Summary of evidence

Transparency
- As in previous years, in many areas of the draft budget there is insufficient detail to allow genuine and meaningful scrutiny
- Any correlation between spending priorities, as stated in the budget document, and actual proposed spend is not clear in many instances

Are levels of health spending adequate?
- There is increasing pressure on the health budget from increasing demand and from growing cost pressures within the health service
- Many health boards continue to be reliant on non-recurring funds to balance their books
- Cuts to local authority budgets will impact on health service provision, so both budgets should be scrutinised together

Are we spending wisely?
- We agree with the intention behind the budget to reduce health inequalities and invest in preventative spend. However, while only a small proportion of the health budget, savings made in the areas of health inequalities, eHealth and research are not being reinvested in these same areas

How are we ensuring that services are efficient? What are we doing to ensure the quality of service regarding outcomes for patients is protected? How are we planning for change?
- Demand for health services is growing as the population gets older and lives longer with long term conditions, yet there is no concrete evidence of a corresponding increase in experienced nurses working in the community
- A third of nurses are due to retire in the next decade yet with nursing levels at their lowest since 2005 and this year seeing the lowest intake of nursing students in 15 years, the budget for nurse education and training, i.e., to fund nursing students, is being cut by 2.2% in real terms
- To be successful, integration of health and social care will require more investment in future years and the integration of health and social care budgets poses a challenge for meaningful scrutiny in the future

Transparency
The draft budget for 2013-14, on the whole, provides insufficient detail to answer the Health and Sport Committee's specific questions fully. It is disappointing that, despite specific concerns raised in previous years by the Scottish Parliament and by organisations that have provided evidence such as the RCN, there is little change to the presentation of the budget to support
improved scrutiny of allocations. We note from the SPICe briefing on the health budget that answers to many of the questions that the RCN has, for example regarding movements in individual budget lines, are contained in unpublished personal communications between the Scottish Government and SPICe. In the interests of transparency and meaningful scrutiny, this level of explanation should be included in the draft budget itself.

Further, we would remind the Committee of our evidence on the 2012-13 budget which highlighted that the headline uplift to health boards’ core, recurring funding was not strictly-speaking all new money. It actually included £76m of waiting times money previously allocated as non-recurring funds and £20m to pay for health boards’ new responsibility to deliver healthcare in prisons. The £80m Change Fund for Older People is also included in that baseline funding. We criticised this lack of transparency and were pleased to see that this approach had apparently not been taken in the 2013-14 draft budget. However, personal communications between the Scottish Government and SPICe indicate that eHealth and health screening budgets, for example, have been reduced in part because some areas of non-recurring funding have transferred to recurring budgets. Whilst these are far smaller shifts than those we highlighted last year, the Scottish Government should be clear about all such transfers to ensure the uplift in recurring resources available to cover inflation and increases in demand is transparent.

Other issues, such as the correlation between priorities set out in the portfolio narratives and available budgets, remain unclear in many instances. If we are to ensure that realistic and transparent priorities are set for our public services through this downturn, the Scottish Government must re-think how annual budgets are presented to make clear to health boards and the general public how funding from across portfolios is intended to support delivery of the National Performance Framework outcomes. This would be a useful annex to the portfolio based presentation and would underline that the Scottish Government is modeling the integrated approach to public service delivery it is advocating for others.

In order to address the Committee’s concerns, where the draft budget cannot provide sufficient detail, we have drawn on our own analysis of other financial information we have gathered. We refer the Committee to the briefing we provided on health board allocations earlier this year for more information.

Are levels of health spending adequate?
The RCN does acknowledge the relatively well-protected position of the health portfolio. However, whilst the headline, core funding of territorial boards is subject to a small but welcome real terms increase, the overall revenue budget for health boards and ‘other health’ is facing a small real terms reduction. It is imperative that this is clear to staff and the public to ensure service expectations are realistic. Demand pressures on the NHS from Scotland’s continuing levels of poor health and demographic change are significant; boards must invest in service change to ensure long term-sustainability; and the NHS faces financial pressures from increasing drug and prescribing bills and significant requirements to refurbish and replace...
buildings and equipment. For example, whilst inflation currently sits at 2.5% (CPI), boards were planning for an average uplift in GP prescribing of 5.2% and an average uplift in hospital drugs of 8.3% this year\textsuperscript{v}.

Whilst all boards met their obligations to at least break even last year, eight of the fourteen territorial boards concluded 2011-12 with a recurring deficit underlying this position. Each of these was reliant on underspending earmarked non-recurring funds to balance their books. Underlying recurring positions help to give some indication of the sustainability of core services and we will continue to monitor trends in this area. By the end of the first quarter of 2012-13, ten boards were overspent on their revenue budget\textsuperscript{v}. Real pressures are being felt.

However, the NHS cannot improve health and wellbeing outcomes in isolation. Partnerships with councils and the third sector are central to delivery and will become ever more important as plans for integrated care progress. Significant strain on national and local allocations in these areas will impact on the adequacy of health-specific budgets to meet need and improve outcomes. In a recent survey of 253 RCN members, 66% thought there was a risk that proposals to integrate budgets would result in NHS funding being stretched to cover social care cuts\textsuperscript{vi}. We ask the Committee to consider the health impacts of budget pressure in other portfolios.

Boards and their partners will have to think quite differently about how to deliver services to make the available budget ‘adequate’ to deliver good quality care and better patient outcomes in the face of current and future demand. However, the Scottish Government must also review its own targets and priorities for health and care, and better join up its spending decisions, to support boards to make the difficult decisions needed to improve services fairly and equitably in tough times.

**Are we spending wisely?**

Significant health inequalities in Scotland, as well as exacting an appalling human cost, remain a barrier to the delivery of the Government’s economic strategy. They are also a cause of the sort of demands on the health service that this budget says it wants to reduce. There is more we must do to understand Scotland’s persistent health inequalities to design services that can better effect change. More generally, shifting our historic focus on treating illness, to encouraging health through early intervention and self-management, should improve the wellbeing of the general population and reduce public sector demand for costly unplanned care. We agree with messages in the budget that increasing preventative interventions and reducing health inequalities are central to both improving outcomes and making the best long-term use of resource.

In this context, we note that non-recurring budget lines for health improvement/health inequalities, eHealth and research are below the level anticipated in the Spending Review forecasts for 2013-14. It seems that these reductions are, in part, a result of new-found efficiencies in these areas\textsuperscript{vii}. Whilst we do not wish to overplay the total amounts of money involved in
these shifts, which are relatively small, we question why these additional monies are not being used to increase much-needed investment in the priority areas in which the savings were found.

In addition, we note from the SPICe briefing that the flat-lined alcohol misuse budget line in the health portfolio will include “implementation of the forthcoming minimum pricing legislation”. Given Scotland’s still significant issues with alcohol misuse, we are concerned that this budget is not only facing an expected real terms decrease during this spending period, but will now also need to stretch to the investment required to implement a significant piece of new legislation. RCN remains in complete support of minimum pricing legislation, but how the new scope of this budget will impact on existing prevention work, such as the Brief Interventions programme, should be explained.

Finally, returning to an earlier point, the presentation of the budget can make it hard to answer the question of whether we are spending wisely. For example, the narrative in the Education and Lifelong Learning portfolio states that investing in the early years to improve life chances is a priority, which we would support. However, under the heading “what the budget does”, the document states: “Most of the expenditure on children’s services is channeled through local authorities and NHS boards”. It is then difficult to track how the ambitions underpinning this priority set out in the Education narrative are joined up through the budgets of other portfolios.

What are we doing to ensure the quality of service regarding outcomes for patients is protected? How are we ensuring that services are efficient? How are we planning for change?
Planning for quality, improved outcomes and efficiency must be considered together if decision-making is to be in the best interest of patients. At present, we are concerned that accounting decisions about staff costs may be overriding sound decisions about safe patient care and improved outcomes.

Public expectation and the quality agenda demand that the disastrous effects of short staffing witnessed at NHS hospitals such as Mid Staffordshire should not be allowed to happen again. Time and again inadequate staffing is identified by coroners’ reports and inquiries as a key factor. The Health Select Committee 2009 report states: ‘inadequate staffing levels have been major factors in undermining patient safety in a number of notorious cases’.

Whilst the Budget Act itself does not determine local staffing levels, the priorities and allocations within it do set the context in which health boards have to make decisions to make ends meet. The budget does set funding for nursing education and training for the whole of Scotland (reducing by 2.2% in real terms) and key investment in the ongoing development of staff (reducing by 2.4% in real terms).

The number of nursing staff in the NHS in Scotland is now at its lowest level since 2005. Figures adjusted to take account of interns and staff transfers in Highland show that another 390 whole time equivalent nursing staff in post
are expected to be lost in this financial year, with the reduction of staff in post between April and June equating to half the projected decrease for the whole of 2012-13. Ongoing cuts to student nursing numbers mean that this year’s intake is the lowest in fifteen years. Around a third of all nurses will be retiring within the decade. Yet all of this is taking place in the context of acknowledged increases in demand from an ageing population and expected growth in the incidence of long-term conditions which will require significant clinical interventions and increased availability of experienced nurses in the community.

With staff the biggest revenue budget for boards facing expenditure and savings pressures, this is inevitably a key focus for reducing costs. The 14 territorial boards are planning, this year, to make nearly £104m in savings through workforce and clinical productivity changes alone. By the end of the first quarter of 2012-13 more than half of all boards had achieved less than 15% of their planned savings target across all savings categories. More than half of all boards classed their savings targets as a high risk to their financial plan. Even where savings are declared, we still cannot verify these as true cash efficiencies (providing at least the same service for less money).

Accounting decisions to meet strict annual targets, such as those set for efficiencies, do not necessarily result in good outcomes for patients. For example, closing a ward may well make a board cash savings to meet their end of year target. But without shifting investment to ensure prevention and support services are available in the community, not only will patients not have access to the alternative services they may need, but in future years unscheduled admissions may well rise as neither preventative services nor the capacity for planned admissions are available. We still do not have the evidence to demonstrate that this re-investment in the community has reached the desired and necessary tipping point.

We appreciate that the impact of the UK fiscal position on the Scottish budget settlement means that tough choices must be made. We continue to advocate that it is time for a much more strategic approach to be taken to realising the significant savings and re-investment required, rather than chipping away at workforce numbers to meet accounting deadlines.

With regards to wider issues about the direction of funding to meet defined national outcomes, we would highlight to the Committee two reports that underline how far the public sector has to go to ensure investment delivers improvements in outcome. A recent Scottish pilot into outcome budgeting concluded:

It was difficult to identify how resources are used to deliver outcomes: in particular, it was hard to identify and cost discrete activities. This makes it difficult to assess the role of different activities in achieving outcomes.

The evaluation of the Integrated Resource Framework Test sites stated:
The IRF test sites used the mapping data to examine equity, efficiency, variation and quality but encountered difficulties in engaging GPs and hospital clinicians in discussion of the data, and also in linking outcome data into the analysis.....Within the timescale of the evaluation, the IRF did not provide evidence of integrated work resulting in the release of resources or of significant changes to fixed costs.xiii

With regard to the integration of health and social care, this draft budget has little in it to demonstrate clear levers to support changes in service provision. This is not surprising given that legislation is still to be drafted. The £80 million Change Fund for Older People incorporated into the core funding of health boards represents just 0.7% of the draft health revenue budget of £11,322.5m. Clearly, this will not be enough on its own, in the longer term, to implement the significant service changes envisaged to improve outcomes and seamless care in communities. We hope that clear costings for change will be developed as integration plans progress.

Finally, we would once again highlight the impact of integration on future budget scrutiny. The RCN has already begun to try to account for the significant budget transfers between the NHS and local government in Highland when conducting our own scrutiny of local performance. We have, as yet, no way to clearly understand how monies channeled through the national budget process to NHS Highland, but transferred to Highland Council to deliver children’s healthcare, are being used. If integrated services do develop towards a position where health and social care budgets lose their identity, a new approach to joint committee scrutiny may be needed to provide assurance on the allocation and use of public funds.

Royal College of Nursing
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ii Ibid.
iii See: http://www.rcn.org.uk/__data/assets/pdf_file/0007/447136/1_May_Health_board_finances.pdf#Health%20board%20finances
iv Information from financial annex to 2012-13 Local Delivery Plans
v Based on unaudited Monthly Monitoring Returns for March 2012 provided by NHS boards to Scottish Government. Accessed through FOI requests.
vi Online survey conducted through the RCN website to inform our response to the Adult Health and Social Care Integration Bill consultation
vii Information from unpublished personal communications between SPICE and the Scottish Government quoted in the SPICE briefing (ibid.)
ix RCN, Guidance on safe nursing staff levels in the UK, 2010, P.4
xi Information from financial annex to 2012-13 Local Delivery Plans