Witness Seminar marking 25 Years of Devolved Health Policy in Scotland: the abolition of the NHS internal market

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Contributors (and transcript key)

Chair

Ellen Stewart (ES), Professor of Public Policy & Health, University of Glasgow.

Witnesses

Malcolm Chisholm (MC)

Malcolm Chisholm was a teacher of English during the first main part of his working life but became MP for Leith, subsequently Edinburgh North and Leith, in 1992. He remained a member of the UK Parliament until 2001, including a spell as shadow Scottish Health Minster for the year before the 1997 election and Scottish Office Minster for Local Government, Housing and Transport in the early years of the Labour Government. He was elected to the Scottish Parliament in 1999 and was deputy Minister for Health and Community Care 2000-2001, Minister for Health and Community Care 2001-2004 and Minster for Communities 2004-2006. He remained in the Scottish Parliament until 2016,involved with a wide range of policy areas, and in the final five years also chaired Cross Party Groups on Cancer, Mental Health, Health Inequalities, Rare Diseases and Men's Violence against Women.

Since retiring in 2016 he has been actively involved with four grandchildren and on the Boards of various mainly local organisations (Pilton Health Project, North Edinburgh Childcare, Dr. Bell's Family Centre, Earth in Common, Scottish Cancer Foundation)as well as patron of Edinburgh Women's Aid.

Susan Deacon (SD)

Susan Deacon has a breadth and depth of experience of working across the private, public and third sectors in leadership and governance roles.

She is currently a Non-Executive Director of Lothian Buses, Chair of the Edinburgh Festivals Forum, and a Trustee of the British Gas Energy Trust.

Previous roles include, Chair of the Institute of Directors in Scotland, Non-Executive Director of Scottish Power and Chair of Scottish Power Renewables, and Chair of the Scottish Police Authority.

Susan has worked widely in building cross-sectoral collaborations and has served on advisory bodies with both the UK and Scottish Governments. She is a

Professorial Fellow and senior adviser at the University of Edinburgh, where she was previously Assistant Principal External Relations.
A Member of the Scottish Parliament from 1999 to 2007, Susan served as Scotland's first Cabinet Minister for Health and Community Care following devolution. She was awarded a CBE for services to business, education and public service in 2017.

Derek Feeley (DF)
Professor Derek Feeley, CB, DBA, is a Senior Fellow at the Institute for Healthcare Improvement (IHI), a Board Member at the Institute for Research and Innovation in Social Services (IRISS), Advisor to the Board at East London Foundation Trust, a Bevan Commissioner, and an Honorary Professor at the University of the West of Scotland. He chaired the Independent Review of Adult Social Care which reported to the Scottish Government in February 2021. Before returning to Scotland in 2020, he was IHI's President and Chief Executive where he was responsible for driving IHI's mission to improve health and health care worldwide.
Prior to joining IHI, he was Director General of Health and Social Care in the Scottish Government, and Chief Executive of NHS Scotland. In that role, he was the principal advisor to the Scottish Government on all health, health care, and social care policy matters, as well as having leadership responsibility for NHS Scotland's 140,000 staff. Some of his earlier Scottish Government roles included serving as Director of Strategy in the Health Department and a period as Principal Private Secretary to the First Minister.

Gerry Marr (GM)
Gerry Marr OBE is the former Chief Executive of South Eastern Sydney Local Health District, Sydney, Australia taking up the position in February 2014 until he retired in August 2018.
Prior to this position, Gerry held Senior Executive roles with the National Health Service (NHS) Tayside in Scotland, firstly as Chief Executive Tayside University Hospitals Trust, then Chief Operating Officer/Deputy Chief Executive Officer, NHS Tayside and then Chief Executive from 2010 until 2013. Prior to his work with NHS Tayside, Gerry held senior roles in the areas of system performance and human resources management with the NHS Scotland Department of

Health. In his early career, Gerry held senior management roles at major tertiary hospitals, including Yorkhill Hospitals NHS Trust in Glasgow and the Women and Children Services, Greater Glasgow Health Board.

Dave Watson (DW)

In the early years of devolution, Dave Watson was seconded from UNISON Scotland to the Scottish Executive Health Department to implement the radical new NHS Human Resources Strategy. It was later described in a Nottingham University study as "probably the most ambitious and important contemporary innovation in British public sector relations". On completing the secondment, he was appointed to the (short-lived) NHS Management Board at a time when the later NHS reforms were being developed.

Dave was then appointed Head of Policy and Public Affairs at UNISON Scotland. This involved regular engagement with the Scottish Executive (then Government) at political and official levels. He served on many working groups and Bill teams, developing new legislation. He was later seconded to the Scottish Government again as an expert advisor to the Christie Commission on Public Sector Reform. He is a past Chair of the Scottish Labour Party and served on its Scottish Executive for 15 years.

He retired from UNISON in 2018 and works part-time as a policy and HR consultant for European think tanks and in the public and third sectors. He drafted the Scottish Labour manifestos for the 2019 and 2021 elections. He was appointed Director of the Jimmy Reid Foundation think tank in 2023.

A graduate in Scots Law from the University of Strathclyde, Dave is a Fellow of the Royal Society of Arts and an Associate Fellow of the Royal Historical Society. He is the secretary of the Keir Hardie Society and the Socialist Health Association Scotland. He is the author of numerous policy papers and the contributing author to several policy books. Dave is also a military historian specialising in the Balkans and author of four books ranging from the Napoleonic Wars to the Cyprus conflict.

Dave was born in Liverpool and spent his teenage years in London before working for UNISON in Wales, Dorset and for the past 34 years in Scotland. He lives in Troon (Ayrshire) with his wife, Liz, doing little to improve his modest golf handicap. That is when he is not travelling the UK to watch his beloved Fulham FC.

Philippa Whitford (PW)

Originally from Belfast, Philippa moved to Scotland and went on to study Medicine at Glasgow University. Prior to her election to the UK Parliament, Philippa was a Breast Cancer Surgeon for over 30 years, including 19 years as a Consultant at Crosshouse Hospital, where she redesigned the local service and led the Scottish Quality Improvement Programme for Breast Cancer from 2000 - 2011.

Elected in May 2015, Philippa served as SNP Shadow Health Spokesperson for 6 ½ years including the height of the Covid pandemic. This was followed by other roles, including as Europe Spokesperson in the aftermath of Brexit and as Scotland Spokesperson at a time of unprecedented attack on devolution.

In the early 1990s, Philippa and her husband spent 16 months working as medical volunteers at Al Ahli Hospital, a UN-sponsored hospital in Gaza. She returned to Gaza in 2016 and, again working with Medical Aid for Palestinians, established a Breast Cancer project between specialist teams in Scotland and Palestinian clinicians in both Gaza and the West Bank. She is a founding member of the Scottish Palestinian Health Partnership.

Kevin Woods (KW)

Kevin Woods career has included roles in the NHS, Government and universities. His first NHS positions were in operational and strategic leadership roles in District and Regional Health Authorities in England. He moved to Scotland in 1995 to take up the post of Director of Strategy and Performance Management in the Scottish Office (subsequently the Scottish Executive). Between 2005 and 2010 he was Director General of Health and Chief Executive of NHS Scotland in the Scottish Government, moving to become Chief Executive of the Ministry of Health and the Director General of Health in New Zealand (2011-2014). Between 2000 and 2003 he was the William R Lindsay Professor of Health Policy and Economic Evaluation at the University of Glasgow. His last role before retirement was as a Civil Service Commissioner (the regulator of the UK Civil Service) between 2015-2022.

Audience members in attendance, who provided additional reflections or asked questions

Mark Dayan (MD)
Mark Dayan is Brexit and Trade Programme Lead at the Nuffield Trust, working on the implications of leaving the European Union and of trade agreements for the NHS, life sciences and social care. His publications include *How will Brexit affect the UK's response to coronavirus*? and *Getting a Brexit deal that works for the NHS*. Mark has also published work on healthcare in Scotland and Northern Ireland; integrated care across the UK; health inequalities; and on legislation. He leads the Nuffield Trust's engagement with Ministers, civil servants and parliamentarians as Head of Public Affairs, and analyses and responds to legislation affecting health and social care.
Mark has also worked on external commissions, including leading a 2018 research collaboration with the King's Fund, Institute for Fiscal Studies and the Health Foundation. Before joining the Trust, Mark gained experience in policy roles for the New Local Government Network and the Scottish Civil Service. He is a graduate of the University of Oxford and has an MSc in Philosophy and Public Policy from the London School of Economics.

Ian Elliott (IE)
Dr Ian C. Elliott is a Senior Lecturer in Public Administration at the Centre for Public Policy, University of Glasgow. His research includes work on strategy in government, public leadership and organisational change. He has extensive experience of advising governments and conducting research on behalf of governments and public bodies including as a member of Scottish Government Expert Advisory Group on the National Performance Framework. His academic publications include "Collaborative leadership in integrated care systems; creating leadership for the common good"; "Leadership of integrated health and social care services" and "Improving employee engagement and distributed leadership through lean systems process mapping".

Mary Guy (MG)
Dr Mary Guy is Senior Lecturer in EU and Public Law at Liverpool John Moores University. Her research interests span health law and policy at EU and national

levels, and include a focus on the interaction between the National Health Service (NHS) and private healthcare, initially in England. Her first monograph, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems* (Intersentia 2019) examined the competition aspects of the Health and Social Care Act 2012 (the "Lansley reforms") by reference to the experience of instituting competition reforms in the Dutch healthcare system. This has been followed by analyses of patient choice policies as located between "going private" and "NHS privatisation", and how the COVID-19 pandemic may be reframing NHS-private healthcare interaction. Dr Guy has also examined the various attempts to repeal the "Lansley reforms", and the shift in England from competition to integration as enshrined by the Health and Care Act 2022. This growing body of work has led to consultation by the Belgian Competition Authority and to written evidence being cited by the Senedd Health and Care Committee. Dr Guy's current projects include mapping patient choice policies in England to understand where regional variations may exist.

Richard Simpson (RS)

Richard Simpson OBE is a former Member of the Scottish Parliament (MSP). As a Labour Party member, Richard represented the Ochil constituency from 1999 to 2003 and the Mid Scotland and Fife region from 2007 to 2016. In his political career, Simpson held key roles, including Deputy Justice Minister under First Minister Jack McConnell. As a Justice Minister he promoted alternatives to custody for women offenders especially those with primary drug misuse issues. He worked on health and community care issues, contributing to reports on organ donation[2001], influenza vaccination and pandemics [2000] , and ensuring public consultation on changes in health services [2000]. He was re-elected to the Scottish Parliament in 2007 and 2011, serving as Labour's lead on health and wellbeing and advocating for various issues, including concerns over local alcohol licensing laws and infrastructure projects.

Before entering politics, Simpson had a distinguished medical career. He was a GP and psychiatrist and held fellowships with the Royal College of Psychiatrists and the Royal College of General Practitioners. Between 2003 and 2007, he specialised in addiction medicine, serving as a consultant psychiatrist for the Drug Addiction Team in West Lothian. A member of Unite, Simpson also played a key role in advocating for two significant gun control laws in response to the Dunblane school massacre, which led to the effective ban on most handguns in the UK through the Firearms (Amendment) Acts of 1997. In 2017, Simpson was

appointed Officer of the Order of the British Empire (OBE) for his contributions to Scottish politics and public service.

Policy background and timeline

At the time of devolution, the NHS internal market was still a relatively recent innovation, having passed into law within the NHS and Community Care Act of 1990. It was far from a universally popular one. Applications from (groups of) Scottish hospitals for Trust status were vigorously debated. In a parliamentary debate on 3rd December 1991 between Secretary of State for Scotland Ian Lang MP, Alec Salmond MP and Donald Dewar MP, Mr Dewar asked:

> "Does the Minister not recognise the dangers of fragmenting the health service and destroying the planning framework; the cost of ever-increasing bureaucracy; the reduction in choice for the doctor; the fear that this is a road that leads to a two-tier system in which money comes first and the Health Service is relegated to a safety-net, fallback provision?"

When the former Yorkhill Children's Hospital in Glasgow became the Yorkhill NHS Trust on 1st January 1993 it made front-page news, with the *Daily Record* badging their coverage 'the opt out row'.

There were 47 NHS Trusts in Scotland by 1999 (National Audit Office, 2000). However while the NHS internal market was embraced enthusiastically in England, Paton argues that in Scotland the organisations required to enact the reform were created, but engaged in little recognisable "market behaviour" (Paton, 2022). An Accounts Commission for Scotland report in 1997 identified a sharp increase in the use of 'simple block' contracts, and an overall move away from more 'sophisticated' forms of contracting across the period of the internal market (Accounts Commission for Scotland, 1997).

Dismantling the internal market was a longer and more gradual process than is sometimes implied in the scholarly literature. New Labour were elected in 1997 with a manifesto promise to dismantle the internal market in the NHS across the UK. On taking office, the Westminster government made the then-unusual decision to issue separate White Papers on health for England, Scotland and Wales (with a Green Paper for Northern Ireland) (Greer, 2008). This pre-devolution White Paper for Scotland exhibited two characteristics which have

gone on to be seen as defining Scottish health policy; it was clinically-led (authored by neurosurgeon and Health Minister Dr Sam Galbraith MP), and it pursued a more collaborative approach than that favoured in England. In speech to NHS managers mere weeks after the General Election, Dr Galbraith called for:

> "management concentrated on delivering quality care instead of being preoccupied with the wasteful, unproductive administration of an internal market… I am on your side. But you must produce significant reductions in your administrative budget and do it soon." (quoted in Teasdale et al., 2016)

The White Paper that followed described its goal as "replacing" the internal market in Scotland, proposing the creation of Primary Care Trusts and reducing the number of acute Trusts.

Following devolution, the first Scottish Executive embarked on a further project of simplifying NHS organisation: strengthening the role of Health Boards sitting above acute and non-acute (community and mental health) Trusts (Paton, 2022). There followed in 2003 a further effort to "remove the last vestiges of the UK Thatcher reforms" (Paton, 2022, p. 45). This initially involved management boards of Trusts being represented on Health Boards, thus retaining a distinction between planning and management in practice, but with no statutory distinction between the two. The territorial Health Boards thus became "all-purpose organisations that plan, commission and deliver a wide range of hospital and community health services, including managing contracts with general practitioners (GPs) and dentists who operate as independent contractors." (Hughes, 2023)

These early reforms took place in "a relatively benign intergovernmental background" (Woods, 2004). In 2007 the Scottish National Party (SNP) inherited, and have largely retained, what Greer *et al* describe as a very 'flat' structure of governance which "puts only two important layers of management between local services and the minister, namely the Boards and the central NHS management in Edinburgh" (Greer, Wilson, & Donnelly, 2016). Early SNP Government policy sought to explore new models of public involvement in governance, under the tagline of "a mutual NHS" (Stewart, 2013), including a short-lived pilot of directly electing non-executive directors of territorial Health

Boards (Greer, Donnelly, Wilson, & Stewart, 2012; Greer, Stewart, Wilson, & Donnelly, 2014).

The definition of Scottish NHS values in *opposition* to the perceived competitive, market-based approach to improvement in England is not only a feature of professional and policy discourse in Scotland (Dayan & Edwards, 2017; Woods, 2004), but also described in public debate (Kerr & Feeley, 2007). SNP policy, while organisationally consistent, has emphasised these Scottish values to a greater extent: "in this narrative, the Scottish people and the staff of the NHS are seen as partners or co-owners of an NHS that relies on cooperation and collaboration rather than internal competition" (Prior, Hughes, & Peckham, 2012).

At 2024, the governance of the territorial Health Boards still has much in common with the reforms envisaged in the early 2000s, with the most significant departure being that required by health and social care integration in 2014's Public Bodies (Joint Working) Act (Exley et al., 2024; Pearson & Watson, 2018).

Timeline of key events

1990	• NHS and Community Care Act creates legislative basis for internal market in NHS
1992	• First NHS Trusts created in Scotland by statutory instrument
1997	• New Labour elected at Westminster with manifesto promise to 'remove bureaucratic processes of the internal market' • Sam Galbraith appointed Health Minister at the Scottish Office • Devolution referendum held on 11th September
1998	• Scotland Act is passed in November, legislating for creation of Scottish Parliament and Scottish Executive • *Designed to Care: renewing the NHS in Scotland* is published in December, claiming to 'replace the internal market': proposes to reduce number of acute Trusts and create Primary Care Trusts
1999	• Health Act 1999 gives effect to separate organisational reforms in England, Wales and Scotland; abolishes GP Fundholding • First Scottish Parliament elections held on 6th May and Labour-Liberal Democrat administration elected at Holyrood • Susan Deacon MSP appointed first Minister for Health and Community Care
2000	• *Our National Health: a plan for action, a plan for change* published
2001	• Malcolm Chisholm appointed Minister for Health and Community Care in November
2003	• *Partnership for Care* is published in February, proposing to dissolve all Trusts • Second Scottish Parliament elections held: Labour-Lib Dem coalition retains power
2004	• NHS Reform (Scotland) Act passes in May, abolishing remaining Trusts and transferring their functions to integrated regional Health Boards • Andy Kerr MSP appointed Minister for Health and Community Care in October

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Seminar transcript

Part 1: before devolution

Witnesses on panel: Kevin Woods and Gerry Marr

ES: Then without further delay, I'll introduce our first panellist. So I'm going to ask you each to say a bit about your own professional roles during the period in question, but I think most of you would probably know Gerry Marr and Kevin Woods have both played ongoing roles throughout the whole period in question, but we've asked in particular today to speak about those pre-devolution years. So, Kevin, could I start with you, could you just describe the roles that you held during this period before devolution in particular?

KW: Thank you very much indeed. I was Director of Strategy and Performance Management, in what was then the Scottish Office, as part of the NHS management between 1995 and the year 2000. My initial job title interestingly was Director of Purchasing - which has got nothing to do with buying, but it was a reflection of the fact that there was an internal market structure. There was a Director of Trusts as well. And then I left the Scottish Executive, as it had become, at the beginning of 2001, went to Glasgow University and various other things, and subsequently returned to the Scottish Government between 2005 and 2010, when I was Director General of Health and Chief Executive of NHS Scotland.

I was very much involved, prior to coming to Scotland, in trying to make the internal market work in parts of England, and then between 1995 and 2000, as I say – 1997 - with the operation of the market here in Scotland, and I was intimately involved in the production of Design to Care, which was the document which unwound the internal market. So perhaps I should pause there.

ES: Thank you. Gerry, do you want to share the same in terms of those roles in the early years?

GM: Yes, I should start with for the purposes of this morning, I was the General Manager at the Yorkhill Hospital, which was the first round of appointments of general management for Scotland. So I'd been there for three years prior to what we'll talk about in more detail this morning. Prior to that, I'd actually been seconded into the private office of Laurence Peterkin, which I spent two years working in. So I've fair insight into the approaches to life in Glasgow at that particular time. And then subsequently, which is a pivotal issue in the evolution of the internal market in Scotland, I then made application to become the children's hospital or actually Children's Services Trust, which provoked a great degree of consternation in response in Scotland for a considerable length of time. And I actually then became a part of this journey that we're talking about because after the election in 1997, just some months after that, I then went into the Scottish Office as Director of Human Resources at the time when the Labour Government were still Westminster, this is pre-devolution. It became the first phase of what the Labour Government at that time and what Kevin then had to deal with in the juxtaposition of still being with Westminster but still having to take forward some very definite plans to shift away from the internal market.

So those are the three sequences of events and I think probably, you know, this being an opportunity to reflect the proper record of events I think the key thing for me was that one time when I established Yorkhill as one of the first NHS Trusts in Scotland.

ES: And Gerry sent me a newspaper clipping of the front page of the Daily Record with a photo of you sitting on a hospital bed, I think, with 'opt-out row' in a circle in bold letters?

GM: Yes, the background to that, if you wish, I can, people might not understand exactly what happened, but I was sitting in my office in Yorkhill minding my own business and the phone went and it was Laurence Peterken inviting me to supper, straight away I thought I was for the chop. And I phoned one or two of my friends and they wished me well in the next job! Anyway I went to supper, but by that time, and Kevin might want to comment on this, Scotland was really reluctant, there had been two trusts established in Foresterhill and in South Ayrshire, but beyond that a deep reluctance. It was quite clear from Laurence Peterken's loyalty and philosophy that he had agreed to do something about that. And I went to supper and he said well Gerry, it's really, ministers are very worried at the lack of progress and I think you're probably the best person to take this forward.

So having got back off the floor under table, I then thought it's really interesting actually because there are two issues here. There is one of the internal market, but there's also, in terms of local decision making. And being Laurence Peterken he gave me forty-eight hours to respond. I went back to our clinical lead group in Yorkhill who really had a long battle with the Greater Glasgow Health Board on a number of things. But the pivotal thing was that the Royal College of Paediatricians at that time had insisted that services for children had to be combined. Glasgow had refused to make that happen, and that had been a running sore for probably about at least two or three years.

So I then went back to them, and also the clinicians were very antagonistic, felt that they were underfunded, that they hadn't seen capital investment. A lot of people when they talk about paediatricians say they're going to take on the characteristics of the client group, but nevertheless they had some reasonable grievances. They were actually supportive of the decision, but said I had to go back and see your boss and say to him, "we will do it but we will do it on the basis that the application will be a combined children's services". I can't deliver it any other way and you will give me some

guarantees about capital investment, particularly the new theatres that have been 'under the stakes' that have been requested for five years.

I had privately taken a view that, given that the children's hospital had been chronically over spent for, for as long as we can remember, that if I took it into trust, then it would be unlikely if, they wouldn't be sympathetic to our financial position, put it that way. I also actually believed that I could do something about something that I've been consistently passionate about, which was local decision making, and I believed that I could do something about industrial relations, competitive tendering and other things that we may touch on. So, for those reasons, we decided to take that decision. I guess from a political point of view, because all the other organisations of Scotland followed pretty quickly once we had taken the heat out of the situation. I was saying to Kevin and I was saying to David, I discovered that years later my sons told me (they were at Paisley Grammar School) all their classmates went out and got themselves a Daily Record and pinned the front page onto the back of their blazers and ran around the playground thinking it was a great deal.

But it was a very difficult time for me personally, but I believed that we were doing the right thing for children's services and I believed that in any case there was no internal market and there never would be. We could use that decision to advance the case of children's services in Glasgow.

ES: Well, Gerry, that's very neatly brought me on to one of my first questions, which is that the sort of academic consensus, as much as there is a literature about the internal market when it existed in Scotland, was that it was formally present but never embedded, never changing behaviour. I'm intrigued as to how far people think that was true, whether it was making a difference on the ground. Kevin, do you have any…?

KW: Yeah I think that is true. When I came to Scotland in 1995 I think it's fair to say that there was a very substantial degree of scepticism about whether the market idea could possibly work. It doesn't, you know, it's pretty obvious why not. Think about the geography of Scotland, large, remote and rural areas, island communities, the notion of competition between hospital entities was just thoroughly impractical. So quite apart from any political distaste for the operation of the internal market, which was the idea of a Conservative Government anchored in Westminster, there were just simply practicalities about how it would not be able to function as a market.

But Gerry said something which I think is quite important. There were some important benefits which came from the creation of trusts and also from the creation of GP fundholding. Not in terms of competition and so on, but probably in the following ways. The strengthening of local governance and operational governance within major hospital entities was undoubtedly of importance, because it was the first time that these institutions had had proper boards of governance, and they had certain freedoms and so local management was strengthened, and I think that that was very important.

Fund holding, again there was a lot of scepticism in some quarters, distaste for the idea of fund holding. What it led to was quite a large number of GPs who had a kind of thirst and ambition for innovation and change and improvement, and it gave them the opportunity to express that. So those GPs, in my experience dealing with many of them, they were - it's possible some of them were motivated by trying to make a better living out of the system or whatever, but generally they were motivated by trying to improve clinical services for their patients. That's where they were coming from, and they were hoping to be able to relocate services more locally, and that's why they got involved.

But there was another, if I may say, there was one other benefit, which I think is very easy to overlook, and it's, because the idea of purchasing

healthcare was so immature, and there was so little experience of doing it and knowledge of how to do it effectively. There was an interesting development, which was that people said what we need is a better understanding of how to buy these things, how to commission these things, and it gave a big boost to sort of clinical guideline work. And there were various entities created in Scotland. They were in embryonic, not embryonic, they were in infant stage. Scottish Intercollegiate Guideline Network organised by the Royal Colleges, that was given a big boost in a sense, because people who were commissioning services say, you know, this is what should we be trying to get you to do. Then there's another thing called, I think it's called Scottish Health Purchasing Information Centre (SHPIC) it was based in Aberdeen, Dr Waugh I think his name was, who was the boss of it, and these people were providing health technology assessment material. So it gave quite a boost to evidence-based perspectives on how to organise services.

So, all of that was true. On the negative side, the whole place was replete with war stories of the consequences of the internal market. So one of them that I remember particularly was what we call the Ayrshire scanner wars where Kilmarnock and Ayr were having a dispute about a new scanner, and who was going to get the new scanner? Well, it's a form of competition or rivalry, but it's entirely destructive. The other that was in my mind was in Forth Valley, the conflict between Stirling and Falkirk. It was incredibly intense and very, very difficult and it was only ever resolved ultimately by the construction of the new hospital at Larbert.

ES: An expensive solution!

KW: It was extraordinarily difficult and then over in Fife, Dunfermline and Kirkcaldy, Susan will remember some of this, because I can remember being in the middle of, not the immediate ones prior to the abolition of the internal market, but it continued after the abolition of the internal market. So

wherever you looked in Scotland, there were either impracticalities or conflict rather than a functioning market, but there were some good things that came out of it as well.

ES: That's immensely useful. Before we move on to the post-New Labour election at Westminster and the changes to the internal market before devolution, does anyone in the audience want to come in?

PW: Yeah, I'll wait for the mic to move. Dr Philippa Whitford MP but I was a breast cancer surgeon for 33 years before taking some kind of blow to their head in 2015 and standing for election, and I worked in Crosshouse after the scanner wars. But when I went there in 1996 the 'us and them' was still absolutely riddled through and I would say that never actually resolved until the people who were there at the time retired and we got new staff. It became a single trust in about 1999/2000 but that whole 'us and them' you saw it in lots of areas, as you mentioned. What you had for governance though was financial governance, and I remember then, this is maybe more late '90s, where we started to talk about clinical governance, making senior management not just responsible for balancing the books but actually for meeting SIGN guidelines. I was on the breast cancer SIGN guideline group from 1996 onwards, and then we had the Clinical Standards Board which was set up in 1999, and I led the breast cancer project up until 2011.

So we had a change, but it started out as "you need to balance the books". And one of the weird, I was overseas working in the early '90s, and when I came back I was in Aberdeen, and one of the bizarre frontline impacts of the fundholding for GPs, and I totally recognise they got to innovate, my husband was a GP, but in Aberdeen GPs wouldn't allow us to refer internally. So if I saw a patient who'd been referred to surgery, and I'm going "no I think this is gynae or urology", we were then being told we had to send them back to the GP with all the risk that they might get lost and not referred on. Because some GPs were saying "well I didn't refer them for that, I'm not

paying for it". And there was also, because GPs, any GP won't see many rare conditions, a failure to recognise that in any regional board you also have to have specialist services. So there was that conflict going on that having sent people back but also just simply not recognising you need melanoma care, you need breast cancer care, you need neurosurgery.

KW: If I just say, you're quite right to point to some of the nonsenses, which, you know, took place. Clinical governance wasn't far behind, but it happened, that was introduced after 1997, which is why I didn't refer to it. And the best definition I ever got on that was corporate responsibility for clinical performance and that was from Sam Galbraith. He was a great advocate for introducing clinical governance. But I think that the corporate governance that was introduced was broader than just balancing the books, it was about actually local responsibility in those institutions. And, of course, you're quite right to point to some of the bad behaviours which arose from that because of local public interest. I'll pause there.

GM: Can I just, before we move onto the next part, if I can just maybe comment because Kevin made reference to that local decision making. People need to understand that in the time, in the lead up before 1997 when we ran the trust in the first phase, I abolished competitive tendering as a trust. The first organisation of Scotland to do that, because I exploited the freedoms, a rather perverse surprise to the people who believed the advantages of the internal market. We also established partnership working with the trade unions, which then became a national strategy.

So those freedoms, not the internal market, those freedoms were profoundly effective, as far as I'm concerned, as managing the business in the way that we wanted to manage in a collaborative partnership basis, and that was in my view a success.

KW: I think that's a very good illustration of the point I was trying to make actually.

GM: Yeah.

ES: Richard?

RS: Richard Simpson, but in this context I was a shadow GP fundholder and it's interesting what Kevin was saying. We had a nominal budget rather than a true budget, but it still allowed us to make changes and we did it. However, by creating a cooperative of local practices, which nobody mentioned so far, it was very important, we had six practices actually joined up who enforced on the hospital changes that they were previously not prepared to make. The most important one, the first one, was actually to have monitoring of the blood thickness, which patients had to travel from Callander and Killin down to the hospital every few weeks to have their blood taken, and we were able to get the funding shifted to actually have that done locally so these patients did not have to travel.

We set up a system and that was lost after the fundholding was abolished. And I think the message, the good thing about losing it locally was actually Stirling and Falkirk competitiveness, because where you had two hospitals competing, as you had in Fife and Forth Valley, they all appointed consultants, numerous consultants when we only needed one, and it was an absolute costly disaster. But, you know, in changing from and losing the internal market, one thing we didn't learn was to look at what the advantages that Gerry was talking about and you Kevin, what the advantages of that was before we actually lost everything by making the changes.

ES: Thank you.

KW: I paused then. I could pick up that theme in the context of the reforms in 1997. Unless there are other points that people want to explore about the internal market?

ES: If we move on to the New Labour period, I think, so New Labour's manifesto commits to dismantling I think the wording is the internal market across the whole of the UK. And Scottish devolution is on the cards but not yet in practice. So what difference was that making to your world?

KW: Well, the key political actors were Donald Dewar who was the Secretary of State and Sam Galbraith was the Minister for Health. And I've made a contribution to this book 'Remembering Sam', which was put together following his death, and there's a chapter in there on health. It's not just my perspectives, I gathered together views from many, many people, but you'll find a lot of detail in that chapter about the period that we're going to talk about.

Interestingly, it was still a Westminster-centric government, and so there was a great deal of interest in what might emerge in Scotland, and there was a lot of exchange between Whitehall and Westminster. But Donald Dewar and Sam were both very clear that we should have a solution in Scotland which suited Scottish circumstances, was how it would have been described. But the exam question which I was given, and the civil service was given was, we want to get rid of the internal market, we don't want to go back to command and control so can you please figure out some arrangement? And it was quite interesting because, as Richard said, there were things which we needed to, we wanted to retain in terms of local

decision-making and the innovation of some of the GPs that we observed, and how were we going to put all of that back together.

And so I'm not going to try to describe all the proposals that were in Designed to Care, because people can read that. But the two critical policy ideas were about trying to maintain some form of vertical integration between primary and secondary care, and I'll come back to that in a second. But the other was to create a form of horizontal integration between primary care and community and mental health services by creating Primary Care Trusts. And so there was machinery invented to try to make those component parts go together. And just picking up Richard's point, it's reminded me of something that one of the proposals in Designed to Care to try to effect this kind of vertical integration, this relationship between innovative practice in primary care and secondary care was something called the JIF, the Joint Investment Fund.

And I think we failed ever to adequately explain what we intended the Joint Investment Fund to be, because former fundholders spent a lot of time looking for the 'f' for the funding. It wasn't there. And in fact there was a bit of a joke doing the rounds, which is where's the F in JIF? But the idea was that there would be, as part of the process of working collaboratively, a discussion about how between primary care and secondary care resources could be deployed in different ways to give a better service to patients and a more local service. And that's what Richard, that's what we were trying to do with Richard, and we tried to do it also through the creation of things called Local Healthcare Cooperatives within Primary Care Trusts. And that was an idea that we picked up from actually a group of GPs in the Oban area, where they, a bit like Gerry said, they come up with their own imaginative ways of tackling problems and we thought that this had real power. But of course it was LHCCs, which were the forerunners ultimately of Community Health Partnerships and all of that.

So that's how we tried to square some of those circles. Interestingly, because it was pre-devolution there was a lot of, there was some interesting interaction between London and Edinburgh. There was a close interest in what we were doing in Whitehall, but an acknowledgment that it might be different. The only time I've ever been paged in an airport to go and answer a phone occurred at Edinburgh Airport when Sam Galbraith's private secretary said I've been asked to get in touch with you to, for you get in touch with somebody else in London because they're having a discussion about the introductory remarks in the White Paper. It was fascinating to experience this debate about whether it should be an 'and' or a 'but'!

The only time in my life, when I was working on this, one evening I was sat at home and I got a telephone call from Downing Street, and the only time in my whole professional life that ever happened, but it tells you something about the nature of the relationship which we were working through. The English were working on their own White Paper. One of Donald Dewar's and Sam's great sources of satisfaction was when both White Papers saw the light of day, the Scottish one got a thumbs up and there were very muted remarks about the English one - which the Health Service Journal opinion gave a tick to what had been done in Scotland, but was a bit curious in questioning about what might happen in England. So I'll stop there.

ES: When we spoke before you mentioned something, Kevin, about, and it's come up there as well, the kind of blank page nature of what was going to be developed, we only knew what was going to be removed. What sources of ideas, evidence, inspiration were you collectively drawing on in formulating this? What were the conversations that were happening?

KW: Well, as I say, it was the kind of how do we retain a degree of local governance but have greater collaboration? So that was how the idea of large acute trusts came about, and about putting, looking at how the

governance had adjusted. I think it ended up including trust chairs on NHS boards as a way of making sure that their voice was heard at that level. But a lot of it was actually based upon the day-to-day engagement that we had with key actors throughout the NHS in Scotland. The great thing about Scotland is that you could actually get all the key players together, it's very easy to achieve that. And the distance between people in Edinburgh working on these things and people all over Scotland is not that great, and so there was already interchange of ideas.

You know, the idea of Local Healthcare Cooperatives was born of some experience which we tapped into in around Oban, where there was a local GP called Eric Jesperson, who was a very energetic and innovative person. And there were people in, I mean I can think of other groups, Gary McFarlane in Glasgow, up in Nairn, Alastair Noble, these people had real energy and ideas. And I have to say it's quite interesting how I got sent a little film of Nairn, Health services in Nairn today, I've come across this recently. And it's really interesting how the same people are still there, still pursuing their ideas, and it looks as how we hoped it would unfold. So if you want to see a film about how, what we were thinking about, it's there in Nairn!

ES: Sounds like a good day trip. Gerry, I'm interested…

KW: You have to get the film. You don't have to go!

GM: Funnily enough, I watched that the other day. I often speak to Alastair Noble who was pursuing it, as you say, relentlessly. I was recruited into the role as Director of Human Resources for the Board of Directors to the Scottish Government and that was in 1997/98, I just can't remember the exact date. I was explicitly recruited to begin to dismantle the freedoms of the Trusts and what was perceived by the general public and by many people, the MPs

included, the abuse of freedoms. And to begin to think about how we dismantle the internal, the mechanisms of the Trusts, which there was a ludicrous number of 47 for a population of five million. And there were three issues I was asked to tackle.

The first was the abuse of freedoms and how we removed those freedoms, the second was the industrial relations environment was toxic, and the third was the opportunity to think about how we began to dismantle that whole structure without the need to worry about bringing in legislation, which was still a reserved matter. And so we did, we did all of those three things. Sam Galbraith was absolutely determined, and I remember my first conversation with him was, and those of you who know Sam know how direct he can be, he said look, Gerry, these executives are needing put in their place, these boards are needing sorted out.

He said whatever you do and I know you'll have to do it in the right way but the maximum salary is £100,000, no-one's getting any more than 100,000 as a Chief Executive in this country. Secondly, I want their credit cards back and I want their cars back and one or two other things like that. Within three months of being a Chief Executive I then had to write at the direction of the Minister to say "can I have his credit card, your car scheme is abolished, you're getting no bonuses and the maximum salary is £100,000". And that happened very rapidly.

What was more serious and more fundamental was the idea of how we changed the industrial relations environment. People who knew me knew my passion for partnership. There's a great deal of literature on European experience of partnership working, and we decided that we would start the process of establishing the Partnership Forum, which is now in use for what David, 20 odd, 21 years? It was difficult. The first meeting that I had with the trade unions was one of deep suspicion, given I'd experienced it in the previous 10 to 15 years, and the managers were completely opposed to it. Particularly the notion of a no redundancy environment in healthcare, which they saw as a great restriction on them. I saw it as forcing them to manage

properly to make the right decisions and to take away something in terms of the competitive tendering, which was an attack of the lowest-paid workers of the NHS in Scotland.

So that was the energy that was applied in those first phases, at least from the human resource point of view, and then what then overlapped into Susan's time was the beginnings of the thinking about abolishing trusts. Which then became something for Susan and then Malcolm to consider was how do we begin to dismantle it? And we began to develop those resources to take forward from moving from 47 to 26 trusts in the first instance. And Audit Scotland produced a report, savings, accountable savings for that part of the exercise was six million, and that was in 1999, 2000, so it's a significant sum of money.

So there was two things going on. Kevin's having to manage that complexity of policy and me brought in deliberately to dismantle the freedoms and negative aspects of what had emerged in general management. And a lot of it was associated with general management rather than just the internal market notion. So that was the big ticket.

KW: Gerry's comments about partnership just prompts me really to say, and it's linked to your previous question about ideas and the rest of it, because Gerry is right about partnership. We weren't going back to command and control - that's what was the big message, because that would have been seen as a retrograde step. We weren't, well we were going to abolish the internal market. So we created this thing, what was it going to be called? So we came up with the idea of calling it a partnership model. And if you read the front segment, 'Designed to Care', it talks about four aspects of partnership. That was the way in which it was described. And it was very different from England in that regard, because the English department, it felt, almost tried to play a three card trick, I would say, which was they said

they were abolishing the internal market, but they left most of it intact. So that's one of the most striking differences between what happened, sorry.

GM: No.

KW: There's one other point I want to make, actually, which is we're focusing on 'Designed to Care' and all of that sets of changes and reengineering it in the way that Gerry has described, but 'Designed to Care' was merely one of a number of things which were initiated in this period, which have had a long, cast a long and I think helpful shadow. The first was that Sam Galbraith also published a White Paper on health as opposed to health services in 1997. The other thing was that the Arbuthnot review into the distribution of resources around the NHS in Scotland was initiated, and Susan saw that over the finishing line. I think Malcolm [Chisholm] was a member of the committee in Parliament that scrutinised it. And I would recommend that people should read the Hansard report of that - I'll say no more.

The other thing that was launched at that time was the acute services review. Now, the acute services review, David Carter led that, the CMO, was really important piece of work, and was the pre, the forerunner of what David Kerr and Derek became involved in subsequently around the Kerr report. But the acute services review was actually a commitment made by the government of Michael Forsyth. Because in about Christmas time, New Year-time 1997, there was a real hiatus at the Royal Infirmary in Edinburgh's A&E department, and it was a really big, big issue. And we took the view that we could deal with the immediate consequences, but there needed to be some longer-term thinking. That's what David Carter's review was about.

So it's important to put 'Designed to Care' in the context of a number of other things which were about reforming dimensions of the way all this worked together.

ES: I think that continuity of policy through from, elements of continuity through from the '90s into the devolution period is really interesting. We're about out of time for this panel. There's an artificiality in the structuring of panels partly dictated by functioning microphones and so on. In a sense, we could have everyone at the front for the whole time, but this means people get a bit of respite to sit back down, but I hope that we've covered most of the ground we need to. Any final points on this before we bring out our devolved panel? Malcolm?

MC: I mean I was going to make this point in the next panel but it's more appropriate to make it now because I was actually Labour's spokesperson on health prior to the 1997 election, so obviously discussed some of these matters with Sam. But I mean I'm really just, I suppose I'm asking the question, would we have been able to have a different White Paper as we did if devolution hadn't been coming? Because I kind of felt those restraints in my position and was actually working pretty closely with Chris Smith and Tessa Gerald, who led on health at that time before the election in England. And it was very much primary care groups, not GP fundholding, but groups of GPs commissioning. And to be honest although I would be more critical of that now, I could see the attractions of that in terms of I thought getting more into primary care, as it were, and similar to what Kevin said about the initiatives from GPs.

So it's really just to make that point and certainly I would see Sam Galbraith, and helped primarily by Kevin and also Gerry, as really the person who initiated this divergence of health, because although there wasn't a real internal market formally before 1997, there was the same system in Scotland and England. So the real break came with Sam Galbraith and the paper that Kevin was talking about.

KW: I think the answer to your question, Malcolm, is that I don't think it would have been that different, it would have been as different as it turned out to be, because there was no doubt that Scottish Parliament was going to come. And anyway Sam knew his own mind, and Donald Dewar respected Sam, and we hardly had any involvement with Donald Dewar or Sam's political adviser on health; it was all about an engagement with Sam. But he was remarkable in the sense that he gave direction, but he then left space for people to think about how they might solve this puzzle.

So I don't think it would have happened, it would have happened differently, I expect. Having said that, we still had to go to meet and Tony Blair's health adviser in Downing Street to discuss what we were going to do, there was still a dialogue. But the direction of travel was clear and it gave confidence to everybody that they could do something different, which would not have been as likely without the prospect of the Scottish Parliament.

MC: I'll make a point on that, I was actually the person who went to see Geoff Scaife prior to the 1997 election, but unfortunately I can't remember what I said to him, but it would be interesting just to know exactly. I don't think it was quietly as it turned out under Sam, so I would definitely give credit to Sam for initiating the divergence.

ES: That's really helpful. Thank you. Thank you so much.

Part 2: the early years of devolution

Witnesses on panel: Malcolm Chisholm, Susan Deacon and Dave Watson

ES: So I think when I initially came up with this event and Malcolm was very generous with his time in chatting to Kat and I early in the process, I hadn't perhaps been fully aware of how much had happened before. And so this moment was kind of my starting point. So I've learnt a lot already in the process of putting this event together. We have here Malcolm Chisholm, Susan Deacon and Dave Watson, who all held important roles during this period. I'll let you each start by saying, describing in your own terms, the roles that you had during this period, and then I've got some starter questions as well. So, Dave, shall we start at your end?

DW: Yeah, sure. I'm Dave Watson, at the relevant time I was a health organiser with Unison. I came to Scotland after I'd been on an English Health Authority for many years, in 1990 so I was mostly in health. When Unison was created in 1993, before that I'd largely been working with the genteel industrial field of admin and clerical workers. In 1993 I, I was in Glasgow, which, with the honourable exception of Yorkhill, was as Gerry said pretty toxic. I mean Glasgow was the wild west of industrial relations at that time. Gerry talks about cars and every year we used to organise, with the Glasgow Evening Times a photo of the chief execs. In one particular Trust one year he famously came out, polished it, just as a photographer from the Evening Times arrived. So that gave me a flavour of how industrial relations was undertaken: there was not much dialogue and plenty of newspaper action.

So when devolution came about, and there was to be a new HR strategy, based as Gerry said on partnership working, and much else besides, the partnership working was agreed. When I was seconded into the health department, for 18 months to implement the strategy, I set up a thing called PIN guidelines, which was common policies right across the NHS in Scotland.

And when I finished that I came back to Unison and slightly later I became Unison's Head of Policy Information, where I was involved in all the legislation both at service level and at political level. So, you know, I've got stories about my liaison with the UK government as well in terms of the challenges and the difference in the way we develop policy in Scotland.

ES: Thank you. Then we're really delighted to have Scotland's first two Secretaries of State for Health. Susan?

SD: Yes, of course. We weren't secretaries of any sort then, cabinet secretaries didn't exist, so we were just ministers. Yeah, so I was elected to the first Scottish Parliament in 1999 and appointed to the first Cabinet as, not insignificantly in terms of the title, as Minister for Health *and* Community Care, which was a big 'umbrella' in itself at the time. I served in that role under Donald Dewar and then under Henry McLeish and then Jack McConnell came in and I was invited to take on a different role in government, but for various personal reasons didn't at the time. So that took me through into 2001, which is where Malcolm can pick up, but there was a crossover because Malcolm served as deputy Minister for part of my time in that role.

We'll say more and we'll discuss more obviously about the specifics of the internal market and health policy and so on. But I think one of the important, a couple maybe important things just to mention about that transition into devolution itself, because I think this is often missed in a lot of study of public policy and politics over that period, is that the transition to devolution was the weirdest mix, in some respects, of continuity and change. Continuity in the sense that across a range of different policy areas, there was a kind of policy platform to build on, and I'm really glad that Kevin actually ran down a whole series of the health policies that had been, or initiatives or reviews, you know, pieces of work that had been initiated between 1997 and 1999, many of which then reported. There was also Bruce Millan's work in mental health, for example. So a huge, huge array of work was carried out in that pre-devolution period.

So there was an extent to which for us coming in as a devolved administration, in health, and elsewhere, given it was a Labour-led coalition, you would expect us to pick up and build on a lot of that. That was continuity, but everything else had changed. Everything else had changed in terms of the environment within which you were doing government, and I think actually the whole system at that point in time, and the Civil Service in the broader sense, was kind of reeling actually by just the degree of that change. I'll maybe come back to that because, you know, there are some really interesting metrics around what that translated into, just in terms of activity and accountability, and how you do policy and how you do politics. And of course everything was new. And it was new to the new people like me and it was new to the, I don't want to say old people, but people who'd served in Westminster because it was so different.

You know, so nobody had the blueprint for all of that. And of course the other additional thing, since there's been rightly a number of references made to Sam Gilbraith, as far as health was concerned everybody but everybody, apart from probably Donald and his inner circle and Sam himself, thought that Sam would continue as health minister. And of course he moved to education, the reasons for which I think I know but this is perhaps not the time to share. Nothing sinister in that, by the way, the point is that that in itself was also a big surprise to everybody, I think.

ES: Malcolm, as someone who had that experience of Westminster politics and then of new Holyrood politics, would you like to say a bit about the difference that made to the policymaking environment?

MC: Right, so I'm just going to do the general introduction first. Well, I've already mentioned the fact that I did health in opposition, but I then became Minister for Local Government, Housing and Transport and a few other things in those days. In the Scottish Office you did, you had a lot of policy areas. But I moved to the Scottish Parliament in 1999, initially I was on the health committee before becoming Susan's deputy and then the minister after that.

The most obvious difference, from where I was at the start not being a minister in 1999, was just the level of scrutiny and attention to health in Scotland in 1999 compared to, say, 1996 when you didn't get a debate on health in the House of Commons and really what you were doing was not subject to any scrutiny at all. So that to me was the big change and suddenly it was this goldfish bowl and health was the number one issue in that goldfish bowl.

So certainly Susan and I were immersed in innumerable issues during those first five years. You'll hear about another one on Monday with the publication of the report on infected blood, I'm sworn to secrecy on that. You will hear this afternoon about smoking in public places, which again the consultation on that began in my time as minister. And one of the other big things before I left office, I was involved in was setting up the David Kerr review. Although it reported after my time and I was very involved in selecting the people on that and it was very ably led Civil Service-wise by Derek Feeley and I'm sure he'll talk more about that later.

ES: Great, thank you, Malcolm. So, Susan, I suppose an opening question then is the continuity from the last panel. Would the reforms have taken a different path were it not for devolution, what difference did it make to that already underway dismantling?

SD: So I think there's an interesting question about the pros and cons, in a sense, of what was done in that 1997 to 1999 period. And the reason I say that is that almost follows on from Malcolm's question to Kevin and Gerry. There's kind of a question mark as to whether so much should have been done pre-devolution because it tied the hands of us when we came in. Now, 90% of what was put in train, coming in as incoming health minister, I was happy with, but there was stuff there that if I had been left to my own devices, and particularly in that new political context within which we were operating,

I would have done differently. So that's the flipside of there being this phenomenal amount of work done before the Parliament came in.

As far as the internal market's concerned, you know, you had the legislation in 1999, which extended to Scotland in terms of the abolition of the market. But as Kevin and Gerry have set out, there was this really interesting question about how you actually then dismantle what had been put in place around that. And the 43 to 25 trusts, or thereabouts, that had actually pre-dated devolution. Gerry, you wrongly credited me with that one.

GM: Yeah, finished before then.

SD: So that pre-dated devolution. So the question for me was, what next? And the fact of there having been this big upheaval in the service, immediately prior to devolution, you couldn't possibly expose the service to another structural reorganisation like that, and all that went with it. Which, Gerry, I know you were at the frontline of in terms of exiting chief executives and merging things and so on. So even if I'd wanted to, and I was predisposed against structural reorganisation because of my own background in management, organisations and so on, even if I'd wanted to, you couldn't have embarked on major structural reorganisation on the back of the one that had just taken place. But what was left there, wasn't necessarily the optimal structure for the future and, you know, there were two key things.

I understand the logic, and Gerry articulated it earlier around the acute and primary care trust model, but in some respects it was almost counterintuitive or at least the perception of that was almost counterintuitive to trying to get a more integrated system in terms of hard wiring that acute and primary care distinction. The second thing was that an awful lot of the same people were still in place. And I can't remember the specific point but someone made the comment earlier, about the system where change didn't really happen until leadership changed and the people changed. And that's a truism I think anywhere. So a big part of my focus was on changing people

and doing further structural change that was doable, deliverable but pragmatic.

So on the structural piece, and please, people in this room, I'm nodding at Kevin and Gerry, if my recollection's wrong, just by all means say. But my recollection was of really trying to push hard to say 'OK what more can we do to integrate the system and develop that partnership model without recourse to primary legislation?' - which would have taken time. We didn't have time, we wouldn't have unlimited time for a lot of consultation and proper design and thought, that's years' worth, and Malcolm could speak to that because he did see that through subsequently. But what can we do without primary legislation and without structural reorganisation? And essentially what we took forward was what I would call a governance review, a governance and leadership review essentially, to create these unified NHS boards to strip back significantly the number of non-executives that were appointed into the trusts to the bare minimum that you needed to have within the legislation. To bring the Trust chairs and chief execs into these unified NHS boards and therefore to start to model and practice a kind of partnership-based system. That was still bloody in parts as well, because there were people moved out of the system, but it was fundamentally different from, you know, wholesale structural change.

So I think I'll pause there because there's so much more to go into but, no, there's one final thing and it links to Malcolm's point about the step change in accountability. You think about needing different, fresh leadership in lots of parts of the system. And it wasn't as simple as often political journalists and others would say, that you had Tory appointments, so let's get Labour people appointed. It wasn't as simple as that. You needed people who were embracing partnership as a way of working and who would lead and champion that. Where that was their leadership style, they could model it, and that was particularly important for the chairs that we appointed for the unified NHS boards.

But you also needed the people who could deal with public accountability and the scrutiny that came along post-devolution. And there were bits of the system notably, and it's been referenced, Fife and Tayside stick in my mind, where they were on fire in terms of issues to do with service reconfiguration. And a lot of the local leadership could not cope, I would argue, with the kind of local scrutiny and engagement that was necessary to take that change forward in a post-devolution era. Where, not only did these become huge local issues for debate, they had by then become national issues for debate as well.

So you needed that effective local leadership that could embrace accountability and face outwards, and that, when I was reflecting for this event, actually the more I've thought about it, the more important I'd realised that was, and was uppermost in my mind at the time.

ES: And is it possible, Susan, to think about whether that increased public accountability and visibility, was due to the reforms or was it a feature of the devolved landscape? Does that make sense as a question, like would that have happened anyway if it had still been...?

SD: No, most of that I think was absolutely a function of accountability. And again on that, I've forgotten these numbers, but these are actually at the front of the Scottish health plan that we produced in 2000. You know, just to give you an example in terms of national activity, just as Malcolm said, leaving to one side media attention which was just wall to wall. But in Parliament there had been, in the pre-devolution period about a year before devolution, there had been one adjournment debate, which isn't even a substantive debate, on Scottish health in Westminster. There were 50 in the first year of devolution in Scotland. On average, pre devolution, Scottish Office ministers answered about 1,500 questions a year across all their areas of responsibility. I received 1,100 in the first six months of devolution on health alone. So that's why I talk about the faults in the system with the

Civil Service as well because, even just in terms of sheer workload, the culture was just completely different.

So I don't think, to try and answer your question, I don't think structurally, that enhanced scrutiny was significant in terms of the direction of travel. But I think in terms of the type of leadership that you were looking for and the kind of practices you were looking for, both board and executive leadership changed fundamentally as a consequence of devolution.

DW: I think, following on from Susan's point I think there are sort of three levels which hit me at the time. One is the political engagement that Susan and Malcolm have talked about, and certainly from an external perspective, we would go to Westminster two or three times a year to talk to a committee. Yet there was barely a week went by when you were not doing something in the Scottish Parliament. Remember the government brought in very early on the Memorandum of Understanding with the trade unions. This was not just for health, this was broader. So civil servants for the first time had to sort of ring you up and say I'm the new head of this project, you know, what do I have to do Dave, what are the issues, and so on and so forth. So that brought an engagement.

I think the second area was the impact on the Civil Service. And it wasn't that there was a team of civil servants who had necessarily the ideological objection to what was going on. But they had had 18 years of a Conservative Government so you get into a way of working, and devolution was a real shock to an awful lot. The level of ministerial involvement in the Civil Service was a shock to many. I remember one civil servant in my team, when I was working in the health department, came in, and she'd done a paper for Susan, and Susan had written all around the outside and on the back and the top of it - in green ink as well which was very naughty of you, you're not allowed to use green ink - and this civil servant said I've never seen anything like this ever from a minister. I mean normally you'd be lucky to

get a tick or something, you know, but Susan, a former management consultant, it was the other way around.

So there was a cultural change for a lot of civil servants. And then we shouldn't forget the London aspect, of course, the governments were the same politically, which had not obviously necessarily been the same. There was a very big difference in political action that I saw probably more later in my political role. But certainly, I mean I remember getting a phone call from one of Tony Blair's Spads, who had previously worked for Unison, telling me, you know, all these reforms, why are you not doing what we're doing in England, was the approach. The Tories say to us, if our reforms are so good why are the Scots not doing it? You know, and I said it's devolution, stupid! She even said to me, could you not sound a bit more like us? That was literally the words.

So I think those are the three levels that hit me in devolution. But, you know, do not underestimate the cultural change it had at all those different levels.

MC: Can I just, the reference to England was interesting for me there. And I suppose we're focusing particularly on the end of the market, the end of purchaser provider, although that's had some caveats even in pre-devolution days, it was different in Scotland. But I think what strikes me, looking back, is the degree of consensus for the changes that took place in Scotland. And the other thing is the extent of continuity. As I said to Kat and Ellen initially, I said look this is a process not an event where the internal market was abolished in Scotland. It's a process and we've all agreed it started, you know, with Sam Galbraith in 1997 and Susan carried it further and I had the bit at the end just to change the legislation. And sometimes people think it's him that abolished trusts, well, this is just formally true, but not really telling you anything important because it was a process and it had been happening for several years.

And in that process, as I say, there was complete more or less consensus in Scotland, and Kat and Ellen were saying to me who could we get to flag up that opposed this in Scotland? And we were struggling to find, I think actually some Conservatives, not even all of them, did speak out against it. I remember David Davidson and the final bill that formally abolished trusts, but very few of the stakeholders in Scotland were against this. For example, the NHS Confederation, Scottish Health Confederation were completely supportive of it, trade unions, you know, stakeholders in general. So it was actually a fairly in that sense painless process in Scotland. And also it was something that wasn't a matter of party political difference in terms of the main parties in Scotland, the SNP and Labour. And as an addendum to that I would say that there has also been great continuity in the course of health policy in Scotland in the transition to the SNP.

So finally on that I would say in terms of the contrast with England, this was a problem for us, because England was actually initially more successful in dealing with the problem of waiting times, and this was attributed by some people to the fact that they were engaging in market reforms. In fact, this was particularly so after Alan Milburn took over in 2001, and there was far more use of the private sector and far more attempt to have a market and eventually with foundation trusts. But I think time has borne this out that actually those market changes were not the fundamental reason, but at that time England was slightly ahead in terms of waiting times and I could give some other reasons for that.

There were actually things in the English Health Service that I very much admired, for example the collaboratives. There were a lot of those in England and some of those eventually started to form in Scotland, I went to visit one during my time. And so they had lots of measures like that that I think were probably very effective. Also quite a lot of command and control and targets in England, forcing people that, you know, was quite effective as well. And of course the additional resources, which was probably the key factor alone

when it came to the English Health Service. But I think that was an issue for us at the time and, you know, we were under quite a lot of pressure.

Finally the criticism by say Tony Blair, I remember once at a Scottish conference, he was critical. But firstly, the reason that England got ahead in waiting times was not because of the market. And secondly, and I should also put this on record as well, we were under no political pressure to go down an English route. Because I know it's sometimes casually said oh when you were in government you had to do what London instructed. Well, the key disproof of that is free personal care, as we all know. But the reality is in terms of the organisation of the Health Service, notwithstanding what David may have heard, you know, in terms of individuals at Whitehall complaining, we were under no pressure to do things differently.

So in that sense devolution actually was effective, we actually could do things differently in health and we did.

KW: Ellen, I wonder if I could ask Susan to comment on this theme of inter-government relations. Because one of the things which happened very soon after devolution was that the new inter-government machinery was invented of joint ministerial committees, and health was the first one, and my recollection is that you attended all of them. And they were in Cardiff, Belfast, I think there was one in Belfast, one in Scotland and one in Downing Street. And this was a very interesting dynamic still relevant today, you know, joint ministerial committee, we hear about them, but I'd be fascinated to hear your take on that.

SD: Yeah I'm really glad you mentioned that. I'm sorry, I'll try and keep this brief or I'll speak about this for a long time. So the notion of joint ministerial committees, if I recall correctly, was a Gordon Brown invention that he announced to us all. But the health one took on a very different form.

Because it came on the back of what had been a really difficult winter for the NHS with flu in the winter of 1999/2000, Tony Blair decided to chair it himself. So, as Kevin said, this committee met four times. I was very cynical about it to begin with to be honest, I thought it was all very performative and so on. I was astonished by just what kicked in by way of the Civil Service activity around it, and briefing and organisation. And it was to be attended, they were attended by the First Minister, the Health Minister and the Secretary of State for the four nations. And the civil servants and all the four nations were trying to kind of script and choreograph this entire thing and it was, you know, the Prime Minister will say X and then the First Minister will say Y and then you'll say Z.

And I'll never forget the very first one, being so relieved that, though there was this fanfare of publicity, it was in Cardiff, and, as well as us all sitting around the table, teams of officials were sitting around the outside of the room. And you know, Tony Blair sort of got as far as welcoming everybody and just ignored the script from there on in and just really set it up as a real, proper discussion about health. I to this day feel really privileged to have been involved in those discussions, because they became real. And I remember the one that was held in the Cabinet Room in Number 10, John Reid was Secretary of State for Scotland at the time, and we were sitting in the Cabinet Room surrounded by all the portraits and all the rest of it, of PMs past. And at that time Donald Dewar was ill so Jim Wallace was standing in as First Minister. You had the executive in Northern Ireland which was active, it went through spells where it wasn't, so David Trimble was there as First Minister and Bairbre de Brun, a Sinn Féin Health Minister was in the room, and then probably the rest of the people in the room were all Labour people. But I remember John Reid, then Secretary of State, leaning over to me saying, "Susan, it's at times like this you have to remember you're part of history in the making".

And do you know, it was phenomenal, to have that combination of people and that mix of party politics actually genuinely sitting around talking about how to provide health services and how to learn from each other. I'm not

saying it was all perfect, I'm not saying they delivered huge amounts of goods, you know, all of that. But something that I thought could have been really just for effect, I actually thought it had a real function. And I would, by the way, completely reinforce what Malcolm said that I never ever felt that we were under any pressure to follow what was happening south of the border. I'm conscious of time but I'd share a couple of things that might be of interest, I think, for the research and for this audience.

One, I think, if anything the problem was that they weren't that bothered about what we were doing and I think recent research papers and so on, this has been dubbed the 'devolve and forget' mindset. And that was sometimes a little problematic. Hesitating whether to share this, but I do remember when Alan Milburn produced the NHS plan in 1999 and I think I'm right saying it was a conference call with the four ministers. The other three of whom all happened to be female, which was just was an interesting dynamic too. We had to really press the point home that this could not be a UK plan. You know, yes, we were happy to, and I think there was a front section added to this effect, we were happy to continue to endorse the founding principles of the NHS, but this could not be a plan for the NHS across the UK. That ship had now sailed. So there were times like that you had to remind your counterparts that devolution had happened, but in terms of pressure and policy, that wasn't the issue.

ES: Philippa, did you want to add anything?

PW: It was really just to come back to Malcolm's point about waiting times and, you know, sometimes the aspersions cast on the NHS in Scotland. But I was obviously a cancer consultant at that time, and it was that freedom to decide what are our issues in Scotland, which was obviously things like not just waiting times but what's actually killing people. And it was recognised by the coalition government and then followed on from the SNP later, actually what was killing people was cancer, was heart disease and was mental health, suicide. So those were the focuses and that's where the money went. That's how we got things like the Scottish Cancer Group that I was part of,

Clinical Standards Board, referral guidelines, managed clinical networks. I mean there was just an enormous energy that went in to those three specialties particularly, because that's actually what was killing people in Scotland, rather than specifically how quickly you had your operation done. And while obviously the backlog from the pandemic at the moment is appalling, if you were a young surgeon, if you had something quite benign, you could be waiting years. I mean I remember when I worked at Canniesburn, a girl who'd finally got called to get her ears fixed, pinned back, she'd jug ears, the NHS doesn't even do that now. And she said could I give my slot to my brother because he's 30 and he's bald and it bothers him, I can hide mine? She'd literally been on the waiting list for 15 years.

So we had that kind of thing. If you were urgent, you got done. If you need it done quickly, you got done. If you actually had something that was relatively benign-ish, you could languish on waiting lists for years. So there was already improvement in waiting times, but not putting that as number one. It was actually looking at what are the most important conditions in Scotland, and that was the freedom that the coalition government had that they didn't have before devolution.

SD: There was also an important shift, again, Kevin and Gerry will remember this, from the emphasis on waiting lists to waiting times. Which was important because the pledge, the Labour pledge was about reducing waiting lists, which was just wrong, it was the wrong measure. It wasn't about how many people were ahead of them in the queue, but how long they would have to wait. And I remember being the person that had to sort of take what was a very short-term hit , but it was a hit nonetheless, you know, of u-turning on the pledge by saying that we would shift to waiting times. And those kind of shifts were important. And I will just say one thing. I know we're looking back rather than being contemporary but, having looked at, putting myself back into, immersing myself and reading about some of these issues over the last couple of days and looking at some of the current policy narratives around issues like governance and leadership and

management of the NHS and so on. I would contend, and by the way I've not been in a political party now since 2008, so this is not a partisan point. I would contend that actually there was a depth of analysis and work done during the early years to really think about a lot of these things; how you operationalise, how you actually change systems, practice and culture. I think there's a lot more superficial narrative now, rather than getting underneath what is complex system change. And I'll just leave it at that I suppose.

Sorry, one other thing just on Malcolm's point, just for the record, because we've all been dusting down our memory boxes. That thing about a continuum is really, really important to stress, absolutely from, the initial 1997-1999 period that's been spoken about, and then when we launched the health plan in December 2000 this was a Herald headline 'Executive's bonfire of bureaucracy will scrap hospital trusts in five years, boardroom purges will start shake up.' You know, so it wasn't just myself, I mean it was explicit, we were on a journey, but you had to do it in bite sized chunks.

ES: We've got lots of hands up. Philippa wants to come back in.

PW: No, it was really just what you were talking about waiting lists versus waiting times. As I said I was already a consultant in the mid-'90s and what we were getting was we want you to do waiting list initiatives, we want you to do a Saturday list and we want you to do 8 toenails. Rather than actually here's someone who's in pain or here's someone who's waited a long time. And there was a lot of anger in the profession, in the frontline staff, because clinically it made no sense. And I think that's a big thing that came from devolution, and it was talked about by Gerry and Kevin, how shallow the hierarchy was from the frontline. I worked in the bottom left-hand corner of Scotland, I was in St Andrews House quite often, but you could actually get over "that makes no sense". And that's something when I talk to colleagues south of the border, the sheer scale and the sheer height of the hierarchy meant people couldn't get that common sense into the sector.

ES: Richard has been very patient…

RS: What we did have as well, and alluded to, is in terms of scrutiny and accountability in the Health and Sport committee, which was very collegiate. In that first committee, it was often quite difficult to tell which party people came from, which I think has changed. But there were a number of things happening. First of all, we had a system which was near abandoned, which was an individual MSP could act as a European-style reporter, and I actually did three reports in that first year, 18 months. One was Stobhill medium secure unit. That's irrelevant about the unit itself, but what it was about was how the health service consults in their area about the changes that we're making and they had failed to consult everybody. I mean the board had just simply made a decision as to what was going to happen and the fury both by clinicians and by the local community around Stobhill was tangible. And I went out actually with a civil servant and took, or I went to a civil servant and we took evidence from people in the community and from the clinicians.

The result, actually I don't know whether it was Susan or Malcolm who introduced it, but we had a new rule that there had to be consultation. And that was the nascent PPI which has become a really major thing, I think it's a major development that was really started at that time. But the health and support committee really did hold, I think, the minister's feet to the fire over issues. And sometimes the Labour and Liberal members would fundamentally disagree with the respective ministers on government decisions.

ES: Thank you. Kevin and Gerry, I'll put questions together, if that's all right…?

KW: I just wanted to return to waiting times very briefly and then I want to go back to the parliamentary scrutiny point. On waiting times, when I rejoined the Scottish Government, in 2005, there was a very real sense of a performance gap between the NHS in Scotland and in England on waiting times, which is why we invented a delivery directorate to really focus on that. And they came up with HEAT, which was the performance management frame. So Susan's right, there was a shift to waiting times, and we used to do a monthly press conference on the latest figures. But I'd like to go back to the discussion about scrutiny, because I think this is really important. The level of scrutiny that Susan described after devolution was completely different from that which went before. And in addition to Richard's committee, the other powerful committee, was the Audit Committee, where I think I had a season ticket. Anyway, leave that to one side.

My question to Malcolm and Susan is what the consequence of this enhanced scrutiny is? And I've often pondered this, and I don't really know the answer to my own question. Do you think this intense level of scrutiny we have now has made difficult decisions easier or easier decisions more difficult?

ES: Excellent question. Yes, does anyone on the panel want to, you can all duck it as well if you wish, but if anyone wants to reply?

MC: Well, I mean I think the Health Committee was a very effective committee in the early years while I was in it myself, so I'm a bit biased. But I noticed that when I was ministering, you certainly didn't get an easy ride from members of your own party. But I mean a lot of my thinking about health and politics generally is obviously comparing the two parliaments and so on. And I think we do forget, Philippa might be able to comment on this, but we do forget the select committees in the House of Commons. And I do think there is a similarity between the kind of scrutiny they sometimes give on Health and other matters and what we've got in the Scottish Parliament.

So I don't think it's unique to the Scottish Parliament, but I do think it does, certainly in my time did put a lot of pressure on you. I think that was generally positive because it really meant you had to be on top of your brief, you had to be able to engage in very detailed debate with the committee. I don't know if that is quite the same, the case now. I think it has become more party political now and ministers, not so much now when there's a minority in government again but I think ministers have perhaps been relatively protected by when they've been a majority government in the Scottish Parliament. But certainly I would say it was a positive thing in my day and I'd certainly have no complaints to make about the committee system and I found it exactly the same when I moved on to be minister for communities. So certainly in my time as a minister, Labour members, never mind Liberal Democratic members, were certainly not being always entirely helpful to the ministers and that I regard as a positive feature of parliament.

SD: I'll take a slightly different tack here. I believe passionately in public accountability, I really do, at a number of different levels. I also believe passionately in building widespread shared understanding of what's really happening in our society and our public services and having open discussion around these things. I think the nature and form that that debate has taken in our politics, north and south of the border but especially here, is entirely bad, entirely bad for improving public services. And that's about the way that people have gone about that debate. It's about the way, you know, you've got that complex mix of politics, media, and now social media.

And instead of actually shining a light on our public services and building that shared understanding and bringing in people that work in our public services for informed discussion around what's happening with them and so on, we're getting this horrible knockabout that's ill-informed and immature and that is just chipping away more and more. I think even just morale for those that are putting in a tough shift, tougher than ever in some cases, in our health services and in our public services. And I think we have to think as a society, I think we have to think radically about how we try and insulate our public services from that kind of knockabout. Not how we use

accountability but how we actually properly build understanding and stop them from being a political football, because I think it's in such a bad place, yeah, I know that's a bit of a provocation.

ES: Two alternative views. Gerry, did you want to make a point?

GM: Yeah, it's an observation about what Susan made reference to around culture and leadership, governance and scrutiny. It is difficult in a kind of research way to capture that, the evolution of that issue, as you see structure in political change and in the system. But the reality is if you take a place like Tayside Health Board as a case study, pre-internal market, during internal market, post-internal market, it tells you a lot about those very issues and the dysfunctionality that emerges out of culture, leadership and governance and scrutiny. And just rolling it forward, I mean I do understand that the public accounts body on appointments was designed to depoliticise appointments to public bodies. But the reality is that when you look at the specification or the individuals who will succeed to occupy our health boards and other bodies, it's not designed to tackle open, transparent, scrutinised system like health, in actual fact it's the opposite. And that's not something that has been, I believe was beginning to evolve in the early days of a devolved Scottish Government.

MC: Well, if I can just in a kind of way pull it back to how the system worked post-internal market, but also following on from Gerry, because one of the things that must be obvious to Susan, as to me, is that there was an unevenness obviously in the success with which different health boards managed the new arrangements. And certainly for me, and I'm not saying this because Gerry's here, but NHS Tayside in my day was the board that I looked to as a kind of model board in terms of how the new system worked. And of course it's not just Gerry, but his chair, Peter Bates, who sadly died several years ago now. And who I actually brought into the executive before I moved on in order to help us move forward, and I think he made a massive contribution to the executive when he was there.

But I think what I've learnt from them was, and what is important for our theme today, is that just because you're moving to single system working doesn't mean that you're ending some kind of separation, to some extent, between the planning of services and the management of services, that was still important. And this is sometimes lost in the debate about the internal market and purchaser, provider and so on. You don't need to have a purchaser and a provider, but you can separate the roles of operational management and that was so important and the wider planning roles of health boards. And even as we moved on to the new system, I still had my fears and I actually articulated these very explicitly in the White Paper that I was responsible for Partnership for Care, there was always a risk that the system would become too centralised. And that is not what was intended, although sometimes it may have happened either too much centralisation in the health board or too much centralisation in St Andrew's House. But operational management was still important in the hospitals. And also devolving power to primary care, which was what Community Health Partnerships were an attempt to deal with, it's another subject whether they were successful in doing that. But the intentions certainly of single system working is not to create a centralised system, and I think it's very important to emphasise that as part of our debate today.

And my final point is this. To me, this is an issue of comparing the system, which we have had with some continuity in Scotland, with the continually changing system in England. And although at times in the day of Susan and I it appeared that England was doing better on certain indicators. And thank you Philippa for emphasising what we emphasised the importance of coronary heart disease, cancer, mental health, which was not to take away from the importance of waiting times but in those days England felt "oh our system's better because our waiting times are better". Well, the waiting times, even by 2007, had evened out and certainly in general have done over the last two decades. But what we've seen in England is in fact a realisation that the market they created, created enormous problems. The great progress that was made in health under Labour in England was not

fundamentally because of the market. And what you're seeing is even a Tory government now more recently moving back towards more integration, and that is again a subject for another discussion. But basically I think time has actually proved that we were wise in Scotland not to go down the English route, to create a system which was based fundamentally on integration, and there's been a lot of discussion today about breaking the barriers between primary and secondary care.

A lot of the support for the final formal abolition of trusts was articulated in those terms by the NHS Confederation in Scotland and others as a way that single system working could help to break down those barriers. I know that's not been entirely successful, but that was partly what the intention of it was, and I think it helped to achieve it and I remember some of the evidence being given on the bill. I remember, for example, Malcolm Wright, Chief Executive of Dumfries and Galloway, who'd already got rid of, dissolved his trusts, saying it had already helped to create more integrated working and more breaking down the barriers between primary and secondary care.

So I think it's important to remember these wider issues. We've come up with lots of other issues this morning about devolution in general and many other topics. But I think without being complacent we can look back and feel that we did, basically from the day of Sam Galbraith onwards we did go down fundamentally the right path in Scotland. Although I admire a great deal that Labour did in England in the Health Service, I believe that from the first decade of this century, went down the wrong route in terms of the organisation of the Health Service in England. And I think to some extent that has had to be undone more recently in the Health and Care bill. But if you can read a book I would recommend by Callum Paton, which was on the reading list which I assume Ellen gave to everyone, it's really well worth reading because it's the best analysis of the English Health Service that I've read.

ES: Malcolm, once a teacher, always a teacher. It wasn't a reading list and there's no homework. Thank you so much. We're going to move into our final session now, but there will be lots more opportunity for input from everyone on this panel. Thank you very much.

Part 3: reflections on the reform

Witnesses on panel: Derek Feeley and Philippa Whitford.

ES: So to move into our more reflective session, I'm delighted that we have here two speakers who can offer big picture reflections on Scotland's new system compared to others, both in the UK and more broadly. So, Derek, can you start by describing the roles that you had during the, in NHS in Scotland specifically?

DF: I'm relatively later to the party than most people who have spoken before me because at the time of those changes that people have described, I was actually the Head of Sea Fisheries, in the time of the Scottish Executive. Which actually was quite good grounding for myself, people used to say to me, I don't know how you deal with the doctors, and I would say I've had fishermen as my stakeholders, doctors are easy compared to fishermen. But I guess my introduction to this firstly was as Principal Private Secretary to the First Minister, which I did between 2001 and 2003. I then became the Head of National Planning in the Health Department and, as Malcolm alluded to, my major role there was to support the work of David Kerr, on the framework for service change in Scotland, a piece of work that Malcolm commissioned. David used to describe me as his minder, he needed quite a lot of minding. You probably knew that when you appointed him! And he'll not mind reading this, he'll love that reference I suspect. And from there I became the Director for Policy and Strategy in the Health Department. And my final job in Scotland was to succeed Kevin as Director General for Health and Social Care.

ES: Thank you. Philippa, do you want to just explain a bit about you?

PW: Yeah I feel I'm probably the one that goes further back in the whole room, except, maybe, Richard. I graduated in 1982 as a surgeon, that was at the

time of the ancillary staff strike, dinner ladies, porters, etc. We then saw the outsourcing of those services in the '80s. The internal market started to come in, as we talked about, in 1990. I then worked overseas as a medical volunteer for a few years and when I came back, I became a senior registrar in Aberdeen, that's when I was talking about the behaviour of GPs. I became a consultant in Crosshouse in Ayrshire, so one of the 'us and thems' that was referred to in the first session. But very quickly became involved in these bodies that were happening in the second half of the '90s. I was on the Scottish Intercollegiate Guideline Network for Breast Cancer under David Carter, I was then part of the Scottish Cancer Group, Scottish Quality Assurance Cancer Group, the Referral Guideline Group. And then got called into a room by Naren Patel, who was talking about setting up the Clinical Standards Board, and I thought great they're going to have clinicians. And he said who do you want on your team? And I realised ah OK, so I'm not contributing, I'm doing, and I led that until 2011.

And that I would say, the biggest differences, I've been at Westminster since 2015, I was health spokesperson for the SNP for six-and-a-half years and was on the Health Select Committee in Westminster for three years in total. And I find that it's amazing regardless of the party if you've been listening to evidence for two months on a committee, the vast majority of reports are unanimous. We may argue about the language, but actually what we're saying is the same. But I think the biggest difference of the route Scotland went down and was empowered to go down purely because of devolution was what we've heard talking about, is collaboration, is joined-up working, pathway development, patient-centred care. Not budget-centred care, that's really important.

Whereas, in England, both under Labour and then later particularly under the Conservatives with Health and Social Care Act, there was this idea if trusts were competing financially, you would get better quality because they were competing for customers. But some patients are not really like that and what you got was everything became budget-centred care. Where we

were doing work on clinical excellence, so setting guidelines, writing standards (I led on the breast cancer standards, as I said, back in 2000) it was all about sitting in a room, putting up our data, which still happens every year in Scotland, where we discuss, "oh we had trouble with this last year", "well this is what we did". You know, M&S and Debenhams are not going to share ideas of how to get better customer service, whereas there was no barrier to that in Scotland.

Whereas I remember I was a clinical adviser to Breakthrough Breast Cancer and there had not been any breast cancer audits of symptomatic services since 2009 because it was left to the clinical commissioning groups, who didn't have the expertise or the input, whereas we were able to do that. So that collaboration rather than financial competition I would say is the biggest difference north and south of the border.

ES: Would you agree Derek?

DF: Yeah I think that really captures it really nicely. Previous speakers have all described, I really like what Malcolm said about this having been a process. And it's I think a process that has been characterised by continuity, we haven't jumped from initiative to initiative. We've had this kind of path in our minds and we've continued upon it. I'm very glad that Susan Deacon said that, you know, we didn't need further structural change at that time. Again that's been a kind of, we've tried to minimise the structural change as far as possible throughout that period, the contrast there with England I think, where they've had multiple of those kind of changes. But I think we made a choice in Scotland throughout that process, where we would, we chose collaboration and collectivism over choice and competition. I think the other choice we made was continuity over change, unless the change was meaningful for patients, but in structural terms we chose a continuity of structures.

PW: I think that enabled a lot of things that maybe get lost in the heat that Susan was talking about in the media, often is into the minutiae of something. But, you know, looking at the literally circular reforms that were happening in England over the last 35 years from a hundred strategic health authorities to basically 300 primary care trusts, then down to 150 primary care trusts, then up to 210 clinical commissioning groups. And what you were often having was you had all these people made redundant on a huge package, and then someone very similar, maybe even the same person, was getting the same salary for running a smaller organisation.

So the clinical disruption, the changes of letterhead, you know, the administration of changing all of that. And one of the things that the Health and Social Care Act, which made all of the trusts separate legal entities, in COVID, when we got the vaccine at the end of December 2020, the Pfizer one, we were able in Scotland, because it was a single legal entity, to have vaccine teams going into care homes, the most vulnerable group, vaccinating residents and staff from mid-December, because it was recognised by MHRA as a continuous legal cold chain. Whereas I remember in England I think it was Barts ran out of vaccines for staff, couldn't even borrow doses from another trust, because they were completely separate legal entities. And people often think about the competing between NHS trusts and private providers, like Circle or Virgin, but actually in big conurbations in England NHS trusts were all competing against each other. And you had the huge waste in that. I mean even the internal market, that paper in 2005 from York University that was never published but shared with the Department of Health, showing the increase in admin costs of the internal market from 5% to 14%. We have no idea what the Lansley reforms cost, but it will have been utterly massive. And if you've got all of this which is buying and selling and moving computer money around, that could actually be going on healthcare.

So I think keeping a single unified Health Service, and obviously the integration that started in 2014 with social care is much more challenging

because it's a much more varied landscape. Obviously you've written extensively on that, than bringing just primary care and hospitals and bringing trusts together as happened for us in Ayrshire. But the two systems have ended up very far apart, and obviously the Health and Care Act, which was the last big piece of work I did as a health spokesperson, spent three months in committee, was trying to wind some of the worst excesses of that back and make it back to place-based services and more integrated. It's a long way from knowing how successful it will be.

ES: I'm minded that, as Malcolm alluded to, this is such a consensus issue in Scotland that we really tried and failed to find opposing voices, around this issue in Scotland. And so I'm keen for us to, I'm thinking about some of those points that were raised in the first session about some of the good things that might have been enabled by the internal market within a context broadly of people thinking it was not very effective. Does the current Scottish Government structure allow for enough local innovation?

DF: I think it does. And I think some very specific things are required to enable that innovation to flourish. And most of them actually aren't about the structures. If you look, for example, at the integration joint boards and the variation that exists in the extent to which health and social care has been integrated through those structures, the very successful ones are successful largely because they've invested in building relationships. And I think that has something to do with the kind of partnership ethos. We need to take the time to, and with a bit of humility, to ask questions and seek some kind of agreed solution, we make these things work. And, you know, not unlike the times of the Kilmarnock and Ayr scanner wars, when you don't invest in the relationships, no amount of structural change can overcome that.

So yeah I think a lot of that goes back to those kind of pre devolution days I would imagine the same was true in Ayr, what made it work, or in Oban,

what made it work was that the local clinicians could come together, build really good relationships, come to a common understanding about what would work for their population and move that on.

PW: I think it goes back to Susan's point about leadership and people, you know, I was in Crosshouse for almost 20 years. We had one executive or medical director, I can't remember his title now, who was just wonderful! I remember him coming to the one-stop breast clinic and obviously…

[Brief interruption for test of fire alarm system]

PW: Well, obviously, in my time as a breast cancer surgeon from early '80s, we evolved into what was called the one-stop clinic. So the patient came, now they were there for hours, they were there a whole afternoon, but they got everything. They got their mammogram, they got an ultrasound, they got a biopsy, they got an initial result. So they came in and they either went out already knowing you're fine or actually being able to face what was coming. But it was expensive, you had a radiologist, you had a pathologist, you had a radiographer, a huge team that was delivering that. You know, so there were management going well, you know, "does that really make sense, it's a bit too expensive". But, you know, this chief executive actually came and spent a whole afternoon in the clinic and went now I get it, and then enabled what started for us in 2000 in Crosshouse, which was a breast cancer redesign.

Unfortunately, by the time we'd finished about a year and a half's work, we had a different chief who then was like "talk to the hand" and wasn't interested in delivering what we'd worked on. We went ahead redesigning what we could control. But I think that also came right from devolution up, which was the empowerment to say we could do this and we could do this as suits us. And I think the thing that Susan was talking about, the public

engagement, you know, when it was Scottish Office, which didn't even have the word health in it but was responsible for so many different things and was so far away, the public just kind of felt that's the NHS, you sit for hours, you wait for years and then you maybe get something. Where suddenly it was now here and they could engage, and they felt they could make a difference. And of course the media wanted to kind of involve all of that.

But if you look at all of the circular changes, the energy that's gone on the circular, well if that hasn't worked quick enough, try something else south of the border. I think regardless of who's been in government or who's been director of the NHS in Scotland, the fact that we've been willing to keep at it, you know, quality improvement, patient safety programme, whatever, involve frontline staff and keep at it, it will take time to deliver. I think that is really important, but managing that in any area is having good leaders who will listen and engage and empower.

ES: Kevin, did you want to go?

KW: Yes, thank you very much. Just listening to the conversation there, the word that's racing round my mind is incentives, and you've actually described a set of different incentives north and south of the border. But I want you to reflect on Scotland and try and answer this question. Over the last 25 years, what are the incentives you think we got right and what are the incentives where we perhaps need to do more? I'm not talking financial incentives, I'm talking about incentives more broadly that drive individual and organisational behaviour, things like, you know, motivation for clinicians. So incentives, I'd just be really interested in your reflections on that subject.

DF: I mean I think some of that, Kevin, goes back to that question about our ethos. Fundamentally I think the incentives, the motivation for clinical teams and indeed executives and non- executives in NHS Scotland have been

intrinsic, where we are motivated by wanting to do the best we can for the people we serve. And I think the approaches that this devolution journey has spawned speak to that intrinsic motivation. There was mention of the Scottish patient safety programme, for example, Philippa, that's a great example of something that was designed to tap into those intrinsic values. No-one got any more money for participating in the safety programme; people did it because they want to make care safer. I don't think we could have pulled off a national collaborative of that nature without some of the underpinning that the devolved legislation and policies enabled, without that stress or that focus on we're going to do this together, we're going to act as a collective, we're not going to compete.

So I think the direction of travel has, and the nature of the motivation and the incentives, Kevin, have actually dovetailed pretty well, and also I think there have been some dissonance. And I think, and some of that I think sits in an occasional toing and froing approach, partially from ministers but maybe more so from us in what was the NHS Executive and became the Health Department, in terms of our relationship with the provider organisations. Sometimes we turn the performance management tap on, and it is a bit about command and control and targets, and I have never been a big fan of those kind of incentives. I understand the political attraction in having a target, but as W Edwards Deming would say a target is just an aim without a method.

So I think what we need to, what we've been perhaps guilty of occasionally, and we need to watch out for the future, is that we stick to our beliefs that those intrinsic motivations are really what's going to work, and we don't start to dabble in the derived motivation that comes from targets and performance management and command and control.

ES: Richard and Susan?

PW: Can I answer it? I mean I think you know I would say one of the issues with targets is a management team, and particularly when we say targets we're often talking about waiting times, waiting list targets, then that becomes the thing that's measured and discussed. And when you're coming with something else, so whatever the waiting time target was, 18 weeks or, you know, something or other, and I'm going that's no use for someone with cancer. Here's the cancer targets, this is the SIGN guideline, this is the Clinical Standards Board I'm trying to get, and you're focusing on what is most clinically important.

I mean in financial incentives obviously the Clinical Excellence awards and things were largely taken away in Scotland, we didn't actually lose all of our consultants. And I think that values approach that Derek was talking about, when we set up the three managed clinical networks, west, east, north, to introduce audit, to measure ourselves against the new clinical standards, what you were bringing, that openness. I mean the very first one was anonymous, you know, hospital one, hospital two, hospital three, but people all stood up and said well that's Crosshouse and this is the Royal and we've got this issue and anyone got any ideas? By the time we did it the next year, it was all just everybody's name on it.

So I think you start to actually enrol people, you mould people in that sort of shared collaborative approach and its quality, so it was peer reviewed. When I went to Westminster, I couldn't believe the hospitals that were struggling, by whatever definition, actually faced having funding cut. So you're making it worse. And what we never did in the clinical standards board, we had a standard you had to get over, and everyone could get over it. We never had a league table, because what if the range is 95 to 99% and the 95% hospitals in the local paper as being bottom of the league? That's a massive disincentive. So you were empowering people to discuss how they could improve their services and it was purely based on peer review, not some kind of external threat. Because I couldn't understand why you would threaten a hospital that was struggling in the first place of taking away

funding then staff start to haemorrhage then it literally goes straight down the pan.

So that I think, regardless of who's in power in Holyrood, that from there down within the NHS, was if you like, it would feel like we were moulding young surgeons and physicians coming up. But also the people who got engaged and were active were people who really wanted to do that, and I think that left the handprints. But, as I say, who your leader was in a health board, who had the power to empower you or disempower you, is just as important as it has always been.

RS: Philippa has actually raised one of the issues I wanted to raise, and that is the concept of managed care networks, because that was fairly unique up here, it was part of the collaborative cooperative system. I was fascinated in 2013 when I had my cancer, oesophageal cancer, Forth Valley had bought into the MCN of the West of Scotland, so I had stuff done at the Beatson, I had stuff down at the Glasgow Royal, I had stuff done at Larbert. But when I talked to Jimmy Forster, who was the main surgeon at Glasgow Royal, he said there were two boards who had not bought into the MCN, they were still doing their own thing. Now, their results may have been reasonably good because the surgeons were very experienced, been doing it for a long time, but what they didn't have was the backup stuff for the subsequent physiotherapy, in my case and in some cases speech therapy as I had problems with my voice after it.

So, you know, there were lots of other issues around it of not having MCN and so my question really to Philippa, does she think the MCNs have been properly developed? And the other side of that is that if you look at the Commonwealth ratings of, not so recently because we have problems with waiting times and waiting lists, but until certainly 2013/14, if you looked at the rankings of the UK Health Service as a whole, you know, we were, out of eight or nine items, we were one, one, one, one, two, one and then you

came to outcomes. We were ninth out of 10. So at the end of the day, what really matters to the individual patient surely is what the hell the outcomes are. And if all this discussion, whether you're a competitive system in England or you have a collaborative system in Scotland, if our outcomes are not actually substantially improving and putting us up that ranking, you know, what is it all about?

PW: Well, the whole point of as I say the standards which were then delivered through the managed clinical networks, the data and audit was absolutely central to that. I mean when we did, in 2001 when we finished writing the standards, we literally moved around Scotland visiting every single breast unit, meeting the staff, looking at the facilities, what they had, what they didn't have, how they organised a multidisciplinary team meeting. And often you had like the three different meetings because they couldn't all agree to be together at one time. You had about a third of the units in Scotland collected no data at all, they couldn't even have told you how many breast cancer patients they had looked after the year before.

By 2003 we were all using the same definitions, we were largely using the same databases and we could suddenly produce all of that data against the standards for every unit in Scotland. And what you then saw was the impact from there over the subsequent five, seven years of them kind of just moving up. Because people would turn up and they'd go shit we're bottom of the heap, you know, and go back and actually want to understand why everyone else had been driving their performance up and they hadn't. And that was all clinical. There was initially waiting times in it, in 2007 we took that out, because we said that's looked at by other people, that is not changing outcomes.

But in the Commonwealth Fund actually where we were, where the UK was always worst, was much more about survival and life expectancy, and that's way beyond the NHS. I mean poverty is the biggest single driver of ill-health,

and the NHS can't fix that. It unfortunately sometimes reinforces it with health inequalities, you know, talking about the map or the decisions about where facilities are and how easy they are to access. But, you know, the NHS is an illness service. What you actually need is a wellbeing system that's investing in health, and that's literally from early childhood onwards. And I think, you know, the Scottish Government founded the Wellbeing Economy Governance Group in 2018 with Iceland and New Zealand, they now have Wales, Finland and Canada. There's a growing recognition that we're picking up the pieces, but actually all the stuff that is driving patients towards us, it happens out with the NHS, and we're sitting there in a boat that's got a hole in it trying to bail it out.

So, you know, there were things in the Commonwealth Fund, obviously there was the big report in 2014, and that didn't yet show any of the changes that were, you know, the Lansley reforms were not kind of in at that point. But to me the managed clinical networks brought people together, not in a threatening way, not in a if you don't hit this your money's cut, but in a learning from each other way. It's really what the theme of this morning has been, that kind of collaboration and sharing solutions, and it was often our performance on this standard has gone down and someone else would say, you know, might be Edinburgh Royal, we were there two years ago, this is what we did, why don't you try that?

DF: My recollection of that Commonwealth Fund report's not, you know, not quite as bleak as yours Richard, but I could be wrong. I haven't looked at it for a while. We did fund in one year of the survey, a sufficiently large Scottish cohort to draw some comparisons between Scotland and England, and I'm raising this point because you'll be able to guess that the outcomes were better in Scotland than they were in England. I think the point that Philippa made about what are those outcomes related to, I think points to perhaps one of the failings of devolution so far, which is we continue to have massive health inequalities.

So the extent that there are poorer outcomes, you'll know better as well as anybody in the room, largely those are driven by very poor health outcomes for a sizable proportion of Scotland and actually not too bad for me. Devolution has made no, as far as I can see, no significant dent in that and inequalities are probably about the same now as they were 25 years ago. And I think there's a legitimate question as to how long are we going to let that happen.

ES: Phillipa?

PW: If I can just add a little bit. I remember there being a paper, I can't remember which journal or newspaper it was in, and it was talking about consultants kind of being snobby in how we treated or look at the access to radiotherapy or chemo in this cohort from a poor background as opposed to a well off background. Having done it for 33 years, I can tell you a 50 year old from a deprived background, you know, with a bad cancer, I'm talking about a year where I am hammering them. And if that person's already had a heart attack, has diabetes, has high blood pressure, has kidney failure, I can't give her chemotherapy. She may or may not tolerate radiotherapy, I may end up I can't even anaesthetise her to do an operation. But the idea that it was the doctors who were going, you know, I can give you any old thing and ignore it, it was just nonsense. Yet that's what I mean about poverty is the biggest single driver of ill-health, and it actually holds the NHS back. And that's where you need to focus if we want to really, really turn the health inequalities around, as Marmot would say, the social determinants.

ES: Susan had a question and Mark at the back had a question.

SD: It's a rhetorical question, maybe, and it's a question to everybody in the room. So the big challenge and the big question for everybody here and everybody beyond is in 25 years have things got better or worse and why? And I do fear, because I've been around quite a lot of retrospectives recently because it is the 25th anniversary, I do fear that we get the balance wrong between on the one hand recognising rightly progress that's been made in the way that we have maybe worked together more effectively than elsewhere and changed things. And on the other hand shining a proper critical light on where we really are and whether the dial has shifted and, if not, why not?

I'm not saying I've got the answers by the way, I just really think we have to be asking that question much more. And to lapse briefly into retrospective mode for the moment, Derek making the point there about the dial not having shifted in terms of the health of the nation. Just a wee look back, 1st September 1999 was the first ever parliamentary debate in Holyrood. It wasn't even in Holyrood; it was in the temporary home. But the first Scottish Parliament debate, once we had assumed powers, everything else before then predated the powers being transferred on 1st July. And I recall this was quite hard fought for internally within government, we managed to get it on public health, and on, I can't remember the exact wording, but essentially how we could work together to rid Scotland of the tag of sick man of Europe. One, I think I remember Mike Russell, MSP, standing outside parliament that day holding up the commemorative medallions the MSPs had been issued with, and making that the story of the day, and there being virtually zero coverage or attention to the debate that we had. Two, I can remember the party politics starting to, you know, come into the mix even then.

So I think, there is something about how, yes we build on agreement, consensus, close working relationships and all these things, but that we don't lull ourselves into a sense of false security about what they've actually delivered. And similarly, coming back very much to the focus of today, well I think it's great that the work's been done to properly capture and track what was done from a structural point of view and so on, then that absolutely has to get matched against, or put alongside, NHS performance.

And I'm deliberately saying NHS performance there, not health, because, there are some pretty bad, and I don't really like the word performance measures, let's make it about people, pretty bad experiences taking place north of the border as well as south of the border, and I think, you know, we've got to face up to that.

ES: I'm going to get Mark's question in as well and then we'll have a reflective…

MD: Yeah I want to come back to something though that Malcolm said, which is that what Scotland did in this era of removing the internal market is the precursor, in terms of moving the distinction between the purchaser and the market, to what is now being done in many countries across Europe, from England and Wales to parts of Spain. That's sort of the structural approach that tries to remove those distinctions. There's now a huge global consensus around that at least in more NHS staff systems and I think something that we really need to have some reflections on. So, the aspirations that often follow about that are incredibly radical and that's the idea that integrated care that will shift the services which are prioritised, and remove market involvement and start possibly moving the balance of health care into primary care, effectively meaning that you will get much better population health for less money. I think, you know, one of the things that Scotland potentially is faced with is that it was an early adopter of the structures which a lot of people hope will achieve that, but even when you get that structure delivering the results has proven really difficult. There are a lot of other barriers to achieving that kind of shift beyond the structure, and people have distinctions of status professional ones and organisation ones that don't go away that quickly. So yeah, it potentially relates I think to some of the discussions we've been having about the consensus that there is around the structure of the Health Service against how incredibly difficult it is to actually deliver the big changes which that was supposed to facilitate.

DF: So it's a great point. I think there are still some distinctions between the various approaches to integration that sort of, and let's just compare and contrast north and south of the border without getting into some of the kind of Spanish regions, etc. The Scottish approach I think has been productive, we try to take things out of the system, and the English approach to integration has been additive through added integrated care systems into the mix. You've now got NHS England, regions, integrated care systems and boards, before you get to the clinical teams; whereas, we've got the Health Department and boards.

So there are still differences. However, I think you're right to identify the fact that the evidence base that integration leads to better outcomes is still relatively weak. I think we could all point to little case studies of examples where it's changed and improved outcomes at population level, but could we say hand on heart that the NHS in Scotland is amongst the best in the world because of integration? I'm not sure we could.

PW: I mean I think on Susan's point I still think that 25 years has been beneficial. I think there's things that are around both health and the NHS and public health, obviously you're going to talk about the smoke-free public areas, minimum unit pricing, other things that happened in Scotland, took a bit longer elsewhere or it didn't happen elsewhere. And I think also a lot of what we've talked about the collaboration, the integration has been positive. I still think that if you want to achieve better population health, which Mark is talking about, to say you need to be upstream, you actually need to be with pregnant women. We now know, you know, the two years, the thousand-day manifesto that actually the health of a pregnant woman is determining a lot of what's going to happen to that child later. If a mother is carrying a female child, all the eggs of that girl are formed while she's in the womb. So actually a pregnant woman could be carrying two generations and marking two generations, if she's hungry, if she's stressed, if she's in a deprived area.

And so it's still that we need to go to public health, you know, smoking prevention, lose weight (I have a cheek to talk!) you know, don't drink so much, tackling drugs, but actually it's going back to that wellbeing. I mean if people, if you have a holistic approach to health and wellbeing where people are reaching for opportunity, leading good quality lives, they don't end up in something that needs to be unpicked and they don't end up on my operating table or in your surgery or whatever it is, and that is a radical shift that we haven't actually got so much. I still think we have an issue with silos, what Mark was talking about, organisational loyalties. We did, part of our redesign was looking at why do we see breast cancer patients in the clinic all the time? You know, what's the point of our follow-up? They need a new prosthetic, they go to the prosthetic department, if they need mental health support, they go to the breast care nurse team. So what are they coming to us for, initially every three months then every six months, then every year? Well, we're looking for recurrence.

What's the best method of that? Mammography. So why are we making them sit two hours, two buses to a clinic waiting to see someone they've never met before and won't ever meet again? And so we completely changed that and about three quarters of our patients don't come to the clinic at all, they have all our phone numbers if they're scared about something, if they find something new. They know all the pieces of the service and they get their mammogram every year and they get the result written to them and copied to the GP. And that allowed our clinics, which were literally running into the night and running into the mid-afternoon, to suddenly have space that if one of them did ring up and say I've found a new lump, we can go right OK come up on Thursday and we'll sort it.

So, you know, there's lots of things that we could do. There will be hundreds of thousands of patients across Scotland who are coming to a clinic to remind a clinician to order a scope or order a scan or order an x-ray. Why are we not using digital power to say, you've got this problem, you need a

scope or a scan every year for five years, 10 years and you know where I am if you need me here's our phone number. And that is something that could take a lot of heat and obstruction out of the system. But sometimes we're not imaginative enough. And when you look at the integration thing, there will be other consultants who don't want to let their patients go. They want their silo, they want their kingdom: look at how hard I'm working, I've got 60 patients in my clinic. Well, no, OK, now my clinic's only 20, but there are people who really need a lot of time.

So, you know, there are consultants who don't want to let go, whether that's integrated joint boards or whether that's looking at how you share follow-up with GPs or actually move things into the community. But I still think if you want a change in population health, a lot of that lies outside the NHS.

DF: I can tell you're keen to wrap up, are you?

ES: Well, there's two more questions that I have here.

DF: Let's take the questions.

ES: Let's do that, OK. Let's say Ian and Mary.

DF: As long as I have a final…

ES: You'll get your, so Ian and Mary. So Ian is just sitting here and we'll take the two questions together and then come back to Derek.

IE: It's really a reflection on the discussions over the day, so kind of question. But we're going to start off by talking about how, prior to devolution, there was quite a top-down approach in the NHS and how pragmatic that was. And then looking more towards the more recent time, there is this discussion about integration, collaboration, less target focussed approach. And I'm curious about whether, to what extent do you feel that is the case? Because I mean one of the interesting dynamics within Scotland is you can kind of get everybody in the same room, you know, it's quite easy. So is there actually more of a centralisation tendency in Scotland and has that actually led to a more top-down approach than existed previously or is it less? I would just be really interesting to hear your reflections on that. And I'm reminded of the start of the review of NHS Highland which raised concerns about bullying and harassment, for example, and highlighted that a targets culture and a performance management culture was directly contributing to that culture within the organisation which was leading to bullying and harassment of staff. So are we in a very collaborative integrated place now or is there a tendency to greater centralisation and actually a greater top-down performance management-led approach?

ES: Thank you, Ian. Mary, do you want to ask your question as well? Then our speakers can respond?

MG: Thank you for a very rich discussion, my question relates, we've talked, obviously touched on the distinction between the approaches in England and Scotland and the shift between competition through to integration backed in the Scottish model. In the background of both is the controversial interaction between the NHS and private healthcare. The guidance we've seen on our latest project, dates from about 2007, so post-devolution, where NHS patients become private patients and vice versa, it seems to be fundamentally the same in Scotland and England.

So my question is really then, given the relevance of devolution and resisting the internal market and the way it went in England, is about basically linking to this wider NHS private healthcare interaction which has been in existence since 1948. How helpful would you say devolution's been in resisting or limiting private health care involvement in Scotland from the point of view of perhaps outsourcing NHS services insofar as that exists in the same way and certainly insofar as developing a private healthcare market [separate from the NHS]?

ES: So those are two great questions and we probably don't have time for both of you to answer both but choose your favourite.

GM: Yeah I would like to make a brief comment on those questions.

ES: We'll come to you as well, Gerry.

DF: I don't know the answer to your question about private healthcare and how, but it has been consistently the case that the biggest customer for private healthcare in Scotland has been the NHS. And it has been occasionally a helpful release valve when there was pressure on the public system, to have access to that. I think those, I don't think there's anything contradictory between an ethos that's about collaboration and collaborating with entities outside the public sector. So long as that's done in a kind of, with that collaboration in mind in a mutually beneficial kind of way.

So the point about top down, I think that, you asked the question about top-down, my sense is that it's less top down now than it was. Kevin, can you remember how many targets there were in the PAF in the performance assessment framework?

KW: Not in the Performance Assessment Framework, but there were significant numbers. We changed that, we got rid of that. We replaced it with HEAT targets and we reduced it to twenty eight. The H stood for health and it was a whole series of targets around health. The E was about efficiency and that was about financial matters, and so on and so forth. So you can look the acronym up, but it was 28, and it was deliberately narrowed down to make it, to really focus everybody's attention.

DF: Health, efficiency, access and treatment, by the time I finished we were at 20, my recollection is there were over 250 targets in the PAF.

GM: It was 243!

DF: So from our operational manager in Tayside, he was responsible for 243 top-down targets to some kind of dialogue about what are the 20 or 28 most important things that we could work on together? You know, Gerry and I would regularly have these conversations. When I was the Director of General and the Chief Executive of NHS, Gerry chaired the chief execs group, he and I would meet every month before the formal meeting of the chief execs and we would say what's the most important things? These are things on the minister's mind, Gerry, what's coming up from the service? We could have that kind of dialogue and focus on the stuff that was really important. I don't think any of that would have been possible in the pre-devolution world.

PW: As I said earlier, when I intervened, the shallowness of the hierarchy in Scotland actually meant that someone like me, who was in a busy district general hospital, was able to influence policy. And actually knowing that through the clinical standards board work you were influencing how other people were treating other patients in Scotland was incredibly rewarding. The issue with Highland Health Board is (a) it's ridiculously huge. I mean the scale of it. We used to live in Mull, my husband was a GP in Mull and a trainee and had to go to Inverness for seminars and training sessions, as of course had patients to do. But a lot of what happened in health board was leadership, in the leadership team, and I still come back to that. Whatever structure you put together, if you have a person who's collaborative and empowering, that's what they'll do. If you have someone who is controlling, that's what they'll do.

When I was a wee lassie surgeon, private practice was enormous. Now, I never did it because I didn't believe in it. But waiting times, as I said, were years and therefore there was this huge business of doing kind of private practice. There was the NHS waiting list initiatives. Actually there were lots of patients who had private health insurance or paid out of pocket. Now, we've seen some of that come back because of what happened in the pandemic and the huge backlog, but in the in between 20 years, that had largely disappeared. Hardly any of my colleagues were doing private by the time I left the NHS in 2015, because the amount they would do was so small and the hassle, the extra defence fees they organisation just simply wasn't worth the candle.

What I would say is yes, where the NHS Scotland has used private is waiting list initiatives. So we go into the Nuffield or Ross Hall and we do a list and they get money and it expands the theatre capacity. What's quite different in England was this outsourcing of services and also the failure to recognise the impact of that on training. So you would get in an area a bid and maybe Virgin or somebody won the hips and knees contract, and suddenly the local hospital isn't doing hips and knees other than the really complicated re-dos.

But the trainees are not in the private system. Private health doesn't train people, it leeches off the NHS, both for nurses and doctors and intensive care backup, etc., and what you saw was the outsourcing of whole chunks of service, and that's what we've not done up here. And the cost of that, I remember the Nottingham Trust wasting half a million pounds putting together a tender versus Circle for some kind of clinical service in Nottingham and then Circle pulled out at the last minute. But half a million pounds had been wasted in doing that. And, as I said earlier, it wasn't just, you know, NHS versus Circle or Virgin or whoever, it was NHS versus each other. I mean Scotland in Aberdeen, Inverness, Dundee, well that's pointless, there only is one big hospital. You could have tried to get something going across the central belt. But for all of that effort, it didn't really make sense.

So use of private services in Scotland is a fraction of what it is in England, and it doesn't involve handing over NHS property, buildings, machinery, which we've seen down south CT scanners, clinics, whatever.

ES: So we're eating into lunch now, which does tend to focus the mind, I find, but let's just, any closing reflections, Gerry?

GM: I'd just like to maybe make a direct response to your question about where we are. I retired and left the Health Service in 2013 and went to what I thought was retirement in Australia. I left because I couldn't in all conscience stay on a leadership role on a legislation that I thought was fundamentally flawed, which was integrated joint boards and I'll leave others to judge whether that has become the position. Interestingly, you talk about Highlands being vast, there are 14 districts in New South Wales, as we've got 14 health boards. One of the districts is the size of Germany, just to give you an idea of size. And I would make a comment that I took over another role but I want to skip that and go back and deal directly with the question.

I've been back just over two years and when I came back I could not recognise the country I'd left nine years before, in the context of devolution, of leadership, decision making, scrutiny, empowerment of clinicians and of the people and addressing the real issues of inequalities. What I have observed, and this is a personal comment, I observed a drive towards centralisation of decision making, disempowerment of participation of clinicians and a definite disempowerment of communities. When we were talking about space and place as a driver for wellbeing, I failed to recognise that. And so let's not be too self-congratulatory about the last 25 years. I think we're in a very, I'm not being political, I'm not political, we are in a very difficult point in time when in my view if we move to the next stage of legislation I'd reflect on the notion that the best predictor of future behaviour is past behaviour, that gives me a fair degree of concern.

KW: I agree with quite a lot of what Gerry has said actually about, you know, the last points about where we are now. My perception is that it has become more centralised but I'd prefer to talk about the really big issue in front of us in Scotland, is post-pandemic, etc. How do we shift upwards the level performance and productivity? Now, we will all have experiences of waiting times, they really do matter to all of us. And I do think there is something about having the incentives in our system, how do we develop new incentives which build upon the platform of collaboration that we've celebrated because of its benefits? How do we do more to lift the level of performance? The debate seems to have got stuck at inputs. I actually think that this question is how do we incentivise the translation of those inputs into more and better outputs and outcomes?

ES: We do need to finish there, I'm sure the conversation will continue over lunch, which will be served outside. Please do stay and join us and thank you to everyone for sharing and I'm really excited to see the transcript.

END OF SESSION