FORMAL RESPONSE FROM THE DIRECTOR-GENERAL HEALTH AND CHIEF EXECUTIVE NHS SCOTLAND TO HUGH HENRY, CONVENOR OF THE PUBLIC AUDIT COMMITTEE

Dear Mr Henry

AUDITOR GENERAL FOR SCOTLAND REPORT – OVERVIEW OF THE NHS IN SCOTLAND’S PERFORMANCE 2008-09

Please find attached at Appendix A, the Scottish Government’s response to the Public Audit Committee’s report on the ‘Overview of the NHS in Scotland’s performance 2008/09’, published on 5 October 2010.

The response comments on each of the Committee’s recommendations which fall for consideration by the Scottish Government. We will keep the Committee informed of progress on action where identified.

Yours sincerely

DEREK FEELEY
Funding and Affordability

21. The Committee welcomes the steps taken by the NHS to improve its financial position over the past five years. The Committee recognises, however, that this success has been achieved during a period of significant funding increases.

SGHD Response – Noted

22. Given the tighter financial outlook over the next few years, the Committee agrees with witnesses that the NHS will not be able to sustain two per cent efficiency savings, year on year, by simply ‘salami slicing’ budgets further.

SGHD Response – Noted

23. The Committee notes that efficiency savings of over two per cent will be required, in future years, if new or improved services are to be funded or just to stand still, if NHS budgets are reduced.

SGHD Response – Noted

24. The Committee would welcome clarification from the Scottish Government as to whether NHS boards:

- will need to secure greater than two per cent savings over the next few years; and
- will be able to retain the efficiency savings they generate.

SGHD Response - Noted
The Scottish Government expect that NHS boards will need to make and retain a minimum of 3% efficiency savings over the next few years. In addition to these savings a higher differential efficiency target has been set for Special Boards services not delivering direct patient care to improve efficiency and support funding of front-line services.

25. The Committee also requests that the Scottish Government provide further information to demonstrate the ability of NHS national procurement contracts to generate future efficiency savings.

SGHD Response – Noted
Since 2005 National Procurement contracts have delivered in excess of £150m worth of efficiency savings. National contracts cover expenditure of £700m and it is forecast that these contracts will expand to £800m by 2013-14, ensuring that all Boards secure the most competitive prices available. Best practice is shared through regular engagement with all Health Boards.

In addition an Accelerated Procurement programme has been put in place for health which involves senior Board representatives, National Procurement and other NSS
departments working together to identify future opportunities for procurement savings both from contracting and operational efficiency.

Service Redesign

37. The Committee recognise the need for a willingness among politicians, the public and NHS managers to co-operate over the delivery of health service redesign.

SGHD Response – Noted

38. In that regard the Committee welcomes the provision of support to NHS boards, through updated guidance and the Scottish Health Council, to ensure that engagement and consultation on future service redesign is high quality and robust.

SGHD Response – Noted

39. However the Committee recognises that significant service redesign is a lengthy process that can take years to come to fruition, and that the decisions taken by NHS Boards can subsequently be reversed by independent scrutiny panels. As a consequence the Committee believes it is less likely that significant service redesign will be able to contribute significantly to efficiency savings in the immediate future.

SGHD Response – Noted

Service Improvement which tackles variation in service models is the immediate focus of the Efficiency & Productivity Programme, such as improving rates of same day surgery and ensuring that pathways of care are efficient and consistent. This drive to improve quality and efficiency underpins NHS Board proposals for service redesign.

Only cases of major service change in the NHS are considered for independent scrutiny. Guidance was issued to NHS Boards in February 2010: CEL (4) 2010: Informing, Engaging and Consulting People in Developing Health and Community Care Services. Independent scrutiny is usually conducted at an early stage in the major service change process in order to inform the proposals Boards put to formal consultation. This reduces the risk that a Board decision might be reversed.

The Scottish Government is keen to ensure that any future Independent Scrutiny Panels operate in the most effective way possible. A formal review has recently been initiated to consider the work of the panels that have been convened to date with a view to informing and improving future policy and practice.

40. The Committee would welcome confirmation from the Scottish Government of how it intends to support NHS boards to generate the necessary savings if service redesign takes longer or is unable to progress.

SGHD Response – Noted

The Efficiency and Productivity Delivery Framework for 2011-14 will set out the support to NHS Boards to realise productive opportunities in the context of implementing the NHS Quality Strategy. The Framework and its supporting NHS
Efficiency & Productivity Programme will focus on maximising the opportunities from support services and tackling variation in service delivery, in areas such as prescribing, procurement and business support.

NHS Boards will be fully engaged in the delivery of the new Framework.

The Audit Scotland review of Orthopaedics (2010) considered recently by the Public Audit Committee set out the type of savings that can be achieved by further standardisation of surgical implants and by increasing rates of Same Day Surgery for that specialty.

We intend to apply a systematic approach to high volume, high cost services in the first instance to identify and reduce variation. We shall do so by highlighting productive opportunities through benchmarking, on-line tool-kits and case studies, the use of redesign techniques and the piloting and sharing of good practice across NHS Boards.

As an example, NHS Boards have access to a number of online toolkits which highlight areas for improvement including variation in Same Day Surgery rates and emergency ambulatory care; and the Better Quality Better Value Indicators developed in 2009. These toolkits are evidence-based and ensure effective, safe and improved quality of care for patients.

Support to NHS Boards to turn these indicators of efficiency into action comes from the national improvement programmes on 18 Weeks, Long Term Conditions and Mental Health and from the National Theatres Implementation Group. NHS Boards are also developing their own capacity and capability for service improvement through adopting lean techniques and through the success and spread of the Scottish Patient Safety Programme.
Staff Salaries are a significant cost

55. The Committee welcomes the pay freeze for senior salaries in the NHS and the savings that this, together with a reduction in management posts, will deliver to the NHS.

SGHD Response – Noted
The Scottish Government recently announced its intention to reduce the number of senior managers in the NHS by 25% by 2014.

56. The Committee notes the steps taken, such as the creation of the Scottish Partnership Forum, to enable any impact of workforce reductions on quality of care to be considered.

SGHD Response – Noted

57. However, the Committee is unclear as to whether the forum will monitor the quality of services to ensure that any workforce reductions do not detrimentally impact on the delivery of front line services.

SGHD Response – Noted
The SPF has been in existence since 1999 and is responsible for providing the Scottish Government, NHSScotland employers and trade unions/professional organisations with an opportunity to work together to improve health services for the people of Scotland. It also provides a forum for all national key policy leads to engage with key stakeholders to inform thinking around national policies on health issues. The SPF has no direct role in monitoring the projected workforce reductions for 2010/11. That is the role of the new National Scrutiny Group (see below).

58. The Committee would therefore welcome further information on how the Scottish Government proposes to monitor the impact of the projected workplace reductions on quality of care.

SGHD Response – Noted
The Cabinet Secretary for Health and Wellbeing announced on 3 June 2010 the establishment of a new, and separate, National Scrutiny Group whose role will be to monitor the implementation of the NHSS workforce changes projected for 2010/11 to ensure that workforce changes are delivered in full partnership between NHSS Boards and staff side representatives and that quality of care is not compromised. The membership and remit of that Group are appended. In future meetings, the National Scrutiny Group will receive commentaries from each NHSS Board’s Area Partnership Forums to enable it to take a national view of the impact of the projected workforce changes. Meeting papers have been and will be made available in SPICe. The National Scrutiny Group will provide reports to the SPF in due course.

59. The Committee would also welcome clarification of how the NHS intends to achieve its projected workforce reduction if, given the current economic climate and job market, the turnover rate reduces.
SGHD Response – Noted

It is important to note that the projected workforce changes for 2010/11 are a reflection of how NHSS Boards would expect to see their workforce adapt to changing patterns of care and modes of service delivery. The projections are not a target and it could well be that the ultimate level of reduction will be less than that projected, regardless of any changes in turnover. Indeed, the Cabinet Secretary for Health and Wellbeing made clear in the Parliamentary debate on the NHS on 3 June 2010 that she expects NHSS Boards to maintain downward pressure on the projected reductions by working hard to maximise non-workforce related efficiencies.
Recurring savings can be reinvested

69. The Committee welcomes the progress made by NHS Boards in reducing their reliance on non-recurring savings and recognises the potential of recurring savings to fund the development and improvement of new and existing services and infrastructure.

SGHD Response – Noted

70. However the Committee is concerned that, given the challenges of achieving two per cent efficiency savings with little growth in future funding, NHS Boards are unlikely to be able to continue to fund from efficiency savings both significant capital improvements and improve and develop new services.

SGHD Response – Noted

71. The Committee therefore would request further information from the Scottish Government on how it will support NHS Boards to address the major infrastructure upgrading challenges over the next few years, including any medium to long term planning figures it has identified.

SGHD Response - Noted

The asset base of the NHS in Scotland is valued at approximately £5 billion and includes in excess of 4 million square meters of floor area in its buildings. To assist in managing the estate which includes equipment, vehicles and IM&T systems, the Scottish Government has procured a national estate management system which is currently being rolled out across Health Boards. This will ensure all information on assets is held electronically and will include a record of asset condition, statutory compliance, functional suitability and space utilisation - and will inform the future programme of infrastructure upgrades.

CEL 2010 (35) 'A policy for property and asset management in NHS Scotland' was issued by Scottish Government to Health Boards in September and formalises a process in which one of the aims is to provide, maintain and develop a high quality, sustainable asset base. To ensure a consistent approach to asset management, Health Facilities Scotland (HFS) have been working with Health Boards in developing local Property and Asset Management Strategies and a standardised risk based methodology to property appraisal. This overall approach will be instrumental in calculating the costs of statutory compliance and backlog maintenance across the NHS estate.

The current cost of statutory compliance and backlog maintenance in 2011-12 is estimated at £150m. From figures submitted in January 2010 and amended in the light of known changes gives an estimate of costs over the Spending Review period are:

<table>
<thead>
<tr>
<th>Year</th>
<th>£m</th>
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<tbody>
<tr>
<td>2012-13</td>
<td>149.4</td>
</tr>
<tr>
<td>2013-14</td>
<td>182.5</td>
</tr>
<tr>
<td>2014-15</td>
<td>206.1</td>
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</table>
Demographic change leading to a growth in demand for services

88. The Committee agrees with witnesses that savings can be achieved in the long term by investing in anticipatory care, both for the elderly and by targeting health interventions at areas of high deprivation.

SGHD Response – Noted

89. The Committee welcomes the work being undertaken through such programmes as ‘Keep Well’ and the over-40s checks but notes that such programmes require additional funding.

SGHD Response – Noted

90. The Committee is concerned that, in the current financial climate, such anticipatory programmes will become difficult to fund and therefore the Committee questions whether it is the most effective use of funding for these programmes to be available to all rather than focussed solely on those in the most deprived areas.

SGHD Response – Noted

The Scottish Government is committed to the extension across all geographical areas of the Keep Well programme of targeted health checks, as a key part of its strategy for reducing health inequalities in Scotland. From 2012-13, the Scottish Government intends to include in all NHS Boards’ activities a programme of inequalities-targeted, high risk primary prevention, supported by similar funding as previously available for Keep Well/Well North. This reflects evidence that, this is an effective approach to delaying the onset of CVD within Scotland’s most deprived communities, which currently experience excess premature mortality.

Ministers have also announced their intention to introduce Universal Health Checks for the whole population aged 40 to 74. A clinical trial is likely to commence next year to ascertain is a cost-effective mechanism for reducing mortality and morbidity and, therefore, whether they contribute added value to existing action, such as Keep Well.

In addition, the Quality Strategy sets out the Scottish Government’s proposals to introduce Anticipatory Care Plans for people with complex long term conditions and at risk of hospitalisation.

91. The Committee would welcome further information from the Scottish Government on how it will support longer term anticipatory care programmes given the financial constraints of the next few years, including any medium to long term planning figures it has identified.

SGHD Response - Noted

As part of the spending review, the Government is considering the level of resource available to support anticipatory care, primarily through the Keep Well extension programme described above.
92. The Committee would also request further information from the Scottish Government on how it proposes to address the potentially rising costs of dementia care, given the predicted increases in the numbers of people with dementia.

SGHD Response - Noted

The National Dementia Strategy, published in June, recognises the importance of addressing the provision of dementia services now, in order to help to fundamentally reshape services in anticipation of the projected doubling of the number of people with dementia over the next 25 years.

The strategy focuses in particular on 2 areas: improving immediate post-diagnosis support and service response in general hospital settings. Improvements in the former will mean that people with dementia are living as independently as possible for as long as possible (with a better quality of life), and in the latter that people are less likely to be inappropriately admitted from general hospital settings to long term care. Both sets of outcomes will also increase the efficiency and cost-effectiveness of long term care in delaying and therefore reducing the costs of residential care.

Key to these improvements will be the redesigning and much closer joint working and joint resourcing of local health, social care and voluntary sector services. We are piloting such approaches in 3 demonstrator sites – Midlothian, North Lanarkshire and Perth and Kinross – over the next year and a half and disseminating learning from and evaluation of the sites through a Learning Network.
The NHSScotland Resource Allocation Committee (NRAC)

98. The Committee notes the concerns of NHS Boards concerning the NRAC formula and would welcome further information from the Scottish Government on:

- How the NRAC formula takes account of levels of deprivation;
- Where the additional funding will come from to enable funding to match the NRAC targets for each board;
- How the NRAC formula allocations will be adjusted if NHS budgets are reduced in future; and
- The timescales for matching NHS Board funding to the NRAC targets.

SGHD Response - Noted

Deprivation

The aim of the formula is to account for all factors that affect a population’s need for healthcare, not just deprivation. These include age, sex, life circumstances other than deprivation, and geography. Details of the formula and its consideration of deprivation can be found at [http://showcc.nhsscotland.com/shsv53_STAGE/5786.html](http://showcc.nhsscotland.com/shsv53_STAGE/5786.html).

Progress toward targets

Progress toward targets has been historically managed through ‘differential growth’, with all NHS Boards receiving a standard increase in funding levels, but those below target receiving an additional increase to move them toward target. This is the same approach that was used for the previous SHARE and Arbuthnott formulae.

In 2010/11, approximately 0.18%, or £13m, of NHS Board revenue funding was allocated to moving boards closer to target.

Future allocations

The adjustment for moving toward target shares in future years has yet to be agreed. This is considered every year as part of the budget setting process and was fully considered as part of the 2010 Spending Review process.

Timescales

The NRAC target allocations change year on year, primarily in response to population movements between the NHS Boards. It is therefore not possible to set a date for the achievement of the target shares.
Appendix A

Measuring Productivity and Efficiency

116. The Committee acknowledges that Scottish Government measures, such as the central health improvement support team, will aid NHS Boards to proactively share and benefit from good practices in other NHS Boards.

SGHD Response – Noted

117. The Committee believes that if NHS Boards are to be able to achieve greater efficiency savings in future then they have to be able to better understand and improve productivity. In that regard, the Committee notes that there is a shift from measuring inputs to measuring outputs and outcomes however agrees with the AGS that more work still remains to be done on measuring quality.

SGHD Response - Noted
In the Quality strategy document published in May 2010, we set out our commitment to develop a Quality Measurement Framework to support our shared vision of healthcare quality. This will support delivery of the Scottish Government’s National Performance Framework. It is proposed that progress towards the three Quality Ambitions will be assessed by reference to a number of Quality Outcome Measures, and that the measures will be based on a combination of patient and staff perspectives, alongside measures of safety and effectiveness. The measures will be used to assess direction of travel, and will not be set as targets.

This work is progressing, and a Quality Measures Technical Group has engaged with Information Services Division (ISD), NHS Quality Improvement Scotland (QIS), NHS Board representatives, clinicians, and others to develop detailed proposals. A report is being prepared for the first meeting of the Quality Alliance Board, setting out recommendations for the Quality Outcome Measures. A number of these measures will be also be used to quality adjust the new index of the aggregate volume of health service output which has been introduced into the Scottish Government GDP publication, in line with the recommendations of the Atkinson Review.

As far as possible these quality measures will inform the wide range of indicators of productivity and efficiency which are used to motivate and measure performance: indicators which cover the spectrum of measurement from the specific to the system-wide level and allow for comparison across types of activity, between hospitals and Boards and through time.

As part of the proposal for the Quality Measurement Framework, the Quality Strategy made a commitment that the HEAT targets would be aligned to the Quality Ambitions. The HEAT targets will therefore reflect the agreed areas for specific accelerated improvement each year, contributing to progress towards the Quality Ambitions.

There are already a number of systems in place which routinely track patient outcomes across three key dimensions: clinical, safety and satisfaction. For example, ISD publishes age-standardised mortality rates over time for major conditions and re-admission rates. There are also procedures in place covering patient safety, clinical governance and adverse incidence reporting arrangements.
Patient satisfaction information at a national level is currently available from the Social Attitudes Survey and a richer dataset focussing on patient experience at both national and local levels is now available from the new Patient Experience Surveys under the Better Together Patient Experience Programme. The Patient Experience, Inpatient and GP Surveys are proving valuable tools in helping to improve services. The final national report and individual practice reports on the GP survey were published on 27 July along with the provisional results from the inpatient survey. As part of the Quality Strategy, we will build on this work, including the collection of appropriate data to measure patient reported outcomes.

In addition, the Scottish Patient Safety Programme (SPSP) is being implemented by every NHS Board. This is a world-leading quality improvement programme which aims to reduce hospital mortality by 15% and adverse events by 30%. Key strands of the programme include:

- Reducing and preventing adverse drug events;
- Reducing and preventing infection from intravenous lines (central line infection);
- Reducing and preventing infection from surgery (surgical site infection);
- Preventing ventilator associated pneumonia for patients on ventilators in intensive care units; and
- Reducing meticillin-resistant Staphylococcus aureus (MRSA) and meticillin-susceptible Staphylococcus aureus (MSSA) infection.

To assess local progress, Boards are gathering a range of information at hospital and ward level, which they scrutinise to drive improvement locally, drawing on national support and expertise from the SPSP, ISD and NHS QIS. As part of the Quality Strategy we are accelerating the SPSP in acute care and implementing a patient safety programme in primary care and mental health. As the Committee will be aware, Hospital Standardised Mortality Rates (HSMR) are also now being published for each acute hospital participating in the SPSP.

118. The Committee recommends that the Scottish Government urgently improves the measurement of quality associated with outputs and in that regard would welcome clarification of how the seven new indicators, arising from the efficiency and productivity programme, take into account the cost and quality of services.

**SGHD Response – Agreed**

The latest update of the Better Quality, Better Value (BQBV) consists of five indicators which provide NHS Boards with access to benchmarking data to highlight variation in current performance between NHS Boards and Hospital sites and identify the potential productive opportunities. In order, to secure improvements in efficiency and quality of care, for each indicator the Improvement and Support Team has also identified the key characteristics of high performing healthcare organisations and the key changes which should be implemented, and have signposted examples of over 100 good practice case studies and links to a range of improvement methodologies and toolkits [http://www.improvingnhsscotland.scot.nhs.uk/](http://www.improvingnhsscotland.scot.nhs.uk/).
<table>
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<tr>
<th>BQBV Indicator</th>
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<tbody>
<tr>
<td>Securing improvements in efficiency and quality of care</td>
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<tr>
<td>Average length of stay (ALOS) for high volume specialties</td>
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<tr>
<td>▪ Plan the date of discharge for patients at admission, or pre-assessment;</td>
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<tr>
<td>▪ Involve patients, family, carers and social services where appropriate in discharge planning;</td>
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<tr>
<td>▪ Implement seven day per week discharge;</td>
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<tr>
<td>▪ Discharge throughout the day;</td>
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<tr>
<td>▪ Develop protocols for nurse-led discharge;</td>
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<tr>
<td>▪ Ensure that the average length of stay, for each high volume procedure/reason for admission is the same regardless of day of admission;</td>
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<tr>
<td>▪ Continuously measure and monitor the length of stay to ensure that improvements made are maintained.</td>
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<tr>
<td>Pre-operative bed days for surgical specialties</td>
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<tr>
<td>▪ Introduce pre-operative assessment arrangements that reduce the need for patients to be admitted in advance;</td>
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<tr>
<td>▪ Introduce a surgical admissions unit allowing patients to go directly to theatre;</td>
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<td>▪ Provide patients with relevant information of what actions to take on the day of admission and a named nurse contact;</td>
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<tr>
<td>▪ Improve access to Diagnostics on an outpatient basis so patients do not need to be admitted for diagnostic procedures;</td>
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<tr>
<td>▪ Continuously benchmark performance against other sites to ensure that admission practices are delivering good performance.</td>
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<tr>
<td>Outpatient Did Not Attend (DNA) rates for high volume specialties</td>
</tr>
<tr>
<td>▪ Ensure there is a readily accessible single point of contact for booking appointments;</td>
</tr>
<tr>
<td>▪ Establish a dialogue with patients about their appointment and offer a choice of date, time and, where possible place;</td>
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<tr>
<td>▪ Contacts patients to remind them of their appointment close to the date of their appointment;</td>
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<tr>
<td>▪ Eliminate the overbooking of clinics to account for Did Not Attends;</td>
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<tr>
<td>▪ Ensure that the booking process orders the waiting list so patients are seen in turn.</td>
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<tr>
<td>Outpatient return to new ratios for high volume specialties</td>
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<tr>
<td>▪ Discharge outpatients to either no follow-up, patient initiated follow-up or GP follow-up as an alternative to routine in hospital outpatient clinics;</td>
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<tr>
<td>▪ Introduce Clinical Outcome Recording</td>
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<tr>
<td>▪ Develop teams and team leaders that work across primary and secondary care to reduce the need for acute services and deliver appointments within the community;</td>
</tr>
<tr>
<td>▪ Put in place techniques such as telephone follow-up, questionnaires and web based services as alternatives to traditional appointments;</td>
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<tr>
<td>▪ Produce departmental guidelines for offering follow-up</td>
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| Day case rates for surgical specialties | • Adopt day surgery as the normal practice for surgical interventions;  
• Develop high quality information for patients and carers regarding the benefits of day surgery;  
• Implement pre-assessment to ensure that the right patients are identified as being suitable for day surgery;  
• Encourage clinical visits and networking between sites where new day surgery practices are in place;  
• Ensure that procedures are scheduled in a way that maximises the potential for the patient to go home that day;  
• Ensure that dedicated day surgery facilities are in place and there is sufficient treatment room capacity. |

119. The Committee would also welcome an update on when the *Scotland Performs* website will link the health service’s performance in relation to the national performance framework with expenditure. The ability to link outputs to financial resources will be particularly important when budgets require to be prioritised over the next few years.

**SGHD Response - Noted**

*Scotland Performs* is a performance information tool that can be used to judge government performance and give a clear sense of what progress government is making progress against the National Performance Framework. The Scottish Government is committed to enhancing our capacity to link as closely as possible our expenditure to priorities and policy outcomes. We took the first steps to doing that 3 years ago, when we presented our spending plans for the 3 years 2008-11, following SR2007. Health & Wellbeing spending plans beyond 2010-11, as with all other portfolio spending plans, will be detailed in the SR2010 document, which will accompany the Finance Secretary’s November 2010 budget statement. In addition, last year, Dr Woods reported on the links between the draft Health Budget, outcomes and targets in his letter of 21 October 2009 to the Health and Sport Committee on the draft Budget 2010-11.

120. The Committee notes the work underway in relation to reviewing the cost book and the future review of the health data collected nationally by ISD Scotland and seeks an update from the Scottish Government on how these reviews will improve the data on quality of outputs and costs in the NHS.

**SGHD Response - Noted**

The Efficiency and Productivity Programme now oversees and directs the work on the NHSScotland Costs Book and tariff project with the current focus being on improving the quality of costing (and tariff) data in order to improve consistency across NHS Boards and promote the use of costing and tariff data as a benchmarking tool for identifying efficiency savings.
Significant work has been carried out over the last 2 years in partnership with NHS Boards and ISD to identify and address specific data quality issues (including carrying out an in-depth review of two specialities), increase consistency between NHS Boards in completing the Costs Book returns, and review the current guidance on the Costs Book. A Costs Book Manual Review Group has been set up to review the guidance manual for the Costs Book in order to improve the read across between the new Chart of Account, AFC job profiles and the Costs Book; improve presentation by making it more user-friendly and recognisable; and increase consistency between boards in completing the Costs Book, a major concern expressed by NHS Boards. The outputs from the group were used in the collection of data for the 2009-10 Costs Book and will be now be reviewed and developed for the 2010-11 Costs Book.

At the same time, ISD have developed a national tariff benchmarking tool which is issued to all NHS Boards each year comparing their estimated costs against national average. Further work has been identified to improve data quality, e.g. on community and family health services, and the focus will be on making these improvements in the next year.
Shifting the Balance of Care

131. The Committee notes the work undertaken by NHS Boards to continue to develop and deliver locally based community care, and that this is not necessarily identifiable by a corresponding shift in resources to primary care providers.

SGHD Response – Noted

132. The Committee also notes however, that if this shift to more locally based community care is to continue without any corresponding transfer of financial resources, then NHS Boards will need to deliver efficiency savings in order to fund its development.

SGHD Response – Noted

133. The Committee recommends that the Scottish Government monitor the resources provided for locally based community care by NHS Boards to ensure that these services are not detrimentally affected as a result of financial pressures elsewhere in the NHS.

SGHD Response – Agreed

All parts of the health system will need to improve productivity and efficiency in order to deal with financial pressures. We recognise that in order to deliver new pathways of care and meet the targets we have set for the NHS, Boards will need to realign their existing resources. We are currently working with all NHS Boards to take forward the Integrated Resource Framework which will help Boards and their partners to move resources over time to support the delivery of new models of care provided in the community.

137. The Committee agrees with the witnesses that integrated working can bring greater productivity and efficiency. However it notes the AGS report which comments that at present, there has been little evaluation of the ways in which partnership arrangements involving the NHS are working.

SGHD Response – Noted

138. The Committee notes that the Scottish Government is currently working on an evaluation of Community Health Partnerships (CHPs). The Committee would therefore welcome an update on the progress of this evaluation and what proposals, if any, it has to evaluate the effectiveness of CHPs and Community Health and Care Partnerships (CHCPs) in delivering improved productivity and efficiency.

SGHD Response – Noted

The Scottish Government published the CHP study in May 2010. One of the main CHP achievements reported by the researchers was improvement in partnership working within and across the NHS. NHS Boards and their partners have evolved local arrangements to strengthen joint working and public involvement and this has included revisions to CHP governance arrangements and management structures. We will be publishing our response to the study in November 2010. In relation to improved CHP (CHCP) productivity, all parts of the health and social care system will
need to improve the effectiveness and efficiency of service planning and delivery. CHPs (CHCPs) are not separate statutory bodies. Boards therefore will continue to be held accountable for delivering overall improvements in productivity and efficiency and CHPs will be expected to maximise the use of devolved resources and reduce inappropriate variation in cost and activity locally. An external evaluation has been commissioned to assess the impact of the Integrated Resource Framework that is currently being developed across 4 Health board/12 council test sites.
The cost of Alcohol Misuse to the NHS

147. The Committee was very concerned to learn that data on aspects of alcohol misuse such as hospital admission rates, particularly for young people, is not collected centrally and the data that is available, requires to be interrogated further in order to be validated.

148. The Committee notes the development of a national A&E data set which “will include the level of data which the Committee is looking for” and that ISD Scotland is to bring forward publication of quarterly data via the ISD ‘data in development’ area on its website to enable quality assurance of the data to take place with interested stakeholders.

149. Whilst the Committee welcomes this response, it has concerns at the speed at which ISD can respond to developing health issues such as alcohol and drug misuse and their impact on the NHS.

SGHD Response – Noted

Hospital admission data, broken down by age group, is collected at the national level and published annually by ISD. What we do not currently have is data on the number of alcohol-related presentations to A&E. Further information on how we are seeking to improve the collection of the latter is provided in the response to comment 150.

ISD has a dedicated Substance Misuse Programme covering both alcohol and drugs. Over recent years they have developed a range of both national and local statistics. Every two years they publish Alcohol Statistics Scotland which provides a wide range of information on the alcohol market, consumption, health harms and social harms.

In relation to drugs, ISD have recently enhanced the ISD held Scottish Drug Misuse Database (SDMD) to provide follow up information will lead to an enhanced understanding of the patient’s journey and experience in drugs services.

ISD is also currently involved in two key strategic pieces of work to improve the information base for national and local decision-making.

They are leading on the development of an NHS Information and Intelligence Strategy which aims to create a health intelligence strategy for Scotland for a 5 year period and will involve multiple health and social care agencies.

In addition ISD is developing a Substance Misuse Evidence Strategy which will identify the key questions for policy, planning and practice and determine how data and information can be assimilated and translated into high quality evidence, advice and interpretation to support decision-makers. The Strategy will cover the wider field of alcohol and substance misuse, including criminal justice, rather than focusing purely on health and social care. Stakeholders are currently being consulted and the aim is to publish the strategy in early 2011.
The Committee therefore recommends that the Scottish Government ensures that the development of a national A&E data set be completed quickly so as to assist NHS Boards to respond more effectively to these growth areas.

**SGHD Response – Agreed**  
In July ISD amended their A&E data mart to allow the submission of data from NHS Boards to identify cases where an individual’s alcohol consumption was a factor in their A&E attendance. The definition of which cases should be identified as ‘alcohol involved’ was clarified in discussion with the Scottish Branch of the College of Emergency Medicine. Updated guidance was issued to A&E information contacts within Boards in September.

ISD have regular 6 monthly A&E Data Quality meetings with Boards at which they are now raising the capture of ‘alcohol involved’ attendances, encouraging Boards to improve recording and reporting and to share good practice with one another.

**151.** More generally the Committee would welcome further information from the Scottish Government of how ISD Scotland identifies those areas of future health decline on which it should begin to collect data nationally so as to assist NHS Boards (one such area may be obesity).

**SGHD Response – Noted**  
ISD’s work is organised within a number of Programmes, each overseen by a steering group or similar arrangement with stakeholders. Consideration of emerging trends, forward planning and reprioritisation of work according to the needs of these stakeholders takes place within these groups and is coordinated across ISD through their business planning processes including as part of the LDP process. Until recently a key mechanism was the operation of a high-level ISD Steering Group to prioritise across all programme areas, based on a steer from key stakeholders about their priority requirements. This process is currently being replaced by the development of a National Information and Intelligence Strategy for Health and Care for Scotland. The aim of the strategy is to ensure that information develops in line with agreed priorities; to ensure that resources are focussed on national and local level priorities and are used effectively; to provide a strategic context against which decisions are made about allocation and prioritisation of resources to support the development of information intelligence; to provide predictability around when new pieces of information or data will be available (both nationally or locally) while maintaining flexibility to changing priorities; and to inform the eHealth strategy for IT systems development. The Strategy should be completed by Spring 2011.
“In order to ensure that the commitment to quality is delivered in practice, I am establishing a national scrutiny group, comprising unions, NHS employers and the Scottish Government. This group will subject Board workforce plans to ongoing scrutiny to ensure that they are the result of genuine partnership working and that they do not impact adversely on the quality of patient care. This group will liaise closely with local Area Partnership Forums and raise any issues of concern with the Scottish Partnership Forum and directly with me.”

Overarching Principles

2. The proposed remit for the Group, which is set out below, is intended to reflect the overarching principles that the Group should:

(i) operate within the existing partnership structures;

(ii) take, as its starting point, the need to add value to Board level partnership arrangements;

(iii) take a strategic national overview, based on collective consideration of reports from the Chairs of Area Partnership Forums;

(iv) focus on variation between actual and anticipated workforce numbers (i.e. on change rather than on the total workforce); and

(v) seek assurance about the impact of such change on quality of care.

Remit

3. Following consultation with stakeholders, the remit of the National Scrutiny Group is:

to provide scrutiny of workforce developments and changes and how they can facilitate improvements in the quality of service delivery and resulting patient benefits. The proposed arrangements are intended to ensure that:

- staff side representatives can play their part in assisting NHS Boards to deliver prudent financial and workforce plans while maintaining a focus on quality, and

- the strong partnership arrangements already in place can be utilised to provide a strategic assessment of progress at a Scottish level.”

Structures and roles

4. The approach set out in the remit envisages the use of existing partnership channels, as set out below:

(i) Area Partnership Forums (APFs)

- Individual APFs should provide a perspective on local delivery plans and on NHS Boards’ progress against the measures set out in the Quality Strategy scorecard.

(ii) National Scrutiny Group

The National Scrutiny Group will:
• Collect feedback from APFs, building a national picture of the delivery of the three Quality Ambitions;

• Identify instances of good practice which might be applied elsewhere; and

• Highlight strategic financial and workforce issues impacting on the quality of service delivery

The National Scrutiny Group will submit summary reports of its monitoring activity to the Scottish Partnership Forum (SPF) and to the Cabinet Secretary.

(iii) Scottish Partnership Forum (SPF)

The SPF will:

• Consider the National Scrutiny Group reports and submit the reports to Board Chief Executives; and

• Represent Partnership interests in the Quality Alliance.

Membership

5. The membership of the National Scrutiny Group should, as far as is possible, reflect the existing partnership structures. Accordingly, the membership is based around the current Partnership Secretariat membership, suitably adjusted to ensure that it does not duplicate SPF membership, and so that trade unions have a balanced representation. The membership is:
<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Co-Chair (Scottish Government)</td>
<td>Ingrid Clayden</td>
<td>Director, Health Workforce, Scottish Government</td>
</tr>
<tr>
<td>Co-Chair (NHS)</td>
<td>George Brechin</td>
<td>Chief Executive, NHS Fife</td>
</tr>
<tr>
<td>Co-Chair (staff side)</td>
<td>Theresa Fyffe</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Member (NHSS)</td>
<td>Rona King</td>
<td>HR Director, NHS Fife</td>
</tr>
<tr>
<td>Member (NHSS)</td>
<td>Ian Reid</td>
<td>HR Director, NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Members (staff side)</td>
<td>Michael Fuller</td>
<td>Unite</td>
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<td></td>
<td>John Gallacher</td>
<td>Union</td>
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<td>Mike McGahey</td>
<td>Unison</td>
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<td></td>
<td>Norman Provan</td>
<td>Royal College of Nursing</td>
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<tr>
<td></td>
<td>Martin Woodrow</td>
<td>Scottish Secretary, BMA</td>
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<tr>
<td></td>
<td>Gillian Smith</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td></td>
<td>Elizabeth Stow</td>
<td>Society of Radiographers, representing AHPs</td>
</tr>
<tr>
<td>Member (Employee Directors)</td>
<td>Ray Stewart</td>
<td>Chair of Employee Directors Group</td>
</tr>
<tr>
<td>Member (Scottish Government)</td>
<td>Jill Vickerman</td>
<td>Deputy Director, Healthcare Planning, Scottish Government</td>
</tr>
<tr>
<td>Member (Scottish Government)</td>
<td>Christine McLaughlin</td>
<td>Deputy Director, Health Finance, Scottish Government</td>
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<tr>
<td>Member (Scottish Government)</td>
<td>John Nicholls</td>
<td>Deputy Director, Health Workforce, Scottish Government</td>
</tr>
<tr>
<td>Member (Scottish Government)</td>
<td>Stephen Gallagher</td>
<td>Health Directorate, Scottish Government</td>
</tr>
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