Service development

1. Please give THREE examples of service developments that:

   (a) you have been able to fund in 2013-14 (please list local service developments, rather than national programmes)

1.a.1 In the 2013/14 financial plan we increased the recurring funding available for mental health services by £1.392 million. This covered increased use of the regional specialist perinatal beds, higher than budgeted use of out of region forensic secure beds, increased use of the Child and Adolescent psychiatry regional specialist beds, an increase to our local community Child and Adolescent recurring budget and provision for some of the anticipated increase in adult psychiatry costs once our mental health strategy is agreed and implemented.

1.a.2 In the 2013/14 an additional £0.802k was made available for nursing in the acute hospital wards following an extensive review using workforce tools.

1.a.3 In the 2013/14 financial plan we increased the recurring budget available for renal transplants by £0.249m to reflect the greater numbers now being carried out. This funds an extra 6 transplants per annum.

Significant development funding was allocated to national policy initiatives. The forecast administration costs for the new immunisation programme for example will be £0.9m in a full year. Funding was also set aside for the roll out of 27-30month development checks, the roll out of insulin pumps, the creation of a national centre for TAVI, treatment costs from the aortic aneurysm screening, additional capacity to meet treatment time guarantees, disclosure checks for protecting vulnerable groups, anticipated increased costs for the transfer of custodial healthcare, the pass out of costs for the diabetic retinopathy auto grader and an increase in the cost of a range of national specialist services. Ringfenced funding e.g. for detecting cancer early has also been fully utilised in the plan.

(b) you would like to develop if you had additional funding i.e. what is next on your list of priorities?

The plan funds the immediate priorities that were seen as essential either because:

- they were as a result of a national requirement
- they arose because of increased use of high cost services/treatments and the funding had to follow patient need
- they were viewed locally as essential to maintain safe services
As part of ongoing financial planning we are assessing the future impact of wide reaching strategies and targets such as our cancer strategy, the dementia strategy and the treatment time guarantee as well as considering a long list of current and future service development needs. Examples of potential service development bids being put forwards for assessment and prioritisation are;

- A significant recurring increase to surgical capacity to meet treatment time guarantees (non recurring funding was provided by the Board to ensure these are met for 2013/14 whilst a sustainable, cost effective longer term proposal is developed)

- Increased dietetics capacity to meet forecast demand, partly linked to more people surviving cancer surgery and requiring specialist feeding

- Increased investment in podiatry services to meet rising demand alongside anticipated new access targets for allied health professionals.

It is important in assessing these that we look at all opportunities for service redesign and efficiency as the list of future demands outstrips any future funding in times of economic constraint.

(c) you have withdrawn in 2013-14 (and why?).

The financial plan did not identify or assume any return of funding from services being withdrawn.

Preventative spending

2. What specific preventative health programmes are included in your budget plans for 2013-14? (please give details of planned expenditure in 2013-14 compared with 2012-13.)

With many of the preventative health programmes targeted at reducing health inequalities there is significant overlap in the answers to this question and to question 7.

Preventative measures are in many instances embedded in the provision of health services and the costs of these are not accounted for separately from the treatment costs. Costs of preventative spend can also be found in the prescribing budgets, e.g. nicotine replacement therapy and are not counted here. The figures quoted refer only to the separate standalone initiatives and incorporates the work of Health Promotion/Health Improvement Health Improvement function and Healthy Working Lives. In total £9,192,036 is committed for 2013/2014 and £9,016,009 was spent in 2012/2013.

This investment both seeks to prevent ill health and reduce health inequalities. It covers wide ranging issues such as:
Smoking cessation and prevention
Developing community assets approach to improving health
Promoting employability and supporting those who are not in employment
Creating environments such as health promoting schools and workplaces that are conducive to the promotion of good health
Anticipatory care through the Keep Well programme
Promoting mental health and wellbeing and
Promoting and supporting breast feeding
Mitigating the negative health impact of Welfare reform
Promoting physical activity and healthy weight
Tackling the problems caused by alcohol and drugs misuse
Early Years

All of this work is delivered under an NHS Lanarkshire overarching aim of reducing health inequalities. Services and programmes seek to support those who need them most.

There have been significant service developments that seek to address health inequalities, particularly in terms of early years’ provision. The principles of Getting it Right For Every Child are being applied. Programmes such as the Early Years Collaborative and Best Possible Start and Family Nurse Partnerships seek to ensure that those who have great needs are appropriately supported. The delivery of such services is changing to reflect the need to address and reduce health inequalities.

There is also significant investment in developing our clinical services to address health inequalities. Staff have been trained and developed in areas such as Alcohol Brief Intervention, addressing worklessness, smoking cessation and prevention. In order to ensure that these issues are routinely addressed efforts are being undertaken to include these issues as part of the routine assessment process.

For example, NHSL is in the process of integrating a brief intervention for physical activity into the everyday work of Allied Health Professionals and issues such as asking questions about alcohol are part of the everyday assessment process undertaken by community nursing staff. Falls prevention work is also linked to relevant clinical services.

Finally, there are preventative measures such as the immunisation programmes (which have been expanded this year at an administration cost of over £0.9m on a full year basis) and control of infection measures which seek to prevent the spread of infection. The 27-30 month developmental checks introduced in 2013/14 seek to identify potential issues at an early stage. There are also secondary prevention
measures such as screening or prescribing to lower lipid levels or blood pressure, diabetic foot care, diabetic retinopathy and diet education.

3. Have you made any assessment of the potential longer term savings from preventative spending? If so, please describe your approach to this modelling.

The national policy decisions to promote certain programmes will have been based on modelling of potential savings, many of which may be some time in the future and may be wider societal benefits rather than specific health savings. For example, the ‘business case’ for developing Early Years Work has been developed as a result of numerous Scottish Government policy documents that have emphasised the importance of getting it right for every child and the benefits that this will bring.

Local programmes do describe the intended long term benefits but it is hard to translate those into realisable cash during the 3-5 year financial planning horizon. Our local Health Improvement/Health Protection Service Improvement Board is developing a consistent modelling framework. The work is in its infancy and is focusing on the development of a standard logic model for preventative spend to save investment.

4. How are the results of any such modelling reflected in your financial planning?

The 3 year financial plan makes no assumptions of savings being released as a result of preventative spending. It has taken into account the impact of preventative spend in certain aspects of sensitivity modelling about future cost rises. For example, in assessing the potential for future cost rises in the new national cervical cytology screening contract we recognised that the HPV vaccination should begin to have an impact. However within the 3 year time horizon no release of resource is forecast.

Access to new medicines

5. In relation to spending on newly-licenced medicines (whether or not approved by the SMC), please complete the table below:

<table>
<thead>
<tr>
<th></th>
<th>GP prescribing £ms</th>
<th>Hospital prescribing £ms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 (planned)</td>
<td>0.150</td>
<td>3.484</td>
</tr>
<tr>
<td>2012-13 (actual)</td>
<td>0.150 est</td>
<td>3.806</td>
</tr>
<tr>
<td>2013-14 (planned)</td>
<td>0</td>
<td>4.648</td>
</tr>
</tbody>
</table>

As part of their support to Boards SMC scan the horizon for new medicines and provide advance intelligence for future planning. The information supplied by drug companies about future products is commercially very sensitive before launch and that stage there still many unknowns. The Board makes full use of that intelligence.
alongside the views of its own clinicians and pharmacists in making financial provision for the potential cost of new drugs

Once the company is near to launching a drug much more detailed information gets presented to SMC. The majority of new medicines reviewed by SMC are new formulations of existing medicines or new chemical entities within a class of existing medicines; only about one third of the drugs they review are novel medicines. Where the SMC accepts a medicine, NHS Boards will make that medicine, or an equivalent, available. If there is already a suitable and cost effective alternative on the clinical formulary there may be no reason to change.

As a result of new drugs the hospital spend has increased from £20.988m in 2007/08 to £35.474m in 2012/13.

* NB The difference between the 2011/12 budget and the 2012/13 actual cost (i.e. the actual increase in funding needed in the financial plan to cover the
increased cost of new drugs) was £3.806m, with the first £0.7m of that covering higher than expected drug cost rises in 2011/12.

6. For each individual patient request agreed in 2012-13 (relating to newly-licenced medicines not recommended by the SMC), please complete the table below (please delete the example provided):

NHS Lanarkshire had 34 IPTRs in 2012/13. Some

<table>
<thead>
<tr>
<th>Request number</th>
<th>Medicine</th>
<th>Therapy area</th>
<th>Actual cost 2012-13</th>
<th>Planned cost 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ecalizumab</td>
<td>Refractory atypical Haemolytic uremic Syndrome (aHus) or PNH</td>
<td>175000</td>
<td>850000</td>
</tr>
<tr>
<td></td>
<td>Belimumab Benlysta</td>
<td>Systemic Lupus Erythematosus</td>
<td>12000</td>
<td>12000</td>
</tr>
<tr>
<td></td>
<td>Ranibizumab (Lucentis)</td>
<td>Diabetic Macular Oedema</td>
<td>64000</td>
<td>Now licensed and SMC approved for this indication so no further IPTR costs</td>
</tr>
<tr>
<td></td>
<td>Olanzapine Embonate depot</td>
<td>Maintenance in Schizophrenia</td>
<td>1800</td>
<td>Nil – treatment stopped</td>
</tr>
<tr>
<td></td>
<td>Ozurdex Intravitreal Implant</td>
<td>Central Retinal Vein Occlusion not amenable to laser therapy</td>
<td>8000</td>
<td>Nil – now SMC accepted indication therefore not an IPTR</td>
</tr>
<tr>
<td></td>
<td>Norditropin Simplex</td>
<td>Growth Hormone Deficiency in Adults</td>
<td>1500</td>
<td>15000</td>
</tr>
<tr>
<td></td>
<td>Infliximab</td>
<td>Steroid Resistant Ulcerative Colitis</td>
<td>5000</td>
<td>7000</td>
</tr>
<tr>
<td></td>
<td>Agomelatine (Valdoxan)</td>
<td>Major Depression</td>
<td>360</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>Ranolazine (Ranexa)</td>
<td>Refractory Angina</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td></td>
<td>Prucalopride (Resolor)</td>
<td>Chronic constipation in women in whom laxatives fail to work</td>
<td>400</td>
<td>1200</td>
</tr>
<tr>
<td></td>
<td>Pregabalin</td>
<td>Anxiety Disorder</td>
<td>200</td>
<td>400</td>
</tr>
<tr>
<td></td>
<td>Prasugrel (Efient)</td>
<td>Antiplatelet therapy</td>
<td>250</td>
<td>450</td>
</tr>
<tr>
<td>Request number</td>
<td>Medicine</td>
<td>Therapy area</td>
<td>Actual cost 2012-13</td>
<td>Planned cost 2013-14</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for patients who can’t take clopidogrel</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stiripentol (Diacomit)</td>
<td>Epilepsy (Dravet Syndrome variant)</td>
<td>2000</td>
<td>4000</td>
</tr>
<tr>
<td></td>
<td>Targinact</td>
<td>Pain Control</td>
<td>450</td>
<td>2000</td>
</tr>
<tr>
<td></td>
<td>Insulin Degludec (Tresiba)</td>
<td>Unstable type 1 diabetes</td>
<td>90</td>
<td>9000</td>
</tr>
<tr>
<td></td>
<td>Buprenorphine Transdermal Patches</td>
<td>Severe osteoarthritis pain in elderly patients, whose pain is not adequately controlled by non opioid analgesics, or whom other analgesics are not suitable</td>
<td>300</td>
<td>500</td>
</tr>
</tbody>
</table>

**Reducing inequalities**

7. (a) **What specific services are aimed at reducing inequalities? (please include details of Keep Well.)**

- Keep Well is targeting those living in our most deprived communities and vulnerable populations
- The Stop Smoking Service is targeting those living in our most deprived communities
- Unit Health Improvement Teams are developing community assets-led approaches
- First Steps – supporting young first time mothers who need additional support

(b) **What is the level of spending on these services in 2012-13 and 2013-14?**

- Keep Well - £1,335,000 (2012/13) and £1,335,000 (2013/14)
- Stop Smoking Service - £1,147,000 (2012/13) of which £400,000 relates to Keep Well. Expect 2013/14 funding to be in line with previous year, await confirmation. This does not include the full cost of the initiative with a substantial NRT cost being picked up by the prescribing budget.
- Unit Health Improvement Teams community assets approach – it is not possible to specify the funding level as it is mostly staff time input.
- First Steps - £621,953 (2012/13) and £794,502 (2013/14)
(c) What outcome measures have been identified for these services?

- Keep Well – the number of health checks to be completed are agreed with Scottish Government on an annual basis.
- Stop Smoking Target – This is set by Scottish Government as a HEAT target
- First Steps – the mothers themselves set and agree their outcomes in collaboration with staff. For example, improved self-confidence, progression in Education
- In the Asset based work the local communities identify the outcomes that they wish to achieve. This varies from project to project.
- Project Search aims for 50% of graduates to achieve employment.

(d) What information is available in relation to these outcomes?

- Keep Well and the Stop Smoking performance is routinely reported to the Scottish Government
- An evaluation of the initial First Steps programme demonstrated the outcomes for the participants.
- Project Search – Year 1 – all 8 graduates found employment
- Project Search – Year 2 – 5 out of 7 graduates found employment
- Project Search – Year 3 – the programme is just finishing and already 4 out of the 24 students have found employment

Resource transfer

8. (a) What level of funding will be transferred from your budget to local authorities in 2013-14 (i.e. resource transfer) and what services will these funds help deliver?

The resource transfer for 2013/14 is likely to be £35.7m. This will provide a range of social care support for people, under previous models, may have been in long term institutional care. The split across the different care groups is:

<table>
<thead>
<tr>
<th>Summary</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>7,877</td>
</tr>
<tr>
<td>Learning Difficulties</td>
<td>21,502</td>
</tr>
<tr>
<td>Mental Health</td>
<td>5,803</td>
</tr>
<tr>
<td>Community Assessment Teams</td>
<td>550</td>
</tr>
<tr>
<td><strong>Total Resource Transfer</strong></td>
<td><strong>35,733</strong></td>
</tr>
</tbody>
</table>
The above answer reflects the funding that is classed as resource transfer in the annual accounts. There are other areas such as the change fund, joint equipment store and joint health improvement initiatives where the Health Board transfers funding to the local authorities to allow joint plans to be delivered.

(b) What level of funding will be transferred to your budget from local authorities in 2013-14 and what services will these funds help deliver?

There are no funding transfers classed as resource transfer from the local authority. However, the local authority does transfer elements of funding to the Health Board e.g. for the health component of avoiding delayed discharges.

Equalities

9. Can you provide any specific examples of how consideration of equalities issues has influenced budget decisions?

It is a prerequisite of any proposal for service change that the equality and diversity impact is considered. When compiling the financial plan proposals the Board’s lead for equality and diversity is asked to review the list of potential inclusions and identify any which may have the potential to have a differential impact on different groups. If any such issues are identified the lead manager and director will be contacted for additional reassurance that an Equalities and Diversity impact assessment has been /will be carried out and acted upon.

Compliance with disabled access requirements is a mandatory feature of any new premises development and any additional costs associated with this are simply regarded as part of the overall cost of the new facility. Where a new service might bring in increased need for interpreting services e.g. the transfer of custodial health care, this is recognised in the costings for the service. Our terms and conditions of service are equality proofed and so any potential changes would already have built in any potential costs of avoiding inequalities.

Sustainable development

10. Can you provide any specific examples of how the NHSScotland sustainable development strategy has influenced budget decisions?

In the 2013/14 financial plan £0.572m was approved to implement the energy saving recommendations of a review carried out in 2012/13 by the Carbon Trust. This is anticipated to save 998 tonnes of CO2 per annum.