Director-General for Health & Social Care and
Chief Executive of NHS Scotland
Caroline Lamb

E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

Richard Leonard MSP
Convener
Public Audit Committee
Scottish Parliament
Edinburgh
EH39 1SP

Publicaudit.committee@parliament.scot

11th March 2025

Convener,

Thank you for your letter of 11 February 2025 following the evidence session of 29 January.

Further to your requests, I am happy to provide further information on these areas as follows.

Focus on preventative measures

Our commitment to driving preventative measures includes significant reform activity to support and deliver the change needed for sustainable health and social care services, so that they can provide greater prevention and early-intervention support, as well as delivering services and treatment where and when people need them.

As the First Minister outlined in his speech on 27 January, we are taking steps to reform and renew our health service and deliver the change that people in Scotland need now. We are focusing on four key areas – prevention, improving access to treatment, shifting the balance of care, and improving access to health and social care services through digital and technological innovation.

Although treating ill health across the population is essential, we want to do more to detect and prevent ill health before it happens and by increasing our focus in these areas, we will improve health and reduce demand on our health and care services. We are therefore building on the positive and innovative actions we are already taking across areas including tobacco and alcohol control to improve population health and reduce health inequalities.

We have developed a long-term Population Health Framework, taking a cross-government, cross-sector approach to improve the key building blocks of health. We anticipate this will be published this Spring. The Framework is being developed jointly with COSLA and in collaboration with key partners, including Public Health Scotland. It will focus on primary prevention activities, and will consider what more can be done to mitigate against the social and economic drivers of ill health and build a Scotland – with places and communities – that positively supports health and wellbeing. This will be complemented by holistic actions which promote health and wellbeing, reduce health harming activities and enable equitable access to healthcare.

As the First Minister also set out, as well as publishing the Population Health Framework, we will be publishing a detailed NHS Operational Improvement plan in March, and a medium-term approach to health and social care reform before summer Parliament recess. This will build on the vision set out by the Cabinet Secretary last June and the actions outlined there, continuing to improve the health and social care system, putting people first, community first, and digital first and demonstrate how we plan our services for our whole population over the period 2025-2030.

We are already taking immediate action on primary prevention actions planned for the next 18 months include taking forward the Four Nations Tobacco & Vapes Bill; improving the food environment through legislation to restrict the promotion of food and drink high in fat, sugar or salt; and building on our work on the uprating the Minimum Unit Price of alcohol.

Recognising the social and economic drivers of ill health and mutual benefits in economic growth, we are also working closely with DG Economy on a programme of work relating to reducing ill health related economic inactivity.

We are also focusing on proactive prevention by investing in general practice and community-based teams to enable more proactive outreach in areas of greatest need and work with people who have a high risk of Cardiovascular Disease (CVD) or frailty.

Staff absence

As requested by the committee, the current sickness absence rates are as follows:

- The sickness absence rate for NHS Scotland in the Financial Year of 2023/24 has remained at 6.2%, the same as last year and the highest rate recorded.

- There was an increase in the sickness absence rate in 13 NHS Boards during the past year, while nine NHS boards reported a decrease. In the three years prior to the pandemic, the average sickness absence rate was 5.4%.

- Sick absence rates have been increasing since 2014 and have increased further post pandemic.

- The three most common absence reasons recorded when an absences type is sickness are:

    - cold, cough, flu – influenza,
    - gastro-intestinal problems, and,
    - anxiety/stress/depression/other psychiatric illness.

Our staff are the most valuable asset to the NHS and we are grateful to them for their dedication. To support them, we have a number of wellbeing initiatives, and improving and maintaining good staff wellbeing will reduce the risks of burnout and staff becoming unwell in addition to having a positive effect on their performance.

From 2024/25, more than £2.5 million has been provided annually by the Scottish Government to support health and care staff wellbeing, underscoring a commitment to offer care to those most in need.

This funding provides our workforce with access to psychological interventions and therapies, self-service resources through the National Wellbeing Hub and the National Wellbeing Helpline delivered by NHS 24. Registered staff also have access to confidential mental health services through the Workforce Specialist Service (WSS).

Financial sustainability – costs of prescribed drugs

Medicines play a crucial role in the NHS and to our commitment to supporting people to live longer, healthier lives. Medicines represent the most frequent healthcare intervention and are the second largest item of expenditure for the NHS in Scotland.

Expenditure on medicines overall is impacted by an ageing population, co-morbidities which manifest at an earlier age in Scotland, health inequalities and associated rising levels of acuity, all of which manifest in a growing volume of prescribed medicines and an associated increase in the cost of medicines for both existing and new medicines.

In addition to demographic differences, there are different approaches taken to decision making on access to medicines across the UK. For example, the health technology assessment approaches used across the UK vary and there are different drug tariff arrangements in place.

There are also a number of commercial arrangements that mean that the published costs of medicines does not necessarily reflect the actual price paid and published. Further information on the mechanisms and controls to ensure the clinical and cost effectiveness of medicines are included in **Annex A**.

There are also different approaches to the supply of some high-cost medicines such as cancer and hepatitis C medicines. Therefore, whilst I have set out a comparison, as requested, the differences between systems and data sources make direct comparisons of the costs of prescribed medicines between UK nations difficult and call into question the appropriateness of making these comparisons publicly available.

Drug Expenditure across Scotland, England, Wales and Northern Ireland

Total NHS Drug Expenditure

The total NHS drug expenditure reported for hospital services, community services and family health services in Scotland in 2023/24 (the latest published NHS Scotland Cost Book) was £2.2 billion[1]. Other NHS services costs data are detailed separately.

The equivalent total NHS drug expenditure reported for hospitals and community services in England in 2023/24 was £20.6 billion[2].

There are no available comparable published data for the total drug expenditure for the NHS in Wales and Northern Ireland.

Hospital Drug Expenditure

This is a subset of data, from the equivalent NHS Scotland[1] and NHS England reports[2].

The cost of drugs dispensed in hospital settings in Scotland in 2023/24 was £651 million.

The cost of drugs dispensed in hospital settings in England in 2023/24 was £10.3 billion.

There are no available comparable published data for hospital drug expenditure for the NHS in Wales and Northern Ireland.

Primary and Community Care Prescription Costs

The following data are a sub-set of the total NHS drug expenditure detailed above[1,2].

In Scotland, the total cost of prescription items dispensed and reimbursed at list price in the community was 1.3 billion[3] in 2023/24. This represented a 5.6% increase from 2022/23 and a 28.3% over the last 10 years.

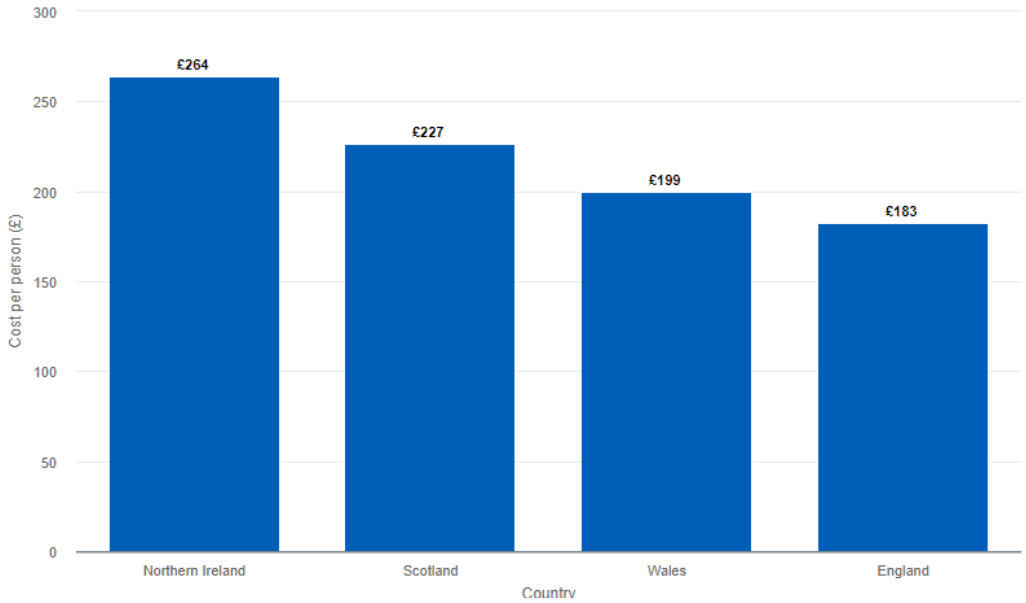
In England, the total cost of prescription items dispensed and reimbursed at list price in the community was £10.9 billion in 2023/24[4]. This represented a 5% increase from 2022/23 and a 22% increase over the last 10 years.

In Wales, the total cost prescription items dispensed and reimbursed at list price in the community was £704 million in 2023/24. This represented a 4.6% increase from 2022/23 and a 21.1% increase over the last ten years[5].

[1] NHS Scotland cost book table - Scotland
[2] Prescribing Costs in Hospitals and the Community - England
[3] PHS – summary statistics Trend for NHS Scotland 2023/24 – Tab 1
[4] Prescription Cost Analysis England 2023/24
[5] Primary care prescriptions: April 2023 to March 2024

In Northern Ireland, the cost of prescription items dispensed and reimbursed at list price in the community was £500.5 million in 2024. This represented a 0.7% decrease from 2022/23 and a 14.3% on 2017 levels (notably data for the last ten years in unavailable).[6]

Primary Care Prescription Costs per Person in the UK 2022/23



England had the lowest prescription cost per person in 2022/23 at £183. Northern Ireland had the highest prescription item cost per person in 2022/23 at £264. This is taken from the Prescription Cost Analysis data from England but covers the 2022/23 period and therefore is a year behind the data shared earlier.

Analysis

The published data shows that there is an overall marginal increase in the costs of the total NHS drug expenditure reported for hospital services, community services and family health services in Scotland compared to England. Comparing hospital expenditure specifically, England's expenditure would appear to be higher than Scotland. The reverse applies when comparing community prescribing. It is worth noting, however, that these data are imperfect and do not provide a direct comparison.

As outlined, the differences between systems and data sources make direct comparisons of the costs of prescribed medicines between UK nations difficult. For example, the Scottish PCA combines Family Health Services and some hospital-issued prescriptions dispensed in the community which can have an impact on the primary care drugs bill and prescriptions dispensed in primary care, while England's PCA compiles the same excluding some high cost medicines, including medicines for the treatment of hepatitis C. For example, this exclusion of some high cost medicines from the English PCA could, in part, explain some of the differences seen in overall costs between Scotland and England. Similarly, it is not obvious from the

[6] Prescription Cost Analysis 2024 – Northern Ireland

published data how administrative fees and overheads are accounted for between the different nations.

It is also difficult to know what impact prescription charges in England has on the data; for example the income from charges may offset some costs, although it is not clear if this is acknowledged in the PCA and equally there is evidence that prescription charges reduce medicine adherence as a result of some people needing to choose between everyday costs and the costs of prescriptions and this may influence behaviours and impact on the overall costs.

It is also important to note that commercial in confidence pricing agreement such as Patient Access Schemes and Primary Care Rebate Schemes and the Voluntary Pricing, Access and Growth arrangements are not captured in the published information and therefore any impact and potential differential impact by UK nation is unknown.

Medium term financial planning

In line with Audit Scotland's recommendation in their NHS in Scotland 2024 report, the Scottish Government is developing a Medium-Term Financial Framework (MTFF) for the Health & Social Care Portfolio, covering the five year period to 2029/30. The model will forecast costs across all areas of the Portfolio's expenditure including prescribing cost and volume growth. The MTFF will be published in due course and will provide valuable insight to prescribing costs across NHS Scotland.

Summary of costs

While the ingredient cost for drugs in Scotland, England and Wales show an overall increase over the past ten years, comparisons with England and Wales are becoming less meaningful as divergence in policy continues to widen.

Whilst creating a comparison based on published data, the figures in this response do not provide a wholly accurate comparison between nations as each uses a different methodology when compiling the available published reports. Examples of these differences are set out in **Annex B**.

Despite difficulties with comparable data, NHS Scotland is experiencing similar prescribing cost pressures as other UK nations and we continue to collaborate with other health systems to share learnings and best practice.

Medicines and Procedures of Limited Clinical Value

The Committee asked for a draft list of medicines and procedures which have been identified to be of limited clinical value. There are several strands of work currently underway which aim to ensure that NHS Scotland delivers better value care for both citizens and our health and care system.

Work to refresh the Exceptional Referral Protocol (ERP) guidance. This work is expected to be completed by the Spring. Until the refreshed ERP guidance is

produced, current guidance within the Exceptional Referral Protocol (2019) and Varicose Vein Protocol (2019) remains extant. NHS Boards are expected to implement both protocols. Following the refresh of the ERP, varicose vein protocols, we will develop a longer term approach to procedures of limited value - one which is clinically led and where resources that are currently spent on lower value care, like varicose vein surgery, can be used to support high value care.

A full list of medicines identified as of low and limited clinical value to NHS Scotland was published in the Scottish Government guidance Achieving Value and Sustainability in Prescribing 9 December 2024. This guidance aims to reduce the use of low value medicines and ensure the effective use of medicines with limited clinical value across NHS Scotland. It also aims to ensure best value in the choice of blood glucose monitoring strips and insulin pen needles and ensure the most effective use of antimicrobials (antibiotics) to minimise inappropriate use and reduce the risk of antimicrobial resistance. It provides guidance to minimise the unwarranted variation in the prescribing of medicines and make the most efficient use of resources.

The guidance was produced by an expert working group and supports the principles of Realistic Medicine through shared decision making, encouraging medicine reviews, and ensuring medicines with low or limited value are not prescribed inappropriately.

Ambulance service waiting times and performance

In relation to ambulance services, the committee enquired about the triage process and performance metrics used to determine response.

In the Call Triage Process, on dialling 999, patients are connected with call handlers who will then make an appropriate assessment and triage. This falls into the following categories, with the call then being colour coded according to the nature of the incident:

- Immediately Life Threatening
  Patients whose condition is potentially life-threatening and a fast response is vital. This accounts for less than 10% of 999 calls received. These patients will be responded to by skilled Paramedics and will normally be taken to A&E or specialist care. An example would be a patient in cardiac arrest.

- Urgent and Emergency
  Some emergency and urgent calls will also require a quick response and conveyance to hospital i.e. GP calls and non-life threatening emergencies.

- Hear, Treat & Refer
  Patients whose condition is not serious enough to require an ambulance to attend or is likely to result in any need to go to hospital. These patients can safely be given telephone advice by a Paramedic, referred onto NHS 24 for further advice or referred onto another service, such as a GP. An example would be a person with flu-like symptoms.

- See, Treat & Refer
  Patients whose condition requires face-to-face assessment by a skilled Paramedic but, in many cases, may be safely and effectively treated by that Paramedic at scene without any need to go to hospital. Alternatively, these patients may be referred directly to more appropriate services. An example would be an elderly patient who has fallen but is uninjured who could be referred onto a specialist community team and their care could be managed at home.

- Anticipatory Care
  Patients living with one or more long-term conditions whose care can be managed proactively at home, where a package of care has been put in place to support patients to stay at home. Specialist Paramedics can help deliver this care package working alongside colleagues in health and social care. An example would be a patient living with Chronic Obstructive Pulmonary Disease whose acute exacerbation requires urgent care.

- Non-Emergency (Scheduled Care)
  Patients who require to be admitted or discharged from hospital, or transferred between hospitals for further treatment and patients attending hospital for a scheduled outpatient appointment. These patients require a degree of clinical or mobility support but are in a stable condition. An example would be a patient admitted for elective surgery or attending an outpatient appointment where ambulance transport was required.

Calls are then placed into the following categories:

- **Purple**: The most critically ill patients. This is where a patient is identified as having a 10% or more chance of having a cardiac arrest. The actual cardiac arrest rate across this category is approximately 53%. Target response <6 mins.

- **Red**: The next most serious category where a patient is identified as having a likelihood of cardiac arrest between 1% and 9.9%, or having a need for resuscitation interventions such as airway management above 2%. Currently the cardiac arrest rate in this category is approximately 1.5%. Target response <7 mins

- **Amber**: Where a patient is likely to need diagnosis and transport to hospital or specialist care. The cardiac arrest rates for all of these codes is less than 0.5%. Target response <15 mins.

- **Yellow**: A patient who has a need for care but has a very low likelihood of requiring life-saving interventions. For example, patients who have tripped or fallen but not sustained any serious injury. Target response <20 mins.

The ability to refer patients to pathways that can best meet the needs of patients within their own communities remains a key priority for SAS and the wider system.

To note, Scottish Ambulance weekly performance data is published on their website at Unscheduled Care Operational Statistics.

I hope this information is useful to the committee.

Kind regards

Caroline Lamb

Chief Executive, NHS Scotland and Director-General for Health and Social Care

Annex A

Mechanisms and controls to ensure the clinical and cost effectiveness of medicines

Scottish Medicines Consortium

Since the introduction of the Scottish Medicines Consortium (SMC) in 2002, new medicines are subject to robust scrutiny, using a globally validated health technology appraisal process, to determine their clinical and cost-effectiveness at a population level for Scotland. No other medical intervention receives the same level of scrutiny. Unlike the National Institute for Health and Care Excellence (NICE), the SMC does not have a formal threshold limit on the cost per Quality Adjusted Life Year (QALY). Instead, the cost per QALY forms part of the SMC's deliberative decision-making framework, which includes a range of additional factors or modifiers as well as any issues which may have been highlighted by the manufacturer of the medicine, by clinical experts and/or by patient groups. Once the SMC has recommended a medicine, it is expected that NHS Boards will make it, or an equivalent SMC-accepted medicine, available on their local formulary for routine prescribing. A formulary is a list of medicines which are available for routine use within a Health Board; they are published on Health Boards' websites.

Area Drug and Therapeutics Committees and Formularies

An Area Drug and Therapeutics Committee (ADTC) is the key professional advisory group for medicine governance in each Health Board. ADTCs are key to ensuring that adequate systems and processes relating to medicines governance are in place in local Health Boards. They are clinically-led and clinically driven committees that ensure medicines issues are addressed across the health system. One of the roles of an ADTC is to produce a prescribing formulary. A formulary is defined as a preferred list of medicines recommended for use, providing appropriate treatment for the majority of patients with common conditions. The recommendations contained within a formulary are evidence based and developed by utilising expert opinion and

considering best practice. A key aim of any formulary is to promote high quality, safe and effective, value-based prescribing. In Scotland, we are currently using a collaborative consensus model, with local and regional cooperation, and local sign-off to develop regional formularies. This was recommended to ensure that the function of developing a formulary continues to be delivered by Health Boards underpinned by local clinical ownership and that a formulary can continue to accommodate local health needs and care pathways appropriate to local service structures and processes. The East Region Formulary (NHS Borders, NHS Fife, and NHS Lothian) is now established and work has commenced on scoping out a West Region Formulary ((NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Forth Valley, NHS Golden Jubilee, NHS Greater Glasgow & Clyde, and NHS Lanarkshire).

Voluntary and Statutory Schemes for Branded Medicines Pricing, Access, and Growth

On 1 January 2024, a new five-year Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) was launched, replacing the previous 2019 Voluntary Scheme for Branded Medicines Pricing and Access (VPAS). The VPAG is a voluntary agreement between the UK Department of Health and Social Care (DHSC), NHS England and the Association of the British Pharmaceutical Industry (ABPI), that is designed to improve patient outcomes, manage the NHS medicines bill, and support the life sciences industry. Over its lifetime, the scheme is expected to generate £14bn in savings (compared to £7 billion from the previous VPAS scheme) across England, Scotland, Wales, and Northern Ireland. Manufacturers or suppliers of branded medicines who choose not to join the 2024 Voluntary Scheme are subject to a statutory scheme.

The VPAG sets a cap on the total allowed sales value of branded medicines to the NHS each year. The cap grows at an agreed rate over the five years of the scheme. Medicine sales above the cap are repaid to the DHSC via a levy on pharmaceutical companies. Company payments are calculated on two affordability mechanisms: one for newer medicines and one for older medicines. The aim is to balance the level of risk held by industry and government, and the level of scheme payments associated with various stages of the lifecycle of a given medicine. The intention is that by generating additional income from older medicines that have not had to reduce prices in response to competition, lower payment rates for newer medicines and those that have made larger price reductions can be supported.

The Scottish Government has committed to investing the rebates we receive from the VPAG to fund the New Medicines Fund (NMF), which provides additional top-up funding to territorial Health Boards to support the cost of introducing new medicines. **This is not captured in any published reports on costs.**

Patient Access Schemes and other commercial arrangements

A pharmaceutical company can offer a Patient Access Scheme (PAS), which is the equivalent of a discount to the listed price of the medicine, to help improve value for money considerations during the SMC assessment process. There are two types of PAS; a simple discount scheme and a complex scheme. The NHS in Scotland commits to maintaining the confidentiality of the arrangements irrespective of

scheme type. A simple PAS involves a discount from the NHS list price which is applied at the point of invoice when supplied through secondary / tertiary care, homecare, or a third-party compounder, as well as a confidential retrospective rebate to Health Boards for any agreed PAS medicine supplied in primary care (community pharmacies, dispensing doctors, and prisons). A complex PAS include all other types of cost reduction mechanism such as: rebates (when medicine is supplied via secondary / tertiary care or homecare), stock supplied at zero cost, dose / spend capping and outcome-based schemes (based on patients' response to treatment). From experience, complex schemes can introduce significant complexity and burden for the NHS and pharmaceutical companies. Notably the perceived financial benefits of such complex schemes may not be fully realised in practice. They tend to be accepted only in exceptional circumstances. **As these are commercial in confidence agreements, they are not captured in any published reports on costs.**

Notably, VPAG requires that the details of national commercial arrangements agreed with the purchasing authority in one UK country will be made available on a confidential basis to purchasing authorities in any other part of the UK. On comparable arrangements provision, scheme members will work with purchasing authorities to achieve comparable arrangements that provide an acceptable value proposition in each part of the UK. This helps to ensure that discounts are applied equably across the UK.

The Scottish Drug Tariff

The Scottish Drug Tariff contains information regarding the NHS prescribing, dispensing and reimbursement of medicines, medical devices, and appliances in the community. It lists the reimbursement prices paid by the NHS for approved prescribable items. With regards to the process, it is for the manufacturers of medicines and devices to consider submitting their products for inclusion in the Scottish Drug Tariff based on their business and commercial operations. Any medicine or device shall only be included in the Scottish Drug Tariff following an appropriate assessment including the clinical benefits and cost effectiveness. Part 7 of the Scottish Drug Tariff details the reimbursement price for non-branded (generic) medicines. The reimbursement price also includes an agreed margin which cross-subsidises all the NHS community pharmacy services provided by community pharmacy contractors.

Annex B

Cost comparisons across the UK – background

The Scottish NHS Cost Book

The NHS Cost Book in Scotland (most recent publication covering 2023/24) and the Prescribing in Hospitals and the Community in England provide an overview of spend across almost the whole healthcare system.

In Scotland, the NHS Costs Book is currently structured to analyse around 95% of the NHS Scotland net operating costs. This includes expenditure on the provision of healthcare within the fourteen territorial health boards, the State Hospital, the National Waiting Times Centre (Golden Jubilee University National Hospital and two national health boards that provide direct patient care – the Scottish Ambulance Service (SAS) and National Services Scotland (NSS).

The information in the NHS Costs Book is split into: hospital services including outpatient clinics and rural community hospitals and primary care services: community services which covers home visits by healthcare professionals and prevention services such as screening; and family health services (GPs, dentists, optometrists, and community pharmacies)

Prescribing in Hospitals and the Community in England

The Prescribing in Hospitals and the Community in England includes prescriptions issued by GP practices and community prescribers, hospitals, dental practitioners, medicines issued in hospitals in England, that were dispensed via the hospital pharmacy, homecare companies, or outsourced outpatient pharmacy partnerships and medicines prescribed and dispensed in the Adult Secure Estate. It does not include dressings and devices issued in secondary care, since supply of these is usually made via the NHS Supply Chain.

Prescription Cost Analysis

Prescription Cost Analysis (PCA) statistics cover drug ingredient costs prescribed and dispensed in primary and community care and therefore is a sub-set of the NHS Cost Book data. **PCA statistics are produced separately by each UK nation**, **and there are differences in data collection, healthcare structures, and methodology.** Therefore, it is difficult to objectively make direct comparisons of the data from the different UK nations in isolation of also considering the broader context of the UK's health and social care landscape. As highlighted previously, there are also other multi-factorial issues that make it difficult to make direct comparisons of the costs of prescribed medicines between UK nations.

It should be noted that different naming conventions are used across the nations.

In Scotland we refer to the following:

- Gross Ingredient Cost (GIC) is the cost of medicines and appliances dispensed and reimbursed at list price. This measure is used to make comparisons of costs of specific items.
- Net Ingredient Cost (NIC) is the costs of items reimbursed after any dispenser discounts (these are discounts received from wholesalers and suppliers). This is used to give an accurate figure of what contractors were reimbursed for total medicines and appliances dispensed.
- Gross Cost is the cost of medicines and appliances reimbursed after discount (NIC) plus the cost of remuneration for pharmacy services provided to the public. This shows the total amount contractors were paid for dispensing items and providing services.
- Total (Net) Cost is the cost of medicines & appliances reimbursed after discounts plus the cost of remuneration for services provided, plus advance payments and minus any patient charges. This shows the final cost to the Scottish Government.

For the purposes of this paper, we have used the GIC and NIC and not Gross Costs or Total Net costs as they reflect spend on medicines and not remuneration for services.

In Scotland, the GIC is considered the cost measure of choice for inter-organisation comparison of prescribing. That is because NIC incorporates the discount rate applied which may include a sliding scale meaning that Health Boards or GP Practices whose prescriptions are dispensed by higher volume pharmacies would appear to be more cost-efficient prescribers than Boards where that was not the case. However, NIC better reflects the actual costs to the NHS, albeit that it does not include the discounts from Patient Access Schemes, Primary Care Rebate or monies returned through the UK Voluntary Pricing, Access, and Growth agreement. NIC tends to be used for looking at changes over time and trends in the cost of medicines to the NHS.

For the cost of items dispensed and reimbursed before deduction of any dispenser discount, England, and Wales both use the term NIC and Northern Ireland use ‘Ingredient Cost’. As a result, the Scottish GIC, is the closest comparison with the NIC in England and Wales. Similarly, for the cost of items dispensed and reimbursed after deduction of any dispenser discount (the Scottish NIC), England use the term ‘Actual Cost’. Wales and Northern Ireland do not report on these measures.