Health and Sport Committee
10th Report, 2013 (Session 4)

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Health and Sport Committee

Remit and membership

Remit:

To consider and report on health policy, the NHS in Scotland, anti poverty measures, equalities, sport and other matters falling within the responsibility of the Cabinet Secretary for Health, Wellbeing and Cities Strategy apart from those covered by the remit of the Economy, Energy and Tourism Committee.

Membership:

Bob Doris (Deputy Convener)
Rhoda Grant
Colin Keir
Richard Lyle
Aileen McLeod
Duncan McNeil (Convener)
Nanette Milne
Gil Paterson
Dr Richard Simpson

Committee Clerking Team:

Clerk to the Committee
Eugene Windsor

Senior Assistant Clerk
Rodger Evans

Assistant Clerk
Myer Cohen

Committee Assistant
Bryan McConachie
The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
10th Report, 2013 (Session 4)

NHS boards budget scrutiny

The Committee reports to the Parliament as follows—

Introduction

1. At its meeting on 19 June 2013, the Health and Sport Committee agreed, as a follow-up to scrutiny of the draft budget, to scrutinise NHS board allocations in spring 2013.

2. This was a continuation of the approach taken in recent years, whereby the Committee had undertaken more detailed budget scrutiny at this stage in the financial year, by which point, board allocations and associated financial plans are finalised.

3. It is recognised that, at the time of the draft budget publication in September, the information available on the planned allocation of the health budget is limited.

4. The Committee’s previous report on budget scrutiny of NHS boards was published on 25 June 2012 and its conclusions included—

   - NHS savings were inherently part of the current picture but quality and consistency of service must be maintained across all boards while allowing for flexibility to meet local needs;

   - The Committee will explore with the boards comparable measures of quality, consistency and flexibility in greater depth in its next round of scrutiny;

   - The Committee will return to consideration of the input of the third sector in the change fund, evaluation of pilot schemes, and the transition from earmarked to mainstream funding;

   - It intended to pursue a more systematic assessment of the balance of additional funding versus cost pressures across the whole system;

   - The Committee would delve more deeply into details of how savings were achieved;
The Committee must be availed of the information necessary to answer fundamental questions;

The Committee was aware that answering survey questions poses additional time costs on boards and ideally the evidence provided would come from existing sources such as the Local Delivery Plans;

The Committee was minded to continue with the survey approach but shifting the focus away from data collection and onto such issues as those highlighted above.

5. The Committee agreed to seek responses again from all NHS boards to a series of questions regarding allocations. Wording of a questionnaire was agreed at its meeting on 16 April 2013.

6. It also agreed that, on the basis of the information received, it would select representatives from a handful of boards to give oral evidence.

7. The Committee took oral evidence on 18 June 2013 from—

- NHS National Waiting Times Centre
- NHS Education for Scotland
- NHS24
- NHS Greater Glasgow and Clyde
- NHS Dumfries and Galloway
- NHS Orkney
- NHS Fife

8. On 25 June 2013, the Committee heard from officials from the Scottish Government Health Directorate.

**Approach**

9. In April 2013, a survey was sent to NHS boards including—

- The 14 boards responsible for planning and providing health care to Scotland’s population within their geographical boundaries, referred to as territorial boards; and

- The eight health boards with specific roles or functions, referred to as special boards.

10. Responses were received from all 22 boards.

11. In order to reduce the quantity of information requested from boards, some financial data and planning assumptions were drawn from the Local Delivery Plans (LDPs) that had been submitted to the Scottish Government.
Findings

12. The Committee’s findings are presented below, captured within two broad headings:

- Financial planning and savings
- Service delivery

Financial planning and savings

Planning assumptions

13. Evidence from the LDPs highlighted wide variation in the planning assumptions adopted by boards in relation to prices in general and, specifically, prescribing costs. Assumptions regarding volumes of drugs also revealed considerable variation.

14. Across the territorial boards, for those boards that had specified their assumptions for 2013-14:

- price inflation assumptions ranged from 1% (Greater Glasgow and Clyde) to 4.3% (Dumfries and Galloway);
- GP prescribing price inflation assumptions ranged from 0.1% (Lanarkshire) to 4% (Greater Glasgow and Clyde)
- hospital drugs price inflation assumptions ranged from 1% (Ayrshire and Arran) to 9.5% (Dumfries and Galloway)
- the assumed increase in the volume of hospital drugs prescribed ranged from 1.3% (Borders) to 9% (Ayrshire and Arran)

15. The Committee questioned the boards about the reasons underlying this wide variation and asked whether the Scottish Government ever queried the reasons for divergence from ‘central’ assumptions.

16. Paul James of NHS Greater Glasgow and Clyde told the Committee—

“...we probably all prepare financial plans on slightly different bases...we have typically used an uplift of 6% for GP prescribing, but this year we used an uplift of 4%...Other boards might not do the same thing.”¹

17. The Committee also suggested that there could be a role for the Scottish Government in setting “central” assumptions, from which boards could only diverge if they were able to provide a coherent justification for this divergence.

18. The boards did not consider the observed variation to be a cause for concern and explained that it reflected different approaches to financial planning, including the treatment of savings from previous years.

¹ Scottish Parliament Health and Sport Committee. Official Report, 18 June 2013, Col 4045
**Planned savings**

19. Boards are asked to provide details of their planned efficiency savings as part of their LDP returns to the Scottish Government. In 2013-14, most territorial boards are assuming 3% efficiency savings. The exceptions are: Highland (4%), Lothian (2%) and Shetland (6%).

20. There is less consistency amongst the special boards, with efficiency savings assumptions ranging from 1% (NHS Education for Scotland) to 6% (National Waiting Times Centre). For most territorial boards, the largest area of savings is “service productivity”, followed by “drugs and prescribing”.

21. Fiona Ramsay of NHS Forth Valley told the Committee—

   “We challenge and share through our pharmacy networks and our financial networks. We are aware of the uplifts and the benchmarking information that is available.”

22. She cited an example of prescription costs and her board learning from the NHS Greater Glasgow and Clyde approach, adding—

   “We share information through all our clinical and financial networks to ensure consistency.”

23. The Scottish Government confirmed that a 3% efficiency saving target remained in place for 2013-14, but emphasised that it wanted boards to avoid taking a “salami-slicing” approach, but rather to target on specific areas for savings.

24. John Matheson told the Committee—

   “If you want to have a conversation with a clinician about a 3% efficiency target, they will have it, but they might well be defensive...However, talking to the same clinician about improving the quality of services will produce a different conversation, and we will be able to get efficiencies on that back of that.”

25. The special boards explained there were some specific circumstances affecting individual boards that affected the comparability of the figures and could account for some of the apparent variations.

26. The territorial boards also indicated local variability. NHS Dumfries and Galloway’s Paul Marriott said—

   “…we might be comparing apples with oranges...We all take slightly different views in our incentive schemes, but they are similar. The national work that is

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2 Scottish Parliament Health and Sport Committee. *Official Report, 18 June 2013, Col 4046*

3 Scottish Parliament Health and Sport Committee. *Official Report, 18 June 2013, Col 4047*

done through the efficiency framework pools the shared learning, so we are all constantly trying to drive down costs.”

27. NHS Education for Scotland emphasised the need to adopt a “bottom-up” approach to identifying opportunities for savings. Caroline Lamb told the Committee—

“…a lot of that is around staff time and staff resources. We try to analyse that to ensure that we are being as efficient and effective as possible across all our areas of spend.”

28. Julie Carter of NHS National Waiting Times Centre said—

“We take a proactive approach to savings. We look at quality…that is our focus. I tend to take a back seat and let the clinical people take things forward, then I come in and we start talking about money.”

29. Witnesses also commented on the increased challenge in identifying areas for future savings, but felt that there were always opportunities.

30. Caroline Lamb told the Committee—

“We plan on a three-year basis, and at present we are struggling to identify the savings that we anticipate we will have to make for 2014-15.”

31. Julie Carter said—

“…we spend a lot of time looking at innovation. Information management and technology services have changed dramatically over the past five years and I am sure they will change over the next five years…There are always better ways of doing things.”

32. The point was also made that existing contracts, for example in relation to accommodation, meant that potential savings could not always be realised in the short term.

33. The Committee challenged witnesses on the level of “unidentified” savings that had been highlighted in the data drawn from LDPs. Lanarkshire, Orkney and NHS Education for Scotland classified around a quarter of their planned efficiency savings as unidentified.

34. However, the Scottish Government highlighted that it monitored levels of both unidentified and high risk savings during the course of the financial year to ensure that any excessive levels of unidentified and/or high risk savings were being addressed. John Matheson told the Committee—

7 Scottish Parliament Health and Sport Committee. Official Report, 18 June 2013, Col 4070
8 Scottish Parliament Health and Sport Committee. Official Report, 18 June 2013, Col 4072
“…we challenge the assessment of those unidentified savings as high, medium or low risk in order to ensure consistency because the assessment is to an extent subjective…We will stay very close to those boards and ensure that they have place and impetus for turning the high-risk savings into medium-risk to low-risk savings to give increased assurance around deliverability, and that they have moved their unidentified savings into specific schemes.”

35. NHS Education for Scotland noted that, by June, it had been able to identify all the required savings. Caroline Lamb said—

“When we submitted our local delivery plan, about £800,000 of our savings were unidentified, but we have now managed to identify all the savings. Essentially, we are looking at areas such as procurement, ensuring that we are maximising the use of national contracts, and looking at how we buy goods”

Non-recurring funding

36. In 2013-14, LDPs showed a total of £355m in non-recurring funding across the territorial boards, accounting for 4% of total revenue allocations. This proportion varied from 1% (Grampian) to 10% (Fife and Lanarkshire) across the territorial boards. There was greater variation in the extent of non-recurring funding for the special boards, with Healthcare Improvement Scotland receiving over a third of its 2013-14 allocation in non-recurring funding.

37. The Scottish Government noted that reliance on non-recurring funding was reducing and it planned to eliminate all reliance on such funding in 2013-14. Several territorial boards spoke positively about brokerage of funds, whereby they could “bank” excess funding with the Scottish Government when there was an expectation additional funds would be required in future years e.g. to support double-running of facilities when a new facility opened.

38. The Scottish Government stressed that such brokerage was “not given lightly” and would only be considered as part of a clear strategy to deal with temporary financial challenges and did not view this as an on-going facility. John Matheson said—

“One issue is the artificial nature of the financial year. If you are trying to plan on a medium to long-term basis…the artificiality of having to hit particular financial targets every 12 months is unhelpful. It might be better to have a rolling statutory target over, say, three years. NHS Forth Valley and NHS Fife recently received brokerage to deal with temporary financial challenges associated with the move into new hospitals, and I was assured – I checked in a very challenging way – that they in place robust financial plans, that the situation was temporary and that they could repay the brokerage and had built that into their financial plans.”

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Earmarked funding

39. The boards receive around £1bn of their funding allocation in the form of earmarked funding, which is ring-fenced for a specific purpose – such as alcohol or drug treatment programmes. A higher proportion of earmarked funding implies less flexibility for boards in how they allocate their funds.

40. According to information presented in LDPs, the proportion of the revenue resource allocation accounted for by earmarked funding in the territorial boards in 2013-14 varies from 9% (Ayrshire and Arran) to 30% (Shetland).

41. The island boards generally have a higher proportion of their funding accounted for by earmarked funding. On average across the territorial boards earmarked funding accounts for 12% of allocations.

42. For the special boards, the extent of earmarked funding is generally lower, with the exception of the National Waiting Times Centre.

43. The Scottish Government emphasised its desire to give boards as much autonomy as possible in the allocation of their budgets and to minimise ring-fencing of budgets. John Matheson said—

“...I have promoted the idea of not giving out individual allocations and micromanaging around inputs, and I have looked to develop the principle of bundling some of those allocations and giving colleagues on boards money around generic themes, such as primary care and mental health, giving them the autonomy to spend the money as appropriate. What is essential, though, is that they still continue to deliver the outcomes and outputs.”

Maintenance backlog

44. Although not the subject of specific questions in the survey, the Committee took the opportunity to ask witnesses about the level of maintenance backlog. Boards referred to the on-going challenge between developing new facilities and maintaining existing facilities.

45. Paul James of NHS Greater Glasgow and Clyde told the Committee—

“The reality is that the bald figure for backlog maintenance for Glasgow needs to be adjusted downwards to take account of the new infrastructure that we will have in place over the next few years. However, I would not want to mislead the Committee, because we still have backlog maintenance and some of our estate is too old.”

46. NHS Dumfries and Galloway’s Craig Marriot outlined plans for “hub development” and “capital aspirations” but said—

“It is a question of taking a twin-pronged approach. We want to do the development to ensure that we hit our 2020 vision and deliver against the equality strategy, and at the same time we want to ensure that we recognise

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that some elements of our estate are ageing and they need to be modernised to provide healthcare facilities that are modern and fit for purpose.”

47. Gerry O’Brien also spoke of the need for that twin-pronged approach for NHS Orkney—

“We need to replace those expensive pieces of equipment, but we need to be mindful of the fact that – we hope – we will be moving to a new facility in five years’ time. We need to determine how we can ensure that we do not invest money that we have to write off over the next four years rather than get the full benefit.”

48. The Scottish Government acknowledged the backlog maintenance figure was high (£948m) but highlighted efforts underway to address the issue, including transfer of resource budgets to the capital budget specifically to address maintenance backlog issues. John Matheson told the Committee—

“Over the next five years, we think that our investment from the capital, plus the disposal of assets, will enable us to cover the high-risk and significant-risk components of the back maintenance challenge.”

49. His colleague John Connaghan said—

“…it will be useful to understand what proportion of the significant risk element is impacting directly on clinical services, what proportion is calculated on redundant buildings that are still on the books but are up for disposal – they are still part of the figure – and how much is in non-essential areas that we can, with good judgement, leave because they do not pose a risk”

50. The Scottish Government also committed to setting out a target figure for next year. On 10 September the Cabinet Secretary for Health and Wellbeing wrote to the Committee with further detail on the maintenance backlog – this can be found in full at Annexe E.

Service delivery

Service development

51. As part of the survey, boards were asked for details of any services that they had withdrawn in 2013-14. Only two examples were given – homeopathy services in Dumfries and Galloway and certain dental services in Tayside.

52. The Committee explored why there were so few examples of services being withdrawn and asked about the monitoring and evaluation of services and how continued effectiveness could be ensured.
53. Boards gave a number of examples of the use of monitoring and evaluation (Dumfries and Galloway, Glasgow). The emphasis appeared to be on service redesign, rather than service withdrawal, with the redirection of savings where appropriate. (Glasgow, Forth Valley).

54. Service productivity was highlighted as one of the main areas for potential savings in 2013-14. The Scottish Government also spoke more in terms of service redesign rather than withdrawal and referred to an evidence base of case studies highlighting examples of service redesign, which included disinvestment where appropriate.  

Prescribing
55. Drugs and prescribing was highlighted by territorial boards as one of the main areas for potential savings in 2013-14 (along with service productivity). Boards outlined a range of initiatives designed to deliver savings on the prescribing budget, including the roll-out of new software to support GPs in prescribing.

56. Some significant savings had been achieved although boards did highlight that such savings could not be repeated year-on-year (Dumfries and Galloway, Glasgow).

57. It is clear from the Committee’s investigations that there is a considerable volume of data in this area that is used for benchmarking purposes. Indicators such as the weighted average prescribing cost are used by boards to inform their activities in this area. There are considerable variations between boards and it was suggested that this is an area that would warrant further investigation by the Committee.

Preventative spend
58. As part of the survey, boards were asked to provide details of specific preventative health programmes included in their budget plans for 2013-14. The information provided was in different formats, making it difficult to make direct comparisons between boards, but the general picture was of spending on preventative spend programmes remaining constant between 2012-13 and 2013-14.

59. The services identified appeared to suggest that boards were spending around 1% of their budget on programmes that were classified as “preventative” (before accounting for Change Fund expenditure); however, as the Committee has noted in the past, the term “preventative spending” can be interpreted in many ways and boards seem to have used a fairly strict public health based definition of the term.

60. In the survey, boards were also asked whether they made any attempt to model the potential savings from preventative spend programmes. The majority of boards made reference to the difficulties in modelling savings with any degree of

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precision and noted that any savings were unlikely to be delivered within the five year planning framework.

61. In oral evidence to the Committee, territorial boards re-iterated the point that the timeframe for financial planning would not be long enough to capture potential savings from preventative spend, but highlighted also work that was underway to improve financial monitoring in this area.

62. NHS Dumfries and Galloway’s Craig Marriott said—

“From a director of finance’s perspective, preventative spend is always one of those things that are just outwith my financial plan in terms of any changes that are going to come forward. The reality is, though, that we need to work closely with commissioners and service providers to consider what it will mean for us further down the line.”

63. NHS Orkney’s Gerry O’Brien told the Committee—

“…we have not yet factored in any financial consequences of the preventative spend…We are doing a lot of work with the board on how we use the preventative and population health agendas to determine which of the services that we currently provide we should continue to provide in the future.”

64. Fiona Ramsay of NHS Forth Valley said—

“…although the preventative agenda might not help us to release cash, it will help us to be sustainable in the long term.”

65. The Scottish Government highlighted patient safety as part of the preventative agenda and also “connectivity with local authorities” via the Early Year Collaborative. John Matheson spoke of the energy with which practitioners were looking at developmental milestones at 30 months and nursery leaving age—

“The aim is to reduce the 30% figure [of children not reaching those milestones] by 50% by two and a half years and then by two thirds by the time children leave nursery.”

Integration

66. NHS Education for Scotland talked of the need to get integration “working operationally and culturally” via partnerships. Caroline Lamb told the Committee—

“We have been working closely with the Scottish Social Services Council for the past three years and have a memorandum of understanding with it and a joint action plan. That work is about bringing together the resources and

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expertise from two organisations to start to identify the areas in which we will need to work together in the future.”

67. On the subject of resource transfer and trying to move resources tied up with acute care, Gerry O’Brien of NHS Orkney said—

“The money does not necessarily need to come back to us to go back out again; we would be more than happy for it to stay in the [integrated] partnership. That is £2m in the equation that is tied up in traditional services at the moment.”

68. The Scottish Government underlined the importance of its annual discussion on uplift and resource transfer. John Matheson told the Committee—

“We work closely with board and local authority colleagues to ensure that there is clarity on what resource transfer is delivering.”

69. He suggested that via the agenda of the Public Bodies (Joint Working) (Scotland) Bill, the discussion of resource transfer would be—

“...incorporated within a much broader discussion about the integration of some of the acute health service budgets with social care budgets.”

Areas for future investigation by the Committee

70. The Committee has agreed to repeat the survey of NHS boards in 2014 as part of its scrutiny of the 2014-15 budget. This will build on the experience of previous surveys as well as focusing in on particular areas that are of interest to the Committee.

71. Information that can be drawn from LDPs and therefore provides a basis for comparative analysis includes:

- Earmarked and non-recurring funding
- Planning assumptions in relation to pay, prices and prescribing prices/volumes
- Efficiency savings

72. These are areas that would warrant continued analysis as part of the survey of boards in 2014-15.

73. It was evident from the Committee session with boards that there was further useful benchmarking information relating to prescribing that could inform more detailed scrutiny in the 2014-15 survey.

74. Maintenance backlog expenditure is another area that is of continued interest and could be a potential issue for consideration in the 2014-15 survey.

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26 Scottish Parliament Health and Sport Committee. Official Report, 18 June 2013, Col 4075-76
Conclusions

75. The Committee welcomes the constructive way in which NHS boards and the Scottish Government Health Directorate have engaged with the Committee’s 2013 questionnaire and its recommendations from last year’s report on NHS Boards Budget Scrutiny; including requests for more detail and clarity in addressing key questions about spending decisions, efficiency of services, quality of outcomes for patients, and planning for change.

76. The Committee recognises the balance that must be struck between making necessary savings and efficiencies, allowing flexibility for boards to meet local needs, and ensuring quality and consistency of NHS services across Scotland.

77. The measure and quality of outcomes (rather than outputs or inputs) is absolutely crucial to the Committee’s ability to arrive at any reasonable assessment of the efficacy of NHS budgetary allocation, prioritisation and spending. The Committee will revisit the matter in next year’s work with the boards.

78. Backlog maintenance has been something of a recurring theme of the Committee’s NHS boards budget scrutiny in the last two years and one to which it will doubtless return in 2014. The Committee will also seek the views of its newly appointed budget adviser to inform its overall approach to next year’s scrutiny of the boards.

79. In broad terms, though, the Committee will continue to make use of Local Delivery Plans and its survey approach established in recent years. The LDPs offer three lines of inquiry: earmarked and non-recurring funding; planning assumptions in relation to pay, prices and prescribing; and efficiency savings. Regarding the questionnaire, officials will also be tasked with liaising with a selection of boards, territorial and special, in order to explore further avenues of potentially useful questioning and meaningful scrutiny.
ANNEXE A: EXTRACT FROM MINUTES OF THE HEALTH AND SPORT COMMITTEE

11th Meeting, 2013 (Session 4)
Tuesday 16 April 2013

1. **Decision on taking business in private**: The Committee agreed to take item 5 in private.

5. **NHS Boards Budget Scrutiny**: The Committee agreed its approach.

18th Meeting, 2013 (Session 4)
Tuesday 4 June 2013

1. **Decision on taking business in private**: The Committee agreed to take items 4 and 6 in private.

6. **NHS Boards Budget Scrutiny**: The Committee considered and agreed its approach.

20th Meeting, 2013 (Session 4)
Tuesday 18 June 2013

5. **NHS boards budget scrutiny**: The Committee took evidence from—

   Craig Marriott, Director of Finance, NHS Dumfries and Galloway;

   Paul James, Executive Director and Director of Finance, NHS Greater Glasgow and Clyde;

   Fiona Ramsay, Director of Finance and Planning, NHS Forth Valley;

   Gerry O’Brien, Director of Finance, NHS Orkney;

   Robert Stewart, Director of Finance and Technology, NHS 24;

   Caroline Lamb, Director of Finance and Corporate Resources/Deputy Chief Executive, NHS Education for Scotland;

   Julie Carter, Director of Finance, National Waiting Times Centre.
22nd Meeting, 2013 (Session 4)
Tuesday 25 June 2013

3. **NHS boards budget scrutiny**: The Committee took evidence from—

   John Matheson, Director of Finance, eHealth and Pharmaceuticals,  
   John Connaghan, Director of Health Workforce and Performance, and  
   Linda Semple, Head of Efficiency and Productivity Portfolio Office,  
   Scottish Government.

29th Meeting, 2013 (Session 4)
Tuesday 8 October 2013

4. **NHS boards budget scrutiny (in private)**: The Committee considered a  
   draft report.
ANNEXE B: ORAL EVIDENCE AND ASSOCIATED WRITTEN EVIDENCE

11th Meeting, 2013 (Session 4) Tuesday 16 April 2013

Written Evidence

Oral Evidence

18th Meeting, 2013 (Session 4) Tuesday 4 June 2013

Written Evidence

Oral Evidence

20th Meeting, 2013 (Session 4) Tuesday 18 June 2013

Written Evidence

NHS Dumfries and Galloway
NHS Greater Glasgow and Clyde
NHS Forth Valley
NHS Orkney
NHS 24
NHS Education for Scotland

Oral Evidence

NHS Dumfries and Galloway;
NHS Greater Glasgow and Clyde;
NHS Forth Valley;
NHS Orkney;
NHS 24;
NHS Education for Scotland;
National Waiting Times Centre.

22nd Meeting, 2013 (Session 4) Tuesday 25 June 2013

Written Evidence

Oral Evidence

Scottish Government
ANNEXE C: LIST OF OTHER WRITTEN EVIDENCE

Golden Jubilee
NHS Healthcare Improvement Scotland
Scottish Ambulance Service
The State Hospital
NHS National Services Scotland
NHS Health Scotland
NHS Ayrshire and Arran
NHS Borders
NHS Fife
NHS Grampian
NHS Highland
NHS Lanarkshire
NHS Lothian
NHS Shetland
NHS Tayside
NHS Western Isles
ANNEXE D: QUESTIONNAIRE SUMMARY

Report on the survey of NHS Board 2013-14 budget plans

Prepared by Financial Scrutiny Unit, SPICe
with input from Dr Andrew Walker, University of Glasgow

Context
The 2013-14 Draft Budget\(^{30}\) allocated a total of £11,977.8m to the health and wellbeing portfolio, representing no change in real terms on the 2012-13 budget. Just over three-quarters of this total (£9,124.8m) was allocated to the 22 NHS boards. In February 2013, final allocations to territorial and special boards were confirmed and are set out in Table 1.

Table 1: Board allocations as at February 2013

<table>
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<tr>
<th>Revenue Resource Allocation £m</th>
<th>% change on 2012-13</th>
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<tbody>
<tr>
<td><strong>Territorial Boards</strong></td>
<td></td>
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<tr>
<td>Ayrshire and Arran</td>
<td>603.4</td>
</tr>
<tr>
<td>Borders</td>
<td>175.4</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>253.3</td>
</tr>
<tr>
<td>Fife</td>
<td>539.5</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>434.2</td>
</tr>
<tr>
<td>Grampian</td>
<td>743.8</td>
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<tr>
<td>Greater Glasgow and Clyde</td>
<td>1,995.1</td>
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<tr>
<td>Highland</td>
<td>509.8</td>
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<tr>
<td>Lanarkshire</td>
<td>865.1</td>
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<tr>
<td>Lothian</td>
<td>1,141.2</td>
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<tr>
<td>Orkney</td>
<td>34.3</td>
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<tr>
<td>Shetland</td>
<td>38.7</td>
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<tr>
<td>Tayside</td>
<td>629.1</td>
</tr>
<tr>
<td>Western Isles</td>
<td>60.7</td>
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<tr>
<td><strong>Territorial Boards total</strong></td>
<td><strong>8,023.6</strong></td>
</tr>
<tr>
<td><strong>Special Boards</strong></td>
<td></td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>44.7</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>207.6</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>281.7</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>15.9</td>
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<tr>
<td>The State Hospital</td>
<td>33.6</td>
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<tr>
<td>NHS 24</td>
<td>61.5</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>390.4</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>18.5</td>
</tr>
<tr>
<td><strong>Special Boards total</strong></td>
<td><strong>1,053.9</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,077.5</strong></td>
</tr>
</tbody>
</table>

For the territorial boards, these revenue allocations represented an average increase of 3.3%, while for the special boards, the revenue allocations represented an average increase of 0.2%.

The Health and Sport Committee has undertaken surveys of NHS Health Board budget plans in both 2010-11 and 2012-13. In both years, the Committee has used the findings from these surveys as the basis for taking evidence from representatives of selected health boards to provide a more detailed insight into spending plans. This reflects the fact that, at the time of the draft budget in the September prior to the start of the financial year, there is no information available on the spending plans of the NHS boards. The draft budget only provides information on the planned allocations to the health boards, which means that for more than three-quarters of the total health budget, there is no detailed information on planned spending. This means that the budget scrutiny that takes place following the publication of the draft budget cannot provide an in-depth examination of spending plans at local level.

**Approach**

Building on the experience of previous surveys, and reflecting the views expressed in the Committee’s report, the 2013-14 survey was amended to try to seek clarity and consistency in the questions and also to reduce the amount of information requested from Boards. In order to reduce the quantity of information requested, some financial data and planning assumptions were drawn from the Local Delivery Plans (LDPs) that had been submitted to the Scottish Government. Some additional questions were included to reflect areas that were of particular interest to the Committee.

The questionnaire (attached at Appendix A) was sent out to the 14 territorial NHS boards and 8 special NHS boards on 19 April 2013 for return by 7 May 2013. Responses were received from all 22 boards. Analysis was undertaken by Nicola Hudson and Andrew Aiton of the Financial Scrutiny Unit, SPICe with input from Dr Andrew Walker from the University of Glasgow. Findings from both the analysis of survey responses and analysis of LDPs are summarised below. Where relevant, analysis is given for both territorial and special boards, although it should be noted that in some cases analysis focuses solely on territorial boards as not all questions were relevant to special boards.

**Earmarked funding**

The boards receive around £1bn of their funding allocation in the form of earmarked funding, which is ring-fenced for a specific purpose, such as alcohol or drug treatment programmes. A higher proportion of earmarked funding implies less flexibility for boards in how they allocate their funds. According to information presented in LDPs, the proportion of the revenue resource allocation accounted for by earmarked funding in the territorial boards in 2013-14 varies from 9% (Ayrshire and Arran) to 30% (Shetland). The island boards generally have a higher proportion of their funding accounted for by earmarked funding. On
average, across the territorial boards, earmarked funding accounts for 12% of allocations. For the special boards, the extent of earmarked funding is generally lower, with the exception of the National Waiting Times Centre. The 2012-13 survey also asked for information on earmarked funding. This also showed that earmarked funding represented 12% of board budgets. Although drawn from a different source and so possibly using different definitions, this comparison does suggest that there has been no marked change in the significance of earmarked funding to board budgets.

**Figure 1: Earmarked funding as % of total revenue allocation, 2013-14**

<table>
<thead>
<tr>
<th>Region</th>
<th>Earmarked Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>9.4%</td>
</tr>
<tr>
<td>Borders</td>
<td>10.5%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>10.9%</td>
</tr>
<tr>
<td>Fife</td>
<td>9.9%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>11.2%</td>
</tr>
<tr>
<td>Grampian</td>
<td>14.5%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>12.7%</td>
</tr>
<tr>
<td>Highland</td>
<td>15.9%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>10.5%</td>
</tr>
<tr>
<td>Lothian</td>
<td>12.3%</td>
</tr>
<tr>
<td>Orkney</td>
<td>24.9%</td>
</tr>
<tr>
<td>Shetland</td>
<td>30.1%</td>
</tr>
<tr>
<td>Tayside</td>
<td>13.9%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>24.4%</td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>29.4%</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>0.8%</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>6.3%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>0.1%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>1.1%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>2.0%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>1.1%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>4.2%</td>
</tr>
</tbody>
</table>
Members may wish to consider:

- which programmes are being awarded ‘earmarked funding status’
- what the Scottish Government’s criteria are for this type of funding
- how such spending is monitored and evaluated; and
- whether the Scottish Government might recommend any changes to the programmes covered or to the way the current system works

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 some circumstances, this can be a response to planned spending on another programme being behind schedule leaving a potential underspend. However, in its annual overviews of NHS financial performance, Audit Scotland has raised concerns about boards relying on non-recurring funding to cover a recurring financial deficit.32

In 2013-14, LDPs show a total of £355m in non-recurring funding across the territorial boards, accounting for 4% of total revenue allocations. This proportion varies from 1% (Grampian) to 10% (Fife and Lanarkshire) across the territorial boards. Fife and Lanarkshire also had above average shares of non-recurring funding last year (although possibly on different definitions). There is greater variation in the extent of non-recurring funding for the special boards, with Healthcare Improvement Scotland receiving over a third of its 2013-14 allocation in non-recurring funding.

Members may wish to ask:

- why some boards have higher non-recurring allocations than others and whether this situation has persisted over several years (Fife, Lanarkshire and several of the special boards)
- whether the non-recurring allocations are being used to address recurring deficits and, if so, what action is being taken to ensure the same pattern is not seen in 2014-15

Figure 2: Non-recurring funding as % of total allocation, 2013-14

- Ayrshire and Arran: 3.7%
- Borders: 2.2%
- Dumfries and Galloway: 1.5%
- Fife: 9.9%
- Forth Valley: 2.3%
- Grampian: 1.1%
- Greater Glasgow and Clyde: 3.0%
- Highland: 6.4%
- Lanarkshire: 9.9%
- Lothian: 3.8%
- Orkney: 8.3%
- Shetland: 4.4%
- Tayside: 4.0%
- Western Isles: 3.3%

- National Waiting Times Centre: 7.2%
- Scottish Ambulance Service: 2.0%
- National Services Scotland: 21.6%
- Healthcare Improvement Scotland: 36.3%
- The State Hospital: -0.1%
- NHS 24: 20.7%
- NHS Education for Scotland: 2.0%
- NHS Health Scotland: 17.0%
Cost pressures

As part of their LDP submissions to the Scottish Government, 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.

Table 2: Planning assumptions, 2013-14

<table>
<thead>
<tr>
<th>Territorial Boards</th>
<th>Pay</th>
<th>Prices</th>
<th>Assumptions</th>
<th>GP prescribing</th>
<th>Hospital drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Base uplift</td>
<td>Price</td>
<td>Volume</td>
<td>Price</td>
<td>Volume</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>1.00%</td>
<td>2.00%</td>
<td>0.00%</td>
<td>2.50%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Borders</td>
<td>0.99%</td>
<td>2.10%</td>
<td>1.29%</td>
<td>3.37%</td>
<td>3.78%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>1.00%</td>
<td>4.30%</td>
<td>0.20%</td>
<td>2.70%</td>
<td>9.50%</td>
</tr>
<tr>
<td>Fife</td>
<td>1.00%</td>
<td>4.09%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>1.00%</td>
<td>3.00%</td>
<td>0.00%</td>
<td>3.00%</td>
<td>10.00%</td>
</tr>
<tr>
<td>Grampian</td>
<td>1.00%</td>
<td>1.05%</td>
<td>0.60%</td>
<td>4.25%</td>
<td>5.50%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>1.00%</td>
<td>1.00%</td>
<td>4.00%</td>
<td>3.00%</td>
<td>7.80%</td>
</tr>
<tr>
<td>Highland</td>
<td>1.00%</td>
<td>1.85%</td>
<td>3.00%</td>
<td>3.50%</td>
<td>6.30%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>0.95%</td>
<td>2.64%</td>
<td>0.14%</td>
<td>3.50%</td>
<td>5.25%</td>
</tr>
<tr>
<td>Lothian</td>
<td>1.00%</td>
<td>1.1% - 2.7%</td>
<td>7.63%</td>
<td>0.00%</td>
<td>4.42%</td>
</tr>
<tr>
<td>Orkney</td>
<td>1.00%</td>
<td>0.00%</td>
<td>3.00%</td>
<td>1.75%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Shetland</td>
<td>1.00%</td>
<td>3.00%</td>
<td>0.00%</td>
<td>3.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Tayside</td>
<td>1.00%</td>
<td>1.77%</td>
<td>2.53%</td>
<td>2.77%</td>
<td>2.59%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>1.00%</td>
<td>2.00%</td>
<td>4.60%</td>
<td>6.00%</td>
<td></td>
</tr>
</tbody>
</table>

In relation to pay, the responses were consistent across boards, with all boards assuming a 1% increase in pay, reflecting the agreed pay policy.

There was much wider variation in relation to assumptions about price inflation. Across the territorial boards, for those boards that had specified their assumptions, the price inflation assumption for 2013-14 ranges from 1% (Greater Glasgow and Clyde) to 4.3% (Dumfries and Galloway). No further detail is provided, so it is not possible from the LDPs to establish any rationale for the variation in assumed inflation.

For territorial boards, there was also considerable variation in the assumptions made regarding price and volume increases for GP prescribing and hospital drugs. Some boards did not appear to have separated out their assumptions for price and volume and just gave one combined figure. Discounting these boards, the GP prescribing price inflation assumption ranges from 0.1% (Lanarkshire) to 4% (Greater Glasgow and Clyde). In terms of the assumption about volume of GP prescribing, the responses show less variation, ranging between 2% and 4.25%. Again, there is no detail to explain the basis for these assumptions and so it is not possible to explain the variation on the basis of these figures alone.

In terms of hospital drugs, the variation in price assumptions is even wider, from a 1% assumed increase in 2013-14 (Ayrshire and Arran) to a 9.5% assumed increase (Dumfries and Galloway). Again, boards that appear to have provided a single assumption combining price and volume have been discounted. In terms of the volume of hospital drugs, assumed increases range from 1.3% (Borders) to
9% (Ayrshire and Arran). It is possible that boards have taken different approaches in assessing price and volume measures and that the combination of the two offers a more meaningful comparison, but again, there is insufficient detail to establish whether this is the case.

Members may wish to consider:

- why there is considerable variation in the planning assumptions and how much of this can be justified by local factors
- whether there is a role for the Scottish Government in suggesting planning assumptions for the whole system (from which boards could justify why they made a different assumption)?
- whether the Scottish Government has made any assessment of predictions versus out-turn in previous years – do some boards consistently ‘get it wrong’ and is anything being done to address this?

Efficiency savings

Boards are asked to provide details of their planned efficiency savings as part of their LDP returns to the Scottish Government. In 2013-14, most territorial boards are assuming 3% efficiency savings. The exceptions are: Highland (4%), Lothian (2%) and Shetland (6%). There is less consistency amongst the special boards, with efficiency savings assumptions ranging from 1% (NHS Education for Scotland) to 6% (National Waiting Times Centre).

Boards are also asked to specify where they expect to achieve these savings. Table 4 sets out the planned savings by category and Figure 3 shows how this varies between boards, highlighting considerable variation in the profile of planned savings between boards.
### Table 3: Planned efficiency savings, 2013-14

<table>
<thead>
<tr>
<th>Territorial Boards</th>
<th>Planned efficiency savings, £m</th>
<th>Efficiency savings as % of revenue allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>18.1</td>
<td>3.0%</td>
</tr>
<tr>
<td>Borders</td>
<td>5.1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>7.5</td>
<td>3.0%</td>
</tr>
<tr>
<td>Fife</td>
<td>16.2</td>
<td>3.0%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>13.2</td>
<td>3.0%</td>
</tr>
<tr>
<td>Grampian</td>
<td>22.3</td>
<td>3.0%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>59.9</td>
<td>3.0%</td>
</tr>
<tr>
<td>Highland</td>
<td>18.4</td>
<td>3.6%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>26.0</td>
<td>3.0%</td>
</tr>
<tr>
<td>Lothian</td>
<td>27.8</td>
<td>2.4%</td>
</tr>
<tr>
<td>Orkney</td>
<td>1.0</td>
<td>3.0%</td>
</tr>
<tr>
<td>Shetland</td>
<td>2.4</td>
<td>6.2%</td>
</tr>
<tr>
<td>Tayside</td>
<td>21.0</td>
<td>3.3%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>1.8</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Total territorial boards</strong></td>
<td><strong>240.8</strong></td>
<td><strong>3.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special Boards</th>
<th>Planned efficiency savings, £m</th>
<th>Efficiency savings as % of revenue allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Waiting Times Centre</td>
<td>2.6</td>
<td>5.9%</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>7.1</td>
<td>3.4%</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>8.5</td>
<td>3.0%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>0.9</td>
<td>5.4%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>1.0</td>
<td>3.1%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>3.0</td>
<td>4.8%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>3.0</td>
<td>0.8%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>1.0</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Total special boards</strong></td>
<td><strong>27.1</strong></td>
<td><strong>2.6%</strong></td>
</tr>
</tbody>
</table>
## Table 4: Planned efficiency savings by type, £’000, 2013-14

<table>
<thead>
<tr>
<th>Territorial boards</th>
<th>Service productivity</th>
<th>Drugs and prescribing</th>
<th>Procurement</th>
<th>Workforce</th>
<th>HR</th>
<th>Other shared services</th>
<th>Support services (non-clinical)</th>
<th>Estates and facilities</th>
<th>Unidentified savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>9,277</td>
<td>4,981</td>
<td>600</td>
<td>1,900</td>
<td>-</td>
<td>75</td>
<td>753</td>
<td>542</td>
<td>-</td>
</tr>
<tr>
<td>Borders</td>
<td>1,300</td>
<td>1,070</td>
<td>783</td>
<td>405</td>
<td>-</td>
<td>-</td>
<td>1,000</td>
<td>563</td>
<td>-</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>2,571</td>
<td>2,013</td>
<td>783</td>
<td>783</td>
<td>-</td>
<td>-</td>
<td>52</td>
<td>835</td>
<td>550</td>
</tr>
<tr>
<td>Fife</td>
<td>6,476</td>
<td>7,520</td>
<td>1,121</td>
<td>378</td>
<td>-</td>
<td>-</td>
<td>185</td>
<td>548</td>
<td>-</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>6,032</td>
<td>1,588</td>
<td>596</td>
<td>2,644</td>
<td>-</td>
<td>-</td>
<td>468</td>
<td>1,341</td>
<td>500</td>
</tr>
<tr>
<td>Grampian</td>
<td>1,950</td>
<td>4,600</td>
<td>3,727</td>
<td>3,242</td>
<td>30</td>
<td>70</td>
<td>500</td>
<td>8,195</td>
<td>-</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>30,344</td>
<td>26,215</td>
<td>2,106</td>
<td>385</td>
<td>-</td>
<td>-</td>
<td>590</td>
<td>260</td>
<td>-</td>
</tr>
<tr>
<td>Highland</td>
<td>7,717</td>
<td>1,490</td>
<td>2,902</td>
<td>1,822</td>
<td>-</td>
<td>-</td>
<td>3,657</td>
<td>1,268</td>
<td>-</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>7,398</td>
<td>4,045</td>
<td>2,753</td>
<td>3,230</td>
<td>-</td>
<td>-</td>
<td>740</td>
<td>1,673</td>
<td>6,114</td>
</tr>
<tr>
<td>Lothian</td>
<td>12,267</td>
<td>4,926</td>
<td>4,085</td>
<td>3,161</td>
<td>-</td>
<td>-</td>
<td>1,436</td>
<td>1,957</td>
<td>-</td>
</tr>
<tr>
<td>Orkney</td>
<td>225</td>
<td>186</td>
<td>75</td>
<td>55</td>
<td>-</td>
<td>-</td>
<td>225</td>
<td>50</td>
<td>243</td>
</tr>
<tr>
<td>Shetland</td>
<td>973</td>
<td>200</td>
<td>78</td>
<td>454</td>
<td>-</td>
<td>-</td>
<td>237</td>
<td>251</td>
<td>172</td>
</tr>
<tr>
<td>Tayside</td>
<td>6,000</td>
<td>1,500</td>
<td>1,000</td>
<td>7,000</td>
<td>-</td>
<td>4,000</td>
<td>500</td>
<td>1,000</td>
<td>-</td>
</tr>
<tr>
<td>Western Isles</td>
<td>678</td>
<td>218</td>
<td>195</td>
<td>352</td>
<td>-</td>
<td>-</td>
<td>47</td>
<td>68</td>
<td>270</td>
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<tr>
<td>Special boards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>1,188</td>
<td>161</td>
<td>632</td>
<td>50</td>
<td>-</td>
<td>-</td>
<td>367</td>
<td>245</td>
<td>-</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>3,832</td>
<td>-</td>
<td>1,330</td>
<td>1,510</td>
<td>-</td>
<td>-</td>
<td>328</td>
<td>100</td>
<td>-</td>
</tr>
<tr>
<td>National Services Scotland</td>
<td>4,395</td>
<td>-</td>
<td>1,183</td>
<td>1,944</td>
<td>-</td>
<td>-</td>
<td>423</td>
<td>507</td>
<td>-</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>-</td>
<td>-</td>
<td>47</td>
<td>560</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>259</td>
<td>-</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>-</td>
<td>14</td>
<td>73</td>
<td>893</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>NHS 24</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,905</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,050</td>
<td>-</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>616</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>764</td>
<td>832</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>639</td>
<td>-</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>270</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

## Figure 3: Planned efficiency savings by type, % of total, 2013-14

![Figure 3: Planned efficiency savings by type, % of total, 2013-14](image-url)
Some points to note are:

- For most territorial boards, the largest area of savings is ‘service productivity’, followed by ‘drugs and prescribing’. Together, these two categories account for more than three quarters of planned savings in Ayrshire and Arran, Fife and Greater Glasgow and Clyde. For Greater Glasgow and Clyde, this implies more than £56m of savings in these areas.

- Grampian shows a different pattern of planned savings, with 37% of savings (£8m) planned to come from ‘estates and facilities’.

- Borders, Highland and Orkney plan to achieve around a fifth of their savings through non-clinical support services.

- Workforce savings account for a third of planned efficiency savings in Tayside (£7m) and around a fifth of savings in Forth Valley, Shetland and the Western Isles.

- Lanarkshire, Orkney and NHS Education for Scotland have classified around a quarter of their planned efficiency savings as unidentified. In Lanarkshire, this represents £6m of unidentified savings.

- Four of the special boards (National Waiting Times Centre, Scottish Ambulance Service, National Services Scotland, NHS Health Scotland) are most reliant on service productivity for their planned efficiency savings.

- Healthcare Improvement Scotland, the State Hospital and NHS 24 plan to achieve the majority of their savings through workforce efficiencies.
Members may wish to consider:

- The reasons for the considerable variation in planned efficiency savings between boards

- How the Scottish Government seeks to ensure savings are being pursued consistently across boards? For example GG&C plan £30m of savings on workforce productivity and Ayrshire & Arran plan £3m – but GG&C does not have ten times as many people or ten times the budget of A&A.

- How are planned savings in relation to estates and facilities to be achieved in the light of a £1bn maintenance backlog identified by Audit Scotland?

- The level of unidentified savings in some boards – is this due to the timing of the survey or are they still unidentified?

- Through its Efficiency and Productivity workstream does the Scottish Government have a view of how efficient or inefficient each board is on each of these headings in the first place? Are continued savings on this scale realistic?

Service development

Boards were asked to provide details of three service developments (other than national programmes) that they had been able to fund in 2013-14. As might be expected, the list was quite broad, but some common themes to emerge included:

- At least nine of the territorial boards stated that they had funded additional staff in particular speciality areas (other boards may also have done this, but it was not always clear from responses whether additional capacity included staff)

- At least seven territorial boards funded new speciality units, sometimes involving new infrastructure. Examples included a new palliative care unit (Borders), a learning disabilities unit (Fife), a low secure forensic unit (Fife), an emergency care centre (Grampian), medium secure units (Grampian and Highland), an acute mental health unit (Highland) and an acute medical unit (Tayside)

- Eight territorial boards mentioned additional investment in mental health services

- A number of boards mentioned developments to improve patient management, including patient management systems (Greater Glasgow and Clyde), a business intelligence tool (Tayside), electronic medical records and digital pens (both Western Isles)

Boards were also asked to state what services would be next on their list of priorities. Again, responses were varied, although three territorial boards (Borders, Dumfries and Galloway and Fife) stated that all priorities had been
funded, or that their existing plans took account of available resources, so that no specific services could be identified. For other boards, there were few common themes with a couple of exceptions:

- Infrastructure – at least five territorial boards mentioned a desire to invest in additional infrastructure
- Services for older patients – two territorial boards mentioned services for older patients as a particular priority

Comparing these responses to the responses to similar questions in the previous year’s survey shows limited overlap i.e. the services which are to be funded in 2013-14 do not correlate closely with those that boards were wanting to fund in 2012-13, nor is there much overlap in the ‘wish lists’. This could mean that priorities have shifted, or that asking for only three services reduces the scope for overlap.

Finally, boards were asked about any services that had been withdrawn in 2013-14. Only two boards said that they had had to withdraw services. These were:

- access to externally provided homeopathy services for new patients (Dumfries and Galloway)
- relocation of underutilised dental services (Tayside)

Lothian also noted that the ‘ongoing process of service redesign…inevitably changes the shape of services and how these are delivered’.

Members may wish to consider:

- Why there are so few disinvestments in services that are not effective.
- What proportion of spending on services in NHS Scotland has been evaluated to see if they are effective? Of this, what proportion of services were found to be ineffective?
- Boards expressed a desire to invest in infrastructure – what types of spending are being deferred and what is the Scottish Government’s assessment of the problems that may be stored up for the future?
- Does the Scottish Government have an infrastructure strategy for the health service to ensure vital spending is maintained?

**Preventative spend**

Boards were asked to provide details of specific preventative health programmes included in their budget plans for 2013-14. Boards provided information in different formats, making it difficult to make direct comparisons between boards. For the territorial boards, preventative spend generally included:

- Smoking prevention/cessation
- Weight management (child/adult)
- Childsmile
- Keep Well
- Maternal and infant nutrition
- Blood borne virus prevention
- Immunisation programmes
- Screening programmes
- Sexual health programmes
- Drug and alcohol programmes

Where information was provided, the general picture was of spending remaining constant between 2012-13 and 2013-14. The services identified appeared to suggest that boards were spending around 1% of their budget on programmes that were classified as ‘preventative’ (before accounting for Change Fund expenditure); however, this figure should be interpreted with caution – as the Committee has noted in the past, the term “preventative spending” can be interpreted in many ways and NHS boards seem to have used a fairly strict ‘public health’-based definition of the term.

Boards were also asked whether they made any attempt to model the potential savings from preventative spend programmes. The majority of boards made reference to the difficulties in modelling savings with any degree of precision and also noted that any savings were unlikely to be delivered within the five year planning framework. Comments included:

“…evidencing cost savings is difficult as many of the benefits are secured only in a medium to long term basis”

“…decisions on whether to proceed with a preventative spending initiative are normally made around the clinical evidence base for the programme rather than on financial considerations.” (Grampian and Highland)

“…a prudent approach to the financial benefit is taken and no assumption of cost reductions are included in plans in subsequent years.” (Fife)

NHS Dumfries and Galloway referred to the commissioning of a detailed project evaluation team, while NHS Borders thought that work on how to identify longer term savings would be best undertaken on a national basis.

NHS Highland stated that it looked to identify a 3:1 return on investment, but went on to note that “to date, it has proven challenging to define a direct relationship between individual project activity and changes in activity.”

NHS Orkney referred to a specific piece of work to review the impact of telecare installations which identified savings of £125,000 per annum achieved through
reduced hospital bed days, care home bed days and a lower number of independent living packages and residential care home packages.

Boards did not give any specific examples of how modelling was reflected in financial plans, mostly stating that the longer term nature of savings from preventative spend means that it is not appropriate to reflect savings within the five year planning framework. No boards made any comment as to when they would expect to be able to start reflecting savings. NHS Orkney did provide an example of how longer term planning reflects the impact of preventative spend, citing the planning for future bed numbers in the replacement Balfour Hospital facility. They explained that this facility would be planned on the assumption of static bed numbers (48 beds), which can only be achieved if patterns of care change and preventative spend achieves a reduced demand for hospital beds. They are working on the assumption that preventative programmes will result in 10 fewer beds being required than in a ‘do nothing’ scenario.

The special boards also gave examples of spending on preventative programmes although, as would be expected, these reflected the unique characteristics of the special boards and their particular remits and responsibilities. Examples given of specific programmes included:

- NHS Inform – portal for patient to access health information (NHS 24)
- "Be Ready For Winter/Easter" campaign (NHS 24)
- Spending on Health Protection Scotland (NHS National Services Scotland)

NHS Health Scotland made the point that its entire budget could be viewed as preventative spend.

In terms of modelling the impact of preventative spend programmes, a number of special boards (NHS 24, NHS National Services Scotland and NHS Education for Scotland made the valid point that savings from their spend on preventative programmes would benefit the territorial boards, rather than delivering savings in their own budget.

Members may wish to:

- Examine examples of interesting practice e.g. Dumfries and Galloway evaluation team, NHS Highland looking for 3:1 return on investment
- It seems that boards see the savings of preventative spending in terms of more productive use of resources (e.g. avoiding admissions). For planning and oversight of past spending it would be helpful if this could be quantified. The Scottish Government seem best placed to lead the development of a method to do this so what are their views and will they commit to doing it?
- Examine further the comment that preventative spending decisions are made on clinical rather than financial grounds. Desirable as this may be, costs (and savings) must be a factor when budgets are so limited. Should Scottish Government guidance on criteria for local decisions be clearer?
Reducing inequalities

Boards were asked about services specifically aimed at reducing inequalities. As requested, boards provided details of Keep Well programmes, as well as a range of other programmes, most of which had also been referred to in the responses relating to preventative spend. In addition to the programmes listed earlier in relation to preventative spend, a number of additional services were listed, including interpreting services (Greater Glasgow and Clyde), community development officers (Highland), staff training on gender-based violence and equality/diversity (Highland).

In terms of spend on these services, the coverage of the information provided varied between boards, making direct comparisons difficult. The majority of boards providing information stated that spending in 2013-14 was remaining at 2012-13 levels, with a few exceptions:

- NHS Borders plans to increase spending on immunisation programmes and screening programmes (note that not all boards classified these programmes as services to reduce inequalities)
- NHS Grampian and NHS Tayside plans to increase spending on Keep Well in 2013-14
- NHS Greater Glasgow and Clyde plans to increase spending on interpreting services and spending on the provision of accessible information
- NHS Highland plans to increase spending on its Family Nurse Partnership programme and has introduced Community Health Co-ordinators
- NHS Lanarkshire plans to increase spending on its First Steps programme, supporting young first time mothers
- NHS Western Isles plans to reduce spending on learning disability programmes and Keep Well in 2013-14, although the reduction in relation to learning disability partly reflects the inclusion of non-recurring funding in 2012-13

Boards were also asked about the outcome measures used in relation to programmes aimed at reducing inequalities. In relation to Keep Well, many boards referred to the national indicators and in relation to child dental health and smoking cessation, reference was made to the relevant HEAT targets. Where details were provided in relation to other programmes, these often related to activity measures rather than outcome measures e.g. uptake of services. Similarly, when asked to provide information on outcome measures, those boards that provided information generally gave statistics on the number of patients participating in services, or the profile of participants, rather than information on progress towards outcomes.

Members may wish to pursue:

- Clearly, inequalities are many and resources are few. How can boards be sure they have targeted the most important local inequality?
• Do NHS boards have a ‘dashboard’ where they can compare the different levels of inequality? Do boards know how they are comparing with other boards in terms of levels of inequality?

• Does the Scottish Government have a view of which inequalities are most important and what evidence is there that these are the ones NHS boards spend money on?

Resource transfer

Health Boards to Local Authorities

The boards were asked to state how much money was to be transferred from their budgets to local authorities in 2013-14. This question was not relevant to NHS Highland due to the partnership between the health board and the local authority in respect of adult social care and children’s services. The responses for other territorial boards are set out in Table 5.

Table 5: Transfers from health boards to local authorities, 2013-14

<table>
<thead>
<tr>
<th>Health Board</th>
<th>£m</th>
<th>% of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>28.6</td>
<td>5%</td>
</tr>
<tr>
<td>Borders</td>
<td>2.5</td>
<td>1%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>9.4</td>
<td>4%</td>
</tr>
<tr>
<td>Fife</td>
<td>18.3</td>
<td>3%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>18.6</td>
<td>4%</td>
</tr>
<tr>
<td>Grampian</td>
<td>33.6</td>
<td>5%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>126.0</td>
<td>6%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>35.7</td>
<td>4%</td>
</tr>
<tr>
<td>Lothian</td>
<td>45.0</td>
<td>4%</td>
</tr>
<tr>
<td>Orkney</td>
<td>2.0</td>
<td>6%</td>
</tr>
<tr>
<td>Shetland</td>
<td>1.3</td>
<td>3%</td>
</tr>
<tr>
<td>Tayside</td>
<td>26.7</td>
<td>4%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>1.8</td>
<td>3%</td>
</tr>
</tbody>
</table>

The transfers detailed represent between 1% (Borders) and 6% (Greater Glasgow and Clyde and Orkney) of total allocations. From the information provided, it is difficult to ascertain whether the differences represent genuine differences in approach and joint working, or whether they merely represent differences in interpretation of the question. For example, it would seem that some boards have included Change Fund monies within their totals, while others have not. Where details were provided, the main categories of spend that were supported by the resource transfer were:

• Mental health
• Learning disabilities
• Older people
• Children
• Alcohol and drug prevention and treatment

Local Authorities to Health Boards

Boards were also asked about resource transfers from local authorities. Only seven boards gave figures in relation to this, with the remainder stating that there was no transfer of funds from the local authorities. Again, it is unclear whether those providing figures had interpreted the question differently and the extent to which Change Funds have been included or excluded in the figures provided. Boards listed the following when asked about the services funded by transfers from local authorities:

• Delayed discharge
• Speech and language therapy services
• Occupational therapy
• Homeless services
• Child and adolescent mental health services
• Drug services
• Premises costs
• Psychology

Members may wish to:

• Explore whether the range in reported transfers from health boards to local authorities represents genuine differences in approach, or simply differences in interpretation
• Examine why some boards appear to have no transfers from local authorities, while others report transfers in relation to a range of services, including in relation to delayed discharge

Access to new medicines

The boards were asked to provide information on spending on newly-licenced medicines. Following some initial requests for clarification, further details were sent to boards in an attempt to clarify the nature of the information being sought.

33 Ayrshire and Arran, Dumfries and Galloway, Fife, Forth Valley, Lothian, Tayside and Western Isles
Nonetheless, it was clear that boards had problems in providing the information in the format requested.

The problem was in the interpretation of ‘newly licensed medicines’. Some boards had looked at medicines due to be reviewed by Scottish Medicines Consortium (SMC) in 2012/13 and 2013/14, others had looked at all SMC approved medicines from a specific date, some included spend on existing medicines for which new indications have been approved. These different approaches mean that it is not meaningful to make direct comparisons between the boards. A number of general points can be made:

- There does not appear to be any single approach for financial planning for new medicines
- Comparing the actual spend on new medicines with the planned spend does not appear to be a straightforward exercise due to the way in which information is held
- The majority of spend on new medicines is in the secondary care setting rather than primary care settings

Despite the difficulties encountered in responding to this question, many of the boards were very helpful in explaining the challenges and issues that would need to be considered in order to get more meaningful data on this subject. NHS Greater Glasgow and Clyde gave a particularly detailed explanation of the factors to be considered and the challenges in financial planning for new medicines.

The boards were also asked for details of individual patient treatment requests (IPTRs). Some boards did not respond to this question due to the low numbers involved and concerns regarding patient confidentiality. For those that did respond, reported spending varied widely, from £1,700 in 2012-13, relating to a single IPTR (Borders) to £750,000 relating to 35 IPTRs (Greater Glasgow and Clyde). NHS Lanarkshire stated that it was anticipating spend of just over £900,000 on IPTRs in 2013-14. The vast majority of this predicted spend (£850,000) relates to eculizumab, for the treatment of refractory atypical haemolytic uremic syndrome (aHus) or paroxysmal nocturnal haemoglobinuria (PNH).

Members may wish to:

- re-consider what information would be useful and either take oral evidence or send a further question to NHS boards, given the overlap with the enquiry into access to new medicines.
- explore the variation in planning for medicines spend, linking this to data on planning for cost pressures and variation in planning assumptions on prescribing (reported earlier in this document).
- ask questions based on emerging findings from the enquiry into access to medicines. For example, if prices of new medicines were negotiated...
between NHS Scotland and pharma companies in the light of an initial assessment of the evidence by Scottish Medicines Consortium, would this help boards (because it might lead to lower prices) or hinder them (because the size of the negotiated change in price is unpredictable)?

**Equalities**

Boards were asked to provide examples of how equalities considerations had influenced budget decisions. The majority of boards made reference to the use of equalities impact assessments to inform budget decisions, or similar processes e.g. a Planning for Fairness assessment (NHS Highland) or a Fair Financial Decision-Making process (NHS Greater Glasgow and Clyde). In addition to more general references to such impact assessments, specific examples provided included:

- Investment in prison healthcare to ensure equality in the provision of services between prisoners and the rest of the population (Ayrshire and Arran)
- Sexual health project for patients with learning disabilities (Borders)
- Funding to support access to Keep Well health checks by migrant populations and gypsy travelers (Borders)
- Increased provision of “Language Line” access points, interpreters and translated written material (Grampian)
- Increased budget for interpreting services (Greater Glasgow and Clyde and Highland)
- Individual child health weight interventions for children with learning disabilities (Orkney)
- Sexual health/blood borne virus services for specific equalities groups (Tayside)

NHS Grampian noted that it took a mainstreaming approach and all its services include specific provision for equalities groups. It also listed a number of working groups with specific remits for equality and diversity groups.

**Sustainable development**

Boards were asked to provide examples of how the NHSScotland sustainable development strategy had influenced budget decisions. All boards gave examples of action being taken to meet emissions and carbon reduction targets and some provided details of anticipated CO₂ and financial savings. NHS Orkney noted that ‘the budgetary impact of ‘A Sustainable Development Strategy for NHSScotland’ has been more evident, to date, in the allocation of capital budgets, than revenue’.
Specific examples given include:

- Installation of wind turbines, ground/air source heating and/or biomass boilers (Ayrshire and Arran, Borders, Dumfries and Galloway, Grampian, Greater Glasgow and Clyde, Highland, Tayside, State Hospital)

- Use of BREEAM (BRE Environmental Assessment Method) for new facilities (Fife, Tayside)

- Energy audit of property portfolio to adjust heating times and temperatures (Borders)

- Property reviews (NHS National Services Scotland and NHS Health Scotland)

- Use of energy saving LED lighting and motion sensors (Dumfries and Galloway, Shetland)

- New laundry driers and/or boilers (Fife, Shetland)

- Reducing business travel through use of videoconferencing (Forth Valley, NHS Health Scotland) and patient travel (Shetland)

- Improved bus linkages to sites, involving both public buses and inter-site buses (Grampian)

- Use of electric/low emission vehicles or improved transport efficiency (Grampian, Greater Glasgow and Clyde, Orkney)

In relation to both equalities and sustainable development, members may wish to ask:

- Whether there is effective sharing of information in relation to initiatives and activity in these areas?

- How is information on examples of good practice disseminated?
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)

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

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

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.)

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

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

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</th>
<th>Hospital prescribing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13 (planned)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012-13 (actual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013-14 (planned)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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):

<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>1</td>
<td>Bevacizumab</td>
<td>Cancer</td>
<td>£10,000</td>
<td>£5,000</td>
</tr>
</tbody>
</table>
Reducing inequalities

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

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

(c) What outcome measures have been identified for these services?

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

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?

(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?

Equalities

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

Sustainable development

10. Can you provide any specific examples of how the NHSScotland sustainable development strategy has influenced budget decisions?
ANNEXE E: FOLLOW-UP INFORMATION FROM THE SCOTTISH GOVERNMENT

Backlog Maintenance
NHSScotland’s estate backlog maintenance expenditure requirement is the base cost required to bring those parts of the existing estate which are currently not in satisfactory condition, back to a satisfactory condition. It is an on-going challenge for the NHS to balance investment between that which is focussed on service improvement and development, and that which is necessary to maintain buildings in a good condition and ensure that they are safe, reliable and fit for purpose. An analysis of the backlog expenditure requirement across NHS Boards identifies a base backlog maintenance expenditure requirement of £948 million, which is a £62 million reduction since 2011.

Indicative figures for 2013 indicate that the overall backlog maintenance has reduced by a further £90 million to £858 million. Further details will be included in the next ‘State of the Estate’ report which is expected to be published later this year.

Reducing Risk Profile of Backlog Maintenance
High and significant backlog has reduced from £538 million to £424 million, a reduction of £114 million. The proportion of the total backlog maintenance categorised as high and significant risk has reduced from 53.2% of the total in 2011 to 44.7% in 2012.

Summary of Backlog Risk Profile and % of Total Backlog

<table>
<thead>
<tr>
<th>Backlog Cost (£M)</th>
<th>Low Risk Items</th>
<th>Moderate Risk Items</th>
<th>Significant Risk Items</th>
<th>High Risk Items</th>
<th>Not Categorised</th>
<th>Total Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 Backlog</td>
<td>218</td>
<td>237</td>
<td>306</td>
<td>232</td>
<td>17</td>
<td>£1,010m</td>
</tr>
<tr>
<td>% OF TOTAL</td>
<td>21.6%</td>
<td>23.5%</td>
<td>30.2%</td>
<td>23.0%</td>
<td>1.7%</td>
<td>100%</td>
</tr>
<tr>
<td>2012 Backlog</td>
<td>239</td>
<td>285</td>
<td>265</td>
<td>159</td>
<td>-</td>
<td>£948m</td>
</tr>
<tr>
<td>% OF TOTAL</td>
<td>25.2%</td>
<td>30.1%</td>
<td>28.0%</td>
<td>16.7%</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Tackling Backlog Maintenance
Of the Total backlog maintenance identified of £948 million the following actions are in hand:

| £m |
|------------------|-----------------|
| Total Backlog Identified 2012 | 948 |
| Less Planned actions by 2017 |  |
| Planned Disposals | (175) |
| Investment/ refurbishment/ upgrading | (256) |
| Note – currently identified high and significant backlog will be eradicated |  |
Within the next five years based on capital projects, disposals and maintenance plans we expect the total backlog to reduce by a total of £521 million to £427 million and for all high and significant risk backlog currently identified to be removed.

In tracking the progress of Boards in tackling backlog maintenance year on year there are a number of actions and measures in already in place. These are:

- Regular review of backlog and its’ risk profile
- Identified actions by Boards that can be tracked – new projects, maintenance plans and planned disposals
- Review of Board’s Property and Asset Management Strategies to identify progress, examine risk management/ mitigation strategies, identify emerging issues and challenge planned actions
- Estate rationalisation and disposal of older properties avoiding the need for expenditure on backlog
- Replacing older properties with new facilities and avoiding the need for expenditure on backlog
- Incorporating backlog works within major modernisation and refurbishment projects
- Undertaking specific projects to target the high and significant backlog
- Incorporating backlog work within operational repair and cyclical maintenance
- £320 million will be transferred from the revenue to capital budget over a three year period starting in 2012-13 to specifically address this issue.

Examples of Projects Making an Impact on Existing Backlog

- NHS Greater Glasgow and Clyde will reduce their identified backlog maintenance of £177.7 million by £88.5 million to £89.2 million. This will be achieved through disposals, in part facilitated by the construction of the New South Glasgow Hospitals Project, and planned, risk profiled maintenance.
- NHS Lothian planned disposals will reduce identified backlog by £30.5 million.
- Royal Edinburgh Hospital In Patient Accommodation will remove £22.6 million of which £19.6 million is High and Significant Risk
- Replacement of Dumfries and Galloway Royal Infirmary (which includes the reprovision of Nithbank Hospital) will remove £40.9 million
- NHS Forth Valley to reduce identified backlog by £13.1 million or 87% through refurbishment of Stirling and Falkirk Royal Infirmaries and planned disposals
- NHS Ayrshire and Arran to reduce identified backlog by £16.1 million from £93.3 million to £77.2 million through investment in North Ayrshire Community Hospital, maintenance and planned disposals.
- Argyll and Bute mental health project being taken forward via hub in NHS Highland will remove £5.9 million of backlog
- The disposal of Forth Park Hospital, Kirkcaldy will remove £3.8 million of backlog maintenance
- Disposal of Woolmanhill Hospital in Aberdeen will remove £2.6 million of backlog
- Replacement of Glenwood Health Centre will remove £0.4 million of backlog

Whilst tackling high and significant risk backlog maintenance will be prioritised we cannot target this in isolation. Whilst those areas containing high and significant risk backlog (particularly in clinical areas) are targeted for investment/ action it is important to recognise that when access can be gained to operational areas the approach is to maximise that opportunity by undertaking planned preventative maintenance and backlog across all risk categories in those areas.

In monitoring these actions centrally it is recognised that local prioritisation of available resources is required and that the timing of planned asset disposals can move subject to the planning process and local market conditions. In order to support the disposals process in particular we are investing £5 million over 3 years to support enabling works, master planning etc. in order to generate disposal income and remove backlog and other liabilities (security) from surplus site.
Members who would like a printed copy of this *Numbered Report* to be forwarded to them should give notice at the Document Supply Centre.