The Scottish Parliament
Pàrlamaid na h-Alba

HEALTH AND SPORT COMMITTEE

AGENDA

15th Meeting, 2015 (Session 4)

Tuesday 12 May 2015

The Committee will meet at 9.45 am in the Robert Burns Room (CR1).

1. **Decision on taking business in private:** The Committee will decide whether to take item 6 in private.

2. **Subordinate legislation:** The Committee will consider the following negative instruments—

   National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2015 (SSI 2015/160)
   Certification of Death (Scotland) Act 2011 (Authorisation of Cremation – Death Outwith Scotland) Regulations 2015 (SSI 2015/162)
   Certification of Death (Scotland) Act 2011 (Application for Review) Regulations 2015 (SSI 2015/163)
   Certification of Death (Scotland) Act 2011 (Consequential Provisions) Order 2015 (SSI 2015/164)
   Certification of Death (Scotland) Act 2011 (Post-Mortem Examinations – Death Outwith United Kingdom) Regulations 2015 (SSI 2015/165)
   Registration of Births, Deaths and Marriages (Scotland) Act 1965 (Prohibition on Disposal of a Body without Authorisation) Regulations 2015 (SSI 2015/166)

3. **Carers (Scotland) Bill:** The Committee will take evidence, in a round-table discussion, from—

   Sarah Davies, Director, East Lothian Young Carers, East Lothian Young Carers;

   James Marshall, Development Manager, Young Carers Service, Stirling Carers Centre;

   Louise Morgan, Co-ordinator, Scottish Young Carers Services Alliance, Carers Trust;

Margaret Murphy, Chief Executive, and Lois Ratcliffe, 16-20 Young Adult Carer Development Worker, Edinburgh Young Carers Project (EYCP).

4. **Carers (Scotland) Bill:** The Committee will take evidence, in a video conference, from—

   Marjory Jagger, Manager, Skye and Lochalsh Young Carers.

5. **Petition PE1550:** The Committee will consider a petition by Andrew Muir, on behalf of Psychiatric Rights Scotland, calling on the Scottish Parliament to urge the Scottish Government to set up a public inquiry into historical cases of abuse of people detained under the Mental Health (Scotland) Act 1984 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

6. **NHS Boards Budget:** The Committee will consider its approach to its scrutiny of NHS Board Budgets.

7. **Alcohol (Licensing, Public Health and Criminal Justice) (Scotland) Bill (in private):** The Committee will consider its approach to the scrutiny of the Bill at Stage 1.

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The papers for this meeting are as follows—

Agenda Item 2

Note by the clerk	HS/S4/15/15/1
National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2015 (SSI 2015/160)	HS/S4/15/15/2
Certification of Death (Scotland) Act 2011 (Authorisation of Cremation – Death Outwith Scotland) Regulations 2015 (SSI 2015/162)	HS/S4/15/15/3
Certification of Death (Scotland) Act 2011 (Application for Review) Regulations 2015 (SSI 2015/163)	HS/S4/15/15/4
Certification of Death (Scotland) Act 2011 (Consequential Provisions) Order 2015 (SSI 2015/164)	HS/S4/15/15/5
Certification of Death (Scotland) Act 2011 (Post-Mortem Examinations – Death Outwith United Kingdom) Regulations 2015 (SSI 2015/165)	HS/S4/15/15/6
Registration of Births, Deaths and Marriages (Scotland) Act 1965 (Prohibition on Disposal of a Body without Authorisation) Regulations 2015 (SSI 2015/166)	HS/S4/15/15/7

Agenda Item 3

Written Submissions	HS/S4/15/15/8
PRIVATE PAPER	HS/S4/15/15/9 (P)

Agenda Item 5

Note by the clerk	HS/S4/15/15/10

Agenda Item 6

NHS Board survey analysis	HS/S4/15/15/11
NHS Boards Budget survey responses	HS/S4/15/15/12
PRIVATE PAPER	HS/S4/15/15/13 (P)

Agenda Item 7

PRIVATE PAPER	HS/S4/15/15/14 (P)

Health and Sport Committee

15th Meeting, 2015 (Session 4), Tuesday, 12 May 2015

Subordinate Legislation Briefing

Overview of instrument

1. There are six negative instruments for consideration at today's meeting.

2. A brief explanation of the instruments, along with the comments of the Delegated Powers and Law Reform Committee, are set out below. If members have any queries or points of clarification on the instrument which they wish to have raised with the Scottish Government in advance of the meeting, please could these be passed to the Clerk to the Committee as soon as possible.

Details on SSI 2015/160

3. **National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2015 (SSI 2015/160)**
The Scottish Government abolished prescription charges in Scotland on 1 April 2011. Practice since then has been to charge the rate applied in England where a patient presents for dispensing in Scotland an English prescription form (unless the patient is ordinarily resident in Scotland and holds an Entitlement Card issued by a Health Board, in which case no charge will be made). The existing exemption criteria arrangements remain ensuring current reciprocal arrangements can continue whereby exempt patients presenting Scottish prescription forms in England can collect their medication free of charge and vice versa.

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

5. The Delegated Powers and Law Reform Committee (DPLRC) has not made any comments on this instrument.

Details on SSI 2015/162, 163, 164

6. **Certification of Death (Scotland) Act 2011 (Authorisation of Cremation – Death Outwith Scotland) Regulations 2015 (SSI 2015/162)**
These Regulations make provision in respect of section 17(4) of the Certification of Death (Scotland) Act 2011 ("the Act"). This is to provide firstly for a form of certificate confirming the verification of foreign death certificates (Form X in the Schedule). Secondly, under section 18(4) of the Act there is provision for the determination by a medical reviewer as to whether it is safe to cremate the body of a deceased person who died outwith Scotland, but for whom an application has been received to be cremated in Scotland. This includes the application form for the determination and the certificate of authorisation (Forms Y and Z in the Schedule).

7. **Certification of Death (Scotland) Act 2011 (Application for Review) Regulations 2015 (SSI 2015/163)** These Regulations provide for the process of review of a medical certificate of cause of death on the application of an interested party, under section 4(8) of the Act. Regulation 2 specifies the form and content of an application. Regulation 3 provides the information which a medical reviewer under the Act must provide on rejection of an application.

8. **Certification of Death (Scotland) Act 2011 (Consequential Provisions) Order 2015 (SSI 2015/164)** The Order makes amendments to the Cremation (Scotland) Regulations 1935 in consequence of the Act. The Act replaces crematoria employed medical referees with independent medical reviewers, and provides for the documentation now required for disposal of the deceased in Scotland. The Order therefore makes consequential changes to the 1935 Regulations, in light of the Act's reforms. Per the Policy Note, this replaces the existing "cremation only" scrutiny of cause of death documentation, and cremation legislation relating to the role of medical referees.

9. There has been no motion to annul these instruments.

10. The DPLRC has drawn these instruments to the Parliament's attention on the reporting ground (j) as they fail to comply with the requirements of section 28(2) of the Interpretation and Legislative Reform (Scotland) Act 2010. The Regulations were laid on 2 April 2015 and come into force on 13 May 2015 which breaches the "28 day rule" (no account being taken of days in the Parliament's Easter recess). The DPLRC recognises that some complex issues, involving representations from and discussion with various stakeholders, led to a delay in laying the Regulations. The DPLRC considers however that where it is critical to announce in advance a coming into force date for a "package" of instruments, sufficient time should be built in to planning the instruments so that any required review of the provisions after consultations can be done before the announced date, while respecting the requirements of section 28(2). This has not happened for these instruments and the related SSIs 2015/165, and 166. The relevant section of DPLRC Committee's report is at Annexe A.

Details on SSI 2015/165

12. **Certification of Death (Scotland) Act 2011 (Post-Mortem Examinations – Death Outwith United Kingdom) Regulations 2015 (SSI 2015/165)** The sole purpose of the Regulations is to specify the form and content of an application for assistance in the making of arrangements for post-mortem examinations, and for the meeting of the cost of such examination, under section 19 of the Act.

13. There has been no motion to annul these instruments.

14. The DPLRC has drawn these instruments to the Parliament's attention under the general reporting ground, as there is a patent drafting error in the form in the Schedule. It specifies that it is a form of application under section 19 of the Certification of Death (Scotland) Act 2015. Regulation 2 cites the Act correctly, as enacted in 2011. The Scottish Government proposes to correct

the error by means of a correction slip, on the basis that it is self-evident. While that may be suitable in this instance if agreed with the National Archives, the Committee considers (having regard to the fact that the only purpose of the instrument is to provide for this form of application) that the patent error should be reported under the general ground. The relevant section of DPLRC Committee's report is at Annexe B.

14. The DPLRC has drawn this instrument to the Parliament's attention on the reporting ground (j), outlined in paragraph 10.

Details on SSI 2015/166

15. **Registration of Births, Deaths and Marriages (Scotland) Act 1965 (Prohibition on Disposal of a Body without Authorisation) Regulations 2015 (SSI 2015/166)** The Act replaces the existing 'cremation only' scrutiny of cause of death documentation, as well the associated fees for this process, with a new process which will: introduce a single system of independent, effective scrutiny applicable to deaths that do not require a Procurator Fiscal investigation; improve the quality and accuracy of Medical Certificates of Cause of Death (MCCDs), and provide improved public health information and strengthened clinical governance in relation to deaths.

16. There has been no motion to annul these instruments.

17. The DPLRC has drawn the instrument to the Parliament's attention under reporting ground (h) as the meaning of regulation 8 and of Form N in the Schedule could be clearer in a particular respect. They could more clearly implement the policy intention that the section of the Form N relating to Post-Mortem Examination will require to be completed by a registered medical practitioner who has appropriate expertise in pathology.

18. The Scottish Government has undertaken to bring forward an amendment to make this clarification "at the next appropriate opportunity." Given that the Form N is significant as having effect to release body parts for disposal after a post mortem examination, the Committee considers that the provision should be clarified by an amendment as soon as possible. The relevant section of DPLRC Committee's report is at Annexe C.

19. The DPLRC has drawn this instrument to the Parliament's attention on the reporting ground (j), outlined in paragraph 10.

Bryan McConachie
Committee Assistant

Annexe A: Extract from Delegated Powers and Law Reform Committee report

Annexe A

Certification of Death (Scotland) Act 2011 (Authorisation of Cremation – Death Outwith Scotland) Regulations 2015 (SSI 2015/162);
Certification of Death (Scotland) Act 2011 (Application for Review) Regulations 2015 (SSI 2015/163);
Certification of Death (Scotland) Act 2011 (Consequential Provisions) Order 2015 (SSI 2015/164);
Certification of Death (Scotland) Act 2011 (Post-Mortem Examinations – Death Outwith United Kingdom) Regulations 2015 (SSI 2015/165); and
Registration of Births, Deaths and Marriages (Scotland) Act 1965 (Prohibition on Disposal of a Body without Authorisation) Regulations 2015 (SSI 2015/166)

Breach of laying requirements: Letter to Presiding Officer

The above instruments were made under sections 4(8), 18(4), 19, 25 and 28 of Certification of Death (Scotland) Act 2011 on 2 April 2015.

They are being laid before the Scottish Parliament on 2 April 2015 and come into force on 13 May 2015.

Section 28 (2) of the Interpretation and Legislative Reform (Scotland) Act 2010 has not been complied with. The reasons for not complying with that section are;

• The Act will introduce a new death certification system in Scotland. As a result the Crown office were required to review their current policy and documentation on authorising disposal after investigation. There were a number of complex technical and legal issues that had to be resolved before the instruments could be laid, and these discussions only concluded on Monday 30th March.

• In constructing legislation for cross border disposals, policy officials had to secure agreement from all other UK administrations. This involved lengthy discussions with the Department of Health and Ministry of Justice to reach conclusions that reflected the formal requirements of the 2011 Act. Despite early representations to counterparts across the UK it proved difficult to get full engagement and a balanced assessment of the cross-border issues. This meant that these discussions only concluded mid- March and so it was not possible to finalise these instruments until the end of March.

• Despite public consultation on the proposals as part of the Bill for the Act and further engagement undertaken with a specialist Implementation and Advisory Group (including NHS; faith group; bereavement services; registration services; medical representatives, BMA and funeral industry

representatives) shortly prior to finalising the above instruments, in early March stakeholders from the Jewish and Muslim faith groups raised concerns about the impact of the legislation on their religious requirements for a quick burial. Officials had to take steps to minimise potential delays to funerals before the instruments could be laid. This required negotiation with all out-of-hours doctors in mid-March. If that negotiation had been unsuccessful we would have had to change legislation and so it was not possible to finalise these SSIs until the end of March.

The coming into force date of 13 May 2015 is critical and cannot be put back. The original intention was that the new arrangements would be introduced in April 2014, however the implementation date was put back a year to accommodate the development of IT systems to enable doctors to complete the required forms electronically, improving quality and reducing the workload in completing these forms. The new system will be delivered by Healthcare Improvement Scotland and National Records of Scotland and both organisations now have the operational infrastructure in place for go-live on 13 May. Any move to put back the go-live date would cause significant operational difficulties and may incur additional costs. There would be a heavy impact on planned operations, communications (public information has been produced with the 13 May date included) and the training of all doctors and registrars (who have been trained on the basis of commencement on 13 May) with the potential to damage the credibility of the new system and reputation of the delivery organisations.

Annexe B: Extract from Delegated Powers and Law Reform Committee report

Annexe B

Certification of Death (Scotland) Act 2011 (Post-Mortem Examinations - Death Outwith United Kingdom) Regulations 2015 (SSI 2015/165)

On 23 April 2015, the Scottish Government was asked:

There is an error in the heading of the form in the Schedule to the instrument, which specifies that it is a form of application under section 19 of the Certification of Death (Scotland) Act 2015 (rather than 2011). Given that the sole purpose of this instrument is to provide for the contents of this form, and that as drafted it purports to be a form under a 2015 Act which does not exist, would the Scottish Government propose to correct this citation of the Act by means of an amendment?

The Scottish Government responded as follows:

We agree that there is a minor typographical error in the Schedule Form which should read the Certification of Death (Scotland) Act 2011. We propose to rectify the error by way of a correction slip.

Annexe C: Extract from Delegated Powers and Law Reform Committee report

Annexe C

Registration of Births, Deaths and Marriages (Scotland) Act 1965 (Prohibition on Disposal of a Body without Authorisation) Regulations 2015 (SSI 2015/166)

On 27 April 2015, the Scottish Government was asked:

Paragraph (2) of regulation 7 provides that a certificate specified by paragraph (1) for the purpose of section 27A(2)(a) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, in either Form M or N, may be given by a person licensed under section 3(2) of the Anatomy Act 1984. Regulation 8 specifies for the same purpose a certificate in the Form N where a body has undergone post-mortem examination, but there is no further provision as to the person/s who are enabled to give this certificate and the qualifications and/or experience which they must possess. The Form N in the Schedule, by the words bracketed in the first line of "Post-Mortem Examination", indicates that a "doctor/pathologist" with medical qualifications may provide the certificate. However this is only a direction to insert the name and the medical qualifications of the person in the form. It does not impose a requirement as to the professional who may sign the form, or as to their required qualifications or experience (unlike the provision in regulation 7(2)).

(a) Please explain therefore whether the Scottish Government's policy intention which underlies those words as quoted above in the Form N is that a person signing the Form must be either a doctor (or a registered medical practitioner?) or a pathologist, or whether it is intended that the person must be both a doctor/registered medical practitioner and a pathologist. Could the meaning of the provision be made clearer in those respects, and to impose a requirement within the Regulations as to the nature of the professional who can sign the form?

(b) Please clarify whether it is intended that the person who can sign the form must have particular qualifications and/or experience, and if so what these are. Similarly, could the meaning of the provision be made clearer to specify the requirement that a person who may sign the Form N under regulation 8 must possess the required level of qualifications and/or experience intended?

(c) If it is considered that the provisions could be made clearer in those respects, would the Scottish Government propose to take corrective action?

The Scottish Government responded as follows:

We are grateful that this matter has been drawn to our attention.

(a) and (b) Regulation 7(2) provides that where anatomical examination has taken place a certificate in Form M or N may be given by a person licensed under section 3(2) of the Anatomy Act 1984. With regard to regulation 8, where post-mortem has taken place, there is no statutory provision equivalent to section 3(2) of the 1984 Act which specifies who may carry out post-mortems. The policy intention is that the section relating to Post-Mortem Examination in Form N be completed by a registered medical practitioner (generally taken to be a doctor), expert in pathology. Consideration of sufficiency of qualifications and/or experience and the completion of the Forms are covered under the National Consultant Contract with Health Boards which outlines terms and conditions of service.

(c) The Scottish Government agrees that the provision could be made clearer and proposes to issue statutory guidance on the subject and to make an amendment at the next appropriate opportunity.

Carers (Scotland) Bill

The Scottish Young Carers Services Alliance is an unconstituted network of over 50 organisations across Scotland who deliver, or intend to deliver services to young carers, or who have an interest in issues affecting young carers. The Alliance was formed around 2002 and is facilitated by a Co-ordinator, who is employed by Carers Trust.

Alliance members met recently in Glasgow to discuss the Bill as it stands. These members represent a good cross section of young carers services; urban and rural, small and large services. Some are from independent services, some sit within condition specific organisations, some are attached to an adult carers centre, some work within larger national children's organisations. We also had representatives from NHS and social services. The group considered the questions put forward by your committee to form the basis of the discussions. The Co-ordinator has brought together the comments and responses from this consultation to present to the Committee to assist the process of the Bill and to ensure that it works as well as possible for young carers in Scotland.

Q1. Do you support the Bill?

The majority of staff support the bill, but some felt unsure, asking how will it impact on young carers, with a few asking how practical it is. It was explained that secondary legislation will be developed to help facilitate how the Bill is enacted. We look forward to being involved in the development of that.

Q2. What do you feel would be the benefits of the provisions set out in the Bill?

The most significant part of the Bill for young carers is the duty to provide a Young Carers Statement (YCS).

There was overall approval of the Young Carers Statement, if some uncertainty about how it would be delivered.

The national strategy for young carers in Scotland (Getting It Right for Young Carers, Scottish Government 2010) acknowledges a large gap between the numbers of children and young people who say they have a caring role and the numbers of those young carers who actually receive support from services. The 'hidden' nature of caring remains an issue. The majority of respondents felt that a YCS would be better at catching young carers as opposed to the more generic approach of *GIRFEC,* as it was specifically targeted at young carers. However, there was still concern around identification of young carers within universal services.

It was felt that there needed to be clarity about how the Young Carers Statement would connect to the Childs Plan under Children and Young People's Act.

Alliance members also welcome the inclusion of young carer strategies within the Bill. Around half of the areas represented at our meeting have a local young carers strategy in place, and this has helped to progress multi agency as well as direct service work to support young carers. We would prefer that Local Authorities and

Health Boards would produce separate strategies for young carers to produce better outcomes for young carers and to acknowledge the very different needs of this group from adult carers.

We wholeheartedly welcome the duty on Local Authorities to provide support to young carers. Our audience voiced comments and concerns about how support would be funded. For young carers up to the age of 16, only 3 of the 4 options within Self Directed Support are applicable.

Involving young carers in planning, shaping and delivering services will be a benefit Scotland wide for young carers. There are services in our network who already do this and will be able to provide examples of local practice to help develop this measure nationally.

Q3. How do you feel the Bill could be amended or strengthened?

Q4/5. Is there anything you would add or remove from the Bill?

Our discussions raised a variety of issues. Many of them point to suggestions for strengthening or adding to the Bill, and they are grouped together to answer Questions 3, 4 and 5.

There were a number of questions posed around the YCS, and how it would work. Whilst some of these concerns might not be able to be directly turned into change within the Bill, we hope that the Committee will find it helpful to consider how the Bill might impact on young carers, and how it is being viewed by practitioners.

People were concerned about the sharing of the YCS with the Named Person (where there is one). We would want to see robust guidance produced about this.

Staff felt that information had to be protected but were concerned about how this was done. There was acknowledgement that there could be occasions where disclosing the young carer statement to Named Person may actually help the young carer, for example it might flag up that the young person is a young carer requiring additional support. However this could also be a Catch 22 situation if the young carer does not want school knowing anything about their caring situation or did not have a positive relationship with the Named Person?

Some staff suggested an option that the Young Carer Statement is only shared with Named Person if it is essential, that is, if being a young carer is likely to impact adversely onto the young person in such a way that it affects the principles within *GIRFEC,* such as safety, education etc.

Our members want to see training for staff within schools around Named Person and confidentiality, as it could be a barrier for some young carers completing a statement knowing that it will go automatically to Named Person.

People also wanted more information about what would be included in the young carer statement, and is it about support for young carer's needs, or is it about support for cared for person's needs?

A recent experience of one young carers worker centred around a young carer contributing care and subsequently being brought in as part of the cared for person's support plan. The Bill needs to provide clarity about the roles of a young carer – about age and gender appropriate input, and about the right to refuse to provide care.

Sometimes giving support to the cared for person can ease pressure on young carer, but a Young Carer Statement should focus on needs of young carer. We would like more clarity within a YCS as to how provision of services to the cared for person and the needs of the cared for person interacts with needs of the young carer. We also need to consider the reverse of this and what is the position when the cared for person refuses to have support into the home.

In line with colleagues from other National Carers Organisations, we would like to see anticipatory and emergency planning as part of the Young Carers Statement.

We discussed the need for eligibility criteria. There was worry that local authorities might set criteria at a high level due to austerity cuts at present. Members felt that national criteria could usefully form a framework within which local criteria could be set.

Questions were raised as to whether local authorities would have a duty to publish any unmet need which may arise as a result of young carer statements. This could be incorporated into local young carer strategies, providing accessible information about this.

Our members thought that the Bill could be strengthened by Local Authorities requiring to set out timescales to carry out young carer statements, or making decisions on implementing young carer statement. We think it is reasonable for young carers and their families to have an indication of how long the process will take to result in support.

In addition to timescales, the question of funding was raised. How will services be funded to meet the needs raised in young carer statements? This may not be a direct function of the Bill, but it is directly related to people's concerns about how effectively the Bill will work for young carers.

We also think that Local Authorities who are under pressure for resources might commission third sector organisations to produce Young Carer Statements. At present, this is not clear. Where Local Authorities are able to carry out young carer statement that is fine, but we would hope that they would work in partnership with local third sector organisations where that is appropriate.

Finally, going back to the provision of young carers strategies, as stated in our response to question 2, we believe that separate young carers strategies would strengthen this Bill in regard to what is being provided for young carers. There is a danger that if strategies to support young carers are combined with those for adult carers, not enough regard will be given to support measures for young carers. There needs to be at least a set of specific measures which will be documented locally to support young carers to achieve the best outcomes.

Young carers strategies should also set out local plans for how they will involve young carers in the planning shaping and delivery of services for the cared for and for young carers.

Scottish Young Carers Services Alliance

Carers (Scotland) Bill

Stirling Carers' Voice consists of a membership of 42 carers living within the Stirling Council area – this paper acts as a collective response from the group to the call for evidence from the Health and Sport Committee for The Carers (Scotland) Bill.

Overall, the group welcome the Carers Bill and are pleased that the Scottish Government has decided to introduce legislation, which will deliver new rights and entitlements to unpaid carers. They particularly welcome that local authorities will have a duty to support carers who meet eligibility criteria, as the current power means that there is a great deal of variation across Scotland in the level of support which carers can access. There is also no clarity in what support carers are entitled to. We hope the Carers Bill will bring greater equity and transparency for carers.

Some areas of the Bill do require strengthening, including the lack of entitlement to short breaks, the role of Health Boards in delivering change, particularly in relation to hospital discharge, the omission of emergency and anticipatory care planning on the face of the Bill and the need for a stronger equalities focus.

In addition, we are particularly disappointed that the Bill makes provision for a duty on local authorities to provide support to adult carers who meet local eligibility criteria. Carers locally are clear that they believe the eligibility criteria must be national rather than local, as this is the only way to avoid a postcode lottery and to ensure that carers have access to the same rights and entitlements across Scotland.

Universal, Preventative Support

The Bill includes the provision for local authorities to have a power to support carers who do not meet eligibility criteria, as well as a duty to support those who do. This is essential in ensuring a preventative approach is taken to supporting carers and protecting their health and wellbeing.

In addition, the Bill makes provisions for all carers to access an Adult Carer Support Plan and information and advice. What needs to be clarified is what support is viewed as universal and preventative and what support will require a carer to meet eligibility criteria.

To put this in context, only a small percentage of carers access a Carers Assessment and statutory support, with the majority accessing support through universal services. Furthermore, with an increase in the number Adult Carer Support Plans being undertaken there will be a corresponding increase on the demands on universal services. It is essential that these supports continue, are properly resourced and that they are not defined too narrowly.

Eligibility Criteria

The Carers Bill will only be viewed as successful if it delivers real change in the form of a right to support and provides resources to assist carers in their caring role.

In order to access this entitlement, carers must first meet eligibility criteria. In other words the eligibility criteria is the key to them unlocking their right to support. We therefore cannot underestimate how important it is to get this criteria right, because as well as delivering an entitlement to carers it also has the potential to tighten eligibility, undermine the preventative approach and make it harder for carers to access support.

We agree that there needs to be local variation, however we do not believe there needs to be variation in the level of service that carers are able to access. If local authorities have a duty to develop local eligibility, we will continue to have 32 different systems operating across Scotland. Inevitably some local authorities will develop stricter criteria than others, meaning some carers will be at a disadvantage. It will also mean that the system will be less transparent and carers will be unlikely to have an understanding of what they are entitled to. By introducing a national eligibility criteria, this is more likely to provide carers with the right to a consistent level of support and care regardless of where they live. The type of service to support the carer will be determined by the local service landscape.

Carers Support Plans

The group support many of the intended changes in the Bill in relation to Adult Carer Support Plans, i.e. the name change from ‘Carers Assessments’ and the removal of the ‘regular and substantial’ test to ensure that all carers are entitled to a Support Plan. There are however some areas where the group feel that the Bill should further strengthen and improve the intended Adult Carer Support Plan.

In particular, Carers’ Voice believe that the Support Plan should be strengthened in relation to emergency, anticipatory or future planning. In order to take an anticipatory approach, it is important that the Support Plan enables carers at the earliest possible opportunity to discuss and identify an emergency plan. This can be overcome by ensuring that Emergency & Anticipatory Care Planning are included as an explicit requirement within the Adult Carer Support Plans.

Within the Bill it states that Local Authorities will be required to set out intended timescales in their local Carer Strategy in relation to the undertaking of an Adult Carer Support Plan following a request. Locally, many carers currently receive a Carers Assessment from the Carers Centre which is undertaken in a timely fashion (i.e. usually no longer than two weeks from request), so this is currently working well. However, issues often arise when carers are assessed by the Local Authority as meeting their current eligibility criteria for support, but then have to wait for a long time to receive the support that they are entitled to. This wait can result in increased pressure for the

carer and the person(s) they care for, and can have a negative impact on both their health and well-being. Therefore, the Bill should ensure that as well as reasonable timescales being set for the undertaking of the Support Plan, there should also be clear guidelines on the intended timescales for support to be put in place for carers who are assessed as meeting the eligibility criteria.

Information & Advice

Within the Bill it states that Local Authorities will have a Duty to establish and maintain an information and advice service. We believe that emphasis should be placed on supporting and resourcing existing local carer support services and therefore the wording should be changed to “the local authority will have a responsibility to maintain existing carer support information & advice organisations or where there is no existing one, then they will have a responsibility to establish a service where required’. The group feel that the Bill should further safeguard and support local Carers Centres, which are a vital lifeline for many, and worry that the current terminology of ‘establish and maintain’ could result in the de-commissioning of valuable local services.

Stirling Carers’ Voice welcomes any feedback from this submission, and are happy to further discuss and clarify any points made within this paper. Again, we would like to echo our overall support for the Bill, and are extremely hopeful that in Scotland there will be specific legislation for carers which addresses the key issues and inequalities that carers face.

James Marshall (Development Manager)
Stirling Carers’ Voice

Health and Sport Committee

15th Meeting, 2015 (Session 4), Tuesday 12 May 2015

Petition PE1550 on a Mental Health Act inquiry

PE1550 – Lodged 1 February 2015
Petition by Andrew Muir, on behalf of Psychiatric Rights Scotland, calling on the Scottish Parliament to urge the Scottish Government to set up a public inquiry into historical cases of abuse of people detained under the Mental Health (Scotland) Act 1984 and the Mental Health (Care and Treatment) (Scotland) Act 2003.
Link to petition webpage

Introduction

1. This is the first time this petition has been considered by the Health and Sport Committee following its referral by the Public Petitions Committee on 31 March 2015.

Background

2. For background information to the petition, Members may wish to read the SPICe briefing that was provided for the Public Petitions Committee.

Public Petitions Committee consideration

3. The Public Petitions Committee considered the petition for the first and only time on 31 March 2015 and agreed to refer it to the Health and Sport Committee to consider in the context of its scrutiny of the Mental Health (Scotland) Bill. In doing so, the Public Petitions Committee also agreed to write to the Scottish Government to seek its views on the petition. The Scottish Government's response is expected in advance of the dates timetabled for Stage 2 consideration of the Bill.

For consideration

4. Psychiatric Rights Scotland made a submission to the Health and Sport Committee as part of its consideration of the Mental Health (Scotland) Bill at Stage 1, in which it requested an investigation into circumstances where people had bad experiences under existing mental health legislation.

5. The deadline for amendments to the Mental Health (Scotland) Bill at Stage 2 is Thursday 14 May. Stage 2, Day 1 is scheduled for the Committee's meeting on 19 May.

6. In line with the terms under which the petition was referred, the Committee may wish to consider the information contained in the petition and the Scottish Government's response (which will be circulated to Members upon receipt) in the context of its scrutiny of the Mental Health (Scotland) Bill at Stage 2, following which the petition will be closed.

Decision

7. The Committee is invited to consider and agree the above approach.

Committee Clerks
7 May 2015

Report on the survey of 2015-16 NHS Board budget plans

Dr Iris Bosa, University of Edinburgh, and Financial Scrutiny Unit, SPICe

Context

The Health and Sport Committee has undertaken surveys of NHS Board budget plans in 2010-11, 2012-13, 2013-14 and 2014-15. In previous years, the Committee has used the findings from these surveys as the basis for taking evidence from representatives of selected boards to provide a more detailed insight into spending plans. This reflects the fact that, at the time of the draft budget, there is no information available on the spending plans of the boards. The draft budget only provides information on the planned allocations to the boards but no detail below this; meaning that for more than three-quarters of the total health budget, there is no detailed information on its planned use. The budget scrutiny that takes place following the publication of the draft budget cannot therefore provide an in-depth examination of spending plans at local level. The current report is based on a survey conducted with all boards, as outlined in the approach section that follows. The aim is to provide more detailed information on Board spending plans for the Committee to support budget scrutiny.

This report is structured as follows:

1. Approach
2. Performance Budgeting
3. Integration of health and social care
4. Earmarked funding
5. Non-recurring funding
6. Cost pressures
7. Efficiency savings
8. National Performance Framework indicators
   i. Increase the proportion of babies with a healthy birth weight
   ii. Increase the percentage of the last 6 months of life which are spent at home or in a community setting
   iii. Reduce emergency admissions

1. Approach

This year, the Committee agreed to adopt a different approach to the Board survey. Recognising the increasing emphasis placed on performance budgeting, and the challenges in aligning budgets with specific performance measures, the Committee decided to focus on a selected number of performance indicators and gather evidence in relation to these specific areas.

Three indicators were selected from the Scottish Government's National Performance Framework, chosen to reflect areas of particular interest to the Committee's wider work programme:

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

Some specific questions in relation to palliative care were also included to inform the Committee's forthcoming inquiry in this area. In addition, this year's survey included some general questions in relation to performance budgeting and questions specific to the integration of health and social care.

Additional financial data and planning assumptions were drawn from the Local Delivery Plans (LDPs) submitted to the Scottish Government. At the time of writing, the Scottish Government had not received LDPs from NHS Fife, NHS Grampian or NHS Greater Glasgow and Clyde so the analysis of LDPs excludes these three boards.

Scottish Government officials and a number of boards were asked for comments on the draft questionnaire before a final version was sent out. The questionnaire (attached as an annexe) was sent out to the 14 territorial boards and 8 special boards on 26 February 2015 for return by 25 March 2015. Responses were received from all boards. The responses are available on the following webpage: http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/89277.aspx

Preliminary analysis was undertaken by Nicola Hudson and Andrew Aiton of the Financial Scrutiny Unit, SPICe, with further input from the Committee's budget adviser, Dr Iris Bosa. Findings from both the analysis of survey responses and analysis of LDPs are summarised below.

2. Performance budgeting

Given that this year's survey was based around indicators from the Scottish Government's National Performance Framework, boards were asked to comment generally on aspects of performance budgeting.

First, boards were asked which performance framework has the most influence on their budget decisions. Boards were offered the choice of the National Performance Framework (NPF), the Quality Management Framework (QMF, which incorporates the HEAT targets), or to specify another framework.

In responses to this question, only one board mentioned the NPF in isolation. Five mentioned the NPF in conjunction with the QMF/HEAT, while the majority (12) said that the QMF/HEAT was the main performance framework influencing their budget decisions. Three of the special boards stated that they had their own performance frameworks tailored to their specific role and remit. Healthcare Improvement Scotland noted that the specific targets within the frameworks did not apply directly to it as an organisation. Many of the boards also noted that they would not rely on a single performance framework, but would combine the NPF/QMF/HEAT with indicators and targets designed to reflect local priorities, for example the Single Outcome Agreement of the Community Planning Partnership. The measures set out as part of the Integrated Care Fund were also mentioned by a number of boards. Several special boards highlighted that their work would aim to support boards in meeting HEAT targets.

Overall, it was clear that no single framework was used in isolation. Although the NPF and QMF were generally considered to reflect board priorities, they were often seen as too broad to be used in the absence of other indicators. Two boards commented that the wider frameworks were too focussed on the acute sector, so did not take sufficient account of the needs of the community sector. Workforce issues and infrastructure requirements were also considered to be inadequately reflected in the wider performance frameworks. Some boards also highlighted the importance of policy and legislation in determining resource allocation, while others referred to particular targets linked to ring-fenced allocations.

Boards were asked to describe how performance information influences budgetary decision-making. Most described the use of performance information in regular reporting and management review. Poor performance was often a driver for service redesign. A number of HEAT targets were mentioned by several boards as influencing resource allocation – these were the treatment time guarantee, delayed discharge and the four hour A&E waiting time target. The analysis of specific NPF indicators later in the questionnaire suggested that performance influenced budget decisions more clearly where there was greater scope for improvement. For example, the % of babies with a healthy birth weight varied little across boards, and there was limited evidence of the influence of this performance indicator on budgets. By contrast, performance on the level of emergency admissions per 100,000 population was more varied and had worsened and, in this case, there was stronger evidence of performance influencing budget decisions, with resources being allocated to initiatives designed to improve performance.

Comment

It is evident that the performance measures are guidelines for the different Boards. It is interesting to notice the variation in the use of the different frameworks, with the majority of Boards using QMF/HEAT targets, and fewer using NPF. It is also interesting that one Special Board suggested it developed its performance framework based on the NPF and QMF. There seems a rather general acceptance that the main indicators are treatment time guarantee, delayed discharge and the four hour A&E waiting time target. A strategy toward prioritising the indicators to focus on seems to be followed. This aligns with the findings in the Committee's report published in December, suggesting the need to place more attention on analysing the performance of targets that are more urgent for change, and leaving a

longer period for revision to targets that have a lower priority. This would allow Boards to feel under less pressure to address a large range of targets.

Some Boards indicated that the targets refer to priorities related to the acute services. Given the focus on integration of health and social care, it is important to ensure that indicators are in place to help monitor progress in this area.
The survey also highlights the need for analysis of the indicators in relation to local specificities (geographical area, population age, level of deprivation) in order to understand the factors that affect the specific performance and might be out of the control of the Board. The respondents reiterate the strengths and limitations of the indicators: they are useful to provide immediate information but this should not be interpreted in isolation.

3. Integration of health and social care

Boards were asked about their preparations, in terms of budgeting, for the Integrated Joint Boards (IJBs) which will be fully operational from April 2016, but will operate in shadow format during 2015-16. The only exception to the IJB model is in North Highland, where a 'Lead Agency' model has been adopted.

The majority explained that shadow budgets for 2015-16 had been determined on the basis of existing budgets for those services that are to be delegated. In future years, an annual budget setting process would be developed.

In addition to the standard delegated functions set out in the regulations, a number of boards have agreed with their local authority partners to delegate a wider range of functions to the IJB. Examples of additional services that a number of boards have decided to delegate, over and above those set out in the regulations, include:

- Additional acute hospital services
- Children's services
- Health visiting and school nursing
- Criminal justice social work
- Youth justice social work

Territorial boards were asked to provide details of the sums allocated to the integrated joint boards for 2015-16. The majority of boards provided figures (although several noted that the figures were indicative at this stage). Three boards declined to provide figures, stating that they had not yet been agreed.[1] The question was not relevant to North Highland, which has adopted a Lead Agency model.

For those boards that provided information, details are set out in Table 1 below. Where a health board has more than one IJB within its area, the figures represent the total of all IJBs. For Highland, figures relate to the Argyll and Bute IJB. In total,

[1] NHS Forth Valley; NHS Greater Glasgow and Clyde; NHS Lanarkshire

for the 11 territorial health boards that provided figures, planned IJB budgets total just over £4bn. Overall, health boards account for £2.7bn (66%) of this total. However, this varies considerably between areas. In Orkney and Shetland, planned resources are split roughly equally between the health board and the local authority, while in all other areas, the health board is allocating a larger sum than the local authority. In Dumfries and Galloway, the health board accounts for the largest share (81%) of the total planned budget. This is likely to be a reflection of the decision to include all acute hospital services within the remit of the IJB in this area.

Note that there may be some differences in methodology between boards – in particular, it was not always made clear whether the health board figure includes the 'set aside' budget (that proportion of the health board budget that is allocated to the IJB in relation to acute hospital services for unplanned care). Where figures were provided separately, the set aside budget has been included in the health board total.

Table 1: Indicative allocations to IJBs, 2015-16

	Health Board allocation to IJB £m	Local Authority allocation to IJB £m	Total IJB budget £m	Health Board allocation as % of total
Ayrshire and Arran	329.9	233.8	563.7	59%
Borders	86.0	48.0	134.0	64%
Dumfries and Galloway	224.0	52.0	276.0	81%
Fife	348.2	144.6	492.8	71%
Grampian	390.0	230.0	620.0	63%
Highland (Argyll & Bute)	189.0	62.0	251.0	75%
Lothian	669.2	342.4	1,011.5	66%
Orkney	16.4	17.0	33.4	49%
Shetland	18.1	19.7	37.8	48%
Tayside	359.0	193.0	552.0	65%
Western Isles	25.2	20.0	45.2	56%
Total of above	**2,654.9**	**1,362.5**	**4,017.4**	**66%**

For Dumfries and Galloway, the planned allocation to the IJB represents 84% of the total health board budget (see Table 2). For the smaller island health boards, their planned allocation to the IJB represents a much smaller share of the total health board budget (in the region of 40%).

Table 2: Planned health board allocations as % of health board budgets

	Health Board allocation to IJB £m	Total Health Board budget £m	Health Board IJB allocation as % of health board budget
Ayrshire and Arran	329.9	635.5	52%
Borders	86.0	184.2	47%
Dumfries and Galloway	224.0	265.9	84%
Fife	348.2	574.8	61%
Grampian	390.0	827.3	47%
Lothian	669.2	1,225.7	55%
Orkney	16.4	41.3	40%
Shetland	18.1	40.7	44%
Tayside	359.0	660.9	54%
Western Isles	25.2	63.7	39%
Total of above	**2,465.9**	**4,520.0**	**55%**

Boards noted a number of perceived challenges in relation to budget planning within the new integrated structure. These included:

- Greater challenges in managing any underspends effectively
- Establishing the scope of the hospital set aside budget

Comment

It would be useful to have targets that help direct the IJBs towards efficient and effective operation. With regard to the resource contribution into the IJBs it is evident that there is a variation on the level committed by the different boards. In some IJBs the Health Board is the major funder while in some there is a more equal split of resources transferred to the IJB. The reasons for these differences are worth further exploration, to investigate whether different funding models result in more or less transition towards new models of care delivery. There is also the risk that the current organisation will be simply transferred under the new board. It would be relevant to investigate the level of collaboration and reorganisation taking place under different levels of health board contribution.

4. Earmarked funding

In 2015-16, the boards will, on average, receive 13% of their funding allocation in the form of earmarked funding that is ring-fenced for a specific purpose, such as alcohol or drug treatment programmes. For those boards that have submitted LDPs, this represents a total of £0.8bn in earmarked funding. A higher proportion of earmarked funding implies less flexibility for boards in how they allocate their funds.

The proportion of the revenue resource allocation accounted for by earmarked funding in 2015-16 varies considerably between boards (see Table 3). Across territorial boards, the proportion varies from 7% in Ayrshire and Arran to 30% in Shetland.[2] Across special boards, the range is even wider, from 3% for the State Hospital and NHS Education for Scotland to 45% for the National Waiting Times Centre. This will largely reflect their specific roles and remits.

In the survey, boards were asked whether they felt they were able to spend earmarked funding effectively and in line with the intended purpose. The majority of boards felt that they were able to do so, but made the following comments:

- Spending earmarked funds effectively can be challenging when the allocation comes late in the financial year and/or is non-recurring. For example, if funding is non-recurring, staff may need to be employed on short-term contracts at higher rates of pay.
- Bundling of allocations within broader funding streams e.g. effective prevention / early years, allows for greater flexibility in the use of funds and also reduces bureaucracy which the boards find helpful.
- Smaller boards, such as Orkney and the Western Isles commented that, when allocations are formula-based, this can result in small funding pots that cannot be used effectively to achieve change e.g. where funding is insufficient to allow for the recruitment of a full-time post. The suggestion of a minimum allocation was considered to be a possible solution to this issue.
- NHS Ayrshire and Arran noted some challenges in using earmarked funding effectively e.g. noting the allocations for hepatitis C which can be used to fund extra staff, but not to cover the extra costs of the drugs required.

[2] Analysis excludes NHS Fife, NHS Grampian or NHS Greater Glasgow and Clyde who had not yet submitted LDPs

Table 3: Earmarked funding

	Earmarked funding as % of total allocation 2015-16
Territorial Health Boards	
Ayrshire and Arran	7%
Borders	14%
Dumfries and Galloway	12%
Fife	..
Forth Valley	11%
Grampian	..
Greater Glasgow and Clyde	..
Highland	18%
Lanarkshire	10%
Lothian	14%
Orkney	20%
Shetland	30%
Tayside	13%
Western Isles	24%
Territorial boards	**13%**
Special Health Boards	
National Waiting Times Centre	45%
Scottish Ambulance Service	4%
National Services Scotland	37%
Healthcare Improvement Scotland	23%
The State Hospital	3%
NHS 24	13%
NHS Education for Scotland	3%
NHS Health Scotland	9%
Special boards	**15%**
All boards	**13%**

5. Non-recurring funding

Non-recurring funding is a one-off allocation in a financial year and can sometimes be earmarked for a specific purpose. In its annual overviews of NHS financial performance, Audit Scotland has repeatedly raised concerns about boards relying on non-recurring funding to break even.

In 2015-16, boards will, on average, receive 4% of their total allocations in the form of non-recurring funding. This is higher than the equivalent figure of 3% in 2014-15.

Of the territorial boards for which information is available, NHS Lanarkshire has the highest proportion of its allocation (9%) in the form of non-recurring funding. Across special boards, there is much wider variation, from less than 1% in the State Hospital and NHS Education for Scotland to 23% for NHS 24.

Table 4: Non-recurring funding

	Non-recurring funding as % of total allocation 2015-16
Territorial Health Boards	
Ayrshire and Arran	2%
Borders	1%
Dumfries and Galloway	3%
Fife	..
Forth Valley	3%
Grampian	..
Greater Glasgow and Clyde	..
Highland	6%
Lanarkshire	9%
Lothian	3%
Orkney	1%
Shetland	1%
Tayside	1%
Western Isles	4%
Territorial boards	**4%**
Special Health Boards	
National Waiting Times Centre	6%
Scottish Ambulance Service	4%
National Services Scotland	13%
Healthcare Improvement Scotland	19%
The State Hospital	0%
NHS 24	23%
NHS Education for Scotland	0%
NHS Health Scotland	9%
Special boards	**6%**
All boards	**4%**

6. Cost pressures

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

In respect of pay, the majority of boards were planning on a base uplift of between 1% and 1.2%. Most boards were expecting incremental drift and other factors to add up to a further 1.5% on top of this. Three boards were expecting incremental drift and other factors to add more than 2% to the pay bill (over and above the base uplift): NHS Shetland, NHS Health Scotland and Healthcare Improvement Scotland. It is not clear why these three boards are expecting pay pressures higher than those of other boards.

Wide variation was evident in the boards' statements of anticipated price and volume pressures in respect of hospital drugs, as shown in Table 5 below which shows data for all the territorial boards and the one special board that provided details for this indicator – the National Waiting Times Centre.

Table 5: Hospital drugs: anticipated price and volume changes 2015-16

	Assumed price uplift	Assumed volume uplift
Territorial Health Boards		
Ayrshire and Arran	2.0%	22.0%
Borders	13.6%	2.0%
Dumfries and Galloway	8.7%	2.5%
Fife	..	..
Forth Valley	10.0%	..
Grampian	..	..
Greater Glasgow and Clyde	..	..
Highland	0.0%	11.7%
Lanarkshire	0.0%	29.6%
Lothian	5.5%	8.5%
Orkney	1.7%	5.0%
Shetland	33.0%	0.0%
Tayside	3.0%	5.7%
Western Isles	6.0%	0.0%
Special Health Boards		
National Waiting Times Centre	5.6%	2.4%

The information suggests that some boards may have taken different approaches to reporting prices and volumes – often, those reporting a low value on one measure report a high value on the other. For example, Shetland reports a 33% assumed price uplift, but no change in hospital drug volumes. Meanwhile, Lanarkshire reports a 29.6% anticipated increase in volume, but no anticipated increase in price.

The LDP evidence is consistent with the information gathered from the survey undertaken. In response to the survey, many of the territorial boards mentioned cost pressures in relation to the budgetary challenges that they face in 2015-16. In particular, drug costs were mentioned by nine of the 14 territorial boards. Pension and workforce costs – including the costs of locums – were also mentioned frequently.

7. Efficiency savings

Eight of the territorial boards and two of the special boards specifically mentioned achievement of efficiency savings target as a particular budgetary challenge for 2015-16.

Boards are asked to provide details of their planned efficiency savings as part of their LDP returns. In total, the boards are reporting planned efficiency savings of £151.5m in 2015-16 (excluding NHS Fife, NHS Grampian and NHS Greater Glasgow and Clyde). This represents 2.4% of board allocations, lower than the 3% efficiency savings target that has been set in previous years.

There is some variation between boards, as shown in Table 6. Of the territorial boards, planned efficiency savings in 2015-16 range from 2.1% in Ayrshire and Arran, up to 3.5% in Shetland. Across the special boards, there is much wider variation in planned efficiency savings (from 0.4% for NHS Education for Scotland to 7.1% for the National Waiting Times Centre).

More detailed analysis of the planned source for efficiency savings highlights that over a third (36%) of savings are expected to come from 'service productivity'. Other main areas for savings are 'workforce' (17%) and 'drugs and prescribing' (16%). A tenth of savings have yet to be identified (see Figure 1).

Across territorial boards:

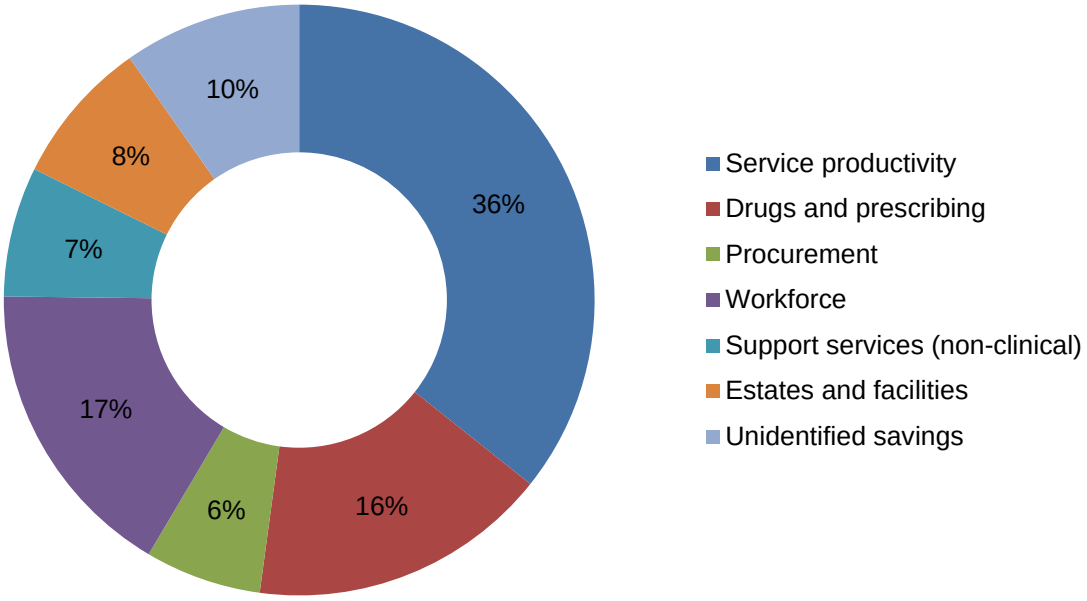
- Forth Valley, Highland and Shetland are planning to achieve half of their savings through service productivity
- Ayrshire and Arran, Dumfries and Galloway and Tayside are planning to achieve around a quarter of their savings from drugs and prescribing
- Forth Valley, Lothian and Tayside are planning to achieve around a quarter of their savings from workforce changes
- In Lanarkshire, the source for one quarter of savings is as yet unidentified; in the Western Isles, the source for one third of savings is as yet unidentified

As highlighted in the Committee's report on the 2014-15 board budgets, there are growing concerns about the extent to which further efficiency savings can be achieved. It would be interesting to get a more in-depth understanding on the Scottish Government's approach to setting targets in this area and its future intentions.

Table 6: Planned efficiency savings, 2015-16

	Planned efficiency savings as % of total budget 2015-16
Territorial Boards	
Ayrshire and Arran	2.1%
Borders	2.4%
Dumfries and Galloway	2.6%
Fife	..
Forth Valley	2.8%
Grampian	..
Greater Glasgow and Clyde	..
Highland	2.2%
Lanarkshire	2.3%
Lothian	2.7%
Orkney	2.6%
Shetland	3.5%
Tayside	2.4%
Western Isles	3.3%
Territorial boards	**2.5%**
Special Health Boards	
National Waiting Times Centre	7.1%
Scottish Ambulance Service	2.6%
National Services Scotland	3.1%
Healthcare Improvement Scotland	1.5%
The State Hospital	1.6%
NHS 24	3.1%
NHS Education for Scotland	0.4%
NHS Health Scotland	5.8%
Special health boards	**2.2%**
All boards	**2.4%**

Figure 1: Planned efficiency savings by source, 2015-16



8. National Performance Framework indicators

Boards were asked some specific questions in relation to three indicators from the National Performance Framework:

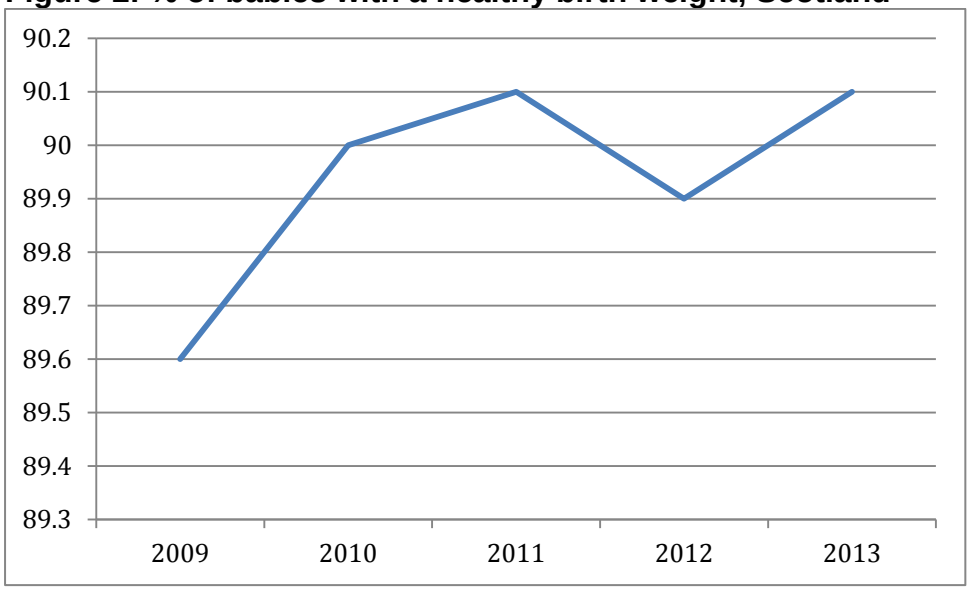
- Increase the proportion of babies with a healthy birth weight
- Improve end of life care
- Reduce emergency admissions

Responses in relation to each of these areas are considered below. This analysis relates to territorial boards only as the questions were not relevant to special boards.

Increase the proportion of babies with a healthy birth weight

Across Scotland as a whole there has been an improvement in this measure over the last five years for which data are available. In 2009, 89.6% of babies had a healthy birth weight; in 2013, the equivalent figure was 90.1.

Figure 2: % of babies with a healthy birth weight, Scotland



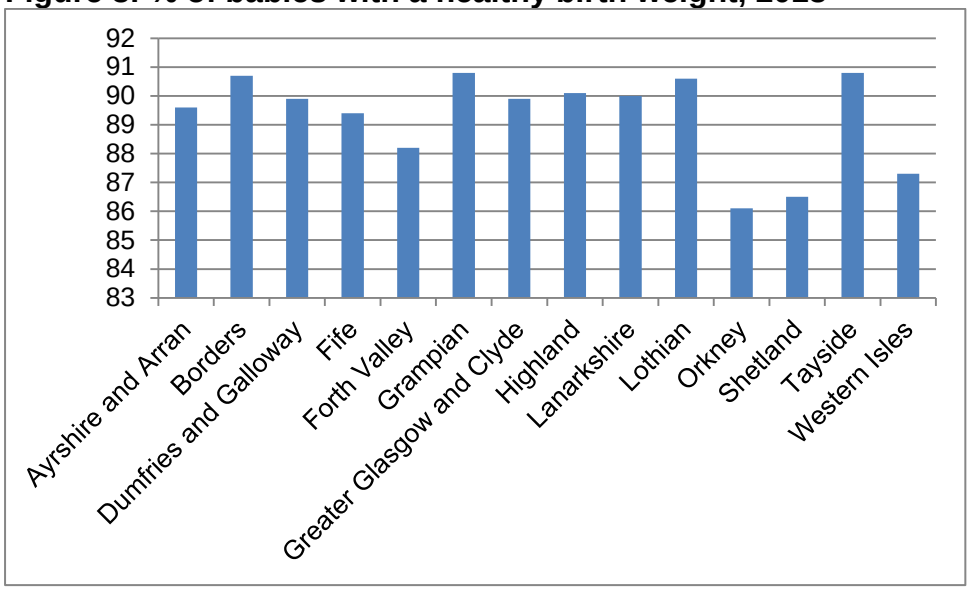
There is not a significant variation in this measure across Boards, with most performing at or around the Scottish average (see Figure XXX). In 2013, four boards were more than one percentage point below the Scottish average of 90.1%. These were Forth Valley (88.2%), Western Isles (87.3%), Shetland (86.5%) and Orkney (86.1%).

The smaller island boards noted that very small changes in the numbers of babies above or below a healthy birth weight had a significant impact on the indicator, due to the small overall numbers of births involved. Forth Valley and the Western Isles had been consistently below the Scottish average throughout the period, while the other two boards had occasionally outperformed the Scottish average on this indicator. Both Orkney and Shetland referred to an increase in the proportion of babies born with an above healthy weight, often reflecting maternal obesity or gestational diabetes.

Boards noted the influence of a range of factors on this indicator, including:

- Deprivation levels
- Smoking/drinking/drug use during pregnancy
- Maternal nutrition
- Obesity
- Maternal age

Figure 3: % of babies with a healthy birth weight, 2013



Differences in performance were often felt to reflect differences in the levels of deprivation, which the health board cannot directly address. Boards described the types of activities that they undertook to ensure performance against this measure, including:

- Smoking cessation programmes
- Maternal and infant nutrition programmes
- Family Nurse Partnership activities
- Work with drug and alcohol partnerships
- Targeted community midwifery activities

However, it did not appear that performance against this indicator had a strong influence on budget decisions as most felt that their performance was in line with the national average and that short-term changes in budget allocations would not directly influence performance on this longer-term outcome measure.

Most boards viewed the proportion of babies with a healthy birth weight to be a useful indicator, but not in isolation. A number commented that activity and output measures were more useful in the short-term.

Boards were asked to provide details of spending in 2014-15 and planned spending in 2015-16 on programmes or services aimed at improving performance in this area. With the exception of Forth Valley and Greater Glasgow and Clyde, all boards provided financial information. However, it is difficult to draw comparisons between boards due to the way in which information was reported. For example, some boards gave their total Family Nurse Partnership (FNP) budget, while others noted that it was not possible to disaggregate spending within this budget to the specific issue of healthy birth weight. It was notable that, for those boards providing details of planned budgets in 2015-16, the majority were planning flat cash budgets in this area i.e. no plans to increase spending. The exceptions were:

- Highland – a planned increased in the community midwifery budget

- Lothian – planned increases in the FNP budget as well as increased budgets for PrePare (a specialist service for pregnant women with substance misuse issues) and for smoking cessation activities for pregnant women

- Orkney – an increased budget for its maternal and infant nutrition programme

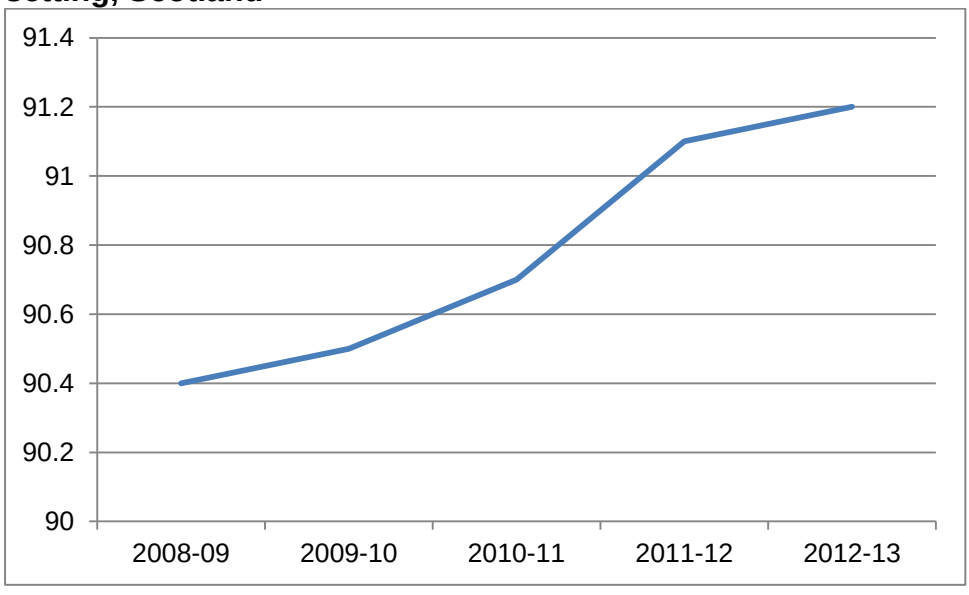
This area involved widespread partnership working, with all boards noting other partners who would contribute towards performance in this area, including:

- Early years partnerships
- Community Planning Partnerships
- Community Health Partnerships
- Alcohol and drugs partnerships
- Local authority services (including education, social work, housing)
- Other third sector partners

Increase the percentage of the last 6 months of life which are spent at home or in a community setting

Scotland-wide performance against this indicator has been improving steadily over the last five years (see Figure XXX). In 2008-09, individuals spent, on average, 90.4% of the last 6 months of life in a home or community setting. This had risen to 91.2% by 2012-13.

Figure 4: % of last 6 months of life which are spent at home or in a community setting, Scotland



Across the boards, in 2012-13, performance against this measure ranged from 89% in Greater Glasgow and Clyde to 93.9% in Grampian. In general, rural areas (Grampian, Highland, Dumfries & Galloway) performed better than urban areas. The smaller island boards showed more variable performance, noting that with such small numbers involved, small changes could lead to relatively large changes in the

performance indicator. The limited options in the smaller island boards was also noted – Shetland noted that it has no hospice beds on the island.

Three boards (Grampian, Highland, Dumfries & Galloway) had performed consistently above average throughout the period. Reasons suggested for this included:

- Rural communities having greater experience in managing care outside of hospital facilities (in some cases due to difficulties in accessing acute facilities) – Dumfries and Galloway
- Investment in staff training to support this approach – Dumfries and Galloway, Highland
- Network of community hospitals – Grampian
- Flexible, integrated approach – Grampian, Highland

Tayside, which also showed a stronger performance than other boards, highlighted its rotational approach to nursing posts, giving staff the experience of both hospital and community care so that they can understand the differences between the two settings and the associated challenges e.g. delayed discharges.

Although most boards felt that the indicator was a useful one, it appeared to have limited, if any, direct influence on budgetary decisions. A number of boards noted that it is a crude measure and takes no account of the quality of care or patient preferences. Tayside noted that there were limitations in measuring change against an indicator where the baseline is in excess of 90% and suggested a number of alternative measures, including '% achieving preferred place of care'.

When asked to provide details of specific funding in this area, four boards (Forth Valley, Grampian, Greater Glasgow and Clyde and Lanarkshire) declined, with some stating that it was not possible to disaggregate palliative care from other funding streams. Of those that provided details of spending in 2014-15 and planned spending in 2015-16, the majority were planning to increase spending in 2015-16, or at least maintain levels of spending in cash terms. Only one board (Tayside) was planning a small decrease (-0.7%) in planned spending in this area. Orkney and Shetland had the largest proposed increases in funding (in percentage terms). For Orkney, this related to a planned pilot scheme involving Marie Curie nurses providing overnight care to patients. For Shetland, the increase planned spend related to increased spend on anticipatory care planning.

All boards noted the contribution made by other partners in relation to this indicator. In particular, all boards noted the importance of organisations such as Macmillan and Marie Curie and the local authority social work departments.

Palliative care and hospice funding

Boards were also asked to provide details of funding for specialist and general palliative care and for hospices.

A number of boards said that it was not possible for them to separate out general palliative care expenditure from other areas of spending and so did not provide any

information in response to these questions. Only seven boards provided details of spending on general palliative care. For these boards, planned 2015-16 expenditure on general palliative care equated to between 0.02% (Ayrshire and Arran) and 1.5% (Orkney) of the total revenue budget allocation, although from the details provided it is not possible to establish whether all boards have reported according to common definitions. In all seven boards, spending on general palliative care was planned to remain constant or increase in 2015-16.

Nine boards gave details of existing and planned expenditure on specialist palliative care. This represented between 0.2% and 0.9% of total budgets, although again it is not possible to determine whether consistent definitions have been used. Tayside and Fife were planning a reduction in spending in this area in 2015-16, while all other boards were planning to maintain or increase spending on specialist palliative care. The reasons for the planned reductions are unclear from the responses.

Boards were also asked about funding for specialist and end-of-life care in hospices. The Scottish Government guidance recommends that boards should establish long-term commissioning arrangements with hospices and meet 50% of agreed costs. Seven boards provided details of funding agreements and these represented between 41% (Western Isles) and 52.7% (Lanarkshire) of agreed costs. Forth Valley also noted that it provided in-kind support to a hospice in its area (pharmacy support, payroll services, procurement services and laboratory and diagnostic support). A number of boards noted that they did not use hospices, although it was not clear whether this was the reason for not providing data in all cases.

NHS Tayside has responsibility for the co-ordination of funding to support the only independent children's hospice organisation in Scotland (Children's Hospice Association Scotland – CHAS). This arrangement was agreed in order to minimise bureaucracy. CHAS operates two hospice facilities – Rachel House in Kinross and Robin House in Balloch.

NHS Tayside provided details for the whole of Scotland as follows:

Table 7: Agreed funding for independent children's hospices

	2014-15	2015-16
Funding from Territorial Boards	672	691
Funding from Scottish Government (Diana nurse funding)	256	279
Total (£'000)	928	970
as % of total CHAS charitable activities	*9.5*	*9.4*

NHS Tayside note that the requirement for Health Boards is to fund 12.5% of hospice running costs. The current funding arrangement falls below this level. NHS Tayside note that an agreed funding baseline was established in 2009-10, which has been uplifted each year using Health Board percentage uplifts and that CHAS management have been content with this approach. Scottish Government guidance states that jointly, NHS boards and local authorities should meet 25% of children's hospice running costs. NHS Tayside was not able to provide information on local authority funding for CHAS.

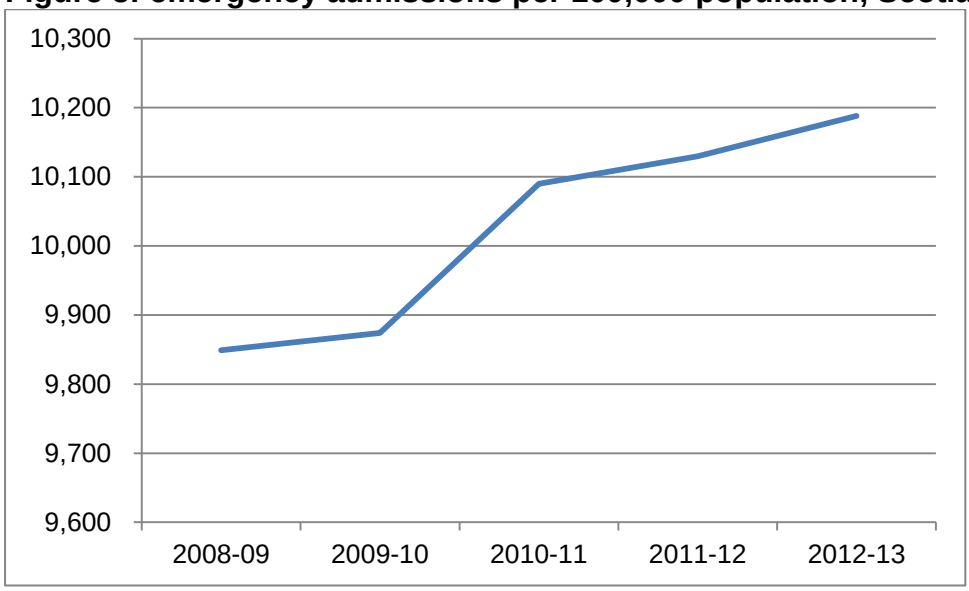
For a service that is of increasing importance given the demographic changes underway, it is important to have more precise information on the cost and usage of this service. Better data and performance indicators need to be identified and collected with regard to this service. It would be useful to understand the rationale for boards planning to reduce the resources for specialised palliative care unit in the coming year, while the other boards plan to increase the resources.

The information provided in relation to highlights that the boards are not meeting the agreement to provide for 12.5% of the running costs. It would be worth further investigation to understand the reasons for this.

Reduce emergency admissions

The number of emergency admissions per 100,000 population has increased steadily since 2008-09, from 9,849 to 10,188.

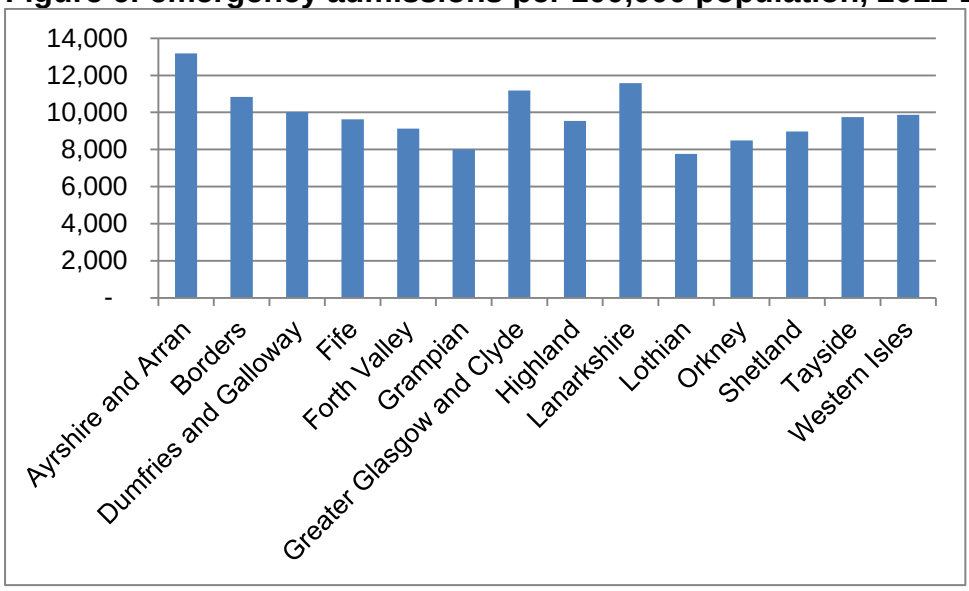
Figure 5: emergency admissions per 100,000 population, Scotland



Across Scotland, performance against this measure varied from 7,768 in Lothian and 8,007 in Grampian up to 11,175 in Greater Glasgow and Clyde, 11,570 in Lanarkshire and 13,190 in Ayrshire and Arran.

Performance against this measure has worsened in most areas over the period shown. In Shetland and Ayrshire and Arran, the number of emergency admissions per 100,000 population increased by 10% and 11% respectively between 2008-09 and 2012-13. In five areas, performance improved – Grampian, Greater Glasgow and Clyde, Lothian, Tayside and Western Isles.

Figure 6: emergency admissions per 100,000 population, 2012-13



Below average performance in this area did appear to have had an influence on resource allocations, with boards developing a wide range of initiatives to tackle this issue. These include:

- Anticipatory care planning
- Local unscheduled care action plans
- Development of Combined Assessment Units
- Joint working with other partners, including GPs, local authorities and the Scottish Ambulance Service
- Hospital at Home services

Some boards mentioned the opportunities offered by the integration of health and social care services to address this issue. Dumfries and Galloway noted their decision to include all hospital services within integration funding reflected the view that improvements in this and other areas can be achieved through a joined up service, avoiding duplication and fragmentation and releasing efficiencies.

All boards felt that it was a useful indicator, although a number noted that it needed to be considered alongside other indicators and that disaggregation e.g. by age, deprivation, reason for admission would provide greater insight.

As with other indicators, boards found it difficult to isolate spending in this specific area. Some provided figures for broader areas of spend e.g. the entire integrated care fund, while others detailed specific capital projects or services. As a result, it is not meaningful to provide any aggregate figures. However, it is interesting to note that, for those boards reporting details of spending, expenditure is planned to increase in 2015-16 for all but one board (Ayrshire and Arran). In Ayrshire and Arran, the reduction reflects lower spending on local unscheduled care action plans in 2015-16.

All boards noted the contribution of other partners in this area, including:

- Local authorities
- GPs
- Scottish Ambulance Service
- NHS 24
- Third sector, including Red Cross

It would be interesting to examine the actions taken to tackle underperformance in this area to identify strategies that have led to success (for example in Greater Glasgow and Clyde and Lothian)

9. Further comments emerging from the survey

The Committee's report last year on the 2014-15 board budget highlighted the need for more consistency in financial data, as comparative analysis was limited by the different approaches adopted by boards in the provision of information. This situation has not been resolved and it appears that information systems are not designed in such a way as to enable ready access to information linking spend to specific performance indicators. It would be interesting to understand whether any action is underway to address this issue. Early indications suggest that this may receive greater focus in reporting required of the IJBs. There is an opportunity for the Committee to highlight the type of information that would be useful to gather in relation to these new organisations.

Annexe

NHS Board Accounts: 2015-16 questionnaire

A: Budget setting process

Performance budgeting

1. Which of the following performance frameworks has the most influence on your budget decisions:
    - National Performance Framework
    - Quality Measurement Framework (including HEAT targets)
    - Other (please specify)

2. Please describe how information on performance influences your budget decisions:

3. Do you consider the performance framework(s) to reflect priorities in your area?

4. Where allocations are made in relation to specific targets, are you able to spend this effectively in the required areas? (please provide examples where relevant)

Integration of health and social care

5. Please set out, as per your integration plans/schemes with each of your partner local authorities, the method under which funding for the joint boards will be determined?

6. What functions will be delegated via the integration plan/scheme? Please explain the rationale for these decisions

7. How much is being allocated to the Integration Joint Board for 2015-16?
    a. by the health board
    b. by local authority partners?

8. Please provide any further comments on budgetary issues associated with integration:

Specific challenges

9. Please provide details of any specific challenges facing your board in 2015-16 in respect of your budget:

B: Increase the proportion of babies with a healthy birth weight

Indicator measure: The proportion of new born babies with a weight appropriate for gestational age

1. How does performance in your area compare with the national performance?

	% of new born babies with a weight appropriate for gestational age	
	Board	Scotland
2009		89.6%
2010		90.0%
2011		90.1%
2012		89.9%
2013		90.1%

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight

2. What factors can help to explain any observed differences in performance?

3. How does performance against this indicator influence budget decisions?

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below.

Programme/service area	Expenditure 2014-15 £'000	Planned expenditure 2015-16 £'000

6. What statutory partners or other partners (if any) contribute towards performance in this area?

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

C: Improve end of life care

Indicator measure: Percentage of the last 6 months of life which are spent at home or in a community setting

1. How does performance in your area compare with the national performance?

	% of last 6 months of life which are spent at home or in a community setting	
	Board	Scotland
2008-09		90.4%
2009-10		90.5%
2010-11		90.7%
2011-12		91.1%
2012-13		91.2%

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare

2. What factors can help to explain any observed differences in performance?

3. How does performance against this indicator influence budget decisions?

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below.

Programme/service area	Expenditure 2014-15 £'000	Planned expenditure 2015-16 £'000

6. What statutory partners or other partners (if any) contribute towards performance in this area?

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

Palliative care and hospice funding

8. Please provide an estimate of spending on palliative care services (as defined by the Scottish Partnership for Palliative Care, here)

	Expenditure 2014-15 £'000	Planned expenditure 2015-16 £'000
Specialist palliative care services		
General palliative care services		

In May 2012, the Scottish Government published new guidance for NHS Boards and independent adult hospices on establishing long-term commissioning arrangements. It stated that funding of agreed specialist palliative and end-of-life care (PELC) should be reached by NHS Boards and independent adult hospices on a 50% calculation of agreed costs. Funding should be agreed for a 3 year period, though this could be longer if appropriate. In addition it indicated intent for NHS Boards and local authorities to jointly meet 25% of the running costs of the independent children's hospices which provide specialist palliative care and respite services for children with life-limiting conditions.

Please provide details of funding agreed by your Board for hospices:

	2014-15	2015-16
Agreed funding for hospice running costs for specialist PELC (£'000)		
£'000		
As % of total hospice funding		
Agreed funding for running costs of independent children's hospices (including local authority funding where relevant)		
£'000		
As % of total independent children's hospice running costs		

9. Please provide any further comments on palliative care / hospice funding that you consider to be relevant:

D: Reduce emergency admissions

Indicator measure: Emergency admissions rate (per 100,000 population)

1. How does performance in your area compare with the national performance?

	Emergency admissions rate (per 100,000 population)	
	Board	Scotland
2009-10		9,849
2010-11		9,874
2011-12		10,090
2012-13		10,130
2013-14 (p)		10,188

Source: http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions

2. What factors can help to explain any observed differences in performance?

3. How does performance against this indicator influence budget decisions?

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the **three** main areas of activity in the table below

Programme/service area	Expenditure 2014-15 £'000	Planned expenditure 2015-16 £'000

6. What statutory partners or other partners (if any) contribute towards performance in this area?

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance