1. **Subordinate legislation:** The Committee will consider the following negative instrument—

   The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207)

2. **NHS Governance:** The Committee will take evidence on staff governance from—

   George Doherty, Director of Human Resources, NHS Tayside;

   Jennifer Porteous, Director of Human Resources and Workforce Development, NHS Western Isles;

   Elaine Mead, Chief Executive, NHS Highland;

   Kenneth Small, Director of Human Resources, NHS Lanarkshire.

3. **Draft Budget 2018-19:** The Committee will take evidence from—

   Andrew Strong, Assistant Director (Policy and Communications), Health and Social Care Alliance Scotland (the ALLIANCE);

   Aileen Bryson, Interim Director for Scotland, Royal Pharmaceutical Society;

   Richard Meade, Head of Policy and Public Affairs, Marie Curie;

   Carolyn Lochhead, Public Affairs Manager, SAMH;

   and then from—
Dr Andrew Fraser, Director of Public Health Science, Scottish Directors of Public Health;

Kim Atkinson, Chief Executive Officer, Scottish Sports Association;

Sheila Duffy, Chief Executive, ASH Scotland;

Alison Douglas, Chief Executive, Alcohol Focus Scotland.

4. **NHS Governance (in private):** The Committee will consider the evidence heard earlier in the meeting.

5. **Draft Budget 2018-19 (in private):** The Committee will consider the evidence heard earlier in the meeting.

David Cullum
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
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The papers for this meeting are as follows—

**Agenda item 1**

Note by the clerk HS/S5/17/20/1

**Agenda Item 2**

PRIVATE PAPER HS/S5/17/20/2 (P)

NHS Governance Written Submissions HS/S5/17/20/3

**Agenda item 3**

PRIVATE PAPER HS/S5/17/20/4 (P)

Draft Budget 2018-19 Written Submissions HS/S5/17/20/5
Health and Sport Committee
20th Meeting, 2017 (Session 5), Tuesday, 19th September 2017
Subordinate Legislation Briefing

Overview of instrument
1. There is one negative instrument for consideration at today’s meeting:
   - The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207)

The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207)

Background
2. Each local authority is required under section 21 of the Carers (Scotland) Act 2016 (“the Act”) to set local eligibility criteria which are to apply in its area. Local eligibility criteria are the criteria by which a local authority must determine whether it is required to provide support to a carer to meet that carer’s identified needs.

3. Under section 22(2) of the Act, each local authority is required to publish its local eligibility criteria within a period of 6 months beginning with the day prescribed by the Scottish Ministers. Regulation 2 prescribes 1st October 2017 as the day from which the 6 month period for publication of the local eligibility criteria commences.

4. Under section 22(3) of the Act, each local authority must carry out a first review of its local eligibility criteria before the end of a prescribed period which begins with the day on which the criteria are published. Regulation 3 prescribes a period of 3 years within which a first review of local eligibility criteria is to take place. The Policy note from the instrument is attached at Annexe A.

5. An electronic copy of the instrument is available at:

6. There has been no motion to annul this instrument.

7. The Committee needs to report by 25 September 2017

Delegated Powers and Law Reform Committee consideration
8. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 June 2017. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.

Health and Sport Committee Consideration
9. The Committee considered this instrument at its meeting on 5 September and agreed to write to the Minister for Public Health and Sport for further information related to implementation of the Act before deciding whether to make a recommendation on this instrument. The letter is attached at Annexe B.
10. The Committee has not yet received a response from the Minister for Public Health and Sport.
POLICY NOTE
THE CARERS (SCOTLAND) ACT 2016 (PRESCRIBED DAYS) REGULATIONS
2017 (SSI 2017/207)

1. The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (“the
Regulations”) are to be made in exercise of the powers conferred by sections 22(2)
and 22(3) of the Carers (Scotland) Act 2016 (“the Act”). The instrument is subject to
negative procedure.

Policy Objective

2. The Regulations make provision about the date for publication and first review of
each local authority’s local eligibility criteria. Local eligibility criteria are the criteria by
which a local authority must determine whether or not it is required to provide
support to an individual carer to meet that carer’s identified needs. These criteria
must be in place, therefore, in time for it to be applied by local authorities in the
course of preparing an adult carer support plan or young carer statement when these
new schemes, provided for under the Act, take effect i.e. from 1st April 2018.

3. Under section 22(2) of the Act, local authorities are obliged to publish their local
eligibility criteria no later than 6 months from a date prescribed by Scottish Ministers.
These Regulations prescribe 1st October 2017 as the start of the 6 month period for
the setting and publication of local eligibility criteria.

4. Under section 22(3) of the Act, local authorities are obliged to carry out a first
review of their local eligibility criteria before the end of a period prescribed by
Scottish Ministers.

5. These Regulations prescribe that the first review of local eligibility criteria must be
carried out within a period of 3 years from the date when the criteria were first
published. The intention is to ensure that local eligibility criteria are reviewed within a
reasonable timeframe, but allowing sufficient time to give local authorities flexibility to
align those reviews with other local service planning.

Consultation

6. There has been limited consultation with COSLA and the national carer
organisations on these technical regulations.

Impact Assessments

7. An Equality Impact Assessment (EQIA), Privacy Impact Assessment (PIA), and
Children’s Rights and Wellbeing Impact Assessment (CRWIA) have been partially
reviewed and updated to take account of the above instrument. These are available
on request. Further reviews and updated are expected to be published before 1st
April 2018.

Financial Effects

8. The Business and Regulatory Impact Assessment (BRIA) has been partially
reviewed and updated to take account of the above instrument. This is available on
request. A further review and update is expected to be published before 1st April
2018.
Scottish Government
Health and Social Care Integration Directorate
Carers Branch
Dear Minister for Public Health and Sport

The Committee considered The Carers (Scotland) Act 2016 (Prescribed Days) Regulations 2017 (SSI 2017/207) at its meeting on the 5 September 2017. The Committee agreed at the meeting to write to the Scottish Government to seek further information related to implementation of the Act before deciding whether to make a recommendation on this instrument.

During our predecessor committee’s scrutiny of the Carers Bill concerns were raised by stakeholders regarding the estimated costs set out in the Financial Memorandum. This including the following concerns:

- The estimated costs of implementing the Carers (Scotland) Act
- Waiving charges and replacement care costs
- Predicted demand for services

In response to these concerns the Scottish Government set up a financial-led group with key stakeholders, including COSLA and carers organisations to consider cost estimates. The Scottish Government’s response to the Committee’s Stage 1 Report stated the Scottish Government would write to the Health and Sport Committee and the Finance Committee setting out the conclusions of the finance-led group.

As the SSI is requiring local authorities to publish its local eligibility criteria we understand the finance-led group must have now concluded its work. We would
request a copy of the findings of the group and detail on how the specific issues raised during scrutiny of the Carers Bill have been addressed.

The SSI is requiring local authorities to publish their local eligibility criteria. At what stage will local authorities know the additional resource that will be provided by the Scottish Government to assist in funding delivery of the provisions of the Carers Act? This will be required before the local authority has to consult and agree its local eligibility criteria. We are keen to ensure the local eligibility criteria that is agreed is primarily driven principally by the aim to deliver better and more consistent support for carers and not financial constraints.

It would also be helpful if you could provide further information on the mechanism that will be used for distributing the funding to local authorities and integrated joint boards.

The Committee plans to consider the SSI again following receipt of the above information. To meet the timetable for scrutiny of the SSI it would be much appreciated if a response could be received by Tuesday 12 September.

Yours sincerely

Neil Findlay MSP
Convener of the Health and Sport Committee
NHS TAYSIDE RESPONSE TO
HEALTH AND SPORT COMMITTEE REVIEW OF STAFF GOVERNANCE:
CREATING A CULTURE OF IMPROVEMENT

1. NHS Tayside Board Background

NHS Tayside is one of NHS Scotland's major teaching Boards, with a total NHS workforce of approximately 11,800 staff, a revenue budget of £805m, and a capital programme of £9.6m.

With a patient population of almost 414,000, NHS Tayside covers a large geography of 755,813 hectares, covering three Health & Social Care Partnerships formed together with Angus, Dundee, and Perth and Kinross Councils. Dundee City is the largest population centre, accounting for nearly 150,000 population. Perth & Kinross covers the western part of Tayside. This includes the city of Perth and covers a very large area of sparsely populated countryside. The eastern part of Tayside is Angus, a substantial largely rural area which includes a number of smaller population centres, notably Forfar, Arbroath, Montrose and Brechin. In addition, NHS Tayside provides a substantial range of services to the population of North East Fife.

2. The Staff Governance Standard

The Staff Governance Standard, as enshrined in law through the 'NHS Reform (Scotland) Act, 2004', applies to all staff employed by NHS Boards, and forms part of a governance suite against which all Health Boards are expected to operate.

The Staff Governance Standard ('the Standard') aims to maintain NHS Scotland's status as an exemplary employer by ensuring the highest possible equity of treatment for all staff regardless of where they may be employed.

The Standard requires all NHS Boards to ensure that staff are:

• well informed;
• appropriately trained and developed;
• involved in decisions;
• treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
• provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community

and places mutual responsibilities on both the employer and employee in ensuring its application in their day to day working.

3. "Does the NHS adequately implement the requirements of the Staff Governance Standard?"

At a Scottish level, oversight and leadership of the five elements of the Standard outlined above flow through a National Partnership structure, involving the Scottish Government, NHS Scotland employers, trade unions and professional organisations. That structure has three key Forums: the Scottish Partnership Forum; the Scottish Workforce and Staff Governance Committee; the Scottish Terms and Conditions Committee. Through these bodies, the common application of NHS Scotland's Partnership Information Network (or 'PIN') workforce policies is monitored, and regular
assessment of employee experience across all NHS Scotland bodies, through iMatter (described below), Dignity at Work survey, and annual Self Assessment Staff Governance Monitoring Framework, is undertaken.

It is through these mechanisms that NHS Scotland has successfully implemented some of the most significant change agendas of any sector - leading changes to staff terms and conditions with the implementation of Agenda for Change, the subsequent whole-system role redesign and re-banding of posts for our lowest paid staff groups, and more recently successfully implementing key provisions of the National Delivery plan with the inception of integrated Health & Social Care Partnerships.

At a Board level, oversight of application of the Standard across NHS Tayside falls to the Board Staff Governance Committee. Co-Chaired by two Non-Executive Directors, including the Employee Director, the purpose of the Committee is to provide assurance to the Board that NHS Tayside is meeting its obligations in relation to the Standard. In particular, the Committee is empowered to ensure that appropriate reporting is in place to monitor the performance of the organisation against the Standard, and that responsibilities are appropriately discharged by the relevant accountable officers for its achievement. The Committee also regularly receives assurance reports on any matters of whistleblowing and their handling, as led by the Board's Non-Executive Whistleblowing Champion.

The work of the Staff Governance Committee is supported by a Board Area Partnership Forum (APF). Co-Chaired by the Chief Executive and Employee Director / Staff Side Chair. That APF is itself supported by a maturing network of recently-introduced Service-level Local Partnership Fora. The Board’s performance around the Standard is also a feature of the Board Annual Review meeting, which takes place between the Cabinet Secretary and the Board APF.

The focus of NHS Tayside’s partnership working is about describing different internal approach between our line managers and trade unions/professional organisations, coming together as equals at the table to better inform our key decision making, working together jointly on leading our long term Board Transformation agenda, and acting as part of our wider strategic Senior Leadership Team.

Working together in this way helps ensure that our APF is strategically focussed on delivery & transformation matters, while moving key transactional discussions out into Local Partnership Fora, grounding staff engagement, core planning and decision making, and mutual accountability, at a day-to-day service-level.

These Local Partnership Fora hold delegated authority and accountability for ensuring strong local staff governance and promoting active staff engagement through leadership of iMatter (see ‘4’ below). Each Forum is required to produce regular progress reporting to our Area Partnership Forum and on to our Staff Governance Committee. It is through this route that we ensure local engagement in partnership in our preparation of National monitoring reporting of Board performance.

4. "Are there particular areas of the Standard that it implements well?"

The Standard was developed through an active partnership of the NHS Scotland employers, the Trade Unions, the Professional Organisations, and the Scottish Government Health Directorate, and all parties continue to play an active role in the monitoring of its application.

This ongoing partnership approach to the application of the Standard described at ‘3’ above is itself reflective of a culturally different approach to employee relations within NHS Scotland - and which has been described as “the most ambitious labour-management partnership......in the UK Public Sector” in an independent study conducted by Nottingham University.
This partnership approach reflects our own Board focus on culture and creating a strong employee voice and putting staff in charge of service change - ensuring we promote staff involvement, invite the contributing of their knowledge and experience, and as far as practicable promote local leadership.

NHS Tayside has placed a refresh of our culture and leadership approach as a central tenet of our wider transformation work, reflecting the strong relationship between staff experience and patient experience and outcome. Working in partnership with the Kings Fund and Professor Michael West, this work reflects the key operating principle that a positive culture of engagement means staff are able, empowered, and responsible for the delivery of effective care.

A key element of our Board culture work builds on and supports the embedding of the National iMatter continuous improvement model as our key staff engagement vehicle. Developed in partnership between NHS Boards and the Scottish Government, iMatter has been described as a leading-edge and holistic approach to defining and measuring the concept of staff experience.

Using an Employee Engagement Index approach, iMatter has been independently validated by the University of the West of Scotland, who found it to be “....a robust, reliable, valid and popular measure of staff engagement. It is also an excellent tool to measure improvement in staff engagement.”

Within NHS Tayside, our use of iMatter means that staff of all job families, professions, and grades across some 1258 teams to date have the opportunity to have their views and voices heard so far in 2017. The iMatter approach is demonstrating high rates of staff participation rates (68%), in contrast to previous poor responses rates to the former more general NHS Scotland National Staff Survey. For NHS Tayside, the iMatter results to date offer an Employee Engagement Score of 74%, with some 78% and 76% of staff responding positively to key Staff Governance Standard domains of 'Well Informed' and 'Treated Fairly & Consistently, with Dignity & Respect, in an Environment where Diversity is Valued', respectively.

5. "Are there particular areas of the Standard that are not implemented well?"

The Staff Governance Standard is intended to continually drive up employment standards and improve the day to day experience of those who work as part of NHS Scotland. The circumstances of any employer at any point in time, and the individual experience of members of staff, can however influence the extent to which they are perceived as performing well at that time in any particular domain.

In our view, the Standard has been very successful in creating a strong focus and common understanding for all NHS Scotland Employers and partners of their mutual responsibility to work together to promote that positive staff experience. It has also ensured that the issues that impact our workforce are central to the considerations of the Board in its decision making.

There will, of course, always be opportunities for further improvement, and emerging national discussions around application of, for example, 'Once for Scotland' workforce policies being led at a National Partnership level, may provide further opportunity to ensure an environment that eliminates any potential variation and secures no difference in treatment for any individual regardless of role or geography.

6. Conclusion

The legacy of the Staff Governance Standard for NHS Scotland is its reflection of the importance of those who work within our services every day, and builds upon existing significant empirical evidence that the experience of staff is a direct influence on the quality of care delivered to all those who use our services, in terms of their patient experience, safety, and health outcomes.
NHS Western Isles Board adequately implements the requirements of the Staff Governance Standard and recognises the significance of the Standard and the need to improve how the diversifying needs of the workforce are treated.

To ensure the standard is achieved and maintained the Board holds Staff Governance Committees quarterly to discuss governance within the Board, ensures processes are in place to help identify any areas of concern, the Board develops an action plan in partnership with staff side representatives, staff groups and managers, which helps to identify how and where improvements are being made and going forward how this will continue. Regular updates are reflected and updated in the action plan to demonstrate this.

Each year a new action plan is developed to reflect the requirements of the Staff Governance Standards and Everyone Matters: 2020 Workforce Vision Implementation Framework and Plan, which also sets out the 5 priorities for action which includes; Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management.

A colossal underpinning of the Staff Governance Standard is that the standard is embedded at all levels of the Board and across all staff members to ensure there is a consistent approach from all managers to their staff members. To assist and help implement this managers are encouraged to work on annual staff governance reports for their departments. Therefore the Board aims to treat all employees fairly and consistently, with dignity and respect, in an environment where diversity is valued.

Consequently having up to date workforce policies in place that meet or exceed the minimum standards set out within national PIN policies and current legislation is crucial and any policies which are developed locally are undertaken in Partnership. For example, the Facilities Time Policy and Annual Leave Policy were recently reviewed and amended and approved via the Area Partnership Forum (APF) as are all policies/procedures within the Board.

In relation to the effectiveness of NHS systems for raising concerns there are different methods in place depending on what the concern or issue is, for example there is a complaints procedure, a grievance policy, a dignity at work policy if this is in relation to bullying and harassment and this can also be logged and raised confidentially in the incident reporting system, which is also an online system for reporting incidents and near misses.

With regards to Whistleblowing, there are no cases of Whistleblowing to date within the NHS Western Isles. There is a Whistleblowing policy for employees and a Champion for the Board whom employees can approach for guidance.

As part of the Board’s Communication/Strategy Plans work is carried out to ensure all departments have ongoing up to date communication plans. Additionally, the
Communications Group monitor and review effectiveness of all communication methods for front line staff and to make recommendations to improve as necessary ensuring staff members are well informed.

To ensure the Board has the highest quality of care for patients it is significant the Board has the right workforce with the right skills and competences are positioned at the right time, highlighting the significance of having effective workforce planning by taking a systematic and consistent approach linking into the standard involved in decisions which affect them.

Service heads and professional leads are required to contribute to the development of the annual workforce projections figures submitted to the Scottish Government on an annual basis in line with national timescales. This then forms the basis of the Workforce Plan and HR continue to work with the Medical Director, General Practitioners and Consultant Medical Staff to develop an effective Recruitment and Retention plan for NHS Western Isles, building on the learning and recommendations of the NHS Western Isles led “Recruit and Retain” Northern Periphery programme project.

Within the Integrated Joint Board (IJB) there is an Integrated CMT and HRF developed to support development and embedding of approaches to workforce planning and development. The Board also works closely with the Local Authority and IJB to develop and support the development of the Young workforce across the Western Isles including the development of an approach to the delivery of Modern Apprenticeships.

In conjunction with this the Board continues to work with Lews Castle College, Universities, Job Centre plus, Skills Development Scotland and Cothrom to develop and support work experience placements across NHS Western Isles for young people locally and wider, University and profession specific placements.

At present there is a focus on developing a robust medical work experience programme. Linking directly with local schools and colleges as well as students from other Universities and nationally and regionally led placement/experience programmes.

**Good Practice**

Areas of the standard which are implemented well and some of the highlights include the implementation of iMatter, the Healthy Working Lives Strategy in particular achieving the Gold Award, strong partnership working with the IJB, the impact of the Learning Review Group and the early development of the Learning Strategy Network Group with further detail below.

The implementation of iMatter, the staff experience continuous improvement tool which was designed to help individuals, teams and Health Boards understand and improve staff experience, was rolled out across the NHS Western Isles last year.
Work is ongoing to support managers and teams to use the process and iMatter system effectively continuing to support partnership working and embed iMatter across the NHS Western Isles Board. There have also been recent discussions with the Chief Officer for the IJB with regards to the Health and Social Care staff members to participate in future iMatter surveys. This will provide a comprehensive view of staff experience within the IJB allowing for enhanced continuous improvement. This is however, still in the early stages and due diligence is being exercised to ensure appropriate governance is in place prior to implementing such changes.

Overall the NHS Western Isles Board’s iMatter Employee Engagement Index Score was 76% which gives the Board a good measurement in relation to staff experience. It is also a key indicator of a healthy organisational culture, linking into the 2020 Workforce Vision priorities for all health boards.

The implementation and usage of iMatter is important as it links in with ensuring staff are treated fairly and consistently and allows for staff’s voices to be heard and any issues/concerns can be raised and resolved. In relation to this and understanding staff satisfaction within the Board the Dignity at Work survey which utilises data within iMatter will attempt to capture and understand staff satisfaction and experience further and goes live on 6th November 2017 until 27th November 2017 for staff to complete. This survey replaces the national annual Staff Survey across the NHS and the National Report for this will be published next year allowing the Board to assess and take relevant action where necessary.

This then links into the Healthy Working Lives strategy under the Staff Governance standard providing staff with a continuously improved and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

The Healthy Working Lives Awards, administered by the Scottish Centre for Healthy Working Lives, encourages employers to promote a healthier workforce and cover a wide range of topics including health promotion, mental health and wellbeing and Occupational health and safety.

One of the action points was to maintain the healthy working lives Gold Award and support local SMEs (small and medium sized enterprises) to access Occupational health and safety support and advice in the Western Isles.

The NHS Western Isles achieved the Gold Award in November 2013 - the second workplace in the Western Isles to achieve the award. In order to achieve the Gold Award, NHS Western Isles developed a partnership-approved three year health, safety and wellbeing strategy and three year rolling action plan, this plan was reviewed in 2016.

The Healthy Working Lives Steering Group monitors the progress of the strategy and action plan at their meetings. The Healthy Working Lives Steering Group monitors progress of the strategy and action plan including the promotion of local and national health campaigns for staff, and availability of regular training opportunities.
This has been achieved for this year and has been included in the next action plan and to help keep maintaining the Gold Award.

The importance of the involvement of staff in service planning and the role of the staff governance standard in affecting change within the NHS is acknowledged by the NHS Western Isles and the significance of having strong partnership working across the organisation inclusive of the integration of health and social care is crucial. Partnership working also assists in the support of effective organisational change and sustains an established employee relations environment.

All service redesign projects are conducted in partnership with staff and are underpinned and supported by the relevant HR policies. The HR department provide support and advice to managers and teams undergoing change processes. For example, the Reception team within the NHS Western Isles hospital underwent an organisational change process in November 2016 and this was carried out in partnership, involving staff, managers and staffside colleagues throughout the process.

This correlates with keeping staff well informed at all times through these processes to ensure staff are regularly updated with accurate, consistent and timely information. These processes also support that staff are involved in decisions which affect them.

Work is ongoing through the Integrated Joint Board (IJB) to develop a joint strategic plan for future services and work on the Lewis Residential Care review is ongoing as is the redesign for Mental Health.

The IJB workforce strategy was developed and approved as per agreed process and moving forward with the IJB we will be working closely to implement the national workforce plan.

The Learning Review Group’s purpose is to ensure that the NHS Western Isles acknowledges the benefits of learning from its untoward events, including all events identified through complaints, ombudsman reports, the incident reporting system and mortality reviews. The aim of the group is to recognise trends and negative outcomes and to co-ordinate thematic learning and ensure appropriate actions have been taken. The group consists of both middle and senior management, is chaired by the Nurse Director and is lead by Clinical Governance meeting on a bi-monthly basis.

It is designed to provide assurance that the Board is investigating, reviewing and learning from serious adverse events occurring from clinical and non-clinical incidents, complaints and claims and to ensure continuous improvement in quality of service. The group look to identify concerning incident trends arising from analysis of all data collated through incident reporting, complaints, claims, HIS visits, HEI visits. As part of their analysis they look to include identification of risks for review or add to the appropriate Risk Register. They also offer recommendations to decrease the likelihood and outcome of further similar incidents occurring. Additionally, the group look to discover learning points and to ensure learning is shared across the NHS Western Isles Board and with local, national stakeholders and partners. They
also ensure reports from external review visits are given to the identified leads and recommendations are auctioned.

The group look to identify themes, recurring themes and produce thematic learning outcomes for the Board. Common themes that can occur include patient falls, medication incidents, violence and aggression and security.

The most frequently reported type of incident in the Board is patient slips, trips and falls and a significant amount occur on the way to the toilet or in the toilet. Therefore in order to help reduce this there are plans to introduce “Baywatch” (a member of staff will be present at the bay at all times, however it has been noted that this may not be possible at all times) as a trial to assess if there will be a reduction in the number of patient falls.

The incident reporting system allows staff to report incidents that occur in a controlled manner, it means they are logged, they can then be reviewed and assessed, the appropriate action can taken and to help reduce it happening again. Additionally, the complaints procedure allows staff, patients and members of the public to raise complaints to the Board. The group can again analyse the complaints made, identify why it was raised/what was the issue/concern and what can be done to resolve the issue/concern and minimise the risk from occurring again.

The impact of this group to the Board is significant as it helps to identify and reduce risks for patients and staff which links into ensuring they are provided with an improved and safe working environment.

**Areas of Development**

The Board acknowledged that a Learning Strategy Network Group was necessary to provide all staff with equity of access to training. Albeit there is a large focus on clinical training and development, however the Board recognised a Learning and Development Strategy should be implemented across all staff groups throughout the NHS Western Isles to capture both clinical and non-clinical learning and development.

The strategy includes a Learning Plan which outlines all Compulsory Training and Mandatory Training, which is identified by individual managers for specific staff groups. The Learning Strategy also enables organisational learning priorities to be reviewed annually in order to create tailored learning opportunities for all staff and there are plans to create a Learning Needs Analysis for all staff groups.

As part of this Learning Strategy, a new local induction programme has been piloted successfully within the Nursing Directorate. Work is ongoing to ensure staff receive their full induction in their first week and managers are involved in setting objectives for this.

Additionally, positive discussions have also taken place to introduce a Management Development Programme to assist all managers in their learning and development.
needs and help provide them with the effective leadership and management tools. There has also been some progress with HR delivering workshops to Managers on HR policies/procedures. A Workshop took place in June 2017 regarding Promoting Attendance, which was well received by Managers and there are plans to deliver these quarterly. This has also prompted the need to introduce other workshops on other HR related policies, which are in the process of being worked on.

Whilst the Learning Strategy is still in the early stages progress is moving steadily and having this in place is a positive step forward to assist with the development and implementation of the Learning and Development of all staff and to support an effective, efficient and quality assured delivery of learning and development. This also helps to support the staff governance standard of ensuring staff are appropriately trained and developed and that they have access to training to be able to carry out their roles effectively.

All NHS Western Isles Senior Managers are expected to ensure completion of all Personal Development Plans (PDP) and KSF Reviews within their area of responsibility. Challenges to completion of the target have been identified, including the low uptake of the use of e-KSF to record reviews and PDP’s undertaken. This therefore impacts on the numbers of completed reviews and PDP’s that can be reported on. If this is identified as an issue within an area managers are expected to address this with their action plan.

Despite this many Managers complete PDP’s by paper format and hold regular reviews, therefore a review of this will be required to identify why the system is not being fully utilised and is this due to a need for refresher training. This would help build confidence and competence among staff in using technology and encourage active participation in learning to help create a capable workforce. The licence for the e-KSF system expires next year and there are discussions nationally in relation to the system.

The development and progression of the Learning Strategy will also help drive the importance of the completion of the Personal Development Plans and KSF reviews as this plays a significant role in staff’s learning and development in ensuring past performance is appraised and will help identify any necessary learning and development opportunities.
HEALTH AND SPORT COMMITTEE REVIEW OF STAFF GOVERNANCE

WRITTEN SUBMISSION FROM NHS HIGHLAND

NHS Governance – Creating a Culture of Improvement

Introduction

NHS Highland serves the largest and most sparsely populated Regional Health Board area, covering 41 per cent of the country’s land mass. NHS Highland provides health and social care services to our resident population of 320,000 and employs over 10,000 staff. The diverse area NHS Highland covers, includes Inverness, one of the fastest growing cities in Western Europe, and 36 populated islands.

Despite the often popular image of a rural idyll, deprivation, fuel poverty and inequalities also affect the population of the area, producing diverse challenges for service delivery. The Health Board includes two Local Authority areas, Highland and Argyll & Bute. In the Highland Council area the Lead Agency Model has been in place since 2012, with NHS Highland acting as the Lead Agency for Adult Social Care Services and Highland Council acting as the Lead Agency for Children’s Services. In Argyll and Bute the Corporate Body Model is in place and the Health and Social Care Partnership has been governed by the Integrated Joint Board since April 2016. In many parts of Highland, the NHS and other public sector agencies are major employers, and changes to services can adversely affect already fragile areas. As an important partner in maintaining the social and economic vibrancy of the areas concerned, health service quality or changes can and do generate considerable attention from communities, local and national politicians as well as staff.

NHS Highland has a higher proportion of older people in the population than the Scottish average. Seasonal work is common, and in some parts of Highland, where younger people have moved away for education and employment, there are considerable difficulties in recruiting to some roles. Some posts are increasingly difficult to fill, particularly in the Rural General Hospitals in Wick, Fort William and Oban. There are also challenges to fill posts in Raigmore Hospital in Inverness and in Community and Primary Care Services, illustrating wider regional and national challenges.

NHS Highland’s financial requirement is to deliver around £47m savings (7 per cent of a budget of £800m) in order to break even in 2017–2018 and around £100m over three years. As part of the Highland Quality Approach the Board’s Quality and Sustainability Plan aims to improve quality and safety, by reducing waste, harm and variation, as well as requiring substantial service redesign, in light of ongoing recruitment challenges and the desire to move resources from acute to community services.

Background

NHS Scotland has a long and strong tradition of providing high quality care to the population and everyone working in NHS Highland has a role to play in this, whatever their job. Our staff are key to delivering services and it is essential that everyone feels well supported in their role.

Staff Governance is defined as “a system of corporate accountability for the fair and effective management of all staff” – it focuses on how staff are managed, and feel they are managed. It forms part of the governance framework within which NHS Boards operate.

NHS Scotland's commitment to Staff Governance was reinforced by the legislative underpinning within the NHS Reform (Scotland) Act 2004. The Staff Governance Standard Framework is the key policy document to support the legislation which aims to improve how NHSScotland's diverse workforce is treated at work – it covers 5 areas;
The Standard requires all NHS Boards to demonstrate that staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

This revised Staff Governance Standard Framework (4th Edition) aims to build on the progress made in previous editions by reflecting changes as NHS Scotland continues to evolve and improve. Staff across NHS Highland, continue to benefit from the positive changes that the Staff Governance Standard Framework can bring to their working lives, which should lead to improvements in staff retention. In NHS Highland we recognise that investment in staff is a direct investment in care, in that evidence demonstrates that positive staff experience leads to a better experience for patients and service users.

Work to achieve the Staff Governance Standard is ongoing and NHS employers must demonstrate that they are striving to both achieve and maintain exemplary employer status. In order to be able to do this, they are expected to have systems in place to identify areas that require improvement and to develop action plans that will describe how improvements will be made. At the present time the Scottish Government are reviewing the Staff Governance Monitoring Framework, which includes both local and Board wide feedback to the Scottish Government on progress, with examples of good practice that helps inform Annual Board Accountability Reviews.

Staff Governance and its underpinning in legislation was a major achievement for NHSScotland and a first for the United Kingdom. The development and implementation of this Framework demonstrates the proactive approach of trade unions and professional organisations, NHS employers and the Scottish Government to modernising employment practices based on the concept of partnership working which has received critical acclaim from independent research by Nottingham University.

An important development in the 4th Edition of the Framework is the recognition that a responsible organisation that ensures that its employees are fairly and effectively managed within a specified framework of Staff Governance, can reasonably expect these staff to ensure that they take responsibility for their actions in relation to the organisation, fellow staff, patients, their carers and the general public. Active engagement of all parties with the principles of good Staff Governance is essential for NHS Highland to achieve continuous improvements in service quality which deliver the best possible outcomes for people.

The Staff Governance Framework is underpinned by the principles of partnership working, with both National and Board structures in place for Governance and to drive the operational agenda in managing and developing people.

**Does the NHS adequately implement the requirements of the Staff Governance Standard?**

NHS Highland would agree that the principles of Partnership Working and Staff Governance generally work well at National level, with a number of formal structures set up between the Scottish Government, NHS Employers and the Trade Union/Professional Organisations. A review is currently underway to ensure that the current arrangements remain fit for purpose and are as streamlined as possible. At NHS Highland Board level, the Staff Governance Committee leads the development of a culture of engagement and positive staff experience, as well as providing assurance to the Board that Staff Governance and workforce planning are being progressed and
continually improved. The Committee is supported by the Area Partnership Forum and Local Partnership Groups in the Operational Units. NHS Highland has recently revised its structure to support Partnership Working and Staff Governance, giving more emphasis on the importance of local discussions about local issues, reflecting the dispersed nature of NHS Highland and the wide range of staff working in both community and hospital settings. Separate arrangements are in place for Medical and Dental Staff and the Bargaining Group meets quarterly, with representatives from Local Clinicians, Clinical and HR Leaders and the BMA.

To ensure that there is a direct line of sight from Board Level strategic priorities to delivery by locally based staff, NHS Highland undertook a ‘Catchball’ Engagement Exercise last year to agree nine Objectives with staff, in line with the three Strategies in the Highland Quality Approach – People, Quality and Care. The three People Objectives are:

- making NHS Highland the employer of choice,
- ensuring staff are proud of their contribution to delivering safe and effective care, and
- increasing the number of staff who feel engaged and valued as part of our Team.

This approach enabled staff to contribute to the development of our objectives and has improved staff's understanding of how their role contributes to that of their team, department and the organisation as a whole.

Staff themselves will inevitably have differing views as to whether NHS Highland adequately implements the requirements of the Staff Governance Standard. It has been difficult in the past to measure progress, through the National Staff Survey, which was only completed by about one third of staff. However the development and implementation of iMatter, the staff experience continuous improvement tool, that covers the five area of the Staff Governance Standard, designed to help individuals, teams and Boards understand and improve staff experience, has been positive. NHS Highland has had a 62% response rate and has improved its Staff Engagement Index from 74% in 2016 to 76% in 2017. The real value of iMatter is in local Teams developing Action Plans, to improve staff experience, and continuous improvement with their line manager that make a real difference. For example a Support Services Team used a large display board to develop a visual tool, enabling all members of the Team to add their own ideas using post-it notes, about areas for improvement actions they could take. This proved to be very beneficial and the Action Plan is now being implemented.

**Are there particular areas of the Standard that it implements well?**

The Staff Governance Standard is well established and embedded into the organisation, supported by National, and local infrastructures. There is a strong track record of effective partnership working in particular in relation to development of local PIN Polices and Terms and Conditions and in Learning and Development, Workforce Planning and Health and Safety. The Health and Safety Committee is jointly chaired by a staff side representative.

Good examples of partnership working include the implementation of Agenda for Change, the development and implementation of the Lead Agency Model. Regarding the latter in the Highland Council Area, 1500 Council employees were transferred to NHS Highland in 2012 to provide Adult Social Care Services, as part of the Lead Agency Model. It also involved 200 staff from NHS Highland transferring from NHS Highland to the Highland Council. This significant change was completed using the principles of partnership working, very successfully and included implementation of a new Management Structure.

The setting up of the Argyll and Bute IJB was also a good example of what was at times quite challenging change. More recently the Band 1 Review, which was a big exercise for NHS Highland, has been successfully completed in partnership.
The iMatter Board Report, shows that all areas in the Staff Governance Standard are strong, particularly well informed, but with ‘involved in decisions’, the least positive response and work is taking place to address this.

As part of the Highland Quality Approach and the use of the Lean Improvement Methodology in particular, nearly 80 five day Rapid Improvement Events have been held in the last three years in NHS Highland. These Events enable the staff who do the work in both clinical and non-clinical areas, to participate in removing waste and improving flow in their own areas. The Lean Improvement Methodology is very engaging for staff and supports them in making changes, as part of a Team in their own work environment. Continuous improvement is then supported through ‘Daily Management’, which ensures that staff are able to monitor their work with patients and processes and problem solve issues there and then, on a daily basis. This includes issues to do with staff, for example, Personal Development Planning and Review and Training.

In addition, NHS Highland has been working with the Institute for Healthcare Improvement (IHI) on a ‘Value Management’ Work-stream which looks at Patient Quality and Safety, Patient and Staff Experience and Cost on a daily and weekly basis. Some of the Wards involved in this work-stream have also used the IHI Framework for Improving ‘Joy in Work’ and some of the wards measure staff experience at the end of each shift by indicating whether they have had a good or bad day. Any issues are then followed up the following day to try and ensure that issues are addressed at source if at all possible. These ways of working integrate Staff Governance and positive staff experience into everyday working.

**Are there particular areas of the Standard that are not implemented well?**

The Staff Governance Standard was implemented at a time of growth and relative prosperity, when the financial challenges in the NHS were not as significant as they are today. Engaging staff in times of austerity where there are real budget and staff pressures and the requirement for significant organisational and service change to ensure that services are sustainable, is more difficult. Competing priorities, in particular for middle managers, sometimes make it hard to ensure staff are kept informed and involved in decisions. In addition financial and staffing pressures make releasing staff for training or engagement events increasingly hard. Disagreements and conflict between staff may lead to use of National PIN Polices to resolve issues that might have been addressed more locally in the past. However when formal processes are used, a resolution is generally achieved and the number of Employment Tribunal Claims remains relatively low.

Although the Lead Agency model was generally implemented very positively there have been challenges for some Trade Unions in moving from a different Employee Relations climate in the Council to the culture of partnership working in the NHS. With the development of the IJB in Argyll and Bute, different ways of working have sometimes challenged the ethos of partnership working and added a different dimension to working with Trade Unions.

Creating a culture where staff feel it is safe to speak up about patient safety or other concerning issues is still developing. The Whistleblowing Policy PIN and the role of the Non Executive Whistleblowing Champion have been welcomed as part of this journey. However whistleblowing needs to remain a necessary, but last resort. Improving staff experience and confidence at local level through using continuous improvement tools like iMatter can be very helpful in facilitating a positive culture change.

Staff side capacity for full Staff side involvement in change remains challenging. Although NHS Highland invests a significant resource into supporting both full time Staff side Representatives and Facilities time, Staff side have struggled at times, particular in recruiting Health and Safety Representatives and ensuing representation at all Forums and in all change initiatives.

**Conclusion**
Moving forward NHS Boards need to continue to provide leadership for the people agenda and Staff Governance and strive to create a culture where staff experience is positive and valued and recognised as an essential component of the provision of safe, high quality care. Having the Staff Governance Framework does enable Boards to create a structure for continuous improvement. However the emphasis for the future needs to be on recognising that effective leadership needs to be in place at all levels, every day and that reliance on Governance Structure at Board level, whilst necessary is insufficient in itself to ensure positive staff engagement and experience and full achievement of the Staff Governance Standard.
Draft Budget 2018-19
Health and Social Care Alliance Scotland (the ALLIANCE)

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. It brings together almost 2,000 members, including a large network of national and local third sector organisations, associates in the statutory and private sectors and individuals.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE welcomes the opportunity to respond to the Health and Sport Committee’s call for views on the Draft Budget 2018-19.

1. Do you consider that the Scottish Government's health and sport budget for 2017-18 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes)? If not, how could the budget be adjusted to better reflect priorities?

A key message from the third sector over recent years has been the divergence between a strong political drive for radical shifts in policy and investment and the experience at a local level. The consistent message, reflected in the Christie agenda and stated frequently by Scottish Ministers, is the need to shift power and resources to communities, re-direct efforts and budgets towards prevention and focus on outcomes.

However, power largely continues to lie with statutory agencies, the bulk of investment continues to be made ‘downstream’ in traditional services and the potential contribution of the third sector remains significantly larger than its influence and resourcing allow it to make. In order to increase the pace of preventative activity, we believe a greater emphasis needs to be placed upon:

- Clearly positioning the finance proposition as investment in outcomes rather than funding services.
- Developing longer term funding models.
- Investing in creating the enabling environment and being realistic about how long it will take for this investment to bear fruit in some contexts.
• Requiring investment in leadership and change management capacity across all sectors, or provision of this centrally.

2. For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

We believe that the 2018-19 Budget should consider further investment in social care services in order to support the development of community based services that would quicken a shift in the balance of care. Earlier this year we published the findings of our research project on people’s experiences of Self-directed Support (SDS) across Scotland, which highlighted a very low uptake of SDS and mixed experiences of its implementation, despite a statutory duty to offer it. Alongside the increasing financial challenges faced by providers of social care, we would like to see further emphasis placed on the important role that social care has in achieving the Scottish Government’s aims with appropriate funding attached.

We would also like to reiterate to the Committee that the third sector can make a significant contribution to the health and wellbeing of Scotland’s people and communities through innovative approaches.

The Self Management Fund\(^1\), administered by the ALLIANCE, is one example of the impact that can be achieved by investing directly into the sector, supporting organisations and individuals to lead innovation and develop effective, high value for money, asset-based approaches, often in partnership with statutory sector health and social care. The fund was recently cited by Sir John Elvidge’s Carnegie UK Enabling State programme as a leading example of how to deliver the vision described by the Christie Commission.

Additionally, the draft budget for 2017-18\(^2\) includes the commitment to recruit 250 Community Link Workers during the lifetime of the Parliament to work in GP practices, with at least 40 being recruited by September 2017.

In 2013 the ALLIANCE developed the Scottish Government funded National Links Worker Programme. We have been operating in 7 ‘Deep End’ GP Practices in Glasgow, alongside 8 further ‘comparison practices’. The final report of an independent evaluation study undertaken to help understand the impact of the Programme was published in July 2017 by NHS Health Scotland\(^3\). The study was carried out by a team from the University of Glasgow’s Institute of Health and Wellbeing.


\(^3\) [http://www.healthscotland.com/documents/29438.aspx]
Some key findings from the study include a greater likelihood among staff in participating practices to engage in activities aimed at promoting team wellbeing and that staff in practices who had fully integrated with the programme, by the time of the evaluation data collection period, were less likely to report feeling like they wanted to give up patient care within the next five years. In the context of well documented pressures on general practice and the current drive to enhance recruitment and retention of GPs to ensure future needs are met, this could be a vital aspect of the programme.

In terms of the people the programme is reaching, over 80 per cent of programme participants live in the most deprived quintile of Scotland’s population and had complex problems spanning physical, mental health and social issues.

At the nine month follow-up stage at which this study was able to assess participants at, improvements were recorded in anxiety and depressive symptoms, as well as self-reported exercise levels. These improvements were significantly better in those who saw a Community Links Practitioner (CLP) twice or more and in those who engaged with a suggested community resource via the CLP. This resonates with previous research undertaken on the programme that found that community resources in neighbourhoods where the programme is active experienced not just an increase in referrals from general practices, but that these referrals were more relevant and appropriate for the work they do.

The significant investment in this external research, along with the publication of significant learning materials has identified a number of critical success factors that should be accounted for as these posts are implemented across Scotland. This includes the importance of clinical leadership, allowing GP teams to embed the proven approach locally, and strong third sector leadership and responsibility for delivery. Much of the success of the programme, including the person-focused role of the CLP and additional success in embedding a 'social prescribing' approach amongst the GP teams, has been credited with the programme being co-designed and delivered from the third sector.

3. Is sufficient information available to support scrutiny of the Scottish Government’s health and sport budget? If not, what additional information would help support budget scrutiny?

Audit Scotland’s ‘NHS in Scotland 2016’ report made a recommendation for the Scottish Government to develop a “clear and detailed plan for change”, which would set out “what the future of the NHS looks like, what it’ll cost to deliver and what kind of workforce is needed to make it reality”.

The Scottish Government’s Health and Social Care Delivery Plan, published in December 2016 stated that a financial plan would be developed to support the delivery plan. We believe that consideration of this financial plan could form an important aspect of the Committee’s approach to scrutinising the draft budget.

4. What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government’s desired outcomes?

A suite of key indicators against which the annual performance reports of each integration authority must be developed, were established in the underlying guidance for health and social care integration. These outline what the Scottish Government considers to be the indicators of success for each of the nine existing Health and Wellbeing Outcomes.

We particularly welcome the Scottish Government’s continued commitment to shifting the balance of care, as outlined in Outcome 2, “People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community” and repeated in the Cabinet Secretary’s recent letter to the Committee. The extent to which this is reflected locally, however, remains limited, with Audit Scotland’s ‘NHS in Scotland 2016’ report concluding that “the balance of care, in terms of spending, is still not changing.”

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5 [Link](http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/Statutory-Guidance-Advice/Indicators)
6 [Link](http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes)
7 [Link](http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/Integration_Authorities_Budget_SG.pdf)
Consultation on the Draft Health and Sport Budget 2018-19

The Royal Pharmaceutical Society (RPS) is the professional body for individual members of the pharmacy profession across all sectors. We welcome the opportunity to respond to this call for views and would like to respond to the questions from the perspective of how the pharmacy profession is able and willing to support the National Performance Framework, the Local Development Plan (LDP) standards and the National Health and Wellbeing Outcomes.

The RPS welcomes any questions from the committee regarding our response and would be happy to discuss any aspects in more detail if required.

Key messages:

- There is not enough emphasis on a longer term budgetary strategy to implement the transformational change required to sustain our NHS for the future.
- Treating illness is only one aspect of the NHS and there must be increased funding for public health measures which encourage prevention of disease and investment in health literacy.
- There is expertise available within the pharmacy profession which is currently under-resourced and under-used which could positively contribute to implementing many of the national outcomes detailed in the National Performance Framework¹.

Question 1: Do you consider that the Scottish Government's Health and Sport Budget for 2017-2018 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National Health and Wellbeing Outcomes)? If not, how could the budget be adjusted to better reflect priorities?

According to the most recent Scottish Government figures², the only health related national indicator to show improved performance is “improve the quality of healthcare experience”. Others such as “reduce the percentage of adults who smoke” and

¹ National Performance Framework
² Performance versus National Indicators July 2017
“reduce emergency admissions to hospital” have remained steady while there has been a worsening performance in “reduce premature mortality”

Outcome 1 – ‘people are able to look after and improve their own health and wellbeing and live in good health for longer’.

Smoking remains one of the biggest causes of death and ill health in Scotland and smoking cessation measures have been most successful in the higher socio-economic groups where life expectancy remains higher than in more deprived areas. More investment in public health and preventative measures to address inequalities are therefore still required. The previous RPS responses to both the Scottish Parliament Health and Sport Committee and Finance Committee outline in more detail the areas where more could be done to achieve this.

Question 2: For the Health and Sport Budget 2018-2019, where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

Medicines account for a very substantial portion of the NHS budget with an annual spend of £1.4 billion but we know that around 50% of medicines are not taken as prescribed. The RPS believes that additional resources could be more effectively deployed and that the expertise of the pharmacy profession in maximising benefit from treatment, minimising unintentional harm and reducing waste is still underused and under-resourced in both primary and secondary care.

Our Manifesto for the Scottish Election in 2016 “Right Medicine - Better Health – Fitter Future” outlined the areas where more resource was required to reduce the number of hospital admissions from avoidable harm, to speedily resolve medicines related issues on admission to hospital and to free up time for pharmaceutical care across primary care, improving adherence to treatment and patient outcomes.

“The Review of NHS Pharmaceutical Care of Patients in the Community in Scotland” by Scottish Government in 2013 outlined the areas where change must be implemented to improve overall care but to date many of these recommendations have not yet been actioned.

There is much more that could be done to provide true person centred, as opposed to system driven, care, and to realise improvements in the patient journey, in particular when people and their medicines move between hospital and other care settings. A shift in funding for 2018-2019 is required to provide a focus on the National Health and

7 The Review of NHS Pharmaceutical Care of Patients in the Community in Scotland, by Dr Hamish Wilson and Professor Nick Barber in 2013
Wellbeing Outcomes\(^8\) with visible investment targeted at provision of pharmaceutical care within Health and Social Care Integration.

**Technology**

In the RPS response to the Technology and Innovation in the NHS call for views\(^9\) we stated that one of the failures of the current Scottish Government’s eHealth Strategy was the lack of read and write access to a patient’s electronic health record by community pharmacists which is now an urgent patient safety concern. Access to the Emergency Care Summary (ECS) was promised for community pharmacists by 2014 and this has not yet been actioned.

The primary care network must have up-to-date technology that functions within a stable infrastructure to support safe and quality care in all settings. Appropriate read and write access to the patient’s health record is essential to allow all health professionals involved in a person’s care to make more informed and safer health decisions. The RPS policy on access to health records\(^10\) cites many examples of where appropriate access to information has improved patient safety and increased access to treatment.

**Future Models of Care**

Currently, in Scotland, £16.2m is being invested to fund pharmacists in GP practices in order to improve patient access during this period of GP workforce deficit. Funding is equivalent to 140 whole time equivalent pharmacists who have advanced clinical skills training. This will improve access for patients, relieve the pressure on both GPs, A&E departments and Out of Hours services, ensure better use of medicines and NHS resources and support improving patient outcomes. This however, is nowhere near the level of resource required to provide every GP practice with access to the expertise of a pharmacist as promised by the current Scottish Government in the SNP manifesto in 2016\(^11\)

**Pharmacists First**

Some Health boards are currently piloting an extension of the NHS Minor Ailment Service in community pharmacies to allow access to the service by all patients. The MINA study\(^12\) established that management of minor ailments from community pharmacies was both cost-effective in terms of lower prescribing costs as well as giving equivalent health outcomes for patients. There are other new initiatives in community pharmacy to improve access to treatment for common clinical conditions such as urinary tract infections and impetigo. The shift to pharmacy as a first port of call improves the capacity of GPs and Out of Hours teams to provide appropriate care

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\(^8\) National Health and Wellbeing Outcomes
\(^9\) Technology and Innovation in the NHS RPS Response to Call for Views July 2017
\(^11\) https://d3n8a8pro7vhmx.cloudfront.net/thesnp/pages/5540/attachments/original/1485880018/SNP_Manifesto2016-web_(1).pdf?1485880018
\(^12\) Community Pharmacy Management of Minor Illness
for more serious conditions. Initial evaluation is proving positive and when established resourcing of a national service must be prioritised.

**Care Homes and Care at Home**

Care homes and care at home are two areas where medicines play an essential part of care but currently there is very little resource in providing pharmaceutical care in order to improve patient safety and improve the quality of life in later years. The RPS Care home report in 2012 \(^{13}\) called for more clinical roles for pharmacists and although there has been some improvement and new roles created this has not yet been established as the norm across Scotland. There is evidence that de-prescribing and addressing polypharmacy issues is most successful when integrated into multidisciplinary team working. \(^{14}\) Our report is currently being refreshed and new and outstanding issues will be highlighted, calling for the changes in the provision of pharmaceutical care required to improve the quality of life of these vulnerable groups of people.

**Question 3: Is sufficient information available to support scrutiny of the Scottish Government’s health and sport budget? If not, what additional information would help support budget scrutiny?**

The RPS believes that there is not sufficient information available to support scrutiny of the budget and in particular, how the budget has been allocated across the individual Health and Social Care Partnerships (HSCP) in relation to achievement of the National Performance Framework Indicators.

The RPS would like clarity on the Scottish Government’s budget proposals to build on the success of existing pharmaceutical care services and to develop new, innovative services which will support the National Performance Framework.

**Question 4: What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government’s desired outcomes?**

It is not yet clear from available outcomes what improvements have been achieved in this area.

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Aileen Bryson MRPharmS  
Policy Lead  
July 2017

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\(^{13}\) Improving Pharmaceutical Care in Care Homes March 2012  
\(^{14}\) NHS Polypharmacy Guidance 2015
1. Marie Curie welcomes the Health and Sport Committee’s inquiry into 2018-19 Budget and how it impacts on health and social care spending, priorities and outcomes.

2. Marie Curie provides care and support to over 8,000 people living with a terminal illness and their families every year in Scotland. We provide a range of services to deliver this care including our two hospices in Edinburgh and Glasgow, as well as our nursing services, which are delivered in 31 local authorities in Scotland. These services are delivered in partnership with local Health and Social Care Partnerships and NHS Boards, who commission us to do this work.

3. Our services are supported through a mixture of statutory funding, as well as our voluntary fundraising income. Without statutory funding we would not be able to deliver the services that we do.

4. Our response to this inquiry will relate to the need for further investment in palliative care resources, and the other services and support that are needed to enable people to receive that care.

5. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs. Treatment will involve medicines, therapies, and any other support that specialist teams believe will help their patients. It includes caring for people who are nearing the end of life. This is called end of life care. It can be delivered in acute and specialist settings including hospitals and hospices, as well as in general settings in the community through GP practices and in people’s own homes.

6. Investment in palliative care and services that can support people living with a terminal illness can play a key part in enabling the Scottish Government to achieve its ambitions to shift the balance of care from the acute to the community, as well as achieve its National Health and Wellbeing Outcomes, and its vision that “By 2021, everyone in Scotland who needs palliative care will have access to it.”

7. As well as introducing its bold vision for palliative care for all that need it, the Scottish Government has also continued to highlight palliative care in other key policy and delivery documents as well as made it a priority for the new Health and Social Care Partnerships.

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8. In the Scottish Government’s Health and Social Care Delivery Plan the Government committed to “doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting”.

9. The Scottish Government has also listed palliative and end of life care provision as a key priority in a letter relating to all Chief Officers of Integration Authorities regarding the Draft Budget 2017/18 (15 December 2016). The letter states that Integration priorities are to: “Increase provision of good quality, appropriate palliative and end of life care, particularly in people’s own homes and communities and also, where appropriate, in hospices, so that people who benefit from such care access it.”

10. At present, around 56,000 people die every year in Scotland, of which it is estimated that 46,000 will need some form of palliative care. However, evidence suggests that nearly 11,000 people do not get the care they need when terminal ill and at the end of life. This is a substantial gap, which must be bridged if the Scottish Government is to deliver on its vision for care for all.

11. However, no additional or specific financial resource has been committed to palliative care services locally to support the delivery of these various commitments and priorities relating to palliative care. Integration Joint Boards (IJBs) have been asked to find this resource from within existing budgets. We would like reassurance that IJBs are recognising these commitments. They should be able to demonstrate how they deliver their palliative care services to ensure they are meeting the needs of their communities and bridging the gap between those that receive the palliative care they need and those that do not.

12. A recent Nuffield Trust report highlighted that Scotland, like other UK countries, has struggled to move care out of the hospital and into the community. The Nuffield report also highlights that Scotland’s NHS is facing financial difficulties, with a need for greater savings than in other UK countries.

13. Difficult decisions will need to be made in order to invest in community and primary care services, which will ultimately lead to savings in the acute setting, as more people stay at home to receive their care and the risk of emergency and unplanned hospital stays are reduced. We believe that palliative care can play a significant role in helping shift care from the acute to community settings and to contribute to efficiency savings in health spending in acute settings.

14. At present, there is a limited evidence base for the economic value of palliative care. However, the research that has been done suggests that investing in palliative care services, both in specialist and community settings, can lead to savings in hospitals.

15. Based on calculations in the Palliative Care Funding Review for England, extending ‘specialist and core’ palliative care services to those that would benefit could result in net

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savings of £4.2 million in Scotland. These figures are based on costs for extending palliative care by £16.8 million in Scotland leading to estimated savings of £21 million in Scotland (nearly 7,000 fewer hospital deaths). While these estimates exclude the full costs of community based support, including care from GPs, district nurses and others, the evaluation of the Marie Curie Nursing Service highlighted below suggests that these costs are not likely to differ substantially between those in receipt and not in receipt of specialist palliative care.

16. An evaluation of the Marie Curie Nursing Service in England, found evidence of lower total care costs for someone receiving the Marie Curie service compared to a similar individual in receipt of usual end-of-life care. This study identified overall healthcare savings of around £500 per person, taking into account the cost of hospital care, community and primary healthcare and social care, as well as the costs of providing the Marie Curie Nursing Service.

17. Although these two separate estimates cannot be readily combined or compared they both support the view that the costs of extending palliative care may be largely, or even completely, offset by savings from reducing the number of people that die in hospital who do not want to be there and can be discharged with proper support.

18. There is also evidence to show that palliative care services do reduce the amount of hospital admissions, A&E admissions and hospital stays that a patient will experience, particularly in the last months of life. They are also increasingly likely to die in their preferred place of death, which for many is their home or in the community. For example, a recent service evaluation of the Marie Curie Hospice at Home Service in Fife found patients supported by the Marie Curie experienced significantly fewer admissions to hospital (27% compared to 40% of similar patients who did not receive the Marie Curie service) and experienced significantly fewer A and E attendances (3% compared to 12). Overall, patients supported by the Hospice at Home model of care spent 24% fewer days in hospital compared to similar patients not receiving Marie Curie services.

19. Social care is an integral part of palliative care. It can mean the difference between being able to stay at home, get out of hospital, remain connected to families and communities, living the life people want to with some element of independence and control, and dying the way they want to. Last year we launched Dying to Care: A report into social care at the end of life. We highlighted that there needs to be significant time and resource invested into redesigning social care processes and provision to ensure that the right people are in the right place at the right time to deliver better outcomes for people in their communities. This should include a focus on earlier interventions, staff support, better planning and better co-ordination and communication across and between services.

20. We believe that the 2018-19 Budget should consider further investment in social care services in order to support people to live at home, and to help shift the balance of care.

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from acute settings to the community. Only with genuine investment and additional resource will Scotland be able to ensure that people get the care they need at home in a way that meets their needs from the point of that need.

21. Investing in palliative care, and those services that ensure that palliative care can be delivered can support the Government achieve its priorities, as set out in the National Performance Framework and meet the National Health and Wellbeing Outcomes. There is also enough evidence to suggest that palliative care services both in acute and community settings can contribute to the wider debate on how to make efficiency savings in public spending on health and social care.

22. We would urge all those with responsibility for palliative care to ensure that they understand the palliative care needs of their local populations, but also they are investing in the right balance of palliative care services in both the community and acute settings. This should include consideration of additional financial resource in order to ensure everyone gets the care that they need.
Introduction
SAMH is the Scottish Association for Mental Health. Around since 1923, SAMH operates over 60 services in communities across Scotland providing mental health social care support, homelessness, addictions and employment services, among others. These services together with our national programme work in See Me, respectme, suicide prevention, sport and physical activity; inform our public affairs work to influence positive social change.

Responses to Committee questions
1. Do you consider that the Scottish Government’s health and sport budget for 2017-18 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes)? If not, how could the budget be adjusted to better reflect priorities?

Ahead of the 2016 elections, SAMH called for an Ask Once, Get Help Fast approach to mental health. This approach is based on the knowledge that many people have to ask repeatedly, in different settings, before receiving any help, and then may have to wait a long time before help is forthcoming. Asking for help with mental health takes courage and this should be respected.

The World Health Organisation estimates mental ill-health is the third most important cause of disease burden worldwide.¹ This is supported by recent data from the Scottish Public Health Observatory, which found that depression causes more years of poor health than all but two other diseases.² It would therefore be reasonable to expect substantial expenditure in this area of health.

We are delighted that the Scottish Government’s mental health strategy commits to the creation of an Ask Once Get Help Fast approach. However, this approach needs both funding and commitment. We have concerns about the resource currently available although we recognise the Scottish Government’s good intentions.

We commend the Scottish Government for its commitment that mental health expenditure in the NHS will rise above £1 billion for the first time in 2017-18. And we note the First Minister’s recent statement that expenditure on mental health has increased by 42% over the period 2006-07 – 2015-16.³

² Scottish Public Health Observatory, The Scottish Burden of Disease study, 2015
³ First Minister’s Questions, 18 May 2017
The First Minister recently announced £35m of expenditure to employ an additional 800 mental health workers in A&Es, GP surgeries, every custody suite in every police station and prisons. This is extremely welcome, although clearly this would need to be a recurring budget to ensure the continued employment of these workers.

However:

- We calculate that the overall budget share for mental health has reduced, from 8.6% in 2015-16\(^4\) to 8% in 2017-18.\(^5\)
- Overall NHS expenditure increased by 45% over the period 2006-07 – 2015-16\(^6\), suggesting that an increase of 42% in mental health funding is in fact a sign that expenditure has fallen behind

We also note and welcome the commitment in the mental health strategy that future investment in mental health will grow at a rate above overall growth in the frontline NHS budget.\(^7\) It would be most helpful to have some details on this, such as:

- What is the target rate of increase?
- For what period does this commitment apply?
- Will any specific conditions be attached to this budget uplift?

We are concerned that funding for mental health is not sufficient to achieve the ambitions set out in the Mental Health Strategy and is not keeping pace with investment elsewhere in the UK. The King’s Fund quotes the mental health share of expenditure in England as 11%.\(^8\) And NHS England’s Five Year Forward View sets out a budget for mental health rising to £1 billion annually by 2020/21: this is in addition to existing expenditure.\(^9\) An equivalent investment in Scotland would stand at £100m annually. Instead, the Mental Health Strategy sets out an additional £30m per year. We say more on this in response to question 3.

2. For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

As above, we suggest that mental health overall requires a greater percentage of health expenditure. We hear regularly from people who have waited many weeks for first appointments, who then wait a further lengthy period for follow-up appointments, and experience enormous frustration through appointments delayed or cancelled because of sickness absence or staff moving on. Beyond this we suggest there are specific areas where additional funding is required.

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\(^4\) Based on figures from Table R340, *NHS Cost Book* 2015-16
\(^5\) Based on figures from Scottish Government *Draft Budget 2017-18*
\(^6\) Based on figures from *NHS Cost Books* 2006-2016
\(^7\) Scottish Government, *Mental Health Strategy*, 2017
\(^8\) King’s Fund, *Has the government put mental health on an equal footing with physical health?* 2015
Psychological therapies
The most recent figures show that in the quarter ending March 2017, just three NHS Boards met the target for starting a psychological therapy within eighteen weeks of referral. During that period 11,208 people started treatment: but at the end of the quarter 20,952 people were waiting to start treatment. Over a quarter of these people had been waiting for more than 18 weeks.\textsuperscript{10} We would therefore suggest that psychological therapies urgently require greater investment.

CAMHS
We would also like to see greater investment in children and young people’s mental health. Half of all adults who are mentally ill experienced the onset of their mental health problems by the age of 14.\textsuperscript{11} By the time they’re 16, roughly 3 children in every class will have experienced mental health problems.\textsuperscript{12} This is why SAMH has launched a campaign on children and young people’s mental health, \textit{Going To Be}.

Within overall NHS mental health expenditure, our latest calculations show spending on children and young people stood at £55,627,378 in 2015/16: around 0.5\% of NHS expenditure.\textsuperscript{13} This is slightly less to the percentage of spend in England, which is 0.7\%.\textsuperscript{14} The Five Year Forward View in England will provide an additional £460m by 2020/21.\textsuperscript{15}

We suggest at least doubling CAMHS expenditure to £152m per year. This would allow greater funding for tiers 1 and 2, which the Health Committee has previously heard is in need of investment.

Counselling in schools
England, Wales and Northern Ireland all have strategies on counselling services in secondary schools. Children in Wales and Northern Ireland have guaranteed access to schools-based counselling. In Scotland there is no clear strategy, despite the 2005 Scottish Mental Health of Children and Young People Framework calling for the provision of schools based counselling.\textsuperscript{16} The Scottish Government’s 2017-2027 Mental Health Strategy commits to reviewing the provision of counselling in schools.\textsuperscript{17} An evaluation of schools-based counselling in Wales showed that counselling was associated with significant reductions in psychological distress across each of the areas in which it was introduced.\textsuperscript{18} Based on costs from England, SAMH estimates that providing counselling in all Scotland’s secondary schools would require an initial investment of £9m. We suggest this is an investment well worth making and call upon the Scottish Government to ensure that, by 2020, counselling services are provided across Scotland’s secondary schools.

\textsuperscript{10} ISD Scotland, \textit{Waiting times for Psychological Therapies January to March 2017}, June 2017
\textsuperscript{11} Kim-Cohen et al., 2003; Kessler et al., 2005
\textsuperscript{12} Green et al 2005, Mental Health of Children and Young People in Great Britain 2004, cited in \textit{Young Minds} key statistics
\textsuperscript{13} Based on figures from ISD Cost Book tables RO4LSX, SFR 8.3 and R300, as referenced in PQ S5W-05018
\textsuperscript{14} CentreForum Commission on Children and Young People’s Mental Health: \textit{State of the Nation}, 2016
\textsuperscript{15} NHS England, \textit{Implementing the Five Year Forward View for Mental Health}
\textsuperscript{16} Scottish Executive, \textit{The Mental Health of Children and Young People}, 2005
\textsuperscript{17} Scottish Government, \textit{Mental Health Strategy 2017-2027}
\textsuperscript{18} Welsh Government, \textit{Evaluation of the Welsh School-Based Counselling Strategy}, 2011
Training staff working in schools
Health and wellbeing is one of eight core areas in the Curriculum for Excellence. But despite a 2005 promise to train teachers, there is no comprehensive programme of mental health training for staff in schools. The Scottish Government’s 2017-2027 Mental Health Strategy commits to rolling out improved mental health training for those who support young people in an educational setting.

The UK Government has pledged to roll out mental health training for all secondary school teachers in England. Based on costs for existing mental health training, SAMH estimates that training all schools staff in mental health would require an initial investment of £4.4m. We call for the creation of a programme to train all school staff in mental health by 2018.

Extension of CAMHS to age 25
Despite a HEAT target to be met from December 2014, almost a fifth of children and young people who are referred to Child and Adolescent Mental Health Services (CAMHS) wait more than 18 weeks to be seen. Most NHS Boards provide CAMHS services up to the age of 18, though in some the cut-off is 16 unless the young person is in full-time education.

Despite guidance on managing transitional support between child and adolescent and adult mental health services, studies have shown this is patchy and often not prioritised by mental health services. The Scottish Youth Parliament reports that young people find the transition from CAMHS to adult services difficult, because neither service feels right.

A previous Health Committee heard that the criteria for accessing CAMHS are significantly different to those for adult services. The Committee urged the Scottish Government to consider establishing a transition service straddling the older adolescent and younger adult age groups. Other such services exist in the UK.

Care-experienced young people may now continue to receive support from children’s services until the age of 25 and we believe this precedent should now be applied in CAMHS. Our initial estimate is that letting young people choose to remain in CAMHS until age 25 would require an initial investment of £19m. We call on the Scottish Government to ensure that by 2020, young people using mental health services may now choose to remain in CAMHS until the age of 25.
services can stay until age 25, if they choose. In the long term, a specialist service for 16-25 year olds should be developed.

3. Is sufficient information available to support scrutiny of the Scottish Government’s health and sport budget? If not, what additional information would help support budget scrutiny?

There are some areas where there is a lack of information. For example, we do not know what percentage of primary care expenditure relates to mental health. We also do not know what current expenditure is on Tiers 1 and 2 of CAMHS.

We would appreciate greater clarity on the allocation and timeframe of the additional £150m budget on mental health. An additional budget was first announced in August 2015, with £100m of new money for the period 2015-20. In January 2016 this was increased to £150m. The Scottish Government now states that this budget is for 2017-22 and is currently being allocated, with £30m profiled for each of the first five years of the strategy.

We understand from a recent parliamentary answer that there will now be two budgets of £150m each, one from 2016-20 and one from 2017-2022. The same answer states that the £25.4m that was spent before 2017-18 is now additional to the £150m set out in the most recent Programme for Government – so it appears that the additional budget is now £175m. This answer further explains that £30m of the £150m is available for 2017-18 and that allocations for this and future years are under consideration.

However, a parliamentary answer in August 2016 stated that £84.3m of the £150 million additional mental health budget had already been committed. This was broken down as follows:

- £54.1m to support CAMHS and psychological therapies
- £10m for mental health in primary care
- £15m for the Mental Health Innovation Fund
- £1 million to SAMH’s physical activity programme
- £4.2m for people in distress who turn to frontline services.

We are unclear whether the initial £150m is still available for allocation, given the breakdown above. We would welcome some clarity on this issue.

We note that in England, expenditure on mental health is one of the metrics in a scorecard which measures Clinical Commissioning Groups’ performance. We would welcome a similar approach in Scotland.

4. What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government’s desired outcomes?

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33 Scottish Government, *Investment in Mental Health*, 25/08/15
34 Scottish Government, *Mental Health Funding*, 12/01/16
35 PQ S5W-07722, answered 16 March 2017
36 PQ S5W-09255 answered 2 June 2017
37 PQ S5W-01768 answered August 2016
We welcome the principle of health and social care integration. However in reality, it appears to us that there is little actual integration of budgets, with council and NHS budgets presented separately within IJB budgets. As the Committee is aware, a number of IJBs still do not appear to have approved their 2017/18 budget, making analysis of planned spending challenging. Where budgets have been approved the level of publically available detail on areas of spend, including mental health, varies greatly between IJBs.

We are concerned at recent, seemingly disproportionate, cuts to mental health services within some IJBs. For example, Glasgow City IJB has recently cut £3.9m from its planned mental health expenditure: this accounts for over half of its planned cuts to health and social care. Similarly budget proposals from NHS Tayside to Perth IJB in March 2017 proposed a £2.8m, 10% cut to mental health inpatient spend. This was rejected by the IJB as unachievable, delaying the 2017/18 budget sign off.

A small number of IJBs have introduced longer term budget forecasting. For example Aberdeen City IJB in their 2017/18 budget outlined a notional 5 year budget position with projected spend broken down annually to 2021/22 by care group, including mental health. This is to be welcomed and encouraged. Longer term financial planning provides more clarity to people using health and social care services and providers delivering services. It also allows IJBs greater scope to align their strategic activities to the National Health and Wellbeing Outcomes, rather than operating in the uncertainty of annual budget cycles.

Nationally, expenditure on adult mental health services stands at 3% of total social work expenditure. We do not believe this reflects the importance of mental health in our communities.

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38 Perth & Kinross Council Integration Joint Board - 24 March 2017
39 Aberdeen City Council Integration Joint Board Tuesday 7th March 2017
The Scottish Directors of Public Health welcome the opportunity to comment on the Health and Sport Committee’s call for views on the Scottish Government’s Draft Budget for 2018-19.

1. Do you consider that the Scottish Government’s health and sport budget for 2017-18 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes)? If not, how could the budget be adjusted to better reflect priorities?

Generally the 2017-18 budget set out actions that reflected its stated priorities. The necessary detail of how the high level priorities set out in the draft budget was clarified in the Health and Social Care Delivery Plan. This was also consistent with its stated priorities.

Within this it was welcome to see commitments to:

- “Help address health inequalities and improve the health of the population”; and
- “Prioritise investment which focuses on prevention and early intervention, to ensure the realisation of our 2020 Vision”.

2. For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

We would encourage the Scottish Government to maintain its focus on prevention and address health inequalities. We consider that it is important that the advice of the Government’s independent advisor on poverty and inequalities in her most recent report on the life chances of young people is reflected in the new 2018-19 draft budget.

Whilst the budget needs to align closely to help ensure that support is offered to those who need it most, as population health practitioners we also recognise that this should not be at the expense of effective population level interventions. Prevention and early intervention can often be more effective when taken forward on a universal basis, with additional effort being taken to target persisting inequalities that give rise to a loss of health and wellbeing.

In this regard we would note that this applies to areas of the Draft Budget beyond the specific elements relating to Health and Sport. There will be occasions when the best investments for reducing health inequalities will be in relation to those social,
economic, and environmental factors that determine health experiences and feed health inequalities.

It is our experience that, in many respects, taking bold action on prevention and inequality reduction has broad public support in many respects. We would welcome the opportunity to help the Scottish Government to take the sort of ambitious action to meet the ambition set out in the national priorities and show that the policy intention has led to effective action.

In requesting views on the effective use of resources, we would simply echo the statement of Benjamin Franklin that “an ounce of prevention is worth a pound of cure”. Whilst this is accepted broadly, achieving the appropriate rebalancing of the Draft Budget between prevention and health and social care delivery remains a challenge. Progress is being made, but perhaps clearer guidance on what proportion of financial efficiencies should be invested in work to address health inequalities may be a useful tool. Such efficiencies are possible. For example, cutting oversupply in care services and removing unnecessary duplication of services can allow rationalisation in, for instance acute hospital services. The new NHS landscape for regional planning will help here, but only if there is an inclusive process toward decision-making concerning ways in which reinvestment can support wider health and social care priorities in general, and preventative interventions in particular.

3. Is sufficient information available to support scrutiny of the Scottish Government's health and sport budget? If not, what additional information would help support budget scrutiny?

We would suggest that until we understand how best to interpret effectively the existing information to evaluate effective use of budgets, the question of what extra information is needed may be premature. In this regard we are also aware of the work being undertaken by Professor Sir Harry Burns, the former Chief Medical Officer, as independent chair of the national review of targets and indicators for health and social care may well have a bearing on understanding health and social care effectiveness. Directors would be keen to contribute to further work to develop his proposals.

4. What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government’s desired outcomes?

At present, we consider that it is simply too early in the development of the Integrated Joint Boards for health and social care to understand the impact of the integration on achieving the Scottish Government’s desired outcomes. We would however note that in the context of prevention and early identification of health problems across the life course and of preventing inequalities and addressing existing health inequalities, health and social care activity is not the only source of resources which are important. In particular resources dedicated across the broad remits of the newly reformed Community Planning Partnerships is also a key concern for meeting the needs of Scotland’s people.
The Scottish Sports Association (SSA) thanks the Health & Sport Committee for the opportunity to contribute to this call for views.

The Scottish Sports Association (SSA) exists to represent and support Scottish Governing Bodies (SGBs) of Sport as the independent and collective voice for SGBs. We represent their interests and currently have 48 full members and 17 associate members. SGBs are responsible for the governance, development and delivery of their individual sports and provide a formal structure for the over 900,000 individuals in Scotland who are members of one of Scotland’s 13,000 sports clubs. Most of these organisations are run on a not-for-profit basis and are managed by volunteers. They provide coaching, competition and participation development opportunities for their local communities and most of the 195,000 people who volunteer in sport do so within the club structure.

The SSA has, as usual, compiled this submission in consultation with our members.

**Question 1 - Do you consider that the Scottish Government’s health and sport budget for 2017-18 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes)? If not, how could the budget be adjusted to better reflect priorities?**

**Scottish Government’s Purpose**
While the ambition of a more successful country with opportunities for all of Scotland to flourish is welcomed, there is an argument to say that there are other means to achieve this, other than simply through increasing sustainable economic growth. Aspects of health, inequality and lifestyle choices are also fundamental to this aspiration, as proposed in a revised purpose:

“To focus government and public services on creating a healthier, more successful country with opportunities and life choices for all of Scotland to flourish, through increasing sustainable economic growth and reducing inequalities.”

This revised purpose reflects the Government’s priorities for reducing inequalities, improving mental health and an increased focus on prevention as outlined within the 2017-18 Draft Budget and the Programme for Government.
Strategic Objectives - Healthier
The aim of the ‘Healthier’ strategic objective is “to challenge the health inequalities that currently exist in Scotland, including the gap in healthy life expectancy, to improve the life chances that are needed to support better health.”

- From discussion with Scotland’s former Chief Medical Officer, Sir Harry Burns, it is understood that the key indicator of life expectancy in Scotland is how physically active a person is – above any other indicator
- The Scottish Government’s Active Scotland Outcomes: Indicator Equality Analysis states that “Once people are frequently active, inequalities almost entirely disappear - among sport and exercise participants, frequency of participation does not vary by any characteristic apart from ethnicity (people of Asian origin participate less)”
- It is widely recognised that sport and physical recreation help people to lead healthier lives.

As such, it is proposed that the ambition of the ‘Healthier’ strategic objective be amended to reflect the contribution of sport and physical activity to this vital objective, and to provide a real and much needed focus on prevention, in line with the priorities detailed in the Draft Budget 2017-18 and the Programme for Government:

“Help people to sustain and improve their health and levels of activity, especially in disadvantaged communities, to embed a prevention approach to healthcare and ensuring better, local and faster access to health care.”

The contribution of ‘A Healthier Scotland’ to the overall Purpose is by: “raising healthy life expectancy, increasing the productivity of Scotland’s workforce, reducing absenteeism, improving public sector efficiency and increasing participation in the labour market by reducing the number of people on incapacity benefit.” Sport and physical activity make a considerable contribution to these priorities, as detailed in the table below.

<table>
<thead>
<tr>
<th>A Healthier Scotland’s Contribution to the Purpose</th>
<th>Evidence of Sport/Physical Activity Contribution</th>
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</thead>
<tbody>
<tr>
<td>Raising healthy life expectancy</td>
<td>Physical activity ‘reduces the risk of premature mortality in general’¹ (US Surgeon General)</td>
</tr>
<tr>
<td>Increasing the productivity of Scotland’s workforce</td>
<td>Work performance can increase by up to 5% when employees are physically active</td>
</tr>
<tr>
<td>Reducing absenteeism</td>
<td>27% fewer sick days are recorded by physically active employees</td>
</tr>
<tr>
<td>Improving public sector efficiency</td>
<td>4-5% improved work performance through being active</td>
</tr>
<tr>
<td>Increasing participation in the labour market by reducing the number of people</td>
<td>Staff turnover can be reduced by up to 15% due to on-site fitness programmes²</td>
</tr>
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</table>

Increasing physical activity levels by 1% each year for five years would save 157 lives per year, with a positive economic impact of £85million. Physical inactivity costs the NHS in Scotland £91 million/year.

While these figures are compelling on their own as to the economic benefits of our nation being more active, the most compelling arguments are very human, with prevention at its heart.

Despite these compelling figures, particularly in relation to the lives that can be saved and in the opportunities for our nation to live longer, healthier and indeed happier lives, the importance of people being active is not currently reflected in those National Outcomes which are identified as having a "focus" within the Healthier Outcomes. The National Indicator for physical activity should be reflected as an identified “focus” target within the ‘Healthier Outcomes’.

In addition to the contribution of sport to the ‘Healthier’ and ‘Wealthier and Fairer’ Strategic Objectives, as detailed above, research supports the impact that participation in sport has on all five of the Strategic Objectives. Further information on this contribution can be found in the SSA’s #WhySportMatters resources.

**National Outcome – We live longer, healthier lives**

It is reassuring to note that the National Indicator for increasing physical activity is identified as related to this outcome. However, the benefits of people participating in sport and physical activity are not recognised as factors in delivering this Outcome, nor is the inactivity of the nation recognised as a main challenge to this.

The importance and influence of this Outcome lacks any real commitment to, or focus on, prevention.

**National Indicators**

While our members welcome the continued use of the National Indicator to increase physical activity, it is also important to recognise the contribution that success in this area can directly have on the following indicators, as research indicates:

- **Reduce traffic congestion** through increased approaches to and opportunities for active travel
- **Improve Scotland’s reputation** through Scotland’s successes in elite/performance sport, through the hosting of the Commonwealth Games, Ryder Cup and a host of other international sporting events and through the significant contribution of sport to Scotland’s tourism economy

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2 sportscotland Strategy Consultation (2010). *Shaping our plans for the future.*
4 Scottish Government: http://www.gov.scot/Topics/ArtsCultureSport/Sport/physicalactivity
- Improve the skill profile of the population through individuals attaining and developing new skills through participating and/or volunteering in sport and sports clubs
- Improve people's perceptions of the quality of public services through people having inclusive, affordable and sustainable access to a diverse range of sporting opportunities and sports clubs
- Improve levels of educational attainment through more young people being active within and beyond the school curriculum
- Increase the proportion of young people in learning, training or work through more young people being active and enhancing their life chances
- Increase the proportion of graduates in positive destinations through more graduates participating in sport and enhancing their life chances
- Increase the proportion of healthy weight children through more young people reaping the benefits of being active in the early years as well as increased activity within and beyond the school curriculum
- Increase people's use of Scotland's outdoors through more people being active outdoors and through increased participation in outdoor/adventure sports
- Improve self-assessed general health through the enhanced health and feel-good factor benefits of more people being more active
- Improve mental wellbeing through sport being recognised as a natural remedy to both prevent and enhance mental health and wellbeing
- Reduce premature mortality by increasing activity levels and getting the least active people to be active through specifically targeted and resourced programmes
- Reduce Scotland's carbon footprint through increased approaches to and opportunities for active travel
- Increase the proportion of journeys to work made by public or active transport through increased approaches to and opportunities for active travel.

The performance of the majority of these Indicators reflects that of the physical activity indicator, ie no change. This creates an argument for increased and targeted investment in sport and physical activity to increase performance against the physical activity target, as well as further research and targeting as to the impact potential that sport and physical activity can have to contribute to these other identified Indicators.

The cross cutting nature of the physical activity indicator further supports the proposal that it should receive higher prominence, given the number of national indicators which it can have a positive effect on.

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5 https://www.bucs.org.uk/page.asp?section=18560&sectionTitle=Value+of+Sport
National Indicator – Increase physical activity
The introduction of this Indicator was greatly welcomed by our members. In order to increase progress towards this Indicator Measure (“the proportion of adults meeting physical activity recommendations”), our members would raise the following points:

- Has the previous target for this indicator been removed “50% of adults, and 80% of children aged 16 and under, should be meeting the current recommended levels of physical activity by the year 2022”?
- The measurement for this indicator only focuses on one of the two guidelines for adults recommended by the UK Chief Medical Officers, ie the number of minutes of aerobic activity per week. It does not report on the second of these guidelines – the number of days per week when activities that improve muscle strength/test balance and co-ordination are undertaken
- Our members support the current refresh of the indicators and data which inform the Scottish Government’s Active Scotland Outcomes Framework to provide more robust and detailed information to appropriately monitor trends to inform decision making at all levels
- The recognition that maintaining population levels of activity, despite a growing and ageing population, actually demonstrates an increase in activity levels and should be celebrated
- A focus on ‘we encourage and enable the inactive to be more active’ must have the same prioritisation as ‘we encourage and enable the active to stay active throughout life’ to achieve the vision of ‘a more active Scotland; where more people are more active more often’
- Targeting the inactive to become more active must be supported by new investment in recognition that specific, targeted programmes have proven of greatest success in this regard and, subsequently, that these require new, additional and specific investment
- The recognition of the preventative properties for positive physical and mental health outcomes within this Indicator are welcomed, but these need to be cross referenced into the Health National Outcome and to the related National Indicators. This will help to raise awareness as to the importance and contribution of sport and physical activity and will promote increased cross-departmental working and, vitally, budgeting at both local and national government levels
- Our members are also concerned that the aspects which will ‘influence this National Indicator’ relate only to the respective Commonwealth Games and Ryder Cup. Our members would suggest that there remain many current and future opportunities which will influence this National Indicator which could be referenced
- It is important to note that the reasons highlighted as to why this National Indicator is important are all health related outcomes – a further strong argument that if health is to be the principal recipient of the benefits of increasing physical activity, that health budgets should also be the principal investor to the achievement of these outcomes
Given that approximately 90% of investment in sport in Scotland is through local authorities, it would add priority to the delivery of this Indicator if a further specified role of the Government within this was liaison with local government to ensure that the breadth of the contribution of sport and physical activity to Scotland is reflected within local government budgets and plans across local government departments.

**National Indicator – Increase people’s use of Scotland’s outdoors**

As detailed above, the National Indicator for increasing physical activity is entirely complementary to the National Indicator for increasing people’s use of Scotland’s outdoors. However, it no longer features in the Healthier Strategic Objective, nor is it reflected as a related National Indicator in relation to the ‘We live longer, healthier lives’ outcome.

Within this it is important to reiterate Scotland’s internationally-recognised landscape in providing a superb venue for a range of outdoor activities, with consequent benefits for individuals in terms of health, fitness and wellbeing, and broader benefits for the economy, especially so in rural and remote areas. Strongly linked to this is our world-leading access legislation which significantly encourages and enables increased outdoor activity.

In order to increase people’s use of Scotland’s outdoors, our outdoor landscape must be considered as an asset. Any plans/developments which could have a negative impact on this asset and the potential opportunities and/or likelihood of people taking part in outdoor/adventure sporting activities must be carefully assessed and their potential impact researched.

**National Health and Wellbeing Outcomes**

The benefits of sport and physical activity are not recognised within the six outcomes which underpin the National Health and Wellbeing Outcomes. Subsequently, each Integration Authority is not required to report annually on their performance in this area towards these national outcomes.

Our members are concerned that this is despite research showing that sport and physical activity can reduce the risk of all causes of mortality by 30% and that ~90% of investment in sport in Scotland goes through local authorities.

**How Could the Budget be Adjusted?**

As identified above, there are a number of areas where the contribution of sport and physical activity could be better reflected. This is also true in relation to the budget. Instead of reducing the budget to sport and physical activity – increasing the budget in this area would better reflect the Scottish Government’s identified priorities of reducing in equality and focusing on prevention and early intervention.
Question 2 - For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?

Where Could Additional Resources be Most Effectively Deployed

In order to achieve our shared vision of a healthier Scotland, where people live longer, healthier lives, a change in culture is fundamentally what is required. There are three principal target groupings with three respective targeted approaches:

1. Proactive, supported intervention programmes need to be targeted to those individuals who are currently not active. Such programmes are supported intervention programmes enabling and encouraging sustainable participation in sport and physical activity and require to be specifically resourced through new, additional investment.

2. Early intervention is key to providing all of Scotland’s young people with the skills and confidence to engage on a pathway of lifelong participation in sport and physical activity; if every young person is taught the fundamentals of physical literacy (ie if every child can run, jump, throw, catch and swim) then they have the tools to self-direct their own activity in sport and physical activity throughout their lives.

3. Everyone (including those detailed above and those that are already active) needs accessible, affordable and diverse opportunities to participate in sport and physical activity. In order to maximise the sustainability of this (in addition to the further health, social, skill-development and intergenerational benefits), voluntary sports clubs need to be supported as a key exit route to the targeted programmes and initiatives identified above. As such, voluntary sports clubs need to be celebrated as a key asset to communities and their contribution to our nation needs to be better recognised by both national and local governments.

As detailed above, the principal benefits of an increase in physical activity/participation in sport will be towards improvements in health (both physical and mental), as well as:

- education (through increased attendance and educational attainment)
- the economy (due to the aforementioned increased productivity in the workforce)
- justice (through increased uptake in sport contributing to diversionary choices for young people).

Given that these policy areas will likely benefit most from increases in physical activity/participation in sport, should these departments and budgets not also be the key paymasters to achieving these outcomes?
The Scottish Governing Bodies of sport, through the SSA in partnership with the Scottish Sports Alliance, outlined within *A Manifesto for Scottish Sport* where further investment in, and prioritisation of, sport and physical activity could lead to the change in culture required to deliver the outcomes desired within the National Performance Framework. Fundamentally these priorities fall into four key headings:

**PE and School Sport:** an entitlement for every child to be equipped with the skills to be active for life;

- Through the primary school curriculum, and significant aspects of learning, every child develops the fundamental skills to allow them to be physically literate (run, jump, throw, catch and swim)
- The teaching of PE is prioritised within initial teacher training and CPD to ensure the confidence and competence of all teachers in quality delivery for all pupils
- Scottish Disability Sport’s award winning Disability Inclusion Training is prioritised within teacher training and CPD to ensure quality and inclusive PE for all pupils
- Educational structures ensure that every child, in every school is active every day, supported by specialist teachers.

**People:** an entitlement for everyone to be supported as a volunteer;

- Everyone is able to contribute to their communities through volunteering
- Every employer and educational establishment provides regular Supported Volunteering options for all as part of wider ongoing support for the voluntary sector.

**Places:** everyone has access to an appropriate range of indoor and outdoor sporting places in their communities;

- Facilities which receive public investment should provide easy and affordable (a rate which is not financially prohibitive) access to community sports clubs
- Facilities which receive public investment should provide priority access to community sports clubs.

**Performance:** an entitlement for all talented individuals to achieve their potential through the sporting system;

- World class performance sporting system for everyone in Scotland
- Increased and long term investment planning into performance sport in Scotland
- Every athlete will have access to a level of facilities, competition, coaching and support which is appropriate for their ability and commitment to sport.

In the Manifesto, our members outline that these four priorities could be enabled and realised from the fifth priority:
**Partnerships**: for everyone to realise the benefits of sport/being active:

- Partnerships between sport/activity organisations are prioritised with and resourced from health, education, justice and transport organisations to lead to a “radical shift towards preventative public spending” (Christie Commission).

Our members are clear that the delivery of the above principles would underpin a change in the culture of sport and physical activity in Scotland which would revolutionise both sport and health in Scotland. These priorities will improve access to, and participation in, sport and physical activity which can play a significant role in the achievement of many of the overall National Performance Framework targets.

To achieve this, we must have the courage to divert investment from other areas of spend in order to achieve greater benefits in the longer term.

**What Evidence Supports These Views**
Many of society’s fundamental health challenges are well versed, although their scale and financial burden, along with the significant contribution that sport and physical can make to these, are perhaps less well highlighted.

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Scale</th>
<th>Financial Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity</strong></td>
<td>29% of our population are obese (2.7% of which morbidly obese); 65% overweight or obese; 24% of 2-6 year olds are overweight or obese, with 13% being considered obese</td>
<td>£175million per year in Scotland⁸</td>
</tr>
<tr>
<td><strong>(Hip) Fractures</strong></td>
<td>One in two women and one in five men will suffer a fracture after the age of 50⁹</td>
<td>£4.3billion for 500,000 fragility fractures per year (including 79,000 hip fractures) across the UK¹⁰</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>271,321 affected in Scotland¹¹</td>
<td>£10billion per year across the UK¹²</td>
</tr>
<tr>
<td><strong>Premature Mortality</strong></td>
<td>2,447 people die each year in Scotland due to physical inactivity</td>
<td>2,447 unnecessary deaths per year in Scotland</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>One in four people will experience</td>
<td>£10.7billion per year in Scotland¹⁴</td>
</tr>
</tbody>
</table>


⁸ Scottish Government (2010). *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight.*

⁹ National Osteoporosis Society: [https://nos.org.uk/about-osteoporosis/what-is-osteoporosis/](https://nos.org.uk/about-osteoporosis/what-is-osteoporosis/)


a mental health problem at some point in their lives\textsuperscript{13}, 30\% of GP consultations are associated with mental health problems. 14\% of the adult population are on prescribed anti-depressants\textsuperscript{15}

The specific impact and burden of physical inactivity in the UK, and the significant associated benefits of being physically active, are also poorly recognised:

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Scale of Physical Inactivity Impact\textsuperscript{16}</th>
<th>Financial Burden (UK/year)\textsuperscript{17}</th>
<th>Correlation between regular physical activity and reduced risk incidence\textsuperscript{18}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease</td>
<td>10.5% of cases in the UK</td>
<td>£117 million</td>
<td>20-35%</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>18.7% of cases in the UK</td>
<td>£65 million</td>
<td>30%</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>17.9% of cases in the UK</td>
<td>£54 million</td>
<td>20%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13% of type 2 cases in the UK</td>
<td>£158 million (type 2)</td>
<td>30-40%</td>
</tr>
<tr>
<td>All Cause Premature Mortality</td>
<td>16.9% across the UK</td>
<td></td>
<td>30%</td>
</tr>
</tbody>
</table>

2,447 people still die prematurely each year in Scotland due to physical inactivity. Research shows that regular physical activity can reduce all-cause mortality by 30\%.

To reiterate this aforementioned Scottish estimate; increasing physical activity levels by 1\% each year for five years would save 157 lives per year, with a positive economic impact of £85million.

Question 3 - Is sufficient information available to support scrutiny of the Scottish Government’s health and sport budget? If not, what additional information would help support budget scrutiny?

\textsuperscript{14} SPICe: http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf

\textsuperscript{15} Information Services Division Scotland: http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Publications/index.asp#1495


The information and level of investment in sport and physical activity provided via the Scottish Draft Scottish Budget for 2017-18 are detailed as below:

<table>
<thead>
<tr>
<th>Sport – Real Terms</th>
<th>2016-17 (£m)</th>
<th>Budget 2017-18 (£m)</th>
<th>Draft Budget 2017-18 (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sport and Legacy</td>
<td>42.3</td>
<td>39.1</td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td>3.3</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45.6</strong></td>
<td><strong>42.4</strong></td>
<td></td>
</tr>
</tbody>
</table>

It further states that “an annual £300,000 Gender Equality in Sport fund” will be implemented.

Our members suggest that further information and detail on the sport budget is required to enable further understanding and scrutiny.

Our members would also like to highlight to the Committee their concerns resulting from the reduction in National Lottery monies, which is further reducing investment available to sport in Scotland.

**Conclusion**

The contribution of sport and physical activity to Scotland’s Strategic Objectives and National Indicators, along with the benefit to our nation, is both significant and compelling. This contribution could be better reflected through higher prioritisation and focus throughout the National Performance Framework’s supporting documentation and in an increased allocation to sport and physical activity in the Draft Budget 2018-19.

The importance of getting more people more active more often is evident and will result from a recognition of, and support for, focused additional investment in sport and physical activity. In order to make this difference, the following is required:

- Equal prioritisation must be placed on the Active Scotland Outcomes Framework Outcomes ‘we encourage and enable the active to stay active throughout life’ and ‘we encourage and enable the inactive to be more active’
- A greater approach to cross-departmental working and budgeting to reflect investment today and savings in the future
- Adoption of the Christie Commission’s “radical shift towards preventative public spending”, particularly in relation to the contribution of a proportion of the health budget into sport and physical activity could make to health budget savings in the future
- Given that 90% of investment in sport is via local authorities, it is vital that they remain key partners in delivering sport and physical activity and are recognised as such. The contribution of sport and physical activity to our nation also needs to remain foremost in the minds of our local authority partners in relation to their planning and budgetary decisions.
The Scottish Sports Association strongly urges the Committee to consider the evidence presented here in its deliberations. We would welcome the opportunity to discuss this further with the Committee as it considers this call for evidence.
Draft Budget 2018-19
ASH Scotland

Key points:

- smoking costs NHS Scotland more than £500 million every year, the equivalent of more than twenty two thousand nurses’ salaries
- action on smoking is highly cost-effective and can lead to a huge return on investment
- targeted mass-media advertising and good funding for stop-smoking services are necessary to close the gap between the richest and the poorest
- smokers are usually from the poorest groups in Scotland and spend on average more than £1,600 per year on tobacco
- cutting the smoking rate by just 1% in the poorest fifth of Scotland would release more than £13 million per year for those communities.

Recommendations:

- fund a well-designed mass-media advertising campaign, using the latest scientific evidence to promote quitting and help smokers stop
- continue to fund stop-smoking services targeted at the poorest areas of Scotland
- maintain the tobacco control budget into the next year, and consider increased preventative spending to save money later.

Smoking costs Scotland more than half a billion pounds a year

Recent estimates suggest that between £573 million and £780 million is spent each year by Scotland’s NHS on treating tobacco-related illness. That equates to between 4.7% and 6.4% of NHS Scotland’s £12.2 billion budget.

Estimates of the healthcare costs of smoking can vary widely. Thanks to the wide range of illnesses related to tobacco, it can be difficult to attribute causes of death and disability accurately and to capture the wide range of harm caused by smoking. Therefore, it is highly likely that the figures given above are underestimates.

Cheap, effective action now can reduce that expense in future years. A report for Westminster’s All-Party Parliamentary Group on Smoking and Health found that preventive spending on tobacco and public health could lead to a 1,100% return on investment over just five years,¹ and economic analyses have consistently found that smoking cessation and prevention programmes offer extremely high value for money compared to other health interventions. 14% of adults in Scotland are smokers who say that they want to stop. It is hard to think of any other intervention that could deliver as much health benefit as helping them to do so.

How we can tackle smoking

Help for smokers should take a range of forms to reflect the range of ways smokers quit. Stop-smoking services have repeatedly been found to be one of the most effective methods of quitting. The success rate of a smoker attempting to quit with the help of these services is much greater than going cold turkey. These services cost less than £1,000 per quality adjusted life year (QALY), compared to up to £130,000 per QALY treating chronic obstructive pulmonary disease. Sustained and increased investment in cessation services targeted at the poorest fifth of Scots will save money and save lives.

Mass media advertising can help encourage and inform smokers to quit. There is a great deal of evidence that these campaigns work well and are highly cost-effective when properly designed. Scotland has not had a stop-smoking advertising campaign for several years (although we have seen the success of the Take it Right Outside campaign on second-hand smoke statistics). A well-designed campaign with decent funding could help many Scots to quit smoking for good.

Smoking costs the poorest people the most in health and wealth

It’s no surprise that smoking is one of the greatest causes of health inequalities in Scotland today. The smoking rate in least deprived fifth of Scotland is just 10%, compared to 36% in the most deprived fifth. That’s reflected in the rates of illnesses like lung cancer, COPD and heart disease and helps cause the huge disparity in life expectancy between rich and poor Scots.

And smoking has a financial cost as well. The average smoker spends more than £1,600 every year on tobacco. It has been calculated that 32,000 households in Scotland are effectively pushed below the poverty line due to this expenditure. The vast majority of people in this situation are not simply making a choice to smoke – more than two thirds of smokers want to quit the habit.

Action on smoking can help tackle poverty. Even a 1% drop in smoking in the poorest fifth of Scotland would put £13 million back in the pockets of the people who need it most.

Action on Smoking & Health (Scotland) (ASH Scotland) is a registered Scottish charity (SC 010412) and a company limited by guarantee (Scottish company no 141711). The registered office is 8 Frederick Street, Edinburgh EH2 2HB.

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Alcohol Focus Scotland (AFS) is the national charity working to prevent and reduce alcohol harm. We aim to reduce the impact of alcohol in Scotland through the implementation of effective alcohol control policies and legislation. AFS welcomes the opportunity to provide written evidence to the Health and Sport Committee on the Draft Budget 2018-19.

Summary

- Alcohol costs Scotland around £3.6 billion each year, including £267m to the NHS, £209m to social care services, and £727m to the justice system.
- Increasing price, reducing availability and restricting marketing are amongst the most effective - and cost-effective - policy measures to reduce alcohol consumption and harm.
- Reducing alcohol consumption and harm will make a valuable contribution towards reducing health inequalities.
- Evidence on alcohol harm should be updated to inform and enable effective budget planning and policy-making.
- Funding for Alcohol and Drug Partnerships should be restored to 2015/16 levels.
- The budget and subsequent reporting mechanisms should enable the tracking of spend on alcohol harm from national to local (ADP) level.
- A national public information campaign should be funded to communicate the revised CMO low-risk drinking guidelines.
- Scottish Government should consider a range of financial mechanisms which could both encourage more responsible retailing of alcohol and provide funds to help offset the significant costs to the public sector of dealing with the consequences of alcohol harm.

The cost and impact of alcohol harm

Alcohol misuse continues to be a major health, economic and social challenge for Scotland, costing Scotland around £3.6 billion each year.

In Scotland, 22 people die every week due to alcohol, and alcohol-related death rates are 54% higher than in England and Wales. In addition, excessive alcohol consumption is a major risk factor for non-communicable diseases (NCDs), which are Scotland’s biggest killers. A detailed analysis of the burden of disease attributable to alcohol in Scotland will be available later this year. Alcohol harm costs an estimated £267 million to the health service each year.

Harm from alcohol not only affects the drinker, but also affects others around them and the wider community. Half of Scots report being harmed as a result of someone else’s drinking and as a result of parental drinking, children in Scotland
have experienced physical abuse and violence, and a lack of care, support and protection. Such adverse childhood experiences (ACEs) have profound and long-lasting consequences, including for emotional and physical health in later life. The cost of alcohol harm to social care in Scotland is around £209 million.

There is also a strong link between alcohol and crime, particularly violent crime. Victims report that the offender was under the influence of alcohol in just over half (54%) of violent crimes in Scotland, and the proportion of violent crime that is alcohol-related is 14% higher in Scotland than in the rest of the UK. Alcohol-related crime is estimated to cost Scotland £727 million each year.

The draft budget and reducing alcohol harm
As recognised by the World Health Organization (WHO) and the Christie Commission, prevention of poor health represents a worthwhile investment across all government departments and should be given priority as a key contributor to a fairer and wealthier society. Evidence-based action to prevent and reduce alcohol-related harms is proven to deliver improved outcomes and can reduce costs to public services without significant public investment. The three ‘best buys’ identified by the WHO are increasing price, reducing availability and restricting marketing.

The Draft Budget 2018-19 should clearly specify funding to prevent and reduce alcohol harm and where this is to be directed at both national and at local level.

Health Improvement and Protection
The refresh of the Scottish Government’s alcohol strategy, Changing Scotland’s Relationship with Alcohol: A Framework for Action, is expected this summer. The priority for the strategy must be to reduce consumption, as “long term health improvement will only be achieved if the overall level of consumption in the population is significantly reduced”. International evidence clearly indicates that increasing price, reducing availability and restricting marketing are amongst the most effective and cost-effective policy measures to reduce alcohol consumption and harm in a population. It is crucial that the alcohol strategy refresh prioritises these three ‘best buys’.

Despite alcohol being a group one carcinogen alongside tobacco and asbestos, less than half of Scots associate drinking alcohol with cancer. To contribute towards the achievement of National Health and Wellbeing Outcome 1 - ‘People are able to look after and improve their own health and wellbeing and live in good health for longer’ – a public information campaign should be funded to communicate the health risks associated with drinking alcohol and the Chief Medical Officer’s low-risk drinking guidelines which were revised in 2016.

Harmful drinking can be both a consequence and a driver of social marginalisation and deprivation, and inequalities in alcohol-related harm are stark: people living in our most deprived communities are six times more likely to die and almost nine time more likely to be admitted to hospital due to alcohol use than those in our more affluent communities. Reducing alcohol consumption and harm will make a valuable contribution to achieving Outcome 5 of the National Health and Wellbeing Outcomes: ‘Health and social care services contribute to reducing health inequalities.’
It is crucial that up-to-date evidence is available to inform and enable effective budget planning and policy-making. Information on the economic cost of alcohol harm in Scotland has not been updated since the original study, undertaken in 2010 using 2007 data. Also required is an update on the number of children affected by parental drinking, as part of the Scottish Government’s priority to improve outcomes for children affected by parental substance misuse (CAPSM). The NHS Health Scotland assessment of the availability of and need for specialist alcohol treatment services in Scotland should also be revised so that we can better understand the level of unmet need for people with an alcohol problem.

**Alcohol and Drug Partnership Funding**

Alcohol and Drug Partnerships (ADPs) are currently operating under significant financial pressure. In 2016/17, direct funding to ADPs was cut by 22%, with half of all health boards indicating they did not make up the shortfall. As well as adversely impacting on the availability of services for individuals and families who need them most, the indications so far are that cuts are likely to have disproportionately affected prevention and early intervention funding and activity. Funding for ADPs should be restored to 2015/16 levels in the 2018-19 Scottish budget to enable local services to meet Ministerial Priorities for service delivery, such as reducing alcohol-related deaths and hospital admissions.

With national funding for ADPs routed via health boards for onward delegation to Health and Social Care Partnerships from the 2017-18 budget, it is increasingly difficult to track spend on addressing alcohol harm at local level. This has been highlighted recently by the Committee. The budget and subsequent reporting mechanisms should enable the tracking of spend on alcohol harm from national to local level.

Reducing the funds available for such support services is a false economy, which will only increase pressures on the health service and general practice in particular. It is hard to see how this decision is compatible with the Scottish Government’s stated priorities in relation to reducing alcohol harm. Funding to ADPs should be restored to 2015/16 levels in the next Scottish budget.

**Polluter Pays Measures**

Requiring those who profit from the sale of alcohol to contribute to the costs of alcohol-related harm would help offset the significant costs to the public sector, implementing the ‘polluter pays’ principle. The Public Health Supplement, for example, was a means of raising funds for preventative spending to address the health and social problems associated with alcohol and tobacco use. Implemented in 2012, this supplement levied a charge on all large retailers selling alcohol and tobacco, and was expected to raise £95m between 2012 and 2015. It is unfortunate that the revenues raised from this levy did not contribute to preventative spending on health, as originally intended, and that the supplement was not renewed on its expiry in 2015.

In addition the Scottish Government has acknowledged that the implementation of minimum unit pricing, whilst delivering considerable health and social benefits, may also result in increased profits for retailers and/or producers. For this reason, as part of the Alcohol (Scotland) Act 2010, Parliament approved provisions to enable a social responsibility levy to be applied to retailers.
Scottish Government should consider a range of financial mechanisms which could both encourage more responsible retailing of alcohol and provide funds to help offset the significant costs to the public sector of dealing with the consequences of alcohol harm.


8 York Health Economics Consortium, University of York (2010), op cit


11 York Health Economics Consortium, University of York (2010), op cit


15 Alcohol Health Alliance UK (2012), *Health First: An evidence-based alcohol strategy for the UK*, Stirling: University of Stirling. p.11


17 Alcohol Health Alliance (2016), *2015 UK Alcohol Behaviour & Attitudes Survey*, Bluegrass Research Ltd.


19 Audit Scotland (2016), *NHS in Scotland 2016*, Audit Scotland


21 Scottish Government (2016), *Scottish Budget: Draft Budget 2017-18*, Edinburgh: Scottish Government, p.31 A footnote to the Health Improvement and Protection budget line in the Draft Budget 2017-18 states “This budget line does not include £53.8 million that is being transferred to NHS Board baselines in 2017-18 for expenditure on Alcohol and Drug Partnerships”; Correspondence from Minister for Public Health and Sport to Neil Finlay, Convener of the Health and Sport Committee, 9th June 2017 [http://www.parliament.scot/S5_HealthandSportCommittee/General%20Documents/20170609_Letter_from_Minister_for_Public_health_ADP_funding.pdf](http://www.parliament.scot/S5_HealthandSportCommittee/General%20Documents/20170609_Letter_from_Minister_for_Public_health_ADP_funding.pdf)
22 Correspondence from Neil Finlay, Convener of the Health and Sport Committee to Shona Robison, Cabinet Secretary for Health and Sport, 'Integration Authorities Budget 2017-18', 20 June 2017
http://www.parliament.scot/S5_HealthandSportCommittee/General%20Documents/Convener_to_Cab_Sec_200617_Final_no_signature.pdf