NHS TAYSIDE

SHAPING SURGICAL SERVICES REVIEW

- Unscheduled surgical care (general, urology and vascular) has been delivered on two sites: at Ninewells (Dundee) and at Perth Royal Infirmary (PRI).
- The Board ran a consultation exercise (3 Aug to 24 Oct) which looked at the delivery of surgery across Tayside.
- On 16 Jan, NHS Tayside Board approved:
    - the continuance of 3 surgical units at Ninewells, PRI and Stracathro;
    - all unscheduled surgery will come to Ninewells;
    - an increase in the number of elective surgery patients at PRI; and
    - an increase in day case and minor elective surgery patients at Stracathro.
- The proposals were received by the Cabinet Secretary for Health and Sport for consideration on 20 Feb.
- Officials are preparing advice for submission to Cabinet Secretary shortly
- The proposals constitute major service change and, as such, require Ministerial approval.
- The Cabinet Secretary for Health and Sport will carefully consider all available information and all representations made to her before coming to a final decision in the best interests of patients.

PRESCRIBING OF PAINKILLERS

- On 30 Apr the Daily Mail stated NHS Tayside would stop prescribing painkillers *"in an effort to plug a £44 million shortfall."* It added that the Board would no longer prescribe paracetamol or ibuprofen to save £1 million per year.
- The article added that patients taking these drugs as part of a longer-term treatment would still be entitled to a free prescription.
- Miles Briggs MSP (Conservative) was quoted as saying *"NHS Tayside would have to find a lot of paracetamol to ban if it's going to make any dent on its finances….the Board needs a root and branch review of its finances not minuscule shortcuts. The fact that Boards are now having to take such measures demonstrates just how desperate the situation has become"*
- NHS Tayside advise that there are no plans to stop prescribing ibuprofen or paracetamol in primary care where they are felt to be clinically appropriate.
- The Board are proposing to raise public awareness of the availability of these medicines and that when they are only required in very small numbers and for a short period of time, it is not necessary to see a GP to request a prescription.

FINANCIAL PERFORMANCE

- Tayside is currently forecasting a deficit of £12.1 million for 2017/18. This includes £5.3 million of eHealth funding which was, in effect, a form of concealed unofficial brokerage from NHS National Services Scotland to NHS Tayside that was not approved by Scottish Government Health Finance.
- Outstanding brokerage totals £33.2 million which was accrued over a period of five years, including £13.2 million provided in 2016-17. Repayment of brokerage is currently suspended, for up to 3 years, to allow the Board to return to financial balance; repayment will follow thereafter.

Perth and Kinross – increases in social care charges

- A story in the Courier (16 May) says Perth and Kinross Council is changing its adult social care policy and charges for regular breaks/support for a 40 year old man with learning disabilities and his family will increase from £400 per year to £4,000 per year.

- Local authorities have the ability to charge for social care, taking into account the annual guidance produced by COSLA. The charges must be proportionate, and must not exceed the cost of providing the service.
- We have worked with COSLA to reduce charges for social care already, by providing £6m to increase charging thresholds in 2016/17.
- From April 2019, we are extending free personal care to under 65s, so that everyone who is assessed as requiring personal care receives it free of charge.
- Local authorities will take into account the ability to pay for services in their financial assessments, and are able to reduce or waive charges according to individual circumstances.
- Local authorities are also required to waive charges for support provided to unpaid carers.

FINANCE

- In 2018-19, NHS Tayside will receive £13.7 million increased investment (an uplift of 1.9%) and a share of £175 million to support reform.
- NHS Tayside's budget has increased in cash terms by £217.8 million (42.1%) from 2006-07 to 2018-19.

A&E PERFORMANCE – 95% Target

- 98.0% compliance against the 4-hour A&E target in March 2018.
- 97.2% performance for the Core Emergency Departments in March 2018.
- 98.8% performance for week ending 29 April 2018 for the Core EDs.

WORKFORCE (September 2006 to December 2017)

- All staff (WTE) up 6.1% or 670.8 WTE (from 11,064.6 to 11,735.4).
- Qualified Nurses and Midwives (inc. interns) up 5.3% or 191.9 WTE (from 3,634.9 to 3,826.8).
- Allied Health Professions (excl Paramedics) up 8.4% or 68.2 WTE (from 812.8 to 881.0).

WAITING TIMES

REFERRAL TO TREATMENT WAITS - 90% Target

- NHS Tayside have not been able to provide 18 weeks RTT figures in October–December 2017 due to reporting problems following the implementation of their new patient management system in June 2017.

INPATIENT WAITS – 100% Target

ET Hub 10/5

- 80.3% of patients were treated within the 12 week legal treatment time guarantee for quarter ending December 2017. (5,527 inpatients, with 4,437 under 12 weeks and 1,090 over 12 weeks, adjusted figures.)
- Nearly 124,000 inpatients and day cases have benefitted from the 12 weeks treatment time guarantee since 1 October 2012 – 91.5% delivery.

OUTPATIENT WAITS – 95% Target

- 62.2% of patients waiting less than the 12 weeks standard for a first outpatient consultation on 31 December 2017. (ISD stats February 2018).

CANCER – 95% Standard

- Quarter ending December 2017, 87.1% of cancer patients started treatment within 62 days of urgently referred with a suspicion of cancer.
- Quarter ending December 2017, 95.1% of cancer patients started treatment within 31 days of decision to treat.

PSYCHOLOGICAL THERAPIES WAITING TIMES – 90% Standard

- 54.7% of patients were seen within 18 weeks quarter ending December 2017.

CAMHS WAITING TIMES – 90% Standard

- 41.5% of patients seen within 18 weeks in quarter ending 31 December 2017.
- This was a partial return based on 2 months of data.
- Tayside were not able to provide data for October due to the introduction of a new patient management system.

DELAYED DISCHARGE

- As at March 2018 there were:
    - 42 delay over 3 days.
    - There were 2,738 bed days lost to delays.

SAFER HOSPITALS

- Since 2007, MRSA have decreased by 100% in the most recent quarter.
- Since 2007 cases of C.diff in those aged 65 and over have decreased by 95%.

BOARD LEADERSHIP

- Acting CEO: Malcolm Wright, Interim Chair: John Brown, Medical Director: Dr Andrew Russell.

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PRESCRIPTION DRUGS - PAINKILLERS

SUMMARY: On Sunday 27 May the Scotland on Sunday published an article with the headline “Revealed – the cost of free Paracetamol to NHS Scotland”. The article highlights that NHS Boards in Scotland spent £57 million pounds on paracetamol since the introduction of free prescriptions in 2011.

- Article was based on information obtained from a Freedom of Information (FoI) request to NHS Information Services Division showing the range of spend across all 14 NHS Boards using a range of selective examples.
- The article typically draws inappropriate comparisons between paracetamol on prescription and limited supplies that can be purchased over the counter (for patient safety reasons) for the treatment of self-limiting illness or conditions.

DRUG COST INCREASE

- Suggestions that the increase in cost is a result of free prescriptions doesn’t stand up to scrutiny.
- Between 2006 and 2016 in England where prescription charging remains and increases annually, costs have gone up by 12.3% to £9.2 billion pounds.
- The increase in the cost of drugs dispensed in the community (2.9%) are in line with anticipated trends.
- This reflects the shift of treating more patients closer to home and increase use of expensive specialist medicines traditionally reserved for hospital.
- These new treatments deliver better outcomes for patients and, although expensive, have been determined to be value for money by the NHS.
- In addition, the aging population increasingly complex health needs, and long terms conditions continues to drive up the cost of prescribing in primary care.
- Clearly more needs to be done on the prices that the NHS is having to pay to drug companies for medicines.
- The introduction of the UK Health Service Medical Supplies (Cost) Act 2017 will all the Scottish Government and other UK administrations to better ensure they are not paying more for drugs than is needed.

SCOTLAND V ENGLAND COMPARISON 2007-08 to 2016-17 (latest 10 year comparable trend available

- Between 2007-08 to 2016-17 the number of prescription items dispensed in the community increased in Scotland by 25.7%, compared to 38.7% in England over broadly the same period.
- The associated ingredient cost increased by 17.5% in Scotland compared to 9.9% in England.
- Prescription charges continue to rise in England – increased to £8.80 per item this year.
- Prescription charges are a tax on ill-health and a barrier to better health for many.
- Charging for prescriptions would mean that many people with chronic conditions, or even those receiving treatment for cancer, could be liable

PRESCRIPTION DRUGS - PAINKILLERS

- Prescription Charges Coalition in England represent nearly 40 charities who support people with chronic conditions. Members include: Arthritis Care, Asthma UK, British Heart Foundation, British Liver Trust, Crohn's and Colitis UK, Cystic Fibrosis Trust, Disability Rights UK, Motor Neurone Disease Association, MS Society, National Rheumatoid Arthritis Society, Parkinson's UK, Stroke Association, and the Terrence Higgins Trust among many others.
- In 2014 they conducted a new survey focusing on employment issues. They reported the finding of this survey of 5,159 people with long-term conditions and it showed that:
- 37% reported that the cost of their medication had prevented them from taking it as prescribed;
- 74% of those who said that they were not taking their medication as prescribed because of the cost reported that this had affected their ability to work; for 70% of these, this had included time off.
- The Scottish Government will continue to work with NHSScotland to encourage the pharmaceutical industry to ensure cost effective drugs are brought to the market.
- There is no direct correlation between increases in dispensing volume and cost and the introduction of free prescriptions
- Increases in volume and cost of drugs have been experienced in England where prescription charges remain in place (and continue to increase);
- For example, the cost of dispensing paracetamol over the 10-year period to 2016-17 has increased in Scotland by £5 million compared with £16.8 million in England (an increase of 91% and 30% respectively);
- The cost of dispensing aspirin over the 10-year period to 2016-17 has decreased by £2.5 million in Scotland compared with £20.2 million in England (a decrease of 47% in both cases);
- The cost of dispensing sunscreen over the 10-year period to 2016-17 has increased by £0.3 million in Scotland compared with £4.4 mllion in England (an increase of 130% and 271% respectively);
- Data in Scotland are published on a financial year basis, while the data in England are published on a calendar year basis.

PRESCRIBING 'EVERYDAY' ITEMS – PARACETAMOL etc.

- Health professionals only prescribe medication to patients who have a clear clinical need.
- Items such as paracetamol, aspirin and sunscreen can be essential as part of managing more serious illness including chronic pain, osteoarthritis, childhood fever, cardiovascular disease and the effects of treatment for cancer.
- There is no reason why someone suffering from any of these conditions should be made to pay a tax on ill health that a prescription charge would represent.

PRESCRIPTION DRUGS - PAINKILLERS

- It is not appropriate to compare the prescribing of items such paracetamol with those purchased over the counter due to the limited quantity that can be purchased for the treatment of self-limiting illness or conditions.
- Analysis of medicines use demonstrates that the majority of patients prescribed paracetamol receive it to manage chronic pain.
- Alternative treatments to paracetamol all have potential for causing more harm to patients through increased risk of side effects.
- In the same Scotsman article published 27 May 2018, Dr John McAnaw, chair of the Scottish Pharmacy Board was quoted *"it is very difficult to comment on the cost of one medicine in isolation"*
- Dr John McAnaw, chair of the Scottish Pharmacy Board, in the same article published in the Scotsman, 27 May 2018, *"Any increase might reflect that paracetamol is used as a first choice and frequently reduces the need for more expensive painkillers which might not have such a good safety profile, particularly in our frail and elderly population".*
- Charing for these items would not change patients' underlying condition. Impact could therefore be substitute prescribing of more expensive and potentially less clinically suitable drugs in some cases.

PARACETAMOL, ASPIRIN AND SUNSCREEN DISPENSING

Paracetamol	2017 (£mill) cost	2007 (£mill) cost	2017-2007 Change (£mill)	2017-2007 Change %
Scotland	10.4	5.4	5.0	91%
England	73.0	56.1	16.8	30%

Aspirin	2017 (£mill) cost	2007 (£mill) cost	2017-2007 Change (£mill)	2017-2007 Change %
Scotland	2.9	5.4	-2.5	-47%
England	23.3	43.5	-20.2	-47%

Sunscreen	2017 (£mill) cost	2007 (£mill) cost	2017-2007 Change (£mill)	2017-2007 Change %
Scotland	0.3	0.1	0.2	130%
England	6.0	1.6	4.4	271%

PRESCRIPTION DRUGS - PAINKILLERS

Note: Figures may not compute due to rounding.
NHS England are working with Clinical Commissioning Groups as part of the consultation to focus on over the counter medicines that would normally attract a prescription charge, and promote self-care.

POLICY FUNDING

- Specific funding has been made available to health boards to meet the costs of the commitment to abolish prescription charges – between 2008/09 and 2011/12 and total of £130 million was transferred to NHS Boards.
- Funding of £57 million was transferred to the baseline budgets of territorial NHS Boards in 2011/12 and so is available to boards on an ongoing basis.

PRIMARY CARE DRUG COSTS

ISSUE: Public Health Scotland published the annual **Dispenser Payments and Prescription Cost Analysis** on **Tuesday 20 September** 2022. The publication sets out the cost of medicines and appliances prescribed and dispensed in primary care and the remuneration made to community pharmacy contractors for the provision of NHS Pharmaceutical Care Services in 2021/22.
No national or local media outlets have reported on the publication to date or approached Scottish Government.
The publication shows that the cost for dispensing items and providing services in 2021/22 was **£1.45 billion**, **increasing by 3.7%** from £1.4 billion in 2020/21. This follows a period of largely rising cost, increasing by 30% over the last 10 years. In 2021/22 remuneration for services was **£296.6 million,** a slight **decrease of 0.2%**, this can be attributed to cessation of additional funding announcements made in 2020/21 to support the sectors response to COVID-19.

The publication shows an increase in line with expectations and reflecting our response to COVID-19 pandemic as we ensure people are treated in their communities and closer to home.

- The total (net) cost for dispensing items and providing services in 2021/22 was £1.45 billion, increasing slightly on 2020/21 by 3.7% from £1.4 billion. This is in line with expectations.
- An ageing population with increasingly complex health needs, and more people living with long term conditions, continues to drive up the cost of prescribing in primary care.
- Access to NHS prescribed medicines are vital, particularly during this Cost Crisis. The people of Scotland do not need to choose between feeding their families or choosing which medicines they can afford this week.
- The Scottish Government know that good quality healthcare is the cornerstone of a decent society and we will always strive to provide that for the people of Scotland. That is proven by the fact that every single prescription in Scotland is free, unlike in **England where charges apply. Currently, the charge is £9.35 per item—not per prescription, but per item**.

Treatment Pathways

- Despite the backdrop of a global pandemic, we continue to ensure that patients have access to vital medicines to treat conditions such as Prostate Cancer and Hepatitis C, treatments using specialist medicines which traditionally are serviced for hospital.
- Specialist medicines such as Abiraterone and Enzalutamide, used to treat prostate cancer, and Sofosbuvir and velpatasvir, used in the treatment of Hepatitis C are now routinely being dispensed in primacy care at a cost of £52 million.
- These new treatments deliver better outcomes for patients and, although expensive, have been determined to be value for money for the NHS.
- The number of items dispensed for Abiraterone in Scotland was just under 8,000, in comparison over the same period in England only 1 (one) item was dispensed as patients continue to be treated through hospital services.

- Similarly Enzalutamide costs (£11.8m) in primary care accounts for 4,303 items dispensed. By comparison in England a total of sixty nine (69) items were dispensed at a cost of £0.178m (one hundred and seventy eight thousand pounds).
- We have seen exciting advances in the treatment of hepatitis C over the past few years. The availability of medicines to treat hepatitis C that can be taken in tablet form, with far fewer side effects, and much better cure rates than with older treatments, has enabled more treatment for hepatitis C to take place in community settings rather than hospital.
- While there has been an increase in items dispensed, up 44.17%, and drug cost, increased 44.49%, it demonstrates the role of community treatment and the Scottish Government's commitment to eradicate hepatitis C in Scotland.
- It's not that we are spending more on these drugs but we are providing a different treatment pathway for patients.

NHS Pharmacy First

- NHS Pharmacy First introduced at the height of the pandemic demonstrates our commitment to free healthcare advice and treatment when needed and free at the point of access, a founding principle of the NHS.
- We have widened the range of common clinical conditions that can treated by your community pharmacist, using Patient Group Directions (PGDS), without the need to see your GP. Along with including treatment for Shingles and Skin Infections we've also increased the scope of who can be treated by pharmacies for Urinary Tract Infections and impetigo.
- A total of 2.954 million consultations were undertaken in 2021/22 with 95% provided with advice on self-care or treatment at the point of contact. And consultations using PGDs accounted for 4% (119,728) with 84% (100,182) being treated by the community pharmacist. That's 100,182 avoided GP appointments in 2021/22.
- The service delivers overall value for money for the NHS accounting for less than 0.5% of the primary care drugs spend and ensuring people get the Right Care at the Right Place at the Right Time.
- The success of NHS Pharmacy First has saw other parts of the UK look to emulate what we do in Scotland.
- Daily Mail on 14 October 2021, reported that then Health Secretary Sajid Javid is looking at a similar scheme for England - "*Mr Javid also revealed that he wants the NHS and the Department of Health and Social Care (DH) to work together on a 'Pharmacy First' scheme for England,* ***building on the existing pilot schemes and the equivalent service in Scotland***".
- On 6 July 2022, Thorrun Govind, chair of the Royal Pharmaceutical Society's English Pharmacy Board, urged Steve Barclay, then Health Secretary, *to see a 'Pharmacy First' service for England "through to completion"*.

Drug Costs

- We are seeing an increasing trend of short supply issues (particularly affecting some commonly used generic drugs), and the impact of volatility in the markets are contributory factors to increased costs.
- Drugs are traded in a global market in US dollars and Euros which has a direct impact on the costs paid by the UK market. The drugs manufacturing market has also been impacted by global pandemic.

- Despite a volatile international drugs market causing shortages and increasing drug costs, through proactive management of the concession price process we have delivered reductions in Tariff prices across number of drug lines such as Sertraline, used in the treatment of depression. The Gross Ingredient Cost in 2021/22 was £11.1 million, a decrease of 55.3%.
- Our policy is to prescribe generically where generic drugs are available. Scotland has consistently had a high generic prescribing rate, circa 85%. While generic prescribing accounts for 85% of dispensed items in primary care, the cost of generic drugs dispensed in the community accounts for less than 30% of the overall spend

PRESCRIBING 'EVERYDAY' ITEMS – PARACETAMOL etc

- Health professionals only prescribe medication to patients who have a clear clinical need.
- Items such as paracetamol, aspirin and sunscreen can be essential as part of managing more serious illness including chronic pain, osteoarthritis, childhood fever, cardiovascular disease and the effects of treatment for cancer.
- There is no reason why someone suffering from any of these conditions should be made to pay a tax on ill health that a prescription charge would represent.
- It is not appropriate to compare the prescribing of items such paracetamol with those purchased over the counter due to the limited quantity that can be purchased for the treatment of self-limiting illness or conditions.
- Analysis of medicines use demonstrates that the majority of patients prescribed paracetamol receive it to manage chronic pain.
- Alternative treatments to paracetamol all have potential for causing more harm to patients through increased risk of side effects.
- Any increase might reflect that paracetamol is used as a first choice and frequently reduces the need for more expensive painkillers which might not have such a good safety profile, particularly in our frail and elderly population.
- Charging for these items would not change patients' underlying condition. The impact could therefore be substitute prescribing of more expensive and potentially less clinically suitable drugs in some cases

Comparison with England

- Each devolved administration in the UK produces their own Prescription Cost Analysis statistics. There are numerous differences between each country's release including the way that data measures are collected and classified.
- While the ingredient cost for drugs in Scotland and England show an overall increase over the past ten years and beyond, comparisons with England are becoming less meaningful as divergence in policy continues to widen.
- In Scotland, the Gross Ingredient Cost (GIC), is the closest comparison with the Net ingredient Costs (NIC) in England.
- Comparing a broadly similar 10 year period which in cash terms means that Scotland has seen an increase of 15.2% compared with 10% in England. The difference is even more marked in real terms with figures suggesting an increase of 1.7% in Scotland while in England there has been an 10.6% decrease over the same broadly similar ten year period.
- However, the position over the last two years we can see broadly similar where the cost of drugs in England have increased in both cash (6.7%) and real terms (0.4%),

whereas Scotland has observed a slight decrease in cash terms (-2.1%) and an increase of 1.7% real terms.

- A key factor in these differences is the difference in the overall funding package available to contractors in England and Scotland – along with availability in Scotland of services such as NHS Pharmacy First, Emergency Hormonal Contraception and Bridging Contraception. This has impacted on the drug reimbursement element of the funding arrangements and therefore the drugs bill in England.
- Many of the changes in the funding arrangements in England are complex, but have been largely to tackle over-provision of community pharmacies and deliver savings in overall health spend.

I am aware that the Pharmacists' Defence Association have published an open letter outlining concerns around unscheduled pharmacy closures in Scotland.

- The NHS remains under sustained pressure, this includes community pharmacies and the wider primary care sector. The pressures are multi-factorial including COVID-19 infection and isolation requirements alongside a significant increase in demand for the pharmacy professions skills across other parts of the NHS.
- Community pharmacy is currently experiencing a workforce challenge across the entire pharmacy team. This has become particularly acute across the pharmacy support team members who are choosing to seek alternative employment opportunities outside of the NHS.
- The Chief Pharmaceutical Officer for Scotland has put in place a Workforce Forum to address the short, medium and long term requirements for the profession. Representatives are taken from across the sector and include Health Boards, Education, pharmacy owners and representative bodies for employees, including the Pharmacist Defence Association.
- Pharmacy closures are always taken very seriously and we will continue to work with all stakeholders to address any ongoing issues and proportionate solutions.

SUPPORT FOR WORKFORCE WELLBEING

This year the Scottish Government has made £12m available to support the wellbeing of the pharmacist workforce.

- That includes £8m from the NHS Recovery Plan to provide ongoing wellbeing support for the workforce – alongside an extra £4m to provide further support to address winter pressures
- The funding supports the 24/7 National Wellbeing Helpline, our National Wellbeing Hub, Coaching for Wellbeing and the Workforce Specialist Service, alongside tailored psychological interventions for staff, providing individualised wellbeing support focusing on people's physical and emotional needs.
- The Chief Pharmaceutical Officer for Scotland in a joint letter (8 December 2021) with the leaders from the pharmacy sector, including the Royal Pharmaceutical Society (Scotland), has written to all pharmacy teams outlining the range of wellbeing support available to pharmacy teams and encouraging them to access these resources for support when needed.

PRIMARY CARE DRUG COSTS

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No national or local media outlets have reported on the publication to date or approached Scottish Government.
The publication shows that the cost for dispensing items and providing services in 2023/24 was **£1.62 billion**, **increasing by 6.5%** from £1.52 billion in 2022/23. This follows a period of largely rising cost, increasing by 35.3% over the last 10 years.
In 2023/24, remuneration for services was **£321.4 million,** an **increase of 6.6%** from the previous year (£301.5 million).

The publication shows an increase in line with expectations as we ensure people are treated in their communities and closer to home.

- The total (net) cost for dispensing items and providing services in 2023/24 was **£1.62 billion**, **increasing by 6.5%** from £1.52 billion in 2022/23. This is in line with expectations.
- An ageing population with increasingly complex health needs, and more people living with long term conditions, continues to drive up the cost of prescribing in primary care.
- Access to NHS prescribed medicines are vital, particularly when many are struggling with the cost of living. The people of Scotland do not need to choose between feeding their families or choosing which medicines they can afford this week.
- The Scottish Government knows that good quality healthcare is the cornerstone of a decent society and we will always strive to provide that for the people of Scotland. That is proven by the fact that every single prescription in Scotland is free, unlike in **England where charges apply. Currently, the charge is £9.90 per item—not per prescription, but per item**.

Treatment Pathways

- We continue to ensure that patients have access to vital medicines to treat conditions such as prostate cancer and hepatitis C, treatments using specialist medicines which traditionally are serviced for hospital.
- Specialist medicines such as enzalutamide, used to treat prostate cancer, and sofosbuvir and velpatasvir, used in the treatment of hepatitis C are now routinely being dispensed in primacy care.
- From 2022/23 to 2023/24, enzalutamide has had the greatest increase in Gross Ingredient Cost rising from £16.3 million to £25 million. The increase was due to the supply route for this drug changing from secondary care to community pharmacy.
- These new treatments deliver better outcomes for patients and, although expensive, have been determined to be value for money for the NHS.

- We have seen exciting advances in the treatment of hepatitis C over the past few years. The availability of medicines to treat hepatitis C that can be taken in tablet form, with far fewer side effects, and much better cure rates than with older treatments, has enabled more treatment for hepatitis C to take place in community settings rather than hospital.
- It's not that we are spending more on these drugs but we are providing a different treatment pathway for patients.

NHS Pharmacy First

- NHS Pharmacy First introduced at the height of the pandemic continues to demonstrate our commitment to free healthcare advice and treatment when needed and free at the point of access, a founding principle of the NHS.
- We have widened the range of common clinical conditions that can treated by your community pharmacist, using Patient Group Directions (PGDS), without the need to see your GP. Pharmacies can provide prescription-only treatment for shingles and skin infections, urinary tract infections (UTIs), impetigo and hay fever.
- A total of 4.7 million consultations were undertaken in 2023/24 with 95% provided with advice on self-care or treatment at the point of contact. And consultations using PGDs accounted for 3.8% (181,174) with 84% (154,809) being treated by the community pharmacist. That's 154,809 avoided GP appointments in 2023/24.
- The service delivers overall value for money for the NHS accounting for 2.24% of the primary care drugs spend and ensuring people get the Right Care at the Right Place at the Right Time.
- The success of NHS Pharmacy First has seen other parts of the UK look to emulate what we do in Scotland.

Drug Costs

- We are seeing an increasing trend of short supply issues (particularly affecting some commonly used generic drugs), and the impact of volatility in the markets are contributory factors to increased costs.
- Drugs are traded in a global market in US dollars and Euros which has a direct impact on the costs paid by the UK market. The drugs manufacturing market has also been impacted by global pandemic.
- Despite a volatile international drugs market causing shortages and increasing drug costs, through proactive management of the concession price process we have delivered reductions in Tariff prices across number of drug lines.
- Our policy is to prescribe generically where generic drugs are available. Scotland has consistently had a high generic prescribing rate, circa 85%.

Prescribing 'everyday' items – paracetamol etc

- Health professionals only prescribe medication to patients who have a clear clinical need.
- Items such as paracetamol, aspirin and sunscreen can be essential as part of managing more serious illness including chronic pain, osteoarthritis, childhood fever, cardiovascular disease and the effects of treatment for cancer.
- There is no reason why someone suffering from any of these conditions should be made to pay a tax on ill health that a prescription charge would represent.

- It is not appropriate to compare the prescribing of items such paracetamol with those purchased over the counter due to the limited quantity that can be purchased for the treatment of self-limiting illness or conditions.
- Analysis of medicines use demonstrates that the majority of patients prescribed paracetamol receive it to manage chronic pain.
- Alternative treatments to paracetamol all have potential for causing more harm to patients through increased risk of side effects.
- Any increase might reflect that paracetamol is used as a first choice and frequently reduces the need for more expensive painkillers which might not have such a good safety profile, particularly in our frail and elderly population.
- Charging for these items would not change patients' underlying condition. The impact could therefore be substitute prescribing of more expensive and potentially less clinically suitable drugs in some cases.

Comparison with England

- Each devolved administration in the UK produces their own Prescription Cost Analysis statistics. There are numerous differences between each country's release including the way that data measures are collected and classified.
- While the ingredient cost for drugs in Scotland and England show an overall increase over the past ten years and beyond, comparisons with England are becoming less meaningful as divergence in policy continues to widen.
- In Scotland, the Gross Ingredient Cost (GIC), is the closest comparison with the Net ingredient Costs (NIC) in England.
- A key factor is the difference in the overall funding package available to contractors in England and Scotland – along with availability in Scotland of services such as NHS Pharmacy First, Emergency Hormonal Contraception and Bridging Contraception. This has impacted on the drug reimbursement element of the funding arrangements and therefore the drugs bill in England.
- Many of the changes in the funding arrangements in England are complex, but have been largely to tackle over-provision of community pharmacies and deliver savings in overall health spend.
- A one year community pharmacy funding package is in place in Scotland providing an increase of 6% to £232.705m for the financial year 2024/25.

Workforce pressures

- The NHS remains under sustained pressure, this includes community pharmacies and the wider primary care sector. The pressures are multi-factorial including significant increase in demand for the pharmacy professions skills across other parts of the NHS.
- Community pharmacy is currently experiencing a workforce challenge across the entire pharmacy team. This has become particularly acute across the pharmacy support team members who are choosing to seek alternative employment opportunities outside of the NHS.
- The Chief Pharmaceutical Officer for Scotland has put in place a Workforce Forum to address the short, medium and long term requirements for the profession. Representatives are taken from across the sector and include Health Boards, Education, Community Pharmacy Scotland and Scottish Funding Council.

- Pharmacy closures are always taken very seriously and we will continue to work with all stakeholders to address any ongoing issues and proportionate solutions.

SCOTTISH CONSERVATIVE LEADER INTERVIEW

28 October [The Times] *The baby box, free prescriptions and free tuition fees should all be "on the table" as part of a radical overhaul of public spending in Scotland, Russell Findlay has said.*

- *He appears to pledge to 'streamline health boards'*
- *He also says that 'ten years ago, the NHS in Scotland treated 68,000 more patients despite having 24,500 fewer staff.'*

[Policy advise figures are correct and difficult to dispute on point of fact

- *He says he is willing to introduce prescription charges: "pointing to occasions where patients have been prescribed for free a relatively cheap medication such as paracetamol. He said: 'I think it's agreed that almost everyone, but especially the wealthiest, can afford 39 pence for a packet of paracetamol or ibuprofen instead of getting it free on prescription."*

This government has already set out a vision for our health and social care services, and that is to enable people to live longer, healthier and more fulfilling lives.

- Although there are significant challenges and difficult decisions for us to collectively navigate but there are non-negotiables for this Government - the founding principles of Scotland's NHS will not change.

Under this Government, the NHS will always remain in the hands of the public and be free at the point of use.

- Our intention to reform health and social care is now well established, outlined in our Programme for Government, the Policy Prospectus and in Parliament.
- Now is the time to drive forward the reform activity that will ensure that we deliver the vision.

Our reform strategy is explicitly focused on *service* reform.

- We will drive new models of care, and improved productivity through innovation, technological advancements, and workforce models that will directly respond to the challenges in our system.

In the future this may require structural changes but the current focus must be transformation of services within the current

structures, working with our Health Boards and maximising current assets.

BOARDS/FUNDING

The 2024-25 Scottish Budget provides over £19.5 billion for the NHS Recovery, Health and Social Care Portfolio.

- Providing an uplift exceeding frontline Barnett consequentials and meaning that resource funding for health and social care has more than doubled since 2006-07 (up 104.9% cash; 37.1% real terms).
- Various programmes of work are being increasingly taken forward at an NHS Scotland level to maximise efficiencies and economies of scale, whilst ensuring a focus on responding to the differing population needs across Scotland.
- These include service planning at the most appropriate population level, which includes planning and delivering on a once for Scotland basis, especially non clinical services

TEN YEAR COMPARISON

Comparing the NHS to ten years ago ignores the seismic impact of a global pandemic.

Addressing the effects of the pandemic, seasonal and staffing pressures and unprecedented levels of inflation across the public sector, has inevitably disrupted the NHS's ability to carry out routine procedures, meaning longer waits for many patients.

- However, in the last year we have seen a 5.1% increase in the number of performed operations compared to the previous 12 months.

Inpatient/day-case activity for Q2 was the highest since the start of the pandemic and the 10th quarterly increase in a row. This is up 9.9% on Q2 last year.

- Over the 12 months to June 2024, **new outpatient activity was over 1.26 million (1,264,565)**; 2.7% more than the previous 12 months.
- The Scottish Government remains committed to delivering reductions in waiting times and our network of National Treatment

Centres, will provide more than 20,000 additional surgeries and procedures annually once fully operational.

Prescription Charges

The Scottish Government has no plans to abolish its free prescription policy. Prescription charges are a barrier to good health for many people.

- This is particularly so for those with long-term conditions and those on low incomes who in the past have faced choices about which medicines they can afford to take. Evidence shows that this can lead to deterioration in health, absence from work, or extra hospital admissions.

At all times, GPs are expected to prescribe responsibly using their clinical judgement based on the health needs of their patient. The prescribing of low cost items such as paracetamol or ibuprofen - cannot be compared with over the counter purchases due to the limited quantity that can be purchased for the treatment of self-limiting illness' or conditions.

- Analysis of medicines use demonstrates that the majority of patients prescribed paracetamol receive it to manage chronic pain. Alternative treatments have potential for causing more harm to patients through increased risk of side effects. The impact could therefore be substitute prescribing of more expensive and potentially less clinically suitable medicines in some cases.

Cabinet Secretary for NHS Recovery, Health and Social Care

BRIEFING FOR CABINET DISCUSSION ON 2024-25 BUDGET – TUESDAY 31 OCTOBER

Purpose

1. Routine - To provide an update on the 2024-25 financial challenge for Health and Social Care, and options available to bridge the anticipated funding gap in advance of Cabinet discussions on the 2024-25 budget on 31st October, with further sessions planned in November.

Background and Context

2. At Cabinet on 31st October, DFM will ask for an approach to be agreed with regards delivering a balanced budget in 2024-25, recognising the challenging decisions that will require to be taken.

3. This is guided by four key pillars which have also underpinned the approach at the health portfolio level, namely strategic reform and reprioritisation; revenue generation; better targeting of spending on existing commitments; and implementation of RSR workstreams.

4. Following this, at Cabinet on November 14th, it is expected that options for savings and prioritisation will be put forward for agreement. Final spend envelopes will then be agreed on 5th December following the UK autumn statement on November 22nd.

5. Cross-portfolio Ministerial workshops, structured around the three strategic missions, are also planned for early November. These will seek to agree on the priorities for each along with the policies and programmes that now need to be paused, delayed or cancelled.

Portfolio Overview

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Options to Close the Funding Gap

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Next Steps

6. The Cabinet Secretary is asked to note:
    a. the portfolio's financial position and significant risks;
    b. the options set out in **Annex B** and **C**, with further due diligence to be undertaken on individual options following your initial consideration

Health and Social Care Finance, 30 October 2023

Annex A

NHS Recovery, Health and Social Care: - Financial Pressures and Funding Gap (Based on July Indicative Allocation) to 2026-27

[Redacted: Section 22 of the FOISA (information intended for future publication)]

Annex B – Review of Unfunded Commitments

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Annex C - 2024-25 Savings Options

Further Stopping or Delaying Unfunded Commitments

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Areas of High Spend

Workforce

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Areas of High Spend

Prescribing

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Other

Income Generation

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Other Savings

[Redacted: section 30(b)(ii) of FOISA (free and frank provision of advice)]

Cost of Prescribing Painkillers

04 Feb: (The Daily Telegraph Scotland) *Scots NHS spends £8 on pack of painkiller £9.90 per item. NHS England has restricted the "routine" prescribing of products such as paracetamol, arguing many such drugs can be purchased far more cheaply from pharmacies and supermarkets.*

Medicines such as paracetamol are an essential part of managing more serious conditions such as chronic pain. There is no justifiable reason why someone suffering from such conditions should be made to pay for their medicine or a pay a tax on ill health that a prescription charge would represent.

- Healthcare professionals only prescribe medicines such as paracetamol to patients who have a clear clinical need.
- Paracetamol is the first line recommended medicine in a stepwise treatment strategy based on the World Health Organization (WHO) pain ladder and SIGN guidelines for the management of chronic pain.
- It is not appropriate to compare the prescribing of medicines like paracetamol with those purchased over the counter due to the limited quantity that can be purchased for the treatment of minor self-limiting conditions.
- Removing paracetamol as a prescribing option would mean those with chronic pain wouldn't be able to purchase enough from retail outlets to treat their pain necessitating even stronger and more expensive analgesics, with more side effects, to ensure people can achieve adequate pain control.

COST OF PAINKILLERS ON PRESCRIPTION

25 May: The Scottish Sun published an article on £185m Freebie Pills

- *The article states that 67m painkillers costing £185m have been dispensed since free prescriptions were introduced 14 years ago. It further states that £129m has been spent on paracetamol along since April 2011, £20m on ibuprofen and £34m on aspirin.*
- *John O'Connell, Chief Executive of the Taxpayers' Alliance quoted "Cheap painkillers should not be on free prescriptions. This is exactly the kind of waste that's dragging public services into crisis."*
- *While the figure quoted in the article is fairly accurate, initial analysis carried out by Public Health Scotland indicates that over 85% of prescriptions for paracetamol, ibuprofen and aspirin were for volumes that are unavailable over the counter for conditions such as chronic pain. This also excludes all formulations you cannot get over the counter, such as infusions. This analysis is not published and is for **internal use only.***

FREE PRESCRIPTIONS

We will continue to protect free prescriptions as prescription charges are a barrier to good health. At all times, healthcare professionals are expected to prescribe responsibly using their clinical judgement.

- Access to NHS prescribed medicines are vital, particularly when many are struggling with the cost of living. The people of Scotland do not need to choose between feeding their families or choosing which medicines they can afford this week.
- The Scottish Government knows that good quality healthcare is the cornerstone of a decent society and we will always strive to provide that for the people of Scotland. That is proven by the fact that every single prescription in Scotland is free, unlike in England where charges apply. Currently, the charge is £9.90 per item - not per prescription, but per item.
- Charging for these items would not change patients' underlying conditions. The impact could therefore be to substitute prescribing of more expensive and potentially less clinically suitable drugs in some cases.

PRESCRIBING PAINKILLERS

The cost of prescribing items such as paracetamol cannot be directly compared with the price of medicines bought in retail outlets due to the limited quantity that can be purchased without a prescription.

- Health professionals only prescribe medication to patients who have a clear clinical need. Any increase might reflect that paracetamol is used as a first choice and frequently reduces the need for more expensive painkillers which might not have such a good safety profile, particularly in our frail and elderly population.
- We know that most people prescribed medicines such as paracetamol receive it to manage chronic pain, where alternative treatments can be more expensive or have the potential to cause more harm through an increased risk of side effects.
- An ageing population with increasingly complex health needs, and more people living with long term conditions, continues to drive up the cost of prescribing in primary care.
- Alternative treatments to paracetamol all have potential for causing more harm to patients through increased risk of side effects.

PARACETAMOL

Paracetamol is a highly effective painkiller and there are no plans to stop it being prescribed.

- Paracetamol in supermarkets and other retail outlets is sold at less than £1 but these are small 'General Sales List' packs, typically containing only 16 tablets. Supplies of paracetamol of 100 tablets or more are a Prescription Only Medicine (POM) and therefore must be prescribed by a GP or other appropriately qualified practitioner.
- As reported by The Scottish Sun, the NHS currently reimburses paracetamol at the rate of £2.88 per 100 tablets, as listed in the Scottish Drug Tariff. Therefore, the rate of reimbursement equates to approximately 46p for 16 tablets. This is the NHS reimbursement price for paracetamol, as listed in the Scottish Drug Tariff.
- This slightly higher price generates an agreed margin which cross-subsidises all the NHS community pharmacy services provided by community pharmacy contractors.

- At all times, healthcare professionals are expected to prescribe responsibly using their clinical judgement based on the health needs of their patient.

THE MINISTER FOR SOCIAL CARE, MENTAL WELLBEING AND SPORT Meeting with IJB Chief Officers and IJB Chairs & Vice Chairs and CFO Executive Groups

AGENDA

Thursday 3 April 2025
08:30-10.00
Microsoft Teams

1.	**Welcome and opening remarks (5 minutes)**	Minister for Social Care, Mental Wellbeing and Sport Prof Soumen Sengupta, Chair of the HSCS Chief Officer Group
2.	**HSCS Presentation (20 minutes)** - **IJB Finances (with a particular focus on prescribing)**	Prof Soumen Sengupta
3.	**Discussion (50 minutes)**	All
4.	**Next Steps, closing remarks and thanks (5 minutes)**	Minister for Social Care, Mental Wellbeing and Sport Prof Soumen Sengupta

ATTENDEES

Chief Officers, Chair and Vice Chairs, Chief Finance Officers	**Chief Officers and their representatives** Alan Best (AB) – Inverclyde Beth Culshaw (BC) – West Dunbartonshire Caroline Cameron (CC) – North Ayrshire Carron O'Byrne (COB) – Renfrewshire Chris Myers (CM) – Scottish Borders Claire Rae (CR) – North Lanarkshire Craig McArthur (CM) – East Ayrshire Dave Berry (DB) – Dundee Derrick Pearce (DP) – East Dunbartonshire Evan Beswick (EB) – Argyll and Bute Fiona Mitchelhill (FM) – Aberdeen City Fiona Wilson (FW) – East Lothian Jillian Galloway (JG) – Angus Jo Robinson (JR) – Shetland Judith Proctor (JP) – Moray Julie Murray (JM) – East Renfrewshire Morag Barrow (MB) - Midlothian Nick Fayers (NF) – Western Isles Pamela Milliken (PM) – Aberdeenshire Pamela Stott (PS) – Highland Sean Coady (SC) - NHS Grampian (Moray) Soumen Sengupta (Chair) (SS) - South Lanarkshire Stephen Brown (SB) – Orkney Apologies Nicole Hamlet - Dumfries and Galloway **CFO Executive Group** Dave Berry (Vice Chair) (DB) – Dundee Deborah O'Shea (DOS) – Moray Donna Mitchell (DM) – Perth and Kinross Margaret Hogg (MH) - Glasgow Marie Keirs (MK) – Falkirk Sarah Lavers (Vice Chair) (SL) - Renfrewshire Apologies Lesley Baiden – East Renfrewshire Moira Pringle - Edinburgh **Chairs & Vice Chairs Executive Group** Andrew Cogan (AC) – East Lothian Annetta Smith (ASM) – Western Isles Brian Moore (BM) – North Lanarkshire Chris Cunningham (CCU) – Glasgow Gerard O'Brien (GOB) – Highland Hussein Patwa (HP) – Aberdeen City John Cooke (JC) – Aberdeen City

	John Fraser (JF) – Shetland John Tomlinson (JT) – Aberdeenshire Lesley-Ann McDonald (Vice Chair) (LM) – South Lanarkshire Linda Semple (LS) – South Ayrshire Muriel Cockburn (MC) – Highland Natasha Cornick (NC) – NHS Shetland Tim Pogson (TP) – Edinburgh Apologies Dennis Robertson – Moray Rachael King – Orkney
CoSLA	Jill Laspa – Policy Manager, Health and Social Care, CoSLA Apologies: Paul Kelly – CoSLA Spokesperson for Health and Social Care
Health and Social Care Scotland	Christine Jack (CJ) – Policy Manager Cat McGoldrick (CMG) – Finance Policy Manager Hannah Gunn (HG) – Policy Officer Lorna Kelly (LK) – National Lead for Primary Care
Scottish Government	Angie Wood (AW) – Director, Social Care and NCS Development Alison Skiba – Senior Social Care Finance Manager Alison Strath (AS) – Chief Pharmaceutical Officer Alpana Mair (AM) – Head Of Effective Prescribing and Therapeutics Derek Grieve (DG) – DD, Social Care Immediate Response and Improvement Iain MacAllister (IM) – DD, Regulation, Improvement and Integration Support Ian Turner (IT) – DD, Adult Social Care Workforce and Fair Work JohnPaul Liddle (JPL) – DD, NCS Development and Delivery Stuart Law – Policy Head - Effective Prescribing and Therapeutics *Other Scottish Government officials will attend.*

Minutes

1. **Welcome and opening remarks**

Ms Todd welcomed attendees and invited SS to provide introductory comments.

SS expressed his gratitude for the opportunity for Chief Officers (COs), Chairs and Vice Chars Exec Group members (C&VCs) and Chief Finance Officers Exec Group members (CFOs) to engage with the Minister. He recognised Ms Todd's background in pharmacology and acknowledged that prescribing can feel intimidating, particularly for those without clinical experience.

Ms Todd responded by noting that mental health prescribing is unlikely to be a major contributor to budget overspend, as relatively few new mental health medications are introduced to the market.

2. **HSCS presentation**

A presentation on prescribing pressures was delivered by **SS**.

2025 IJB Financial Pressures.Prescribing

Key asks from the presentation are:

1. Consider effectiveness of current arrangements for national approval of medications.
2. Consider updated mechanisms to facilitate IJBs access to proportionate share of the New Medicines Fund where prescribing costs are devolved.
3. Consider other options for engaging independent contractor prescribers directly in board delivered Medication Sustainability and Value Schemes.
4. Consider whether a specific Realistic Medicine approach could be taken alongside a national Once for Scotland communications program regarding use of medicines.

3. **Discussion**

Ms Todd reflected on the data presented, describing some of the numbers as stark. She invited discussion to hear attendees' thoughts and questions, highlighting the current challenges in effective messaging around medication, particularly given the spread of misinformation around vaccines and the declining public trust in health professionals.

LS noted that in Ayrshire and Arran, the NHS still retains the prescribing budget, although this is under review. She highlighted Scotland's strengths in shifting to generics and managing polypharmacy and queried whether there is appetite to move towards a national Scottish Formulary. She emphasised the need for Public Health Scotland to provide better data on the affordability of new medicines.

Ms Todd invited SG officials to speak to the development of a national formulary, recalling previous efforts to explore a regional approach.

AM confirmed she could provide information on this topic. She referred to the availability of quality prescribing guidance, particularly concerning polypharmacy reviews, which have demonstrated improved individual outcomes. She offered to return to this forum to further discuss programmes specifically related to the prescribing of antidepressants, benzodiazepines and respiratory medicines.

AS explained that the Scottish Medicines Consortium has been supporting the development of regional formularies. She provided examples, including the Eastern region (Borders, Lothian and Fife) and work underway in the West, led by Lanarkshire. She also discussed the importance of optimising the role of multidisciplinary teams (MDTs) in primary care, praising the world-leading work of **AM** on polypharmacy. She expressed concern that pharmacists in primary care are not being fully utilised.

MC raised concerns about the variability in prescribing practices among locum practitioners, citing Highland's experience. She asked whether pharmacists could play a more significant role in MDTs under these circumstances. She also shared that in Highland, there is a cohort of patients returning to Scotland with complex health needs after time abroad. She identified neurodiversity as another pressing issue, noting that private clinics in the area provide assessments, diagnoses and associated prescriptions that may lack appropriate oversight.

Ms Todd acknowledged growing concerns around neurodiversity diagnoses and questioned the clinical standards of some private clinics. She recognised Highland's long-standing patterns of emigration and the challenges of repatriation. She noted that a national formulary could support more consistent prescribing, including among locum staff, and reaffirmed the role pharmacists can play within MDTs.

NF, reflecting on earlier remarks regarding misinformation, asked how practitioners could be better supported to engage with patients in meaningful reviews.

Ms Todd agreed and reflected on her experience as a pharmacist, stating that effective patient conversations require time and trust.

HP echoed earlier sentiments on communication. He reported anecdotal evidence from primary care colleagues who are increasingly overwhelmed and struggling to take on the additional workload associated with medication reviews. He noted that although some short-term efforts may deliver long-term savings, they risk overwhelming the current system.

Ms Todd stated that investment in MDTs within primary care had been beneficial and expressed hope that this investment would continue.

GOB emphasised the importance of evaluating the value of prescribing beyond mere cost, questioning whether sufficient attention is paid to the benefits of appropriate prescribing and the risks of under-prescribing.

Ms Todd agreed, acknowledging the high cost of new medicines while noting the importance of ongoing work around cardiovascular health. She highlighted that approximately one-third of people are unaware they have the condition, while another third are undertreated, both of which may lead to development of more serious diseases and more costly treatment.

JF asked for further investment in talking therapies for mental health and queried whether there was an overreliance on Cognitive Behavioural Therapy (CBT) at the expense of more person-centred approaches.

Ms Todd responded by discussing ongoing work to expand the availability of evidence-based psychological interventions. She expressed concern that the current system focuses too heavily on only two targets, CAMHS and psychological therapies, at the expense of broader service delivery.

SS thanked attendees for recognising the current challenges. He referenced another recent meeting and ongoing engagement on the role of pharmacists and future investment. He emphasised that value-based care remains a priority under the framework of realistic medicine. He acknowledged the financial reality, noting £70 million in pressures, which presents an affordability dilemma; either the service cannot be provided, or something else must be stopped.

JM highlighted the local tensions created by financial pressures. She stated that balancing the budget often results in cuts to social care, leading to perceptions among councillors that local authorities are subsidising NHS costs. She proposed returning prescribing costs to health boards to protect integration.

CM reported on difficult local conversations about where cuts could be made. He expressed concern that such decisions hamper the development of community services. On a positive note, he shared an example where a £150,000 investment in polypharmacy reviews led to demonstrable savings within six months across pharmacy and care sectors.

DB raised concerns about the New Medicines Fund, noting its limited application in primary care settings. He observed that CFOs and COs often lack the means to fund new medicines and asked what Scottish Government could do to provide clearer direction to health boards. He stated that, last year, the fund was used to support boards' bottom lines and called for greater equity in its distribution.

AM reiterated that polypharmacy reviews are preventive in nature. She cited data indicating that one in six hospital admissions is due to medication-related harm. She emphasised that polypharmacy is always cost-effective, even when accounting for the additional workforce required. She advocated for a person-centred approach, including non-medicinal interventions.

Ms Todd thanked **AM** for the slide and suggested it be circulated.

LM asked how the system could win over hearts and minds, observing that patients often believe branded, more expensive medicines are better. She noted that patients are frustrated when they finally access a GP, only to be told their medication will be

reduced. She questioned how polypharmacy reviews could be better framed as beneficial to patients.

Ms Todd responded by affirming that even simple medicines, like paracetamol, are valuable. She noted that many patients are unable to purchase sufficient quantities over the counter.

AS explained that paracetamol restrictions are in place to prevent overdose but confirmed it can be prescribed for those who need it in higher quantities. She supported the continued emphasis on timely medication reviews.

JF asked Ms Todd whether she would consider reviewing the distribution of over-the-counter codeine and co-codamol, sharing personal experiences with addiction concerns.

Ms Todd agreed to take this forward outside the meeting, noting that AS may be better placed to respond in detail. She advised JF to write to her and committed to ensuring AS receives the correspondence.

AW summarised several potential actions from the discussion. She highlighted a need to focus more on the benefits of reviews for patients rather than solely on budgetary pressures. She questioned how resources are aligned with the aim of delivering realistic medicine and asked whether Scottish Government investment to reduce waiting lists this year would impact prescribing pressures.

CC discussed where prescribing responsibilities lie, noting that in Ayrshire and Arran the risk remains with the health board. She emphasised the need for continued discussion on where the prescribing budget should sit and acknowledged both the £70 million in prescribing pressures and the broader £560 million in financial pressures. She stated that the operational plan had been published but no additional funding had yet been attached. She requested early clarification on whether additional resources would be made available.

SS responded to AW, suggesting that medical directors would likely be involved in further discussions. He reiterated the importance of recognising the value and benefits of prescribing. He reported that the total prescribing cost last year was £1.6 billion, representing a 60% increase over the last decade. He emphasised that, even without service expansion, costs continue to rise. He noted that COs work closely with executive teams, including CFOs, medical directors and pharmacy directors.

TP called for greater emphasis on the benefits rather than burdens of prescribing. He shared that in Edinburgh, £29m in non-statutory services is being cut, while prescribing is largely protected, making it essential to demonstrate the value of prescribing reductions where appropriate.

Ms Todd concluded by reflecting on the broader system implications. She noted that social care is often the part of the system most easily affected. She called for a long-term perspective on risks and benefits and suggested that future discussions should identify specific strands of work to progress. She raised the possibility that increased

taxation may be necessary, particularly to support social care, and invited specific proposals that could be pursued nationally.

4. **Next Steps, closing remarks and thanks**

SS closed by thanking Ms Todd for her leadership and acknowledged the leadership provided by COs and C&VCs across the system. He underlined the importance of detailed engagement with these complex issues.

Ms Todd concluded by expressing appreciation for the discussion, stating that it had provided valuable insights into the challenges and opportunities within the system. She reaffirmed her openness to future engagement and assured attendees of her ongoing availability, along with that of her officials. She anticipated further opportunities to reconvene and continue the conversation.

ACTION POINTS

1. National/Regional Formularies

Explore appetite for a national Scottish Formulary – LS raised this; Ms Todd to explore whether officials can contribute to the conversation.
Follow-up on regional formulary work – AS mentioned ongoing work in East and West; progress to be monitored and shared.

2. Prescribing Data and Affordability

Distribute AM's slide on polypharmacy – Ms Todd requested this be shared with attendees.

3. Medicine Access and Regulation

Review OTC codeine and co-codamol distribution – JF raised this; Ms Todd agreed to pick up offline and suggested direct correspondence from JF to progress this.

4. Strategic Direction

Encourage submissions of specific 'asks' to SG – Ms Todd invited participants to raise national-level items for action.