NHS in Scotland 2016

AUDITOR GENERAL

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NHS Scotland key performance targets met at March 2016

1 out of 8

£12.2 billion

Total health budget in 2015/16

Increase in drug costs between 2012/13 and 2014/15

10 per cent

£291 million

Total savings reported by NHS boards in 2015/16

Number of outpatients waiting for an appointment at March 2015 and March 2016

254,911
275, 517

£492 million

Total savings planned by NHS boards in 2016/17

Summary

Key messages

1 Over the last decade, there have been improvements in the way health services are delivered and reductions in the time that patients need to wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. At the same time, demands on health and social care services have been increasing because of demographic changes. People are living longer with multiple long-term conditions and increasingly complex needs.

2 NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many had to use short-term measures to break even. NHS boards are facing increasing costs each year, for example drug costs increased by ten per cent, allowing for inflation, between 2012/13 and 2014/15. NHS boards will need to make unprecedented levels of savings in 2016/17 and there is a risk that some will not be able to achieve financial balance.

NHS boards are facing an extremely challenging financial position

3 Despite the significant financial challenges facing NHS boards, there have been improvements in some areas, for example in reducing the overall number of bed days from delayed discharges. However, boards are struggling to meet the majority of key national standards and the balance of care, in terms of spending, is still not changing. It is difficult balancing the demand for hospital care, alongside providing more care in the community. Boards need to ensure they maintain high-quality hospitals, while investing in more community-based facilities.

4 The NHS workforce is ageing and difficulties continue in recruiting and retaining staff in some geographical and specialty areas. Workforce planning is lacking for new models of care to deliver more community-based services. There is uncertainty about what these models will look like and the numbers and skills of the workforce required. NHS boards' spending on temporary staff is increasing and this is putting pressure on budgets.

5 The NHS is going through a period of major reform. A number of wide-ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.

Recommendations

The Scottish Government should:

- provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including:
  - immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities
  - support for new ways of working and learning at a national level
  - long-term funding plans for implementing the policies
  - a workforce plan outlining the workforce required, and how it will be developed
  - ongoing discussion with the public about the way services will be provided in the future to manage expectations (paragraphs 88-92)
- set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration (paragraph 69)
- consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning (paragraphs 13-19).

The Scottish Government, in partnership with NHS boards and integration authorities, should:

- model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required (paragraph 93)
- share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning (paragraphs 81-85)
- in line with the national policy on realistic medicine:
  - work to reduce over-investigation and variation in treatment
  - ensure patients are involved in making decisions and receive better information about potential treatments (paragraph 87).

NHS boards, in partnership with integration authorities, should:

- take ownership of changing and improving services in their local area, working with all relevant partner organisations (paragraph 96)

- develop long-term workforce plans (more than five years) to address problems with recruitment, retention and succession planning and to ensure high quality of care (paragraphs 94-95)

- work with the public about the need for change in how they access, use and receive services and to take more responsibility for looking after their own health and managing their long-term conditions (paragraph 33).

Background

1. The NHS in Scotland provides a range of vital services across the country to thousands of people every day, often in partnership with other bodies. Increasing costs and growing demand for services, combined with continuing pressures on public finances, mean the NHS continues to face significant challenges in delivering its services. The NHS is going through a period of major reform. The Scottish Government has an overarching policy to provide integrated health and social care, with a focus on prevention, anticipation and supported self-management. A number of wide-ranging strategies are proposing significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. New integration authorities have been in place since April 2016. They manage more than £8 billion of resources that NHS boards and councils previously managed separately.

About this audit

2. This is our annual report on how the NHS in Scotland is performing. 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 and performance in 2015/16?

- Is the NHS in Scotland equipped to deal with the financial challenges in 2016/17 and beyond?

- Is the NHS making good progress towards implementing public service reform?

3. The report has two parts:

- Part 1 Financial and service performance

- Part 2 Service reform.

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

- the audited annual accounts and auditors' reports on the 2015/16 audits of the 23 NHS boards

- NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as 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), part of NHS National Services Scotland
- interviews with senior staff in the Scottish Government and a sample of NHS boards.

5. We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of NHS boards is included in the Appendix.

6. Alongside this report we have published a self-assessment checklist for NHS non-executive directors. Its purpose is to help non-executive directors in scrutinising and challenging their board's performance and to help them gain assurance on the board's approach to dealing with the issues raised in this report.

Part 1

Financial and service performance

Key messages

1. In 2015/16, the total health budget was £12.2 billion, 40 per cent of the Scottish Government's budget. Although the budget increased by 2.7 per cent in real terms from the previous year, it is not keeping up with growing demand and the needs of an ageing population. In addition, NHS boards continue to face increasing pressures from rising staff and drug costs.

2. Many NHS boards struggled to achieve financial balance in 2015/16 and many had to use short-term measures to break even. Boards found it difficult to achieve the savings required and this will be even more challenging in 2016/17.

3. NHS boards need to look at reorganising acute services to free up more resources for investing in community-based facilities, but they are often faced with considerable public and political resistance to proposed changes to local services. Along with the Scottish Government, they need to engage with the public about the need for and benefits of changing how services are provided.

4. NHS boards continue to find it difficult to meet key national performance targets. Overall NHS Scotland failed to meet seven out of eight key targets. The only standard met nationally was the drug and alcohol treatment standard. The cancer 31 days referral to treatment standard was just missed by 0.1 per cent.

NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs

Although health spending has increased it is not keeping up with growing demand and the needs of an ageing population

7. The Scottish Government is responsible for managing the overall health budget and allocating budgets to individual boards. Our NHS in Scotland 2014 supplement provides a summary of how health budgets are managed. In 2015/16, the total health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.2 billion. This accounts for 40 per cent of the Scottish Government's budget (£30.1 billion).[1] The Scottish Government allocated:

- £10.4 billion to the 14 territorial NHS boards that serve each area of Scotland and deliver frontline healthcare services

- £1.3 billion to Healthcare Improvement Scotland, the Mental Welfare Commission and the seven special NHS boards that provide specialist and national services (for example, the Scottish Ambulance Service and NHS 24)

- £0.5 billion to national programmes, such as immunisations, health and social care integration, health improvement and health inequalities.

8. Between 2008/09 and 2015/16, the total health budget increased by 16 per cent in cash terms. Taking into account inflation, the real-terms increase was five per cent.[2] In 2015/16, the health budget increased by 2.7 per cent in real terms from the previous year. This includes a:

- 3.2 per cent increase in the revenue budget (for meeting day-to-day expenses, such as staff costs, medical supplies, rent and maintenance)

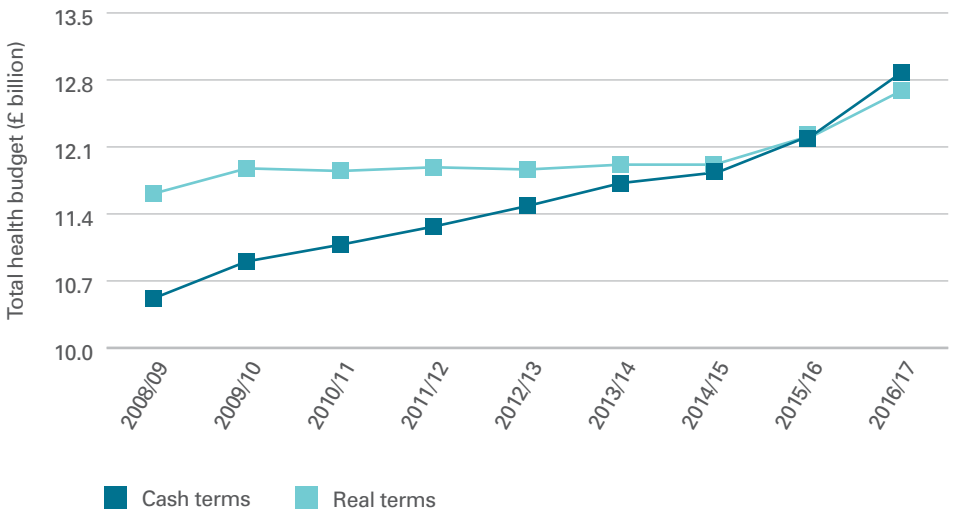
- 20.3 per cent decrease in the capital budget (for developing long-term assets, such as buildings or major IT programmes).

9. Following the economic recession in 2008/09, available public money has reduced overall. Between 2010/11 and 2014/15, the annual percentage change in the total health budget has been less than one per cent and below the UK inflation rate. Health inflation is generally higher and is estimated to be 3.1 per cent in 2016/17.[3] Although the total health budget increased recently, this was preceded by much smaller increases and some decreases (Exhibit 1). The overall trends in revenue and capital expenditure are quite different. Between 2008/09

Exhibit 1

Trend in the health budget in Scotland, 2008/09 to 2015/16, and draft budget figures for 2016/17

Since 2008/09, the health budget has increased in cash terms and had small real-terms increases and decreases each year.



Note: Figures include both the revenue and capital DEL budgets.

Source: Scottish Government

and 2015/16, the revenue budget increased by 8.6 per cent while the capital budget decreased by 64.7 per cent.

10. Despite the recent real-terms increase in the revenue budget, NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs. Spending on drugs increased by over ten per cent between 2012/13 and 2014/15 and the Scottish Government predicts that drugs spending will continue to rise by five to ten per cent each year (paragraph 37-38, page 18). The number of emergency admissions increased by six per cent and the associated costs increased by five per cent (between 2010/11 and 2013/14).[4] Since 2008/09, although the real-terms increase in the total health budget was five per cent:

- the budget per head of population only increased by 1.6 per cent
- the population aged 75 and over increased by 11.8 per cent
- the number of patients waiting for an inpatient or day case appointment increased by 5.6 per cent and the number waiting for an outpatient appointment increased by 89 per cent.[5,6]

11. The Scottish Government forecasts that the overall health budget for 2016/17 will increase by 5.6 per cent to £12.9 billion in cash terms. This includes a smaller increase in the revenue budget compared to 2015/16 (1.8 per cent in real terms). The Scottish Government has ring-fenced just under two per cent of the health budget for 2016/17 (£250 million) for health and social care integration. This funding is to be transferred to integration authorities to support additional spending on social care aimed at improving outcomes in social care. The remaining £12.6 billion of the NHS budget equates to a 0.3 per cent real-terms reduction in the revenue budget and a 2.1 per cent real-terms increase in the total budget. In 2016/17, the Scottish Government has reduced some of the funding allocations to territorial NHS boards. For example:

- Funding for Alcohol and Drug Partnerships has reduced by 22 per cent in cash terms, from £69.2 million in 2015/16 to £53.8 million in 2016/17. However, NHS boards are expected to maintain existing services, resources and outcomes at 2015/16 levels. A further £1.5 million is being provided centrally for developing alcohol and drug treatment services.
- Eleven funding streams have been combined into one single source of funding of £161.2 million. An efficiency saving of 7.5 per cent has been applied to the overall fund in 2016/17, which boards are expected to manage locally. This funding is part of an overall outcomes framework that aims to provide boards with more local flexibility on decisions about the funding. It focuses on prevention and reducing health inequalities, including dental services, infant nutrition and maternity services.

12. The capital budget is set to more than double, from £202.5 million in 2015/16 to £494.5 million in 2016/17. The increase is mainly to fund a £215 million investment in four new facilities. These are: the Royal Hospital for Sick Children and Department of Clinical Neurosciences in Edinburgh; the Dumfries and Galloway Royal Infirmary; the Scottish National Blood Transfusion Service Centre; and a new hospital in Orkney. The Scottish Government expects to reduce the capital budget again after 2016/17.

NHS boards struggled to achieve financial balance in 2015/16

13. To meet Scottish Government annual financial targets, NHS boards must end the financial year with at least a break-even position. This means they must spend no more than the limits of their revenue and capital budgets. All boards ended 2015/16 within their final revenue and capital limits.

14. After spending more than planned for every month during the year, the NHS in Scotland had an overall surplus of £4.5 million against its revenue budget of £10.9 billion (0.04 per cent) at the end of March 2016. This was a turnaround from having spent £12 million more than planned at February 2016. All boards reported at least a balanced revenue position (break-even or surplus), with surpluses ranging up to £0.7 million. There was an overall surplus for the NHS in Scotland of £0.4 million against the final capital budget of £329 million. All boards reported at least a balanced capital position, with surpluses ranging up to £0.147 million.[7]

15. The break-even position was achieved in a number of ways. For example, NHS Tayside required a loan from the Scottish Government (known as brokerage) of £5 million. This was on top of brokerage of £15 million received in previous years that the board was not able to repay. The board and the Scottish Government are discussing a revised timescale for repaying the total £20 million brokerage. NHS 24 was also unable to repay brokerage in 2015/16. At the start of 2015/16, the board repaid £0.79 million of a total £20.36 million brokerage received in previous years, but this was returned by the Scottish Government later in the financial year. NHS 24 was due to repay its outstanding brokerage by 2019/20. It has now agreed with the Scottish Government that it will not make any repayment in 2016/17. Instead repayments will recommence in 2017/18 and be made over a five-year period up to 2021/22. We have prepared separate reports on the 2015/16 audits of NHS Tayside and NHS 24.[8]

16. Three other boards that received brokerage in previous years are due to conclude repayment in 2016/17. The boards and amounts due to be repaid are NHS Highland (£1 million), NHS Orkney (£1.06 million) and NHS Western Isles (£0.54 million). The need for small amounts of brokerage highlights that NHS boards are facing real challenges in managing their budgets. Repaying brokerage reduces the amount boards have available to spend in future years.

17. There is evidence of boards increasingly using short-term approaches to meet the annual financial targets in 2015/16. Some boards only managed to achieve financial balance through one-off measures. In NHS Ayrshire and Arran, the auditors identified a prepayment for the cost of public holidays of over £1 million that was contrary to proper accounting practice. This involved the board moving costs from 2015/16 into 2016/17 to achieve financial balance. The auditor concluded that this was not an acceptable approach by the board to achieve its financial targets and the board corrected the accounting treatment.[9]

18. Other approaches that enabled boards to break even in 2015/16 include:

- additional funding allocations from the Scottish Government late in the financial year or after the year-end
- making savings by delaying or under-spending on services or capital projects
- transferring capital funding to revenue funding to allow it to be used to cover increasing operational costs

- reclassifying core funding as non-core to release additional funding for operational costs (non-core funding is provided to boards for unpredictable costs such as capital and pension accounting adjustments)

- other approaches, such as one-off benefits from rates and VAT.

19. These short-term approaches, and the significant amounts (up to £17 million) involved in some cases, illustrate how much pressure NHS boards' budgets were under in 2015/16 and into 2016/17. These approaches are unsustainable and make it difficult for boards to plan and invest in longer-term policy aims, such as developing more community-based services and treating people in homely settings.

20. A new sustainability and value programme board, jointly chaired by the chief executive of NHS Dumfries and Galloway and the Scottish Government's Director of Health Finance, was set up in September 2016. It is overseeing four work streams that will focus on delivering efficiencies. The aim is to make efficiency savings of up to two per cent over the next three years. The four areas are:

- Clinical transformation: improving theatre and outpatient productivity and eliminating unwarranted clinical variation.

- Effective prescribing: minimising harm, waste and unwarranted variation in prescribing.

- NHS workforce: improving recruitment and retention of the workforce and reducing locum and agency staff costs.

- Shared services: identifying opportunities for shared use of buildings and facilities and improving procurement of services.

Some boards are still below their target funding allocation

21. Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate most of territorial boards' budgets. The formula is based on the number of people living in each board area and adjusted to reflect age and gender within the local population. It is also adjusted for additional needs based on local circumstances such as geography, sickness and deprivation levels. When the formula was introduced, some boards' allocations were considerably below the amount proposed by the formula. Territorial boards receive an increase in funding each year and boards below their target allocation have received additional funding to gradually bring them closer to it. The Scottish Government made a commitment that all boards would be within one per cent of the target allocations by 2016/17. However, initial funding allocations provided to NHS boards for 2016/17 (excluding the £250 million for integration) indicate that four boards are still more than one per cent under their target allocation:

- NHS Grampian: 1.4 per cent below target (£12.2 million)

- NHS Highland: 1.5 per cent below target (£8.5 million)

- NHS Lanarkshire: 1.5 per cent below target (£15.9 million)

- NHS Lothian: 1.5 per cent below target (£18.8 million).

22. While these amounts are relatively small in terms of the overall budgets for each NHS board, all four of these boards are finding it challenging to meet key performance targets and have seen large increases in spending on temporary staff. NHS Lothian subsequently received a further £6 million and NHS Lanarkshire further £2 million of recurring funding from the Scottish Government in 2016/17. This was to bring the two boards closer to their target allocations and help them deliver their financial and performance targets. Three other boards that have previously received less than their target allocations are now within one per cent: NHS Fife (0.2 per cent below target), NHS Forth Valley (1.0 per cent below) and NHS Shetland (0.9 per cent below). The remaining territorial boards have received more than their target allocations (up to 9.4 per cent more in NHS Western Isles).

NHS boards found it difficult to achieve the savings required in 2015/16 and this will be even more challenging in 2016/17

23. At March 2016, boards reported overall savings of £291.3 million, which was £1.8 million (0.6 per cent) less than the target savings of £293.1 million stated in their local delivery plans (LDPs). Special boards exceeded their target by 25 per cent, while territorial boards were three per cent behind. Three territorial boards missed their savings targets: NHS Lothian (by 17 per cent), NHS Tayside (by 13 per cent) and NHS Western Isles (by one per cent). Boards retain the savings they make for reinvestment in local services.

24. Recurring savings are savings that, once achieved, recur year-on-year from that date, for example savings on costs as a result of streamlining services. Non-recurring savings are one-off savings that apply to one financial year, and do not result in ongoing (recurring) savings in future years, for example not filling a vacancy on a temporary basis. Identifying new recurring savings becomes more difficult for NHS boards each year. Boards that make high levels of non-recurring savings will have to find further savings in future years. Non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.

25. In 2015/16, five territorial boards and one special board achieved around 60 per cent of their planned savings through non-recurring means (NHS Borders, Fife, Highland, Shetland and Tayside and The State Hospital). Only three boards (Healthcare Improvement Scotland the National Waiting Times Centre Board and NHS Forth Valley) were successful in achieving more recurring savings than they had planned in their LDP. Overall non-recurring savings were 32 per cent of total savings (compared to 25 per cent in 2014/15).

26. Boards are setting higher savings targets, from an average of three per cent in 2015/16 to an average of 4.8 per cent in 2016/17. Some boards are reporting that they will need to make unprecedented levels of savings in 2016/17, up to around eight per cent in NHS Shetland and NHS Tayside. The total savings that boards are aiming to make has increased by 65 per cent in real terms, from £293 million in 2015/16 to £484 million in 2016/17 (£492 million in cash terms). This is by far the largest annual percentage increase in the savings target over the last four years. Case study 1 (page 15) illustrates the level of savings NHS Lothian needs to make to break even in 2016/17. The percentage of savings that NHS boards have classified as at high risk of not being achieved increased from nine per cent in 2013/14 to 14 per cent for 2016/17. Seventeen per cent of savings had yet to be identified by boards, and boards estimated that 30.5 per cent of savings will be non-

recurring (these are both higher compared to previous years) (Exhibit 2, page 16). This will put considerable pressure on boards during 2016/17 and there is a significant risk that some boards will not be able to remain within their budgets.

NHS boards need to balance maintaining high-quality hospitals with increasing investment in community-based care

27. NHS boards need to manage their hospital and community buildings and other assets, such as medical equipment, to ensure patients receive high-quality care. This includes:

- investing capital funding in new assets in line with national policy and local requirements
- maintaining and modernising current assets to ensure they are of a good standard, fit for purpose and used efficiently
- disposing of assets that are no longer fit for purpose or not required.

28. The NHS owns physical assets worth around £6.3 billion. This includes an estate of land and buildings of £5.7 billion. The remaining £0.6 billion relates to medical equipment, IT equipment and vehicles. Because of their significant value, it is important for NHS boards to manage assets well. In 2015/16, NHS Shetland was unable to locate over four per cent of its assets included in its fixed asset register. The total cost of assets which could not be located was £1.4 million (the value of these was £48,000 allowing for depreciation). The auditor's overall conclusion was that adequate accounting records had not been kept in relation to elements of property, plant and equipment assets.[10]

Case study 1

NHS Lothian's financial position in 2016/17 and level of savings required to break even

NHS Lothian identified a gap of £20.1 million in its budget for 2016/17. It received a further £6 million from the Scottish Government to bring it closer to its target NRAC position. To break even in 2016/17, the board needs to deliver £73.1 million of savings; at July 2016, it had still to identify £14.9 million of these. It carried over unmet efficiency savings from previous years of around £13 million. At 31 July 2016, NHS Lothian had overspent against its revenue budget by £7.1 million, mainly driven by over-spending on pay and prescribing. NHS Lothian has a financial recovery plan in place and is closely monitoring its financial position, which has been reported clearly to its Board. A new clinical quality approach is being led by a Quality Director to improve patient care and efficiency. This includes identifying and reducing unwarranted variation and cost across specialties.

Source: NHS Lothian Board papers for meeting on 3 August 2016, NHS Lothian Finance and Resources Committee, Quarter One Financial Review and Financial Position to July 2016, 14 September 2016. NHS Lothian Local Delivery Plan 2016/17

Exhibit 2

Percentage of planned non-recurring, unidentified and high-risk savings by NHS board, for 2016/17

Across many boards, a significant proportion of planned savings for 2016/17 are non-recurring, at risk of not being achieved or still to be identified.

		Of the total planned savings:		
	Total savings as % baseline resource funding	% non-recurring	% unidentified	% high risk
Territorial boards				
Ayrshire and Arran	3.7%	0.0%	27.4%	9.7%
Borders	5.9%	33.0%	0.0%	54.8%
Dumfries and Galloway	4.6%	45.1%	11.0%	28.4%
Fife	5.1%	42.2%	33.0%	44.2%
Forth Valley	5.5%	0.0%	7.9%	26.6%
Grampian	3.0%	55.4%	28.0%	20.9%
Greater Glasgow and Clyde	5.0%	24.5%	24.5%	8.3%
Highland	5.0%	10.4%	8.0%	13.7%
Lanarkshire	4.1%	15.5%	8.8%	22.1%
Lothian	5.6%	45.2%	20.4%	0.0%
Orkney	5.1%	27.4%	4.0%	15.4%
Shetland	8.7%	37.7%	0.0%	20.6%
Tayside	8.4%	60.0%	10.2%	12.1%
Western Isles	5.9%	38.8%	18.3%	11.5%
Special boards				
National Waiting Times Centre	8.5%	0.0%	0.0%	11.4%
NHS 24	5.1%	2.3%	7.8%	0.0%
NHS Education for Scotland	0.5%	15.9%	15.0%	0.0%
NHS Health Scotland	5.3%	8.8%	6.3%	0.0%
NHS National Services Scotland	5.1%	0.0%	0.0%	3.2%
Healthcare Improvement Scotland	11.3%	17.2%	0.0%	0.0%
Scottish Ambulance Service	4.4%	33.3%	0.0%	0.0%
The State Hospital	5.2%	72.2%	0.0%	0.0%
All territorial boards	**5.0%**	**31.9%**	**18.0%**	**15.4%**
All special boards	**3.5%**	**13.9%**	**1.7%**	**2.4%**
All boards	**4.8%**	**30.5%**	**16.7%**	**14.4%**
Key				
High	>5%	>50%	>20%	>20%
Medium	3-5%	20-50%	1-20%	3-20%
Low	<3%	<20%	<1%	<3%

Notes:
1. Total savings as a percentage of baseline resource funding was calculated using baseline funding allocations that include £250 million funding for health and social care integration.
2. The Mental Welfare Commission for Scotland does not provide savings figures.
3. The key is based on Audit Scotland's assessment of the level of savings in each category.

Source: Audit Scotland using information from NHS boards' Local Delivery Plans, June 2016

29. The Scottish Government's latest annual review of NHS assets (for 2015) shows a number of improvements overall in the management and physical condition of property assets, but this varies considerably by board:[11]

- Overall 79 per cent are less than 50 years old (compared to 75 per cent in 2014). More than 60 per cent of properties are 30 years and older in four NHS boards (NHS Ayrshire and Arran, Dumfries and Galloway, Tayside and Shetland). In NHS Shetland, 47 per cent of properties are over 50 years old.

- 66 per cent are in good condition (compared to 59 per cent in 2014), with 29 per cent requiring investment to improve their condition. The remaining five per cent are in an unsatisfactory condition and require major investment or replacement. In NHS Ayrshire and Arran, Highland and Orkney, more than 50 per cent of buildings require some level of investment to improve their condition (including Balfour Hospital in NHS Orkney which is being replaced).

- 81 per cent are fully utilised (compared to 77 per cent in 2014). NHS Ayrshire and Arran and NHS Dumfries and Galloway have high levels of overcrowded properties (24 and 30 per cent). NHS Highland and NHS Orkney have high levels of under-used properties (59 and 40 per cent). Both of these boards face challenges in providing critical healthcare facilities in locations with relatively low levels of population. In four boards, over five per cent of properties were empty (NHS Dumfries and Galloway, Fife, Grampian and Tayside). These boards have plans to sell unused properties over the next five years.

30. In 2015, the outstanding maintenance required to keep the NHS estate across Scotland up to a good standard amounted to £898 million. This is £101 million (13 per cent) more than in 2014.[12] High-risk and significant maintenance requirements reduced to 44 per cent overall in 2015, compared to 47 per cent in 2014. However, in some boards it increased, particularly in NHS Dumfries and Galloway, Greater Glasgow and Clyde, and Tayside. In five boards, the level of high-risk and significant backlog maintenance is over 50 per cent (NHS Dumfries and Galloway, Greater Glasgow and Clyde, Lothian, Tayside and Shetland). Most of these boards have new properties recently completed or under way and are rationalising their property portfolios.

31. Based on NHS boards' property and asset management strategies, and depending on approval and availability of funding, around £2.8 billion investment in assets is planned over the next five years. This relates to property, medical equipment, IT equipment and vehicles and will combine capital and revenue funding. Of the total of £1.1 billion planned for investment in major projects, the majority of this is for new hospitals (70 per cent).[13] A further £290 million is planned for new primary and community care projects for new models of care, to help deliver the Scottish Government's overarching health and social care policy which aims to provide more care in community-based and homely settings.

32. NHS boards need to balance maintaining high-quality hospitals with increasing investment into community-based care. A clear national strategy is required for capital investment that will support a shift in the balance of care. Boards can use revenue funding for major projects, rather than capital funding, to spread costs over a long period of time, such as non-profit distributing (NPD) projects. However, revenue budgets are under increasing pressure.

33. The National Clinical Strategy recommends that more specialist care should be provided on a regional or national basis. The capital budget has reduced significantly over recent years and the Scottish Government is providing limited additional funding for transforming services. NHS boards need to change the NHS estate to allow investment for new services. This includes reorganising acute services to free up more resources for investing in community-based facilities. This is happening to some extent, but boards can face considerable public and political resistance to proposed changes to local services. It is important that the Scottish Government has an ongoing discussion with the public about the way services will be provided in the future and manages expectations. A significant cultural shift is needed in terms of how people access, use and receive services. The Scottish Government, NHS boards and integration authorities need to work with the public about the need for and benefits of change, and develop and agree options for providing services differently.

NHS boards continue to face increasing cost pressures

34. The NHS is facing continuing pressure from increasing demand for services and a growing, ageing population, as we have highlighted in previous reports. The number of frail, elderly people is growing more rapidly than the rest of the population. People are living longer with multiple long-term conditions and increasingly complex needs. Overall, healthy life expectancy (the number of years people might live in good health) has improved. But significant health inequalities still exist and people living in the most deprived areas of Scotland have a much lower healthy life expectancy. The number of people being admitted to hospital in an emergency is increasing and GP practices are seeing increasing demand for their services.[14]

35. Other cost pressures include drug costs, salaries and wages, other staff costs, achieving national waiting time targets, and new technologies. In real terms, since 2010/11:

- total NHS staff costs have increased by 6.4 per cent to £6.2 billion in 2015/16
- NHS spending on national insurance has increased by 3.4 per cent, from £386 million to £399 million in 2015/16 (an increase of 2.2 per cent since 2014/15 from £390 million)
- total NHS spending on pensions increased by 18.6 per cent, from £550 million to £652 million in 2015/16 (an increase of 12 per cent since 2014/15 from £582 million).

36. Most NHS boards overspent on their acute budgets by a considerable amount in 2015/16. For example, NHS Ayrshire and Arran overspent on its acute budget by £8.5 million (3.2 per cent) and NHS Grampian overspent by £14.3 million (3.6 per cent).

Rising spending on drugs is a major pressure

37. Territorial NHS boards highlight spending on drugs, in both hospitals and the community, as a significant cost pressure.[15] The NHS in Scotland's total spending on drugs increased steadily between 2004/05 and 2011/12. Since decreasing by

a small amount in 2012/13, spending has been rising at a higher rate Exhibit 3 (page 20). The NHS spent £150 million more on drugs in 2014/15 than in 2012/13, after adjusting for inflation.[16,17] This is an increase of over ten per cent. In 2014/15, three times more was spent on drugs in the community (£1.2 billion) than on hospital drugs (£388 million). In 2015/16, examples of the main drugs prescribed in terms of volume and cost were:

- omeprazole, prescribed for reducing stomach acid. This was the most commonly dispensed drug in the community (3.6 million items at a cost of £11.7 million)
- inhalers that contain salmeterol with fluticasone propionate, prescribed for respiratory conditions such as asthma. This drug had the highest total cost in the community (£35.5 million)
- adalimumab, used to treat inflammatory conditions including arthritis, Crohn's disease and psoriasis. This accounted for the highest spending in hospitals on one drug (£32.5 million)
- paracetamol, ibuprofen and antihistamines; common drugs also available to buy over the counter. In total, over 4.3 million of these three drugs were dispensed at a cost of around £17 million.[18] Over the last ten years, the quantity dispensed has increased by two-thirds. This is double that of the increase in quantity of all drugs dispensed in the community.

38. Between 2012/13 and 2014/15, spending on drugs in the community rose by nearly eight per cent in real terms, while spending on drugs in hospitals increased by 20 per cent (Exhibit 3, page 20). The Scottish Government is predicting that overall spending on drugs will continue to rise by five to ten per cent each year.[19]

39. NHS boards in Scotland have been successful in increasing the prescribing of unbranded medicines rather than branded medicines to generate efficiencies.[20] This is known as generic prescribing. Scotland, along with the rest of the UK, has one of the highest generic prescribing rates in the world.[21] Generic prescribing rates have risen slowly and steadily over the last ten years and reached 83.6 per cent in 2015/16. Our 2013 report on GP prescribing found that most of the potential savings from switching to generic drugs have already been made.[22]

Spending on drugs is rising because of increases in demand and cost

40. NHS spending on drugs has increased in recent years owing to:

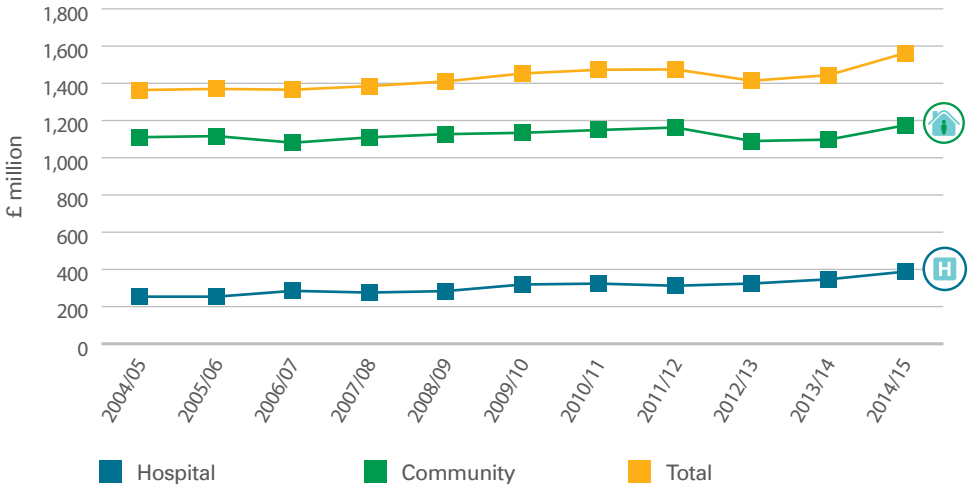
- more drugs being dispensed
- rising costs of many existing drugs
- new drugs becoming available.

41. The quantity of drugs dispensed in the community increased by almost a third between 2006/07 and 2015/16.[23] Reasons for this include an ageing population, more people living with long-term conditions and the increased use by GPs of evidence-based guidelines that recommend drugs to treat certain conditions. For example, statins (drugs to lower people's cholesterol level) are routinely prescribed for patients with heart disease.[24]

Exhibit 3

Spending on drugs by NHS boards in Scotland, in real terms, 2004/05 to 2014/15

Spending on drugs in the community has been rising since 2012/13. Between 2004/05 and 2014/15, spending on drugs in hospitals increased by 53 per cent.



Source: Cost book – drugs, ISD Scotland, November 2015

42. The cost of existing drugs has increased for a number of reasons:

- Increasing global demand for drugs has led to higher prices. Global pharmaceutical sales are projected to increase by an average of 6.9 per cent each year between 2014 and 2018.[25]

- There has been a global shortage of some drugs, caused either by rising demand or by manufacturing problems. This has resulted in prices rising or patients being prescribed more expensive alternatives.

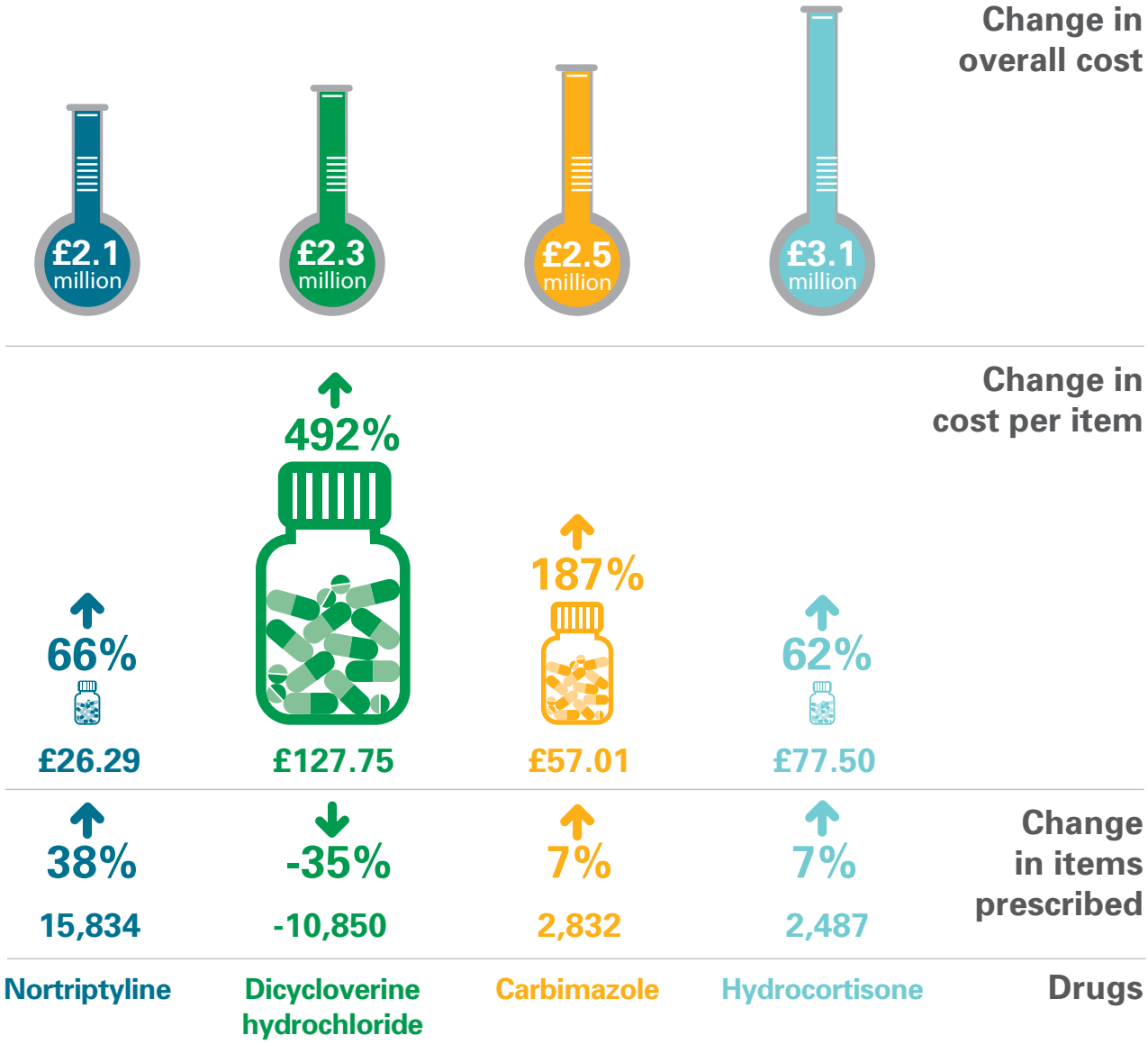
- Some pharmaceutical companies have sold the rights to a small, but significant, number of branded drugs to other companies that then sell them on under their generic name at a much higher price.[26] These tend to be drugs that do not have a big market and have few, if any, alternatives. In many cases it is unsafe or difficult to switch patients away from these drugs and NHS boards have no choice but to pay the higher price. Exhibit 4 (page 21) illustrates the financial impact of this practice on the NHS between 2013/14 and 2015/16. For example, prescribing of dicycloverine hydrochloride (a drug commonly used for irritable bowel syndrome) fell by a third but the overall cost to the NHS rose by nearly 300 per cent (£2.3 million) because of an increase in price of nearly 500 per cent.[27]

43. It can be difficult for NHS boards to predict these types of price increases as there is often little warning of which drugs will be affected. However, the UK Government has made progress in controlling excessively high prices of some unbranded medicines. The UK-wide Health Service Medical Supplies (Costs)

Exhibit 4

Examples of cost increases in four branded drugs sold under their generic name, 2013/14 to 2015/16

Four branded drugs that were sold under their generic name cost the NHS over £10 million (128 per cent) more in 2015/16 than in 2013/14. Over this period, overall demand for these drugs rose by seven per cent while prices rose by between 62 and 492 per cent.



Source: Drugs analysis provided to Audit Scotland by ISD, July 2016

Bill, introduced in September 2016, intends to limit the price of unbranded medicines where competition in the market fails and companies charge the NHS unreasonably high prices. The Bill is expected to be enacted in spring 2017.[28]

New drugs are a cost pressure for NHS boards

44. The Scottish Medicines Consortium (SMC) is the body that assesses new medicines for use in Scotland. The SMC analyses information supplied by the

medicine manufacturer on the health benefits of the medicine and justification of its price. The introduction of new approaches by the SMC, including an appeals process involving patients and clinicians, has increased access to new high-cost drugs.[29] Between May 2014 and March 2016, the SMC approved 75 per cent of medicines (for treating very rare and rare conditions and for use at end of life). This compares to 48 per cent of medicines approved by the SMC between 2011 and 2013 (for cancer medicines and those for treating rare conditions).

45. Access to some of these new drugs can be life-changing for patients and their families. Advances in research mean that more treatments are becoming available for rare conditions that previously had no or little treatment options. The SMC assesses the effectiveness of new drugs, but not affordability. This means that NHS boards have to fund an increasing number of very high-cost drugs. This has a significant impact on boards' budgets. For example, in 2015/16, the cost of drugs to treat:

- cardiovascular disease increased by nearly £14 million compared to 2013/14 as a result of the introduction of new anticoagulant drugs[30]
- hepatitis C was £50 million compared to £32 million in 2014/15, an increase of over 50 per cent (Case study 2, page 23).[31]

46. The Scottish Government has commissioned a review to consider how the changes made to the SMC process in 2014 have improved patient access to medicines for rare and end-of-life conditions. It will also look more broadly at how the whole system for getting patients access to newly licensed drugs safely and quickly is working. The review is due to report in late 2016. The SMC also provides early intelligence to NHS boards on new medicines in development through an annual horizon-scanning report with the aim of improving boards' financial planning.[32]

47. The Scottish Government has provided additional funding for new drugs through the New Medicines Fund (NMF). NHS boards received £21.5 million from the NMF in 2014/15, and £85 million in 2015/16. The NMF provides additional funding to NHS boards to cover costs incurred for increasing patient access to treatments for very rare conditions and end-of-life medicines. It does not cover the cost of high-cost new drugs, such as those to treat hepatitis C, or other new treatments for more common conditions. The Scottish Government has yet to advise boards of the total amount of additional funding available from the NMF in 2016/17.[33] If the NMF reduces in 2016/17, this will place further pressure on boards' drugs budgets.

Staff costs are a major cost pressure for NHS boards

48. The NHS is going through a period of major reform. A number of wide-ranging strategies including the National Clinical Strategy, integration of health and social care services and a new GP contract are likely to change the roles and skills required of the workforce. 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 in Scotland continues to rise despite a third of NHS boards reducing their staff numbers during 2015/16. Overall staff levels are at the highest level ever, with 138,458 whole-time equivalent (WTE) staff employed as at March 2016. This is an increase of 0.6 per cent (855 WTE) in the last year.[34]

Case study 2

Curative treatments for hepatitis C

It is estimated that around 37,000 people in Scotland are infected with hepatitis C (20,000 diagnosed, 17,000 undiagnosed). The effectiveness of treatments which eradicate hepatitis C infection has increased dramatically over the last 20 years. In 2014, new highly effective, short-duration, safe and easy-to-administer treatments became available and offered a cure to more than 90 per cent of hepatitis C patients for the first time. These cost over £13,000 per patient for a month's supply in 2015/16 but are expected to reduce spending in the future. Courses of treatment tend to range from two to six months.

The key aim of investing in hepatitis C services in Scotland is to reduce the number of people who develop hepatitis C virus (HCV)-related liver failure, liver cancer and the number of people who die from HCV-related disease.

Given the current high cost of the new treatments, NHS boards are prioritising treatment for people at risk of developing severe life-threatening or seriously debilitating liver disease and non-liver hepatitis C-related disease. However, the longer-term aim is to offer therapy to all people with chronic hepatitis C, as early treatment is likely to deliver benefits throughout the population in terms of prevention and onward transmission.

It is estimated that a minimum of 1,500 patients need to start treatment each year during 2015-20 to reduce the number of new liver failure or cancer presentations from the current level of nearly 200 down to 50 presentations by 2020.

The annual cost to the NHS in Scotland of treating hepatitis C-related liver disease is estimated to more than double between 2008 and 2030, from £9.9 million to £20.2 million, totalling £362 million over this period. This figure does not include economic costs such as costs related to patients not being able to work. Further health economic work focusing on the cost-effectiveness of different models of diagnosis, assessment, treatment and care still needs to be carried out.

Source: Audit Scotland; ISD; Scottish Medicines Consortium - SMC No 964/14 (sofosbuvir), SMC No 1002/14 (daclatasvir); National Clinical Guidelines for the treatment of HCV in adults, Health Improvement Scotland, 2015; The Scottish Government Hepatitis C Treatment and Therapies Group Report, Health Improvement Scotland, Scottish Government, 2015; Expansion of HCV treatment access to people who have injected drugs through effective translation of research into public health policy: Scotland's experience, Hutchison, S International Journal of Drug Policy 26 (2015) 1041–1049

49. Staff costs are the largest spending area in the NHS. In 2015/16, they were £6.2 billion, accounting for around 55 per cent of total revenue spending. This is an increase of 6.4 per cent in real terms since 2010/11. The majority of staff costs, just under £5 billion, were for salaries and wages, including overtime pay. A further £1 billion was spent on national insurance and pension costs and £175 million was spent on agency staff.[35]

50. The Scottish Government surveys NHS staff regularly. In the latest survey for 2015, with a 38 per cent response rate, almost two-thirds of staff said they would

recommend their workplace as a good place to work. However, only a third of respondents said there were enough staff to allow them to do their job properly.[36] This has remained unchanged over the last three years. This tended to be more positive in special boards (around half of respondents said there were enough staff), excluding the Scottish Ambulance Service, where it was 15 per cent. In a survey of 1,800 GPs in Scotland in 2015, a quarter of GPs described their workload as unmanageable and over two-thirds felt that workload had a negative impact on their personal commitment to their career.[37]

The NHS is facing problems recruiting and retaining staff

51. 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 since 2012/13 (Exhibit 5, page 25). In 2015/16:

- staff turnover was 6.4 per cent (WTE leavers divided by the number of staff in post as at 31 March). The highest turnover was at two special boards, NHS 24 (13 per cent) and NHS Health Scotland (14.8 per cent). Among the territorial boards, the three island boards had the highest turnover (9.5-11.5 per cent), followed by NHS Tayside (9.2 per cent). High turnover can be a way of getting new skills into the organisation on a short-term basis. However, it can also affect consistency and costs if boards are required to frequently provide training for new staff

- nursing and midwifery vacancy rates were 3.6 per cent overall but this varied among boards. NHS Orkney and NHS Shetland had the highest rates at over eight per cent. NHS Ayrshire and Arran and NHS Western Isles both had rates of less than one per cent[38]

- health visitor nursing had the highest vacancy rates of all nursing specialties (nine per cent, 182 vacancies). This was followed by paediatric, district and public health nursing, which all had vacancy rates of almost five per cent. NHS Shetland had the highest vacancy rate of all boards for health visitor nursing and district nursing (39.6 and 22.8 per cent respectively)

- consultant vacancy rates were 6.5 per cent overall. This is a reduction from 7.7 per cent in 2015. However, there is variation among territorial boards. NHS Orkney had the highest rate by far at 37 per cent, followed by NHS Dumfries and Galloway, Ayrshire and Arran, and Fife at 14.5, 13.9 and 12.6 per cent. These vacancy rates are likely to be an underestimate owing to the way the data is collected[39]

- clinical radiology and anaesthetic consultants had the highest number of vacancies of all specialties, at 40.3 WTE (11 per cent) and 32 WTE (four per cent) vacancies. Psychotherapy and occupational medicine consultants had the highest vacancy rates (23 and 22 per cent) as a percentage of the establishment (when the total establishment was more than ten). Vacancy rates for other grades of hospital medical staff are not available

- GP vacancy rates were 4.8 per cent (this figure is for the most recent data from 2015), but again there is wide variation. The three island boards had the highest vacancy rates (8.6 per cent in NHS Orkney, 16.5 per cent in NHS Western Isles and 17.9 per cent in NHS Shetland), along with NHS Forth Valley at 8.9 per cent[40]

- five per cent of GP practices (49) are being run directly by their local NHS board, mainly due to GPs retiring, the rural location of practices and problems recruiting GPs. The number of practices taken over by boards has been steadily increasing since 2013/14[41]

- sickness absence was 5.2 per cent overall. The Scottish Government has set boards a target of a maximum of four per cent. Only three boards had rates below the target (NHS Education for Scotland, NHS Health Scotland and Healthcare Improvement Scotland). The highest rates were at NHS Western Isles (5.9 per cent), the Scottish Ambulance Service (7.6 per cent) and The State Hospital (8.1 per cent).[42] High sickness rates put more pressure on boards to cover posts on a temporary basis.

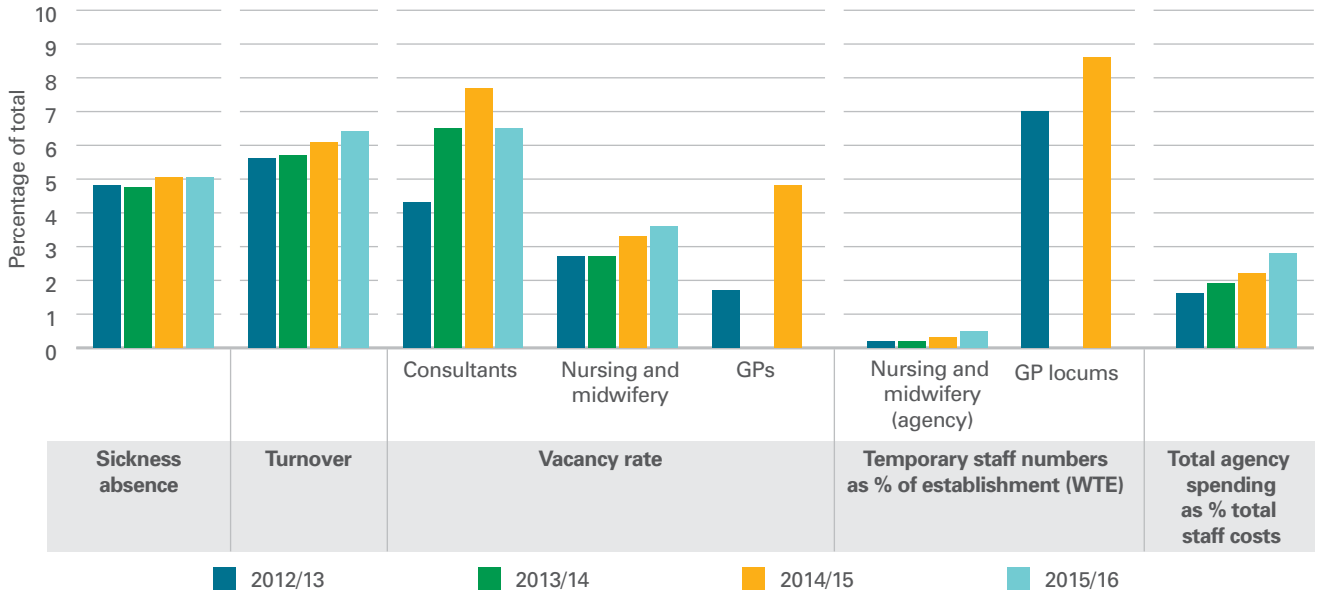
There are challenges filling junior doctor training posts

52. Junior doctors complete two-year foundation training after graduating from medical school. They can then apply for a core training post, which provides general grounding in a particular specialty and lasts around two to three years. After this, they can undertake higher-level specialist training that can ultimately lead to a consultant post. For some specialties, the core and higher-level specialist training is combined into one course, for example GP training.

Exhibit 5

Trends in key workforce indicators, 2012/13 to 2015/16

Rising sickness absence, turnover and vacancy rates are contributing to an increase in NHS boards' spending on high-cost agency staff.



Notes:
1. Sickness absence rate is the number of hours lost as a percentage of total contracted hours. The LDP standard is four per cent.
2. Turnover is the number of WTE leavers divided by staff in post as at 31 March each year.
3. Vacancy rate is the number of vacant posts as a percentage of the establishment.
4. Data on GP vacancy rates and locums was only available for 2013 and 2015.
5. ISD do not publish data on temporary consultant numbers.
6. Total agency spending includes medical, nursing, other clinical and other non-clinical staff.

Source: Audit Scotland using NHS Scotland Workforce Information as at 31 March 2016, ISD Scotland; and for total agency spend, the Scottish Government consolidated accounts, June 2016

53. In 2016, there were 850 foundation year one posts advertised across the NHS in Scotland, with a 100 per cent fill rate. For recruitment and training commencing in August 2016, 820 core and specialty training posts were advertised across the NHS in Scotland. Only 718 of these posts were filled, leaving 12.5 per cent of posts unfilled. Most specialties were filled. The main exceptions were general practice (90 unfilled posts) and psychiatry (11 unfilled posts). This is eight per cent and seven per cent of the total establishment of funded training posts for each of these specialties. This has worsened compared to 2015, where 66 GP training posts and three psychiatry training posts were unfilled (six and two per cent of the training post establishment). For recruitment to higher-level specialty training, 374 posts were advertised. Only 266 of these posts were filled, leaving 29 per cent of posts unfilled. Specialties with the highest unfilled vacancy rates were old age psychiatry (eight posts and 32 per cent of the establishment) and clinical oncology (nine posts and 22 per cent of the establishment). While the unfilled vacancy rate for old age psychiatry is equal to that in 2015, the rate for clinical oncology has worsened since 2015, when it was 15 per cent.[43]

Rising costs for temporary staff are a significant pressure

54. As a result of these recruitment and retention problems, and pressure to meet waiting time targets, the amount NHS boards are spending on temporary staff has increased each year over the last four years. It increased from 1.6 per cent of total staff costs in 2012/13 to 2.8 per cent in 2015/16. In 2015/16, NHS boards spent:

- £135 million on internal bank nursing and midwifery staff, an increase of four per cent compared to 2014/15. The largest percentage increase was at NHS Borders (14 per cent, to £1.8 million) and The State Hospital (16 per cent, to £0.2 million). NHS Greater Glasgow and Clyde spent the highest amount (£48.7 million)

- £23.5 million on agency nursing and midwifery staff, an increase of 47 per cent compared to 2014/15. Spending more than doubled at five boards (NHS Ayrshire and Arran, Borders, Forth Valley, Grampian, and Lanarkshire). Of all territorial boards, NHS Tayside spent the most (£5 million), followed by NHS Lothian (£4.8 million)

- £30 million on internal medical locums, four per cent less than 2014/15. Eight boards spent less on internal medical locums. NHS Borders, Highland, Greater Glasgow and Clyde, Lanarkshire, Orkney and Tayside spent more. In NHS Highland, spending increased by 78 per cent to £2.9 million

- £101 million on agency medical locums, an increase of 33 per cent compared to 2014/15. NHS Lanarkshire saw the biggest percentage increase (80 per cent), to £11 million. NHS Greater Glasgow and Clyde spent the highest amount of £20 million. [44]

55. The increasing use of temporary staff, that can cost significantly more than permanent staff, is putting considerable pressure on NHS boards' budgets and does not represent value for money. For example, in 2015, while the average cost of salaried nursing staff was £36,000 per WTE, agency nursing staff cost more than twice this, at £84,000 per WTE.[45] A review of the use of temporary staff in NHS Greater Glasgow and Clyde by auditors found that the board is using agency medical

locums to cover long-term vacancies. An analysis of the top value invoices by individual agency workers identified a small number of individual consultants being paid over £400,000 to provide cover for periods of less than a year.

56. The Scottish Government launched a national Managed Agency Staffing Network in December 2015 to review temporary staffing across Scotland. It aims to reduce spending, improve the quality and governance of temporary staffing, and roll out good practice. The steering group is exploring several options and has still to identify the level of efficiency savings for 2016/17. Options under consideration include:

- ensuring consistent and reasonable rates for temporary staff
- ensuring nursing and medical staff banks are set up in all boards to reduce the need for higher-cost agency staff
- preventing permanent staff within a board from carrying out some shifts through an agency at considerably higher cost.

Staff shortages and high use of temporary staff can affect quality of care

57. Difficulties in recruiting and retaining staff and greater use of temporary staff may pose risks to patient safety and quality of care. These risks can arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or a lack of staff to provide safe care. As part of its remit, Healthcare Improvement Scotland (HIS) carries out inspections of healthcare facilities, such as scrutiny of safety and cleanliness, and care of older people. Since April 2015, HIS reports have included 12 care of older people inspections, 31 safety and cleanliness inspections, one review of hospital-based clinical care in NHS Lothian and five joint inspections of health and social care conducted with the Care Inspectorate. These reports cover many different issues and the findings are largely positive. We have drawn out the concerns that specifically relate to staffing shortages and the use of temporary staff. Seven care of older people reports stated that vacancies, staff shortages or a high number of bank and agency staff affected quality of care or patient safety. Examples of concerns highlighted in the inspection reports are set out below:

- The review in NHS Lothian was carried out in response to issues highlighted in a complaint made about the care provided in hospital facilities. Failures to adequately document care requirements and care were found. The report stated that it was not possible to be clear if the record keeping or the care provided needed to improve. Examples of poor documentation included records indicating patients with pressure ulcers being left in the same position for most or the whole of a day and patients being fed by tube not receiving the appropriate oral care. The report stated that staff shortages were affecting the time staff were able to spend with patients. This made it difficult for staff to have sufficient time to fully meet individual patient needs and treat them with dignity and respect. Bank and agency staff were used regularly and the board acknowledged that the quality and continuity of care had the potential to be compromised.[46]
- At the Langlands Unit, part of the new Queen Elizabeth University Hospital site in NHS Greater Glasgow and Clyde, an acute stroke and rehabilitation ward was short-staffed each day of the inspection. The absence of a senior charge nurse meant there was a lack of leadership and risks for patient

safety. There were particular issues in relation to poor nutritional care of patients. Some patients on the ward said that there were not enough staff and that nurses were too busy to check up on them or answer their requests for help with toileting or bathing.[47]

- In the Aberdeen Royal Infirmary and Woodend Hospital in NHS Grampian, staff expressed concerns about staff shortages and patient safety. This included being unable to provide sufficient care for patients with pressure ulcers and an increasing number of patient falls.[48]

- In several rural areas, challenges in recruiting and retaining GPs, consultants and community mental health teams were reported to have led to a reduction in the quality of services (Argyll and Bute and Western Isles).[49]

There are major challenges for the future NHS workforce

58. In addition to the current workforce problems, there are a number of challenges for the future. As the general population is ageing, so is the NHS workforce:

- Around one in two community nurses were aged 50 and over, compared with one in three hospital nurses in 2015.[50]

- A third of all GPs and 42 per cent of GP partners were aged 50 and over in 2015.[51]

- At March 2016, 20 per cent of the total of hospital and community medical staff and 37 per cent of nursing and midwifery staff were aged 50 and over. Of all staff groups, support services and administrative services had the highest percentage aged 50 or over (54.6 and 43.9 per cent).[52]

59. We are carrying out a separate audit looking at the NHS workforce in more detail. We plan to publish a report in 2017.

NHS boards continue to struggle to meet key national performance targets

60. The Scottish Government agrees a performance contract with NHS boards through its annual LDP guidance.[53] Within this guidance, the Scottish Government sets out a number of performance targets that NHS boards are required to meet. These are referred to as LDP standards. These LDP targets intend to help achieve the Scottish Government's overall purpose and national outcomes, as well as the quality standards that NHS Scotland seeks to meet. Introducing targets has helped to improve performance within the NHS and reduce waiting times for patients. However, national targets have become more challenging at the same time as finances have been tightening. Over recent years, NHS boards have found it increasingly difficult to meet some of the key performance targets.

61. Overall at March 2016 NHS Scotland failed to meet seven out of eight key targets (Exhibit 6, page 29). The only target met nationally was the drug and alcohol treatment target. The cancer 31 days referral to treatment target was just missed by 0.1 per cent. There has been an improvement in the four-hour A&E target over the last year. At March 2016, NHS Scotland was two per cent below the interim target of 95 per cent. During 2015/16, NHS Ayrshire and Arran, Lanarkshire and Highland particularly struggled to meet performance targets (Exhibit 7, page 30).

Exhibit 6

National performance against key waiting time standards, 2013 to 2016

The national performance has declined in six of the eight key waiting standards over the last four years.

		Year			
Standard		**2013**	**2014**	**2015**	**2016**
A&E, four-hours[1]	98% (95% interim)	91.9	93.3	92.2	93.1
Referral to treatment (RTT), 18-weeks[1]	90%	90.6	89.2	87.8	86.6
Child and Adolescent Mental Health Services (CAMHS), 26-weeks in 2013 and 2014 and 18-weeks thereafter[2]	90%	96.0	91.4	78.9	84.2
Drug and alcohol treatment, three-weeks[2]	90%	94.4	96.0	95.1	94.8
Inpatient/day case appointment treatment time guarantee (TTG), patients who waited less than 12-weeks[2]	100%	98.2	97.0	94.7	92.7
Referral to outpatient appointment, patients waiting less than 12-weeks[2]	100% (95% interim)	96.7	96.9	92.2	88.8
Cancer: 62-day referral to treatment[2]	95%	94.5	91.5	91.8	90.2
Cancer: 31-day decision to treat to first treatment[2]	95%	97.7	96.2	96.5	94.9

Key: Red = standard missed. Green = standard met. Orange = within 5 per cent of standard. Orange = within 5 per cent of interim standard.

Notes:
1. Month-ending March.
2. Quarter-ending March.

Source: Audit Scotland using ISD Scotland data as at June 2016

62. Although none of the 14 territorial boards met all eight key targets, only three boards missed the three-week drug and alcohol treatment target (NHS Highland, Lothian and Shetland). Over half of all territorial boards failed to meet three targets (12-week first outpatient appointment, 12-week treatment time guarantee (TTG), and 62-day cancer referral to treatment). Boards' declining performance against hospital waiting time targets is an indication of the building pressures they are facing from increasing demand.

63. Five out of the 14 territorial boards failed to meet the 18-week children and adolescent mental health services (CAMHS) target. Between March 2015 and 2016, performance against the CAMHS target improved (from 78.9 to 84.2 per cent) but still failed to meet the 90 per cent target. Over the same period, the total number of CAMHS patients seen has increased by four per cent, from 4,269 to 4,436 patients. We plan to carry out an audit in this area in 2017.

Exhibit 7

Comparison of key indicators by NHS territorial board at 2015/16

There is significant variation in the pressures individual boards are facing.

Indicator/ Board	Population aged 75+	Finance				Performance		
		Core revenue outturn (£m)	Total savings made (£m)	Non-recurring savings	NRAC: distance from parity	Treatment Time Guarantee	Treatment Time Guarantee unavailability	Referral to outpatient appointment
Territorial boards								
Ayrshire and Arran	9.3%	703.6	19.1	34.5%	-0.5%	88.3%	14.1%	77.7%
Borders	10.2%	210.2	6.9	59.3%	1.6%	99.2%	17.5%	93.8%
Dumfries and Galloway	10.8%	299.3	8.0	23.4%	3.8%	90.4%	8.9%	95.0%
Fife	8.5%	637.2	18.0	60.0%	-1.1%	97.4%	7.2%	96.5%
Forth Valley	7.9%	515.5	13.7	2.5%	-1.5%	95.8%	12.4%	84.1%
Grampian	7.6%	927.1	25.1	34.6%	-2.0%	88.3%	17.3%	84.6%
Greater Glasgow and Clyde	7.6%	2,197.3	59.6	19.3%	3.0%	99.9%	27.3%	98.7%
Highland	9.5%	639.7	16.0	61.9%	-1.2%	81.0%	8.7%	64.7%
Lanarkshire	7.5%	1,160.9	31.7	26.7%	-1.6%	83.3%	11.2%	93.0%
Lothian	7.2%	1,392.2	30.5	32.7%	-1.2%	94.6%	9.8%	85.4%
Orkney	9.7%	49.1	1.4	35.8%	-1.7%	96.6%	16.5%	71.9%
Shetland	7.9%	52.8	2.2	67.2%	-1.9%	100.0%	53.5%	89.9%
Tayside	9.5%	764.0	23.4	65.2%	-0.1%	83.8%	16.2%	90.1%
Western Isles	11.0%	78.1	2.5	25.5%	7.9%	100.0%	9.0%	90.3%
Scotland	**8.1%**	**9,627.0**	**257.9**	**34.9%**	**N/A**	**92.7%**	**16.8%**	**88.8%**
Key				>50%	<-1%	<95%	>20%	<90%
				20-50%	-1 to 0 %	95-99.9%	10-20%	90-94.9%
				<20%	>0%	100%	<10%	≥95%

Notes:
1. Core revenue outturn and savings data is at 2015/16 financial year end. Non-recurring savings are expressed as a percentage of total savings. NRAC is the NHS Scotland Resource Allocation Committee and is expressed as the percentage distance from parity.
2. Treatment Time Guarantee (TTG) performance is expressed as the percentage of patients who waited less than 12-weeks for an inpatient/ day case appointment for the quarter-ending March 2016. Treatment Time Guarantee unavailability is expressed as the percentage of patients who were unavailable for an appointment for the month-ending March 2016.
3. Referral to outpatient appointment performance is expressed as the percentage of patients waiting less than 12-weeks for the quarter-ending March 2016.

Notes continued...(page 31)

Exhibit 7 continued

	Performance		Workforce					
	Accident and emergency	Change in bed days occupied by delayed discharge patients	Sickness absence rate	Consultant vacancy rate	Change in consultant agency spending	Nursing and midwifery vacancy rate	Change in nursing and midwifery agency spending	Total agency staff costs as % total staff costs
	91.2%	-17.8%	5.01%	13.9%	61.7%	0.4%	125.6%	2.7%
	95.2%	-10.6%	4.36%	7.2%	5.6%	3.7%	103.7%	3.3%
	94.3%	-21.3%	5.08%	14.5%	20.4%	4.4%	-45.7%	6.2%
	95.5%	5.2%	5.12%	12.6%	12.2%	2.4%	-19.6%	2.9%
	92.0%	-13.2%	5.10%	3.6%	4.6%	3.4%	116.3%	2.4%
	96.1%	-17.4%	4.62%	6.2%	72.6%	7.3%	110.0%	3.4%
	90.5%	-30.5%	5.39%	3.9%	29.5%	4.3%	86.4%	2.0%
	97.0%	11.9%	5.09%	6.1%	40.5%	5.4%	41.5%	4.3%
	91.9%	16.1%	5.20%	10.1%	-28.2%	3.3%	183.1%	3.3%
	92.1%	-10.9%	5.02%	3.5%	79.6%	1.6%	-11.6%	3.0%
	98.8%	54.6%	5.10%	37.0%	62.9%	8.8%	-100.0%	5.2%
	96.5%	-56.9%	5.20%	0.0%	-68.6%	8.1%	-37.4%	6.8%
	99.2%	12.0%	5.04%	6.9%	14.8%	2.9%	61.3%	1.9%
	99.5%	-2.1%	5.93%	0.0%	76.2%	0.8%	*	6.2%
	93.1%	**-8.9%**	**5.16%**	**6.5%**	**32.9%**	**3.6%**	**46.6%**	**2.8%**
	<90%	>0%	>5%	>10%	>50%	>10%	>50%	>3%
	90-94.9%		4-5%	5-10%	0-50%	5-10%	0-50%	1-3%
	≥95%	<0%	<4%	<5%	<0%	<5%	<0%	<1%

4. Accident and emergency performance is expressed as the percentage of patients who waited less than four hours to be seen in March 2016.
5. Change in the number of bed days occupied by delayed discharge patients is expressed as the annual percentage change between 2014/15 and 2015/16.
6. Sickness absence is the number of hours lost as a percentage of the total contracted hours in 2015/16. The LDP standard for this is four per cent.
7. Vacancy rates are expressed as a percentage of the establishment at March 2016.
8. Agency spending is expressed as the percentage change in spend between 2014/15 and 2015/16. *NHS Western Isles spent £0 on nursing and midwifery agency costs in 2014/15, but £158,000 in 2015/16.
9. The key is based on Audit Scotland's assessment of the performance of boards against each indicator.

Source: Audit Scotland using financial data from the Scottish Government financial reports and consolidated accounts, performance and workforce data from ISD Scotland, and agency spend data using information provided by individual NHS boards.

64. NHS boards can record patients waiting for outpatient or inpatient treatment as being unavailable for treatment. This means that the period when a patient is unavailable for treatment or unable to attend an appointment is not included in the patient's overall waiting time. The national average in March 2016 was 17 per cent, which is a slight improvement from 18.5 per cent in March 2015. The main reasons for patients being unavailable were personal commitments (22 per cent), other medical conditions (22 per cent), patients requesting a named consultant (23 per cent) and patients requesting to be treated within their local NHS board (14 per cent).

65. The trend in reasons for unavailability has been fairly consistent since April 2014. Patient unavailability against the TTG standard at March 2016 was highest at NHS Shetland (54 per cent), NHS Greater Glasgow and Clyde (27 per cent) and NHS Borders (17 per cent). NHS Greater Glasgow and Clyde has consistently been one of the top three boards for patient unavailability throughout the year. The board recorded the main reasons for patient unavailability as patients requesting a named consultant (44 per cent of unavailable patients), followed by patients requesting to be treated within their local NHS board (22 per cent of unavailable patients).

66. The target that no patient should wait in hospital for more than 14 days from when they are clinically ready for discharge was not met by any board throughout 2015/16. An exception was in NHS Borders, Orkney and Shetland in some months of the year. However, there have been some improvements in performance compared to 2014/15:

- At March 2016, 49 per cent of patients delayed for discharge from hospital were delayed for more than 14 days, a slight improvement from 51 per cent at March 2015 (excluding code 9 delays).[54]

- The total number of bed days occupied by delayed discharge patients in 2015/16 reduced by nine per cent compared to 2014/15, from 623,438 to 567,853. However, this pattern masks wide variation among boards.

- In 2015/16, the overall delayed discharge bed day rate per 1,000 population aged 75 and over was 915. This is a 12.5 per cent reduction from 1,044 in 2014/15.

67. There have also been improvements in performance against some other targets. This includes more people in deprived areas stopping smoking and an increasing proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer. Performance against the target that at least 80 per cent of pregnant women will have booked for antenatal care by the twelfth week of gestation was exceeded in 2014/15, at just over 82 per cent (data for 2015/16 is still to be published). NHS boards are also trying to reduce their spending on the private sector. Boards use the private sector to increase short-term capacity and when specialist treatment is not available in the NHS. Private sector spending does not include agency staff costs. Since 2010/11, NHS spending on using the private sector increased by 18 per cent in real terms, from £69.5 million to £81.8 million in 2015/16 (0.7 per cent of total revenue expenditure). However, this reduced over the last year by four per cent from £85.3 million in 2014/15.

68. The Scottish Government has a strong focus on national targets. We have commented in previous reports about the extensive effort that NHS boards put into meeting these targets. NHS boards are under significant pressure to meet hospital waiting time targets, in particular. This does not help to support the overall strategy of moving to more community-based care. Funding is focused on meeting acute targets and it is unclear what the unmet need in the community is as this is not measured. Most boards are overspending on their acute budgets. Some NHS boards have agreed with their Boards that they face risks in continuing to achieve performance targets while remaining in financial balance and meeting financial targets (NHS Ayrshire and Arran, Lothian and Grampian).

69. The Scottish Government announced in June 2016 that it will review national NHS targets. The review's aim is to ensure the targets deliver better outcomes for patients and make best use of NHS resources. It will also look at how targets help to deliver the national strategy for the future direction of NHS and social care services. An expert group will be set up to lead the review and work with staff, stakeholders, social care and clinical bodies. The group is due to report its findings by early 2017.

Part 2

Service reform

Key messages

1. The NHS is undergoing significant changes in how it delivers its services. This is at a time of great uncertainty about the detail and implications of many of the changes planned, and while it is facing considerable financial challenges.

2. The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. But most spending is still on hospitals and other institutional-based care.

3. New integration authorities are still developing and some progress is being made in shifting to new models of care, but it is not happening fast enough to meet the growing need. Effective leadership and a clear plan are required to manage the change.

the NHS is undergoing significant change, but the shift to more community-based services is slow

The NHS is undergoing significant change

70. Over the last decade, there have been improvements in the way services are delivered and reductions in the time that patients wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. However, the health of Scotland's population is still poor compared to other developed countries and significant health inequalities still exist. A review of public health in Scotland states that 'The population health challenge remains complex and persistent and current measures are not seen to be sufficiently accelerating improvement in the country's public health.' The report highlights that in Scotland there:

- is lower life expectancy than our European counterparts, with no single explanation
- are high levels of preventable death, disease and poor health in the ageing population
- are continued increases in the numbers of overweight and obese people, which could overturn life expectancy gains achieved in recent decades
- are high levels of poor health from multiple conditions, in particular of people with both physical and mental health conditions.[55]

71. The NHS in Scotland is undergoing major reform. A number of significant changes to the way health and social care services are delivered are under way or planned. These include:

- national policy aimed at transforming the way services are delivered, including shifting the balance of care from hospital-based services to more community-based services:
  - 2020 Vision for health and social care
  - National Clinical Strategy
- integrating health and social care services
- a new GP contract from April 2017
- a review of the current structure of NHS boards.

72. The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. In 2004, the then Scottish Executive commissioned an expert group to consider the necessary changes required to 'build a health service for the future'. The report, published in 2005, made various recommendations and outlined a new way of delivering care to expand services in the community and deliver care as locally as possible and as specialised as necessary. It highlighted the need for a whole-system approach with partnership working and better integration of primary, secondary and social care.[56]

73. In response, the Scottish Executive set out an action plan that aimed to shift the balance of care through Community Health Partnerships (CHPs) and expanding community services. It identified four main priority areas for investment and reform to transform the NHS:

- the NHS is as local as possible
- systematic support for people with long-term conditions
- reducing the inequalities gap
- actively managing hospital admissions.

74. In September 2011, the Scottish Government set out an ambition to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[57] This restated many of the aims set out by the Scottish Executive in 2005. These were to have a healthcare system with integrated health and social care, and a focus on preventing and anticipating problems, and helping people to manage their conditions. Two years later, the Scottish Government set out high-level priority areas for action during 2013/14 for its 2020 Vision for health and social care.[58]

75. In June 2015, the Cabinet Secretary for Health and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress towards delivering the 2020 Vision. The Scottish Government published a National Clinical Strategy in February 2016, including new measures for delivering the 2020 Vision and setting out its plans for health and social care in Scotland over the next ten to 15 years.[59] It describes a number of new proposals and changes to current services. This includes the following:

- GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities
- a new structure for a network of hospital services with more specialties planned and provided on a regional or national basis
- the development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres
- a strong focus on the need to reduce waste, harm and variation in treatment and to make more use of technology to support and improve care.

76. The Scottish Government has introduced several major strategies, reviews and reform since 2015 aimed at addressing the changing needs of the population and improving health (Exhibit 8, page 37).

The Scottish Government's long-term aim to shift the balance of care has still to be realised

77. Since 2005, there have been improvements in the way services are delivered with more of a focus on developing community services. There have been reductions in the time that patients wait for hospital inpatient treatment and the length of time they stay in hospital. There has also been a shift to more day case and outpatient treatment. There have been improvements in overall health, life expectancy and survival rates for a number of conditions, such as heart disease. However, there has not been a significant shift in the balance of care.

78. The latest available figures show that in 2014/15, for health and social care combined, 56 per cent of spending was on hospital care, care homes and other accommodation-based social care, compared to 44 per cent spent on community-based care. For the NHS alone, 62 per cent of expenditure was for hospital services, compared to 38 per cent spent on community health services. These percentages have remained the same for the last five years and most spending is still on hospitals and other institutional-based care.[60]

79. It is not clear what the Scottish Government's aim of shifting the balance of care looks like and how it will be achieved. But indications of a shift would include reducing A&E attendances, emergency admissions to hospital and delayed discharges from hospital. This will require either reducing acute spending to shift resources into the community, or investing additional resources in the community while maintaining spending on acute services. The NHS cannot continue to do everything within the current resources and needs to slow the rate of growth of hospital demand. In Canterbury, New Zealand, spending was prioritised on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community. We provide more information on this on page 31 of our *Changing models of health and social care* report and Case study 10 of the accompanying supplement.

Exhibit 8

Key national NHS policy and service reform in Scotland

There are many national policies and reforms that NHS boards are expected to deliver, working with integration authorities, councils and other partners.

Overarching policy

Quality Strategy (May 2010)
The three quality ambitions – safe, patient-centred and effective – underpin all healthcare policy

2020 Vision for health and social care (September 2011)
The overall aim is to provide care closer to home or in a homely setting

Everyone Matters: 2020 Workforce Vision (June 2013)
Sets out a vision of what will be required from the workforce

Health and social care integration
All integration authorities were in place by April 2016. They are expected to coordinate health and care services to improve outcomes for their local population

National Clinical Strategy (February 2016)
Includes new measures for delivering the 2020 Vision
Sets out plans for health and social care over the next 10-15 years

- A new structure for a network of hospital services with more specialties planned and provided on a regional or national basis
- Development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres
- GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities

Consultation with the public

Creating a healthier Scotland: What matters to you? (March 2016)
Consultation with people who use or work in health and social care services

Our Voice (June 2016)
To support people to get involved in planning and improving health and social care services

Changes to General Practice Contract

Removal of the quality and outcomes framework (QOF) – April 2015

Groups of GP practices (clusters) in local areas working together more closely and setting clear outcomes focusing on providing integrated care – during 2016/17

New GP contract from April 2017

National strategies and reports

Realistic Medicine (January 2016)
Chief Medical Officer report focusing on reducing waste, harm and variation in treatment

Palliative Care Framework (December 2015)
Sets out a vision for the next 5 years, with outcomes and 10 commitments to support improvements in the delivery of palliative and end-of-life care

Cancer Strategy (March 2016)
Sets out ambitions and actions in 7 key areas, including prevention, improving survival, early detection and diagnosis, and improving treatment

6 Essential Actions to Improving Unscheduled Care (May 2015)
A national two-year programme which aims to improve unscheduled care

Review of Public Health (February 2016)
Highlights that the health of Scotland's population is still poor and significant health inequalities still exist
Makes recommendations for development of a national public health strategy

7-day Services Interim Report (March 2015)
Considers the implications of delivering a sustainable seven-day clinical service across NHS Scotland and includes proposals for working towards achieving it

Mental Health Strategy Consultation (July 2016)
Proposed framework and priorities for mental health for the next ten years
Strategy due to be published in late 2016

Out-of-Hours Review (November 2015)
Recommends a model for out-of-hours and urgent care in the community
Delivery plan due to be published in late 2016, with £10 million funding

Source: Audit Scotland

80. The population is growing and ageing, and people are living longer with multiple conditions and more complex needs. This is putting increasing pressure on NHS boards' finances, as funding is not keeping pace with the increasing needs of the population. Demand for hospital services continues to rise. This makes it difficult for NHS boards to release resources to invest in more community-based services. At the same time, demand for community services, such as GP appointments, is also rising (Exhibit 9). But there are not significant additional resources available.

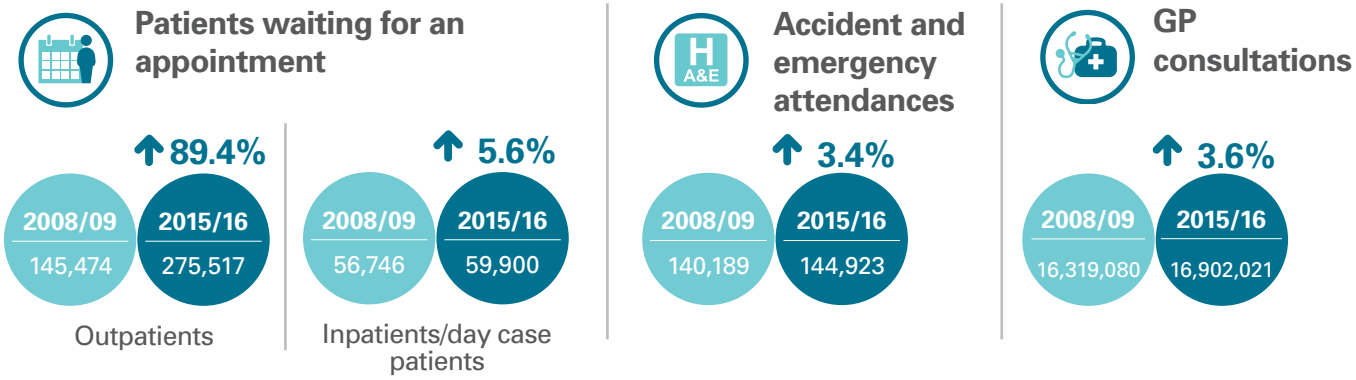
New integration authorities are still developing

81. Integrating health and social care is central to delivering transformational change and shifting the balance of care from hospitals to more homely and community-based settings. Under new arrangements for health and social care, NHS boards and councils are required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. This accounts for more than £8 billion of funding that NHS boards and councils previously managed separately. The new integration authorities are expected to coordinate health and care services, and to commission NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided, with a greater emphasis on preventative services. This means providing care for people in their home or local community, and reducing admissions to hospital. Our recent report on progress towards integration of health and social care services sets out the structure and requirements of integration authorities in more detail.[61]

Exhibit 9

Indicators of demand for NHS services, 2008/09 to 2015/16

Demand for NHS services in Scotland continues to increase.



Notes:
1. Outpatients waiting: the number of patients waiting for an outpatient appointment at March.
2. Inpatients waiting: the number of inpatient or day case patients waiting for an appointment at March.
3. Accident and emergency attendances: the number of patients that attended Accident and Emergency in March.
4. GP consultations: The number of GP consultations carried out in that year. Data is actual for 2008/09, but projected for 2015/16 using the same figures as the Changing models of health and social care report, Audit Scotland, March 2016.
5. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.

Source: Audit Scotland using ISD Scotland data as at June 2016

82. All 31 integration authorities were operational by the statutory deadline of 1 April 2016.[62] However, there have been difficulties in agreeing budgets and delays in developing comprehensive strategic plans. Councils normally set their budgets by February, whereas many NHS boards do not finalise their budgets until June. In April 2016, integrated joint boards (IJBs) in five NHS board areas had not yet finalised their budgets (Fife, Lanarkshire, Lothian, Orkney and Tayside). None of the integration authorities have set budgets for future years, although some have indicative budgets. For 2016/17, the amount that NHS boards delegated to integration authorities and the total income that NHS boards received from their integration authorities was either the same, or almost the same. This indicates there has been little change in the way services are being provided during 2016/17.

83. As at April 2016, most integration authorities were still developing performance management frameworks and establishing how progress towards delivering the national outcomes for health and wellbeing will be measured.[63] Dumfries and Galloway IJB has agreed a three-year workforce plan, but workforce plans covering more than one year have still to be developed in other integration authorities. The governance arrangements for integration authorities can be complex and in several NHS board areas there are different reporting regimes in place. In some areas, local auditors of NHS boards highlighted the governance arrangements, such as roles, responsibilities and oversight, as a risk (Borders, Fife, and Lanarkshire). Local auditors also highlighted that reporting arrangements between NHS boards and the IJBs need to improve (Lanarkshire and Greater Glasgow and Clyde).

84. NHS boards in some areas have highlighted challenges they are facing owing to the way IJBs are operating in their area. These include:

- difficulties in decision-making – where IJBs have different views or priorities from each other or from the NHS board. It can also take a lot longer to reach decisions if separate discussions are being held in the NHS board and the IJBs. In Grampian, a senior leadership team, with representation from the NHS board and three IJBs, meets quarterly to review performance and make joint decisions about services

- a potential for services to become fragmented – some services are board-wide but decisions about how they are provided have to be agreed across multiple IJBs. In Ayrshire and Arran, each of the three IJBs host different specialist services on behalf of the other IJBs, such as inpatient mental health services. The board reports that this is often more practical and cost-effective than setting up separate arrangements to deliver services for individual IJBs

- clarity of operational and strategic responsibilities – accountability is not always clear, particularly when issues affect services that are not required to be delegated to the IJB. For example, delayed discharges involve a wide range of hospital specialties. In most IJBs, hospital services included in integration are those inpatient medical specialties which have the largest proportion of emergency admissions to hospital. Other hospital specialties are often not included. Argyll and Bute IJB and Dumfries and Galloway IJB are overseeing all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

85. During 2015/16, a lot of time and effort was put into setting up the new bodies. Although integration authorities are now operational, there is still considerable work to do to ensure they are operating effectively. It is important for integration authorities to get these arrangements working, so they can focus on delivering their objectives and work towards improving outcomes for their local populations. It is therefore unlikely they will make a major impact during 2016/17. We plan to carry out further work on the progress made by integration authorities after their first year of being established and on their longer-term impact.

Some progress is being made in developing approaches to transformational change

86. In our report *Changing models of health and social care*, we highlighted that the shift to new models of care, that is transforming how care services are provided, is not happening fast enough to meet the growing need. We found that the new models of care in place were generally small-scale and were not widespread. We also recommended that the Scottish Government develops a clear framework to guide local development and consolidate evidence of what works. NHS boards and integration authorities also need to ensure that new models for how they provide care are properly planned, implemented, monitored and evaluated. This is to ensure they provide value for money and sustainability.

87. Although there is still limited evidence of transformational change, some progress is being made in developing approaches that aim to enable more change to happen:

- Testing new models of care in the community – in May 2016, the Scottish Government allocated £20 million of primary care transformation funding plus £10 million of mental health funding to NHS boards to test new ways of working. It is also supporting ten primary and community care 'test sites'.[64] The Scottish Government is providing support and advice to local areas in how to monitor and evaluate projects. It is also coordinating regional and national events to ensure learning is shared. It is still too early to see benefits or improved outcomes from these new models, but the Scottish Government is developing a framework to consolidate emerging evidence.

- Primary care teams to play a lead role – this approach is being tested in local areas. The new GP contract has still to be agreed. It needs to recognise and support the role of general practice in helping to implement the changes required to shift the balance of care. GPs are taking on more strategic roles and working with new integration authorities to help lead change. During 2016/17, a new approach is being introduced that requires groups of GP practices (clusters) in local areas to work together more closely. GP clusters are required to agree a clear set of outcomes with local partners, such as the NHS board and integration authorities, that focus on providing integrated services that benefit patients.

- Realistic medicine – the Chief Medical Officer's annual report and the National Clinical Strategy outline the need to reduce waste, harm and variation in treatment. There is evidence of oversupply of some services or interventions, including some that are of limited value. It is estimated that up to 20 per cent of mainstream clinical practice brings no benefit to the patient. This includes increased over-investigation and treatment, prescribing multiple drugs that are of limited benefit and lead to excessive

side-effects, surgical procedures with low benefits to patients, and clinical variation that is not reasonably explained by patient need.[65] The Scottish Government is working with NHS boards to resolve these issues. It is also trying to ensure patients are more involved in making decisions and receive better information about potential treatments to enable them to make informed decisions.

- **Improving efficiency** – NHS boards will need to make unprecedented levels of savings in 2016/17 and identifying recurring savings is becoming increasingly difficult. However, it is recognised that there is still significant variation among boards and opportunities for further efficiencies to be made. This includes making better use of technology. A national sustainability and value programme board has been set up (paragraph 20, page 13). The Cabinet Secretary for Health and Sport has also committed to review the number, structure and roles of NHS boards. The timescales for this are not clear yet. The National Clinical Strategy sets out a case for reorganising services. This includes reducing the number of hospitals providing more specialist services and reducing the number of acute sites. These measures aim to make hospital services more efficient and will potentially release resources that could be invested into the community. However, this will take a considerable period of time to put in place. High levels of investment will also be required over the coming years to fund the proposed new diagnostic and treatment centres, due to be completed by 2021/22, and trauma centres. The Golden Jubilee National Hospital is aiming to complete the initial phase of the expansion of its diagnostic and treatment centre by the end of 2016/17. An investment in MRI scanners will provide an additional 10,000 scans per year from 2017/18. The Golden Jubilee is also testing new ways of working to roll out across Scotland, for example learning from an approach in India in treating cataracts with the potential to improve efficiency and outcomes for patients.

A clear plan for change is needed

88. We have previously reported that the Scottish Government is not making sufficient progress in achieving its policy aim of shifting the balance of care or keeping pace with the changing needs of the population.[66] The 2020 Vision lacks a clear framework of how it expects NHS boards and councils to achieve this in practice, and there are no clear measures of success, such as milestones and indicators to measure progress. The cost implications of implementing the 2020 Vision are unknown and there is a lack of detail about the main principles of the policy. There is also slow progress in developing the workforce needed for new models of care and a lack of information about capital investment to support the 2020 Vision.

89. The National Clinical Strategy includes new measures for delivering the 2020 Vision and also comments on how health care in Scotland is likely to develop beyond 2020. The new strategy continues to focus on providing more care and support in the community and people being able to live longer, healthier lives at home, or in a homely setting. However, there is also a major focus on hospital services. There is currently considerable uncertainty about the implications of this strategy and other proposed changes. This includes the new GP contract, new models of care, review of NHS board structures and review of national targets. This makes capacity planning particularly challenging for NHS boards as it is not yet clear what resources are needed for the many new models

of care proposed in various strategies. Implementation of the strategy needs to incorporate the principles of the Scottish Government's wider public service reform. This focuses on prevention and tackling inequalities, working closely with the public to help improve services and meet the needs of communities, and effective partnership working across the public, third and private sectors. Integration authorities in particular will have an important role to play in helping to deliver public service reform.

90. The Scottish Government carried out a consultation with people who use or work in health and social care services during 2015/16 and published a summary of the findings in March 2016.[67] The Scottish Government has committed to consider the findings when developing existing and future policy. In June 2016, the Cabinet Secretary for Health and Sport launched 'Our Voice', an approach to support people to get involved in planning and improving health and social care services at an individual, community and national level.[68]

91. The Scottish Government has set up a transformational change programme board with the aim of accelerating progress towards the 2020 Vision. It has membership from across the Scottish Government health directorate, NHS boards, integration authorities, councils, the third sector (such as charities and voluntary groups), and people who use health and social care services. In addition to the National Clinical Strategy, the programme board has identified a number of areas that it will focus on to help to make change happen. It is reviewing the current position with each of these strands and then plans to identify priorities for implementing change. These are:

- public health reform
- health and social care integration
- supporting the wellbeing of children and young people.

92. Many elements of the National Clinical Strategy remain uncertain and a clear plan has yet to be put in place:

- There are no measures or milestones in place that will allow progress to be measured against the strategy.
- The financial implications of implementing the strategy are unknown and it is unclear what funding will be available for it.
- The implications for the workforce have still to be identified. This includes the numbers of various professions, training and skills required for the new ways of working outlined in the strategy.

93. Evidence is still emerging about new models of care, including the impact and outcomes of proposed new ways of working. It is important that the new models of care being tested are properly evaluated and the cost implications fully understood. New ways of working need to be sustainable and affordable within current financial constraints. The Scottish Government, in partnership with NHS boards and integration authorities, should use financial modelling to estimate the cost of implementing its national strategy and how this will be funded. It is challenging for boards to make significant changes to services while continuing to react to immediate pressures. But this makes it more important than ever

to find more efficient ways of working. There also needs to be a real focus on implementing more preventative measures to reduce admissions to hospital. Increasing demand for hospitals is putting more pressure on NHS boards' acute budgets each year. It is also better for patients to be treated in the community in a more homely setting where possible.

94. The workforce is critical to delivering new models of care. The right staff, with the right skills, need to be available to provide the new ways of working. However, it is not clear yet what number and levels of staff will be required until further work is done on testing new models and a clearer plan is in place. The Scottish Government has published a workforce implementation plan for 2016/17. It states that activity will focus on identifying workforce actions to help tackle health inequalities across Scotland; and developing a workforce to deliver integrated health and social care services across NHS boards, councils and third party providers. However, the plan is high level and does not outline the workforce requirements to deliver the 2020 Vision and the National Clinical Strategy.

95. Each NHS board is required to produce its own workforce plan. Many of these acknowledge the changes that will be required to deliver the national strategies, but they are still working on more detailed plans. There is a lack of long-term workforce planning (more than five years) and many boards' plans do not sufficiently address problems with recruitment and retention or succession planning. A clear plan for the workforce must be a priority for the programme board. The time to train new staff varies, but it takes several years (at least seven years to train a junior doctor), and this needs to be built into workforce plans. In their manifesto, Scottish ministers have committed to introduce a national and regional workforce planning system across the NHS in Scotland.

96. The King's Fund, drawing on learning from high-performing healthcare organisations across the world, has identified key areas for reforming the NHS in England. However, the principles identified about what needs to be done to implement new models of care in the medium and longer term are applicable to NHS organisations across the UK. These include:

- engaging doctors, nurses and other staff in improvement programmes
- investing in staff to enable them to achieve continuous quality improvement in the long term so improvement is based on commitment rather than compliance
- recognising the importance of leadership continuity, organisational stability, a clear vision and goals for improvement, and the use of an explicit improvement methodology
- the need for leadership in NHS organisations to be collective and distributed, with skilled clinical leaders working alongside experienced managers
- NHS organisations prioritising leadership development and training (preferably in-house) in quality-improvement methods.[69]

Endnotes

1 *Scotland's Spending Plans and Draft Budget 2016-17*, Scottish Government, December 2015.

2 Real terms figures have been calculated using *GDP deflators at market prices, and money GDP: June 2016 (Quarterly National Accounts)*, National Statistics, July 2016.

3 *Economic assumptions 2016/17 to 2020/21,* NHS England, March 2016.

4 IRF – NHS Scotland and Local Authority Social Care Expenditure – Financial Years 2010/11–2013/14, ISD Scotland, March 2015; SMR01 activity analysis provided to Audit Scotland by ISD, November 2015.

5 Audit Scotland using *Mid-year population estimates: Scotland and its NHS Board areas by single year of age and sex: 1981 to 2015,* National Records of Scotland, April 2016.

6 *Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2016,* ISD Scotland, June 2016. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.

7 These figures exclude non-core funding which is provided to boards for unpredictable costs such as capital and pension accounting adjustments.

8 *The 2015/16 audit of NHS Tayside: Financial sustainability*, Audit Scotland, October 2016; *The 2015/16 audit of NHS 24: Update on management of an IT contract*, Audit Scotland, October 2016.

9 *2015/16 Annual Audit Report for the Board of NHS Ayrshire and Arran and the Auditor General for Scotland*, Audit Scotland, June 2016.

10 *2015/16 Annual Audit Report for the Board of NHS Shetland and the Auditor General for Scotland*, Audit Scotland, June 2016.

11 *Annual State of NHS Scotland: Assets and Facilities Report for 2015,* Scottish Government, August 2016.

12 The increase of £101 million in the maintenance backlog includes an adjustment for inflation (this was not applied in previous years). It also includes a real-terms reduction of around £40 million in most NHS boards' backlog position in 2015. NHS Greater Glasgow and Clyde has identified around £50 million of new maintenance from recent surveys.

13 Investment planned for new hospitals: completion of the Queen Elizabeth University Hospital, Royal Edinburgh Hospital, Royal Hospital for Sick Children in NHS Lothian, East Lothian Community Hospital, new hospitals in NHS Dumfries and Galloway, Highland and Orkney.

14 *Changing models of health and social care*, Audit Scotland, March 2016.

15 Thirteen out of the 14 territorial NHS boards in Scotland included drug costs as a financial risk in their LDPs.

16 2015/16 data on total spending by the NHS in Scotland on drugs in hospitals and the community is not available until November 2016. However, 2015/16 data is available on the cost of NHS prescriptions dispensed in the community (£1.1 billion). Also, ISD provided Audit Scotland with data on the top ten drugs used in hospitals for 2015/16.

17 *Costs book – drugs*, ISD Scotland, November 2015.

18 This statistic relates to items reimbursed. ISD data provided to Audit Scotland, August 2016.

19 *A National Clinical Strategy for Scotland,* Scottish Government, 2016.

20 A generic, or unbranded, drug is comparable to the equivalent branded drug in dosage, strength and quality but is usually cheaper. Prescribing by generic name ensures that when a product comes out of patent, generic drugs/devices can be dispensed against the prescriptions, allowing savings to be realised without any change having to be made to the prescription.

21 *Better value in the NHS: the role of changes in clinical practice,* The King's Fund, 2015.

22 *Prescribing in general practice in Scotland*, Audit Scotland, January 2013.

23 Information provided to Audit Scotland from ISD Scotland, July 2016.

24 *Chief Medical Officer's Annual Report 2014-15: Realistic Medicine,* Scottish Government, January 2016.

25 *Global outlook: Healthcare,* The Economist Intelligence Unit, March 2014.

26 The cost of all patented drugs is regulated at a UK level to reduce the cost to the taxpayer. The NHS does not cap the price of generic drugs because they are meant to be widely available with prices driven down through competition.

27 ISD data provided to Audit Scotland, August 2016.

28 *Health Service Medical Supplies (Costs) Bill Factsheet,* Department of Health, 2016.

29 *Access to newly licensed medicines progress update, Health Improvement Scotland, HS/S4/16/12/1,* Health and Sport Committee, Scottish Parliament, 1 March 2016.

30 ISD data provided to Audit Scotland, August 2016. This figure relates to drugs dispensed in the community.

31 ISD analysis for the Scottish Government, provided to Audit Scotland, August 2016. This relates to drugs dispensed in the community and in hospitals.

32 *Guidance on horizon scanning process,* Scottish Medicines Consortium, 2015.

33 The New Medicines Fund is funded from rebate payments from the UK Pharmaceutical Price Regulation Scheme (PPRS). The receipts for Scotland from this scheme have not yet been finalised for 2016/17.

34 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, June 2016. For March 2016, there was a coding issue which excluded a small number of staff (approximately 200 WTE) on fixed term secondments within NHS boards. NHS Tayside figures were affected by this the most.

35 *NHS consolidated accounts*, Scottish Government, June 2016.

36 *NHS Scotland Staff Survey 2015 National report,* Scottish Government, November 2015.

37 *The future of general practice - survey results,* British Medical Association (BMA), February 2015.

38 *Vacancies – NHS Scotland Workforce Information - as at 31 March 2016,* ISD, June 2016.

39 ISD consultant 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.

40 *Primary Care Workforce Survey Scotland 2015,* ISD Scotland, June 2016.

41 Information provided by NHS boards to auditors, June 2016.

42 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, June 2016.

43 *Information on the national recruitment for junior doctors in Scotland in 2016,* NHS Education for Scotland, July 2016.

44 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, 2016; and information provided by NHS boards to auditors, June 2016.

45 *Scottish Health Service Costs year ended 31 March 2015,* and NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland.

46 *Review of hospital-based complex clinical care: NHS Lothian,* HIS, May 2016.

47 *Unannounced Inspection Report – Care for Older People in Acute Hospitals: Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde,* HIS, December 2015.

48 *Unannounced Inspection Report – Care for Older People in Acute Hospitals: Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian,* HIS, November 2015.

49 *Services for older people in Argyll and Bute; Services for older people in the Shetland Islands; Services for older people in the Western Isles: Reports of a joint inspection of health and social work services for older people,* The Care Inspectorate and HIS, February 2016, November 2015 and March 2016.

50 *Community nursing staff in post and vacancies,* ISD Scotland, June 2015; *Nursing and midwifery staff in post,* ISD Scotland, September 2015.

51 *Number of GPs in Scotland by age, designation and gender,* ISD Scotland, December 2015.

52 *Overall NHS Scotland workforce summary by staff grouping,* ISD Scotland, June 2016.

53 *Local Delivery Plan Guidance 2016/17,* Scottish Government, January 2016.

54 Patients recorded under 'code 9' are those with complex needs. This includes patients delayed due to waiting for a place in a high-level needs specialist facility where no facilities exist or where an adult may lack capacity under adults with incapacity legislation.

55 *2015 Review of Public Health in Scotland: Strengthening the function and re-focusing action for a healthier Scotland,* Scottish Government, February 2016.

56 *A National Framework for Service Change in the NHS in Scotland,* Scottish Executive, May 2005.

57 *2020 Vision: Strategic Narrative,* Scottish Government, September 2011.

58 *Route map to the 2020 Vision for health and social care,* Scottish Government, May 2013.

59 *A National Clinical Strategy for Scotland,* Scottish Government, February 2016.

60 *IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2014/15,* ISD Scotland, March 2015 and May 2016.

61 *Health and social care integration: Progress update*, Audit Scotland, December 2015.

62 All areas, apart from Highland, are following the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, continuing arrangements established in earlier years for integrated services. In this model, the NHS board and the council delegate some of their functions to each other.

63 The national health and wellbeing outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and improving quality across health and social care. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

64 *A Stronger Scotland: The Government's Programme for Scotland 2015-16,* Scottish Government, September 2015.

65 *Chief Medical Officer's Annual Report 2014-15: Realistic Medicine,* Scottish Government, January 2016.

66 *Changing models of health and social care*, Audit Scotland, March 2016.

67 *Creating a healthier Scotland: What matters to you?*, Scottish Government, March 2016.

68 https://ourvoice.scot/

69 *Reforming the NHS from within: Beyond hierarchy, inspection and markets,* The King's Fund, June 2014.

Appendix

NHS financial performance 2015/16

	£(000)			£(000)		
NHS board	**Revenue Resource Limit**	**Outturn**	**Variance**	**Capital Resource Limit**	**Outturn**	**Variance**
Ayrshire and Arran	725,762	725,697	65	43,409	43,408	1
Borders	214,209	214,119	90	2,375	2,369	6
Dumfries and Galloway	306,487	306,427	60	60,075	60,058	17
Fife	665,244	665,010	234	12,552	12,550	2
Forth Valley	533,973	533,772	201	3,894	3,894	0
Grampian	963,459	963,316	143	11,249	11,249	0
Greater Glasgow and Clyde	2,311,134	2,310,894	240	81,370	81,344	26
Highland	662,779	662,680	99	10,925	10,925	0
Lanarkshire	1,187,796	1,187,515	281	33,210	33,210	0
Lothian	1,462,183	1,461,834	349	107,875	107,875	0
Orkney	50,290	50,118	172	2,688	2,541	147
Shetland	54,992	54,593	399	362	286	76
Tayside	809,022	808,877	145	11,090	11,090	0
Western Isles	80,065	80,060	5	1,640	1,639	1
Territorials total	10,027,395	10,024,912	2,483	382,714	382,438	276
National Services Scotland	405,066	404,324	742	27,182	27,150	32
The Scottish Ambulance Service	227,688	227,634	54	10,773	10,772	1
NHS Education for Scotland	432,775	432,372	403	712	702	10
NHS 24	74,237	74,182	55	90	87	3
National Waiting Times Centre	70,112	70,112	0	6,387	6,387	0
The State Hospital	21,240	21,229	11	300	271	29
NHS Health Scotland	19,925	19,699	226	100	53	47
Healthcare Improvement Scotland	23,004	22,599	405	50	50	0
Mental Welfare Commission	4,417	4,417	0	0	0	0
Specials total	1,278,464	1,276,568	1,896	45,594	45,472	122
Total	**11,305,859**	**11,301,480**	**4,379**	**428,308**	**427,910**	**398**

Note: Figures include core and non-core revenue and capital funding (resource limit) and expenditure (outturn).
Source: Scottish Government consolidated accounts, June 2016

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