# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Performance budgeting</strong></td>
<td>1</td>
</tr>
<tr>
<td>HEAT targets</td>
<td>1</td>
</tr>
<tr>
<td>National Performance Framework</td>
<td>4</td>
</tr>
<tr>
<td>Care in last 6 months of life</td>
<td>5</td>
</tr>
<tr>
<td>Reducing emergency admissions</td>
<td>9</td>
</tr>
<tr>
<td>Increase the proportion of babies with a healthy birth weight</td>
<td>10</td>
</tr>
<tr>
<td>Overall conclusions on National Performance Framework</td>
<td>11</td>
</tr>
<tr>
<td><strong>Earmarked funding and Non-recurring funding</strong></td>
<td>12</td>
</tr>
<tr>
<td>Earmarked funding</td>
<td>12</td>
</tr>
<tr>
<td>Non-recurring funding</td>
<td>13</td>
</tr>
<tr>
<td><strong>Cost pressures</strong></td>
<td>13</td>
</tr>
<tr>
<td>Hospital drugs anticipated price and volume changes</td>
<td>14</td>
</tr>
<tr>
<td><strong>Efficiency savings</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>Integrated joint boards (IJBs)</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Data quality</strong></td>
<td>20</td>
</tr>
<tr>
<td>Quality of survey responses</td>
<td>20</td>
</tr>
<tr>
<td>Presentation of budget information</td>
<td>20</td>
</tr>
<tr>
<td><strong>Annexe A</strong></td>
<td>24</td>
</tr>
<tr>
<td>Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence</td>
<td>24</td>
</tr>
<tr>
<td>List of other written evidence</td>
<td>26</td>
</tr>
<tr>
<td><strong>Annexe B</strong></td>
<td>27</td>
</tr>
<tr>
<td>Analysis of the Survey of 2015-16 NHS Board budget plans</td>
<td>27</td>
</tr>
</tbody>
</table>
Health and Sport Committee

To consider and report on health policy, the NHS in Scotland, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Sport, and measures against child poverty.

scottish.parliament.uk/healthandsport
HealthandSport@scottish.parliament.uk
0131 348 5224
Committee Membership

Convener
Duncan McNeil
Scottish Labour

Deputy Convener
Bob Doris
Scottish National Party

Malcolm Chisholm
Scottish Labour

Rhoda Grant
Scottish Labour

Colin Keir
Scottish National Party

Richard Lyle
Scottish National Party

Mike MacKenzie
Scottish National Party

Nanette Milne
Scottish Conservative and Unionist Party

Dennis Robertson
Scottish National Party

Note: The membership of the Committee changed during the period covered by this report, as follows:
Malcolm Chisholm replaced Richard Simpson on 2 September.
Introduction

1. The aim of this report is to provide insight into current and future actions for NHS boards within the context of their budgets for 2015-16.

2. It draws upon the themes and issues explored by the Health and Sport Committee in its report in January 2015 to the Finance Committee on the Scottish Government Draft Budget 2015-16 (Draft Budget Report).

3. The findings and recommendations in this report have been informed by the Committee’s survey of NHS boards 2015-16 budget plans and the report on the survey produced by the Committee’s Budget Adviser Dr Iris Bosa, University of Edinburgh and the Financial Scrutiny Unit of the Scottish Parliament Information Centre (SPICe). The Committee also held two oral evidence sessions with selected NHS Territorial Board Financial Directors (9 June 2015) and NHS Scotland/Scottish Government Officials (16 June 2015).

4. The Committee wishes to thank the Scottish Government and NHS boards for collaborating with the Committee on its scrutiny of NHS board budgets. The Committee also wishes to thank Dr Iris Bosa for her work over the last two years in supporting the Committee’s scrutiny of the Scottish Government draft budgets and NHS board budgets.

5. This is the fifth year in which the Committee has adopted a two-phase approach to budget scrutiny. This approach reflects the fact that detailed information on the spending plans of NHS boards is not available at the time of the publication of the Scottish Government’s Draft Budget. The Committee’s survey of NHS board budgets is conducted following Boards’ annual submissions of their local delivery plans (LDP) to the Scottish Government.

Performance budgeting

6. This year the Committee adopted a different approach to its board survey and based its questions around indicators from the Scottish Government’s National Performance Framework. This was to reflect the recognition in the Committee’s Draft Budget Report of the increasing emphasis placed on performance budgeting. This approach has enabled the Committee to explore further the large number of performance measures and frameworks used by the Scottish Government in relation to health, and the challenges faced in aligning budgets with specific performance measures.

HEAT targets

7. In the Committee’s Draft Budget Report it noted that the then Cabinet Secretary for Health and Wellbeing, when discussing the performance measures and
frameworks for health used by the Scottish Government, focused mainly on HEAT targets. There was no explicit reference made to the National Performance Framework (NPF).\(^1\) NHS Boards in their survey responses and oral evidence to the Committee placed a similar emphasis on HEAT targets. Although there was also some acknowledgement of the role of the NPF, this framework did not appear to have the same priority in terms of shaping decisions and resource allocation.\(^2\)

8. HEAT targets were presented by boards as the performance framework which had the most impact on their LDP and ultimately their budget decisions.\(^3\) HEAT targets which were mentioned by boards as having influenced resource allocation the most included the treatment time guarantee (TTG), delayed discharge, and the four hour A&E waiting time target.\(^4\)

9. Whilst there are benefits in performance targets being used to steer the strategy and changes at board level, there are some possible limitations with this approach.

10. The Committee received evidence that, where there was a risk of boards failing to meet targets, they would divert resources in order to ensure the target was met.\(^5\) The Committee is concerned that some projects that might have a potentially valuable impact on the service provided could be neglected because of the focus on meeting performance targets.

11. Another potential area where concern was identified by NHS boards was whether there was sufficient account being taken of the community sector in current targets. The Committee received evidence that the focus on the acute sector in HEAT targets may have limited the drive to deliver change in shifting the balance of care\(^6\) (this issue is explored further in the report’s section on Integrated Joint Boards).

12. Another point made by some NHS boards was that the focus on HEAT targets could result in large sums of money being spent to achieve marginal improvements in target performance.

13. NHS Ayrshire and Arran highlighted that sometimes, to achieve a small improvement in the performance indicator(s), required a disproportionate financial and resource investment, and noted that “the law of diminishing returns applies”.\(^7\) The Board explained that to meet waiting time targets it had sometimes deployed a waiting list initiative if it had high levels of staff sickness or operational difficulties. Employing consultants as part of this initiative could cost up to three times the normal rate and there had also been additional costs if the private sector had to be used rather than in-house provision. Waiting time initiatives had cost NHS Ayrshire and Arran roughly £3 million per annum.\(^8\)

14. NHS Western Isles also spoke about the costs involved in striving to achieve the set targets. If it anticipated breaching the TTG for patients NHS Western Isles had had to consider sending patients to another board which it did not have a contract with and this resulted in “incremental costs which can be enormous.”\(^9\)
15. It can be difficult for boards to determine the costs involved in meeting the last one or two per cent of a specific HEAT target. Whilst NHS Greater Glasgow and Clyde told the Committee that it spent an extra £5 million over the winter to try to meet the A and E waiting times target the board explained that it was difficult to work out how much of the £5 million was spent moving the percentages towards the target as the provision of support beds and staff were part of a wider picture. 

16. The boards agreed that the focus on achieving “high profile” target measures could lead to an inefficient allocation of resources. The Committee heard that where it was going to be costly to meet the last percentage points of specific HEAT targets, flexibility around targets may be one way to ensure money was being used effectively to deliver meaningful change. NHS Dumfries and Galloway explained that NHS boards must ensure that there is a sustainable and balanced demand and capacity model for all health systems, and that targets can impact on an NHS board’s ability to ensure flexibility in this system.

17. NHS Ayrshire and Arran suggested that there may not be a need for a 100% target for the TTG. The board suggested that there may be merit in being able to differentiate between the urgency and clinical need of a patient as identified by a clinician, and having a blanket requirement for everybody to be treated within the same time.

18. Paul Gray, Chief Executive of NHS Scotland, Director General of Health and Social Care also acknowledged that whilst there was a legislative requirement for boards to meet the TTG, some clinicians had questioned whether at the far end of the target, it was clinically necessary to meet it in every single case.

19. He stated that the cost of meeting a 95% target would be driven somewhat differently from the cost of meeting a 100% target. He acknowledged that there was a degree of flexibility for clinical decision making in the A and E target that was not present in the TTG.

20. The Committee explored with the Chief Executive of NHS Scotland whether flexibility with regards to targets should be considered where there was disproportionate levels of investment needed to achieve a target. He told the Committee that currently there was no system in place that routinely collated the overall cost of meeting the last percentage points of a HEAT target to enable an assessment of whether spending was proportionate. In oral evidence he offered the following commitment to the Committee—

“…[I will] discuss [it] with ministers, because ultimately it will be a decision for them, what more we might do to collect information about the incremental costs of meeting the last percentage points of the target.”
He added—

“If the expenditure to reach the last fraction of a target is proportionately excessive and does not deliver clinical benefit, that may be something that we should look at.”¹⁷

21. Following the Chief Executive of NHS Scotland’s oral evidence he provided an update to the Committee in writing on 24 July 2015. The update explained that the Scottish Government would not be seeking to assess the incremental costs of delivering the last percentage points of the TTG and detailed the reasons for this decision—

“Given the complexities of setting up a recording system that would accurately track overtime and other costs related solely to waiting time guarantees we do not consider this to be cost effective. However, information on the use of bank, agency, overtime and private sector costs are gathered for each NHS board in Scotland and are readily available for scrutiny.”¹⁸

22. The Committee recognises that it is difficult to assess the level of investment being made by NHS boards to achieve the last percentage points of the Treatment Time Guarantee and HEAT targets. The Committee notes the comments made by the Scottish Government that it would not be cost effective for the Scottish Government to establish a recording system to capture this data. The Committee therefore seeks clarification from the Scottish Government as to whether this should be the responsibility of each NHS board.

23. The Committee asks the Scottish Government how it makes sure that the drive to meet the HEAT targets remains an efficient use of money for NHS boards, when it is not able to establish how much it is costing boards to meet the last percentage point of these targets. This is especially relevant where a board’s performance may only be 1-2% below the target and the money may be able to achieve much greater gains elsewhere. The Committee ask the Scottish Government to consider whether some flexibility in the targets might be appropriate.

24. The Committee notes that a number of boards were able to provide evidence of the costs associated with ensuring HEAT and A&E targets were met and would ask that the Scottish Government considers whether, if routine monitoring is considered too costly, some form of one-off analysis could be undertaken to review these issues.

National Performance Framework

25. The Committee’s Draft Budget Report called for the Scottish Government to demonstrate more explicitly the links between budget lines, targets and
The Committee explored through its NHS board survey the ability of boards to report spending against specific NPF indicators.

26. In contrast with the influence HEAT targets have on boards’ budget decisions, the Committee found that the NPF does not appear to be a major factor in determining allocation of resources for NHS boards. The Scottish Government’s response to the Committee’s Draft Budget Report commented on the role of the NPF—

“... some indicators are more reflective of longer-term outcomes and whilst annual data is available and is reported in the NPF, it is direction of travel and longer term trend which are the focus rather than a target for year-to-year change.”

27. The Committee found that boards held a similar view on the NPF to that expressed by the Scottish Government.

28. The Committee’s NHS board budget survey considered three indicators from the NPF, which were chosen to reflect areas of particular interest to the Committee’s wider work programme:

- Increase the proportion of babies with a healthy birth weight;
- Improve end of life care; and,
- Reduce emergency admissions.

29. Provided below are comments on the Committee’s findings on each of these indicators followed by some general conclusions regarding how the NPF relates to the work of NHS boards.

Care in last 6 months of life

30. As with other NPF indicators boards felt that increasing the percentage of people who spend the last six months of life at home or in a community setting is a useful indicator. However, the findings of the NHS board survey suggested that it had limited, if any, direct influence on budgetary decisions.

31. A number of boards noted that it was a ‘crude’ measure as it did not take account of the quality of care patients received in their last six months of life or patients preference for where their care was provided.

32. NHS Tayside believed that there were limitations in measuring change against an indicator where the current performance level is in excess of 90%, and suggested a number of alternative performance measures, including percentage achieving preferred place of care.

33. The quality and level of data provided by NHS boards in the survey responses on palliative and end of life care and hospice funding was mixed. A number of boards said that it was not possible for them to separate out general palliative care
expenditure from other areas of spending and so did not provide any information on palliative and end of life care and hospice funding.23

34. NHS Dumfries and Galloway explained the challenge in determining what services to include to measure the cost of palliative care provision, “most of us have struggled to pull that information together because we do not count activity in exactly that way.”24 NHS Dumfries and Galloway identified for inclusion in its survey response specialist services comprising in-patient facilities and commissioned services through Marie Curie Cancer Care. However, it was more difficult for the Board to measure what percentage of the role of community and district nursing teams was spent on supporting individuals at the end of life and disaggregating costs in its main acute hospitals.

35. The Chief Executive of NHS Scotland also acknowledged that the way information was recorded at present made it difficult to identify palliative care spend, however he stated that more could be done to separate out this information.25 Dr Calderwood, Chief Medical Officer added—

“… the difficulty […] regarding data and the way that we are collecting it, or rather not collecting it, means that we are not able to understand what is going on in different boards, which is perhaps why they cannot articulate the situation to your committee”26

36. The Committee notes that the Scottish Government did not have separate or further data it has captured on spending on palliative care. The Chief Executive of NHS Scotland, when giving evidence on the Committee’s forthcoming inquiry into palliative care in April 2015 described the Committee’s NHS Board Survey as providing the latest and most up-to-date evidence on palliative care spending.27

37. The Scottish Government explained that it is seeking to address concerns regarding provision and assessment of palliative care services in Scotland, through the development of a strategic framework for action on palliative care. Paul Gray explained—

We need to improve the information that we have. […] Through the strategic framework for action, we are seeking to improve the delivery of anticipatory care, our understanding of what people want through their anticipatory care plans and the information that we have, in order to assure us that palliative care is being delivered appropriately in appropriate settings. We absolutely want to improve things.”28
38. The Committee believes that palliative care and end of life services are of increasing importance given the demographic changes Scotland is facing. It is important that accurate and detailed information on the cost and usage of palliative and end of life care is collected and reported on. At present the quality and detail provided by NHS boards in relation to the funding streams associated with the NPF end of life indicator is mixed. The Committee is therefore concerned that some NHS boards were unable to provide any breakdown of funding in relation to palliative care services and of those NHS boards which did the information was of mixed quality and detail.

39. As a result of this information gap it is difficult to assess the effectiveness of additional spending on palliative care services now and in the future.

40. The Committee welcomes the acknowledgement by the Chief Executive of NHS Scotland that there is a need to improve the information the Scottish Government holds on palliative care. The Scottish Government needs to ensure that better data, performance indicators and assessment of spending is identified and collected with regard to palliative and end of life care.

41. Whilst the Committee recognises that there are challenges to measuring and collating palliative care spend at NHS board level the Committee believes that further steps could be taken by the Scottish Government to assist boards with this collation. The Committee recommends as part of the Scottish Government’s forthcoming strategic framework on palliative care that it provides health boards with parameters in which to measure and quantify the services that are encompassed by palliative care and their associated spend.

42. The Committee will explore these issues further in its current inquiry into palliative care and the evidence the Committee will take from the Scottish Government in early 2016 on its strategic framework on palliative care.

Specialist and end-of-life care hospices

43. The NHS board survey asked about funding for specialist and end-of-life care in hospices. The Scottish Government guidance recommends that boards should establish long-term commissioning arrangements with hospices and meet 50% of agreed costs.29

44. Seven NHS boards provided details of funding agreements and these represented between 41% (Western Isles) and 52.7% (Lanarkshire) of agreed costs. Forth Valley also noted that it provided in-kind support to a hospice in its area (pharmacy support, payroll services, procurement services and laboratory and diagnostic support). A number of NHS boards stated that they did not use
hospices, although it was not clear whether this was the reason for not providing data in all cases.\(^{30}\)

45. The Committee is unable to establish how many of the NHS boards are currently delivering the Scottish Government’s recommendation of meeting 50% of agreed costs for hospices as a number of NHS boards did not provide this data in response to the NHS board survey.

46. The Committee asks the Scottish Government whether its forthcoming strategic framework on palliative care will ensure that this data is collected on a consistent basis so an assessment can be made regarding whether NHS boards are delivering the Scottish Government’s recommendation.

Children’s Hospice Association Scotland

47. The NHS board budget survey included specific questions regarding the funding of the only independent children’s hospice association in Scotland, the Children’s Hospice Association Scotland (CHAS).

48. NHS Tayside has responsibility for the co-ordination of funding to support CHAS with all health boards required to fund 12.5% of hospice running costs. Scottish Government guidance states that jointly, NHS boards and local authorities should meet 25% of children’s hospice running costs. CHAS has a separate agreement with COSLA regarding funding.\(^{31}\)

49. The Committee heard, from NHS Tayside, that NHS boards were not meeting the 12.5% required funding level. In 2013-14 out of overall care costs for CHAS of £9 million, the NHS provided a total of £655,000, 7.2% of CHAS care costs.\(^{32}\)

50. Correspondence the Committee received from the Scottish Government explained that the funding level for CHAS was not being met by NHS boards because not all CHAS running costs were being included in the commissioning discussions with NHS boards.\(^{33}\)

51. NHS Tayside confirmed that an agreed funding baseline was established in 2009-10, which had been uplifted each year using health board percentage uplifts and that CHAS management had been content with this approach.\(^{34}\)

52. However, the Committee heard that the needs of the service had expanded significantly with patients needing more complex clinical care which required specialist medical and nursing staff.\(^{35}\)

53. The Scottish Government explained in correspondence that there was limited data about the number of children and young people requiring palliative and end of life care which meant that it was difficult for CHAS to provide evidence of the need for their services and the specialist nature of what they provide compared to palliative care provided by health boards. The Scottish Government detailed that there was
research which was due to be completed in October 2015 which would assist with this.\textsuperscript{36}

54. NHS Tayside explained that there were plans to revisit the baseline of the agreement between CHAS and the health boards and confirm the agreed hospice running costs.\textsuperscript{37}

\begin{quote}
55. The Committee is concerned that boards are not currently delivering the agreed 12.5\% of hospice running costs for CHAS because not all CHAS running costs are being included in the commissioning discussions with NHS boards. The Committee therefore welcomes the plans to revisit the baseline of the agreement between CHAS and the health boards.

56. The Committee notes that there is also a requirement for local authorities to provide funding for CHAS and asks the Scottish Government to provide information on whether local authorities are achieving their agreed funding level.

57. The Committee asks the Scottish Government to provide further information on the timescales for revisiting the baseline of the agreement between CHAS and the health boards and when it expects that the hospice running costs will be confirmed.

58. The Committee also asks the Scottish Government what assurances it can provide that if NHS boards’ contributions to CHAS services are to increase in future years how it will ensure that boards deliver on this requirement, when current funding is falling short. The Committee asks the Scottish Government how it will monitor and challenge boards in the future to deliver on their funding commitment.
\end{quote}

\textbf{Reducing emergency admissions}

59. In contrast with other NPF indicators considered by the Committee there was evidence that performance in relation to emergency admissions was influencing budget decisions. Findings from the NHS board budget survey suggest that a reason for this was that performance against this measure has worsened in most areas since 2008-09 and boards were seeking to address this performance issue. The Committee notes that this is an indicator with greater variation in performance between boards than the two other NPF indicators considered by the Committee. This variation may be another relevant factor with regard to it influencing budgetary decisions.

60. Below average performance was resulting in boards developing a wide range of initiatives to improve performance including: anticipatory care planning; local unscheduled care action plans; development of Combined Assessment Units. Some boards identified the opportunities offered by the integration of health and social care services to address this issue.
Boards also drew attention to the role GPs play in preventing the need for emergency admissions and ensuring the management of people in the community, GPs were described as “critical to the sustainability of the system”. The Committee received evidence from some boards regarding current issues with the recruitment and retention of GPs. NHS Dumfries and Galloway explained that it was proving difficult to recruit to its GP training posts. There were currently around 11 vacancies in GP practices in its NHS board area with future challenges expected due to around 10% of its GPs planning to retire in the next 18 months.

NHS Dumfries and Galloway felt that whilst there were no easy solutions to this issue it had looked at different models of provision, including involving an advanced nurse practitioner and other professionals supporting provision. The Board also referred to the current national review of out-of-hours services as being of relevance. The Board explained that it was giving consideration to how to maximise the intake of GPs in its rural areas which included working with local partners to find employment for candidates’ spouses or partners.

As with other indicators, boards found it difficult to isolate spending for the emergency admissions NPF indicator. Some provided figures for broader areas of spend e.g. the entire integrated care fund, while others detailed specific capital projects or services.

Reducing emergency admissions is a priority area for NHS boards. The Committee notes the key opportunity that the integration of health and social care will play to deliver improvements in current performance in this indicator.

Given their role in preventing emergency admissions the Committee notes the concerns expressed by some boards regarding the recruitment and retention of doctors in general practice. The Committee asks the Scottish Government for further information on how it is seeking to address the challenges of recruitment and retention of GPs in Scotland.

Increase the proportion of babies with a healthy birth weight

The Committee acknowledged, in its recent inquiry on health inequalities, that whilst the health service had an important role to play in addressing health inequalities many of the primary causes lie outside the health field. This issue was also highlighted in the NHS Board budget survey findings on the NPF indicator on healthy birth weight. Boards suggested that there may be limits to the influence they could have on improving performance in the indicator as performance could be affected by differences in the level of deprivation between boards which the NHS board could not directly address.
67. Boards noted the influence of a range of other factors on performance against this indicator, including: smoking, drinking and drug use during pregnancy; maternal nutrition; obesity; and maternal age, some of which they could address.

68. The evidence received indicated that performance against this indicator did not strongly influence budgetary decisions as most Boards felt that their performance was in line with the national average. In that regard they considered that short-term changes in budget allocations would not directly influence performance on this longer-term outcome measure. 43

69. Assessment of boards’ performance against this indicator also highlighted that it may not always be appropriate to compare the performance of a larger health board with that of a smaller board.

70. Smaller island boards noted that very small changes in the numbers of babies above or below a healthy birth weight had a significant impact on the indicator, due to the small overall numbers of births involved. This could result in smaller boards appearing as an outlier in performance indicators when really it was only one or two patients that were involved. 44

71. Another limitation of this performance indicator was that it does not distinguish between assessing and costing the factors associated with addressing a low birth weight and those relating to a high birth weight. For example, NHS Orkney and NHS Shetland referred to an increase in the proportion of babies born with an above healthy weight, often reflecting maternal obesity or gestational diabetes. It is likely to be different factors which result in a low birth weight.

72. The Committee believes that consideration should be given to having a more nuanced indicator for healthy birth weight that distinguishes between high and low birth weight. The current indicator is a ‘blunt’ indicator as it does not enable this distinction to be made and therefore the indicator’s effectiveness is limited.

Overall conclusions on National Performance Framework

73. The Committee notes from its consideration of three specific NPF indicators that there are challenges in boards being able to identify how much money they spend to achieve specific NPF indicators. Aligning budgets with some of the specific performance measures is difficult for Boards.

74. Boards’ main focus is on meeting day to day operational targets. Boards view the NPF more as an overarching framework rather than one which influences day-to-day decision making activities and changes in planned spending.
75. The Committee, in its previous report on the Scottish Government Draft Budget, proposed that further consideration be given to distinguishing between these short and long term targets. The Committee’s findings on Boards’ relationship to HEAT targets and NPF indicators endorse this proposal.

76. The Committee also believes that when setting NPF indicators, the Scottish Government should consider whether selecting target indicators where all Boards are performing relatively well will drive further improvements in a board’s performance. Whilst the Committee recognises the merit in retaining NPF indicators to ensure performance does not decline as a result of an indicator no longer being used, greater impact may be achieved by in future choosing indicators where there is a wider variation in performance. This approach can encourage those boards who are weaker performers to improve their performance, learning from the experience of those showing stronger performance. Where performance is uniformly at or close to target, there is limited incentive to drive for improvement.

77. The Committee asks the Scottish Government if it will take the views expressed to the Committee on the effectiveness of NPF indicators into account in any future review of the National Performance Framework and its indicators. The Committee recognises that it is important that the NPF indicators remain a useful tool for enabling comparisons to be made at an international level regarding the Scottish Government’s performance.

Earmarked funding and Non-recurring funding

Earmarked funding

78. In 2015-16 the boards will receive, on average, 13% of their funding allocation in the form of earmarked funding that is ring-fenced for a specific purpose, such as alcohol or drug treatment programmes.

79. As in previous years the proportion of the revenue resource allocated by earmarked funding in 2015-16 varies considerably between boards. The higher percentage levels are provided to island boards with the proportions varying from 10% in NHS Lanarkshire to 30% in NHS Shetland.
80. The Committee notes that a higher proportion of earmarked funding implies less flexibility for boards in how they allocate their funds. The Committee seeks further information from the Scottish Government on the rationale for the level of resources allocated as earmarked funding and the justification for the variance between NHS boards. The Committee also asks the Scottish Government whether it is seeking to reduce future reliance on earmarked funding to enable greater flexibility in how boards spend their money.

Non-recurring funding

81. Non-recurring funding is a one-off allocation in a financial year and can sometimes be earmarked for a specific purpose.

82. In its report last year on NHS board budgets the Committee raised concern that non-recurring funding may actually be seen as a recurring source for some territorial boards as it was a high percentage of some boards’ total funding.\(^45\) This concern remains in consideration of this year’s budget especially as the level of total NHS board allocations in the form of non-recurring funding has risen from 3% in 2014-15 to 4% in 2015-16. Also, some boards’ allocations remain particularly high; NHS Lanarkshire has the highest proportion of its allocation (9%) in the form of non-recurring funding.

83. The Committee notes that Audit Scotland has repeatedly raised concerns in relation to non-recurring funding being relied upon by boards to break even. Audit Scotland has highlighted that this is a less suitable way to meet savings targets than making recurring savings as it means the boards need to find these same savings again in other areas in future years.\(^46\)

84. The Committee is concerned that a high percentage of funding allocation is non-recurring for some boards. This means that these resources cannot be used for longer term service provision as the allocation is a one-off. There is also concern regarding non-recurring funding being relied upon by boards to break even. The Committee asks the Scottish Government how it monitors the balance between recurring and non-recurring funding for boards. The Committee also asks the Scottish Government what steps it is taking to support boards to reduce their reliance upon non-recurring funding to meet savings targets.

Cost pressures

85. In response to the survey, many of the territorial boards mentioned cost pressures in relation to the budgetary challenges that they face in 2015-16. In particular,
drug costs were mentioned by nine of the 14 territorial boards. Pensions and workforce costs, including the costs of locums, were also mentioned frequently.

**Hospital drugs anticipated price and volume changes**

86. As part of their LDP submissions NHS boards were asked to set out their planning assumptions in relation to a range of cost areas, including pay, prices and prescribing costs and volumes.

87. A recurring theme for the Committee in its previous reports on the Scottish Government draft budget and NHS board scrutiny is concerns regarding the comparability and consistency of definitions in some of the LDP data, specifically that relating to the price and volume pressures in respect of hospital drugs.

88. Last year’s NHS Boards Budget Report found that there was large variation in price assumptions in terms of hospital drugs. The report stated that Boards may have taken different approaches in assessing price and volume measures: however, there was insufficient detail to establish whether this was the case or to explain the very low and high assumptions at the extremes.47

89. Analysis of this year’s NHS board budget survey showed a similar wide variation in the Boards’ statements of anticipated price and volume pressures in hospital drugs. Again the information suggested that some Boards may have taken different approaches to reporting prices and volumes. Often, those reporting a low value on one measure reported a high value on the other. For example NHS Shetland reported a 33% assumed price uplift, but no change in hospital drug volumes. Meanwhile NHS Lanarkshire reported a 29.6% anticipated increase in volume, but no anticipated increase in price.

90. NHS Ayrshire and Arran was also one of the highest boards for assumed volume uplift at 22% but only 2% assumed price uplift. NHS Ayrshire and Arran explained that the cause of the uplift was that new drugs for Hepatitis C were expensive and were being more widely used. In addition there was a policy initiative to increase access to end-of-life drugs and drugs for ultra-orphan and orphan conditions. When the wide variation between volume and price uplift was explored with NHS Ayrshire and Arran it stated that “the split between price uplift and volume uplift is a bit subjective”.48

91. The Committee discussed with the Scottish Government the actions it took to understand the source of the variation on volume and price between boards. The Scottish Government emphasised the role of boards in reviewing their planning assumptions and consistency of approach through the Corporate Finance Director Network. John Matheson, Director of Health Finance explained that where there were outliers these boards were asked to review their position. These boards would then decide whether to change their position or confirm that there were specific reasons why they were an outlier.49
92. Following the Scottish Government’s oral evidence session it wrote to the Committee with further comments on the variation in the price and volume pressures on hospital drugs between NHS boards. The Scottish Government’s response acknowledges the concerns that the Committee has expressed on the comparability and consistency of this information from NHS boards—

“It is clear that there are examples of differences in the way in which some NHS boards account for and present information about current and anticipated costs and utilisation of medicines. Whilst the Scottish Government is satisfied that there are no inexplicable anomalies, there will be further discussions with NHS boards to explore how a more consistent approach could be adopted.”

93. The Committee recognises that some variation between NHS boards in hospital drugs price and volume uplift is to be expected given, for example, regional differences between boards in the prevalence of certain health conditions. However, there is wide variation between some boards with those reporting a low value on one measure and a high value on another. This does not seem to be explained adequately by demographic and other pressures being faced by individual health boards.

94. The Committee has raised concerns regarding this issue in its previous NHS board reports and is pleased that the Scottish Government has now acknowledged that there is a variation between how boards assess and present information on price and volume pressures on hospital drugs.

95. The Committee also welcomes the commitment made by the Scottish Government that it will explore this variation further with NHS boards to improve consistency in their approach. The Committee asks for further information on what this exploration with NHS boards will entail, and how it will ensure that consistency of approach has been achieved.

96. Once the Scottish Government has ensured a more consistent approach has been adopted by NHS boards, the Committee asks the Scottish Government to provide to the Committee a revised breakdown by NHS board of the price and volume pressure on hospital drugs for 2015-16.

**Efficiency savings**

97. The Scottish Government is expecting NHS boards to continue to pursue efficiency savings in order to achieve their statutory financial targets. In evidence to the Committee the Scottish Government explained that whilst collectively NHS Scotland has a commitment to deliver 3% efficiency savings, this does not translate to a 3% target for each individual health board. John Matheson told the Committee—
“There is an overall target across NHS Scotland but individual boards determine their local needs […] We do not say that individual boards must achieve a 3 per cent target.”

98. There is variation between NHS boards in the level of efficiency saving that they have set. This ranges from 2.6% in NHS Orkney up to 4.5% in NHS Shetland.

99. The majority of territorial boards in their responses to this year’s survey mentioned the achievement of efficiency savings targets as a particular budgetary challenge for 2015-16.

100. The Committee notes that, as with the previous financial years, this year boards expect to achieve the majority of savings via ‘service productivity’, medicines and prescribing and workforce. According to this year’s survey, over a third (36%) of efficiency savings are expected to come from ‘service productivity’, workforce (17%) and ‘drugs and prescribing’ (16%). A tenth of savings have yet to be identified by NHS boards.

101. The Committee’s report on NHS board budgets 2014-15 highlighted that there was growing concern about the extent to which further efficiency savings could be achieved by boards. The Committee remains concerned at the continuing expectation that boards can deliver the efficiency targets which have been set year on year.

102. The Committee is concerned that some NHS boards were unable to identify where all planned efficiency savings were to be made. This may reflect the difficulties for the boards in identifying areas for improvement, given the efficiency savings already delivered in previous years.

103. The Committee also notes the variation between boards in the efficiency savings that are anticipated. The Committee suggested in its report on last year’s board budgets that the Scottish Government give consideration to identifying factors that will facilitate an understanding of whether an organisation is efficient in its management of services and resources, which could then ensure that the efficiency savings levels that specific boards need to achieve is appropriate. The Committee notes that the Scottish Government has not sought to adopt this approach in the current spending year.

104. The Committee asks the Scottish Government to reflect and respond to whether, given the recognition by boards themselves of the challenges they face in delivering on their efficiency targets, there is merit in adopting the approach previously proposed by the Committee. It is important that the Scottish Government can ensure that a board’s delivery of efficiency targets does not have an adverse effect on a board’s provision of services.
The Committee would welcome further clarification from the Scottish Government on what is expected from boards, given the comments to the Committee that it does not expect each individual board to achieve 3% efficiency savings.

**Integrated joint boards (IJBs)**

106. The Committee’s Draft Budget Report considered proposals for integration of health and social care. The Committee stated in that report that the risk was that the acute sector was not going to be sufficiently challenged to reconfigure the way it organised and provided its services, with the result that the hoped for degree of integration and reorganisation of services would not be fully realised. As part of its NHS board budget survey the Committee sought further clarity and transparency on the budgetary processes that will underpin the new arrangements.

107. The Committee found from its survey that a range of approaches were being taken by NHS boards to IJBs. Boards were seeking to move funds from acute care and elective and emergency surgeries to more preventative action and consider IJBs as supportive of this shift. However this was described by one board as “complex” as there was a need for a balance to be struck between investment in the community and the increasing demand on acute services.

108. There was a wide variation in the percentage allocated by boards to IJBs and in the mix and range of services that boards had delegated to IJBs.

109. In NHS Orkney and NHS Shetland, planned resources had been split almost equally from the health board and the local authority, while in all other areas, the NHS board had allocated a larger sum than the local authority to the IJB.

110. In Dumfries and Galloway, the health board accounts for the largest share (81%) of the total planned budget for IJBs. In contrast the original figures NHS Western Isles provided to the Committee indicated that initially 56% of its Board allocation was to IJBs.

111. NHS Western Isles explained that initially it had “decided that it wished to put the minimum that it could into the IJB” based on “apprehension about losing control of some of the acute services that we manage”. Following feedback on the integration scheme NHS Western Isles had included more services and its percentage contribution was now comparable with some of the larger health boards.

112. In contrast NHS Dumfries and Galloway explained that it had taken a “bolder decision than other health board areas had chosen to take” in its approach to IJBs. As the Board was coterminous with its local authority it had placed all its
acute services and a range of other clinical services within the IJB. The decision had been taken through discussions within the health board and “local partnership” about what would be the right approach and that it had sought to ensure “that the focus of integration is improvement of services to patients.”.

113. In assessing the different approaches taken to IJBs several boards referenced the Integrated Resource Framework (IRF) as enabling local partnerships to understand more clearly their patterns of spend and activity across health and social care. Although the IRF had been in place for some years the Committee received evidence that issues about understanding the data and how each individual area uses its health resource remained. This included improvements required in the data collected at a community level on spend and ensuring data collected by social work services was comparable with that collected by health boards.

114. The Committee recognises that as well as considering the budgetary input into IJBs it is important to assess whether the allocation of resources is delivering change to the provision and quality of services for users.

115. The Committee heard from NHS boards that there were steps being taken to ensure that IJBs’ financial reporting would be linked to spend on specific outcomes. NHS Greater Glasgow and Clyde, said that “the challenge will come in how we will measure outcomes from the IJBs”, and the Board highlighted that there was a suite of performance indicators that would be used to assess whether the allocation of resources had been working.

116. The Committee discussed some of the issues raised by NHS boards with the Scottish Government. The Chief Executive of NHS Scotland told the Committee that whilst the outcomes for the IJBs were set in legislation, there was variation in the approaches being taken in the level of resource being transferred to IJBs. Some of this was explained by the demography and geography of the IJBs, but also that there was some autonomy about what services had to be included in the IJBs.

117. He explained that as this was the shadow year for IJBs operation the Scottish Government would review and analyse the propositions this year before the first full year of operation in 2016-17.

118. The Committee explored with the Chief Executive of NHS Scotland how he would ensure that outcomes would be comparable given the different approaches being taken to IJBs structures—

“There is no straightforward answer to that, as different factors apply in each board and in each IJB. However, each board operates to the same financial standards, each territorial board operates to the same performance standards and each integrated joint board operates to the same set of outcomes, which are set in legislation. To that extent there is commonality.”
119. He added that as the accountable officer he sought to assure himself that the different IJB budgets and approaches would deliver improved performance by looking at a series of assurance and governance mechanisms—

“I am confident that what we have in place currently provides me with sufficient assurance. I am equally confident that it could be better. There are areas where we could improve.”

120. Different models and approaches to IJBs are being adopted. These different approaches will require close monitoring by the Scottish Government to ensure that they achieve real change in the delivery of care and ultimately lead to the improvement of services for patients. The Committee invites the Scottish Government to comment further on whether it considers this variation between boards in the level of resource transferred to IJBs to be reasonable and whether it has a view on what is the most appropriate level of resource transfer.

121. In order to influence decisions on resource allocation it is important that robust data is available that clearly assesses the pattern of spend and activity across health and social care. The Committee asks the Scottish Government for further information on what changes it is seeking to make to deliver improvements in the data available at a community level on the use of resources, so that the full resource consumption can be understood. The Committee also asks what steps the Scottish Government is taking to make sure that data is comparable across the health and social care sectors to ensure that there is sufficient quality data available to inform decision taking.

122. As well as ensuring that financial investment in IJBs can be quantified it is important that the outcome in delivery and improvement of services can be assessed. The Committee, therefore, welcomes the proposal that the allocation of resources to IJBs will be measured against a suite of performance indicators. The Committee asks the Scottish Government for further information on the range of indicators that will be used.

123. As discussed earlier in this report the Committee has found from its NHS board survey that it is difficult to link NHS board spend to specific NPF indicators and there are challenges in following spend through to the policy outcome. The Committee asks the Scottish Government for further information on how it will ensure that resources are being spent effectively to deliver these outcomes.

124. As the first full year of operation of IJBs will be 2016-17 the Committee expects to return to consideration of IJBs as part of its draft budget scrutiny in the autumn.
Data quality

Quality of survey responses

125. As noted earlier in this report, this is the fifth year in which the Committee has conducted a survey of NHS board budgets. Receiving responses from all territorial and special health boards is the result of effective collaboration between the Committee, all NHS boards and the Scottish Government. However, the quality and depth of the detail provided by NHS boards in response to the survey continues to vary.

126. In the case of NHS Greater Glasgow and Clyde the Committee received more limited evidence than another boards in answer to some of the questions posed in the survey. This limited the ability of the Committee to scrutinise and assess its performance in comparison to other health boards. This is particularly frustrating given that NHS Greater Glasgow and Clyde receives the largest board allocation from the Scottish Government. The Committee therefore welcomes the commitment made by NHS Greater Glasgow and Clyde that any future submissions “will be far more comprehensive”.71

Presentation of budget information

127. To facilitate the Committee’s scrutiny of the Scottish Government’s Draft Budget the Committee seek a commitment from the Scottish Government that it will provide the following information alongside the publication of its draft budget for health and wellbeing:

- More detail on the links between budget and performance indicators and in particular, the National Performance Framework;
- Information on how integrated health and social care budgets are being developed and allocated and related performance information; and,
- Budget information to support the Health and Sport Committee’s ongoing inquiries, specifically Health Inequalities and Palliative Care.

128. As the Committee has highlighted in its previous reports the quantity and level of detail it receives on both the Scottish Government Draft Budget and NHS board budgets is key to ensuring that the Committee can assess and provide recommendations to the Government and boards on their budgets.
129. The Committee is disappointed that the quality and depth of detail provided by NHS boards in response to the NHS board budget survey continues to vary. In order to enable effective comparisons between NHS boards and for best practice to be identified and shared, the quality, consistency and robustness of the data provided needs to be improved. The Committee would welcome any moves by the Scottish Government to collate and publish the type of information covered by the Committee’s survey, in order to ensure that it is robust and comparable.

130. The Committee continues to believe that while the health and wellbeing budget absorbs 32.4% of the total resources available to the Scottish Government, the level of detail provided is not proportionate to the size of this budget allocation.

131. The Committee also notes the difficulties faced in gathering comprehensive data on specific areas of spend e.g. alcohol and drug programmes. Information on total spend across all boards on such areas would support effective scrutiny and the Committee would welcome any progress by the Scottish Government in compiling and publishing such information.

---

2 The Committee notes that as of April 2015 the term LDP Standards is being used to replace HEAT targets and HEAT standards. Written submission from the Scottish Government to the Public Audit Committee, 16 February 2015.
3 Health and Sport Committee. Official Report, 9 June 2015, Col 2, (Derek Lindsay and Mark White.
9 Health and Sport Committee, Official Report, 9 June 2015, Col 5 (Marion Fordham).
12 Health and Sport Committee, Official Report, 9 June 2015, Col 34.
Report from the Health and Sport Committee

Board budget plans

NHS boards budget scrutiny 2015

Director-General Health and Social Care. Written submission, 24 July 2015.
Director-General Health and Social Care. Written submission, 24 July 2015.
Health and Sport Committee, Official Report, 9 June 2015, Col 27.
Health and Sport Committee, Official Report, 9 June 2015, Col 27.
Director-General Health and Social Care. Written submission, 24 July 2015.
Health and Sport Committee, Official Report, 9 June 2015, Col 27.
Health and Sport Committee, Official Report, 9 June 2015, Col 13. (Katy Lewis)
Health and Sport Committee. 9th Report 2014 (Session 4) NHS board budget scrutiny (SP Paper 586) paragraph 4.
Audit Scotland. (2014) NHS in Scotland 2013/14
Health and Sport Committee. 9th Report 2014 (Session 4) NHS board budget scrutiny (SP Paper 586)
Health and Sport Committee, Official Report, 9 June 2015, Col 32.
Director-General Health and Social Care. Written submission, 24 July 2015.
Health and Sport Committee, Official Report, 9th Report 2014 (Session 4) NHS board budget scrutiny (SP Paper 586)
Health and Sport Committee, Official Report, 9 June 2015, Col 10 (Mark White).
Health and Sport Committee, Official Report, 9 June 2015, Col 9 (Derek Lindsay).
Health and Sport Committee, "Official Report, 9 June 2015, Col 8 (Katy Lewis).
Health and Sport Committee, "Official Report, 9 June 2015, Col 11 (Lindsay Bedford).
Health and Sport Committee, "Official Report, 9 June 2015, Col 10 (Mark White).
Annexe A

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence

15th Meeting, Tuesday 12 May 2015
1. **Decision on taking business in private:** The Committee agreed to take item 6 in private.
6. **NHS Boards Budget:** The Committee agreed its approach.

19th Meeting, Tuesday 9 June 2015
**NHS boards budget scrutiny:** The Committee took evidence from—
NHS Greater Glasgow and Clyde
NHS Ayrshire and Arran
NHS Tayside
NHS Dumfries and Galloway
NHS Western Isles

**Written Evidence**
- NHS Greater Glasgow and Clyde
- NHS Ayrshire and Arran
- NHS Tayside
- NHS Dumfries and Galloway
- NHS Western Isles [Original Submission]
- NHS Western Isles [Revised]

20th Meeting, Tuesday 16 June 2015
**NHS boards budget scrutiny:** The Committee took evidence from—
Paul Gray, Chief Executive NHSScotland and Director General Health and Social Care, Dr Catherine Calderwood, Chief Medical Officer, John Connaghan, NHSScotland Chief Operating Officer, and John Matheson, Director of Health Finance, eHealth and Analytics, Scottish Government.

**Supplementary Written Evidence**
- Scottish Government
25th Meeting, Tuesday 22 September 2015

**NHS boards budget scrutiny:** The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at its next meeting.

26th Meeting, Tuesday 29 September 2015

**NHS boards budget scrutiny:** The Committee considered a revised draft report. Various changes were agreed to, and the report was agreed for publication.
List of other written evidence

Example of questionnaire that was issued:

- NHS Board survey 2015-16
- Territorial Health Boards
- NHS Borders
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Highland
- NHS Lanarkshire
- NHS Lothian
- NHS Orkney
- NHS Shetland
- NHS Shetland - Supplementary Documentation
- Special Health Boards
- NHS 24
- NHS Education for Scotland
- NHS Health Scotland
- NHS Healthcare Improvement Scotland
- NHS National Services Scotland
- NHS National Waiting Times Centre Board
- Scottish Ambulance Service
- The State Hospital
Annexe B

Analysis of the Survey of 2015-16 NHS Board budget plans

Analysis of the survey of 2015-16 NHS Board budget Plans, Dr Iris Bosa, University of Edinburgh and Financial Scrutiny Unit, SPICe.