Good Governance Institute

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

The Future

for the NHS in Scotland: The Debate

#NHSFutureScot

February 2018

"For health and social care integration to work, we need to see a shift in resource… that shift in resource has not happened – the acute sector still dominates spend"

Professor John Connell, Chair, NHS Tayside

"The current model of health and social care integration will fail for two reasons - no integration of money and no integration of information"

Professor Charles Swainson, Royal College of Physicians of Edinburgh

"Are the public really at the heart of our health and social care system? Do we engage in the right way?"

Claire Sweeney, Associate Director, Audit Scotland

"Is defensive medicine and fear of litigation or of being accused of negligence hindering the NHS' ability to innovate?"

Angela Grahame QC, Vice Dean of the Faculty of Advocates

"Medicine copes poorly with uncertainty. We struggle to manage risks and expectations"

Dr Caroline Whitworth, Associate Medical Director, NHS Lothian

"There is a disconnect between expectations and the available resource to meet those expectations…The NHS in Scotland needs a view independent of Government on how much healthcare should cost, and what the money could buy"

Lord Newby, Liberal Democrat Leader in the House of Lords

"Governance can be used to navigate step change and manage the risks needed to take bold steps forward. It is an opportunity that all organisations can grasp"

Dr Andrew Corbett-Nolan, Chief Executive, Good Governance Institute

1. Executive Summary

Several recent strategy documents for Scotland recognise the need to balance an increased demand for health services with the requirement to manage the health system more effectively to meet the needs of patients, both now and in the future. Following the devolution of political power in 1999, health policy and the way in which the National Health Service (NHS) is run across the four nations of the United Kingdom has become increasingly varied, yet each devolved nation is grappling with similar challenges. These include changing demography (a fast growing, ageing population and an increasing number of people living with complex health needs and multiple long term conditions), unequal health outcomes, difficulties with moving care from hospital to the community and integrating health and social care, and significant financial pressures, with funding for the NHS failing to keep pace with increased demand. This is creating a progressively difficult setting in which to function, both within the Scottish NHS, and across the UK. [1]

The recent Nuffield Trust publication, *Learning from Scotland's NHS*, drew some important conclusions:[2]

1) Scotland has a unique system of improving the quality of care and NHS Scotland has benefitted from a continuous focus on quality improvement over many years. There is much other countries in the United Kingdom can learn from this.

2) A watershed moment came in 2008 with the introduction of the Scottish Patient Safety Programme (SPSP), which was viewed by many as the cornerstone of quality improvement in Scotland.

3) Limited national planning over the coming years, together with Scotland's polarised, hostile political culture, makes holding an honest national debate on healthcare reform and the possible reallocation of resources difficult.

Recognising the need to challenge the status quo and debate the issues critical to the sustainability of the NHS in Scotland, the Royal College of Physicians of Edinburgh and the Good Governance Institute jointly hosted a breakfast debate on Tuesday 26 September 2017. The focus of the seminar was to debate the future for the NHS in Scotland and, specifically, to transparently explore the pressures facing the Scottish health system in relation to funding, demand for services, workforce challenges, health and care infrastructure, access, and quality improvement.

The event, chaired by **Professor Michael Deighan,** Heritage Chair at the Good Governance Institute, brought together a range of experts including the following speakers:

- **Professor Derek Bell**, President, Royal College of Physicians of Edinburgh
- **Professor John Connell**, Chair, NHS Tayside
- **Claire Sweeney**, Associate Director, Audit Scotland
- **Dr Caroline Whitworth**, Associate Medical Director, NHS Lothian
- **Angela Grahame QC**, Vice Dean of the Faculty of Advocates

[1] Nuffield Trust, Learning from Scotland's NHS (July 2017) https://www.nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf
[2] Ibid.

- **Lord Newby**, Liberal Democrat Leader in the House of Lords
- **Professor Charles Swainson**, Royal College of Physicians of Edinburgh
- **Dr Andrew Corbett-Nolan**, Chief Executive, Good Governance Institute

Contributions from the audience were also welcomed, a selection of which are included in this paper.

It was proposed that a radical and challenging approach to healthcare reform in Scotland must now be taken to protect the future sustainability of Scotland's NHS, particularly when considering the "looming cloud" of Brexit and potential impact this could have on, for example, workforce and research and development. Adopting a radical and challenging approach will require health service leaders and clinicians across Scotland to work together, to steer the future direction of healthcare. And, as stated in *Learning from Scotland's NHS,* politicians must be prepared to make some difficult and potentially unpopular decisions in support of this ambition.[3]

2. Recommendations

There are a number of fundamental priorities that arose from the debate that can, and indeed must, be addressed to create a climate of radical change and ensure the future of the NHS in Scotland. These are set out under the following recommendations:

Recommendation 1: stronger health and social care integration with joint financial arrangements: urgent collective action is still required by government, health and local government leaders to put in place fit-for-purpose, sustainable governance arrangements for health and social care integration (IJBs)

- Governance needs to be clear and understood by all parties. It is recommended that where governance arrangements are working, the arrangements must now be recast across Scotland to ensure IJBs are able to pursue a working model of integration, which makes primary care clinical leaders feel supported in driving forward practical change.

Recommendation 2: A new political agreement: stakeholders in the future of health and social care from all backgrounds must make rapid progress in securing a cross-party commitment to "de-politicise" integrated care

- The recommended intention was to build a genuine consensus, which reduces the destructive impact of health and social care remaining a political battleground. It is not a new idea or an easy one to achieve but looks increasingly like a prerequisite for action.

Recommendation 3: creating a public platform for more active public engagement - a more creative and systematic approach to engagement is needed to connect the public,

[3] Nuffield Trust, Learning from Scotland's NHS (July 2017) https://www.nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf

particularly focusing on the true cost of healthcare and the public's essential role in the future design of health and social care

- Scotland has many examples of excellent programmes delivering high impact results in supporting changes in public behaviour and improving the quality of care. The same skills have not yet been mobilised to help reframe old age, health and social care, and the reducing role of the state in future care provision. Well-co-ordinated national and local engagement frameworks are now needed to drive this forward.

Recommendation 4: Shifting the balance of care: this must be much more firmly established as a shared priority for Scotland's health and social care system, informed by policy based on evidence, with a series of clear, collective outcomes underpinned by strong governance structures

- Both the delegates and speakers quoted that there are too few examples of systems in Scotland that have been able to generate genuine momentum and energy into shifting the balance of care. This is not surprising given well-entrenched obstacles. It was recommended that there ought to be shared governance accountability across both health and social care.

  Progress now depends on energising a shared accountability across borders both for unlocking and redistributing resources within systems, and for handling the consequences jointly in terms of the public impact of change.

Recommendation 5: introducing evidence-based implementation approaches to new technologies and where appropriate, finding the means by which to implement at scale across Scotland

- *Resourcing innovation*: fit-for purpose governance models must now be developed which stimulate and support innovation. So far support for real innovation has proved elusive to too many front-line public organisations, who have relied too often on project-based funding to lever short-term change. Innovation governance should feature in the risk appetite of every public-facing organisation.

3. Commentary from the Future for the NHS in Scotland debate

The commentary below sets out the core arguments arising from the *Future for the NHS in Scotland* debate. In addition, the paper describes and outlines the set of recommendations above in greater detail, which are deemed necessary to safeguard the future sustainability of the health system in Scotland.

3.1. Health and social care integration

Scotland has a longer history than the other UK nations of encouraging different parts of the health and care system to work collaboratively and in using legislation to underpin this.[4] In April 2016, Scotland introduced legislation requiring the integration of health and social care services,

[4] Ibid

resulting in the establishment of Integration Authorities with responsibility for a budget of over £8 billion for local services, previously managed separately by NHS Boards and local authorities.[5] Whilst the concept of integration is unarguably central to the Scottish Government's plan for the NHS, and at the forefront of its 2020 vision, there were some fundamental issues raised during the debate that must be addressed for integration to succeed.

Financial resources

The financial environment has become more challenging, and this trend is unlikely to be reversed in the short to mid-term. In January 2017, Dr Peter Bennie, Chairman of the British Medical Association in Scotland (BMA) stated that an increase in funding of at least 4% was necessary for the health service in Scotland *"just to stand still"*, and as reinforced by **Lord Newby**, Liberal Democrat Leader in the House of Lords, social care is facing an equally significant, if not greater funding squeeze, with the Kings Fund and Nuffield Trust forecasting at least a £2.8 billion social care funding gap for 2019-20 across the United Kingdom. Therefore, the NHS in Scotland, together with the wider care system, is facing unprecedented financial pressure, which it currently appears poorly placed to address.

Claire Sweeney, Assistant Director, Audit Scotland, described how 43% of the Government budget in Scotland goes on health (excluding social care), yet the system remains stretched and could, "*spend everything and still not deliver what it would like to for the people of Scotland*". She proceeded to explain that Scotland would "*do well to talk about the money*" and transparently discuss how resources are used. The lack of clarity regarding the relationship between available resource, how this is utilised and what difference this actually makes to patients must be addressed. The health system in Scotland must really understand where best to invest resource and must be open, both with its staff and with the public, in terms of investment decisions and priorities. As **Claire Sweeney** concluded, talking about service change in the absence of any real clarity around what this costs and the resulting impact makes it very difficult to engage the public in a meaningful dialogue around a better way of delivering services. She also noted that while making efficiency savings can be well intended, it can cause more problems than it solves.

Dr Caroline Whitworth and **Lord Newby** explained how Scotland, as with England and Wales, must find a tangible way to address the disconnect between public expectation and available resource. In addition, **Dr Whitworth** described how clinicians are *"bombarded on a daily basis by information about new technologies, new drugs, new ways of approaching things, new guidelines"* and that "*this creates new expectations that clinicians will meet the requirements of this new bit of evidence-based medicine...*". **Dr Whitworth** also highlighted the need to *"recognise that these developments are the lifeblood of pharmaceutical and health technology industries"* whereby the mark of success is a *"statistically significant P-value"* – a drug is deemed statistically better than its comparator*, "so we must start using it".* Furthermore, **Dr Whitworth** questioned whether statistical significance was equal to clinical significance – "*new drugs are brought in, but do they really make a difference or does it simply increase cost?"* She concluded by describing how a commentator in the last week had described this in the field of cancer as *"the ruthless peddling of marginal hope to dying people at huge expense. That actually is the core of it".*

[5] Scottish Government, Health and Social Care Integration http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration

Critically, the public must be empowered to understand the actual cost of healthcare interventions and the Scottish health system must find a tangible way of informing the public to this end. Unless the public *really* understand the true cost of healthcare, it will be very difficult to move forward. The debate drew links with the annual reports published by Scotland's Chief Medical Officer, Dr Catherine Calderwood, on *Realistic Medicine*[6] and *Realising Realistic Medicine.*[7] Realistic Medicine places the person receiving health and care at the centre of decision-making and encourages a personalised approach to their care.

Regarding future funding for the NHS in Scotland at a national level, a number of proposals were debated. **Professor Charles Swainson** argued the need for *a "one system, one budget approach",* describing how the current model of health and social care integration would fail in part due to the failure to integrate the health and social care budgets. Integration of the money and realignment of incentives were described as the real drivers of change - "*unless you integrate the money into a single pot, you cannot play with the incentives that encourage people to change the way they work or behave".*

Regarding long-term, sustainable NHS funding, **Lord Newby** discussed the introduction of a hypothecated health and social care tax, based on National Insurance, which would enable people to see what they contribute to the health service, and the associated output. Alongside this, it was suggested there could exist an independent body, similar to the Office for Budget Responsibility (which has experienced success in determining the future path of public finances), that would hold responsibility for determining the cost required to achieve a certain quantum of outcome. Although the Government would not be bound to follow this, there would be pressure to do so, just as the Government must take into account the Office for Budget Responsibility. This could support, therefore, the development of a credible approach to determining what is needed without the *"taint of political bias".* As **Lord Newby** concluded**,** the NHS will continue to "*stumble from crisis to crisis unless something dramatic is done in a way that the public feel confident in the system".*

The model for leadership and accountability

Professor John Connell, Chair of NHS Tayside, argued that Scotland must reconsider the model of leadership and accountability for health and social care integration. Attempting to impose integration via a top down approach does not work. As recognised by **Andrew Corbett-Nolan,** Integrated Joint Boards (IJBs) "hold promise" of a structure that that could support the delivery of better services more rapidly. However, as described by **Professor John Connell,** there currently exists a lack of clarity regarding whether integration of health and social care should be rooted in a system of delegation or devolution. A system of delegation means that accountability for social issues rests with local authorities and accountability for health issues with NHS boards, with the IJB having delegated authority but commissioning back the service to parent bodies. In contrast, a system of devolution means that responsibility and accountability for health and social care also transfers to the IJB. This was described as generating confusion over where true accountability for service change rests, and who is ultimately liable for decisions made.

---

[6] NHS Scotland, Realistic Medicine: Chief Medical Officers Annual Report (2014 – 15) http://www.gov.scot/Publications/2016/01/3745

[7] NHS Scotland, Realising Realistic Medicine: Chief Medical Officers Annual Report (2015 – 16) http://www.gov.scot/Publications/2017/02/3336

The debate recognised that integration requires strong *clinical* leadership at a local level. Clinical leaders must take advantage of the "burning platform" and the permissions that are being created to facilitate change and, as stated by **Professor Harry Burns,** former Chief Medical Officer in Scotland, clinicians must collaborate and be more active in suggesting improvements, instead of awaiting instruction on what to do. It was posited that clinical leadership for driving change should come from general practice, yet the debate acknowledged that general practitioners do not usually sit at the heart of the leadership of IJBs - they are present, *"but somewhat peripherally".* This was described by **Professor John Connell** as a *"missed opportunity"* and it was suggested that in some parts of the country, general practitioners felt "*disengaged from IJBs and not fully listened to when it comes to making decisions about the way care should be developed and delivered locally"*. Scotland must therefore consider how best to energise the leadership in general practice to drive forward the integration agenda and, as highlighted by **Jonathan Passmore**, Chair of Aberdeen City Health and Social Care Partnership IJB, the system must consider what engagement looks like in the context of integration, as at present, clinicians are not full voting members of IJBs**.** In other words, how do we bring clinicians into IJBs, and should clinicians be made full voting members?

The Scottish health system benefits nationally from an informed and connected group of experienced individuals who are driving the agenda at a national level. However, at individual health board level, it was argued that the issue of large, mixed ability boards needs addressing. **Lord Newby** argued that leaders in the health service must be prepared to be the subject of fierce public scrutiny, and to stand their ground, because often, they will be up against people who are going to oppose change for very parochial reasons.

Governance was acknowledged by **Professor John Connell** as being "*very important",* particularly in the context of moving towards a model of regionalisation for a number of health service provisions across Scotland – Scotland must rapidly consider the structure that will support regional delivery of services and who, with regard to public accountability and political accountability, holds responsibility for regionalisation. As explained by **Andrew Corbett-Nolan, Chief Executive of the Good Governance Institute,** governance can be used to navigate step change and manage the risks needed to take bold steps forward. It is an opportunity that all organisations can grasp. It was argued that Scotland, as with many other countries across Europe, still has some way to go in using governance as the mechanism to navigate such change.

The use of the NHS as a political battleground

As described within *Learning from Scotland's NHS,* limited national planning for future years and a polarised, hostile political context make integration difficult[8]. In light of this, the debate considered the following questions

- What is the possibility of making health and social care apoliticised?
- Are there structures that could make this work?
- Is devolution of responsibility possible in reality?

It was argued that political involvement is inevitable when talking about such a large percentage of public wealth (35.1% of the total Scottish Government budget in 2016/17 went on health and

[8] Nuffield Trust, Learning from Scotland's NHS (July 2017) https://www.nuffieldtrust.org.uk/files/2017-07/learning-from-scotland-s-nhs-final.pdf

wellbeing alone[9]) – politicians must be involved in determining how resources are used. However, the NHS is not a vote-shifting tool and, as argued by **Professor John Connell,** it must stop being used as a "*political battleground"*. It was suggested that running the NHS as an arms-length body, with political accountability but without day-to-day political interference would enable hard choices about change to be made in a safe, accountable way. Similarly, **Lord Newby** argued the need for cross-party working in order to develop a sustainable system in the long term – "*there is a lot of agreement about what we want out of the healthcare system"*. Scotland must instil a political consensus on behalf of the public, which would require a brokering arrangement that lasts longer than one political cycle.

In further consideration of the political context, **Jonathan Passmore, Chair of Aberdeen City IJB,** described how a significant proportion of IJB membership across Scotland are in fact locally-elected political appointees. A key governance question, therefore, is how to leverage this to facilitate conversations that are difficult to have when coming from the perspective of a health board, but easier for local politicians to instigate? The governance levers must be in place to promote a collaborative narrative.

Shifting the balance of care

The speakers came from the premise that the Scottish Government's policy to shift the balance of care out of hospitals has lacked any real progress and failed to keep pace with the changing needs of the Scottish population. As posited by **Professor John Connell, Chair of NHS Tayside,** health and social care integration necessitates the need to shift resource from the acute to the community setting, yet in Scotland, whilst money may have been moved in to IJBs, this is capped and the acute sector continues to dominate spend. **Professor John Connell** went on to argue that effective system change required "*double running"* with funding – "*you cannot simply take money out of the acute system and move it in to the community with the expectation that care would continue in a seamless manner".* Instead, it was argued that to facilitate health and social care integration, additional resource should go into the community whilst, simultaneously, the acute sector reduces bed numbers and occupancy.

However, in comments echoed by the Nuffield Foundation and others, it was argued that even reductions in bed occupancy would not be sufficient to make financial savings - the only way to save money, and to fund the community side of care properly, was to "*close hospitals, or close facilities*", which was described as a *"painful, timely and expensive"* process. Therefore, there are some key issues to address, and, in comments echoed by Audit Scotland, the Scottish Government must identify the mechanisms by which to drive the shift in resource required for community-based models to succeed.[10]

3.2. Innovation and technology

The debate recognised that a failure to innovate will result in a failure to change. It was argued that innovation can often become conflated with high-tech solutions or with scientific research driving the development of new drugs, but at its core, innovation is about how to do things

[9] SPICE Briefing: The National Health Service in Scotland (December 2016) http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-100_The_National_Health_Service_in_Scotland.pdf

[10] Audit Scotland, Changing models of health and social care (March 2016) http://www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_160310_changing_models_care.pdf

differently to achieve change. For change to happen, the NHS in Scotland must embrace and drive innovation, whether it be digital, in data, in technology or in new medications. Importantly, it must also consider what is currently hindering the NHS' ability to innovate.

As indicated by **Dr Caroline Whitworth**, the NHS in Scotland is entering into an era of innovation, which is a sign of a healthy, evolving organisation. This innovation promises personalised care, but personalised care at a very technical level – aided by genomics, stem-cell engineering, targeted biomedical technologies etc. Therefore, unsurprisingly, this is creating high public expectations and, as **Dr Whitworth** explained ***"****over the decades we have created expectations that as doctors, I can fix things, because that is my job. The media, the politicians, and the public expect us to fix things given sufficient application and resource. If we fail to meet those expectations, then it seems that we have failed our patients"*. As described by **Angela Grahame,** Vice Dean of the Faculty of Advocates, from the moment patients arrive, these high expectations can "*set off a chain of disappointments that are then going to colour their experience of care...couple with this the publicity regarding bad news stories, and you have a culture of complaining more. If you are not improving [a patients'] life dramatically, the families of the patient, and the patient themselves, are more likely to complain – they are going to question the medical professional's fitness to practice and they make accusations of negligence. This creates fear."*

Dr Whitworth linked to this is the concept of risk and how this is managed. Risk can be defined as the effect of uncertainty on objectives. **Dr Whitworth** described how medicine copes very poorly with uncertainty and struggles to manage both risk and expectation. This means that innovation is viewed as being too risky, making staff engagement in innovation, and willingness to change, difficult. In light of this, **Angela Grahame** challenged whether defensive medicine, and a fear of litigation or being accused of negligence, was not only resulting in "*over admission, over investigation, over treatment and the medicalisation of ageing"*, but was also hindering the NHS' ability to innovate.

Scotland must consider how to develop a culture of innovation and how to sustain this culture, and the debate questioned whether there was a role for academic health science networks through their ability to bring together the best in the NHS, the best of academia and the best of the industry. It was noted by **Professor John Connell** that this had achieved great success in driving change in the health system in some parts of the world (for example, the East coast of the USA, parts of Europe, and England). In Scotland, for example, the development of an academic health science partnership in NHS Tayside was beginning to show promise in terms of bringing the NHS, industry and university colleagues together. Could this be a model to consider replicating elsewhere in Scotland? And, as raised by **Angela Grahame,** should Scotland consider the development of innovation hubs?

As described by **Professor Charles Swainson**, the NHS has invested significantly in digital services, and has seen some great successes in this field, but it was argued that this investment had seen "*much less impact than was hoped"* and that piecemeal implementation has not proven to work. Furthermore*, 'the interface between clinicians and technology is appalling. It is usually slow, it is counterintuitive, and most tasks take longer than they did using paper*.' When considering how to overcome this, **Professor Charles Swainson** described how the NHS in Scotland spends less than 2% of its budget on digital services, with about 90% of that being used to "*keep the lights running and existing systems in place*". This leaves relatively little for innovations or new technologies. Conversely, Professor Swainson noted that other face-to-face service providers spent at least 4% of their budgets on these services, investing more often in new technology to better serve their

customers. A crucial difference between the NHS and other face-to-face service providers, it was noted, was that other organisations often invest the extra spend in the change management that must accompany the introduction of new technologies.

Whilst the NHS in Scotland is "*awash"* with fine examples of successful digital innovations – including repeat prescriptions and GP appointment booking systems – there still lacks the ability to consistently implement these at scale across the country. In a publicly-funded service of a country of just 5.6 million, the debate recognised this as being increasingly unacceptable. Similarly, and linked to technology, **Professor Charles Swainson** argued that a failure to share information between sectors posed a significant barrier to integration – *"if you do not share the same information about the people that you are looking after, you cannot do anything for those people because you cannot enable one person in one sector to see clearly what is going on in another".* This was echoed by **Major-General Bob Bruce CBE**, who brought attention to the situation faced by many military personnel and their families – *"we lead unnaturally peripatetic lifestyles. We move around the country… service men and women get to see military doctors, their families do not. In terms of the efficient transfer of records, this is constantly a problem".* With regards to the armed forces covenant, which states that military families should not be disadvantaged, **Major-General Bob Bruce CBE** continued by asking the panel "*to what extent should this be a planning factor among all other challenges facing the health system in Scotland?"* The fundamental challenge of the transfer of record remains a live debate that needs addressing.

Professor Harold Thimbleby, Professor of Computer Science at the Swansea University, went on to highlight the need to focus on the evidence of improvement arising from interventions – where is the evidence? IT and innovation cover every part of healthcare, yet currently there exists no specialty focusing on and promoting them – i.e. there exists no expertise. Whilst there is no expertise, "*we confuse excitement for evidence".* An example was given of a hospital where iPads were bought but were subsequently permanently fixed to prevent them from being stolen.

The debate recognised that there is not a lack of willingness within the NHS and social care to see innovation happen, and similarly there is no lack of people wanting to be involved. These people must be given the time, space and support to do this, but equally important, is the provision of permission to fail. It was argued that the NHS in Scotland, and more widely, has a fundamentally risk averse culture. As stated by **Claire Sweeney,** unless we allow people to fail, and to learn from this, they will never take the risks that will drive forward change and success – the health system is in danger of becoming so risk averse that it is afraid to innovate.

As described by **Dr Caroline Whitworth,** it is important to maintain a compassionate health service. In consideration of the digital computer science interactions, **Dr John Gillies,** Deputy Director of the Scottish School of Primary Care, emphasised that "*it is worth remembering that we do need relationships, continuity and compassion, and indeed compassion as being defined as an understanding of suffering, pain or distress, and attention to alleviate it".* This remains at the very heart of the NHS.

Digital innovation should not simply be about a gentle evolution from paper to screen, it should be about challenging the health system to think and work differently. As described by **Andrew Corbett-Nolan,** over the next three to five years, advances in digital health, population health, artificial intelligence, and cybernetics hold extraordinary possibilities for the Scottish health system to deliver better, sustainable care at scale. Crucially, there is a

need in Scotland to secure better value from investments, and digital technologies should be used to innovate effectively.

3.3 Workforce planning

The July 2017 Audit Scotland report on NHS workforce planning[11] posited that the Scottish Government and health boards have not planned effectively for the long term, with responsibility for NHS workforce planning being described as "*confused, and split between the Scottish Government, NHS boards, and three regional workforce groups"*[12]. As health and social care integration authorities develop their own workforce planning arrangements, there is a risk that these responsibilities will become further fragmented.[13] Therefore, there exists an urgent need to be realistic and identify what the future medical and nursing workforce will look like. Additionally, when developing strategies for the future development of health and social care, there must be triangulation of the financial envelope, the available workforce, and feasible clinical outcomes. **Professor John Connell** suggested two options to address the workforce challenge: either the Scottish health system trains more staff and/or recruits more staff from outside of Scotland, or the system considers different ways of working, which is perhaps where technical and digital solutions may provide some opportunity. In reference to the recruitment crisis, **Peter Bennie** highlighted the opportunity to accentuate the strengths of the health service in Scotland, as *"we're in a competitive market when it comes to recruiting doctors and other health service staff".*

Improved workforce planning is critical to addressing the urgent workforce challenges facing the NHS in Scotland, particularly in the context of the "*looming cloud"* of Brexit, and the potential effect that this would have on staffing of the health service and on the finances of the country as a whole, a point emphasised by **Peter Bennie.**

3.4 Public engagement and population health

As stated by **Andrew Corbett-Nolan,** "*authentic public and community engagement comes through empowerment, information and responsibility"*. The following questions were reflected upon during the debate:

- Are the public really at the heart of the health system?
- Are we open enough with the public, and do we engage in the right way?
- Are we running services for the public? Or are we running them in some instances for professionals or for politicians?

The debate recognised that getting public engagement right and authentically involving the public in decisions is difficult, and much work remains to be done around building relationships with local communities who have aspirations of doing things differently – the future health and care system must be developed with the people that it affects most. Similarly, as explained by **Dr Caroline Whitworth,** we must stop creating a gap between expectation and reality - this results in

[11] Audit Scotland, NHS workforce planning: the clinical workforce in secondary care (July 2017) http://www.audit-scotland.gov.uk/report/nhs-workforce-planning
[12] Ibid
[13] Ibid

patients feeling a lack of control. We must consider the patients' objectives – "*ask them what they want".*

In consideration of public health, **John Gillies** described a revision of the public health function in Scotland – "*Health Protection Scotland, NHS Health Scotland and probably the information and statistics division will be combining into a revitalised NHS*". He continued by suggesting that *"this could move into thinking about healthy companies, how our industries promote health and how we can effectively lobby the food and alcohol industries to prevent the detrimental effects on health…something radical and innovative like this is a possibility".*

Critically, and as touched upon earlier in this paper, there is a need to address the public perception that healthcare is free. This requires a focus on public education to support a better understanding of the true cost of healthcare – from tablets, to tests, to infrastructure. Enabling the public to understand the actual costs of health interventions would really help. Similarly, as described by **Harry Burns,** there exists the need to rediscover the role of public health medicine in determining how best to energise patients to take control. This was echoed by **Peter Bennie,** who argued that *"in considering the future, we should be talking about the future health of the people of Scotland, as opposed to just the future of the NHS in Scotland. Health in all policies is essential to that."* Understanding in particular how to energise people at the lower end of the social-economic scale to be in control of their lives was described by **Harry Burns** as being key to reducing demand in acute medicine. Similarly, investment in public health prevention is equally key when considering value, outcomes, costs, and it was argued that the Scottish Government must play a more active role in affecting real change in public health prevention.

4. Conclusion: what is required for radical action?

Scotland is facing some significant challenges, particularly with regard to demography, whereby the number of people aged 75 and over is set to increase substantially by 2020, with many of these individuals living with more than one chronic condition. It is very easy to be pessimistic about the future of the NHS, and it is clear that incremental changes to the existing system will not be sufficient to ensure sustainability into the future. It is also clear that the need for radical action is now.

According to **Professor Derek Bell**, the *Future for the NHS* debate marked the beginning of a conversation that must now be moved forward at pace, both in terms of initiating the difficult discussions needed to enable progress, and in taking steps to implement the required change. The system must be prepared to take risk and must consider innovation in a productive way. Critically, attention must be given to the importance of governance as an opportunity that all organisations can grasp at a local level, and as the mechanism to navigate step change.

As established in the executive summary of this report, five recommendations have been suggested in order to initiate more radical change within the Scottish healthcare system. They are:

- **Recommendation 1**: stronger health and social care integration with joint financial arrangements: urgent collective action is still required by government, health and local government leaders to put in place fit-for-purpose, sustainable governance arrangements for health and social care integration (IJBs).

- **Recommendation 2**: a new political agreement: stakeholders in the future of health and social care from all backgrounds must make rapid progress in securing a cross-party commitment to "de-politicise" integrated care.
- **Recommendation 3**: creating a public platform for more active public engagement - a more creative and systematic approach to engagement is needed to connect the public, particularly focusing on the true cost of healthcare and the public's essential role in the future design of health and social care.
- **Recommendation 4**: shifting the balance of care: this must be much more firmly established as a shared priority for Scotland's health and social care system, informed by policy based on evidence, with a series of clear, collective outcomes underpinned by strong governance structures.
- **Recommendation 5**: introducing evidence-based implementation approaches to new technologies and where appropriate, finding the means by which to implement at scale across Scotland.

Professor Derek Bell, President, Royal College of Physicians of Edinburgh
Lisa Rooke, Head of External Relations and Policy, Royal College of Physicians of Edinburgh
Professor Michael Deighan, Heritage Chair, Good Governance Institute
Cassie Hill, Knowledge Development Lead, Good Governance Institute

@RCPEdin @GoodGovernInst #NHSFutureScot