A Fractured Service: A Report on NHS Scotland

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Our Scottish Future

Health Commission Report

Foreword by Professor David Kerr

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Karr, not Kerr, opined, “plus ça change, plus c’est la même chose”, the more things change, the more they stay the same, speaking to a resigned acknowledgement of the fundamental immutability of human nature and institutions. Some time ago, I worked with a fantastic team to bring together the voices of the public and health professionals in Scotland and to provide a framework for the future development of health services in Scotland.

The Kerr Report, published in May 2005, set out a Scottish framework to allow the NHS is Scotland to deal with current and future challenges such as Scotland’s overall poor health, health inequalities and the ageing population.

We found then, as now that “the basic ethos of the NHS in Scotland- free comprehensive care to all- still commands universal public support. The future of our health service needs to be built from that base. Fair to all and personal to each of us”. We made a number of key proposals which gained unprecedented cross-party support from the Scottish Parliament and endorsement by health unions, the royal colleges, and the citizenry of Scotland:

- NHS Boards to put into place systems to care for the most vulnerable people with long term conditions at home or in their communities
- Target anticipatory care in deprived areas to reduce future ill-health and reduce health inequalities
- Encourage and support patients and their carers in managing their health care needs
- Urgently introduce new technology like electronic patient records and tele-medicine to improve access, quality and integration of NHS
- Use community casualty departments with multidisciplinary teams for the majority of hospital based unscheduled care. Use tele-medicine to link these units to consultant led emergency units
- Move to day surgery as the norm. It was proposed that the separation of planned and unplanned care would reduce waiting times. The report emphasised that this needed to be linked to improved community access to diagnostics and information for patients.

- Specialist and complex care to be concentrated in fewer sites.
- Rural areas need a different type of service. Rural hospital networks to be developed and a School of Rural Health care established
- Health Boards to make regionally coordinated decisions about hospital based services to avoid overlap, deliver focussed high quality care and value for money
- Community Health Partnerships to have a clear agenda to work across barriers between primary and secondary care and engage with social care partners to shift the balance of care.
- Given recruitment and retention challenges, the workforce required re-profiling and investment in training and education across clinical professions.

In this report, we have used publicly available information and interviewed senior health professionals to see how far Scotland's NHS has advanced over the past two decades and to consider whether it still commands the confidence of the community of patients and carers whom it serves. The Scottish government has something of a tendency to mark its own homework rather than invite independent scrutiny, one would have to say in contradistinction to its Labour predecessor, whose first instinct was to engage transparently with the public, health professionals, unions and royal colleges and provide the full machinery of the state to permit data access to every nook and cranny of Scotland's NHS.

As Bacon said, "ipsa scientia potestas est", knowledge itself is power, but we hope to demonstrate in this report that the true power of knowledge is in its sharing and using it to hold up a mirror to Scotland's NHS, revealing all that is good, but also showing those imperfections that need to be examined, understood and corrected.

Introduction

> For the first time in its 70-year existence, people in Scotland are beginning to lose faith in the NHS.

The last words Anne Sinclair, 64, told said to her son were these: “Keep fighting, tell my story. We need to stop this happening to anyone else.” Mrs Sinclair’s tragic story was told during First Minister’s Questions at the beginning of October by the Scottish Labour leader Anas Sarwar. He revealed how she had died in Edinburgh after waiting seven months to be diagnosed with cancer – and then a further five months for treatment to start. Her story hushed the Scottish Parliament to silence. Yet Mrs Sinclair is just one of many thousands of Scots who must wait in silence at home, scared for their future, waiting for the treatment they need. She was right. Her story – and theirs – must be heard. This report aims to put the spotlight back on the crisis in the NHS in Scotland and make the case for urgent change.

Polls now show that, for the first time in its 70-year existence, people in Scotland are beginning to lose faith in the NHS. Half the population believes they will not receive timely treatment when they fall ill. One in five Scots say they have no confidence at all that they will get treated in a prompt fashion if they get ill tomorrow. Just as with other faith systems, our “national religion” appears to be going the same way - as a society, we are no longer prepared to believe in it. This winter, the Scottish Government is hoping that its Covid Recovery Plan will help to ease the pressure on the service. An extra £600m is being spent to increase staffing and rush through operations. Ministers promise that reforms are taking place to help patients more quickly through their NHS journey. This report does not argue that these efforts will fail to improve matters. The extra staffing that will be supplied, and the faster operations the money will purchase, is immensely welcome.

Rather, this report argues that these well-intentioned reactive responses to NHS crises – from successive governments across the UK, not just this one - are never going to be enough to put our most precious public service on a sustainable footing. It will always be a sticking plaster. Instead, what is needed, from all political parties, is a basic understanding that serious change is needed to keep our NHS afloat.

Because that is the reality we now face.

Scottish clinicians we have spoken to in producing this report are clear. Without radical action, the founding principle of the NHS – of high quality treatment free at the point of use – is going to end, and end quickly. The NHS will be replaced with a two-tier healthcare system, in which a booming private sector caters for better off people to receive treatment more quickly. This will widen Scotland’s already gaping health inequalities. For those poorer families who are unable to pay, they will have to accept a second class service.

With an ageing society placing ever greater pressure on frontline care, clinicians will – in the words of one medic we spoke to, be left “providing an increasingly frayed and torn safety net, which will leave patients a hostage to fortune as to whether it catches them or not.”

The constant drumbeat of “crisis” that now surrounds the NHS is telling us something. This organisation is failing. And we need to re-think how it is done.

This report is divided into three sections.

Firstly, we set out the evidence within the health service as things stand: the facts on the ground in emergency care, on waiting times, on the increase in private sector provision, on workforce, and on trends in social care and primary care.

Taken together, the metrics demonstrate that the NHS is an organisation in crisis.

Secondly, we assess the broader health picture in Scotland, and the health outcomes we are now seeing: our record on health inequalities, our age profile, on obesity, multi-morbidities and mental health. These too all provide major cause for concern: first and foremost, poor health is blighting peoples' life chances and wrecking their quality of life. Overwhelmingly, poor health affects people in our poorer communities. But this poor health crisis is costing Scotland dear. It prevents people from working. It piles further pressure on the NHS. It means we are losing out as a nation on the value that our fellow citizens could be bringing to our society, both as taxpayers and stakeholders.

And thirdly, we set out a series of recommendations on what can be done immediately to support the Scottish NHS this winter and over the coming year to relieve the pressure on medical staff and provide patients with safer and quicker outcomes.

In some cases, we argue that these emergency measures – for example, our proposal for a public information campaign to reduce demand on the NHS – should be done on a "four nation" basis, with the NHS services in Scotland, England, Wales and Northern Ireland acting together.

This kind of collaboration already happens widely: within the health sector, there is much cross UK-learning which is welcome and needs to be encouraged. The most obvious example came during the pandemic when a shared UK wide response delivered a vaccine at speed and when our four Chief Medical Officers collaborated to amplify key public health messages. We believe that, as the NHS faces a crisis of similarly deep proportions to the pandemic, the same collaborative and cooperative approach should be taken.

This plays into a wider theme that Our Scottish Future intends to examine in future papers. Health care in Scotland is delivered independently. In many ways, the NHS in Scotland has its own culture and distinct set of values. All this is to be cherished and protected. But we also believe that, while retaining this valuable autonomy, we can "value-add" by deepening strategic cooperation with the UK wide NHS, both in terms of efficiency of delivery and improvement in outcomes. We believe this is the key to overcoming the crisis in healthcare we all face.

That is for papers to follow: for this report, however, we will focus on the here and now, and the immediate crisis the NHS is facing.

The Current State of our NHS

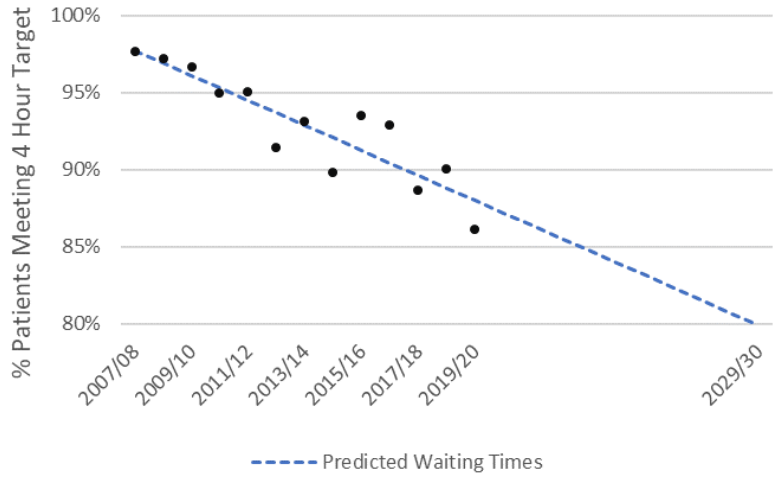
> Scotland is facing significant challenges with healthcare. The current trajectory is unsustainable.
>
> *- Surgeon, west coast of Scotland*

As Scotland entered lockdown in March 2020, the reasoning was clear. Covid-19 was spreading rapidly through the country and hospitals were quickly reaching capacity. “Protect the NHS” was the rallying call. The NHS was forced to abandon elective treatment, move long stay older adults into care homes and build extra hospital capacity in the form of the Louisa Jordan and Nightingale hospitals. Progress in waiting times for cancer and orthopaedic treatment which took years to build, and millions of pounds of investment, were wiped out in a matter of weeks. As we look back over the past two years of the pandemic, it would be easy to conclude that the pandemic has caused the NHS issues we currently see today. However, our analysis shows that the warning signs were already there – the pandemic merely accelerated the decline.

Emergency care

A&E is sometimes referred to as the “front door” to hospitals, so it is useful to understand the pressures currently facing the NHS in the emergency department. The Scottish Government has set a target of having 95% of patients admitted or discharged within four hours. The last time this was achieved nationally (prior to Covid) was in August 2017 – five years ago. A&E tends to be busier in winter months, causing waits to increase. We have carried out analysis showing that if pre-Covid trends were to continue, by winter 2029/30, only 80% of patients would be seen within four hours (four times higher than the recommended target).

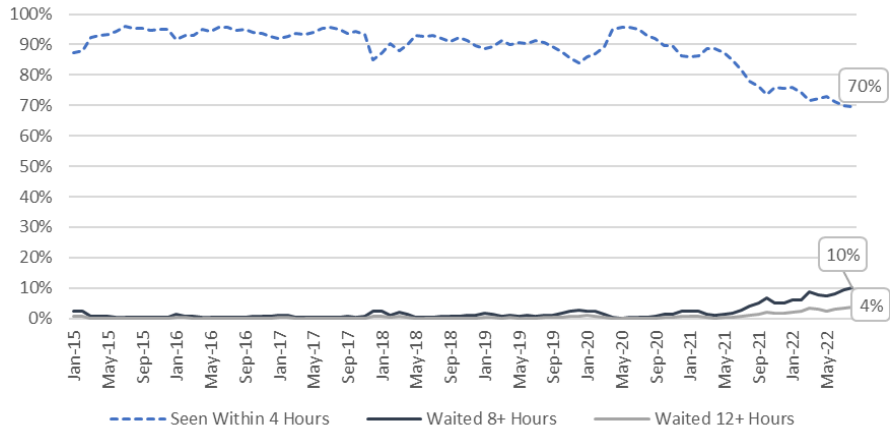
Average Winter A&E 4 Hour Waiting Times (2007/08-2019/20)



Source: A&E Waiting Times (Public Health Scotland)

Covid has accelerated this trend. In August 2022, the Scotland-wide average saw only 69.7% of attendances meet the four-hour target. Almost 1 in 10 people (9.9%) waited more than 8 hours, and most worryingly, 3.8% of people waited more than 12 hours. And this was all in late Summer, several months before the winter pressures hit. We estimate that if these new trends were to continue longer term, the 4 hour winter waiting time target in 2030 would average 56%.

Scotland-wide Average Monthly A&E Waiting Times (Jan 2015-Aug 2022)



Source: A&E Waiting Times (Public Health Scotland)

Whilst targets may seem arbitrary, patients not being seen promptly could lead to deteriorating health or death. A recent study by the British Medical Journal found the risk of death was 16% higher for patients who waited 12+ hours in A&E compared with those who waited less than four hours.[1]

Scotland-wide figures are averaged across the country. Smaller hospitals in more rural parts of the country are performing at-or-above target, with most large hospitals struggling with increased patient numbers. Some large hospitals including Ninewells Hospital in Dundee, averaging 89% in August, are performing considerably better compared with similarly sized hospitals. Forth Valley Hospital near Falkirk averaged 46.4% in August, the worst performing. Care provision is not equal across the country and directed investment is needed to those areas performing poorest.

Despite the increased investment from the Scottish Government, this winter will be an incredibly challenging time for both staff and their patients. A&E attendances may be averaging around 80-90% of pre-Covid volume, but with increased staff absences, lack of beds in other wards and patients presenting to A&E with more complex needs, wait times are higher than they have ever been.

> The provision of emergency care has already failed. You cannot reliably get an ambulance for your heart attack, trauma or stroke. Are we going to replace that with an insurance based subscription service, like some kind of 18th century fire brigade, with a patchwork of charities and volunteers like a developing country?
>
> *- Hospital consultant, south of Scotland*

Elective care

Alongside emergency care, the number of patients waiting to be seen through scheduled appointments is growing. For new outpatient appointments, the Scottish Government set target is to be seen within 12 weeks. At the latest census date of 30th June, 451,020 new outpatients were waiting to be seen. This was up 46.4% from the pre-Covid average. Over half of these patients (50.9%) have been waiting for longer than 12 weeks, with 8% waiting more than 52 weeks to be seen.

Comparable statistics are observed in inpatient treatment. The treatment time guarantee (TTG) states that following the decision to treat, all eligible patients should wait no longer than 12 weeks for treatment. At the latest census date of 30th June, 139,584 patients were waiting to be admitted for treatment. Compared with the 2019 average, this was up 81.2%. In contrast to the TTG, 68.5% were waiting for more than 12 weeks, with 7.2% (10,066 patients) waiting more than two years for treatment

Inpatient Waiting Times

New Outpatient Waiting Times

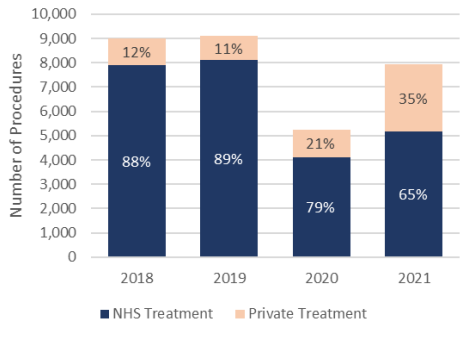
Source: Inpatient and New Outpatient Waiting Times (Public Health Scotland)

Like A&E, a crisis in elective treatment waiting times has not suddenly emerged due to the pandemic. We have witnessed a gradual increase in waiting times over the five years prior to Covid-19. In 2015, 89% of new outpatients were waiting less than 12 weeks, 97% for inpatients. In June 2019 (almost a year before the pandemic), the proportion of new outpatients waiting less than 12 weeks had already dropped to 68%, with inpatients falling to 73%. Since the pandemic, waiting times and patient lists have increased substantially. During the first peaks of Covid-19, routine appointments were cancelled to free up capacity in hospitals, forcing the waiting times to drastically increase.

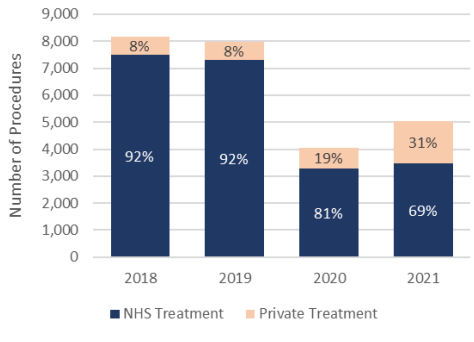
Delays to diagnosis or treatment can result in more serious health issues. However, it may also lead to patients looking elsewhere for treatment.

Between 2019 and 2021, the number of people seeking private treatment for hip or knee arthroplasty rose by 162% (2019: 1,655 procedures; 2021: 4,328 procedures). This increase has resulted in a sizable increase in the proportion of procedures taking place in private care, from 11% in 2019 to 35% in 2021. Similarly, private providers completed 31% of all knee replacements in 2021, up from 8% in 2019. Whilst the overall number of procedures has not returned to pre-Covid volumes, this does suggest the emergence of a two-tier system. We estimate that Scots have spent circa £57.3m on hip and knee arthroplasty in 2021. Most of these individuals will be over the age of 66, meaning we are asking pensioners to pay for the failings of the health system they have spent a lifetime contributing into.

Primary Hip Replacement Procedures



Primary Knee Replacement Procedures



Source: Scottish Arthroplasty Project (Public Health Scotland)

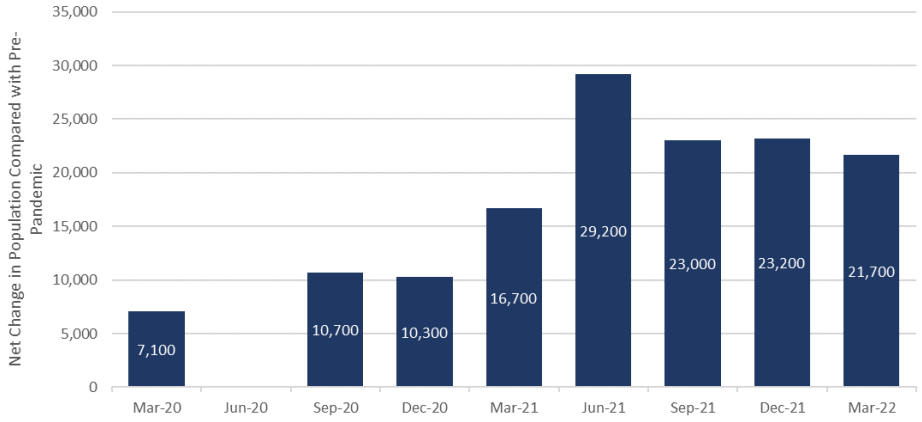
The financial costs to patients seeking private treatment are high, however the costs may be artificially deflated due to the burden carried by the NHS. One consultant we spoke to said, “private healthcare in the UK is underwritten for training and treatment of complications by the NHS, keeping prices artificially low”. Patients who develop complications from private surgery are normally transferred back into an NHS hospital which is better equipped to deal with emergency care. If waiting times are not brought under control, a further divergence in care will be seen across the population. Where operations go wrong, private patients will receive priority treatment in NHS hospitals over non-urgent patients.

> This deteriorating situation has promoted private medicine. This has run in parallel since the inception of the NHS but has resulted in a two-tier health service one for the rich who can avoid queues and another for the poor. Pandemic generated waiting lists provide another opportunity for private erosion of the NHS. If this trend continues without NHS changes health service provision may no longer be based on need and free at the point of contact.
>
> *- Retired consultant, east of Scotland*

Patient Outcomes

The delays in accessing both emergency and elective treatment are potentially leading to increased numbers of people registering as long-term sick and a cause of mortality.

Change in Scottish Population not in Employment, due to Long Term Sickness, compared with pre-Pandemic



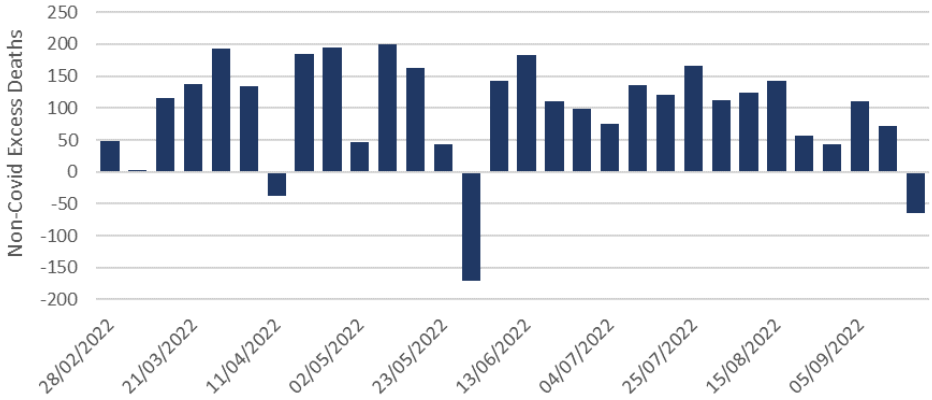
Source: Annual Population Survey - Regional - Economic Inactivity by Reasons (Office for National Statistics)

In comparison to other highly advanced nations, the UK continues to see above pre-Covid averages of individuals economically inactive and not seeking work. In Scotland, there are around 48,000 more individuals who are not seeking work compared with 2019. Within this group, which includes those entering early retirement or returning to full-time education, just under half (21,700) are off on long-term sick. In a UK context, some analysts believe this excess is due to waiting times in hospital.[2] Impacts of long Covid and increased mental health conditions due to lockdowns will also contribute. However, from our analysis showing patients turning to private treatment as a last resort and waiting times longer than ever, we also believe a large proportion will be attributable to the inability to be treated. We estimate that rising waiting times are costing the Scottish economy £700 million a year from people staying off work due to ill health, rather than receiving treatment and returning to employment. In total, 187,000 Scots are currently economically inactive due to long-term sickness.

The total loss of economic potential for this population is £5.9 billion per year to the Scottish economy. We note that many of these individuals will be living with incredibly complex health conditions and unable to work no matter the circumstances.

As we all bore witness to during the pandemic, Scotland's death toll since March 2020 has been higher than average. A key metric to understanding the difference between pre- and post-Covid is by applying an "excess deaths" calculation. Against a 5-year pre-pandemic average, Scotland has seen higher than average deaths in the Covid years.

Non-Covid Excess Deaths Compared with Pre-Pandemic 5-Year Average



Source: Weekly Death Registrations (National Records of Scotland)

When Covid is a factor in someone's death, it is recorded in their death certificate. This allows us to calculate the non-Covid excess deaths in the country. Between April 2022 and September 2022, the period after the last Covid wave, Scotland has had 1,476 non-Covid excess deaths compared with the pre-pandemic 5-year average. Factors including an ageing population may play a role here, however, many analysts across the UK believe that the current excess deaths in the country are due to pressures within the NHS.[3, 4] Longer waiting time and poor access to emergency care are causing Scots to die. If the failings of the NHS are not adequately addressed, increased mortality rates will likely continue.

Four Great Problems

> It is pretty easy to see where Healthcare in the UK will be in 10 years, you just need to look at Dentistry, or Veterinary services. If you can pay you are fine, as long as it's office hours.
>
> *- Hospital consultant, Scotland*

There are four leading causes for the decline in the health system in Scotland: hospital capacity, workforce, service utilisation and general health of the nation. We will discuss the former three in greater detail here, and the last in the next chapter.

Hospital Capacity

Scotland currently has around 13,300 beds available for patients, equating to 1 bed for every 412 citizens. In 2015, we had a larger capacity – 1 bed for every 389 people.

Between financial years 2014/15 and 2019/20, Scotland saw a reduction in staffed hospital bed capacity by 810 beds, around 5.8% of its total capacity. The reduction in staffed beds would be manageable if patient volumes were low. This was not the case. Prior to the pandemic, Scotland ran "hot" in hospital occupancy. This meant that few beds were freely available for a surge in the system, like those we saw in March 2020. Over the five years prior to Covid, the Scotland-wide occupancy rate averaged around 86.5%, with some health boards considerably higher than that. Both NHS Ayrshire and Arran and NHS Lothian had 5-year occupancy rates above 90%, at 92.8% and 90.0% respectively.

As Covid rapidly spread through the country and hospitals dangerously reached full capacity, the government built a temporary hospital – the NHS Louise Jordan. This make-shift hospital within the SECC in Glasgow, with the ability to accommodate up to 1,000 beds, saw the NHS return to bed volumes seen in 2014/15. A temporary hospital may still have been required during the pandemic, but this could have been a much diminished focus had the system been adequately prepared for such a surge.

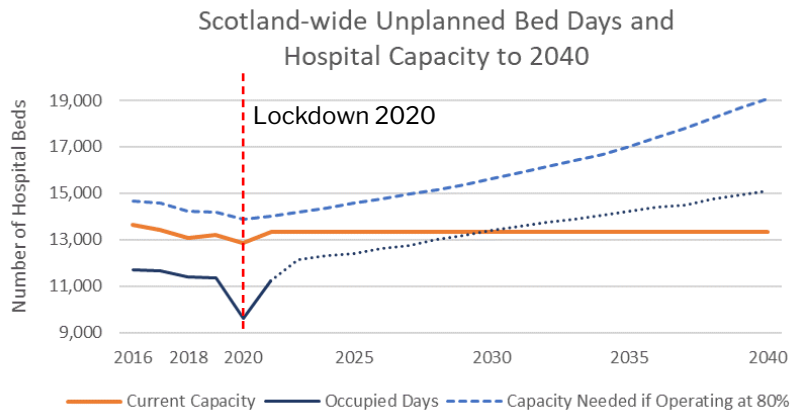
Around 90% of all inpatient hospital beds are assigned to individuals with an unplanned admission. Urgent care is given priority over elective treatment, meaning that when no beds are available, elective procedures may need to be pushed back. Therefore, reducing emergency admissions is an effective way of increasing capacity.

Many emergency admissions cannot be prevented. People will always have accidents. But just under half of all admissions (47.3%) in 2021 were attributed to individuals who had already been admitted within the previous year. Older adults with complex needs and greater risk of falls or complications, make up a large proportion of those with multiple emergency admissions. In 2021, adults aged 65+ accounted for 58% of individuals with multiple emergencies, with adults aged 85+ accounting for 10%. The older the patient, the greater the probability of spending longer in hospital compared to younger patients. Patients aged 85+ spent on average an extra 10 days in hospital compared with those aged 18-64.

As the population of Scotland ages, more individuals will require medical support. But on current trends, this support is unsustainable. A slight reduction in length of hospital stay was observed between 2012 and 2018, before a flattening out in 2019. Average length of stay has increased due to the pandemic. Reductions were seen in length of stay of 60+ population, probably due to increased social care support. However, this has remained steady these past few years. If the rates of older adults being treated as emergency admissions continue and reductions in hospital length of stay does not reduce, we estimate the NHS will require a further 3,500 beds by 2040. This amounts to a new 450 bed hospital (average sized general hospital) being constructed every 2.5 years for the next 20 years. There are currently plans to construct 10 national treatment centres (NTCs) covering various elective treatments. Whilst these new hospitals are welcome, they will not provide any extra capacity in emergency wards where this requirement is needed. The only option is to reform the way care is delivered. If no extra capacity is provided, then shorter

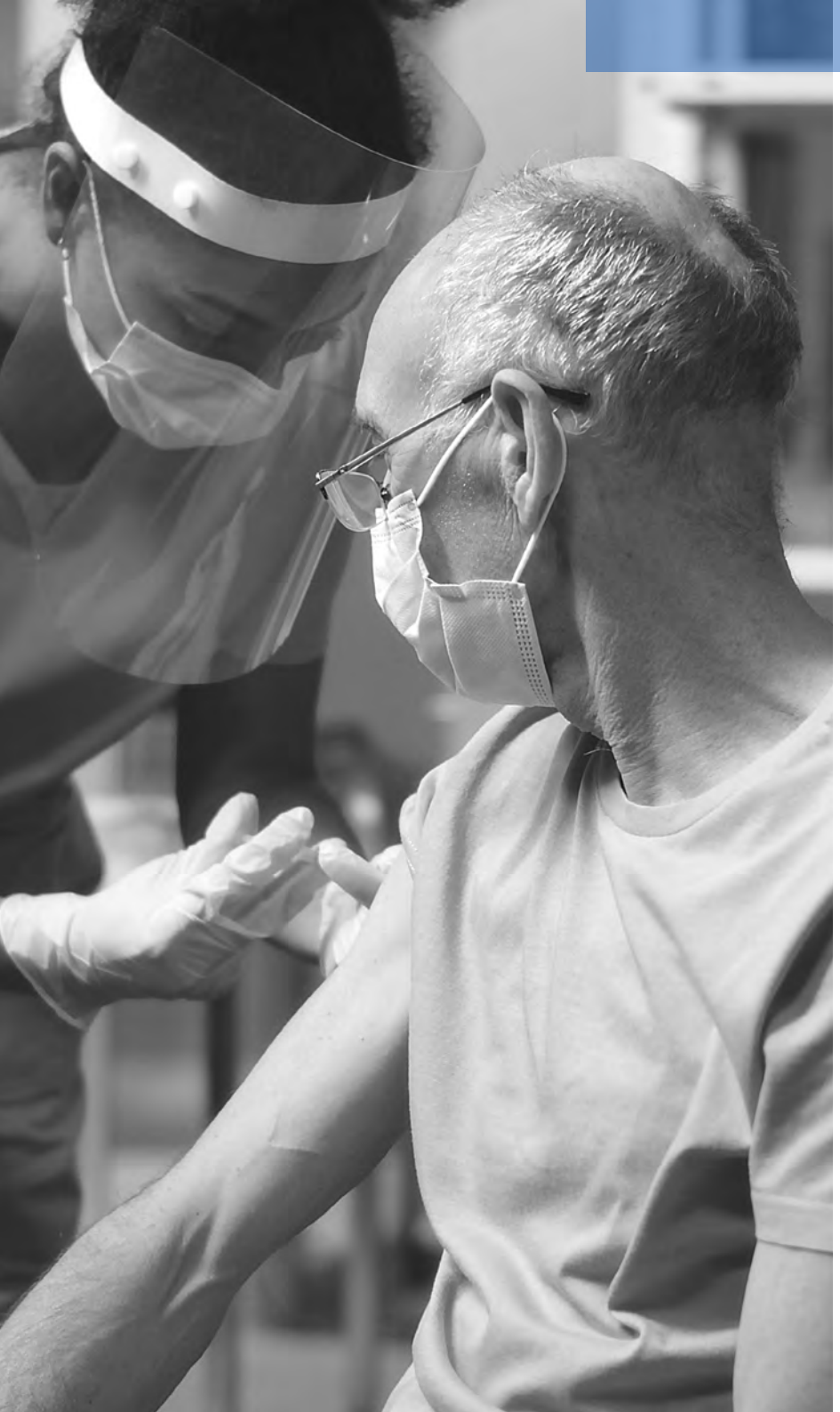
stays in hospital from efficiencies in treatment and therapies will be necessary. The other option would be increased provision in community services, including enhanced primary care and adequate social care, to avoid admissions in the first place. As one retired consultant told us, “Failure of social services put more strain on the health service, increasing admissions and resulting in bed blocking”.

Scotland-wide Unplanned Bed Days and Hospital Capacity to 2040



Source: Acute hospital activity and NHS beds information – annual (Public Health Scotland), Population Estimates (National Records of Scotland)

Analysis we have carried out alongside Public Health Scotland has shown that home care provision can reduce the length of time a patient stays in hospital. We identified a cohort of individuals in 2018, aged 65+ and in receipt of a more intensive home care package (receiving more than 10 hours of home care each week). Comparing their hospital activity one year before and one year after starting the home care package, we observed a 15% reduction in unplanned beddays. This totalled a saving of 14,955 beddays in one year – reducing capacity by 41 beds each day. Whilst this is strong evidence that social care reduces hospital demand, we did observe a 19% increase in hospital admissions over the same period. This suggests that individuals attend hospital more frequently, possibly due to increased frailty one year later, but are spending less time in hospital. Further analysis is required to better understand the relationship between hospital activity and social care packages.

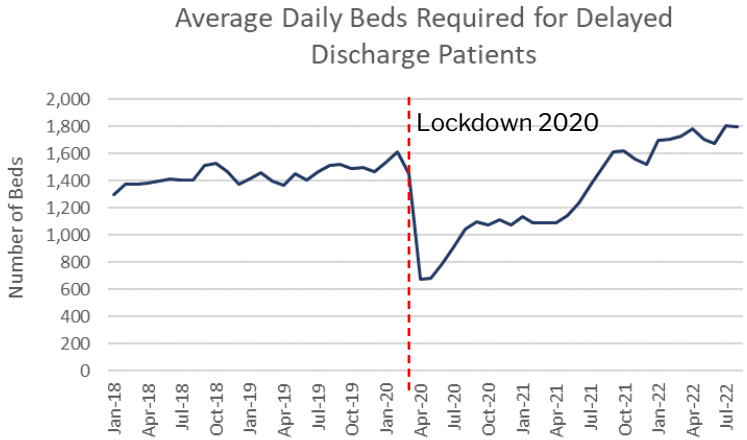


Whilst understaffed A&E units leave people waiting at the start of their hospital journey, the lack of provision in community services, namely social care, is causing a bottleneck at the end of a patient's journey in hospital.

Prior to Covid-19, around 9% of all beddays in hospital were the result of patients who were classed as a delayed discharge, otherwise known as "bed blocking". These are patients who were medically fit to leave hospital, but due to other factors, such as waiting for a care plan to be put in place, were unable to return home.

As the pandemic began to seriously impact the health service in March 2020, delayed discharges dropped considerably as places in care homes or other social care settings were found. As that priority has now waned, we are beginning to see delays increase. At the August 2022 census date, an average of 1,798 beds in Scotland were for individuals classed as delayed discharge. This was up nearly a quarter, 26%, from a pre-Covid average of 1,431 beds. This bottleneck leads to fewer hospital beds available for new patients, driving up waiting times.

Average Daily Beds Required for Delayed Discharge Patients



Source: Delayed discharges in NHSScotland monthly (Public Health Scotland)

As well as having an impact on hospital capacity, delayed patients are at greater risk of contracting a hospital acquired infection (HAI). A study by Glasgow Caledonian University found around 1% of patients in Scottish hospitals develop a HAI. This figure is below the European average of 3%, but still costs the NHS more than £46 million each year.[5]

Workforce

Access to beds may be one cause of the increased waiting times; staffing them is another. Having worked flat-out during the pandemic, NHS frontline staff are increasingly feeling burned out, exhausted and suffering from their own ill health.[6] The absence rate for the past year was 5.69%, the highest in a decade and well above the rate seen ten years ago, 4.83%.[7] In staffing terms, the difference over the past decade has meant an extra 2,100 staff are unable to attend to patients each day.

Alongside illness, increasing numbers of clinicians and nurses are deciding to leave the NHS. In the year ending March 2022, 1,144 NHS doctors and 7,597 nurses (including midwives) decided to quit.[7] In both counts, this was the highest number of leavers ever recorded in Scotland. Most worryingly, it represented 10.6% of all nursing staff in the country. Whilst new doctors and nurses replaced those who left in higher numbers (1,391 and 8,498 respectively), these professionals will inevitably be less experienced and require increased training. Despite joiners outpacing leavers, there currently remains 6.6% of doctors' posts currently vacant and 8.6% of nurses posts vacant. We estimate this to be around 450 doctors and 6,800 nurse posts currently vacant.

Looking towards the projected increase in hospital activity by 2040, if adequate community care is not in place, we estimate that an extra 2,300 hospital doctors and 17,000 hospital nurses would be required to maintain current staff to patient ratios. This would be excess requirements over and above current recruitment. Whilst the Scottish Government has made considerable progress particularly to address the increased staffing required for the NTCs, there is little evidence for wider emergency care staffing.

It doesn't look like the loss of experienced care givers is going to let up anytime soon. After a decade of stagnant wages, resulting in a real terms pay cut, NHS staff feel increasingly undervalued. Nurses are currently considering industrial action after the Scottish Government's latest pay deal would still result in a real terms pay cut, caused by the current high levels of inflation.[8] And a recent survey of junior doctors in Scotland found half are considering leaving the profession completely within the next two years.[9] Unable to choose their own holidays, potentially missing significant family events, and with hospital pressures meaning training is neglected to shore up service provision, the future leaders of care in the country are already feeling demoralised.

Clinicians we spoke to for this report agree. One consultant told us, "Increased recruitment, training and retention of staff, along with improving staff moral are fundamental. With an anticipated decrease in the NHS budget in real terms, savings will need to be made but we still need to maintain the quality of service provision. This can only be achieved by focussing on training and increasing the numbers of doctors and nurses". Adequate training is vital for the continued level of care we all expect.

For the past several years, NHS staff have been constantly firefighting with no time to properly care for patients – the hospital flow must be maintained. Many do not have enough time in the day to work on administrative tasks such as writing up follow-up letters to GPs. Instead, they will spend their own time completing such tasks. As one consultant put it, "Doctors and nurses want to look after patients but are overwhelmed with paperwork. Everything should be done to reduce this bureaucracy".

NHS workers really do care and want to spend time treating their patients. We now need to support them more than ever. Clapping on a Thursday evening during the height of the pandemic is nowhere near enough.

We need to make the NHS more cost-effective. Increased recruitment, training and retention of staff, along with improving staff moral are fundamental. With an anticipated decrease in the NHS budget in real terms, savings will need to be made but we still need to maintain the quality of service provision. This can only be achieved by focussing on training and increasing the numbers of doctors and nurses.

- Consultant, east of Scotland

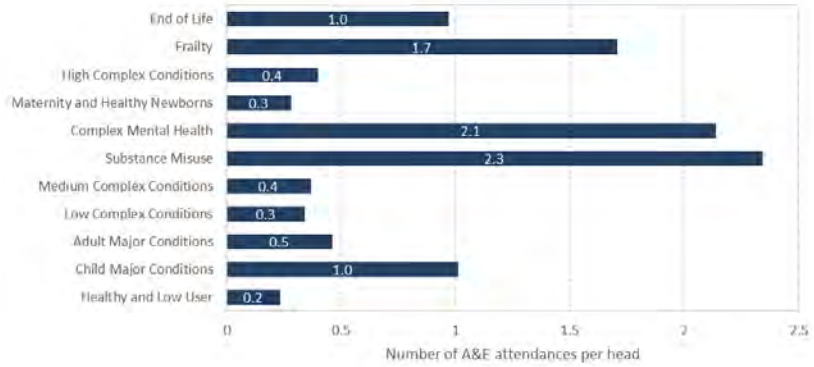
Service Utilisation

Alongside capacity and workforce issues, how we interact with the health service impacts on availability for others. To deliver the most appropriate care for each individual, the NHS needs to address overuse of services (e.g. multiple admissions), underuse of services (e.g. lack of initial detection of long term conditions such as cancer) and misuse of services (e.g. treated in a hospital setting rather than community). This is the getting it right first time (GIRFT) approach.[10]

For this report, we submitted a Freedom of Information request to Public Health Scotland to release information on their population and pathways matrix for the financial year 2019/20. This tool identifies the population of Scotland by intuitive user groups, with an aim to understand who the population are, what services they use and how they interact.

Using their segmentation approach for demographic cohorts (understanding who the population are), we have been able to identify the most common service users in health settings. Individuals who were classified within the Substance Misuse cohort each had on average 2.3 A&E attendances. This was ten times greater than those classified as low health users. Similarly, individuals classified within the Complex Mental Health cohort each accessed A&E services 2.1 times within the year, nine times more than those in the low health user group. If greater targeted intervention were in place for these individuals, such as in community services and co-agency models of care, A&E attendances would reduce. We estimate that halving the number of A&E attendances for these two cohorts would reduce overall A&E attendances by 2.5%, freeing up much needed capacity and saving over £4 million in direct health costs.

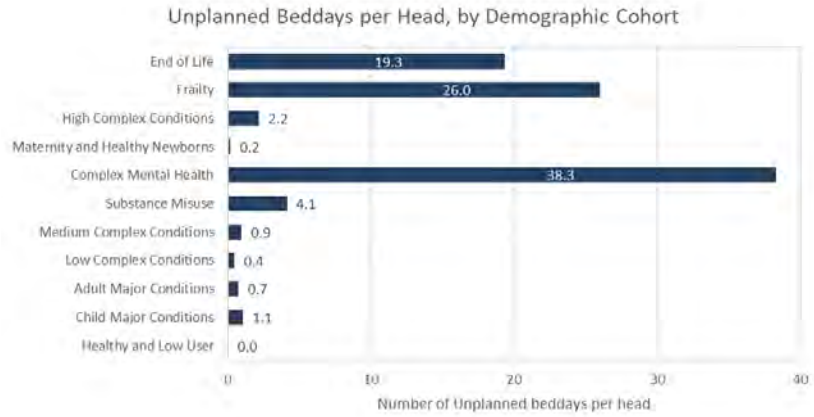
A&E Attendances per Head, by Demographic Cohort



Source: Public Health Scotland

Reducing A&E attendances through targeted intervention will help, but inpatient stays are a larger issue for the NHS. Individuals within the End of Life and Frailty cohorts spent on average 19 days and 26 days in hospital due to an unplanned admission. As discussed in the capacity section, these cohorts are likely to increase due to an ageing population. Targeted interventions through community services, including enhanced primary care, social care, and palliative care, would likely reduce unplanned stays. If unplanned stays reduced by 25% for these two cohorts, we would see 2,200 beds freed up for other patients. This would have a direct health cost benefit of £325 million.

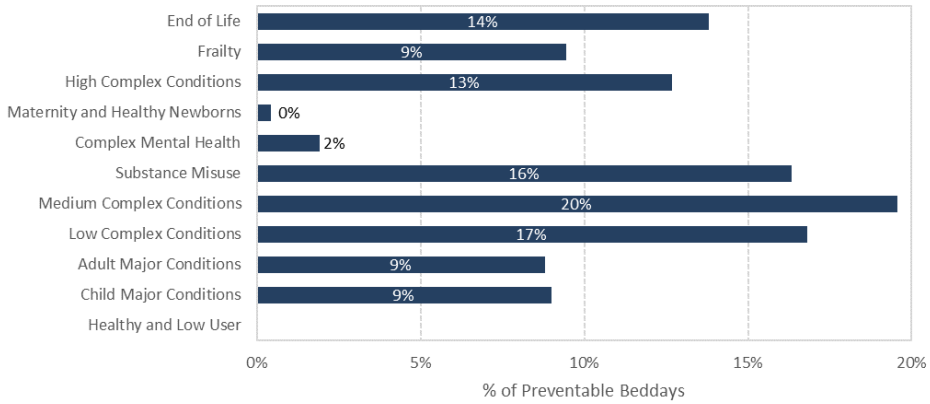
Unplanned Beddays per Head, by Demographic Cohort



Source: Public Health Scotland

Potentially preventable admissions is another metric capable of identifying cohorts where increased support in the community could reduce hospital admissions. These experimental statistics identify hospital stays which may be preventable. In FY 2019/20, around 7% of all hospital admissions were considered potentially preventable, totalling 1,800 beds per day. Medium Complex Conditions (individuals who live with conditions including Coronary Heart Disease, Parkinsons, Multiple Sclerosis or COPD) and Low Complex Conditions (individuals who live with conditions including Asthma, Arthritis, Epilepsy or Diabetes) had the highest proportion of hospital beddays which could be potentially preventable. Greater analysis would need to be carried out by Public Health Scotland at an individual level, but it suggests that care management pathways for some of these conditions are worth exploring. One example could include predicting when self-administered medicines, such as statins for heart disease need to be introduced or dosage increased. We estimate potentially preventable admissions cost the NHS around £300 million in FY 2019/20, so pilot programmes could be incredibly cost-effective if they reduce admissions.

Percentage of Preventable Beddays, by Demographic Cohort

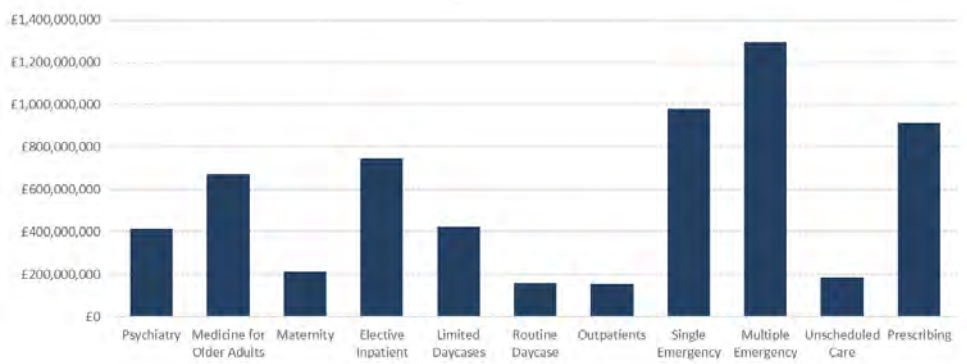


Source: Public Health Scotland

The other classification developed by Public Health Scotland is the service use cohort. Each patient is assigned to a service use class based on the main service type of form of care they have experienced in the year. At present, these cohorts do not include primary care, nor other community services such as social or palliative care. The single largest service use by cost in 2019/20 was for multiple emergency admissions (£1.3 billion), followed by single emergency admissions (£979 million) and prescribing (£912 million).

To better utilise finite NHS resources, it is important to understand which demographic cohorts are using most of these services. In some instances, such as individuals in the Low Complex Conditions cohort, shifting the balance of care back into the community is vital to reduce preventable admissions.

Total Costs, by Servcie Use Cohort



Source: Public Health Scotland

Targeted interventions can help reduce admissions for certain groups. And increased investment in community services including enhanced primary care, social care and other associated infrastructure are needed. But if the underlying health issues of the population are not addressed, improvements will not be long lasting.

“

In many ways, the NHS in Scotland has its own culture and distinct set of values. All this is to be cherished and protected. But we also believe that, while retaining this valuable autonomy, we can “value-add” by deepening strategic cooperation with the UK wide NHS, both in terms of efficiency of delivery and improvement in outcomes. We believe this is the key to overcoming the crisis in healthcare we all face.

Health of Scotland

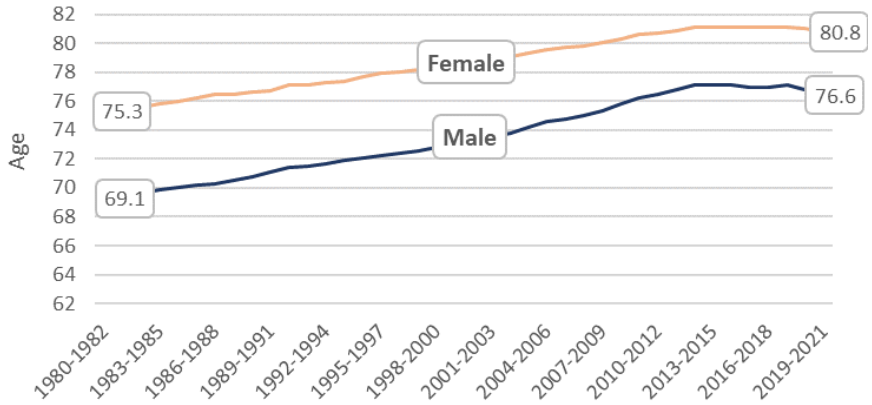
> By understanding and addressing the overall health of Scotland, we can reduce NHS demand and improve the health of citizens.

Scotland is an ageing society with increasing levels of obesity, mental ill health, and inequality. These factors are all drivers of poor health, increasing the need to access health services. By understanding and addressing the overall health of Scotland, we can reduce NHS demand and improve the health of citizens.

Life Expectacy

A good measure of the general health of a country is to analyse its average life expectancy. The life expectancy in Scotland at birth for 2019-2021 was 76.6 years old for men and 80.8 years old for women. These are the lowest life expectancies in the UK and the lowest compared with every other nation in Western Europe.[11] Scottish men have a projected shorter life expectancy than English men by 2.5 years, with Scottish women 2.1 years compared to those south of the border. Despite the lowest life expectancies, Scotland has seen little to no growth for the past decade.

Scotland Life Expectancy (1980-Present)



Source: Life Expectancy in Scotland 2019-2021 (National Records of Scotland)

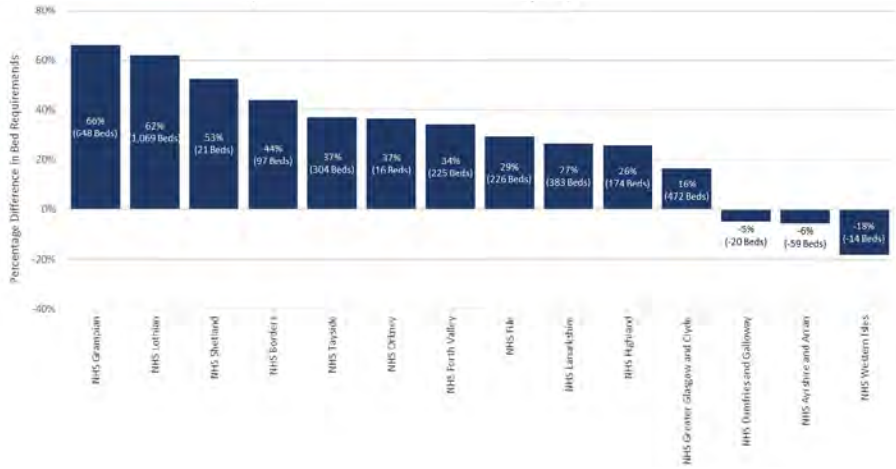
Between the early 1980s and early 2010s, Scotland's life expectancy saw a continuous increasing trend of around 16.3 weeks per year for males and 9.9 weeks per year for females. Improvements to circulatory disease mortality, including strokes and heart failure, were driving a lot of the improvements in life expectancy. However, from 2012-2014, improvements to life expectancy began to slow and plateau. This was due to a mixture of causes, including drug related deaths and deaths from dementia and Alzheimer's. The figures in both 2018-20 and 2019-2021 are a slight decline from the previous trend. This recent fall in life expectancy at birth was mostly due to deaths from Covid-19.

Deprivation has a large impact on life expectancy in Scotland. In 2019-2021, the life expectancy for men living in the most deprived areas was 13.7 years less compared to those in the least deprived areas. For women, this difference was 10.5 years. We will discuss the impacts of these health inequalities further on in this section.

Ageing Population

As life expectancy statistics show, more citizens are dying due to Dementia and Alzheimer's. These neurodegenerative conditions are predominantly observed in older adults – though not necessarily as a condition of normal ageing. Scotland is ageing faster than the rest of the UK, with our 85+ population the fastest growing age band.[12] It is set to grow by up to 56% by 2040, with rural and island communities seeing the largest increases in population. Both the Highland region and island of Orkney are likely to see their 85+ population double by 2040. This may not be surprising as older adults opt to retire away from cities. However, this will put increased pressure on rural and island communities to deliver health and social care. As our analysis showed, we would need an extra 3,500 hospital beds by 2040 if activity rates do not change. This would not be equally distributed across the country. In boards such as NHS Grampian, an increase of 648 beds (66%) would be needed if community services are not adequately available to reduce demand.

Predicted Proportional Difference in NHS Board Bed Capacity between 2019 and 2040



Source: Acute hospital activity and NHS beds information – annual (Public Health Scotland), Population Estimates (National Records of Scotland)

Older adults have a greater propensity to develop multiple health conditions, increasing the need for health services. Dementia and Alzheimer's are some of the most prevalent and care intensive conditions for older adults. It is hard to pinpoint an exact prevalence, but modelling produced by Alzheimer's Scotland suggest around 93,000 people in Scotland live with Dementia. A deep dive into Dementia in NHS Lothian demonstrated that patients with this condition spent on average 21 days in hospital each year as unplanned admissions. On top of this, 45% of all delayed discharge bed days within the region were from a patient with Dementia.[13] If we were able to move some of this activity out into the community through social care, it could potentially free up bed capacity.

Living in the community, rather than staying in hospital, is a more adequate setting for individuals with Dementia. It can reduce fears and anxieties when presented with unknown faces and locations. However, it can be more cost-effective too. A recent report carried out by Alzheimer's Society estimated the total cost of Dementia including indirect costs at £3 billion each year, with estimates that this could rise to £9 billion by 2040[14].

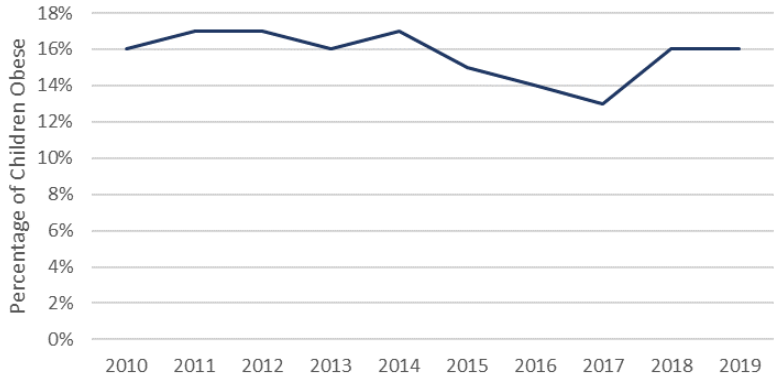
As Scotland rapidly ages, it is important that we understand the care needs of the population and begin to make decisions. To reduce runaway hospital usage, investment in communities and social care is imperative. We will address some of this in the final chapter.

Obesity

Another major concern for Scotland's health is our physical wellbeing. We are increasingly inactive and eating foods rich in fats, salt, and sugar. In 2019, 66% of Scottish adults aged 16 and over were classed as overweight. This was the highest levels seen, but not significantly different to the observed percentages this past decade. Included in this cohort were 29% of the population who were considered obese.[15] Individuals who are obese are at greater risk of developing more complex health conditions including Type 2 Diabetes, Heart Disease, and some cancers.[16] Direct health costs associated with obesity is estimated to be in the range from £363 million to £600 million per year.[17] Indirect costs, including loss of economic potential, is estimated to be as high as £4.6 billion per year.

Scotland's overweight population grew substantially between 1995 and 2008, from 52% to 63%. The increased proliferation of fast-food vendors and ready meals contributed to the poor food intake. These meals are quick, easy and relatively cheap. A study by NHS Health Scotland found 50% of those on the lowest household income agreed that 'healthy food is too expensive' compared with 34% on the highest household income.[18] This is just one reason why obesity disproportionately impacts the poorest in societies. 36% of the most deprived in society are classed as obese, compared with 23% for the least deprived. This inequality gap trickles down to children. Children from the most deprived areas were almost 50% more at risk of being overweight compared with those from the least deprived background.[19]

Childhood Obesity Prevalence in Scotland (2010-2019)



Source: Scottish Health Survey 2019

Childhood obesity levels have fluctuated over the previous decade, however no clear trends have emerged19. From the latest figures in 2019, around 30% of children aged 2-15 were at risk of being overweight or obese. This amounts to around 250,000 children. Similarly, 16% of children aged 2-15 were at risk of being obese, totalling 131,000 children. These figures are from before the pandemic. In England, statistics produced by NHS Digital for 2020/21 showed a large increase in childhood obesity – up over 20%. This may be an anomaly due to the pandemic with schooling disruption and reduced data collection. More data is required, but NHS Digital do believe that there was an increase in childhood obesity prevalence during the pandemic.[20]

Children at risk of obesity are likely to remain obese in adulthood. Alongside this risk, children are more likely to suffer health problems including an increased risk of fractures, hypertension, type 2 diabetes, asthma as well as poorer mental health including lower wellbeing and self-esteem.[21]

There are many initiatives underway to reduce obesity in Scotland. The Scottish Government have set a prevalence target of 7% for obesity in Scottish children by 203021. Several policies have been recommended by health campaigners and charities to reach this. The UK wide introduction of the Soft Drinks Industry Levy, a tax on high sugared soft drinks, has seen sugar intake decrease by 9.8% (29.5g) per person per household.[22] Further longitudinal analysis is required to understand the longer-term impacts of this population level intervention, but early evidence is positive. Whilst individual actions have the largest impact on reducing obesity, population level interventions can help drive improvements. Other population level policies suggested by campaigners include advertisement bans pre-watershed, increased taxes on highly processed and fast foods, as well as capping the salt content in regular processed foods.

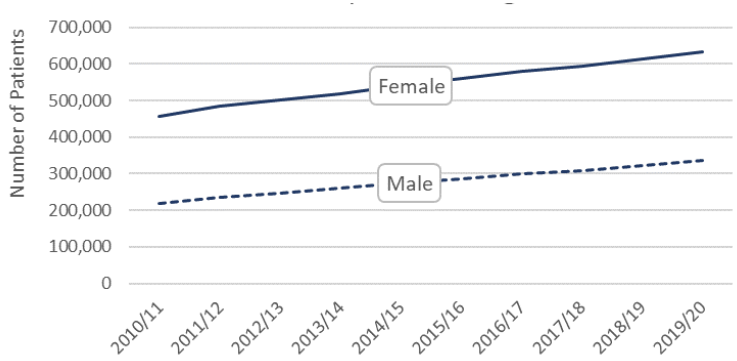
Mental Health

Mental health is an increasing health burden in Scotland. Population estimates vary, but around one in three people are affected by a mental health condition each year, with depression and anxiety the most common conditions21. With such a high percentage of the population living with mental ill health, the economic costs to society are incredibly high. It is estimated that the total direct and indirect health costs of mental ill health cost the Scottish economy at least £8.8 billion per year.[23] The social costs facing this population are even higher.

In 2019/20, over 977,000 patients were dispensed at least one antidepressant, just over one in five of the adult population. Two in three of this population were women, one in three were men. Like other health conditions, mental ill health is more prevalent in the poorest communities. Around 2.3 times as many anti-

depressants are prescribed to those living in the most deprived areas than the least deprived.

Number of Patients Prescribed Anti-depressant drugs



Source: Medicines used in Mental Health (Public Health Scotland)

Mental ill health is growing at a rapid pace. Prescriptions for anti-depressants have increased by 80% since 2010/11 and referrals to child and adolescent mental health services (CAMHS) have increased by 48% between 2012 and 2022. As the stigma around mental health begins to reduce, people who seek health services will inevitably increase. This means new services and programmes will need to be adopted to avoid any massive influx of patient numbers.

One area of potential prevention is in the workplace. It is estimated that around half of all work absences are due to mental ill health. In 2017, this was estimated at around 1.3 million workdays.[24] A labour force study stated that the largest self-reported absence time in mental ill health was caused by heavy workloads.[25] It is critical as Scotland enters a post-pandemic state, workplaces are equipped with tools to reintroduce employees who have spent the past two years isolated at home.

Another area of prevention is in community services. Isolation and chronic loneliness can increase the chances of an early death by 26%.[26] As a larger proportion of older adults live alone, such as after the death of a spouse, it is important that they are supported in their communities. A study by Age Scotland showed that prior to the pandemic, around 100,000 older people said they felt lonely all or most of the time. This rose to 200,000 people who said they went through at least half a week without hearing from or seeing anyone. That's the equivalent to two people on every street in Scotland.[27]

Homelessness

When adequate community support is not available, it can lead to the most tragic of outcomes.

Homelessness represents the ultimate failure of our society and social safety net. In 2021/22, 28,882 households were assessed as homeless or threatened with homelessness.[28] 28% of these households contained children, totalling 14,372 children in 2021/22 who were classified as homeless. Where permanent housing is not found, children can develop complex health needs, poor attainment in school and worse health and economic outcomes compared with their peers – widening as they age. For one child to live in such circumstances would bring shame to the nation, that it impacts around 2% of children today is a tragedy.

In total, 32,592 adults and 14,372 children were classified as homeless in 2021/22. These statistics included 2,100 adults who reported sleeping rough during the previous three months. The majority (63%) were aged between 24 and 49 years old, normally living with a form of mental health issue. A 2014 survey by the Homelessness Link Project found that 80% of respondents reported some form of mental health issue, 39% said they take drugs or are recovering from a drug problem, and 27% have or are recovering from an alcohol problem.[29] These complex conditions lead to increased health system usage.

A deep dive in North Lanarkshire in 2014/15 found those currently facing homelessness were three times more likely to attend A&E and have an emergency inpatient stay.[30] These statistics used the total population of North Lanarkshire as a benchmark. Since homelessness is skewed towards younger people, hospital activity is likely to be higher compared against those of the same age. Health expenditure averaged an extra £700 per person compared with the North Lanarkshire population. Scaling this value up to the Scotland-wide homeless population, direct health costs would be in the region of £33 million. We estimate that indirect costs including loss of economic potential could be around £490 million each year.

Individuals experencing homelessness have increased levels of loneliness, shame and feelings of hopelessness. Socially excluded communities develop due to the similar lived experiences, however this can cause increased isolation when resettling. Whilst housing is the solution, taking individuals away from their communities can increase levels of loneliness. It is important that public services are sensitive and emotionally intelligent to these social bonds when finding care solutions.

Addressing homelessness requires a whole system approach, with a partnership between local government and the NHS required to provide the housing, health, and wellbeing services needed. When budgets for local authorities are cut, progress in reducing homelessness is significantly impacted, with potentially catastrophic outcomes for the individuals.

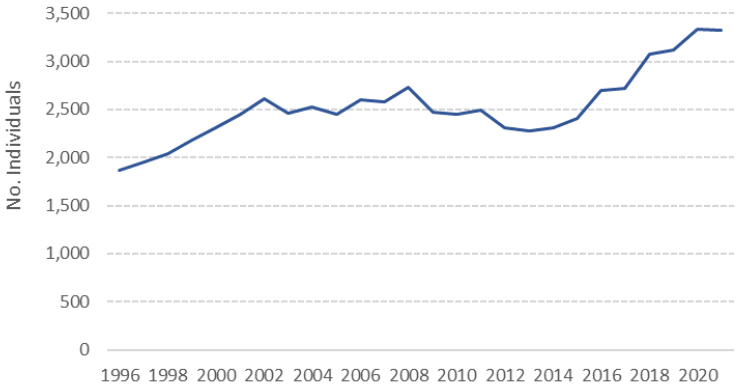
> “Health inequality lies at the heart of Scotland’s poorer health outcomes. Improving health services alone will not address all the issues.

Deaths of Despair

In 2020, 256 people in Scotland died from homelessness. Despite these deaths occurring during the pandemic, none were recorded with Covid-19 as an underlying cause. More than half (59%) were drug related.[31] These deaths represent a growing crisis in Scotland.

As will be discussed in the following section, poorer life expectancy is continuing to be seen for the most deprived and vulnerable in society. For many on low pay and insecure work, pay has been stagnant or deflationary since the financial crisis of 2008/09. Individuals stuck in this position are more likely to experience despair and hopelessness, with the belief that their long term social and economic outlook is bleak. A worrying trend is emerging from rising hopelessness. Over a 25-year period between 1996 and 2021, Scotland has seen a 78% increase in deaths from alcohol, drugs or suicide. In 2021, 3,327 individuals died due to one of these causes.

Deaths due to Alcohol, Drugs or Suicide



Source: Alcohol Deaths, Drug-related Deaths in Scotland, Suicides (National Records of Scotland)

A significant driver to the increase in deaths of despair these past few years is from drug deaths. Between 2014 and 2021, individuals who have had a drug related death has more than doubled (614 deaths in 2014, 1,330 deaths in 2021). Today, Scotland has the largest drug deaths per capita of any other European country.[32] These poor statistics have forced the Scottish Government to act, setting out a five-year plan with a total of £250 million in funding up to 2026. These plans and extra funding are welcome, but it is important that local communities and those with lived experience are able to share their ideas about alternative solutions. Despite the policy differences between Holyrood and Westminster on considering drug deaths as a public health emergency, we would hope to see further and deeper efforts to work collaboratively in the interests of all citizens.

Health Inequalities

This chapter has demonstrated that in life expectancy, obesity, mental health, and homelessness, inequalities increase the risk of ill health and death. Whilst the NHS is free at the point of use to all citizens, it is those from the most deprived areas who need to access services more. With increased waiting times in hospital, we are already witnessing the emergence of a two-tier system, further denying those with greatest care needs due to lack of personal wealth.

Underlying inequality exists across all parts of the health system. GPs per citizen remains relatively stable irrespective of deprivation, suggesting that on the surface, primary care is equally accessible. However, as we have demonstrated, those from the most deprived backgrounds have the highest care need. They will require more GP consultations and so need more GPs per citizen than affluent areas. A study conducted by the Health Foundation found that patients seeing a GP in the least deprived areas would on average receive a consultation lasting 11.2 minutes, compared with 10.7 minutes for patients in the most deprived areas.[33] Those extra 30 seconds can add up when diagnosing or treating individuals with multiple morbidities.

> There have been great examples of using combined social and health approaches to people's issues like the Govan SHIP Project. We should fund these properly rather than put them in the CMO report then pull the funding. These reduce demand in the long term.
>
> *- Consultant, south of Scotland*

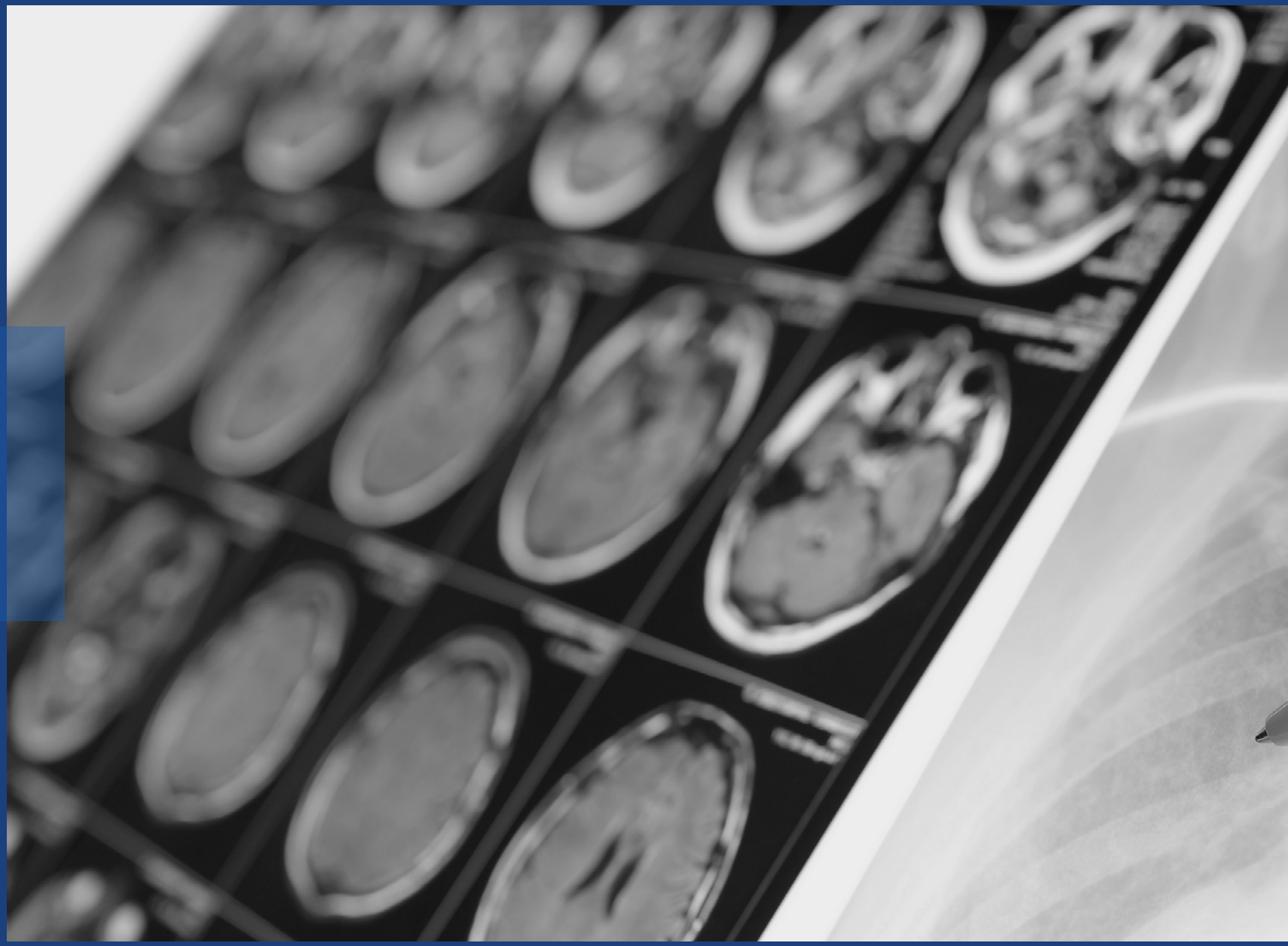
Projects such as the Deep End GP practice network have been set up to address such health inequality in Scotland. Deep End is designed to engage GPs, share best practice, and advocate for more resources to mitigate health inequalities in very deprived areas.[34] The project has introduced innovative schemes to help patients with their complex health needs, including community link practitioners to help with housing and employment. Support for such projects is necessary if Scotland is to improve health inequality outcomes.

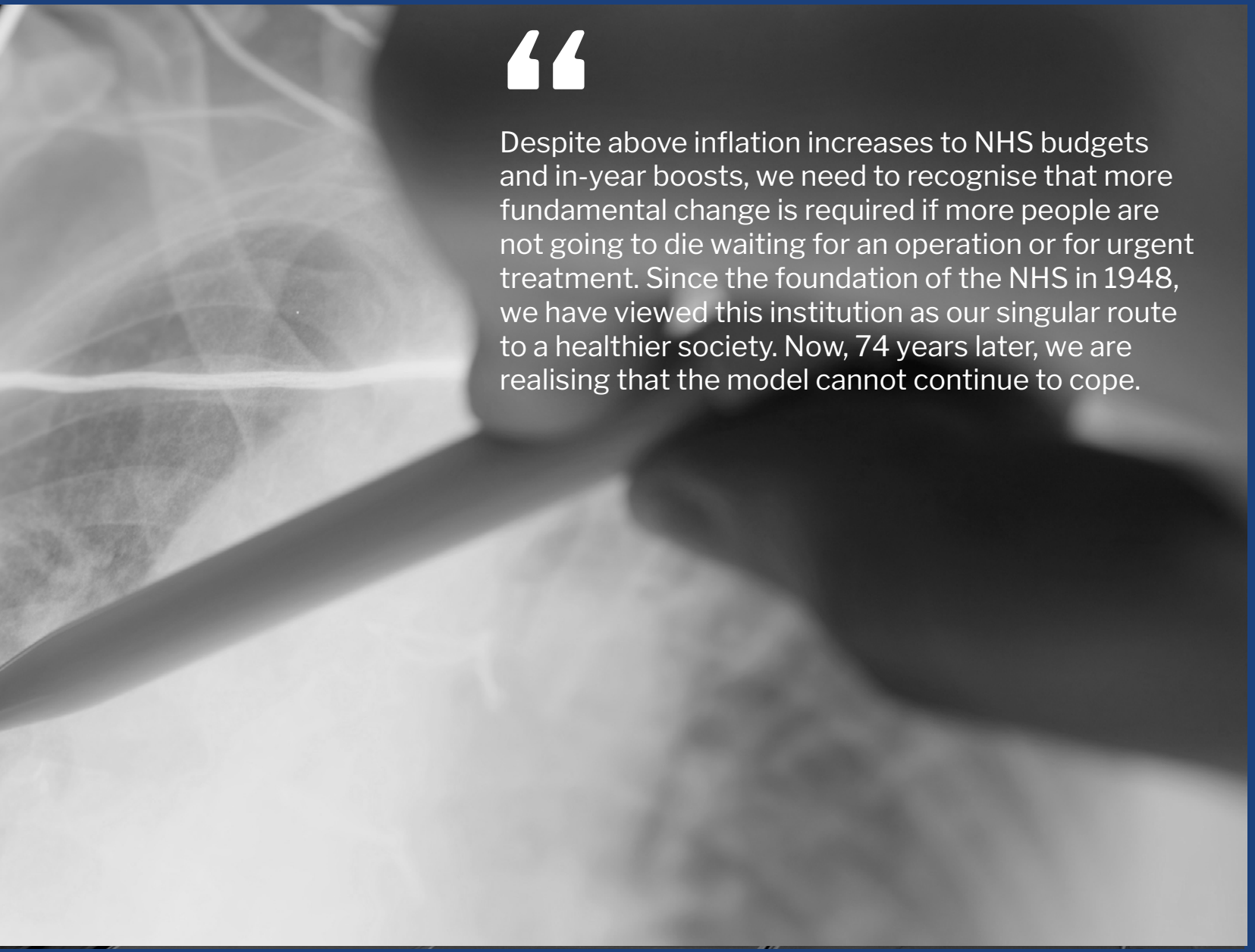
Equitable access to healthcare feeds through to life expectancy. If individuals from the most deprived backgrounds receive timely treatment or preventable care, they would inevitably live longer. However, this may not increase healthy life expectancy.

Healthy life expectancy in Scotland has a 24-year difference between the most and least deprived areas.[35] Men in the most deprived areas are expected to have a healthy life expectancy of 45.5 years, compared with a healthy life expectancy of 69.7 years for men in the least deprived. Women in the most deprived areas have a healthy life expectancy of 48.6 years compared with 72.9 years for those in the least deprived areas. Using these statistics, it would mean men in the most deprived areas spend 33% of their lives in poor health, women 35% in poor health. In comparison, both men and women in the least deprived areas spend 15% of their lives in poor health.

We estimate that indirect costs to the Scottish economy, including loss of economic potential, due to the extra number of years of poorer health is around £9.3 billion per year. As a comparison, this would equate to around 60% of the Scottish NHS budget. This is a high financial burden. It is important that policymakers shift their view to healthcare and the determinants of health being a core investment, and not an economic cost. Investing in health will lead to healthier citizens, driving economic growth and leading to a wealthier society.

Health inequality lies at the heart of Scotland's poorer health outcomes. Improving health services alone will not address all the issues. Professor Sir Michael Marmot is one of the most renowned thinkers in health inequality. His landmark study, The Marmot Review, identified six areas to improve lives: early child development, education and lifelong learning, employment and working conditions, minimum income for healthy living, healthy and sustainable communities, and a social determinants approach to prevention. Tackling these areas can lead toward a healthier, happier, fairer and wealthier Scotland.





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Despite above inflation increases to NHS budgets and in-year boosts, we need to recognise that more fundamental change is required if more people are not going to die waiting for an operation or for urgent treatment. Since the foundation of the NHS in 1948, we have viewed this institution as our singular route to a healthier society. Now, 74 years later, we are realising that the model cannot continue to cope.

Our Collective Future

The two previous chapters set out the daunting challenge facing the NHS in Scotland. They make clear that those challenges are only going to get more acute over the coming decades. We have laid this out to try and make a simple point: that the NHS as it stands will not be able to cope. Despite above inflation increases to NHS budgets and in-year boosts, we need to recognise that more fundamental change is required if more people are not going to die waiting for an operation or for urgent treatment. We need all political parties in Scotland to acknowledge this.

Since the foundation of the NHS in 1948, we have viewed this institution as our singular route to a healthier society. Now, 74 years later, we are realising that the model cannot continue to cope. With the ever-increasing number of complex health conditions: ageing, obesity, mental health, addiction, homelessness, inequality; a one-and-done treatment plan is not enough. The NHS cannot deal with all the complex reasons for these health outcomes: education and skills, quality employment, warm and safe homes, diet and exercise, inclusive communities. It is but one vehicle to a healthier, happier, wealthier Scotland.

In this section, we turn to what can be done.

Proposals to reform the NHS have come and gone: as he sets out in his foreword to this report. it is now more than 15 years since our own Health Commission chair Professor David Kerr set out a wide-ranging plan for change. Many of his recommendations – to view the NHS as a service delivered predominantly in local communities not in hospitals; to shift to preventative and anticipatory care, to welcome new technology and telemedicine – were right then, and remain right now.

But the NHS is not just where the issues lie. As we look to the wider community health system and health determinants, Scotland needs to change too, for if we are to truly "protect the NHS", then – as we did during the pandemic – it will be for members of the public to play their part as well, either by adopting healthier lifestyles or using the NHS in a responsible manner.

These changes are not easy. As noted in the introduction, Our Scottish Future will be publishing a series of reports over the coming months examining how greater collaboration and cooperation across the United Kingdom can both build public support for change and make the NHS a more efficient organisation.

But in this paper, we intend to restrict our recommendations to immediate measures that can be taken now to support the NHS through the winter when, as many clinicians are warning, we face the prospect of hospitals simply having to close their doors.

As outlined in our introduction, the Health Secretary has set out policies to tackle the impending winter NHS crisis. Whilst these are welcomed, more needs to be done. This could be the worst winter for the NHS we have ever seen. We must go further to reduce demand, increase staffing and transition to providing care locally.

Scotland is not unique with these needs over Winter. Therefore, for the suggestions below, we advocate for the four Health Ministers from the UK to come together and propose such actions.

Reducing NHS Demand

1. Emergency Care Signposting Campaign

A pan-UK television advertising campaign to identify which services to access when. When emergency hits, many of us do not know the most appropriate place to access care. This may not be by phoning 999 or travelling directly to A&E. Pharmacists are able to prescribe some medicines and minor injury units are best placed to treat broken bones. A campaign like this is needed to emphasize where to go and reduce unnecessary backlogs.

2. Encourage mask wearing on public transport and all clinical settings

Whilst the lifting of the face mask requirement was celebrated by most, it remains one of the simplest ways to reduce the spread of Covid and flu. The reduced transmission will lead to reductions in hospital admissions. On public transport and in clinical settings, we believe the public should be encouraged to wear them again. If possible, this public message should be done on a UK wide basis as, if any one nation does not agree, public support in the others could be severely impacted. This will complement the drive for Covid and flu vaccine uptake.

3. Individual and Community Resilience

More than ever, this winter will require citizens to become more self-resilient to avoid ill health. Acting as good community advocates can also improve the collective health and reduce potentially preventable admissions. Using feel-good stories in the media, demonstrating community acts such as gritting elderly neighbours' paths, or grocery shopping for them, can highlight the ways which people could reduce the chance of falls and potential hospital admissions.

Increasing Staffing

4. Support for Improved Staff Wellbeing

To increase retention, some small acts can help improve wellbeing. These could include out of hours provision of hot food and drink; guaranteed leave for family events; and not requiring staff to find their own replacement if planning on taking a day off – instead using HR services to support.

However, we must go further than these acts of goodwill. Renumeration must be increased, particularly for nurses and care assistants. And guaranteed protected time for training must be provided for care workers from Spring 2023.

5. Incentivise recent clinical and nursing leavers to return for a six month winter period

Almost 5,000 clinicians and over 27,000 nurses have left within the past five years. Offering locum salary (with pension protections) and the opportunity to work in roles which are more general duty/admin support rather than frontline service provision could entice some back.

6. Support from Royal Logistics Corps for hospital transportation and general duty personnel

If staff levels remain critically low, there are opportunities to increase it through military assistance. This has been implemented over the past few years and can include ambulance transportation and support like general duty on wards. Help with social care such as installing adaptions to homes remain an option if required.

Provide Care Locally

7. Expand number of out of hours GP/Pharmacy services

To improve access to out of hours services – which are effective for signposting away from A&E – expansion is required. Since GP surgeries and many pharmacies are independent businesses, financial support is needed.

8. Introduce an emergency Care Leave act for the winter with a sunset clause of April 2023

A bill is currently going through the House of Commons to guarantee care leave. However, as this will unlikely cover this coming Winter, we advocate for the UK government and devolved administrations to introduce a special emergency bill. Equipped with a sunset clause at the end of this forthcoming Winter, this bill would provide a statutory right for carers to take up to six months leave of absence from work. We would include a clause which allows for those who are returning to the NHS (see point 4 on incentives for returnees) to use this leave to return to NHS frontlines. It is hoped this bill will incentivise some families to support elderly relatives this winter who may not qualify for social care. To support families financially, increases to carers allowance in line with inflation should be immediately introduced.

9. Rapid Support Teams for Non-Critical Falls

Following NHS England's lead, we propose Scotland introduces rapid support teams comprised of care workers, firefighters, police officers and other community service personnel, to assist older adults who have had a fall, but are uninjured and do not require hospital admissions. The longer these individuals wait outside, there is an increased chance of more serious illnesses such as hypothermia. Therefore, faster treatment can prevent a potential hospital admission.

These proposals may help to ensure the NHS is able to offer healthcare to all citizens free at the point of use over the short term. With a focus on fairness and health inequality, technical innovations, learning and pooling resources from across the UK, we can create a health system fit for the 21st Century.

Many of these measures can be pursued by the Scottish Government independently if it wishes. To end where we began in the introduction, however, we believe that by cooperating and collaborating in areas of mutual need and mutual interest, Scotland and the whole of the UK will see better outcomes. We share a common culture and common approach to healthcare delivery. Cooperation and partnerships across the whole country can improve best practices and ensure we all benefit.

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About the Author

Andrew is a recent graduate from the University of Cambridge, where he studied a Masters in Population Health Sciences. Prior to this, he worked in a variety of analytical roles both within the NHS and private sector. During his time at the NHS, he developed numerous data products currently used by clinicians across the country. He also holds a Masters in Mathematics and Physics from the University of Glasgow.

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Our Scottish Future believes that good government in Scotland and across the United Kingdom has to be based on the values of cooperation, empathy, solidarity and reciprocity.

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