

# NHS in Scotland 2017



AUDITOR GENERAL 

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# NHS in Scotland 2017


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-  PDF download
  -  Web link
  -  Interactive Tableau exhibit, where further information can be viewed at an NHS board level

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## Exhibit data

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

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# Summary



## Key messages

- 1** Every day the NHS provides vital services to thousands of people across Scotland. It has a budget of around £13 billion each year, equivalent to 43 per cent of the overall Scottish budget in 2016/17. At some time in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland employed almost 140,000 whole-time equivalent staff, performed 1.5 million hospital procedures and conducted an estimated 17 million GP consultations.
- 2** The NHS in Scotland is 70 years old next year. In the intervening decades since it was set-up demographic and health trends have changed significantly and demand for services has increased dramatically. We have reported many times on the challenges facing the NHS including increasing costs, growing demand, and the continuing pressures on public finances. In 2016/17, these challenges continued to intensify. Demand for healthcare services continues to increase and more people are waiting longer to be seen. For example, the number of people waiting for their first outpatient appointment increased by 15 per cent in the past year and there was a 99 per cent increase in the number of people waiting over 12 weeks. Scotland's health is not improving and significant inequalities remain, while general practice faces significant challenges, including recruiting and retaining GPs and low morale. In the face of this, NHS staff have helped maintain and improve the quality of care the NHS provides. Yet there are warning signs that maintaining the quality of care is becoming increasingly difficult. The findings in this year's report illustrate why the way healthcare is planned, managed and delivered at all levels in Scotland must change.
- 3** Healthcare is likely to look very different in future. Health and social care integration marks a significant change in how the different parts of the health and social care system work together and how the Scottish public will access and use services in future. Yet the scale, complexity, and interdependencies of health and social care make achieving the changes needed a highly complicated and long-term undertaking. A number of factors provide a positive basis on which to build. Scotland has had a consistent overall policy direction in health for many years and there is broad consensus on the aim that everyone will be able to live longer, healthier lives at home or in a homely setting. Staff remain committed to providing high-quality care and there is a continued focus on safety and improvement. Levels of overall patient satisfaction continue to be high and the Scottish public hold the NHS in high regard. There are also early signs that changes in the way services are planned and delivered are

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the NHS faces increasing challenges and crucial building blocks to enable change still need to be put in place

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beginning to have a positive impact. For example, delayed discharges have reduced in a number of areas and this provides opportunities for sharing learning across the country.

- 4** There is no simple solution to addressing the issues facing the NHS and achieving the changes required. Previous approaches such as providing more funding to increase activity or focusing on specific parts of the system are no longer sufficient. Attention needs to focus on overcoming a number of barriers to change. Managing the health budget on an annual basis is hindering development of longer-term plans for moving more care out of hospital. It is still not clear how moving more care into the community will be funded and what future funding levels will be required. A clear long-term financial framework is a critical part of setting out how change will happen and when. Culture change is an essential part of transforming health and social care services. A different way of involving the public and staff in how they access, use and deliver health and care services is needed to help make the necessary difficult decisions. More information about how the NHS is working and the impact changes have on different parts of the system would help. For example, there are indicators measuring access to acute care services, such as hospitals, but there is little or no monitoring of activity levels and still little public information about primary care, such as GP practices, and community care.

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## Recommendations

### To provide the foundations for delivery of the 2020 Vision and changing the way healthcare services are provided:

The Scottish Government should (paragraphs 63–70):

- develop a financial framework for moving more healthcare into the community which identifies:
  - the anticipated levels of funding available for future years across the different parts of the healthcare system
  - how funding is anticipated to be used differently across NHS boards and integration authorities to change the way services are delivered
- develop a longer-term approach to financial planning to allow NHS boards and integration authorities flexibility in planning and investing in the longer-term policy aim of developing more community-based services.

The Scottish Government, in partnership with NHS boards and integration authorities, should (paragraphs 71–78):

- develop a capital investment strategy to ensure the NHS Scotland estate is appropriate for delivering more regional and community-based services
- continue to develop a comprehensive approach to workforce planning that:

- reflects forecasts of future staffing and skills requirements to deliver changing models of healthcare provision at regional, local and community level
- provides a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training.

### **To improve governance, accountability and transparency:**

#### **The Scottish Government should (paragraphs 61–62):**

- develop a robust governance framework for the delivery of the *Health and Social Care Delivery Plan*. This should:
  - set out all the work currently under way and planned, and the interrelationships between them
  - move on from statements of intent to developing the specific actions, targets and timescales to deliver all of its workstreams and plans, to allow better oversight and progress to be assessed and reported publicly
  - simplify and make clear the lines of accountability and decision-making authority between the Health and Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and integration authorities
  - improve transparency by including measures of performance covering all parts of the healthcare system which include indicators of quality of care in addition to indicators of access.

#### **The Scottish Government and NHS boards should (paragraphs 18–26):**

- work together to develop a consistent way of measuring and reporting savings to ensure that it is clear how boards have planned and made savings, and what type of savings they have made.

### **To promote the culture change necessary to move to new ways of providing and accessing healthcare services:**

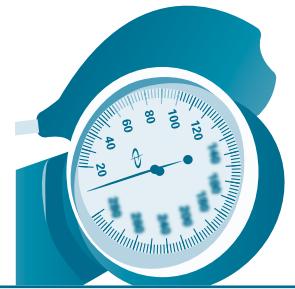
#### **The Scottish Government should (paragraph 87):**

- work with the entire public sector to develop a shared commitment to, and understanding of their role and interrelationships in improving public health and reducing health inequalities.

#### **The Scottish Government, NHS boards and integration authorities, should (paragraphs 83–84 and paragraphs 53–56):**

- continue to work with the public, local communities and staff to develop a shared understanding and agreement on ways to provide and access services differently
- work together to embed the principles of 'realistic medicine' in the way they work, monitor progress in reducing waste, harm and unwarranted variation; and creating a personalised approach to care.

# Introduction



## Healthcare in Scotland needs to be delivered differently in future

**1.** The NHS in Scotland is 70 years old next year. The NHS was set up in 1948 to provide free healthcare at the point of need. In the intervening seven decades, the range of services it provides, the number of staff it employs, and the Scottish public's demand for its services have all grown considerably. At some point in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland:

- employed almost 140,000 whole-time equivalent staff across 14 mainland and island health boards and eight national boards
- performed 1.5 million procedures in acute hospitals
- responded to 741,000 accident and emergency incidents
- conducted an estimated 17 million GP consultations
- had a budget of £12.9 billion for delivering healthcare.<sup>1, 2, 3, 4, 5</sup>

**2.** NHS staff are committed to their work and patient satisfaction is at an all-time high.<sup>6</sup> An increasing percentage of the overall Scottish budget is spent on health yet the NHS faces significant challenges in continuing to meet everything expected of it. Over the years, in our national and local audit work, we have highlighted these growing pressures. These include continuing increases in demand, a tightening financial environment, difficulties in recruiting staff, advances in expensive technology and medicines, and a demanding public and political environment. These features are common in many other countries around the world.

**3.** There is general consensus in Scotland that healthcare cannot continue to be provided in the same way but as we have reported previously, more progress needs to be made if transformational change is to happen. To help support this change, this annual overview of the NHS in Scotland focuses on two main areas:

- In [Part 1](#), we examine how different parts of the healthcare system in Scotland currently perform and why healthcare needs to change.
- In [Part 2](#), we identify the progress being made and the barriers which urgently need to be overcome to ensure the NHS can continue to provide high-quality care in the future.

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the way  
healthcare is  
planned and  
delivered is  
changing

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### The Scottish Government has a consistent and long-standing vision of how it wants healthcare to look in the future

**4.** For well over a decade, successive Scottish Governments have had a policy of integrating health and care services to improve the health of the population.<sup>7</sup> A healthy population served by a high-quality healthcare system is central to the Scottish Government's ambition to create 'a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. In 2011, the Scottish Government published its 2020 Vision for transforming healthcare and the health of the population. Its aim is that everyone should live longer, healthier lives at home or in a homely setting by 2020.<sup>8</sup> Achieving this aim will mean that healthcare services will look very different in the future ([Exhibit 1, page 9](#)).

**5.** To achieve this vision, the way that people access and use health and social care services across Scotland will need to change, services will need to be delivered differently, and there will need to be a significant change in how people manage their own health. It is not possible to stop or pause services while these changes are made and the scale of the task should not be underestimated. This is an exceptionally large-scale, complex change involving not just structural, but also significant culture change, for the people providing care and the public. Attitudes towards the role and responsibilities of the NHS, the way health and social care services are accessed and delivered, the part the rest of the public sector has to play in improving Scotland's health, and how people manage their own health, will all need to change. This can only be achieved by involving and supporting the Scottish public, NHS and other public sector staff throughout this process. The NHS cannot achieve this vision alone. All parts of the public sector have a role to play, such as housing, sports and education, if the Scottish Government's vision for health is to be realised.

### The way in which healthcare is planned is becoming more complex, with a mix of local, regional and national planning

**6.** Historically, health services in Scotland have been planned on a geographical health board basis with some services provided regionally and nationally. Health and social care integration and the move to greater regionalisation are changing this. Some services will now be planned on a much more local basis while others will be planned regionally ([Exhibit 2, page 10](#)).

**7.** It is not yet clear how planning at each of the different levels will work together in practice. It is important that roles and responsibilities at each level, and how they link together, are well defined to ensure:

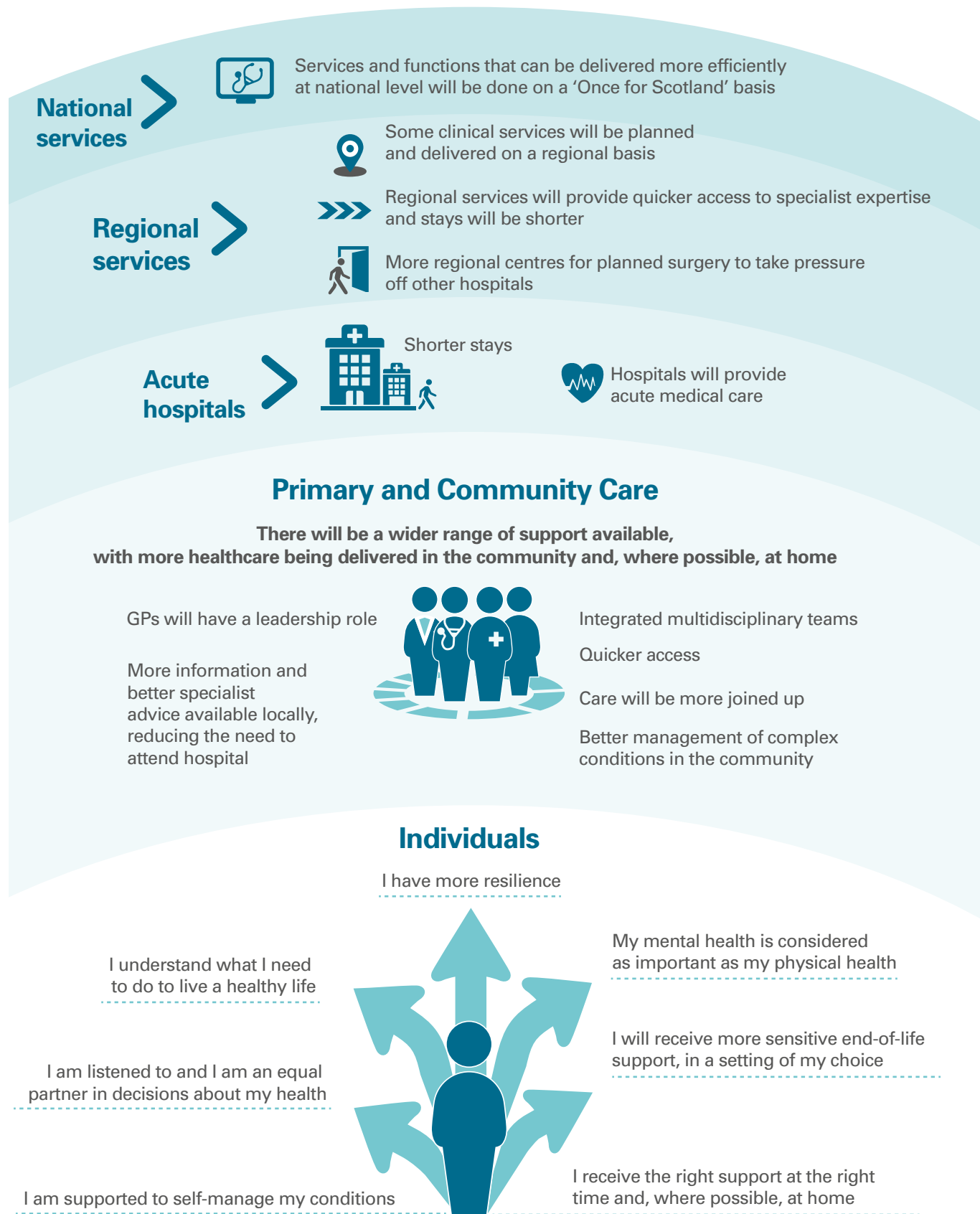
- there is clear accountability
- it is clear how public money is being used
- the public are easily able to access health and social care services that are joined up effectively.



## Exhibit 1

### The Scottish Government's vision for how healthcare will look in the future


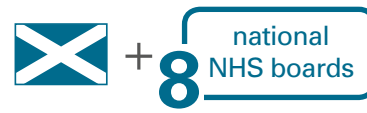
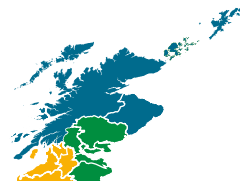








The way people will access and use health and social care services is changing.



## Exhibit 2

### Planning levels in the Scottish health system

Multiple planning levels for healthcare are being developed.

Planning levels	Breakdown	Delivery
<b>National planning</b> 	The Scottish Government and eight national NHS boards 	Services that can be delivered more efficiently nationally will be done on a 'Once for Scotland' basis.
<b>Regional planning</b> 	3 regions <ul style="list-style-type: none"> <li><span style="color: blue;">■</span> North</li> <li><span style="color: orange;">■</span> West</li> <li><span style="color: green;">■</span> East</li> </ul>	Some specialist services will be planned and delivered on a regional basis. The aim is that services should be provided more quickly, will take pressure off other hospitals, and mean fewer delays for urgent or emergency care.
<b>NHS boards</b> 		These will continue to provide a range of acute services to their population.
<b>Community Planning Partnerships (CPPs)</b> 		Each CPP is responsible for improving outcomes and tackling inequalities of outcome in their area. Each CPP must identify smaller areas in their local authority which experience the poorest outcomes, known as localities, and develop a plan to improve outcomes in these areas.
<b>Integration authorities (IAs)</b> 		In control of a range of health services, for example primary care and adult social care. They are responsible for planning and commissioning services in their area. IAs are statutory members of CPPs.
<b>Localities</b> 	 Each integration authority must have at least two localities	Localities are responsible for planning how their IAs' resources will be spent to best meet the needs of the local population. These are not necessarily the same as the CPP localities

# Part 1

## The NHS in Scotland in 2016/17



### Key messages

- 1** In 2016/17, the health budget was £12.9 billion, 43 per cent of the total Scottish Government budget. Health funding continues to increase but NHS boards had to make unprecedented levels of savings in 2016/17, at almost £390 million, as operating costs also continue to rise. The lack of financial flexibility, with NHS boards required to break even at the end of each financial year, and lack of long-term planning are barriers to moving more care out of hospitals.
- 2** Demand for health services continues to rise but previous approaches of treating more people in hospital are no longer enough. People are waiting longer to be seen with waiting lists for first outpatient appointment and inpatient treatment increasing by 15 per cent and 12 per cent respectively in the past year. The majority of key national performance targets were not met in 2016/17 and wider indicators of quality suggest that the NHS is beginning to struggle to maintain quality of care.
- 3** The overall health of the Scottish population continues to be poor and significant health inequalities remain. Life expectancy is lower than in most European countries and improvements have stalled in recent years. Smoking rates have continued to reduce but drug-related deaths increased significantly in 2016/17 and are now the highest in the EU.
- 4** General practice is central to changing how health services are accessed and used, yet there are significant challenges. These include difficulties in recruiting and retaining GPs and low morale, and a lack of data on demand and activity.

health funding continues to increase but cost pressures are intensifying and health inequalities remain significant

### Funding for the NHS continues to increase and accounted for 43 per cent of the Scottish Government budget in 2016/17

**8.** Health funding is the single largest area of Scottish Government expenditure. In 2016/17, the total Scottish Government health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.9 billion. This accounted for 43 per cent of the overall Scottish Government budget, an increase from 38 per cent in 2008/09.

**9.** The vast majority of the health budget is allocated to the 14 territorial health boards, £11.2 billion in 2016/17. The eight national NHS boards received £1.4 billion in 2016/17, and the remaining budget was for national programmes and

initiatives, such as health improvement and protection.<sup>9</sup> A significant percentage of territorial health boards' budgets, 45 per cent, £5 billion in 2016/17, is now allocated to Integration Authorities to fund delegated health services, such as primary care.

**10.** Between 2015/16 and 2016/17, the overall health budget increased by 5.7 per cent in cash terms. Taking into account inflation, the real terms increase was 3.6 per cent. This was made up as follows:

- Revenue funding, for day-to-day spending, increased by 3.1 per cent in cash terms from £12 billion to £12.4 billion, an increase of one per cent in real terms.
- Capital funding, for example for new buildings and equipment, increased from £203 million to £525 million, an increase of 159 per cent in cash terms, 154 per cent in real terms. The majority of this increase is due to changes in the way capital funding is accounted for, and excluding this the real terms increase was 35 per cent.<sup>10</sup>

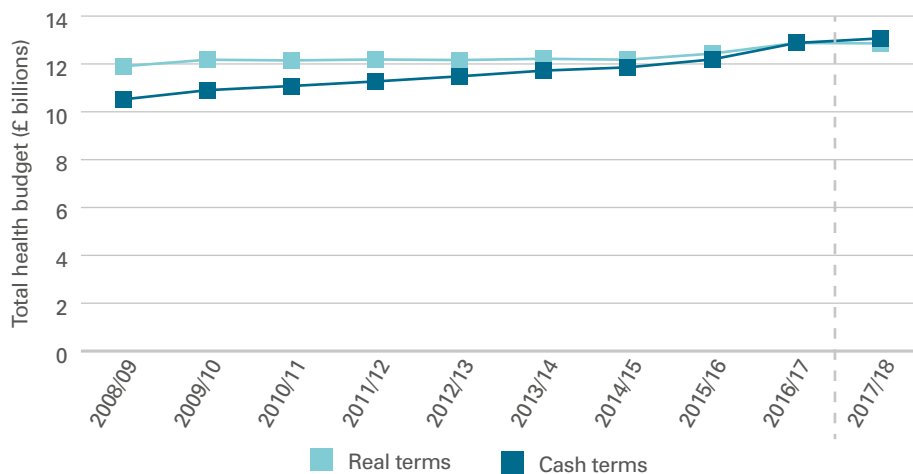
**11.** In 2016/17, the NHS budget included £250 million ring-fenced for social care funding for health and social care integration. Although this funding was for social care, it was included in the health budget and NHS boards were required to give this funding directly to Integration Authorities. Without this element of non-health funding, the health revenue budget decreased by one per cent in real terms between 2015/16 and 2016/17. It is important that it is clear what is included in budget figures to ensure transparency and to help scrutiny take place.

**12.** Between 2008/09 and 2016/17, the overall health budget increased by 8.2 per cent in real terms ([Exhibit 3](#)).<sup>11</sup> This has mainly been driven by funding increases in the most recent five-year period. Revenue funding increased by 5.7 per cent in real terms and capital funding by 9.2 per cent in real terms between 2012/13 and 2016/17.

## Exhibit 3

### Trend in the health budget in Scotland, 2008/09-2016/17, and budget figures for 2017/18

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



**13.** The 2017/18 health budget is £13.1 billion, an increase of 1.5 per cent in cash terms, and a decrease of 0.1 per cent in real terms from 2016/17. This is due to an increase in the revenue budget of 2.5 per cent in cash terms, 0.8 per cent in real terms. The capital budget is projected to decrease by almost a quarter, from £525 million to £408 million, a 23 per cent reduction in real terms.<sup>12</sup> This is mainly due to Dumfries and Galloway Royal Infirmary and the Royal Hospital for Sick Children capital projects being close to completion.

### Most territorial NHS boards moved closer to their target funding allocation in 2016/17

**14.** The Scottish Government allocates most funding to territorial NHS boards according to a formula developed by the NHS Scotland Resource Allocation Committee (NRAC). This is based on a number of factors including population size, age and gender profiles, and deprivation. Since the formula was introduced in 2009/10, the Scottish Government has been working towards ensuring that by 2016/17, no NHS board would be more than one per cent below their target allocation. In 2016/17, four NHS boards – NHS Grampian, Highland, Lanarkshire, and Lothian – remained more than one per cent below their target allocation, between 1.4 and 1.5 per cent below parity. Seven NHS boards received more than their target allocation, ranging from 0.3 per cent more in NHS Tayside to 9.4 per cent more in NHS Western Isles.<sup>13</sup> No board will be more than one per cent below their target funding allocation in 2017/18.




### Lack of long-term planning and financial flexibility are barriers to moving more care into the community

**15.** NHS boards are required by the Scottish Government to achieve a balanced financial position at the end of each financial year, meaning they must spend no more than the limits of their revenue and capital budgets. All NHS boards broke even in 2016/17, achieving an overall surplus of £8 million.<sup>14</sup> A significant amount of work is carried out across the NHS to achieve financial balance each year. However, this is becoming harder to achieve each year and current approaches are unsustainable.

**16.** As with last year, the majority of NHS boards had to use short-term measures to break even. These included:

- receiving loans, known as brokerage, and late allocations from the Scottish Government
- reallocating capital funding to revenue funding to allow it to be used to cover increasing operational costs
- using reserves
- making one-off accounting adjustments, such as releasing surplus holiday pay accruals and insurance rebates.

**17.** NHS Tayside was the only board to require brokerage from the Scottish Government in 2016/17, receiving £13.2 million. We have prepared a separate report on [The 2016/17 audit of NHS Tayside](#) . Three NHS boards – NHS Highland, Orkney, and Western Isles – repaid all their outstanding brokerage ranging from £0.5 million to £1.1 million, and NHS 24 repaid £1.1 million from an existing balance of £20.4 million. NHS 24 is scheduled to repay the remaining loan over the next four years.

## NHS boards made unprecedented levels of savings in 2016/17 but failed to meet the overall planned savings target

**18.** NHS boards need to make annual savings to achieve their financial targets of operating within their resource and capital limits and achieving financial balance at the end of each financial year. This is because there is a gap between the funding and income they receive and their expenditure, that is how much it costs them to deliver services. NHS boards are responsible for identifying and then making their own savings. This has become more complicated with the introduction of Integration Authorities (IAs). NHS boards now need to negotiate with their IAs to agree savings in primary care and other health services to contribute to their NHS board's savings target. NHS boards set out planned savings in their Local Delivery Plans (LDPs), which set out NHS board priorities. Savings targets are then revised through the year as revenue and capital resource limits change due to additional funding allocations from the Scottish Government.

**19.** NHS boards made £387.4 million savings in 2016/17 as reported in the external annual audit reports, 3.8 per cent of total revenue allocations to NHS boards. The level of savings made in 2016/17 was unprecedented, and was a third higher than the £291.3 million made in 2015/16. Despite this, the NHS did not meet its savings target of £406.3 million, falling short by 4.7 per cent, £18.9 million.

**20.** Although the overall target was missed, the majority of NHS boards did meet their individual savings targets in 2016/17. Five territorial boards – NHS Borders, Forth Valley, Highland, Lothian, Tayside – did not meet their savings targets despite almost all making higher levels of savings than in previous years. The shortfall ranged from NHS Lothian missing its original planned target by £9.8 million (28 per cent), to NHS Tayside which missed its original planned target by £1.3 million (three per cent). All the national boards reported that they achieved their savings targets.

**21.** It is becoming more difficult for NHS boards to identify the savings they need to make. In 2012/13, boards were unable to identify in their LDPs how they would make five per cent of their planned savings. In 2016/17, this had risen to 17 per cent. As a result, three NHS boards – NHS Ayrshire and Arran, Fife, and Tayside – projected in their 2016/17 LDPs that they would not achieve financial balance at year-end. In 2015/16, no territorial NHS boards predicted a deficit at year-end in their LDP.

**22.** NHS boards are also forecasting savings targets and financial break-even to be achieved at a later stage in the financial year than previously. In particular, more boards relied on making a greater amount of savings in the final month of the financial year in 2016/17 than in 2015/16:

- Twelve out of 14 territorial boards predicted that they would still be in a deficit position at February 2017, compared to nine boards in 2015/16.
- Between February and March 2016, NHS territorial boards recovered £35 million to move to a year-end surplus position. A year later, they had to recover almost double that amount, £61 million, to break even, and ended the financial year with a surplus of £8 million.

**23.** Forecasting in this way creates risks if planned savings do not materialise. For example, projects aiming to redesign services, that is providing them in new ways that may also cost less, may not be delivered on time. Then boards will be unable to recover any deficit in time to achieve financial balance.

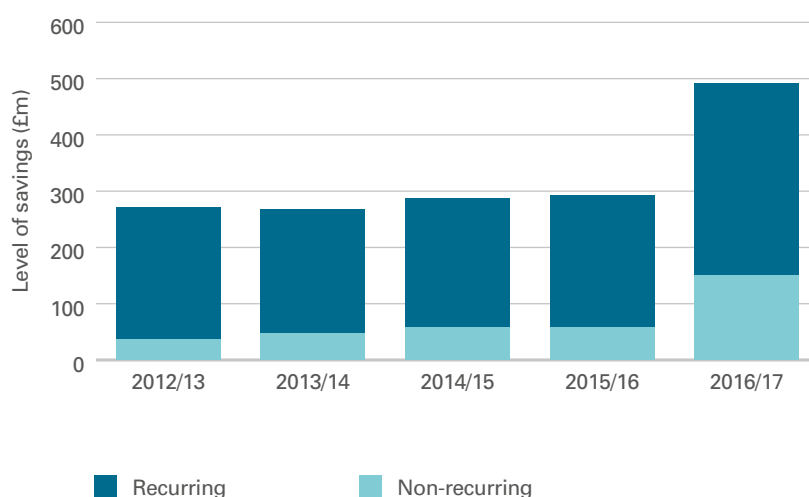
### NHS boards' increasing use of one-off savings is unsustainable

**24.** The level of savings NHS boards have planned to make in their LDPs has increased significantly over the past five years, increasing by 81 per cent in cash terms, 71 per cent in real terms between 2012/13 and 2016/17 ([Exhibit 4](#)). NHS boards make savings in various ways and while they reduce expenditure and contribute to achieving financial targets, they do not necessarily demonstrate increased productivity or efficiency. Savings are classed as either recurring or non-recurring. The former recur year-on-year from that date, for example savings as a result of providing services in a different way. Non-recurring savings are one-off savings that do not result in ongoing savings after that financial year, for example selling a building or delaying filling a vacant post. The percentage of non-recurring savings planned by NHS boards in their LDPs has increased significantly over the past few years ([Exhibit 4](#)). Non-recurring savings accounted for 30 per cent of all savings planned in 2016/17, more than double the level of five years ago when they accounted for 13 per cent of planned LDP savings. The percentage of savings made up from non-recurring sources varied widely across the NHS in 2016/17. Among the territorial boards, as reported in the external annual audit reports, non-recurring savings accounted for seven per cent of total savings in NHS Forth Valley to 71 per cent in NHS Fife. Among the national boards they ranged from zero in NHS National Services Scotland to 86 per cent in The State Hospital.

## Exhibit 4

### Overall level of planned LDP savings by NHS boards between 2012/13 and 2016/17 split by planned recurring and non-recurring

The planned use of non-recurring savings has increased over the past five years.



Note: Figures are in cash terms.

Source: Audit Scotland using NHS board Local Delivery Plans 2016/17




**25.** We have stated previously that increasing reliance on non-recurring savings is unsustainable. This is because:

- it is becoming more and more difficult for NHS boards to identify areas in which they can make one-off savings
- boards that make high levels of one-off savings will have to find more savings in future years as they have less recurring savings to use

- non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.<sup>15</sup>

**26.** Currently, NHS boards report their LDP savings target, and progress towards it, to the Scottish Government with savings categorised under set headings. In the course of our work we discovered differences between the level of planned and achieved savings NHS boards reported to the Scottish Government and that reported to their own boards. Given the scale of the savings NHS boards need to make, it is essential that it is clear how boards have calculated their savings and what types of savings are planned and then made, for example different types of recurring and non-recurring savings. It is also important that this is then reported in a consistent and clear way to ensure appropriate planning and scrutiny can take place.

**27.** The majority of NHS boards' financial plans cover three years or less. This is partly driven by one-year funding allocations from the Scottish Government, and the need to break even each year. However, a short-term approach to financial planning makes 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. If services are to be transformed, NHS boards need to develop longer-term financial plans. To support boards to do this, the Scottish Government needs to consider giving NHS boards more financial flexibility. As we stated in our report, [NHS in Scotland 2015](#) , greater flexibility as part of good long-term financial planning can help boards respond better to local needs and priorities.<sup>16</sup> Even a small amount of flexibility at financial year-end, for example allowing NHS boards to manage their finances to within plus or minus 0.5 per cent of break-even, can make a difference. This is because increased flexibility can help in ways such as managing cost pressures over a longer period, provide opportunities for spend-to-save investment, and provide greater autonomy and responsibility of finances at a local level.

### **Rising operating costs continued to make it difficult for NHS boards to manage their finances in 2016/17**

**28.** NHS boards must manage the cost of delivering services within the funding and income they receive. As discussed earlier, this is increasingly challenging for boards to do as costs have continued to rise in key areas. [Exhibit 5 \(page 17\)](#) sets out the main cost pressures boards faced in 2016/17. NHS boards face a high level of fixed costs, for example staff costs accounted for over half of all revenue expenditure in 2016/17. It is therefore important that NHS boards, IAs and the Scottish Government work together to ensure:

- spending on fixed costs is as economical as possible, for example managing utility costs by implementing energy-efficiency measures
- they minimise spending on areas within their control, such as staff agency spending or developing new healthcare facilities.

**29.** An example of this is the focus on reducing temporary staffing costs in many boards in 2016/17. Despite overall spending on agency medical locums increasing in the past year, six territorial boards reduced their expenditure between 2015/16 and 2016/17. They did this through a mix of filling vacancies, greater use of internal locums, and tighter controls on agency use.



## Exhibit 5

### Cost pressures in 2016/17

#### Most NHS boards overspent on their pay budgets and agency costs continued to be high



**£6.5 billion** was spent by NHS boards on staff in 2016/17 (57 per cent of revenue expenditure) and the majority of NHS boards overspent on their pay budget.<sup>1</sup>



In 2016/17, NHS boards spent £171 million on agency staff, an increase of 79 per cent in real terms over the past five years.<sup>2</sup> Spending decreased, however, by three per cent between 2015/16 and 2016/17.<sup>3</sup>



Boards reported spending £109 million on agency medical locums in 2016/17, an increase of six per cent in real terms on the previous year.<sup>4</sup>

#### Backlog maintenance costs have reduced but remain considerable



**£511 million** was spent by NHS boards on capital projects in 2016/17, with the majority, £465 million funded by the Scottish Government, and the remaining amount from asset sales and donations.<sup>5</sup>



70 per cent of the estate was rated in good physical condition in 2016/17, a slight increase from 66 per cent in 2015/16. There is wide variation across territorial boards, from 24 per cent of the estate rated good in NHS Orkney to 98 per cent in NHS Borders.<sup>6</sup>



NHS boards had a total backlog maintenance of £887 million in 2016/17, a slight decrease from £898 million in 2015/16. There has been a seven per cent increase in backlog maintenance classed as significant and high risk, to 47 per cent in 2016/17. There was wide variation across territorial boards, from 18 per cent of all backlog maintenance rated significant and high risk in NHS Forth Valley to 72 per cent in NHS Tayside. Over half, 56 per cent, of all backlog maintenance was accounted for by three boards: NHS Greater Glasgow & Clyde, Grampian and Tayside.<sup>7</sup>

#### Spending on drugs continues to rise



**£1.68 billion** was spent on drugs in 2015/16 (£1.26 billion in the community and £420 million in hospitals), an increase of £112 million in real terms (7.1 per cent) from 2014/15.<sup>8</sup>



Between 2014/15 and 2015/16, spending on drugs in hospitals increased at a higher rate (8.1 per cent in real terms) than spending on drugs in the community (6.8 per cent in real terms).



In the last five years, spending on drugs in hospitals rose by 34.4 per cent in real terms as opposed to a rise of 7.9 per cent in spending on drugs in the community.



Since 2014/15, the Scottish Government, via the New Medicines Fund (NMF), has provided £183 million additional funding to NHS boards to cover the costs of increasing patient access to treatment for very rare conditions and end-of-life medicines. The fund reduced from £85 million in 2015/16 to £53 million in 2016/17, placing further pressure on boards' drugs budgets. The amount available to boards from the NMF in 2017/18 is not yet known.<sup>9</sup>

Cont.



## Exhibit 5 (continued)



The Scottish Government's Effective Prescribing Programme Board has been in place for two years. It is not yet known what savings have come from effective prescribing activities to date but it has contributed to a reduction in the annual increase in volume of community prescribing. Between 2013/14 and 2016/17 the quantity of drugs dispensed in the community increased by around two per cent or less, in comparison to annual increases of between 2.6 and 5.1 per cent between 2008/09 and 2012/13.<sup>10</sup>

### Clinical negligence costs have increased



The way in which the amount of compensation in personal injury claims is decided has changed in the UK. The cash amount will now be higher which means that the amount boards set aside for claims increased from £330 million in 2015/16 to £582 million in 2016/17.<sup>11</sup>

#### Notes:

1. *NHS workforce planning*, Audit Scotland, July 2017.
2. *NHS Consolidated Accounts*, Scottish Government, July 2017.
3. *Ibid.*
4. Information provided to Audit Scotland by NHS boards, June 2017.
5. *Ibid.*
6. NHS Orkney's Balfour Hospital is in the process of being replaced with a new hospital.
7. *Annual State of NHS Scotland Assets and Facilities Report for 2016*, Scottish Government, July 2017.
8. 2015/16 is the most recent year figures are available. *Scottish Health Service Costs – drugs*, ISD Scotland, November 2016.
9. 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 2017/18.
10. ISD Scotland data provided to Audit Scotland, August 2017.
11. The lump sum compensation awarded to victims of life-changing injuries is adjusted according to the interest they could expect to earn by investing it. Courts use a calculation to work this out using a discount rate. The discount rate has been reduced by HM Treasury from 2.5 per cent to minus 0.75 per cent. This reduces the expected value of the future investment, making the cash value of the settlement higher.

Source: Audit Scotland

### The financial outlook for NHS boards in the near future will be very challenging

**30.** NHS boards are predicting in their 2017/18 LDPs continuing cost increases year-on-year over the next three to five years across a wide range of areas:

- staff costs, including the annual one per cent pay uplift, pay rising as staff move up pay scales, the apprenticeship levy, and the impact of the living wage
- increases in spending on hospital drugs of between four and 16 per cent and increases in GP prescribing costs of around four per cent. The Healthcare Financial Management Association projected spending on drugs in hospitals as a proportion of all hospital costs will rise from 5.4 per cent in 2012/13, to 8.5 per cent in 2019/20 if they continue to grow at the rate they have done over the last four years.<sup>17</sup>
- business rate rises in 2017/18 of up to 27 per cent and energy increases of upwards of 2.5 per cent over the next three years.

**31.** Differences in anticipated funding from the Scottish Government and the cost of delivering services in 2017/18 means NHS boards are planning savings in their LDPs of £445 million. [Case study 1 \(page 19\)](#) gives an example of what these cost pressures mean financially for a territorial board over the next three years.

## Case study 1

### Financial pressures in NHS Grampian



#### NHS Grampian's cost assumptions between 2017/18 and 2019/20

In its draft 2017/18 Local Delivery Plan, NHS Grampian has set out its financial planning assumptions for the next three years based on its funding from the Scottish Government, cost increases and the net value of savings it will have to make to balance these. These are set out in the table below. NHS Grampian has estimated the figures for 2018/19 and 2019/20 as Scottish Government funding is confirmed for 2017/18 only. In setting out these projections, it has also assumed no funding for any further service investments or new posts within those services under the direct control of NHS Grampian.

	2017/18	2018/19	2019/20
	£m	£m	£m
<b>New resources:</b>			
Baseline increase in Scottish Government funding	13.2	18.9	19.4
Additional funding to achieve NRAC target allocation	3.0	-	-
<b>Total</b>	<b>16.2</b>	<b>18.9</b>	<b>19.4</b>
Less: allocation to Integration Joint Boards	(9.9)	(15.2)	(15.6)
Total new resources for NHSG direct services	6.3	3.7	3.8
<b>Forecast expenditure: NHSG direct services</b>			
Pay (including increments)	6.2	6.3	6.3
Secondary care drugs	6.3	6.0	6.0
Non-pay and planned developments	3.4	2.0	2.0
Impact of legislative changes (such as the apprenticeship levy and rates revaluation)	3.8	4.0	1.0
Other – depreciation reduction	(2.0)	(1.3)	(1.3)
Brought forward deficit	14.4	10.0	10.0
Impact of service investments, policy changes or national decisions (such as the Baird Family Hospital and Anchor Centre development)	0.9	1.0	1.0
Contingency	1.0	1.0	1.0
<b>Sub total</b>	<b>(34.0)</b>	<b>(29.0)</b>	<b>(26.0)</b>
Net additional cash efficiency challenge	(27.7)	(25.3)	(22.2)

Source: Audit Scotland using NHS Grampian's Local Delivery Plan 2017/18

## Previous approaches of treating more people in hospital and speeding up treatment are not sufficient any more and a different approach is needed

**32.** There is no one indicator of demand for healthcare services. Historically, any analysis of demand has focused on the acute sector due to a lack of national data on primary and community care. This continues to be the case and makes it difficult to assess overall demand or to better understand changes in demand. Examining a range of different indicators, however, shows that demand is continuing to grow. In particular, demand for outpatient appointments and planned inpatient and day case treatment have risen significantly in the past five years ([Exhibit 6](#)).

### Exhibit 6

#### Indicators of demand for NHS services, 2012/13-2016/17

Demand for NHS services continues to increase.

	Emergency admissions (A)	Number of procedures (A)	Number of people waiting for first outpatient appointment (C)	Number of people waiting for inpatient and day case treatment (C)	GP consultations (A)
<b>Five year change</b>	+3.5%	+11.4%	+43.4%	+33.5%	+4.6%
<b>2016/17*</b>	565,344	1,476,055	306,393	65,684	16,974,857
<b>2012/13</b>	546,258	1,325,111	213,694	49,191	16,236,010

Notes:

1. A= annual figure, C=March census figure.

2. Emergency admissions and number of procedures – figures are for 2015/16 as this is the most recent data available.

3. GP figure for 2016/17 is estimated using the same projection methods as in *Changing models of health and social care*, Audit Scotland, March 2016.

Source: Audit Scotland using ISD Scotland data at August 2017; *Changing models of health and social care*, Audit Scotland, March 2016.



**33.** In previous years, the NHS was able to partially offset growing demand by seeing more patients. However, there are signs that this is no longer sufficient and demand is beginning to back up in the acute system. For example:

#### Outpatients


- NHS boards see over one million people as outpatients every quarter, and over a third of these are new attendances. In the quarter to March 2017, the number of new attendances seen was 12 per cent higher than in the same period in 2013, meaning almost 39,000 more new people were seen. Most of this increase, however, was at the start of the five-year period, and the number seen since then has remained fairly static.
- Over the same period, waiting times have increased. The number of people that waited over the standard 12 weeks for their first appointment

increased by over 300 per cent (from 21,500 people waiting in the quarter to March 2013 to 87,500 people in the quarter to March 2017). Of these, the number of people that waited over 16 weeks for their first appointment increased ten fold, from 5,000 to almost 58,000 people.

- In the past year, the number of people waiting for their first outpatient appointment increased by almost 40,000, a 15 per cent increase.

### Inpatients and day cases

- For planned inpatient and day case treatments, the number of people treated over the past few years has reduced while the length of time people are waiting, and the number of people waiting, have increased:
  - Around 74,500 people received planned inpatient or day case treatment in the quarter to March 2017, almost 13,500 fewer people (15 per cent less) than the peak in the quarter ending March 2014 where boards treated almost 88,000 people. In the past year, almost 4,400 fewer people were seen in the quarter to March 2017 compared with the same period in 2016 – a six per cent reduction.
  - At the same time, waiting times increased. The number who waited over the guaranteed 12 weeks for their treatment increased by over 800 per cent, from 1,450 in the quarter ending March 2013 to 13,300 in the quarter ending March 2017. The past year has seen a marked increase in people waiting longer than 12 weeks – an additional 7,500 people waited over 12 weeks in the quarter to March 2017 compared with the same period in 2016.
  - The number of people on the waiting list rose to almost 66,000 at the census point in March 2017, an increase of 12 per cent from March 2016 and 34 per cent higher than March 2013.<sup>18</sup>

**34.** Redesigning acute services to make them more efficient is one way in which NHS boards are trying to treat more patients. However, as we stated last year in our report, *NHS in Scotland 2016* , the NHS cannot continue to do everything within the current resources and needs to slow the rate of demand for hospital services. The NHS cannot do this on its own and needs to work with integration authorities and wider public services, to redesign primary and social care, and improve the general health of the wider population. This is discussed further in [Part 2](#).

### Current national performance standards do not measure quality of care across the whole healthcare system. They provide an indication of pressure in the acute sector, with the majority of targets not being met and performance declining

**35.** National NHS performance measures have been in place in Scotland for over a decade. Previously known as HEAT targets, since 2015 these have been referred to as Local Delivery Plan (LDP) standards. Most LDP standards are measures of access to acute healthcare services, for example the four-hour accident and emergency waiting time standard or the 12 weeks to first outpatient appointment standard. Acute services are only one part of the healthcare system and access is only one measure of the quality of that system. There are a lack of indicators providing information on quality of care, primary care and community care.

**36.** The existing measures do not provide a comprehensive, balanced assessment of the performance of our healthcare system. However, performance

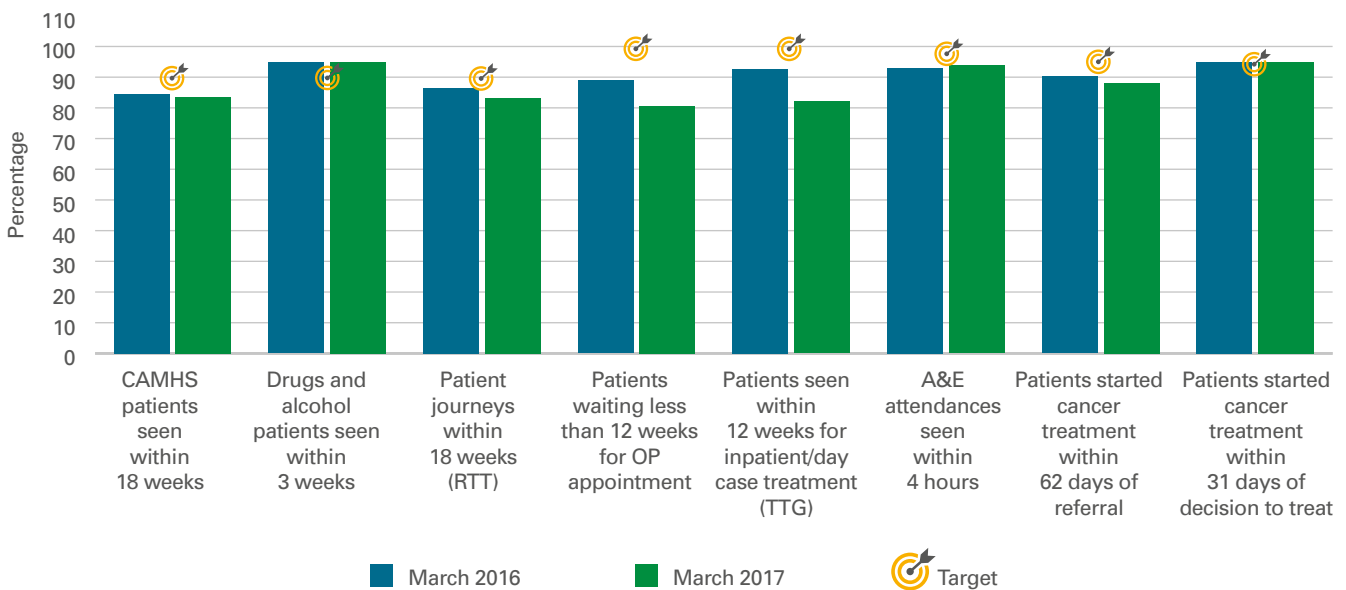
against LDP standards does indicate the pressure the healthcare system is under. An independent review of the national LDP standards is currently under way and an interim report was due to be published by August 2017.

**37.** As with last year, NHS Scotland failed to meet seven out of eight key performance standards in 2016/17 ([Exhibit 7](#)). Nationally, the NHS met its target of 90 per cent of patients referred for drug and alcohol receiving treatment within 31 days, at 94.9 per cent. The target of 95 per cent of patients starting cancer treatment within 31 days was missed by just 0.1 per cent, the same as in 2015/16. [Appendix 3](#) shows performance against the national standards by NHS board. Over the past five years, overall performance has declined in six of the eight key performance standards and remained static in one, with performance only improving against the four-hour accident and emergency standard.

## Exhibit 7

### National performance against key national performance standards, 2015/16-2016/17

NHS Scotland did not meet the majority of key performance standards in 2016/17.



**Notes:**

1. CAMHS is Children and Adolescent Mental Health Services.
2. Figures are for month/quarter/census point ended March 2017 ([Appendix 3](#)).


Source: See [Appendix 3](#) for sources



**38.** Overall performance dropped significantly between 2015/16 and 2016/17 in two key performance standards:

- Performance against the 12-week treatment time guarantee (TTG) for patients waiting on planned inpatient or day case procedures dropped by over 10 percentage points, from 92.7 per cent in the quarter to March 2016, to 82.2 per cent in the quarter to March 2017. This means that in 2016/17:
  - over 13,200 people were not seen within the 12-week standard, a 132 per cent increase in the number of people who waited over 12 weeks compared with the same period in 2016.

- Performance against the 12-week waiting time standard for first outpatient appointment dropped by over eight percentage points, from 88.9 per cent at the census point of March 2016, to 80.7 per cent at the same point in 2017. This means that over this period:
  - the number of people on the waiting list increased by 15 per cent, with almost 40,000 more people waiting
  - of those on the list, the number of people waiting over 12 weeks increased by 99 per cent, with over 29,000 more people waiting
  - of those on the list, the number of people waiting over 16 weeks increased by 108 per cent, with almost 22,500 more people waiting.

Achieving waiting time standards has been a top priority for the Scottish Government and NHS boards for a number of years. Approaches by the Scottish Government include providing additional funding to improve performance against individual standards and providing support teams in NHS boards. NHS boards continue to make extensive efforts to meet the targets. These efforts include redesigning processes and services, recruiting additional staff and using the private sector to increase short-term capacity. In our report [NHS in Scotland 2015](#) , we noted that these approaches may help meet targets in the short term but do not necessarily demonstrate value for money in achieving the longer-term aims and objectives of the NHS.<sup>19</sup> Our auditors reported in 2016/17 that NHS boards are increasingly struggling to improve performance against national targets while also achieving financial balance. The continuing effort being put into balancing these two priorities is detracting from the overall strategy of moving more care into the community.

### **There are signs that the NHS's ability to maintain quality of care is under pressure and this needs to be closely monitored**

**39.** No single annual assessment is made of the overall quality of care provided by the NHS in Scotland by any organisation. Analysis of a range of measures indicates there were no significant weaknesses in the overall quality of care being provided by the NHS in 2016/17. Positive examples include the following:

- Inpatient satisfaction is at an all-time high. Ninety per cent of patients rated their care and treatment as good or excellent in 2016.<sup>20</sup>
- Patient safety indicators continued to improve: between 2007 and 2016, there was a reduction in the hospital standardised mortality ratio of 16.5 per cent, and a 21 per cent reduction in 30-day mortality due to sepsis.<sup>21 22</sup>
- The Nuffield Trust's 2017 report, *Learning from Scotland's NHS*, found there was a strong culture of continuous improvement in the NHS in Scotland.<sup>23</sup>

**40.** There are signs, however, that the pressures described throughout this chapter may be beginning to impact on the quality of care staff are able to provide and this needs to be closely monitored. For example:

- one in five inpatients surveyed in the national inpatient experience survey in 2016, 20 per cent, said they had experienced problems during their hospital stay, such as infections, sepsis, bed sores or falls. A significant minority, 39 per cent, felt they were not involved in decisions about their care or treatment as much as they would have liked.<sup>24</sup>

- Patient complaints are increasing. Complaints to health boards increased by 41 per cent between 2012/13 and 2016/17, to 23,500.<sup>25</sup> NHS boards have worked to raise awareness of the complaints process, and make it easier for patients to make a complaint. This may account for at least some of this increase in complaint levels.
- Recent surveys of staff indicate pressures on maintaining quality of care. A 2016 British Medical Association (BMA) survey of GPs in Scotland found more than nine out of 10 GPs (91 per cent) believe their workload has negatively impacted on the quality of care given to patients. A 2017 survey of nurses and healthcare support workers by the Royal College of Nursing found that half of respondents in Scotland felt patient care was compromised on their last shift. The main reason respondents gave was a lack of registered nurses and healthcare support workers.<sup>26</sup>

Healthcare Improvement Scotland (HIS) provides public assurance about the quality and safety of healthcare by inspecting NHS and independent healthcare services. It has developed a new Quality of Care programme to support improvements in quality, underpinned by a framework. The framework provides guidance about what good-quality care looks like and how this can be measured and demonstrated. The framework is designed for use by service providers, but also as part of HIS assurance activities.

## Scotland's health is not improving and significant inequalities remain

**41.** Scotland continues to be a country with significant health problems. There have been improvements in some areas in recent years, such as reducing smoking, but the majority of key trends show that Scotland's overall health is not improving, and in some areas is deteriorating:

- Average life expectancy, at 77.1 years for men and 81.1 years for women, is consistently lower than most European countries and has been static since 2012.<sup>27</sup>
- Healthy life expectancy, that is the number of years a person lives in good health, has remained almost the same since 2009, at 59.9 years for men and 62.3 years for women.<sup>28</sup>
- Overall mortality rates were higher in 2015 and 2016 than in 2014, although it is not yet clear the extent to which there is an emerging trend. Mortality rates from cancer and heart disease remain higher than the rest of the UK.<sup>29,30</sup>
- The number of drug-related deaths increased by 23 per cent between 2015 and 2016, from 706 to 867, and was double the number of deaths in 2006. Scotland now has the highest drug-death rate in the EU.<sup>31</sup>
- The proportion of adults in Scotland who are current smokers has reduced by five percentage points to 21 per cent between 2008 and 2016.<sup>32</sup>
- The average number of units of alcohol consumed per week for adult drinkers aged 16 and over fell from 16.1 units in 2003 to 12.2 in 2013 and has subsequently stayed at similar levels (12.8 in 2016).<sup>33</sup>





**42.** A recent study by the Scottish Public Health Observatory examined the burden caused by various diseases in Scotland. These are measured in disability-adjusted life years (DALYs) with one DALY equal to one lost year of healthy life. The conditions in Scotland causing the greatest loss of healthy life are heart disease, low back and neck pain, and depression. Comparing Scotland with other countries around the world shows that Scotland is less healthy (that is, it has more healthy years lost) compared to countries with similar socio-demographic profiles.<sup>34</sup>

**43.** Scottish health is still marked by significant health inequalities. These affect a wide range of groups, including people of different ages, gender, ethnicity, religion, sexual orientation, gender identity and levels of disability. For example:

- Mortality rates for chronic liver disease in 2015 were nearly twice as high for men than women (19 per 100,000 compared to 11 per 100,000) and stroke rates remain consistently higher for men than women across all age groups.<sup>35</sup>
- Scottish Government research based on the 2011 census found that gypsies/travellers had the worst overall health among ethnic groups, being more likely to report a long-term health problem or disability and more likely to report bad or very bad general health.<sup>36</sup>
- A 2015 Equality Network survey found that 21 per cent of LGBT respondents had personally experienced discrimination or poorer treatment in Scotland's healthcare services because of their sexual orientation or gender identity.<sup>37</sup>


**44.** A recent report by NHS NSS noted that while reliable data exists on age and gender in health, there continues to be a lack of data relating to disability, gender identity, religion, and sexual orientation. The report stated that 'without good data on inequalities in health it is impossible to plan and prioritise effective action or to monitor progress towards a more equal society' and that 'there is a need to collect equality data to directly improve the care and experience of individual service users...'<sup>38</sup>

**45.** People living in areas of deprivation are still much more likely to be in poorer health than those living in more affluent areas. The gap is not closing and in some measures is widening. People living in the most deprived areas of Scotland, compared to those living in the least deprived areas:

- are likely to die 8.6 years sooner if female and 12.2 years sooner if male, with the gap in life expectancy increasing as improvements in those living in the least deprived areas outpace those in the most deprived areas<sup>39</sup>
- spend an average of 11.5 years longer in ill health if female, and nine years longer if male<sup>40</sup>
- are most likely to be diagnosed with breast, colorectal and lung cancer at stage 4, the most advanced stage of the disease, whereas those living in the least deprived areas are most likely to be diagnosed at stages 1 or 2<sup>41</sup>
- are more than twice as likely to attend A&E, and are slightly more likely to then be admitted to hospital.<sup>42</sup>

## General practice is central to the changes that are needed to the healthcare system but difficulties in recruiting and retaining GPs and low morale are among many challenges

**46.** Primary care is usually the first point of contact with the NHS and refers to services provided by health professionals in clinics and practices or in a patient's home. General practice is a key part of primary care and is central to the changes needed in how services are accessed and delivered. In 2016, there were 4,913 GPs in Scotland working in 963 practices.<sup>43</sup> Most GPs are independent contractors who run their own practices, known as 'partners', or are employed and paid by the partners running a practice. GPs are not normally employed by the NHS board area they work in, although their funding comes from NHS boards.

**47.** No up-to-date national information is available on levels of demand and activity for general practice in Scotland. From projections in our 2016 report, [\*Changing models of health and social care\*](#) , we estimated the number of GP consultations would increase by 4.6 per cent between 2012/13 and 2016/17, to 17 million consultations.<sup>44</sup> This is equivalent to every person in Scotland visiting their GP at least three times a year. In 2016 the Kings Fund analysed 177 practices in England (with a total of 30 million patient contacts). They found a 15 per cent increase in the number of consultations between 2010/11 and 2014/15.<sup>45</sup> Therefore it is possible that 17 million is an under-estimate.

**48.** Although data is lacking, evidence suggests that general practice in Scotland is struggling to meet demand and the pressure of this is, in turn, creating wider problems for the profession:

- The number of GP practices has fallen by three per cent in the past five years, to 963. Consequently, the average practice list size has increased to 5,881, an increase of six per cent. However, there has not been a corresponding increase in the number of GPs, whose numbers have only increased by one per cent in the last five years.<sup>46</sup> This means workload pressures are likely to have increased.
- Recruitment and retention data is not available nationally, however, a 2017 BMA survey of GPs in Scotland found that 26 per cent of practices had vacancies and of those vacancies, 73 per cent had been open for at least six months.<sup>47</sup> Workforce pressures are likely to continue increasing due to an ageing workforce. A third of all GPs and 42 per cent of GP partners were aged over 50 in 2016, and a BMA survey in December 2016 found that over a third of GPs planned to retire within the next five years.<sup>48 49</sup>
- Due to reported recruitment difficulties and other issues such as retiring partners, locum costs, and premises issues, an increasing number of GP practices were taken over by their NHS board in 2016/17 compared to previous years. This means the GP partners running a general practice have handed their practice over to an NHS board and the practice is no longer run by GPs who are independent contractors. In 2016/17, 15 practices were taken over compared to 11 in 2015/16 and four in 2014/15.
- Morale is deteriorating. A BMA survey of GPs in Scotland in December 2016 found that over two-thirds of GPs, 70 per cent, felt they experienced significant work-related stress and 15 per cent felt their stress was unmanageable. More than half, 55 per cent, reported their workload had a negative impact on their commitment to being a GP.<sup>50</sup>



# Part 2

## Achieving change



### Key messages

- 1 There is significant activity under way by the Scottish Government, NHS boards, and integration authorities to transform the healthcare system in Scotland and building blocks for moving more care out of hospital are being put in place. Integration authorities are beginning to have a positive impact, helped by the development of better primary care data. Initiatives to embed the 'realistic medicine' approach, that is putting people at the centre of their own healthcare decisions, are also beginning to be developed.
- 2 There are a number of key areas that need addressed as a priority, however, if meaningful change is to be achieved. A key action is developing a financial framework to set out how existing and future funding will be used to move more care into the community. Improvements in planning the future healthcare estate, and the workforce are also needed.
- 3 Successfully changing how services are accessed and used is dependent not just on NHS boards, but many other partners working together. Gaining GP agreement to the new GP contract is critical to changing how primary care works. Improving people's health means doing more to involve local communities and individuals in decisions, and a commitment across the public sector to improve public health.

significant activity is under way to transform healthcare but a number of key areas need addressed as a priority

### The national Health and Social Care Delivery Plan sets out the main ways the Scottish Government aims to achieve change

49. The Scottish Government published a *Health and Social Care Delivery Plan* (the Delivery Plan) in December 2016 to set out how the 2020 Vision will be achieved. Its aim is to 'increase the pace of improvement and change within Scotland's health and care system'.<sup>51</sup> The Delivery Plan brings together four major existing programmes of work and cross-cutting initiatives:

- health and social care integration
- the National Clinical Strategy
- public health improvement
- NHS board reform.


The Delivery Plan sets out the main activities that are currently being undertaken or are planned in each of the four areas and sets out timescales for achieving these ranging from 2017 to 2021.

## **Integration authorities are beginning to have a positive impact but challenges remain**

**50.** 2016/17 was the first year all integration authorities (IAs) were fully operational. Controlling a budget of £8.2 billion, they are responsible for a wide range of health services, including primary care, mental health, accident and emergency, and adult social care. Their role is to coordinate health and social care services, and to commission NHS boards and councils to deliver services in line with a strategic plan. Our first report on health and social care integration, [Health and social care integration](#) , published in December 2015, sets out the structure and requirements of IAs in more detail.

**51.** IAs published their first annual performance reports in July 2017. IAs are expected to set out their performance against a set of national performance indicators and provide information on their work to move more healthcare into the community and improve patient outcomes, such as better health. It is not possible to identify changes in performance across years and IAs from these reports due to a lack of clarity in how the national measures have been presented. Examples provided in the reports, however, indicate that IAs are beginning to have a positive impact in some areas ([Case study 2, page 29](#)).

**52.** There are still challenges to be overcome in how NHS boards and IAs work together. These include the following:

- Budget-setting: our report, [NHS in Scotland 2016](#) , highlighted there had been difficulties in agreeing IA 2016/17 budgets, mainly due to differences in when local authorities and NHS boards finalise their budgets. This was still the case in 2017/18. Only 17 IAs agreed budgets by March 2017, and these were based on indicative NHS budget offers.
- IAs and NHS boards are still developing clinical governance processes.
- Developing agreed financial reporting timescales: the majority of NHS auditors reported that IAs submitted late financial information to NHS boards for the 2016/17 accounts process. Therefore relevant financial information was not available to boards and auditors at the appropriate time for inclusion in the draft accounts.

We will examine progress in integrating health and social care services in more detail in our second report on integration, due to be published in 2018.

## **Progressing 'realistic medicine' will support the culture change necessary to transform healthcare**

**53.** Realistic medicine is described as putting the person receiving health and care services at the centre of decision-making, creating a personalised approach to their care and promoting responsibility for looking after one's own health. It aims to reduce harm, waste (in terms of interventions, or treatments, that do not add value for patients) and unwarranted variation in practice and patient outcomes, all the while managing risks and innovating to improve.

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## Case study 2



### Examples of how integration authorities are beginning to change the way services are accessed and delivered

- Nationally, there are early signs of improvement in delayed discharges. In March 2017 there was an average of 1,338 beds occupied per day by a delayed discharge, 14 per cent fewer bed days than six months earlier in October 2016.
- Aberdeen City Health and Social Care Partnership has made improvements in delayed discharges, with a 22 per cent reduction in the number of people delayed in hospital at the end of the first full partnership year. This was achieved through initiatives such as ensuring social work staff are part of hospital discharge processes and the use of intermediate care beds, which allow patients and their families more time to consider care options.
- In East Dunbartonshire the Integrated Care Fund funded the Red Cross to provide transport home from A&E for older people, and provide support to settle them back home. In 2016, 118 people were helped by this service, which avoided unnecessary hospital admissions.
- Edinburgh Health and Social Care Partnership worked with Edinburgh Leisure to develop a 'Fit for Health' physical activity programme, to help people manage their long-term conditions. Seventy-eight per cent of participants reported greater wellbeing, including weight loss and improved sleep.
- Orkney Health and Care commissioned NHS Orkney to expand foot care provision through the use of the third sector to provide an alternative service. This has reduced waiting times.

Source: Audit Scotland using ISD Scotland data and IAs' annual performance reports

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**54.** The concept of realistic medicine was introduced by the Chief Medical Officer in her 2014/15 annual report. A vision and strategy were developed the following year, that by 2025 everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of realistic medicine. Actions set out in the Delivery Plan to achieve the vision include the following:

- refreshing the 'Making It Easy' health literacy plan to help everyone in Scotland to live well with any health condition they have
- reviewing the consent process for patients in Scotland – a key element in transforming the relationship between individuals and medical professionals
- incorporating the principles of realistic medicine as a core component in medical education and into medical professionals' working practice

- commissioning a collaborative training programme for clinicians to help them to reduce unwarranted variation
- developing a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost; and reducing the overall cost of medicine.<sup>52,53</sup>

A realistic medicine policy team is currently being put in place to take forward these actions. The Scottish Government has yet to set out how it will measure progress in achieving realistic medicine, for example how it will monitor progress in reducing waste, harm and unwarranted variation and creating a personalised approach to care.

**55.** A range of realistic medicine initiatives are already happening in NHS boards across Scotland. These range from posters in waiting rooms asking patients to think ahead about the questions they should ask doctors in NHS Borders to using data about acute admissions to change practice. An example of the latter includes standardising diabetic foot care processes to reduce variation in NHS Forth Valley. [Case study 3 \(page 31\)](#) illustrates an example of realistic medicine in NHS Lothian.

**56.** Part of the culture change involved in realistic medicine is reducing unwarranted variation in clinical procedures. A person-centred healthcare system means that variation will always exist, but it is important to identify and reduce variation that does not improve patient outcomes and cannot be explained. ISD Scotland, part of NHS National Services Scotland, examines activity data across a range of clinical scenarios to identify potential savings. This work shows a range of potential savings to the NHS. For example:

- If all NHS boards achieved an average length of inpatient stay in line with those operating in the upper quartile of performance, an estimated 91,444 bed days could be saved annually, equating to £31.4 million.
- Reducing the number of inpatient admissions from a set list of procedures and moving them to a day case setting could potentially save £19.8 million annually.
- Some procedures should only be considered when specific thresholds have been met to ensure that they add value to a patient's outcomes. Reducing the number of these procedures, such as tonsillectomies and minor skin lesions, could potentially reduce admissions by almost 21,000 annually, or £39 million.<sup>54</sup>

### **The data needed to transform healthcare is beginning to be put in place**

**57.** It is essential that reliable and comprehensive information is available to support moving more care into the community and to support efforts to manage acute sector demand. We have reported previously that there is a major gap in information about demand and activity for most community health services, including general practice.<sup>55</sup> Two initiatives are under way to try and address this, called 'Source' and LIST.

**58.** The 'Source' project, managed by ISD Scotland, aims to support integration authorities' strategic planning by improving data sharing across health and social care. The project links anonymous individual-level data on health and social care

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## Case study 3

### Realistic medicine activity in NHS Lothian



The Renal Department at NHS Lothian has been practising principles of shared decision-making and person-centred care since 2008. People with end-stage kidney failure often have other health problems and their quality of life is variable; for some the burden of treatment is too much. In 2008, stemming from discussions with patients, the renal service in Edinburgh began to offer an alternative option of conservative care. It was adopted as a culture for all staff. The service runs open evenings every couple of months for those approaching end stages of kidney failure to give them a chance to learn about the different options. It was evolved so that patients now do much of the speaking, with clinical staff in the background. The service has two conservative care nurses that act as a point of contact and support for patients. Patient and family reports are very positive about the service and research has shown that those opting to receive treatment are, on average, likely to live three months longer than those opting not to receive treatment.

Source: Audit Scotland and NHS Lothian

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activity (excluding general practice data), costs, and demographic information to enable IAs to understand how individuals, groups of people, and communities interact with services and how resources are being used. 'Source' is designed to be flexible enough to include additional datasets, for example housing and homelessness data, and there are plans to include GP data from participating practices in the future.

**59.** ISD Scotland is also providing data and analytical support to IAs through the Local Intelligence Support Team (LIST) initiative. This has placed information specialists from ISD Scotland with IAs to build local capacity and capability, facilitate access to national information and expertise, and share methods and results across Scotland. Working jointly with the central ISD Scotland teams, work is driven by local priorities. Examples of work include:

- forecasting service demand and impact of service changes
- examining how individuals and groups move between services
- identifying individuals who most frequently attend accident and emergency departments, to help focus preventative care.

The LIST team also provides some support to community planning partnerships, the third sector, and other organisations. The LIST service is being expanded in 2017/18 to offer support to GP clusters.

**60.** To specifically address the lack of data on general practice in Scotland, NHS NSS is currently rolling out a new system called the Scottish Primary Care Information Resource (SPIRE). SPIRE extracts patient information from GP records in a standardised and secure way and will:

- be used by the NHS in Scotland and researchers to learn more about the health needs of the population, better plan services and support research into new treatments for particular illnesses
- assist GPs by providing tools for practices such as a flu vaccination dashboard and statistics on patients with more than one long-term condition.

SPIRE data will not, however, be automatically linked to the 'Source' data being used by IAs. It is up to individual GP practices to decide if they want their information to be used by IAs. This means there is potential for IAs to plan services without key information on their population and for there to continue to be a lack of reliable and comprehensive data on demand and activity at a national level on general practice.

## **Action is needed as a priority in several key areas if meaningful change is to happen**

### **Governance arrangements for overseeing activity and scrutinising progress need finalised**

**61.** As we set out in [Part 1](#), the Scottish Government is attempting a change programme that is exceptionally large in scale, difficult, and long term. It is essential that a robust governance framework is in place to oversee the work.


**62.** The Health and Social Care Delivery Plan National Programme Board was established to 'provide strategic oversight and operational assurance of the delivery of the Health and Social Care Delivery Plan'.<sup>56</sup> The Programme Board contains representation from across the public sector, including directors from the Scottish Government Health and Social Care Directorate, NHS board Chief Executives and Chairs, COSLA, Integration Authorities and NHS staff representatives. It met for the first time in April 2017. At August 2017, governance arrangements that still need to be addressed:

- Lines of accountability and authority with existing governance structures: the current major work programmes have their own governance arrangements, for example health and social care integration has a Ministerial Strategic Group. Decision-making authority and lines of accountability between these existing structures and the Programme Board are not yet clear and there is potential for duplication and lack of clarity about connections to the work of other groups.
- How to assess progress: the Delivery Plan sets out the government's intention to develop a robust, integrated performance framework for the different components of the delivery plan by early 2017. At August 2017, the Scottish Government was still developing this framework. The Delivery Plan does not set out in detail how the changes described in it will be achieved and many of the actions contained in it are statements of intent rather than actions. Therefore it is important that the performance framework sets out clearly what work is being done and how progress will be measured.
- How to oversee activity: a mapping exercise is currently being carried out of all the work currently under way or planned across the multiple areas of work and programme boards. Completing this exercise will help ensure



there is no duplication across workstreams and will allow the Programme Board to prioritise activity and assess the impact of different activities and decisions on other areas.

### **A financial framework is needed to show how moving healthcare into the community will be funded**

**63.** It is not clear how moving to new ways of providing healthcare will be funded. In our report *NHS in Scotland 2016*  we recommended that the Scottish Government should develop long-term funding plans for implementing the changes set out in the 2020 Vision and the National Clinical Strategy. The Delivery Plan stated that a financial plan would be developed to support the delivery plan. It added that ‘the components within the delivery plan will be financially and economically assessed at key stages in their development...to create a comprehensive assessment of affordability and sustainability’. A financial plan has not yet been developed and it is not clear how, and when, the main work programmes will be assessed.

**64.** A financial framework is needed to show how moving more healthcare into the community will be funded, addressing questions such as:

- What levels of funding are likely to be available in future years, and how does this compare to the likely levels of funding that will be needed in different parts of the system?
- How will existing funding be used differently to deliver health and social care in new ways? Where and when will money be spent or stop being spent?

**65.** Previously we have commented that shifting the balance of care will require either:

- reducing spending on acute services, such as hospital care, to move funding into the community, or
- investing more money in the community to develop and establish new models of care while maintaining spending on acute services.

**66.** Neither are straight forward to achieve financially. Community health services need to be capable of looking after patients before resources can be shifted from acute services. This effectively means double-running services, which requires additional funding. The Scottish Government has announced additional funding in the Delivery Plan of £500 million in primary care by 2021. However, it is not clear how much of this will be new investment or reallocated funding from other areas.

**67.** Currently, there is little indication that the balance of funding between acute and community services will shift in coming years. In 2016/17, NHS boards’ funding from integration authorities was almost exactly the same as the budget they initially provided.<sup>57</sup> Analysis of NHS boards’ 2017/18 LDPs shows that only eight territorial boards plan to increase cash funding to their integration authorities between 2017/18 and 2019/20. The Nuffield Trust in their 2017 report, *Learning from Scotland’s NHS*, examined a sample of NHS board LDPs and found little evidence of multi-year plans to move funding and reduce the number of acute beds. Our own analysis of all territorial NHS board LDPs supports this. The majority of 2016/17 LDPs only discussed the current year’s funding and only a

minority of NHS boards have high-level financial plans for five years. The Ministerial Strategic Group for Health and Community Care is currently considering how it can help integration authorities and NHS boards to shift funding.

**68.** Long-term financial planning is currently difficult, because scenarios which set out potential future demand are still being developed and the financial implications of this for the acute and community sectors are unknown. Future demand for acute services will be influenced by a range of factors. These include:

- how effective community healthcare is in lowering or slowing demand for acute services
- the fact that healthcare needs are not static and will continue to increase as Scotland's population ages
- the impact of efforts to improve the health of the Scottish population.<sup>58</sup>

**69.** The financial consequences of future demand will similarly be influenced by a wide range of factors. These include:

- The level of savings that can be realised from investment in community services. A survey of integration authorities in 2016 by the Health and Sport Committee found only one example in the responses provided of specific savings resulting from investment (North Ayrshire Health and Social Care Partnership provided a specific example of a £600,000 investment in its care at home reablement service that was estimated to have saved 4,710 acute bed days).<sup>59</sup>
- The level of resources that can be freed up in the acute hospital setting given the high levels of fixed costs involved.
- The extent to which structural redesign, such as increased regional planning and management of health services and using national elective centres, results in delivering more efficient services and financial savings.

**70.** A recent submission by the IJB Chief Finance Officers Group to the Health and Sport Committee on the draft budget 2018/19 stated that 'there is emerging evidence which indicates that the current level of resources is less than that required to meet current cost and demand pressures'.<sup>60</sup> An example cited is a funding gap of £30 million that North Ayrshire Health and Social Care Partnership identified over the next two financial years. North Ayrshire stated in its own submission that 'it is unlikely that transformation alone will bridge the gap, and service reductions within community based, preventative services will be required, which is in direct opposition to what the partnership is seeking to achieve'.<sup>61</sup> The lack of financial flexibility NHS boards have and their limited planning horizons makes it difficult for NHS boards, and subsequently integration authorities, to make long-term decisions to redesign health and care services. If the Scottish Government is to achieve its aim of moving more care into the community, it needs to work with NHS boards, integration authorities and local authorities to set out a clear medium and long-term framework for how shifting the balance of care will be funded.

### The Scottish Government does not yet have a strategic approach to capital investment and developing health and social care facilities

**71.** The estate, that is the facilities and buildings needed to provide health and social care services in Scotland, is likely to change significantly as these services become more focused on communities. As integration authorities develop their understanding of their local communities and the services needed, they will identify what primary care and community assets they need. Regional and national planning will also change the estate as services are delivered differently in different locations. A particular example is the development of regional elective centres, which will carry out procedures such as hip, knee and cataract treatments. To ensure the right assets are in the right place at the right time, it is essential that capital investment plans fully support service planning.

**72.** NHS boards have had asset management plans for a number of years and detailed national information is available on the NHS estate and other capital assets, such as equipment and vehicles. However, there is no national capital investment strategy that sets out how capital investment by the Scottish Government and NHS boards supports the aim of moving more care into the community.

**73.** A range of factors make it important that the Scottish Government develops a strategic approach to capital investment in future years. For example:

- There is no national-level information available on how much it would cost to fully fund NHS boards' capital programmes in future years. We have estimated that around £2 billion would be required over the next five years. It is not known what level of funding will be available from the Scottish Government, therefore there is the potential for a funding gap.
- The continuing high level of backlog maintenance, £887 million in 2016/17, and the likely future need for investment in primary care facilities mean there is an opportunity to change the type, location, and size of healthcare facilities.

### Workforce planning needs to improve urgently and staff need to be involved in designing changes to the way they work

**74.** Comprehensive workforce planning across all staffing groups is essential if the appropriate numbers of skilled staff are to be in the right place at the right time as services are provided in new ways. It has become significantly more complex to plan the health workforce due to the integration of health and social care, and regional and national planning arrangements. Integration authorities are now responsible for identifying their local workforce needs in primary and social care and working with NHS boards and local authorities to ensure this links to their respective workforce plans.

**75.** In July 2017, we published *NHS workforce planning: The clinical workforce in secondary care* [\(download icon\)](#), the first report in our two-part audit on the NHS workforce. We found the following:

- Urgent workforce challenges face the NHS in Scotland. These include continuing recruitment and retention difficulties, an ageing workforce, greater use of temporary staff, and the changing demands of an ageing population that is living longer.
- The Scottish Government and health boards have not planned effectively for the long term and responsibility for workforce planning is confused.

- The Scottish Government has not yet adequately estimated what impact increasing and changing demand for NHS services could have on the workforce or skills required to meet this need.

**76.** The Scottish Government aimed to publish a single national workforce plan in early 2017. This became three plans. The first, *National Health and Social Care Workforce Plan - Part 1*, published in June 2017, covers the NHS workforce.<sup>62</sup> The second plan, covering the social care workforce is due to be published in autumn 2017, and the third, covering primary care is due to be published by the end of 2017. Part 1 is not a detailed plan to address immediate and future issues, rather it is a broad framework to consider future workforce planning challenges. The Scottish Government is likely to find it challenging to provide any more detail in the next two plans. This is due to a lack of national data on the primary care and social care workforces and the fact that integration authorities are still in the early stages of identifying their workforce needs in their areas.

**77.** In our report, we recommended that the Scottish Government:

- improves understanding of future demand to inform workforce decisions, including carrying out scenario planning on the future populations' health demand and workforce supply changes
- provides a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups
- sets out the expected transitional workforce costs and expected savings associated with implementing NHS reform; this includes collating transitional costs attached to greater regional and national working, costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.

We will publish a second report on the community-based NHS workforce, including those employed by general practices as part of our future work programme.

**78.** Change to the way services are delivered has significant implications for the NHS workforce. How people do their job, where they work, and the types of work they undertake will change in future years. And it is not just staff in the community that will be affected; embedding realistic medicine principles will change how everyone works. NHS boards currently work with staff in a range of ways, including staff forums, newsletters and by using social media. It is essential staff are fully involved in designing changes to services and roles or change will not be successful.

### **Agreeing a new GP contract is critical to delivering more care in the community**

**79.** The Scottish Government and BMA are currently negotiating a new GP contract. This was expected to be completed by April 2017 but is now scheduled for April 2018 depending on GPs voting to agree the new contract in December 2017. The contract aims to set out a new role for GPs, agree a new payment scheme, and agree measures to resolve current challenges relating to GP premises, and recruitment and retention. Delivering primary care in different ways and moving more care into the community is dependent on the agreement reached in the new contract.

**80.** Recent work at a national level has set out the Scottish Government's aim to make GPs the lead clinical decision-maker in the community, working with a multi-disciplinary team. This will involve other professions, such as physiotherapists and nurses taking on some of the current responsibilities of GPs ([Case study 4](#)).<sup>63</sup>

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## Case study 4

### Future role of the GP within a wider multidisciplinary team



In February 2016, the Scottish Government's *A National Clinical Strategy for Scotland* proposed a revised role for the GP. This will see the GP as the senior clinical decision-maker in a wider community multi-disciplinary team, who will focus on:

- the complex care and management of people in the community
- people attending the practice with the first presentation of illness.

Alongside this is the introduction of GP clusters – typically made up of between four and eight practices covering 20,000 to 40,000 patients. This will see GPs directly involved in improving the quality of all health and social care provided to patients in their area, including secondary care. Two roles have been created within the clusters:

- cluster quality lead – a GP from the cluster with responsibility to provide a continuous quality improvement leadership role. The cluster quality lead liaises with practices, the board and the integration authority on quality improvement issues.
- practice quality lead – a GP from each practice who has responsibility to link with the cluster quality lead. Practice quality leads in a cluster will meet regularly to discuss the quality of care in their area.

Other health and care professionals in the multidisciplinary team will take on a greater role in the care of patients to alleviate some of the workload pressures on GPs. For example:

- Pharmacists' role will be considerably enhanced, with their expertise ensuring that people with complex medication regimes have their care optimised.
- Advanced physiotherapists will work within GP practices to provide enhanced care for those patients with musculoskeletal issues.
- Advanced nurse practitioners will take on more routine tasks usually carried out by a GP.

Source: Audit Scotland using *A National Clinical Strategy for Scotland*, February 2016; *Improving Together: A National Framework for Quality and GP Clusters in Scotland*, January 2017

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**81.** A range of work is currently ongoing as part of, and related to, the contract negotiations to identify ways to resolve the challenges facing general practice as set out in [Part 1](#). This includes the following:

- Modelling future demand scenarios to identify workforce requirements for both GPs and the wider primary care workforce.
- Identifying options for how to plan and manage GP facilities. The Cabinet Secretary for Health and Sport is currently considering findings from a working group set up by the Scottish Government and BMA to examine this issue.
- Additional investment in primary care by the Scottish Government. A £500 million investment in primary care by 2021 announced in October 2016, included £71.6m to be invested in 2017/18 to improve GP recruitment and retention, stabilise GP pay and make general practice a more attractive profession. The GP recruitment and retention fund is increasing from £1 million in 2016/17 to £5 million in 2017/18 to fund GP training bursaries, expand the GP returners scheme and increase the GP retainer reimbursement scheme.

### Open and regular involvement with local communities about the NHS will be needed to develop options for delivering services differently

**82.** NHS boards have had legal duties to involve the public in designing services for a number of decades. More recently, the Public Bodies (Joint Working) (Scotland) Act 2014 also placed duties on Integration Authorities. The Community Empowerment (Scotland) Act 2015 (the Act) marked a significant shift in the Scottish Government's expectations of how the Scottish public should be involved in decisions that affect them. NHS boards, integration authorities, and local authorities all have legal duties placed on them by the Act. The Act:

- provides a statutory basis for community planning partnerships and places duties on them for the planning and achievement of local outcomes. NHS boards and integration authorities have a legal duty to participate in community planning.
- means that community groups can make a request to a public body, such as an NHS board, to get involved in trying to make services better. The public body must agree to the request unless there are reasonable grounds for refusing it.
- gives communities greater rights to buy land and to request asset transfers for any land or buildings which a public body owns, or rents from someone else. Public bodies must agree to the asset transfer request unless there are reasonable grounds for refusing it.<sup>64</sup>

**83.** Proposals to change the way health services are delivered attract considerable attention. As we noted last year, NHS boards can face considerable public and political resistance to proposed changes to local services.<sup>65</sup> The Scottish Government's transformation programme is based on changing the way services are delivered. It is therefore critical that NHS boards and integration authorities are able to do this. This means working with the public to develop a shared understanding and agreement on the need for, and benefits of, change, and then to develop and agree ways to provide services differently.

**84.** NHS boards and integration authorities are working with their local populations in a range of ways. A review of a sample of integration authorities' annual reports for 2016/17 found examples such as a public participation forum

used by Scottish Borders Health and Social Care Partnership to engage directly with members of the public. This meets six times a year to make decisions about local services. East Renfrewshire Integration Authority has held team-building days involving young people, elected members and senior managers. NHS boards are also working with their local populations, for example through media campaigns and involving patient representatives on working groups. The Scottish Government has set up a citizens' panel with 1,300 members of the public from across Scotland and developed 'Our Voice' framework to help involve people in improving health and social care.

**85.** National Standards for community engagement have been in place since 2005. These were revised in 2016 and are good practice principles for organisations to use when working with communities. It is important that NHS boards and integration authorities refer to these to ensure their work with the public is meaningful and achieves the desired outcome.

### **More information will help to involve staff and communities in developing the future of healthcare**

**86.** It is important the public, staff, and elected officials are able to easily access information about how the NHS and integration authorities are performing. This is so that they can get involved with and hold these bodies to account. Our audit work has identified a range of areas where transparency could improve. Examples are as follows:

- Not all NHS boards or integration authorities publish all board and committee meeting papers and minutes on their websites.
- The public are not able to attend committee meetings in some NHS boards.
- Regular data is lacking in some areas of the NHS. For example:
  - Currently no data is published on most aspects of primary care such as how many consultations are undertaken and the types of conditions seen. There is little reliable information on the primary care workforce, for example staff employed by general practices, such as nurses and Allied Health Professionals, including physiotherapists and podiatrists.
  - Public information is lacking in areas such as waiting lists for inpatient and outpatient specialties in NHS boards. Most NHS boards do not publish information on the length of their waiting lists or inform patients of their likely wait to be seen.

### **All parts of the public sector need to have a shared commitment to, and clear actions on, improving the health of the public in Scotland**

**87.** Although public health has traditionally been seen as the domain of the NHS, as little as ten per cent of a population's health and wellbeing is linked to access to healthcare. Factors such as the local environment, housing, transport and employment all affect people's health.<sup>66</sup> It is therefore important that, across all parts of the public sector, there is a shared understanding of, and commitment to, improving the health of the public in Scotland.

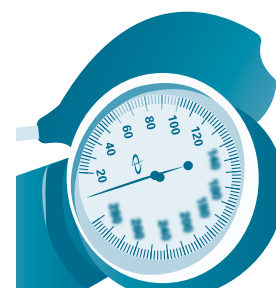
**88.** Improving people's health is a key part of the Scottish Government's vision for transforming health and social care. A healthier population is likely to reduce the future burden on health and social care services as fewer people develop conditions stemming from unhealthy lifestyles. Yet it will not be a quick process






and may take decades before any meaningful financial savings can be identified. The BMA's submission to the Health and Sport Committee's investigation into the prevention agenda in 2016 illustrates this point. It noted that measures that reduced obesity in children and young adults might not lead to financial savings in health services until they reached middle to older age. This was when weight-related complications would otherwise be more likely to occur.<sup>67</sup>


**89.** As part of the Delivery Plan, the Scottish Government committed to developing a public health strategy and creating a new single, national public health body. The Scottish Government has been working with COSLA to agree a joint set of public health priorities by the end of 2017. The new public health body will come into existence at the start of 2019 and a Public Health Reform Oversight Group has been set up by the Scottish Government to oversee its development. It will bring together the existing functions of Health Scotland and Health Protection Scotland and potentially ISD Scotland which is currently part of NHS National Services Scotland. Work to take forward the national public health priorities at a local level will be started once the new body is in place.






# Endnotes



- ◀ 1 *Overall NHS Scotland workforce summary by staff grouping*, ISD Scotland, June 2017.
- ◀ 2 Procedures data is for 2015/16 and provisional (this is the most recent data available); *Number and types of procedures carried out by health board*, ISD Scotland, 2017.
- ◀ 3 *Annual Report and Accounts for Year ending 31 March 2017*, Scottish Ambulance Service, 2017.
- ◀ 4 GP consultations data is an estimate based on actual data at 2012/13 from our report, [Changing models of health and social care](#) , Audit Scotland, March 2016.
- ◀ 5 *NHS Consolidated Accounts for financial year 2016/17*, Scottish Government, 2017.
- ◀ 6 *NHS Scotland Staff Survey 2015 National Report*, Scottish Government, December 2015; *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2017.
- ◀ 7 This vision has its roots as far back as 2000, with the publication of the joint futures agenda. See [Reshaping care for older people](#) , Audit Scotland, February 2014, [Exhibit 3 \(page 12\)](#) for a policy summary.
- ◀ 8 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.
- ◀ 9 *Revenue and Capital expenditure limits, NHS Consolidated Accounts*, Scottish Government, July 2017.
- ◀ 10 Real terms increase excluding accounting changes – source is *Draft budget 2016/17: Health and Sport*, SPICe Briefing, December 2015.
- ◀ 11 This includes the £250 million social care funding for integration authorities in 2016/17.
- ◀ 12 *Draft budget 2017/18*, Scottish Government, December 2016.
- ◀ 13 Information provided by Scottish Government, July 2017.
- ◀ 14 *NHS Consolidated Accounts for financial year 2016/17*, Scottish Government, 2017.
- ◀ 15 [NHS in Scotland 2016](#) , Audit Scotland, October 2016.
- ◀ 16 [NHS in Scotland 2015](#) , Audit Scotland, October 2015.
- ◀ 17 *Medicines Costs in Scotland*, Healthcare Financial Management Association Briefing, July 2017.
- ◀ 18 *Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times*, ISD Scotland, August 2017.
- ◀ 19 [NHS in Scotland 2015](#) , Audit Scotland, October 2015.
- ◀ 20 *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2016.
- ◀ 21 The hospital standardised mortality ratio (HSMR) is based on all acute inpatient and day case patients admitted to all specialties in hospital. The calculation takes account of patients who died within 30 days from admission and includes deaths that occurred in the community as well as those occurring in hospitals. HSMR is equal to observed deaths divided by predicted deaths.
- ◀ 22 *Scottish Patient Safety Programme Acute Adult End of Phase Report*, Healthcare Improvement Scotland, August 2016.
- ◀ 23 *Learning from Scotland's NHS*, The Nuffield Trust, July 2017.

- ◀ 24 *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2016.
- ◀ 25 *NHS Scotland Complaints Statistics 2016/17*, ISD Scotland, October 2017.
- ◀ 26 *Survey of GPs*, BMA, 2017; *Draft budget 2018-19 submission*, RCN, 2017.
- ◀ 27 *Table 1: Expectation of life, by sex and selected age, Scotland 1861 to 2015*, National Records for Scotland, September 2016.
- ◀ 28 *Healthy life expectancy: key points*, Scottish Public Health Observatory, December 2016.
- ◀ 29 *Table 1: All ages age-standardised death rates for all causes and certain selected causes, Scotland, 1994 to 2016; Age-standardised death rates calculated using the European Standard Population*, National Records of Scotland, August 2017.
- ◀ 30 *Scotland's Population 2016 – The Registrar General's Annual Review of Demographic Trends*, National Records of Scotland, August 2017.
- ◀ 31 National Records of Scotland report that differences in coding, coverage and under-reporting in some countries means that the comparison between Scotland and other countries should be viewed with caution. *Drug-related deaths in Scotland in 2016*, National Records of Scotland, August 2017.
- ◀ 32 *Scottish Health Survey 2016*, Scottish Government, October 2017.
- ◀ 33 Ibid.
- ◀ 34 *The Scottish Burden of Disease Study 2015*, the Scottish Public Health Observatory, July 2017.
- ◀ 35 *Table 1: Chronic Liver Disease: Deaths rate (EASR) per 100,000 population, for Scotland by gender, calendar years of registration of death 1982-2015*, Scottish Public Health Observatory, December 2016; *Scottish Stroke Statistics Publication Summary*, ISD Scotland, February 2017.
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- ◀ 37 *The Scottish LGBT Equality Report*, Equality Network, July 2015.
- ◀ 38 *Measuring use of health services by equality group*, NHS National Services Scotland, 2017.
- ◀ 39 *Scotland's Population 2016 – The Registrar General's Annual Review of Demographic Trends*, National Records of Scotland, August 2017.
- ◀ 40 Between 2009 and 2013, the most recent data available, healthy life expectancy among those living in the least deprived areas in Scotland was 72.7 years for men and 74.1 years for women, compared to 51.1 years for men, and 65.3 years for women living in the most deprived areas. *Health life expectancy: deprivation deciles*, Scottish Public Health Observatory, December 2015.
- ◀ 41 The highest proportion, 29.4 per cent, of patients living in the most deprived areas were diagnosed at stage 4. Of those living in the least deprived areas, the highest proportion, 28.6 per cent, were diagnosed at stage 2. *Detect cancer early staging data: Year 5*, ISD Scotland, July 2017.
- ◀ 42 *Who attends Emergency Departments*, ISD Scotland, September 2015.
- ◀ 43 *GP Census*, ISD Scotland, December 2016.
- ◀ 44 Actual data for 2012/13 is from *GP Practice Team Information*, ISD Scotland, October 2013. Data for 2016/17 is estimated using the same projection methods as in [Changing models of health and social care](#) , Audit Scotland, March 2016.
- ◀ 45 *Understanding pressures in general practice*, The Kings Fund, 2016.
- ◀ 46 *GP Census*, ISD Scotland, December 2016.
- ◀ 47 *Vacancy survey shows GP recruitment problems*, News Release, BMA, June 2017.

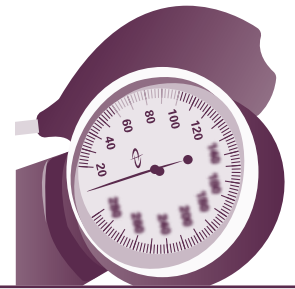
- ◀ 48 *GP Census*, ISD Scotland, December 2016.
- ◀ 49 *Survey shows pressures on GPs in Scotland*, News Release, BMA, December 2016.
- ◀ 50 Ibid.
- ◀ 51 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.
- ◀ 52 Ibid.
- ◀ 53 A formulary specifies the drugs GPs and other prescribers should use for different conditions based on their clinical effectiveness, safety, and cost effectiveness. There are currently ten formularies in Scotland.
- ◀ 54 Data supplied by ISD Scotland, July 2017. Data is standardised for age, gender, and deprivation. The savings opportunities identified may not necessarily be cash-releasing. They may instead provide opportunities to reinvest or address new demands. The figures stated should not be added together as the savings may span a number of clinical areas.
- ◀ 55 [NHS in Scotland 2016](#) , Audit Scotland, October 2016.
- ◀ 56 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.
- ◀ 57 [NHS in Scotland 2016](#) , Audit Scotland, October 2016. Comparable 2017/18 data was not available at the time of writing.
- ◀ 58 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, BMA Scotland, 2017.
- ◀ 59 *Health and Social Care Integration Budgets, 2nd Report 2016 (Session 5)*, Health and Sport Committee, Scottish Parliament, November 2016.
- ◀ 60 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, CIPFA IJB Chief Finance Officer Section and CIPFA, July 2017.
- ◀ 61 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, North Ayrshire Health and Social Care Partnership, 2017.
- ◀ 62 *National Health and Social Care Workforce Plan - Part 1 a framework for improving workforce planning across NHS Scotland*, Scottish Government, June 2017.
- ◀ 63 See the *National Review of Primary Care Out-of-Hours Services*, November 2015; *A National Clinical Strategy for Scotland*, February 2016; *Health and Social Care Delivery Plan*, December 2016.
- ◀ 64 *Community Empowerment (Scotland) Act 2015*, Scottish Parliament, July 2015.
- ◀ 65 [Changing models of health and social care](#) , Audit Scotland, March 2016.
- ◀ 66 *What makes us healthy?*, The Health Foundation, June 2017.
- ◀ 67 *Submission on Preventative Agenda*, Health and Sport Committee, Scottish Parliament, BMA, 2017.

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# Appendix 1

## Audit methodology

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This is our annual report on how the NHS in Scotland is performing. Our audit assessed how well the NHS managed its finances and performance against targets in 2016/17 and how well the NHS is adapting for the future.

Our findings are based on evidence from sources that include:

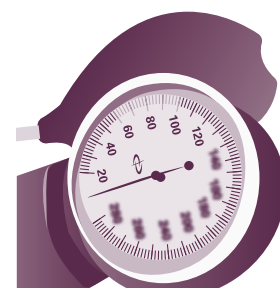
- the audited annual accounts and auditors' reports on the 2016/17 audits of the 22 NHS boards
- Audit Scotland's national performance audits
- NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as indicative spending plans for the next three years
- activity and performance data published by ISD Scotland, part of NHS National Services Scotland
- publicly available data and information on the NHS in Scotland including results from staff and user surveys
- interviews with senior officials in the Scottish Government, professional bodies, and a sample of NHS boards and integration authorities.

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 the NHS is included in [Appendix 2 \(page 45\)](#).

# Appendix 2

## Financial performance 2016/17 by NHS board

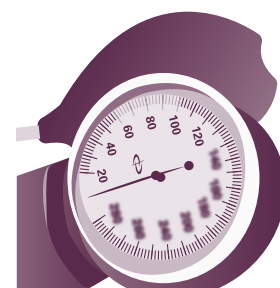


Board	Core revenue outturn (£m)	Total savings made (£m) Annual Audit Report	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	743.7	25.4	20%	0.7%
Borders	220.5	8.1	53%	2.3%
Dumfries and Galloway	311.1	12.7	43%	4.6%
Fife	665.6	30.8	71%	-0.2%
Forth Valley	532.5	23.8	7%	-1.0%
Grampian	983.0	26.5	43%	-1.4%
Greater Glasgow and Clyde	2273.7	69.0	33%	1.6%
Highland	664.4	22.1	60%	-1.5%
Lanarkshire	1204.3	45.9	20%	-1.5%
Lothian	1457.1	24.5	16%	-1.5%
Orkney	52.8	2.2	47%	0.6%
Shetland	54.8	4.2	54%	-0.9%
Tayside	803.1	45.5	49%	0.3%
Western Isles	80.1	4.0	43%	9.4%
Healthcare Improvement	27.6	1.9	61%	
National Services Scotland	394.5	18.1	0%	
National Waiting Times Centre	65.1	4.4	11%	
NHS 24	71.6	3.3	2%	
NHS Education for Scotland	436.0	2.6	26%	
NHS Health Scotland	19.1	0.9	9%	
Scottish Ambulance Service	221.1	9.9	45%	
State Hospital	32.1	1.8	86%	
Mental Welfare Commission	4.3			

Note. The Mental Welfare Commission does not provide savings figures.

# Appendix 3

## NHS performance against key LDP standards by NHS board in 2016/17



Measure	Child and Adolescent Mental Health Services (CAMHS), patients seen within 18 weeks	Drug and alcohol treatment, patients seen within 3 weeks	Referral to treatment (RTT), patient journeys within 18 weeks	Referral to outpatient appointment, patients waiting less than 12 weeks
	standard = 90%	standard = 90%	standard = 90%	standard = 100%, interim 95%
Ayrshire and Arran	93.8	96.8	73.6	82.6
Borders	98.4	94.4	90.0	90.8
Dumfries and Galloway	100.0	97.1	89.5	92.0
Fife	84.5	96.6	89.1	95.5
Forth Valley	99.7	98.7	79.4	81.6
Grampian	45.2	93.3	74.5	72.6
Greater Glasgow and Clyde	98.0	96.8	89.7	86.0
Highland	96.0	84.0	78.2	63.4
Lanarkshire	87.2	99.8	78.7	83.4
Lothian	47.8	83.3	79.1	72.7
Orkney	100.0	100.0	94.3	67.8
Shetland	100.0	88.9	84.2	68.1
Tayside	95.2	96.7	86.7	86.0
Western Isles	100.0	94.2	95.6	95.6
<b>National total</b>	<b>83.6</b>	<b>94.9</b>	<b>83.2</b>	<b>80.7</b>

Key	Green = Standard met
	Red = Standard missed

Measure	Inpatient / day case treatment time guarantee (TTG), patients beginning treatment within 12 weeks	A&E, Patients seen within 4 hours	Cancer referral to treatment, patients beginning treatment within 62 days	Cancer decision to first treatment, patients beginning treatment within 31 days
	standard = 100%	standard = 98%, interim 95%	standard = 95%	standard = 95%
Ayrshire and Arran	86.6	93.7	92.8	99.7
Borders	95.7	93.2	95.1	98.3
Dumfries and Galloway	86.3	93.7	96.3	96.5
Fife	91.2	95.2	80.5	97.8
Forth Valley	63.5	97.2	89.3	96.6
Grampian	74.4	96.1	86.2	92.2
Greater Glasgow and Clyde	87.2	90.7	83.3	93.9
Highland	75.8	96.8	87.2	97.8
Lanarkshire	66.7	90.0	95.9	96.9
Lothian	81.4	95.7	90.6	93.6
Orkney	90.3	97.5	84.6	100.0
Shetland	98.1	97.1	94.1	100.0
Tayside	81.2	98.6	89.6	93.1
Western Isles	100.0	99.3	85.0	100.0
<b>National total</b>	<b>82.2</b>	<b>93.8</b>	<b>88.1</b>	<b>94.9</b>

## Sources:

CAMHS Waiting Times – Number of patients seen during the month by health board, Quarter ending March 2017; ISD Scotland, September 2017

Drugs and alcohol – Waiting times for referral to treatment, quarter ending March 2017; ISD Scotland, September 2017

18 weeks referral to treatment (RTT), Month ending March 2017; ISD Scotland, August 2017

New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2017, August 2017

Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2017; ISD Scotland, August 2017

Accident and Emergency: attendances and time in department by NHS board and month, Month ending March 2017; ISD Scotland, July 2017

Performance against the 62 day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, Quarter to March 2017; ISD Scotland, September 2017

Performance against the 31 day standard from date decision to treat to first cancer treatment by NHS board, Quarter to March 2017, ISD Scotland, September 2017.

# NHS in Scotland 2017

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