

Research report July 2017

# Learning from Scotland's NHS

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nuffieldtrust

## About the report

This is the first in a series of reports from the Trust that looks at each of the four health services of the UK in a detailed, qualitative way, and asks what lessons they hold for the other countries.

It aims to identify how health care in Scotland is different, where its approach seems to solve problems being faced elsewhere in the UK, and whether that approach could be transplanted to England, Wales and Northern Ireland. Conversely, it assesses whether there are areas where Scotland could learn from its peers.

The report arises initially from an event we held a year ago, in May 2016, at the Royal College of Physicians of Edinburgh, which invited 30 senior leaders and experts from Scottish health and care to discuss the country's unique policies and institutions across quality improvement, workforce and integrated care. Key themes from the seminar were followed up in a series of interviews with 24 academics, health service managers and senior officials in Scotland between autumn 2016 and early 2017.

### Suggested citation

Dayan M and Edwards N (2017), *Learning from Scotland's NHS*. Research report. Nuffield Trust.

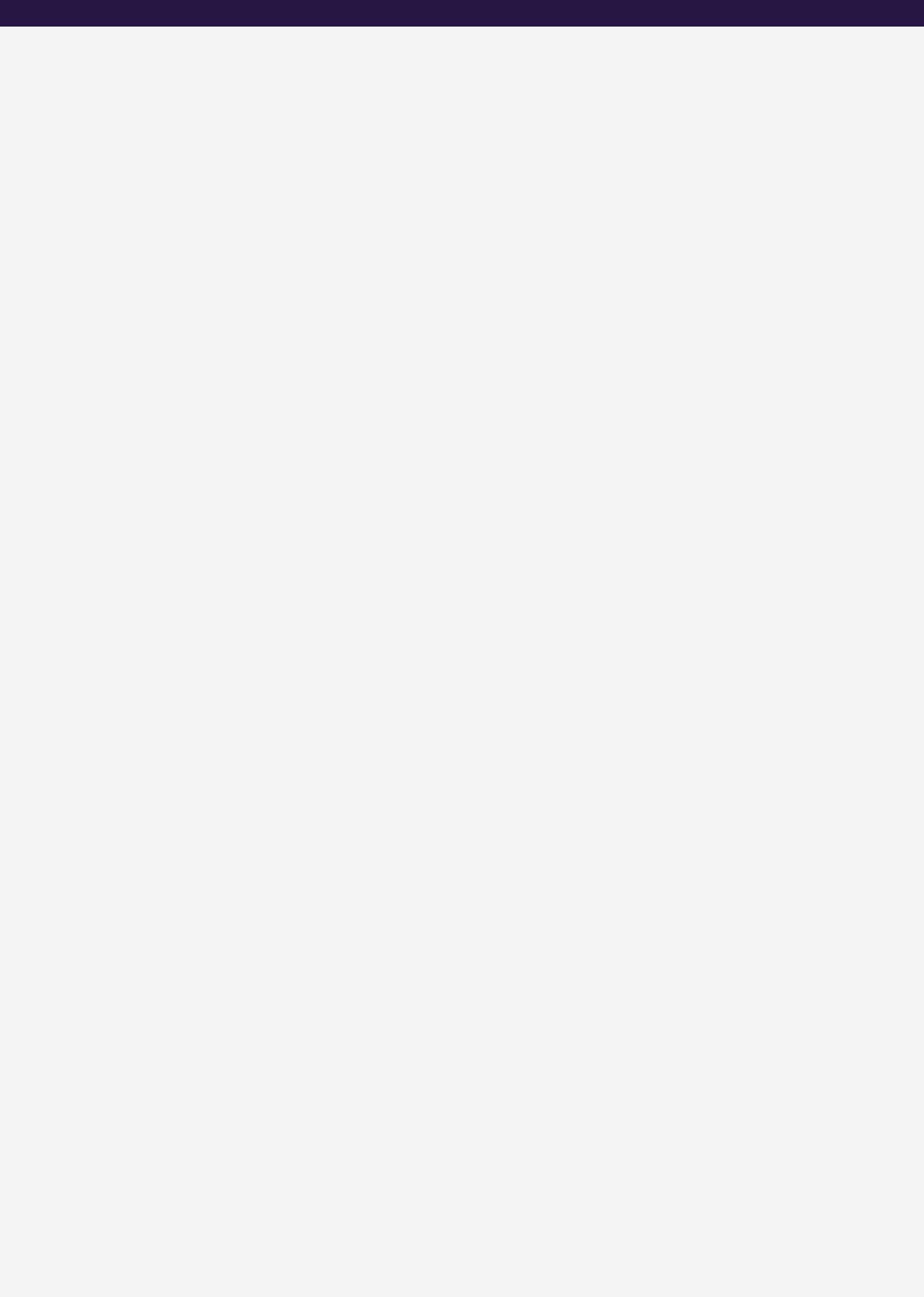
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## Acknowledgements

We would like to thank Professor Derek Bell of the Royal College of Physicians of Edinburgh for making the event that began this work possible; David Steel for all his vital work in looking over the report; Aoife McDermott for both her keynote address and her invaluable help in reviewing the report; Professor Jim McGoldrick and Rachel Cackett for their keynote addresses; Professor Alan Paterson, who spoke at the event; and all of our interviewees, listed in Appendix 3 on page 46, for their honesty and insight.

Russell Gunson of IPPR Scotland also played an important role in supporting our event. Within the Nuffield Trust, we are grateful for the time and expertise provided by Katherine Jarman, Meilir Jones, Sally Gainsbury and Fiona Johnson.



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# 1 Introduction

The Nuffield Trust has a remit to look across the United Kingdom for evidence and inspiration that support our core mission to improve health care. Over the last decade, we have published two reports with the Health Foundation that aimed to track performance and policy, comparing indicators across the four countries. Our last report in 2014, led by professors Nick Mays and Gwyn Bevan, compared a wide range of measures of health care quality and access. However, it also found that the indicators used in the different countries were diverging, and there was no clear basis for policy recommendations from one country to another.

This report represents the first in a new series from the Trust that will look instead at each of the four health services of the UK in turn in a more detailed, qualitative way, and asks what lessons they hold for the other countries. It aims to identify how health care in Scotland is different, where its approach seems to solve problems being faced elsewhere in the UK, and whether that approach could be transplanted to England, Wales and Northern Ireland. Conversely, it assesses whether there are areas where Scotland could learn from its peers.

## 2 Key points

- Scotland has a unique system of improving the quality of health care. It focuses on engaging the altruistic professional motivations of frontline staff to do better, and building their skills to improve. Success is defined based on specific measurements of safety and effectiveness that make sense to clinicians.
- Scotland's smaller size as a country supports a more personalised, less formal approach than in England. The Scottish NHS has also benefited from a continuous focus on quality improvement over many years. It uses a consistent, coherent method where better ways of working are tested on a small scale, quickly changed, and then rolled out. Unlike in the rest of the UK, this is overseen by a single organisation that both monitors the quality of care and also helps staff to improve it.
- There is much for the other countries of the UK to learn from this. While comparing performance is very difficult, Scotland has had particular success in some priority areas like reducing the numbers of stillbirths. Scotland's system provides possible alternatives for an English system with a tendency towards too many short-term, top-down initiatives that often fail to reach the front line. It also provides one possible model for a Northern Irish NHS yet to have a pervasive commitment to quality improvement, and a Welsh system described as needing better ways to hold health boards to account while supporting them in improving care.
- Scotland faces particular issues of unequal health outcomes, and very remote areas. There are pioneering initiatives to address these, like the Links worker programme<sup>1</sup> and Early Years Collaborative to support people in very deprived areas, and use of video links for outpatient care on remote islands. These should be considered in other parts of the UK facing similar issues.
- Scotland has a longer history of drives towards making different parts of the health and social care system work together. It has used legislation to get these efforts underway while recognising that ultimately local relationships are the deciding factor. There is much for England and Wales to learn from this.

- However, like other UK countries, Scotland has struggled so far to move care out of hospital. There will be a need for Scottish health service leaders and politicians to face up to the difficult and unpopular decisions this may require, and to be ready for some initiatives not to work.
- The Scottish NHS faces a serious financial predicament. The need for savings is at least as great as for other UK countries, and health boards are struggling to find ways to deliver them. Limited national planning for the next few years and a polarised, hostile political context make an honest national debate difficult. While the strengths of the Scottish NHS could help it to save money, there is also a risk that they are undermined by the intense financial squeeze.

## 3 Methodology

This project began with an event in May 2016 at the Royal College of Physicians of Edinburgh, inviting 30 senior leaders and experts in Scottish health and social care to discuss the country's unique policies and institutions across quality improvement, workforce and integrated care. Based on this, we identified key themes for learning from Scotland.

Quality improvement was selected because Scotland has a distinctive emphasis and approach on this area, which repeatedly emerged as a particular point of pride for Scottish interviewees and curiosity from elsewhere in the UK. Scotland also has particular lessons in integration, because it has a longer history of policy aimed at achieving this and a particular legislative approach, and it uses its workforce differently to address the issues of rurality and health inequality that it faces to a particular degree. Lastly, we decided to examine the finances and financial management of the Scottish health service, reflecting that, especially in a period of austerity, this plays a critical role underpinning other themes.

These themes were then followed up in a series of interviews with 24 academics, health service managers and senior officials in Scotland held from autumn 2016 to early 2017. Interviewees are listed in Appendix 3 on page 46. We approached Scottish Government ministers, but they felt that we should speak to the NHS chief executive rather than political leaders. Our policy throughout the report has been to avoid naming particular interviewees, in order to allow people in sensitive and important posts to speak widely and freely.

Alongside this, we undertook a review of policy and audit literature from the Scottish Government and its arm's-length bodies, and academic and NGO papers that assessed the culture, performance and relative characteristics of the Scottish health and care system. Where relevant, we also looked at equivalent English, Welsh and Northern Irish studies and publications to contextualise the Scottish picture, further informing our assessment of whether Scottish ways of working could be realistically transferred. We also analysed publicly available data on access to services, indicators of integrated care and quality across all four countries.

## 4 Quality improvement and change

Our interviewees supported the findings of a recent review by the OECD<sup>2</sup> that Scotland is home to a unique culture and set of institutions that seek to improve the quality of health care. This was usually the first area that interviewees highlighted when asked what they felt Scotland's NHS had to teach its equivalents across the UK.

### Defining Scotland's path

A Scottish system of setting and monitoring goals for better health care stretches at least as far back as the Clinical Standards Board established at the dawn of devolution in 1999. But most interviewees felt that the current institutions and culture emerged between the establishment of NHS Quality Improvement Scotland in 2003 (now Healthcare Improvement Scotland) and the 2010 publication of the Healthcare Quality Strategy by the Scottish Government.<sup>3</sup> A watershed came in 2008 with the introduction of the Scottish Patient Safety Programme (SPSP), which many of our interviewees saw as the exemplar and the keystone of quality improvement in Scotland. This trains clinicians and managers, refines skills and methods, and oversees the testing and roll out of changes to care, with success measured by data submitted by boards to the national programme. SPSP initially focused on acute care for adults but has now expanded to mental health, primary care and maternity. Its interventions and targets are highly specific – an example of one of the changes it has sought to implement is shown in Figure 1, which aims to reduce the number of surgical site infections.

Figure 1: Scottish Patient Safety Programme – changes to reduce surgical site infections

Aim	Primary drivers	Secondary drivers
<p>Provide appropriate, reliable and timely care to patients using evidence-based therapies to prevent surgical site infections</p>	<p>Reliable, evidence-based perioperative <b>ward care</b></p>	<ul style="list-style-type: none"> <li>• Ensure that a clinical risk assessment for Methicillin-resistant Staphylococcus aureus (MRSA) has taken place</li> <li>• Hair is not removed if possible. Razors were not used if hair was removed</li> <li>• Patient has showered (or bathed/washed if unable to shower) on day of or day before surgery using soap</li> <li>• The wound dressing remains intact for 48 hours post operatively, unless clinically indicated</li> <li>• Aseptic technique is used if there is excessive leakage and need for dressing change</li> </ul>
	<p>Reliable, evidence-based perioperative <b>theatre care</b></p>	<ul style="list-style-type: none"> <li>• The appropriate prophylactic antibiotic is administered within 60 minutes before the operation (blade to skin)</li> <li>• 2 per cent chlorhexidine gluconate is 70 per cent isopropyl alcohol solution – if patient sensitive use povidine-iodine solution</li> <li>• The patient’s body temperature is maintained <math>\geq 36^{\circ}</math> in the perioperative period (exclude cardiac patients)</li> <li>• Known diabetic patients’ glucose level kept at <math>&lt; 11</math> mmols/l throughout the operation</li> </ul>

Source: The Scottish Patient Safety Programme<sup>4</sup>

## Five factors that set Scotland apart

Drawing on the existing literature<sup>5</sup> and the interviews carried out for this report, we identify five factors that set the Scottish system apart.

The first is continuity and consistency, over time and at different levels of the system. The Scottish NHS, the Scottish Government directorates that oversee it, and Healthcare Improvement Scotland have retained their current form for nearly a decade. This is matched by continuity of thought and action within these institutions, with an academic interviewee describing a “clear, long-term and uncontested agenda” on quality. In fact, several interviewees made the point that this agenda stretches back even further than the institutions themselves, and survived the change of party in government in 2007 from Labour and the Liberal Democrats to the SNP. Policy documents produced by the Scottish NHS and Scottish Government refer back to earlier work, and retain the same language and stated priorities through the years.

This is in marked contrast to England and Wales. In England, the picture is one of constant change and reorientation. The Health Foundation describes a “priority thicket”, a huge number of new initiatives not unified by any overall strategy.<sup>6</sup> They count 179 policy initiatives over a three-and-a-half-year period, with many not really followed up by the body initiating them. This is difficult to reconcile with the sustained focus and long timespan that literature on quality improvement generally agrees is needed to secure real change. In Wales, the OECD found a steady and deep commitment to improving quality but that consistency needed to be improved – central plans and ideas were not yet being carried forward into institutions and systems to bring about change at the front line.<sup>7</sup>

The second is Scotland’s reliance on intrinsic ethical and professional motivations and personal connections between tiers of the hierarchy to bring about change, supported by specific data that focus on patient outcomes. This tends to mean a relatively lower reliance on hard incentives, process or access indicators, or direct lines of authority. One senior Scottish Government official told us that, although they might sometimes seem necessary, “fundamentally, scrutiny and assurance are evil – unshackled altruism is my ideal”. The Scottish NHS has a relatively low number of tiers in the hierarchy between the centre

and the front line: board chief executives know and regularly meet with central civil servants and even ministers. In England, by contrast, a more formalised system of command is generally used to deal with a system with greater scale, interpersonal distance, and heterogeneity – although personal intervention by government ministers can also cut through this in a somewhat unpredictable manner. Closer to the front line, Scotland appears to have a relatively high level of trust in colleagues and counterparts doing the right thing, and again an emphasis on persuasion rather than incentives.

This translates into a view of frontline engagement as the chief mechanism of change, and an emphasis on reaching clinicians in particular. A senior official expressed the theory: “Stepping back, we are looking at a delivery system where the key players are clinicians, nurses, doctors and physios. The realistic implications are that their loyalties tend to go to the patient; to the GMC and NMC; to their colleagues; and, lastly, to their employer. So if you land an organisation-focused plan on them, it won’t work.”

The third is widespread use of a model of small-scale testing and revision of new quality improvement initiatives, and a relatively informal approval and expansion of initiatives perceived to be successful. This reflects many elements of the Model of Improvement developed by the Institute for Healthcare Improvement in Boston, USA<sup>8</sup>, which has had a long relationship with the Scottish NHS, including as the technical lead for helping to design and run SPSP.<sup>9</sup> It emphasises a “plan-do-study-act” cycle, where real-world testing of a change begins immediately after aims and principles are agreed, allowing it to be adapted without further input from management above the front line, and then picked up for roll out once goals are being achieved. Neither Wales nor England have such a consistent model for improvement. In England, a model of larger, more formal pilots and change programmes, with most design done once at the centre, is often prevalent. It extends to changes in the use of workforce and resources, as well as quality improvement.

A fourth difference is that Scotland’s institutions for scrutiny of health care sit within the same organisation as its institutions for quality improvement. Healthcare Improvement Scotland (HIS) has a scrutiny and assurance directorate, which includes the Healthcare Environment Inspectorate (HEI) that monitors cleanliness and safety through announced and unannounced inspections. Alongside this sit the improvement and clinical directorates that

oversee SPSP, the use of data for improvement, and the Improvement Hub that brings together clinicians and stakeholders. The OECD and McDermott et al<sup>10</sup> have both highlighted this as a relatively unusual arrangement that creates particular challenges and opportunities. The OECD warned that “the mix of these roles means that the system’s inspector risks ‘marking its own homework’”.<sup>11</sup> It can also create tensions in the relationship between regulated and regulating bodies, discussed further below.

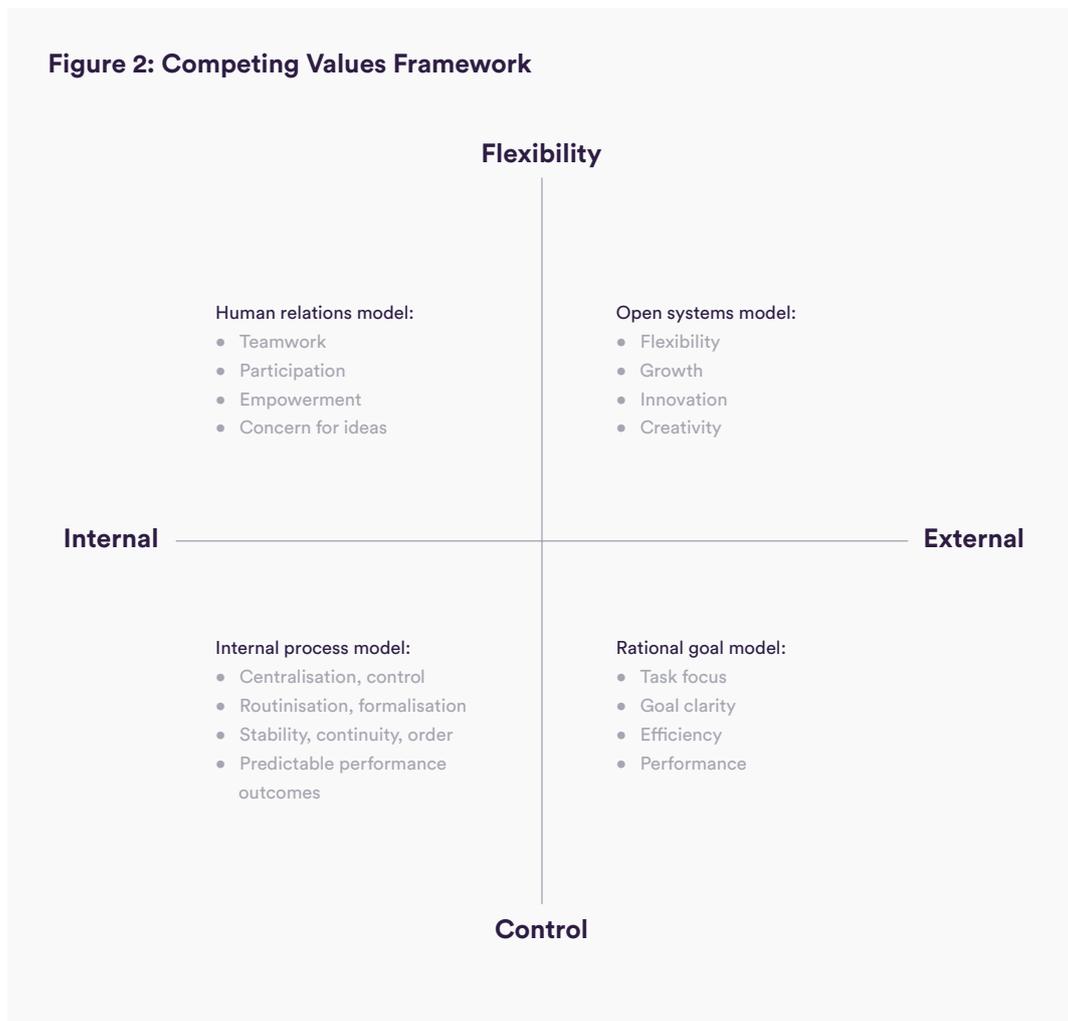
However, our interviewees from within the Scottish NHS and Scottish Government were almost universally clear that the benefits of combining the two were more important than any risks. “If you’re not doing regulation for improvement, you’re missing a trick,” a senior civil servant told us. McDermott et al<sup>12</sup> identify several potential advantages to a single body overseeing both top-down assurance and scrutiny, and bottom-up improvement – as long as certain conditions are met, such as credibility being vested in the body by clinicians and an initial focus that is not on urgently rooting out poor performance. Having a regulator under the same roof can allow flexibility when quality improvement undermines consistent performance in the short term. It can make it easier for the system as a whole to have an agreed agenda of capacity, innovation and goals that reflect what is needed for improvement.

However, many interviewees did identify a different tension at the receiving end, where the dynamic of judgement and conflict that might characterise the inspection process “contaminated” the trust required for successful quality improvement. “Improvement work can conflict with inspections that can make people feel attacked,” one board leader told us. There was general agreement that HIS recognised this and was becoming better at dealing with it, largely through managing the impact of negative findings from inspections.

The fifth and final difference is Scotland’s emphasis on building up a cohort of staff equipped with skills for change. SPSP and other programmes, like the Early Years Collaborative that brings together different public services to improve life chances for children, emphasise conferences, training and education for frontline staff. Quoting a medical leader, quality improvement in Scotland has “infiltrated the ward level” because of “the ability to have people who understand it scattered all over the health boards”.

## Placing Scotland in context

The Competing Values Framework is a way of categorising organisational culture and has been used in the English and American health care systems to analyse the values that guide the management and functioning of organisations.<sup>13</sup> An example is shown in Figure 2, tested for consistency against a sample of 300 hospital managers and supervisors.<sup>14</sup> One dimension (vertical here) runs from “flexibility” or a “relationship” orientation that values distributed and informal leadership, to “control” that emphasises following rules and clear lines of command. The other (horizontal here) runs from an orientation towards the “internal”, the values and interests within the organisation, to an orientation to the “external” values and interests imposed by customers or stakeholders.



Source: Kalliath et al<sup>15</sup>

In our judgement, the Scottish health system, with the high levels of trust leaders show in their colleagues and an emphasis on skills and autonomous testing at the front line, generally appears to be more flexible than the English and to some extent Welsh ‘control’ systems. Placing it horizontally is more complex. On the one hand there is an orientation towards intrinsic motivation, staff capacity as a goal, and an aversion to negative criticism seen as leading to disengagement. On the other hand, there is a genuine orientation towards delivering better care to patients, and a willingness to test this against clear indicators – both “external” outcomes. Many interviewees embraced this apparent tension, feeling that attentiveness to internal drivers could create better outcomes by harnessing altruism and professional values. While marketised competition and the use of procurement for clinical services by competitive tender is largely absent, interviewees in the Scottish Government did claim they had made a “deliberate effort” to encourage competition based on reputation and altruism.

The English health system is more unequivocally externally oriented, with a competitive internal market at least in theory and an overriding interest in targets and performance. The Welsh system is again more complex, with a hierarchical system but some work to do in improving external accountability.<sup>16</sup>

It is important to emphasise that this is a relative distinction. Scotland too has mechanisms of accountability and central control that are very visible at the front line. Interviewees in central bodies generally expressed high trust in local leaders, but boards are still firmly managed against targets, and “sending in the ministers”, in the words of a senior official, continues to be a frequent reaction to high-profile problems. Local delivery plan standards enshrine many of the same fixed standards for access to care as the target systems in Wales and England, although without the former’s financial penalties.<sup>17</sup> HEI reports do deliver serious criticism, sometimes resulting in harsh negative publicity, as illustrated by a report criticising deficiencies in cleanliness and equipment at Gartnavel General Hospital in Glasgow in late 2016, which was picked up by national news media.<sup>18</sup>

## Potential drawbacks

A system that sometimes prioritises the internal over the external can run the risk of complacency – the focus on skills and morale ceasing to be about productive investment for better care, and becoming an end in itself. Is this a risk that faces the Scottish NHS?

Many of the independent academics we interviewed felt that it could, although not to the extent of becoming a serious problem across the board. One described the system as having the potential to “leave people feeling protective; any challenge from outside or even inside is not welcome; there can be a self-congratulatory air.” Another described an “unwillingness to face up to external critique”. Reconfiguration at the national level, and atypically poor performance in individual hospitals locally, were the main issues on which these criticisms centred.

Academic interviewees also pointed to reluctance to commission independent evaluation of new initiatives, while admitting that, as the people likely to be given evaluation contracts, they were always likely to argue for more. Looking across major recent initiatives, there do appear to be few in Scotland that have been independently evaluated for success in the way seen in England for initiatives like the Prime Minister’s Challenge Fund and Partnerships for Older People. However, other major English programmes have been subject to similar concerns over a lack of evaluation, as the National Audit Office found with the English Better Care Fund.<sup>19</sup> As described, Scottish programmes do have strong internal data analysis and clear success criteria. Performance against these is often – though not always – available publicly in sporadic reports.<sup>20</sup>

One interviewee with a pivotal role in developing Scotland’s system answered the challenge by reflecting the question back on us: did we think the people we had spoken to were complacent? The answer is, generally, no. The “chronic unease” about whether more could be done, which has been identified<sup>21</sup> as an important orientation in improving safety and quality, was widespread. Interviews carried out by McDermott et al with a wider set of central and frontline employees came to the same conclusion.<sup>22</sup> But particularly when considering whether Scottish institutions could be transferred elsewhere, it is

important to recognise that cultural and even individual factors, as much as hard institutions, are the part of the system that guards against complacency.

A more specific criticism was that improvement “spreads a certain amount, then tends to stop. Things get rolled out to two or three areas, and then there is a sort of firewall,” as one of several senior Scottish Government officials to allude to this weakness put it. Given the awareness of this issue at the highest levels and the personal connections that mediate change in Scotland, this is not necessarily a problem the system would be unable to address. Nor is it by any means unique to Scotland. The Nuffield Trust has found similar patchy roll out of apparently promising initiatives in several fields in England.<sup>23,24</sup>

However, it may shade into a deeper problem – how a model oriented more towards intrinsic motivation and personal connection deals with a minority of staff or organisations who may not respond. “Looking at England, I sometimes see the disadvantage of not having financial incentives,” one senior official told us. “If we don’t hook people, they’re lost.”

As one academic put it, however, there are trade-offs here. They saw England’s health care system as “bedevilled” by using conflict-based, low-trust techniques to deal with poor performance as the default setting for relationships.

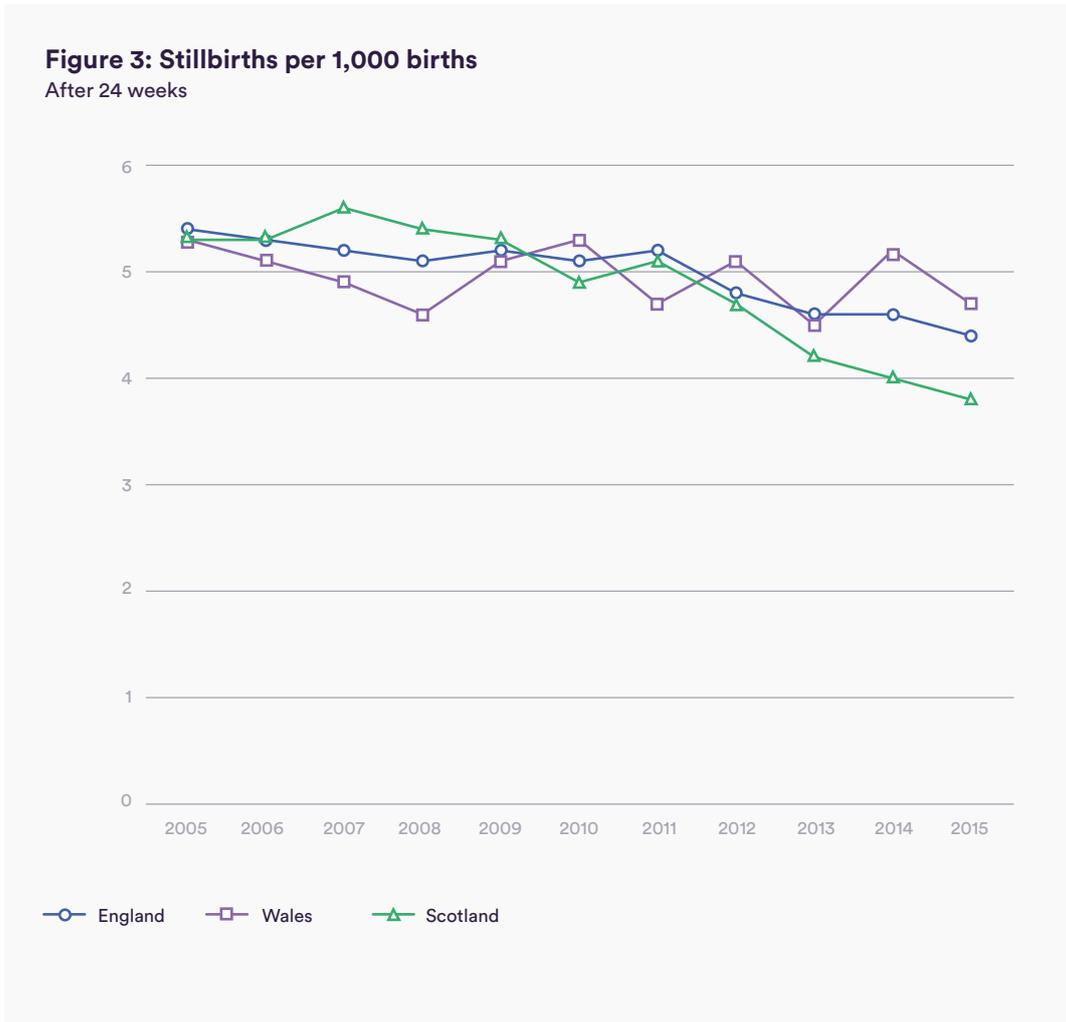
## A model to learn from?

So should health services elsewhere in the UK look to adopt some elements of this model?

The first question to ask is whether there are areas where the Scottish system objectively seems to be succeeding, and in particular where it seems to be delivering better results than its counterparts elsewhere.

Reducing the numbers of stillbirths has been an objective of both the maternity element of SPSP within the NHS and of the Early Years Collaborative that reaches beyond it.<sup>25</sup> On the SPSP side, for example, this has involved a drive to increase the proportion of women who consult a midwife about how foetuses are expected to move and when to consider seeking help.<sup>26</sup>

Comparing the rates of stillbirths across England, Wales and Scotland, we see a marked improvement in Scotland consistent with the impact of these quality programmes, both of which began in 2012. For much of the period up to 2010, Scotland had the highest rate of stillbirths. From 2011, however, a prolonged decline takes it to the lowest rate of the three countries. England also appears to improve during this period, but to a lesser extent.

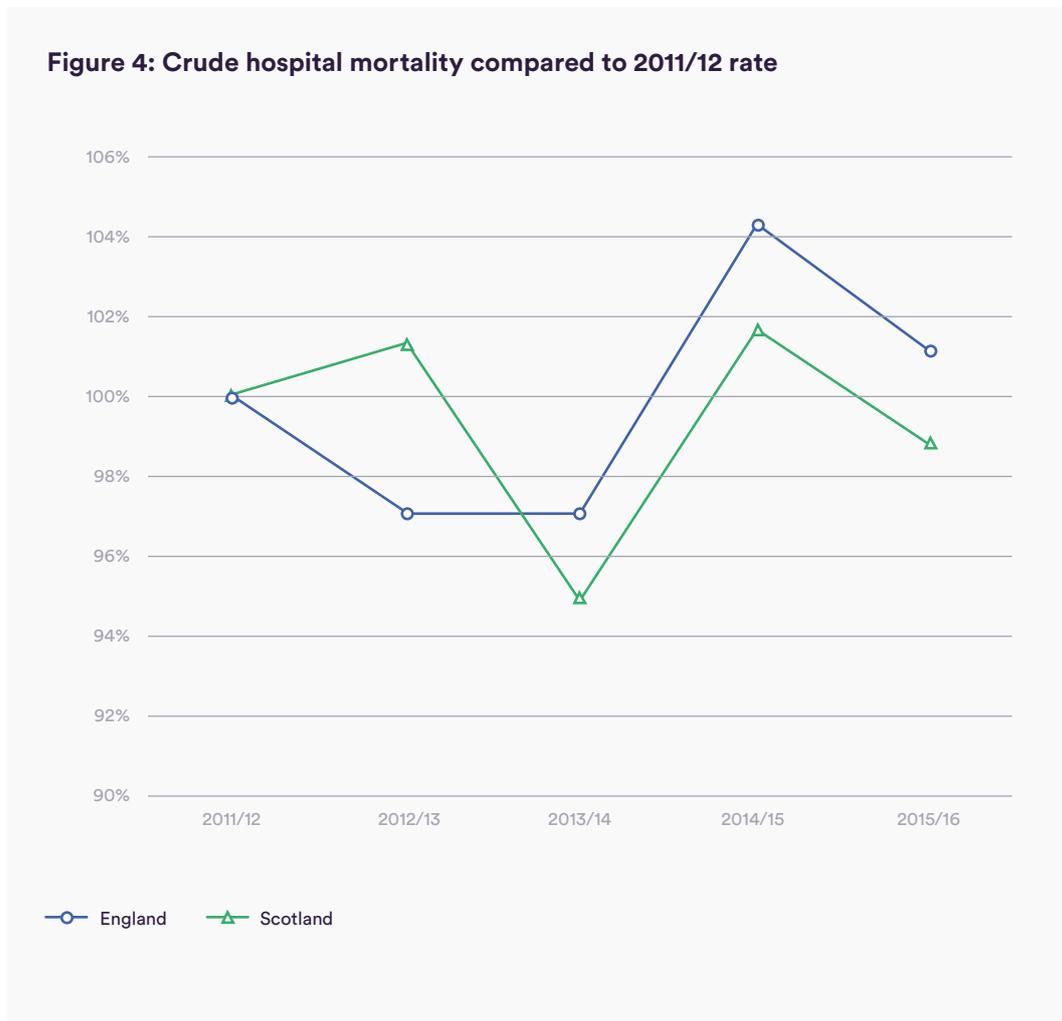


Source: Office for National Statistics (England and Wales)<sup>27</sup>, National Records of Scotland<sup>28</sup>

To take a second example, deaths from sepsis – where the immune system’s overreaction to infection damages organs and blood flow – are internationally considered to be a major source of avoidable hospital mortality.<sup>29</sup> Several programmes within SPSP, including adoption of the National Early Warning System and an emphasis on providing antibiotics within an hour, have sought to reduce sepsis mortality.

It is not possible to compare hospital mortality like for like across the four countries of the UK. However, we can produce an index of crude mortality (see Figure 4) to see how it has changed over time in England and Scotland. This has two flaws. Coding may have changed over time, creating an artificial improvement. Conversely, the patient population in both countries now has more complex conditions than earlier, meaning that a roughly constant mortality rate in reality signals a significant improvement detectable with more sophisticated tools like Scotland’s Hospital Standardised Mortality Ratio (HSMR) and England’s Summary Hospital Mortality Indicator (SHMI) – this may distort the relative results due to the countries’ different populations. However, the results are certainly consistent with Scotland substantially improving mortality, and perhaps at a higher rate than England.

Figure 4: Crude hospital mortality compared to 2011/12 rate



Source: NHS Digital (England)<sup>30</sup>, ISD Scotland<sup>31,32</sup>

However, other indicators recently published by information services working together across the four countries show a more mixed picture for Scotland. Scotland made considerable progress between 2008 and 2010 in closing what was once a large gap in hospital mortality for heart attacks compared to the other three countries. However, in stroke mortality, Scotland performs worse than the UK average with little sign of relative improvement between 2008 and 2013. Meanwhile, England and Wales have caught up with Scotland’s once superior performance in beginning hip fracture surgery within two days.<sup>33</sup> On the one hand, this underlines that Scotland’s NHS is certainly not categorically superior at improving quality. On the other, it is consistent with improvements in sepsis, stillbirths and mortality being closely associated with the specific programmes we have discussed.

## Are there problems elsewhere in the UK to which Scotland may have the answer?

Another way to consider the scope for other UK countries to learn from Scotland is to ask whether there are issues facing other countries' health services that Scotland's system appears to resolve.

England's quality improvement system has been extensively examined by, among others, the King's Fund, the Health Foundation and the OECD. They consistently praise its ambitions, but also identify a consistent range of faults. These are "hyperactive policy-making"<sup>34,35</sup> with conflicting and shifting ideas about both the aims and methods of quality improvement, and an insufficient focus on listening to frontline staff and developing their capacity for improvement. They exist in a context where most power is exercised in a relatively 'top-down' fashion, and where heavy emphasis on access targets, inspection and assurance can tend to drown out quality improvement as a priority.<sup>36,37</sup>

We are not suggesting that the answer is a wholesale, crude transplant of the Scottish system into England. The size of England and its different historical path would make this very difficult. Even if Scottish institutions could be replicated, the culture that goes alongside them could not, and this appears to play an important role in safeguarding against complacency.

But considering the features of Scottish health care quality improvement already discussed, it is clear that they do offer a plausible, concrete alternative to nearly all the specific flaws identified in the English system. The value of Scotland as an example for different areas of quality improvement has been identified before, including by the Health Foundation<sup>38</sup> and by Don Berwick following his 2013 review of health care in England.<sup>39</sup> The literature suggests there is still a lot left to learn.

The OECD notes that Wales has a "rich health care quality architecture" and gives a high priority to improving care.<sup>40</sup> However, they suggest that it needs more work on supporting its health boards and consistent levers to actually make improvement happen. "Systemic quality improvement initiatives" need to be in place throughout the service.

Scotland is an example of a similarly sized country that has nonetheless built up a comprehensive system, which addresses many of the needs implied by the OECD in a coordinated way. Wales's 1000 Lives national improvement programme is held up as a success by the OECD. It shows commonalities with Scottish initiatives in terms of an emphasis on skills, safety and inspiring clinicians, and appears to be one way to provide the kind of support and guidance to boards the OECD calls for.<sup>41</sup> 1000 Lives is considerably younger than SPSP and might have much to learn from it. So far, the Welsh programme is less visible as a national priority and has not served as a template for other work in the same way – it is not clear that 1000 Lives has developed and expanded from its starting point in the same way as SPSP. Responsibility for it has been transferred to Public Health Wales, rather than sitting with regulatory or performance bodies.

Scotland also has more hard-edged ways to hold local managers accountable, often through personal relationships between the centre and board leaders. Alongside this sits a use of hard data on patient outcomes designed to appeal to altruistic motivators, which is less available in Wales, and a prolonged and consistent emphasis on building up capacity. Healthcare Inspectorate Wales is currently moving to a more systematic process of inspection, rather than looking at particular areas and concerns. This might be a good opportunity to look at how inspection sits – not always easily – within a wider quality improvement system in Scotland.

Northern Ireland has published a series of quality plans, and has a body with clear responsibility for improving care – the Regulation and Quality Improvement Authority – which conducts reviews with guidelines of different areas. However, it does not yet have an overall quality improvement initiative that combines a method for making change happen with clear goals and metrics that suit the process. The OECD found that Northern Ireland shared with England a sometimes confusing panoply of quality initiatives without clear prioritisation. The recent expert panel on health and social care found “innovation and quality improvement are subordinate to daily fire fighting and crisis management”.<sup>42</sup> Scotland's institutions may offer several lessons here.<sup>43</sup> The Northern Irish Regulation and Quality Improvement Authority has recently started to undertake systemic inspection.<sup>44</sup> There may be a risk that this programme of assurance crowds out more supportive and strategic

ways to improve quality, as was seen by several of our interviewees to have happened in the past in Scotland, as has been described in England.

## Can the Scottish system work elsewhere?

It is nonetheless important to be clear that, even where it is desirable for other UK health systems to learn from Scotland, it will not always be possible. Scotland's quality improvement system is facilitated by a number of underlying features of the country and its public policy.

Three of these are fundamental and institutional features that are difficult to change, at least without legislation or major reorganisation. First, almost every interviewee asked what enabled the Scottish system to work pointed to the country's size. "Scotland is a small village," one union leader told us. He meant that people in positions of importance in the NHS – unions, board leaders, civil servants, ministers and leading clinicians – knew one another personally. This is a crucial enabler for the higher levels of trust compared to England, and for the reliance on personal relationships over hard authority as a mediator of change and authority. Size may not be a sufficient condition – as one academic told us, "you don't hear people saying this about Wales, which is interesting if size is a key indicator". But it may be a necessary one. One senior official suggested that "above 10 million people, it would be difficult to operate a national health service as we do". Wales and Northern Ireland are already comparable in size, but it would require a devolutionary shift currently only in its infancy in places like Manchester for England's health service to be run at a comparable scale.

Second, many interviewees referred to the lack of the marketisation and competition between teaching hospitals that mark the English NHS as conditions that favoured a higher trust and more personally mediated system. "There's no history of adversarial relationships," one said. This is by no means a determining factor, however, as again it was pointed out that the same factors do not necessarily appear to have the same effect in Wales.

The combination of regulatory and quality improvement functions may also have deep and specific institutional roots. McDermott et al look specifically at Scotland’s “hybrid” HIS – which includes both assurance and improvement roles, both top down and bottom up.<sup>45</sup> They conclude that advantages do emerge from doing this together rather than separately. But these emerged from the particular path of development in Scotland – the fact that the quality system started off in a supportive role giving advice and standards, and that continuity of purpose has allowed adaption and evolution over time towards a constant goal. This would be difficult to replicate, and serious thought would be needed for other ways to derive similar institutions.

But recognising that quality improvement in Scotland arose from a particular context is not a counsel of despair for those who might learn from it. Two more critical factors underlying the Scottish system lie directly within the control of health service managers and leaders.

The first is the choice of a single quality improvement approach with a rigorous method. The emphasis on clinical engagement, small-scale testing and building up skills reflects the influence of the Institute for Healthcare Improvement and the extension of a model that began in SPSP. Interviewees associated the focus on intrinsic motivation and the decision to put scrutiny alongside quality improvement with particular individuals in prominent roles in Scotland. In the initial phase with the introduction of Quality Improvement Scotland around 15 years ago, these included Malcolm Chisholm as Health Minister and the first chairs of the organisation, Lord Naren Patel and Sir Graham Teasdale. In a second crucial period often highlighted around a decade ago, which saw the introduction of SPSP, these included Nicola Sturgeon as Health Minister, Derek Feeley and Professor Jason Leitch at the Scottish Government, and Sir Harry Burns as Chief Medical Officer.<sup>46</sup>

Last, perhaps most important of all has been the decision not to change course, which has given the Scottish system its stability and tangible impact at the front line, and is perhaps another underlying variable in supporting a culture of trust and common understanding.

# 5 Integration

## Scotland's path to integrated care

In common with other UK countries, Scotland has sought in recent years to 'integrate' its health service and other related services like social care. The term means getting different sectors to cooperate, with the aim of reducing people's needs for health care, and providing the care they need outside expensive and intensive settings like hospital. In 2013, the King's Fund found that Scotland appeared to have made the most progress across the UK.<sup>47</sup>

This section will look primarily at the policy and organisational changes undertaken to drive integration, rather than specific initiatives at the front line. In Scotland, these changes began in earnest in 2004 when GPs were told to evolve from earlier forms of cooperation into community health partnerships (CHPs), of which 36 existed by the start of this decade. These had a remit to take responsibility for all out-of-hospital care and the promotion of good health, as well as to improve workings with local government and the services it ran (including social care). More recently, legislation in 2014 created 31 integration authorities across Scotland, which replace and supplant CHPs. All but one are 'integration joint boards' working across health and social care.

These went live by April 2016, one year ahead of English Sustainability and Transformation Plans (STPs), and two years ahead of joint commissioning under regional partnership boards in Wales. They exercise responsibility across social care and the areas governed by CHPs, and are also responsible for the integration of emergency hospital care – including all hospital care in specialties with high emergency admissions, such as geriatrics. In total, they oversee spending in excess of £8 billion – the majority of all public care spending in Scotland – although most of this is not directly controlled.<sup>48</sup>

## Lessons from the process of integration

So what has been learnt from this extensive history? There is some evidence of knowledge from this history being picked up and used in Scotland. The “poisonous” collapse of Glasgow’s CHPs, as a senior civil servant put it, was widely reflected on by interviewees. Poorly laid out plans for devolution to five CHPs by the single NHS and single local authority resulted in a public falling out, with the NHS side believing the council to not be devolving powers as anticipated. The result was that the CHPs had to be dissolved and replaced by a single larger one that only covered health.<sup>49</sup>

This perhaps informed a point made by several interviewees about the importance of flexibility around what localities should be – that they might legitimately define themselves as being at very different scales and with overlapping elements. Glasgow’s experience with CHPs, and other less severe and public episodes of stalling or disagreement, also underlined the centrality of relationships. A further lesson drawn from CHPs was that “this takes longer than you think”, something that the Nuffield Trust and others have consistently warned about through various iterations of English integration initiatives.<sup>50,51</sup>

The extent to which councils were to be involved in CHPs was not specifically set out. It varied between different areas, sometimes with a gap between theory and practice – one interviewee closely involved with CHPs described local authority involvement as having been an “afterthought”. This, along with a perception that progress generally was “very uneven”, fed into the decision to create integration authorities.

The 2014 legislation<sup>52</sup> gives integration authorities a much firmer legal standing and a clearer role for local government than English STPs, which have a similar remit in bringing together the organisations responsible for health and social care. It sets out the mandatory and optional delegation of a wider and more specific range of powers than CHPs previously, or Welsh regional partnership boards.<sup>53</sup>

Interviewees in the Scottish Government and representative bodies described the role of legislation as that of a “catalyst”, important primarily for its initial effect and for areas lagging behind. The new boards “overcome inertia, but

they maybe don't give velocity," one told us. "Legislation was helpful in setting the agenda, but compliance is a distraction." Several interviewees suggested that the central role played by individuals and relationships was an argument in favour of legislation that set down clear, specific responsibilities. "Having it in law reduces the space to defect," one told us, referring to the danger of organisations pulling out and undermining joint agreements when they felt their interests were threatened. Another said that legislation enabled decisions to be "taken out of the month-to-month push and pull".

Scottish Government officials saw the legislation as offering local NHS leaders a deal of sorts, where they surrendered some power in return for a system that addressed some longstanding problems. However, they admitted that not every area had embraced this. Reliance on local human factors and vulnerability to defection is still very real, and some saw this as a fatal flaw requiring deeper institutional change. "We have a system of health boards and local authorities that isn't working very well, and adding an extra layer won't fix it," as one senior official put it. Locally, interviewees on integration joint boards (IJBs) tended to acknowledge the role of legislation, but point to an individual local leader as the deciding factor in making change actually happen. Underlining the reliance on organic rather than legal impetus, this leader was not always the same person – in some it was the NHS board chief executive, in others the IJB's chief officer.

Frictions were described as emerging primarily from hospital clinicians, NHS boards and local government. "The acute sector wants to hang on to what it has," one told us. In some areas, the legislative footing of the IJB fed "concern from council-elected members over losing democratic control".

## Points for England, Wales and Northern Ireland

There is an important lesson for England and Wales in the role played by legislation in Scotland as a carefully aimed catalyst for processes that achieve change, rather than something that could itself directly change services. We did not hear an assumption that the creation of integration authorities had been the delivery stage of a process – their establishment appeared to

shift local and national attention away from structure towards relationships, specific changes and performance.

Northern Ireland's long history of a joint legal structure for health and social care, which is generally not seen as having resulted in real frontline changes<sup>54</sup>, shows how important it is to regard organisational changes that legislation can quickly push through as a means rather than an end.

For all three other UK countries, there is something to be learnt from Scotland's thinking about how responsibilities and the scale that people work can be constructed with the impact on local relationships clearly in mind. What the Scottish experience does not offer is any way around the difficult problem of defection and the strength of individual institutional interests and responsibilities, or the difficulty in turning integrated structures into action.

From an English point of view, it is sobering that these tensions exist in a system that has a generally more cooperative culture and legal framework. We noted the absence of the additional requirements imposed by England's internal market. As the Nuffield Trust's Senior Associate Sharon Lamb has written: "The current [English] NHS structure was based on the ideology that competitive tension between autonomous bodies would lead to an efficient marketplace," yet the emphasis now is on collective action. The result is a reliance on complicated and sometimes legally risky manoeuvres to cooperate without breaking the rules mandating competition and accountability for individual organisations.<sup>55</sup> A sense from north of the border of how it is possible to work without this complexity should inform the undoubted risks of yet another NHS reorganisation against the effort and time needed to work around England's rules.

## Integration at the front line

What has the impact been at the front line? Audit Scotland issued a report at the end of 2015, five months before integration authorities took on their duties, warning that they "would not be in a position to make a major impact in 2016/17," with strategic work on staffing and financial requirements largely incomplete.<sup>56</sup> Another report in late 2016 found that, "although there is still limited evidence of transformational change, some progress is being made

in developing approaches that aim to enable more change to happen". They found widespread small-scale testing of new pilots, but not yet a significant reallocation of funding to integration authorities, and called for a more explicit national plan to drive this forward. The Health and Social Care Delivery Plan<sup>57</sup> sets some ambitious targets, to some extent meeting this challenge, but there remain real questions about the financial implications, discussed later.

To get a comparative sense of progress, we reviewed strategic documents from England and Wales. We looked at whether initiatives such as improved out-of-hospital rehabilitation, more clinical support for care home residents, improved end-of-life care, pathway redesign and support for self-care currently exist (as of early 2017). In England, most areas plan changes across the full spectrum of these and have several initiatives well underway, but will not have the majority up and running until well into 2017/18 or 2018/19. In Wales, initiatives on public health and social care are well underway with dashboards of outcomes used to set ambitious targets for better preventive care. However, most of the country's health boards have yet to start redesigning the delivery of specific conditions, better support for care homes seems limited to certain areas, and timescales are often not clearly set out for delivery.<sup>58</sup>

Overall, it seems that Scotland is at broadly the same stage of particular changes in particular areas having some measurable impact, but not yet adding up to a radical overall shift in the system. This does not mean, though, that there are not valuable lessons from achievements locally.

Audit Scotland, and several of our interviewees, pointed to promising work in Ayrshire, which has adopted a model where each of the three IJBs lead in particular fields. For example, North Ayrshire oversees change and innovation, and manages the necessary relationships in mental health across the county. It has reportedly reduced bed requirements on inpatient services.

There are some promising signs that Scotland's strengths in quality improvement have been transferred to the task of shifting care out of hospital. Both IJB members and central officials were keen to emphasise their receptiveness to ideas from the front line. "Our change agenda has been driven by peers, which helped a great deal," one told us. Initiatives to

bring GPs into hospitals to examine processes and suggest changes were mentioned several times, reflecting this bottom-up approach to motivation and knowledge.

The iHub is a Scotland-wide initiative supporting integration authorities to “enable people to receive the right support and care, in the right place, at the right time,” which draws on much of the language and methods of SPSP and its peers.<sup>59</sup> This includes skills capacity building, “learn and share events”, and support for using evidence and data to measure success. The “six essential actions” are a set of changes designed to help patients move swiftly through the emergency care system. Although hospital focused, they include steadier discharge from hospital and intervening to prevent people from having to be admitted in an emergency. Implementation includes ‘local champions’ and use of local data, in a model not dissimilar to SPSP.

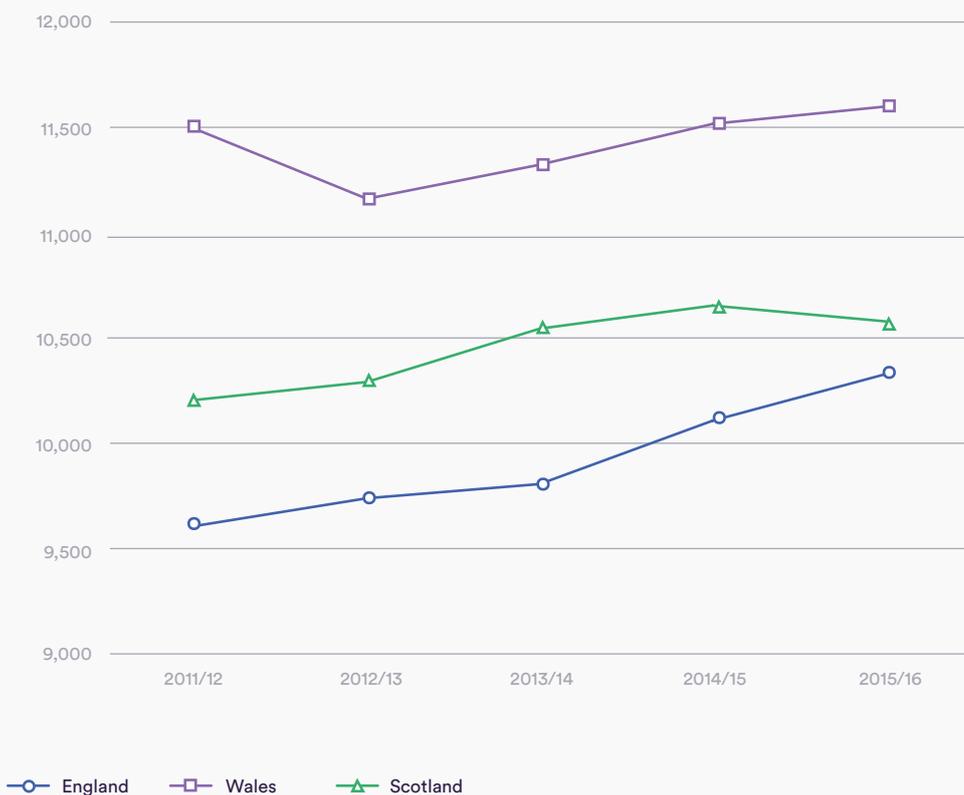
Engagement with the world beyond care services – areas like housing, welfare and child care – remains limited, but there are initiatives from which England in particular could learn. The Links worker initiative, discussed later, and the Early Years Collaborative already discussed are perhaps especially promising.

The question of whether the initiatives under way are the right ones, and how they could be reprioritised as data comes through, remains somewhat under-explored. The Nuffield Trust recently found that of 27 common initiatives for shifting care out of hospital, only seven had an evidence-based record of delivering savings.<sup>60</sup> The issue of the evidence base for the effectiveness or efficiency of changes involving moving care out of hospital tended not to be discussed by either Scottish Government officials or frontline leaders we spoke to. The Informing Investment to reduce health Inequalities (III) programme, run by the Scottish Public Health Observatory, tracks the impact of different schemes on health activity and outcomes. However, the programme’s head Gerry McCartney recently told the Scottish Parliament Health and Sport Committee that “it is not being used as much as we would like”, partly because it currently only covers a relatively limited range of interventions.<sup>61</sup>

Recent comparable data is not available for many of the indicators that would give us the truest picture. It is clear that Scotland has succeeded in controlling delayed discharges in recent years, even as the numbers have swung wildly in

the wrong direction in England. Wales uses an entirely different methodology to count delays – it saw an increase in delayed discharges up to 2015, but these have since levelled off. These differences may reflect higher social care spending in Wales and Scotland, and the roll out of the essential actions in Scotland. However, Scotland started from what appears to be a generally higher baseline of delays, with around a fifth as many delayed days as England, despite having only 15 per cent as many acute beds.<sup>62</sup> This may simply be an artefact of different approaches and definitions in recording delays, although since July 2016 Scotland has only recorded delays from hospital due to non-health care reasons – in theory a tighter definition.

**Figure 5: Emergency admissions per 100,000**



Source: Office for National Statistics<sup>63</sup>; Patient Episodes Database Wales<sup>64</sup>; NHS England<sup>65</sup>; Information Services Division (Scotland)<sup>66</sup>

Looking at emergency admissions per head of population, Scotland again appears to have succeeded in levelling off a rising trend more than England. Wales's reported rate fell sharply in one year before rising again, which may reflect data discontinuities. Further research would be justified in looking at why this is the case. Hypotheses might again include better social care funding, a longer history of joined-up working between GPs and other parts of the health service, and what appears to be a head start on NHS-backed initiatives at the front line dealing with health prevention and public health.

Recent comparative indicators published by data services across the UK show that Scotland has higher rates of admissions for most long-term conditions that could have been prevented as of 2013 or 2014, and is making little progress in closing the gap. It would be well worth continuing to update these figures to see whether the signs of potential success in Scotland on wider indicators translate to reductions in avoidable admissions in future.<sup>67</sup>

## Political barriers to further progress

Scotland shares with England and Wales political realities that can make integration difficult. Most of those we spoke to involved in integration believed there was a real reticence about being seen to embrace an agenda of doing less in hospital. Political constraints were seen to apply above all when difficult conversations were to be had about taking capacity out of hospitals.

As in England, Wales and Northern Ireland, targets for hospital care retain a powerful public and political role as the benchmark of health care success. Centralisation of services in Scotland has proved politically contentious, just as it has in various regions of England. A reorganisation of trauma care will see four major trauma centres across Scotland, rather than one or two as originally recommended by an independent report<sup>68</sup>, and has been delayed by several years.<sup>69</sup>

Several interviewees from across the spectrum of roles referred to a polarised political culture, with the SNP Government seeking majority support for independence and a largely hostile press looking to attack their record on the NHS. This could make contentious decisions on shifting resources away from

hospital care seem almost impossible. “We are always in a pre-election or pre-referendum phase and the Government don’t want to say difficult things,” a member of an IJB told us. One senior official within NHS Scotland said bluntly: “I don’t think there is currently any public and political appetite for things that sit in that area of long-term quality improvement.”

Some also believed that Scottish Government civil servants “are still working in silos – there is an acute silo, and then a larger NHS silo”. While the civil servants interviewed for this report seemed to show a genuine commitment to integration, it is equally fair to say that most still saw NHS boards as the service’s defining structure.

There are some encouraging signs. A set of indicators for integrated care has been drawn up, which includes survey-based data on how well people are being supported to live independently.<sup>70</sup> A review of targets and indicators led by Sir Harry Burns was set up last year to look at all targets and how well they serve as measures of actual success and value for money.<sup>71</sup> We heard from several interviewees a hope that this would make it easier to demonstrate to the public that the NHS was delivering without having to focus on hospital care. The SNP manifesto for 2016 emphasised doing more outside hospitals<sup>72</sup>, and Scottish Government politicians have started to respond to press queries about struggles to meet acute targets by using the narrative of doing more in the community.<sup>73</sup> However, leaders on the ground do not yet appear fully convinced. Scotland is not immune from a tendency seen across the UK – zeal for moving care out of hospitals tends to waver at the point of hard decisions about how much money and which services will leave which hospitals.

## 6 Workforce

### A problem shared

Many of the staffing issues facing health care in the UK cross national boundaries. Scotland, like England, Wales and Northern Ireland, has not seen enough GPs coming forward to fill training places and has experienced a rise in the vacancy rate for both general practice and nursing.<sup>74</sup> Meanwhile, as we have seen in England<sup>75</sup>, the shift in the patient population towards long-term illnesses requiring joined-up preventive care is creating a need for new roles beyond traditional job categories.

There are, however, significant differences. Scotland's overall nurse vacancy rate is considerably lower than it is across the other UK countries, at only around 4 per cent as opposed to 9 per cent.<sup>76,77,78</sup> This may reflect a recent history of more generous pay settlements north of the border, although the difference in hourly wages is only around 1.4 per cent<sup>79</sup> and for 2017 the Scottish Government has moved in line with England to raise wages by only 1 per cent.<sup>80</sup> Meanwhile, Scotland's vacancy rate for consultants seems to be higher, with the problem, as in England and Wales, particularly acute in certain specialties such as psychiatry and particular areas of pathology.<sup>81</sup>

Scotland, like other UK countries, has recently seen temporary staff costs rise, although they remain slightly lower at 2 per cent<sup>82</sup> of the total health budget, compared to 3 per cent in England (even after the introduction of price caps).<sup>83</sup>

### A more consensual model?

For around 20 years, the NHS in Scotland has pursued a consensual model of relations with staff described as “partnership working”. This “involves the Scottish Government, NHS employers, trade unions and professional organisations working closely together to ensure that the NHS Scotland workforce is actively involved in the decisions which affect them.”<sup>84</sup>

Our interviewees, and discussions at our event, generally supported the view that the Scottish NHS is characterised by higher levels of consultation and engagement with staff bodies compared to the NHS in England in particular. Union leaders especially made this point. “There is a degree of trust most of the time, across all the parties. Ministers come to us for advice – you would sit down and have a pint with the minister,” one said. This was reciprocated by some employers and board members we spoke to, with one IJB member mentioning “lots of good work from union reps”. At a higher policy level, one official did add that he felt staff had not been sufficiently consulted in the introduction of CHPs and integration authorities, and indeed we heard little from those involved to suggest they had been, despite the importance of frontline engagement. However, both union leaders and government officials viewed the ongoing negotiation of the GP contract as reflecting goodwill from both sides and an active effort to avoid conflict. This would not be typical in England, where industrial relations are often distant and rancorous.

This could be helpful in a health system that needs to change fast. Each of the union leaders we spoke to gave particular examples where staff had used the system to contribute ideas for change. They pointed to local agreements between employers and unions about the handling of staff involved in reconfigurations helping to create a sense that “if you come up with a bright idea, you won’t be turkeys voting for Christmas”.

Leaders in England, Wales and Northern Ireland should consider whether a less combative approach to industrial relations may be one factor in creating the trust that supports the use of intrinsic motivation for quality improvement. However, it has clearly not served as a full answer for problems in recruiting for key roles, either because it is not reflected in frontline morale or simply because these issues are driven by deeper fundamentals of supply and demand. Equally, it has not meant that hospital reconfiguration is any less of a contentious issue in wider politics in the NHS in Scotland.

We were also unable to answer the crucial question of whether improved relationships are a reality at the level directly between frontline staff and employers, as opposed to when mediated through unions. There was acknowledgement from national union leaders that their good relationships with the Government did not always filter down – a doctor pointed to the creation of the new Queen Elizabeth Hospital in Glasgow as an example of a

major change locally “done to us, rather than with us”. National staff surveys in Scotland and England largely use differently worded questions, which makes comparison difficult. However, some relevant questions do exist. The most recent surveys showed almost identical responses on whether there were enough staff to carry out roles properly, with a plurality of 45 per cent saying there were not; whether staff would recommend their organisation as a place to work, with around 60 per cent agreeing; and whether responsibilities were clear, with very high agreement. Notably, 47 per cent of staff in Scotland felt they were not always consulted about changes at work, while only 28 per cent felt that they were. The equivalent question for England is worded too differently for valid comparison.<sup>85,86</sup>

## Doing things differently

New ways to deploy staff are emerging across Scottish health and social care, as in the rest of the UK. There are potential lessons for other countries from these developments.

Scotland’s rural and remote areas – the Highlands, the Western Isles, Shetland and Orkney – are by far the most remote in the UK. As such, they face the challenges of recruitment and access to specialists also seen in places like Cumbria and parts of Wales to an extreme degree. For hospital doctors, operating in a small, remote hospital requires a much more generalist skillset, but this can conflict with a tendency towards greater specialism and a perception that this is what is needed to advance in a career. NHS Highland has begun a programme of rotating consultants through larger hospitals and smaller ones<sup>87</sup>, and specialists from Aberdeen visit the northern isles on rotation. Interviewees told us that they hoped this would have the benefits both of not forcing doctors to abandon the opportunity to develop specialist skills, and of exposing them to the potential appeal of a more generalist career.

There are also innovations in ways of coping with an inevitable lack of doctors in all the specialties that would be available in an urban area, as well as frequent problems recruiting GPs. The use of video links for outpatient work, and inpatient preparation and follow up, is advanced in many fields. In Shetland, as much work as possible is done over video link for orthopaedic

surgery, with a physiotherapist as well as the clinician present with the patient. Nurse-led chemotherapy and dialysis are carried out in both patients' homes and the Balfour Hospital on Orkney, with phone or video connections to consultants at the Royal Infirmary in Aberdeen, 150 miles away.<sup>88</sup>

Advanced nurse practitioners (ANPs) are used to provide primary care, taking responsibility for entire islands with visiting GP oversight. In the health centre in Lerwick on Shetland Mainland, ANPs triage patients and take on 60 per cent of appointments. They are able to prescribe, and GPs are brought in to oversee referrals to hospital. Board leaders told us that they sometimes had to have frank discussions with local communities about the choice between access to care and continuity of care. In one case, an island community had favoured having one GP who could not always be on the island over a permanent series of visiting GPs.

Innovative use of other professionals to deal with GP shortages extends across Scotland. Almost all health boards now allow patients to refer themselves to physiotherapists rather than GPs for certain musculoskeletal conditions, and this has been incorporated into the algorithms used by the NHS 24 helpline. A pilot study suggested this could deliver net cost savings, through reducing contacts with GPs and meaning that fewer people went to a doctor when they ended up not needing an operation.<sup>89</sup> Since 2015, Scotland has had a programme to invest in supporting clinical pharmacists in GP surgeries to help absorb workloads.<sup>90</sup> England has an initiative on a similar scale relative to national population<sup>91</sup> – Wales has also taken some steps to encourage this.<sup>92</sup>

New roles also form part of efforts to make care more preventive and address inequalities by addressing the social determinants of health. The Links worker programme introduces a member of staff in GP practices in deprived areas, responsible for connecting patients who face issues like loneliness, addiction and debt to support in their local areas.<sup>93</sup>

These initiatives are of interest both in themselves and also as example of how new ideas are picked up and rolled out in the Scottish system. Physiotherapy self-referral, Links workers and clinical pharmacists were adopted and spread through a more personal, less formal process than normally the case for centrally supported initiatives in England. Funding was allocated in a relatively informal fashion through discussions in the Scottish Government,

and roll out happened through conversations and negotiations directly with local health boards to pilot and roll out the new ways of working, and try to persuade them to take on responsibility for ongoing funding. The conversion of clinical and leadership opinion was an important factor. For physiotherapy self-referral, the Chartered Society of Physiotherapy played a promotional role. For Links workers, an organisation called GPs at the Deep End represented GPs in deprived areas and the Health And Social Care Alliance, which brings together charity, patient and carer groups, have jointly delivered roll out.<sup>94</sup>

There could be a risk with this kind of social spread by enthusiasts that it promotes schemes beyond what the evidence justifies, although formal evaluation following initial roll out is ongoing for Links workers<sup>95</sup> and was carried out for physiotherapy self-referral.<sup>96</sup> It is also worth noting that this way of working can mean that areas who do not want these initiatives can opt out. This echoes the concerns heard around spread of quality improvement. To the extent that these are relatively well-founded changes, this is undesirable. However, it also allows for continuing testing and innovation – for example, we heard that some areas rejected telephone triage to physiotherapy because they felt they could do the same locally in a more efficient manner. For physiotherapy self-referral roll out in particular, it is also worth noting that adoption in Scotland, with clear central backing, has actually been faster and much more complete than in England.<sup>97</sup> In the case of pharmacists in GP surgeries, there has been a specific commitment in numbers and timescales comparable to England and more ambitious than in Wales.<sup>98</sup>

# 7 Finance

## A serious predicament

Scotland's health boards are being required to make very high levels of savings. In 2016/17, Audit Scotland found that these amounted to around 5 per cent, or £492 million. The underlying driver is rapid rises in costs and the need for care, coupled with historically low funding increases as across the UK.<sup>99</sup> A review of territorial health board papers shows that boards anticipate needing to find an average of 4.3 per cent in savings for 2017/18, with some boards needing to make savings of up to 8 per cent.<sup>100</sup> Several papers comment on the raised or unprecedented level of risk – of the 12 boards publishing 2017/18 plans, nine either planned to run an unbalanced budget or had not identified a significant proportion of the savings required. One frontline leader told us “next year’s budget settlement is horrendous. I can’t see it balancing and we’re running out of one-off options.”

These rates of efficiency savings are somewhat higher than the 4 per cent that is implicit in NHS England’s target of saving £22 billion over five years, and was explicit for NHS trusts before that in the rate at which the tariff was raised before 2015. These targets have not been fully met, resulting in large unplanned overall deficits emerging in English trusts.<sup>101</sup> The Scottish figure is much higher than the savings that the Health Foundation identified as necessary in Wales.<sup>102</sup>

Nobody we spoke to believed that this was feasible in the medium term, at least not without unprecedented transformational change. Audit Scotland shows that several boards have broken even in the past – leaving aside those that did not – by relying heavily on non-recurrent savings, one-off measures that deliver efficiency savings for one year but do nothing to stop the gap from re-emerging the next. They suggested this reliance had become even more pronounced in 2016/17.<sup>103</sup>

Scotland, like all the other UK countries, has been missing its main waiting times targets for most of the last year.<sup>104,105</sup> These only measure access to certain types of care rather than quality in a wider sense, and there are good reasons to review them as already discussed – but the failure to meet them is symptomatic of a level of pressure that leaders are struggling to contain.

Scotland has yet to produce a multi-year national analysis that sets out how much funding will be available, how much needs to be saved and what services may be undeliverable as a result of this at a regional level. This is in contrast to England’s Five Year Forward View and delivery plan<sup>106</sup>, and the reports commissioned by the Welsh Government from the Nuffield Trust and Health Foundation.<sup>107</sup> The Bengoa report into Northern Ireland’s NHS recommended that it move to a multiple-year approach to allow more strategic planning.<sup>108</sup>

This carries a number of risks, especially given that fundamental change in the way services work will be absolutely necessary for the Scottish NHS to cope financially. At the front line, it leaves the single year as the only concrete unit of financial success. In England, STPs set out itemised savings against revenue and savings figures given to them from the centre, on a five-year timeframe. While Scottish boards are currently drawing up three-year financial plans, many of the board papers we examined noted specifically that details on likely financial increases were to be seen as “indicative”. Although these plans are only at a draft stage awaiting the review into targets, and will not be finalised until September, most so far hardly mention any provision past 2017/18 and, where savings are concerned, choose clearly to focus on the next year.<sup>109</sup>

Many of the frontline leaders we spoke to saw their financial horizon in terms of the next three to 18 months, even though they knew very well that transformational savings in health care take years. One senior Scottish official reflected that there was “too much focus on hitting the one-year audit, and not enough on long-term strategies”. Another said, “I know just how much effort goes into meeting the one-year financial target in each board, and that this is not helpful.”

Within the health service leadership, the lack of a longer-term plan allows the ambiguity discussed on the next page, which permits different people to proceed with fundamentally different views of where money will and should go.

Last, at a national level, it contributes to postponing a debate with the public and politicians on the blunt choice that ultimately faces Scotland and all its neighbours: whether the NHS is going to get more money than planned, or do less. Our interviewees, from union leaders to health board leaders to civil servants, were almost unanimous that this was needed. Many also felt, however, that the “toxic” political culture in Scotland made it especially difficult. Several noted that health and social care were subject to inevitably intense parliamentary and media scrutiny in the context of a devolved Government where more than 40 per cent of all department spending is on health care.<sup>110</sup>

We have been informed that the health and social care directorates are currently working on a national financial plan to go alongside their delivery plan, based on local delivery plans from individual boards. If this draws on more detailed local work it has the potential to answer this challenge, and it should not be passed up.

## Difficult decisions on funding care outside hospital

There is no sign yet in the finances of the Scottish NHS of any drive to shift care out of hospital.<sup>111,112</sup> While much of the marginal increase for 2017/18 will be ringfenced for social care, a significant proportion will be taken up by the rise in the national living wage, and this will need to be maintained for several years to mark a true shift in the budget.<sup>113</sup> Our review of draft local delivery plans being drawn up by territorial boards generally did not show multi-year plans to remove significant revenue funding from hospitals or to reduce the number of beds.

This is not an issue unique to Scotland. England has combined rhetoric about general practice taking on more work with the reality of funding cuts for several years, most recently guaranteeing to reverse this in the General Practice Forward View.<sup>114</sup>

Scotland's headline commitments to reduce bed days by 400,000 days next year, and to increase GP spending by £500 million and spend 50 per cent of funding in the community by 2020<sup>115</sup>, are similarly ambitious. But there is not a shared understanding of the extent to which this means funding and beds will have to be taken out of hospital, if at all. One Scottish Government official was clear that there would be "disinvestment, getting the cost out... we would get to the point of having fewer acute beds... taking out beds removes the temptation to fill them with someone else." Others had a more nuanced view that some areas would take out beds but not others. Meanwhile, a health board leader told us that, "I would expect us to reduce bed days, but not beds. So it wouldn't release a penny."

A member of an IJB reflected on the dynamic this created locally. "People will say, why are we saving all this money in the community when it never comes to us?" Reflecting this lack of clarity, local draft plans do not generally lay out any plans for moving funding in the next three years.

To some extent, this reflects a real uncertainty on the underlying evidence about how much money can be saved from shifting care outside hospitals. The Nuffield Trust has repeatedly argued that plans in England have been too optimistic about how difficult it is to reduce hospital care, and how difficult it then is to take out savings at anything approaching full cost.<sup>116,117</sup> These issues are now emerging publicly as STPs are published showing inconsistent and sometimes unrealistic savings and reductions in hospital beds.<sup>118</sup> There is a chance here for Scotland to learn from its neighbour and face up early to difficult decisions and inherently unknown risks.

## The dangers and opportunities

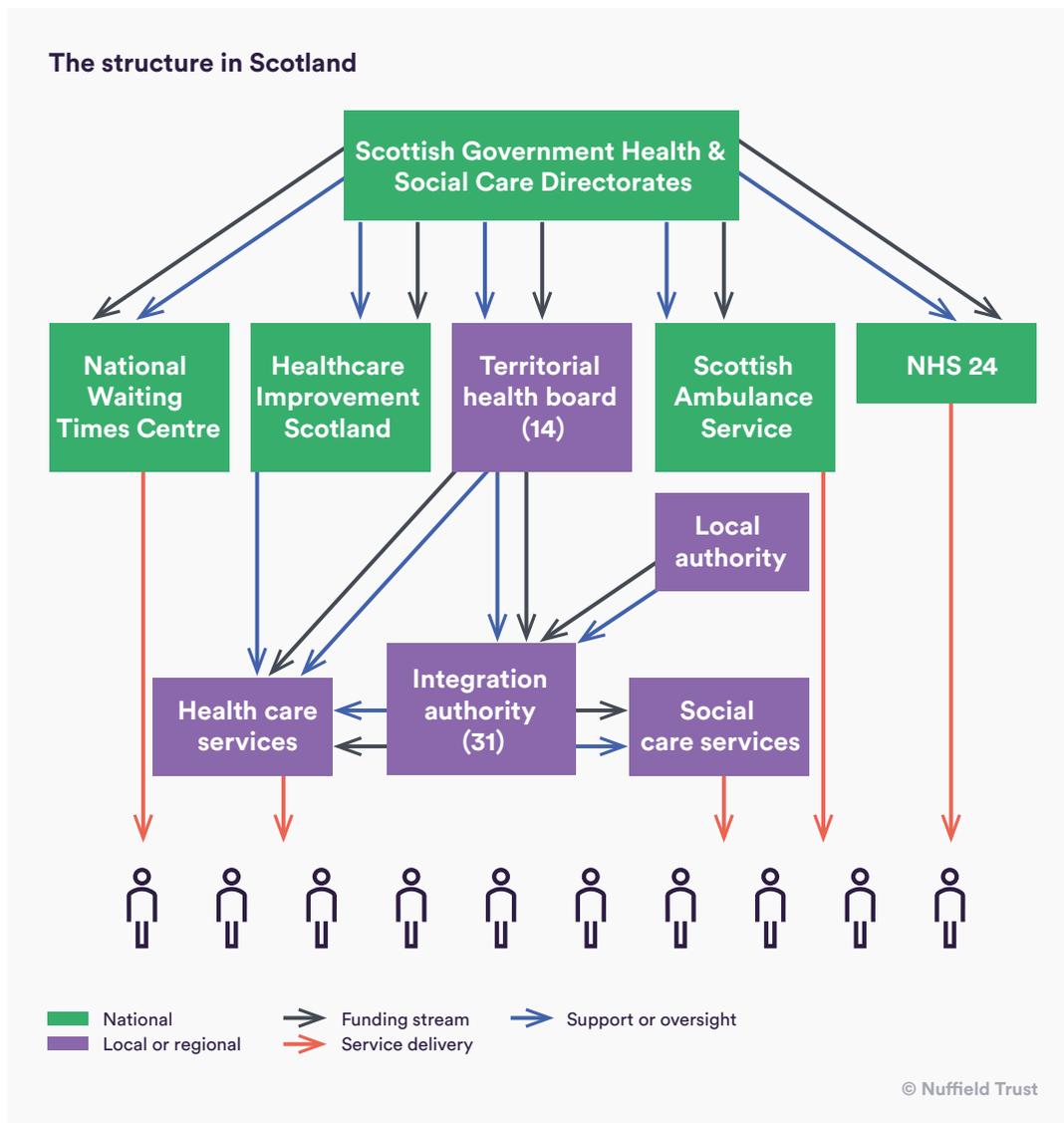
Reflecting across the situation in Scotland's NHS, our interviewees could see both positive and negative scenarios. There is one vision in which Scotland's strengths make it able to cope with its ominous financial situation. The deep commitment to quality will have real resilience under pressure – this remained a clear priority through our interviews and in the plans we looked at. A higher trust system with high regard for intrinsic motivation, with broad political consensus around the NHS, could find it easier to persuade hospitals and local authorities to relinquish control and funding in the interests of sustainability and more flexible services for patients. It may even find it easier to have the difficult conversation with the public needed across the UK about the trade-off between taxation and health care provision.

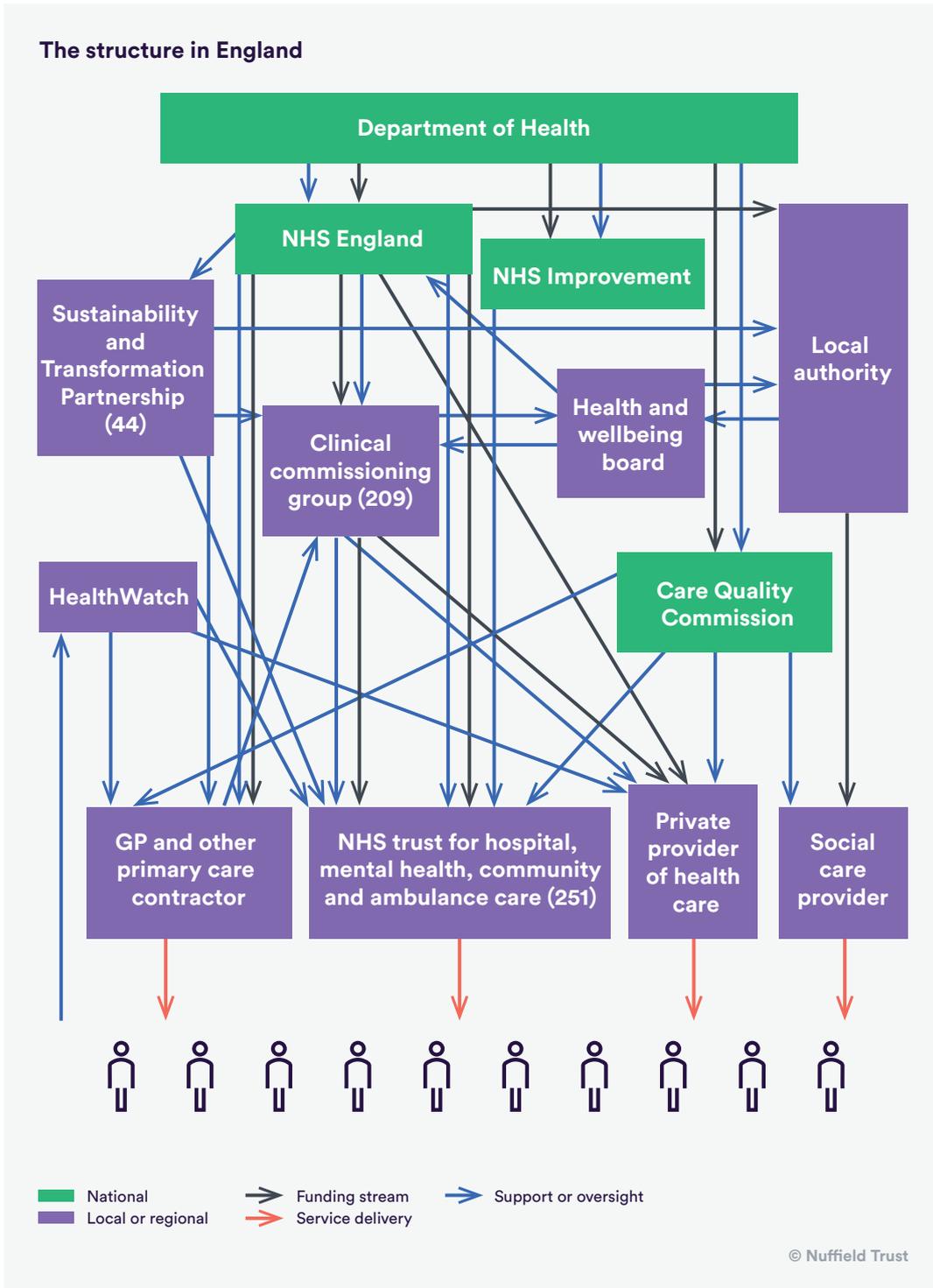
Conversely, we heard major concerns about the next few years. There is a risk of collusion between different understandings of what integration means financially. Interviewees were worried that politicians might “panic” and focus on meeting targets and keeping local acute services open at the expense of longer-term change. One senior official voiced his fear that “you can already see, in the early movement of financial pressure, quality starting to edge off” the agenda. Clinicians will find they leave quality improvement programmes to go “back on the treadmill... no time to take days off to improve things”. Managers will find that “it becomes very difficult to get onto longer-term issues when every single discussion is about money”.

In short, there is a risk that the financial situation will undermine the best aspects of the Scottish NHS before they can be brought to bear in addressing it.

## Appendix 1: The structure of the UK's National Health Services

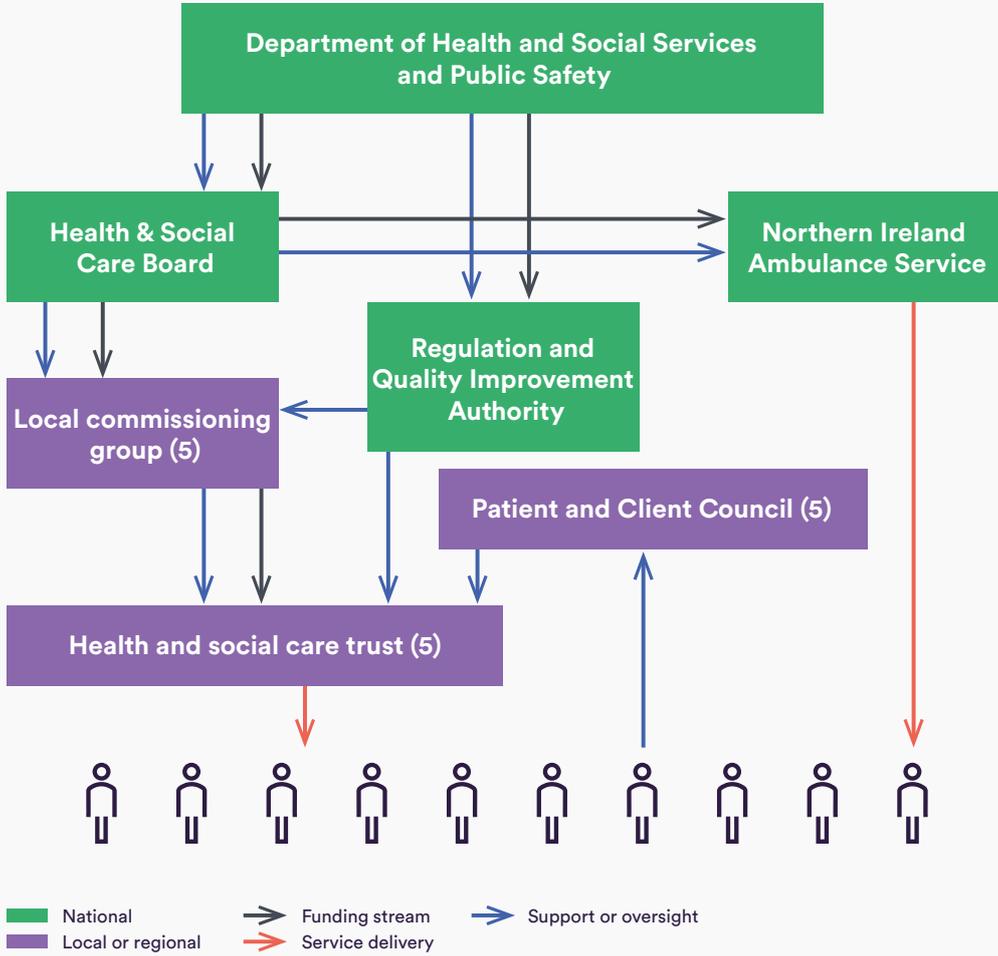
Note: these structures do not include bodies responsible for public health, clinical education and training, or blood services, all of which exist at a national level in each country; or professional regulators, which exist at a UK level. For England, new care models such as multispecialty community providers join up aspects of the care provided by GPs and trusts – these are not shown.



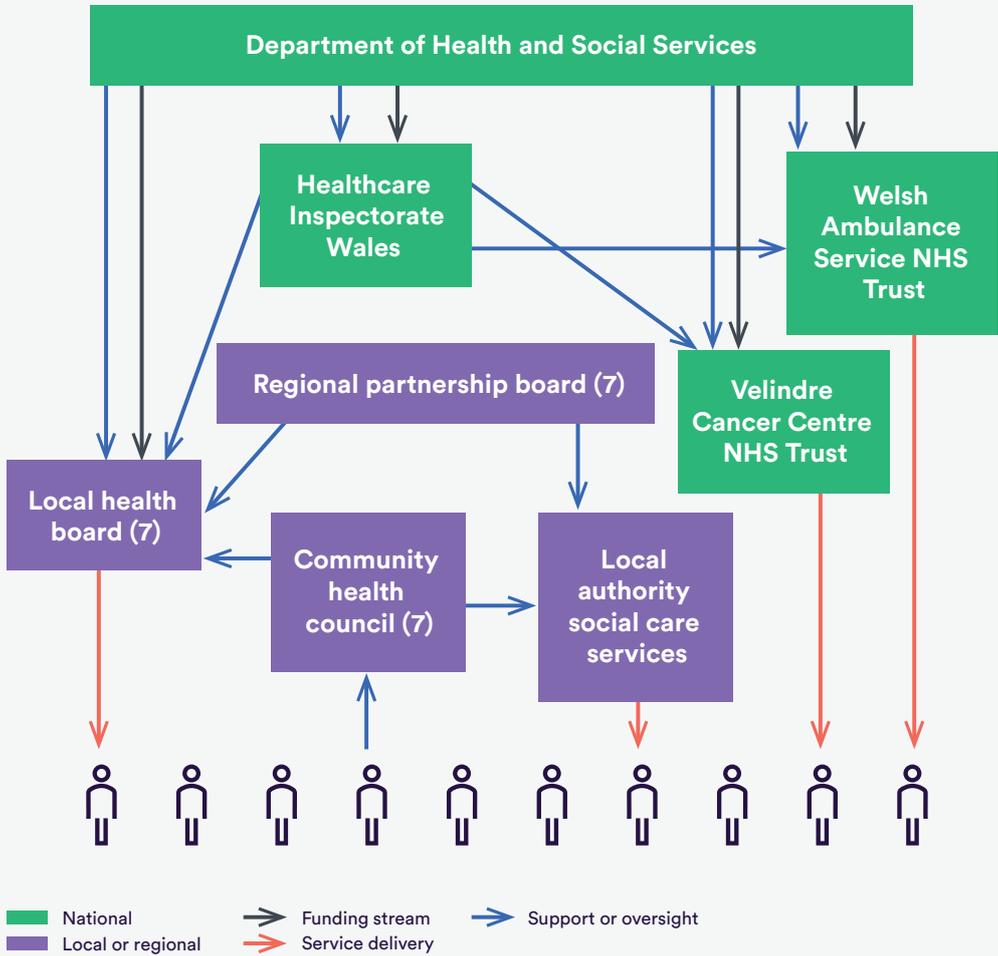


\*English Sustainability and Transformation Partnerships are not statutory bodies, but rather groups bringing together the different bodies shown to draw up joint plans. The extent to which they have an ongoing role overseeing local systems is still evolving, and varies between regions.

The structure in Northern Ireland

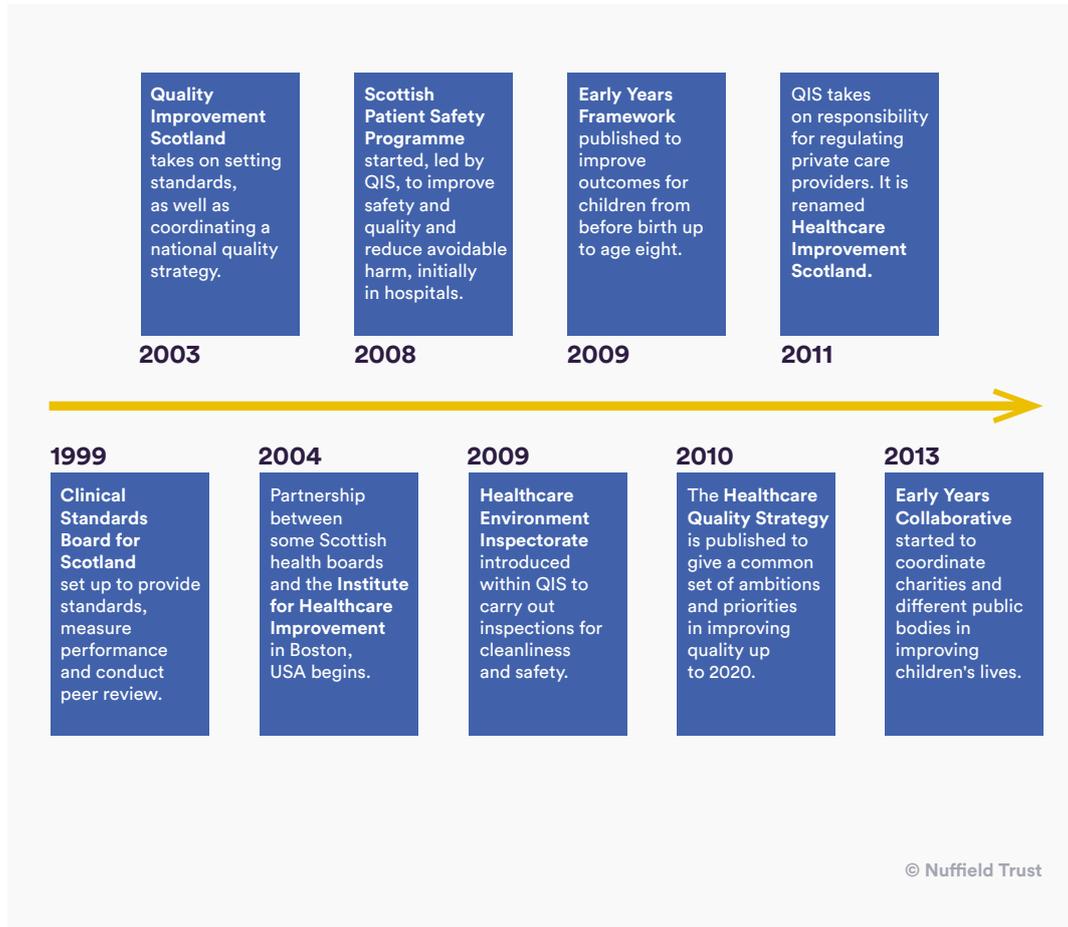


The structure in Wales



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## Appendix 2: Timeline of quality improvement policy in Scotland



## Appendix 3: Interviewees

Dr Peter Bennie, Chair of BMA Scottish Council

Sir Harry Burns, former Chief Medical Officer

Dr Catherine Calderwood, Chief Medical Officer

Professor Huw Davies, Professor of Health Care Policy and Management,  
University of St Andrew's

Tim Davison, Chief Executive, NHS Lothian

Neil Findlay, Member of the Scottish Parliament for Lothian

Angiolina Foster, Chief Executive, NHS 24; former Chief Executive,  
Healthcare Improvement Scotland

Caroline Gardner, Auditor-General, Audit Scotland

Paul Gray, Chief Executive, NHS Scotland

Geoff Huggins, Director for Health and Social Care Integration,  
The Scottish Government

Marie Law, Lochaber District Manager, NHS Highland

Professor Jason Leitch, National Clinical Director for Healthcare Quality  
and Strategy

Kenryck Lloyd-Jones, Policy Manager for Scotland, Chartered Society  
of Physiotherapy

Trisha McAuley, Co-Chair, Glasgow City Integrated Joint Board

Dr Aoife McDermott, Reader in Human Resource Management,  
Cardiff University

Professor Jim McGoldrick, Convener, Scottish Social Services Council

Professor Lorna McKee, Professor of Management, University of Aberdeen

Stephen McKenzie, NHS Ayrshire & Arran board; North Ayrshire Integration Joint Board

Christine McLaughlin, Director for Health Finance, The Scottish Government

Professor Alan Paterson, Professor of Law, University of Strathclyde

Ralph Roberts, Chief Executive, NHS Shetland

Caroline Sinclair, Chief Officer, Orkney Integration Joint Board

Dave Watson, Scottish Organiser, UNISON

Christina West, Chief Officer, Argyll & Bute Integration Joint Board

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ISBN: 978-1-910953-35-8

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