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The National Health Service in Scotland

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This briefing provides an introduction to the NHS in Scotland. It includes:

- A brief history of recent reforms
- The current organisation of the NHS in Scotland
- Governance and accountability arrangements
- Regulation, inspection, complaints and enforcement
- Funding

It also examines some key issues that may be topical during session 5 of the Scottish Parliament.

The Scottish Parliament
Pàrlamaid na h-Alba

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EXECUTIVE SUMMARY

The National Health Service (NHS) in Scotland was created in 1948 and provides comprehensive health services, predominantly free at the point of use and based on need. It is funded from general taxation.

Health was largely devolved to the Scottish Parliament in 1999 but a number of areas are still reserved to Westminster. This includes the regulation of medicines and the regulation of the health professions.

The NHS is the term used to cover a variety of services. These can be divided in to public health, primary care, secondary care and tertiary care. Local authorities have the statutory responsibility for social care (p5-8)

The NHS in Scotland has undergone significant changes over the last two decades. At the start of devolution these changes mainly included dismantling the internal market that was created during the 1990s. In subsequent years, less focus was placed on major organisational change and more so on quality, the patient experience and shifting the balance of care away from the acute sector. However, further organisational change has recently been brought about via the integration of health and social care (p8-9).

The responsibility for delivering health services is mainly devolved to the health boards. There are 14 territorial health boards which arrange services for their local population, and there are seven special health boards which provide a specific service for the whole of Scotland. National Services Scotland provides support functions to both territorial and special health boards (p10-15).

Since the 1st April 2016, territorial health boards and local authorities have been required to integrate certain health and social care services. This has resulted in the creation of 31 integration authorities, usually called Integrated Joint Boards (IJBs). It is hoped that greater integration will bring about improved quality and efficiency in services (p12-13).

Health boards are accountable to Scottish Ministers and ultimately to the Scottish Parliament. They are held to account through a number of measures such as Local Delivery Plan standards and annual accountability reviews (p15-17).

The NHS is not regulated by a single body and indeed the roles of regulation, inspection, complaints and enforcement are divided between several different bodies. Healthcare Improvement Scotland has a key role in ensuring good standards in the NHS, while complaints are dealt with by health boards in the first instance with possible referral to the Scottish Public Services Ombudsman. Only Ministers and the Courts have the power to enforce a particular action on health boards (p17-18).

The total budget for health and wellbeing in 2016/17 is £13.04 billion. This accounts for 35.1% of the total Scottish Government budget. Approximately three quarters of the health budget is allocated to health boards (approximately £9 billion per annum). Together with local authorities, health boards now have to delegate resources to the integration authorities to bring about the

integration of health and social care and improve outcomes. The combined budget of the new partnerships was believed to be in the region of £8bn in 2016/17 (p19-20).

Some of the key issues likely to be encountered in the coming session of Parliament include; debates about ensuring the future sustainability and funding of the service, health and social care integration, the implementation of the new National Clinical Strategy and the impact of leaving the European Union (p20-23).

INTRODUCTION

The National Health Service (NHS) was established in 1948 and provides the vast majority of health care in Scotland. The NHS in Scotland carries on the principle of collective responsibility by the state for the provision of comprehensive health services, predominantly free at the point of use. Services are funded from central taxation and access is based on need. The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978 (c.29).

Health policy was, in the main, devolved to the Scottish Parliament under the terms of the Scotland Act 1998. However, subsequent Scotland Acts saw further health powers devolved, including powers over abortion, as well as tangential health powers such as control over drink driving limits. However, there are some areas of health policy which remain reserved to Westminster, namely:

- Xenotransplantation (i.e. the use of non-human organs for transplantation)
- Embryology, surrogacy and genetics
- Medicines, medical supplies and poisons - although decisions on the funding of medicines are devolved
- The regulation of the health professions that were regulated prior to devolution (the regulation of newly regulated professions is devolved)
- Health and safety.

While the remainder of health is devolved to the Scottish Parliament, there are a number of areas where the Scottish Government chooses to work with some/all of the other UK health departments. This is usually where there is a recognised mutual interest and some examples include participation in the Joint Committee on Vaccinations and Immunisations (JCVI) and the National Screening Committee (NSC). Historically, there has also been coordination of the pay and conditions of health professionals but in recent years there has been greater divergence between Scotland and the rest of the UK, most notably in relation to GP contracts.

DEVOLVED HEALTH POLICY

The NHS is a term which encompasses a variety of different services. Such services can broadly be divided into:

- public health
- primary care
- secondary care, and
- tertiary care.

Local authorities are responsible for the delivery of social care.

Public Health

Public health is often defined as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society” (Acheson, 1988). It is the part of the NHS which is generally tasked with improving and protecting the health of populations as opposed to individuals. Public health measures include, but go beyond, the provision of traditional health services, and public health professionals work to affect all of the determinants of health. These determinants include individual behaviours such as smoking and diet, as well as life circumstances like housing, education and the environment. As a result, public health is

closely linked with other organisations responsible for these determinants, such as local authorities.

The national lead for improving public health lies with the Chief Medical Officer, a post which sits within the Scottish Government. In addition to this, NHS Health Scotland is a special health board with a remit to improve Scotland's health. Locally, however, each territorial health board has a Public Health Department and a Director of Public Health who holds a place on the board (see Current Organisation of the NHS in Scotland for more information on NHS Boards).

PRIMARY CARE SERVICES

Primary care refers to the services provided by health professionals in either clinics and practices, or sometimes in a patient's home. Primary care is normally the first point of contact with the NHS and primary care professionals are considered the 'gatekeepers' to secondary and tertiary services. The majority of patient contacts occur at this level.

Within primary care there are four practitioner services:

- Medical i.e. General Practitioners (GPs)
- Dental
- Pharmaceutical, and
- Optical.

These practitioners are usually independent of the NHS and are contracted by health boards to provide their particular service. Their contracts are usually negotiated on a national basis (either at a Scottish or UK level) but health boards still have some scope to negotiate local contracts or to employ practitioners directly as salaried NHS employees. Services offered in medical general practice are free of charge but some services provided by other primary care practitioners are chargeable (e.g. dentists and opticians) although eye and dental check-ups were made free in 2006 and prescription charges were abolished in 2011.

Medical General Practice

GPs normally work together as partners in a local practice. Practices are responsible for employing their own administrative and practice nursing staff but the team also includes NHS employed community nursing staff such as health visitors. However, the Scottish Government is currently in negotiations with GPs about renewing their contract and there has been some suggestion that the role of the GP as an employer of practice staff may end (Price, 2015). The new GP contract is expected to be introduced in April 2017.

At the moment, most GPs are contracted under the General Medical Service (GMS) contract which remunerates a practice using a global sum (generally based on list size[1]) and in accordance with what other services the practice delivers. All practices must provide essential services and can choose to provide additional services such as vaccinations and immunisations. Additional services carry further remuneration.

Figures for 2012/13 show an estimated 24.2 million patient contacts with GPs and practice nurses. The majority of these were with GPs (16.2 million) but an increasing number and proportion of patients are being seen by practice nurses (8 million) (ISD Scotland, 2016a).

[1] Number of patients registered with a practice

Dental Services

The NHS General Dental Service (GDS) is usually the first point of contact for people requiring dental treatment. The majority of dental treatment is provided by ‘high street dentists’ who are independently contracted by health boards. However there is a more mixed economy within dental services in the sense that there are also significant numbers of private dentists and dentists directly employed by health boards. 91% of the Scottish population is registered with an NHS dentist (ISD Scotland, 2016b).

Pharmacy

The main role of community pharmacists contracted by health boards is the dispensing of NHS medication. However, the range of NHS services provided by community pharmacists has grown over the years and their role now also includes the provision of the minor ailments service, the chronic medication service, the acute medication service and public health services such as smoking cessation and the provision of emergency contraception. Health boards can also contract directly with pharmacies to provide other services to meet local needs, for example, the provision of needle exchanges and substitute prescribing for drug dependence.

In order to provide services on behalf of the NHS, a pharmacy must first be entered on to the pharmaceutical list of the NHS Board. Entry on to the list is therefore controlled by the NHS Board in accordance with regulations[2].

Optical

There are a range of eye care professionals working in General Ophthalmic Services (GOS). These include optometrists and dispensing opticians. Ophthalmic practitioners use a variety of tests and procedures to examine the eye and may prescribe glasses/contact lenses or they may refer the patient for more specialised medical procedures at a GP practice or hospital. In order to provide services on behalf of the NHS, a practice must join the General Ophthalmic Services list of the local NHS Board. Everyone is now entitled to free eye checks in Scotland and 1.65 million free eye examinations were carried out in 2014/15 (ISD Scotland, 2016c).

SECONDARY CARE

Secondary care is mainly hospital-based health care provision and is also often referred to as ‘acute care’. Services range from emergency care (via Accident & Emergency) to non-emergency treatment, usually through outpatient departments or elective treatment. In recent years there has been a move towards providing more care and treatment in outpatient departments, or on a day case basis, as well as trying to prevent unscheduled inpatient admissions. An increasing amount of secondary care is being provided by nurses and allied health professionals (e.g. dieticians and physiotherapists). Annually, there are approximately 1.5m hospital stays each year in Scotland and over 4.4m outpatients are seen at consultant clinics (ISD Scotland, 2016d and 2016e). Unlike primary care, staff within secondary care are usually directly employed by the NHS, including hospital consultants.

TERTIARY CARE

Tertiary care refers mainly to the provision of specialist services for people with an existing disease which requires higher levels of expertise and support services. An example of this would be cancer services such as those provided at the Beatson Oncology Centre in Glasgow.

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[2] NHS Pharmaceutical Services (Scotland) Regulations 2009

Tertiary care services are usually provided in a limited number of locations around the country and some services are so specialised that they may only be provided on a national basis e.g. liver transplantation. There are also some services which are commissioned from the other parts of the UK on behalf of all health boards, for example, paediatric heart transplants (National Services Division, 2016)

Scotland has also developed Managed Clinical Networks (MCNs) as a means of providing tertiary care (together with elements of primary and secondary care). MCNs are groups of health professionals and organisations such as local health services, social service departments and support groups, working together to provide treatment and care to patients. MCNs co-ordinate their work with health professionals and organisations across NHS Board boundaries and examples include the cancer networks and the national Scottish muscle network for people with neuromuscular disorders.

KEY SCOTTISH NHS REFORMS

There have been many changes to the NHS in Scotland over the last two decades and the following section aims to provide a brief history since 1997.

1997-1999 – THE UK LABOUR GOVERNMENT

In 1997, the incoming UK Labour government inherited an NHS which had undergone radical changes under the Conservative Government in the preceding years. These changes were geared towards introducing elements of market economics to the NHS in a bid to improve cost-effectiveness and efficiency. Such elements included the creation of NHS Trusts and a purchaser/provider split, whereby fundholding GPs purchased care on behalf of their patients from providers such as Acute Hospital NHS Trusts. This system was opposed by Labour and the party's 1997 manifesto contained a pledge to abolish what was then known as the 'internal market'. In line with this manifesto commitment, the new UK Labour Government signalled the end of the internal market by abolishing GP fundholding and contracting for services, removing the autonomy of NHS Trusts and replacing competition with a culture of partnership.

1999- 2007 – THE SCOTTISH LABOUR/LIBERAL DEMOCRAT GOVERNMENT

In the first and second sessions of the Scottish Parliament, the Labour/Liberal Democrat coalition continued the policy drive of dismantling the internal market, culminating in 2004 in the abolition of NHS Trusts entirely. This was seen as the final stage in dismantling the internal market. The functions of the NHS Trusts were incorporated into Operating Divisions of health boards however, unlike Trusts, Operating Divisions had no independent legal status so this left a single tier of governance and accountability in the shape of the 14 territorial health boards (see Territorial Health Boards below).

Around this time, there was increasing public concern over service reconfigurations and the centralisation of services. The then Health Minister, Malcolm Chisholm MSP, convened an expert group tasked with looking at how NHS services could be developed in the longer term. In May 2005, the Kerr Report was published and set out its vision for the NHS as:

> "[The NHS] should deliver safe, high quality services that are as local as possible and as specialised as necessary" (the National Advisory Group on Service Change, 2005, p 64).

One of the key themes to emerge from the Kerr report was support for the concept of 'shifting the balance of care' away from acute services and closer to the community.

2007-2016 – THE SNP GOVERNMENT

When the SNP Government came to power in 2007, there was no manifesto pledge for a radical reorganisation of the NHS. Instead the structure established by the previous administration was maintained and built upon with promises of shorter waiting times and more accessible and accountable health services. The manifesto included a commitment to operate a 'presumption against the centralisation of core hospital services' (SNP, 2007). This was evident in the decision to reverse the closure of Accident & Emergency departments at Monklands and Ayr hospitals.

The publication of Better Health, Better Care set out the SNP Government's vision of creating a 'mutual NHS', where patients are treated as co-owners of the NHS (Scottish Government, 2007). This resulted in a number of initiatives to shift ownership and accountability, including the piloting of elections to health boards[3] and the Patient Rights (Scotland) Act 2011 with its key policy of a statutory treatment time guarantee. The policy drive to shift the balance of care from secondary care to the community was also retained by the SNP administration. Other key policy developments taken forward by the SNP Government included:

- The abolition of prescription charges
- The publication of the NHS Quality Strategy (Scottish Government, 2010)
- The publication of the 2020 vision which aims to enable everyone to live longer, healthier lives at home or in a homely setting (Scottish Government, 2012)
- A commitment to protect the health budget.

2016 ONWARDS

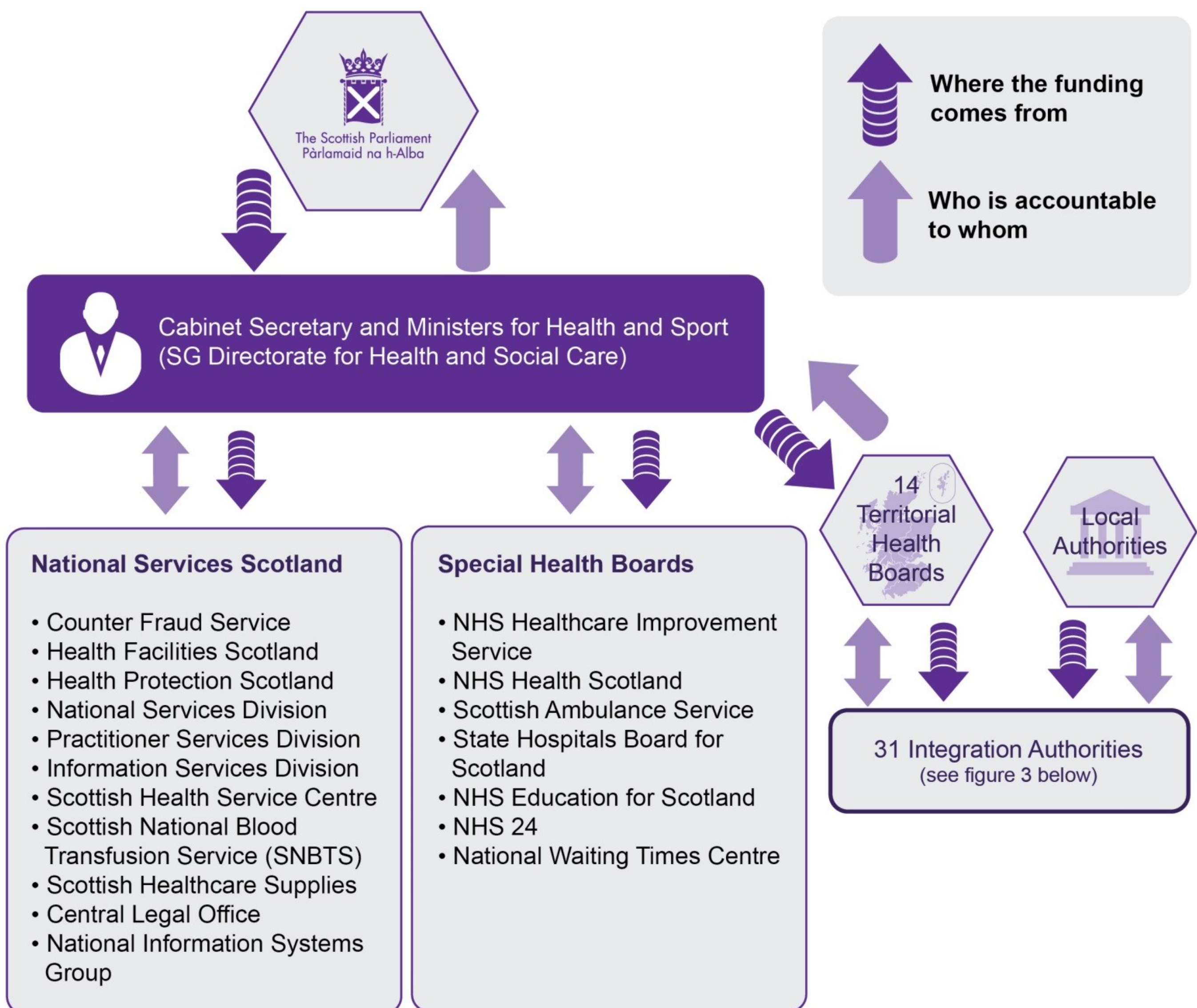
Significant changes which came about towards the end of the last session included legislating for the integration of health and social care and the publication of the National Clinical Strategy (Scottish Government, 2016a). Both of these are likely to dominate the future direction of the NHS in the coming years and are therefore explored in more detail in the Key Issues for the Coming Session section of this briefing. The 2016 SNP manifesto also signalled some other key changes which are likely to occur in the coming session (SNP, 2016). These included:

- A ten year plan to transform mental health.
- Reviewing the number, structure and regulation of health boards and their relationships with local councils
- Developing how budgets are allocated, focussing on areas of clinical activity as well as geography and continuing to shift the balance of care by increasing, in every year of the next parliament, the share of the NHS budget dedicated to mental health and to primary, community, and social care.
- An outcomes-based approach to targets to give patients the best possible care according to their needs.

[3] Piloted in Fife and Dumfries & Galloway following the passing of the Health Boards (Membership and Elections)(Scotland) Act 2009. The pilots were subsequently evaluated and, based on the findings, the act was repealed.

CURRENT ORGANISATION OF THE NHS IN SCOTLAND

Figure 1: Current Organisation of the NHS in Scotland



SCOTTISH GOVERNMENT DIRECTORATE FOR HEALTH AND SOCIAL CARE

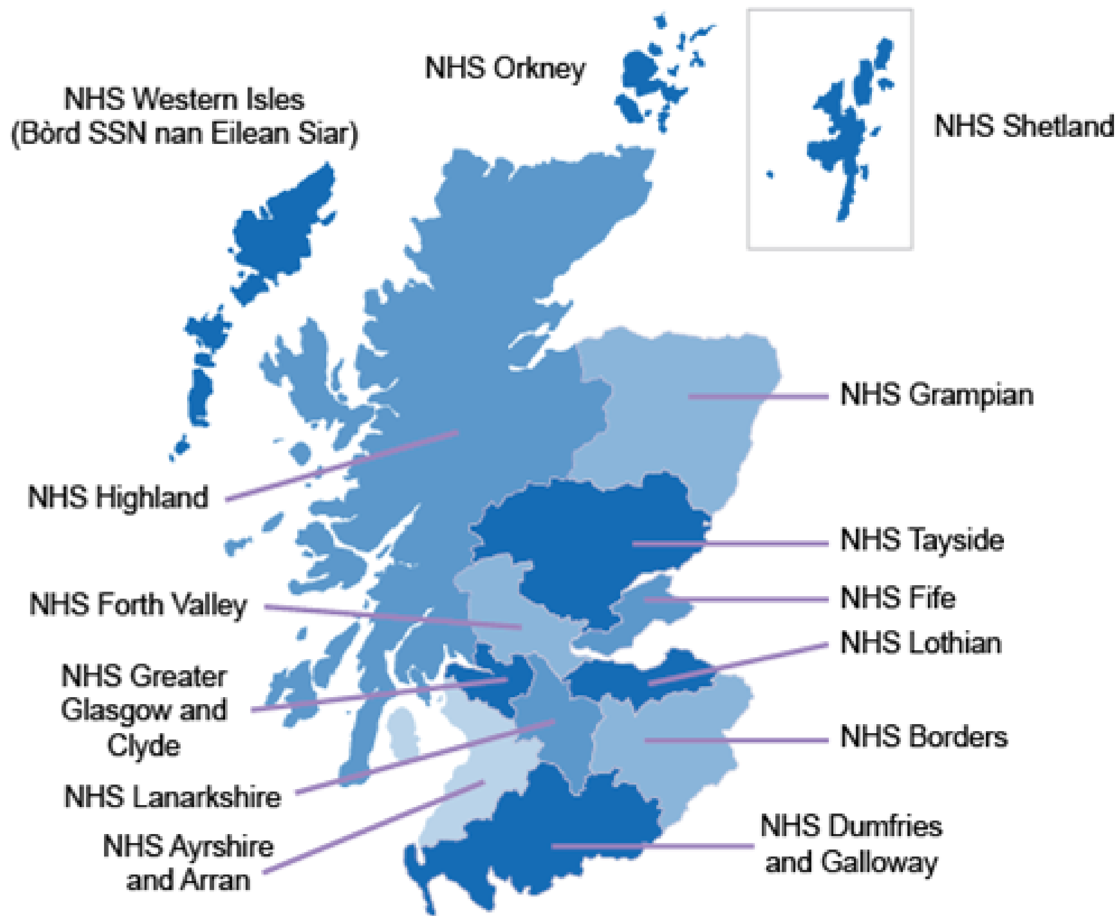
In Scotland, the Scottish Government Directorate for Health and Social Care has responsibility for health policy, the administration of the NHS, social care and public health. The Directorate is headed by the Director General for Health who is the Chief Executive Officer of the NHS. At the time of writing this position was filled by Paul Gray.

The department is subdivided into Directorates alongside which, there is the Chief Medical Officer (CMO) who is the principal medical adviser to the Scottish Government and is also closely involved with the Chief Scientist Office (CSO). The CSO oversees the management and funding of research within the NHS in Scotland.

TERRITORIAL HEALTH BOARDS

The responsibility for running the National Health Service in Scotland is predominantly devolved from the Scottish Government to the 14 territorial health boards.

Figure 2: Territorial Health Boards, Scotland



The functions of the Boards can broadly be divided into:

- Strategy development
- Resource allocation
- Strategy implementation
- Performance management.

The territorial health boards are therefore essentially responsible for the provision of health services for their area as well as, more generally, for the public health of their population (i.e. any measure designed to improve health and/or prevent illness). Collectively, the 14 boards are responsible for approximately £9bn of the total £13bn health, wellbeing and sport budget for 2016/17.
Each Board is made up of:

- **Non-Executive Lay Members** – appointed by Ministers after open competition

- **Non-Executive Stakeholder Members** – appointed and paid in the same way as lay members but are representatives of specific interests that must be represented on the Board (e.g. chair of the area clinical forum)
- **Executive Members** – hold a place by virtue of their employed position within the Board (e.g. Chief Executive or Medical Director).

Since April 2016, health boards and local authorities have been required to integrate certain health and social care services by delegating functions, either to each other, or to an 'Integrated Joint Board' (see below).

INTEGRATION AUTHORITIES

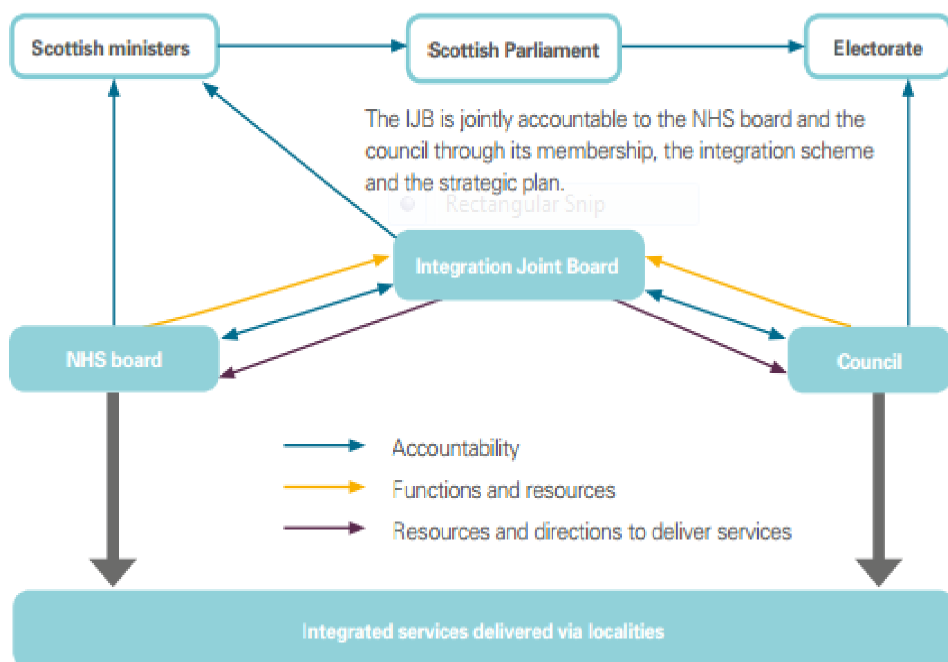
The Public Bodies (Joint Working)(Scotland) Act 2014 requires the 14 territorial health boards and 32 local authorities to jointly submit an integration plan for each local authority area in order to integrate health and social care services. This has resulted in the creation of 31 integration authorities. All but one area (Highland[4]) has chosen the 'body corporate' model, whereby the NHS Board and local authority delegate functions (and the associated funding) to an Integrated Joint Board (IJB). The IJB is subsequently accountable to both parent bodies (see figure 3 below for the different integration models).

Local authorities and health boards are required to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some adult hospital services. Hospital services covered by integration include inpatient medical specialties with high rates of emergency admissions, for example, general medicine and palliative care. Each IJB area has to identify localities within its area to provide an organisational mechanism for local leadership of service planning. Integration authorities can also choose to integrate other services, such as children's services. The services that are integrated in an area will be set out in the integration plan.

For more information on integration, please see SPICe Briefing SB16-70 (Burgess, 2016)

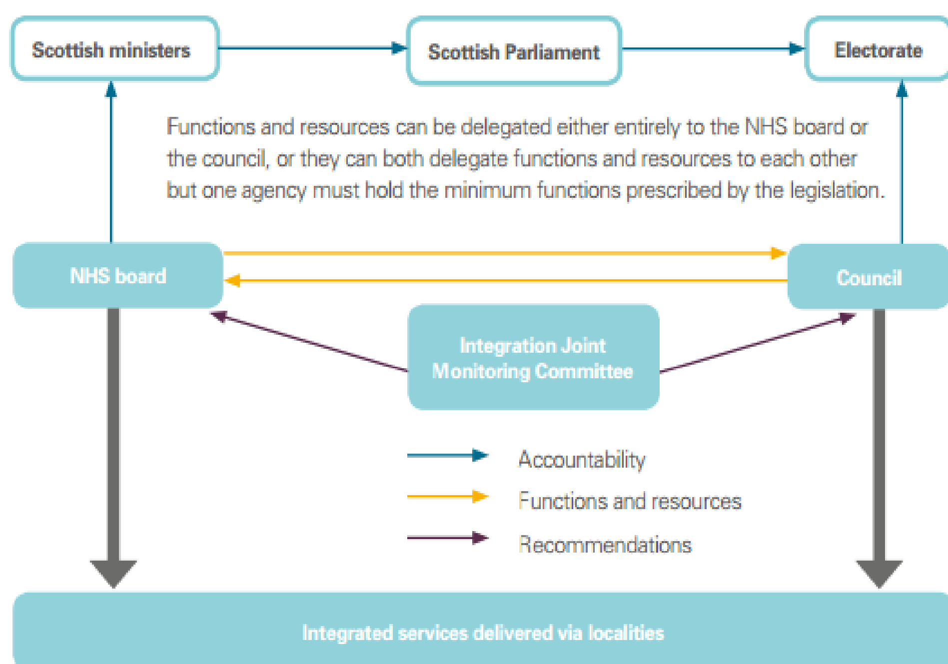
[4] Highland has chosen the lead agency' model, whereby NHS Highland is the lead for adult health and care services and Highland Council the lead for children's community health and social care services. There is no Integrated Joint Board.

Figure 3: Models of Integration in Scotland



Body corporate

- NHS boards and councils delegate health and social care functions to an Integration Joint Board (IJB)
- The Act allows for partners to work jointly, for example, for two councils to work with their local NHS board to create a single IJB



Lead agency

- NHS boards and councils delegate some of their functions to each other
- Carrying out of functions is overseen and scrutinised by an Integration Joint Monitoring Committee

Source: Audit Scotland (2015) licensed under the Open Government Licence.

SPECIAL HEALTH BOARDS

In addition to the territorial boards, there are also seven special health boards. The distinction between special health boards and territorial boards is that the special boards perform a specific function for the whole of Scotland, not just a local population. Table 1 briefly outlines each of the special boards and their functions.

Table 1: Special Health Boards and their functions

Name	Function	Funding
NHS Health Scotland	NHS Health Scotland is the agency responsible for improving population health. It is responsible for all aspects of health improvement including understanding the determinants of health, gathering evidence on how to improve poor health, disseminating evidence and evaluating activities aimed at improving health.	Funding for NHS Health Scotland in 2016/17 is **£18.2m**.
NHS Healthcare Improvement Scotland (NHS HIS)	NHS HIS was previously known as NHS Quality Improvement Scotland and it is the body tasked with improving the quality of care in the NHS. Its functions include providing advice and guidance on effective clinical practice, setting standards for care and reviewing and monitoring performance. It also acts as an umbrella organisation for a number of other key bodies such as the Scottish Medicines Consortium (which provides advice on the funding of newly licensed medicines), The Scottish Intercollegiate Guidelines Network (which produces clinical guidelines) and the Scottish Health Council (which oversees public consultation in the NHS).	Funding for NHS HIS in 2016/17 is **£15.5m**.
NHS Education for Scotland (NES)	NES is responsible for designing, commissioning and quality assuring education, training and lifelong learning for the NHS workforce.	Funding for NES in 2016/17 is **£408.7m**.
Scottish Ambulance Service (SAS)	SAS provides ambulance services for accidents, emergencies and non-emergencies.	Funding for the SAS in 2016/17 is **£223.5m**.
State Hospitals Board for Scotland	The State Hospital provides high security forensic and psychiatric care at Carstairs in Lanarkshire.	Funding for the State Hospital in 2016/17 is **£34.3m**.
NHS 24	NHS 24 is an online and telephone based information and advice service.	Funding for NHS 24 in 2016/17 is **£64.6m**.
National Waiting Times Centre	The National Waiting Times Centre is based at the Golden Jubilee Hospital in Clydebank. It receives referrals from across Scotland in order to reduce waiting times in key elective specialities such as orthopaedics.	Funding for the national waiting times centre in 2016/17 is **£46.5m**

NATIONAL SERVICES SCOTLAND

While often thought to be a special health board, National Services Scotland (NSS) was separately constituted in the National Health Service (Scotland) Act 1978 and so has a separate legal status. Under the 1978 Act its official name is the Common Services Agency.

NSS provides a range of support services to health boards. These include Scottish Healthcare Supplies, the Scottish Blood Transfusion Service, the Central Legal Office and procurement services. Funding for NSS in 2016/17 was £293.4m.

GOVERNANCE AND ACCOUNTABILITY

Health boards are accountable to Scottish Government Ministers, who are in turn accountable to the Scottish Parliament. There are various means in which the Scottish Government ensures good governance and performance within the NHS, these include:

- Local Delivery Plan Standards (formerly HEAT targets)
- National health and wellbeing outcomes
- National guidelines and standards
- Annual accountability reviews.

LOCAL DELIVERY PLAN STANDARDS

Local Delivery Plan (LDP) Standards are one of the key mechanisms for performance managing health boards. Most of the standards are former 'HEAT' targets, with HEAT being an acronym relating to four key objectives:

- **H**ealth Improvement for the people of Scotland – improving life expectancy and healthy life expectancy
- **E**fficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS
- **A**ccess to Services – recognising patients' need for quicker and easier use of NHS services
- **T**reatment Appropriate to Individuals – ensure patients receive high quality services that meet their needs.

LDP standards are measured nationally and reviewed on an on-going basis by the Scottish Government as well as in the annual performance reviews of boards by the Cabinet Secretary. Progress against each of the standards is published on the Scotland Performs website.

Each health board produces a Local Delivery Plan (LDP) which contains a 'planned performance trajectory' showing how they will achieve the standards. The Scottish Government agrees the plan with boards and this then forms a 'performance contract' between the two (Scottish Government, 2016b).

Professor Sir Harry Burns is currently leading a review on the use of targets in the NHS and is expected to publish an initial report and recommendations by spring 2017.

NATIONAL HEALTH AND WELLBEING OUTCOMES

Integration authorities are expected to be involved in the development of the territorial Boards' LDPs but they are also accountable to health boards and local authorities for delivering the national health and wellbeing outcomes[5]. The outcomes are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People who use health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

There are 23 core integration indicators to support these outcomes (Scottish Government, 2015) and integration authorities will be required to report annually on how their activities have contributed towards the nine outcomes.

NATIONAL GUIDELINES AND STANDARDS

While, the management of the NHS is generally devolved to the health boards (with some functions subsequently delegated to integration authorities), they do not operate independently of the Scottish Government. As well as meeting LDP standards, they are often expected to abide by national service standards or guidelines. Within Scotland, standards and guidance to Boards come from both the Scottish Government and some of its arms-length bodies. Sources of guidance include:

- Scottish Government – for example, Chief Executive Letters (published on the Scotland's Health on the Web)
- NHS HIS – produces standards for care and also incorporates organisations such as the Scottish Intercollegiate Guidelines Network (which produces guidelines on clinical practice) and the Scottish Medicines Consortium (advises Boards on the clinical and cost-effectiveness of newly licensed medicines)
- Health Protection Scotland – issues guidance on the management of infectious and environmental hazards.

[5] The Public Bodies (Joint Working)(National Health and Wellbeing Outcomes (Scotland) Regulations 2014

ANNUAL ACCOUNTABILITY REVIEWS

Each year, the Cabinet Secretary for Health and Wellbeing (or one of their Ministers) will undertake an accountability review with each of the health boards. Reviews are now open to members of the public who can submit questions to be answered by either the Cabinet Secretary/Minister or the Chair of the Board. During the review, the Cabinet Secretary may meet with other stakeholders (e.g. patient and staff representatives) and will also review performance against the Board's LDP and the LDP Standards.

REGULATION, INSPECTION, COMPLAINTS & ENFORCEMENT

The NHS is not overseen by a single regulatory body in the same way that care services are (i.e. by the Care Inspectorate). Instead the roles of regulation, inspection, complaints and enforcement are divided between different bodies (detailed below). Health care professionals are regulated by professional regulatory bodies such as the General Medical Council (doctors) and the Nursing and Midwifery Council and complaints about professional conduct should be directed to the relevant body.

REGULATION AND INSPECTION

Healthcare Improvement Scotland

NHS Healthcare Improvement Scotland (HIS) has a key role in setting standards for care and treatment and then inspecting Boards' performance against them. However, health boards still have a large degree of autonomy and HIS has few legal powers to enforce sanctions against Boards who do not meet the standards (see 'Enforcement' below). One exception to this is that HIS is now responsible for the regulation of independent healthcare, a role which previously belonged to the Care Inspectorate. In line with the powers the Care Inspectorate had, HIS will register and inspect services against the national care standards. It can also take enforcement action against an independent healthcare provider and has the power to cancel a service provider's registration.

HIS does not have the same powers for NHS services and instead it describes itself as an improvement body for the NHS as opposed to a regulator. However, recently HIS was given the power to close hospital wards to new admissions where there is a serious risk to the life, health or wellbeing of persons[6].

HIS also incorporates the Healthcare Environment Inspectorate (HEI) which is responsible for inspecting hospital compliance with Healthcare Associated Infection standards. HEI undertakes one announced, and one unannounced inspection of each Scottish hospital every 3 years.

Mental Welfare Commission

The Mental Welfare Commission (MWC) performs a scrutiny function for mental health services. The Mental Health (Care and Treatment)(Scotland) Act 2003 gave the MWC a duty to monitor the operation of the 2003 Act and to promote best practice. It also has a role in monitoring the operation of the Adults with Incapacity (Scotland) Act 2000. It carries out its duties by monitoring the implementation of the legislation, visiting those receiving care and treatment, publishing good practice guidance and investigating potential service failures. Like HIS, the MWC does not have statutory enforcement powers. However, it holds annual meetings with health boards and

[6] The Healthcare Improvement Scotland (Delegation of Functions) Order 2016 (SSI 2016/86)

local authorities and it operates an escalation policy whereby matters of concern can be escalated either informally locally, or more formally with the Scottish Government.

Audit Scotland

Audit Scotland scrutinises the financial performance, efficiency and effectiveness of the NHS in Scotland. It conducts annual account audits of each health boards as well as an overview of the financial and service performance of the NHS in Scotland. In addition to this, it undertakes individual performance audits on key policy areas. All reports are considered by the Scottish Parliament's Public Audit Committee.

COMPLAINTS

Complaints about NHS services are dealt with in the first instance by health boards, with possible referral to the Scottish Public Services Ombudsman (SPSO) if not resolved to the complainant's satisfaction. Patients may also pursue legal action through the civil courts. Forms of legal action include bringing a claim in respect of negligence or lodging a petition for judicial review.

The Patient Rights (Scotland) Act 2011 (the '2011 Act') gave patients a right to complain and placed a duty on Scottish Ministers to publish a comprehensive Charter of Patient Rights and Responsibilities. The Charter outlines all of the rights available to patients, as well as the responsibilities expected of them. The 2011 Act also provided for the establishment of the Patient Advice and Support Service (PASS), which advises patients wishing to give feedback or make a complaint.

ENFORCEMENT

Only Scottish Ministers and the Scottish Courts have the power to enforce a particular action on a health board. Ministers have a general power to direct boards[7] as well as the power to intervene in the case of service failures[8]. Scottish courts can also employ a number of legal remedies, such as an order to pay damages.

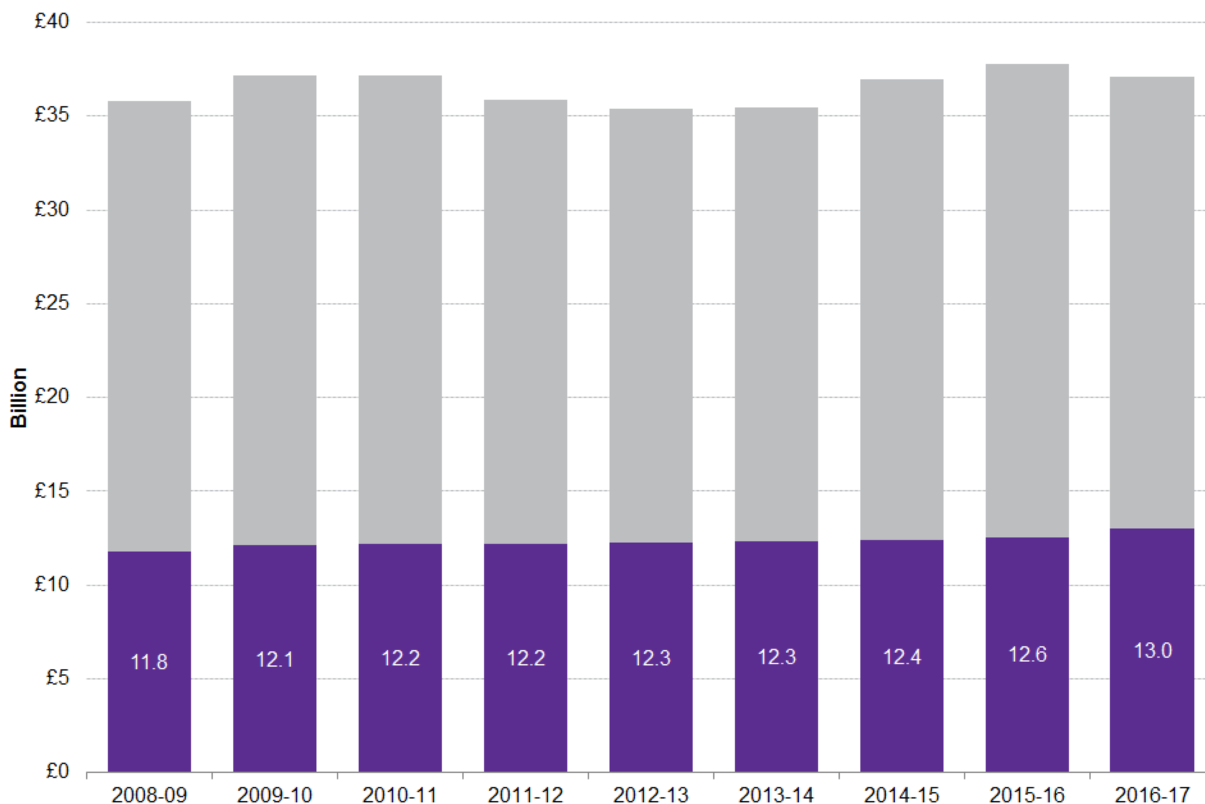
While the SPSO, HIS and the MWC would expect a health board to comply with any recommendations it makes, they have no statutory powers to enforce those recommendations (with the exception of HIS' powers to close hospital wards). However, findings from each organisation may be fed into the annual accountability reviews of boards and both HIS and the MWC operate escalation policies which could ultimately lead to a matter being brought to the attention of Scottish Ministers.

[7] Section 2(5) of the National Health Service (Scotland) Act 1978
[8] Sections 77, 78 and 78A of the National Health Service (Scotland) Act 1978

FUNDING OF THE NHS IN SCOTLAND

The total budget for health, wellbeing and sport in 2016/17 is £13.04bn. This now accounts for 35.1% of the total Scottish Government budget. The Scottish Government has repeatedly pledged to protect the health budget and figure 4 below shows the real terms trend in the health budget alongside the total budget since 2008/09. The health budget could be described as relatively flat since 2008-09 and has not experienced the same fluctuations as the overall budget.

Figure 4: Total health, wellbeing & sport budget and total Scottish Government budget, 2008-09 to 2016-17 (2016-17 prices)



Around three-quarters of the total health budget is allocated to health boards, which determine spending in order to reflect local priorities and/or specific remits. The health board allocations are determined by the NHSScotland Resource Allocation Committee (NRAC) formula, which reflects factors such as the age/sex distribution of the population, geographic factors and other health-related indicators. In practice, actual allocations can differ from the implied NRAC allocations. This is because the Scottish Government is managing the transition to NRAC allocations so as to ensure that no individual board faces a real terms reduction in its allocation in any year. Full implementation of the formula is referred to as 'parity' although this has not yet been reached. The 2016-17 allocations show that four health boards remain more than 1% below NRAC parity:

- NHS Grampian (£27.2m below parity)
- NHS Highland (£8.9m below parity)
- NHS Lothian (£30.0m below parity)
- NHS Shetland (£0.5m below parity)

The hospital sector accounts for over half of all NHSScotland expenditure. Within this, the largest areas of spending are staff costs and pharmacy costs, which together account for over three quarters of all spending in the hospital and community sectors.

As mentioned previously, since 1 April 2016, health boards and local authorities now have to integrate certain health and social care services, along with the required funding. In 2016/17, the integration authorities were in charge of around £8bn of public money.

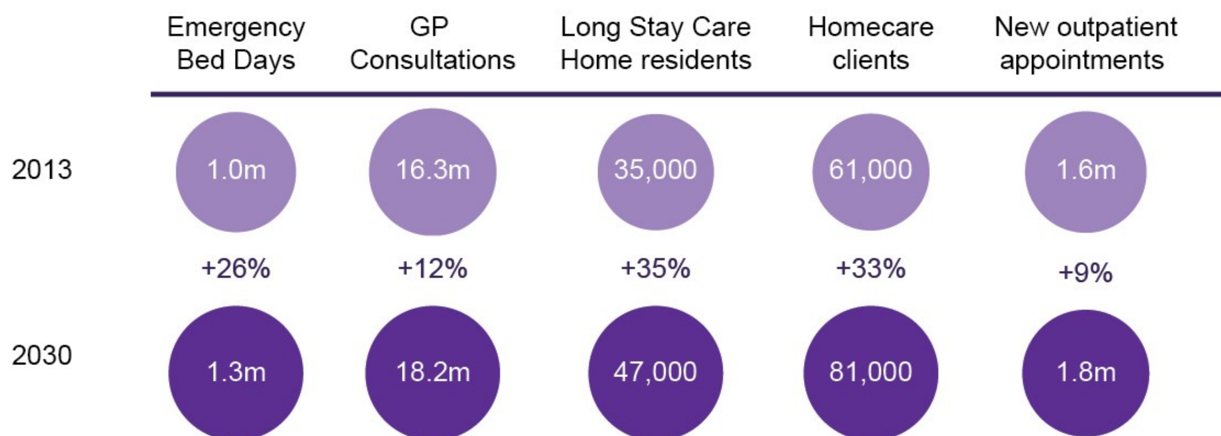
KEY ISSUES FOR THE COMING SESSION

Funding and Sustainability

The SNP Government has repeatedly pledged to protect the health budget and the 2016 manifesto indicated that it would increase the revenue budget by £500m above inflation each year until the end of the session. The health service has fared relatively well in funding terms when compared to other portfolios, but there are still concerns about the extent to which funding can keep pace with rising demand while the health service is its current form.

The potential mismatch between demand and resources stems from an ageing population suffering from multiple chronic conditions, workforce shortages, and cost pressures from technological and medical advances (to name but a few). Figure 5 shows some of the projected increases in service demand expected by 2030.

Figure 5: Pressures on health and social care services, 2013-2030



Source: SPICe, data from Audit Scotland 2016

Audit Scotland recently published a report stating that the shift to new models of care is not happening quickly enough and the new models that are in place are small-scale and not widespread (Audit Scotland, 2016). The report presented estimates that, within current service models, health and social care services would need increased investment of between £422m and £625m per annum in order to keep pace with demand. While the promised £500m + inflation increase per annum will certainly go some way to meeting that, the sustainability of such levels of funding is uncertain. One of the key messages from the report was that the Scottish Government needs to provide stronger leadership by developing clear frameworks to guide local development, consolidating evidence of what works, setting measures of success for monitoring progress and modelling how much investment is needed in new services and ways of working (Audit Scotland, 2016, p 5).

The more recent report from Audit Scotland on the overview of the NHS concluded:

> “NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many had to use short-term measures to break even. NHS boards are facing increasing costs each year, for example drug costs increased by ten per cent, allowing for inflation, between 2012/13 and 2014/15. NHS boards will need to make unprecedented levels of savings in 2016/17 and there is a risk that some will not be able to achieve financial balance.” (Audit Scotland, 2016b, pg5)

The implementation of the National Clinical Strategy and the integration of health and social care are likely to be pivotal to the future sustainability of the NHS.

Integration of Health and Social Care

The perceived benefits of integrating health and social care include preventing problems like delayed discharges and ensuring care is provided in the most clinically and cost effective way. The quest for integrated care is not new and there have been many attempts to achieve greater integration over many decades. However, there have been persistent concerns that joint working between partners has not been as effective as it could be. The Public Bodies (Joint Working)(Scotland) Act 2014 effectively forces health boards and local authorities to integrate certain functions and put in place the required funding. The estimated efficiency savings from integration are estimated to be between £138m and £157m per annum (Audit Scotland, 2015).

The integration authorities went live on the 1 April 2016 so are still very much in their infancy. However, a recent Audit Scotland report (2015) identified a number of significant challenges facing integration authorities. These included complex governance arrangements, workforce planning difficulties and difficulty in agreeing the final budgets. At the time of writing (August 2016) the total amount of money delegated to IJBs was still unknown. Audit Scotland also stated that it was unlikely IJBs would make a significant impact in their first year. While this may be understandable, Audit Scotland’s report on the Changing Models of Health and Social Care presses home the urgency that is required in reforming care in order to ensure the future sustainability of the NHS (Audit Scotland, 2016).

National Clinical Strategy

Just prior to the 2016 Scottish Parliament elections, the Scottish Government published the National Clinical Strategy for Scotland (Scottish Government, 2016a). This is intended to set out the blue print for health services in Scotland for the next 10-15 years. Many of the aspirations are familiar and restate previous Scottish Government commitments and priorities, for example, shifting the balance of care away from the acute sector towards the community, and enabling people to self-manage their conditions. Other key commitments included:

- Provide care that is person centred rather than condition focussed.
- Transform primary care by enhancing capacity, increasing recruitment of GPs, developing technological solutions to enhance access and developing extended professional roles. Care will become centred around a practice, with GPs focusing on complex cases and the assessment of new cases.
- Services will be planned and delivered across populations, regardless of geographical locality.

One thing the strategy also signalled was the possibility that some services many need to be provided on fewer sites i.e. centralised. Given previous experiences of centralising services, this could prove to be controversial.

Prior to the SNP Government coming to power in 2007, there was controversy surrounding the proposed closure of A&E units in Lanarkshire and Ayrshire. Much of the ensuing debate centred on the evidence that linked improved patient outcomes with higher volumes of clinical work. The incoming SNP Government over-turned the decisions in Lanarkshire and Ayrshire and stated there should be a presumption against the centralisation of core hospital services. However, the recent clinical strategy highlights that there is now better evidence that the volume of clinical activity is linked to outcomes, particularly for highly specialised services, and it signals the possibility that certain services may be provided on fewer sites:

> "Where clinically appropriate we will continue to plan and deliver services at a local level. Where there is evidence that better outcomes could only be reliably and sustainably produced by planning services on a regional or national level, we will respond to this evidence to secure the best possible outcomes." (Scottish Government, 2016a, p3)

It remains to be seen which services will be affected and whether there will be similar public controversy.

Leaving the EU

While the EU has limited competence in the healthcare systems of EU Member States, certain important aspects of health care are regulated to a greater or lesser extent by EU law. This includes:

- reciprocal access to healthcare (via the European Health Insurance Card and the Cross Border Healthcare Directive 2011/24/EU),
- the regulation of medicines,
- working hours of staff via the Working Time Directive (2003/88/EC),
- mutual recognition of qualifications and free movement of health and care workers,
- public health measures such as the Tobacco Products Directive (2014/40/EU).

These are topics largely reserved to Westminster and therefore out with the legislative competence of the Scottish Parliament.

In terms of what might have the biggest impact on service delivery in Scotland, the future of EU workers in the NHS and social care is perhaps the issue that has caused the most concern. There are various estimates of the number of EU nationals working in the NHS and social care in Scotland, but there is no definitive figure because the data is not collected centrally. Estimates range from 3% of health and social care workers (Hudson & Aiton, 2016) to the Scottish Government's estimate of 5% (S5W-014332).

However, the figure is likely to differ across the professions and in different parts of the country. We know that 5.8% of doctors in Scotland received their qualification in another EU country[9], but as this does not take account of EU nationals who trained here, the number with an EU nationality currently working in Scotland is potentially higher. In addition, some parts of Scotland employ a relatively higher proportion of EU workers. For example, it is reported that of the 13 consultants working in the Western Isles hospital, one is Scottish, three are from outwith the EU and eight are from the EU (Scottish Parliament Health and Sport Committee, 2016).

[9] According to the General Medical Council, as at 27 October, there were 20,028 licensed doctors located in Scotland. 1,159 had a non-UK EEA primary medical qualification representing 5.8% of the total workforce. Personal communication, November 2016.

The Secretary of State for Health, Jeremy Hunt, and senior NHS leaders in England have sought to provide reassurances to NHS employees from the EU that they continue to be welcome in the UK, as has Scotland's First Minister.[10] However, there is great uncertainty about the resulting outcome of negotiations around free movement and how it might impact on recruitment and retention in the NHS. This comes at a time when the NHS across the UK faces workforce pressures.

Ultimately, the impact on the NHS workforce, medicines and public health will be dependent on the outcome of UK negotiations with the EU. More detailed information on the potential impact on health of leaving the EU can be found in the House of Commons Library briefing on the policy impact of Brexit (House of Commons Library, 2016).

[10] HSJ, 27 June 2016 and Telegraph, 18 July 2016

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