in practice and Scotland has the opportunity to lead the way. What might that look like?

- **Subsidised access** to qualified strength coaches for older adults.
- **Investment in community gyms** and accessible training spaces equipped for progressive resistance training.
- **Public-health campaigns** reframing muscle as a key pillar of longevity, and sowing the seed of understanding that, in most cases, we have control over how we age.
- **Inclusion of muscle-strength metrics** in NHS health checks and ageing research.

A stronger population is a healthier population.

For my parents, this experiment has been about far more than physical strength. It has restored joy, confidence, and purpose. It has shown them — and me — that it is never too late to rebuild and that we are not destined to age into frailty.

Clare Johnston is an Edinburgh-based journalist and content creator dedicated to sharing evidence-based approaches to ageing well. Through her *Rebuilding Mum and Dad* series, she documents the power of strength training to restore health, mobility and independence in later life. A former editorial director of the Press Association in Scotland & Ireland and media executive, she now creates content viewed by millions worldwide.

33. Walking and Wheeling – A Silver Bullet for Addressing Health Inequalities? – Ian McCall

Originally published 10/02/2026

Walking and wheeling should be at the heart of public health.[1] Being more active through walking and wheeling supports healthier and longer lives. That takes pressure off our health and social care services.

Older adults, people in more deprived communities and those with disabilities or long-term conditions have lower levels of physical activity. Public Health Scotland says that the biggest impact on disease will come through enabling those people to be more active. For that to happen we need to remove barriers to living actively.

Promoting walking and wheeling is key to this.

Preventative Spend

This could also reduce the economic challenge of an ageing population. The Scottish Fiscal Commission says that "… if improvements in population health can be achieved, pressure on health-related spending may be reduced in the future". Preventative spend can improve population health and help address rising health care costs.

A recent meeting of the Scottish Parliament Finance and Public Administration Committee highlighted this. This included discussion of measures to improve population health and reduce health inequalities, such as walking and wheeling.[5]

Walking Scotland stressed that getting very inactive people more active and enabling them to stay active for longer is crucial.

Public Health Scotland (PHS) said that a public health approach to prevention "would stop issues emerging in the first place" and that "by supporting individuals with chronic health conditions, Scotland can improve workforce participation, tackle child poverty, support economic growth and contribute to fiscal sustainability".

This is an approach taken in the Population Health Framework and the PHS 10-year strategy. This is a shift in culture, from treating illness to prevention – a whole-system approach to improving health.

The health and economic case for preventative action is well evidenced.

This is nothing new. From the public health measures of the 19th Century onwards – sanitation, housing, vaccines, tackling smoking through to our response to Covid – we have long known that it is often more effective to address the cause of illness rather than treat the symptoms. The Christie Commission recommended this in 2011.

The challenge is making this happen.

Spend a little now to save more later

Walking has been described as 'a best buy for public and planetary health'.[10]

The principle of 'spend a little now to save more later' has never been more relevant. Preventative spending is about investing in addressing causes, rather than endlessly treating symptoms.

In doing this we need to consider health inequalities.

The people most in need of access to health services and healthy behaviour often do not or cannot access it. There are accessibility challenges for marginalised or protected groups. Factors like language barriers, gender, cultural and religious sensitivities, and sensory impairments all play a part. Crucially, poverty is a key barrier for many.

We need treatment when we are ill, but we should also try to keep as well as possible for as long as possible. An emphasis on enhancing people's wellbeing moves health care beyond hospitals and health centres and into the community. It can help move the NHS from a 'sickness service' to a 'wellness service.'

Walking and wheeling can play an important part in this.

Why walking and wheeling?

Investing in walking and wheeling is a good example of preventative spend. It helps people with long-term conditions to keep active longer. This is important as our population ages and pressure increases on NHS budgets.

There is wide support for greater focus on preventing illness. We need to educate and support people to make healthy lifestyle choices. Being more active is an important part of this. Participation in sport varies by age, gender, deprivation, and household income. With walking, the gap narrows. Walking is a good leveller and can help tackle health inequalities.

Walking brings mental and physical health benefits. It reduces the risk of chronic diseases such as heart disease, diabetes, obesity, and certain cancers. Lower income and marginalised communities often have higher rates of these – so walking can help reduce inequality. Walking helps in managing weight, improving cardiovascular health, and enhancing overall fitness, which can lead to longer and healthier lives.

Prioritising physical activity is the population-wide approach that will help more people enjoy benefits in their social, mental, and physical health.

Walking is one of the most inclusive and accessible forms of physical activity – needing no specialist equipment or the need to travel to take part. Increasing investment in it nationally and locally will increase the scale, pace, and reach of change.

Barriers and solutions

Regular walking and wheeling are popular, accessible, and effective. It is simple, low-cost, enjoyable and fits into everyday life.

Our Walking and Wheeling Survey 2025 shows that 57% of adults now walk or wheel every day (up from 52% in 2023) and 86% walk several times a week. But 5% still say they never walk, despite over half saying they would like to walk more for leisure (68%) and routine reasons (63%).

Poor pavement quality, safety concerns, and poor access to local amenities are the top barriers to walking more. 55% say that they would be encouraged to walk or wheel more often if routes in their area were safer.

Encouraging walking and wheeling is not free. It requires significant, sustained investment to make our paths and streets accessible to all, in rural and urban communities across Scotland. We need commitment to a National Path Fund to improve paths, path networks. We also need sustained investment to support outdoor access, access officers, and ranger services.

Regular maintenance of paths can prevent slips, trips and falls. These reduce the mobility of older people and increase pressure on health and social services.

Investing much more in promoting physical activity as part of our daily lives is the type of change that will deliver positive outcomes. It will create healthier, happier, and more resilient people and a more sustainable health system.

Where paths and local environments are safe, accessible, and well-maintained, people choose to walk and wheel more often.

Walking Scotland's aim is to make this a choice for everyone.

Ian McCall is the Policy and Campaigns Officer at Walking Scotland

---

[1] Both words represent the action of moving at a pedestrian's pace, whether or not someone is walking or wheeling unaided or using any kind of wheeled mobility aid, including wheelchairs, mobility scooters, walking frames, prams or buggies.

34. From FAST to BE FAST – James Bundy

Originally published 14/05/2024

Introduction

Public Health campaigns serve a crucial role in promoting healthier behaviours and improving health outcomes. These initiatives aim to disseminate information to raise awareness about health risks and encourage positive behavioural changes. For example, campaigns targeting smoking or excessive alcohol consumption aim to prevent health issues by prompting individuals to quit smoking or moderate alcohol intake. Similarly, campaigns like CPR awareness and FAST (Face, Arms, Speech, Time) for stroke recognition aim to empower individuals to respond effectively in medical emergencies in the hope of saving lives.

Assessing a campaign's effectiveness involves evaluating its impact on public perception and healthcare systems. Demand-side outcomes include public awareness, information retention, and overall satisfaction, while supply-side outcomes focus on intervention received, equitable provision, and performance improvements within healthcare systems.

The efficacy of public health campaigns lies in their ability to prevent the onset of illness and minimise fatalities through proactive measures. The main purpose of this article is to explore if Scotland's FAST (Face, Arms, Speech Time) stroke public health campaign is effective, and if it can be improved upon.

Stroke public health campaign

In essence, the purpose of a stroke public health campaign is to save lives by seeking to change people's behaviour when a stroke is suspected. Stroke is a medical emergency and requires rapid medical attention; therefore, any stroke public health campaign must prioritise seeking emergency medical treatment quickly.

Due to this requirement of quick treatment, a stroke public health campaign must also seek to educate the public about stroke symptoms. If a stroke cannot be identified early due to a lack of knowledge within the general population, then emergency medical attention will not be sought, with potentially devastating consequences. It is also important to note that stroke can happen to everyone (and anyone could be asked to respond to somebody else having a stroke), meaning that the stroke public health campaign must be aimed at everyone in the general population.

An effective stroke Public Health campaign must result in the following:

1. An easy to remember message whilst containing key information regarding stroke (symptoms and the need to call 999).
2. Funding for this message to be repeatedly seen on different channels
3. A successful increase in awareness across the public about stroke symptoms and the need for emergency help.
4. The public being satisfied that the campaign is giving them the information they need to act accordingly when stroke occurs.

5. An increase in people receiving the emergency treatment they need on time after suffering a stroke.
6. Ensures that all stroke sufferers get access to emergency treatment. The campaign cannot prioritise some forms of stroke over others.
7. Ultimately, that lives are saved.

Does FAST work?

To help us determine if FAST is an effective public health campaign, before considering if it can be improved, we will briefly analyse the above bullet points.

1. An easy to remember message whilst containing key information regarding stroke (symptoms and the need to call 999).

FAST is an easy to remember message. At its core is the three most common symptoms of stroke (drooped face, arms struggling to be raised, and slurred speech) and the importance of time, highlighting the need to call 999. The requirement for quick, emergency treatment is re-emphasised by the use of the acronym, FAST. Therefore, FAST does contain key information on stroke symptoms and the need to call 999 in an easy to remember format.

- Funding for this message to be repeatedly seen on different channels

Research shows that without repetition, knowledge of the FAST campaign amongst the general public fades over time. If the purpose of the campaign is to increase stroke recognition, and to prompt quick treatment when a stroke occurs, then this implies that the FAST campaign must be repeated and on different platforms.

Unfortunately, this is currently not happening in Scotland. In 2023, England and Wales re-launched a FAST stroke public health campaign. Northern Ireland re-launched one in 2021. In Scotland, however, there has been no FAST stroke campaign since before the COVID-19 pandemic. Even in the Scottish Government's 2023 Stroke Improvement Plan, the footnote for the FAST stroke public health campaign is a link to the Chest, Heart, and Stroke Scotland website, an independent charity.[1]

Knowledge of stroke symptoms within the Scottish general public, and the need to call 999 if you suspect a stroke, is likely not reaching its full potential due to a lack of Government backed stroke Public Health campaign.

- A successful increase in awareness across the public about stroke symptoms and the need for emergency help.

Whilst FAST is easy to remember, does it help the general population understand the symptoms of stroke and the need to call 999?

A paper published in 2013 titled, 'The impact of the UK 'Act FAST' stroke awareness campaign: content analysis of patients, witness and primary care clinicians' perceptions', highlighted mixed results. Positively, the paper concluded that "The majority of stroke patients reported being aware of the campaign overall (n = 14/19) at the time of experiencing the stroke." However, only "Two

patients reported being influenced by the campaign". The paper then went on to say: "The majority of patients who were aware of the Act FAST campaign reported that the campaign had no impact on stroke recognition or response (*n* = 11/14). Some patients commented on the mismatch between the severity of advertised stroke symptoms and the stroke experience…A mismatch between expected and experienced symptoms was reported to prevent the recognition of stroke." Even more worryingly, "One witness reported a negative impact of the campaign due to misdiagnosis leading to delay".

Another paper titled, 'Can people apply 'FAST' when it really matters? A qualitative study guided by the common-sense self-regulation model', published in 2019, noted that "Despite clinicians reporting that the campaign improved stroke awareness, they assumed that this awareness had little, or no effect on patients' and witness' response behaviour. One of the limitations of this study was that patients experienced a variety of symptoms, which were often not in line with those depicted by (the) campaign." This paper also noted that "It was also common for participants to lack association between the symptoms they observed, and the symptoms presented in the campaign." It also highlighted that for "Two of the youngest participants in their 40s, (they) felt that they failed to correctly identify that they were having a stroke because they did not associate themselves with the campaigns, or their own, representation of a stroke."

The biggest limitations regarding the FAST campaign, however, is that it does not contain all symptoms of stroke, which can result in misdiagnosis and a delay to emergency treatment.

Various research papers have come to a similar conclusion. One paper noted that a "Significant limitation of the 'Act FAST' campaign, however, is that the acronym excludes any reference to the symptoms of sudden visual loss, which may be a manifestation of embolic disease either in the anterior or posterior circulation…If patients with vision loss are not aware that this can be a symptom of stroke, they may not present in the first place." [2]

Another paper concluded that "FAST identified 69% to 90% of strokes but missed up to 40% of those with posterior circulation events."[3] An article published on BMJ Journals in 2014 stated that "the most common symptoms among false negative patients were speech problems, nausea/vomiting, dizziness, changes in mental status and visual disturbance/impairment".[4]

Within this measurement, it is safe to say that the FAST stroke public health campaign has had mixed success. For many sufferers of stroke, they were aware of the FAST campaign when their stroke occurred. This is a positive. However, academic research shows that it has had little impact on how people respond to a stroke. To the contrary, the inability to associate with the FAST campaign (through severity of symptoms and age difference) potentially stops people seeking emergency medical treatment immediately. Additionally, the research shows that the lack of stroke symptoms within the FAST campaign has resulted in delay to emergency medical treatment.

The inability to associate with the campaign and the restrictions of stroke symptoms within the FAST campaign, show that Scotland's stroke Public Health campaign is failing to get people to call 999 when some strokes occur, highlighting that it is not reaching its full potential.

- The public being satisfied that the campaign is giving them the information they need to act accordingly when stroke occurs.

Critical to any Public Health campaign is members of the public feeling that they have the information they need to look after their health, or the health of a loved one.

In December 2023, the Stroke Association made a post on their Facebook page which asked people: "Did you have a stroke without FAST symptoms?".[5] There was over 500 responses to this post. Here are a sample:

- "My husband died at the end of June aged 53 with an undiagnosed stroke. He attended his GP nearly two weeks before as he had taken a really bad turn at work. Loss of balance, cold sweats, violent vomiting & blurry vision. He asked if he had suffered from a mini stroke, was assured no and advised to get his eyes tested. Out shopping eleven days later he took really ill again with the same symptoms he had attended his GP with but this time his speech was really slow too and an ambulance was called. They refused to attend initially as he passed the FAST test and he wasn't having chest pains. We called back and insisted on an ambulance and he was then taken to hospital and seen by a triage nurse. My daughter and I reiterated to her that my husband had suspected he had had a mini stroke less than a fortnight before but yet again he passed the FAST test and was left in the hospital corridor for 5 ½ hours before taking the full-blown stroke in front of myself and daughter. This was on the 25th June and Tony passed away on the 29th June."[6]

- "I'm an Orthoptist in an Eye Hospital. Many of my stroke patients only have vision problems (double vision, eye movement problems or vision loss) with no FAST signs or symptoms. In fact, many of them delay going to hospital because they don't think they've had a stroke".

- "No FAST signs. Loss of my peripheral vision, tiredness, and memory problems! Left untreated for over 8 months while waiting to see an ophthalmologist!"

These are just three testimonies of separate incidents. All highlight that treatment was delayed, either by the patient not going to the hospital or medical staff ruling it out, because symptoms were out with of the FAST campaign. On top of showing how FAST can restrict examinations carried out by medical staff, it highlights that there is some level of dissatisfaction within the general public about the FAST campaign.

- An increase in people receiving the emergency treatment they need on time after suffering a stroke.

The FAST campaign has undoubtedly resulted in some victims of stroke receiving emergency treatment they needed on time. Without the FAST campaign, more people in Scotland would be dying from stroke. Yet, as highlighted earlier, the FAST campaign does not include all symptoms of stroke. In some cases, this means individuals, fully aware of the FAST campaign, do not seek emergency treatment because they do not think they are having a stroke, or that their symptoms are not part of an emergency situation. In other cases, it means stroke is ruled out by medical staff, resulting in treatments being delayed. Both of these scenarios, which we know are happening through research and personal testimonies, indicate that the FAST stroke public health campaign may be playing a role – in some cases – in stopping, or at least slowing down, the emergency treatment that stroke patients should receive.

On a brief note, it should be highlighted that the FAST stroke campaign is also the basis of the test that call handlers use to try and detect stroke. In Public Health Scotland's Stroke Improvement Programme 2023, it reads: "*All emergency calls are triaged using the Medical Priority Dispatch System (MPDS). SAS call handlers assign a diagnostic code and call priority (represented by a response colour) to each incident. Once the call priority has been determined SAS 25 dispatchers will identify and allocate a SAS resource as soon as possible. For any call suggestive of stroke, callers are taken through performing a screening 'Face, Arm, Speech Test' (FAST)*."[7]

With ample evidence that FAST does not contain all symptoms of stroke, does it make sense that the test used by call handlers to try and detect stroke is so restrictive? Answering this question in their Programme, though not directly, Public Health Scotland say: "Lack of diagnostic sensitivity risks missing a stroke which could benefit from time critical thrombolysis, whilst over diagnosis leads to unnecessary deployment of emergency resources which are then unavailable for other urgent cases."[8]

This contribution from Public Health Scotland highlights a real concern about expanding FAST. It could increase the number of people wrongly thinking they are having a stroke, taking limited emergency resources that could be used for proper emergencies. This is something that needs serious consideration.

- Ensures that all stroke sufferers get access to emergency treatment. The campaign cannot prioritise some forms of stroke over others.

Following directly from above, it is clear that the status quo does not result in all stroke sufferers getting equal access to emergency treatment. If your symptoms are out with the FAST campaign, then there is less chance that you will get emergency treatment. This means that the FAST campaign is failing one of the key requirements of a Public Health campaign: the equitable provision of intervention. The results of this failure can be devastating. A paper published in Emergency Medicine Australasia put it bluntly: "Upon patient presentation at an ED (Emergency Department), missed identification and appropriate categorisation of stroke patients results in longer waiting times, delays in treatment, and in some cases potentially irreversible damage."[9] The current inequality of emergency treatment for some stroke victims – due to the limitations of FAST – is resulting in some people in Scotland losing their lives prematurely.

- Ultimately, that lives are saved.

For the most part, FAST has saved lives. It has increased awareness of the three most common symptoms of stroke, and the need for 'fast', emergency treatment. Yet, this essay has highlighted some research and examples which suggest that FAST could actually be preventing 'fast' treatment. With a FAST test ruling out stroke, either by the patient, call handler, or medical staff, treatment is delayed. Research from the Scottish Parliament Information Centre implies that 8-10% of strokes could be missed by the FAST campaign/test, implying that these situations are not rare.[10] If that is the case, then it means that despite all the improvements that the FAST campaign has helped bring forward, there are some serious shortcomings that are resulting in some Scots losing their lives prematurely.

The Alternative – FAST to BE FAST

One alternative to FAST is BE FAST, which incorporates Balance (a loss of balance) and Eyes (Eyes struggling to focus) as potential symptoms of stroke. There are two key advantages to BE FAST. Like FAST, it is easy to remember and re-emphasises the need to 'be fast' when you suspect a stroke. Unlike FAST, however, it contains five symptoms of stroke rather than three. As highlighted earlier, "the most common symptoms among false negative patients were speech problems, nausea/vomiting, dizziness, changes in mental status and visual disturbance/impairment".[11] Incorporating Balance and Eyes to the FAST acronym, therefore, includes two of the most common symptoms associated with strokes which were missed by FAST. In theory, therefore, BE FAST should be able to identify more strokes, but noting the concerns of Public Health Scotland, it could also result in an increase in false positives, putting additional strain on emergency department resources. [12]

Whilst research into the effectiveness of BE FAST is immature, there are some encouraging signs. One paper published in 2017 concluded that "The 14.1% of stroke patients who would not have been identified by FAST alone was reduced to 4.4% with the addition of these 2 symptoms (BE-FAST; z=7.62; 95% confidence interval, 2.99–6.098; P<0.0001)."[13] There is one key weakness with this study, however: it was retrospective. That means everyone in the study was confirmed to have suffered a stroke. Therefore, what this research paper does is confirm that by broadening the test, you would detect more symptoms of stroke. What this paper does not do is determine the impact of 'false positives.

However, there is one recent study, published by the Australasian College for Emergency Medicine, which aims to examine the impact of the 'implementation of the BE FAST stroke screening tool at the Emergency Department and determine whether its usage improved timely stroke detection.' This paper was published in January 2024 with the summary that "Patient outcomes were improved after implementation of the BEFAST stroke triage tool. More stroke patients were identified upon presentation to the ED, and in a timely fashion. For those with a stroke diagnosis, time-critical interventions can take place earlier, allowing patients to return home sooner, and with less disability." Whilst this is only one study it is highly encouraging and should prompt further investigation.

However, we should not be looking at the stroke public health campaign in isolation. We must consider it alongside ways we can improve stroke screening tools, understanding that broadening the Public Health campaign will expand sensitivity, training needs, and potentially, the use of limited resources. The BMJ Journal published in 2015 goes on to say, "Without screening tools and training to improve the identification of patients with less common stroke symptoms, inequity of available stroke care for patients will remain, particularly for patients with posterior stroke."[14]

The research into the effectiveness of BE FAST, in comparison to FAST, is encouraging, though at its early stages. Scotland should be at the forefront of this research but understand that simply adopting BE FAST is not enough. By including more symptoms of stroke, a BE FAST stroke Public Health campaign should result in greater awareness of stroke symptoms amongst the public, resulting in more people seeking emergency treatment if they suspect a stroke. For this outcome, however, such a campaign would need funding to be consistently repeated. On top of this, further

funding is required to invest in training and technologies used by call handlers and medical staff to detect stroke.

Seeking to improve knowledge of stroke symptoms amongst the public and promoting an equality of access to intervention by expanding the symptoms within the stroke Public Health campaign, and further seeking to improve efficiency of intervention by investing in training and technology is the correct approach for Scotland.

Conclusion

Prevention lies at the core of public health campaigns. By seeking to promote positive behavioural change, campaigns can either seek to discourage certain behaviours; prevent the development of long-term illness; or prevent fatalities in emergency situations. Public health campaigns for emergency situations must be easy to remember, contain key information, emphasis the requirement to call 999, and target the general population.

Whilst FAST is easy to remember and contains key information, there are many shortcomings:

- The lack of funding from the Scottish Government to advertise the FAST campaign will mean that public awareness is not as high as it could be.
- It has been noted that whilst stroke survivors were aware of FAST, they found it difficult to associate with the campaign. There were various reasons for this: symptoms were not as severe as the advertising suggested; they believed they were too young to suffer a stroke; or their symptoms were not contained within FAST.
- By not including more symptoms of stroke, the FAST campaign is failing to provide an equitable provision of medical intervention. If strokes occur with symptoms that are out with the FAST criteria, there is a higher risk that the stroke will become fatal due to the lack of timely medical intervention. This is because people will either not seek emergency treatment or because medics will rule-out the possibility of stroke.

Whilst research into BE FAST is immature, the results were promising:

- BE FAST (Balance, Eyes, Face, Arms, Speech, and Time) is easy to remember and contains even more key information.
- Initial evidence from a live-setting showed that "Patient outcomes were improved after implementation of the BEFAST stroke triage tool. More stroke patients were identified upon presentation to the ED, and in a timely fashion. For those with a stroke diagnosis, time-critical interventions can take place earlier, allowing patients to return home sooner, and with less disability." [15]

One concern regarding the implementation of BE FAST is the potential to increase the number of 'false positives' in an emergency medical setting, but this concern must be balanced and considered alongside the 'false negatives' we know are happening due to the restrictions of FAST.

I am acutely aware of the pain and suffering that follows a 'false negative'. My 53-year-old father, Anthony Bundy, passed away following a fatal, undiagnosed stroke. At every stage he sought medical help (GP, Call Handler, Paramedic, and Triage Nurse), a stroke was ruled out. The reasons

for ruling out a stroke were as follows: My Dad was too young; my Dad did not have risk factors (he did not smoke, he was not overweight, etc); and, my Dad's symptoms were out with FAST. A stroke being ruled out meant that my Dad was prevented 'proactive' or 'fast' treatment, which ultimately cost him his life.

This is the cost of a 'false negative' diagnosis for stroke. It is unacceptable for the Scottish Government to continue with the status quo, knowing that it is resulting in stories like my Dad's, when there is a ready-made alternative in the form of BE FAST. Yes, regular funding would be needed to run a new stroke Public Health campaign constantly. It would also need investment in training and technology to improve stroke detection in medical settings to reduce the pressure of 'false positives'.

Yet, these investments would result in the Scotland stroke Public Health campaign being closer to fully fulfilling its objectives: Sharing information with the public that could save their lives, or the life of a loved one; making sure the information is consistently available in many forms; allows the public to act accordingly when they suspect a stroke; an increase in the equality and quality of the provision of emergency medical treatment for stroke; and ultimately, save lives.

Now is the time for the Scottish Government to take the lead on stroke awareness and consider adopting BE FAST as Scotland's public health campaign.

James Bundy is a Scottish Conservative Councillor for Falkirk North. After the sudden death of his 53-year-old Father in June 2023, following an undiagnosed, fatal stroke, James and his family have been campaigning to expand Scotland's stroke campaign from FAST to BE FAST.

---

[1] '*Stroke Improvement Plan 2023*', Scottish Government. 2023. Available at: https://www.gov.scot/publications/stroke-improvement-plan-2023/pages/6/

[2] *'Is the 'Act FAST' stroke campaign lobeist? The implications of including symptoms of occipital lobe and eye stroke in public education campaigns'*, Journal of Neurology, Neurosurgery & Psychiatry. 2015. Available at: https://jnnp.bmj.com/content/86/7/818

[3] '*BE-FAST (Balance, Eyes, Face, Arm, Speech, Time): Reducing the Proportion of Strokes Missed Using the FAST Mnemonic'*, American Heart Association. 2017. Available at: https://www.ahajournals.org/doi/10.1161/STROKEAHA.116.015169

[4] '*Characteristics of patients who had a stroke not initially identified during emergency prehospital assessment: a systematic review*', Emergency Medicine Journal. 2021. Available at: https://emj.bmj.com/content/38/5/387

[5]Facebook post by the Stroke Association in December 2023 https://www.facebook.com/TheStrokeAssociation/posts/pfbid02vexka1vbXtZLoFn1tseg737aphMun2RfzxfYzT59gVHAGz7toM9DjTXw5EAg2Ekal

[6] This contribution was from my mother, Selena Bundy.

[7] '*Scottish Stroke Improvement Programme 2023: national report*, Public Health Scotland. 2023. Available at: https://www.publichealthscotland.scot/media/20499/ssip-june2023-english.pdf

[8] '*Scottish Stroke Improvement Programme 2023: national report*, Public Health Scotland. 2023. Available at: https://www.publichealthscotland.scot/media/20499/ssip-june2023-english.pdf

[9] '*Time is brain, so we must BEFAST: Improving stroke identification and triage in a rural emergency department*', Australasian College for Emergency Medicine. 2024. Available at https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.14369

[10] '*Briefing for the Citizen Participation and Public Petitions Committee on petition PE2048: 'Review the FAST stroke awareness campaign' , lodged by James Anthony Bundy',* Scottish Parliament Information Centre (SPICe). 2023. Available at: https://www.parliament.scot/-/media/files/committees/citizen-participation-and-public-petitions-committee/correspondence/2023/pe2048/pe2048_spice_briefing-(2).pdf

[11] '*Characteristics of patients who had a stroke not initially identified during emergency prehospital assessment: a systematic review*', Emergency Medicine Journal. 2021. Available at: https://emj.bmj.com/content/38/5/387

[12] '*Scottish Stroke Improvement Programme 2023: national report*, Public Health Scotland. 2023. Available at: https://www.publichealthscotland.scot/media/20499/ssip-june2023-english.pdf

[13] '*BE-FAST (Balance, Eyes, Face, Arm, Speech, Time): Reducing the Proportion of Strokes Missed Using the FAST Mnemonic'*, American Heart Association. 2017. Available at: https://www.ahajournals.org/doi/10.1161/STROKEAHA.116.015169

[14] '*Characteristics of patients who had a stroke not initially identified during emergency prehospital assessment: a systematic review*', Emergency Medicine Journal. 2021. Available at: https://emj.bmj.com/content/38/5/387

[15] '*Time is brain, so we must BEFAST: Improving stroke identification and triage in a rural emergency department*', Australasian College for Emergency Medicine. 2024. Available at https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.14369

35. The Country We Could Become: Reimagining Scotland's Future Through Courage, Compassion and Collective Purpose – Alison McGrory

Originally published 26/03/2026

New figures on healthy life expectancy landed in Scotland with a familiar sense of disappointment last month. Scots can now expect to live longer lives but spend more of those years in poor health and we remain at the bottom of UK league tables. Yet behind the national average lies an even starker reality: the gap in healthy years between our most and least advantaged communities is measured in decades. This gap is not down to bad luck or an accident of biology, rather it reflects the political choices and omissions that allow an unequal and extractive economy that drives poverty, hunger, hopelessness, and despair.

Those of us who care about population health and wellbeing, respond to these statistics in predictable ways. We analyse, we warn and we call for national action. In this space we are exceptionally good at producing policy briefings that we use to implore politicians into action. But in our urgency, we often skip over a fundamental truth:

Politicians act when voters demand it

Right now, the demand for fair, preventive and equity driven policy is simply not loud enough to compete with the polarising discourse shaping public opinion. Support for the populist right is rising across the UK and Scotland cannot afford to think we're immune to a prevailing wind of blame, prejudice, division and stigma.

Population health and politics are inextricably linked but we stick firmly to politics spelt with a small *p*. If we want to amplify the conditions that create health, we need to step into the political arena with more clarity, confidence and purpose. Speaking in caveats and qualifiers is no longer enough to counter the malevolent forces that pin health inequalities on personal misfortune, individual failure and blame our most disadvantaged people.

Credibility is not enough

A credible blueprint for a fairer Scotland already exists. This includes ideas already in political debate: putting health in all major government decisions, shifting towards a wellbeing economy, eradicating child poverty, improving housing quality and affordability, and regulating harmful commercial practices. There is nothing radical or out of reach in this list.

But rigour and drive do not automatically translate into public demand. Too often, us evidence-driven professionals speak upwards, briefing ministers, refining manifestos, submitting consultation responses. We assume that if our rationale is strong enough, political leaders will act. But while legislation may be passed in Parliament, the mandate for that legislation is built in living rooms, workplaces, community halls and online spaces.

If the electorate is not demanding action, progressive policy becomes fragile. Now is the time to make progressive legislation feel like common sense and imagine a Scotland where everyone can flourish.

Who is deserving?

But increasingly it seems we have work to do here. As times get harder and everyone feels the strain, progressive policy can be vilified as help for people who are undeserving, or people who bring their own downfall upon themselves. Yet both targeted interventions and societal wide actions benefit the whole country.

- Warm, affordable homes reduce illness.
- Fair incomes and stable work lift families out of poverty.
- Affordable and healthy foods build strong and healthy bodies.
- Safe streets, clean air and reliable transport make healthy living part of daily life.
- Green space and vibrant communities make us feel good.
- Strong local networks create connection, opportunity and hope.

These are universal investments with universal returns. When people see how they improve everyday life for themselves and their families, progressive policy becomes compelling common sense. To counter stigmatising narratives, we need to stop theorising and show these benefits clearly and concretely.

The health and equity community must do politics differently

We can remain non-partisan while being far more politically astute. The question is not whether we enter party politics, we shouldn't. The question is whether we are willing to take our in-depth understanding of health creation into the mainstream.

That requires a shift in mindset and method and how we articulate the *what*, the *so what*, the *how*:

1. Speak to voters, not just ministers

Persuasion cannot be constrained to parliamentary committees. We need to build public appetite for prevention, fairness and long-term thinking. That starts by talking in human terms, not technical ones.

2. Focus on a small number of clear, costed proposals

People vote for what will make a difference to their lives now and not theoretical frameworks. A short set of clear proposals, explained through the lens of how they make everyday life better, should sit at the centre of meaningful community engagement.

3. Build relationships, not transactions

Trust is currency that grows through presence, honesty and following through on promises. Strong relationships create the foundations for shared purpose. Let real people guide the agenda from the start so communities feel respected and confident to shape change.

4. Shift power back to communities

A fairer, healthier economy depends on recognising where power sits and moving it closer to the people affected by decisions. Sharing decision-making and resources allows communities to lead, not simply respond. When power is local, action becomes more grounded and more effective.

5. Collective leadership

No single organisation can shift societal attitudes. Cross sector alliances and local partnerships create momentum that makes progressive policy politically irresistible. Collective leadership means *doing with* rather than *doing to*, and amplifying voices that are too often overlooked.

2026, a pivotal year for Scotland

The Scottish Parliament election on 7 May 2026 is an opportunity to reset Scotland's direction after a decade of stalled or declining healthy life expectancy. Scotland has led before, on smoke free public spaces, on the Scottish Child Payment, on minimum unit pricing. We can lead again, but only if we stop assuming good policy sells itself.

People care about whether their children are fed and can breathe clean air, whether their heating is affordable, whether their community is safe and if their neighbourhood is a good place to live. We must appeal to hearts and minds with creative storytelling that a better future is possible.

The new healthy life expectancy statistics are a call to action and not a pre-determined destiny. The choice is in our hands – will we continue to describe problems in ever finer detail while the political ground shifts beneath us, or will we roll up our sleeves and build a shared mandate for a Scotland that thrives, for a country where everyone has a fair chance to live a long and healthy life?

I know which vision I want to create for Scotland's future generations.

Alison McGrory is Associate Director – Public Health at NHS Highland – Argyll & Bute Health and Social Care Partnership

Workforce

36. Pharmacists Must be Fully Integrated into the NHS - Fiona McIntyre

Originally published 09/07/2024

Medicines are the most common intervention in healthcare. The creation of the National Health Service (NHS) in 1948 improved access to medicines and prescription numbers leapt from 70 million in 1947 to 250 million in 1949.[1] And it continues to grow with over 1.7 billion prescription items dispensed across the UK[2][3][4] in 2022/23; in Scotland alone, this figure was around 110 million.[5]

The Royal Pharmaceutical Society is the professional leadership body for pharmacists and pharmacy in Great Britain. Our mission is to put pharmacy at the forefront of healthcare. In recent years, pharmacy has been catapulted forward in the public's eye as the first, or Pharmacy First, point of contact for healthcare in our communities. Accessing a highly trained, regulated, healthcare professional in their local pharmacy who provides high quality care, often without an appointment, has become the norm for many citizens. Pharmacists do not only practice in communities, though the vast majority of pharmacists registered with the General Pharmaceutical Council (GPhC), do. The second largest group practice in hospitals and similar settings; and a growing number, bolstered by the introduction of new roles following the General Medical Services (GMS) Contract implemented in 2018, in general practice. Pharmacists also practice in academia, research and the pharmaceutical industry.

Gone are the days of pharmacists wearing white coats, making up medicines extemporaneously on the dispensing bench, tied to the processes of medicines production and dispensing. White coats have been replaced with appropriate personal protective equipment; skills once used for making the medicinal products now applied to therapeutics and the development of new skills in patient consultations, clinical assessment and prescribing. From 2026, all new pharmacy graduates fulfilling the necessary registration requirements for the GPhC will be qualified to prescribe medicines.

Legislative changes surrounding supervision of activities by the pharmacist are anticipated which will extend the role of registered pharmacy technicians and pharmacy support staff to manage the safe storage, procurement, quality assurance, dispensing and supply of medicines across all sectors of practice. Educational reforms brought about pharmacist prescribing and legislative changes will release the pharmacist from the shackles of supply. So, what will this mean for pharmacists and pharmacy in the future #NHS2048?

Capacity – Access to Care

Patients regularly interact with their local community pharmacy service. Core NHS services include public health services such as health promotion advice, smoking cessation and access to emergency hormonal contraception; treatment for common clinical conditions through the Pharmacy First service and providing pharmaceutical care and support for those taking medication for long-term conditions. Community pharmacies opt in to deliver a host of other services ranging

from stoma care, substance use services, vaccination and support for care homes linked to the needs of their local population and commissioned by local Health Boards.

Community pharmacies are independent contractors like general practitioners (GPs) but are often not seen in the same light as GPs. They are not fully integrated into the NHS and until this is remedied the benefits of the enabling legislation and educational reforms will not be fully realised. To optimise the clinical capacity that prescribing community pharmacists can offer, local health needs of patient populations must be assessed and used as the basis for commissioning appropriate services to address health inequalities.

An essential building block to full integration of community pharmacists into the Scottish healthcare system is access to the Integrated Social Care and Health Record. Many members of the public think that pharmacists can already see their medical notes, however, there is variation across Scotland in terms of which pharmacists can access certain digital systems giving them access to different parts of the health record. In the main, community pharmacists can access the Emergency Care Summary, a centrally held record populated by data from GP practice systems. Limited data available includes a list of repeat medicine prescriptions, latest acute prescriptions and allergies. Inconsistency of pharmacist access to patients' health records is a missed opportunity to access clinical capacity for care, delivered by capable health professionals who already nurture positive therapeutic relationships with the people in their communities.

The 2018 GMS contract in Scotland introduced a substantial programme of service redesign and transformation of primary care. One of the fundamental elements was the introduction of a comprehensive pharmacotherapy service that embeds greater numbers of pharmacists, pharmacy technicians, and pharmacy support workers in GP practices to provide pharmacy and prescribing support for patients. [6]

These general practice pharmacy teams are working towards delivering patients a comprehensive service with core and additional elements. Much progress has been made in the last 6 years, with substantial investment in general practice pharmacy teams, however significant challenges remain, and further investment is required in workforce, skill mix and infrastructure to realise the full benefits of the service. These challenges mean a failure to unlock the full potential of the professional role of some pharmacists. These issues need to be addressed urgently to ensure that roles are, and remain attractive, to recruit and retain pharmacists, to provide positive patient care, free up GPs, and build a sustainable pharmacotherapy service that will endure.[6]

Pharmacists in primary care should be focused predominantly on patient-facing clinical roles: using pharmaceutical expertise and independent prescribing skills to deliver clinical medication review, support safer use of high-risk medicines, and improve complex pharmaceutical care.[6] To properly support clinical pharmacists in this complex role it is vital that the appropriate number of pharmacy technicians and pharmacy support workers are available. At present, shortages of these roles in many areas necessitates pharmacists having to provide services that could be provided effectively by other members of the pharmacy team: addressing this gap would markedly improve efficiency and release pharmacists' clinical capacity.

There is potential for community pharmacists to take on some aspects of the pharmacotherapy service and this should be explored. This may include some aspects of prescription management

being undertaken in community pharmacy through extension of the Medicines Care and Review service. The knowledge and skills of community pharmacists already exists; however, funding and contractual arrangements require to be adapted to enable these new models of care. As a minimum, stronger links between pharmacists in GP practices and community pharmacy practice should be achieved to deliver seamless care for patients.[6]

The linkages between each sector of practice at the interfaces of health and social care has never been more necessary as we look to the future of an integrated NHS. A shift in the balance of care is vital so that patients accessing scheduled care services for the management of a long-term condition that has been traditionally managed in outpatient clinics need to be able to interact with their local community pharmacist or general practice pharmacy team for more conditions. In the immediate future, this will be enabled by emerging digital technology i.e. wearable devices and apps for patient reported outcomes and monitoring. E.g., a patient prescribed an oral cancer therapy has a remote consultation with a specialist cancer care pharmacist who accesses the data from the app, confirms the clinical picture with the patient and approves the release of the medication supply from their local community pharmacy via ePrescribing.

Expanding healthcare capacity in the community, alongside technology advances in automation, will enable hospital pharmacy transformation and a shift in the clinical practice of hospital pharmacists and pharmacy teams. Pharmacy teams ensure the medicines necessary for patients requiring both hospital inpatient and outpatient services are prescribed, optimised and administered, or taken, in a way that maximises their positive outcomes while reducing avoidable harm. Pharmacy teams in hospitals oversee the safe and effective procurement, storage, handling, distribution and dispensing of medicines, undertaking the oversight of the governance aspects of the introduction of new medicines, production and quality assurance of medicines and support for the growing number of non-medical prescribers practicing within the system. Achieving these diverse aims in the context of a national health service in recovery from a global pandemic is challenging but provides an opportunity to make the changes necessary to secure a sustainable future.

In the future, algorithms and artificial intelligence embedded in electronic prescribing systems will support safe and effective multiprofessional prescribing under the leadership of pharmacists. Prescribing pharmacists will have a blended job plan where they work in new clinical environments to increase access to care and contribute to avoiding hospital admission wherever possible. In some areas, pharmacists already manage a caseload of patients in scheduled care clinics, in-reaching to review complex inpatients or work across the interface providing care for patients being managed at home to prevent hospital admission or directly reviewing patients in unscheduled care settings. Pharmacy teams will harness the skills of pharmacy technicians and pharmacy support staff to provide leadership in the safe and effective use of medicines, responding to hospital demand and patient flow, releasing pharmacists to optimise the impact of advanced medicinal therapies, pharmacogenomics and the application of precision medicine.

The Chief Pharmaceutical Officer committed to publishing a strategy for hospital pharmacy transformation and this is eagerly awaited by the pharmacy community.

Conclusion

Imagining the healthcare landscape for #NHS2048 can feel somewhat out of reach. However, there is certainty that medicines will remain a critical aspect of healthcare. Pharmacy teams are pivotal in the healthcare system, supporting professionals and patients alike, to optimise the best outcomes from medicines and preventing harm. To fully optimise the impact of legislative and education reforms in pharmacy, pharmacists in all settings must be fully integrated into the NHS. When planning future developments, it is essential that pharmacy teams are included from concept to delivery, with co-production in models of care and digital systems designed to support the safe and effective use of medicines and delivery of health and social care.

Fiona McIntyre is the Policy & Practice Lead at the Royal Pharmaceutical Society Scotland

---

[1] A History of Pharmacy in Great Britain. S Anderson. BSHP – British Society for the History of Pharmacy. Accessed 4th July 2024
[2] NHS Business Services Authority. Prescription Cost Analysis – England – 2022-23 | NHSBSA. Accessed 27th February 2024
[3] Welsh Government. Primary care prescriptions: April 2022 to March 2023. Primary care prescriptions: April 2022 to March 2023 | GOV.WALES Accessed 27th February 2024
[4] Family Practice Services Practitioner Unit. General Pharmaceutical Services Annual Publication 2022/23 (hscni.net) Accessed 27th February 2024
[5] Public Health Scotland. Dispenser Payments and prescription cost analysis. Dispenser payments and prescription cost analysis – Financial year 2022 to 2023 – Dispenser payments and prescription cost analysis – Publications – Public Health Scotland. Accessed 4th July 2024
[6] Joint RPS and BMA Scottish GP Committee statement on the Pharmacotherapy Service. Joint BMA-RPS pharmacotherapy service 13 Jan 2023_1.pdf (rpharms.com). Accessed 27th February 2024

37. Fast Track Investigations & Treatments for NHS Staff – Gabriela Maxwell

Originally published 15/10/2024

I am an NHS employee prepared for the role of a registered nurse in one of the finest universities – the University of Stirling. For the past 24 years, I have seen and experienced the many issues and challenges that nursing in the NHS faces. I have tried to view it from different perspectives, always aiming to keep objective.

I have had the benefit of experiencing different healthcare systems – I was not born here, nor did I grow up in the UK and my nursing career has allowed me to work abroad. I have also had the experience of being a patient in three different countries, all of which has provided a range of perspectives to draw upon.

One issue I think worth reflecting on is considering that of comparing NHS staff privileges with those of other industries. Lately, the thought I mostly frequent is worry – I am worried that should my health start to fail would I still be able to do my job or return to it? My experiences to date with delays to treatment and investigations leave me feeling vulnerable as a result of seeing first-hand the dire consequences delays can cause. But that's just one side of it.

The NHS is dependent upon the provision of care by staff who themselves might need treatment and health interventions. Delays in investigations and treatments as a result of staff shortages have an impact throughout the whole system for all patients. But these shortages are exacerbated by increasing staff absence due to their growing waiting times, which further contribute to overall delays in a vicious circle.

An illness requiring investigations and treatment unleashes a cascade of events impacting the staff member's physical and mental health, which continues to deteriorate with an increasing recovery time and duration of absence, which then leads to deterioration in the NHS team functioning and morale, reduced staffing ratios and other staffing implications and ultimately leading to a reduction in patient services.

One example of how breaking the cycle can be achieved is by enabling fast track of investigations and treatments for NHS staff as part of the NHS reforms. It was not so long ago when this approach was used during the COVID 19 epidemic when staff were prioritised for vaccinations and COVID 19 tests – so that they were then enabled to stay at work and do what they know best – care for others. The FastTrack suggestion is not dissimilar to this as the principle and outcome focus remains the same.

It is also worth remembering that the NHS competes for its workforce with many industries. How does the NHS compare with benefits available to staff elsewhere? In my 24 years working for the NHS I have not experienced change or comparison in that regard. Regardless of which industry you look into, there are benefits for staff working in that industry and it might be that NHS staff offer is slacking behind and needs to up its game.

NHS staff need recognition for the caring work they do by being cared for themselves. It would make sense that as a part of staff NHS contribution recognition that staff have access to investigations and treatment fast track scheme as a part of the staff NHS employment benefit. The positive impact of this act would be undeniable and felt across many areas, not least better provision for all patients.

Gabriela Maxwell is a Queens Nurse and Senior Advanced Nurse Practitioner in NHS Lanarkshire

38. Foundation Apprenticeships: Building a Future NHS Workforce in Scotland – Jane Ewen & Andrew Ritchie

Originally published 25/09/2025

As Scotland's health and social care sector faces growing pressure from workforce shortages and an aging population, Foundation Apprenticeships (FAs) in Aberdeenshire are proving to be a vital tool in developing the next generation of NHS Scotland professionals. These innovative career pathway programmes, aimed at senior-phase secondary school pupils, combine academic study with hands-on formally assessed workplace experience, creating a pipeline of skilled, motivated young people ready and able to step into health and social care careers.

Bridging the Gap Between Education and Employment

In Aberdeenshire, Foundation Apprenticeships offer students in S5 and S6 the opportunity to gain qualifications equivalent to at least one Higher while undertaking the theory-based National Progression Award (NPA) in school and industry-recognised Scottish Vocational Qualifications (SVQ) qualifications while on work placements. This dual approach provides 'parity of esteem' between traditional 'academic' and industry-related 'vocational' qualifications and helps bridge the gap between classroom learning and the practical demands of the workplace. For NHS Grampian, this means engaging young people early, introducing them to the realities of healthcare roles, and fostering long-term interest in careers within the health care sector.

All Scottish colleges and universities recognise FAs as entry qualifications. Aberdeen University, one of Europe's top medical schools, recognises the Health and Social Care FA as equivalent to an A pass at Higher for entry into medicine – a real indicator of the parity of esteem between the FA and the Higher.

Pathways That Align with NHS Scotland Needs

Several FA pathways directly support NHS Scotland's workforce priorities:

- **Social Services and Healthcare**: Provides hands-on experience in care homes, hospitals, and local authorities, preparing students for roles such as healthcare support workers and adult care workers through to a career in clinical nursing and medicine.
- **Scientific Technologies**: Introduces students to laboratory work and biological sample-testing—skills essential for clinical diagnostics.
- **Business Skills**; **Creative & Digital Media**; **ITH**; **ITS** and **Hospitality**: Supports vital non-clinical roles in administration, finance, catering, communications and IT.

The FAs are mapped to real occupational standards and offer clear progression routes into Modern and Graduate Apprenticeships, as well as health and social care degree pathways, ensuring students can continue their professional development beyond school.

A Strategic Response to Workforce Challenges

Scotland's healthcare sector is experiencing a steady decline in applications for healthcare undergraduate programmes, alongside an ever-increasing demand for services. Foundation Apprenticeships in Aberdeenshire offer a proactive solution by:

- **Attracting talent at an early stage**: Engaging students before they leave school helps build a sustainable and local talent pipeline.
- **Promoting inclusion**: FAs are accessible to the widest possible range of learners, including care-experienced young people and those with additional support needs.
- **Meeting employer needs**: Apprentices arrive with sector awareness and practical experience, easing their transition into full-time roles.
- **Building stronger links** with local schools and local communities.
- Providing industry experience with employers which helps young people **improve their confidence** and develop their **teamwork and life (Meta) skills** so they are **better prepared for their next step.**

NHS Grampian: Developing Local Talent through Foundation Apprenticeships

In partnership with Aberdeenshire Council, NHS Grampian is embedding Foundation Apprenticeships (FAs) into its workforce strategy as part of its *Plan for the Future* . As a key regional employer and anchor institution, NHS Grampian is committed to inclusive workforce development, community resilience, and ensuring equitable access to career pathways in healthcare. Supporting and developing FAs is a key commitment in the health board's ambition of fostering and supporting the development of talented local young people on their first step on a lifelong learning pathway to a career in healthcare.

As with other rural areas, Grampian's relatively remote geography presents significant challenges. For example, many students who relocate to the North East for university often return home after graduation, and applications to healthcare degree courses have declined year on year. These factors have significantly contributed to the pressure on the clinical workforce.

To address this, NHS Grampian is working collaboratively with local authorities and communities to 'grow our own' – identifying and nurturing local talent and encouraging young people to pursue long-term careers in healthcare. This approach supports the development of meta-skills and clinical potential, with the aim of retaining talent within the region. Many of our communities are vulnerable due to their rurality and developing and supporting resilience and capacity in our communities has been a central feature of our partnership working.

Foundation Apprenticeships offer structured placements, mentoring, and person-centred support, giving students meaningful exposure to a variety of clinical roles. This experience helps them make informed decisions about future pathways. For some, this leads to university and college; for others, it opens doors to Modern and Graduate Apprenticeships or direct employment—ensuring every young person has a pathway into the NHS.

Not all students pursue university career routes, and FAs provide valuable opportunities for career exploration, skills development, and alternative progression pathways. Through FA work placement exposure, the young person is enabled to make an informed choice through the experience and mentoring they have received to choose an undergraduate programme that best

suits their strengths and ambitions. NHS Grampian's commitment to this model has been well received by clinical teams, who recognise the enthusiasm, capability, skills and commitment of young people to healthcare careers.

Across Aberdeenshire, Foundation Apprenticeships are a vital entry point for building a sustainable, locally-rooted healthcare workforce. The value of the partnership working in Health & Social Care FAs can be seen with the growth in uptake. Aberdeenshire Council now has over 160 FAs currently undertaking the Health & Social Care FA. Their growing success reflects NHS Grampian's strategic focus on developing young talent and securing the future of healthcare in the region.

Whether for those who are aspiring to pursue a career in medicine, nursing or a role in social care, the impact of the FA on the young people is significant. The improved outcomes performance data is remarkable;

- On average FA pupils increased their attainment by 70% compared to the Aberdeenshire average.
- 30% attendance increases and 50% increase in engagement in learning for FA students
- 80% of FAs said that completing the FA had made them more confident about their futures
- 51% of FAs said that completing the FA had a positive impact on their mental health
- Improved and Sustained Positive Destinations – over 98%
- Improved employability skills (meta-skills)

The new Foundation Apprenticeship model helps to challenge long-standing misconceptions among employers – such as the belief that "young people aren't interested in careers in our sector." In reality, our pupil career aspiration data reveals that health and social care careers are among the most sought-after by senior pupils. The real barrier is not a lack of interest, but ambiguous career pathways—an issue we're actively addressing through the FA partnership between NHS Grampian and Aberdeenshire Council.

Investing in Scotland's Future

Foundation Apprenticeships are more than just qualifications – they are a strategic investment in Scotland's health and wellbeing and a key component of Scotland's approach to sustainable workforce development. The OECD highlights the 'Investment Benefits' and potential costs savings of a national Career Pathways Programme, particularly through collaborative, systemic, inter-authority delivery models.

For NHS Scotland, embedding work-based learning within the education system is more than a skills initiative – it's a strategic lever for cultivating a confident, capable, and resilient workforce. NHS Grampian's experience illustrates the value of engaging young people early: strengthening talent pipelines, supporting community wellbeing, and enhancing service delivery across the health sector.

Jane Ewen is Nurse Director, Excellence & Innovation at NHS Grampian and Andrew Ritchie is Lead Officer DYW at Aberdeenshire Council

39. Safe Nurse Staffing Levels Are Critical to Scotland's Health – Eileen McKenna

Originally published 23/03/2026

If you, or someone you love needs care in hospital or a community setting, you would hope that there would be enough nurses to keep them safe. But public polling commissioned by RCN Scotland shows that most people do not believe this likely; 78% think there are not enough nursing staff to provide safe and effective care to patients and care home residents in Scotland.

They're right to be concerned, despite nursing staff across Scotland going above and beyond every day to provide the best care they can.

At no point has the NHS in Scotland employed the number of nursing staff it says it needs. Scotland's safe staffing legislation came into force in 2024, but nursing vacancies remain stubbornly high, with over 2,700 NHS posts unfilled. Care homes also report significant retention and recruitment challenges.

Last summer more than 500 RCN members in Scotland answered questions about the safe delivery of care. 27% of respondents said their work setting rarely or never has enough registered nursing staff, with the right skills, to care for patients safely. 61% said the number of nursing staff working during their last shift was insufficient to meet the needs of patients. In a recent report from the Nursing and Midwifery Council (NMC), 37% of nurses and midwives in Scotland said they witnessed a patient safety incident in the last year.[1]

Decades of research from the UK and around the world consistently shows that when nurse-to-patient ratios drop, the risk of harm rises, from preventable complications and falls to higher death rates.[2] A recent observational study in NHS England found that increasing permanent staff to avoid low staffing reduced the hazard of death by 7.7%[3]

Meanwhile, nursing staff are also harmed, through increased pressure, stress, and risk of burnout. The NMC reported that more than a quarter (30%) of professionals from Scotland were 'struggling' with their workload, with 27% of registered nurses at high risk of burnout.

The evidence is clear and compelling: safe nurse staffing saves lives, protects exhausted staff and strengthens health and care services.

Too often, nurse staffing decisions are based on affordability rather than need. This is a false economy. There's increasing evidence that, as well as improving safety, ensuring adequate levels of registered nurse staffing is cost effective. Recent economic analysis in the NHS suggests that investing in better nurse to patient ratios is likely to be highly cost effective and may lead to net cost savings due to reduced length of hospital stay and readmissions, as well as reduced staff sickness.

Delivering safe staffing is also vital for improving retention of experienced nurses and attracting new individuals into the profession. Both are key for securing a sustainable nursing workforce able to meet the increasing needs of Scotland's ageing population.

Scotland's safe staffing legislation, which came into force in April 2024, places a legal duty on NHS and care providers to make sure there are always suitably qualified staff working in the right numbers to maintain safe and effective care. However, a study by Penn Nursing's Centre for Health Outcomes and Policy Research and Edinburgh Napier University found that at the point of implementation the Act's goal of ensuring safe staffing was not being met. Their research found that only 9% of nurses believed that staffing levels on every shift were adequate.[4]

RCN Scotland's manifesto[5] includes a call for the introduction of mandatory minimum nurse-to-patient ratios for all health and care settings, a policy that is supported by 86% of those surveyed in our recent public polling. Without safe nurse to patient ratios, people are being put at risk.

Funding our health and social care services is a political decision. Yes, budgets are tight, and we recognise the severe financial challenges facing health and care services. Change is necessary, services need to transform and opportunities to do things differently, including a better understanding of how digital infrastructure can support service delivery, need to be embraced. Nursing needs to be at the heart of these decisions and engaged in shaping the future, and all of this must be built on staffing levels that are safe.

The costs of not investing in nursing are significant both in terms of the long-term impact on service delivery, and the very real risk of harm to patients and residents being cared for today. Population health is pivotal to the wider goals of government, including economic growth, ensuring children and young people thrive in education and keeping people in employment. The right investment now will release wide-ranging benefits.

Not investing in nursing is the financially unsustainable choice. That's why, ahead of this Scottish parliament election, we're calling for nursing to be recognised as an asset, rather than viewed as a cost.

It's time to value nursing properly, because Scotland's health depends on it. **Eileen McKenna is Associate Director for Nursing, Policy, Professional Practice at the Royal College of Nursing Scotland**

---

[1] Insight spotlight – The Nursing and Midwifery Council
[2] Unsafe nurse staffing in European Region can harm patients and drive nurses out of the professio
[3] Safe Staffing | Publications | Royal College of Nursing
[4] The Scottish Safe Staffing Act at Baseline: Quantitative Findings – Lake – 2025 – Journal of Nursing Scholarship – Wiley Online Library
[5] Election manifesto themes for the RCN in Scotland for 2026 elections | RCN Scotland | Royal College of Nursing

Governance and Leadership

40. Governance of NHS Scotland – Sir Ewan Brown

Originally published 28/11/2023

The three main political parties at Holyrood appear to agree that the £19 billion NHS Scotland is out of control and in need of reform. Recent quotes from senior politicians include:

- Labour – "Across Scotland, our NHS is on life support".
- SNP – "Scotland's NHS is in need of fundamental reform. The health service must be overhauled".
- Conservative – "There is a crisis in our NHS"

If nothing is done to address the over-complex/dysfunctional structure and weak governance of NHS Scotland, the situation is very likely to get worse.

I have previously written about governance in both the private and public sectors. My concerns about NHS Scotland's structure and governance stem from Humza Yousaf's Parliamentary statement in November 2022, "that because of leadership, governance and cultural failures, NHS Forth Valley has been put under Scottish Government control".

The NHS Scotland crisis is clearly much more than failures of leadership, governance and culture in regional boards – but weak governance and concerns around culture are frequently warning signs that "all is not well in the state of Denmark"

There are 14 regional health boards which are supported by Public Health Scotland, seven special health boards providing national services, and four Integration Boards (expected to co-ordinate with thirty-two local authorities). The aggregate annual budget of the 14 regional boards is in excess of £12 billion.

The authority and discretion of regional health boards, which have statutory form and governance and financial responsibilities, has been progressively eroded by the increasing emphasis on the entirely theoretical entity called NHS Scotland, which appears to have no statutory existence or legal identity of any kind.

This has resulted in increasingly directive behaviour, without proper accountability for financial and operational consequences, and a vehicle for disrespect for the chairs and other directors of health boards, which at times has extended into a quasi-bullying environment. It takes an enormous commitment to public service for anyone with serious career achievements to their name to want to become a health board chair under those conditions. There is also a risk that potential board members, who might wish to assert the governance authority of a regional board, are not welcome.

That said, Government should be encouraging the best qualified people to join the regional boards (which oversee circa 30% of Scotland's budget) as chairs and non-executive directors.

In February 2023, Audit Scotland put its finger on the conflicts and ridiculousness within NHS Scotland in reporting "Regional NHS boards are expected to deliver services well beyond their

budget's capacity. The Covid Recovery Plan was promised in 100 days. Achieving this meant that boards were not consulted. Yet they are the ones expected to deliver".

To improve governance, it is essential to clarify accountability and improve lines of communication.

Have regional boards merely become rubber-stamping bodies which are regularly second-guessed by Ministers and civil servants? If so, should they be abolished? If not, how can they better demonstrate the value they add; and how can the effectiveness of chairs and non-executives be strengthened once they are in post? The quality of information available to board members needs to be improved, for example by allowing papers to be non-publicly disclosable and preventing dominant chief executives from controlling the agenda (a major problem in the private sector).

Principles of good governance would require that NHS Scotland, which has a chief executive, should be formally constituted with a chair and non-executive directors. This is clearly not the case. An alternative governance structure would be to create a real entity, NHS Scotland, that is accountable to Ministers and at arms' length, confining Government to policy, monitoring and agreeing strategy and the business of protecting health and preventing disease (which is a cross-governmental function) and holding NHS Scotland to account on behalf of the electorate.

The 2022 Blueprint 2 governance document (which built on Blueprint 1), is fundamentally flawed. Instead of spending time researching best governance practice, the review team should first have mapped NHS Scotland and its complex structure and considered whether it was capable of being conventionally governed. Instead, there are 37 references to the research material examined and no references to the structure and complexity of NHS Scotland. The result is no more than a fig leaf for good governance. The Blueprint addresses "effective governance across NHS Scotland", with a "primary audience of Board Members and Executive Leadership Teams". However, it does not seem to apply to NHS Scotland, its chief executive or those who work for her.

Presiding over health and care spend of more than 40% of the Scottish budget, as well as major capital projects, the chief executive of NHS Scotland (who is also Director General Health and Social Care) has routinely been a civil servant. Is a career civil servant, with little or no experience of running a small business (never mind a £19 billion behemoth) necessarily the best person to lead the biggest organisation in Scotland?

I have no political affiliation. Nor do I have an understanding of how, when or why a Government might be prepared to reach out to other parties to find common ground on a major issue of national importance that affects every citizen of Scotland.

It is therefore as a political innocent that I would love to see Scotland showing the world what could be achieved by its political leaders laying down their partisan positions and coming together around a cross-party forum charged with redesigning and reforming NHS Scotland for the 21st century – and ensuring that it is capable of embracing a National Care Service in whatever form Government decides it should take. Embedded in this process must be a fresh look at good governance that is effective and fit for purpose. By creating a non-partisan forum, it should be acceptable to deploy the huge body of knowledge and experience of senior civil servants and health professionals to assist the process.

If, politically, this is seen as a bridge too far, an alternative approach might be to set up a short-life group with a brief to:

- map all the constituent parts of NHS Scotland and determine who reports to whom
- map the proposed National Care Service and its relationship to NHS Scotland
- map all significant collaborators and other key stakeholders
- consider digitisation opportunities (eg artificial intelligence and robotics) to do more for less
- plan removal of some health care services (eg diagnostics) from hospitals to the community

and only then determine what structure and governance model might be most appropriate.

What must not be allowed to happen is to perpetuate a £19 billion organisation that is in urgent need of major overhaul and does not make best use of public money**.**

Ewan Brown, who has served on the boards of listed and private companies, universities and charities, is the author of Corporate Ego. His book describes the spectacular fall from grace of seven prestigious Scottish companies – Burmah Oil, Ivory & Sime, Lilley, HBOS, RBS, Johnston Press and Standard Life; and he identifies major failings in governance as the common cause. Ewan contends that governance in the public sector, and NHS Scotland in particular, is not fit for purpose.

41. Reflections on People-Centred Leadership in the NHS – John Sturrock KC

Originally published 05/12/2023

"The key to doing well lies not in overcoming others, but in eliciting their co-operation." (Robert Axelrod)

"…whatever change we seek to undertake, we are only as good as the relationships we are capable of creating and sustaining." (respondent in NHS Highland)

"We are confronting a …foundational moment: one that demands decisive cures, rather than palliatives. These times require… boldness, innovation, and above all… long-awaited action." (OECD)

I welcome this initiative by Enlighten. It seems particularly important that this discussion is hosted by an independent and credible body, to enable full and frank conversations to be had, received wisdom to be challenged where appropriate and all issues explored without fear or favour. As Paul Gray has suggested, the process (*how* things are approached) may be just as important as, and will influence, *what* outcomes are reached.

In offering these comments, I draw on my experience of conducting a review for Scottish Government into allegations of bullying in NHS Highland and my report published in 2019, in which I comment on various matters, including culture and leadership. I also draw on a number of other professional engagements with the NHS in recent years as a mediator and facilitator.

This initiative will require **assumptions and preconceptions** about how the NHS works to be set aside (together with acknowledgment – and understanding – of the inevitable cognitive biases we all have) and genuine openness to new ways of looking at things. Strategically, this will entail moving away from **binary thinking** to a deep exploration of the underlying issues (*a proper diagnosis*), before identifying options for the way ahead (*possible remedies*) and then arriving at sensible provisional conclusions and a course of action (*the prescription for healing*).

I suggest that identifying a **clear common purpose** to which everyone associated with the NHS in 2048 could subscribe would be a useful initial exercise.

This leads into the important topic of **leadership**. The NHS model of leadership (with echoes in its structure and nomenclature of a military-style command and control, power-based approach) may appear top-down and hierarchical. The NHS is too big and complex to be micro-managed from the top. In my NHS Highland report and elsewhere, I have commented on the danger that **fear is a driver**: fear of failure, of being criticised, blamed or shamed, of not achieving targets or not meeting expectations, of being made a scapegoat.

This can lead to **deferential, defensive and protective behaviour**, group think, unwillingness to raise issues of concern, concealment, wilful blindness/bystanding, low morale, increased staff turnover, unhealthy relationships and indeed stress, ill health and individual and collective

trauma. In turn, these can also lead to accusations of bullying, where often those perceived as "bullies" also feel "bullied". This may apply even to the Cabinet Secretary from time to time and in any event can rebound throughout the system. Fear stifles performance, creativity, openness and imagination. Fear kills, ultimately, whether it's a person, an organisation or a community.

The economists **John Kay and Paul Collier** capture some of these concerns well in their book *Greed is Dead*, stating that activities in the public sector world, like health and care, are high in intrinsic motivation but are hard to monitor, so workers are turned into automata, to be monitored and incentivised, rather than trusted for their judgement. Further, as the conflict resolution specialist, **Ken Cloke**, puts it: *"…nearly all of our focus in solving …problems and making decisions is on the content, and comparatively little is devoted to improving either the processes or the relationships. This is often because of pressure to deliver, achieve results, under great pressure. Short term gains [but] with longer term losses*."

I suggest that, from Cabinet Secretary through to ward level, a more **enabling, empowering, compassionate, shared and supportive leadership culture** would enhance relationships, which are central, and performance, which is critical. A **people-centred**, rather than a transactional, approach, where everyone feels valued and appreciated, based on **mutual trust** at all levels, would make a huge difference. Encouragement of a culture of cooperation to achieve optimal outcomes and recognition of **shared interests and common objectives**, rather than competition for scarce resources, seems key. "Working with" rather than "working against".

The author **Ken Cloke** again: *"there needs to be a shift from paradigms which are power-based (resting on hierarchy and status, win/lose, operating by command, with an expectation of obedience) and/or rights-based (resting on bureaucracy, operating by control, with a high expectation of compliance) to one of mutual interests, with shared vision and openness, where power and decision-making is shared, and distributed, wisely and thoughtfully."*

As an **NHS Highland Public Health report** put it: "*The key, then, is to pay attention to the emotional, psychological and spiritual resources that allow people to build relationships and establish social networks, so that people have opportunities to find what is meaningful to them, in a way that fosters optimism and control."*

There are already good examples of such a culture in the NHS in Scotland and identifying and **sharing good and best practices** across boards and throughout the country is surely an important aspiration. We can perhaps then view the NHS as a vast web of cooperative activity, sustained by mutual kindnesses and reciprocal obligations.

Training and education seem fundamental to all of this. Huge resources are allocated to physical and technical infrastructure. Many of the difficulties in the NHS could be addressed by the allocation of sufficient resources (including time) to developing the **skills and competencies** associated with building and sustaining constructive and respectful relationships at all levels, dealing with difficult situations, resolving tough dilemmas, making hard choices, and effectively handling ambivalence and uncertainty. These core attributes cannot be taken for granted and can be learned.

This applies at all levels: to senior executives, board members, Scottish Government officials and managers throughout the service. It is key to effective strategic governance and to delivery in the ward. Timely and robust challenge, holding people to account, and speaking up about concerns, is easier and more likely to be effective if individuals have the skills to communicate, listen well, explore issues openly and objectively and be respectful of others throughout.

I would suggest that increased and **system-wide use of mediation and facilitation skills** would also be beneficial to ensure early intervention in difficult matters and the avoidance of unnecessary escalation, nipping tensions and possible conflict in the bud and offering safe spaces for dialogue. **Prevention rather than cure**. Focus on learning rather than blame. As ACAS puts it: *"What is beyond doubt is that conflict, and its effective management, is a critical issue for organisations in maximising productivity and efficiency. More fundamentally it underlines the link between employee wellbeing and organisational effectiveness."*

Finally, change will be greatly assisted by **de-politicising discussion of the health sector** and finding cross-party and cross-organisational willingness to work towards solutions which benefit everyone. Much of this is about changing habits, both personal and institutional. We need to reset the neural pathways, both individually and in organisations. This takes time and commitment. Authenticity, humility and courage are vital components. It may also be about letting go of the past, of things that may have defined us and given us a sense of identity. But there seems no other way.

John Sturrock KC is Founder and Senior Mediator at Core Solutions

42. Governance of NHS Scotland: A Supplement – Sir Ewan Brown

Originally published 20/02/2024

On reading the NHS2048 submissions to Enlighten, I realised that my own, "Governance of NHS Scotland", was strong on criticism, but weak on proposals that might make things better. The purpose of this supplement is to set out what is wrong with much of Scotland's public sector governance and offer specific suggestions for improvement appropriate to the NHS.

Suggested governance improvements

1. Create NHS Scotland as a real entity with a strong, experienced board.
2. Split the roles of NHS chief executive and Director-General Health & Social Care and appoint a chief executive to NHS Scotland with a proven track record in running a large and complex private sector organisation.
3. Reduce the number of NHS regional boards from 14 to 4 and the number of regional board members from a maximum of 28 to a maximum of 15.
4. Detail the responsibilities of regional boards and define their relationship with NHS Scotland.
5. Investigate digitisation opportunities and the application of artificial intelligence to do more for less. Confirm availability of necessary front-end investment to realise the benefits.
6. Replace Blueprint 2 governance guidance with a prescriptive Governance Code applicable across the organisation.
7. Use mapping to clarify accountability across the whole of the NHS in Scotland and strengthen lines of communication.
8. Introduce more effective recruitment and development for chairs and non-executives. Ensure that there is diversity of thought, experience and background on all boards.
9. Each regional health board should include, in addition to the chief executive, a member of staff who is not part of the senior management team.
10. Require NHS Scotland and regional boards to have audit and risk committees comprising only non-executives.
11. Strengthen whistleblowing to give concerned staff direct access to the non-executive members of boards; and, where appropriate, provide assurance of anonymity.
12. Increase the remuneration of board members to reflect their roles and responsibilities. Replace the daily rates element with fixed fees.

Background

My principal concerns about the present governance structure of the NHS in Scotland are:-

- The authority and discretion of the 14 regional boards, with combined budgets of c£12 billion, has been eroded by the increasing emphasis on a theoretical government entity called NHS Scotland.
- In addition to the regional boards, there are 8 specialist health boards, 3 regional structures, 31 health and social care partnership boards, other non-statutory bodies and the Scottish Government's Health Directorate – a highly complex matrix in which double-running regional and local interests is complicated by different priorities.
- There have been recent governance failures at several regional boards including Ayrshire & Arran, Lanarkshire, Highland, Tayside, Forth Valley and Greater Glasgow & Clyde.
- When boards can be second guessed by ministers and officials, it takes a massive commitment to public service for anyone with serious career ambitions or achievements to apply to be a chair.
- The culture and structure of the NHS are such that potential non-executives, who might wish to assert governance authority, are unlikely to be welcome.
- Audit Scotland's withering condemnation in 2023 was that "*regional NHS boards are expected to deliver services well beyond their budgets' capacity*". This is infeasible.
- Principles of good governance would expect that NHS Scotland, which has a chief executive, should be formally constituted with a chair and non-executive board members providing oversight. This is not the case.
- The 2022 Blueprint 2 governance document, produced by a committee with vested interests, sets out "*the key functions and enablers including relationships between Government and NHS Boards and also the delivery, evaluation and continuous improvement methodology underpinning governance".* However, the document has no teeth and is fundamentally flawed.
- The Blueprint document claims to provide "*effective governance across NHS Scotland"*, with "*a primary audience of Board Members and Executive Leadership Teams*". However, it does not apply to NHS Scotland, its chief executive or those who work for her.
- For many years, the chief executive of NHS Scotland has been appointed from within the civil service. It is not clear why the Scottish Government believes that a civil servant, who may never have run a business, is regarded as the best person to head a £19 billion organisation in an executive capacity.

The proposed integration of health and social care services – if approved by the Scottish Parliament – would add complexity and create major structural challenges. Whether there is full integration or just greater co-ordination than at present, there is the need for strong, transparent, accountable and best-practice governance.

If nothing is done to address the over-complex, dysfunctional structure and weak governance of the NHS in Scotland, the present crisis is likely to get worse.

Across the public sector, the Scottish Government's approach to governance has been irregular and inconsistent. In addition to the NHS, the following examples from other parts of the sector show a governance framework that was either badly conceived or sadly lacking:-

- Good governance requires the positions of chair and chief executive to be held by different people – otherwise there can be no proper checks and balances. The **Edinburgh Tram Inquir**y revealed that the Scottish Government, through Transport Scotland, supported the roles of chair and chief executive being combined in one person That person was allowed to lead the contract negotiations that resulted in many years of delay and an overspend of several hundred million pounds.
- The **Ferguson Ferries** fiasco has revealed a confusion of strategy and accountability between Transport Scotland, Caledonian Maritime Assets Ltd, Caledonian MacBrayne and Ferguson Marine – all of which are owned by Scottish Ministers. There could be no better example of a government not understanding what good governance means. The outcome has been many years of delay and a monumental waste of public funds.
- The key economic drivers of **Enterprise and Skills** have been shackled by the Scottish Government creating, in 2017, an umbrella Advisory Board that blunts the autonomy and governance roles of Scotland's 3 Enterprise Agencies, the Funding Council and Skills Development Scotland. A confusion of responsibilities.
- The structure of the "independent" **Scottish National Investment Bank** allows for direct government interference. The Scottish Government can influence the Bank through the priorities it sets and by designing its missions. This is a serious risk of politics creeping into the SNIB boardroom and compromising good governance. A recent example of political risk being ignored was the loan the Bank gave to the ill-fated deposit return scheme.
- The governance of **Police Scotland** involves oversight by the Scottish Police Authority, an independent body tasked with ensuring accountability and transparency. The SPA appoints the Chief Constable and sets the strategic direction for the force. However, since 2013, the SPA has had 3 chairs and an interim chair; and there have been 4 chief executives and 3 interim chief executives of Police Scotland. Together with several well-publicised controversies, this suggests that the governance framework was poorly conceived.
- Audit Scotland reported in December 2023 that there was "*unacceptable spending*" and "*poor governance of public funds*" at the **Water Industry Commission for Scotland** (WICS). WICS is the executive non-departmental body of the Scottish Government responsible for regulating the water and sewage industry. WICS' chief executive resigned when it was revealed that many thousand pounds of expenditure had been unauthorised.
- Oversight of **Transport Scotland,** the national transport agency, is provided by the Scottish Government. It is accountable to Parliament and the public. The governance structure requires coordination with regional authorities, local councils, and the private sector. The agency's inability to prevent the Edinburgh Trams and Ferguson Ferries debacles from happening confirms flawed governance.

- Students at **Scotland's4** A**ncient Universities,** which are publicly funded, elect Rectors, who preside at Court meetings. Following an ideological Scottish Government intervention in 2016, students also have a vote on who are appointed as Senior Lay Members (who have specific Court responsibilities). Where different student constituencies support persons with opposing views, there is a real risk of creating major conflicts which, in turn, stultifies good governance
- Clues to how the Scottish Government consistently fails to appreciate what good NHS governance looks like can be found in the following responses it gave:-
- to a highly critical Times article on NHS Forth Valley- *"We are grateful to the many people from a range of backgrounds who come forward to work on NHS boards. All candidates go through a rigorous recruitment process, regulated by the ethical standards Commissioner, and are formally appointed by government ministers".*
- to me in an email – *in addition to the non-executive members, health boards contain a mix of executive members that in addition to their executive function have the same governance responsibility as other board members".*

The first response misses the point that relevant skills, knowledge and experience are essential requirements for regional boards, which have annual budgets of up to £2 billion. The second displays a fundamental misunderstanding of the role and purpose of non-executives. While all board members have the same governance responsibility, non-executives should not be appointed to constitute *"a mix with executive directors";* but rather to be independent, challenging, diligent, informed – and not influenced by others.

If a purpose of regional boards is to represent, and be accountable to, local communities, why did the 280,000 people in Forth Valley not seem to care when their board was required to step aside because of "*failures of leadership, governance and culture*"? (Cabinet Secretary Humza Yousaf to Parliament in November 2022)

There is a sound rationale for regional boards in terms of Scotland's geography. Boards have a role in sustaining both national and local external relationships which are complex and important – but this should not obscure the need for skilled and transparent governance.

Strengthening governance will not fix an NHS in crisis. However, even a superficial examination of present governance arrangements throws up glaring structural and communication weaknesses that do, inevitably, result in inefficiencies and sub-optimal use of public funds.

The Scottish Government sets national objectives and priorities for the NHS, agrees delivery plans with the regional and other boards, monitors their performance and supports them to ensure achievement of these objectives. However, it is not clear what "the Scottish Government" is in this context. If it relates to the present civil servant-led NHS Scotland, there is a fundamental anomaly with the potential to produce confused governance, labour market inefficiency and a seriously flawed command and control structure.

Irrespective of policy decisions on the merging, or otherwise, of Scotland's health and social care services, this contribution demonstrates that the status quo is not acceptable. There is an urgent need for a change of approach to governance.

Suggestions to improve the governance of the NHS in Scotland

Structural

Create a real entity that is NHS Scotland, accountable as a whole to Scottish Ministers and at arm's length, confining Government to policy, monitoring, agreeing strategy and the business of creating, protecting health and preventing disease – and holding the board of NHS Scotland to account. This structural change would likely require a change of legislation.

Separate the roles of NHS chief executive and Director-General Health & Social Care, leaving the civil service to focus on policy and strategic direction.

Appoint a chief executive to NHS Scotland with a proven track record in running a large and complex private sector organisation.

Appoint a chair and non-executive members of the highest possible calibre and establish an audit and risk committee of the NHS Scotland board, comprising only non-executives.

Regional boards

Government statements that "*regional boards are responsible for planning, commissioning and delivering NHS services in their area*" imply that boards have autonomy and that the Blueprint 2 governance document will enhance their performance. The number and extent of board failures confirms that this has not been the case and that change is essential.

Audit Scotland's withering criticism, in January 2023, that "*regional boards are expected to deliver services well beyond their budget's capacity*", confirms the need to clearly define the relationship and expectations between regional boards, NHS Scotland and the Scottish Government.

For regional boards to achieve their remits, they need direction at a high level that is clear to interpret and prescribes where accountability lies.

Government should be encouraging the best qualified people to join regional boards as chairs and non-executive members. There needs to be more effective recruitment and development for chairs and non-executives, ensuring diversity of thought, experience and background.

There are 7 regional boards in England serving approximately 60 million people. For a country with a population of around 5.3 million, Scotland has too many regional boards. Some of them serve very small areas, most struggle to identify high-quality board members and very few cover the same area as the country's 32 local authorities. If the number of regional boards was reduced from 14 to 4, they could cover:-

- Greater Glasgow and Clyde.
- Lothian
- North of Scotland, comprising Fife; Forth Valley; Grampian; Highland; Orkney; Shetland; Tayside; Western Isles.
- South of Scotland, comprising Ayrshire and Arran; Borders; Dumfries and Galloway; Lanarkshire.

Chairs and non-executives of the highest possible calibre should be appointed to the regional boards, with their roles and responsibilities clearly defined. Boards of up to 28 members are

unwieldy, face challenges with co-ordination and consensus building and are too big for effective decision making. The number of board members should be reduced to a maximum of 15.

Establish board audit and risk committees, comprising only non-executives.

Appoint chief executives to each of the 4 regional boards.

It may also be worth investigating whether the NHS structure could be further simplified and governance strengthened by combining the 8 speciality boards into a single unit.

Mapping

Stakeholders of the NHS in Scotland, which help to influence clinical and professional standards, include, but are not limited to, health and social care partnerships, local authorities, national clinical groups, Royal Colleges, local and national charities, Police Scotland, Universities, Trade Unions and patient organisations.

To provide relevant data that will assist in building a governance structure for the NHS in Scotland that is appropriate**:-**

- map the constituent parts of the NHS in Scotland and determine who reports to who; and why.
- map the proposed National Care Service and its relationship to align with the NHS.
- map all significant NHS collaborators and other key stakeholders. Ensure that public services such as the Police (who are collaborators in the myriad partnerships that engage and surround the NHS, with their own governance, accountability, underlying values, and culture) are aligned.
- take account of possible shift of some health care services from hospitals to the community.

Digitisation

Using experienced consultants where appropriate, investigate digitisation opportunities and the application of artificial intelligence to do more for less – and ensure that the Scottish Government finds (either from its own resources or externally), the necessary front-end investment that will be required to fully realise the benefits

Accountability

Clarify accountability across the whole of the NHS in Scotland. The Scottish Hospitals Inquiry is investigating the defective construction of Glasgow's Queen Elizabeth Hospital Campus, Edinburgh's Royal Hospital for Children and Aberdeen's Baird Family hospital. There is an urgent need to define who carries responsibility for capital projects and make them accountable.

The Effective Government Forum, a UK non-partisan group argues that power, accountability and finance should be pushed down to the lowest possible level so that there is accountability when things go well – and also when things go badly.

Communication

External: Re-cast the notion that the NHS in Scotland is an arm of political delivery. Promote it as a service with strong values – and manage expectations.

Internal: Strengthen lines of communication across the whole of the NHS in Scotland.

Responsibilities

The Scottish Government's Cabinet Secretary has the impossible task of being responsible for a £19 billion organisation that is larger, and certainly more complex, than most FTSE 100 companies. The responsibilities include NHS recovery & remobilisation, primary care & GPs, community care, acute services, NHS performance, workforce training, planning & pay, patient services & safety, health & social care integration, health improvement & protection, quality & improvement, person-centred care, eHealth, the NHS estate, the centre of excellence for rural & remote medicine and social care and allied healthcare services.

This huge responsibility carries with it an absolute entitlement for the Cabinet Secretary to take the credit when things go well – but if a strong and relevant governance structure is in place across the NHS in Scotland, he or she should not be held accountable for failures that properly lie at the doors of NHS Scotland or the regional and other boards – but only for failures of policy and its implementation.

Governance Code

The Blueprint 2 governance document:-

- is impenetrable. It runs to 63 pages and 50 footnotes (some longer than the document itself);
- constitutes guidance only, contains no sanctions and is not prescriptive.
- does not appear to require regional boards to submit reports on compliance.
- appears not to apply to NHS Scotland's chief executive or her senior staff (despite referring to "*executive leadership*" and "*across NHS Scotland*").
- was sponsored by a regional board chair who had a vested interest in its scope.
- is fundamentally flawed because regional boards are "*expected to deliver services beyond their budget's capacity*" (Audit Scotland report of February 2023).
- requires NHS boards to ensure that "*robust, accountable and transparent governance arrangements are in place throughout the healthcare system*" and *"to add a collaborative approach to governance*". Both are beyond the power and authority of a regional board.

These governance weaknesses demand a Code of Governance that:-

- is no longer than 15 to 20 pages (similar to the Governance Code for UK listed companies).
- applies across the NHS in Scotland.
- is prescriptive.
- requires those covered by the Code to comply or explain.
- embraces the core principles of accountability, leadership, integrity, stewardship and transparency.
- adopts effective communication with stakeholders
- does not shelter key people (particularly chairs) when things go wrong (eg NHS Forth Valley).

- gives some protection to board members against civil servants and/or ministers taking decisions that offend the principles and/or the considered judgement of a chair or non-executive.

Whistleblowing

Measures include the Independent National Whistleblowing Officer (INWO). The INWO provides external review of how health boards, independent primary care contractors, and other providers handle whistleblowing cases.

Staff Governance Committees (SGCs) are required to implement the Staff Governance Standard. A function of SGCs is "*to oversee the board's whistleblowing arrangements, including implementation of the national standards, reviewing trends and learning over time and preparation of performance reports for submission to the board".* From this, it is not clear how whistleblowers can be confident that their concerns will be heard by the non-executives on the board .

Accepted best practice across the private sector provides for the chair and non-executive directors to be made aware of whistleblowing incidents and how they have been resolved – or not. When this was first introduced, companies were worried that there would be a surge in petty and/or vexatious complaints. This did not happen.

It should be to a board, not a government minister, that a whistleblower can express serious concerns. Arrangements akin to those in the private sector should be implemented by the NHS in Scotland – so that concerned staff can have a line into the board – and confidentiality assured where appropriate. The board would be required to take seriously the issues that are raised; to consider whether there are any persistent themes; and to take appropriate action.

In practice, responsibility for overseeing whistleblowing would be delegated to a board's audit and risk committee, which comprises only non-executive members.

Recruitment of board members and their remuneration

Embed better recruitment and development processes for chairs and non-executives. There has been a focus in recent years on diversity as it relates to gender and ethnicity. To be effective, health boards must also ensure they capture diversity of thought, experience and background.

Each regional board should include, in addition to the chief executive, a member of staff who is not a member of the senior management team

To attract chairs and non-executive board members of the highest quality, their remuneration should be increased to align with what is paid for similar roles and responsibilities in the private sector.

Replace the daily rates for non-executives (which, perversely, can discourage attendance at meetings), with an annual fee. Require board members to resign if they don't attend regularly.

Conduct of board meetings

For chairs and non-executive board members to be effective and properly held to account, it is essential that they receive board papers that are concise, accurate and relevant. The chair should

approve all board papers and has a particular responsibility to ensure nothing of importance (good or bad) is withheld from the board.

The Public Bodies (Admissions to Meetings) Act requires health boards to hold board meetings in public. Standing Orders allow boards to meet in private to discuss certain matters. While these arrangements would continue to apply to regional and other boards, the board of NHS Scotland should meet in private – but make public its agendas and minutes.

Sir Ewan Brown, who has served on the boards of listed and private companies, universities and charities, is the author of Corporate Ego. His book describes the spectacular fall from grace of seven prestigious Scottish companies – Burmah Oil, Ivory & Sime, Lilley, HBOS, RBS, Johnston Press and Standard Life; and he identifies major failings in governance as the common cause. Ewan contends that governance in the public sector, and NHS Scotland in particular, is not fit for purpose.

43. From Christie to Covid: Why We Need to Reform the NHS – Gerry Marr

Originally published 19/03/2024

"The public services of the future must not only continue to provide a safety net for the vulnerable but make a coherent contribution to a stronger, healthier, economically viable and more equitable society". (The Christie Commission 2011)

Introduction

This article is one of two papers which seeks to examine the evidence of key aspects which have impacted on the NHS in Scotland from the year of publication of The Christie Commission report in 2011 to the outbreak of the global pandemic circa 2020/21. This represents a contribution to the collective thinking on how we need to act differently to achieve fundamental reform, and secure the sustained change needed to build a future based on the founding principles of our health service.

The recent Audit Scotland report on NHS Scotland (Feb 24) has drawn unprecedented comment and reporting, having raised fundamental issues about the sustainability of the NHS in Scotland in the short to medium term.

The Scottish Budget (2024/25) approved by the Scottish Parliament in February 2024, has raised further concerns about the progress of the post pandemic recovery plan, and the infrastructure support needed to deliver it in the short term.

The overwhelming sense of crisis in the health service pervades every discussion nationally, calling for an urgent, open, and honest national conversation about the future.

The majority view is the need to preserve the founding principles of our health service. Despite this, some take the view that raises the possibility that amongst many of the difficult decisions needed in any national dialogue, there may be the need to include the future possibility of charging for certain services, striking at the heart of universal cover, the very essence of the founding principles of the NHS.

Why has such a view emerged at this time? Careful analysis of the evidence on funding and performance over the last decade, as well as progress on strategy, policies and performance designed to take forward The Christie Commission's recommendations, provides part of the answer.

The Institute of Fiscal Studies and The Scottish Fiscal Commission analysis shows that the NHS enjoyed a period of real growth in the first decade of devolution of circa 5%. By 2020, the real term growth was 0.4%. In 1999-20 Scotland spent 22% more per head of population than England but by 2019-20 that had fallen to 3%.

Real terms growth is the normal term used in financial analysis of available resources. It is more useful to use the actual budget allocations to the health service, documented in the annual reports of Audit Scotland. This is important because the cash allocation available to the NHS in Scotland,

is the most reliable indicator that provides the evidence to understand year on year performance and the effectiveness of implementation of government policy and reform.

An analysis of budget allocations from 2011/12 to 2018/19 shows that they were significantly above the figure of available real term growth, providing clear evidence of government supporting the financial sustainability and performance of the NHS.

As early as 2011/12, despite growth in available resources, nine of the fourteen Health Boards had an underlying deficit. The Audit Scotland report of this period stated that the requirement for Health Boards to break even, encourages short term actions with little evidence of plans to secure financial sustainability over the short to medium term.

By 2018 Audit Scotland provides a helpful summary of a consistent pattern of financial pressures and the adverse impact on workforce and service delivery. The report states that no Health Boards were meeting all key national performance targets, with only one national target met across all the Health Boards. Despite an increase of 2.5% in cash, brokerage (loans) by Scottish Government was £50.7m, with Health Boards continuing to rely on non-recurring savings. Only three Health Boards met the 62-day cancer target, while waiting times continued to deteriorate. The report provides a summary of key workforce data over a 5-year period: key indicators show a 38% increase in agency/bank costs, affecting the medical and nursing workforce. Regarding clinical activity, there was an increase of 26.9% and 34.9% in waiting for outpatient and inpatient elective admissions respectively. The total number of elective admissions had fallen by 18.9% with emergency admissions increasing by 5.3%.

The report concluded that "*The NHS is not in a financially viable position*" and that "*decisive action is needed to secure the future of the NHS in Scotland*".

While not seeking to diminish the impact of the pandemic, the reality is that the NHS in Scotland was experiencing sustained challenges in financial viability and performance prior to the outbreak of the pandemic. The need for recovery was already urgent.

Against this backdrop, what has been the progress in strategy, policy, and the implementation in the drive towards the reforms set out in The Christie Commission?

The Christie Commission's four pillars of prevention, performance, participation, and partnership has been the driving force for reform since its publication in 2011. A commitment reinforced by the present government in the ten-year review in 2021.

The Christie Commission emphasised amongst other issues, the need for better integration as a means of shifting the balance of care and resources to community-based services.

Well in advance of 2011, there had been many efforts to achieve that objective. Governments consistently placed significant emphasis on structural change to achieve their objectives, in both policy and strategy.

Using international comparisons, the Scottish Government is not alone in pursuing structural change as the driver of reform, nor demonstrating that such approaches fail.

Since devolution, there have been a plethora of attempts to restructure as a route to integration. The creation of Integrated Joint Boards is the latest and most far reaching. A fundamental test of progress following the creation of Integrated Joint Boards is evidence of change in systems of care at a national level that is sustainable, with measurable outcomes. Regrettably, there is no evidence of this.

This should not detract from the considerable local efforts of progress in innovation, commitment and leadership, achieving meaningful changes in services to local people.

The Accounts Commission Report (2018) on progress of Integrated Joint Boards provides details of financial and service pressures. More significantly, the report states that a key part of the reforms would be that Integrated Joint Boards would achieve a shift of care closer to home. By 2018 key national measures showed no progress on this key objective. The report makes a series of far-reaching recommendations on actions needed to drive implementation. The recommendations were accepted by the Joint Ministerial Group on Health and Social care (2019).

By 2018 the total resource to Integrated Joint Boards was £9bn made up of a 70/30% allocation from health and social care respectively.

The legislation included the transfer of the management of several acute hospital services to Integrated Joint Boards. This had not happened. In addition, the report shows that resource allocations between hospital and community care remained static.

The government insisted that the creation of Integrated Joint Boards would produce major improvement in delayed discharges, with a projected saving of £160m annually. This has not happened.

In 2019/20 there were 542,204 delayed discharges, 67% were patients over 75 years. This represented a total of 8.9% of available beds (Public Health Scotland).

The combination of fiscal pressures, deteriorating performance and little evidence of success on integration and transfer of resources and activity was a sustained pattern in the health service before the global epidemic.

During this period there was no lack of policies and implementation plans supported by one off supplementary funding. What evidence points to the success or otherwise of such approaches?

The Finance and Public Administration Committee of the parliament budget scrutiny report (2023/24) provides a helpful analysis based on evidence from submissions from several key stakeholders.

In summary, it presents a picture confusing and constantly changing government strategy in health and social care. Their report highlights a pattern of dislocated, subject based policy developed in isolation, alongside disparate implementation plans with a lack of clarity over transparent measures of progress.

Failure of implementation is a recurring theme. The Health Foundation report (Leave no one Behind: The State of Health and Health Inequalities, Jan 23) is a comprehensive report on inequalities in Scotland. The report is clear on the lack of progress due to complex, multiple,

disconnected policy initiatives with little evidence of effective interventions intended to improve key aspects of health and wellbeing. The report echoes the failures of intended transformation in health and social care.

In his recent NHS 2048 blog Sir Ewan Brown raises fundamental issues of stewardship and governance. Having reviewed the membership of non-executives on boards he concludes that they lack the appropriate skill set. He is also clear that the relationship between Government, the Civil Service and Health Boards is not fit for purpose. His blog echoes much concern on the effective stewardship of health services in Scotland.

Jackie Ballie, in her recent article, expresses disappointment at the view of NHS Scotland Chief Executives on proposals that include the need for charging for services in the future. Her disappointment reflects her concern that this information became public through a leak from a private meeting.

The culmination of the lack of reform and failure of policy development and implementation, compounded by the extreme service pressures post pandemic, has provoked a compelling plea for an honest, transparent conversation on the future of our NHS in Scotland. Given the evidence presented in this paper, are the views of chief executives justified in the current circumstances? Or does it reflect further on the failure of the stewardship of our NHS in Scotland?

There is real danger that such ideas at a time of "crisis" particularly by a group of senior executives who must share their part in the failures of the last decade, gain credence. If nothing else there is no way of predicting the unintended consequences of such decisions, leaving a legacy that would compound inequalities in health and social care that currently exist.

The point is, a rush to a debate about affordability in the current crisis fails to reflect on the failures of reform over the last decade, compounding the errors of the past. A reactive response that denies the people of Scotland the opportunity to be involved in at transparent, honest conversation.

Many sources have called for brave decisions. The brave decision is the unequivocal commitment to the founding principles of our NHS as part of any conversation about the future. Anything less would be a betrayal of our future generation who would never forgive us.

My next article will explore how recovery from the current crisis can be the first step in the reform of our health services and that there is evidence of how that can be achieved and sustained.

Gerry Marr, is the former Chief Executive of South Eastern Sydney Local Health District, Sydney, Australia taking up the position in February 2014 until he retired in August 2018. Prior to this position, Gerry held Senior Executive roles with the NHS Tayside, firstly as Chief Executive Tayside University Hospitals Trust, then Chief Operating Officer/Deputy Chief Executive Officer, and then Chief Executive from 2010 until 2013. Prior to his work with NHS Tayside, Gerry held senior roles in the areas of system performance and human resources management with the NHS Scotland Department of Health. In his early career, Gerry held senior management roles at major tertiary hospitals, including Yorkhill Hospitals NHS Trust in Glasgow and the Women and Children Services, Greater Glasgow Health Board.

44. Through Recovery to Reform – Gerry Marr

Originally published 10/04/2024

Victor Adebowale was one of the first group of people appointed as People's Peers in 2001 and became a life peer on 30th June 2001. In 2012 he established Collaborate (for social change), a year after the publication of The Christie Commission (2011). The vision of Collaborate is of a collaborative society: equitable, caring, and sustainable. Such a vision echoes the essence of The Christie Commission which stated that reforms must aim to empower individuals and communities receiving public services, by involving them in the design and services they use.

In December 2023 Collaborate published an update on Towards a Manifesto for Public Services. The manifesto urges a shift in services from paternalistic silos which retain power, doing to rather than with communities, to a shift that requires services which are enabling, sharing power and moving from silos to a system based on learning and adaptation.

The Christie Commission best reflects such ambition by the statement 'recognising that effective services must be designed with and for people and communities' – not delivered 'top down' for administrative convenience.

The starting point for both recovery and reform needs to recognise the failure of an approach owned by institutions in control. Integration means nothing to ordinary people. Integrated services for elderly people with progressive illness, where being at home is the norm and treatment, or care, as close as possible means everything. Up to the present time integration has been dominated by structural change with control retained by the public bodies, with little evidence of shifting care at scale to a model where people have a service to support them at home, with hospital admission only when needed.

A national conversation is an opportunity to rethink the term integration and the associated failing structures and plans. Integrated Joint Boards are designed to fail in their current form and function, the evidence speaks for itself. The National Care Bill has reached its second stage. The first stage evidence was dominated in some quarters by opposition, and in others fundamental concerns over cost and efficacy. Diverting time, effort, significant resource, and potential cost is more likely to simply repeat the mistakes of the past. Put simply it entrenches the persistent drive to centralisation with no detail of the anticipated benefit. What is needed is the development of a truly national service, free from even more legislation, control, and centralisation. A service that truly meets the needs of the population.

This article looks at an international case study and offers an alternative to our current approach to recovery and reform and demonstrates solutions which have overcome the complexity of the structures and finance regimes that have dominated systems of care almost universally.

On the 22nd of February 2011, Christchurch in New Zealand experienced a devastating earthquake with the loss of 185 lives and enormous damage to the infrastructure of the city. Much commentary suggests that the event in 2011 was the catalyst for such transformation of their system of care. This is not the case.

In 2007 Canterbury District Health Board (DHB) was in deficit. Analysis showed that if the system did not change, by 2020 it would need a hospital twice the size, 20% more GPs and an increase of 40% in residential care beds for the elderly. This was unaffordable, unachievable, and not the right thing to do.

The Canterbury DHB is an integrated system of health and social care. However, like Scotland, despite the structure, there was little evidence of integration leading to real change in the services delivered to their communities. The Canterbury DHB Board was clear that it required one system, and one budget, in which a dollar could only be spent once. They concluded that cost shifting was unsuccessful and unsustainable.

Within a structure and financial regime that would not change, they determined that their reforming principles would be based on professional leadership and ownership, characterised by partnership, and supported by data that demonstrated real evidence of success.

The Kings Fund report (2019) provides a detailed summary of the Canterbury journey. The report makes no claim that Canterbury DHB has transformed but rather is on a continuous journey of changing how services are provided to their population. It does not claim that there have been dramatic reductions in acute care beds, but rather it demonstrates the avoidance of both capital and revenue costs associated with models of care that would have continued the cycle of deficit, with little effective change in the delivery of services.

There are two key learnings from this case study.

Firstly, the Board agreed to support the principles of the strategy, not the detail of the plan. The Board recognised the timescale for achieving financial sustainability and the need for investment to support innovation and change would require a long-term commitment. They expressed the view that "What we have tried to do is not focus on the marginal edge of money that we have not got…. Rather we have tried to say we have $1.4bn here and how we use it is what matters".

The second learning point is the role of primary care. Significant investment was made to support general practice development. Importantly this investment was owned and managed by the GP consortium, a vital driver of the entire programme of reform. Pegasus is the business entity for the GP consortium in Canterbury. GPs were at the centre of the programme. Canterbury DHB recognised the vital need to maintain and continue to develop the sustainability of general practice, a vital part of their plans. Significant funding and investment were made available to Pegasus for the necessary time commitment and professional development required. Canterbury DHB also determined that the development of care pathways would be a pivotal part of their programme. A fully funded Health Pathways Programme became central to building the much-needed alliance across primary and secondary care.

To summarise a quote from the King's Fund report "Arguably the biggest change Canterbury DHB has made however, is to re-invest in the pride of clinicians and other staff, taking significant steps to re-empower them to make changes themselves after a long period of managerialism".

The overall point to consider is that structure, central control, and excessive scrutiny from government are all barriers to reform. Despite these issues being beyond the direct control of

Canterbury DHB, they designed a local programme of change and innovation that reflected the needs of their local communities.

The learning from this for Scotland is that a national conversation needs to look beyond national structures and systems to inform the way forward.

The Lancet Global Commission on Primary Care (2022) conclusions and recommendations on the organisation of primary care in health systems, underpins the considerable strengths of primary care in the Scottish health system, a vital part of future reform.

Its central, most important recommendation was the need to increase the allocation of resources to primary care, a view that has been consistently reinforced by representative organisations in Scotland.

Scotland's allocation of total sums to primary care has been circa 8%, across many years. The case has been made that this needs to increase to circa 11%, a figure reinforced in the Lancet report.

We face two challenges. The first is an absolute commitment to shift to an increase in the allocation of share to primary care. The second is more immediate. We need to face the challenge of rapid, sustainable recovery, doing so in a way that creates the conditions for meaningful reform that succeeds in shifting the balance of care from hospital to home.

The 2018 General Medical Services Contract is in deep trouble. The BMA are in dispute with government over the lack of progress on the expansion of GP numbers and concerned about the support to general practice development. The BMA, having secured the development of GP clusters, argue that there has been a lack of real investment and support.

The RCN have raised persistently the impact of the introduction of the contract and the development of multi-disciplinary teams. Their concerns range from the incentives and grading of roles and the professional development of nursing in the community. Their members are concerned about the fragmentation of the primary care team and its impact on patients. Rural GPs also voice difficulties regarding the multi-disciplinary team approach embedded in the contract and the breakup of the practice-based teams, a vital component of rural services.

More concerning is the number of General Practices returning their contracts to Health Boards who feel unable to respond adequately to reprovision given the pressures they themselves are under.

The above problems are now even more acute given the challenges post pandemic.

Despite this, the NHS Recovery Plan makes only one significant reference to primary care, the 2021 joint agreement on the ongoing implementation of the 2018 contract. There is little in the Recovery Plan of the investment required to deal with the post pandemic pressures. There is a need to re-engage with all parties involved in the key elements of the national contract. Further investment is needed to deal with the post pandemic pressures as an immediate priority.

Reform presents different challenges and solutions. The second most important recommendation of the Lancet Commission was the need for allocations based on population and need. Scotland has an international reputation for such an approach. The current view is that the approach in

primary care is wrongly weighted and does not reflect the broader determinants of health. The Deep End Practices express concern about the failure to make a difference to the inverse care law. They recognise that there has been considerable funding support from government, however, in their most recent briefing, they call for an end to “pilot-itis”, a plea for allocations that recognise the wider determinants of health.

There may be concerns that such a change may destabilise general practice. However, Scotland has a long-standing track record of a population based approach to allocations and equal share in a sustainable way. Through a long history of share allocation and the Arbuthnot formula, Scotland has achieved equal allocation rather than a reduction of the base allocation. With this experience there is every possibility of preserving the benefits of a national contract, the independent position of general practice and the redistribution of increased resources tackling the wider determinants of health. An important part of any future national conversation might be that the National Care Bill is an example of continued centralisation and control despite the irrefutable evidence of failure of such an approach. The alternative is to a real shift of power to leadership and innovation based on a coalition of effort on those best placed to drive reform. Have the confidence that investment in primary care, in the first instance, is vital to recover and stabilise our general practice services. In the second instance, trust the investment to drive the reform and development of our system of care, while starting the journey of a model that deals with the challenges of inequalities and deprivation.

Gerry Marr, is the former Chief Executive of South Eastern Sydney Local Health District, Sydney, Australia taking up the position in February 2014 until he retired in August 2018. Prior to this position, Gerry held Senior Executive roles with the NHS Tayside, firstly as Chief Executive Tayside University Hospitals Trust, then Chief Operating Officer/Deputy Chief Executive Officer, and then Chief Executive from 2010 until 2013. Prior to his work with NHS Tayside, Gerry held senior roles in the areas of system performance and human resources management with the NHS Scotland Department of Health. In his early career, Gerry held senior management roles at major tertiary hospitals, including Yorkhill Hospitals NHS Trust in Glasgow and the Women and Children Services, Greater Glasgow Health Board.

45. Delivering the Care & Health Services Which We Will All Need (Eventually) – David Belfall

Originally published 03/02/2025

In this blog I seek to compare the current arrangements for managing community health and social care services in Scotland – through "Integrated Joint Boards" with the National Care Service (as proposed until 23 January). With an ageing population these services are a crucial part of our public services. They are also expensive. The annual budget of the Glasgow IJB is £1.5 billion and that of the Edinburgh IJB £900 million. There are 31 IJBs across Scotland with a total annual budget which must be around £5 billion pa.

My blog takes account of my experience as a non-voting "service user representative" on the Edinburgh IJB from June 2024 until January 2025.

My view is that IJBs are dysfunctional and not fit for purpose. I reach that view not because of the personalities involved, but because, in my view, the basic structure is fundamentally flawed.

Integrated Joint Boards

IJBs were set up in 2015 under the Public Sector (Joint Working) (Scotland) Act 2014. That Act sought to bring together the community health services of the local NHS Board – basically all health services apart from hospitals – with the social care responsibilities of Councils. The voting members of IJBs are equal numbers of Councillors appointed by the Council and representatives appointed by the Health Board. The Chair is appointed for 2 years by the Council and is then replaced by an appointment from the Health Board.

In my time on the Edinburgh IJB there were 5 voting members from the Council – all Councillors from different political parties, reflecting the fragmented political make-up of Edinburgh City Council – and 5 Non-Executive Board members of NHS Lothian. It is important to understand that the 5 NED members of the NHS Lothian Board were originally appointed to that Board to bring their experiences and skills from their working and private lives to bear on the work of NHS Lothian which then appoints them, additionally, to serve on the EIJB as voting members. They receive an allowance (usually for one day's work) from the NHS Board, but are not NHS employees.

The structure is inherently unstable and does not provide the continuous firm leadership which an organisation with a budget of £900M pa needs.

The problem is compounded – at least in Edinburgh – by the fact that the Chief Officer of the EIJB has changed so frequently. The Board is now about to greet its sixth Chief Officer since it first met on 17 July 2015 – plus 2 interims.

This unstable structure is especially difficult for the other senior officials – and there are some very able officials at the EIJB – because of the changes in leadership so often.

Also relevant is the fact that IJBs do not employ any staff of their own. All IJB staff are employed either by the Council or the Health Board. The IJB – with its operational arm the Health and Social Care Partnership – is a commissioning body. With its budget – which is provided by the Council and the Health Board – it commissions services, most but not all of which are provided by the Council and the Health Board from which it obtains its budget!

This curious arrangement – which, so far as I am aware, is not replicated in any public service anywhere in the UK – is compounded by the fact that demand is growing faster than the resources provided. In an excellent report in July 2024 Audit Scotland drew attention to this disparity. The report did not receive the attention it deserved.

The consequence of the disparity between resources and demand is that IJBs spend much of their time trying to work out where savings can be made. In Edinburgh the challenge is to find £105M of savings in 3 years between 2025 and 2028.

Since most of an IJB's resources is tied up in services which it is legally obliged to provide, the focus has been on other services, particularly preventative services and services provided by the voluntary sector. However, any short term savings which can be obtained in respect of these services come at the expense of additional future demand – and therefore cost. As Audit Scotland has eloquently put it : "...collaborative, preventative and person-centred working is shrinking at a time when it is most needed".

The IJB model for providing community health and social care services is therefore deeply flawed. A massive additional financial input might help, but it would not resolve the fundamental structural problem.

What then has been the alternative?

The Scottish Government's answer has been to create a National Care Service, based on the model advocated in a report from a group led by Derek Feeley, former Chief Executive of NHS Scotland and published in 2021.Essentially Feeley proposed a National Care Service on the lines of the National Health Service, with a central body and local delivery mechanisms, similar to NHS Boards, which would be employing bodies, taking over health employees of the Health Board and social workers employed by the Council. The proposed removal of social workers from Council control immediately raised complaints about the lack of democratic control, to which I will return, but in truth the current IJB model has only a tenuous connection with local democracy.

However, as Feeley made clear, the introduction of a National Care Service would require substantial additional public expenditure and, since he reported, the public finances have deteriorated significantly. The consequence is that, although there is legislation creating a National Care Service on the statute book, its implementation has been repeatedly deferred, and has now been abandoned by the Scottish Government in the statement made to the Scottish Parliament on Thursday 23 January 2025 by Maree Todd MSP, the Minister for Social Care.

Where do we go from here?

In her statement Ms Todd said, among other things, that "…I will move quickly to establish a National Care Service Advisory Board, on a non-statutory basis. It is my intention that the Advisory Board will include people with lived experience of accessing care services, those who work in the sector, care providers, the third sector, trade unions the NHS and local government. I expect the Board to meet for the first time in March this year…" What could we expect that Board to consider?

The case for a National Care Service was based on the need for greater consistency and quality across the services provided across Scotland by the IJBs. Can these objectives be met without the massive restructuring which the creation of a National Care Service would have entailed?

In this connection it should be noted that, apart from the work of Audit Scotland and the scrutiny provided by the Care Inspectorate and the Mental Welfare Commission, IJBs are free to go their own way. There is no representative body for IJBs such as COSLA provides for local authorities. Nor is there any annual conference or other arrangement for sharing experiences and good practice. IJBs generally conduct their business in isolation from each other.

There is already scope for greater sharing of information between IJBs, and for providing some form of inspection or monitoring by a national body. There would be a cost to this, but not nearly so much as a National Care Service would entail.

The function of IJBs would also repay consideration. What does "integration" mean? Does it just mean a mechanism for managing parallel health and care services, and ensuring that there is no unnecessary friction between them? Or does it mean much more integrated patterns of working such as asking care workers to undertake basic health checks? Co-operation between health and care services is certainly vital in dealing with the central problem of delayed discharge from hospital, but is there scope for ensuring that health staff are better able to identify care needs in the community and ensure that they are met? A central monitoring body could certainly help in ensuring that synergies of this kind are identified and addressed.

There remains the issue of the structure of the IJB itself. The current arrangements are a compromise – in my view an unsatisfactory compromise – between a model based on local democracy and a model based on expertise and continuity of leadership – in other words a quango.

The argument for a quango would be based on the need to attract, and then appoint, really senior people from the business world or the professions as Chairs and Board members, with appropriate skills and background, to lead an organisation with a hefty budget and very significant responsibilities for a substantial period – say 5 years. They would need to be paid sufficiently to attract people of high quality.

The argument for a democratic model would be based on the need for the leader(s) of such an organisation to be publicly accountable, and to be able to serve as the public voice for such important public services. Is it beyond possibility that IJB Chairs could be directly elected at the time of Council elections? Or would such a system run into opposition in the Scottish Parliament, given its reluctance to create powerful democratically elected posts at local level such as elected mayors?

In this blog I do not wish to express any preference between the quango model and the democratically elected model – but I do suggest that either would be preferable to the current arrangement.

The future

But I should not just stop there, because it is clear that, whatever model of management is adopted for community health and social care, additional resources will undoubtedly be needed as a result of an ageing population. The statistic which will remain with me as a result of my membership of the Edinburgh IJB is the estimate that Edinburgh will need a new 60-70 bed old people's care home – capital cost say £3m, running cost say £4m pa – every year for the next 20 years.

Failure to provide the resources needed across the spectrum of community health and care services will inevitably result in decline in the services provided – of which the increasing difficulty in obtaining a GP appointment is already evident. In that event families who can afford it will turn to private services and those who cannot will be increasingly dependent on the voluntary services who already provide substantial support to those in need

Are our politicians up for up for the challenges which the future holds in this area – and indeed in relation to public services generally? Public opinion surveys suggest that the general public recognise the need for greater expenditure on the NHS and care services. Of course, whether they are prepared to vote for the extra taxes or alternative funding models (yet to be devised) which that would mean is a different question entirely. And certainly our mainstream political parties, locked in their perpetual mutual blame game, are unlikely to test the public willingness to vote for more taxes. But their failure to do so – and the decline in public services which will result – may well lead to the public turning to more extreme parties of the left and right under the illusion – and of course it is an illusion – that their simple remedies will serve to solve very complex social and financial problems.

David Belfall was a senior civil servant at the Scottish Office/Executive between 1988 and 2002. David was Group Head responsible successively for Police and Fire Services, Health Policy and Public Health and Housing and Area Regeneration. Following retirement, among other things, he was a Non-Executive Member of NHS Lothian Board for 5 years. During his time with NHS Lothian, David was Chair of the North Edinburgh Community Health Partnership and then of the combined Edinburgh Community Health Partnership. He was a non-voting member of the Edinburgh Integration Joint Board for 7 months in 2024-25. He is writing in a personal capacity.

46. Reforming Health And Care In Scotland: Getting Strategy Right – Peter Williamson

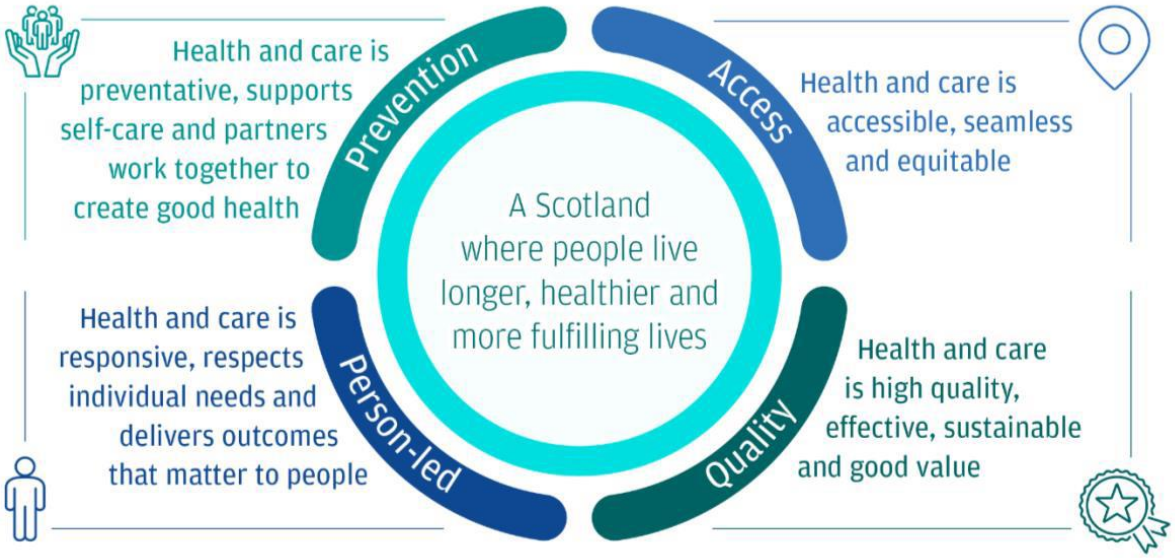
Originally published 21/08/2025

The following article considers critical limitations upon the development of strategies to take forward what many regard as much-needed reform to health and care services in Scotland. A second article will look at what might be done to address these constraints.

In its report on the NHS in Scotland in 2023, Audit Scotland (AS) noted that there was "a range of strategies, plans and policies in place for the future delivery of healthcare, but no overall vision. To shift from recovery to reform, the Scottish Government needs to lead on the development of a clear national strategy for health and social care." It was added that the "current absence of an overall vision makes longer-term planning more difficult for NHS boards."

The following year AS, in its report NHS in Scotland 2024, repeated its call for a national strategy for health and social care, but noted that that the Cabinet Secretary for NHS Recovery, Health and Social Care, Neil Gray, had by then described his overarching vision for health and care. This vision was of "a Scotland where people live longer, healthy and fulfilling lives", supported by four key areas of work – improving population health, a focus on prevention and early intervention, providing quality services, and maximising access. (See Figure 1.)

Figure 1: Health And Care Vision



The Cabinet Secretary was, according to AS, said to have been clear that no work would be undertaken to produce a strategy setting out how the Scottish Government intends to deliver this vision. Instead, it was argued that existing plans and strategies were already aligned to his vision. Mr Gray told the Scottish Parliament on June 4 2024 that "I am not looking to publish another strategy. Our work is already being guided by multiple plans, notably the National Clinical Strategy of 2016. Our task now centres on listening and delivery."

AS however argued that Gray's particular vision "is a restatement of the 2020 vision and is reliant on a number of the same delivery plans." AS viewed the 2020 vision not to have achieved its ambitions and was lacking "in significant operational detail in terms of how it will contribute to ensuring that services remain affordable." If this 2020 vision did not meet expectations of a strategy for AS, one has to recognise that the multiple use of the terms "strategies", "visions", "plans" and subsequently "frameworks" probably muddied the water as to what was actually under consideration.

That said, the Government did thereafter attempt to promote a renewed specification of its change agenda by producing in 2025 three plans for health and care. The first was an Operational Improvement Plan (March) which had been a direct recommendation from AS contained in The NHS in 2024. The second was a population health Framework covering the period 2025-2035 and the third a service renewal Framework for health and social care also covering the period 2025-2035. Interestingly, neither of these latter two was described as a strategy. Both plans were published in June 2025 and were jointly sponsored by Cosla. All three plans were to build upon the NHS Recovery Plan 2021-2026 and together were intended to realise the Health and Social Care Vision set out by the Cabinet Secretary in Parliament in June 2024, now in a more formalised version. Whatever the issues of nomenclature, clearly there had been a rethink on the need for strategic plans.

The foreword to the Operational Plan hinted at a reform agenda connected to the Government's wider ambitions for the NHS, but the Cabinet Secretary emphasised that this particular document "is focused on the short term." In reality what it does, drawing upon plans developed by NHS Boards, is bring forward pre-existing initiatives rather than adopting truly innovative changes. These initiatives are to be directed at improving access to treatment, shifting the balance of care, improving access to health and social care services through digital and technological innovation, and developing various prevention services. The Operational Plan is not really a reform document of any hue. Moreover, the total additional funds underpinning it represented about 2.4% of the total Health and Social Care budget for 2025-26, indicating the marginal nature of the potential changes. Instead, it has the hallmarks of a reactive response to pressing problems that over the years can be said to have displaced fundamental reform and underwritten continuing patterns of service provision.

The population health paper (Scotland's Population Health Framework 2025-2035) is committed to an unspecified improvement in Scottish life expectancy by 2035 whilst also reducing the life expectancy gap between the most deprived 20% of local areas and the national average. The Framework was supported by an evidence review (Scottish Government Population Health Framework: Evidence paper). The background to the Framework was that since the mid-2010s the long-term trend in increasing life expectancy had effectively stalled and then moved into reverse, mental health had deteriorated over the same period and health inequalities had grown. These setbacks were attributed to economic austerity and the existence of inequalities of income, wealth and power along with other adverse social circumstances such as poor housing and insecure work and "health harms" such as obesity and alcohol consumption. Improving the health of Scots and closing the health gap between "rich" and "poor" is said to require "macro-level policies" with an emphasis on primary prevention.

The case was being made – and not for the first time – that better health for all lay through significant socio-economic reform, although improvement in access to, and use of, health and care services was also said to be needed to address health inequalities. The supporting evidence paper did acknowledge that the current evidence base that could be translated into effective policy solutions is far from fully developed. Nonetheless, it was concluded that the evidence paper "outlined a range of measures and frameworks… which can form the basis of an effective prevention focused system."

The Population Health Framework does not amount to a concrete programme of policy actions. The Initial Actions set out in the Population Health Framework are very general and are preparatory in nature rather than directly pursuing new, innovative policy interventions. For example, one Initial Action is to "Develop a Healthcare Inequalities Action Plan". Another proposes that a "Health and Work Action Plan" is published. A third calls for an action to "Develop new approaches to resource allocation that support prevention across health and other public services."

Of course, improving the health of the population is by any standards a major public policy challenge, not helped by the state of the public finances. There is a multiplicity of social causes to poor health, the understanding of which is sometimes ambiguous because of the sheer complexity of the factors involved. Similarly, responsibility for the causes of, and answers to, ameliorating poor health lie with a myriad of organisations that makes matters of strategic influence and coordination by government exceedingly difficult. However, the sheer scale of preliminary work that still needs undertaken should raise concerns. There is a lot of catching up to do. It would seem – if improving the health of the population and reducing health differences are priorities – that in past years there has not been enough strategic development work in support of these ambitions.

The final one of the three plans is the Health & Social Care Service Renewal Framework 2025-2035. As the Cabinet Secretary told Parliament at its launch, it "sets out a clear path ensuring a sustainable, high-performing health and social care system that meets the future demands and evolving needs of our population" while also "ensuring long-term financial sustainability." At its core, however, the document is in effect another timetable for producing plans to bring about significant change over a ten-year period. There are few defined changes to health and care services contained within it, which gives an impression that the strategy for reform still requires significant development. The Framework is built around a list of Renewal Principles:

- Prevention Principle: Prevention across the continuum of care
- People Principle: Care designed around people rather than the "system" or "services"
- Community Principle: More care in the community rather than a hospital focused model
- Population Principle: Population planning, rather than along boundaries
- Digital Principle: Reflecting societal expectations and system needs [concerning both people's experience of care and making services modern, joined up and efficient].

These Principles are summarised in the document in terms of what they generally imply for services going forward, which is elaborated by some illustrative – admittedly selective – examples

of current services that demonstrate possibilities and by some lists of high-level service changes that will help to create the right conditions to align services with the Principles. The Framework also contains so-called enabling shifts in resources and finance and on how performance and outcome measures can be developed to assess whether progress against the desired changes is being made.

What is not there is a complete suite of service changes needed to reform health and social care. Indeed, this Renewal Framework explicitly highlights that the required range of changes to services will only become clear in years three and four of the 10-year timescale, and that the renewed health and social care system will not have all the components in place until subsequent years, although proven innovations will continue to be fast-tracked. There are some examples of interventions that have led or could lead to improvements. But overall the plan is a familiar repetition of the benefits of particular types of changes (e.g. prevention and early intervention, new models of hospital care and clinical benefits of high throughput) that does not elaborate upon how general principles can be converted into new, innovative interventions to realise the anticipated benefits. Instead, most of the document is taken up with stating what the ambitions are, not how they can be realised.

In 2019, AS called for the development of "a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed."

The Covid pandemic of course significantly got in the way of making progress with a health and care strategy, but the subsequent delay looks to be odd given that AS along with many other observers have been calling out for systematic reform of health and social care, particularly around financial sustainability. The Government looks slow off the mark, and does not have a cupboard full of fresh, effective interventions upon which to draw. This again suggests that strategic development for health has over many years not been given the attention needed.

These three plans raise questions about how well placed the Scottish Government is to set out the strategic changes that will bring about the reform to the health and care system that First Minister John Swinney outlined in a speech on January 27 2025, signalling a new effort to have a systematic approach to improving health care. As noted, the Operational Delivery Plan is not a strategic document but about short-term, marginal improvements. In this sense it runs counter to strategic change by using quick fixes that are ready and available – rather than contributing steps that are explicitly linked to longer-term strategic change. This seems a missed opportunity to kick-start fundamental reform.

The Population Health Framework and the Health and Social Care Renewal Plan were, however, a very different form of document, each with a decade-long timescale. However, neither were in fact strategies but what might be termed "pre-strategies" that contain a timetable for producing the different components that would form in due course a strategy. A proper strategy would require setting out actual interventions to deliver major reform of how the health and care system actually operates in practice and which as a result delivers significant improvement in the population's health and the health and care provision people receive. These plans will need to set out in some level of detail how resources will be acquired, organised and mobilised towards achieving

particular outcomes. This must go well beyond current policy rhetoric. The outcomes will have to incorporate measurable improvement to people's health and well-being in a variety of ways so that progress against strategic aims can be assessed and confirmed.

Certainly both documents are explicit that this will take time and that the full 10 years – and possibly more – will be needed for development and delivery. There is, however, a critical question that goes beyond the patience implied by this timeframe. Does the Scottish Government have the necessary strategic capability such that the health system in Scotland can be set on the path to real reform? Looking back, it is possible to reference ten or more plans since 1976 from the Scottish Office/Executive/Government that have included most of the strategic themes and ambitions contained in these two current Framework documents, especially regarding health and social care. Yet over those five decades these plans have never been seen to have resolved the strategic health challenges facing the country. Instead, each one is a revisiting of a familiar agenda. Each time, previous Scottish administrations simply appear to have gone around a familiar circuit without seriously considering and describing why things will be different this time to enable fundamental change to happen.

In a second piece I will explore in the Scottish context why developing health strategy is such a tale of woe and what might be done about it so that all the good ideas on health reform, including those from Enlighten's NHS2048 forum**,** can be translated into strategic changes that make a difference for the people of Scotland.

Peter Williamson taught and researched health care policy and management at Aberdeen Medical School, was a strategy director for NHS Boards, and led policy work on health and innovation for the Scottish Government.

Scottish Government/NHSScotland *Achieving Sustainable Quality In Scotland's Healthcare: A '20:20' Vision* (2011)

NHS Scotland *A Route Map to the 2020 Vision for Health and Social Care* (2013)

Scottish Government *A National Clinical Strategy For Scotland* (February 2016)

Audit Scotland *NHS in Scotland 2019* (October 2019)

Scottish Government *NHS Recovery Plan 2021-2026* (August 2021)

Audit Scotland *NHS in Scotland 2023* (February 2024)

Scottish Government Vision for health and social care: Health Secretary speech – Health Secretary

Neil Gray's opening speech to Scottish Parliament on 4 June 2024 (https://www.gov.scot/publications/health-secretary-opening-speech-vision-health-social-care/) (Accessed 28/07/25)

Audit Scotland NHS in Scotland 2024: Finance and performance (December 2024)
Scottish Government *An Operational Improvement Plan* (March 2025)

Scottish Government Strengthening Scotland's NHS: New plan to focus on delivery (Press Release) (31 March 2025). (https://www.gov.scot/news/strengthening-scotlands-nhs/) (Accessed 28/07/25)

Scottish Government-COSLA

Scotland's Population Health Framework 2025-2035 and *Population Health Framework: Evidence paper* (June 2025).

Scottish Government-COSLA *Health & Social Care Service Renewal Framework 2025-2035* (June 2025)

Scottish Parliament, Meeting of 17 June 2025, a statement by Neil Gray (Cabinet Secretary for

Health and Social Care) on delivering reform and renewal for health and social care.

Resource Allocation and Shifting the Balance of Care

47. Productivity and Value for Money in Integrated Health and Social Care- Dr Alastair Noble

Originally published 16/01/2024

Both Health and Social Care are service industries. This means that their main preoccupation should be the individual and their community. They are not there to bring glory to the service providers or temples to their grandeur!

If we accept that the clinical decision is the purchasing decision, we must look at the outcomes for each individual and the optimum pattern of care from each locality integrated team and their integrated relationship with specialist care – both in and in many ways more importantly out-back into their own community care team.

The major users of our service industry is care of the frail elderly and mostly in the last year of their life. The best example is a frail elderly woman and what we have found is where she is put at the centre of the care package and given the best local community care, she does best. This is supported by all the evidence from for example Torbay and all the Multi Agency Inspection for Services for Older People in Scotland (MAISOP)

Given the choice of being well supported in her own home, local nursing home, Community Hospital/Hospice or being the dreaded delayed discharge in a specialist bed or spending an extra 2-3 years in a nursing home it is no surprise that most individuals will choose the community-based model. Unfortunately, the model on offer in the big cities like Glasgow does not offer that choice. In Scotland we have a range of occupied bed days for the over 75 age group ranging from over 60% being in their own local GP led Community Hospital bed in Aberdeenshire to none in Glasgow. In simple terms where we have allowed the domination of the big teaching hospital e.g. The Queen Elizabeth we have not given the choice to the individual of what is seen to be best clinical care. They are forced to be the square peg in the round hole.

Covid has surely taught us that the big hospital model does not always work. The Italian Government's response to the failure of the big hospital model with Covid is to build 3-400 Community Hospitals.

What is best for Scotland going forward?

The best Scottish Traditions has always been based on productivity and value for money. There is ample experience that both private and public services can be well managed and run or alternatively badly managed and trade in insolvency/go broke!

So, this is not a sterile argument about Public or Private Ownership or Management – it is about putting the quality-of-care for each individual at the centre of the process and using locality based clinical and financial DATA to quality control care and as a big bonus give value for money.

"*Looking after old people well is better value than looking after them badly*" has long been the clarion call from Dr Colin Currie.

What then are the benefits I see in prioritising integrated Community Care including GP led Community beds in all localities in Scotland.

The first and most obvious is that it allows the individual person a choice with their integrated health and social care team to choose what is best option for them at this moment in time. It also allows that decision to change as necessary depending on the individuals current clinical need.

The second major benefit is to each locality in having properly trained, housed, equipped, and maintained community teams – with all the benefits that brings to each locality.

The third major benefit is to the specialist team who can then concentrate on what they do best. In all my discussion with many excellent consultants and GPs the simple main message is please keep them out of my specialist bed unless I, as a Specialist, have a specific role or treatment which will benefit them. As soon as that has been done, they should be moved back into the care of their Integrated Locality Based Community Team. It also means that the specialist hospital will have no blocked beds. This allows for maximum efficiency in elective care in the specialist setting.

The fourth benefit is around this rather "annoying problem" that very few of these elderly patients are only suffering from one specialist condition. The evidence is all in favour of continuity of care. The better the community care team is – the more confidence the individual, their family and their locality has in that team – the better the outcomes will be. As an added bonus the Consultant Team will be even more confident in transferring the patients care back to an excellent locality team.

The fifth benefit is around recognising and supporting the essential difference between the "Generalist " and "Specialist". We need both but a massive mistake has been in trying to staff "specialist " units when there is not the total infrastructure available on the site. This means we will have a lot more community based team and fewer, but properly staffed and functioning, "specialist" units doing the job they are trained and equipped to do. It also means a lot more "generalists " in all professions.

The sixth benefit will be in educating and training the workforce for all the professions. You cannot train generalist in a specialist unit. All professionals will benefit from training in both.

The seventh benefit will be to social and home care staff. They will be seen as essential and equal members of the same Integrated Team. This will mean better pay and working conditions for them.

Lastly on the thorny issue of mean's testing – all the evidence I have seen would support the position that within the existing Fair Share Health and Social Care Budgets we can afford this Integrated Model of Care. It means each locality would receive their Fair Share Budget and would have to stay within that budget. It clearly means fewer staff working in "specialist" care and more working in "generalist "care. This is exactly what all our need's assessment tells us is optimal care. If clinically and financially it is best for the individual and our communities, then we can afford it. There is no doubt in my mind that we are wasting a lot of money in areas such as delayed discharges in "specialist" beds and underfunding community and social care. Value for money means exactly that – we make sure we manage the whole system for what is clinically best for each patient. The fairest way of paying for health and social care is by taxation. In committing to

continuing that model we must optimise the correct clinical care for each individual, prioritise Integrated Community Teams and make optimum use of Specialist Care.

To echo Professor Gray and Enlighten's position – now is not just the time for a National Conversation it is the time to deliver the best health and social care in the world to our Scottish population.

Dr Alastair Noble worked as a GP in Nairn and was awarded an MBE for his work in integrating Health and Social Care in Nairnshire

48. Restore the Balance Between General Practice and Hospital Care – Professor Philip Wilson

Originally published 13/02/2024

The massive increase in expenditure on the NHS in Scotland since 2012 (27% in real terms) has been accompanied by a fall in life expectancy. Population aging does not explain the size of the increase in funding over time. The NHS is not working well, and money is being wasted.

NHS spending is mainly directed towards hospital care, and it has increased dramatically. In contrast, expenditure in general practice has remained static (at best), so there has been a relative decline in expenditure on general practice, where over 90% of patient contacts take place and which is subject to the same demographic pressures as the NHS as a whole. General practice spending as a proportion of the overall NHS budget was 9.8% in 2008, 7.8% in 2013 and 6.25% in 2021.

It is important to distinguish the terms 'general practice' and 'primary care', although the terms are often conflated by politicians. Most general practices in Scotland are still run by 'independent contractor' GP partners who provide a broad-ranging set of services through their contracts with Health Boards. Practices in the UK hold comprehensive, lifelong medical records for everyone registered with them and so hold the key to a holistic picture of patients' health. In recent years, many practices been unable to recruit new partners and so have handed their contracts, and the keys to their surgeries, back to the Health Boards. This has dramatically increased costs to the health service because Boards, in general, do not run community-based services well. Not only are these Health-Board run practices expensive, often employing highly paid short-term locum staff, but publicly available data on patient experience show that their patients are much less satisfied with their services – probably because, as the surveys show, they are much less likely to provide personal continuity of care. There is a large body of evidence that continuity of care is associated with better outcomes for patients. Perhaps equally importantly, independent contractors, unlike NHS employees, are able to speak out publicly in advocating for their patients and to hold the NHS to account when things go wrong.

'Primary care' consists of all the other community services provided and managed by NHS Boards – district nursing, health visiting, physiotherapy etc., plus the pharmacists, dentists and optometrists who are also generally independent contractors.

Since 2004, there has been a progressive disempowerment and atomisation of general practice. Out-of-hours services, antenatal care and preventive child health services were transferred to Health Boards in 2004, while immunisation and hospital-recommended tests were lost in 2018 – and many more aspects of general practice are going to be run by Boards in the near future. As with immunisation, this will almost certainly be at much greater cost, much more inconvenience to patients and will deliver poorer outcomes. General practitioners are losing their power to coordinate services for their patients – and adequate funding for GP services would have prevented this.

There are several explanations for the failure of general practice funding to keep up with overall NHS expenditure and it brings serious consequences for the smooth running of the health service. First, politicians and the media constantly demand increasing numbers of nurses and doctors in hospitals, increased installation of cutting edge technology ('scanners' seem to be a particularly attractive suggestion) as the solution to the dire state of the NHS. It is very rare to hear similar demands for expenditure on primary care, and this situation has become a self-fulfilling prophecy. Second, doctors' organisations (particularly the BMA) are much more likely to make loud and effective demands for funding of hospitals rather than primary care. This is in part because there are now twice as many hospital doctors as there are GPs, compared to roughly equal numbers 30 years ago, and their voices are louder. Third, hospital medical staffing has become bloated through an inexorable tendency towards super-specialisation. When I began my career as a GP in the late 1980s, every hospital had at least one general physician and a general surgeon. These tended to be the most senior members of their professional groups and they were an invaluable resource to the GP in sorting out the best way to deal with more complex cases. These generalists have now all but disappeared apart from a handful in our few rural general hospitals, while many hospital departments have seen a doubling or tripling of consultant numbers while waiting lists continue to increase. One result of increasing hospital specialisation is that increasing numbers of referrals are rejected, leading to more work for the GP and inconvenience (at best) for the patient. Paradoxically, every new consultant post leads to increasing work for their GP colleagues and to a general increase in referral activity. Fourth, general practice has become a less attractive career choice for young doctors – it was not uncommon there to be a hundred applicants for GP partnerships in the 1990s, and now it is more common for there to be none at all. It has become increasingly difficult for GPs to act as effective advocates in the NHS and to practice holistic care.

One important consequence of super-specialisation is a potentially disproportionate focus on individual pathologies, and a holistic approach is easily lost. One consequence is that far too many patients are subjected to futile and hugely expensive treatments at the end of life, which might extend their lives by a week or two but often decreases the quality of those lives. A previous Chief Medical Officer, Catherine Calderwood, made the astute observation that most doctors would themselves choose to have less treatment than they feel obliged to recommend to patients.

What are the potential solutions for this situation where we are pouring more and more money into a health service which is delivering less and less effective and compassionate care?

First, we need to stop increasing the funding for hospital care and ensure that future developments deliver more efficiency. This should involve a rolling back of the tendency towards increasingly specialised silos which do not communicate well with each other. Second, we need to transfer funds from the hospital sector to general practice and other community care services such as district nursing and health visiting. Third, we need to celebrate and support generalism, both in general practice itself and in hospitals. It is easy to fall into the trap of thinking that specialists always deliver better care than generalists – this may be true for individual technical procedures but it is too easy to forget the person behind the pathology being treated. Fourth, we need to renew a commitment to independence and continuity of care in general practice. This will require a re-jigging of contracts in favour of partnership rather than locum or salaried work which currently pays better. Finally, we need to take a long, hard look at how to assess when medical

treatments are futile and to be more honest with patients. Much NHS expenditure takes place in the last few months of life and resources might be better used in keeping people healthy in the first place.

Philip Wilson is a retired GP and Professor emeritus of primary care and rural health, University of Aberdeen

49. Gain with Least Pain: Using Economics Thinking to Advance Population Health in a Budget-Neutral World – Cam Donaldson & Alastair Noble

Originally published 08/05/2024

Gain with least pain: using economics thinking to advance population health in a budget-neutral world

Almost since the inception of the NHS, there have been debates about its sustainability as well about how to set priorities across the competing claims on its limited resources. Often unrecognised is that these two issues are linked. The sustainability of a publicly-funded NHS (and social care) might require more resources to be allocated to it, but it also requires us to do better with the resources we have. The latter becomes even more important when the options with respect to the former are limited: as they are currently, and seem to be no matter the colour of government going forward.

Managing scarcity: the basic economic principles

At any point in time, health boards or integration joint boards (IJBs) will be faced with a given mix if resources. Although the nature of claims on such resources are changing all the time, a constant feature is that such claims will be greater than the total resource available. This requires us to think about changing the given mix of resources to better meet the needs, or claims, with which we are faced. Choice is inevitable – this is 'managing scarcity'.

To help manage scarcity, two key economic concepts can be brought to bear. The first is 'opportunity cost' which represents the benefit forgone in the next best alternative use of any given pot of resources. The implication of opportunity cost is that we need to be able to measure the resource inputs (or costs, as well as any cost savings) and benefits (e.g. well-being) associated with alternative claims on resources. This information allows to spend our budget in the best way possible; maximising well-being and, conversely, minimising well-being forgone. But, with such measurement being hard to achieve for everything, this brings us to second economic principle, that of the margin, or marginal analysis. The margin is concerned with change, which is almost always the focus of policy and planning. Questions of resource allocation will normally involve addressing issues such as: should we *expand* services for older people? Should there be *fewer* hospital places for people with mental illness? Should the number of hysterectomies be *increased/decreased*? These are all *questions of change*, leading us to think about marginal costs and marginal benefits. It is comparison of these (cost and benefits at the margin) that can lead us decide on which changes in services should be implemented.

Operationalising the management of scarcity

Please note that word 'margin' should not be equated with small. Changes examined can be large or small. The notions of opportunity cost and the margin are often operationalised through asking five questions about resource use as follows:

1. What resources do we have available in total?
2. How are those resources currently used?
3. What would we like to do more of and what would be the implications of these in terms of resources required and improved outcomes?
4. Are there areas of care which can be provided to the same level of outcome but with less resources?
5. If not, are there areas of care which, despite being effective, provide less outcomes than some items on our 'wish list' in 3.?

The first two steps are commonly known as *programme budgeting* and are based on the logic of 'how can we know what to change if we do not know where are currently?'.

Questions 3-5 are the basis of *marginal analysis*. The logic of programme budgeting and marginal analysis (PBMA) can be applied at any level of the health and social care system where resource scarcity exists and choices have to be made. This may be across a whole health board or IJB (often referred to as 'macro PBMA') or within a programme (often defined by disease [e.g. diabetes] or demography [services for frail older people]). Indeed, we have worked with this framework since the mid-1990s when using it to plan for chronic disease management in a general practice in the Highlands.[1]

PBMA: a route out of the stalemate of budget-neutrality

Many reviews of service areas get stuck around question 3; that is, they know what they want to do more of in order to address unmet needs, but are unable to implement change because they do not think they have the resources. Disillusion often sets in. But, if we can address technical efficiency (question 4) and even allocative efficiency (question 5), we then have the freedom to consider how all resources are currently used and whether some things should be given up in order to do more of others.

So, we now have a way forward out of the perceived stalemate of not being able to do anything without extra money. It is also important to note that costs and resources are often thought about in monetary terms. But money is hard to free up in health care systems. If we become more efficient, it just allows the system to do more, rather than allowing us to take money out of one part of the system and plug it in elsewhere. Since working together in the early 1990s, we have promoted the use of PBMA thinking as useful for any resource allocation discussion.[2] Detailed guidance is available for how to work through the five questions above.[3]

Take, for example, our biggest resource; staff. The key from PBMA thinking is not how much our staff cost (or in monetary terms) but, rather, to ensure that our workforce is working to deliver the right clinical outcomes.

PBMA thinking can be brought to bear on big questions such as:

- in the complicated area of Integrated Community Care, might more home carers or social workers produce better clinical care and outcomes than, say, A&E consultants or nurses looking after delayed discharges in a secondary care setting, especially when

we know that, despite expanded numbers of such consultants, no improvements in the 4-hour target have been observed (which, it could be argued is problematic in and of itself)?
- do we need Geriatricians to look after these delayed discharge patients or will we deliver better clinical care if we have more general practitioners?

Most of these patients should be being looked after by the extended primary care team. Variations across Scotland show this. We know that general practitioners look after over 60% of the occupied bed days for over-75s' medical admissions in their Community Hospitals in Aberdeenshire; yet in Glasgow they are all under consultant care, mainly geriatricians. The DATA, especially MAISOP (Multi agency inspection of services for older people), all support the view that the Aberdeenshire clinical care produces better outcomes than the Glasgow Model. This is just one of several examples of achieving equivalent (or improved) outcomes alongside potential resource savings which could be put towards meeting currently-unmet needs.

Such questions extend beyond delayed discharges and care of older people. For example, publicly-available data in Scotland allow us to ask:

- if, in one hospital in Scotland, four orthopaedic surgeons were undertaking 1600 hip replacements per annum in 2006, why now are 20 orthopaedic surgeons in the same hospital delivering a similar number per annum?
- why are obstetricians in some locations required to look after low-risk pregnancies and is this associated with unwarranted rates of caesarean section deliveries in those same locations?

Of course, resolution of such issues would require decisions about relative workforce to be made over time in order to achieve a better 'balance of care' model; a model of integrated care more suitable to addressing key modern issue of managing chronic diseases closer to home. One such model was recently outlined in this series.[4] Nevertheless to facilitate such a model, it should be possible to move some staff around the system or cease recruitment of some to employ more of others. At least, that's what the theory of integrated care tells us.

Using PBMA at the local level

In such integrated care models, we might begin to ask, if we take 100 nurses or doctors or allied health professionals, are we sure they are all doing the right clinical activity? For example, it is hard to understand how we can take a system like Nairn Healthcare, with immunisation rates in the high-90%s, with well-trained nursing and secretarial support, good premises and capable of delivering over 800 Covid Vaccinations in a day and watch the vaccination rates fall to the low 80% and not worry about the quality of our decision making.[5]

The use of PBMA would also help to us to understand where the Specialist Model fails, as in some of the examples above. Taking the maxim of "which bed did you sleep in last night?" as a guide to where we might want to get to, we can see which communities are delivering quality integrated care and which are not, especially in the over 75 age group. This group represents our largest area of spending in health and social care, many of whom will be in the last year of their life. Previously-collected data, referred to as (Multi Agency Inspection of Services for Older People – MAISOP)

clearly identified variations in practice throughout Scotland. Continuing this work in in Perth & Kinross, using linked data, we identified that using which-bed-did-you-sleep-in-last-night on a defined locality basis (for this purpose, GP clusters) highlighted important variations in patterns of clinical care. There were no clinical reasons for this, such patterns often representing historic use of existing buildings.

Which-bed-did-you sleep-in is really a form of PBMA (without the money) as it is really about trying to identify the best 'balance of care'. The best outcomes are where there is high-quality integrated community care – see Box 1 for what this means in terms of balance of care. The poorest are where there are high numbers of delayed discharges or people spending longer than needed in nursing homes. We know 2% of patients take up 79% of occupied bed days (OBDs) and that we have around 1600 OBDs due to delayed discharges. That is equivalent to filling two District General Hospitals (out of roughly 20 in Scotland) with patients who will be better looked after in a community setting. Using PBMA thinking each community could look at where they are now with respect to 'which bed you slept in last night?' and what this means for resource spending, and, from that, map out a better balance of care and plan for how to get there. To an extent, this would allow us to move away from finance and austerity as the excuses for avoiding change to how best to train and retain staff doing the right job in the right place with the right patients. It may seem simplistic, but thinking about resource re-allocations to bring people closer to home brings into play £1b currently spent on unproductive delayed discharges.[2] Returning to the issue of sustainability, if we can do this, then we minimise the most difficult choices, reducing opportunity costs, so maintaining belief in and support for publicly-funded systems.

Cam Donaldson, PhD FRSE Yunus Chair & Distinguished Professor of Health Economics, Yunus Centre for Social Business & Health, Glasgow Caledonian University, UK; Professor of Health Economics, National Centre for Epidemiology & Public Health, Australian National University, Australia.

Dr Alastair L. Noble, MBChB MBE retired General Practitioner, Nairn, UK.

References

1. Scott A, Currie S, Donaldson C. Evaluating innovation in general practice: A pragmatic framework using programme budgeting and marginal analysis. *Family Practice* 1998; 15:216-222.
2. Donaldson C, Knight P, Noble A, Strathearn S. Health and social care integration in Scotland: evidence versus rhetoric. *International Journal of Integrated Care* 2024; 24 (1): 4, 1-4 (DOI: https://doi. org/10.5334/ijic.7759).
3. Mitton C, Donaldson C. *Priority Setting Toolkit: a Practical Guide to the Use of Economics in Health Care Decision Making*. BMJ Books, London, 2004.
4. Marr G. Through recovery to reform. Enlighten (www.enlighten.scot), 10th April 2024.
5. https://www.enlighten.scot/2024/02/vaccinations-the-real-risk-of-not-prioritising-quality-clinical-care-dr-alastair-noble/

50. The Equity and Efficiency of a Free NHS – Cam Donaldson

Originally published 22/05/2024

Just last week, Neil Gray, Cabinet Secretary for NHS Recovery, Health and Social Care in Scotland, stated that he is "open to ideas" about NHS reform whilst vowing that the service would, nevertheless, remain free at point of delivery. I agree with this direction of travel. But it does leave open questions as to the funding basis for the system and whether, if continuing to fund it via taxation, is there any role for other funding sources that proponents might describe as supplemental to the basic system; these being user charges and private insurance, often innocently-promoted as helping to relieve pressure on the NHS and, hence the taxpayer. Social insurance, too, is often touted as an alternative to taxation and could still involve care being free at the point of delivery.

So, let's unpack this by (re)stating what most health economists would see as a settled case, that a publicly-financed health care system is not only more equitable but also efficient. This is a lesson that has been learned in almost all advanced economies of the world. The case stems from the economic notion of 'market failure', the elements of which were first brought together by the great Canadian economist, Robert Evans[1], reinforced by others over the years.[2-4]

Before proceeding, there is obviously a valid (equity-based) humanitarian case for a free NHS. However, it is interesting that this case does not necessarily stretch to other commodities, such as food, for which, it could be argued, access is even more of a fundamental human right than access to health care. Yet we do not have a National Food Service. Apart from income supplementation on the demand side and regulation of standards on the supply side, this fundamental commodity can be provided adequately largely through market forces. So, are their additional things about the nature of health care as a 'commodity' that makes it different?

Market failure and the nature of the commodity, health care

In most advanced economies, public funding of health care dominates. In the table below, this is portrayed for some comparable countries, showing also that this phenomenon is sustained over time. Some of the recent dominance of public sources of funding lies with the COVID-19 pandemic. But, more generally, the explanation lies in the following three sources of market failure.

Table: Total health expenditure in current $PPP (and % of total which is public), 1990 and 2022

	1990		2022	
Country	Per capita total expenditure on health care	% of health care spend from public purse	Per capita total expenditure on health care	% of health care spend from public purse
Australia	1663	46	6372	72
Canada	1670	76	6319	71
France	1459	76	6105	92
Germany	1724	75	7518	92
UK	783	84	5466	83
US	2685	40	12197	87

$PPP is simply a form of currency conversion making spends across countries more easily comparable. The percentage calculations are for government/compulsory schemes relative to *all* spending.

Source: Organisation for Economic Cooperation & Development: www.oecd.org

The failure of insurance

Without government intervention, an insurance market would develop to deal with unpredictable health care needs. However, with financial risks mitigated by insurance, costs may receive less emphasis in the decisions of consumers and providers. Indeed, this 'moral hazard' is at the root of the continuing challenge of cost inflation in US health care, exacerbated by administrative costs (of billing and advertising) which further inflate premiums; pricing people out of the market who otherwise would have insured. Several academic papers, notably those of Steffie Woolhandler and David Himmelstein[5,6], have shown that around 30 percent of US health expenditure is spent on administration, twice that of the public system in Canada. It costs a lot to administer the market.

These problems exist in public systems too. But government funding and supply-side controls (limiting human and capital resource) make it easier to keep a lid on costs, despite tensions in controlling some parts of the budget (e.g. pharmaceutical costs).

Lack of consumer knowledge

Markets work well when consumers are well informed, which is not the case in health care. In health care, consumers are protected in terms of quality through (rightly) granting license to practice to professionals with the qualifications to do so. But this inadvertently grants market power to professions, especially physicians, which requires what Evans has referred to as 'countervailing power' of government; to negotiate with professions over pay and levels of provision.[7]

Markets don't care; but people do

Insurance also excludes the less-well-off and neediest. If we think about it, a well-functioning insurance market will tailor lower premiums to those at low risk and higher premiums to those at higher risk. In health, those at higher risk tend to be less-well-off, and unable to afford cover. This is termed 'adverse selection' in the sense that those in most need end up facing the highest, and often prohibitive, premiums. Inequalities are further exacerbated in that, with the wealthier now selected into their own part of the market, higher-quality, hotel-like services can be tailored towards them due to their willingness and ability to pay. Although, as indicated above, these outcomes may be thought merely to be the product of a well-functioning market, these types of 'adverse selection' count as market failure because people care enough about them to be willing to transfer resources from the rich and more-healthy to the poor and less-healthy; something which markets, with their focus on individuals acting on their own behalf, fail to do and which charitable and philanthropic endeavours cannot come close to making up for.

This 'caring externality' is why governments intervene in food markets too. But failures there are not comprehensive enough to warrant going further; in short, food needs are more predictable and, generally, consumers know what they like. It could also be argued that societies could deal

with caring through public 'safety nets', such as Medicare and the Medicaid systems for vulnerable groups in the US. However, at least pre-Obamacare, this still left around one in six people in the US inadequately insured with multiple tiers of access to health care of variable quality. Even with Obamacare, what the US has still not learned is that taxation is the most effective way to achieve the transfers necessary to ensure 100% coverage of its population for health care and keep administration costs down. Despite the (apparent) startling change in the percentage of health care which is public, much of this is still achieved through private insurance schemes; hopefully reflecting the that the US is still on a journey towards the greater fairness and efficiency achieved in many other advanced economies.

It's the comprehensiveness of market failure!

The key point is that, although many readers will recognise aspects of market failure in other goods, there is no good for which market failure is as comprehensive as in health care. It is all of these aspects occurring together that make extensive government intervention in health care, in our case in the form of an NHS, not only more equitable but also more efficient.

Can we help the NHS with supplemental or alternative sources of funds?

Why not user charges?

A naïve observer would say that user charges could help control costs or reduce frivolous demands on the NHS. However, evidence of frivolous use by patients is hard to come by. What the evidence does show is that charges reduce demand only amongst the poor (and less healthy), have been shown not to discriminate between needed and unneeded care and do not control total costs anyway (as the system simply switches its care-giving powers to those willing and able to pay or those put-off by charges present with more-costly ailments later). This then creates a system with widening inequalities in quantity and quality of provision, much as we see when a large proportion of funding of the care system is based on such charges. Exemptions are possible, but, then, add administrative costs (of billing and collection of funds) whilst counteracting the original arguments for charges in the first place; as the exempt can access care as before whilst the non-exempt can likely afford to aswell.

Why not supplemental health insurance?

Supplementary health insurance is often promoted as having the ability relive pressure on the NHS. Again, there is very little evidence to back this up. Most of the evidence shows the impact to be detrimental with respect to waiting lists in the public part of the system. The reasons for this are quite obvious. At any one point in time, there are only so many doctors available to provide treatment. If their attention is diverted to the private part of the system this has to be at the expense of the public part. Likely, too, patients left in the public part of the system will be in greater need of care.

Why not social insurance?

We now know that continuous health care reform, often intended to promote greater market discipline, and a constant feature of the NHS throughout its existence, has led to little gain at the cost of significant disruption.[4,8] So, too, I would predict, with the oft-lauded switch to the social

insurance systems of some of our neighbouring countries. The above table gives a clue as to why such systems might seem to do better than here in the UK; they spend significantly more. This also gives them capacity to focus more on care out of hospital and in general practice; things that have been eroded here and could be restored without much disruption.

Conclusion

There are many in government, who, as with other goods once thought to be the preserve of public financing and provision, would divest themselves of the NHS if they could. The reasons they cannot are due to the nature of health care as a commodity. As early as 1952, the UK Government proposed an enquiry into the cost of the NHS, with a view to dismantling it. This backfired when the subsequent Guillebaud Report of 1956 declared the NHS as value for money. Despite all health care systems being different in terms of their public-private mix of financing, it is the similarities that are striking; universal coverage is sought and 'insurance' is based on groups rather than private, individual transactions. An added benefit of this is that, by everyone being locked in together, more vulnerable and needier groups benefit from the drive towards higher standards demanded by the vocal middle class, who might otherwise vote for permission to opt out. Rather unusually in this modern world, the key to paying for a better health care system is compulsion not freedom. The lesson that publicly-funded health care is more efficient as well as more equitable has been learned by all countries as they seek to move towards Universal Health Coverage, continuously promoted by the World Health organisation since 1948 and reflected in the Table above.[10] Aneurin Bevan promoted the establishment of the NHS 'in place of fear' of financial ruin amongst those unfortunate enough to fall sick.[11] He was concerned with fairness and equity. Hopefully, the arguments presented here also show that our current approach to funding the NHS, through taxation, is also more efficient than any alternative. All is not rosy in the NHS, but that would be the subject of another blog! However, recent LSE-Lancet Commission on the Future of the NHS has shown that modest increases in taxation are the best way to ensure its sustainability (along with social care) going forward.[12] Alongside the challenges of alternatives and to avoid the continuation, indeed spiralling, of our current NHS crisis, our politicians just need to find the courage to explain the virtues of this to the public.

Cam Donaldson PhD FRSE is the Yunus Chair & Distinguished Professor of Health Economics at Glasgow Caledonian University and Professor of Health Economics at Australian National University

References

1. Evans RG, Strained Mercy: the Economics of Canadian Health Care. Butterworth, Toronto, 1984.
2. Donaldson C, Gerard K. Economics of Health Care Financing: The Visible Hand. Macmillan, London, 1993.
3. Donaldson C and Gerard K (with Mitton C, Jan S and Wiseman V). Economics of Health Care Financing: The Visible Hand (2nd edition). Palgrave/Macmillan, London, 2005.
4. Donaldson C. Credit Crunch Health Care: How economics can save our publicly-funded health services. Policy Press, Bristol, 2011.

5. Woolhandler S and Himmelstein DU. The deteriorating administrative efficiency of the U.S. health care system. New England Journal of Medicine 1991; 324: 1253-1258.
6. Woolhandler S, Campbell T and Himmelstein DU. Cost of health care administration in the United States and Canada. New England Journal of Medicine 2003; 349: 768-775.
7. Evans RG. Going for the gold: the redistributive agenda behind market-based health care reform. Journal of Health Politics, Policy and Law 1997; 22: 427-465.
8. Maynard A and Bloor K, Introducing a market to the United Kingdom's National Health Service. New England Journal of Medicine 1996; 334: 604-608.
9. Donaldson C and Bryan S. Compulsion: the key to successful US health care reform. Journal of Health Services Research and Policy 2012; 17(2): 106-9.
10. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
11. Bevan A. In Place of Fear. William Heinemann, 1952.
12. Anderson M, Pitchforth E, Asaria M, Brayne C, Casadei B, Charlesworth A, Coulter A, Franklin BD, Donaldson C, Drummond M, Dunnell KH, Foster M, Hussey R, Johnson P, Knapp M, Lavery G, Longley M, Macleod Clark J, Majeed A, McKee M, Newton J, O'Neill C, Raine R, Richards M, Smith P, Sheikh A, Street A, Taylor D, Watt R, Woods M, Johnston Webber C, McGuire A, Mossialos E. The Future of the NHS: re-laying the foundations in a post COVID-19 world. The Lancet 2021; 397: 1915-78 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00232-4/fulltext).
13. Charlesworth A, Anderson M, Donaldson C, Johnson P, Knapp M, McGuire A, McKee M, Mossialios E, Smith P, Street A, Woods M. The Future of the NHS: What is the right level of spending needed for health and care in the UK? The Lancet 2021; 397: 2012-22 (https:/doi.org/10.1016/S0140-6736(21)00230-0).

51. Social Impact Bonds for Health: Free Money, Mirage or Somewhere In-Between – Neil McHugh, Olga Biosca & Cam Donaldson

Originally published 19/06/2024

Governments across the globe harbour genuine concern with the optics of asking the public to pay more taxes after (and during) a cost-of-living crisis. This situation of fiscal tightness has persisted longer; effectively since the advent of the 2008 financial crisis, with previous governments stating "I'm afraid there is no money" to their successors. But, with many of our public services in disarray, how do we square the circle of giving the public what they need (and want) from such services without allowing those willing and able to pay to opt for the excesses of the free market whilst some remain stuck in what would eventually become sub-standard publicly-funded care? The latter will only lead to greater inequity and unrest and also inefficiencies associated with subsequent multi-tiers of service provision that would emerge. Note the expensive, and no more effective, US health care system.

Thus, with politicians looking for innovative ways to fund our public services, we undertook a thorough review of the conceptual basis and evidence of two possible sources of 'social finance' – in our case, in the context of health – that have become popular since the 2008 crisis[1]. The two sources are social impact bonds and microfinance, the latter of which will be the subject of a separate blog. So, what is a social impact bond and does this offer our communities the solutions they want in terms of fair financing of an efficient National Health Service?

Social impact bonds: the rhetoric

The financial crisis of 2008 led to widespread conversation about "the need to do things differently". Questions arose to whether some dormant banking funds could be put towards more social uses whilst, at the same time, injecting more of a business culture into funding and performance of public services – surely a win-win? More public-private partnerships would be created to drive forward innovation in addressing social challenges more efficiently as contracts established would be outcomes-focused and performance-based.

Essentially all this is achieved via the creation of a social impact bond whereby a service provider, seeking to expand current services or create something new, strikes a deal with a funder that involves:

- Money being paid upfront by a third-party investor;
- Funds flowing, via an intermediary, to providers of the specified service;
- Provision of such funds being tied to goals related, in the health sphere, to health outcomes achieved or improved access for, say, harder-to-reach groups;

- In the event of goals being reached, payments being triggered from the public funder back to the investor, via the intermediary.

As well as already-stated advantages of being outcomes-focused, social impact bonds, at least in theory, attract money into service developments quicker and transfer the burden of risk to the investor. If the investment fails, the investor loses their money.

What's not to like? Only very recently, former UK Prime Minister, Gordon Brown, has proposed a social impact bond for expansion of children's services, especially for those in the most austere circumstances – a revitalisation of the earlier approach.[2] His case is built partly on what he claims as the "worldwide success" of social impact bonds.

Social impact bonds: the reality

In reality, there are several challenges associated with such bonds. First, despite the argument for getting money into service developments quicker, social impact bonds are administratively burdensome to negotiate and set up. Furthermore, even if the cash does arrive quicker it is not 'free money'. If the specified goals are achieved, the money has to be paid back by the public funder who, as ever, will be operating under constraints of whatever government finances have been allocated to them. This has similar alarm bells to the Private Finance Initiative (PFI), brought in to finance capital developments in the NHS (and elsewhere) whilst keeping the public debt down, but which often tied service providers into quite draconian payback terms which would have been more efficient to fund through public borrowing.[3] At least with social impact bonds, failure to meet objectives means that the investor takes the risk of losing their money. This seems slightly better than PFI.

This brings us on neatly to the specification of outcomes. In health research, the term 'outcome' is a statistical concept in the sense that much research tells us what works on average; but with variation around it. 'Outcomes' are not deterministic. It is difficult to establish contracts on such bases. Furthermore, there may be incentives to go for safe bets in terms of what can be achieved when it is the more-difficult problems in health care that we wish to crack, e.g. how to reduce health inequalities by tailoring services to hard-to-reach groups. Going for safe bets will distort priorities.

Finally, there is the question of what happens 'beyond the bond'. In the event of success, what happens once the loan is paid back? In the event of failure, will future such investments be disincentivised? Is this a long-term, sustainable funding mechanism for our health care systems?

To the left, to the right. Ideologically-neutral or commodifying health?

One of the claimed advantages of social impact bonds is that they appeal across the political spectrum. To the left, services remain publicly-funded; the timings and risk-bearing associated with such financial flows are just different. To the right, an element of market discipline is instilled into service development within our publicly-funded systems.

The counters to this are, however, that it is ironic that after talk of "the need to do things differently" the very market 'discipline' that led to the 2008 financial crisis should be promoted as the basis of social impact bonds. Going further, such bonds might also be seen as commodifying (and making money from) social vulnerability.

What does the evidence say?

In our book, we have outlined how we identified 58 'health impact bonds' across the world, which we characterise by country, different health and non-health domains (physical health and housing, respectively, being the most popular in each domain, followed by mental and reproductive health and then very few in other areas such as criminal justice or infectious diseases), with more details provided on the nature of specific interventions funded and the outcome measures used.[1]

The key findings are that, with only 58 bonds identified, this is not something that is proving to be as transformational as had been hoped, so far, which somewhat dampens claims to "worldwide success". More seriously, just under a half of the bonds are targeted on health outcomes, either alone or in combination with some other indicator such as risk- factor reductions or service coverage. This is likely due to the difficulties alluded to above with pinning down precisely what the outcome(s) should be in any particular context.

These challenges have been taken on by one of the first health impact bonds in the UK – the 'Ways to Wellness' initiative in Newcastle upon Tyne. The first six years of experience of Ways to Wellness have been reported[4], and refers to a detailed evaluation, led by researchers at Newcastle and Durham Universities and funded by the National Institute of Health Research, but yet to be reported upon. The case, too, has been made for similar initiatives in Scotland.[5]

Where now for health impact bonds?

Safe to say that health impact bonds have not been as transformational as might have been hoped for since social finance came into greater vogue post-2008. Also, they are not the gift horse that they may initially seem. In the event of success, the money has to be paid back and what happens beyond-the-bond is not entirely clear.

Most crucially, failure to tie most bonds to health outcomes does, to an extent, call their legitimacy into question. Our (perhaps academic) conclusion, and following the Newcastle model partnering initiatives and research, is that more of such research is required on how to better make this tie, so evaluating social impact bonds on basis of the outcomes they seek to promote.

Neil McHugh PhD is from the Yunus Centre for Social Business & Health at Glasgow Caledonian University. Professor Olga Biosca PhD is from the Yunus Centre for Social Business & Health at Glasgow Caledonian University. Cam Donaldson PhD FRSE is the Yunus Chair & Distinguished Professor of Health Economics at Glasgow Caledonian University and Professor of Health Economics at the National Centre for Epidemiology & Public Health at Australian National University.

References

1. McHugh N, Biosca O, Donaldson C (2024) Social Finance and Health. Routledge, Abingdon, Oxon.
2. Brown G (2024) Millions of British children born since 2010 have only known poverty. My £3b plan would give them hope. Guardian, 15th April.
3. Pollock AM (2006) NHS PLC: the Privatisation of Our Health Care. Verso Books, London.
4. Case T, Drinkwater C, Moffatt S, Bromhead S (2021) Ways to Wellness, the First Six Years: Approach, Findings and Learning. WTW-Publication-Digital-with+links.pdf (squarespace.com)
5. Marr I (2024) Preventative health care social impact investing. Enlighten 9th January.

52. Universal Cover: Lessons from Australia – Gerry Marr

Originally published 13/11/2024

After challenges, difficulties, proposed solutions and failed attempts over ten years, Australia implemented the provision of universal health cover for Australian citizens in 1984. This was by any measure a remarkable success by a relatively young nation in the creation of a national system of provision. That pride may be tempered somewhat by current circumstances in Australia. It is difficult to imagine that the founding fathers would have anticipated that present-day Australia is second only to the United States in individuals' contribution to their health care, and at population level a substantial contribution of their share to the GDP percentage contribution to healthcare nationally.

There have been many adjustments and reforms to the scheme over the last ten years. The principle of universal provision is intact but the progressive cost to individuals continues to grow, impacting not only on inequalities, but also on the ability of families to meet the annual cost of their health care.

This paper is a critique of Medicare, and the lessons Scotland can take on board. We are at a point of crisis in our own health service, where we are faced with reforms needed to preserve the founding principles of our health service. I am not advocating we move to an Australian model, but rather seek to learn from international models to clarify what matters most to Scotland.

It is not a criticism of healthcare in Australia.

The Commonwealth Fund, a charitable organisation based in the USA, provides international comparisons of health care systems internationally, including the UK, ten other European countries and Australia. Unfortunately, Scotland is not considered separately. The Fund's primary objective is to use such analysis to provide definitive evidence of the need for radical reform of the system in the United States. The United States proportion of GDP spent on health is a significant outlier compared with other countries, but its key performance indicators are firmly in the lower quartile. Australia rates highly in several categories, and rates number one in health outcomes, particularly in cancer care. However, they rate poorly in relation to access of the public hospital system. So why would this be the case?

The analysis suggests that the answer is addressed by the difference in universal cover and universal provision. In Scotland, apart from dentistry and eye care, universal cover means free at the point of service in healthcare. This and subsequent papers set out both the imperative, and the ability and capability, of Scotland to preserve that universal system of health care through reform.

In 2013 I resigned as CEO of Tayside Health Board, taking early retirement after over forty years in healthcare. I moved to New South Wales in Australia with my wife who had been recruited to a senior role in one of the health districts in Sydney. My ambitions of a long retirement did not last long and after four months I accepted the role of CEO of Southeast Sydney Local Health District which I held until August 2018. The district was one of the largest in NSW with a budget of circa $2bn. It is important to note that the public health system in Australia is the responsibility of the

individual states such as New South Wales. Primary care along with elderly care is funded from the federal government who have jurisdiction of these services.

In Scotland, following the advent of free prescriptions, universal cover means universal provision with no out of pocket expenses from individuals, free at the point of service. That is not the case in many countries with universal cover and Australia is no exception.

The following is the Australian Government analysis of health expenditure. Australia is a member of the 38 countries in the OECD and their accounting of expenditure follows the OECD guidance to provide meaningful comparison. In 2021-22 the proportion of GDP in healthcare was 10.5%. The contribution from government was $176bn, 72.9% of the total. The remaining 27.1%, a total of $65.3bn, was from non-government sources including insurance, individuals and other non-government sources. Individuals contributed $33.7bn, 55% of the total. Put simply this represents the out-of-pocket expenses incurred by individual citizens.

Care in public hospitals is effectively free with some very limited exceptions. General Practice is more complex. In effect if the cost of a standard appointment is at the prescribed Medicare rate the cost to the individual is nil. However, 14% of practices charge more so individuals incur out of pocket expenses as well as prescription charges. The payment system is very complex as are the robust safety net measures in the total health system. There are clear safety net provisions in the Australian Medicare System. It applies to citizens and patients with benefits or concessions where there are no personal expenses. Citizens who require to make some contributions are protected to a maximum out of pocket expense of $770 per annum.

Private insurance is a significant feature in Australian health care. 55% of the population have some form of private insurance but post covid that number is falling. The government provide a variety of incentives to encourage private insurance uptake by individuals and employers. The subsidy from public expenditure is $6.5bn, a politically controversial issue.

In the final analysis, the reality is that it is estimated that individuals contribute 15% of all health expenditure in out-of-pocket expenses, with significant variation based on economic status and other factors. A number of assessments suggest that families out with any concessions can expect to budget for in excess of $2,500 per annum.

What is the impact on ordinary Australians?

Reference has been made to three issues: Cancer, Access and Variation.

The Cancer Council New South Wales provides advice on out-of-pocket expenses that patients with cancer may face. As stated earlier, Australia has an enviable record on outcomes in treatment, but at what cost? The Council lists a set of likely expenses which range from travel, accommodation, childcare or home help to scans or tests, theatre fees and medicines. The range can be between a few hundred dollars to $10,000.

One study from Western Australia concluded that patients treated in private hospitals had a better 5-year survival rate. The study also showed patients treated in private services had a higher rate of socio-economic advantage, a higher index of economic resources and a higher index of

education and occupation. The study also concluded that public hospital patients were more likely to have stage 4 disease.

Individuals can choose their care outwith the public system either by insurance or self-funding.

Turning to access, the waiting time guarantee for elective surgery is 365 days. However, the total wait for outpatient appointments and onward referral for surgery are not part of the public reporting requirements. In Scotland the total waiting time guarantee measures the entire journey of care. The target is significantly better than the public system in New South Wales.

My responsibilities as CEO in New South Wales included the Sydney Eye Hospital. Surprised at the exclusion of the total patient journey, I commissioned a study of the total wait for cataract surgery in patients over 75 years. The time from GP referral to surgery was regularly greater than 2 years. Using Queensland public hospital data 20% of non-urgent cardiac patients and 30% of non-urgent respiratory patients had a waiting time of more than 365 days.

Private health care is a significant feature of provision and cost to individuals, either by electing insurance cover or self-funding. Diagnostics, tests and elective surgery are significant part of this but is not restricted to these areas of care.

To put this into perspective, the Local Health District I led included two major teaching hospitals: The Prince of Wales and St George Hospitals. Both have private hospitals on site. St George Private Hospital provides 23 different services in surgery, diagnostics, cancer and maternity. The St George Private Hospital has 246 beds compared with the St George Public Hospital with circa 600 beds. The Prince of Wales Private Hospital in Sydney, is on the same campus, providing a total of twenty services, offering a full range of health services including maternity. Both private hospitals on their web site reference access to comprehensive health care however emergency and ambulance services are the responsibility of the public system. The current target in emergency departments is for 70% of patients to be seen within 4 hours.

The Medical Journal of Australia (2023) noted that only 44% of admissions to private hospitals occurred no out of pocket expenses. Attendance for specialist appointments (outpatients) showed 34% were billed as out of pocket expenses.

In addition, the article makes the point that the Australian Constitution prevents private provider fees being regulated. Anecdotally, I required spinal surgery when living in Australia. The only choice was private care. My excess billed to me was $500 (Our insurance monthly fee was circa $600 monthly!) However, I was able to choose my surgeon and his anaesthetist. Their fee was $12,000.

It is no surprise that this article concludes that out-of-pocket expenses are a major barrier to certain socio-economic groups. Regrettably there is also evidence of individuals choosing to avoid much needed health care due to affordability issues.

It is self-evident that the economic social status of individuals has a clear influence and therefore access to services.

Unwarranted variation is a complex feature in all health care systems with evidence of over and underutilisation of care. The Australian Atlas of Variation is a remarkable analysis, now in its fourth

publication. Two of the main topics are over supply and socio-economic impact on access. One striking example is repeat gastroscopy and colonoscopy with the variation at times 12 times higher in higher economic populations. These procedures are almost always private and paid by individuals. The report concludes that there is significant evidence of interventions with the risk of harm or no evidence of benefit. In addition, there was evidence of low rates of intervention in groups with the highest burden of disease. These findings are replicated and evidenced in the work of the Deep End Practices in Scotland.

In addition, there is much commentary on the learnings from social insurance systems in Europe, a proposed solution for the current crisis in England in particular. This subject is comprehensively discussed and debated by reports from The King's Fund and the Health Foundation. Essential learning in the debate on reform is summarised by the phrase "Be careful what you wish for" as France, Germany and the Netherlands spend more on health but also raise greater revenue from taxation. In France 95% of the population choose to purchase private insurance supplementing their cover from the national social insurance scheme. The Health Foundation report concludes that spending large amounts of resources and changing to a social insurance system would be highly wasteful and a diversion from the sustained investment, innovation and incremental reform the NHS needs.

In the current crisis in health there has been uninformed speculation that the preference of the former Westminster Government was privatisation, a ludicrous notion.

More likely was a preference for an incremental shift in the direction of Medicare in Australia where individuals contribute 15% of the total allocation to health care as a share of GDP.

If the previous Westminster pursued such an approach in England with a system of universal provision rather than cover, a 10% reduction from government sources to health would reduce government's contribution to the share of GDP in England. Over time a 10% reduction would have saved government £18bn annually per annum.

The recent change of government has negated such an approach. However, the use of self-insurance or self-funding is well established and growing in England. Regrettably that trend is emerging in Scotland, leading to uninformed commentary on the inevitability of such an approach being an essential part of our future health care. With the right approach and real incremental reform nothing could be further from the proof.

Scotland is in unique position. There is virtually a political consensus to preserve the fundamental principles and funding of our health service. Yes, at this point of crisis people are choosing insurance and self-funding care from life savings or other means, just to secure the care needed. This remains at the margins but a worrying trend.

Despite all of this we are well placed given the policy position and the devolution of health and social care to achieve the incremental reform urged by the Health Foundation. We are at a crossroads. We embrace real reform led by our population and our staff, or we perpetuate the mistakes of the last fifteen years, a central bureaucratic control characterised by structural change as the driver of reform.

The evidence points to the failure of structural change as a driver of much needed reform. It also sets out the position in the lead up to the pandemic showing that despite investment, policy intent and attempts at structural reform the NHS was under increasing financial and performance pressures and our ability to recover from the legacy of the global pandemic.

The current proposals on a National Care Service are an act of folly, compounding the waste of opportunity and resources to create meaningful reform. Based on the past being a reliable indicator of future behaviour, its effect will be further deterioration of the will and ambition to support our staff and deliver real improvements in health and social care.

The drift to self-funding is a symptom of failure not an indication of our loss of faith in our system of health care. Our government and our leadership need to acknowledge past failures and embrace a new path to reform and sustainability.

Gerry Marr, is the former Chief Executive of South Eastern Sydney Local Health District, Sydney, Australia taking up the position in February 2014 until he retired in August 2018. Prior to this position, Gerry held Senior Executive roles with the NHS Tayside, firstly as Chief Executive Tayside University Hospitals Trust, then Chief Operating Officer/Deputy Chief Executive Officer, and then Chief Executive from 2010 until 2013. Prior to his work with NHS Tayside, Gerry held senior roles in the areas of system performance and human resources management with the NHS Scotland Department of Health. In his early career, Gerry held senior management roles at major tertiary hospitals, including Yorkhill Hospitals NHS Trust in Glasgow and the Women and Children Services, Greater Glasgow Health Board.

References:

1. Australian Institute of Health and Welfare “Health Expenditure” October 2023
2. Australian Institute of Health and Welfare “Patients Out of Pocket Spending on Medicare Expenses” August 2018
3. The Medical Journal of Australia “Out of Pocket Fees for Healthcare in Australia: Implications for Equity” April 2023
4. Cancer Council NSW “Cancer and Your Finances” October 2024
5. Kingsfund “Healthcare Funding: Is the Grass Greener on the Other Side” March 2017
6. Kingsfund “The NHS in Crisis – Evaluating the Radical Alternatives” July 2023
7. Health Foundation “Social Health Insurance: Be Careful What You Wish For” August 2023

53. NHS Scotland and Social Care – Shifting the Balance by £1 Billion – Sir Ewan Brown

Originally published 25/04/2025

Chinese general Sun Tzu —
"*Strategy without tactics*
is the slowest route to victory.
Tactics without strategy
*is the noise before the defeat***"**

The NHS was founded in 1948 – a year of bread rationing and rickets. Polio, diphtheria, whooping cough, tuberculosis and measles led to many deaths.

Fifty years on, when Labour became Scotland's first devolved administration, Professor David Kerr was asked to lead a review into the NHS. His comprehensive report focused on telemedicine, unscheduled care, integration & innovation, partnerships & local needs and separation of services. The report was widely welcomed by all parties – but was sidelined when the SNP became the minority government.

In 2010, the SNP invited Campbell Christie to head a Commission into the future delivery of public services. His well-evidenced report, which was based on the principles of empowerment, integration, prevention and efficiency, recommended a framework of priorities and was once again widely welcomed by all parties.

It was a great opportunity for inspired political leadership to envelop Kerr's practical recommendations within Christie's robust framework – and effect meaningful reform. However, an independent budget review, which occurred around the same time, focused on managing major squeezes in public spending and overshadowed Christie's broader vision.

The Commission had emphasised the need for a radical reform of public services, highlighting that health and social care should be integrated to better empower people and communities. It criticised existing systems for failing to sufficiently enable individuals and for funding models that disadvantaged smaller providers. Christie advocated for preventative, collaborative and asset-based approaches designed with, and for, individuals, to reduce inequality and improve outcomes.

Scotland legislated in 2016 to integrate health and social care into a single system managed by thirty-one integration authorities. This brought together NHS Scotland and local authority services designed to improve care by focusing on anticipatory and preventative support, enabling people to live independently and improving service responsiveness to community needs. Since then, the focus has not shifted sufficiently towards preventative strategies so that significant spending is still directed towards acute care and hospitals.

There is a consensus at Holyrood that the health service in Scotland is out of control and in need of reform. Recent highly critical reports by Audit Scotland have included:-

"R*egional NHS boards are expected to deliver services well beyond the capacity of their budgets."* and "*Patient safety and experience are being compromised due to overcrowding, lack of privacy, poor building conditions and workforce issues."*

More positively, there would appear to be key areas of broad political agreement:-

- that whatever reforms are introduced, it is essential to continue to provide the highest possible levels of clinical care and patient safety.
- health provision and social care services should, as far as possible, be aligned.
- the principle of "free at the point of delivery" should continue to be observed; but with a reality check that because demand for access to health services cannot be capped, actions will inevitably be needed on the supply side.
- the need to embrace innovation and digital technology to improve efficiency and make better use of public funds.

Given this, why is no mature, constructive debate taking place about NHS reform and the need to secure a sustainable basis for social care services?

- Is it apathy?
- because it is all too difficult?
- concern about how trade unions would react?
- because there can be no compulsory redundancy in the public sector?
- that it doesn't fit with the five year Holyrood electoral cycle?
- worry that the electorate don't want politicians interfering in a much loved institution?
- lack of political will/leadership?
- an unwillingness of political parties to work together?
- complicated by the need to address social care in parallel?
- most/all of these?

Donald Macaskill, chief executive of Scottish Care stresses that social care is in a "*deep and unsustainable crisis*" requiring "s*ignificant investment, systemic reform, and valuing of the workforce to meet rising demand and ensure quality care*". He criticises the Scottish budget for focusing obsessively on the NHS at the expense of social care, leading to funding shortfalls that threaten care service sustainability, closures and job losses.

NHS 2048 invites contributors to outline the changes they think can improve and preserve Scotland's health and care services. My observations have included:-

- *The need to map a national care service and its relationship to best align with the NHS.*
- *Given that a divide has been created because of the inequality of treatment between the NHS and social care, its workforce and its resourcing, should social care be a joint partner with NHS Scotland in the embedding of social health and care in the community?*
- *Integration of health and social care services – if approved by the Scottish Parliament – would add complexity to reform and create major structural challenges. Whether there is full*

integration or just greater co-ordination than at present, there is the need for strong, transparent, accountable and best-practice governance.

I have also suggested that political parties should take a bipartisan approach to NHS Scotland reform and social care provision in the national interest. There would have to be compromises on some strategic issues including NHS and social care alignment, as well as on structural issues such as regional boards and workforce planning. However, with goodwill, none of these should be impediments to change. Cross-party action for the common good is an imperative for a restored and strengthened NHS, improved social care services and, thereby, a healthier Scotland.

While waiting for this to happen, there are specific steps that could be taken to shift the balance of funding from the NHS to social care. The following is one of these.

Health service costs

NHS Scotland's 2023/4 operating costs were £17.2 billion and comprised:-

1. Hospital Services
   £9.7 billion – 56.5% of total operating costs

- Inpatient and Day Case Services: Care provided to patients admitted to hospitals, including surgeries and treatments requiring overnight stays or same-day discharge.
- Outpatient Services**:** Consultations, diagnostic tests, and minor procedures that don't require hospital admission.
- Accident & Emergency: Immediate treatment for urgent and emergency health conditions**.**

2. Community Health Services
   £3.7 billion – 21.5% of total operating costs

- District Nursing**:** Provided in patients' homes or community settings.
- Health Visiting**:** Support and advice for families with young children.
- Allied Health Professionals**:** Physiotherapy, occupational therapy, and speech and language therapy.
- [*The combined cost of staff working in the hospital and community sectors accounted for £9 billion of expenditure – constituting 52.2% of total operating costs*]

3. Family Health Services
   £3.3 billion – 19.2% of total operating costs

- General Medical Services**:** Primary care services provided by GPs**.**
- Pharmaceutical, Dental and Ophthalmic Services.

4. Public Health Initiatives

- Health Promotion: improving public health and preventing illness**.**
  - Screening Programs**:** Early detection**.**
  - Vaccination campaigns to prevent infectious diseases**.**

5. Mental Health Services

- Support and treatment for mental health conditions within the community**.**
- Inpatient Mental Health Services for individuals with severe mental health needs.

6. Capital Expenditure

- Construction and maintenance of healthcare facilities.
- Investment in new technologies and equipment.

7. Administrative and Support Services

- Development and maintenance of health information systems.
- Continuous professional development for healthcare staff.

4. to 7. above account for the balance of £0.5billion.

Health service savings and their re-allocation

My proposal for shifting the balance between the NHS and social care is in two parts:-

- that the NHS is required to make financial savings, principally by reducing headcount; but also in other ways.
- that the funds released are ring-fenced and channelled directly into improving social care provision.

Instructing public sector organisations, such as NHS Scotland, to make savings periodically is a good discipline. It promotes efficiency; it drives innovation and productivity improvements; it strengthens accountability; and it supports sustainable public service delivery.

I have uplifted the 2023/4 operating costs from £**17.2m** to **£20m** – which is broadly where I would expect them to be in two or three years when reforms could begin to be implemented. If the increase was spread evenly across the seven headings above, the numbers would be:-

	£bn
Hospital services	11.3
Community services.	4.5
Family services.	3.8
Other.	0.4
Total.	**20.0**

The mandated savings need to be meaningful, but at the same time realistically achievable within a short period of time. For the purposes of this paper, I am suggesting that all parts of the NHS in

Scotland be required to make a minimum of 5% savings. In total, this would release at least £1 billion.

The savings would be*:-

	£m
Hospital services	565
Community services.	225
Family services.	190
Other.	20
Total.	**1,000**

* *It would be for those with a detailed understanding of health budgets to determine whether this across the board allocation is appropriate*

The second part of the proposal is to channel all of the health service savings into social care and use them to address unmet need, staff shortages and low pay, with the priorities being determined by those who have expert knowledge and experience of the care sector.

Ideally, staff losing their jobs in the NHS would be redeployed in providing social care services – although without trade union agreement, this would offend a long-standing public sector policy of no compulsory redundancy. An alternative approach would be to combine voluntary redundancy with a freeze on new recruitment.

Plea

Asking the parties at Holyrood to include wording along the following lines in their manifestos for the 2026 parliamentary election:-

"***We acknowledge that reform of health services in Scotland and their alignment with social care services would best be taken forward, in the national interest, on a cross party basis; and we support the principle that savings from health services reforms should be used to improve social care services***."

Sir Ewan Brown CBE FRSE has served on the boards of listed and private companies, universities and charities. He is the author of Corporate Ego, which describes the spectacular fall from grace of seven prestigious Scottish companies – Burmah Oil, Ivory & Sime, Lilley, HBOS, RBS, Johnston Press and Standard Life; and he identifies major failings in governance as the common cause.

54. Can We Afford not to Make Integrated Health & Social Care Work in Scotland? – Alastair Noble

Originally published 07/05/2025

This contribution is in response to recent Enlighten articles. First, Sir Ewan Brown's "Shifting the balance by £1 billion" and asking for those with detailed understanding of Health (and Social Care) budgets to respond. It also builds on Dr Richard Simpson's recent piece on structural reform including Health Boards and Quangos.

I have recently supported Nairnshire through our Community Led Local Place plan process and that fits well with Naomi Mason's article "Can Community Wealth Building change the Conversation." This takes us back to our natural Scottish model of the county town and its rural hinterland and in the cities – smaller natural groupings and support – the "Old Scottish Parish Model"

I have long argued that "the clinical decision is the purchasing decision". All else has been simply a recording of that clinical decision.

Both Health and Social Care are service industries. We are there to serve our public and should deliver best clinical care in line with value for money and productivity .

This means local accountability and responsibility. We have the best data set in the world because of every patient's registration with their GP and as we found with MAISOP (Multi Agency Inspection of Services for Older People), we can allocate health and social care costs against each individual. This showed up very clearly the variations in clinical care in different localities with no obvious clinical reason for it. It was just "Aye Been".

Simply put an elderly patient in one area was being well looked after at home, in another was in a nursing home and in another was in a consultant bed (often as delayed discharge) – all with the same medical condition – the difference was in what support package each locality chose to provide.

What could be worse than spending your last few months as a delayed discharge or an extra year or two in a nursing home – when you could have stayed in your own home with the correct care package.

The nearer you lived to a big teaching hospital -the more likely you were to be in it.

It is worth looking at these clinical variations first.

In Aberdeenshire over 60% of the OBD (Occupied Bed Day) for the over 75 population are in GP led Community Hospital beds. Glasgow had none.

In the UK, Torbay had prioritised "Mrs Smith and her home/Community care" and the figures contrast starkly again with Glasgow, which has followed the "Big Hospital Specialist Model." Torbay had 18,000 OBD per 100,000 over 75, Glasgow has 72,000 OBD – four times as many!

Highland region has the highest delayed discharge rate in Scotland, with Raigmore Hospital losing over 3,500 acute bed days in November 2024 due to >75s “blocking” acute beds. Additionally, Raigmore has the highest re-admission rates in Scotland: 8.6% at seven days (compared to 5.4% nationally) and 14.5% at 28 days (compared to 11% nationally). Preventable admissions, particularly among the >75 population, where the average stay exceeds 40 days, could alleviate these pressures.

To put these figures into context NHS Scotland has around 6.4 million OBD

- 0.8 million are scheduled/planned procedures -still with big variation in day care and outpatient investigation rates-but for another paper.
- 5.6 million unscheduled/unplanned OBD
- 600,000 OBD are delayed discharges = 2 District General Hospitals (out of 20 approx. in Scotland including teaching and DGH as Specialist “Big Hospitals”.

Richard Simpson is quoting 1964 beds occupied by delayed discharges out of a total 13,700 beds.1 in every 7 beds blocked

- 4 m OBD are by patients over 65
- 2% of all patients occupy 79% of OBD
- 2.5 % of all patients = 50% of hospitals and prescribing total spend

Of the patients who are in hospital today 33.3% will be dead within 1 year and 1 in 10 will die in this hospital admission

This year’s National Care of the Elderly Day of Care Audit (DOCA) again found that in these geriatrician led specialist beds over 60% of OBD (patients) would be better looked after in their own community/locality. Put bluntly they would have been receiving better and more appropriate care in their own community with an Integrated Community Care team. The geriatric bed complement being the biggest single specialty in medicine in terms of inpatient care.

To address these disparities, a holistic approach must be taken, one that emphasizes local solutions tailored to the needs of individual communities. Integrated Health and Social care can bridge these gaps by ensuring seamless transitions between services, thereby enhancing the quality of life for patients. Innovative models, such as increased investment in home-based care and community health initiatives, can prevent unnecessary hospitalizations and provide the right care at the right time.

Moreover, leveraging data analytics to monitor and evaluate care outcomes can guide policy decisions and resource allocation. By fostering collaboration between healthcare providers, social care services, and the community, we can create a responsive and adaptive system that truly serves the needs of our population. The goal should be proactive care rather than reactive measures, ultimately reducing the strain on hospitals and improving overall healthcare delivery in Scotland.

Over 65 unplanned admissions are biggest spend by far. Therefore, we start by concentrating on them. This builds on "*The Perfect Equation, Perth & Kinross 98% work*." Which came out of the MAISOP visit and was built on by P&K to show difference in clinical activity and outcomes.

We need to model the changes that we must now commission per locality.

Fundamentals are to use locality-based data built on individual patient's health and social care activity and spend. Per locality-in fact, each General Practice list combined up to a natural locality. Differentiate between GP led community/locality team care and Consultant led specialist team care.

The simple question will be '*Which Bed Did You Sleep In Last Night?*'

This stops all "Cheating on Coding and Tarif"- the major failing in private and fund holding models. This is why Cam Donaldson has long argued against "Privatisation" and in support of our current taxation based funding system. We certainly do not want the "American Model". We need to prioritise patients being cared for in the bed/location that is best for them on any current day and we reallocate staff to where that patient care is best delivered for them as individuals.

<u>DATA based on all patients on GP list over 65 OBD =100% of OBD</u>

Level 1: at home (own house) no care package = 94 %(in best areas) –length of stay as long as needed, but under regular review (This reflects how successful Health and Social Care are at present). The "Golden Oldies" are looking after themselves well and we should be celebrating the success of Health and Social Care.

Level 2: at home (own home) with complex care package =3% (in best areas) -length of stay as long as needed, but under regular review. This is where we must get staffing levels right. Good home helps are worth their weight in gold. Each locality should have its own "Integrated Community Team" and they should follow the patient and provide the necessary care wherever the patient is within the locality.

This fits well with the "Community Wealth Building "/Place Planning/Local Democracy Thinking. It is very beneficial for each community to have people living and working within their own community and contributing not just their economic wealth but also what good people contribute to each other in a viable and sustainable Model. This in particular will address the "Depopulation Worry" in many of our Rural districts.

Level 3: in nursing/residential home with complex care package = 1% (in best areas) -length of stay should average out to about 1 year-outcome data driven-performance target. Again, the right local staffing is an essential component for this Model to work at its best.

Level 4: in community hospital bed (includes hospice, intermediate care, and step-down definitions). No Delayed Discharges in Consultant beds. All non-consultant specialist beds with minimal DDs =1% – length of stay should average out to about 14-21 days-outcome data driven-performance target

Level 5: in consultant specialist bed with agreement of GP and Consultant =less than 1% -length of stay should average out to about 7 days –outcome data driven-performance target. GP and

Consultant should agree all admissions and after 7 days there should be a further clinical discussion and agreement before continuing Specialist treatment. This should be kept under regular review.

Again, the best of GPs and Consultants are in complete agreement about this. The patient should be getting the best of Consultant Care with minimal waiting times and once the benefits of that care are no longer clinically needed and agreement reached they are transferred back to the Generalist Community team

We then can reduce OBD x acute consultant level 5 tariff by 50%. Stress no delayed discharge at this tariff at this rate. Instant clinical discharge from level 5 to level 4 when clinically decided. This means real pressure on management to re-allocate staffing levels and costs.

We then can re allocate the money/resources/staff to the locality/community teams-again using OBD x tariff for levels 2-4.

Level 3 Again looking at reducing nursing home variation per locality from 3 to 1% for example. Also reducing length of stay down to 1 year –better admission planning.

Level 2 Again look hard at optimum % rate

The locality should end up with as close to fixed locality staffing costs as possible using bench marking for staffing levels 2-4.This model will also drive better capital costs -1 building as is being delivered in Nairn is a good example.

Additional work in progress

Look at admission rates per GP -identify the high admitters, poor copers. Then look at short length of stay – good consultants sorting out poor admissions. Then look at long length of stay – poor consultants and poor GPs not looking after individual patients properly. This will be very clear in bad /poorly performing localities.

One other very interesting and useful quality indicator is to record which bed did you die in for each locality?

Again, using the same 5 levels per locality:

Level 1 &2 -Own bed with or without complex care package =25%

Level 3 -Nursing Home bed= 25%

Level 4 – Community Hospital/Hospice bed = 30%

Level 5 – Specialist Consultant bed =20%

Both these indicators are much better than our existing waiting times and targets, especially as nobody can cheat or manipulate them.

I think this dynamizing around Which bed did You Sleep In? -OBD will drive the commissioning of good locality intermediate care faster than any other indicator.

So, what about money?

We must start with a “Fair Share Locality Budget” for each locality. This will include weighting for deprivation/rurality/age etc. This also prioritises local responsibility and accountability.

Using Sir Ewan projected budget of £20 billion for health this would equate to around £4,000 for health and about £1,000 for Social Care.

For example for Nairn this would be 16,000 patients x £5,000 = £80 million. Our current estimate is £14.2 million. A huge discrepancy.

We have chronically and deliberately underfunded “good community care” and equally deliberately over funded secondary care- “the Big Glasgow Hospital Model,” also found in Dundee (Ninewells and Aberdeen ARI). Various health Boards have traded in insolvency for many years and are just repeatedly bailed out.

This must not be allowed to continue. Health, as those of us who have worked in America know only too well, could swallow our entire spend. Corrupt coding and tariffs plus prolonged and unsuccessful /fruitless medical care is not a quality service.

We have clearly established that the variation in care practice within Scotland is not based on clinical need or indeed even the quality of clinical care as judged by outcome. It is just historic patterns and, in many ways, reminiscent of the “Old Demarcation Disputes “ which ended shipbuilding on the Clyde. They were still riveting when the Japanese were welding. This was aided and abetted by bad trade union behaviour but equally by bad management behaviour.

Care has moved on. The Health and Social Care systems have produced our fittest elderly population. I would love to see what £40-50 million a year spent in Nairn Healthcare would deliver, not just in health and social care ,but also in the sustainable wealth and happiness of our whole community.

If we re-allocate staff on the basis of this Occupied Bed Day x an agreed indicative national tariff, then moving, for example, all the OBD for Delayed Discharges would in effect move all these individual people to the best level of care for them and in practice make the staff available in the correct number and with the right training and support for all 5 levels of care.

The important difference would be that community and specialist care were treated similarly and fairly. The big benefit would be to all patients and their communities. All communities would benefit from this enhanced Community capacity including local spending power. Better functioning Communities throughout Scotland must be our goal.

We have all the data -clinical and financial we need to make this work. Now is the time for real reform based on our natural Scottish working unit – the “Old Scottish Parish” and our firm belief in “Community Empowerment” and the “Common Good” whilst making best practical use of our “Common Good Assets“ including our people and our irreplaceable Natural Environment.

We also need to restore faith in local democracy and our politicians at both local and national level. I think these reforms will help greatly in that renaissance.

If we let the voices of “doom and gloom” conquer, then we will have to find an alternative and I have not seen any evidence that we know what that will be. So, if we can simply start putting the

patient first, their locality team as the priority, and right sizing secondary care this can be a win for all, and affordable within existing and even shrinking resource allocation.

A sensible Scottish solution based on the quality of our health and social care staff and above all best for each individual patient.

Dr Alastair Noble worked as a GP in Nairn and was awarded an MBE for his work in integrating Health and Social Care in Nairnshire

Special thanks to all who have contributed over the years- Paul Leak, Campbell Mair, Gail Greig, Ken Crowden, Pete Knight ,Cam Donaldson, Sandy Strathearn, John Walker, Helen Tucker, Helene Irvine, Joan Noble, Gerry Marr, Liz and Dannie Bow. The Scottish Association of Community Hospitals (SACH Alumni), CHA, Nairn Healthcare, MAISOP Team and Fergus Ewing for being a good MSP.

55. Wealthy Nation, Healthy Nation – Alan McNeill

Originally published 05/11/2025

When considering reform of the NHS and social care, a quote from Socrates comes to mind: "The secret of change is to focus all of your energy not on fighting the old, but on building the new".

This was in evidence in abundance, last week, when I attended the conference Enlighten organised with Chest, Heart and Stroke Scotland, and which took place at the Royal College of Physicians of Edinburgh, of which I am a Fellow.

As doctors and medical professionals, we have had enough of "fighting the old". We know what's wrong. Together with colleagues providing a commentary for the Wealthy Nation, Healthy Nation publication, we identified at least nine areas or aspects of the NHS in Scotland where the people of Scotland are being served poorly, from overall health outcomes through staffing to the provision of primary, secondary and public healthcare.

We have moved on to talking about how we "build the new". To help that endeavour, we want to learn from other European countries such as Germany and Sweden. They have different models of how healthcare is funded, but in both countries responsibility for funding and delivery of healthcare is decentralised, there is an allowance for a mix of public and private provision, and there is better retention of staff beyond the age of 60. As a result both have superior outcomes to Scotland across most areas of healthcare.

We think we can start by studying Germany and Sweden in closer detail, and learning lessons.

However, we are also cognisant of the politics of our time. Although the opinion polling commissioned by Enlighten for last week's conference, carried out by Diffley Partners, showed that the public have a nuanced understanding of the NHS's predicament, and are ready and keen for change, politicians are still in a fix. Six months out from an election, they are disincentivised to advocate meaningful change, because there will always be an opponent ready to accuse them of causing harm to 'our NHS'.

As doctors we need to understand that, and use these six months effectively. We need to create a forum with which politicians across all parties can engage after the election is over and a government is in place.

This forum – in effect, a Commission – should be led by the medical profession and should take to the government and the opposition a blueprint for a new NHS which can deliver the outcomes the nation is entitled to expect.

The medical profession and the political profession need to agree to implement it in the national interest, and if the latter need to use the former for political 'cover', then so be it. It is a price wort paying to "build the new".

Professor Alan McNeill FRCS(Urol), FRCP(Ed), FFSTEd co-authored an essay as part of the Wealthy Nation, Healthy Nation collection of essays published by the Centre for Policy

Studies. He was a Consultant at NHS Lothian University Hospitals. The full collection of essays can be read here.

56. Why Not! The Illusion of Social and Supplemental Health Insurance As Solutions to NHS Funding – Cam Donaldson

Originally published 13/11/2025

Last year, in this series, the case was made for a publicly-funded National Health Service (NHS) on grounds of both equity and efficiency.[1] In the UK, this public funding takes the form of taxation. Yet, as the current NHS and social care crises continue, we observe politicians and others suggesting 'solutions' that, despite making apparent sense on the face of it, do not address the fundamental issues of managing our tax-funded resources better[2] and facing up to the need to spend more. Such suggestions were raised again at a recent Enlighten event hosted by the Royal College of Physicians of Edinburgh, which has prompted this blog.

Are there not solutions to be offered by switching to a social insurance system of the sort they have in countries like France and the Netherlands? Surely even supplemental health insurance will help the NHS or a hypothecated tax would take the politics out of health care and the NHS, wouldn't it? The short answer to all these questions is 'no', the aim of this paper being to explain in more detail as to why, in my view, that is the case.

Why not social insurance?

We now know that continuous health care reform, often intended to promote greater market discipline, and a constant feature of the NHS throughout its existence, has led to little gain at the cost of significant disruption.[3-5] So, too, I would predict, with the oft-lauded switch to the social insurance systems of some of our neighbouring countries. Examples of particular forms of care are often quoted as being better in countries like France, Germany and the Netherlands. Table below gives a clue as to why such systems might seem to do better than here in the UK; they spend significantly more, the pattern being similar if we measure spend by percentage of gross domestic product. This also gives them capacity to focus more on care out of hospital, in general practice and public health; things that have been eroded here in the UK and could be restored without much disruption. rather than relying on the unevidenced and unrealistic expectations of prevention and social care 'saving' the NHS, the main lesson to learn from these other countries is that these things are complements to and not substitutes for each other. Perhaps this is why, in the Table, we see the UK coming last in two of our three health outcome measures, and second-to-last on the other.

The fact that some countries operate social insurance schemes and others taxation-based funding is more a product of history than anything else. The UK had Beveridge, Germany had Bismarck and other countries their versions of the visionaries who helped establish their welfare states in different ways. These systems share more similarities than they have differences, especially the deductions from payroll of the man source of their funding. Change from one to the other –

whether from an NHS to social insurance or vice versa – would, at best, be futile and, at worst, lead to high costs of disruption.

Why not supplemental health insurance or hypothecation?

Supplementary health insurance is often promoted as having the ability to relieve pressure on the NHS. Again, there is very little evidence to back this up. Most of the evidence shows the impact to be detrimental with respect to waiting lists in the public part of the system. The reasons for this are obvious. At any one point in time, there are only so many doctors available to provide treatment. If their attention is diverted to the private part of the system this must be at the expense of the public part. Likely, too, patients left in the public part of the system will be in greater need of care.

Total health expenditure per head and health outcomes, selected OECD countries (2022)

Country	2022 total health exp US$PPP*	Life expectancy at birth (years, 2022)*	Infant mortality rate per 1,000 live births (2021)*	Reported Covid-19 mortality rate per 100,000+
Australia	6372	83	3.3	4.7
Canada	6319	82	4.5	41.9
Denmark	6280	81.5	2.4	29.6
Sweden	6438	83	2.4	77.2
France	6630	82	3.6	97.4
Germany	8011	81	3.0	66.4
Netherlands	6729	81	3.3	65.8
UK	5493	80	4.0	130.1

Notes:

Sources: *OECD, Health at a Glance 2023 (https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2023_13bdff54-en). Public funding is calculated using spending by government schemes and social health insurance. + Covid-19 Excess Mortality Collaborators[6]

$PPP (Purchasing Power Parity) is a form of currency conversion making spends across countries more easily comparable.

Indeed, it could be argued that the most likely policy direction of government with respect to health care financing is along these lines, and that we may be at a tipping point in this regard. In 2024, the Joseph Rowntree Foundation reported that a majority of people in the UK now expect to pay privately for many common treatments.[7] This alone is problematic in the sense of those willing and able to pay purchasing the ability to 'jump the queue' for treatment whilst, at the same time, taking resources in the form of medical time from the publicly-funded part of the system where the needs are likely to be greater. The tipping point arises whereby, if enough people are doing

this, and the myth continues to be peddled that it relieves pressure on the NHS, such groups are likely to begin to demand tax rebates to support them in their apparently altruistic, but actually selfish, endeavour. This would begin to mimic the Australian health care system, where such inequities, sponsored by government via tax rebates, have been known about for some time.[8] Further political controversies and headaches would arise over the extents to which public hospitals can sell bed space to privately-insured patients and to which even private hospitals themselves might receive support from the public purse. Once embarked upon, it would be difficult to reverse such a policy which would only enhance two-tierism and inefficiency; the latter in the sense of less need being met for resources spent on health care.

Hypothecated taxes – that is money collected by taxation for a particular purpose – are often put forward as a way of taking the politics out of health care. But, again, if this was the solution, many more governments would have tried it. Inevitably, a tax reserved only for the NHS and/or social care would itself become the subject of great political debate. The recent supplement to National Insurance introduced by the Johnson-led UK Government shows the volatility of such taxes. The supplement was meant to provide the funding for proposals to ease burden on those deemed to be paying too much for social care. The main point here is that, due to fiscal pressures, this hypothecated tax was subsequently withdrawn.

Conclusion

There are many in government, who, as with other goods once thought to be the preserve of public financing and provision, would divest themselves of the NHS if they could. Experience of recent decades with respect to the stagnation in plans to reform social care would also back up this observation. For the NHS, the reason they cannot abandon is due to it being the best system on offer. this lesson also needs to be learned for social care. In the end, the answer will centre around more cash being made available. As early as 1952, the UK Government proposed an enquiry into the cost of the NHS, with a view to dismantling it. This backfired when the subsequent Guillebaud Report of 1956 declared the NHS as value for money and that more should be spent on it.

Despite all health care systems being different in terms of their public-private mix of financing, it is the similarities that are striking; universal coverage is sought, 'insurance' is based on groups rather than private individual transactions and the vast majority of funds are deducted from payroll.

Cam Donaldson PhD FRSE is Emeritus Yunus Chair at Glasgow Caledonian University and Professor of Health Economics at Australian National University. In July 2025, Palgrave MacMillian published Cam's latest book 'Financing Health & Social Care: Bringing Health Economics Back into Public Policy available at: https://link.springer.com/book/10.1007/978-3-031-86769-9

References

1. Donaldson C. The equity and efficiency of a free NHS. Enlighten, 22nd May 2024.
2. Donaldson C and Noble A. Gain with least pain: using economics thinking to advance population health in a budget-neutral world. enlighten, 8th May 2024.

3. Donaldson C and Gerard K (with Mitton C, Jan S and Wiseman V). Economics of Health Care Financing: The Visible Hand (2nd edition). Palgrave/Macmillan, London, 2005.

4. Donaldson C. Credit Crunch Health Care: How economics can save our publicly-funded health services. Policy Press, Bristol, 2011.

5. Maynard A and Bloor K, Introducing a market to the United Kingdom's National Health Service. New England Journal of Medicine 1996; 334: 604-608.

6. Covid-19 Excess Mortality Collaborators. Estimating excess mortality due to the Covid-19 pandemic: a systematic analysis of Covid-19-related mortality, 2020-21. Lancet 2022; 399: 1513-1536.

7. Davis A, Blackwell C, Ellis E, Padely M, Stone J and Balchin E. A minimum Income Standard for the United Kingdom in 2024. Joseph Rowntree Foundation, York, 2024. (https://www.jrf.org.uk/a-minimum-income-standard-for-the-united-kingdom-in-2024#about-the-authors)

8. Smith J. How fair is health spending? The distribution of tax subsidies for health in Australia. The Australia Institute, Paper Number 43, October 2001. (https://australiainstitute.org.au/wp-content/uploads/2020/12/DP43_8.pdf)

Rurality

57. Recruitment and Retention in Rural Areas – Stephen McCabe

Originally published 27/02/2024

Despite growing up in industrial North Lanarkshire, I knew from my early teens that I wanted to become a remote rural doctor. It is what I went to medical school to do and, after 7 years of postgraduate training, I took up a post as a relief doctor for the islands of Islay and Jura in 1995 before moving on to a partnership in Portree, Skye in 1996.

I became aware almost immediately of what I regarded as a looming rural healthcare recruitment and retention crisis. In 1999 I received funding from the Scottish Executive and the Royal College of General Practitioners to spend a month in New Mexico to look at how they had addressed their own extant rural recruitment and retention crisis. On the back of this mini sabbatical I wrote two reports – one looking at alternative models of primary care provision in remote communities, the other looking at measures to address recruitment problems.

In this second report I made a number of suggestions – identifying and mentoring school pupils showing an interest in rural healthcare; allowing preferential admission to medical school for students from rural areas; developing an undergraduate medical curriculum which is student-centred, problem-based and community-orientated with a strong emphasis on the primary care setting; seeing rural healthcare as a separate speciality and developing a specialist postgraduate training programme for rural health instead of just lumping it into standard general practice training; offering financial incentives to rural working in the form of signing on fees and terminal bonuses; addressing rural infrastructure issues (roads, public transport, internet access, mobile phone signal); protecting rural primary schools; ensuring employment opportunities for the partners and spouses of health workers; providing adequate childcare; looking at affordable housing; asking communities themselves what they can do to attract and keep hold of key workers; and so on.

Fast forward 25 years and I am now a member of a number of email groups to do with primary care, some of which are world-wide in their reach. The rural recruitment and retention crisis has hit rural Scotland hard, just as I predicted it would. But what quickly becomes clear from my involvement with these 'virtual' email groups is that in almost every other developed country the problems with recruiting and retaining rural doctors are just as bad as if not worse than the situation in Scotland. That is certainly the case in England, Wales and Northern Ireland but what about things elsewhere?

Across the Irish Sea the situation in the Irish Republic is no better. In rural Ireland 25 – 50% of GPs are at retirement age. Speaking in 2017 Dr Padraig McGarry, then Chairman of the Irish Medical Organisation's GP Committee, said "The loss of general practice in rural areas is similar to the loss of many services in rural Ireland. We have an increasingly older population of GPs facing retirement and young GPs are not prepared to come in under present circumstances of excessive hours and poor supports. There is a very real threat that GPs in the worst affected counties will

not be replaced. We might have areas in rural Ireland, particularly west of the Shannon, where they will not be able to attract GPs."

In Ireland a reduction in funding has been highlighted as a key issue – specifically the Financial Emergency Legislation of 2009 which saw funding to many rural practices cut by as much as a third or more.

The rest of Europe is fairing little better. In Germany, for example, one third of rural GPs are over 60 and the majority are struggling to find anyone to replace them when they retire. And in many parts of neighbouring Austria rural GPs have all but disappeared. In 2020 the European Commission reported a shortage of doctors, nurses and healthcare assistants in almost every European Union country and in 2022 the European Public Services Union put the figure for these shortages at around 2 million workers.

In September 2022 the World Health Organisation published a report entitled Health and Care Workforce in Europe: Time to Act, which found that 40% or more doctors in one third of all European and Central Asian countries were close to retirement age. The highest rates were seen in Italy at 60% and Latvia at 50% and overall across the EU the average rate was 30%. The figures for nurses were only marginally better.

In Sweden, despite it being a wealthy country with a long tradition of state-funded healthcare and welfare, they cannot recruit rural GPs either and rural hospitals are being closed because they cannot staff them and rural social services cannot be delivered for the same reasons.

In rural north Iceland there are waiting times of up to six weeks to see a GP in Akureyri, by no means an isolated social or cultural backwater. In June 2018 Jón Helgi Björnsson, the director of the Health Care Institution of North Iceland said "What we are struggling with is the difficulty of enlisting doctors to work here. There are simply too few doctors for the clinics we have. It's maybe a little easier in Akureyri, but generally speaking, it's just really difficult to hire a doctor to work in the countryside."

In Portugal doctors are opting to work in private healthcare leaving vacancies in the National Health Service there unfilled. In Eastern European countries like Bulgaria, Romania and Serbia the emigration of medical graduates has left those countries with severe shortages.

Writing in Politico in November 2022, Sarah-Taissir Bencharif reported on the situation in the rural town of Le Vigan in France's Massif Central. Here in the face of three GPs reaching retirement age they had tried to future-proof the local healthcare services by building and creating a new multidisciplinary healthcare centre in the hope of attracting younger doctors. But after 5 years of looking no potential replacements came forward. She goes on to point out that 44% of French GPs are reaching retirement age and 7 million French people have no access to a referring GP and nearly one third of the entire French population lives in a region with poor access to GPs.

Just last month I received an email from a contact in Belgium which stated "I am a GP and health activist in Antwerp, and we have a huge shortage of staff in Belgium"

On the other side of the Atlantic both Canada and the USA are also facing major problems.

Rural Canada is witnessing large gaps in rural GP service provision. In British Columbia, for example, it is estimated that 700,000 people (15% of the population) have no family doctor.

In 2018 the US National Rural Health Association estimated that rural America would be short of 45,000 rural doctors (mainly family physicians) by 2020. James Dickson, CEO of the Copper Queen Community Hospital in rural Arizona, describes the rural areas he serves as "the new inner cities because we have the same shortages and lack of access to care."

In Australia, despite what appear to be the lucrative packages on offer (at least on paper) they cannot find enough doctors to work in rural communities. Again cuts in funding are cited as at least one possible factor. The Australian Government froze Medicare payments in 2014 and since then some rural doctors have lost as much as 40% of their incomes as a consequence. Further south in New Zealand the rural GP vacancy rate is currently running at 20 – 25%.

So what is the underlying issue? In essence Governments don't generally look for ways to do things better. Rather they look first and foremost for ways to do things cheaper. This is true wherever you look in the developed world where there has been a persisting and consistent underfunding of primary care in general and rural healthcare in particular for many, many years.

The new Scottish GP contract of 2018 was yet another example of this trend. Yes, more money was going into primary care as a whole but almost all rural practices were to receive no real uplift to their finances and most would become dependent on a form of 'income support' known Minimum Practice Income Guarantee (MPIG) for their very survival.

However it's not just a matter of adequate finance, important though that is. And it's not just about doctors either. There are shortages of nurses, midwives, health visitors, mental health workers, physiotherapists, radiographers, social workers, home carers, and school teachers. In addition, too often the debate becomes localised to regions (like Highland) or nations (like Scotland) with lots of ire directed at local healthcare managers or national politicians but no recognition that this is an international problem and there has been no real attempt by anyone – politicians, academics or the professions – to ask why that is so.

Solutions are often proposed – but these are often just the same solutions that have been proposed more than once before, as I did for the Scottish Executive in 1999 and the Dewar Committee Report did before me in 1913. We fail to distil the origins or essence of the crisis.

When faced with apparent complexity, as seems to be the case with rural recruitment and retention, it sometimes helps to use a heuristic approach such as 'Occam's razor'. The theory of Occam's razor is that when faced with a very complex problem the solution may well be the simplest, most straightforward one.

I believe that the fundamental issue we are facing is the 'Westernisation' of our society which explains why we see consistent patterns of rural recruitment and retention crises across the developed world. In its current iteration this Westernisation has seen a huge shift towards urbanisation – unmatched since the original industrial revolution in each of those countries.

Urban towns and cities are expanding rapidly. At the same time rural populations are dwindling and ageing.

This results in young people, and especially young professionals, preferring (on the whole) to make their lives in urban or suburban communities rather than rural areas. These young people in particular value what might generally be termed amenity – good broadband and mobile signals; fast and reliable transport links; affordable housing; easy access to a wide variety of activities both for themselves and their children; an acceptable work/life balance that keeps their working hours down; schools offering the best range of educational opportunities; nice shops and cafés to walk round or hang out in; and so on.

Unless and until we can provide similar levels of amenity in our rural areas we will struggle to fill our vacancies. So we need to stop asking "What is about this job that no-one is applying?" and start asking "What is about our community that young professionals do not want to live and work here?"

As things stand, and given the current financial crisis we face, I see no way to sufficiently address these amenity issues and reverse this societal shift so that we will, once again, be able to attract key workers to rural areas and allow rural communities to become sustainable and to flourish.

Stephen McCabe is the Clinical Director of Primary Care with NHS Highland. He graduated from medical school in Edinburgh in 1988 before undertaking GP training in the Scottish Borders, gaining MRCGP in 1993. Stephen worked on Islay and Jura in 1995 as an Associate GP before becoming a GP partner in Portree in 1996. He became a Fellow of the Royal College of GPs in 2013 and was also for a while the remote rural representative for RCGP Scotland. In 2018 Stephen became a salaried GP in Inverness then in 2023 took up the role of Clinical Director of Primary Care with NHS Highland with the remit of supporting primary care services in Caithness and Sutherland.

58. The Future of the NHS in Scotland: Don't Ignore the Challenges of Rural Hospitals – Paul Cooper & Kevin Fox

Originally published 16/04/2024

Rural Hospitals are under threat in many countries, with the same recurring issues.

Recruitment and retention of medical and nursing staff and Allied Health Professionals is inconsistent and unpredictable, leading to shortages of key workers and the reliance on (usually more expensive) locum and temporary staff. Whilst it is possible to create an appropriately skilled and resilient body of interested clinicians, it can be difficult and expensive and time-consuming. A recent article in the British Medical Journal highlighted the consultant recruitment problem in Scotland, with many advertised Consultant posts in rural hospitals receiving no applications.

The problem of recruiting and retaining a sustainable workforce is multi-faceted.

Training is overwhelmingly based in urban centres and in units offering specialised care. Each speciality focuses on their own training requirements and recruitment needs, and where referring patients is straightforward and advice from other specialists is readily available, the role and skills of a generalist have been minimised. There is evidence that centralisation and specialisation has improved outcomes in some clinical conditions, for instance stroke and trauma, but these conditions are only a small proportion of acute presentations to rural hospitals.

With education and training being focussed on urban centres, there are strong incentives to remain once training is completed. Established cultural interests and social connections may not be so readily available or duplicated in the smaller, dispersed rural community. Employment opportunities for partners, who may also have professional qualifications, are more varied and accessible in an urban environment. Travel to visit friends and relatives is much more straightforward (and cheaper) and children may be in a happy, stable school and social environment. Families and individuals are understandably reluctant to move when there are so many and varied reasons not to relocate.

There are also professional issues that affect rural recruitment.

- There may be the lack of generalist skillset that gives clinicians the confidence to see a mix of clinical presentations and problems. They may be required to manage conditions and provide care that will be at the limits of (or occasionally outside) their usual scope of practice and comfort zone. This has been labelled 'clinical courage'.
- Due to small numbers, the burden of frequent on call responsibilities.
- The lack of a clinical community of peers to provide support and advice when needed.
- Difficulty in accessing educational opportunities – many rural areas suffer from poor broadband and the logistics of travel, locum cover and expense make attending meetings problematic.
- Concerns over 'clinical drift', where the clinical practices of a small, relatively isolated group can deviate from newer changes to standard clinical practice , exacerbated by

lack of significant turnover in staff and problems accessing educational and updating opportunities.

- Small client groups with high demands will be relatively more expensive to maintain and thus are not provided for.
- When individual clinicians with specific additional skills are working in a rural hospital it may be possible to support a 'special interest' as an alternative to patients being sent to larger hospitals for some parts of their clinical journey. However, agreeing funding arrangements, governance, integration and appropriate support staff for what may end up being a one-off site-specific pathway can be problematic.

Offering flexible working (weeks on-weeks off arrangement or an annualised contract) may be an attraction for some. However, this can bring additional issues. Audit, governance, education, formal management roles and other professional and administrative activities can be difficult to support in an irregular or intermittent commitment. Travel can be time-consuming and expensive and for Scottish islands, subject to significant disruption in the winter. Finding and funding satisfactory accommodation that will be used intermittently can be difficult.

In the current situation regarding recruitment and staffing, being an ad-hoc locum, frequently through an Agency, offers more flexibility (if that is an important consideration) and more money (if that is important consideration) and more varied work (if that is important consideration), when compared to a more fixed 'flexible working' arrangement.

But the problems facing rural hospitals aren't just about individual recruitment and retention.

To make a hospital an attractive place to work will rely on there being a 'critical mass' of activity to maintain and develop appropriate knowledge and skills. Specialities are often inter-dependent and problems with staffing one service can often have knock-on effects on the provision of other services –for example problems in providing paediatrics can have repercussions in emergency department, maternity , and community services. There is a 'critical mass' of clinical work and colleagues that can make a hospital an attractive place to work. The danger when co-dependant specialities are removed is that the hospital enters a 'death spiral' where an increasingly struggling hospital finds it difficult to recruit, which leads to services being withdrawn, which makes it harder to recruit.

If a rural hospital does recruit an individual with more specialist skills, it can prove difficult to create the environment where those skills can be utilised, to the benefit of clinicians, hospital and community. Patients would have to travel less and for the hospital improving the range of what is on offer and can provide additional educational opportunities and experience. However, funding and resource issues, governance and integration with the existing service can be difficult problems to solve, for what may end up being appropriate only to a single site.

Hub-and-spoke arrangements, where a larger, urban hospital provides resources (usually visiting senior staff) to the spoke (rural) hospital have evolved as provision of care has become more specialist-based and centralised. Such relationships can operate with the issues, services and needs of larger central hub remaining the priority rather than maximising the potential of the rural hospital to create an active and attractive environment for work and recruitment that serves the community.

Any possible 'economies of scale' available in administrative, estates and other essential functions do not exist, and in a geographically dispersed population services mean staff spend more time unproductively in travelling. Because of distance and transportation difficulties with travel (ferries, B-class roads) and the much smaller scale of operations, logistics arrangements and supply will be more expensive.

Although the primary activity of a hospital is the provision of secondary care, in rural environments hospitals can contribute to the provision for the community of many other services and functions. This has been described by the Health Foundation as the role of an 'Anchor institution' within the community. The social determinants of health refer to the social, cultural, economic, commercial and environmental factors that influence the conditions in which people live and thereby influence their health. In rural environments hospitals can contribute to the health and well-being of the community in many ways. Hospitals provide secure and stable employment, not just in medical and nursing areas, but in ancillary support services –for example Estates, management, IT and catering. Education and training opportunities can be provided for individuals who would be unable to travel or relocate. The addition of distance learning supported by brief secondments to other units, rather than longer term placements, can greatly increase the scope of what can be offered.

Procurement strategies can support and encourage the development and sustainability of local services and make a significant contribution to the local economy.

Clinicians and many in the community accept that provision of some aspects of care can be impracticable at small scale. But the response to financial or clinical problems in small hospitals is frequently to close units or scale back services. In recent years this has been most obvious in the provision of rural obstetrics, where Units providing surgical obstetric care have been replaced by midwife units and patients are required to travel , often large distances, to receive care. The effect of forcing patients to travel is to transfer risks and problems from the Institution to the patient. Patients receiving care at remote institutions are deprived of family and social support and frequently suffer disjointed care when transferred back to their community. And when closure of Units and down-grading of hospitals occurs it is to solve a problem which is not of the communities' making, and such closures can make access to appropriate care harder for an already disadvantaged group and can worsen health inequalities in the rural population

In most societies, the principle of equitable access to good quality health care for all the population is accepted. Due to distance and time involved in travel and infrequent public transport links, accessing appropriate healthcare can be more difficult for a rural community where the population tends to be older, more deprived with more co-morbidities and hence greater health needs. In Scotland, the allocation formula , calculated by the National Resource Allocation Committee (NRAC) and Technical Advisory Group on Resource Allocation (TAGRA), developed between 2005-2007 takes into account age and sex profile of the NHS board population, additional needs based on morbidity and life circumstances (including deprivation),excess costs of providing community services to different geographical areas, and excess costs in rural areas of 'hospital costs', together with Service Level Agreements for work that cannot be carried out locally.

The current funding arrangements do not recognise the difficulties in recruiting and retaining appropriately skilled and interested staff and is not flexible enough to allow rural hospitals to take advantage of serendipitous opportunities to improve services when they arise to the benefit of patients. Such flexibility would also contribute to the sustainability of services and increase educational opportunities and work experience for all staff working there. An active sustainable hospital can play an important role in the community as an Anchor Institution, addressing social determinants of health and funding jobs, opportunities and training that can contribute to the stability, resilience, economic sustainability and attractiveness of rural communities as places to live, contribute to the community, and work. This important, wider societal role should also be reflected in any funding settlement .

Paul Cooper is a bank locum Consultant Anaesthetist with NHS Orkney and NHS Highland; Kevin Fox is a consultant physician with NHS Orkney and a Consultant Cardiologist with Imperial Healthcare NHS Foundation Trust.

59. Fixing Vaccine Delivery in the Highlands – Ross Jaffrey

Originally published 15/01/2025

My name is Ross Jaffrey and I am a GP principal at Croyard Road Medical Practice in Beauly and a Cluster Quality Lead (CQL) for a group of seven Practices across the Black Isle and Beauly surround. I also represent South and Mid-Highland as their CQL representative.

The CQL role has a remit to improve health care standards and my comments below reflect significant concerns in relation to the national Vaccination Transformation Programm (VTP).

- That the current VTP model, particularly in NHS-Highland, is failing to provide effective vaccination uptake for children and eligible flu groups
- That the current national VTP likely costs significantly more than the previous model
- The IT system used for childhood vaccination does not record into the Primary Care record (we are blind to identify children requiring immunisation)
- The VTP process is creating environmental harm and damage through additional travel and waste
- The VTP model appears to be increasing rural-urban health inequalities.

BMA Scotland in negotiation with the Scottish government produced the "new GP contract" in 2018. This promised to improve the stability of Primary Care in Scotland, its vision was bold. GPs across Scotland voted in favour of this change. Highland GPs voted 75% to reject the contract due to significant flaws within the proposed new model for rural health care. Vaccination was identified by BMA negotiators as a work-stream, that if delegated directly back to Health Board control, would aid a reduction in workload to GP surgeries. It was my belief, that for some regions, this had potential to create real harms: cause a widening of health inequalities, have a greater impact on our environment through unnecessary travel and waste, lead to a reduction in both patient satisfaction and respect for their family doctor, and a larger cost to the taxpayer. In Highland the 2018 GP contract implementation has had an enormous destabilising effect.

I have been a long term advocate for vaccination within my community and the wider Highland region. I ran a grassroots Facebook Group during the COVID-19 pandemic providing pandemic information to the Highland population, and provided free hand sanitiser stations across a number of villages and towns. Primary Care in Scotland faced the COVID-19 pandemic challenge and assisted our transition back to "normal". Without GP surgeries providing the early backbone of the COVID-19 immunisation delivery we would have struggled to do this rapidly across Scotland.

NHS-Highland was the last mainland Health Board to take back vaccination from Primary Care. In part, this was due to local GP pressure. Highland Practices last delivered vaccines to children in Feb 2023, our last seasonal flu involvement was the 2022/2 season. Health Board teams visited each Practice to remove vaccine stock. It was a sad day for our Practice affecting morale. I then had to watch uptake of childhood vaccination plummet. NHS-Highland childhood vaccine uptake figures dropped so badly our Public Health lead requested a peer review report from the national Vaccination and Immunisation division, led by Dr Sam Ghebrehewet. This visit occurred between

6th-14th June 2024. Their report produced 11 recommendations. An options appraisal group was created to look at alternative models. I was a part of this. Over 90% of Highland GP Practices were willing to take back vaccination. Since the review childhood vaccination continues to perform well below the pre-VTP standard. MMR uptake in children aged 6 has dropped off dramatically: 85.2% (previously >91%), uptake is only 71% (was 85%) in the most deprived, and dropped to 85% in the least deprived (formerly >96%). We are now open to historical long forgotten childhood illness. Record numbers of cases of whooping cough and Scotland's first infant pertussis death since 2014 occurred this year. Preventable illness is causing harm. Polio is re-emerging in Gaza, measles outbreaks occur across the country and a number of Primary Schools with SIMD 1 and 2 (most deprived) are likely extremely vulnerable.

Seasonal influenza is a national emergency. Uptake trends are following the same pattern seen in the childhood immunisation programme. Uptake figures in "at risk groups" are down almost 50% from 2022/23. It has taken over 4 weeks longer to vaccinate the 1 millionth flu vaccination patient.

Hospitals across the UK are seeing huge pressures. I feel some of this was absolutely preventable. Through my direct interaction with patients, feedback from my Facebook posts and through discussion with peers, people are finding it more difficult to get a vaccine and have real confusion about how to arrange it. Some very vulnerable people are without protection, waiting for letters, digitally naive elderly struggle with an online booking, or find it physically difficult or too costly to travel far and wide to access their vaccine. This should not be happening. We used to vaccinate over 60% of our local population in 3 weeks through October. Surge population protection. We could target those most likely to benefit and made great efforts to do so. It took effort, it took purpose, and it took direct interaction with patients. All lost in the new system. People now feel anonymous and forgotten. Trying to book my own vaccine slot in early October faced a 3 month wait! Cancelled clinics, and little flexibility to change appointments makes access a challenge. Even the most motivated are finding this new process difficult.

Referencing the VTP cost makes for difficult reading. Despite directly asking on numerous occasions people are not keen to discuss this. I have done my own rough calculation. In 2018 GP Practices were reimbursed on average £8 per influenza vaccination, COVID-1 provided £12.58, Childhood flu £7.67, Childhood immunisations were for a brief period in 2022 reimbursed at £10.06. Through the options appraisal process for Highland I am aware current costs are now in excess of £6 million pounds, and this is like an underestimate.

In 2023/24 approximately 5900 childhood immunisations were delivered in Highland for the national vaccination schedule. Figures for seasonal influenza are not currently available to me. Using an estimated population proportion of 6.1% this equates to approximately 4000 pre-school childhood influenza completed so far in the 2024/25 season. GPs were not responsible for school age children (27000 vaccination). Using these numbers the total childhood immunisation cost for NHS-H using the previous GP payment schedule would have been £86000 (seasonal pre-school flu + national immunisation schedule) Adult costs for seasonal flu can be calculated in the same fashion. Using £8 as the baseline price gives a total of £592,744 (based on 74093 immunisations) and for COVID-19 using £12.58, a cost of £828,883.

The total vaccination cost approximated to £1.5 million. Other vaccines such as shingles, tetanus and other vaccines eligible under the NHS are not included. This would not be a majorly significant added component to costs.

NHS Highland use several locations for vaccination. 32 for Argyll and Bute and 51 for Highland. Not all run every day, each likely has some form of running cost. The “jewel in the crown” of Highland vaccination is the Highland Vaccine Centre based within the Eastgate Centre. NHS-H rents this unit. The Unit was refitted for health care use. The cost of VTP is not obviously visible in NHS Highland accounts. The central vaccine hub is located in Unit 67. A review online suggests the rental, rate and service costs are likely upwards of £200,000 per annum, based on an online review of commercial property adverts for units in the Eastgate. Running this venue alone, exclusive of staff, appears to cost upwards of 10% the previous total GP vaccination budget. I am not privy to the exact costings but merely use it as an possible example of VTP policy impacts the overall Highland NHS budget. GPs in Highland are desperate to help our patients. Supporting Primary Care teams to deliver a sustainable and reliable model of vaccine delivery for those that want it appears a win-win situation for all involved. Please help stop the damage this is doing to our population and health care service.

Dr Ross Jaffrey is a GP

Patient-Led Change

60. Transforming Healthcare: Putting People First Could improve the NHS and reduce costs – Clare Cable

Originally published 04/04/2024

The Queen's Nursing Institute Scotland works with community nurses and midwives to help them build a fairer, kinder, healthier Scotland. We now have over 150 contemporary Queen's Nurses who work in many different roles across health and social care, including care home nursing, mental health nursing, and learning disability nursing.

What we are hearing from the nurses and midwives that we work with is that many of their colleagues are feeling stressed and abandoned, that staffing and resource pressures are making it challenging to deliver person centred care. Yes, more appropriately qualified staff cannot be argued with, but that will take time and investment. QNIS believes that we need to prioritise building a healthcare system that is designed with people and communities, and that utilises nursing expertise in prevention. Community nurses and midwives are an untapped resource and the current system undervalues their contribution.

The challenges faced by the NHS in Scotland are well documented. Audit Scotland's report '*NHS in Scotland 2023*', published in February this year, states that "*Significant service transformation is required to ensure the financial sustainability of Scotland's health service. Rising demand, operational challenges and increasing costs have added to the financial pressures on the NHS and, without reform, its longer-term affordability*."

There are many factors contributing to the rising costs of running the NHS, including increasingly sophisticated technology and an increasing pool of people likely to benefit; staffing costs; increasing demand; an ageing population and greater prevalence of chronic disease; an increasing reliance on drugs; and burgeoning infrastructure requirements. However, rising costs are not the only challenge facing the NHS.

Conditions influenced by lifestyle and cultural factors encompass a range of health issues such as obesity, diabetes, cardiovascular disease, and mental ill-health. Scotland, like many other countries, is seeing an increase in conditions that are influenced by socio-economic and cultural factors.

Obesity rates, for example, have been rising in Scotland, leading to higher rates of related health conditions such as type 2 diabetes, cardiovascular disease, and certain cancers. Factors contributing to this trend include poverty, the dominance of cheap ultra-processed products over wholesome food, decreased physical activity levels, and psychological factors.

Likewise, mental health, which is strongly influenced by cultural and social factors, has also been a growing concern in Scotland. Issues such as social isolation, economic inequality, stigma surrounding mental illness, and access to mental health services all play a role in the prevalence of mental illness and distress.

It is becoming increasingly urgent for the NHS to adapt to recognise the influence of lifestyle, cultural, and socio-economic factors on health outcomes. Currently care is seen as clinical,

organised around body parts and specialisms, and designed around those providing the care rather than those seeking help.

But what if we built a system that had a more compassionate and patient-centred approach to healthcare delivery. Margaret Hannah's '*Humanising Healthcare*' advocates for just such a system. She emphasises the importance of empathy, communication, and understanding in improving patient outcomes and satisfaction. This involves a shift towards holistic care that considers people's emotional, social, and psychological needs alongside their medical conditions. She highlights the role of healthcare professionals in building trusting relationships with individuals and communities, and creating environments that promote dignity and respect. Ultimately, *Humanising Healthcare* calls for a cultural transformation within healthcare systems to prioritise empathy, compassion, and human connection in all aspects of care delivery.

Margaret Hannah believes that our healthcare system could be better and cost less. She points to the Nuka System of Care which has garnered attention for its success in improving health outcomes, patient satisfaction, and cost-effectiveness. It is a healthcare delivery model developed by the Southcentral Foundation (SCF) in Alaska. It serves as a model for person-centred care that prioritises cultural responsiveness, collaboration, and innovation.

Before the development of the Nuka System of Care, Alaska faced several challenges in its healthcare system, including geographic barriers, health inequalities, cultural insensitivity, fragmented care delivery, workforce challenges, and funding and resource constraints.

Key features of the Nuka System include:

- Primary Care serves as the central point for coordinating all aspects of a person's care.
- People are assigned to interdisciplinary Family Wellness Teams that typically consist of a primary care provider, nurse case manager, behavioural health consultant, and administrative support staff. This team-based approach allows for holistic and coordinated care.
- Building strong relationships between people and their care teams is a core principle of the Nuka System. This focus on trust and communication helps improve engagement and outcomes.
- SCF places a strong emphasis on collecting and analysing data to measure performance and identify areas for improvement. This commitment to continuous learning and quality improvement drives innovation and efficiency within the system.
- SCF actively engages the community in healthcare planning and decision-making through advisory boards, focus groups, and other participatory mechanisms.

Overall, the Nuka System of Care integrates self-care (of communities and of its staff) and compassion into its healthcare delivery model by empowering citizens, creating supportive relationships, addressing cultural needs, and promoting holistic wellbeing. These principles contribute to a person-centred approach that prioritises the dignity, autonomy, and wellbeing of individuals within the healthcare setting. Nuka restores hope, meaning and connection in people's lives.

It is becoming increasingly apparent that the levers traditionally used to control healthcare spend are not sustainable. There is little evidence to suggest that finding efficiencies, reducing demand, and implementing staffing policies such as pay freezes and not filling vacancies, make any significant dent on rising spend and therefore do not provide a long term solution to the challenges facing the NHS in Scotland.

With the right support structures and policy framework, Scotland could deliver better healthcare at a lower cost, and whilst it may seem like a mammoth task to transform our National Health Service, there are already examples of a more compassionate way of providing care taking shape on smaller scales within communities across Scotland.

QNIS has worked with community nurses and midwives to support a number of projects including mental health nurses providing trauma-informed access to cervical screening for those who have experienced sexual violence; parish nurses providing health promotion, education, and support services to those experiencing homelessness and addiction; family nurses developing a local peer support network to encourage and support breastfeeding among teenage mums; and a dementia nurse consultant providing a programme to improve the psychological wellbeing of family carers.

Integrating compassion and supportive relationships is also a focus of QNIS's work. We recently delivered a programme of online workshops for community nurses and midwives in primary care working in some of the least affluent areas in Scotland. We know that populations in these areas have much greater rates of adverse childhood experiences. This matters for later relationships, including relationships with health and social care providers. Recognising the impact of adversity means adapting clinical practice, and adapting the organisation of services, to account for the ambivalence felt by traumatised people when they access healthcare.

Inspired by the work of Scotland's Deep End GPs, the workshops focused on the importance of the relationship between the person receiving care and the person providing it. By drawing on contemporary psychodynamic ideas, the workshops aimed to deepen participants' abilities to understand how this relationship works, make sense of all the things that influence it, figure out how to respond in ways that strengthen it, and promote therapeutic optimism. Initial evaluation of these workshops has been very positive and we hope to be able to continue this work in the future.

There are already parallels between the Nuka system and Scottish Government's health policy in terms of the emphasis on person-centred care, community engagement, and integrated service delivery. By recognising the influence of real life on our health and shifting our approach to how we treat illness, Scotland has the potential to create a radically new and improved National Health Service that truly puts people at its heart.

Clare Cable is the Chief Executive and Nurse Director at the Queen's Nursing Institute Scotland

61. Healthcare Needs to Address Biography as Well as Biology – Margaret Hannah

Originally published 28/05/2024

Introduction

There is a consistent thread which runs through the various contributions to Enlighten's NHS 2048 debate which is a desire to keep our NHS public and largely funded from central taxation. Equally consistent is a concern that this is becoming unachievable: waiting lists are sky-high, the workforce depleted, governance and decision-making are poor and there is an over-reliance on short-term, disjointed and incremental solutions. More hopefully, there have been hints from some contributors and examples from around the world showing we could organise very differently and build a more effective and resilient NHS for the future. But this requires a deep culture shift and has to be underpinned by fresh thinking – a new paradigm for health and care.

In this contribution, I describe such a paradigm shift taking place which sees relationships and community health as essential alongside care and treatment for individuals. Effective reform of the NHS is being enabled by a shift in the mindset of the clinicians who work in it. There are pockets of a new system growing in Scotland and around the UK. I will conclude with a brief update on IFF's work in this arena – humanising healthcare for NHS 2048.

Body-part medicine

There is much to celebrate in modern medicine which can treat and extend survival in a large number of well-defined conditions. But patterns of disease are changing. If you are over 65 years old in Scotland, you are more likely to have two or more health conditions than one. Over 75, over 50% of the population has three or more health conditions. It is not uncommon for younger adults to have long-term conditions with the impacts of COVID on physical and mental health well-documented. This change in the pattern of disease means many more people require healthcare treatment for long- term conditions. Part of this is because of the improved survival from many previously fatal conditions. In this sense, we are victims of our own success.

It is taking a long time for the healthcare system to adapt and respond effectively to this changing pattern of disease. Whereas attention on individual pathology within different body parts has led to major discoveries and treatments for specific forms of trauma and diseases, there is a limit to the effectiveness of this reductive approach when dealing with chronic ill health.

Moreover, many people and clinicians are finding medical definitions inadequate to describe the nature of what is being experienced as ill health. Even when physical markers of disease are found, treatment options can be limited and are rarely curative. The traditional body-part approach to illness is no longer sufficient as a treatment response.

Research in the last two decades has gradually revealed connections between our life experiences (biography) and our health (biology). Chronic stress from poverty, discrimination, institutional bias, poor housing and air pollution have cumulative effects. Arlene Geronimus has described this as "weathering" – the impacts on the body of living in an unjust society. How effective can healthcare be if someone returns to an unheated home, with no-one to call in to check how they

are getting on? What happens after someone is treated for head injury if they go back to a violent partner? A child treated for their asthma attack can only partially recover if they live in a damp flat.

Relational health

There is growing acknowledgement of the social nature of health and wellbeing: the paradigm is shifting. For example, in a recent report on the epidemic of loneliness the US Surgeon General's states: "O*ur relationships are a source of healing and well-being hiding in plain sight – one that can help us live healthier, more fulfilled, and more productive lives."*

Quality relationships provide a web of human connection and help grow collective approaches to improving health and reducing the burden of disease. They are integral to achieving local collaboration for whole community health. To give a flavour of what's different about this way of working:

- It sees the whole person, not only the disease, problem or condition people present with. This enables people to understand what's happening to them in the context of their own lives. It helps them work towards recovery from illness and distress by drawing on a range of help which comes from personal and lay networks as well as professional health and care providers, reducing reliance on the latter.
- Health and care staff have person-centred conversations routinely with people, helping them discover for themselves what matters to them and enable them to shape their lives accordingly. The word "Patient" is used less and "People" or "Agents" is used more.
- It sees staff as having their own health needs and takes their wellbeing seriously. This restores and sustains staff, leading to better retention and reduced sickness absence.
- Managers are working towards people achieving their personal outcomes with governance and resources to enable this. This turns out to be much more cost effective than current use of funds.
- With the system designed to help people and communities achieve what matters most them, it improves working lives and generates mutual thriving, reversing the current trend in costs and workload pressures.
- Advanced technological treatments are still available but used in conjunction with well-informed shared decision-making. People are given time to come to their own judgements on risks and benefits in the context of their own lives.
- The system is not confined to individual care. Rather, people (formerly known as patients) are seen as whole persons with histories and cultures, embedded in families, personal networks and communities. Practitioners are skilled in producing inclusion to enable everyone to feel their views are listened to and taken seriously.
- The system creates a strong synergy between the needs of our planet and of people with both supported by transformation of the health and social care system. As such, it configures around an economy based on reciprocity, mutuality and sources of abundance.

What is evolving is a practice of *community health* – creating the conditions for better health and care through the combined efforts of everyone in local communities. Where this is working well,

health centres are doing less one-to-one care and more group work, signposting, connecting and working with people in their communities in health-related activities. The Queen's Nursing Institute for Scotland understands the value of this way of working and is enabling community nurses to work effectively in real partnership with local people. Health Connections in the Mendips, Somerset starting in the Frome Health Centre is now operating across a large number of connected towns and villages in the region. Working with local people, they are speeding up hospital discharge, helping people to stay well at home for longer and through group work, increasing health literacy in self-managing many health conditions.

IFF is fostering learning and networking with practitioners, healthcare managers, educators and others keen to evolve this way of working. Slowly this paradigm shift is taking hold, enabling a humane, responsive and resilient system in health and care to grow across the UK.

Dr Margaret Hannah FFPH is the Director of Health Programmes at the International Futures Forum

62. Enabling Individuals to Be Active Participants in their Health and Wellbeing – Sara Redmond

Originally published 11/06/2024

Public service reform is often viewed through the narrow lens of delivering better services for the public in a more sustainable manner. Yet an important missing dimension is a focus on the purpose of public services and where reform is needed. Scotland needs reform that brings greater empowerment for people with lived experience of accessing health and social care.

When we review the evidence of what makes up an individual's sense of wellbeing, health features as one of the most important parts. Health matters, and when we experience ill health, it impacts negatively on our wellbeing. Currently there are more than 2 million people living in Scotland with one or more long term condition and recent projections predict that our health as a nation is going to worsen over the next 20 years. Furthermore, you are more likely to experience ill health and from an earlier age if you are living in deprivation.

Yet there is insufficient attention given to shifting the focus of the health and social care system on supporting people to realise good health and wellbeing. One of the key drivers outlined by Christie was to deliver better outcomes for people which avoided and prevented the amount of harm and unmet need that is currently too often a feature in our services and how they integrate.

I would not deny the current analysis that the NHS is facing crisis, nor indeed social care, and can't overlook the burnout and harm too many of the workforce are feeling because of the current way in which they are being required to carry out their roles.

But we must acknowledge that often time is spent on doing things that don't offer the outcomes people need and value.

At the Health and Social Care Alliance Scotland (the ALLIANCE), we know from the people we engage with that the ways health and social care services are delivered do not meet individual's needs. Through our Health and Social Care Academy[i] we have been exploring with a range of people working in and accessing health and social care the systemic changes required to make a more equitable society with public services designed to support people to thrive. One of the ambitions for change is to move away from measuring success in health and social care from short-term targets towards the outcomes that matter to people.

All too often challenges in health and social care are described with reference to delayed discharges waiting lists, increasing demand, and long waits in ambulance bays. Yet I would suggest that these are the symptoms of a wider systemic issue – the disempowering way in which services and care are delivered.

Yes, there are too many people sitting on waiting lists to see a healthcare specialist or to get health and social care services. However, the issue is not just the waiting lists, but the limited engagement with the person about the options and support available to them *while* they are waiting.

Rising demand could indicate that people increasingly understand what treatment, care and service options are available to them, rather than this being about growing need (and often need which goes unmet).

The limited control and involvement available to people navigating their way through health services is a key driver of the inefficiency that should be designed out of the system, alongside the reductionist way in which health and social care defines a person by the nature of their condition, their symptoms, or an equivalent label.

There is a well-developed evidence base – including the Marmot Review and its '10 years on report' – that outlines having control over one's life is critical to an individual's health and wellbeing.

Over the past 18 years the ALLIANCE has actively engaged with thousands of people across the country on multiple issues. We regularly hear people describe the systemic harms they have encountered when trying to access care, support and treatment, and which ultimately leads to disengagement. There is a concerning accountability gap in the health and social care system.

People too often describe the passive way in which they are engaged with – commonly describing having to fight, feeling 'gaslit', the self-doubt this can lead to, and to "significant impact on my mental health" and "suffering as a result". "People are bounced around like pinballs in a pinball machine and then we wonder why they disengage[ii]".

One of the most seminal pieces of policy making the ALLIANCE was involved in was the co-production of the 'Self Management Strategy for Scotland: Gaun Yersel', which was led by our members in partnership with Scottish Government. This strategy describes, through a focus on powerful composite stories, the importance of the health and social care system working with people as active participants in their health and wellbeing, and of the need to see the whole person beyond merely the condition they present with. It was bold not only in prioritising a focus on supporting people to be equal partners in their health and wellbeing, but also by 'walking the walk' by inviting individuals with lived experience and the third sector to write the strategy and leading the agenda. Change happens when power is shared[iii].

Despite a shift to greater involvement and recognising the value of lived experience, and an attempt to be more inclusive and person centred in Scottish policy and legislation, there are still very limited and constrained ways for people to have meaningful engagement in redesigning the system. There is much to welcome in the Realistic Medicine narrative which has been present in Scotland for the past few years, yet the importance placed on shared decision making in policies and action plans is not being seen in their implementation. Indeed, I would suggest there needs to be even greater ambition by moving towards supported decision making in line with the UN Convention on the Rights of Disabled People.

I believe there are two fundamental shifts required if public service reform is to truly serve people across Scotland – free, active and meaningful participation, and empowering, inclusive prevention.

This first shift is towards greater participation of people with lived experience in decision making – both individually as an expert in their own experiences and also collectively at the level of system reform. I would suggest that this needs to be deliberative, inclusive of a diverse range of perspectives, and meaningful.

I often hear views expressed by policy makers and healthcare professionals that 'peoples need to take greater responsibility for their health', but the same could be levelled at the NHS. We get the system we have designed – so policy makers and professionals must recognise their responsibility for redesigning it, be courageous, and ask themselves who is well placed to identify the reforms which are needed. I would argue that it's the people whose health outcomes are currently not being met by the current system. They, too, have a right to participate in free, meaningful and active decision making; a right that is too frequently infringed.

The second shift is to understand that prevention is impossible without inclusive, empowered communities. The circumstances in which we live have a greater role in shaping our health than the NHS. The focus must shift away from merely focusing on the services that are delivered towards a strategy for mobilising and supporting community assets. We only need to consider what happened during the COVID-19 pandemic, which demonstrated the significant role that communities and the third sector played in supporting people when statutory services were redirected or stopped. Yet this essential sector of voluntary organisations, charities, social enterprises and community groups is still overlooked and undervalued.

The concept of social capital is an important one when understanding the risk and protective factors in individual and collective health and wellbeing. By social capital I refer to the existence of strong bonds and trust, communication, joint activity, cohesion and a sense of collective efficacy within a community. Wider evidence describes the need for neighbourhood connections, decision making influence, supporting a community's capabilities, as well as consistency and commitment over the long term as enablers which can lead to greater community agency and control.

Scotland was pioneering in setting up the Self Management Fund for Scotland back in 2009. Since then, the Fund has invested £26 million to over 430 community led approaches that work to empower and support people to live well. Scotland also demonstrated social innovation by recognising the need to invest in a role that combines a focus on self management and empowerment, with a deep understanding of the social determinants of health, to bridge the gap between services and communities – the Community Links Worker role. The ALLIANCE has been fortunate to lead and work with Scottish Government on both these initiatives, but both have also been constrained by the limits of short term funding or a lack of a strategy to sustain them.

We need to move away from short term pilots, these serve to destabilise the third sector and community trust and engagement.

Millions of people living with long term conditions are self managing daily, but without access to the building blocks of good health and within an environment which has enabled a range of health harming commercial activities to flourish which expose people to negative health outcomes – gambling, alcohol, tobacco, foods and drink high in fat, sugar or salt.

Rather than being left to 'get on with it', the approaches invested through the Self Management Fund and the Community Links approach demonstrate the support we need for people to feel empowered and able to live well. They are examples of the enabling scaffolding which help people feel able to 'take greater responsibility' but this needs to be accompanied by a reframing of this narrative which moves us away from a blame culture towards an unwavering commitment and long term strategy of investing in our communities and the building blocks of health.

I refer to the previous contributors who have critiqued the problems with NHS governance and the confusing, dislocated government strategy for health and social care in Scotland. To this I would add that if we are serious about focusing policy on prevention and investing in the conditions which support good health and wellbeing, we need to shift the locus of the conversation away from policy makers and those who work in the system to people and communities. Decision making must be shared with – if not led by – the people accessing health and social care. They should have a greater and more meaningful say in the changes which are needed. Crucially, this is the route through which to mobilise and support community agency but which will require a fundamental change to existing culture, mindsets and practices.

Sara Redmond is the Chief Officer of The Health and Social Care Alliance Scotland

[i] Five Ambitions for the future of Health and Care – Health and social care integration (alliance-scotland.org.uk)
[ii] Analysis Full Report – National Collaborative – Health and Social Care Alliance Scotland (alliance-scotland.org.uk) [iii] Five Ambitions for the Future of Health and Care – Health and Social Care Alliance Scotland (alliance-scotland.org.uk)

63. Microfinance in Scotland – Neil McHugh, Olga Biosca & Cam Donaldson

Originally published 26/06/2024

In a recent blog, we reviewed the role of social finance – specifically in the form of social impact bonds (SIBs) – as an alternative (or supplemental) mode of financing health services.[1] At least rhetorically, there is great enthusiasm for SIBs, although, as we showed, this is not necessarily backed up by experience and evidence. However, social finance has other potential roles beyond aiding politicians looking for innovative ways to fund our public services. The other main form of social finance that we have examined in our work is that of microfinance. As well as helping fulfil the right of access to credit for those worst off in society, recent research has shown it to have more-pervasive positive impacts on health and wellbeing. Thus, as opposed to SIBS trying to get more money into the health care system, here we are suggesting that microfinance for individuals may, through helping them out of poverty, poor housing etc., or at least live more stable lives in such situations, also contribute to poor health outcomes. Yet, rather contradictorily when compared with SIBs, we are seeing governments withdraw from supporting the key community development finance institutions (or CDFIs) who operate most microfinance provision in the UK. Scotland is no exception, with the closure of our only CDFI offering small, personal loans at fair interest rates – Scotcash – announced last year. This policy move requires some unpacking and, perhaps, rethinking.[2]

In the UK, estimates suggest that millions of people are still under-served and denied access to the financial services they need to buffer against shocks and build financial resilience. Poor or no credit histories, low and unstable incomes, digital exclusion, immigration status, or language barriers, among others, are all common challenges to accessing loans at affordable interest rates. At the same time, 18% of families in the UK had no savings in 2021-2022. Perhaps as a consequence of this there is evidence that 22% of adults have increased or started their borrowing during the cost of living crisis. However, access to affordable lending is certainly not expanding at a similar pace. Options to smooth consumptions are limited with the main alternatives being high-cost lenders (also in decline due to financial regulation introduced to protect consumers), illegal lenders, and Buy Now Pay Later (BNPL) products which help spread costs of large purchases but can also become extremely costly when payments are missed or late.[3]

What is microfinance? How can it impact on health?

It is important to acknowledge that microfinance is not new. There are several historical examples of communities aiding each other financially; some of which developed into long-standing institutions such as savings banks and financial cooperatives or credit unions. More current examples have come in the form of microfinance institutions, such as Grameen Bank (founded by Nobel Peace Laureate, Muhammad Yunus, after whom our research centre is named). These examples are all documented in our recent book.[1] These days, microfinance is associated with lower-income countries through the provision of collateral-free small loans, mainly for enterprise, to the poorest of the poor.[3] Once these banking communities are established, they have been able

to build health initiatives on top, so enhancing access of their clients to advice and care that would otherwise not be possible.

In more-advanced economies, its role is different. Mostly, loans are issued to cover personal needs and for income-smoothing, as illustrated avbove. Our work has demonstrated the potential of this not only to enhance people's financial wellbeing but also their health.[5-7] The mechanisms for this are multiple and complex. For example, microcredit enables borrower's capacity to plan and feel secure when faced with (un)expected financial events, reducing the associated stress, sustaining social relationships and empowering borrowers to take greater control over their lives.[6] Although, in lower-income countries, the priority might be that of enhancing access to health care, in higher-income countries, we are talking about microfinance acting on the social determinants of health by acting on 'upstream' aspects of people's lives. This is due to the persistent inequalities that exist in such countries – again, Scotland being no exception, where we know that inequalities in income are strongly related to inequalities in health and where traditional approaches to public health, such as telling people to reduce more-risky behaviours (e.g. smoking, drinking, drug use) do not appear to be working. We need to think differently about acting on the wider, more structural, aspects of people's lives, and microfinance is one possible vehicle for that.

To be clear, we are talking about financial institutions, CDFIs, adjudged to be providing loans at fair rates as well as sound advice on financial management, including savings. A large part of their missions is to avoid people being driven into the hands of 'loan sharks' and never being able to create any surplus or relief for themselves. Perhaps to the disadvantage of CDFIs based in Scotland, there is a strong network of credit unions here, and an accompanying myth that they are able to handle the savings and loans requirements of the clients we are talking about. Credit unions generally target more-affluent households and have quite restrictive rules on lending. This is not a criticism. It ensures their survival, but just means that finance policy continues to fail a substantial group of Scotland's least-well-off.

Such a situation is unfortunate, to say the least, when our conceptualisation of 'microfinance as a public health initiative' provides a new lens through which to view different forms of social finance opening up the 'evaluative space' when assessing such initiatives. Although a nascent area of research, empirical evidence is suggestive of microcredit – through its general use, lending and repayment mechanisms – positively impacting on upstream determinants of health. Interestingly, this is the case in both lower- and higher-income countries. This provides a counterpoint to the traditional narrative of the Global South learning from the Global North. The innovative responses of some microfinance institutions to the COVID-19 pandemic, especially for those living with long-term conditions, provides a recent and pertinent example of how microfinance can enable their clients' in managing their long-term health conditions.[1]

Where now for policy?

For public health stakeholders, microfinance represents another way for thinking about how to impact on health. Microcredit, for example, will not dramatically reduce health inequalities. However, this is beside the point. Evidencing microcredit as a socioeconomic determinant of health demonstrates the importance of non-health interventions and initiatives for health outcomes. At a minimum, the provision of microcredit illustrates how to avoid inflicting further

unnecessary harm on vulnerable individuals through, for example, stress, shame and guilt. More constructively, there is scope for debt being a positive experience that contributes to, for example, increases in confidence, control, feelings of self-worth and social participation. Taken together, this body of work illustrates the importance of not just *what* you do but *how* you do it.

For microfinance practitioners, evidencing how their institutions positively impact on (determinants of) health adds to the case for regulation, and public sector funding, designed to strengthen and develop these alternative economic spaces. This is particularly relevant for those institutions operating in contexts that cannot benefit from economies of scale. It costs about as much to administer a microloan as it does a larger loan; likely more given all the advice and alternative forms of affordability-checking that go on. This is why the big banks and other financial institutions are not interested; it is easier just to innovate in providing more trendy and accessible services to the middle class; but it does little to advance the lives of populace more widely. Estimates indicate that each year in the UK, microcredit providers originate just £250m of loans, while over the same period, high-cost short-term credit providers originate £3bn – more than ten times as much.[8] Microlenders already respond to market failures, operating in areas vacated by private sector institutions who cannot generate a profit. The relatively high transaction costs require subsidisation, especially with research emerging as regards positive social impacts of microfinance. Short-sighted governments in advanced economies, including Scotland, are failing to see the potential for microcredit to be part of a progressive welfare state and, as we have seen above, the funding landscape fails to recognise such wider social benefits. But glimmers of hope can be seen, especially where dormant assets have recently been ring-fenced for initiatives focused on financial inclusion. Organisations such as Fair4All Finance, one of our partners in the ongoing Real Accounts research project led by Nest Insight, have been working, since 2019, on addressing the problem of access to affordable microcredit in England through funding providers using dormant assets. Financial Inclusion for Scotland has argued that dormant asset monies should be similarly deployed in Scotland. In fact, this is the main recommendation of Scotland's first Financial Inclusion Strategy, published last month.

Conclusion

The challenge of arresting the growth of health inequalities requires new solutions. Different forms of social finance could complement their more traditional publicly-financed and public health counterparts, leading to health creation in ways not often recognised. While microfinance acts imperfectly in these roles, the process of exploration has generated new tools for action to policymakers, practitioners and researchers working in, and across, public health and microfinance. However, it seems that the place of microfinance is not being recognised adequately in Scotland, leading us to fail those in vulnerable communities suffering the most from multiple inequalities.

Neil McHugh PhD and Professor Olga Biosca PhD are from the Yunus Centre for Social Business & Health at Glasgow Caledonian University. Cam Donaldson PhD FRSE is the Yunus Chair & Distinguished Professor of Health Economics at Glasgow Caledonian University and Professor of Health Economics at the National Centre for Epidemiology & Public Health at Australian National University.

References

1. McHugh N, Biosca O, Donaldson C. Social Finance and Health. Routledge, Abingdon, Oxon, 2024.
2. McArthur M. Glasgow affordable loan lender Scotcash to cease lending. Glasgow Times, 15th May 2023.
3. Financial Inclusion Commission. Fixing Financial Exclusion across the Four Nations. June 2024. https://financialinclusioncommission.org.uk/wp-content/uploads/2024/06/FIC_Fixing_Financial_Exclusion_2024.pdf
4. Yunus M. Banker to the Poor. Aurum Press, 2003.
5. McHugh N, Biosca O and Donaldson C. From wealth to health: evaluating microfinance as a complex intervention. Evaluation 2017; 23(2):209-225 (DOI: 10.1177/1356389017697622).
6. Ibrahim F, McHugh N, Biosca O, Baker R, Laxton T, Donaldson C. Microcredit as a public health initiative? Exploring mechanisms and pathways to health and wellbeing. Social Science & Medicine. 2021 Feb 1;270:113633.
7. Biosca O, Bellazecca E, Donaldson C, Bala A, Mojarietta M, White G, McHugh N, Baker R, Morduch J. Living on low-incomes with multiple long-term health conditions: a new method for disentangling the vicious circle. PlosOne.
8. Fair4All Finance. £65 million in Dormant Assets funding released to Fair4All Finance. Fair4All news. 20th May 2020. https://fair4allfinance.org.uk/about-fair4all/

64. A Patient's Perspective – Liz Bow

Originally published 18/07/2024

Let me introduce myself.

I have Spina Bifida and for much of my life I have required NHS intervention. This has given me great appreciation of the health service and the good it can do when it is working well. But, as with many other patients, I have also experienced frustration and disappointment.

I have had the privilege of representing patients on many groups including, the Nairn Patient Participation Group and NHS Quality Improvement Scotland. I also chaired the Nairn Access Panel which was aimed at increasing participation, integration and inclusion in Nairn, and was fortunate to be involved as a patient representative in the planning for the multi-disciplinary community hospital in Nairn.

From my experience I think there are two particular issues that need to be addressed by the NHS in Scotland – understanding the importance of good locally delivered care; and improving data sharing.

Staying local

In Nairn I have experienced first-hand the many benefits of good local care. Without the wonderful support from my GP practice and local Community Hospital I would have spent many months of my life in bigger hospitals, away from my family and community.

Continuity of care is so essential for a complex case like me, but because of the different way of working in Nairn, continuity of care is still delivered in our community. The local team involves nurses providing out of hours response care with our own GPs on call 24/7. The whole local team liaise and co-ordinate with the hospital and community care to meet individual needs.

The staff are confident and proud of their work. And being treated and looked after in my own community, by people who know me, also helps build up trust and understanding between patient and medic.

I am aware that this way of operating is not the norm across Scotland and the level of holistic care that I am used to is sadly lacking in too many general and acute hospitals.

Obviously not everything can be done at a local level and specialist services are required. Thanks to the ability of a GP to provide a referral to a named consultant anywhere in the UK, I was able to have highly specialised lifesaving back surgery for my scoliosis in Nottingham in 1998, surgery that could not have been delivered in Scotland.

We don't need every specialism to be delivered everywhere in Scotland, but we do need access to specialist teams and individuals who are able to treat us in a timely manner.

During the last 12 months I have experienced care in a district general hospital, a London city hospital, and our local community hospital. The hospitals were each appropriate for my care needs at the time. However, time in the district general could have been reduced by transferring me for

the second week of treatment to our community hospital, which would have enhanced my care and prepared me for discharge.

Data sharing

The period in the London hospital also highlighted to me another issue that the NHS needs to address in terms of sharing information.

I became very unwell recently whilst on holiday and I had to spend time in emergency care in London. The experience was a far cry from what I am used to.

Caring staff were fighting a losing battle, unable to provide the care needed under impossible circumstances. I had seen news coverage of such problems, but to experience it as a patient was challenging.

I was 'fortunate' and spent only 12 hours on a trolley. The hospital was at capacity, there were no free beds and at least 20 trolleys with very unwell patients being cared for by paramedics & ambulance staff.

I was also surprised at the fact that the NHS England were unable to access my medical records from NHS Scotland. As I have outlined, I have required a great deal of medical care over the years, so to find myself in a situation where I was unwell and struggling to convey information directly, it seemed incredulous to me that the NHS in England could not access my records.

While health is devolved and responsibility for the service rests with two different governments, in this day and age bureaucracy seems a poor excuse for an inability to share data.

Indeed, this is not only a problem that exists between countries, but also within Scotland where information is not always shared between GP and hospital; or between hospital and health worker. How many of us have had to explain our history on multiple occasions because there is not shared access to our files? Again the local multi-disciplinary approach in Nairn has reduced this problem locally.

I am now ticking the last box for age group on forms. This is a genuine refection on the excellent health and community care I have experienced, without which I would never have reached this milestone.

I have had a long and happy married life, 2 beautiful children, but have also had great sadness and loss. I have benefited greatly from being part of a hugely supportive community in Nairn, a community that came together to create a wonderful legacy for our family in the town, www.teamhamish.org. That community sprit has been key to the wonderful healthcare I have been fortunate to receive and I hope others can learn something from our successes.

Liz Bow MBE

65. Relational Injury & Relational Access to Healthcare – Adam Burley

Originally published 28/11/2024

What is healthcare if not, at its heart, a relationship? We hear people talking of going to an appointment, or visiting the GP, or even seeing the eye specialist. What do they mean? I might argue that they may not notice it, but they are describing entering into a relationship where they will play the part of someone seeking care in relation to someone who will hopefully be able to play the part of providing it.

Similarly, as the consultation plays out, they may not notice that any relationship is happening – they enter the consulting room, describe their symptoms or complaint, and the health professional nods sincerely and offers care appropriate to their understanding of the issue. If all goes well in this relational transaction then healthcare is delivered, and both sides of the relationship can go home feeling fulfilled and happy, completely unaware of the relational aspect of what either of them have just taken part in. I often refer to this as the 'John Lewis' model of healthcare; A care relationship that goes smoothly, untroubled by any real relational anxiety, leaving both parties feeling as if something useful has happened. So smoothly in fact that the relationship element is almost invisible due to its mundanity – like the air around us that quietly keeps us alive. I would suggest however that for any healthcare to happen then to a greater or lesser degree this type of relational dynamic needs to be present. Interestingly I have never seen this overtly (or even covertly) stated within health service literature – in fact there seems to be a basic unstated assumption that everyone can do the healthcare relationship with equal capacity; that everyone has equal relational access to care.

But where do any of us learn to do this care relationship? We all start in relationships – in fact our psychological and physical survival is dependent upon it. A new-born infant will not survive long in this world if it cannot get into a relationship with a caregiver in pretty quick time, and after that on an ongoing and regular basis. In this regard it is a relationship of extreme vulnerability; a vulnerability that may not be noticed as long as it is responded to appropriately, but one that may become all too apparent if it is not. One might even say that continuity of care is essential for life, at least initially, and possibly for the full duration. This perspective throws a particular light on the care relationship, positioning it as one of *the* fundamental human experiences, and one that given its occurrence within such critical periods of development is learned quickly and so deeply that it can last a lifetime. But as with many of the things that we learn in our early years we typically do so in an unconscious way, meaning that we do not notice it happening (who can remember learning to speak? And who has ever tried to unlearn it?). We learn automatically and carry that learning into adulthood in ways that we are not always fully aware of.

The connection with healthcare provision should be clear. The healthcare relationship is one that maps very closely on to care experiences that we learned about at times that we did not know we were learning, and certainly at times where we had no *choice* in *what* we were learning. If we were lucky, we learned that being-in-need-of-care was a safe relational place to be, one relatively free from anxiety about how the need would be met. From these experiences we may then be able to

go forward into the rest of our life with enough relational capital to freely access healthcare almost completely unaware of the resources we have that allow us to do so. We can walk into the GP surgery or hospital clinic troubled only by the anxiety related to the procedure rather than any fear about the relationship surrounding it. But this is not a universal experience.

There are many people for whom the earliest experiences of being-in-need-of-care were run through with large and at times chronic and unmanageable levels of anxiety and fear. Developmental trauma, just like healthcare, tends to be defined by, and occur within a relationship. For those whom being in early dependent relationships was primarily a frightening and deeply aversive experience, by virtue of trauma, neglect, or other forms of mistreatment, then the consequences can be a variety of life limiting injuries. These can take the form of the acute physical and psychological injuries associated with the various events they had to endure, as well as longer term physical and psychological consequences. Of these longer-term effects, a severe relational injury is something that can have profound impact upon an individual's capacity to engage with anything where relationships are required – which is pretty much everywhere and everything. By relational injury, I mean a profound insult to the persons capacity to trust, connect and attach to others in ways that might allow them to get even their most basic physical, psychological and emotional needs met. And by severe, I mean an injury so profound that it is learnt as deeply, quietly and routinely as the learning of a language, and so can be just as impossible to unlearn despite different future experience. Such a severe injury can have life limiting impacts across all social and interpersonal settings and across the whole lifespan. From early education that requires a pupil to get into a teaching/learning relationship with a teacher, to the interpersonal and romantic world that require a capacity to trust and believe in the solidity of the other, to healthcare as described above. Such an injury can leave people with a deep feeling of disconnection to the human world they exist in, often exacerbated by a recognition that all around them seem to be able to the business of relating as easily as they breathe – making friends, going to the cinema, finding work, joining a running group…. Like a bird with a deep fear of flying, comfort must be found elsewhere, and there are many who find relationships with psychologically soothing substances are the only ones they can come to depend upon, filling the hole that smashed trust has left behind.

A severe relational injury, like any other injury to a life critical system, if left untreated can lead to a myriad of physical and mental health problems. But where is the healthcare provision that may help them with their growing sense of distress and isolation? Bounded by invisible relational barriers that only they seem to be able to see or feel. For healthcare systems were typically designed by the relationally healthy, and they designed them in their own image – organised around a never verbalised idea that everyone has the relational ability required to access care. But for those with a developmentally acquired severe relational injury, seeking care can feel to be one of the most dangerous things they could ever consider doing. Despite this, there are of some with relational injuries who do manage to seek care and offer some description of their need and distress, but who are then unable to access the care that is then offered. I have heard them called such things as, 'Serial non-attenders', 'Smear defaulters', and 'Time wasters', and seen many signs and notices around healthcare settings that come close to shaming those who do not attend offered care. Conversely, I have not seen much that attempts to think about what we as healthcare providers may not be attending to in these situations. All the existing responses locate the blame

and responsibility onto the patient in a way that we would never get away with should we have placed a wheelchair clinic on the fourth floor of a building with no lift.

And then there are those that are just missing. Those for whom the health services may as well be at the peak of Mount Everest they are so relationally distant. Those for whom the being-in-need-of-care *is* the health problem. Those for whom the relationship with care *itself* is the life limiting condition. For those who try and get so far, and for those who cannot even manage that, my experience is that the condition is typically a worsening one. As care is *not* accessed, potentially treatable conditions worsen, and as conditions worsen and the need increases, so does the anxiety and fear about seeking care. And so, the injury is progressive in all the wrong ways. Conditions that may have been ameliorated with relatively straightforward care become chronic and lead to the development of secondary issues. The increasing sense of disconnection and aloneness leads to an ever-worsening state of mental health. The healthcare system is in sight, but the relational stairs are too many, too steep, too costly, too remote, too frightening. Too dangerous.

I would argue that for those with severe relational injury, the continuity of care is not the context within which care needs to happen, rather it *is* the care that needs to happen (as was actually the case for all of us in our developments.) This may not be easy work, as relational dynamics born in trauma can often be traumatic to be part of, and in the absence of a dedicated 'NHS trust repair service', difficult to fit into current job plans.

Those with severe relational injury are at least four-times disadvantaged. Firstly, their early experiences leave them at increased risk of developing a range of physical and psychological difficulties. Secondly, the services they could benefit from can only be fully accessed through a relational capacity that their injury has left them without. Thirdly, it is not unusual that the ways in which their relational injuries manifest do not evoke care, concern or compassion in those trying to deliver care. Fourthly, the longer they are without care, the worse their care needs typically get, and the less likely they become to seek anything that might address those needs in a progressively worsening cycle.

I would argue that we need to recognise that there are some injuries that while not readily visible or discernible on any scan or x-ray, are nevertheless present and are of such a severity as to be chronically life limiting. We need to recognise that our healthcare systems, while laudable in many areas of adaptation and accommodation for the limitations people experience by virtue of other injuries, typically make little or no allowance for those who have been most psychologically harmed in their earliest experiences of care, are in the greatest need of health, and who are some of the least able to access it.

Dr Adam Burley is a Consultant Clinical Psychologist. He has written more about the 'invisible relationship' here.

66. Applying a Missingness Lens to Healthcare – Andrea Williamson

Originally published 18/12/2024

Making serious system-wide attempts to address missingness in healthcare may not feel like a high priority with all the current understandable concern about high demand and resource challenges in the NHS. However, it is important as an overarching way to address Scotland's great rhetoric, but poor record on tackling health inequalities.

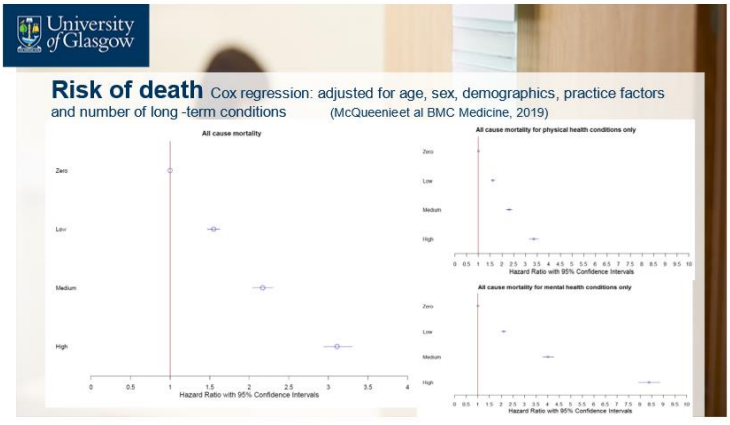
We define missingness as the '*repeated tendency not to take up offers of care such that it has a negative impact on the person and their life chances*'(1).

GPs at the Deep End Scotland are a group of (mainly) GPs campaigning to improve healthcare for people living in the most socio-economically deprived communities. We realised that *multiple* missed appointments was a major issue- a daily concern for practitioners but an invisible issue for policy makers.

For decades there has been a focus on missed appointments more generally, however this has tended to focus on the impact of missed appointments at the *service level* such as cost to the NHS of missed appointments(2) rather than at the patient level, and makes no distinction between one off 'situational' missed appointments and more enduring patterns(3). Our large-scale, Chief Scientist Office (Scotland) award winning research investigated *patterns* of missed appointments at the *patient level* in the general population. This was in more than half a million Scottish general practice (GP) patient records, for the first time(4).

We found that a high rate of missed GP appointments (an average of more than 2 per year) predicted very high premature death rates. Patients were more likely to have multi-morbidity (2 or more co-existing long term health issues), especially mental health conditions(5), and to experience high socio-economic disadvantage and other challenging social factors(4, 6). Patients experienced high treatment burden – the work needed to manage their health – and *missingness* in use of acute hospital services too(7).

These graphs(5) shows the chance of dying between the different patterns of missed appointments. If this stark difference in associated outcomes were for a health condition rather than health service utilisation patterns, there would be outrage.



The existing research was sparse on *why* people may be missing from healthcare and what could be done to address it. It also tended to problematise the issue as being the fault of patients and an issue for services, rather than the fault of services, and an issue for

patients. It was also viewed as being about single issues, hence tended to come up with 'one size fits all', reductive solutions(3).

Our current National Institute of Health (UK) research uses realist methods to create a theory about the causes of missingness and to determine what might work, for whom, and under what circumstances, to address these causes. This was a review of 197 published papers(3), interviews with 61people, and stakeholder workshops with 16 people to review our results, and develop our intervention. Our participants were health and care professionals and people with lived experience of missingness from a range of clinical, social and inclusion health contexts.

We found that causes of multiple missed appointments occurred across the patient journey and are driven by complex interactions between patients' circumstances and the ways in which services are designed and delivered.

Patients may feel that the service is not *for them* – not needed, not able to improve their health, not appropriate, or is unsafe. This may be influenced by past experiences of mistreatment, conflicting understandings of health, poor communication, and offers of care in the NHS that do not 'fit.'

"There's a constant dynamic of conflict [...] and this is a theme you'll find from anybody you speak to, who has a child or an adult with complex health needs, a constant fight. And some people; they get exhausted, and they give up, and I can't blame them." (Jodie, Glasgow)

Some may experience issues physically getting to appointments because of travel costs and difficulties, poor health impeding mobility, and concerns about safety. NHS services have often

specific, inflexible rules for how they are used, making it hard for patients to arrange the right appointment for them – at the right time, by the right method, with the right person

'Missing' patients may be subject to a host of competing demands with limited resources to manage or meet them, including work, other appointments, caring responsibilities, or urgent and pressing needs or crises caused by precarious circumstances.

"*It's all very much about the now, where you're going next. How you're going to make a living. […] Is it 'go to the appointment', or 'I've just been offered this job, which is going to give me a couple of hundred quid in the pocket, which is going to make a difference*." (Naomi, Brighton)

Finally, a lifetime's worth of experiences of stigma, hostility, trauma, and difficult relationships with care may act as a deterrent against accessing care.

We are finalising our suite of interventions developed along with our professionals and experts by experience of missingness. A key aspect of this involves changing the attitudes of NHS staff and the wider public – applying a missingness lens to health care. This, along with additional resource, will create the conditions to make widespread change.

Some mainstream and Inclusion Health GP practices have already started applying a missingness lens. For example, Scottish Government have provided seed funding to Deep End GP practices to provide assertive outreach for patients they identify as at risk of missingness. The early qualitative evaluation of this shows that with some additional funding, a change in thinking and a different response from practices, then a real difference can be made for previously missing patients.

Tangible positive experiences of healthcare, able to adapt to *everyone's* circumstances is required to start closing the health equity gap and realise our ambitions of a healthcare system rooted in human rights.

Professor Andrea E Williamson is Professor of General Practice and Inclusion Health at the University of Glasgow.

Illustrations by Jack Brougham.
Thanks to Dr Calum Lindsay and Dr Carey Lunan who gave useful feedback on the draft blog.

References

1.Lindsay C, Baruffati D, Mackenzie M, Ellis D, Major M, O'Donnell K, et al. A realist review of the causes of, and current interventions to address ?missingness? in health care. [version 1; peer review: awaiting peer review]. NIHR Open Research. 2023;3(33).
2.England N. Missed GP appointments costing NHS millions. UK: NHS England; 2019.
3.Lindsay C, Baruffati D, Mackenzie M, Ellis DA, Major M, O'Donnell CA, et al. Understanding the causes of missingness in primary care: a realist review. BMC Medicine. 2024;22(1):235.
4.Williamson AE, Ellis DA, Wilson P, McQueenie R, McConnachie A. Understanding repeated non-attendance in health services: a pilot analysis of administrative data and full study protocol for a national retrospective cohort. BMJ Open. 2017;7.
5.McQueenie R, Ellis DA, McConnachie A, Wilson P, Williamson AE. Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Medicine. 2019;17(1):2.
6.Williamson AE, McQueenie R, Ellis DA, McConnachie A, Wilson P. General practice recording of adverse childhood experiences: a retrospective cohort study of GP records. BJGP Open. 2020:bjgpopen20X101011.
7.Williamson AE, McQueenie R, Ellis DA, McConnachie A, Wilson P. 'Missingness' in health care: Associations between hospital utilization and missed appointments in general practice. A retrospective cohort study. PLOS ONE. 2021;16(6):e0253163.

67. Real Policy Comes from Real Lives: Why Addiction Strategy Must Start with People, Not Systems – Stuart Patterson

Originally published 22/07/2025

For too long, addiction policy in the UK has been shaped more by metrics than by people. It counts attendance, compliance, and prescriptions—while lives unravel quietly beyond the clipboard. Real recovery doesn't happen on paper. It happens in places of belonging, in honest conversations, and in the slow rebuilding of identity.

We must stop asking why people don't engage with services—and start asking whether services truly engage with people.

A Silent Majority

In 2023, 1,172 people died from drug misuse in Scotland (National Records of Scotland, 2024). Meanwhile, Public Health Scotland estimates only 60% of those with opioid use disorder are in contact with services. That leaves thousands unreached—not just by services, but by hope itself.

These are not "hard-to-reach" individuals. They are often easy to find, but hard to approach with the right kind of help. Traditional services can feel cold, clinical, or irrelevant to the lived experience of addiction. Outreach must begin where people already are—emotionally, culturally, and geographically.

Identity, Not Just Intervention

Addiction recovery is not about simply removing a substance—it's about reconstructing a person. Recovery means helping someone discover who they could become, not just stopping what they've been doing.

When I entered rehab, I didn't need a lecture – I needed a vision. A reason to try. The most powerful recovery catalysts weren't professionals with clipboards; they were people who had walked the same path and still remembered my name the next week. That's where change began.

Yet systems are often built around risk management, not transformation. Compliance Is celebrated. Vision is optional.

Managed Despair

Many policies operate on a deficit model – expecting relapse, measuring stability, and avoiding liability. The unspoken message is: "You'll never be fully well, but we can help you manage not dying."

This is harm reduction as ceiling, not floor. It can keep people alive – but it rarely helps them live.

No one ever said I'd be on methadone for life. But twice, I was placed on it – with no vision for life beyond it. The second time, I reduced my dose from 80ml to 2ml. I did everything asked of me. But no one ever asked what I wanted my life to look like beyond the dosage. I wasn't told I had no future – but I was never shown one.

I didn't relapse—I just returned to heroin. Because I'd never been invited into a different story. My dosage changed. My life didn't.

This is not personal failure. It's systemic drift.

Hope You Can See

Recovery often begins with borrowed hope – someone believing in you before you can believe in yourself. That hope must be embodied in relationships and role models, not just mission statements. It must show up consistently, credibly, and compassionately.

Policy can't manufacture hope – but it can fund environments that carry it.

Peer mentors. Recovery cafés. Church volunteers. Street pastors. These aren't "soft supports" – they're essential infrastructure. They are the spaces where people encounter grace, not just guidance.

Community Is Not Optional

Addiction recovery is relational before it's clinical. It depends on proximity, belonging, and contribution. You don't get free by sitting in a waiting room. You get free when you feel part of something again.

The European Monitoring Centre for Drugs and Drug Addiction (2018) found that community-based models improve outcomes across employment, housing, and wellbeing – especially when led by peers and rooted in real-life settings.

Yet churches, peer homes, and local hubs are often treated as fringe add-ons. Worse, they're asked to mimic clinical systems to qualify for funding – when their very difference is what makes them effective.

In the churches and community groups I'm involved with through my role at Street Connect, I've seen what happens when people in addiction are welcomed without judgement. No referral

forms—just shared meals, honest conversations, and gospel hope. Men and women who would never cross the door of a clinic have found family, sobriety, purpose—and some are now leading others. That's what real community does.

What Gets Measured Gets Funded

Policy still funds what's countable, not what counts. It tracks urinalysis but not trust. It fund retention but not reintegration.

Yet people in addiction don't just need to be monitored – they need to be mentored. They need places where:

- Their stories are heard, not just assessed
- Their growth is celebrated, not just managed
- Their identity is renewed, not just recorded

Imagine a system that:

- Measured reconnection with family
- Funded spiritual care and mentoring
- Valued the testimony of lived experience as real evidence

It's not naïve. It's necessary.

Stop Managing Pain. Start Funding Futures.

We don't just need safer systems. We need braver ones.

Systems that expect people to fail will never invest in who they might become. But systems that believe in transformation – and design for it – change everything.

This isn't about dismantling clinical care. It's about completing the picture. Harm reduction has a vital role – but it's a beginning, not an end.

If we want recovery to be more than rhetoric, we need to:

- Fund the places where hope lives – community groups, churches, peer-led homes
- Invite lived experience to shape, not just inform, strategy
- Shift outcomes from compliance to connection, from retention to release

Because real policy doesn't come from data alone. It comes from lives lived, futures reclaimed, and people who are finally seen not for their addiction – but for their potential.

Stuart Patterson is the Partnership Coordinator for Street Connect and Pastor at Easterhouse Community Church. Drawing on his own lived experience of recovery, he advocates for addiction policy that prioritises transformation, community, and hope

68. Continuity of Care Works – Alastair Noble

Originally published 23/10/2025

The Scottish Parliament on behalf of all our population now faces a simple stark choice. Do we want to continue with our National Health Service and build trust and productivity into our Integrated Health and Social Care Teams, or do we just continue to fragment and destroy the parts of the care service we know work best.

The most difficult diagnosis in medicine to make and get right is to tell a patient there is nothing seriously wrong with them and be proven correct, at least for a time! It is so much 'safer' to say there might be something wrong and keep investigating and referring.

It is important to realise all doctors have the same final outcomes-100% of their patients will be born and 100% of their patients will die. This makes it essential to use Place /Locality data to measure productivity and value for money. Nobody can manipulate or selectively use 'Locality Based data.'

Why is this important?

After the disaster of the 2018 'Glasgow biased GP Contract' we now have the Scottish Government proposing 'Drop-In GP Clinics' to provide one million extra appointments. Again this appears to be very much a 'city model'.

This is just another fragmentation of 'Continuity of Care.' Similar in many ways to giving the responsibility for vaccinations to health boards with no IT back up and no capacity. We have repeatedly been assured that vaccination will be returned to a GP/Locality based service but so far we have seen no hard evidence of that being implemented.

So, what are the numbers about which we are talking?

GP Teams provide 720,000 consultations per week= 37,500,000 per year

A&E Teams provide about 27,000 consultations per week=1,500,000 per year

The 'Drop in GP teams ' are said to be delivering about 20,000 per week=1 million per year.

This is meant to help both existing GP Teams and A&E Teams.

Is there a better more productive and value for money alternative? Well, the obvious answer is yes. Expand existing GP Integrated Locality Teams with all their 'Infrastructure and IT in Place.'

I have argued that the 'Nairn Model 'of Integrated Teams based on one site works best and in particular builds that essential trust between individual patients, their family and community and the appropriate use of secondary/specialist care. It is sometimes worth remembering that a lot of the clinical debate is really at heart an old fashioned 'demarcation dispute'- similar in many ways to the demise of ship building on the Clyde, mainly caused by 'bad management' and 'bad unions.'

How do we now make sure we are not making the same terminal mistake in Health and Social Care?

My advice is that we encourage urgent sensible contract discussions with the Scottish BMA with RCGP Scotland support and use this opportunity to increase existing GP/Community Care Team Capacity. We have GPs and doctors in training looking for jobs. Contracting on a locality based model will enable no delayed discharges in consultant beds. Our Nairn audits showed 80% of our patients attending A&E in Inverness could have been dealt with in our own Community Hospital A&E/Minor Illness unit (perhaps our already in place GP Drop in service, with our own GPs, nurses and other staff and IT in place 24/7.)

The KPMG report on Grampian illustrates very clearly that if you reduce GP out of hours services, followed by closing minor injuries and community hospitals, everybody ends up in Aberdeen Royal Infirmary, with 90% of the bed capacity being used for emergency/delayed discharge care resulting in not enough capacity for elective work and producing longer waiting times for all. The multi agency inspections for services for older people showed over 60% of Occupied Bed Days for over 65-year-old patients were in GP led community hospitals previously. Centralisation is a very dangerous route and tool!

A positive way forward is to commit resources, mainly staff, to Integrated community care teams in each locality. This will be balanced by reduction in staff in consultant care, but most importantly of all it will allow the specialist/consultant teams to deliver what they are best at – real specialist care. All other generalist care should be in patients own locality.

In terms of figures and targets, this could mean an increase from 720,000 to 800,000 per week contacts between patients and their GP/locality care team. As long as we staff the localities properly this is a very realistic outcome/target and will allow real monitoring of clinical and financial data.

We now need leadership and courage. It is best for our patients, their friends and relatives, communities and specialist care – what is not to like about it!

It also means we can easily stay within a 'Fair Share integrated Budget ' and in terms of 'Place Building' encourage a much better allocation of staff across Scotland, especially helping rural locations.

I think we can make our health and social care world class. We have the best data in the world. Now is the time to use it.

Dr Alastair Noble worked as a GP in Nairn and was awarded an MBE for his work in integrating Health and Social Care in Nairnshire

69. Efficiency by Design: Making the NHS more Productive for Patients - Nigel Kirkpatrick

Originally published 04/03/2026

Efficiency is probably the most overused word in health policy.

Every funding settlement assumes it. Every budget promises it. Every programme of NHS reform relies on it. Yet productivity in NHS Scotland remains stubbornly difficult to improve – and even harder for patients to perceive. The problem may not be a lack of will, but rather a lack of clarity about what efficiency in healthcare actually means and where it is realistically found.

Healthcare is not a factory. Outputs are complex, variable, and increasingly long-term. A patient with multiple chronic conditions cannot be processed like a standardised product. At the same time, the NHS cannot escape economic reality. Demand is increasing faster than funding, partly due to Scotland's rapidly ageing population, and clinical expectations rightly increase over time. In this environment, maintaining current service levels already requires productivity growth.

The paradox is this: national policy treats efficiency as a centrally driven target, while operational efficiency is usually local, pathway-specific and clinically led. When productivity becomes an abstract percentage attached to a budget, it risks becoming detached from how care is actually delivered.

In ophthalmology, as in many specialities, inefficiency oftens presents not as dramatic waste, but as friction in the system which patients perceive only too well. Whether this be delayed follow-up appointments, bottlenecks in diagnostics or patients lost between primary and secondary care, they have the same effect as rusted gears grating against one another.

Take glaucoma care. The greatest threat to sight after delayed diagnosis is missed follow-up. Yet across the country, there has historically been no consistent mandate to measure follow-up delays. Where data is incomplete, accountability is blurred. When accountability is blurred, inefficiency persists. This is not about individual performance – it is about system design.

Perhaps unsurprisingly, where innovation is encouraged, meaningful productivity gains can be found. Ones that go hand in hand with treating patients faster and delivering better health outcomes.

Scotland's experience establishing National Treatment Centres offers a useful example of what design-led efficiency looks like in practice. Established by the Scottish Government to increase elective capacity and reduce waiting times, these centres focus on high-volume, planned procedures delivered in streamlined environments. By separating elective care from unscheduled pressures, standardising pathways and concentrating specialist teams, they demonstrate that productivity gains are most durable when they are embedded in service design rather than imposed as percentage savings.

Since our inception in 2007, Newmedica has been working to apply this same logic to ophthalmology services, partnering with the NHS to meet growing patient need with the number

of cases of chronic eye conditions, such as glaucoma, forecast to increase in the coming years as the population ages.

To meet this demand, Newmedica delivers end-to-end pathways, or a partial element working with a hospital, for a range of ophthalmology services including glaucoma, Age Related macular Degeneration (AMD), oculo-plastics and cataracts. By optimising clinic workflows, harnessing the latest diagnostic and surgical technology, and focusing teams on highly specialised pathways, we can treat more patients safely and effectively each day. This doesn't just mean higher throughput – it also means patients spend less time waiting for appointments, diagnosis or treatment, which is crucial as demand for eye care rises.

When clinicians are empowered to redesign care pathways, streamline processes and adopt evidence-based efficiencies, more patients can be treated without compromising quality.

There are roughly 26,000 patients waiting for ophthalmology treatment in Scotland. As the Scottish Government grapples with severe funding constraints, surely, we must consider how care can actually be delivered most efficiently and how existing system capacity can be used to bring down waiting lists.

The NHS has always operated as a mixed economy, commissioning services from NHS trusts, social enterprises, and independent providers – all delivering free at the point of care treatment. We all appreciate the convenience of popping into our local pharmacist or optician to access the care we need at the most convenient time and location. Using all the available capacity is not about ideology – it is about practicality. It is about ensuring that every part of the system is empowered to deliver its potential, reducing bottlenecks and making full use of available expertise, while remaining free at the point of use.

Ultimately, efficiency cannot be an accounting exercise. For patients, it means not waiting months for follow-ups. Not having appointments cancelled at short notice. Receiving care closer to home.

When follow-up delays lead to avoidable sight loss, the cost is not only clinical – it is social, emotional and economic. Preventing that outcome is both compassionate and efficient.

If NHS reform is to succeed, efficiency must be reframed. It is not about extracting more activity from overstretched teams. It is about designing pathways that prevent friction, clarifying accountability and enabling practitioners to innovate and encouraging the reinvestment of profits back into the services and training of the future generation of clinicians.

Efficiency is not delivered by proclamation. It is delivered by design.

Nigel Kirkpatrick is Newmedica's Medical Director

End of Life

70. How Doing End of Life Differently Can Help Sustain the NHS (and lead to better endings) – Mark Hazelwood

Originally published 23/04/2024

"*Neither the sun nor death can be looked at with a steady eye*."
Francois de La Rochefoucauld

Amongst the stranger places on the internet are the sites which, if you plug in a few details, will tell you when you are due to die. I checked just now and I am due to die in #2048. It feels a bit sad, but at least it fits perfectly for this blog.

Famously, the final phase of life was embedded in the foundational rhetoric of the NHS – the new service would address needs "from the cradle to ***the grave***". In practice the newly established NHS didn't seem terribly interested in the needs and suffering of people approaching the end of life. By the early 60s this neglect, in part, drove the emergence of the modern hospice movement. Although much improved since the 60s the NHS, like most western healthcare systems which were designed to treat and fix, retains an ambivalent relationship with incurable disease and dying. I'm going to argue that re-focusing on end of life is an essential part of building a sustainable NHS. Finding a better way through the uncertainties of modern mortality can unlock resources and improve people's experiences of living with serious illness, dying and bereavement. And this is a growing issue – by 2040, the number of people dying with a palliative care need is projected to increase by 12% to 63,000 each year. I'm going to talk about services but also about the need for a wider whole-system approach.

People often argue that an aging population is a key factor in the cost pressures facing the NHS. Of course this is true, but only in a very general sense. Yes, people tend to use a bit more healthcare as they age, but the real jump in use (and therefore cost) occurs with proximity to death. It is this expenditure in the last few months of life which accounts for most of the extra expenditure observed when you compare young and old populations. In turn most of this expenditure relates to hospital admissions which increase dramatically in the final few months of life.

Take a walk through your local acute hospital anywhere in Scotland and look around – one in three beds is being used by people who are within their last year of life. Some of these people are in hospital for very good reasons and will benefit. However, at population level, with the aid of a retrospect-oscope, we can see with certainty that many people spend time in hospital at the end of life undergoing treatment which has little or no benefit, or waiting to be discharged, when they would often prefer to be elsewhere. Too many admissions are the result of health and social care supports in the community being unable to respond to crisis or deterioration. Acute hospital is the default and that is bad for people and bad for public finances.

At the individual rather than population level things are more complex. Together, clinicians and people who are "sick enough to die" often face great uncertainty. Will this particular admission to hospital extend life such that a grandchild's wedding can be attended? Or perhaps, despite hopes and best judgement, this admission will see the person die in hospital having undergone invasive

investigations and treatments which in retrospect can be seen as having been futile. The key to navigating such personally and clinically challenging territory are open and honest conversations about what the future may hold – the likely limits of medical intervention, the balance of harms and benefits, and what is most important and valuable to you as a person who is now living final chapters of uncertain length. Evidence shows that making a "future care plan" can reduce avoidable hospital admission and make it more likely that you live final months, weeks, days or hours as you might hope. It's not so much about the actual plan itself but that the conversations, thinking, relationships and learning that go with it can leave you (and supporting professionals) better prepared to respond to circumstances as they eventually and inevitably unfold.

The significance of end of life to our health and social care system is largely "invisible in plain sight" in the media and policy discourse. Emergency admissions, queuing at A&E, delayed discharges and insufficient acute beds are the stuff of headlines. You won't see any reference to the fact that nearly 1 in 10 will die during their current admission. We prefer to frame policy responses in terms of clinical conditions or settings. You'll sometimes find end of life in the margins of other plans and strategies or given its own little separate domain as if it has nothing to do with the big boy issues. Despite the vast resources involved and the significant scope to improve people's experiences you'll search in vain for the laser-sharp institutional focus or the well-established and resourced programmes for research, innovation and improvement. Sometimes I think this neglect must be cultural in origin, something to do with the personal existential challenges of confronting mortality. We don't like to look at the sun.

How do we change this? At local level there is a need for:

- a visible locus of senior leadership and accountability for the improvement of end of life care
- interagency partnerships charged with improving care. These partnerships will need representation from across the health and social care system, and need time to develop relationships, trust and shared ownership of improvement
- a systematic and effective approach to identifying people with high and increasing needs who are at risk of dying
- routinization of future care planning
- a digital platform which can share and update people's plans across settings
- investment in rapid response community support for people and their carers (to be funded from resultant reduced hospital admissions and quicker discharge)
- shared accountability for outcomes which are measured, understood, reported and published. Critically we need to refocus resources on outcomes which represent value – to the system, to society and to individual people.

I'm not unaware of the institutional and governance challenges in establishing and making such arrangements effective – other more knowledgeable authors explore these issues elsewhere in the #NHS2048 series. Encouragingly attempts to implement this sort of whole-system, value-based, population approach are underway, for example the Highland End of Life Care Together

partnership. As William Gibson said "The future is already here – it's just not very evenly distributed."

Of course how you experience serious illness, dying and bereavement isn't wholly or even mostly determined by contact with formal services. Structural factors – for example your financial resources, your community and social connectedness, and your identity make a huge difference. Death is not "the great leveller": people who are already disadvantaged tend to have worse end of life experiences. It is important that we think beyond service solutions and take a whole system approach. As a country we can take action on these structural factors – for example newly devolved welfare benefits are now more accessible to terminally ill people, and support for funeral costs increased. "Compassionate Community" initiatives are strengthening social connections and nurturing community-led informal capacity to provide care and support.

Education is important too. You are reading a policy blog, so statistically you have a higher than average education. How confident would you feel about supporting a family member, neighbour or colleague if they were dying or bereaved? Public education (such as SPPC's *End of Life Aid Skills for Everyone* course) can build comfort and confidence to deal with these challenging circumstances which will impact most people at some point. This sort of public education needs to take its rightful place alongside ante natal classes, first aid and other foundational life skills. Scotland can become a country where everyone knows how to respond when someone is caring, dying or grieving. We can be a place where people increasingly have the knowledge, skills and opportunities to plan and support each other through death, dying, loss and care.

In summary, death, dying and bereavement are inevitable, but they are not immutable. We can improve experiences whilst making better use of scarce resources.

Mark Hazelwood is CEO of the Scottish Partnership for Palliative Care and Good Life, Good Death, Good Grief

71. A Good Death? The Long and the Short of it – Stephen Pearson

Originally published 04/06/2024

At my remarkable dad's funeral in March 2024, it was "standing room only". We were short on seats and orders of services; but long on blessings, tributes, tears and laughter. Of the many stories shared about dad, one in particular described him as a "Rescuer" of my little sister who as a young child had a tendency to lock herself into rooms. Dad always managed to rescue her.

50 years later, my sister became dad's rescuer. After a major stroke 3 years ago and a fall in February, we were fearful that dad would die alone in a large hospital. None of us wanted this. Despite our repeated requests for him to be treated as a palliative patient (including GP support and the requisite DNR forms), he was instead treated as a surgical patient who needed fixing rather than a 92 year old man who was dying. This meant x rays, scans, antibiotics, physio and forcing him out of bed every day over a 3 week period. He was long on clinical interventions, stress and fear but short on comfort, and pain free peace of mind.

The family is convinced that he would have died in that hospital, had my sister not turned "Rescuer". As a palliative care specialist, she worked hard to have him referred back to his care home so he could die in comfort, with expert care, pain control, peace and his family around him, as indeed happened 3 weeks later. But even for my sister, that referral was a struggle, frustrating and very stressful. She shouldn't have needed to rescue him from the NHS.

The hospital doctors our family spoke to were relatively junior, well meaning but seemed to miss the evident signs of the need for palliative treatment – dad's age and immobility prior to hospitalisation, the clear requests from the family on his behalf and GP support. Instead they focussed on clinical interventions to reduce pain and strategies for healing and recovery. One of the doctors even said "We're not giving up on him yet". A laudable intent for most clinical situations but what they failed to see was that dad was already past the point where this was helpful. Indeed the enforced regime of getting him out of bed everyday and sitting in chair backfired badly, when, unsupervised, he fell out of the upright and slippy chair to be found on the floor a while later. The doctors were reluctant to sign him over to the care home for several reasons including his need for oxygen and pain relief when in fact these were relatively easy to organise in the care home.

I wonder what training the NHS doctors and nurses receive about palliative pathways and options? And I recognise the importance of checks and balances to prevent inappropriate early discharge of patients. On the positive side, in our case and others like it, an earlier discharge would free up a hospital bed and clinical resources for other patients.

Surely, as the national "cradle to grave" health service, the NHS itself should provide ready access to palliative care where it is evidently needed? So we strongly support Marie Curie's campaign that everyone has the right to good palliative care, whether they are being cared for at home, in a care home, hospice or in hospital.

Stephen Pearson is a former lawyer and now Chair of Castle Community Bank and the charity Leuchie.

Political Contributions

72. Four Parameters for the National Conversation – Kate Forbes

Originally published 02/01/2024

Our NHS workers are plumbing new depths of fatigue and pressure. Sitting in hospital, I watch the nurses rush around, scribbling notes on the backs of their hands for lack of paper, pen and time.

I know doctors and nurses who consistently work longer hours than they are paid to, every shift. Some only stay in the NHS because they know that, if they left, the burden on the remaining staff would become unmanageable.

NHS workers are pouring every ounce of effort, professionalism and kindness into their roles. That is what has really sustained the NHS in 2023. If we relied on the politics, the policies and the Budget alone, it might have keeled over by now.

Even with the herculean effort of NHS workers, patients are waiting too long for almost every service (the only exception is midwifery – babies don't wait). As MSPs, we receive copious quantities of casework from constituents detailing their agonising waits for treatment. Some end up going private, others stay in pain. Nearly all report excellent care – after waiting too long.

That is why senior NHS workers, including the new Chair of the BMA, are starting to query the sustainability of the NHS, without a massive injection of funding or a series of policy shifts that permanently relieves our workers of the immense pressures they carry. The BMA have called for a 'national conversation' (their title) on the future of the NHS, based on evidence, expertise and genuine engagement.

In principle, who could disagree with the need for a frank debate? But only if it leads to results. We've heard talk of reform in the NHS for years – but without urgent interventions there might not be an NHS to reform in a few decades. The greatest risk, however, is the wrong diagnosis of the root causes, which will be inevitably followed by incorrect treatment. In real life, GPs despair of patients googling their symptoms and comically self-diagnosing. There's a similar trend in political debate about the NHS. Tune into Parliament TV most weeks and you'll hear it yourself.

Everybody can list the symptoms – waiting times, a shortage of workers, bed blocking. The problem comes when politicians and commentators immediately jump to conclusions and suggest certain treatments which would almost certainly exacerbate the symptoms. You hear some insist that it's the public sector to blame – if it were privatised it would become more efficient! Others condemn the shortage of money – if every penny of the devolved settlement was expended on the NHS, we'd wave away the problems. Both are ridiculous suggestions.

So, yes we need a frank debate, but it's got to have parameters. That's to protect it from being a talking shop or, even more worryingly, a cover for politicians to promote their favoured policies without proper accountability. And Government should implement changes, even while the conversation is ongoing, by giving a cast-iron guarantee that they will back effective, sensible results, even if it comes at a cost – financially or politically.

I suggest four parameters to the conversation. First, there must be zero tolerance of any suggestion of moving away from the founding principles of the NHS, especially 'free at the point of need'. Anything short of that is not the NHS, so don't pretend that it is. Beware trojan horses, dressed up to look like the founding principles but which actually open the door to profit-driven, shareholder-appeasing healthcare. We're trying to shift away from that approach in the care sector, so let's not double down on it in the NHS.

Second, the NHS exists for the patients and not the government. It has become sacred (in name only), and the danger is that politicians give the appearance of caring without actually delivering what is required to sustain the NHS for the very patients who rely on its services. The NHS isn't merely a debating point in Parliament or a line to defend in the Budget – it is those, of course, but also so much more. If preventative spend works, then we should see change to acute care – but somebody has to be willing to take the flack for the tough decisions first.

Third, we don't need more consultants to tell us what's wrong. Nor do we need more managers to manage away the problem. We need to listen to the janitors, carers and nurses who work night and day and know exactly what's going on. There was a day – or so I am told – when the ratio of doctors to managers meant that the administrative burden fell on clinicians. Now, there's a risk that the ratio of managers to doctors mean we've quadrupled the administrative burden to keep pace with the ballooning bureaucracy, leaving less budget for the front line.

Last, let's not rearrange the deck chairs while the ship sinks. Major structural reform might be required, but it will inevitably distract from the simpler changes that could be made and will need to be made irrespective of structural reform. That's self-evident in the proposals for the National Care Service. At the end of the day, carers deserve a higher wage and better terms and conditions with or without a major overhaul of the care sector. The same principle applies to the NHS. Free up resources in the deep recesses of management in order to employ more frontline staff, and you probably don't need to put everything on pause whilst you redraw the NHS.

Our lasting gratitude to NHS workers should motivate us all to take a step back and actually listen. It can be an optimistic conversation, because there are solutions out there. Empowering NHS workers. Resourcing teams with better technology. Innovating processes and procedures. Putting the patient first. Full funding of the frontline. Ultimately the aim is simple: guaranteeing another 75 years of the NHS, free at the point of need, attractive as an employer and able to treat every citizen.

Kate Forbes is the MSP for Skye, Lochaber & Badenoch

73. My Action Plan to Fix the National Health Service in Scotland – Alex Neil

Originally published 29/01/2024

The National Health Service is under the greatest pressure it has ever been since it was created in 1948. Stories abound daily about the NHS in crisis, not just in Scotland but throughout the UK. Patients are facing much longer waiting times for essential operations or, especially in the case of cancer patients, for a proper diagnosis and treatment. Accident and emergency departments are nowhere near meeting their (medically driven) target of dealing with patients within a four-hour waiting time. The ambulance service cannot meet its target for reaching the most urgent patients within eight minutes because of the delays in admission to A and E departments. Between 10% and 16% of hospital beds are occupied by people who are medically fit to be discharged but are stuck in hospital because of the lack of available social care services and care home beds. Mental health services are facing unprecedented levels of demand without having the necessary resources to deal with it. Many rural health services are at risk. Chronic staff shortages are common in both the acute and primary healthcare sectors, including mental health, as well as in social care. Staff turnover levels are far too high, and morale is low, made worse by the long-term reduction in real wages since 2010. As well as the exhaustion of dealing with the Covid pandemic when it was at its height, the NHS is now having to deal with its long-term impacts, thus adding to all the other pressures on the system.

During the two years I was the Cabinet Secretary for Health, having taken over from my predecessor Nicola Sturgeon in September 2012, many of these problems had already been longstanding. It quickly became clear to me that wide-ranging reform of the NHS was needed to meet the challenges facing it. The societal changes which have taken place since its creation in 1948 have placed far greater demands on the NHS than had ever been envisaged by its founders. It has now become a large and complex organisation whose modus operandi, including its management and decision-making structures, has become too bureaucratic and out-dated – an issue addressed in greater detail later in this paper.

Within a few months of becoming Health Secretary, I drew up a list of action items needed to improve the NHS's performance and outcomes as well as overhaul various aspects of its organisation, giving top priority to dealing with the growing crisis in Accident and Emergency departments throughout Scotland.

It was of great regret to me when I was moved to another Cabinet portfolio before I could implement my action plan. I would have much preferred to serve long enough as Health Secretary to make the changes which were needed then and are much more urgent now.

Founding Principles of the NHS

The core principle on which the NHS was founded is being eroded in some areas. NHS patients in both Scotland and the rest of the UK are being forced to pay for private healthcare because they cannot access the treatment they need within the NHS. This defies the principle that care is provided free at the point of use and based on clinical need, not the ability to pay.

Some patients are in so much pain they are using up their entire life savings to pay privately for operations they cannot get on the NHS. Not because they want to but because they can no longer tolerate the consequences of having to wait an inordinate amount of time to be treated on the NHS. A report published by the King's Fund in June 2023 found that "there is growing concern that people in the UK may be forced to choose between funding their own care or enduring longer waits for treatment".

This situation highlights how urgent it is to address the various crises which currently beset our National Health Service as well as the longer-term challenges which have been ignored or remained unresolved for far too long.

If we are to deal successfully with the critical issues facing the NHS, it is essential to build a national consensus on the way forward. That includes agreement amongst our politicians as well as with the public. The Health Service has enough on its plate without constantly being used as a political football. The Scottish Government should lead the way in building cross-party support for its health and social care policies.

There is already tacit agreement on the way the NHS should be run and funded, as well as the future direction of travel.

The core principle referred to above that access to NHS care be based on clinical need and not the ability to pay is not open to serious challenge, at least in Scotland.

There is no support for imposing charges for NHS services such as visiting a doctor or for a stay in hospital, or for substituting our current system of paying for the NHS through general taxation with a system of "co-payment" or "social insurance". As the highly respected King's Fund, a leading authority on health policy, has pointed out, there is no evidence that introducing either health service charges or a system of co-payments or social insurance would be of any material advantage and would not of itself lead to either better outcomes or greater efficiencies in the National Health Service.

The Link between Poverty and Ill-Health

There is also general agreement in Scotland that by far the single biggest cause of avoidable ill-health in our country is poverty and deprivation. This is supported by a large amount of research evidence from health professionals and others. The link between poor health and poverty is now irrefutable.

There is an urgent need for a national comprehensive, effective, and ambitious anti-poverty strategy in Scotland. Although developing such a strategy is not part of its remit, the NHS should nevertheless play its part in targeting advice, assistance, support, and substantially more resources at people living in poverty on helping them to live healthily. It should also do much more to directly help people from deprived areas by, for example, offering job and training opportunities in the NHS.

The Critical Role of Social Care in Improving Healthcare

A third policy area where there is already a broad consensus in Scotland is the recognition of the critical role that social care must play in delivering an effective and humane health service.

However, there is no consensus on how best to organise social care services in Scotland to do this.

The creation of 31 "health and social care integrated joint boards" has not had the desired impact on improving social care provision or on health outcomes. There is an urgent need to fundamentally review these arrangements as part of a wider radical reform of the management and decision-making structures within the NHS. The last thing we need, however, is another costly and unnecessary national bureaucracy through the creation of a new National Care Service. This proposal should not just be deferred. It should be withdrawn with immediate effect.

The Centre for Children's Care and Protection at Strathclyde University conducted a research study on behalf of the Scottish Government in 2023, looking at social care programmes in Finland, the Netherlands, New Zealand, Northern Ireland, and Ireland. The study found that none of the countries researched had successfully attempted to create a national adult and children's social care agency. Any attempts to centralise these services had all failed.

The Scottish Government has failed to produce any evidence that transferring responsibility for delivering children and adult social care services to a new national agency would succeed in improving outcomes. The millions of pounds already spent on this ill-advised project should instead have funded enhanced pay and conditions for frontline social care workers.

The Need for Investment and Reform

The fourth area of health policy where there appears to be general agreement is the urgent need for NHS "investment and reform." The problem is the lack of definition of what "investment and reform" means in practice.

The purpose of this article is to fill that void by mapping out a plan of action to make the NHS in Scotland fit for the future.

The starting point must be to deal with the legacy of gross under-investment in the NHS dating back to 2010.

The Truth about Funding

The Nuffield Trust has shown that there was virtually no growth in UK healthcare spending in the decade leading up to 2020 "after adjusting for changes in the population size and demographics". The spending per head on health was basically stagnant in real terms for 10 years, even though the demand for services continued to grow significantly due principally to the increase in the UK's population and the increase in the number of older people within our population.

The gross under-funding of the NHS during this period has had a disastrous and long-lasting impact on today's NHS.

To put the scale of the under-funding in perspective, the NHS needs a 4% real-terms annual increase in funding to maintain its commitments and achieve its targets. The average annual increase in funding in the period after 2010 was only around 1%. The annual 3% shortfall in necessary funding accumulated over the decade from 2010 resulted in a real term cut of well over 30% in the NHS's budget. A catastrophic amount by any standard.

During the decade from 2010, total healthcare spending in the UK as a share of GDP averaged 9.9% per year. This compares to 12% in France and 13% in Germany. Measured as investment per head of population, the UK spent £40 billion less than France and £73 billion less than Germany on healthcare during this period. Research undertaken by the House of Commons Library in August 2023 showed that the annual UK health outlay per person of £5,884 is now about a third less than Germany and Norway at £9,104 and £8,817, respectively.

Put simply, the chronic under-funding of the NHS has left it without the capacity to cater for the current and projected levels of demand for its services. We do not have enough doctors, nurses, and other medics. We do not have enough of the modern equipment needed to help with accurate and speedy diagnosis. We do not have enough beds in our hospitals and care homes.

The King's Fund's comparative study of the UK's NHS against 18 other wealthy, developed nations has shown that we now have the lowest number of CT and MRI scanners per million people; 2.5 beds per 1,000 people compared to an average of 3.2 per 1,000; and, along with Greece, the second highest avoidable mortality rate. Only the US was worse.

As well as finding that the UK lags other countries in its capital investment it also states that "the UK has strikingly low levels of key clinical staff, including doctors and nurses, and is heavily reliant on foreign-trained staff. Remuneration for some clinical staff groups also appears to be less competitive in the UK than in peer countries."

On a more positive note, this report also found that "the UK health system performs well on some measures of efficiency, such as the rate at which cheaper generic medicines are prescribed. The UK also spends a low share of its health budget on administration".

NHS Priorities

In Scotland NHS spending per head is about 3% higher than England. In 1999-2000, the spending on health per person in Scotland was 22% higher than in England. It dropped to 10% higher in 2009/10. Had successive Scottish Governments maintained these differentials then spending per person on health in Scotland would today be comparable to our European counterparts.

The key conclusion from the King's Fund analysis is the need for both Scotland and the UK to significantly increase spending on the NHS. These additional resources should focus on expanding capacity by recruiting, training, and improving the terms and conditions of medical staff and in physical resources such as advanced diagnostic equipment, more hospital beds along with a major expansion in primary, community/social, and mental health services. The recent (welcome) announcement by the Scottish Government of an additional £500 million for the NHS in 2024/25 should be targeted at these priorities.

Future investment plans must cater for the changing nature of healthcare demands, especially the rising tide of chronic diseases such as arthritis, diabetes, dementia, etc.

Today's NHS is not well enough placed to deal with these chronic conditions. The failure to deal with them in the community is leading to too many people being hospitalised even although it is both safer for patients and more cost-effective for the taxpayer to have these patients treated in the community.

A central theme of planning future healthcare must be to provide the primary and community care sectors of the NHS with the resources needed to keep people healthy and out of hospital. Thus, the bulk of future NHS spending increases must be directed towards the primary and community care sectors.

Experience tells us that we cannot rely on the existing territorial health boards in Scotland to do this so the Scottish Government will have to devise a method of ensuring the necessary funds reach our GP surgeries and other primary and community care agencies.

Staffing

In Scotland, the most urgent issue is to deal with the dire shortages of medical staff, including nurses and allied professionals, in both GP surgeries and the acute sector. Failure to do so quickly and effectively will result in the NHS being unable to improve health outcomes for patients or meet its key performance targets or recover from the pandemic. Solving the staffing problems are what should keep the Cabinet Secretary for NHS Recovery, Health, and Social Care up at night.

In its Workforce Strategy for the NHS and Social Care published in March 2023, the Scottish Government committed to grow the NHS workforce by 1% over the next five years.

This target is totally inadequate and needs to be urgently revised.

Given the number of existing staff shortages, the wholly inadequate rates of recruitment and retention currently being experienced by the Scottish NHS, the number of staff who are due to retire within the next five years, the numbers taking early retirement from the NHS, staff turnover levels involving the loss of existing staff to various destinations, the projected increase in population, the increasingly older age structure of the Scottish population plus the additional demands which the NHS will face in the next five years it is very difficult to see how a 1% increase in the total workforce will come anywhere near meeting the workforce numbers needed by the Scottish NHS to meet its targets.

In December 2017, the Scottish Government pledged to increase the number of GPs in Scotland by at least eight hundred over the next 10 years (2018 to 2028). Six years on, only 11% of that target has been reached.

Meantime in real terms (after adjusting for part-time work) the size of the GP workforce in Scotland has shrunk by 5.4% over the past decade while the number of patients registered has increased by 7%.

Without urgent action to rectify this situation there is no chance of the Scottish Government coming anywhere near achieving its target of 800 more GPs by 2028.

In any case the target is too low, for the same reasons cited above as to why the overall 1% workforce target is too low.

It is also not the right target to set. A more realistic target would be the number of WTE (whole-time equivalent) GPs needed to meet the projected increase in demand for their services.

Given the trend for an increasing number of GPs choosing to work part-time at various stages of their career, simply targeting an increase in the crude number of GPs is likely to lead to a significant under-estimate of what is required.

For all these reasons the target therefore needs to be revisited, as does the Scottish Government's plan for achieving it.

More generally, the Scottish Government must waken up to some new realities. There is now a global market for medical staff, including nurses and allied professionals such as dentists. Obamacare in America alone has created a demand for many thousands more medical personnel. India now has a middle-class population who rightly are demanding high-quality healthcare. The NHS can no longer rely on huge influxes of Indian medics. Meantime increasing numbers of young medics from Scotland and the rest of the UK are flocking to countries like Australia who are offering much higher pay and much better terms and conditions than are currently available in the UK.

Aided and abetted by the crisis in the NHS, many profit-making private healthcare companies throughout the UK are thriving. The higher salaries and better working conditions in this sector act as a magnet for attracting staff away from the NHS. Meantime the "traditional" private sector which operates as part of the "NHS family", including the GPs and dentists who are contracted to work for the NHS, are struggling to cope with rising demand and too few resources.

As the recent strikes by medics have shown, the NHS must waken up to the new reality. We must significantly enhance the pay and conditions of our entire NHS workforce.

Key aims should include restoring the real-term levels of pay to what they were prior to 2010; to ensure that NHS pay rates are internationally competitive; and to close the gap between remuneration levels (and terms and conditions regarding hours, travelling expenses, flexible working arrangements, etc) for permanent staff and those for temporary staff such as locum doctors, bank nurses and agency nursing.

This last measure is needed to end the vicious cycle of staff shortages resulting in much greater use of locums and bank/agency nursing, whose superior pay and conditions cause more permanent staff to leave the NHS to become locums and bank/agency nurses, thus causing further shortages!

The vacancy rates for medical staff demonstrate the need to make a medical career in Scotland much more attractive, both financially and through enhanced terms and conditions.

According to the Royal College of Nursing about 500 (10 %) consultant positions are currently vacant, with many being so for a considerable period. Vacancies for oncologists/radiologists are running at over 20%. Over 6,000 (10%) nursing and midwifery jobs are unfilled. The number of GPs in Scotland has also fallen in recent years.

Equally concerning is the recent drop-off in the number of applicants to study nursing in Scotland, resulting in over 500 university places not being filled. These figures are ominous for the future of the NHS in Scotland.

Until we can solve the projected longer-term crisis in medical staffing (which will take five to 10 years, given the time it takes to train doctors and nurses) an ambitious and comprehensive recruitment drive is urgently required to deal with more immediate staffing shortages, to fill existing vacancies and reduce the pressures on existing staff. As a matter of priority, we should be incentivising doctors, nurses and allied health professionals who have previously worked for the NHS and who retain their licence to practise to return to work on either a part-time or full-time basis in the NHS.

In the last eight years or so, over 2,000 doctors have taken early retirement from the NHS in Scotland. If we can persuade even a quarter of these people to return to work for the NHS, even on a part-time basis, it could significantly improve performance; especially if a similar return rate of return for nurses and other healthcare professionals can be achieved.

There was an attempt by some local NHS organisations during the pandemic to undertake such a recruitment exercise. Unfortunately, it was not done very satisfactorily. For example, the Royal College of Surgeons in Scotland reported that only 15% of its retired members have been contacted to ask them to return to work, hardly an ambitious effort. I also know of many nurses who responded to the call for help during the pandemic but didn't even receive an acknowledgement, let alone a reply, to their offer to help from the NHS. The NHS must try again but do so properly and professionally this time.

While such a recruitment drive is designed to meet the immediate needs of the NHS, there is also an urgent need to address longer-term staff requirements.

Across the UK, only 16% of medical school applicants were successful last year. The other 84% were rejected for admission to medical schools.

These figures are a disgrace and represent a massive failure by our political class north and south of the border. Surely it makes sense both financially and for securing the future of the NHS, that a much higher percentage of these applicants be accepted into medical school. If we do not do so, then the scale of future staff shortages in the NHS will become astronomic, possibly to the point where it becomes unviable in its present form.

In Scotland there are about 5,000 medical undergraduates going through training in Scottish universities, 55% of whom are domiciled in Scotland. When they graduate only about 70% of the Scottish graduates take a medical job in Scotland. Less than half of all the medics we train in Scotland stay in Scotland.

These statistics demonstrate the need for action.

The Scottish Government needs to significantly raise the cap on the number of Scottish-domiciled students admitted to Scottish medical schools; the SNHS needs to work closely with the medical schools to increase the percentage of Scottish-domiciled students who remain in Scotland to work for the NHS here; it also needs to recruit many more of those students from the 55% who are non-domiciled in Scotland to stay and work in the Scottish NHS, ideally on a permanent basis; incentives should be offered to undergraduates and trainees to encourage them to work in the SNHS for a given period of, say, five years on completion of their course by, for example, offering to write off all or part of their student loan; the SNHS should also make much more use of

apprenticeship and graduate apprenticeship programmes to help solve staffing shortages. Consideration should also be given to offering maintenance grants to medical undergraduates in return for signing up to a commitment to work in the Scottish NHS for a given period upon graduation. Failure to keep to the terms of the contract would require repayment of the maintenance grant.

Such incentives could also be used to encourage graduates to work in those parts of the NHS where the shortage of skills is greatest, such as in rural areas.

Increasing the availability of free accommodation for junior nurses and doctors should also be considered to help recruit and retain staff.

More Beds

As well as too few staff, the NHS in Scotland and the UK has one of the lowest ratios of beds to population in Europe. According to the Royal College of Emergency Medicine (RCEM) between 2011 to 2019, Scotland experienced a loss of 1,500 beds, although on a more positive note "the NHS in Scotland has consistently maintained the highest level of beds per 1,000 people of any UK nation".

At a UK level, the RCEM states that "compared to OECD EU nations, the UK is the second least bedded per 1,000 population".

The recommended safe occupancy rate for NHS beds is 85%. This figure allows for extra capacity to manage sudden increases in demand, as well as reducing the chances of patients contacting hospital-acquired infections. The RCEM has estimated the average hospital bed occupancy rates to be 95.5% in Wales, 94% in England and 89% in Scotland as of September 2022.

The RCEM estimates that an additional 448 beds are required in the Scottish NHS "to achieve optimum occupancy levels", an increase of 3.3%.

Waiting Lists

The shortage of staff and beds as well as the pandemic are the main reasons why waiting lists for elective procedures have grown to record levels over the past three years. A range of initiatives are required to get these waiting lists reduced more rapidly, including making more extensive use of robotic surgery techniques, for example to remove prostate cancers; using already available AI technology to undertake a range of activities including the enhancement and speeding up of diagnosis and improving bed management; making greater use of theatre facilities in the evenings and at weekends when and where the necessary staffing is available; and learning other tried and tested ways for safely increasing the volume of procedures.

Patients spending a long time on a waiting list for a vital operation can often develop other symptoms of ill-health, including mental health problems. It is therefore vital that getting the waiting times and lists down to reasonable levels must be a top priority.

Accident and Emergency four-hour and Ambulance Service Targets

The lack of enough beds is also one of the main reasons why the NHS continues to miss its four-hour target for treating patients within our Accident and Emergency departments. Too many patients who are being admitted to hospital by their A and E consultant cannot be discharged to

a hospital ward because there is no bed available for them. There is also a knock-on impact on the ambulance service, as it cannot discharge its patients from the ambulance as there is no available room for these patients in A and E departments.

As reported in the Herald newspaper on 16th December 2023, 10% of all ambulances arriving at Accident and Emergency Departments in Scottish hospitals on 4th December 2023 had to queue for two hours to offload their patients. That meant around 750 patients in need of emergency medical care spent two hours waiting in the back of an ambulance before being admitted to A and E. It also meant that many other patients had to wait much longer than should be the case for their ambulance to arrive to transport them to A and E.

These were the average figures across Scotland. In some parts of the country, patients had to wait up to five hours to be offloaded from the ambulance and admitted to A and E.

Once in the A and E departments, less than 65% of patients are being seen by a doctor within the four hours' target time. That is 30 percentage points fewer than the 95% target for being seen within four hours.

Delayed Discharges and Social Care Services

The problem of bed shortages is further exacerbated by the number of "delayed discharges", accounting for up to 16% of all hospital patients at any one time. These are patients who are medically fit to be discharged from hospital but do not have the necessary social care support in place to return home, be it to their own house or a care home.

The only way to solve this problem is to invest more in the social care sector, starting with urgent action to solve the severe staffing shortages.

In Scotland there is general acceptance that the problems of the health service cannot be solved without greater funding for social care and that a prerequisite to successfully addressing the problems in social care is an increase in the minimum wage for frontline staff from its current level of about £12 to at least £15 an hour, coupled with measures to enhance social care as a career. Without doing so, high staff turnover rates currently running at over 40% a year and equally high staff shortages will persist.

Such an increase would require very substantial funding, amounting to hundreds of millions of pounds and will take time to implement given the current state of the Scottish Government's finances. Frankly, the recent Scottish Government Budget should have earmarked the £150 million it used for a council tax freeze to invest in tackling the crisis in social care instead. Also, instead of allocating over £200 million for next year to "active travel" it should re-direct this money to the social care budget; a much higher policy priority by any measurement. Such a move would be much more in line with the First Minister's stated priority of tackling poverty.

Another critical issue is the lack of enough care home places in Scotland, the availability of which has gone down by over 2,000 places in the last decade. This shortage must also be tackled, ideally as part of a wider strategy for improving both the availability and quality of care provision.

Meantime the NHS should establish a network of "convalescence units," sometimes referred to as "step-up, step-down" or "intermediate" facilities, to accommodate and support those patients who have been medically discharged but are unable to go home immediately.

Such a policy was agreed to 10 years ago when I was the Health Secretary but was never properly implemented.

Primary Care and Community Services

These improvements to social care and the others set out above must be delivered within the context of the need for systemic change within the NHS.

Increased budgets and capital resources for the NHS will not on their own be enough to solve its underlying problems. There needs to be a comprehensive, long-term business plan for health and social care which addresses the strategic challenges arising from the ageing of the population, the rapidly changing demands from patients and the increased costs of new medicines and innovative technologies.

As the King's Fund has stated, "priority must be given to investing in primary care and community services in order to anticipate people's needs, promote independence and offer alternatives to hospital".

In Scotland, the primary care sector's share of the NHS's budget has fallen to 9%, down from 11%, making it the "poor cousin" of the service. Given that GP surgeries deal with about 90% of visits to a doctor in Scotland and given the current crisis in this sector, it is essential that the primary care sector's budget share be restored to at least 11% of the total budget.

We should learn from the Netherlands. There, primary and social/community care services are available locally on a 24/7 basis. One of the results is that attendances at their A and E departments are one quarter of those in the UK in relation to population size. We should aim to replicate the Netherlands to help realise the King's Fund vision for the primary health sector.

Prevention of Ill-Health

Prevention of avoidable sickness and ill-health is essential for the success of the NHS. A report published in December 2023 by Tony Blair's Institute for Global Change highlights the need for an "NHS illness prevention service". Its purpose would be to "scour medical records to identify and seek out those who need pre-emptive treatment, health advice and weight-loss drugs."

It argues that "the NHS app must be revamped to alert people to treatments and tests they should be having" and that by doing so the NHS "could save billions of pounds a year and boost the economy by reducing record levels of illness absence". Given that about 40% of the NHS budget is spent on treating preventable conditions this proposal should be pursued with urgency subject to adherence to patient authorisation protocols and a guarantee regarding the privacy of the data being accessed with artificial intelligence.

The report's author, Ryan Wain, said that the proposed prevention programme "would build on the infrastructure created during the pandemic and be delivered in communities, pharmacies, primary care and other settings".

Our strategic objective should be to maximise the opportunities throughout the healthcare system so that, as far as possible, prevention replaces the need for treatment.

In my view, in Scotland the obvious organisation to lead such a transformation would be Public Health Scotland.

The Critical Role of Medical Science and New Technologies

The proposal mentioned above regarding the prevention of avoidable illnesses is an example of the revolution which the use of new technologies can have on the NHS and patients. As well as AI, other key technologies which can help bring about dramatic improvements in healthcare include the greater use of data analytics, genomics, robotics, digitisation, and the much greater use of tele-medicine. Every patient should have access via an app or other devices to their own medical records, to help them better manage their own health as well as provide the necessary data to those who are treating them.

We should also be aiming to substantially reduce the time-gap between the development of new medicines, new technologies and new techniques and their implementation.

The Covid crisis demanded new vaccines be developed and delivered for patients within months, whereas traditionally that process would have taken many years. This was revolutionary for the world of medicine. We need to do much more of it. Fortunately, with new technologies like AI increasingly available it should be possible in future to develop new cures and have them safely available for patients much more rapidly.

Health and Social Care Management and Decision-making Structures

Reference is made above to the need for radical reform of the management and decision-making structures for health and social care services.

The current structures are not fit for purpose. There are too many separate organisations. In a country the size of Scotland we do not need 14 territorial health boards, 8 specialist health boards, 3 regional structures, 31 health and social care partnership boards, plus a plethora of other non-statutory bodies plus the Scottish Government's Health Directorate. This structure needs to be streamlined.

The quality of management is variable. In my view the NHS would benefit from having more managers who are medically qualified and experienced.

There are far too many layers of management within many of the boards listed above. Decision-making at every level is too centralised.

Overhead costs are too often inflated. For example, many of these boards have their own separate IT systems which cannot communicate easily with others in the health and social care network, too many properties are lying empty or are under-used because they are no longer fit for purpose and should be sold off to help fund essential capital equipment.

The effectiveness of the boards of directors appointed to run these organisations is variable. They are also not accountable enough to the communities they are there to serve.

It's not just the number of management boards which is important. Remits also need to be changed to ensure the maximum decentralisation of decision-making.

In my view there should be about three or four strategic regional healthcare authorities in Scotland whose responsibilities would be to set targets and budgets, monitor performance and outcomes, etc.

Within the strategic confines set by the regional authorities each local delivery unit, be it an acute hospital or provider of primary care services, should operate autonomously.

The specific issue of the relationship between healthcare and social care services must also be re-visited. My own view is that there is a convincing case for retaining social care services within the remit of local councils, especially given the important links with other essential services such as Housing and Benefits Support. But there also needs to be a clear plan for ensuring that health and social care services are properly co-ordinated and where apposite integrated.

The Scottish Government should set up an independent task force to review these issues and to make detailed recommendations to the Scottish Government and Parliament within twelve months.

Conclusion

Finally, the Scottish Government's recently announced massive cuts to other essential services will be detrimental to improving the health of the nation. The £200 million cut to the housing budget will put even more pressure on the NHS, as the people affected suffer avoidable physical and mental health problems.

The Scottish Government's Budget for 2024/25 should have adopted a much more progressive approach. It should have used its powers to introduce a land levy on the largest estates in Scotland to raise at least £1 billion in revenue for additional investment instead of cuts to the NHS and other core public services. It should now use the time still available for it to amend its budget to legislate for a land levy and reverse the cuts.

It should also prepare a detailed 10-year Plan for the Future of Health and Social Care in Scotland and do so with the active participation of those who will be expected to deliver it as well as the wider community.

The proposals outlined above are by no means an exhaustive list of what the NHS needs to do to prepare for the future. But implementing these recommendations would certainly make a massive difference to the NHS, its staff and, most importantly, the patients. The question is whether our rulers have the necessary wherewithal to implement these changes, or whether they will just continue tinkering at the edges. Time will tell.

My message to the Scottish Government is that if it is serious about addressing the crisis in the NHS in Scotland it needs to do much more than it is currently doing and it needs to do so now.

Alex Neil was the Cabinet Secretary for Health from 2012 until 2014 in the Scottish Governmen

74. Delivering the Change our NHS Needs – Jackie Baillie MSP

Originally published 13/03/2024

The founding of the National Health Service remains one of the Labour Party's – and our nation's – proudest and most important achievements. At its heart is the promise that if you are ill or have a serious accident, you will receive the care that you need – free at the point of use, whatever your background or circumstances.

It's a matter of deep regret, therefore, that some 75 years on from the founding of our NHS, too many of our fellow citizens will rightly feel that this binding promise largely exists in theory only.

The reality facing patients in Scotland is stark – and a far cry from the aspirations of its post-war architects. At the time of writing: –

- A staggering 824,725 Scots – that's almost 1 in 6 – are on NHS waiting lists for tests and treatment. More shocking still, almost 83,000 of those waiting have done so for more than a year.
- Cancer is Scotland's biggest killer, with cases being predicted to rise by 22% in Scotland by 2040. Despite these warnings, the latest figures show that more than more than 1 in 4 patients waited longer than 62 days between urgent referral and treatment.
- Thousands of children and young people are on waiting lists for mental health treatment.
- Life expectancy in Scotland is declining and health inequalities are widening.
- NHS staff feel overworked and undervalued trying to keep the system going which only exacerbates existing problems – over 5,300 vacancies are currently unfilled.

Patients don't need to be convinced of the calamitous state of services; they can see it every day in their own communities. Whether it's the long waits in A&E or hanging on the phone desperate for an appointment at their GP surgery as they struggle to get through. At the same time, NHS staff on the frontline are bearing the brunt of decisions beyond their control. Doctors, nurses, and indeed all staff do not want to work in an NHS where they see patients being let down. Healthcare workers are burnt out and exhausted; many have already been lost to early retirement, whilst others are on the brink of handing in their notice.

The SNP have been in power for almost 17 years, and they must take responsibility for the mess that has unfolded on their watch. Unfortunately – and rather desperately, in my view – Humza Yousaf stands in the parliament chamber each week and peddles the myth that the pandemic is the sole cause of the NHS's woes. This is simply untrue. It would be churlish, of course, to claim that the pandemic did not have a devastating impact on our healthcare system. The suggestion, however, that services were running smoothly before anyone had even heard of Covid is a fallacy. The facts speak for themselves. This SNP Government has not met its 62-day performance target for starting cancer treatment across Scotland since 2012, and the CAMHS target for 90% of children and young people to start treatment within 18 weeks of referral has never been met.

The pandemic was the lightning conductor which exposed a system already under pressure. The challenges across the NHS are not new, but they are certainly more acute now.

The recovery stage of the pandemic must be seen as a first step of generational reform; not just fixing the problem without confronting the challenges that have not been addressed since the Christie Commission report.[1] As Don Berwick, from the Institute of Healthcare Improvement, rightly says, "Fate will not create the new normal, choices will".[2] As it stands, the SNP's NHS Recovery Plan is delivering little more than broken promises and "whataboutery".

There are, of course, some in society who believe that the NHS is no longer able to meet the needs of a growing population – one that is living longer and with comorbidities. I also hear it argued that the NHS will never be able to keep up with the pace and change of innovation in global healthcare. It was dismaying to hear that NHS Scotland chief executives had met behind closed doors and mooted the idea of a two-tier health service.[3]

I think they are wrong. I refuse to believe this is as good as it gets – the Labour Party created the NHS, and we will always fight for our NHS.

It is true, however that the status quo is not working – and more of the same simply will not cut it.

That's why Scottish Labour is determined to transform the NHS to ensure it is fit for future generations.

We are calling for an NHS Recovery Plan that is community care-led, focuses on preventative healthcare and rewards staff. But how do we get there, and what do we need to do to lay the foundations of transformation?

Reforming NHS governance

More than a decade ago, Scottish Labour set out plans to reform the cluttered landscape of NHS bodies. The current system is top-heavy, bureaucratic and, quite frankly, is not delivering the standard of services that both patients and staff rightly expect and demand. Instead of operating as one NHS, barriers to co-operation and sharing of resource are the norm.

As it stands, Scotland – with a population of c.5.4 million – is served by 14 territorial health boards, 8 special boards, 3 regional planning bodies and 31 health and social care partnerships. This is excessive, inefficient and epitomizes the all-too-common problem with this SNP Government: the desperate need to create more layers of bureaucracy and governance in the hope of papering over cracks, rather than identifying the problems and offering solutions.

What is Scottish Labour's alternative?

We want to reduce the number of territorial boards from 14 to 3 and will review the current number of special boards. In doing so, we will work with island and rural communities to ensure that any change to arrangements meet their specific needs. These reforms are about decentralising decision making. We need to drive improvement in primary care and align our

governance structures with that priority. These reforms are also about delivering services closer to communities. This is what matters to patients.

Let me take, for instance, my constituents in Dumbarton. They do not care where their health board is headquartered. But they do care whether the clinicians and managers in the Vale of Leven Hospital are empowered to implement the service changes that patients need and want. Similarly, they want to be able to visit their GP surgery or health centre and access a range of services and treatments that can and should be delivered locally. By harnessing the opportunities offered by digital technology and ensuring that GP surgeries are staffed with the multidisciplinary teams needed, this can become a reality.

National Clinical Council

Reforming NHS decision-making must mean learning from mistakes. I meet with health professionals on a regular basis, and I've lost count of the number of times I hear them tell me that they feel like the government machine and powers-that-be do not listen to them. Scotland is facing an NHS workforce crisis, and this is only going to get worse unless there is a cultural change in how decisions are made.

At our conference, last month, I announced that a future Scottish Labour Government will establish a National Clinical Council – a statutory body that puts clinicians at the top table where they can use their skills, expertise, and knowledge to inform decision-making. This policy commitment will empower clinicians and health professionals and ensure that Ministers are being advised by the right people, who know what patients want and need.

Clinical Councils play a crucial role in healthcare systems across the world, and it is time that Scotland followed best practice. I am confident that by changing culture, it will allow for more informed policy decisions that improve services for patients and, in time, improve health outcomes.

This National Clinical Council would be tasked with advising Ministers on service delivery, workforce planning and patient safety. On the latter, no one can ignore the toxic culture of cover-up and secrecy we've witnessed after 17 years of SNP Government. The Council will be required to advise Ministers on patient safety and encourage a culture that is characterised by openness and accountability and supports whistle-blowers.

These changes alone will not fix the NHS, but they are critical steps in a journey of transformation. In the months to come we will set out our plans to transform primary care, to encourage innovation, to make the most of the skills and talents of NHS staff and to deliver improved health for the nation.

Conclusion

It's not enough for the NHS to exist in name. We must aspire to better. The NHS must continue to meet the needs of patients and value its staff.

Scottish Labour have started the groundwork of setting out our vision for how we want the NHS to look in 2048. The NHS of tomorrow must be rooted in local communities, deliver better outcomes for patients and empower clinicians and staff. This is our mission for delivering the change our NHS needs.

Dame Jackie Baillie is the MSP for Dumbarton, Scottish Labour Deputy Leader and Spokesperson for Health and Social Care

[1] https://www.gov.scot/publications/commission-future-delivery-public-services/

[2] https://jamanetwork.com/journals/jama/fullarticle/2765699

[3] https://www.bbc.co.uk/news/uk-scotland-63659754

75. Scotland's NHS: What's Wrong With it, And Thoughts on How to Fix it – Dr Richard Simpson

Originally published 19/04/2025

How We Got Here

There is a current pattern around the NHS debate whereby opposition parties criticise the failure of successive recovery plans and the Government accuses them of undermining NHS staff. This is, to put it mildly, unhelpful.

The problems within the NHS go back long before Covid made them worse. In 2011, after a period since 1997 of improvement, the SNP government made a number of bad decisions. The worst were to reduce the medical student intake by 8% between 2011 and 2014, and to further delay the Calman Paulson Report of 2004 which proposed the establishment of a graduate entry scheme. This scheme was finally introduced in 2018.

The consequence has been to substantially increase medical workforce vacancies in senior roles, as GPs' and consultants' training is a process which takes 10 or more years. There was also a 20% cut to nursing student intakes, a 40% cut to midwifery student intakes and the closure of three midwifery schools. These decisions were to have a lasting effect. At the time, as shadow public health minister, I vehemently opposed the cuts. I cited a growing and ageing population, and increasing multi-morbidity.

The hubris of the government, which had an overall majority, was such that it passed a law which said no Scot should wait more than 12 weeks for in-patient or daycare treatment. This has never been met in any year since enactment and the law has been broken for over 1,000,000 patients in the ensuing 12 years.

But apart from these errors, the elephant in the room – then and now – has been social care. This despite the introduction of "free personal care" following the Sutherland Report in 2002, which was really only a sticking plaster for a fundamental problem. Labour proposed a Beveridge-style commission in 2012 to examine in a non-partisan way the fundamental problems facing health and social care. This proposal was rejected as taking too long. In 2015, the government promised to end delayed discharge, which has not happened. All these factors contributed to a situation in 2019 where only two out of eight NHS targets were met.

No-fault Compensation

In 2009, a commission on "no-fault" medical injury compensation was established, chaired by Professor Sheila McLean. It reported on the options for implementation, which were then consulted on extensively by the government. However there has been no progress since 2014. The result is higher levels of litigation. Some cases of birth injury have taken more than eight years to settle. Clinical negligence claims under the CNORIS scheme ("clinical negligence and other risks indemnity scheme") exceeded £600 million in 2023 – more than double the £250 million reported in 2014 (the increase is in part due to adjustments under PIDR, (personal injury discount rate),

which sets compensation at a level which takes into account future costs and returns on investment).

Attempts at Reform

The arrival of Covid became a classic example of Warren Buffet's maxim on investment: "only when the tide goes out do you discover who's been swimming naked." Despite the heroic efforts of its staff, NHS waiting lists burgeoned. In September 2024, the total number waiting for inpatient and outpatient treatments reached over 725,000, the highest figure since records began.

One of the main drivers for reform was the Christie Commission Report. Its emphasis on integration, involving communities, and a focus on prevention is as relevant today as when it was published in 2011. If Campbell Christie were alive I think he would be disappointed by the lack of progress.

Audit Scotland has for many years been advocating for structural reform, including integration of health and social care and longer-term planning.

Health and Social Care Integration

Successive governments have attempted integration between health and social care. Between 1997 and 2007, Labour ran pilots of integrated care. These were slow to be implemented, in part due to the problems of separate workforces and management in the NHS and local authorities. A successful pilot in Perth and Kinross was terminated by Tayside Health Board. The SNP government resolved that further voluntary integration wouldn't work and enacted a law which saw all councils except Highland opt for new Integrated Joint Boards (IJBs). These, funded jointly by NHS boards and local authorities, are responsible for care of the elderly, children and community care. These new bureaucracies have had variable success. In a 2024 report the Accounts Commission paints a bleak picture, reporting widening health inequalities, increasing demand, and a growing level of unmet and more complex needs. There is no significant evidence of any shift from hospitals to the community, which was one of the core purposes in the creation of IJBs. There was also a lack of "whole-system planning", undermined by the complexity of governance arrangements. The quality of data was inadequate to reliably determine outcomes.

The government, recognising that there were serious problems, proposed a National Care Service. This plan has now collapsed in the face of serious opposition to even more centralisation and the emasculation of local authorities.

Delayed Discharge

The delay in hospitals discharging patients deemed fit has been a perennial problem in managing efficient throughput. There are currently 1,964 out of 13,700 NHS beds occupied by delayed discharge patients {see *Care Home Census for Adults,* Public Health Scotland 2014-2024]. The resulting pressure on admissions is evident in the sub-optimal and sometimes undignified corridor care of patients. The situation has been made worse by cuts to hospital beds of around 1,200 since 2010. It has also been affected by the decision in 2016 to terminate any funding in future of patients in care homes by the NHS. They must now remain in hospital long-term (there are 50,000 in care homes funded by NHS England, and there were 1,900 funded in Scotland

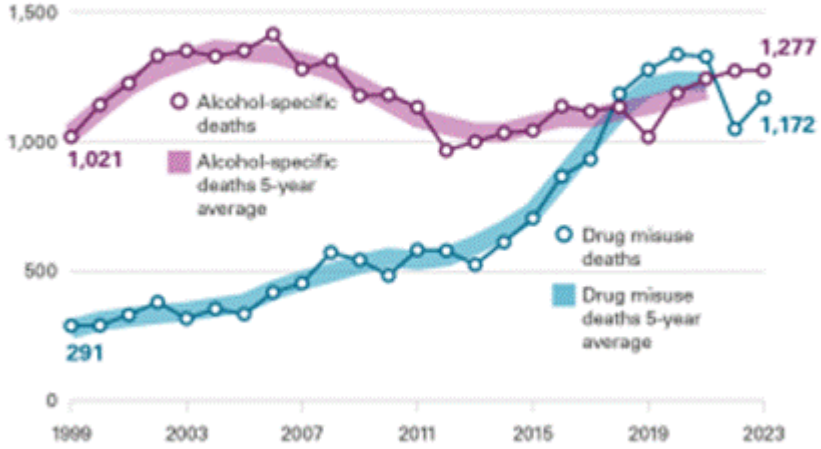
in 2016). The latest statistics show that only 34,113 out of 40,079 registered care home beds are occupied. In 2022, the NHS funded 300 care home beds as an "emergency" measure. But given the situation in hospitals, failure to fund many more and reverse the perverse decision to end such funding in order to minimise delayed discharges is incomprehensible.

Alcohol and Drugs

The government has relied on Minimum Unit Pricing [MUP] and brief interventions in primary care to tackle Scotland's alcohol problem. Tertiary alcohol services were cut.

Advertising bans proposed in my Members Bill were rejected by the then government. I note that Ireland has now banned alcohol advertising.

Exhibit 1.
Total number of alcohol-specific and drug misuse deaths in Scotland, 1999–2023
Drug misuse deaths have risen significantly since 1999, and alcohol-specific deaths are at their highest rate since 2008.



Source: Alcohol-specific deaths 2023, National Records of Scotland, September 2024, Drug-related Deaths in Scotland in 2023, National Records of Scotland, August 2024

Despite criticism of MUP, it has been associated with a significant narrowing of the gap in Scotland's consumption of alcohol over that of England, along with a reduction in hospital admissions.

On drug treatment we have had the restoration of funding [cut by 23% 2015-17], a national emergency with a taskforce producing new medication-assisted treatment [MAT] standards, and a National Mission. Yet drug deaths remain stubbornly the highest in Europe. In 2002, while I was the Minister in charge of drugs, we opened two drug courts, one of which is now closed. Drug treatment and testing orders [DTTOs] had reached 1,100 per annum but then plummeted to below 500. We piloted the diversion-from-custody treatment centre for women in Glasgow's Bath Street, as recommended by the McLean review of 2001 in its report "A Safer Way". This centre was commended as a model for women in the 2012 Angiolini report, "A Better Way". The centre treated 4,000 women over 20 years before being closed by Glasgow Council with government approval.

There was a failure to fully fund the welcome transfer of Scottish Prison Health Services back to the NHS. Prisons are overwhelmed with drug-using prisoners, with nearly 40% reporting using them. A report in September 2022 noted that opiate substitution treatment was not recorded on the Vision software, only on paper-based records. The number of deaths from drug overdose following release from prison have improved, but remains a concern.

Primary Care, 1999-2024

A further problem has been the substantial reduction in the proportion of funds applied to primary care. This reduced from 9.79% in 2005/6 to 7.78% in 2012/3. Direct spending as a proportion of overall NHS funding reduced from 7.5% to 6.5% between 2017/18 and 2023/24. Audit Scotland also report there are fewer whole time equivalent GPs and the Scottish Government commitment to increase the number of GPs by 800 by 2027 is unlikely to be met. This is against a backdrop of an increase population, significant demographic change with a consequent increase in complex multi-morbidity.

Since 90% of health care, primary prevention and most of secondary prevention takes place in primary care, a more realistic proportion would be around 12%. Even the recent increase was subject to a cut of £65 million in the emergency budget [FOI: December 2022].

One result following the 2003 GP contract has been an inexorable contraction in GP out-of-hours services, with many centres closing. A second was the closure of Saturday surgeries, resulting in up to four days of closure when there were public holidays.

By 2011, the numbers applying to join partnership GP practices had declined substantially. In 2015, I conducted a survey of Scottish GPs and reported an impending crisis in recruitment, with increasing closure of branch surgeries and of partnership practices. These reverted to Health Board-run "2c contracted practices". By 2024, 2c practices had doubled to 90, while the total number of practices had shrunk from 990 in 2012 to 889.

Not only had funding failed to keep up with hospitals, but the "Inverse Care Law", first propounded by Julian Tudor Hart in 1971, has continued, resulting in practices in the most deprived communities, which have the greatest demand, receiving less funding than the least deprived.

My 2015 paper, "Fit for the Future – a Challenge to Revitalise General Practice", proposed implementation of the Greenaway Report on medical education and a review of IT and data collection, with improved linkage to other primary services and hospitals. Many of the issues and solutions which I proposed for primary care were replicated in a Royal College of GPs' 2019 document also entitled "Fit for the Future".

The addition of many more health workers to primary care has been a welcome development. But at the same time, some Integrated Joint Boards are disrupting health-centre-based teams, removing district nurses and health visitors from local primary care to distant teams. The result is a significant loss of continuity and cohesion in long-term care. The integrated network, including GPs, district nurses, health visitors, practice nurses, and also social workers, physiotherapists, pharmacists, mental health nurses, psychologists (clinical and health), phlebotomists, and – for some networks – paramedics, is vital. (In the 1980s, the Forth Valley GP Research Group ran a pilot attachment of a social worker to three Stirling practices, urban, suburban and rural, all with

differing levels of deprivation. It demonstrated clearly the benefit of early intervention and support from social work alongside health visiting. Unfortunately, despite its evident success the pilot was never followed through.)

Proposals for Structural Changes – Territorial Health Boards, National Health Boards and the Abolition of Integrated Joint Boards

In Scotland, with the recent collapse of the Government's proposed National Care Service, there needs to be a new vision for the future. Whilst structural change is important if it simplifies governance and increases efficiencies, the disruption of networks caused by major changes can be problematic in the short term.

In 1997, Scottish Labour rejected the English model of separate and competing trusts covering hospitals and health in the community, reverting to a cooperative and collaborative model. The number of boards was reduced from over 40 trusts to 14 territorial boards, but retained the seven special (national) boards. This process, begun under Labour to reduce the cluttered NHS landscape, should be continued. The territorial hospital boards should be further reduced to three mainland boards, matching the successful cancer regions of West, East and North. The island boards should be merged with their local authorities.

On new medicines, the Scottish Medicines Consortium does a great job, and is highly cost-effective compared to NICE in England. It has improved its operation steadily since inauguration. It is faster than NICE and involves patients more. However, having determined that patients should be able to access a new medicine, this decision then goes out to all 14 health boards for a decision as to whether and when such access should happen locally. This creates a postcode lottery.

The concept of Managed Care Networks[MCNs] should be mandatory, expanded and fully supported. For example the MCN for oesophageal cancer in the West cancer region has data which shows clearly that integrated specialist care provided by that MCN had better outcomes than those across the UK. But some boards chose not to join their regional MCN, resulting in poorer outcomes.

The roles of the non-territorial boards, as listed below, should be reviewed.

- Public Health Scotland
- Healthcare Improvement Scotland
- NHS Education for Scotland [NES]
- NHS National Waiting Times Centre
- NHS 24
- Scottish Ambulance Service
- The State Hospital's Board for Scotland
- NHS National Services Scotland
- Golden Jubilee Hospital

Public Health Scotland should be retained nationally, but the local functions and staff should be based in local authorities, with ring-fenced government funding. Local public health should be driven by implementation of primary prevention, including where appropriate tackling the social determinants of poor health:

• **from hospital to community** – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary
• **from treatment to prevention** – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill-health
• **from analogue to digital** – greater use of digital infrastructure and solutions to improve care.

The Golden Jubilee Hospital should become part of the new West Territorial Board.

The 30 IJBs should be abolished and their functions allocated to local authorities with direct government funding. Audit Scotland, in its latest Account Commission Report, refers to big deficits, large turnover in senior staff and little evidence of any shift from hospital to community.

A "National Health and Social Care" oversight body should be established, promoting standards, training and incorporating current inspection of both health and social care. This should incorporate NES.

NHS 24 and the Scottish Ambulance Service should be amalgamated. The State Hospital Board should have responsibility for all forensic services, including medium secure units and prison medical services. I welcome the restoration of female high security beds at the state hospital.

NHS Administration

Another major issue is NHS administration. There are many aspects to this and few are currently good. A Kings Fund "long read" included a survey which showed that one in five people who used the NHS in the past 12 months received an appointment invitation *after* the date of the appointment. Nearly one in three people said they have had to chase up results of tests, scans or x rays. The same proportion said they had not been kept updated about how long they would have to wait for care or treatment. Close to a quarter of people had not been told who to contact about their care while waiting.

More than three in five people said it made them think NHS money was being wasted, while 56% felt that their time was being wasted, and 55% felt that staff time was being wasted. Although the statistics are for England, there is little reason to believe that the NHS in Scotland is any different. It is no wonder that satisfaction with the health service is at its lowest since records began.

Digitisation may help, while the staff managing appointments need to be more valued.

Prevention

Politicians have extolled prevention over the years. Vaccination programmes and screening programmes have increased. Uptake of the former is good but too many do not participate in screening. However there is little other primary prevention. The concept of tackling the social determinants of health, contained in the Marmot proposals, are critical to improving health and reducing pressure on the NHS. Creating Marmot "cities" is just one part of a need to get serious about applying new funding to community and neighbourhood services – see the Kings Fund blog and NHS England's Neighbourhood Health Guidelines. This is vital if secondary and tertiary services are not to be overwhelmed. There also needs to be a focused approach to tackling obesity and physical inactivity, such as through the Daily Mile, which is now in 973 Scottish schools.

Primary Care

Primary care is central to primary, secondary and tertiary prevention. Its central role was iterated in the Alma Alta declaration of 1978 and has been updated in the ASTANA Kazahkstan declaration of 2018.

In the UK, the shift to primary and community care, which has long been sought, needs new impetus and proper funding. Neither the 2003 nor the 2018 GP contract has proved satisfactory. In particular, rural and remote areas have been poorly served by the changes. The current situation of unemployed qualified GPs is unacceptable. Meantime, the trend of employing physician associates in any situation diagnosing undifferentiated presentations is causing concern, even when supposedly supervised by a GP. Whilst workforce planning is never easy, it is imperative that this is undertaken as a matter of urgency.

Another example of wasting GP time in Scotland but not in England is the requirement for paper-based prescriptions to be signed manually. GPs spend hours each week on this.

Other Primary Health Professionals

Community pharmacies in Scotland have developed their roles significantly, with a minor illness system, a chronic prescribing system, and pharmacist prescribing, mitigating pressure on GPs. However some scripts cannot be filled because of lack of medicines, causing inconvenience to patients, community pharmacists and GPs. These medicine supply problems have been ongoing since 2013.

Community opticians have also increased their role in screening, monitoring, prescribing and linkage to specialist ophthalmology. Free eye tests, introduced in 2006, have been shown to increase early diagnosis and prevention of sight loss with increased uptake, though more so in better-off communities. [H.Dickey et al]

Specialist nurses should be attached to either large practices or clusters. Community link workers must be permanently funded and become an integral part of primary care. Social workers should be attached or linked to primary care teams or clusters.

IT and Digitisation

In 2005, as an addiction psychiatrist I was concerned by poor outcomes and a lack of data in the addiction services. I proposed replacing the 25a, 25b and waiting list data with a Single Shared Assessment IT system, which would include audit data of process and outcomes. It was developed on an iterative basis working with stakeholders, and was at beta testing in 2007 when it was terminated. A new system was ordered in 2014 and rolled out to all health board areas in April 2021. This delay has contributed to the poor Scottish record on drug misuse.

Another example of poor procurement is GP IT. In 1984, Dr David Ferguson created a GP software system called G-Pass. In the 1990s, he gifted the system to the Scottish NHS and by 2003 it was being used by 80% of GPs. But it was never developed and eventually needed substantial upgrading. In 2006, a Deloitte Report stated that it was not fit for purpose, but noted that the existing commercial alternatives were also poor.

ATOS, which was the NHS's preferred provider, offered to take it over and TUPE the existing staff. ATOS would then modernise the platform. Instead, the Scottish NHS opted to make the staff redundant and switch to EMIS and Vision at considerable cost. Now EMIS has withdrawn from Scotland and Vision's parent company is in administration. GPs are almost universally unhappy with the IT systems or their connectivity to hospital-based portals. These hospital portals were reported by a parliamentary committee in 2012 as failing to communicate with each other.

Another example is when NHS 24 decided to develop its own IT in 2008. Some years later, and with substantial cost overruns, it was piloted but withdrawn rapidly for not meeting patient safety standards.

Cyber security is also a concern due to recent ransomware attacks on some hospital systems, while some hospitals report still using faxes, pagers and paper records.

IT problems are not exclusive to the NHS, and reflect a larger problem in the Scottish Government where there has been a lack of expertise on technology, in part due to a reluctance to pay the necessary level of remuneration.

At government level, unless there have been substantial changes since I was an MSP, there is movement of civil servants from department to department every few years. This

is simply no longer effective. Committees and task forces too often find that the supporting civil servant is changed in the middle of their work.

In the NHS, managers are tasked with meeting multiple targets. This has led at times to "gaming". The worst example was exposed by a whistleblower in Lothian. A subsequent report by Audit Scotland was carried out because "public trust in the waiting list system had been undermined", according to Lothian NHS. Audit Scotland found a management culture across the NHS of "managing" waiting lists to minimise missing targets but was unable because of poor data to say whether this practice was widespread.

This was not the first time this had happened. There was a similar abuse in 2005 which led to the current overly complex waiting lists system. Since many NHS targets have not been met across the UK there needs to be careful reconsideration of the target-led approach.

Mental Health Services: Adult, Child and Adolescent [CAMHS]

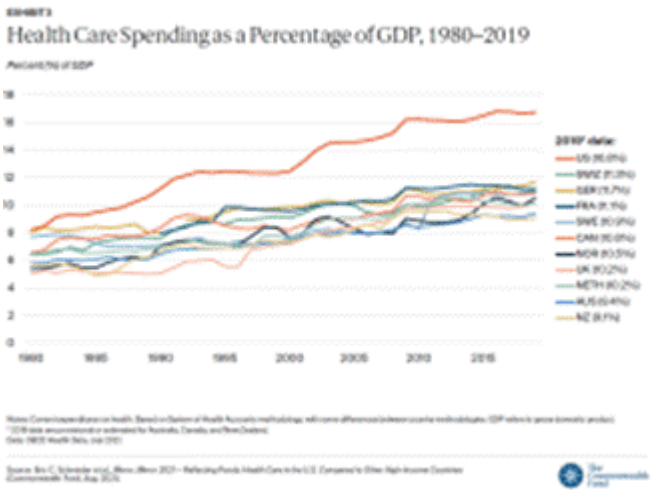
Mental health services have been under pressure for years. Continuing the funding of the learning disability hospital beds until they were replaced by fully funded new community facilities was a great success but has not been replicated. There is a lack of beds in adult psychiatry. This is evidenced by, for example, the difficulty in ensuring the transfer of mentally ill offenders from prisons (without a visit by the Mental Welfare Commission being completed and the report/findings being gathered and produced, it would not have been possible to highlight the lack of progress in mental health issues in prison that has taken place over a 10-year period since the 2011 report).

The child and adolescent services have been particularly poor. In 2015 it was noted that, from 2008, although there had been an increase in nurses and psychologists, there had only been one additional consultant appointed. At the same time it was reported that 15% of referrals were

"rejected" and the non-attendance rate was also 15%. A Freedom of Information request found that out of the 6,250 rejected referrals, almost two-thirds were from GPs who had often already tried other agencies suggested by CAMHS. The frustration of parents was palpable.

The target of having 90% seen within 18 weeks is improving. However, tackling assessment of children who are neurodiverse remains a problem.

Conclusion



In summary, we cannot go on spending more and more on the NHS without radical change. Structures are only a small part of such change. It requires a major shift to primary and preventive care whilst addressing the social determinants of ill-health. It requires a whole-system approach to health and social care.

The NHS is a cherished institution, but Covid exposed what we already knew – that it has the worst outcomes of many countries except the US.

See also Alex Neil's essay for Enlighten on the NHS in Scotland

Dr Richard Simpson OBE FRCPsych FRCGP is a former GP and psychiatrist, and was a Labour MSP from 1999-2003 and 2007-2016. He was shadow Public Health Minister from 2007 to 2016.

APRIL 2026

Contact Information:

Chris Deerin, Director
Email: chris.deerin@enlighten.scot

Alison Payne, Research Director
Email: alison.payne@enlighten.scot

enlighten.scot

enlighten
Scotland's independent think tank