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Mr Duncan McNeil MSP
Convener
Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
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Our Ref: A12828912

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Dear Mr McNeil

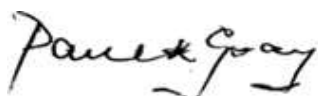
NHS Boards Budget Scrutiny 2015-16

I am grateful to the Committee for their report, and for the points raised in it. As I explained to the Committee in my evidence on 16th June, I believe that we have a strong base in NHSScotland budgets. Our plans cover both the long term and the short term, and we have clear financial planning assumptions, as well as funding methods that promote equity, stability and efficiency. While maintaining this position is becoming more challenging, we are tackling this through a focus on improvement and through our important work on the integration of health and social care.

A related theme from your report is the quality and sufficiency of the information available, both to the Scottish Government in our oversight of NHSScotland, and to members of the Scottish Parliament in exercising scrutiny over spending. I agree that high quality information is essential for effective management and scrutiny and we are working on continuous improvement in a number of areas. For example, in the data available to Health and Social Care Partnerships, through work led by NHS National Services Scotland, we are putting in place a dataset which will allow comparison of outcomes and performance both within and across Partnerships.

I have provided detailed responses to your individual recommendations and questions within the attached annex. If you require anything further I would be pleased to help.

Yours sincerely



Paul Gray

Response to questions and recommendations in the “NHS Boards Budget Scrutiny 2015-16” report.

Performance Budgeting

Paragraphs 22 – 24: Costs associated with achieving performance targets and standards

NHS Boards have a responsibility to develop robust Demand Capacity Activity and Queue plans for elective and unscheduled care waiting time standards. There can be temporary reductions in capacity – perhaps as a result of sick leave – or spikes in demand. In such cases Boards have a range of options including a waiting times initiative, use of a locum, drawing on the Golden Jubilee, or use of the independent sector. Boards will choose the most appropriate approach based on timeliness, cost and quality.

We expect NHS Boards to record spend on these measures but these records do not differentiate between spend to deliver the last percentage points of a target or standard, and spend to meet other pressures on core capacity. We cannot therefore provide a specific cost associated with achieving the final percentage of particular performance targets and standards.

National Performance Framework

Paragraphs 38 – 42: Care in last 6 months of life

Components of palliative care services are provided throughout acute and community settings. With the exception of hospice care, there is no simple way to identify the supply of services solely, or primarily, for palliation. Equally, there is no single disease based code that allows data collection on that basis. However, I recognise the legitimate interest of the Committee in this issue and I have established that Boards could provide estimated costs from the information they have, if the Committee would find it useful. NHS Greater Glasgow and Clyde have offered to undertake this exercise if the Committee would find that helpful in the first instance.

Paragraphs 45 and 46: Specialist and end-of-life care hospices

Seven Territorial NHS Boards have independent hospices and five contribute at least 50 per cent funding. The hospice used by NHS Forth Valley receives 43 per cent funding, as well as extra services as “in kind” support. NHS Western Isles is working with their provider to improve its operational efficiency and reduce its running costs, which will increase their funding contribution percentage. Other Boards have specialist medical and nursing posts in palliative care that ensure people can access this advice and expertise when it is required.

The strategic framework on palliative care will highlight the need to improve the quality of data on palliative and end of life care in Scotland across all services. Decisions will be taken on the data that is to be gathered following the agreement of the strategic framework and we will share the data collected with the Committee when it is available.

Paragraphs 55 – 58: Children’s Hospice Association Scotland

Local authority funding for Children’s Hospice Association Scotland (CHAS) is negotiated between CHAS and COSLA, and the Scottish Government does not hold information on whether local authorities are meeting their agreed funding level. We do, however, engage regularly with CHAS and they have not raised issues with us regarding the receipt of the agreed funding from local authorities.

NHS Tayside commissions services from CHAS on behalf of all 14 Territorial NHS Boards in Scotland. NHS Tayside are undertaking a review which will confirm the agreed running costs on behalf of NHS Scotland, and which will be concluded by the end of this financial year.

Taking into account the recent Children in Scotland Requiring Palliative Care study, the Scottish Government has agreed with CHAS to do further work with them looking at the sustainability of their funding model and this work is underway. Mechanisms for monitoring NHS Boards’ delivery of the agreed funding will be considered as part of this review. We will make the data collected as part of monitoring available to the Committee.

Paragraphs 64 and 65: Reducing emergency admissions

We are working closely with the Scottish General Practitioners’ Committee to redesign the GP contract, addressing issues of workload and bureaucracy, and aim to have the first iteration of this in place by April 2017. The detail of contractual changes will be subject to extensive negotiation with the SGPC in 2016.

This is in addition to a series of other measures. The Quality and Outcomes Framework will be dismantled by April 2016, and in October 2015 the First Minister also announced an increase in GP training places each year from 300 to 400 starting in 2016. Changes have already been made to the GMS contract in Scotland to support recruitment and retention. We have earmarked £2.5 million to be invested in a programme of work to explore with key stakeholders the issues surrounding GP recruitment and retention. The three-year programme will examine and take forward proposals to increase the number of medical students choosing to go into GP training, as well as encouraging those wanting to work in rural and economically deprived areas.

Paragraph 72: Increase the proportion of babies with a healthy birth weight

I acknowledge the Committee’s point about the need for more nuanced information on health birth weight. The indicator will continue to monitor the proportion of babies born a healthy birth weight, but it will now be supplemented by figures that show trends in the proportions of babies ‘large for gestational age’ and ‘small for gestational age’. The most recent ISD Scotland release on Births in Scottish Hospitals, issued on 24th November and covering the year to 31st March 2015, includes this information. It can be found at:

<http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/data-tables.asp?id=1543#1543>

Paragraphs 73 – 77: Overall conclusions on National Performance Framework

The Scottish Government promotes the importance of the outcomes approach, for example, in our improvement collaborative on early years, person centeredness, safety and our work to integrate Health & Social Care – including the integration outcomes.

I have passed the Committee's views on the NPF on to the Chief Statistician and he is considering these as we take forward work on Scotland Performs.

Earmarked Funding and Non-Recurring Funding

Paragraph 80: Earmarked funding

The report notes the variation in earmarked allocations between NHS Boards and, in particular, Territorial NHS Boards. Some of this variation is explained by island NHS Boards receiving substantial allocations to meet, for example, Patient Travel costs. Such allocations increase the percentage of earmarked funding an NHS Board receives.

We are considering including in baseline allocations some of the allocations currently classed as earmarked, which will give NHS Boards flexibility in how the funding is used. An example of this is the Highlands and Islands Travel Scheme funding, which we have moved from earmarked funding into NHS Boards' baselines in 2015-16.

Paragraph 84: Non-recurring funding

Non-recurring funding is allocated on a one-off or time-limited basis, for example for a specific project or initiative with a fixed time span. While such allocations make up nearly two thirds of the volume of allocations, they only account for a small proportion of the total value of allocations, less than three per cent in 2014-15. In time, some allocations will be transferred into baseline funding, but most are non-recurring by their nature.

Cost Pressures

Paragraphs 93 – 96: Hospital drugs anticipated price and volume changes

Following the Committee's evidence session on 16th June, we undertook to explore with NHS Boards how a more consistent approach could be adopted with regard to price and volume changes on hospital drugs. Since then NHS Board Directors of Finance have reviewed the position and determined that NHS Boards took differing views on whether the cost of a new drug becoming available was viewed as a price or volume increase. In addition, NHS Boards made different assumptions around the New Medicines Fund. The inclusion or exclusion of drugs funded through the New Medicines Fund is the main reason for differences between NHS Boards.

We are currently working with NHS Boards to update our data on price and volume changes to improve consistency. We expect revised data to have been compiled and reviewed by the end of January 2016 and will provide the Committee with these figures when they are available.

Efficiency Savings

Paragraphs 101 – 105: Sustainability and variation of planned efficiency savings

NHS Boards are responsible for developing their own financial plans, including efficiency savings targets. We expect that they plan, as part of their Local Delivery Plans, to generate an achievable level of savings, consistent with meeting their statutory financial targets.

We agree with the Committee's position that account should be taken of existing levels of efficiency in management and use of resources, and this is what is done at local level as NHS Boards formulate their financial plans. As part of the Local Delivery Plan review and sign-off process we robustly assess these plans and work with NHS Boards to ensure that NHSScotland collectively achieves a minimum of three per cent efficiency savings.

Integrated Joint Boards (IJBs)

Paragraph 120: Varying approaches to Health and Social Care Partnerships

Each Health and Social Care Partnership will use an integrated budget, including budgets delegated by the NHS Board and Council, to support delivery of integrated functions. The minimum scope of the budget is covered by legislation, and will include at least adult social care, adult community health care and those aspects of adult hospital care that offer the best opportunities for service redesign in support of prevention and better outcomes. We have issued statutory guidance on due diligence, setting out that all three parties – the NHS Board, Council and Partnership – must be assured that all assumptions and risks built into the budget are reasonable. This approach provides for consistency between Partnerships on the principle of integrating service planning and delivery for people with multiple complex needs, while permitting local flexibility to extend the scope of integration beyond the minimum scope described in legislation.

Paragraphs 121 – 124: Quality of information available to Health and Social Care Partnerships

Health and Social Care Partnerships will need access to robust and appropriate data to underpin their strategic commissioning plans. A programme of work led by NHS National Services Scotland (NSS), known as the Health and Social Care Data Integration and Intelligence Project (HSCDIIP), will improve the data and information available to Partnerships while developing local analytical capacity and skills:

- HSCDIIP will put in place a dataset accessible by each Partnership. This dataset will allow a wide array of analysis of resource use and outcomes across health and social care, at levels from individual patient up to national. Some linked data is available now and a more comprehensive resource will be available from April 2016, when Partnerships will go live.
- To support full and effective use of the dataset, we have commissioned NHS NSS to provide analytical support “on the ground” in each Partnership, provided via a hub-and-spoke arrangement and supporting any NHS Board and Council planning analysts already in post.

Each Partnership is required to publish an annual performance report setting out progress against the statutory outcomes for health and wellbeing, using the integrated budget. Annual performance reports will report on a core set of indicators as well as additional measures agreed locally. Detailed information on the core integration indicators can be found at:

<http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators/Indicators>

Data Quality

Paragraphs 128 – 131: Quality of survey responses and presentation of budget information

I am mindful of the Committee's independence, and that it will wish to choose its own areas of focus for its budget scrutiny work each year. The approach to date has been for the Committee, with the assistance of a team of researchers, to gather information directly from NHS Boards. Should the Committee wish to explore the potential for a different approach, with more information gathered for the Committee by the Scottish Government, we would be happy to discuss this. We would equally be willing to work with the research team preparing future surveys to develop the question set to help improve the quality and consistency of responses from NHS Boards.