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Your ref:
Our ref: A6495241

11 September 2013

Dear Convener

Draft Budget 2014-15

Following your Committee's report to the Finance Committee on the 2013-14 Draft Budget, I responded to the report on a range of different issues at the beginning of February 2013. In advance of the publication of the 2014-15 Draft Budget, I thought that it would be helpful to update you on progress against each of the recommendations contained in last year's report. Below is a copy of the original recommendation, original response and the current position.

The update also includes details on the split between significant risk and high risk backlog, and the target figure for maintenance backlog for next year which we agreed to provide you following the evidence session on 25 June featuring John Matheson, Director of Finance, eHealth and Pharmaceuticals, John Connaghan, Director of Health Workforce and Performance, and Linda Semple, Head of Efficiency and Productivity Portfolio Office, Scottish Government.

Prior to the publication of your report, officials from the Committee met with Scottish Government officials at the beginning of the year to identify areas where we can work more closely together and I would be happy to offer a similar session again.

Finally during the evidence session on 4 June where the Committee took evidence from three Directors of Finance from Special Health Boards, the feedback that I received was that it was an extremely productive and helpful session and that they have suggested that it might be useful if they prepare a submission for the Committee which more fully explains the crucial role that Special Health Boards play in the running of NHSScotland.

Yours sincerely

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Policy Priorities HEAT etc.	**REF 15**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee therefore recommends that future statements of policy priorities be concise and focused.	We have established a clear shared and focussed 2020 vision for safe, effective and person-centred care which supports people to live as long as possible at home or in a community setting. This vision provides the basis for all of our policy and improvement priorities going forward. We are working with NHS Boards and other public sector partners to ensure that consistent and concise language is developed, shared and used to emphasis the integrated approach that we are taking, and to ensure focus and clarity.	The Route Map to the 2020 Vision for Health and Social Care was published on 23 May 2013. The paper sets out a new and accelerated focus on a number of priority areas for action in the form of a 'Route Map' to the 2020 Vision for Health and Social Care in Scotland.

POLICY AREA - Management of Cost Pressures	**REF 21**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that SGHD publish a discussion paper within the next six months, which analyses: (i) types of cost pressures relevant to the health service, (ii) evidence on the historical levels of these variables, and (iii) recent time trends in these pressures in Scotland. An example of this would be a detailed analysis of the maintenance budget.	I can confirm that a discussion paper will be provided to the Committee within the timescale requested.	See annex 1 for further details.

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Management of Efficiency	**REF 40**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that SGHD produce a paper showing how previous years' efficiency savings have been reinvested by territorial health boards in order to inform future discussion and debate around the use of efficiency savings for preventative spending.	The linked paper was sent to the Committee. Efficiency Portfolio Office report to The Health and Sport Committee	In December, Scottish Government will publish the 2013 Annual Report on the Quality and Efficiency Support Team. Annex 2 illustrates some of the excellent work that has been carried out by NHS Boards across Scotland. Many of the case studies in the report provide innovative solutions to the challenges facing NHS Boards and we expect NHS Boards to identify examples of good practice that may be applicable in their local context.

POLICY AREA - Management of Efficiency	**REF 41**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee notes the BMA's suggestion that all new public policies should include a health impact assessment. This could be a way to start to gather evidence on the health benefits of programmes outside the health portfolio.	Launched by the Scottish Government in November 2011, Health Inequalities Impact Assessment (HIIA) aims to improve policy making through a creative and systematic process that gives a broader perspective on issues and considers wider population groups and impacts, beyond those considered for EQIA. This process should to be proportionate but still provide helpful and robust information to support decision making. The process brings together elements from Equalities Impact Assessment (EQIA), Health Impact Assessment and Human Rights Impact Assessment, meeting the legislative requirements for EQIA. The HIIA process seeks to define the likely positive and negative health, equality and human rights impacts of a policy (including unintended impacts) and the population groups who will bear them. The assessment considers impacts on equalities groups and other potentially	The Equality Team at NHS Health Scotland have supported delivery of many impact assessments with Scottish Government, NHS Boards and the third sector including: Scottish Breast Screening Service Review - A formal review of the Breast Screening Service was undertaken to ensure it can adapt to meet future challenges, and remain a sustainable high quality and equitable breast screening service. Developing a primary care resource centre at Queen Margaret Hospital - This involves closing a well-known local facility and relocating various primary care services from some community clinics, to provide an integrated and co-located service. 'Cool Heads – Stress Central' - a publication providing information and tips on ways of coping

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Management of Efficiency	**REF 41**	
Recommendation	**Original SG Response**	**Updated SG Response**
	affected populations. Impacts on disadvantaged groups, who already suffer poorer health, are particularly important.	with stress targeted at 12-16 year olds

POLICY AREA - Management of Efficiency	**REF 42**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that the Scottish Government report to the Committee, in due course, on the feasibility of introducing a health impact assessment for all new SG policies.	See response to point 41 above.	See ref 40 above.

POLICY AREA - Resource Transfer	**REF 50**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that SGHD collect from health boards a detailed analysis of the amounts of money used for resource transfer, what these are being used for and – if this is different – what they are intended to be used for. The response should include plans to make the data much more accessible than they are at present.	Information on resource transfer is broken down by Health Board and client group and published annually in the NHS Cost Book. The Scottish Government, the NHS and COSLA agreed a set of protocols around resource transfer in October 2010. This included a protocol that "NHS Boards should reach local agreement with each local authority partner as to an accurate reflection of resource transfer for the current year, separating what is historic bed closure Resource Transfer under MEL (1992) 55 from any other agreed sources of NHS funding to Councils". As part of those protocols, local government and NHS representatives have also agreed a nationally agreed inflationary uplift for the last two years and are in discussion about uplift for next year. Legislation to integrate adult health and social care will end the resource transfer	Details of Resource Transfer expenditure is already collected and reported in the NHS Costs Book and is broken down over the following categories: ▪ General Psychiatry Services ▪ Learning Disability Services ▪ Geriatric Continuing Care Services ▪ Younger Physically Disabled Services ▪ Other Community Services NHS Boards will have further detail which will allow them to work effectively with Councils to identify the most efficient use of these resources. The Resource Transfer policy has been in existence for over 20 years and allows Health Boards to fund local authority social care services for people who formerly received, or would have in

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Resource Transfer	**REF 50**	
Recommendation	**Original SG Response**	**Updated SG Response**
	arrangements as this money will form part of the overall integrated resources.	the past received, care in NHS continuing care beds. The policy has underpinned the closure of learning disability hospitals and significant reductions in NHS long-stay beds for older people and for mental illness. Over the same period, local authority social care services for older people, adults and children with disabilities, have been refocused to provide care and support for people with more complex needs, who formerly would have received NHS continuing care. Resource Transfer, together with these wider changes, has made a very significant contribution to shifting the balance of care, better use of hospital inpatient beds, reductions in delayed discharge, and better outcomes for people who use health and social care services. It was agreed that resource transfer payments are for explicit use in supporting social care arrangements and as such should be voted into aligned or integrated budgets for Health and Social Care Partnerships.

POLICY AREA - Efficiency and Productivity	**REF 54**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee asks SGHD to submit a report of the efficiency and productivity programme to date, including disinvestment or service redesign and evidence that this work has had an impact at NHS	See attachment in ref 40.	See ref 40 above.

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Efficiency and Productivity	**REF 54**	
Recommendation	**Original SG Response**	**Updated SG Response**
board level. In addition, the response should set out how this work will be developed into 2013-14.		

POLICY AREA - Quality / Service Delivery	**REF 62 and 62**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee also considers that more needs to be done to align data collection activities more closely with the 12 National Quality Outcome Measures. The Committee asks that, as a matter of high priority, the Cabinet Secretary send the Committee a progress report on the development of the quality measures promised over two years ago, including deadlines for when the data will be available to inform the Committee's discussions.	Measurement of the Quality Outcome Indicators	The Route Map to the 2020 Vision for Health and Social Care was published on 23 May 2013. The paper sets out a new and accelerated focus on a number of priority areas for action in the form of a 'Route Map' to the 2020 Vision for Health and Social Care in Scotland.

POLICY AREA - Preventative Spend	**REF 76**	
Recommendation	**Original SG Response**	**Updated SG Response**
Although the Committee acknowledges that this is a matter for the next comprehensive spending review (CSR) rather than annual budget scrutiny, it recommends that SGHD be clearer about its expectations for spending on preventative programmes and set out a medium- and long-term plan for the shift in funding it expects to see.	We will provide an update on our strategic plans including preventative measures at the next spending review in 2013. The former Cabinet Secretary set out our strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland. Significant progress has been made in recent years through impressive improvements in waiting times for access to services and treatments. We have a world leading patient safety programme which is making a real	The next spending review will conclude with the publication of the Draft Budget 2014-15 on 11 September 2013 and these reflect the Strategic Vision as detailed in the Quality Strategy and 20:20 Vision.

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Preventative Spend	**REF 76**	
Recommendation	**Original SG Response**	**Updated SG Response**
	difference to standards of care and to hospital mortality. Over the next 10 years the proportion of over 75s in Scotland – the highest users of NHS services – will increase by almost 60% and there will be a continuing shift towards long-term conditions. That is why we have been bold enough – via the Quality Strategy and 20:20 Vision to visualise the NHS that will best meet the needs of the future in a way that is sustainable, and then make the changes necessary to turn that vision into a reality	

POLICY AREA - Health & Social Care Integration	**REF 81**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that SGHD present plans to the Committee to describe how national budget scrutiny would be undertaken when health and social care budgets have been integrated.	The SG has established an expert group to consider and advise on the implications for financial governance (for all stakeholders) of integrating health and social care budgets. National budget scrutiny will be considered as part of this work and SGHD will come back to the Committee with a plan reflecting its recommendations.	The work of the expert groups looking at integrating health and social care budgets continues and they are expected to finalise their report by the end of September 2013.

POLICY AREA - Health & Social Care Integration	**REF 82**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee also recommends that SGHD publish periodic reports analysing the variation in spend in different territorial boards in different services. These reports should include outcomes.	See response above (Ref 81).	See response above (Ref 81).

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Further Information Requested to Support Draft Budget Scrutiny	**REF 93**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee recommends that the Cabinet Secretary present such information as is available for 2013-14 as soon as possible. The Committee also recommends that the Cabinet Secretary undertake to publish a supplementary document to the draft budget for 2014-15, containing all of the information requested, on the SGHD website, on the same day as the draft budget.	Health Finance officials met recently with the Health and Sport Committee Clerks and SPICe officials to discuss in detail the additional information requirements set out in paragraph 91 of the Committee's report. The information discussed at that session is currently being gathered and will be submitted before 31 January 2013. In addition Health Finance officials will provide support in validating and providing information in support of the information gathering survey that the Committee intends to send to Health Boards in February 2013. Finally I can confirm that I will provide this information requested by the Committee in relation to 2014-15 at the same time as the 2014-15 Draft Budget is published.	Officials from Health Finance met with representatives of the Committee and the requested information was provided and is currently being considered by SPICe and the Committee. Health Finance continue to work with SPICe and the Committee to assist them in improving their understanding of the financial information provided by SGHSCD and NHS Boards. Annex 3 contains details on the latest position on the issues highlighted below: • retrospective and anticipated cost pressures such as pay, prescribing, backlog maintenance etc. • performance against existing efficiency savings and planned future efficiency savings • anticipated high, medium and low financial risks identified by the Scottish Government and how they are provided for in the budget document • trends in available outcome focused and quality-related data. • compiled information on actions agreed following NHS boards annual review meetings. • information on how policy priorities, including preventative spend initiatives (eg through the change fund) and HEAT targets have been and will be supported within the budget • an assessment of the change in the suite of 12

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS

POLICY AREA - Further Information Requested to Support Draft Budget Scrutiny	**REF 93**	
Recommendation	**Original SG Response**	**Updated SG Response**
		quality measures proposed in the Quality Strategy over the coming 12 months.

POLICY AREA - Equalities	**REF 105**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee notes the Cabinet Secretary's comments on the way in which the budget will promote equalities. The Committee also welcomes the publication alongside the draft budget, of an Equality Budget Statement, which should help ensure that equality considerations are taken seriously during the annual budgetary process and help subject committees to assess the equality impact of the Scottish Government's spending plans.	We welcome the support of the Committee for the publication of the Equality Budget Statement and the approach which we are taking to ensure that equality considerations are an integral part of the annual budgetary process. We will continue to develop and improve our work on equality analysis and assessment as part of the budget process and to publish an Equality Budget Statement alongside the draft budget. We will continue to work with the Equality Budget Advisory Group.	No further action required.

POLICY AREA - Climate Change	**REF 109**	
Recommendation	**Original SG Response**	**Updated SG Response**
The Committee notes the Cabinet Secretary's response to its questions on climate change. Comparing the response on climate change to that on equalities, the Committee concludes that mainstreaming of the former appears to be at a much earlier stage of its development than the latter. While the publication of the sustainable development strategy for NHS Scotland is to be welcomed, the Committee considers that more could be done within the budgetary process to demonstrate how measures in future draft budgets	NHSScotland continues to target activity at improving sustainability and reducing our climate change impact. As part of the overall, performance management arrangements for NHS Boards, the HEAT Target E8 requires NHSScotland to reduce direct carbon emissions by 3% and within that increase energy efficiency by 1% per annum. The 3% target is aligned to the Scottish Government's interim carbon reduction target for 2020. The Annual State of NHSScotland Assets and Facilities Report published on 11	No further action required.

POLICY AREA - Climate Change	**REF 109**	
Recommendation	**Original SG Response**	**Updated SG Response**
can contribute to what are widely acknowledged as ambitious climate change targets.	January 2013 provides significant detail on the performance of NHSScotland with regard to energy performance. The report can be accessed at: http://www.scotland.gov.uk/Publications/2013-01-1957 In addition, the Cabinet Secretary for Health and Wellbeing announced a targeted investment of £24m over three years on 21 October 2012 for eco hospital projects. These projects are expected to reduce direct greenhouse gases across NHS Scotland by around 10 per cent, and will save around £4 million in energy costs each year. In a wider context, NHSScotland has adopted the Good Corporate Citizenship Assessment Model which tests NHSScotland's approach to sustainability in its' day to day business by focusing on six key areas. These are travel, procurement, facilities management, workforce, community engagement and buildings. Support materials are provided to assist NHS Boards in tackling these issues via a website http://www.corporatecitizen.scot.nhs.uk	

Management of Cost Pressures

Although health spending has been protected from the significant budget reduction being experienced in other areas of Government spending, NHS Scotland still faces considerable cost pressures and is also required to find efficiency savings, along with the rest of the Scottish public sector. The main cost pressures currently facing NHS Scotland are:

- Pay
- Demographics and New Technologies
- New Drugs and Volume
- Property Backlog Maintenance
- Emerging cost pressures

Pay

Pay is the most significant cost facing NHS Scotland representing approximately 50% of the net operating costs of NHS Scotland. Table 1 shows the pay costs and whole time equivalents (WTEs) since 2009-10:

	2009-10		2010-11		2011-12		2012-13	
Staff Group	**WTE**	**Cost (£m)**	**WTE**	**Cost (£m)**	**WTE**	**Cost (£m)**	**WTE**	**Cost (£m)**
AfC Staff	121,153	4,048	120,412	4,137	120,593	4,120	120,433	4,158
Medical & Dental	11,203	1,075	11,292	1,092	11,777	1,126	11,943	1,143
Senior Managers	1,330	103	1,255	98	1,082	88	971	77
Unallocated	821	41	295	13	174	11	630	25
Total	**134,507**	**5,267**	**133,254**	**5,340**	**133,626**	**5,345**	**133,977**	**5,403**

The Scottish Government Pay Policy for 2013-14 and 2014-15 was published on 18 December 2012 and both the NHS Pay Review Body and the Doctors' and Dentists' Remuneration Body (DDRB) reported on 31 March 2013.

There remains a commitment in place to pay Living Wage to 2015-16 (£7.20 2012-13, £7.45 2013-14 or £14,583 per annum) and protect workforce numbers, though we would expect that pay constraint is likely to continue.

Details of the pay settlement for NHS staff in 2013-14 are also now available for Agenda for Change (AfC) and Medical and Dental (M&D) staff and these have been incorporated into the cost models. The models assume that all staff will receive a 1% uplift in the years 2014-15 to 2016-17.

The projected percentage changes in whole time equivalent (WTE) workforce numbers used in the SGHSCD pay models are shown by staff group and year in the table below:

Staff Group	2013-14	2014-15	2015-16	2016-17
AfC Staff	-0.6%	0.4%	-0.2%	-0.1%
Management Staff (non AfC)	-1.8%	-1.8%	-0.6%	-0.1%
Consultant	2.0%	2.0%	2.0%	2.0%
Staff and Associate Specialist Grade	0.5%	0.0%	0.0%	0.0%
Doctors in Training	-1.6%	-1.6%	-1.6%	-1.6%

The total paybill for 2012-13 was £5,403 million. Based on the projected staff number changes, the pay settlement for 2013-14 and a 1% uplifts for senior managers, it is estimated that the total paybill will increase by £65 million to £5,469 million in 2013-14, before increasing by £59 million to £5,528 million in 2014-15. If all staff were to receive a 1% uplift in 2015-16 and 2016-17 it is estimated that the total paybill would increase by a further £53 million over the next two years.

Staff Group	2013-14	2014-15	2015-16	2016-17
AfC Staff	4,240	4,280	4,311	4,342
Medical and Dental	1,152	1,171	1,194	1,217
Senior Managers	77	77	76	75
Total	**5,469**	**5,528**	**5,581**	**5,634**

Demographics

The Independent Budget Review and Christie Commission on the Future Delivery of Public Services, both commissioned by the Scottish Government, have already helped to stimulate wide-ranging debate about the nature and design of our public services and the ways that these might respond to the impact of an ageing population along with the wider economic and social challenges faced by Scotland.

The Scottish Government's policy approach is based on a strong belief in the entitlement of Scotland's people to make decisions about this country's future, including the way that services are designed locally. To help enable rounded debate at local levels, we have already acted to strengthen arrangements for community planning and adult care to support discussion about the kinds of services needed to meet the needs and aspirations of different communities, both now and over the longer term. In developing new Single Outcome Agreements by June 2013, for example, all Community Planning Partnerships have been asked to consider how all partners will work together to improve "outcomes for older people", one of six key policy priorities agreed by the National Community Planning Group.

The forecast growth in the number of older people in Scotland has significant implications for health spending. The Registrar General has projected that the number of people in Scotland aged over 75 will grow by around 10,000 every year, over the decade ahead. Changes in demography will vary in scale depending on location. Around one quarter of Scotland's population will be aged 65 and over by 2033; for some of our more rural areas the proportion is predicted to rise to nearly one third.

Emergency Admissions and Readmissions in Older People

The impact of an ageing population is reflected in a range of different areas, for example in the rate of emergency admissions and readmissions in older people (details published here). A number of national policies specifically target improvements in the provision of integrated care (primary, secondary and community) for older people, particularly in relation to safely reducing the number and duration of unplanned admissions to hospital. It is recognised that by making such improvements patient outcomes (in terms of on-going health, patient choice and dignity) can be significantly enhanced. Implementing and sustaining these changes represents a significant challenge to the NHS as the Scottish population of people aged 65 or more is estimated to increase by 22% by 2020 and 50% by 2030 (based on projected change from 20103).

- The emergency admission rate per 100,000 population for patients of all ages has increased over the last ten years from 9,176 in 2004-05 to 10,070 in 2011-12. The highest rate was observed at 10,149 in 2008-09.

- The emergency admission rate is strongly related to patient age. With the exception of the very young (ages 0-4) rates rise with increasing age group with patients aged 75+ having 6.6 times more emergency admissions per 100,000 than 15 to 29 year olds and 4.3 times more than 45 to 59 year olds (see chart 7 overleaf).

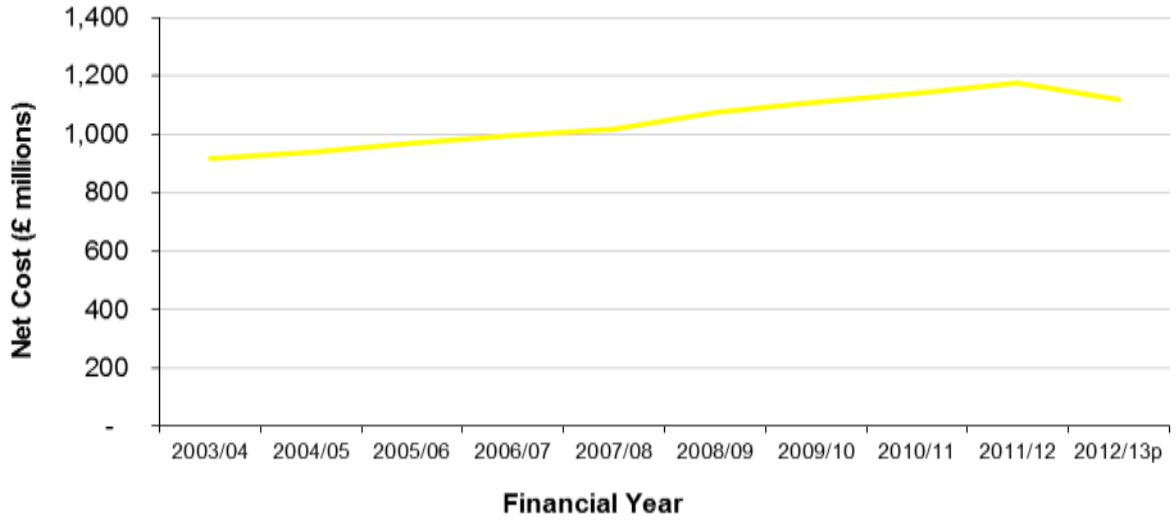
- As the likelihood of emergency admission increases with age, so too does the likelihood of a patient having multiple emergency admissions. For patients aged 65 years and over who have had 2 or more emergency admission spells in hospital, the rate per 100,000 population has increased over the last ten years from 4,380 in 2002-03 to 5,132 in 2011-12.

Health Boards and their partners have been taking forward significant work through local Change Plans to redesign and improve the quality of care and support for older people, including key targets to reduce emergency admissions and delayed discharge. The change plans are still in the early stages of implementation but there is a programme of evaluation and improvement support that sits alongside the change fund provided by the Joint Improvement Team.

Drugs - Prescribing costs

The total (net) cost of prescriptions dispensed in 2012-13 was £1.12 billion, a decrease of 5.0% compared with the previous year. This is a break in the trend in recent years; prior to 2012-13 the net cost was steadily increasing year on year (between 2003-04 and 20012-13 the net cost increased by 22.1% overall).

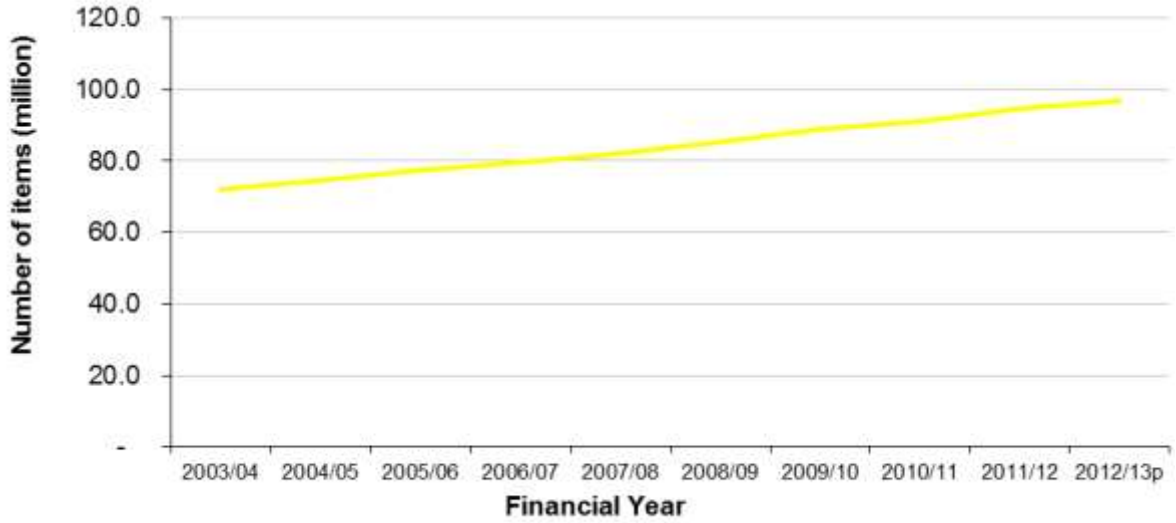
This is due to on-going successful efforts by Health Boards and GPs to ensure that prescribing in primary care is as cost effective as possible. This reduction has been achieved despite continuing increases in the number of drugs dispensed by making best use of generic drugs where there is no reduction in the clinical benefits for patients.



Volume growth

The total volume of items dispensed in Scotland in 2012-13 was 96.8 million, a rise of 2.3% from the previous year, and compared to an increase of 3.8% in 2011-12.

The number of items dispensed has been increasing year on year with a total increase of 34.0% between 2003-04 and 2012-13. This growth reflects not only the availability of new or more effective medicines, but also increasing patient expectation, demographic changes and latterly the implementation of clinical guidelines and recommendations.



Generic prescribing

The rate of generic prescribing was 82.8% in 2012-13. The percentage of generic prescribing has increased steadily since 2003-04, perhaps beginning to plateau from 2007-08.

The rate of generic prescribing remains very high and the number of generic prescriptions has risen slightly year on year. There is limited potential for further immediate savings from higher rates of generic prescribing as there remains a significant residual volume of dispensing in respect of drugs still protected by patent or prescribed as proprietary drugs by GPs for clinical reasons.

Prescribers are strongly encouraged to write prescriptions generically. This is because generic drugs are generally cheaper than proprietary drugs. It is also best practice; when generic substitutes become available at a cost lower than the proprietary drug, the prescriber is already used to writing the generic name

Key Figures

	2009-10	**2010-11**	**2011-12**	**2012-13**
Total prescription items dispensed (millions)	88.97	91.13	94.60	96.78
Volume Growth	4.1%	2.4%	3.8%	2.3%
Net Ingredient Cost (NIC) (£m)	936.1	950.5	973.7	910.2
NIC Growth	3.3%	1.5%	2.4%	-6.5%
Total cost of items dispensed (£m)	1,112.3	1,140.4	1,176.5	1,118.0
Net cost Growth	3.6%	2.5%	3.2%	-5.0%
Net average cost per head of population (£)	214.1	218.4	223.9	212.8

Backlog Maintenance

NHSScotland's estate backlog maintenance expenditure requirement is the base cost required to bring those parts of the existing estate which are currently not in satisfactory condition, back to a satisfactory condition. It is an on-going challenge for the NHS to balance investment between that which is focussed on service improvement and development, and that which is necessary to maintain buildings in a good condition and ensure that they are safe, reliable and fit for purpose. An analysis of the backlog expenditure requirement across NHS Boards identifies a base backlog maintenance expenditure requirement of £948 million, which is a £62 million reduction since 2011.

Indicative figures for 2013 indicate that the overall backlog maintenance has reduced by a further £90 million to £858 million. Further details will be included in the next 'State of the Estate' report which is expected to be published later this year.

Reducing Risk Profile of Backlog Maintenance

High and significant backlog has reduced from £538 million to £424 million, a reduction of £114 million. The proportion of the total backlog maintenance categorised as high and significant risk has reduced from 53.2% of the total in 2011 to 44.7% in 2012.

Summary of Backlog Risk Profile and % of Total Backlog

	Backlog Cost (£M)					
	Low Risk Items	Moderate Risk Items	Significant Risk Items	High Risk Items	**Not Categorised**	**Total Backlog**
2011 Backlog	218	237	306	232	**17**	**£1,010m**
% OF TOTAL	21.6%	23.5%	30.2%	23.0%	**1.7%**	**100%**
2012 Backlog	239	285	265	159	-	**£948m**
% OF TOTAL	25.2%	30.1%	28.0%	16.7%	**0%**	**100%**

Tackling Backlog Maintenance

Of the Total backlog maintenance identified of £948 million the following actions are in hand:

	£m
Total Backlog Identified 2012	**948**
Less **Planned actions by 2017** Planned Disposals Investment/ refurbishment/ upgrading Note – currently identified high and significant backlog will be eradicated	 (175) (256)
Residual Low and Moderate risk backlog	517
Further Planned maintenance to reduce currently identified low and moderate backlog	(90)
Residual low and moderate backlog to be addressed post 2017	**427**

Within the next five years based on capital projects, disposals and maintenance plans we expect the total backlog to reduce by a total of £521 million to £427 million and for all high and significant risk backlog currently identified to be removed.

In tracking the progress of Boards in tackling backlog maintenance year on year there are a number of actions and measures in already in place. These are:

- Regular review of backlog and its' risk profile
- Identified actions by Boards that can be tracked – new projects, maintenance plans and planned disposals
- Review of Board's Property and Asset Management Strategies to identify progress, examine risk management/ mitigation strategies, identify emerging issues and challenge planned actions
- Estate rationalisation and disposal of older properties avoiding the need for expenditure on backlog
- Replacing older properties with new facilities and avoiding the need for expenditure on backlog
- Incorporating backlog works within major modernisation and refurbishment projects
- Undertaking specific projects to target the high and significant backlog
- Incorporating backlog work within operational repair and cyclical maintenance
- £320 million will be transferred from the revenue to capital budget over a three year period starting in 2012-13 to specifically address this issue.

Examples of Projects Making an Impact on Existing Backlog

- NHS Greater Glasgow and Clyde will reduce their identified backlog maintenance of £177.7 million by £88.5 million to £89.2 million. This will be achieved through disposals, in part facilitated by the construction of the New South Glasgow Hospitals Project, and planned, risk profiled maintenance.
- NHS Lothian planned disposals will reduce identified backlog by £30.5 million.
- Royal Edinburgh Hospital In Patient Accommodation will remove £22.6 million of which £19.6 million is High and Significant Risk
- Replacement of Dumfries and Galloway Royal Infirmary (which includes the reprovision of Nithbank Hospital) will remove £40.9 million
- NHS Forth Valley to reduce identified backlog by £13.1 million or 87% through refurbishment of Stirling and Falkirk Royal Infirmaries and planned disposals
- NHS Ayrshire and Arran to reduce identified backlog by £16.1 million from £93.3 million to £77.2 million through investment in North Ayrshire Community Hospital, maintenance and planned disposals.
- Argyll and Bute mental health project being taken forward via hub in NHS Highland will remove £5.9 million of backlog
- The disposal of Forth Park Hospital, Kirkcaldy will remove £3.8 million of backlog maintenance
- Disposal of Woolmanhill Hospital in Aberdeen will remove £2.6 million of backlog
- Replacement of Glenwood Health Centre will remove £0.4 million of backlog

Whilst tackling high and significant risk backlog maintenance will be prioritised we cannot target this in isolation. Whilst those areas containing high and significant risk backlog (particularly in clinical areas) are targeted for investment/ action it is important to recognise

that when access can be gained to operational areas the approach is to maximise that opportunity by undertaking planned preventative maintenance and backlog across all risk categories in those areas.

In monitoring these actions centrally it is recognised that local prioritisation of available resources is required and that the timing of planned asset disposals can move subject to the planning process and local market conditions. In order to support the disposals process in particular we are investing £5 million over 3 years to support enabling works, master planning etc. in order to generate disposal income and remove backlog and other liabilities (security) from surplus site.

Emerging Pressures
The following are example emerging cost pressures which need to be addressed:

Contribution to Rare medicines drugs fund
- In January 2013 we launched a fund to cover the cost of medicines for individual patients with rare conditions, which are not available for routine prescription. £21.7 million will be invested to pay for the cost of medicines known as 'orphan drugs'. These are medicines for illnesses which affect fewer than 1 in 2,000 people.

One Year Job Guarantee – Interns
- SG will fund NHS Boards for 50% of the cost of interns on the internship scheme during 2013-14 (including interns placed before and during 2013-14). Based on current demand for and uptake of the scheme, this would equate to £5 million.
- SG will continue to contribute to the cost of interns in 2014-15, though on a reduced basis of £2 million.

New and Extended Immunisations
- New immunisation programmes likely to commence in 2013-14, including extension of the seasonal flu immunisation programme to all children and young people, rotavirus and shingles, with full implementation likely to be phased in over 3 years to 2015-16.
- Cost of vaccines will be centrally funded.
- Prudent to consider that Board will pick up the costs of administration and delivery – depends on vaccines costs
- SG officials liaising with the Service Delivery Group on immunisation to develop estimates of delivery costs.

Police Custody Healthcare and Forensic Medical Services
- Timetable for transfer of services varies across police force areas.
- Work is on-going to determine the costs to the NHS of providing these services, the value of funding to transfer to the police and how to manage any residual funding gap.
- Boards should work locally to minimise any perceived funding gap, pending completion of the work of the finance sub group.

Protecting Vulnerable Groups (PVG)
- The PVG Scheme is the Scottish response to the principal recommendation of the Bichard Inquiry Report which was undertaken following the Soham murders in 2002. This recommendation called for a registration system for all those who work with children and vulnerable adults in the UK. The PVG Scheme helps to ensure that those who have regular contact with children and/or protected adults through paid and unpaid work do not have a known history of harmful behaviour.
- The introduction of the new scheme will mean increased costs attributable to both the implementation and the proposals for retrospective vetting of staff. Estimates suggest that around 80% of Board staff will need to join the scheme, with an original cost of £59 for each member of staff.
- NHS Boards will need to fund the cost of registration for all relevant staff. This is likely to be phased over a period of time up to 3 years and is estimated to cost £6 million.

Management of Efficiency - Update

NHS Boards have implemented these sustainable and innovative ways of delivering quality services whilst also achieving significant cash releasing savings and productive gains (i.e. time releasing savings). During 2012-13 NHS Boards reported efficiency savings of £270 million, as a result, over the last five years efficiency savings of over £1 billion have been retained by NHS Boards and used to further enhance services.

The Quality and Efficiency Support Team (QuEST) plays a key part in supporting NHSScotland to deliver the priority areas for improvement. In particular, QuEST will support delivery of the following priority areas through its programmes:

- Efficiency and Productivity – the Efficiency Portfolio Office will support NHS Boards to achieve value and sustainability, for example by increasing shared services where appropriate to reduce waste, duplication and variation

- Unscheduled and Emergency Care – the Whole Systems Patient Flow Programme* will support NHS Boards to increase flow through the healthcare system

- Primary Care – the Outpatients, Primary and Community Care Programme supports NHS Boards to shift the balance of care from acute to primary care and home to meet increasing demand

- Prevention – the Cancer Performance Support Team supports NHS Boards to improve survival for people with cancer in Scotland by diagnosing and treating the disease at an earlier stage

Using Primary Care as an example, the Chief Executives of the NHS Boards in Scotland have established a programme to improve quality and cost-effectiveness in prescribing. The programme is in its third year.

In January 2013 Audit Scotland produced a report into primary care prescribing in Scotland. Expenditure on medicines in primary care is almost £1 billion a year, out of a total expenditure on medicines in Scotland of almost £1.4 billion.

Audit Scotland reported that “the NHS has improved how it manages prescribing in general practice”, highlighting a decrease in expenditure in real terms over the last 10 years.

However, the report highlighted that there is still the potential to save money, without detriment to patient care.

National Therapeutic Indicators

The prescribing efficiency programme introduced National Therapeutic Indicators in 2012-13. These are comparative measures of prescribing down to GP practice level .in areas where significant opportunities exist to improve prescribing quality. They include opportunities to reduce costs, in line with the latest clinical evidence and opportunities to tackle public health concerns (eg inappropriate use of antibiotics).

Within these areas of prescribing, costs were reduced by over £40m in 2012-13. This included the impact of some significant price reductions, due to patent expiry. The amount

of saving associated with change in prescribing behaviour is around £7.8m for the financial year. This is a genuine efficiency improvement, with recurring benefit to the NHS.

Poly-pharmacy guidance
The other major initiative from the prescribing programme within the last year was the launch of poly-pharmacy guidance in October 2012. The volume of medicines being prescribed is increasing every year. Among the population of Scotland aged 65 years and over, around half are now prescribed at least 5 medicines. While there is no doubt that medicines have helped to improve life expectancy, there are growing concerns that too many medicines are being prescribed in frail patients that can be harmful.

This clinical guidance has been followed up with incentives for GP practices to implement poly-pharmacy reviews for their most vulnerable patients. It is intended that Scotland plays a leading role in addressing poly-pharmacy over the coming years.

Waste in repeat prescribing
In addition to the waste (and harm) that can be associated with poly-pharmacy, it is also recognised that waste occurs from medicines that are dispensed to patients but not taken. It is inherently difficult to measure. Sometimes it is inevitable (e.g. patient dies or health deteriorates) but there is also preventable waste (eg over-ordering, duplicate ordering etc.). Repeat prescribing accounts for around 80% of total prescribing in primary care. Audit Scotland estimate there is an opportunity to save £12m a year, by tackling this waste.

The prescribing programme has supported the development of software by NHS Lothian to help GP practices identify preventable waste in their repeat prescribing. This software is being tested with the intention that it is made available nationally over the next few months. It will be supported by best practice guidance for repeat prescribing.

National prescribing guidance
In specific clinical areas, national guidance is being developed where opportunities exist to improve prescribing quality, based on clinical evidence and cost effectiveness. The following areas are all being addressed and guidance should be issued by December 2013.

- Asthma & COPD
- Diabetes
- Oral nutritional supplements
- Wound care
- Gluten free foods

The addition of prescribing in pain management to this programme of work is being reviewed.

DRAFT BUDGET 2013-14
HEALTH AND SPORT COMMITTEE REPORT RECOMMENDATIONS **Annex 3**

Further Information Requested to Support Draft Budget Scrutiny

Information requested	Current Position
• retrospective and anticipated cost pressures such as pay, prescribing, equal pay claims etc.	Annex 1 has details of retrospective and current cost pressures.
• performance against existing efficiency savings and planned future efficiency savings	Reference 40 has details on efficiency savings. Going forward we are working on the assumption that a requirement to deliver 3% efficiency savings will remain.
• anticipated high, medium and low financial risks identified by the Scottish Government and how they are provided for in the budget document	Annex 1 has details of the expected financial pressures facing NHS Boards. These pressures will be managed through a combination of additional resource provided and efficiency savings retained locally by NHS Boards.
• trends in available outcome focused and quality-related data.	See annex 4 below.
• compiled information on actions agreed following NHS boards annual review meetings.	This information is available online on local NHS Board websites.
• information on how policy priorities, including preventative spend initiatives (eg through the change fund) and HEAT targets have been and will be supported within the budget	The Health and Wellbeing chapter within the Draft Budget 2014-15 contains detail on all these policy priorities.
• an assessment of the change in the suite of 12 quality measures proposed in the Quality Strategy over the coming 12 months.	This is covered in the original quality note.

Progress with Quality Outcomes: update for Health & Sport Committee, September 2013

The six healthcare Quality Outcomes provide a description of the priority areas for achievement in support of the three Quality Ambitions. The outcomes are represented by a set of Quality Outcome Indicators, which are intended to provide a high level longer term view.

This summary shows information on the currently available Quality Outcome Indicators (some are still under development). This is supplemented with other outcome information such as National Indicators or HEAT indicators.

1. Everyone gets the best start in life, and is able to live a longer, healthier life

- There has been a steady reduction in the mortality rate among under-75s over the last decade. The age-standardised mortality rate in 2012 was 335.6 per 100,000 people, which is a 24 per cent reduction on the 2002 figure.

- In 2010, the death rate among under-75s was 3.4 times as high in the 10% most deprived areas compared to the 10% least deprived areas.

- In 2011, 75.8% of adults described their health in general as 'good' or 'very good'. This has remained fairly consistent over the last few years.

- In 2011, the mean score on the Warwick-Edinburgh Mental Wellbeing Scale was 49.9 – the same as in 2010. It was not significantly different from the WEMWBS scores in 2008 or 2009.

- The percentage of low birth-weight babies (below 5th percentile) has reduced in the last few years to 3.9%. The proportion of ‘healthy weight’ (Appropriate birthweight for Gestational Age (AGA)) has remained relatively stable over the last ten years and was 89.9% in 2012.

- Over the past few years, there has been an increase in the percentage of P1 children with no obvious decay experience in their primary teeth, to 67% in 2011/12. In 2011/12, for the first time, all NHS Boards achieved the national target set for 2010 of 60% with no obvious decay experience.

- The percentage of adults who smoke has gradually reduced from 30.7% in 1999, to 25.7% in 2007 and 22.9% in 2012.

- Rates of alcohol related hospital admissions have for the most part shown an annual increase over the past few decades, but have decreased by 13% from a peak in 2007/08. In 2011/12, the rate of alcohol related hospital admissions was 689 per 100,000 population. This represents a 1.1% decrease from 2010/11, when the rate was 697 per 100,000, but a 19.8% increase since 1997/98, when the rate was 575 per 100,000 population.

2. People are able to live well at home or in the community

This outcome should reflect the success of partnership working between NHS and Local Authorities and third sector, in particular to improve care and support for people who need it and reduce the need for hospitalisation.

- The emergency admission rate has risen slightly in the most recent year – based on provisional 2011/12 figures – to just over 100 per 1,000 population. It is still below the 2008/09 peak but above the level in the early 2000s when it averaged around 92 per 1,000 population per year.

- The per cent of the last 6 months of life spent at home or in a community setting has risen slightly since 2007/08 and is now just over 91 % in 2011/12. (Note that the 'community' includes community hospitals and long stay hospitals as well as care homes and hospices).

- In 2012, the percentage of in-patients who were confident that they could look after themselves when they left hospital saw a further reduction by one percentage point to 85 per cent; it had dropped by two percentage points in 2011.

- In 2012, twenty four per cent of inpatients required care or support services to be arranged after they left hospital. Of these, 82 per cent of patients rated that, overall, the care or support services they got after leaving hospital were excellent or good, and 89 per cent felt that they had received the type of care or support services that were right for them

- Twelve per cent of the inpatients needing care or support on leaving hospital said they had to wait longer than expected in hospital for this to be arranged. There were 164 people waiting over 28 days to be discharged from hospital in July 2012, compared with 108 waiting in April 2012 and 197 in January.

- The percentage of people receiving personal care at home, rather than in a care home or hospital increased from 57.1% in 2007-08 to 60.4% in 2011-12.

3. Healthcare is safe for every person, every time

Key indicators of patient safety have shown improvement in recent years:

- The Healthcare Associated Infection (HAI) point prevalence survey showed the prevalence of HAI was 4.9% in acute care, which was significantly lower than the previous survey.

- HSMR at Scotland-level has decreased by 11.6% between October to December 2007 and January to March 2013. Twenty eight (90%) of the thirty one hospitals participating in the SPSP have shown a reduction in HSMR since October-December 2007 (end of the baseline period); seven of those had a reduction in excess of 15%.

- Rolling annual HSMRs show that there was a sustained reduction in hospital mortality between 2009 and 2011; the level thereafter has remained relatively constant.

4. Everyone has a positive experience of healthcare

Scotland's Patient Experience programme carries out 2 national surveys as well as facilitating local improvement work based on patient feedback. In general these show that people have positive experiences of NHS services.

- In 2011/12, 89% of people rated the care provided by their GP practice as excellent or good (down 1 percentage point from the previous survey). 75% of people rated the overall arrangements for getting to see a doctor as excellent or good (down 6 percentage points).

- 87% of inpatients in the 2011 survey agreed that they got the best treatment for their condition, a reduction of 2 percentage points from 2010.

- The national patient experience indicator, which is based on the survey of inpatients, showed an improvement between 2011 and 2012.

5. Staff feel supported and engaged

Work is underway to develop better measures of Staff Engagement or experience.

- There is room for improvement in staff survey results, for example in 2010, 40% of respondents said they were confident their ideas for change would be listened to and 58% would recommend their NHS board as a good place to work.

- The staff attendance rate was 95.2% in 2012/13, down from a rate of 95.4% in 2011/12 (a difference of almost -0.2 percentage points). However, since 2006/07 the overall attendance rate in NHSScotland has increased from 94.5% (a difference almost of +0.7 percentage points).

6. The best use is made of available resources

- For the financial year 2012/13, NHS Boards delivered efficiency savings of £270 million, exceeding the target of 3%.

- In the Commonwealth Fund International Health Policy Survey 2010, 28% of Scottish patients reported experiencing inefficient or wasteful care[1] in the previous 2 years – which was a lower percentage than for any other country included in the survey.

- In the year ending March 2012, 80.9% of procedures considered to be suitable for same day surgery by the British Association of Day Surgery (BADS) were performed in a day case or outpatient setting, an increase of 1 percentage point since 2010/11.

[1] Wasteful or inefficient care is defined as patients feeling that time was wasted because of it taking too long to schedule tests or appointments, because of being kept waiting too long to see a doctor for a scheduled appointment or because care was poorly organised or coordinated.

- The return to new ratio for outpatient attendances has decreased from 2.5 return outpatients seen for each new outpatient in 2001/02 to 2.1 in 2011/12. The rate has been 2.1 for the last 3 years. This indicates more efficient use of clinical and other resources, and shows that more patients are being recalled to hospital outpatient appointments only when clinically necessary.