NHS financial performance 2012/13

AUDITOR GENERAL

Prepared by Audit Scotland
October 2013

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website:
www.audit-scotland.gov.uk/about/ags

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

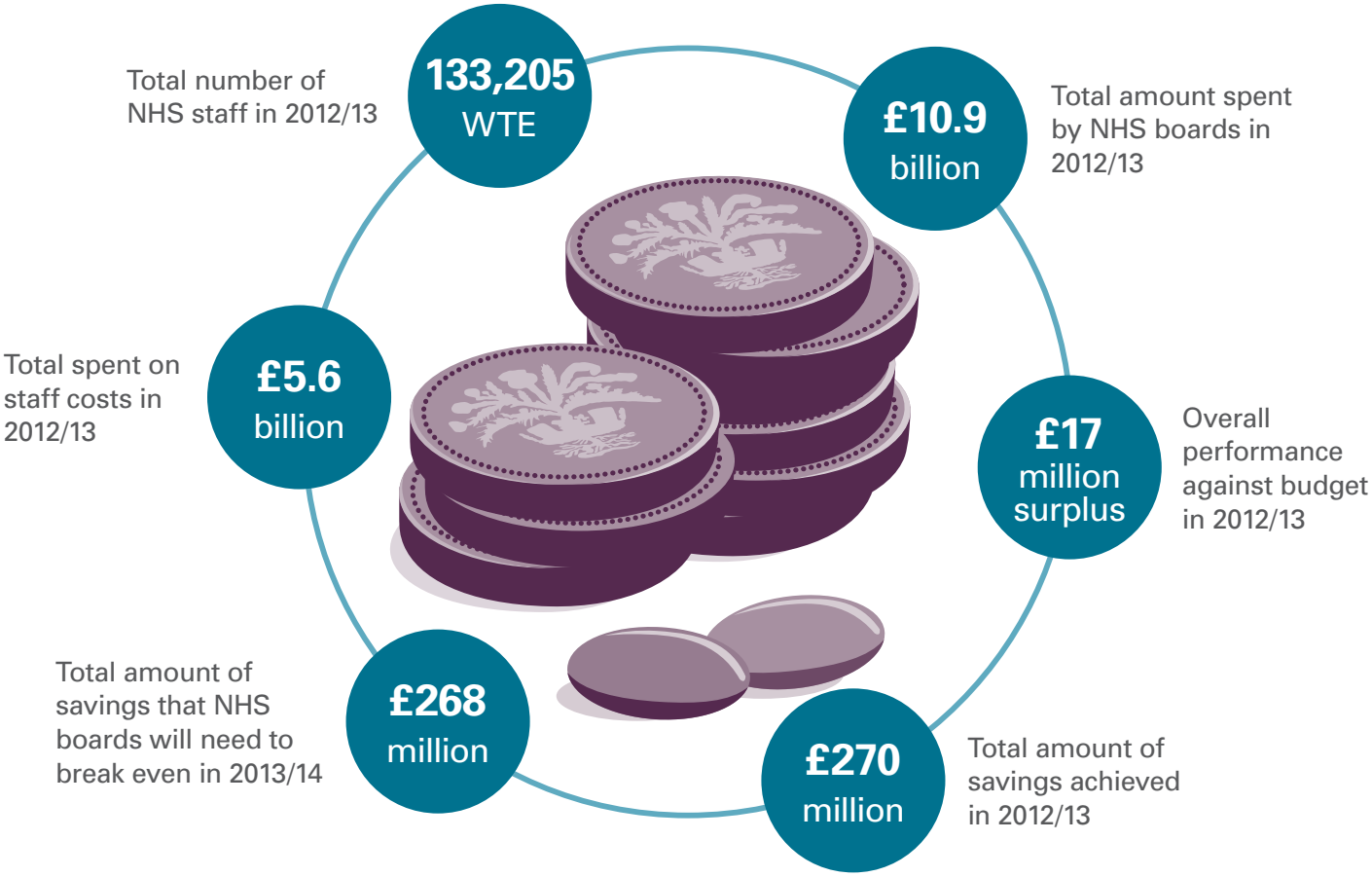
Contents

Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Summary

Key facts



Background

1. The Scottish Government spent £11.9 billion on health and wellbeing in 2012/13, 35 per cent of Scotland's total public sector spending. The total budget for the Scottish Government's Health and Wellbeing Portfolio includes the budgets for health, sport and equalities. Most of the funding (£10.9 billion) was allocated to the 14 territorial health boards that serve each area of Scotland and provide direct patient care, and nine special health boards that provide national services.[1] In this report we refer to these collectively as NHS boards. The Scottish Government manages the Health and Wellbeing Portfolio budget as a whole. It allocates funding to the NHS boards and oversees their financial performance. This includes monitoring NHS boards' financial performance on a monthly basis (Exhibit 1, page 6).

2. Over the last ten years, the overall health budget has increased in cash terms, that is, not taking inflation into account. It increased by 2.2 per cent in cash terms from 2011/12; and by 0.6 per cent in real terms, taking inflation into account. The overall health budget is forecast to decrease by 1.6 per cent in real terms over the next three years (Exhibit 2, page 7). However, there are significant differences between the forecasts for the capital and revenue budgets. The revenue budget is forecast to increase by 0.6 per cent over the next three years in real terms, while the capital budget is forecast to decrease by 61 per cent in real terms over the same period.

3. Territorial boards continue to receive small real-terms increases (0.6 per cent in 2013/14), but these are lower than in previous years (Exhibit 3, page 8). The Scottish Government has reduced some special boards' budgets and redirected these funds to territorial boards and special boards which provide direct patient care.

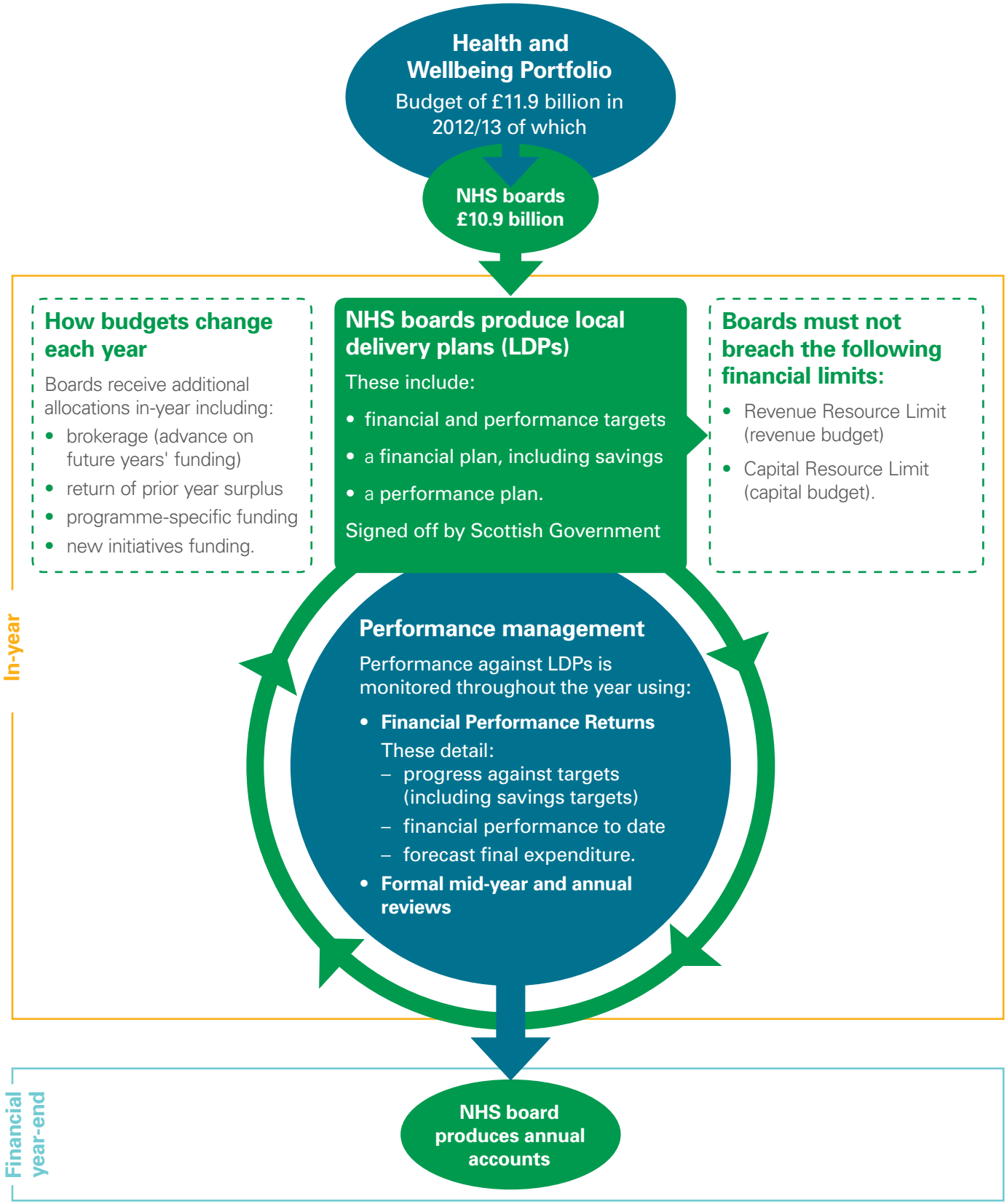
4. In October 2012, we reported that all 23 NHS boards in Scotland broke even in 2011/12, with a small overall surplus of £13.4 million (0.12 per cent of the total budget).[2] However, this involved money being moved between NHS boards during the year, and this was not clearly reported in the NHS boards' annual accounts. NHS boards must break even each year, which means their income must equal their expenditure. This requirement can lead to a short-term focus, and we recommended that the NHS increases its focus on longer-term financial planning. The report highlighted a number of risks to financial management in the future, particularly that boards need to increase the amount of recurring savings that they make.

5. This is a challenging time for NHS boards. While budgets are getting tighter, demand for healthcare is rising due to an ageing population, more people with long-term conditions and the impact of factors such as increasing rates of obesity. This presents significant challenges for NHS boards delivering services, both now and in the longer term. The number of people of pensionable age is estimated to increase by about 26 per cent by 2035, meaning that a quarter of Scotland's population will be over 65 by that time. The number aged 75 and over is projected to increase by 82 per cent.[3] The number of people with a long-term condition increases with age. Over 62 per cent of 65–69 year olds report having a long-term condition, increasing to 68 per cent of 75–79 year olds.[4] These population changes are placing more demands on unscheduled care (emergency and urgent care). In February 2013, the Scottish Government launched the Emergency Care Action Plan and announced that it would invest £50 million over the next three years to improve unscheduled care.

Exhibit 1

Overview of financial management in the NHS in Scotland

The Scottish Government allocates most of the health budget to NHS boards and monitors how much they are spending throughout the year.

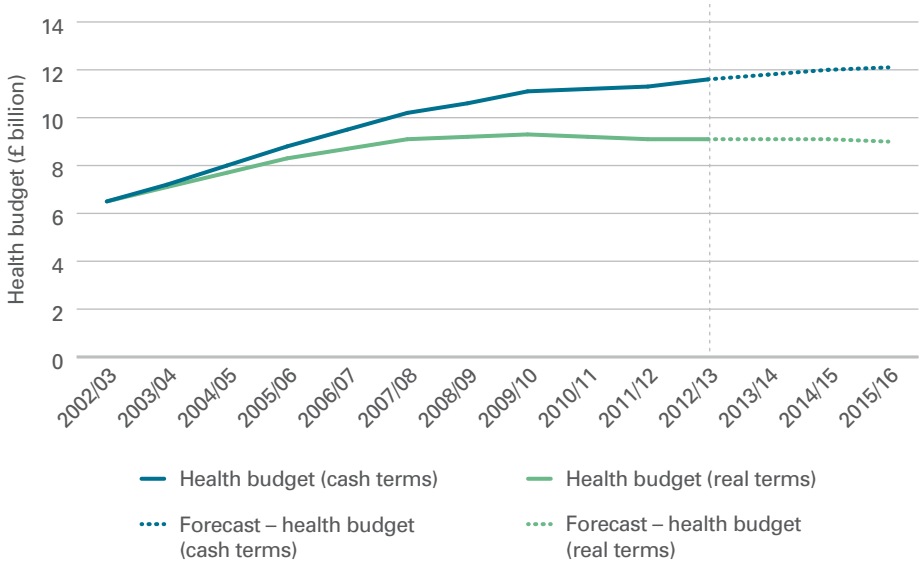


Source: Audit Scotland

Exhibit 2

Actual Scottish health budget, 2002/03 to 2012/13, and forecast to 2015/16

The health budget continues to increase in cash terms, but it is decreasing in real terms.



Note: 2002/03 used as reference year for GDP deflator.

Source: Scotland's draft budgets: 2007/08, 2008/09, 2009/10, 2010/11 2011/12, 2012/13 and 2013/14, Scottish Government

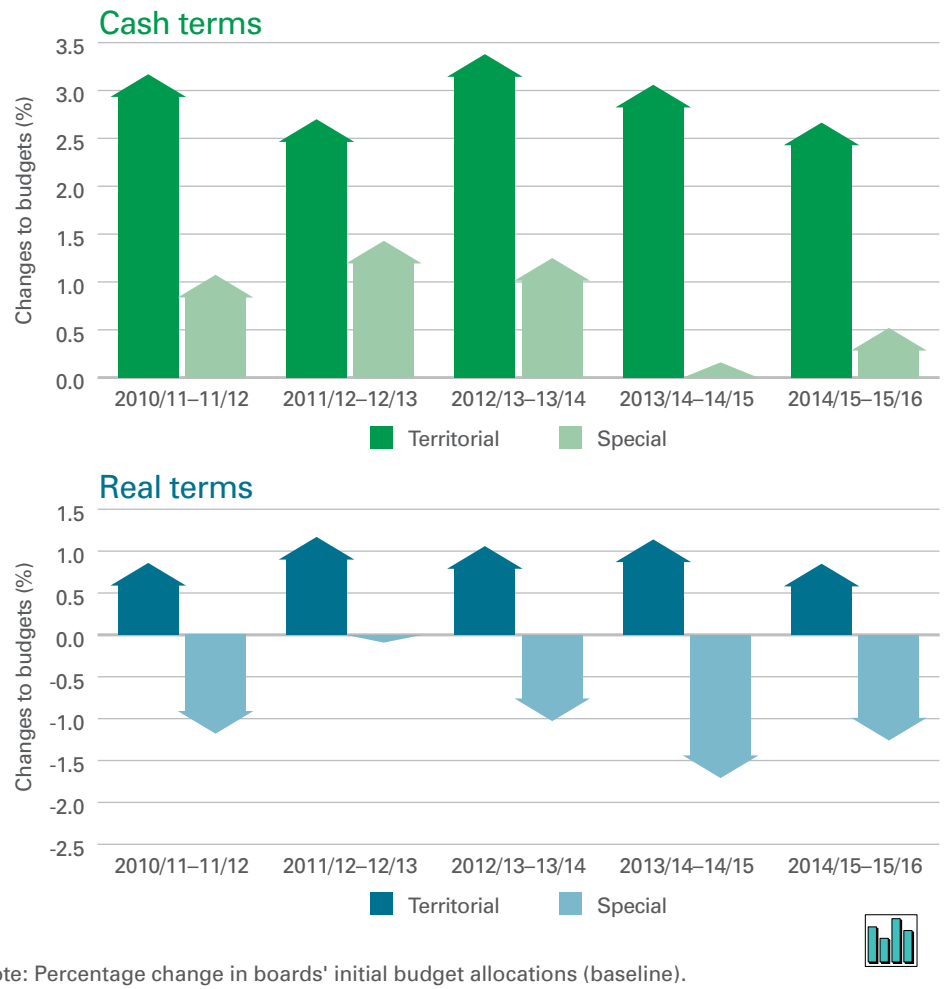
6. The NHS in Scotland also experienced some significant change in 2012/13. NHS boards were working to achieve the new Treatment Time Guarantee (TTG). This was introduced by the Scottish Government on 1 October 2012 as part of the Patient Rights (Scotland) Act 2011. It gives patients a legal right to inpatient or day case treatment within 12 weeks of a decision being made to go ahead, and it has been a key priority for the NHS during the year. In May 2013, the Scottish Government published a Bill to implement its plans for health and social care integration from April 2015. The NHS and councils have started planning for this major change.

7. The Scottish Government published its *Route Map to the 2020 Vision for Health and Social Care* in May 2013.[5] This sets out what it expects the NHS to achieve in 2013/14 to further implement the Healthcare Quality Strategy and the 2020 Vision.[6, 7] The Route Map reinforces that the main objectives for the NHS in Scotland are to deliver safe, effective and person-centred care. Since 2008, the NHS in Scotland has had a coordinated approach to improving patient safety through the Scottish Patient Safety Programme (SPSP). The programme aims to reduce mortality and adverse events, which are defined as events that could have caused or did result in harm to people or groups of people.[8] Since 2008, the hospital standardised mortality ratio (HSMR) has fallen by 11.6 per cent across Scotland.[9, 10]

Exhibit 3

Changes to NHS board budgets, 2010/11 to 2015/16

Budgets for territorial and special boards have increased in cash terms, but special boards' budgets have decreased in real terms.



Note: Percentage change in boards' initial budget allocations (baseline).

Source: Scotland's draft budgets: 2011/12, 2012/13, 2013/14 and 2014/15, Scottish Government

About the audit

8. This report summarises and comments on the financial performance of the NHS in 2012/13 and on its future plans. It is based on an analysis of:

- the audited annual accounts and auditors' reports on the 2012/13 audits of the 23 NHS boards
- NHS boards' Local Delivery Plans (LDPs), which set out their detailed plans and anticipated budget for the next year and indicative plans for the next three to five years
- Financial Performance Returns (FPRs), which detail boards' financial performance throughout the financial year
- data published by Information Services Division (ISD) Scotland.

Key messages

1 All NHS boards are required to meet annual financial targets. This can mean that the key focus for NHS boards and the Scottish Government is on breaking even each year. But they also need to increase their focus on longer-term financial planning to meet the significant challenges associated with rising demand and tightening budgets.

2 The NHS managed its overall finances well in the short term, and all NHS boards achieved their financial targets in 2012/13. Across all NHS boards there was a small overall surplus of £16.9 million, 0.16 per cent of the total revenue and capital budget.

3 The NHS made savings of £270 million in 2012/13, and achieved the Scottish Government's target of saving a minimum of three per cent of the baseline budget. NHS boards also set their own savings targets as part of their plans to break even. Overall they made 99 per cent of these savings. Twenty-two per cent of savings were one-off savings that boards will need to make again in the next year. NHS boards did not achieve their forecast levels of recurring savings. This will be a continuing challenge next year and in the future as it becomes more difficult to identify further opportunities to make significant savings.

4 The NHS has made good progress in improving outcomes for patients, such as reducing death rates from heart disease, stroke and cancer. Demand for healthcare is rising, and there were signs of pressure within the system in 2012/13. Not all boards met their waiting times targets; vacancy rates for consultants and nursing and midwifery staff increased; and boards increased their use of agency and bank staff and their spending on private sector healthcare. The introduction of the Treatment Time Guarantee in October 2012 has been a particular pressure and remains a key challenge for the future.

Key recommendations

The NHS is facing significant challenges. This means it needs to change how services are delivered, and increase its focus on longer-term financial planning.

Good practice includes NHS boards working with their partners to undertake:

- detailed analysis of the expenditure required each year to meet known needs and pressures
- scenario planning to compare expected funding with projected expenditure under different models of service delivery, and modelling the pressure on financial and other resources
- detailed planning of how these pressures will be managed, linked to the financial, workforce, asset and information technology strategies.

To ensure their savings forecasts are realistic and achievable, NHS boards need to:

- improve the accuracy of their short-term savings forecasts
- review previous savings forecasts against actual performance to assess their reliability and to inform future projections and plans.

To further improve the transparency of the annual accounts, NHS boards should:

- report movements in the capital budget, such as brokerage, and significant delays and slippage leading to the return of capital funds to the Scottish Government. This should build on the improvements NHS boards have made in the past year to disclosure about movements in planned revenue expenditure.

To help improve NHS boards' financial planning, the Scottish Government should:

- work with NHS boards to provide greater clarity on the timing, value and nature of funding allocations earmarked for specific purposes during the year. This would help to reduce financial uncertainty for the boards and any potential impact on providing services
- consider moving away from the current arrangements of setting annual financial resource limits for each NHS board. This would help NHS boards plan for the longer term and lead to fewer movements in their budgets during the year.

Financial performance and sustainability

All boards met their financial targets in 2012/13 with a very small overall surplus

9. In 2012/13, the Health and Wellbeing Portfolio in the Scottish Government spent £11,830 million, of which:

- the 14 territorial boards spent £9,638 million (82 per cent)
- the nine special health boards spent £1,274 million (11 per cent) (Exhibit 4)

Exhibit 4
Overall NHS performance against budget (capital and revenue), 2012/13
The Health and Wellbeing Portfolio had a small overall surplus of £27 million.

	2012/13 budget (£ million)	2012/13 expenditure (£ million)	Surplus (£ million)	Surplus (% of budget)
Health and Wellbeing Portfolio	11,857	11,830	27	0.23
of which:				
Health	11,757	11,730	27	0.23
Territorial boards (14)	9,652.9	9,638.1	14.8	0.15
Special boards (9)	1,276.6	1,274.4	2.1	0.17
All boards	**10,929.4**	**10,912.5**	**16.9**	**0.16**

Note: Table does not sum due to rounding.

Source: NHS boards' annual accounts 2012/13 and Scottish Government management information

the NHS met its financial targets in 2012/13 but there are some signs of pressure

10. All NHS boards have to meet two financial targets each year: they must break even against both their revenue and capital budgets at the end of the financial year (Appendices 1, 2 and 3). Their annual revenue and capital budgets are formally known as the Revenue Resource Limit (RRL) and the Capital Resource Limit (CRL). All boards met these financial targets in 2012/13, for the fifth year running.

11. NHS boards reported a small overall surplus of £16.9 million. This was made up of £16.7 million revenue and £0.2 million capital. The final expenditure,

called the outturn, is very close to the annual budget, with the surplus only 0.16 per cent of the overall budget (Exhibit 4, page 11). This highlights that the Scottish Government and the NHS boards very closely monitored and managed the forecast and actual financial position against budget throughout the year.

12. The NHS in Scotland continues to manage its finances within its total budget. During 2012/13, NHS boards delivered a higher than forecast underspend, and the Scottish Government balanced this by using these funds in other areas of the NHS. For example, they were used to provide brokerage to other boards, and for investment in insulin pumps and contributions to a new orphan drugs fund. This funds medicines for people with rare conditions, which are not available routinely.

Three NHS boards retained larger surpluses as part of their longer-term financial planning

13. NHS boards have limited flexibility in their budgets, and cannot build up any reserves from surpluses they have at the end of a financial year to spend on future plans. Instead, each board must agree with the Scottish Government any surpluses that it wishes to have available for future years. During 2012/13, NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Lanarkshire agreed with the Scottish Government that they would make a managed revenue surplus at the end of 2012/13. They did this because their financial planning had shown that they will need these funds in future years. This longer-term planning allows these boards to manage an element of their spending over more than one year, giving them more flexibility in how they budget.

14. NHS Lanarkshire delivered a year-end revenue surplus of £4.5 million. This plan was agreed with the Scottish Government in November 2012. The board will carry forward the surplus to help fund refurbishment works at Monklands Hospital and implement the adult mental health strategy over the next two years. NHS Dumfries and Galloway delivered a year-end revenue surplus of £4 million, agreed with the Scottish Government in August 2012. The Scottish Government will return the surplus to the board between 2014 and 2017. The board will use this money to help fund the double-running costs it will have as it commissions the new Dumfries and Galloway Acute Hospital and keeps the existing hospital open until the new facility is available.

15. NHS Ayrshire and Arran also reported a revenue surplus of £3.4 million. This was £1.4 million above the £2 million forecast agreed with the Scottish Government in the board's LDP. The board agreed the additional surplus with the Scottish Government in January 2013. The board has been using surpluses built up over a number of years and forecasts that it will reduce this surplus to £2 million in 2013/14 and break even from 2014/15 onwards. The board has earmarked the surplus for specific projects in 2013/14, including £1.4 million to pay for initiatives to manage waiting times.

16. The surpluses reported by these three boards accounted for 71 per cent of the total surplus against the total NHS revenue budget. The remaining 20 boards made an overall surplus of just 0.05 per cent of their combined revenue budget. The Scottish Government can permit some flexibility in NHS boards managing their budgets across more than one year, but needs to manage expenditure within the budget of the Health and Wellbeing Portfolio as a whole. This may mean the Scottish Government is not able to agree any further flexibility if it is requested by a large number of boards.

Four boards received brokerage in 2012/13 to help them break even

17. The Scottish Government can agree to provide extra funding to an NHS board in a financial year. The board then repays this money at a later date. This is referred to as brokerage. Brokerage can introduce an element of flexibility into budgeting and spending plans, helping boards to manage changes to planned expenditure, or providing extra money at a time of pressure. The Scottish Government makes the funding available only when a board provides assurance that it can repay the funds. In agreeing to receive brokerage, boards take on the risk that they may need to prioritise future repayments of brokerage over investment in services. The Scottish Government may also put in place other non-financial support packages. These packages are known as tailored support and help a board deal with areas of difficulty. This can be help to return to financial balance, or with other areas of their performance. This may mean staff from the Scottish Government or another NHS board working with staff to help them identify potential savings in specific areas of difficulty.

18. Four boards received brokerage from the Scottish Government to help them break even in 2012/13 (Exhibit 5, page 14) and (Case study 1, page 15). This was all for specific purposes. Unlike the previous year, no board required tailored support from the Scottish Government to help it achieve financial balance.

19. Both NHS Fife and NHS Tayside needed brokerage to help them break even in 2012/13 because capital sales did not happen as planned in the year. This meant their actual income was less than forecast by very small amounts (0.2 per cent and 0.3 per cent of their respective RRLs). This highlights the limited flexibility in their financial plans and the impact of the requirement to break even each year. The requirement to meet the annual financial target meant that the boards needed to make formal brokerage agreements with the Scottish Government, instead of managing the impact of the timing difference at board level over a longer period. The commitment to repay the brokerage within agreed timescales is an additional financial risk that the boards need to manage.

20. There is a risk that the planned capital sales at NHS Fife and NHS Tayside do not occur in 2013/14, or that the income they receive is lower than planned. This would mean that the boards could not afford to repay the brokerage from the sales, and would need to defer other expenditure or make additional savings to meet the repayment. NHS Fife continues to assess market conditions to monitor this risk. NHS Tayside has agreed increased flexibility in the timing of the repayment with the Scottish Government to minimise the impact of this risk.

21. NHS Orkney's auditors noted that the board's financial position has improved due to concentrated efforts to make targeted savings and to change the way it delivers services to make them more efficient. Therefore, the board did not require brokerage in 2012/13, having received £4.38 million over the previous three years. However, there are still risks to the financial position. The board will repay the brokerage from 2014/15 through further savings and receipts from property sales, and the auditors highlighted that the savings targets are very challenging. They highlighted a risk that if the board does not achieve its planned savings, it may need to curtail investment in services to repay brokerage.

Boards have improved disclosure about revenue funding changes

22. Our 2011/12 report recommended that boards' annual accounts should clearly report brokerage or plans to use surplus funds. The Scottish Government subsequently issued guidance to boards reiterating that information about financial flexibility agreed with the Scottish Government must be transparent, that is clear, understandable and easy to obtain.

23. The four boards that received brokerage, and the three boards that reported larger than forecast surpluses, worked with their auditors to improve the proposed disclosure of these arrangements. All boards were open to making improvements to disclosure, and there are clearer statements in the audited annual accounts.

Exhibit 5

Brokerage provided by the Scottish Government in 2012/13

Four boards received brokerage in 2012/13.

Board	Amount received in 2012/13	Why brokerage was provided	Repayment schedule
NHS 24	£16.6 million	NHS 24 received brokerage to put changes to its services in place, including a new IT system. Brokerage of £0.3 million was provided in 2011/12, with a further £1.7 million to be provided in 2013/14.	Total brokerage of £18.6 million to be repaid over three years starting 2014/15.
NHS Lothian	£8 million	The board received £10 million brokerage to help improve its waiting times. The board spent £8 million of this and returned £2 million at the end of 2012/13.	Total amount of £8 million repayable over two years to 2014/15.
NHS Tayside	£2.25 million	The board received brokerage to deliver its financial plan after a planned asset sale was delayed until 2013/14.	The board will repay £0.25 million in 2013/14, with the following £2 million to be repaid by 2015/16. The exact timing of the repayment is flexible depending on the timing of the sale and required planning consent.
NHS Fife	£1.4 million	In 2012/13, NHS Fife was due to use profits from the sale of St Andrews Memorial Hospital to repay the remaining £0.75 million from the £1.11 million brokerage that it received from the Scottish Government in 2011/12. However, due to the delay in the sale of the hospital the board agreed with the Scottish Government to defer the brokerage repayment. In 2012/13, NHS Fife received an additional £1.4 million of brokerage to support expenditure and this is also scheduled to be repaid from the profit from the sale of the hospital. NHS Fife anticipates repaying the combined brokerage amount of £2.15m from the sale of the hospital in 2013/14.	Total combined brokerage of £2.15 million to be repaid in 2013/14. The exact timing of the repayment is flexible depending on the timing of the sale.

Source: Audit Scotland, based on board annual audit reports and information from the Scottish Government

Case study 1
Use of brokerage to support NHS 24's Future Programme

NHS 24's strategic plan includes significantly changing the way it delivers services, through its 'Future Programme'. This involves implementing new ways of working using IT and developing a shared approach to patient assessment with the Scottish Ambulance Service. To avoid paying £4.6 million in financial charges over the life of the contract with the main supplier, NHS 24 agreed with the Scottish Government that upfront repayable funding would be provided to enable the board to fund this programme. The board agreed to repay this from savings generated by the new programme. By 2012/13, the board had received £16.9 million in brokerage, over 85 per cent of the total amount forecast to be received.

This is a good example of planning by the board and the Scottish Government to deliver a major investment in services for patients. However, the auditors have highlighted a number of significant risks to the board in achieving the planned savings and managing the planned repayment of the brokerage between 2014 and 2017. The auditors concluded that achieving future financial targets will be extremely demanding.

Source: NHS 24 Annual Audit Report 2012/13 and information from the Scottish Government

NHS boards' budgets changed over the year

24. The Scottish Government provides NHS boards with an initial baseline budget at the start of the year and additional funding allocations throughout the year. On average, the boards received 85 per cent of their total budget in April 2012, with the remaining 15 per cent being made available throughout the year. However, the final budgets were not agreed until after the end of the financial year (31 March 2013), and as late as June 2013 in some cases, largely to process technical accounting adjustments. NHS boards' financial targets are to break even against these final capital and revenue budgets, and this requires careful management. Auditors for NHS Forth Valley and NHS Greater Glasgow and Clyde recommended that the boards need to discuss the timing of allocations for project-specific or partnership funding further with the Scottish Government. This is to enable better phasing of spending and allocations over the lifetime of projects.

25. In their LDPs, seven boards note the risks around their actual allocations not being as much as they assume or require to deliver services.[11] This is particularly for earmarked allocations. This is funding that the Scottish Government allocates to NHS boards for specific purposes, such as for drug and alcohol treatment and support. NHS National Services Scotland noted in its LDP that if funding arrangements were not finalised by the end of the first quarter of the financial year in June, it would need to take action to minimise the financial risk to the board. This could potentially mean reducing the services it delivers.

There were significant movements across the capital budget during 2012/13

26. The overall capital budget for 2012/13 reduced by 20 per cent from 2011/12, to £605.5 million. NHS boards reported an overall surplus of £0.2 million, 0.04 per cent of the budget (Appendix 3, page 43). The decrease in the overall capital budget is largely due to reduced funding for the technical accounting implications in the first year of new Public Private Partnerships (PPPs). In accordance with the boards' accounting and budgeting framework, this funding is provided in full by the Scottish Parliament and so does not impact on the amount of capital available for boards to spend. In 2011/12, two large PPP projects came into use during the year at NHS Fife (Victoria Hospital) and NHS Forth Valley (Forth Valley Royal Hospital). The boards received additional funding from the Scottish Parliament for the accounting implications of these projects. Murray Royal Hospital in NHS Tayside was the only significant new PPP project in Scotland in 2012/13. This means the overall capital funding for the accounting treatment of new PPP projects from the Scottish Parliament fell from £278 million in 2011/12 to £77 million in 2012/13.

27. When the funding for new PPP assets is removed, the capital budget available to fund investment at NHS boards increased by ten per cent, from £481 million in 2011/12 to £528 million in 2012/13 (Exhibit 6). The 2012/13 budget included additional capital funding made available by the Scottish Government to NHS boards through a revenue-to-capital transfer of £95 million (£320 million over three years), and £15 million for 'shovel-ready' projects (backlog maintenance projects that were ready to start immediately). These projects were brought forward from 2013/14 to 2012/13 to boost economic activity. Barnett consequentials led to an additional £10 million in the 2012 autumn budget review. These are proportionate changes in funding that the Departments of the UK Government provide to the Scottish Government and other devolved administrations when the UK Government announces changes in funding.

28. NHS boards' LDPs for 2012/13 planned for capital expenditure of £603.5 million. This figure excluded Scottish Parliament funding for new PPPs and included some of the Scottish Government's planned increase.

Exhibit 6

NHS capital budget 2011/12 and 2012/13

The overall capital budget decreased from 2011/12, but the budget available for investment in capital programmes increased.

	2011/12 £ million	2012/13 £ million	% change
Total capital budget	**758.3**	**605.5**	**-20.15%**
Split into:			
Capital provided for investment in board capital programmes	480.6	528.1	9.87%
Capital funded by the Scottish Parliament for accounting treatment for new PPP projects	277.7	77.5	-72.09%

Source: Boards' financial performance returns, March 2013, and annual accounts 2012/13

However, the final capital expenditure of £528 million was seven per cent lower than originally planned in the LDPs. There were multiple movements in boards' capital budgets during the year. The movements were both increases and decreases, with a number of boards having changes of over 60 per cent. These movements resulted from additional allocations for projects from the Scottish Government, or boards returning unspent funding due to project delays or slippage (Exhibit 7, page 18).

29. Despite the increase in available capital funding in 2012/13, NHS boards returned about £36 million of capital funding to the Scottish Government due to project delays and slippage. NHS Grampian and NHS Highland returned capital funds to the Scottish Government in 2011/12, received these back in 2012/13 and then returned them again later in 2012/13. Both boards have spending commitments in 2013/14 for these funds.

Transparency of movements in the capital budget needs to improve

30. Like the revenue budget, the Scottish Government very carefully manages the capital budget during the year, in discussion with individual boards. Any delays or changes to proposed plans or timing of expenditure mean that a board's budget is adjusted. The Scottish Government moves funding between boards' budgets according to what they need. While these movements may be necessary to try to maximise how boards use funds, they emphasise the focus on annual break even driven by the current framework of annual financial targets.

31. While agreed movements in the revenue budget were more transparent in 2012/13 (paragraph 23, page 14), boards now need to improve the way they report on any movements in capital funding so they are also clear. Boards' annual accounts have relatively little detail about the capital budget and explanations of significant changes from the original plan.

Changes in budgets and movements in funds during the year make it difficult to monitor underlying financial performance

32. Revenue and capital budgets can change significantly during the year. Auditors have reported no weaknesses in short-term financial management. However, changes to the budgets during the year mean that it is difficult to assess NHS boards' actual performance against their budget. They also mean that it is difficult to identify any underlying difficulties with boards' financial sustainability, ie their ability to fund all required services within budget over the longer term.

33. There were a number of changes to budgets during 2012/13:

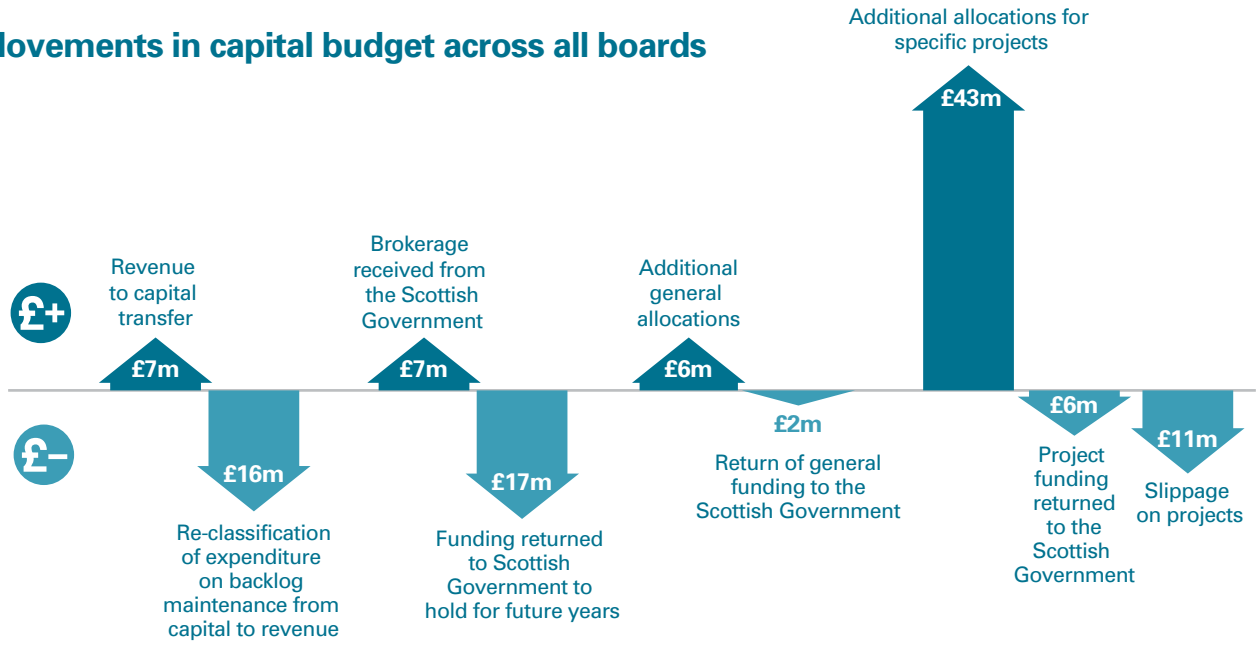
- NHS boards that were at risk of breaching their financial target by spending more than their budget received brokerage from the Scottish Government (Exhibit 5, page 14).
- The Scottish Government provided additional funding allocations to NHS boards for particular reasons during the year, for example to help meet waiting times targets in those boards where performance was below target.
- The Scottish Government and NHS boards agreed that unspent capital funds would be returned to the Scottish Government during the year and then allocated to another NHS board (paragraph 30).

Exhibit 7

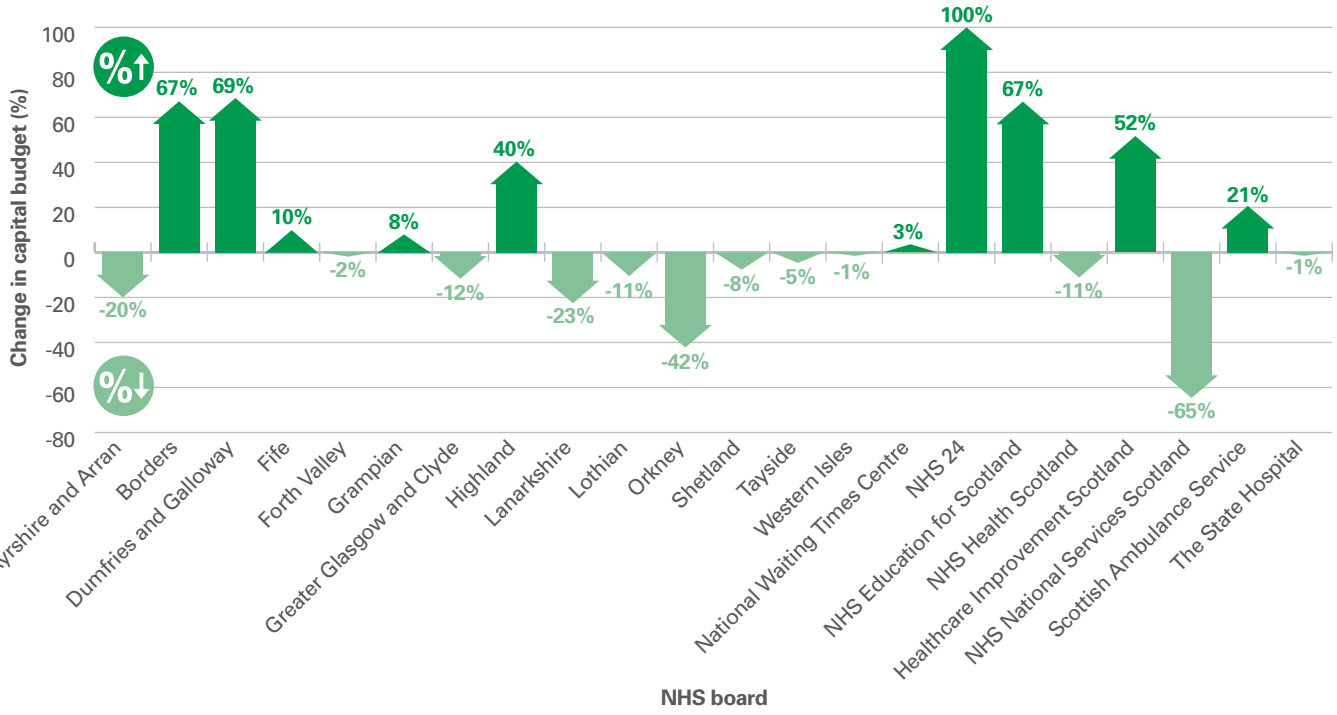
Significant movements in the capital budget across boards, and changes to individual board budgets from LDP forecast to final capital budget

Capital budgets decreased from original plans at more than half of the territorial boards.

Movements in capital budget across all boards



Movements in capital budget in individual boards



Notes:

1. Scottish Government funding was available to NHSScotland to make hospitals more energy efficient. NHS National Services Scotland manages boards' funding applications centrally. Its capital budget was reduced by £5 million at the end of the year due to the accounting treatment for this funding.
2. The Mental Welfare Commission did not have a capital budget in 2012/13.

Source: LDPs 2012/13 and annual accounts 2012/13

34. The requirement that all boards break even each year can contribute to these movements in allocations and changes in budgets. This is because the Scottish Government and boards actively monitor and manage the budgets to ensure they all break even. Annual financial targets can also be inflexible. NHS boards' spending on projects rarely fits in one financial year only, and so boards need to phase expenditure on a project over a number of years. Significant service redesign requires upfront investment which will be recouped by future savings. While some NHS boards have made agreements with the Scottish Government to save now to pay for future changes in services, the current system may not have enough flexibility to enable this to happen on a larger scale. NHS boards and the Scottish Government are currently tied to achieving a break-even position each year and movements in funds support this objective, rather than longer-term strategic objectives.

35. The Wales Audit Office has commented on the lack of flexibility in Welsh health boards having to break even each year. The Welsh Government's Department of Health intends to move from a requirement for health boards to break even every year to a more flexible requirement to break even over a three-year period.[12]

36. The Scottish Government could consider a similar approach for the NHS in Scotland as it thinks about ways to increase the flexibility available for boards to manage their expenditure over a number of years. The NHS boards, as individual public bodies, would continue to be accountable for the money they spend, but could shift the focus from aiming to break even every year to financial sustainability over the longer term. The Scottish Government and NHS boards would need to work together to manage any risks arising from this approach. This would include improving forecasting and planning, so that the whole Health and Wellbeing Portfolio can continue to meet overall Scottish Government budget requirements.

The NHS boards met 99 per cent of their savings targets but did not meet the forecast level of recurring savings

37. In his statement on the draft budget 2012/13, the Cabinet Secretary for Finance and Sustainable Growth stated that NHS boards would need to make efficiency and productivity savings of at least three per cent. At the start of 2012/13, NHS boards forecast that they needed to make total savings of £271.7 million to break even. Across all boards, this was 3.1 per cent of the baseline revenue budget that they were allocated by the Scottish Government at the start of the year. For individual boards, their savings target to break even ranged from 1.7 per cent of baseline at NHS Grampian to 7.1 per cent at NHS Shetland.

38. The NHS as a whole achieved savings of three per cent of baseline, as required by the Cabinet Secretary, and 99 per cent of its overall savings target (£269.8 million against the target of £271.7 million) (Exhibit 8, page 20). While both NHS Lothian and NHS Orkney achieved savings of over three per cent of their baseline budget, they missed their own savings targets by ten per cent and five per cent respectively. NHS Lothian achieved savings of £33.8 million against a target of £37.5 million. It was able to use underspends from across the organisation to break even. Some boards made more savings than they planned. These savings helped to make up the overall difference between the target and the actual savings across Scotland.

Exhibit 8

Savings achieved in 2012/13, and savings required in 2013/14

Boards made significant savings in 2012/13 but need to make the same again in 2013/14.

NHS board	Savings achieved 2012/13 £m	% of target	% of baseline revenue budget	Savings required 2013/14 £m	% of baseline revenue budget
Ayrshire and Arran	13.1	100	2.23	18.1	3.01
Borders	6.0	102	3.53	5.1	2.92
Dumfries and Galloway	7.8	105	3.18	7.5	2.96
Fife	17.5	100	3.36	16.2	3.01
Forth Valley	11.9	100	2.86	13.2	3.03
Grampian	12.0	100	1.68	22.3	3.0
Greater Glasgow and Clyde	59.0	100	3.05	59.9	3.0
Highland	23.7	100	4.79	18.4	3.60
Lanarkshire	19.2	100	2.29	26.0	3.0
Lothian	33.8	90	3.10	27.8	2.44
Orkney	1.3	95	4.10	1.0	3.0
Shetland	2.7	100	7.10	2.4	6.21
Tayside	25.2	103	4.13	21.0	3.34
Western Isles	2.6	104	4.35	1.8	3.01
Total territorial boards	**236.1**	**99**	**3.04**	**240.8**	**3.0**
National Waiting Times Centre	2.6	113	6.59	2.6	5.91
NHS 24	1.7	100	2.86	3.0	4.80
NHS Education for Scotland	7.3	100	1.87	3.0	0.77
NHS Health Scotland	1.0	100	5.23	1.0	5.45
Healthcare Improvement Scotland	2.0	115	11.78	0.9	5.45
NHS National Services Scotland	10.4	101	3.75	8.5	3.0
Scottish Ambulance Service	7.4	101	3.61	7.1	3.42
The State Hospital	1.4	101	4.21	1.0	3.07
Total special boards	**33.7**	**102**	**3.24**	**27.1**	**2.57**
All boards total	**269.8**	**99**	**3.07**	**267.8**	**2.95**

Note: Table does not sum due to rounding.

Source: Board LDPs 2012/13 and 2013/14; FPRs March 2012 and March 2013

Exhibit 9

Recurring savings 2011/12, performance against forecast 2012/13, and forecast 2013/14

Ten boards did not meet their forecast level of recurring savings in 2012/13.

NHS board	Percentage of savings that are recurring			
	2011/12	2012/13		2013/14
	Actual savings (%)	Forecast savings (%)	Actual savings (%)	Forecast savings (%)
Ayrshire and Arran	97	100	✗ 95	67
Borders	57	86	✗ 65	50
Dumfries and Galloway	89	100	✓ 96	100
Fife	56	58	✗ 53	89
Forth Valley	65	94	✗ 78	100
Grampian	98	65	✓ 87	67
Greater Glasgow and Clyde	100	100	✓ 100	100
Highland	42	75	✗ 45	67
Lanarkshire	94	91	✓ 91	57
Lothian	66	94	✗ 70	100
Orkney	85	80	✗ 69	100
Shetland	100	97	✗ 80	86
Tayside	57	59	✗ 44	52
Western Isles	82	69	✓ 71	83
Total territorial boards	**77**	**86**	**76**	**81**
National Waiting Times Centre	97	92	✓ 87	96
NHS 24	67	100	✓ 100	100
NHS Education for Scotland	81	86	✓ 86	67
NHS Health Scotland	100	100	✓ 100	100
Healthcare Improvement Scotland	98	92	✓ 83	100
NHS National Services Scotland	100	98	✓ 100	100
Scottish Ambulance Service	83	97	✓ 96	99
The State Hospital	100	78	✗ 73	51
Total special boards	**97**	**94**	**93**	**94**
All boards total	**79**	**87**	**78**	**82**

✗ Did not meet forecast ✓ Met forecast ✓ Board made actual forecast recurring savings, but made additional non-recurring savings above their overall target. This affects the percentage recurring savings.

Source: Board LDPs 2012/13 and 2013/14; FPRs March 2012 and March 2013

39. We highlighted the high percentage of non-recurring savings as a risk in our 2011/12 report, and this risk remains. These are savings that are only made for one year, rather than savings that the board will continue to make every year. Boards continued to rely on non-recurring savings in 2012/13, indicating that some are finding it hard to make more savings on an ongoing basis. Almost half (11 boards) had a lower percentage of recurring savings than they had in 2011/12 (Exhibit 9, page 21). Across all boards, 78 per cent of savings were recurring. This was around the same level as 2011/12 (79 per cent), but nine per cent lower than forecast.

40. Eight territorial boards forecast an increase in the proportion of total savings delivered on a recurring basis in 2012/13, but only NHS Dumfries and Galloway achieved its full forecast.[13, 14] Three of these boards, NHS Ayrshire and Arran, NHS Fife and NHS Tayside, achieved a lower percentage of total savings on a recurring basis than in the year before.

41. The percentage of savings made on a recurring basis was lowest in NHS Tayside, NHS Highland, NHS Fife and NHS Borders. These four boards also had the lowest percentage of recurring savings in 2011/12. NHS Borders' level of recurring savings increased slightly, but NHS Tayside decreased from 57 per cent to 44 per cent. Continuing to rely on a significant proportion of non-recurring savings is a high-risk strategy for boards. As savings get more difficult to find, the risk of these NHS boards not being able to identify such high levels of non-recurring savings year after year will continue to increase. In their audit reports, auditors highlighted that relying on non-recurring savings is not sustainable in the long term. It is also more difficult for a board to manage the impact of non-recurring savings in a planned way, particularly for those non-recurring savings that were higher than planned in order to meet the overall savings target. For example, the board may not have included these savings in its workforce or clinical service plans, and therefore the savings may not fit with the direction of these plans.

Boards will not be able to increase their savings from prescribing to the same extent in future years

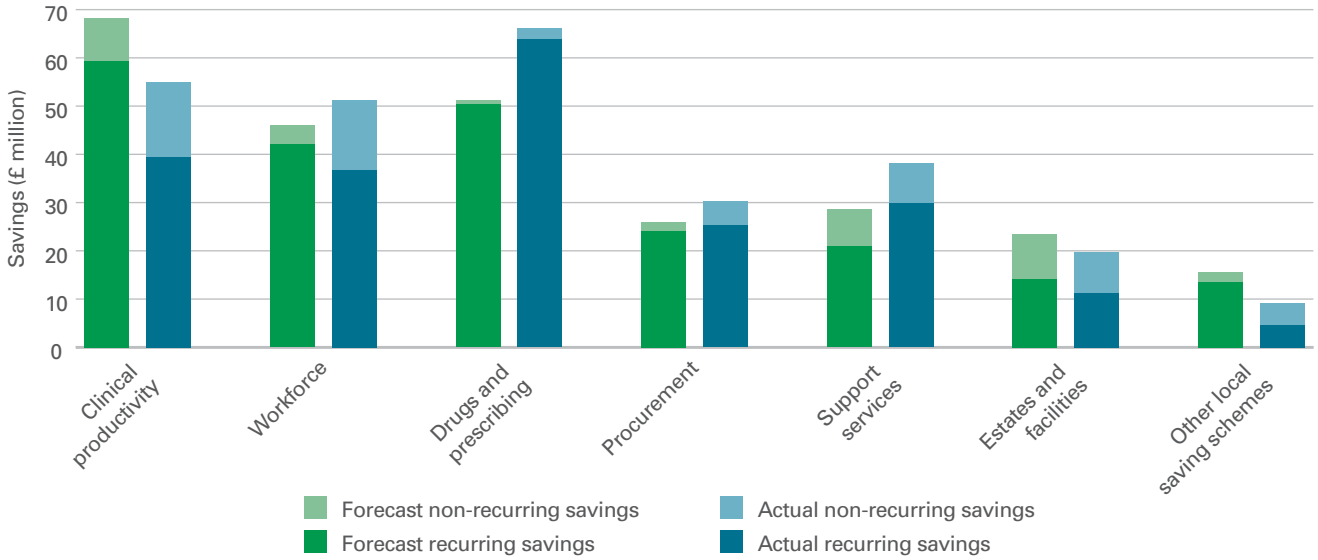
42. The NHS spent over £1.46 billion on prescribing in general practice and hospitals in 2012/13, the second largest area of spending after staffing.[15, 16] NHS boards made most savings in this area in 2012/13, classifying £66.2 million savings to the category 'drugs and prescribing'.[17] This is £15 million more than NHS boards predicted in their 2012/13 LDPs (Exhibit 10, page 23). Drugs and prescribing contributed most to recurring savings (30 per cent of total recurring savings). Clinical productivity and workforce were the largest areas of non-recurring savings, contributing 26 per cent and 25 per cent respectively, which was higher than the forecasts. As more of the savings than planned in these categories were non-recurring, it suggests that they resulted from short-term initiatives rather than significant changes to ways of working.

43. The NHS has been successful in using a range of measures to control spending on prescribing in general practice in recent years.[18] In addition, a number of commonly used drugs came off patent in 2012/13, contributing to higher than anticipated cost savings. However, NHS boards will not be able to rely on making new recurring savings from the expiry of drugs patents to the same extent in future years. The Scottish Government is continuing to work with NHS boards to improve the quality and cost effectiveness of prescribing.

Exhibit 10

Comparison of savings planned and achieved, 2012/13

Boards made less recurring savings than planned in all areas apart from drugs and prescribing, procurement and support services.



Note: There was also £11.14 million recurring savings and £1.48 million non-recurring savings forecast as unidentified which are included as actual savings in the categories above.

Source: Audit Scotland analysis of FPRs and boards' LDPs 2012/13

44. While drugs coming off patent has contributed to cost savings, some NHS boards identified increased prescribing as a cost pressure in their LDPs. General practice accounts for most spend on prescribing, but spending on hospital prescribing is increasing more. High-cost, specialist drugs are a particular cost pressure (Case study 2, page 24).

The target of £268 million savings for 2013/14 will be challenging for boards to achieve sustainably

45. In their 2013/14 LDPs, NHS boards forecast that they will need savings of £268 million to break even. This is £69 million (35 per cent) more than they had planned for 2013/14 in the 2012/13 LDPs. As NHS boards made less recurring savings than planned in 2012/13, this means that they need to make these additional non-recurring savings again in 2013/14. This accounts for approximately £20 million of the increase.

46. The £268 million in savings is three per cent of the NHS boards' baseline revenue budgets, the same level as 2012/13 (Exhibit 8, page 20). For territorial boards, this ranges from 2.4 per cent of the baseline revenue budget at NHS Lothian to 6.2 per cent at NHS Shetland. Overall, boards reported that nine per cent of these savings are categorised as high risk in terms of how likely the boards are to achieve them. This is less than the previous year when 20 per cent of the target was classified as high risk. Four boards have classified over a quarter of their savings as high risk.[19] Auditors for all boards reported that the savings targets will be a significant challenge for boards to achieve and sustain, and will make it difficult

to maintain or improve on the performance targets set by the Scottish Government. The savings targets will require boards to prioritise further how they use the funding available to them. At the end of July 2013, NHS boards had made £83 million in savings for 2013/14. This is approximately £5.7 million ahead of their in-year target.[20]

Case study 2

Spending on high-cost specialist hospital medicines

NHS boards spent over £115 million on the top ten high-cost, low-volume (HCLV) drugs in hospitals in 2012/13, a third of total spending on all drugs in hospitals.[1] These are expensive specialist drugs that are used for a comparatively small number of patients. These can be a pressure on NHS boards as spending increases at a higher rate than other costs and it can be less predictable. The top ten drugs are generally a specialist type of drug used to treat rheumatology conditions and irritable bowel conditions (anti-TNFs) and cancer drugs.

Spending on HCLV drugs increased more than spending on overall hospital drugs and drugs prescribed in general practice over the past two years:

	Change in total spending 2010/11 to 2011/12[2]	Change in total spending 2011/12 to 2012/13[3]
Top ten HCLV drugs – cash terms	↑ £12.2 million **(15%)**	↑ £13.5 million **(13%)**
Top ten HCLV drugs – real terms	↑ £10.4 million **(12%)**	↑ £12 million **(12%)**
All hospital drugs – cash terms	↑ £13.4 million **(5%)**	↑ £28.2 million **(9%)**
All hospital drugs – real terms	↑ £7 million **(2.4%)**	↑ £23 million **(7%)**
Drugs in general practice – cash terms	↑ £12 million **(1%)**	↓ £60 million **(-6%)**
Drugs in general practice – real terms	↓ £11 million **(-1%)**	↓ £74 million **(-7%)**

Notes:
1. Data are not included for NHS Tayside as they are currently being processed by ISD Scotland. The drugs included for this analysis are those on the NHS England Payment by Results exclusions list (given their specialist and high cost nature), which the Scottish Medicines Consortium has accepted for use in Scotland.
2. Spending on HCLV drugs and all hospital drugs excludes NHS Highland and NHS Tayside.
3. Spending on HCLV drugs and all hospital drugs excludes NHS Tayside.

Source: Audit Scotland based on analysis of ISD Scotland data

47. Boards have forecast that they will increase the percentage of recurring savings in 2013/14 to 82 per cent (Exhibit 9, page 21). The majority of boards did not achieve their forecast increase in recurring savings in 2012/13 (paragraph 40, page 22), making it a significant challenge to meet this forecast in 2013/14.

NHS boards do not have enough focus on longer-term financial planning

48. While breaking even in the short term is important, boards also need to focus on further developing strategic financial plans which cover the longer term. This would require more detailed focus on planning for significant developments and redesign to ensure these are affordable. In their LDPs, boards provide financial projections for between three and five years, depending on the Scottish Government's requirements.[21] These projections set out expected funding, projected expenditure, and the forecast savings required each year to close the gap between income and expenditure. Boards provide a breakdown of the forecast categories of savings.

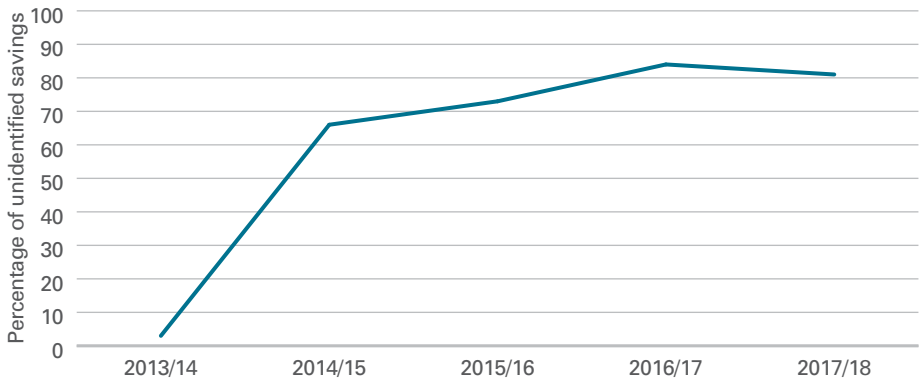
49. However, detailed financial planning is mainly limited to year one of the LDP. For 2013/14, NHS boards have forecast which category 97 per cent of their savings will be in, leaving three per cent of savings unidentified. For the following year, 2014/15, the amount unidentified increases to 66 per cent and it goes up to 73 per cent for 2015/16 (Exhibit 11). This means that for just one and two years ahead, boards have not identified how or where they will achieve over two-thirds of the savings required. For five boards, all savings are unidentified after 2013/14.[22] This indicates a lack of planning about how boards are:

- making their finances sustainable over the long term
- prioritising and redesigning services and associated expenditure so they can plan and achieve savings.

Exhibit 11

Percentage of NHS boards' savings that are unidentified, 2013/14 to 2017/18

Boards' LDPs do not always identify where future savings will come from.



Note: Savings up to 2015/16 are based on all boards' LDPs. Savings for the final two years are based on the 13 boards that submitted LDPs for five years.

Source: NHS board LDPs 2013/14

50. In paragraph 40 (page 22) we noted that most NHS boards did not meet their forecasts for reducing reliance on non-recurring savings in 2012/13. We also highlighted that boards have had to increase the savings they require to break even in 2013/14 by approximately £70 million compared to what they had projected (paragraph 45, page 23). This highlights a level of optimism in the forecasts.

51. The Scottish Government's central Quality and Efficiency Support Team works closely with NHS boards to help them to identify and achieve efficiency savings and deliver improvements in services. This includes work to improve efficiency and productivity by reducing waste, duplication and unnecessary variation across services and NHS boards.

52. Our 2011 report, *Scotland's public finances: addressing the challenges,* highlighted that public bodies need to focus on achieving long-term financial sustainability. To meet the challenge of reducing budgets and increasing cost pressures, they need to think more radically about how to reduce their costs in the longer term. Rising demand from an ageing population with complex health needs, significant reform of health and social care services through integration, and the need to generate considerable recurring savings mean that NHS boards need to change how they deliver services. They have started planning for this, but they have not carried out detailed financial planning to make sure that their strategies are affordable.

53. Several auditors have highlighted that boards have good processes in place for identifying and delivering savings each year and prioritising funding annually. The auditors have described boards' short- and medium-term planning as generally sound. However, a number have also commented that boards' strategies are not yet fully underpinned by detailed long-term financial planning:

- Auditors at NHS Highland reported that while the LDP takes into account cost reductions and the other efficiency savings required, it does not detail how the board will achieve the plans. They noted that the five-year financial forecasts are very high level.

- NHS Lothian's annual audit report highlights that the board will be working to align its financial, asset management and workforce strategies to its new strategic clinical framework which was approved in February 2013.

- Auditors at NHS Forth Valley reported that the board is developing the next stage of its healthcare strategy. This will include its ability to deliver service change and cost savings to meet future demographic and technology changes.

- Auditors at NHS Lanarkshire reported that the 2012-17 finance plan could more clearly demonstrate how the board has allocated funding in line with its corporate objectives

- Auditors at NHS Education for Scotland and the Scottish Ambulance Service recommended that the boards consider planning over a longer period and incorporating risk-based contingency planning based on the range of different potential funding scenarios.

54. There is some evidence that NHS boards and the Scottish Government carry out some longer-term financial planning. An example is NHS Dumfries and Galloway planning for the impact of the new Dumfries and Galloway Acute Hospital. At the start of 2012/13, the board identified a number of one-off savings that amounted to £4 million. This included benefits from GP prescribing (£0.85 million) and budgeted costs being less than forecast (£1.9 million). The board agreed with the Scottish Government that this money would be shown as an underspend by the board at the year-end. The Scottish Government retained the surplus, and will return it to the board over 2014 to 2017 to help fund double-running costs as the new hospital comes into use. While this is good longer-term financial planning, the board's original financial forecast did not identify these one-off savings. The auditors highlighted that the board should scrutinise the assumptions underpinning the LDP more closely.

55. The funding cycle for the NHS boards means longer-term funding levels are uncertain. However, this should not prevent boards from developing more detailed long-term financial plans. Boards are starting to progress the detailed financial planning they need to help them develop long-term strategies to meet future needs. In line with good practice, this would include:

- forecasting and analysing levels of demand and changes arising from service redesign
- modelling how much they need to increase spending by, and in what ways spending will change.

56. Boards could use scenario planning to forecast projected levels of income and identify the range of savings that may be required. Boards should analyse the savings to be achieved through service redesign and plan in detail for how they will make up the remainder of savings. This type of analysis would underpin the LDPs as the overall planning document and link to workforce, asset and information technology strategies. As some specialist services are configured on a regional basis and there are significant patient flows between board areas, boards should work together and in their Regional Planning Groups to collaborate on future service configurations and identify where savings can be made.

Increasing cost pressures will bring more challenges for the boards

57. Auditors reported that the future financial position is becoming more challenging. NHS boards face limited funding increases, rising cost pressures and challenging savings and performance targets. Demand for services is also growing, with more people living longer and more people having health conditions that need managed on a long-term basis.

Five NHS boards are still receiving less than their target funding, four years after a new funding formula was introduced

58. Five NHS boards continue to receive funding below their National Resource Allocation Committee (NRAC) target allocations (Fife, Forth Valley, Grampian, Lanarkshire and Lothian). The Scottish Government first used the NRAC formula to allocate NHS board funding in 2009/10, so the formula has now been in place for four years. These NHS boards have been under-funded by a total of £517 million over that period. Every year, their allocations move towards parity with the level they should receive under the formula, but the Scottish

Government has no specific timescales for achieving NRAC parity. It has said that it does not want to destabilise other boards by reducing and reallocating their funding. The Scottish Government allocated a further £32 million in total to the boards below their target allocation in 2012/13, and an additional £42 million in 2013/14. However, the lack of clear plans and an agreed timescale to move towards parity adds uncertainty to NHS boards' planning.

59. In 2012/13, two of the boards that received brokerage were below their NRAC target allocation. NHS Lothian received £54 million less than expected under the formula, and NHS Fife £12 million. Our 2012 report commented that there did not appear to be any strong relationship between financial performance and the distance from target NRAC allocation. This is still the case. While under-funding may have been a factor in NHS Lothian's and NHS Fife's financial position, other boards that are below their NRAC funding target have managed the position. This includes NHS Grampian, and NHS Lanarkshire which delivered a managed surplus.

Backlog maintenance reduced by six per cent to £948 million but continues to require attention

60. NHS boards have a backlog of maintenance that they need to carry out to ensure their buildings are fit for purpose. The spending needed to address the backlog reduced from £1 billion in 2011 to £948 million in 2012.[23] It reduced in nine of the territorial boards, but increased in the other five.[24, 25] The Scottish Government has estimated that £175 million of the backlog is in buildings that the NHS plans to dispose of in the next five years.[26]

61. The Scottish Government has classified £159 million of the maintenance backlog as high risk, which is defined as work that must be addressed as an urgent priority. This is down from £232 million in 2011. Over 90 per cent of NHS Orkney's backlog is classified as high risk, but the board's plans to replace Balfour Hospital should address much of this. NHS Borders, NHS Lanarkshire and NHS Lothian have between 30 and 40 per cent of their backlogs classified as high risk. Across Scotland, approximately 88 per cent of the backlog is in clinical areas, where patients receive care. The Scottish Government has stated that it expects that NHS boards will prioritise high- and significant-risk backlog maintenance. On that basis, it has projected that the high-risk backlog will be cleared within two years, and the significant backlog within four years (Exhibit 12, page 29) and Case study 3 (page 29).

62. The Scottish Government made additional capital funding available to help boards reduce their backlog maintenance (paragraph 27, page 16). This helped boards to target spending on this area. Backlog maintenance is funded from a mix of capital and revenue funding. During the year, as boards developed detailed plans for work on backlog maintenance, £16 million of the expenditure was re-classified as revenue from capital. This was due to the nature of the works and to comply with accounting requirements.

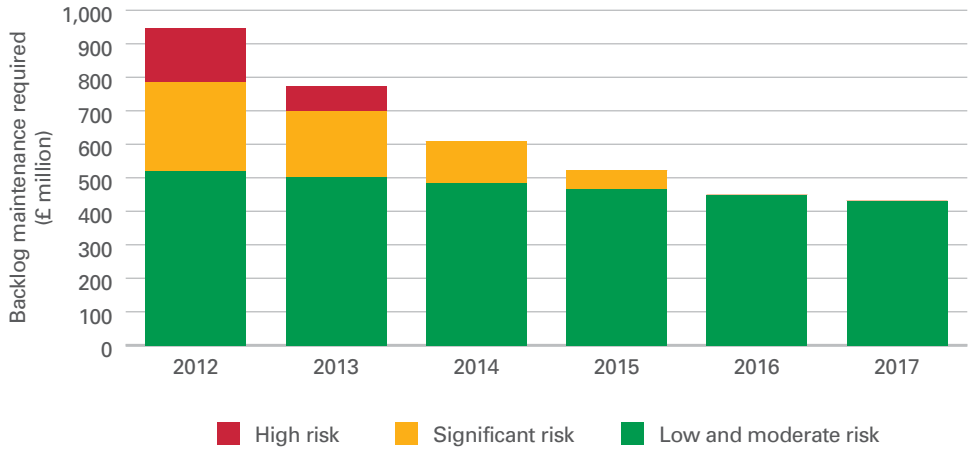
The financial impact of pension revaluation and equal pay claims is still unknown

63. Our 2012 report highlighted that the NHS in Scotland had received about 10,000 equal pay claims but it was not possible to estimate the impact of the claims. This position continued in 2012/13, and boards disclosed an unquantified contingent liability in their accounts. This is to identify that they face a potential

Exhibit 12

Total and forecast backlog maintenance across Scotland, 2012 to 2017

Backlog maintenance is reducing, and the high- and significant-risk backlog is forecast to be cleared by 2016.



Source: Audit Scotland analysis of information provided by the Scottish Government

Case study 3

Reducing backlog maintenance at NHS Lanarkshire

NHS Lanarkshire has recognised that its backlog maintenance represents a significant challenge. Its backlog maintenance is largely at Monklands Hospital. With no plans to build a new hospital or dispose of Monklands, the board needs to ensure the building is fit for purpose. Monklands Hospital accounts for approximately two-thirds of the total backlog maintenance in the board and there are plans to spend just over £18 million on this over the next five years. As part of the board's plan to focus expenditure in this area, it agreed with the Scottish Government during 2012/13 that it would keep its forecast surplus of £4 million and spend part of this on backlog maintenance in 2013/14.

To date, NHS Lanarkshire has successfully reduced its total backlog maintenance by 50 per cent, and the amount of significant- and high-risk backlog from £111 million to £34 million. This focus on tackling backlog maintenance is part of a wider Property and Asset Management Strategy. This includes investing approximately £85 million in a four-year programme of works to construct and refurbish buildings and to dispose of buildings surplus to requirement.

Source: *Annual state of NHSScotland Assets and Facilities Report for 2012*, Scottish Government, 2012; information provided by the Scottish Government; and *Property and Asset Management Strategy 2013–2017,* NHS Lanarkshire, August 2013

financial cost in the future. The scope of large liabilities is reducing, but there is still a risk of a potential future financial impact. We also highlighted in last year's report that:

- the most recent actuarial valuation for the NHS Superannuation Scheme was for the year ending 31 March 2004
- a more recent valuation dated 31 March 2008 had not been published due to ongoing public sector reforms.

64. This position was the same for 2012/13, and means it is not clear if current contributions are high enough to meet the future costs of the scheme.

Trends in the workforce suggest signs of pressure on NHS boards

Overall staff numbers were similar to 2011/12

65. Staffing is the largest area of spending in the NHS in Scotland. NHS boards spent £5.6 billion on staff costs in 2012/13, 51 per cent of their total spending.[27] The total number of whole time equivalent (WTE) staff employed increased slightly, to 133,205.[28] This is an increase of 2,033 WTE staff and compares with a 2,154 decrease in 2011/12. The increase is partly due to staff transferring from Highland Council to NHS Highland as part of the new arrangements to integrate health and social care. Excluding NHS Highland, the total number of staff increased by 1,024 WTE (0.8 per cent). The WTE number of staff increased for almost all clinical staff groups. The NHS has a target to reduce the number of senior managers by 25 per cent between 31 March 2010 and 1 April 2015. By March 2013, the number had reduced by 23 per cent.[29]

There were more medical and nursing staff but vacancy rates also increased

66. There was an increase in consultants and nursing and midwifery staff in post between March 2012 and March 2013, although vacancy rates for both groups also increased (Exhibit 13, page 31). In spite of the higher staff numbers, the increase in vacancy rates indicates that services are still under pressure. Among the mainland boards, vacancy rates for nursing and midwifery staff were highest in NHS Grampian (6.3 per cent, up from 3.8 per cent in March 2012) and NHS Borders (4.1 per cent, up from 0.3 per cent in March 2012).[30]

67. Medical staff in post across all grades increased by one per cent. Consultant numbers in post increased by 2.3 per cent. However, the number of doctors on training grades reduced across all grades except Foundation Year 1 (the most junior grade), which increased by 7.6 per cent to 962.2.[31]

Increases in spending on agency and bank nurses and the private sector suggest boards needed more staff time and facilities to meet demand

68. Boards can use internal bank or external agency nursing staff on a temporary basis to increase their staffing numbers when required. They may also need to use private sector healthcare providers to help deliver services, for example to make sure patients are seen within waiting times targets. Increases in spending on the private healthcare sector and on bank and agency nursing staff indicate that NHS boards needed to carry out more activity than they could manage with their existing staff and facilities. Alongside increases in vacancy rates, these indicate signs of strain in the system (Exhibit 14, page 31).

Exhibit 13

Trends in WTE consultant, nursing and midwifery workforce, March 2011 to March 2013

Staff numbers and vacancy rates increased in 2013 compared with 2012.

	At 31 March 2011	At 31 March 2012	At 31 March 2013	% increase 2012 to 2013
Consultant staff in post	4,423.9	4,427.7	4,531.6	**2%**
Consultant vacancies number and rate	135.7 (2.98%)	167.3 (3.6%)	202.5 (4.3%)	**21%**
Nursing and midwifery staff in post	57,166.9	56,467.3	57,036.6	**1%**
Nursing and midwifery vacancies number and rate	552.4 (1%)	1,027.9 (1.8%)	1,609.1 (2.7%)	**57%**

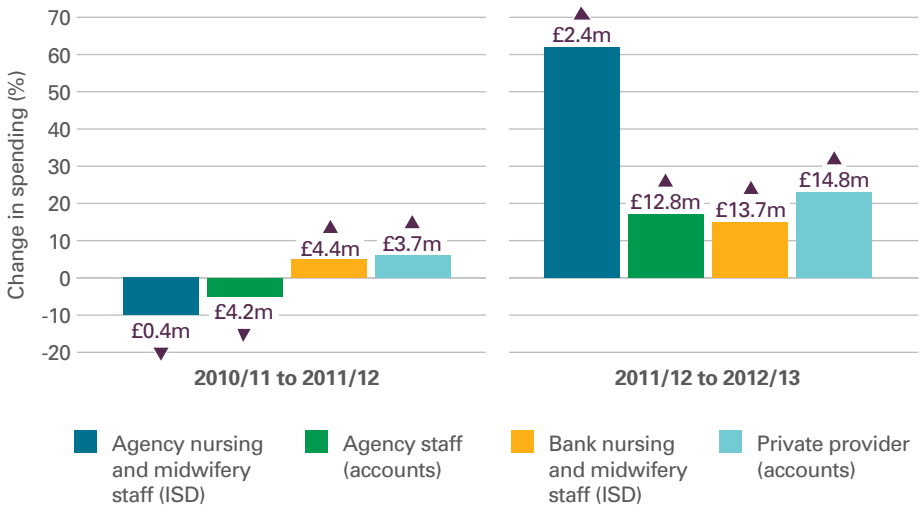
Notes:
1. The Mental Welfare Commission is not included in these figures.
2. A total of 350 staff (headcount) in the prison healthcare service transferred to the NHS in November 2011. This includes all staff groups.

Source: ISD Scotland workforce statistics, consultant vacancies, May 2013 and ISD Scotland workforce statistics, nursing and midwifery vacancies, May 2013

Exhibit 14

Change in spending on bank and agency staff and private sector, 2010/11 to 2012/13

Boards increased their use of agency and bank nurses and private sector healthcare providers.



Note: The agency staffing information from the NHS board annual accounts relates to all agency staffing, not just nursing and midwifery staff.

Source: ISD Scotland workforce statistics, agency nursing and midwifery staff, May 2013, ISD Scotland workforce statistics bank nursing and midwifery staff, May 2013 and NHS board annual accounts 2012/13

Spending on agency nurses increased by 62 per cent in 2012/13

69. Bank staff are employed by the NHS and register to work additional hours as required. Bank nursing is recommended as the most cost-effective and safe way to manage the need for additional temporary staffing hours. NHS boards can also contract nursing staff through agencies. Using agency staff is more expensive and should be kept to a minimum, for example to cover specialist posts where bank staff are not available. NHS boards' use of, and spending on, agency nurses increased by 62 per cent, from £3.9 million in 2011/12 to £6.4 million in 2012/13.[32] Spending was highest in NHS Lothian, where it more than doubled, from £1.2 million to £2.7 million. Although the amounts involved were lower, spending increased significantly in three boards:

- NHS Grampian, from £70,139 to £375,865.
- NHS Lanarkshire, from £13,090 to £344,140.
- NHS Forth Valley, from £14,383 to £273,292.

70. While the total spending on agency staff is still a very small percentage of total nursing and midwifery costs, the increase reverses the trend of falls in spending every year since 2008/09.[33] Spending on bank nurses across Scotland increased by 15 per cent to £104.2 million. Ninety-four per cent of NHS boards' total spending on bank and agency nurses was on bank staff, compared to 96 per cent in 2011/12.[34]

Spending on private sector healthcare increased by almost a quarter

71. Spending on private sector healthcare increased by £14.8 million in 2012/13 to £80.3 million, a rise of 23 per cent compared to 2011/12. Across the NHS in Scotland, spending on private sector healthcare accounted for less than one per cent of total spending on hospital and community health services (0.95 per cent).

72. Spending increased in eight of the territorial boards.[35] The largest rise was in NHS Lothian, which had an increase of £9.5 million, taking its spending to £14.8 million (21 per cent increase). It spent £12 million on sending patients to have treatment in the private healthcare sector to help manage waiting lists, over 80 per cent of its total spending on the private sector. NHS Grampian more than doubled its spending compared to the previous year, spending £6.3 million. It required additional theatre capacity to ensure that patients were treated in line with the requirements of the Patient Rights (Scotland) Act 2011. NHS Grampian has committed £10 million of capital expenditure and £8 million of recurring revenue expenditure to increase local operating theatre capacity and reduce its use of the private sector from 2014/15.

The Treatment Time Guarantee is a further pressure on NHS boards

73. NHS boards have been focusing on achieving the TTG, which came into effect in October 2012. The Scottish Government provided NHS boards with additional funding of at least £16.7 million in 2012/13 to support TTG, excluding the £8 million brokerage to NHS Lothian.[36] During March 2013, 1.8 per cent of patients (565 patients) who had inpatient or day case treatment, and who were added to the waiting list after 1 October 2012, were not seen within 12 weeks.[37]

74. Meeting the TTG continues to be a key priority for the Scottish Government and NHS boards. However, auditors reported that the TTG will require significant resources to achieve and sustain, and has increased pressure on boards at a time when they require to make significant savings on a recurring basis (Case study 4).

Case study 4

NHS Lothian challenges and financial position

In 2012/13, NHS Lothian met or exceeded several performance targets. However, it is still working on its waiting times problems, initially highlighted in 2011/12, and has not achieved performance targets in this area. NHS Lothian spent an additional £27.2 million on working towards waiting times targets in 2012/13. This included spending on private sector healthcare, other NHS boards and additional staffing and activity within the board. This spending was part-funded by the £8 million brokerage received from the Scottish Government towards improving its waiting times performance in 2012/13. The board has to repay the brokerage over the next two years, and the amount will be offset against future increases in its NRAC allocation.

NHS Lothian has recognised that it will struggle to meet waiting times targets with the funds, facilities and staffing available to it. This is particularly so given constraints in staff numbers in particular specialties (such as urology and vascular surgery) and the number of patients it can treat in certain facilities (such as orthopaedics and ophthalmology). It is likely to need to buy additional healthcare for its patients from other boards and private healthcare providers in the short term, while it redesigns its own services. It has identified that investment of £50 million will be required to expand its internal services and fund its use of other healthcare providers over the next two years.

The auditors highlighted that the cost challenges facing the board are significant and delivering recurring savings is pivotal to achieving sustainable financial balance. In 2012/13, the board made 90 per cent of its planned savings and it relied on underspends to break even. The board made less in recurring savings than planned in 2012/13, but forecasts that all savings will be made on a recurring basis in 2013/14. Auditors reported that this will be a significant challenge for the board.

Source: NHS Lothian Annual Audit Report 2012/13

75. Audit Scotland will be publishing a report on the management of NHS waiting lists in December 2013, following up on the recommendations in our February 2013 report and the Public Audit Committee's report.[38, 39]

The failure to meet some waiting times standards in 2012/13 suggests capacity pressures in boards

76. The NHS in Scotland has a range of HEAT targets and standards for managing NHS boards' performance, and many of these relate to waiting times for patients.[40, 41] NHS boards need to plan and manage their services well to meet these waiting times targets and standards, some of which have become shorter and more challenging for NHS boards in recent years.[42] These are in addition to the TTG.

77. NHS boards performed well against some standards in 2012/13. For example, in the quarter ended 31 March 2013, all met the cancer waiting time standards to start treatment within 31 days of the treatment decision being made. All but one met the target on waiting times for drug and alcohol treatment. Most (13 boards) met the overall 18-week referral to treatment waiting time standard in March 2013. However, there are signs of pressure within the system. Only the National Waiting Times Centre met the separate waiting time standard for outpatients, and only four boards achieved the standard for waiting times at accident and emergency departments in March 2013. Performance against the 62-day standard from urgent referral to first treatment for cancer worsened in the last quarter of 2012/13. Eight boards did not meet the standard, compared to two boards in the previous quarter (Exhibit 15, pages 36 and 37).[43]

78. Delayed discharges occur when patients need to stay in hospital longer than necessary and also indicate pressure in health and social care. Only seven NHS boards met the HEAT target that no patients should have a delayed discharge of more than four weeks by April 2013.

79. NHS boards failing to meet some of the waiting time standards and delayed discharge targets in 2012/13 suggests pressure on their capacity. Capacity means boards' ability to provide the level of services required with their current staffing, available beds and operating theatre sessions, and other resources. There are risks that these pressures will increase as demand continues to grow. NHS boards' spending on the private sector to get additional activity to treat patients increased in 2012/13, but this is not a sustainable way to meet waiting time standards. Auditors have highlighted the risks of NHS boards meeting increasingly demanding targets while also making increased savings.

80. The Scottish Government is continuing to work with NHS boards to help them meet waiting time standards and TTG in a way that they can maintain. During 2012/13, NHS Fife had tailored support from the Scottish Government and another NHS board to work with them on improving their waiting times performance.

81. Performance against the other HEAT targets and standards was mixed. The NHS as a whole met four of the ten performance standards and four of the eight targets due for delivery in 2012/13. In addition, some national outcome indicators relating to health have improved, such as premature mortality rates, with death rates from heart disease, stroke and cancer falling.[44] The *NHSScotland Chief Executive's Annual Report 2011/12* comments on overall performance against the targets.[45] The 2012/13 report will be published later this year.

Boards need to plan for significant change in health and social care services in 2015

82. The Scottish Government published the Public Bodies (Joint Working) (Scotland) Bill on 28 May 2013. The Bill outlines its proposed principles for integrating health and social care across NHS boards and councils. The proposed move to integrated health and social care partnerships by April 2015 will require significant service redesign in collaboration with the council partners. This reinforces the need for detailed long-term financial planning so that boards understand the costs associated with their planned service models.

83. NHS Highland and Highland Council are the first to formalise health and social care integration through their lead agency agreement (Case study 5, page 38). NHS Highland has highlighted financial risks around providing adult services in 2013/14, and the need to make savings. In 2012/13, it received an additional non-repayable £1 million from the Scottish Government to help it meet the one-off costs associated with health and social care integration.

84. NHS Highland and Highland Council had to work through the changes in accounting treatment as a result of integration and the transfer of staff, including the accounting treatment of pensions. A total of 1,620 staff transferred from the council to the board but stayed within the Local Government pension scheme. As a result, NHS Highland became an admitted member of the Highland Council Pension Fund. This is a defined benefits scheme and requires significantly more accounting disclosures than the NHS Superannuation scheme, which is treated as a defined contribution scheme. The board's accounts now include a pension liability (£1.3 million in 2012/13), which has long-term implications for future budgets and funding.

85. In preparation for the move to integrated partnerships, NHS boards and the councils within their board areas are holding discussions about the arrangements required for the move. A number of boards have approved or are considering establishing shadow health and social care boards, which will bring together council and health board representatives, ahead of the formal move to integration in April 2015.[46]

86. The Scottish Government is monitoring progress across Scotland and sharing any learning points. It has set up a series of working groups to develop guidance on specific issues, such as workforce and finances, and will publish further guidance later this year.

87. The Scottish Parliament Health and Sport Committee is carrying out scrutiny of the Bill and invited written evidence on a number of questions over summer 2013. Audit Scotland submitted a response based on our experience and evidence from our previous audit work, particularly our work on partnerships.[47] We welcome the principle of public bodies in Scotland delivering seamless integrated health and social care, but there are a number of areas that still need to be addressed as the Bill progresses. These include:

- how members of the public, GPs, health and social care staff will be involved in the new arrangements

Exhibit 15

Performance against key waiting time targets, March 2013, and delayed discharge targets, April 2013

Performance against waiting times and delayed discharge targets was mixed.

	Waiting times, quarter or month ended 31 March 2013			
	Child and Adolescent Mental Health Services (CAMHS)[1]	Drug and alcohol treatment[2]	Referral to treatment (RTT)[1]	Outpatients[1]
Target/standard	**26 weeks**	**3 weeks**	**18 weeks**	**12 weeks**
Ayrshire and Arran	✓	✓	✓	⇵
Borders	✓	✓	✓	✗
Dumfries and Galloway	✓	✓	✓	✗
Fife	✓	✓	✓	✗
Forth Valley	✓	✓	✗	✗
Grampian	✓	✓	✓	⇵
Greater Glasgow and Clyde	✓	✓	✓	⇵
Highland	✓	✗	✓	✗
Lanarkshire	✓	✓	✓	⇵
Lothian	✓	✓	⇵	✗
Orkney	✓	✓	✓	⇵
Shetland	✓	✓	✓	⇵
Tayside	✓	✓	✓	⇵
Western Isles	✓	✓	✓	✗
National Waiting Times Centre	–	–	✓	✓
NHSScotland	✓	✓	✓	✗

✓ Met ✗ Not met ⇵ Within 5% ✗ Met for over 99% of patients

Exhibit 15 (continued)

	Waiting times, quarter or month ended 31 March 2013				April 2013
	Inpatient/ day case treatment time guarantee (TTG)[1, 3, 4]	A&E[1]	Cancer – urgent referral to first treatment[2]	Cancer – decision to treat to first treatment[2]	Delayed discharges[5]
Target / standard	**12 weeks**	**4 hours**	**62 days**	**31 days**	**4 weeks**
Ayrshire and Arran	✗	✗	⇅	✓	✓
Borders	✗	⇅	✓	✓	✓
Dumfries and Galloway	✗	⇅	✓	✓	✗
Fife	✗	⇅	✓	✓	⇅
Forth Valley	✗	✗	✓	✓	✓
Grampian	✗	⇅	⇅	✓	✓
Greater Glasgow and Clyde	✗	✗	⇅	✓	✗
Highland	✗	⇅	⇅	✓	✓
Lanarkshire	✓	✗	✓	✓	⇅
Lothian	✗	✗	✓	✓	✗
Orkney	✓	✓	✗	✓	✓
Shetland	✓	✓	⇅	✓	✓
Tayside	✗	✓	⇅	✓	⇅
Western Isles	✓	✓	⇅	✓	✗
National Waiting Times Centre	✓	–	–	✓	–
NHSScotland	✗	✗	⇅	✓	✗

✓ Met ✗ Not met ⇅ Within 5% ✗ Met for over 99% of patients

Notes:
1. Data for month ended 31 March 2013. There is currently a ten per cent tolerance against the CAMHS target. This will be reviewed in October 2013.
2. Data for quarter ended 31 March 2013.
3. TTG applies to patients added to the waiting list from 1 October 2012 only. The data are for patients seen in March 2013.
4. TTG incorporates a legal right to treatment, so we have categorised this as met, not met or met for over 99 per cent of patients.
5. Performance against this standard is based on a census at point in time. The delayed discharges data are at the end of April 2013.

Source: Based on data from ISD Scotland, and subject to any caveats described by ISD Scotland

- how funding will flow under the new arrangements, for example there needs to be clarity about what resources will be included in the budgets devolved to partnerships
- the links between health and social care integration, community planning and changes to children's services
- the implications for audit and scrutiny arrangements
- the role of the partnership chief officers and how this will relate to the role and remit of the Board of the NHS board and council elected members.

Case study 5

Health and social care integration in Highland

The new partnership arrangements in Highland started officially on 1 April 2012 after 15 months of formal planning. NHS Highland is the lead agency for adult community care services and Highland Council is the lead agency for children's community health services. They have joint responsibility for specifying the outcomes to be achieved and the total budgets allocated to these two service areas. The adult social care budgets that were transferred from the council are large and complex, and the final figure of £89 million was not fully agreed until March 2013.

For 2013/14, any budget increases received from the Scottish Government for adult and children's services will be passed on in full. The board received a budget increase of 2.8 per cent for children's services for the year, which it passed on to the council. The council received no uplift for adult community care services, so NHS Highland did not get any uplift for these services. This means that NHS Highland will need to achieve savings to cover inflation and demographic pressures on adult services. It has acknowledged that it will need to make significant savings to break even in 2013/14 and it has included £3.7 million savings in the budget for adult services.

Source: NHS Highland Annual Audit Report 2012/13

Endnotes

1 For the purposes of this report we refer to NHS National Services Scotland, the Mental Welfare Commission and Healthcare Improvement Scotland as special health boards.

2 NHS financial performance 2011/12 (PDF) Audit Scotland, October 2012.

3 *Projected population of Scotland (2010-based)*, National Records of Scotland, October 2011.

4 *The Scottish Health Survey Older People's Health Topic Report*, Scottish Government, 2011.

5 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

6 *The Healthcare Quality Strategy for NHSScotland*, Scottish Government, May 2010.

7 *2020 Vision for Health and Social Care*, Scottish Government, September 2011.

8 *Learning from adverse events through reporting and review: A national framework for NHSScotland*, Healthcare Improvement Scotland, September 2013.

9 The HSMR is the ratio of the actual number of deaths within 30 days of admission to hospital to the expected number of deaths, taking into account the characteristics of the patients, such as the severity of illness.

10 *Quarterly Hospital Standardised Mortality Ratios Release*, ISD, August 2013. The HSMR fell by 11.6 per cent between the periods October to December 2007 (before the SPSP was introduced), and January to March 2013.

11 The boards are: NHS Dumfries and Galloway, NHS Grampian, NHS Shetland, NHS Tayside, NHS Education for Scotland, NHS National Services Scotland and Healthcare Improvement Scotland.

12 *Health Finances 2012-13 and beyond*, Wales Audit Office, July 2013.

13 The boards are: NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Highland, NHS Lothian and NHS Tayside.

14 NHS Dumfries and Galloway forecast 100 per cent recurring savings for 2012/13. The board delivered five per cent more savings than its target, and this had an impact on the split between recurring and non-recurring savings. We have assumed that all target savings were achieved recurrently, with additional savings made on a non-recurring basis. This also applies to the National Waiting Times Centre, Healthcare Improvement Scotland and the Scottish Ambulance Service.

15 *Prescribing & Medicines: Prescription Cost Analysis Financial Year – 2012/13*, ISD Scotland, June 2013. The total net cost of items dispensed in general practice in 2012/13 was £1.12 billion.

16 ISD Scotland analysis of spending on hospital drugs in 2012/13 from the Hospital Medicines Utilisation Database (HMUD). The total spending of £342 million on hospital drugs in 2012/13 excludes NHS Tayside as their data were not included in HMUD.

17 The Scottish Government's LDP guidance requires boards to categorise savings by six themes: clinical productivity; workforce; drugs and prescribing; procurement; support services; and estates and facilities. *NHS Scotland Local Delivery Plan Guidance 2012/13*, Scottish Government, 2011.

18 Prescribing in general practice in Scotland (PDF) Audit Scotland, January 2013.

19 The boards are: NHS Borders, NHS Forth Valley, NHS Tayside and Scottish Ambulance Service.

20 Scottish Government Financial Performance Returns 2013/14.

21 The Scottish Government requires NHS Borders, NHS Lanarkshire, NHS Tayside and all special boards to submit LDPs for three years only. All other boards submit LDPs for five years. NHS National Services Scotland and NHS 24 submitted plans for five years rather than three years.

22 The boards are: NHS Fife, NHS Forth Valley, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Western Isles.

23 *Annual state of NHSScotland Assets and Facilities Report for 2012*, Scottish Government, 2012.

24 Information provided by Scottish Government.

25 The five boards are: NHS Borders, NHS Greater Glasgow and Clyde, NHS Highland, NHS Lothian and NHS Tayside. In 2012, NHS Highland's total included, for the first time, backlog maintenance in approximately 45 properties owned by Highland Council, but which the board uses to provide services.

26 Scottish Government letter to the Scottish Parliament Public Audit Committee, 16 January 2013.

27 NHS board annual accounts 2012/13.

28 ISD Scotland workforce statistics, Overall summary, ISD Scotland, May 2013.

29 *25% Reduction in Senior Management Posts Target – National Progress Towards 25% Reduction as at 31st March 2013*, Scottish Government, August 2013.

30 ISD Scotland workforce statistics, nursing and midwifery vacancies, May 2013.

31 ISD Scotland workforce statistics, HCHC staff by grade, May 2013.

32 ISD Scotland workforce statistics, agency nursing and midwifery staff, May 2013.

33 Ibid.

34 ISD Scotland workforce statistics, bank nursing and midwifery staff, May 2013.

35 The eight boards are: NHS Ayrshire and Arran, NHS Fife, NHS Forth Valley, NHS Grampian, NHS Lanarkshire, NHS Lothian, NHS Shetland and NHS Tayside.

36 Scottish Government allocation letters to NHS boards, 2012/13.

37 ISD Scotland waiting times, patients added to inpatient, day case and outpatient waiting lists from 1 October 2012, May 2013.

38 Management of patients on NHS waiting lists (PDF) Audit Scotland, February 2013.

39 *3rd Report, 2013 (Session 4): Report on the management of patients on NHS waiting lists*, Scottish Parliament Public Audit Committee, May 2013.

40 The NHS is working to a number of HEAT targets and standards. These relate to Health improvement for the people of Scotland; Efficiency and governance improvements; Access to services; Treatment appropriate to individuals.

41 Where due dates for targets have passed, the target becomes a standard.

42 Management of patients on NHS waiting lists (PDF) Audit Scotland, February 2013.

43 Scotland Performs: NHSScotland performance against the HEAT targets and standards

44 Scotland Performs: Performance against the national indicators

45 *NHSScotland Chief Executive's Annual Report 2011/12*, Scottish Government, November 2012.

46 This includes NHS Ayrshire and Arran, NHS Fife, NHS Grampian and NHS Lothian.

47 *PBJW0066 – Audit Scotland on Behalf of the Auditor General for Scotland and the Accounts Commission*, Written Responses on Public Bodies (Joint Working) (Scotland) Bill, Scottish Parliament Health and Sport Committee, August 2013.

Appendix 1

Financial performance of NHS boards in 2012/13 – Total revenue and capital

	2012/13				2011/12	2010/11
NHS board	Total resource limit £m	Outturn £m	Variance under/ (over) £m	Percentage of total resource limit %	Variance under/ (over) £m	Variance under/ (over) £m
NHS Ayrshire and Arran	674.1	670.7	3.4	0.51	3.0	5.0
NHS Borders	202.7	202.6	0.1	0.04	0.1	0.1
NHS Dumfries and Galloway	290.6	286.6	4.0	1.38	2.2	4.2
NHS Fife	616.9	616.6	0.3	0.05	0.4	0.0
NHS Forth Valley	503.1	503.0	0.1	0.02	0.1	0.1
NHS Grampian	891.5	891.4	0.1	0.01	0.1	0.0
NHS Greater Glasgow and Clyde	2,581.3	2,580.7	0.6	0.02	0.3	0.7
NHS Highland	595.5	595.2	0.3	0.05	0.2	0.1
NHS Lanarkshire	953.1	948.5	4.5	0.48	2.0	7.6
NHS Lothian	1,339.4	1,338.7	0.6	0.05	0.9	0.3
NHS Orkney	44.5	44.3	0.1	0.29	0.2	0.1
NHS Shetland	49.5	49.4	0.1	0.24	0.1	0.6
NHS Tayside	837.4	837.0	0.4	0.05	0.2	0.2
NHS Western Isles	73.4	73.3	0.1	0.14	0.5	1.4
Total territorial NHS boards	**9,652.9**	**9,638.1**	**14.8**	**0.15**	**10.3**	**20.3**
Mental Welfare Commission	3.6	3.6	0.0	1.35	0.0	0.0
National Waiting Times Centre	61.3	60.6	0.7	1.23	0.0	0.7
NHS 24	86.8	86.7	0.1	0.14	0.3	1.1
NHS Education for Scotland	433.7	433.2	0.6	0.13	1.8	5.9
NHS Health Scotland	23.7	23.4	0.3	1.26	0.6	1.1
Healthcare Improvement Scotland	19.5	19.5	0.0	0.19	0.1	1.0
NHS National Services Scotland	379.4	379.1	0.3	0.07	0.3	0.9
Scottish Ambulance Service	229.2	229.2	0.0	0.02	0.0	0.0
The State Hospital	39.2	39.2	0.0	0.01	0.0	0.3
Total special NHS boards	**1,276.6**	**1,274.4**	**2.1**	**0.17**	**3.2**	**11.1**
Total all NHS boards	**10,929.4**	**10,912.5**	**16.9**	**0.16**	**13.4**	**31.4**

Note: Table does not sum due to rounding.

Appendix 2

Financial performance of NHS boards in 2012/13 – Revenue

NHS board	2012/13 Revenue resource limit £m	2012/13 Outturn £m	2012/13 Variance under/ (over) £m	2012/13 Percentage of RRL %	2011/12 Variance under/ (over) £m	2010/11 Variance under/ (over) £m
NHS Ayrshire and Arran	662.0	658.6	3.4	0.52	3.0	5.0
NHS Borders	196.3	196.2	0.1	0.04	0.1	0.1
NHS Dumfries and Galloway	280.4	276.4	4.0	1.43	2.1	4.2
NHS Fife	603.6	603.3	0.3	0.05	0.3	0.0
NHS Forth Valley	499.8	499.7	0.1	0.02	0.1	0.1
NHS Grampian	837.1	837.1	0.1	0.01	0.1	0.0
NHS Greater Glasgow and Clyde	2,261.1	2,260.5	0.6	0.03	0.3	0.7
NHS Highland	582.2	581.9	0.3	0.05	0.1	0.1
NHS Lanarkshire	941.2	936.7	4.5	0.48	2.0	7.6
NHS Lothian	1,305.0	1,304.4	0.6	0.05	0.9	0.3
NHS Orkney	43.9	43.8	0.1	0.21	0.1	0.0
NHS Shetland	48.3	48.1	0.1	0.25	0.1	0.5
NHS Tayside	745.2	744.9	0.3	0.04	0.2	0.2
NHS Western Isles	71.7	71.6	0.1	0.14	0.5	1.3
Total territorial NHS boards	**9,077.9**	**9,063.2**	**14.7**	**0.16**	**10.0**	**20.1**
Mental Welfare Commission	3.6	3.6	0.0	1.35	0.0	0.0
National Waiting Times Centre	58.2	57.5	0.8	1.30	0.0	0.6
NHS 24	86.2	86.1	0.1	0.12	0.2	1.1
NHS Education for Scotland	430.4	429.8	0.6	0.13	1.7	5.9
NHS Health Scotland	22.5	22.2	0.3	1.32	0.6	1.1
Healthcare Improvement Scotland	19.0	19.0	0.0	0.18	0.1	1.0
NHS National Services Scotland	376.2	376.0	0.2	0.07	0.2	0.9
Scottish Ambulance Service	212.1	212.0	0.0	0.02	0.0	0.0
The State Hospital	37.7	37.7	0.0	0.01	0.0	0.3
Total special NHS boards	**1,246.0**	**1,243.9**	**2.1**	**0.17**	**2.9**	**10.9**
Total all NHS boards	**10,323.9**	**10,307.1**	**16.7**	**0.16**	**12.8**	**31.0**

Note: Table does not sum due to rounding.

Appendix 3

Financial performance of NHS boards in 2012/13 – Capital

	2012/13				2011/12	2010/11
NHS board	Capital resource limit £m	Outturn £m	Variance under/ (over) £m	Percentage of CRL %	Variance under/ (over) £m	Variance under/ (over) £m
NHS Ayrshire and Arran	12.1	12.1	0.0	0.00	0.0	0.0
NHS Borders	6.4	6.4	0.0	0.11	0.0	0.0
NHS Dumfries and Galloway	10.2	10.2	0.0	0.02	0.1	0.0
NHS Fife	13.2	13.2	0.0	0.02	0.0	0.0
NHS Forth Valley	3.3	3.3	0.0	0.00	0.0	0.0
NHS Grampian	54.4	54.4	0.0	0.00	0.0	0.0
NHS Greater Glasgow and Clyde	320.2	320.2	0.0	0.00	0.0	0.0
NHS Highland	13.4	13.4	0.0	0.00	0.1	0.0
NHS Lanarkshire	11.9	11.9	0.0	0.00	0.0	0.0
NHS Lothian	34.3	34.3	0.0	0.00	0.0	0.0
NHS Orkney	0.5	0.5	0.0	6.92	0.1	0.0
NHS Shetland	1.2	1.2	0.0	0.00	0.0	0.1
NHS Tayside	92.2	92.1	0.1	0.11	0.0	0.0
NHS Western Isles	1.7	1.7	0.0	0.00	0.0	0.0
Total territorial NHS boards	**575.0**	**574.8**	**0.2**	**0.03**	**0.3**	**0.2**
Mental Welfare Commission	0.0	0.0	0.0	0.00	0.0	0.0
National Waiting Times Centre	3.1	3.1	0.0	0.00	0.0	0.2
NHS 24	0.6	0.6	0.0	2.33	0.1	0.0
NHS Education for Scotland	3.3	3.3	0.0	0.00	0.1	0.0
NHS Health Scotland	1.2	1.2	0.0	0.09	0.0	0.0
Healthcare Improvement Scotland	0.5	0.5	0.0	0.75	0.1	0.0
NHS National Services Scotland	3.1	3.1	0.0	0.96	0.0	0.0
Scottish Ambulance Service	17.2	17.1	0.0	0.02	0.0	0.0
The State Hospital	1.6	1.6	0.0	0.00	0.0	0.0
Total special NHS boards	**30.6**	**30.5**	**0.1**	**0.17**	**0.3**	**0.2**
Total all NHS boards	**605.5**	**605.3**	**0.2**	**0.04**	**0.6**	**0.4**

Note: Table does not sum due to rounding.

NHS financial performance 2012/13

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0845 146 1010 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on Twitter or subscribe to our email delivery service:

@AuditScotland

Subscribe to updates

AUDIT SCOTLAND

Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0845 146 1010 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 15 9 AGS/2013/10