

# NHS in Scotland 2015



 AUDITOR GENERAL

Prepared by Audit Scotland  
October 2015

# 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](http://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



Key facts	4
Summary	5
Part 1. Financial and service performance	9
Part 2. Workforce	24
Part 3. Looking ahead	35
Endnotes	44
Appendix. NHS financial performance 2014/15	45



## **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.

---

# Key facts



Total spending by NHS boards in 2014/15

**£11.4 billion**

Number of staff employed by NHS boards at March 2015 (whole-time equivalent)

**137,600**

Number of inpatient cases at March 2015

**394,000**  
**1,139,000**

Number of outpatient appointments at March 2015

Total savings reported by NHS boards in 2014/15

**£285 million**

**2 met**  
**7 missed**

Number of key waiting time targets and standards met and missed at March 2015

# Summary



## Key messages

- 1** Significant pressures on the NHS are affecting its ability to make progress with long-term plans to change how services are delivered. Tightening budgets combined with rising costs, higher demand for services, increasingly demanding targets and standards, and growing staff vacancies mean the NHS will not be able to continue to provide services in the way it currently does. Together, these pressures signal that fundamental changes and new ways to deliver healthcare in Scotland are required now.
- 2** During 2014/15, NHS boards spent £11.4 billion, and ended the year with a very small underspend of £10 million (0.09 per cent) against the budget available. This is commendable given the financial challenges it faces. All territorial NHS boards are finding it increasingly difficult to meet national performance targets and standards while remaining within their annual budgets. The NHS in Scotland missed seven of its nine key waiting time targets and standards at March 2015, reflecting a general decline in performance in recent years. Many boards relied on one-off savings and two boards required extra financial support from the Scottish Government to break even. Greater flexibility in managing their finances as part of good long-term planning would help boards respond better to local needs and priorities.
- 3** The number of people working in the NHS is at its highest level, although recruiting and retaining staff remains a significant problem for many boards. Reasons for this include the rural location of some boards, competition between boards for specialist staff and a greater demand from staff for more flexible working patterns. NHS boards hire temporary staff to help keep services running and meet performance targets and standards but this approach is increasingly expensive and provides only a short-term solution. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent from 2013/14. The ability to attract, recruit and retain medical professionals across Scotland, with the right skills to deliver the services required, is one of the biggest challenges facing the NHS today. A coordinated national approach to managing current and future workforce pressures is needed.
- 4** The Scottish Government has not made sufficient progress towards achieving its 2020 vision of changing the balance of care to more homely and community-based settings. There is some evidence of new approaches to delivering healthcare although it is unlikely that all

the necessary changes will be in place by 2020. To help increase the pace of progress, the Scottish Government launched a new national conversation in August 2015. The conversation is expected to inform plans to change how services will be provided in Scotland over the next ten to 15 years.

---

## Recommendations

The Scottish Government needs to increase the pace of change if it is to achieve its 2020 vision. In doing so, it is important that the Scottish Government and NHS boards ensure changes are underpinned by good long-term financial and workforce planning. They also need to consider the implications for performance targets and standards and the NHS estate, as well as ongoing initiatives and reform programmes. By doing so, the Scottish Government and boards will gain a better understanding of the nature, scale and impact of changes required.

### In developing its long-term approach, the Scottish Government and NHS boards should:

- ensure better longer-term financial planning which extends beyond the three-or five-year period currently used by boards. Boards should assess their spending needs and options over a longer period of five to ten years. To support this, the Scottish Government should consider options to offer greater financial flexibility to NHS boards. Flexibility that is managed well and planned in advance can help boards meet local needs and priorities over an extended period
- ensure that work towards meeting financial and performance targets also supports longer-term changes to delivering healthcare. This will help ensure that short-term actions do not conflict with longer-term plans. In doing so, the Scottish Government should continually review each national performance target and standard to assess its relevance, priority and sustainability as new changes are introduced
- develop a coordinated, national approach for workforce planning and outline what changes mean for all NHS staff. This should assess what levels and types of jobs are needed, including skills required, roles and responsibilities, to meet the requirements of how services will be delivered in the future. This should also include detailed plans on how and when changes will be made
- assess what changes are required to NHS assets, such as land, buildings and medical equipment, to help deliver effective healthcare services in the future. Transforming services and bringing care closer to people's homes and communities will involve significant changes to where assets are located and what type of equipment is needed. Greater links are necessary to demonstrate how capital investment activity will result in the changes required
- ensure ongoing initiatives and reform programmes such as health and social care integration, seven-day services, out-of-hours and maternity services fully align with, and contribute to, the longer-term changes in healthcare services.

### The Scottish Government should:

- be clear about what improvements are expected at each stage of the process and how they intend to monitor and assess progress. In doing so, they should assess the financial impact of any changes to help inform boards' funding allocations and financial planning. The Scottish Government should also apply any lessons from the slow progress made towards achieving the 2020 vision to help improve the pace of change.
- 

## Background

1. The NHS continues to deliver a wide range of vital healthcare services to thousands of people across Scotland each day. Almost 140,000 NHS staff are involved in providing a variety of high-quality services, support and advice in different settings such as hospitals, GP and dental surgeries, community facilities and patients' homes. The level and quality of care provided have contributed to people living longer along with continued advances in diagnosis, treatment and care. Although Scotland's population is living longer, demand for healthcare is increasing as older people are more likely to have complex health and care needs. In recent years, the cost of delivering health services has increased significantly, coinciding with a period of constrained public finances.

## About this audit

2. This is our annual report on how the NHS in Scotland is performing. It analyses the performance of the NHS during 2014/15 and comments on its future plans. The overall aim of the audit was to answer the question: How well is the NHS in Scotland performing and is it equipped to deal with the challenges ahead? The specific audit questions were:

- How well did the NHS manage its finances in 2014/15?
- Is the NHS in Scotland equipped to deal with the financial challenges in 2015/16 and beyond?
- How is the NHS performing against national targets and standards and is it making good progress towards achieving the 2020 vision?
- How effectively are NHS boards managing changes to their workforce?


3. The report has three parts:

- [Part 1](#) Financial and service performance
- [Part 2](#) Workforce
- [Part 3](#) Looking ahead.

4. Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2014/15 audits of the 23 NHS boards
- NHS boards' Local Delivery Plans (LDPs), which set out indicative spending plans for the next three to five years
- monthly Financial Performance Returns (FPRs) that each NHS board submits to the Scottish Government throughout the year
- activity and performance data published by Information Services Division (ISD) Scotland
- information submitted by auditors on the use of temporary staff in the NHS
- interviews with senior staff in the Scottish Government and a sample of NHS boards.

5. We reviewed service performance information at both national level and board level. Our aim was to present the national picture as well as highlighting any significant variances between boards. It is important to note that performance can vary between boards and also within boards, for example between different hospitals within the same board area. We focused on a sample of nine key targets and standards, covering some of the most important activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. There is limited data available on primary care services, such as the number of appointments with GPs, therefore we are unable to assess activity levels in this area. Details on the financial performance of NHS boards is in the [Appendix](#)

6. Alongside this report we have published a [self-assessment checklist for NHS non-executive directors](#) . The purpose of the checklist is to help non-executive directors with their scrutiny and challenge of their board's performance and to help them gain assurance on the board's approach in dealing with the issues raised in this report.



# Part 1

## Financial and service performance



### Key messages

- 1** During 2014/15, NHS boards spent £11.4 billion, and ended the year with a very small underspend of £10 million (0.09 per cent) against the budget available. This is commendable given the size of the budget and the scale of the challenges faced. Many boards relied on one-off savings and two boards required extra financial support from the Scottish Government to break even. Greater flexibility in managing their finances as part of good long-term planning would help boards respond better to local needs and priorities.
- 2** All territorial NHS boards are finding it increasingly difficult to meet performance targets and standards while remaining within their annual budgets. The national performance against seven out of nine key targets and standards has deteriorated in recent years. Boards performed strongly against two standards: three-week referral for drug and alcohol treatment and cancer 31-day decision to treat to first treatment.
- 3** Improvements in public health, diagnosis and medical treatment have helped Scotland's population live longer. In the last ten years, the number of people aged over 75 increased by 17 per cent. Average life expectancy for both men and women also grew during this period. Although people are living longer, they are more likely to have complex health issues meaning increased activity and demand for health services. Ongoing financial pressures, combined with greater activity and demand, made achieving targets and standards more difficult.

---

**NHS boards are finding it increasingly difficult to meet their financial and performance targets**

---

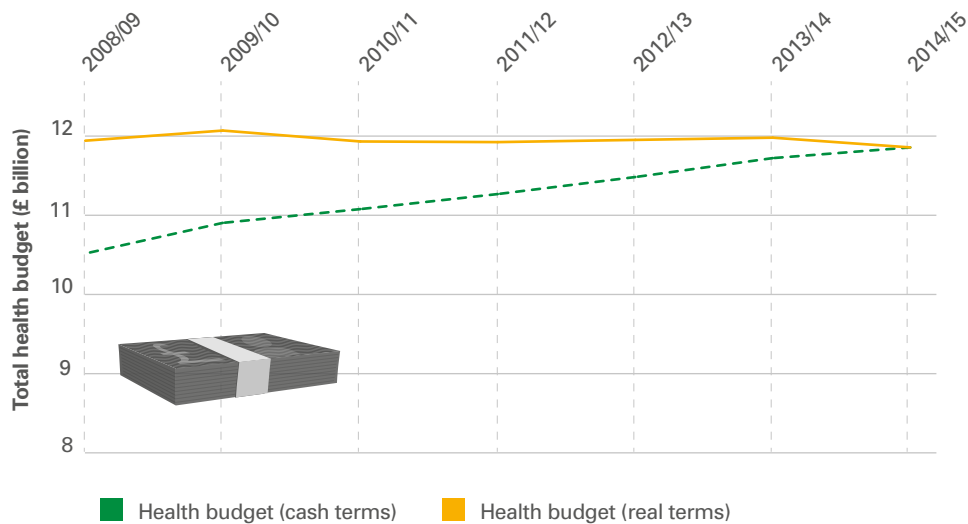
### The health budget decreased by 0.7 per cent in real terms between 2008/09 and 2014/15

**7.** The Scottish Government is responsible for managing the overall health budget and allocating budgets to individual boards. Since 2008/09, budgets have only changed slightly each year in real terms (that is, adjusting to remove the effects of inflation) owing to the overall reduction in available public finances following the 2008 economic recession ([Exhibit 1, page 10](#)). In 2014/15, the health budget was £11.9 billion. The Scottish Government allocated £10.1 billion directly to the 14 territorial boards which cover each area of Scotland and provide frontline healthcare services. It also allocated £1.3 billion to the nine special health boards that provide specialist support and national services. The remaining £0.5 billion provided funding for national public health programmes such as tackling health inequalities, improving access to services, eHealth initiatives and medical research.

## Exhibit 1

### Health budgets (revenue and capital), 2008/09 to 2014/15

The health budget in Scotland decreased by 0.7 per cent in real terms between 2008/09 and 2014/15.



Note: Figures include both revenue and capital Departmental Expenditure Limit (DEL) budgets. Between 2008/09 and 2014/15, the revenue DEL budget increased by 2.2 per cent, while the capital DEL budget decreased by 57 per cent.

Source: Scottish Government



**8.** In 2014/15, the total amount of revenue funding allocated to boards, for day-to-day running costs such as staff pay and medical supplies, was just under one per cent more than in 2013/14 (in real terms). Territorial boards received an average increase of one per cent, and special boards an average increase of 0.7 per cent. The smaller increase for special boards reflects the Scottish Government's policy to transfer savings from boards that do not provide frontline services to those that do. In contrast, capital funding for boards, decreased by 35 per cent in 2014/15 from the previous year. Capital funding is used to develop NHS buildings and major IT programmes.

**9.** Looking ahead, the overall budget for 2015/16 will increase by 1.4 per cent, from £11.857 billion in 2014/15 to £12.022 billion. The revenue budget will increase by 1.9 per cent in real terms between 2014/15 and 2015/16. The capital budget will decrease by 21 per cent in 2015/16, from £254 million to £200 million. This reduction is largely due to the completion of the new Queen Elizabeth University Hospital in Glasgow, which was funded from the capital budget.

**10.** The amount of funding available beyond 2015/16 remains unknown. In November 2015, the UK Government will publish the results of its spending review. This will set out the UK's public spending plans for the next four years including much of the funding available to the Scottish Government. The Scottish Government will then decide how to allocate its budget to healthcare and to its other portfolio areas, such as education and justice.

### All territorial boards are within at least two per cent of their target funding allocation

**11.** Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate around 70 per cent of the total NHS budget to the 14 territorial boards. This provides funding for hospital and community health services and GP prescribing. The formula is based on the number of people living in each board area and then adjusted for:

- the age and sex profile of the local population
- additional needs based on local circumstances such as geography, sickness and deprivation levels.

**12.** The final shares allocated to boards are different from the levels determined by the formula. The Scottish Government adjusts the formula to ensure all territorial boards receive an increase in funding each year until the target share determined by the formula is reached. The target share also changes each year in line with changes in population and local circumstances. This makes it more challenging to ensure all boards receive an increase in funding at the same time as progressing towards their target share.

**13.** The Scottish Government aims to be within one per cent of the target allocations by 2016/17. Initial funding allocations for 2015/16 show that eight boards are between one and two per cent from their target allocation, with the remaining six boards within one per cent or above parity. NHS Grampian is the furthest away, at two per cent (£16.9 million) behind its target share. This is an improvement on 2014/15, where the board was 3.7 per cent (£30.2 million) behind its target. In the last year, the board also saw an increase in its target share owing mainly to population changes.

### NHS boards are finding it increasingly difficult to remain within their annual budgets

**14.** NHS boards are required to meet two key financial targets in each financial year: to at least break even against both their revenue and capital budget limits at the end of the financial year. This means that boards must not overspend against these two limits. Throughout the financial year, the Scottish Government changes boards' revenue and capital budget limits to help address short-term needs and to ensure the overall health budget is balanced. The limits change throughout the year, particularly in March which is the final month of the financial year, as boards work towards their year-end financial position. In one case, for NHS Tayside, an adjustment was made to their 2014/15 financial limit in June 2015, nine weeks after the financial year-end in order to avoid breaching their original limit.

**15.** In 2014/15, all boards were within their final revenue and capital limits at the year-end. Overall, boards spent £11,378 million and ended the year with a very small surplus of £10 million, 0.09 per cent of the £11,388 million limit. Only two per cent of the surplus related to capital spending as NHS boards remained within £0.2 million of their £431.9 million overall capital limit ([Appendix](#)).

**16.** This small year-end surplus, combined with changes to financial limits throughout the year, highlights the tight financial position facing boards. The requirement for boards to manage their finances within changing limits makes it more difficult for them to balance in-year funding of services and the need for investment to meet longer-term requirements.

### NHS Ayrshire and Arran and NHS Tayside required loans from the Scottish Government to break even

**17.** The Scottish Government can agree to provide an NHS board with additional funding to help it manage unexpected changes to planned expenditure. This is agreed on the basis that the board provides assurance that it can repay the loan over an agreed period. This form of loan funding is known as brokerage. The amount of brokerage received by boards is generally very small compared to their overall budget.

**18.** In 2014/15, two boards received brokerage from the Scottish Government to help them cope with financial pressures during the year:

- NHS Ayrshire and Arran received £378,000 (0.05 per cent of its revenue budget) for demolition costs at its Heathfield site. It plans to repay this in 2015/16 using income raised from selling the site.
- NHS Tayside received £14.2 million (two per cent of its revenue budget):
  - £8 million to cover retrospective holiday pay enhancements and overspends in workforce costs and primary care prescribing
  - £6.2 million related to an accounting adjustment identified by the auditors in recognition of the sale of land (formerly Ashludie Hospital) in the draft 2014/15 accounts.

**19.** This is the third consecutive year NHS Tayside has received brokerage. The board repaid £4 million of previously agreed brokerage during 2014/15 and plans to repay all remaining sums (£15 million) during 2015/16. The Auditor General has prepared a separate report on the 2014/15 audit of NHS Tayside, which comments on the financial position and challenges of the board.<sup>1</sup>

**20.** Six boards have ongoing commitments to repay brokerage to the Scottish Government over the next five financial years to 2019/20. This will reduce the amount they have available to spend during these years. Two boards, NHS Forth Valley and NHS Lothian, made final repayments of previously borrowed sums in 2014/15. Three further boards, NHS Orkney, NHS Tayside and NHS 24, have requested brokerage in at least three of the last six financial years. This need for small amounts of brokerage highlights that NHS boards have limited flexibility to manage their budgets to deal with fluctuations in spending ([Exhibit 2, page 13](#)).

### NHS Highland and NHS Orkney made improvements in managing their finances

**21.** In 2013/14, we reported weaknesses in NHS Highland's financial management arrangements. The board was unable to make all of the savings required and this, together with an overspend at Raigmore Hospital of almost £10 million, required brokerage of £2.5 million from the Scottish Government.<sup>2</sup> The need for brokerage was not formally reported to NHS Highland's Board until close to the end of the financial year. During 2014/15, auditors concluded that the board had strengthened its financial management arrangements, including an action plan to address savings shortfalls and a training programme for budget holders at Raigmore Hospital. Auditors also reported that the board's financial position is sustainable in the short term, but a robust longer-term financial plan is required to support this in the future. The Auditor General has prepared separate reports on the 2013/14 and 2014/15 audits of NHS Highland.<sup>3</sup>

## Exhibit 2

### Brokerage and planned repayments, 2009/10 to 2019/20

Six boards have commitments to repay brokerage over the next five years to 2019/20.

NHS board	(£ millions)	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	Total brokerage by board
Ayrshire and Arran	Brokerage						0.38						0.38
	Repayments							(0.38)					
Forth Valley <sup>2</sup>	Brokerage		2.10	11.00									13.10
	Repayments			(1.55)	(2.57)	(3.57)	(4.41)						
Highland <sup>5</sup>	Brokerage					2.50							2.50
	Repayments						(0.50)	(1.00)	(1.00)				
Lothian <sup>3</sup>	Brokerage				10.00								10.00
	Repayments				(2.00)	(4.00)	(4.00)						
Orkney <sup>5</sup>	Brokerage	1.11	1.01	2.26		1.00							5.38
	Repayments			(0.32)		(1.00)		(3.00)	(1.06)				
Tayside	Brokerage				2.25	2.85	14.20						19.30
	Repayments					(0.25)	(4.05)	(15.00)					
Western Isles <sup>4</sup>	Brokerage	3.10											3.10
	Repayments			(0.63)	(0.59)	(0.26)	(0.54)	(0.54)	(0.54)				
NHS 24 <sup>5</sup>	Brokerage			0.32	16.58	3.86							20.76
	Repayments						(0.40)	(0.79)	(3.58)	(4.34)	(6.22)	(5.43)	
<b>Total brokerage by year</b>		<b>4.21</b>	<b>3.11</b>	<b>13.58</b>	<b>28.83</b>	<b>10.21</b>	<b>14.58</b>						

#### Notes:

- Numbers in brackets represent brokerage repayments to the Scottish Government.
- NHS Forth Valley received financial support of £2.1 million in 2010/11. The board received a further £11 million in 2011/12 towards the cost of implementing its healthcare strategy and to help it break even. The Scottish Government agreed that £1 million of this £11 million brokerage did not need repaid.
- In 2012/13, NHS Lothian received £10 million to help improve its performance against waiting time targets.
- In 2009/10, NHS Western Isles received £3.1 million following financial year 2008/09 to help pay for a historical deficit.
- Reasons for NHS Highland, NHS Orkney and NHS 24 receiving brokerage are in paragraphs 21 to 23 and case study 1.

Source: Scottish Government

**22.** During 2014/15, auditors reported that NHS Orkney had also made improvements in financial management ([Case study 1, page 14](#)).

### NHS 24 faces challenges in meeting future financial targets

**23.** NHS 24 has experienced financial difficulties owing to problems implementing a new IT system. The delay in implementing the new system has led to additional costs and risks to the board's ability to meet its financial targets in future years. These include cost pressures associated with the additional expenditure involved in delivering the new operational system, and the costs associated with the

## Case study 1

### Financial management at NHS Orkney



In October 2014, the Auditor General reported concerns about weaknesses in financial management in NHS Orkney during 2013/14. This was a factor in the board receiving brokerage of £1 million from the Scottish Government to break even, owing mainly to hiring locum doctors to cover vacant medical posts. This was the fourth time in five years that the board received brokerage. In addition, concerns were raised about the capacity of the finance team, given the financial pressures facing the board.<sup>4</sup>

The 2014/15 audit report highlights improvements in the board's financial management arrangements over the past year, particularly the quality of its financial forecasting. The board met its two main financial targets, remaining within £0.068 million of its £57.419 million revenue budget limit (0.1 per cent) and within £0.014 million of its £3.55 million capital budget limit (0.4 per cent). During the year, the Scottish Government provided the board with additional revenue (£0.6 million) and capital funding (£1.5 million) to help towards locum costs and the purchase of land for the new hospital in Kirkwall. NHS Orkney also reported delivering £1.567 million of savings, in line with those outlined in its local delivery plan. Savings achieved were 52 per cent higher than in 2013/14. The board is due to finish repaying all outstanding brokerage in 2016/17.

NHS Orkney still faces challenges in recruiting to vacant medical posts and continues to rely on locum doctors. In January 2015, an internal audit review concluded that the board could improve its use of temporary staff but there were no major weaknesses in its approach. The internal auditor found that the board explored alternative options before resorting to locums and that monitoring and reporting locum costs is part of financial reporting arrangements. The internal auditor also found that the approval process, succession planning and greater consistency with nationally agreed agency rates were areas for improvement. NHS Orkney reduced spending on temporary staff by 21 per cent, from £2.8 million in 2013/14 to £2.2 million in 2014/15.

Source: NHS Orkney, 2014/15 annual audit report

maintenance of the current system. The estimated cost of the new system is £117.4 million, £41.6 million (55 per cent) higher than the original estimate of £75.8 million. The Scottish Government has provided £20.8 million in brokerage between 2011/12 and 2013/14 to help fund the new system ([Exhibit 2, page 13](#)) The Auditor General has prepared separate reports on the 2013/14 and 2014/15 audits of NHS 24.<sup>5,6</sup>

#### NHS boards made a total of £285 million of savings in 2014/15 to meet financial targets

**24.** At the end of March 2015, boards reported savings of £285 million to help them meet their financial targets. This was £3 million (one per cent) less than the overall target savings of £288 million in their financial plans for 2014/15.

Seven boards exceeded their savings targets by at least one per cent, with special boards delivering on average 17 per cent more savings than planned. Territorial boards achieved on average three per cent fewer savings than planned.

**25.** Many boards are relying more on non-recurring savings to achieve their targets. On average, 25 per cent of boards' savings in 2014/15 were non-recurring, four per cent higher than last year, and three per cent higher than 2012/13. These are one-off savings that only apply to one financial year, and do not result in ongoing (recurring) savings in future years. Non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided. It can be appropriate to have some non-recurring savings. But recurring savings are more important to ensure boards' ability to continue to meet financial commitments. We have highlighted this as a risk in each of our last three annual reports on the NHS.

**26.** In their LDPs for 2015/16, boards expect non-recurring savings to be on average 19 per cent. As in recent years, there is considerable variation in the type of savings boards are looking to achieve. NHS Borders, NHS Tayside and The State Hospital all plan to continue high levels of non-recurring savings in 2015/16, whereas NHS Greater Glasgow and Clyde continues to report all savings as recurring.

### NHS boards are continuing to experience significant cost pressures

**27.** The health sector is experiencing significant cost pressures in a number of areas. For example:

- Latest available data shows that primary and secondary care drug costs increased by four per cent in cash terms from £1.37 billion in 2012/13 to £1.42 billion in 2013/14. Looking ahead costs are expected to increase significantly with boards planning for average cost increases in primary and secondary care drugs of five and 16 per cent respectively.
- Costs associated with using temporary staff increased in 2014/15 ([see paragraph 68](#))
- Changes to superannuation rates will result in an increase in employer contributions. In 2015/16, the rate will increase to 14.9 per cent from 13.5 per cent in 2014/15. Changes in national insurance rules are expected to increase employer costs from 2016/17.
- Significant investment is required to ensure the NHS estate, such as land and buildings, is fit for purpose. The NHS reports that only 65 per cent of the estate is functionally suitable for its current use and around £797 million is required in backlog maintenance.<sup>7</sup>
- Revenue costs for signed private finance initiative (PFI) and non-profit distributing (NPD) projects were £223 million in 2014/15. Costs will increase by an estimated 38 per cent to £307 million in 2027/28. With around £560 million worth of major capital projects currently in progress using private finance, these payments will rise further.

### There were 30 settlement agreements in the NHS in 2014/15

**28.** In 2014, the Scottish Government introduced new guidance on settlement agreements with the aim of providing more transparency, promoting consistency



and ensuring value for money.<sup>8</sup> A settlement agreement is any binding agreement between an employer and an employee to settle an employment dispute. Settlement agreements are used in circumstances where:

- the employment relationship has broken down or been significantly impaired
- the situation cannot be remedied through mediation or other personnel processes, and
- alternative routes to resolution would involve disproportionate cost at a tribunal or other legal process, and hinder the service from functioning effectively.

**29.** In 2014, confidentiality clauses were removed from standard NHS settlement agreements in Scotland. The clauses can still be used where there is explicit agreement between the employee and the employer. In June 2015, the Scottish Government reported to the Scottish Parliament's Public Audit Committee that there were 30 settlement agreements across 15 NHS boards.<sup>9</sup> Of these, 13 had confidentiality clauses. The total cost of settlement agreements was £895,000 including non-contractual payments of £533,000 made to employees.

### **Greater flexibility as part of good long-term financial planning would help boards respond better to local needs and priorities**

**30.** Local delivery plans (LDPs) set out how boards plan to deliver national priorities for the NHS in Scotland. Within their LDP, each board produces spending plans for the next three or five years, highlighting expected funding, projected spending and where savings are required to balance the budget. Although these plans provide an insight into boards' activity, detailed financial planning continues to be limited to the first year of the LDP.

**31.** NHS boards need to do more longer-term financial planning. We have highlighted in past reports the need for NHS boards to undertake detailed long-term (five to ten years) financial planning to help demonstrate financial sustainability. Setting out a long-term financial strategy over an extended period can help identify problems with affordability at an early stage. The current short-term approach to financial planning means boards are focused on delivering services as business-as-usual. A lack of longer-term financial planning limits the potential for boards to plan and invest in opportunities that have a longer payback period, resulting in greater efficiencies in the long term. For example, the fundamental changes required in providing more care in people's homes and community settings needs investment now if the 2020 vision is to be successful. It is important that boards recognise the need to plan their finances effectively in both the short and long term. Being able to strike the right balance between the two will help boards manage their resources in a more sustainable manner over a longer period of time.

**32.** Depending on the timing of UK and Scottish Government spending reviews, boards may know indicative spending levels up to a period of around four years. At the time of our audit, boards did not know what their funding levels would be beyond the current financial year ([see paragraph 10](#)). However, this should not prevent boards assessing their spending needs and options over a longer period. This short-term approach to budgeting makes it more important that boards



undertake work to outline the best, worst and most likely scenarios of their financial position as part of good longer-term financial planning.

**33.** A short-term approach to budgeting and the setting of annual financial limits provides little opportunity for boards to manage their finances more flexibly over a number of financial years. The Scottish Government provides some flexibility for boards that wish to carry forward a planned underspend from one year to the next and boards need to agree this in advance. Similarly, brokerage provides some flexibility, but in recent years this has provided only small amounts and is mostly used to help boards break even. Some additional funding may also be made available through Scottish Government underspends (through the budget exchange mechanism) but amounts cannot be guaranteed or planned in advance. Although this provides some flexibility, it does not allow boards to plan for it with great certainty.

**34.** Over this year and next, the Scottish Government will receive greater fiscal autonomy through new financial powers created by the Scotland Act 2012. These changes will bring closer links between the Scottish Government's policy decisions and the income generated through taxation. With greater autonomy in the overall Scottish budget, there is an opportunity for the Scottish Government to explore how it can use this increased flexibility to support longer-term financial planning by NHS boards. We recognise that to introduce greater flexibility would require careful consideration of any practical challenges such as how the Scottish Government manages the overall health budget and distribution of funding to individual boards. However, increased flexibility can help:

- manage cost pressures over a longer period
- provide opportunities for spend-to-save investment
- provide greater autonomy and responsibility of finances at a local level
- allow greater certainty in service planning with greater certainty over longer-term funding.

**35.** Flexibility that is managed well and planned in advance can help boards with longer-term financial planning. The Scottish Government needs to manage the benefits of supporting greater financial flexibility alongside the risks of greater volatility (caused by any variations in its income levels) within its overall budget.

## **National performance against key targets and standards has declined in recent years**


**36.** NHS boards are required to meet a number of performance targets and standards that the Scottish Government sets each year. These cover health improvement, efficiency, access and treatment, and are commonly known as HEAT targets and standards. They are designed to help achieve the Scottish Government's overall purpose and national outcomes as well as the quality standards that NHS Scotland seeks to meet. The introduction of performance targets and standards has improved how the NHS manages and delivers its services. Each year the Scottish Government issues boards with guidance on completing their LDPs. The guidance forms a performance contract between the Scottish Government and boards by setting out its expectations of boards' performance against targets and standards. NHS boards use the guidance to outline how they plan to achieve these targets in their LDPs.

**37.** The overall performance against key targets and standards worsened in recent years with performance declining in seven of the nine key targets and standards ([Exhibit 3, page 19](#)). Performance was strong against two standards:

- The three-weeks to referral for drugs and alcohol standard improved steadily as the number of patients referred within three weeks increased from 87.8 per cent in March 2012 to 95 per cent in March 2015. Demand for referrals during this time decreased by nine per cent from 12,242 to 11,114.
- There was a strong performance against the cancer 31-day decision to treat to first treatment standard. The national average of 98 per cent at March 2012 and 96.5 per cent in March 2015 both exceeded the 95 per cent threshold. This performance level was achieved at the same time as the number of referrals increased by two per cent from 5,481 in 2012 to 5,563 in 2015.

**38.** The performance against the other seven targets and standards has shown a pattern of steady decline over recent years. For example, the number of outpatients waiting over 12 weeks for their first appointment increased from three per cent in March 2013 to eight per cent in March 2015. Of those waiting, five per cent were waiting over 16 weeks.

### An ageing population and higher activity levels made achieving targets more difficult

**39.** Improvements in public health, diagnosis and medical treatments have all contributed to people living longer in the last decade. Between 2004 and 2014, the population aged over 75 has increased by 17 per cent from 370,000 to 433,000. Average life expectancy also increased during this period. The average life expectancy of men increased by three years from 74 to 77; and by two years for women, from 79 to 81. Although the population is living longer, it is not necessarily doing so in good health. Our 2014 report, [Reshaping care for older people \[PDF\]](#)  highlighted that the length of time people live in good health, known as healthy life expectancy, did not increase in line with life expectancy.<sup>10</sup> This means that some people will live longer with multiple and long-term health problems. The number of long-term health problems people have also increased significantly with age.

**40.** The increase in demand for health services is reflected in greater activity. For example, activity increased in the last five years at acute hospitals, such as general hospitals. Between March 2010 and March 2015, inpatient cases and outpatient appointments increased by 13 per cent and two per cent to 394,000 and 1,139,000 respectively.<sup>11</sup> Data recorded for the first time this year showed that there were over 990,000 GP out-of-hours consultations during 2014/15.<sup>12</sup>

**41.** These changes in population and health conditions and subsequent increased use of health services, combined with recent financial pressures, may explain why NHS boards have found it challenging to maintain or improve performance in recent years. These patterns are predicted to continue in the foreseeable future, placing further demands on future healthcare provision in Scotland. Forthcoming audit work will examine the implications of these patterns for health and social care over the longer term. We plan to publish the results in spring 2016.

### Exhibit 3

#### National performance against key waiting time targets and standards, 2012 to 2015

The national performance has declined in seven of the nine key waiting time targets and standards in recent years.

Target/standard		Year			
		2012	2013	2014	2015
A&E, four-hours <sup>3</sup>	98% (95% interim from April 2013)	95.4	91.9	93.3	92.2
Referral to treatment (RTT), 18-weeks <sup>3</sup>	90%	91.3	90.5	89.6	88.5
Child and Adolescent Mental Health Services (CAMHS), 26-weeks, changed to 18 weeks in December 2014 <sup>3</sup>	90%	90.1	98.5	92.5	81.1
Drug and alcohol treatment, three-weeks <sup>2</sup>	90%	87.8	94.4	96.0	95.0
Inpatient/day case appointment treatment time guarantee (TTG), 12-weeks <sup>2</sup>	100%	–	98.2	97.0	94.5
Referral to outpatient appointment, 12-weeks <sup>3</sup>	0% (5% interim from December 2014)	–	3.3	3.1	8.0
Cancer: 62-day referral to treatment <sup>2</sup>	95%	94.8	94.5	91.5	91.8
Cancer: 31-day decision to treat to first treatment <sup>2</sup>	95%	98.0	97.7	96.2	96.5
Delayed discharges (42 day target to January 2013, 28 day target to January 2015 and a 14 day target from April 2015) <sup>2</sup>	Zero patients delayed over target time	13	44	173	357

00: target missed. 00: target met. 00: within 5 per cent of target. 00: within 5 per cent of interim target.

#### Notes:

1. Blanks represent a time where earlier data is non-comparable owing to changes in data collection methodology.
2. Quarter ending.
3. Month ending.
4. Most data shows the position as at March. CAMHS 2012 data is at April 2012, and all delayed discharge data is for the quarter ending April.

Source: Audit Scotland using ISD Scotland data as at June 2015. Data is subject to any caveats described by ISD Scotland

### All territorial boards found it difficult to meet key performance targets and standards in 2014/15

42. All territorial boards had difficulties in meeting their key performance targets and standards. Many NHS boards failed to meet most key waiting times targets and standards at the end of 2014/15 ([Exhibit 4, page 20](#)). All boards met the cancer (31-day decision to treat to first treatment) standard, while only two boards, NHS Lothian and NHS Dumfries and Galloway, failed to meet the three-week drug and alcohol treatment standard.

## Exhibit 4

Performance against key waiting time targets and standards in territorial NHS boards at the end of 2013/14 and 2014/15

The performance against most key targets and standards has declined in the last year.

Target/ standard	A&E		Referral to treatment (RTT)		Child and Adolescent Mental Health Services (CAMHS) <sup>3,5</sup>		Drug and alcohol treatment		Inpatient/ day case treatment time guarantee (TTG)		Referral to outpatient appointment		Cancer: urgent referral to first treatment		Cancer: decision to treat to first treatment		Delayed discharges: number of patients delayed over target time <sup>5</sup>	
	4 hours	18 weeks	26 weeks, reduced to 18 weeks in Dec 2014	3 weeks	12 weeks	12 weeks	62 days	31 days	28 days, reduced to 14 days in April 2015	98% (95% interim)	90%	90%	90%	100%	0% (5% interim) <sup>7</sup>	95%	95%	Zero patients
	Mar 2014 <sup>2</sup>	Mar 2015 <sup>2</sup>	Mar 2014 <sup>2</sup>	Mar 2015 <sup>2</sup>	Mar 2014 <sup>2</sup>	Mar 2015 <sup>2</sup>	Mar 2014 <sup>1</sup>	Mar 2015 <sup>1</sup>	Mar 2014 <sup>1</sup>	Mar 2015 <sup>1</sup>	Mar 2014 <sup>2</sup>	Mar 2015 <sup>2</sup>	Mar 2014 <sup>1</sup>	Mar 2015 <sup>1</sup>	Mar 2014 <sup>1</sup>	Mar 2015 <sup>1</sup>	Apr 2014 <sup>1</sup>	Apr 2015 <sup>1</sup>
Ayrshire and Arran	93.7	87.8	90.5	78.4	72.2	92.7	96.7	98.1	99.7	96.3	3.7	10.7	95.6	91.6	98.9	99.5	0	7
Borders	98.0	91.8	90.1	90.1	100	89.6	96.1	99.3	94.9	92.9	2.6	7.6	96.7	94.4	100	97.8	1	0
Dumfries and Galloway	96.8	96.8	91.4	90.4	100	100	97.7	88.9	97.9	95.5	2.3	7.0	96.3	96.6	100	100	6	7
Fife	95.8	92.5	92.3	86.3	96.0	80.2	95.3	98.6	99.8	97.9	3.4	11.2	91.0	89.0	98.0	96.0	14	17
Forth Valley	97.2	93.6	80.8	89.8	90.4	48.6	97.2	98.9	99.9	99.5	6.4	5.8	87.5	91.2	98.6	98.0	16	1
Grampian	95.0	95.0	89.0	83.7	91.5	74.5	93.1	92.9	93.9	92.8	4.0	17.8	85.6	84.9	93.6	95.0	45	86
Greater Glasgow and Clyde	89.6	88.5	90.4	91.3	100	99.3	96.5	95.5	100	100	0.1	0.1	90.9	91.0	94.5	96.6	22	44
Highland <sup>4</sup>	96.7	97.4	–	–	–	94.2	91.3	91.4	97.8	74.1	7.6	25.5	90.0	96.0	91.6	96.0	11	56
Lanarkshire	92.4	91.8	94.1	92.3	98.6	94.6	99.9	99.2	100	96.3	1.4	4.8	96.2	95.3	95.8	96.5	12	39
Lothian	92.2	92.6	85.2	88.0	83.1	62.2	92.2	87.1	87.8	87.9	6.4	6.1	92.9	94.7	98.3	95.2	39	75
Orkney	98.8	99.7	97.3	96.6	100	100	100	100	99.3	95.7	2.5	7.4	100	100	100	100	0	0
Shetland	98.7	97.2	96.2	91.8	100	100	94.7	100	99.8	100	5.0	9.2	86.7	91.7	100	100	0	5
Tayside	99.3	99.3	91.4	86.9	79.7	35.9	94.9	91.8	99.4	94.5	1.7	11.4	90.2	92.3	96.5	95.3	4	14
Western Isles	98.1	99.0	82.0	92.4	100	100	97.5	94.9	100	100	9.3	13.3	91.7	80.0	100	100	3	6
<b>Scotland</b>	<b>93.3</b>	<b>92.2</b>	<b>89.6</b>	<b>88.5</b>	<b>92.5</b>	<b>81.1</b>	<b>96.0</b>	<b>95.0</b>	<b>97.0</b>	<b>94.5</b>	<b>3.1</b>	<b>8.0</b>	<b>91.5</b>	<b>91.8</b>	<b>96.2</b>	<b>96.5</b>	<b>173</b>	<b>357</b>

00: target missed. 00: target met. 00: within 5 per cent of target. 00: within 5 per cent of interim target.

Notes: 1. Quarter ending. 2. Month ending. 3. CAMHS data for island boards are grouped when reported by ISD Scotland. 4. NHS Highland did not provide CAMHS data in March 2014 or 18-week RTT in March 2014 or 2015. 5. Targets for CAMHS and delayed discharges changed during 2014/15, so the 2014 and 2015 values are not directly comparable. 6. National Waiting Times Board (Golden Jubilee National Hospital) is not included in this table. The board met all four of the targets and standards that apply to it: RTT, Outpatients, TTG, and Cancer: decision to treat to first treatment. 7. Five per cent interim target introduced from December 2014.

Source: Audit Scotland using ISD Scotland data as at June 2015. Data is subject to any caveats described by ISD Scotland

**43.** Many NHS boards found it difficult to meet the other seven key targets and standards, with the national average also below the target set:

- Only NHS Greater Glasgow and Clyde met the interim **12-week outpatient appointment** standard of five per cent consistently throughout the year. At March 2015, more than a quarter of patients in NHS Highland were waiting longer than 12 weeks for an outpatient appointment.
- The majority of boards did not meet the inpatient **12-week treatment time guarantee (TTG)** and the performance of ten boards deteriorated over the last year. Only NHS Greater Glasgow and Clyde, NHS Shetland and NHS Western Isles achieved 100 per cent at March 2015.
- In no quarter during 2014/15 did more than three boards meet the **delayed discharges** target. At April 2015, NHS Borders and NHS Orkney had no delayed discharges, while NHS Grampian, Lothian and Highland had the highest number of delayed discharges, together accounting for 61 per cent of the national total. In 2014/15, the number of bed days occupied by patients who were delayed was 498,545, an increase of 77,388 (18 per cent) from 2013/14.
- In March 2015, half of territorial boards met the **18-week referral to treatment** standard of 90 per cent although the national average misses this. NHS Orkney was the highest performing board with 97 per cent. NHS Ayrshire and Arran was the lowest performing board with 78 per cent.
- Only NHS Tayside, NHS Western Isles and NHS Orkney met the **four-hour accident and emergency (A&E)** waiting time standard of 98 per cent at the end of 2014/15. NHS Dumfries and Galloway, NHS Grampian, NHS Highland and NHS Shetland met the interim target of 95 per cent. NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran were the only boards below 90 per cent.
- In any month, five or six boards were not meeting the **Child and Adolescent Mental Health Service (CAMHS) 18-week** target of 90 per cent since the target was introduced in December 2014. Five boards had not yet met the target. In March 2015, NHS Forth Valley and NHS Tayside met the target in fewer than half of their cases (49 per cent and 36 per cent respectively).
- NHS Lanarkshire was the only board to consistently meet the **cancer 62 days to treatment** standard with five boards not meeting the standard once during 2014/15. NHS Dumfries and Galloway, NHS Highland and NHS Orkney were the only other boards to meet the standard at the end of 2014/15.

**44.** Performance varied across Scotland with no boards consistently above or below all of the main targets. For example, NHS Greater Glasgow and Clyde consistently met targets for 18-week referrals to treatment and CAMHS but missed the A&E and the cancer 62 day to treatment targets throughout the year. Similarly, boards that found it challenging to meet financial targets in recent years also found it difficult to meet performance targets and standards. For example, NHS Highland and NHS Tayside were amongst the lowest performing boards against the outpatient standard and CAMHS target respectively.

**45.** Failure to meet certain targets and standards can increase the pressure in other parts of the service. For example, delays in discharging patients from hospital mean that beds are not available for other patients who need them, causing delays and blockages. This can significantly reduce boards' ability to manage the flow of patients effectively. Similarly, the failure to meet outpatient standards can have implications for patients receiving timely treatment.

**46.** Unexpected levels of activity can also affect boards' ability to deliver an effective service across the whole system. For example, the Scottish Government reported that during winter 2014/15 emergency admissions from respiratory illness and influenza were higher than in previous years and also continued over a longer period of time. Although NHS boards increased their staffing capacity during winter to help, boards reported that the additional emergency activity resulted in more cancellations of elective inpatient procedures during the period.<sup>13</sup>

### Changes to targets and thresholds did not alter trends in performance

**47.** The Scottish Government is responsible for setting national performance targets. Within a target it may also raise or lower the thresholds that NHS boards must meet. Changes to performance thresholds and targets did not result in significant changes to the pattern of performance across Scotland. Recently, two targets have become more challenging for boards:

- **Delayed discharges:** since April 2013, no patient should wait in hospital for more than 28 days from when they are clinically ready for discharge. This is a reduction on the previous target of 42 days. From April 2015, this was reduced to 14 days. At this date, NHS Borders and NHS Orkney were within the 14-day target with a further two boards, NHS Ayrshire and Arran and NHS Forth Valley, meeting the previous 28-day target.
- **CAMHS:** in December 2014, a new target was introduced that 90 per cent of patients should wait no longer than 18 weeks from referral to treatment compared to the previous target of 26 weeks. At March 2015, an average of 88 per cent met the previous target of 26 weeks, compared to an average of 81 per cent meeting the new target of 18 weeks.

**48.** In April 2013, the Scottish Government established an interim reduced threshold for the four-hour A&E target. It lowered the threshold from 98 per cent of patients to be seen within four hours to 95 per cent. At the target due date in September 2014, five boards missed the interim target: NHS Forth Valley, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian, and NHS Lanarkshire. Overall, the national average performance declined with the target only being met twice in July and August 2013. The 95 per cent interim target remains in place and the Scottish Government expects boards that meet this target to then progress towards achieving the 98 per cent target.

### Achieving waiting time targets remains a top priority for the Scottish Government and NHS boards

**49.** The Scottish Government and NHS boards place great importance on achieving waiting time targets and standards. Although responsibility to meet targets and standards remains with individual boards, the Scottish Government provides support where performance is particularly poor. For example, during 2014, the Scottish Government provided support teams to help boards missing

cancer waiting time targets. Similarly in 2015, the Scottish Government provided a support team to help improve A&E waiting times performance at the Royal Alexandra Hospital in Paisley and the new Queen Elizabeth University Hospital in Glasgow. The Scottish Government also provided funding to NHS boards of £26 million in 2014/15 to help them improve their performance against the 18-week referral to treatment standard and the 12-week treatment time guarantee. In January 2015, it committed to spend £100 million over three years to help reduce delayed discharges from hospitals.

**50.** NHS boards are increasingly using the private sector to help them meet performance targets and standards by increasing short-term capacity. Capacity refers to the resources available to do work, for example available equipment and staff time. Boards typically use the private sector to help meet waiting time targets and standards and also where specialist treatment is not available in the NHS. Since 2009/10, NHS spending on using the private sector has increased by 18 per cent in real terms, from £72.3 million to £85.2 million in 2014/15. This accounted for around 0.8 per cent of NHS revenue spending in 2014/15. NHS Lothian spends over 20 per cent (£17.8 million) of all private sector spending in Scotland, over 140 per cent more than it spent in 2009/10 (£7.3 million). In the last year, the largest increases were in four boards: NHS Grampian, NHS Highland, NHS Lanarkshire and NHS Shetland. Each increased their private sector spending by over a quarter.

**51.** The extensive effort and focus placed by the Scottish Government and NHS boards on meeting performance targets and standards may be detrimental to the longer-term ambitions of redesigning services, focusing more on prevention and moving more care into the community. Additional short-term funding, increased use of the private sector and deploying support teams may help meet targets in the short term but do not demonstrate value for money in achieving the longer-term aims and objectives of the NHS.

**52.** The Scottish Government and boards should consider setting targets that will help them achieve longer-term aims such as implementing the 2020 vision. This will help ensure that short-term actions do not conflict with longer-term plans. In doing so, the Scottish Government should continually review each performance target and standard to assess its relevance, priority and sustainability ([see also paragraph 106](#)).



# Part 2

## Workforce



### Key messages

- 1** The number of people working in the NHS in Scotland is at its highest level, although recruiting and retaining staff on permanent contracts remains a significant problem for many boards. The ability to attract, recruit and retain medical professionals across Scotland, with the right skills to deliver the services required, is one of the biggest challenges facing the NHS today.
- 2** Vacancy rates, staff turnover rates and sickness absence levels have all increased during 2014/15. As a result, boards are now hiring more temporary staff to help keep services running and meet targets. This approach is increasingly expensive and only provides a short-term solution. In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent in real terms from 2013/14.
- 3** A national coordinated approach is needed to help resolve current and future workforce issues in the NHS in Scotland. The approach should assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the NHS workforce adapts to changes in the population's needs and how services are delivered in the future.

---

recruiting  
and retaining  
permanent  
staff is a  
significant  
problem for  
many NHS  
boards

---

### The number of people working in the NHS is at its highest level

**53.** NHS staff provide a wide range of healthcare services and are essential to ensuring high-quality, safe and effective care. The number of people working in the NHS is at its highest level ever with 137,600 whole-time equivalent (WTE) staff employed as at March 2015.<sup>14</sup> This is an increase of 1.5 per cent in the last year. Of the special boards, Healthcare Improvement Scotland had the largest increase of 7.4 per cent (22 WTE) and NHS Lothian had the largest increase for a territorial board of 3.1 per cent (601 WTE). Four boards saw their overall WTE decrease: NHS Western Isles, NHS Borders, Health Scotland and The State Hospital.

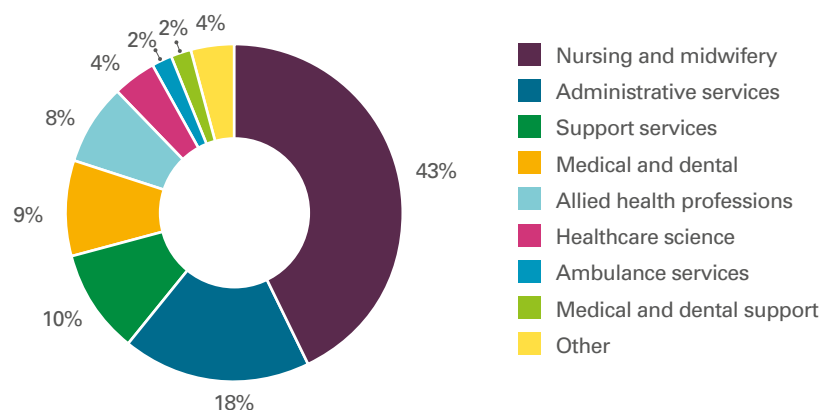
**54.** Nursing and midwifery are the largest staff group in the NHS, making up 43 per cent of the workforce (59,175 WTE). Administrative staff are the second largest staff group with 18 per cent (25,144 WTE) while medical and dental staff account for nine per cent (12,538 WTE) ([Exhibit 5, page 25](#)).



## Exhibit 5

### NHS workforce, by main staff groups, at March 2015

Nursing and midwifery are the largest staff group in the NHS in Scotland.



Source: ISD Scotland

**55.** Staff costs are the largest spending area in the NHS. In 2014/15, staff costs were almost £6 billion, accounting for around 55 per cent of total revenue spending. The majority of staff costs are for salaries and wages (£4.8 billion; 81 per cent) with a further £977 million (16 per cent) spent on national insurance and pension costs.

**56.** In recent years, the age profile of the NHS workforce has changed. There has been limited change in the gender balance of staff and the proportion working part-time, but the workforce has continued to age. At March 2015, almost 20 per cent of staff were aged 55 and over, compared to 16 per cent in March 2011.<sup>15</sup> This means that nearly a fifth of staff will be retiring, or close to retiring, in the next ten years. Good succession planning helps to ensure that enough new staff are being trained to replace the people who retire. For example, the percentage of GPs over 50 years old increased from 28 per cent in 2004 to 34 per cent in 2014.<sup>16</sup> It takes around ten years for a GP to become fully qualified, so replacing these skills requires good long-term planning.

### Recruiting and retaining staff on permanent contracts is a significant problem for many boards


**57.** The NHS in Scotland is under pressure from rising staff vacancies owing to difficulties in recruiting and retaining staff on permanent contracts. Retaining staff has become an increasing problem for boards with turnover rates increasing in recent years. In 2014/15, net staff turnover was 6.8 per cent on average, an increase of 0.5 per cent from 2013/14.<sup>17</sup> Net turnover measures the rate at which staff are leaving the NHS. Changes in staff are more common amongst medical and dental staff than other staff groups with a turnover rate of 9.2 per cent in 2014/15. This compares to 6.5 per cent in nursing and midwifery. The four territorial boards with the highest turnover were all generally rural boards: NHS Shetland (13.3 per cent), NHS Grampian (11.1 per cent), NHS Western Isles (10.4 per cent) and NHS Orkney (10.2 per cent).

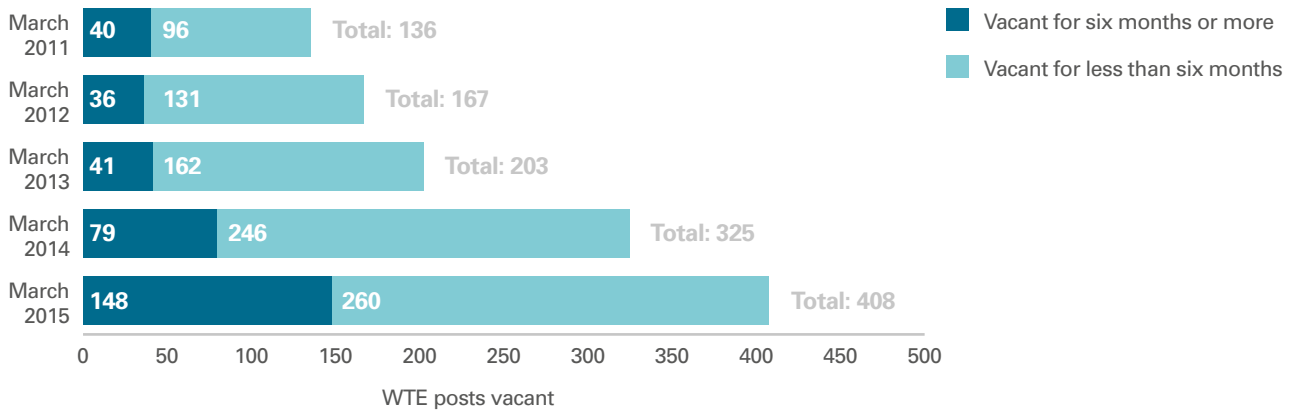
**58.** The number of vacant posts across all boards increased during 2014/15. Vacancies for consultant posts increased by about a quarter between March 2014 and March 2015 from 325 WTE to 408 WTE. Island boards have the highest consultant vacancy rates with NHS Western Isles and NHS Orkney having rates of 28 per cent and 19 per cent respectively. Posts vacant for more than six months increased by 87 per cent over the last year to 148 WTE ([Exhibit 6](#)). Specialties with the highest number of vacancies were:

- Clinical radiology: 40 WTE (12 per cent of posts)
- Anaesthetics: 37 WTE (five per cent)
- General acute medicine: 26 WTE (17 per cent)
- Emergency medicine: 24 WTE (11 per cent)
- Paediatrics: 24 WTE (eight per cent).

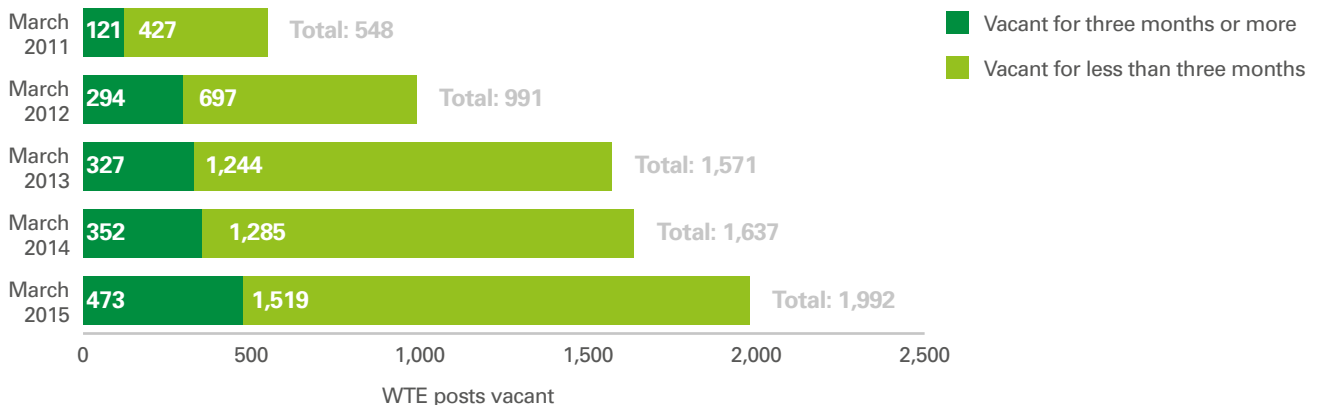
### Exhibit 6 Consultant and nursing and midwifery vacancies

The number of long-term vacant consultant and nursing and midwifery posts increased in the last year.

 Trend in consultant vacancies by length



 Trend in nursing and midwifery vacancies by length



Note: Figures subject to rounding.

Source: ISD Scotland

**59.** In emergency medicine, 71 per cent of vacancies were vacant for more than six months. Similarly, clinical radiology, anaesthetics, general acute medicine and paediatrics all had around 40 per cent of vacancies vacant for more than six months.

**60.** Nursing and midwifery vacancies have a similar trend to consultant vacancies. In March 2015, 1,992 WTE posts were vacant, with 473 WTE (24 per cent) of these vacant for more than three months. This is almost four times the number of vacancies vacant for more than three months at March 2011. NHS Shetland had the highest percentage of nursing and midwifery vacancies at over nine per cent (19 vacancies) whereas NHS Greater Glasgow and Clyde had the highest number of nursing and midwifery vacancies at 584 vacancies (four per cent of their establishment). Specialties with the highest number of vacancies across Scotland were:

- Adult nursing: 1,101 WTE (three per cent of posts)
- Mental health: 256 WTE (three per cent)
- Paediatrics: 122 WTE (five per cent).

Learning disabilities had the highest percentage of vacancies open for more than three months at 37 per cent.

**61.** Vacancies of allied health professions (AHP), such as dieticians and occupational therapists, fell by 11 per cent from 453 WTE in March 2014 to 403 WTE in March 2015.

**62.** The vacancy data shows advertised vacancies only. It does not include vacant posts that are not advertised and being covered by other staff such as temporary agency or bank staff. Advertised vacancies where the incumbent is still in post are included in the data. The length of vacancy does not include the time in which the post has been offered to other staff through redeployment.

**63.** Vacancy rates vary among boards, and within boards, with vacancies in some specialties and locations taking longer to fill. There are several reasons why boards are finding it challenging to recruit and retain staff on a permanent basis. These include:

- the rural location of some posts
- the increasing number of specialist posts within the NHS
- strong competition between boards for staff with specialist skills
- greater demand from staff for flexible working patterns such as part-time working
- staff seeking posts that allow greater opportunities for further training and development.

**64.** Where posts remain unfilled, boards are able to identify associated savings, on either a recurring or non-recurring basis. For example, NHS Highland reported that its policy is to hold corporate services vacancies open for at least six months, unless there are exceptional circumstances, to allow it to generate non-recurring savings.

**65.** Some NHS boards have launched marketing campaigns abroad to try and fill vacancies. Filling vacancies is not only about the role being advertised but also about the lifestyle it offers, such as housing, education and career progression opportunities for the candidate. More rural boards, such as NHS Highland and NHS Grampian, are enhancing their recruitment campaigns by showing the advantages of working in rural areas to try to recruit staff from outside the UK for difficult-to-fill posts. For example, NHS Highland launched a website showing the advantages of being a rural GP to help recruit GPs from countries such as the Netherlands and Spain. Similarly, NHS Grampian has advertised posts in countries such as New Zealand and South Africa.

**66.** Unsuccessful recruitment can lead to difficulties for boards in maintaining service levels. It can require boards to re-evaluate how they deliver services to ensure there is no risk to patient safety or care. For example, reducing opening hours to maintain safe staffing levels or altering the skills mix within a service are options that boards have recently considered ([Case study 2](#)).

---

## Case study 2

### Dealing with staff shortages in NHS Lothian and NHS 24



In July 2015, **NHS Lothian** decided to stop admitting child inpatients at St John's Hospital in Livingston for six weeks over the summer to maintain patient safety. It made this decision owing to unsuccessful national and international campaigns to fill key medical and specialist nursing posts. As a result, the service relies heavily on locum doctors and staff from the Royal Hospital for Sick Children in Edinburgh. Staff shortages meant during this period the service would assess patients between 8am and 8pm but children needing inpatient care were transferred to the Royal Hospital for Sick Children in Edinburgh. This is the second time in three years that the board has made this decision. During the temporary closure, the board consulted with clinical staff and the Scottish Government. At its October 2015 Board meeting, the board reported that no significant issues had been identified. Everyone agreed that the current staffing model is not sustainable in the longer term. The board is reviewing acute paediatric services to explore the options for providing sustainable and safe children inpatient services across NHS Lothian.

**NHS 24** provides a national telephone and online-based health service. Telephone demand has increased year-on-year to over 1.57 million calls. The board implemented a multi-disciplinary team approach using different skill sets and grades with clinical supervision from band seven nurses and allied health professions. Under the new model, the board exceeded its HEAT target to provide at least 30 per cent of patients with self-care advice. The board also reported its staff had high levels of satisfaction from this new approach.

Source: Audit Scotland using information from NHS Lothian and NHS 24

---

### Increasing rates of sickness absence adds pressure to maintaining staff levels

**67.** Monitoring levels of sickness absence is important as it is an indicator of the health and wellbeing of staff. Managing sickness absence is also important as absenteeism can lead to cancelled appointments and procedures for patients. Recruitment problems reduce the ability of services to cope flexibly with staff sickness. This can lead to additional costs as boards have to hire temporary staff to cover posts. In 2014/15, sickness absence in NHS Scotland was five per cent, one per cent higher than the national standard of four per cent and 0.3 per cent higher than 2013/14.<sup>18</sup> During the year, the highest rate was in The Scottish Ambulance Service at over seven per cent. The service reported this was mainly due to high levels of musculoskeletal complaints linked to the unique working environment for ambulance staff. NHS Education for Scotland had the lowest rate (2.4 per cent) and NHS Orkney was the only territorial board to meet the four per cent standard.

### NHS boards are spending more on temporary staff to ensure they maintain levels of service and meet targets

**68.** Difficulties in recruiting and retaining staff have meant boards have increased their use of temporary staff. NHS boards use bank or agency staff to fill gaps in staffing when posts are either vacant or cover is needed for staff sickness or leave. This helps maintain safe staffing levels, allows services to continue and fills short-term skills gaps. Boards also use temporary staff to help them meet waiting time targets and standards. However, relying too much on temporary staff may pose risks to patient safety. These risks can arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or from limited staff management to detect poor performance.

**69.** In 2014/15, NHS boards spent £284 million on temporary staff, an increase of 15 per cent in real terms from £247 million in 2013/14. This is the equivalent of five per cent of total NHS staff costs. This included additional work for those already employed in a substantive NHS role as well as those employed through external agencies. Some external agencies are part of a national contract where rates, and other terms, are agreed in advance following an open procurement process. Temporary staff covered both clinical and non-clinical roles including nurses, midwives, doctors and administration staff.

### The number of agency nursing and midwifery staff increased by 53 per cent in 2014/15

**70.** In 2014/15, the NHS spent £146 million on nursing and midwifery bank and agency staff. This was a real terms increase of 12 per cent from 2013/14. It spent most of this on NHS bank staff (£130 million, 89 per cent). This bank is made up of NHS staff carrying out additional shifts above their core working pattern. The remaining £16 million (11 per cent) was spent on using agency staff. This was a real terms increase of 68 per cent from £9.5 million in 2013/14.<sup>19</sup>

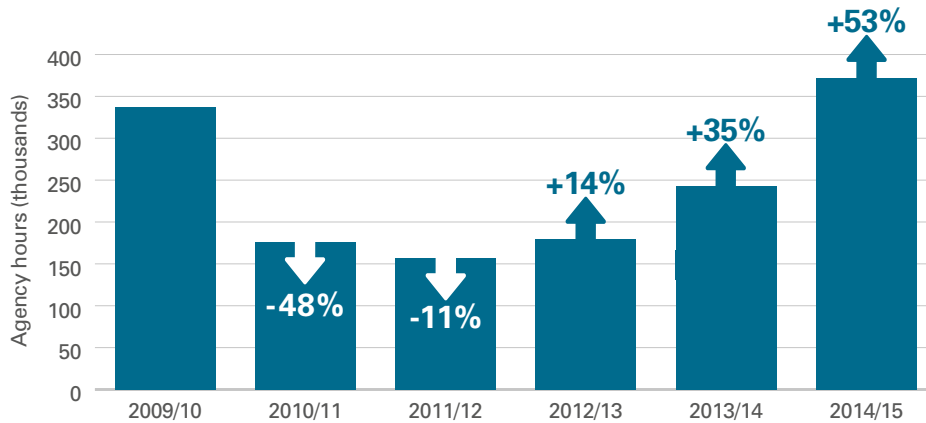
**71.** The number of agency nursing and midwifery staff increased 53 per cent from 124.5 WTE to 191 WTE over the last year, delivering 372,356 hours of work. NHS Lothian and NHS Tayside accumulated half of the 191 WTE agency staff cover, with 60 WTE and 36 WTE respectively ([Exhibit 7, page 30](#)).

**72.** Using agency nursing and midwifery staff costs the NHS almost three times more than using NHS bank staff. In 2014/15, the average hourly cost of using agency nursing and midwifery staff increased by nine per cent to £42.97 from

## Exhibit 7

### Agency nursing and midwifery staff, 2009/10 to 2014/15

The number of hours worked by agency nursing and midwifery staff increased by 53 per cent between 2013/14 and 2014/15.



Note: Percentage shows change in hours used by NHS in Scotland compared to previous year.

Source: Audit Scotland using ISD Scotland data



£39.26 in 2013/14. In comparison, in 2014/15, NHS bank staff for nursing and midwifery was £15.62 an hour, a decrease of just under one per cent. The cost of agency staff is particularly difficult for more rural boards where the average agency hourly rate exceeds the Scotland average. NHS Shetland (£84.05), NHS Orkney (£58.98) and NHS Dumfries and Galloway (£57.44) paid the highest rate per hour for agency staff ([Exhibit 8, page 31](#)).

### Spending on locum doctors increased by 22 per cent in 2014/15

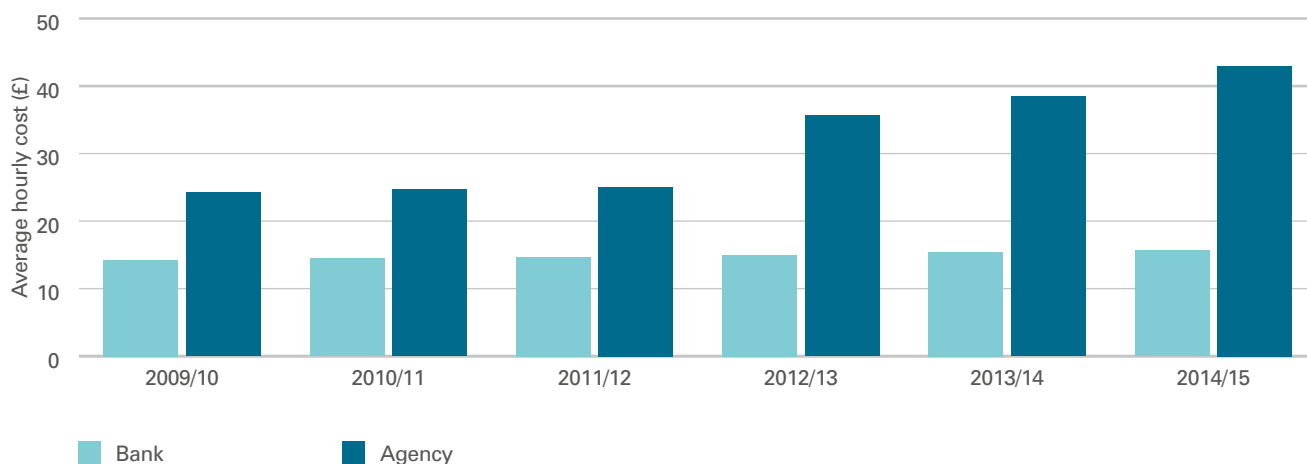
**73.** To help keep services running and meet targets, NHS boards are increasingly using locum doctors to cover shifts and fill vacant posts on a temporary basis. In 2014/15, NHS boards spent almost £107.5 million on using locum doctors. This was a real terms increase of 22 per cent from £88.2 million in 2013/14 ([Exhibit 9, page 31](#)). Spending increased on both internal and agency locums, with agency locums accounting for around 70 per cent (£76 million) of total locum spending. Internal locums are employees of the board while agency locums are recruited from external agencies. Approximately two-thirds was spent on consultants with a third on doctors of other grades.

**74.** The National Waiting Times Centre had the highest increase in locum spending of all boards in the last year. It increased by 78 per cent in real terms to just over £311,000 owing mainly to difficulties in recruiting junior doctors. This was followed by NHS Dumfries and Galloway and NHS Fife. Both boards spent between 40 and 50 per cent more on locums compared to 2013/14, spending £10 million and £8.2 million respectively. Only two boards reduced spending on locum doctors during 2014/15. NHS Orkney and NHS Forth Valley reduced their spending by 25 per cent (£0.6 million) and five per cent (£0.3 million) respectively.

## Exhibit 8

### Average hourly cost of bank and agency nursing and midwifery staff, 2009/10 to 2014/15

The average hourly cost of using agency staff was almost three times higher than using NHS bank staff in 2014/15.



Note: The average hourly cost is the total cost divided by total number of hours paid for. The hourly cost is expressed in real terms at 2014/15 prices.

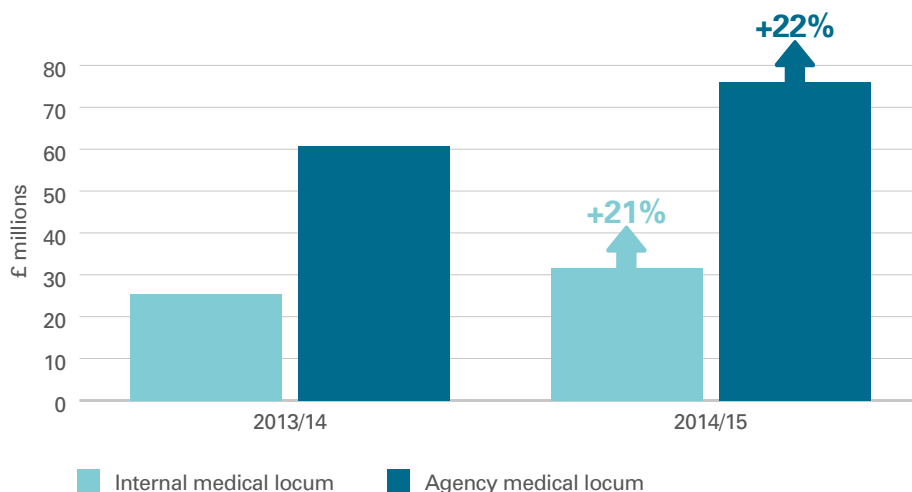
Source: Audit Scotland using ISD Scotland data



## Exhibit 9

### NHS boards' spending on locum doctors, 2013/14 and 2014/15

Total spending on locum doctors increased by 22 per cent between 2013/14 and 2014/15.



Note: Total spending is expressed in real terms at 2014/15 prices.


Source: Audit Scotland using information from NHS boards



### NHS boards often experience problems in recruiting temporary staff

**75.** NHS boards often face difficulties after taking the decision to recruit temporary staff. Boards reported a variety of reasons for struggling to fill nursing and midwifery and doctors posts using both internal and agency staff. These included:

- staff unable to work additional hours owing to European Working Time Regulations
- staff unwilling to work in areas where staffing levels and support are poor
- excessive costs of using agencies not on the national contract
- agency doctors unwilling to work for the national contract rate
- short supply of staff in certain specialities and grades
- unwillingness of staff to work in more rural locations
- agencies unable to provide the required numbers of staff
- short notice demand increasing the likelihood of using off-contract agencies
- competition between boards for the same skills and specialities.

**76.** Using temporary staff provides short-term flexibility to workforce plans but it does not address the underlying problems of recruitment and retention, skill shortages and sickness absence. Together, the Scottish Government and NHS boards should address the comparatively high costs of using agency staff and encourage greater use of internal or bank staff, or national contracts where temporary staffing is required. Reducing the cost of temporary staff is the collective responsibility of medical, clinical, human resources and finance professionals. Sharing information between these groups will support better and more cost-effective decision making. Our 2010 report [Using locum doctors in hospitals \[PDF\]](#)  made a number of recommendations to help boards better manage the costs and demand of using locums.<sup>20</sup> Boards should revisit these recommendations to ensure their approach to using locums meets good practice and also to help them manage other types of temporary staff.

### A national approach to managing current and future workforce pressures is needed

**77.** All NHS boards currently produce local workforce plans covering one year, although there are plans to move towards producing three-year plans. Local workforce plans have the advantage of allowing planning to fit the needs of individual boards. But they do not give an overview of national workforce issues or trends and do not provide solutions across boards, or nationally, to problems such as difficulties in recruiting and retaining staff.

### Scottish Government initiatives aim to improve workforce planning and wellbeing but are limited in scope

**78.** In 2014, the Scottish Government published a review of workforce planning across the NHS in Scotland, *Pan Scotland Workforce Planning Assessment and Recommendations*.<sup>21</sup> The review concluded that boards needed a more joined-up



approach to gathering and sharing information to support better workforce planning. Six priority actions for 2015/16 were agreed, including:

- reviewing workforce planning guidance
- improving the way in which boards record and report vacancies
- improving consistency in data coding for medical staff
- establishing a pan-Scotland perspective on use of job planning and eRostering systems
- clarifying workforce planning expectations for Integration Authorities (these are part of the new arrangements for integrating health and social care)
- establishing a workforce observatory for the NHS to make better linkages and use of intelligence for workforce planning in the long term.

**79.** In June 2013, the Scottish Government published *Everyone Matters: 2020 Workforce Vision*.<sup>22</sup> This followed a consultation with over 10,000 staff and stakeholders. The purpose was to identify staff concerns and where things could be done better, as well as setting out a commitment on how boards value and treat staff. It requested each board to bring their local values in line with the national core values of the NHS in Scotland:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

**80.** The Scottish Government publishes annual implementation plans identifying actions to deliver these values against five priority areas. The latest implementation plan, published in November 2014, outlines priorities for action against each area in 2015/16.<sup>23</sup> While the actions are strategic, they do not outline what indicators or measures are in place to monitor boards' progress or achievements.

### **A coordinated national approach can help identify future workforce requirements**

**81.** Workforce pressures in the NHS are unlikely to be solved by boards working in isolation. A more strategic and collaborative approach is needed for workforce planning, bringing together knowledge and experience from across the Scottish Government and individual boards.

**82.** A sustainable workforce should meet the needs of both patients and staff, while at the same time delivering services that meet, and deliver on, local and national priorities and outcomes for the NHS. To enable this to happen, the Scottish Government and NHS boards should build on recent initiatives such as *Pan-Scotland Workforce Planning* and the *Everyone Matters: 2020 Workforce Vision* to develop a national, coordinated approach to workforce planning.

**83.** Adopting a national coordinated approach would give the Scottish Government and NHS boards the opportunity to generate greater efficiencies through better sharing of staff resources, better information and aligning recruitment plans. It could also provide a basis for boards to adapt to changes in the workforce, for example as demands for services change and new technologies emerge. A coordinated approach would help address the workforce implications of transferring more care into people's homes and communities. Future changes are likely in relation to staff roles and responsibilities, job design, skills and training requirements and individual career progression. Such an approach would help the Scottish Government and NHS boards to work towards creating a sustainable workforce. The approach should:

- assess what types of jobs are needed, including roles and responsibilities, to meet the requirements of how services will be delivered in the future
- bring predictions of population health in line with the types of jobs and number of posts boards need
- align workforce demand and supply with recruitment and training plans to ensure there is a good supply of staff across different groups and specialties
- develop and use consistent information and data about vacancies, absences and staff availability to help local and national decision-making
- develop a coordinated approach to recruiting and retaining staff that will help boards fill vacancies successfully.

# Part 3

## Looking ahead



### Key messages

- 1 The Scottish Government has not made sufficient progress towards achieving its 2020 vision of changing the balance of care to more homely and community-based settings. There is some evidence of new approaches to delivering healthcare although it is unlikely that all the necessary changes will be in place by 2020. The Scottish Government plans to continue working towards the vision as part of an overall, longer-term plan for healthcare in Scotland. To help increase the pace of progress, the Scottish Government launched a new national conversation in August 2015. The conversation is expected to inform plans to change how services will be provided in Scotland over the next ten to 15 years.
- 2 Providing more options for care in patients' homes, care homes and communities has significant implications for how the NHS estate, such as land and buildings, operates in the future. In the last three years, around £1.4 billion was invested in major capital projects to improve the NHS estate. Major projects worth a further £849 million are currently in progress. It is not clear how recent and planned changes to the NHS estate are contributing to the 2020 vision.
- 3 Several initiatives and major reform programmes aimed at improving longer-term healthcare in Scotland are under way. It is important that the Scottish Government is able to demonstrate how various policies and reform programmes align and contribute to the longer-term vision for health and social care. Without alignment, there is a risk that reforms will operate in isolation. This could result in duplication, competition for limited resources such as staff or money, or conflicting priorities.

---

the Scottish Government needs to increase the pace of change if it is to achieve its 2020 vision

---

### The Scottish Government has not made sufficient progress towards achieving the 2020 vision

84. In September 2011, the Scottish Government set out an ambitious vision for health and social care to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.<sup>24</sup> This 2020 vision aims to help shape the future of healthcare in Scotland in the face of changing demographics and increasing demand for health services. In May 2013, the Scottish Government set out 12 priority areas for action in the form of a route map to the 2020 vision.<sup>25</sup> The Scottish Government sees achievement of the vision providing:

- integrated health and social care services
- a focus on prevention, anticipation and supported self-management
- day case treatment for hospital treatment where possible
- highest standards of quality and safety, with the person at the centre of all decisions, whether at home or in hospital
- a focus on ensuring that people get back home as soon as appropriate, with minimal risk of re-admission.

**85.** There is limited evidence of progress towards achieving the 2020 vision. For example, a progress report on the *Everyone Matters* 2014/15 workforce implementation plan found that boards had improved at embedding the values of the 2020 vision.<sup>26</sup> However, we found that progress was slow in getting consistent workforce data and more evidence is needed that boards are meeting the other aspects of the vision. Similarly, Scottish Government plans to develop a route map for capital investment to support the 2020 vision have not yet materialised.

**86.** Achieving the 2020 vision requires major changes in the way healthcare services are provided. This includes a significant shift of resources such as money and staff into more preventative and community-based services. It also requires use of new and innovative ways of delivering services, including using new technology to generate greater efficiencies. Following on from our 2014 report recommendation, the Scottish Government has yet to introduce milestones and indicators to measure progress of moving towards more preventative and community-based care. This makes it more difficult to assess developments and progress towards the vision.

### The Scottish Government is planning to revise its long-term plan for health and social care

**87.** In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress quickly enough towards delivering the 2020 vision.<sup>27</sup> At the same time, the Scottish Government announced plans to launch a new national conversation on the future of healthcare in Scotland. The Scottish Government decided to consider a longer-term plan, beyond 2020, because it wanted:

- more progress and pace towards achieving the vision
- to expand the current focus of the vision.

**88.** The conversation focuses on 'creating a healthier Scotland' and the future of health and social care over the next 15 years to 2030. The Scottish Government considers this an extension to the 2020 vision by including a greater emphasis on prevention and addressing health inequalities. The Scottish Government plans to hold events across Scotland up to April 2016 with staff, service users and other interested groups to get feedback about the aspirations of the 2020 vision. The Scottish Government wants to emphasise the need for cultural and behavioural changes in the approach to improving health outcomes.

**89.** In developing a revised long-term plan, the Scottish Government will need to engage widely with clinical representatives, councils, new integration authorities, community planning partnerships, patients and the wider public. The Scottish Government will also need to outline milestones and indicators of planned progress and how it plans to measure this between now and 2020, and beyond to 2030. In doing so, it should learn from the slow progress made so far in achieving the 2020 vision and ensure the new approach includes any lessons learned.

### Several major initiatives and programmes aim to improve longer-term healthcare in Scotland

**90.** The 2020 vision provides the strategic context for ongoing Scottish Government-led health initiatives and programmes. The most significant of these is the *Healthcare Quality Strategy*, published in May 2010.<sup>28</sup> This strategy aims to make Scotland among the best countries in the world for providing healthcare and is centred on three ambitions:

- **Safe:** There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
- **Person-centred:** Mutually beneficial partnerships between patients, their families and those delivering healthcare services, that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- **Effective:** The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

**91.** A number of initiatives are under way to help implement the strategy, including the following:

- **Scottish patient safety programme:** This aims to improve the safety and reliability of healthcare and reduce harm, where care is delivered.
- **Whole system patient flow programme:** This aims to reduce delays and help ensure that patients receive the right care at the right time, improving the quality of care received.
- **eHealth:** This aims to use information and technology in a coordinated way to help achieve the three quality ambitions.
- **National review of primary care out-of-hours services:** This is considering how best to deliver primary care out-of-hours services in light of the challenges of Scotland's ageing population, and as health and social care services are integrated.
- **Taskforce on sustainability and seven-day services:** This is considering the implications of delivering a sustainable seven-day clinical service across the NHS.

**92.** Similarly, the Scottish Government has established several programmes to help specific groups or healthcare conditions. These include 'reshaping care for older people', 'getting it right for every child' and separate heart and stroke improvement plans.<sup>29, 30, 31</sup> It will be important for the Scottish Government to demonstrate how its revised, longer-term approach links with ongoing national initiatives and programmes and what fundamental changes will arise from them and how these will be embedded in mainstream services. The speed at which substantial changes are needed within the NHS means that good progress with supporting programmes and initiatives is vital if the Scottish Government is to achieve the overall ambitions of the 2020 vision and beyond. There is a risk that underpinning programmes may lack coordination, compete for limited resources, lose focus or become subject to delay as changes are made to the overall strategic direction. The Scottish Government is aware of this risk and has recently established a transformational programme board including senior representatives from NHS boards to try and address this.

### **Changes to the NHS estate are vital for achieving the vision**

**93.** Investing in hospital and community buildings and other assets such as IT and transport is vital to delivering high-quality patient care and making services more efficient. Providing more options for care in patients' homes, care homes and communities has significant implications for ensuring assets are in the right place at the right time, suitable for their purpose and well maintained. For example, some patients will need specialist technology and equipment installed in their homes where this is the location of their care. It is important that the NHS estate and other assets evolve to reflect the longer-term vision of transferring care to more local settings to help ensure services are fit for purpose and sustainable.

### **Significant changes to the NHS estate are needed to improve its suitability and the way it is used**

**94.** The NHS in Scotland has physical assets worth about £5.4 billion (net book value), of which land and buildings are worth £5 billion with medical and IT equipment and vehicles accounting for the rest. The NHS uses a further £1.5 billion worth of privately owned assets. These assets include some GP surgeries and dental surgeries and those delivered under PFI contracts (such as the Royal Infirmary of Edinburgh). The overall size of the estate is around 4.5 million square metres, with 74 per cent of this (3.34 million square metres) covering 228 hospitals.

**95.** In February 2015, the Scottish Government published its annual NHS assets and facilities report (covering 2014) which showed:

- Twenty-five per cent of the NHS estate is over 50 years old. Fifty-nine per cent of the estate is in good condition, 37 per cent requires investment and four per cent requires major refurbishment or replacement. The percentage of the estate in good condition is eight per cent lower than in 2013, but this is largely attributed to changes in surveying methods.
- NHS boards reported that approximately 77 per cent of the estate is fully used, with a further 14 per cent underused or empty. Nine per cent is overcrowded. Although over three-quarters of the estate is fully used, boards considered around 65 per cent as functionally suitable. This is a three per cent decrease from 2013.

- The level of backlog maintenance and repair was reduced during 2013/14. The backlog maintenance requirement as at the end of March 2014 was £797 million, equivalent to 15 per cent of NHS estate value. This is a decrease of £61 million (seven per cent) from £858 million in 2013 and includes £95 million of newly identified backlog from additional survey work carried out during the year. Overall, 12 per cent (£96 million) of the backlog is considered high risk with 35 per cent (£279 million) considered as significant risk. Of the backlog, £80 million relates to properties expected to be disposed within five years and £65 million relates to replacements planned in the next five years. Together, various projects planned are expected to address £275 million (35 per cent) of backlog.<sup>32</sup>

### It is unclear how capital investment plans link to achieving the 2020 vision

**96.** The NHS in Scotland completed 22 major capital projects (projects with a capital value of at least £5 million) in the last three years costing £1.4 billion ([Exhibit 10, pages 40-41](#)). The three largest projects were:

- Queen Elizabeth University Hospital (NHS Greater Glasgow and Clyde): £842 million.
- Emergency Care Centre (NHS Grampian): £110 million.
- Mental health developments (NHS Tayside): £100 million.

**97.** A further 13 major capital projects are currently in progress with an estimated capital value of £849 million. Projects vary in size from large-scale developments such as new hospitals in NHS Dumfries and Galloway and NHS Orkney to smaller projects such as community health centres.

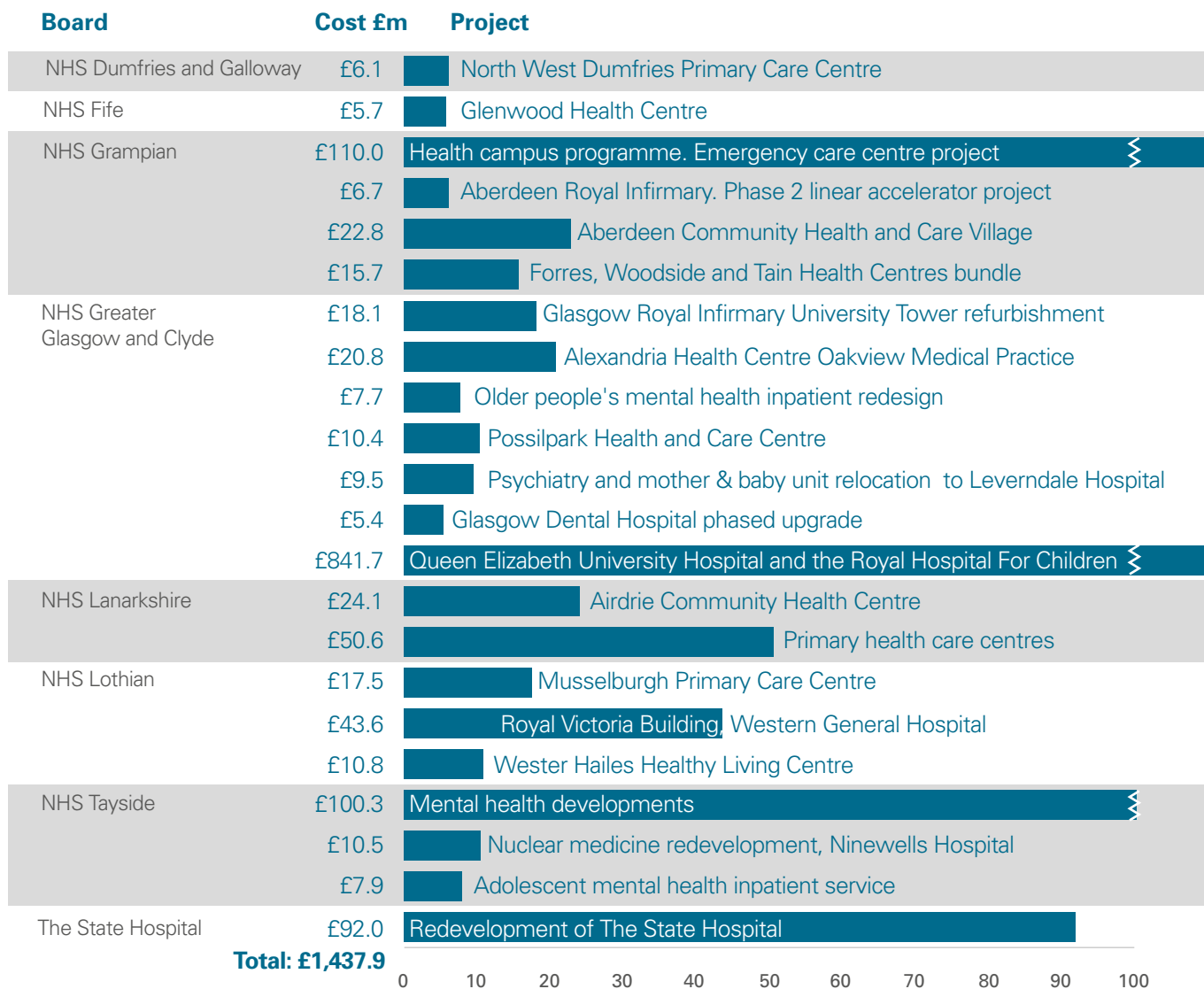
**98.** Recent and planned investment aims to improve the quality of patient care and experience, and efficiency, by improving facilities and using assets and technology in a better way. Similarly, such improvements can enhance the wellbeing of staff who are able to work in an environment more suited to the needs of their role.

**99.** The Scottish Government has yet to finalise its planned route map for how capital investment activity and changes to the NHS estate will help achieve the 2020 vision. The route map is intended to support the implementation of the vision and form the basis of guidance material for boards. The scale and cost of planned capital investment means there will be significant changes to how the NHS estate contributes to effective service delivery. The 2020 vision of changing the balance of care from hospitals to more homely settings is likely to change the scale, type and quantity of NHS assets needed to deliver services in the future. The Scottish Government needs to demonstrate how planned investment and changes to the NHS estate aim to achieve this.

## Exhibit 10a

### Major capital investment activity in the NHS

Major capital projects completed between 1 April 2012 and 31 March 2015.



Note: Break in bar graph is where project is over £100 million.

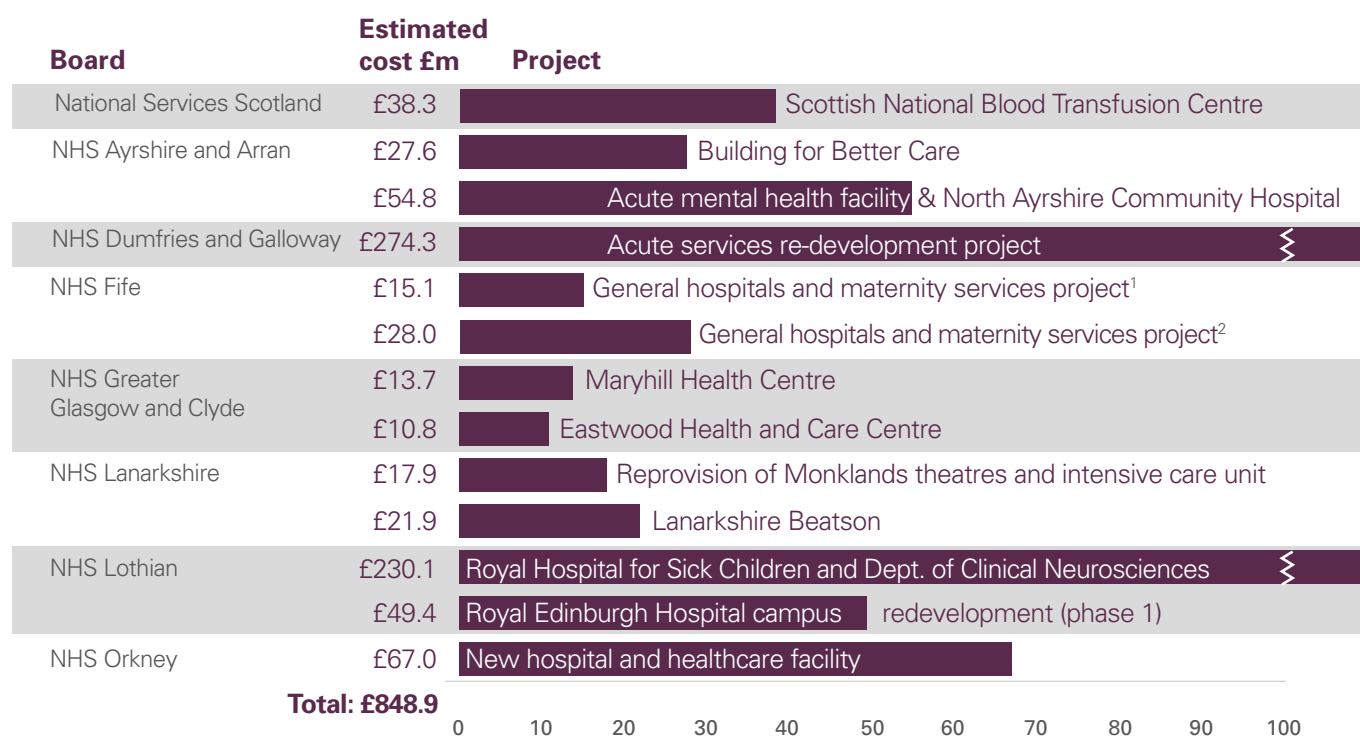
Source: Scottish Government, NHS boards and the Scottish Futures Trust



## Exhibit 10b

### Major capital investment activity in the NHS

Major capital projects in progress as at 1 April 2015.



#### Notes:

1. Reconfiguration works.
2. Enabling works to retained estate.
3. Break in bar graph is where project is over £100 million.

Source: Scottish Government, NHS boards and the Scottish Futures Trust

## Better understanding of demand, capacity and patient flow is needed to support future plans

**100.** Our 2014 report highlighted the complexities of the health and social care system in which patient flows need to be understood and managed to ensure the right resources meet demand.<sup>33</sup> We reported that the NHS needs a better understanding of:

- current capacity, for example having the right number of hospital beds, outpatient clinics, community services and trained staff available when and where they are needed
- current and future demands for services.

This information will help the NHS make the major changes needed to ensure it can deliver services and meet the longer-term needs of the population.

**101.** There is limited evidence of boards or the Scottish Government evaluating: whether health and care services can adapt to changes in demand; if they have sufficient capacity to implement the 2020 vision for health and social care; and the financial implications of NHS boards and councils implementing the vision. We plan to analyse projections for activity and conditions and use some case studies to examine the implications for health and social care resources over the longer term. We plan to publish the results of this work in spring 2016.

## Responsibility for delivering health and social care services in the future extends beyond the NHS

**102.** Responsibility for delivering health and social care in Scotland has extended beyond the boundaries of the NHS. The Scottish Government has launched many policies and reform programmes aimed at improving health and social care in Scotland. These have resulted in local government and the private and voluntary sectors getting more involved. Examples of these policies and reform programmes include:

- Community Care Act 2002
- NHS Reform Act 2004
- Better Health Better Care Strategy 2007
- NHS Quality Strategy 2010
- Social Care (Self-directed support) Act 2013
- Public Bodies Joint Working Act 2014.

**103.** Major reform is under way to integrate health and social care services in Scotland. This is an important part of the Scottish Government's 2020 vision. It requires NHS boards and councils to redirect resources towards more community-based and preventative care. Under these arrangements, NHS boards and councils will be required to delegate services and resources to a new body, known as an integration authority. As a minimum, integration authorities will be responsible for adult social care services, adult community health services and

some adult acute health services. The integration authority will be responsible for planning these services and directing NHS boards and councils to deliver services in line with their plans. The reforms are intended to ensure that partners work better together, develop different models of care and make better use of their resources to improve outcomes for people. The 31 new integration authorities will be operational by the deadline of 1 April 2016. We plan to publish a report on progress with health and social care integration in December 2015. This will identify the key risks and challenges that are likely to face the new bodies.

### **Better performance monitoring is needed to assess progress in delivering long-term ambitions for health and social care**

**104.** In January 2015, the Scottish Government issued revised guidance to NHS boards on completing LDPs. The guidance reaffirmed the Scottish Government's commitment to assessing NHS performance against HEAT targets and standards as well as six new improvement priorities covering:

- health inequalities and prevention
- antenatal and early years
- person-centred care
- safe care
- primary care
- integration.

**105.** The Scottish Government plans to assess overall NHS performance using HEAT targets and standards, improvement priorities and, from April 2016, new health and social care performance indicators for integration authorities.

**106.** In our 2014 report, we recommended that the Scottish Government should review current performance targets and standards and the planned indicators for integration authorities to ensure consistency with, and support for, the 2020 vision.<sup>34</sup> It remains unclear how these targets and indicators will align. The Scottish Government, NHS boards and integration authorities need to work together to ensure the targets and indicators provide comprehensive coverage of all activity across health and social care in Scotland.

# Endnotes



- ◀ 1 [The 2014/15 audit of NHS Tayside: financial management \[PDF\]](#) , Audit Scotland, October 2015.
- ◀ 2 [The 2013/14 audit of NHS Highland: financial management \[PDF\]](#) , Audit Scotland, October 2014.
- ◀ 3 [The 2014/15 audit of NHS Highland: update on financial management \[PDF\]](#) , Audit Scotland, October 2015.
- ◀ 4 [The 2013/14 audit of NHS Orkney: financial management \[PDF\]](#) , Audit Scotland, October 2014.
- ◀ 5 [The 2013/14 audit of NHS 24: management of an IT contract \[PDF\]](#) , Audit Scotland, October 2014.
- ◀ 6 [The 2014/15 audit of NHS 24: update on management of an IT contract \[PDF\]](#) , Audit Scotland, October 2015.
- ◀ 7 *Annual State of NHSScotland Asset and Facilities Report for 2014*, Scottish Government, February 2015.
- ◀ 8 *Finance guidance note to Scottish Public Finance Manual*, Scottish Government, June 2014.
- ◀ 9 *Scottish Government Annual Report on the Use of Settlement Agreements 2014-2015*, Scottish Government, June 2015.
- ◀ 10 [Reshaping care for older people \[PDF\]](#) , Audit Scotland, February 2014.
- ◀ 11 *Quarterly inpatient, day case and outpatient activity*, ISD Scotland, June and September 2015.
- ◀ 12 *GP Out of Hours Services in Scotland 2014/15*, ISD Scotland, August 2015.
- ◀ 13 *Health & Social Care: Winter in Scotland in 2014/15*, Scottish Government, August 2015.
- ◀ 14 *NHS workforce data tables*, ISD Scotland, June 2015.
- ◀ 15 Ibid.
- ◀ 16 *GP workforce and practice population statistics to 2014*, ISD Scotland, December 2014.
- ◀ 17 *NHS workforce data tables*, ISD Scotland, June 2015.
- ◀ 18 Ibid.
- ◀ 19 Ibid.
- ◀ 20 [Using locum doctors in hospitals \[PDF\]](#) , Audit Scotland, June 2010.
- ◀ 21 *Pan Scotland Workforce Planning Assessment and Recommendations*, Scottish Government, March 2014.
- ◀ 22 *Everyone Matters: 2020 Workforce Vision*, Scottish Government, June 2013.
- ◀ 23 *Everyone Matters: 2020 Workforce Vision Implementation Plan 2015/16*, Scottish Government, November 2014.
- ◀ 24 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.
- ◀ 25 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.
- ◀ 26 *Everyone Matters: 2020 Workforce Vision, review of progress in 2014-15*, Scottish Government, September 2015.
- ◀ 27 Cabinet Secretary for Health, Wellbeing and Sport, NHSScotland Event 2015, 23 June 2015.
- ◀ 28 *The Healthcare Quality Strategy for NHSScotland*, Scottish Government, May 2010.
- ◀ 29 *The Reshaping Care for Older People: A Programme for Change 2011-2021*, Scottish Government, 2011.
- ◀ 30 *Getting it right for every child*, Scottish Government, 2008.
- ◀ 31 *Heart disease and stroke improvement plans*, Scottish Government, 2014.
- ◀ 32 *Annual State of NHS Scotland Assets and Facilities Report for 2014*, Scottish Government, December 2014.
- ◀ 33 [NHS in Scotland 2013/14, \[PDF\]](#) , Audit Scotland, October 2014.
- ◀ 34 Ibid.

# Appendix

## NHS financial performance 2014/15



Health board	£(000)			£(000)		
	Revenue Resource Limit	Outturn	Variance	Capital Resource Limit	Outturn	Variance
Ayrshire and Arran	697,885	697,539	346	35,321	35,319	2
Borders	208,675	208,599	76	1,581	1,573	8
Dumfries and Galloway	311,974	309,945	2,029	31,917	31,917	0
Fife	643,738	643,504	234	13,458	13,458	0
Forth Valley	510,847	509,821	1,026	4,144	4,144	0
Grampian	912,346	912,209	137	22,191	22,191	0
Greater Glasgow and Clyde	2,258,960	2,257,727	1,233	159,357	159,337	20
Highland	624,294	624,158	136	16,243	16,243	0
Lanarkshire	1,127,908	1,127,508	400	53,410	53,410	0
Lothian	1,393,050	1,392,811	239	46,613	46,613	0
Orkney	57,419	57,351	68	3,550	3,536	14
Shetland	53,315	53,271	44	759	756	3
Tayside	790,447	790,389	58	13,871	13,868	3
Western Isles	78,472	78,470	2	1,756	1,756	0
<b>Territorials Total</b>	<b>9,669,330</b>	<b>9,663,302</b>	<b>6,028</b>	<b>404,171</b>	<b>404,121</b>	<b>50</b>
National Services Scotland	389,165	388,929	236	10,257	10,220	37
The Scottish Ambulance Service	246,853	246,792	61	11,730	11,729	1
NHS Education for Scotland	434,299	433,657	642	2,002	2,002	0
NHS 24	69,742	67,943	1,799	300	283	17
National Waiting Times Centre	65,165	64,664	501	3,824	3,821	3
The State Hospital	35,485	35,395	90	198	198	0
NHS Health Scotland	20,630	20,426	204	-816	-864	48
Healthcare Improvement Scotland	20,395	20,002	393	50	42	8
Mental Welfare Commission	4,626	4,626	0	212	212	0
<b>Specials Total</b>	<b>1,286,360</b>	<b>1,282,434</b>	<b>3,926</b>	<b>27,757</b>	<b>27,643</b>	<b>114</b>
<b>Total</b>	<b>10,955,690</b>	<b>10,945,736</b>	<b>9,954</b>	<b>431,928</b>	<b>431,764</b>	<b>164</b>

Source: Scottish Government

# NHS in Scotland 2015

This report is available in PDF and RTF formats,  
along with a podcast summary at:

[www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk) 

If you require this publication in an alternative  
format and/or language, please contact us to  
discuss your needs: 0131 625 1500

or [info@audit-scotland.gov.uk](mailto:info@audit-scotland.gov.uk) 

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

 [@AuditScotland](https://twitter.com/AuditScotland)

 [Subscribe to updates](#)

 [pinterest.com/AuditScotland](https://pinterest.com/AuditScotland)



Audit Scotland, 110 George Street, Edinburgh EH2 4LH

T: 0131 625 1500 E: [info@audit-scotland.gov.uk](mailto:info@audit-scotland.gov.uk) 

[www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk) 

ISBN 978 1 909705 74 6 AGS/2015/9

