NHS in Scotland 2018

AUDITOR GENERAL

Prepared by Audit Scotland
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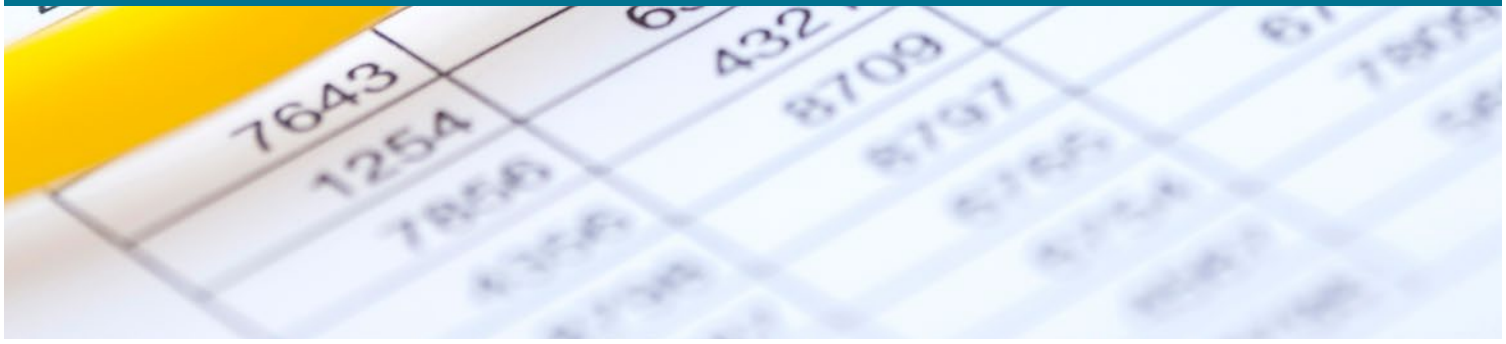

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Interactive Tableau exhibit, where further information can be viewed at an NHS board level

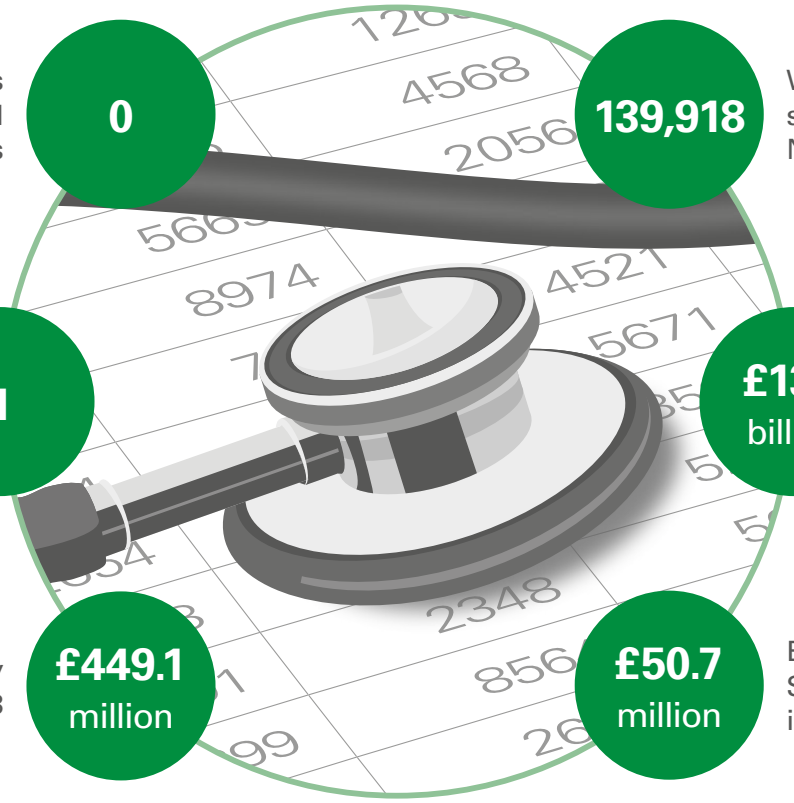
Exhibit data

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.

Audit team

The core audit team consisted of: Leigh Johnston, Kirsty Whyte, Nichola Williams, Martin Allan, Agata Maslowska, and Veronica Cameron, with support from other colleagues and under the direction of Claire Sweeney.

Key facts



0
Number of boards meeting all key national performance targets

139,918
Whole time equivalent staff employed by the NHS

1
Key national performance target met

£13.1 billion
Total Scottish Government health budget in 2017/18

£449.1 million
Total savings made by NHS boards in 2017/18

£50.7 million
Brokerage provided by Scottish Government in 2017/18

Summary

Key messages

1 To meet people's health and care needs, the NHS urgently needs to move away from short-term fire-fighting to long-term fundamental change. The type of services it offers, and the demand for those services, have changed significantly over the 70 years since the NHS was created. The challenges now presented by an ageing population means further and faster change is essential to secure the future of the NHS in Scotland.

2 The NHS in Scotland is not in a financially sustainable position. NHS boards are struggling to break even, relying increasingly on Scottish Government loans and one-off savings. The Scottish Government's recent health and social care medium-term financial framework and other measures are welcome steps but more needs to be done.

3 The pressure on the NHS is increasing. Performance against the eight key national performance targets continues to decline. No board met all of the key national targets. Only three boards met the 62-day target for cancer referrals. The number of people on waiting lists also continues to increase. The only target met nationally in 2017/18 was for drug and alcohol patients to be seen within three weeks.

4 The scale of the challenges means decisive action is required, with an urgent focus on the elements critical to ensuring the NHS is fit to meet people's needs in the future. These include being clear about how the NHS is governed, multiple planning layers exist at local and national level, it is unclear how regional planning will operate in the future and health and social care integration continues to develop.

5 Ensuring effective leadership is also critical. Much more engagement and information is needed about how new forms of care will work, what they cost and the difference they make to people's lives. Without this, it will continue to be difficult to build support among the public and politicians to make the decisions needed to change how healthcare is delivered in Scotland.

decisive action is required to secure the future of the NHS in Scotland

Recommendations

The Scottish Government should:

- develop a robust and transparent financial management system for managing and monitoring NHS boards' new year-end flexibility and three-year break-even arrangement

- ensure NHS governance arrangements are clear and robust by making sure roles and responsibilities are explicit and lines of accountability are clear at each planning level

- report publicly on the progress of the Health and Social Care Delivery Plan, including measures of performance covering all parts of the healthcare system to show progress towards delivering more healthcare in the community.

The Scottish Government, in partnership with NHS boards, should:

- strengthen board-level governance arrangements, including developing an improved national approach to induction, training, and assessment for non-executive directors

- identify why NHS leadership posts are difficult to fill and develop ways to address this.

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

- develop a national capital investment strategy to ensure capital funding is strategically prioritised

- 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.

The Scottish Government, NHS boards and integration authorities should:

- work together to develop a clearer understanding of demand for services, and capacity and activity trends within primary and secondary care and use this to inform medium to long-term service and workforce planning

- publish clear and easy to understand information on how the health funding system works, including how much funding was provided, what it was spent on, and the impact it has on people's lives

- put NHS staff, local communities, and the public at the heart of change and involve them in planning and implementing changes to how services are accessed and delivered.

Introduction

1. The NHS is 70 years old this year and continues to provide a range of vital services to thousands of people every day across the country. In 2017/18, the NHS in Scotland:

- employed almost 140,000 (whole-time equivalent) staff across 14 mainland and island NHS boards and eight national boards
- conducted an estimated 17 million GP consultations
- carried out four million outpatient appointments
- responded to 764,201 emergencies
- spent £13.1 billion on healthcare.[1,2,3,4,5]

2. Over the years we have highlighted the growing pressures facing the NHS in our national and local audit work. These include a tight financial environment, increasing demand for services, difficulties in recruiting staff, and rising public and political expectations. In the face of these pressures, a committed workforce has continued to work to deliver high-quality care. However, the demands of a growing and ageing population on top of these pressures mean the current healthcare delivery model is not sustainable.

3. The Scottish Government set out how it wants healthcare and the health of the Scottish population to change in its 2020 Vision, published in 2011.[6] Its aim is that everyone should live longer, healthier lives at home or in a homely setting by 2020, and significant activity is under way to work towards this. However, progress is too slow and major issues still need to be addressed if the vision is to be achieved. These include ensuring the NHS is financially sustainable in the medium to longer term, recruiting the right number of skilled staff in the right places, identifying what the public wants from its healthcare system, and fully integrating health and social care services.

4. This report sets out why immediate action is needed, identifying the financial and performance position of the NHS in Scotland in 2017/18. Part 2 of the report sets out what needs to change to ensure the NHS can continue to meet the needs of the Scottish people.

Part 1

Why is immediate action needed?

Key messages

1 The overall health budget in 2017/18 was £13.1 billion, a 0.2 per cent decrease in real terms on the previous year. The NHS struggled to break even. Three boards required a loan from the Scottish Government and the majority relied on short-term measures to balance their books. NHS boards achieved unprecedented savings of £449.1 million in 2017/18 by relying heavily on one-off savings. This is not sustainable.

2 The pressures facing the NHS continue to intensify. Financial pressures such as drug costs, a backlog of maintenance, and the use of temporary staff are predicted to continue in future years. Projected funding increases are unlikely to be enough to keep pace with rising health costs and the need for investment in the NHS estate. EU withdrawal will mean additional challenges, including recruiting and retaining staff and procuring vital supplies such as drugs.

3 Performance declined against the eight key national targets between 2016/17 and 2017/18. More people waited longer for outpatient and inpatient appointments. The number of people waiting over 12 weeks for their first outpatient appointment increased by six per cent in the past year, while the number waiting over 12 weeks for an inpatient appointment increased by 26 per cent. No board met all eight targets. Only one of the eight key performance targets was met nationally– for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within three weeks.

4 The NHS faces significant workforce challenges. Recruitment remained difficult in 2017/18, while sickness absence and turnover increased.

the NHS is not in a financially sustainable position and performance against national targets is declining

The NHS is not in a financially sustainable position

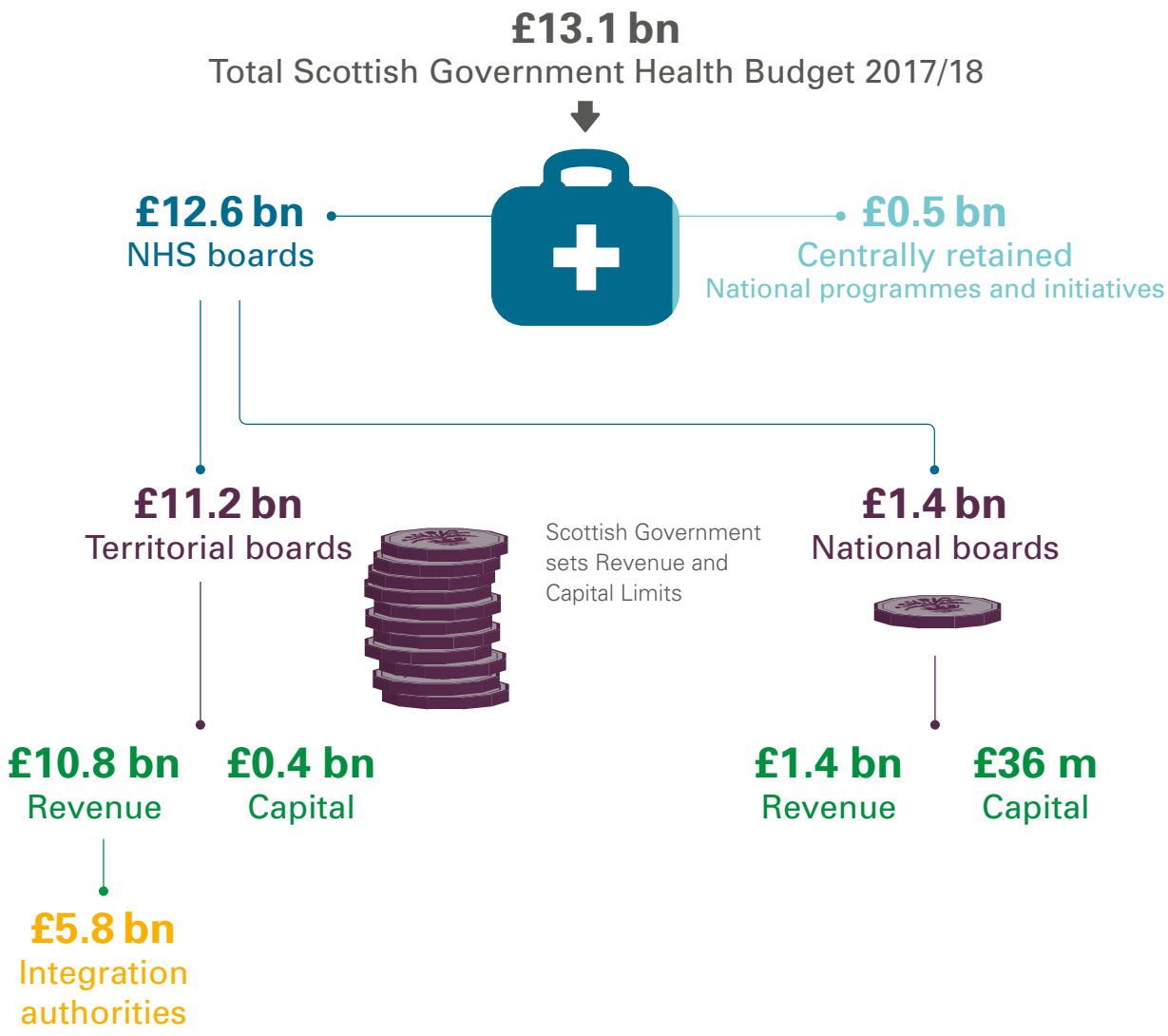
5. Financial sustainability considers whether a body is likely to be able to continue delivering services effectively or change how services are delivered in the medium to longer term with the available resources. We have looked at a number of measures which indicate risks to the sustainability of the NHS and we examine these below.

6. In 2017/18, the total Scottish Government health budget for spending on core services was £13.1 billion.[7,8] Health remains the single largest area of Scottish Government spending, accounting for 42 per cent of the total budget in 2017/18. The majority of health funding is provided to territorial boards to deliver services (Exhibit 1, page 9).

Exhibit 1

Health funding breakdown 2017/18

The majority of funding in 2017/18 was given to mainland and island NHS boards.



Source: Audit Scotland using Scottish Government draft budget 2018/19 and NHS Consolidated Accounts for financial year 2017/18

7. NHS boards delegate a significant percentage of their budget (£5.8 billion, 46 per cent in 2017/18) to integration authorities to fund health services such as primary and community care.[9] We will be publishing our second report on health and social care integration in November 2018.

8. Between 2016/17 and 2017/18, the overall health budget increased by 1.5 per cent in cash terms. Taking inflation into account, the budget decreased by 0.2 per cent:

- Revenue funding for day-to-day spending increased by 0.8 per cent in real terms (2.5 per cent in cash terms).

- Capital funding, for example for new buildings and equipment, decreased from £524.5 million to £408 million. This was a decrease of 23.5 per cent in real terms (22.2 per cent in cash terms). This was mainly due to the new Dumfries and Galloway Royal Infirmary being completed and the near completion of NHS Lothian's new Royal Hospital for Sick Children and Department of Clinical Neurosciences.

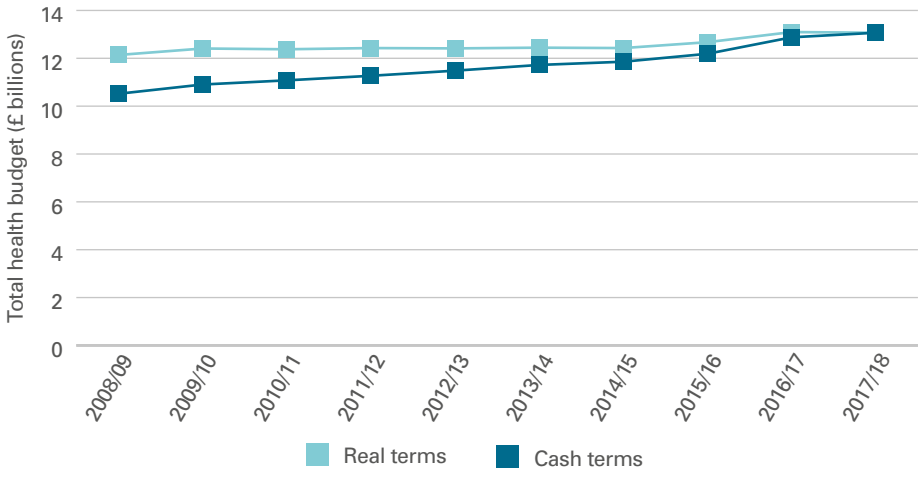
9. In 2017/18, NHS boards' budgets included £107 million ring-fenced funding for health and social care integration. NHS boards were required to pass this funding directly to integration authorities.

10. The overall health budget has increased by 7.7 per cent in real terms over the past decade (Exhibit 2). Revenue funding increased by 9.7 per cent between 2008/09 and 2017/18, while capital funding reduced by 32 per cent. This has mainly been driven by funding increases in the most recent four-year period, with the total budget increasing by five per cent since 2014/15.

Exhibit 2

Trends in the health budget in Scotland, 2008/09 to 2017/18

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



Source: Audit Scotland

11. Although health funding has increased over the past decade, funding per head of population has increased at a slower rate. In 2017/18, health funding in Scotland was £2,409 per person. This compares to £2,333 in 2008/09, a 3.3 per cent increase in real terms.[10]

The NHS met its overall financial targets in 2017/18, but boards are struggling to break even

12. NHS boards have been required by the Scottish Government to break even at the end of each financial year. This means that they must stay within the limits of their revenue and capital budgets. All NHS boards broke even in 2017/18, achieving an overall surplus of 0.07 per cent, £8.5 million.[11]

13. The majority of boards used short-term measures to break even. These included:

- Late allocations of funding from the Scottish Government. NHS Greater Glasgow and Clyde received a late allocation of £8 million for winter beds and acute strategy in February 2018 which allowed them to break even at year-end (31 March 2018).
- Reallocating capital funding to revenue funding to cover operating costs–for example, in NHS Borders, Forth Valley, Greater Glasgow and Clyde, and Tayside.
- Postponing new investments and using slippage on funding–for example, in NHS Borders, NHS Grampian and NHS National Services Scotland.
- One-off gains, including writing off accruals and lower than budgeted medical negligence payments. This was the case in NHS Greater Glasgow and Clyde and NHS Lanarkshire.

More boards are predicting year-end deficits

14. In 2015/16, all territorial NHS boards predicted at the start of the year that they would break even or record a surplus. In 2016/17, three boards predicted they would be in deficit at the end of the year. This increased to seven in 2017/18. In 2018/19, eight boards predicted at the start of the year that they would be in deficit at the end of the year.[12]

15. The size of the predicted deficits is also growing. In 2015/16, territorial boards predicted at the start of the year they would achieve an overall surplus of £0.5 million at year-end. In 2016/17, this moved to a predicted deficit of £34.1 million. A year later, this figure had almost tripled with boards predicting a deficit of £99.3 million by the end of financial year 2017/18.[13]

16. In the 2017/18 annual audit reports, auditors highlighted significant levels of risk around boards' ability to break even in 2018/19. At May 2018, NHS boards were predicting a deficit of £131.5 million in 2018/19.[14]

The amount of loans provided by the Scottish Government to enable boards to break even is increasing

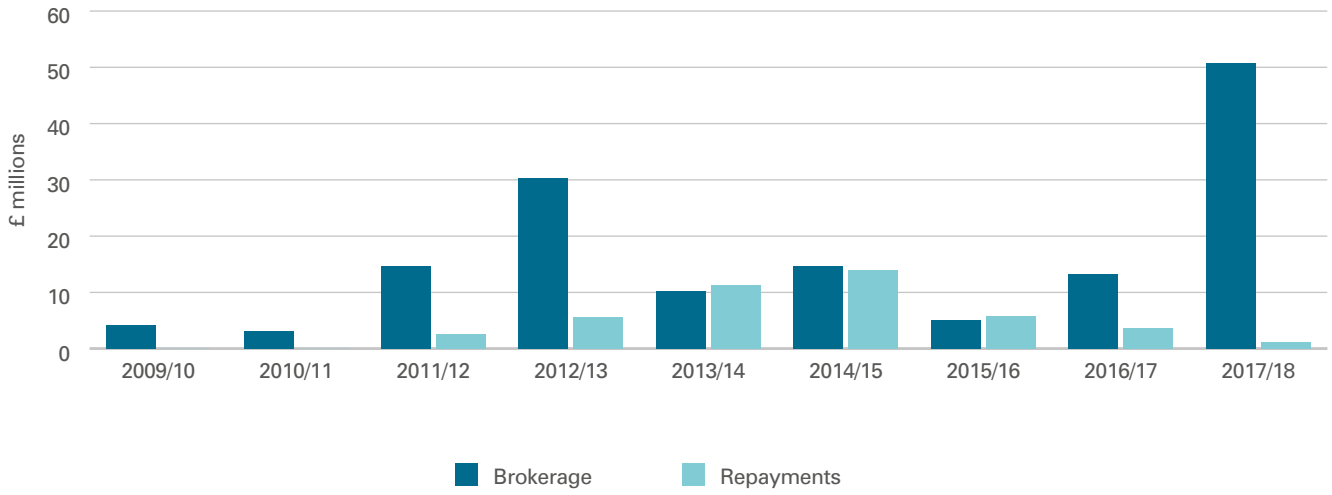
17. In 2017/18, the Scottish Government provided loans totalling £50.7 million to NHS Ayrshire and Arran, Highland, and Tayside. This allowed them to break even. This is significantly more than in 2016/17 and in previous years (Exhibit 3, page 12). The total amount of outstanding loans across all NHS boards at the end of 2017/18 was £102 million. Four boards (NHS Ayrshire and Arran, Borders, Highland and Tayside) have predicted they will need loans totalling £70.9 million in 2018/19. This has implications for other NHS boards since loans must be financed from the existing overall budget.

18. In October 2018, the Cabinet Secretary for Health and Sport announced that all territorial boards' outstanding loans will be written-off at the end of the 2018/19 financial year. We are carrying out further work to understand the implications of the recent announcement.

Exhibit 3

Scottish Government loans provided to NHS boards, 2009/10 to 2017/18 and repayments made by NHS boards

Loans paid out are greater than the amount repaid.



Note: In 2011/12, NHS Forth Valley received brokerage of £11 million, of which £1 million did not need to be repaid.

Source: Audit Scotland

NHS boards made unprecedented savings in 2017/18, but this was only achieved through one-off measures

19. NHS boards need to make savings to break even at the end of the financial year, to close the gap between the funding they receive and how much it costs to deliver services.

20. In 2016/17, NHS boards made overall savings of £387.4 million, which at the time was unprecedented. In 2017/18, the figure rose to £449.1 million. This represents 3.6 per cent of total revenue allocations to NHS boards. Despite this, the NHS did not meet its overall savings target of £480.8 million in 2017/18, falling short by seven per cent, £31.7 million.

Boards relied heavily on one-off savings in 2017/18

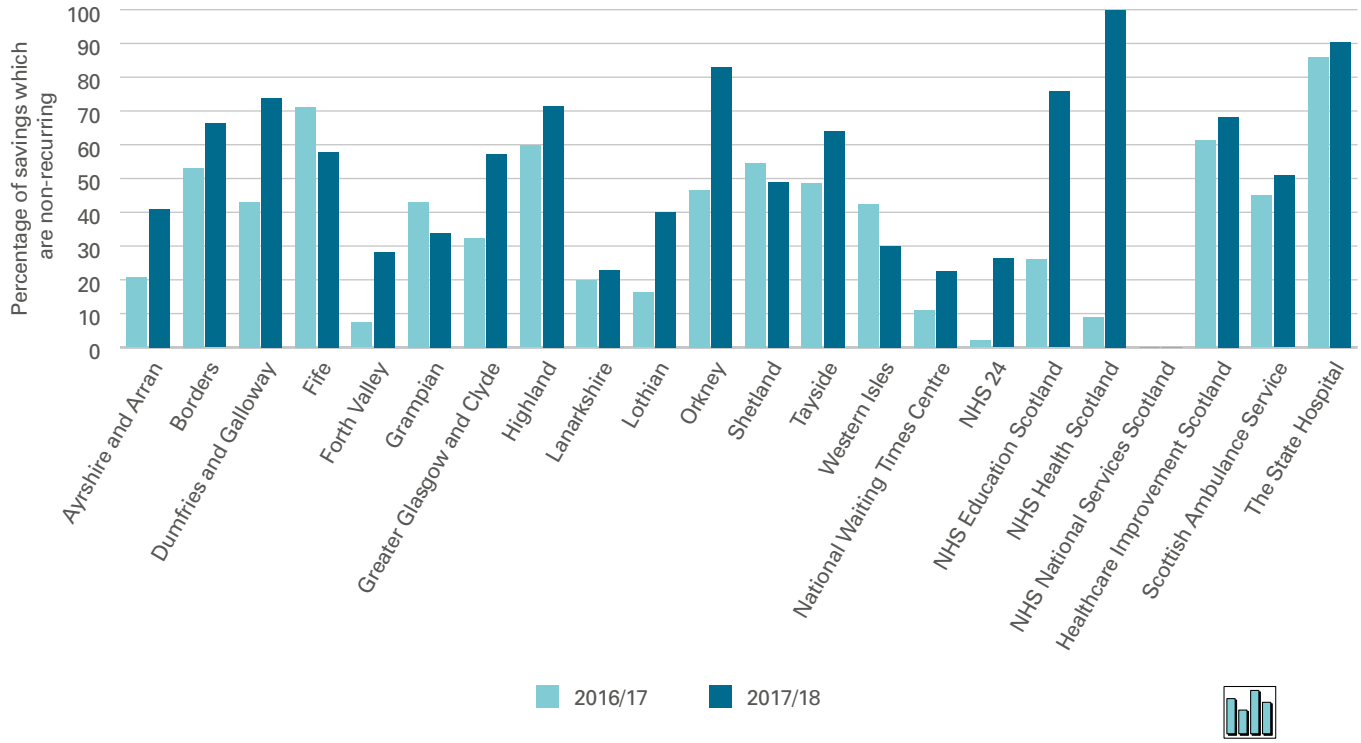
21. In 2017/18, 50 per cent of all savings were one-off (non-recurring), up from 35 per cent in 2016/17, and 20 per cent in 2013/14.[15] Savings reduce expenditure and contribute to achieving financial targets, but they do not necessarily mean increased efficiency or effectiveness.

22. Savings are classed as either recurring or non-recurring. The former recur in future years, for example as a result of providing services in a different way. Non-recurring savings do not result in ongoing savings, for example selling a building or delaying filling a vacant post. The reliance on one-off savings varied widely, from 23 per cent in NHS Lanarkshire to 83 per cent in NHS Orkney among the territorial boards. In the national boards, the range was from 0 per cent at NHS National Services Scotland to 100 per cent at NHS Health Scotland (Exhibit 4, page 13).

Exhibit 4

Percentage of total savings that were non-recurring by NHS board, 2016/17 to 2017/18

The use of non-recurring savings increased significantly in 2017/18.



Source: NHS board annual audit reports 2017 and 2018

23. Relying on one-off savings is not sustainable:

- It is becoming more and more difficult to identify areas in which NHS boards can make one-off savings.
- NHS boards that make high levels of one-off savings have to find more savings in future years.
- Non-recurring savings don't address the need to change the way NHS boards provide services.

Boards increasingly don't know where future savings will come from

24. At the start of the 2017/18 financial year, NHS boards were unable to identify where 28 per cent of all planned savings would come from, up from 17 per cent the previous year, and three per cent five years ago.[16]

Projected future health funding increases are unlikely to be enough to keep pace with rising costs

Cost pressures continue to intensify

25. NHS boards' costs are of two main types:

- Fixed–these are costs that boards have limited room to change in the short term. They make up significant parts of their budgets. The largest area is staff costs, which accounted for £6.6 billion (54 per cent) of total revenue spending in 2017/18. Other fixed costs include annual repayments on hospitals funded through private finance initiative (PFI) arrangements. These are fixed annual amounts which boards have to manage as part of their overall budget.

- Discretionary–these are costs that boards can influence to differing extents. Examples include:
  - prescribing or temporary staffing. For example, boards can reduce the volume of drugs dispensed, prescribe cheaper alternatives, or use less temporary staff from agencies to reduce costs
  - areas where boards can influence their costs by deciding, for example, how they provide services in their area.

26. In 2017/18, costs continued to increase in several key areas (Exhibit 5, page 15).

Health is projected to remain the single largest area of Scottish Government expenditure in future years

27. Health is one of the Scottish Government's six key policy priorities, alongside social security, police, early learning and childcare, higher education, and pupil attainment.[17] The share of the overall Scottish Government resource budget taken up by these six priorities is projected to increase from 56 per cent in 2019/20 to 64 per cent in 2022/23, with overall health spending accounting for the majority of this.[18] The Scottish Government's five-year financial strategy states that all other funding commitments will need to be met from the remainder of the budget.

Increases in health costs are likely to outstrip funding increases

28. Between 2008/09 and 2017/18, increases in health funding have averaged 0.8 per cent per year in real terms. The Scottish Government's five-year financial strategy, published in May 2018, sets out a potential annual real terms health funding increase of 1.1 per cent between 2018/19 and 2022/23.[19]

29. At the same time, health costs are projected to increase more quickly. Scotland's ageing population means that more people will be living longer with multiple long-term conditions, leading to greater costs for the NHS. Other cost pressures, such as increases in drug spending, are also projected to intensify. The Fraser of Allander Institute has predicted that the health resource budget is likely to have to increase by around two per cent per year in real terms to 2030 just to stand still.[20]

30. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[21] We discuss the framework in more detail in Part 2. The framework sets out a total projected funding increase to 2023/24 although it is not yet clear how the figures relate to those set out in the Scottish Government's overall five-year financial strategy in May 2018.

Exhibit 5
Cost pressures in 2017/18

Most NHS boards overspent on their pay budget and agency costs remain high

£6.6 billion was spent by NHS boards on staff in 2017/18 (54 per cent of revenue expenditure) and the majority of NHS boards overspent on their pay budget.[1]

£165.9m
Amount spent on agency staff in 2017/18.

5% decrease in real terms on the previous year.

38% increase over the past five years.[2]

£100m
Amount spent on agency medical locums in 2017/18.

10% decrease in real terms on the previous year.

40% increase over the past five years.[3]

£152m
Amount spent on bank nurses in 2017/18.

5% increase in real terms on the previous year.

21% increase over the past five years.[4]

Backlog maintenance has increased

£448.9m
Amount NHS boards spent on capital projects in 2017/18.

£417.2m
The amount funded by the Scottish Government. The rest was funded by selling assets such as land and buildings, and donations.

72%
NHS estate rated in good physical condition in 2017/18.

increase from **70%** in 2016/17.
The figures vary widely across territorial boards, from **25%** of the estate rated good in NHS Orkney to **98%** in NHS Borders.

£899m
Total maintenance backlog in 2017/18.

increase from **£887m** in 2016/17.
45% of all backlog maintenance is classed as significant or high risk, a **2%** reduction since 2016/17. The figures vary widely across territorial boards, from **12%** of all backlog maintenance rated significant or high risk in NHS Western Isles, to **74%** in NHS Tayside. Over half, **56%**, of all backlog maintenance was accounted for by three boards, NHS Greater Glasgow and Clyde, Grampian, and Tayside.

Spending on drugs continues to rise

£1.7bn
Amount spent on drugs in 2016/17.

1.5% increase in real terms from 2015/16.

19.4% increase over the past five years.

£1.3bn
spend in community.

£0.4bn
spend in hospitals.

2.2% increase in real terms spending on drugs in the community between 2015/16 and 2016/17.

0.7% decrease in real terms spending on drugs in hospitals.[5]

Cont.

Exhibit 5 (continued)

Spending on drugs continues to rise (continued)

103 million items. Number of items dispensed in the community.

0.1% decrease
Volume of drugs dispensed in the community between 2016/17 and 2017/18.[6]

Clinical negligence costs continued to increase

£643m
Amount set aside to manage potential future clinical negligence payments in 2017/18.

9% increase
in real terms since 2016/17.[7]

Notes:
1. *Financial Performance Returns,* Scottish Government. *NHS Consolidated Accounts*, Scottish Government, July 2018.
2. *NHS Consolidated Accounts*, Scottish Government, July 2018.
3. *NHS Scotland Workforce*, ISD Scotland, June 2018.
4. Bank and agency nursing and midwifery comparison (capacity), ISD Scotland, June 2018.
5. R600 pharmacy drugs expenditure, ISD Scotland cost book data, November 2017. 2016/17 is the latest cost book data available.
6. *Volume and Cost (NHS Scotland)*, ISD Scotland, July 2018. This only includes items dispensed in the community.
7. *NHS Consolidated Accounts,* Scottish Government, July 2018.

Source: Audit Scotland

The NHS estate will need more investment than is likely to be available in future years

31. The NHS capital budget fluctuates over time. In recent years, new hospitals have been built in Dumfries, Edinburgh, and Glasgow. In general, however, the budget has been declining over the past ten years. Backlog maintenance remains significant across the whole estate at £899 million in 2017/18 and a number of hospitals and other health facilities will require significant investment to ensure they remain fit for purpose. Capital funding will also be required for other purposes, such as replacing significant amounts of medical equipment in the short to medium term.

32. The Scottish Government's five-year financial strategy projects the overall capital budget to remain relatively static between 2018/19 and 2022/23.[22] There is no breakdown by policy area but health will be competing with other policy areas for capital funding.

33. As the way healthcare is delivered changes, the existing NHS estate will need to adapt to reflect this. The Scottish Government has not planned what investment will be needed.

The number of patients on waiting lists continues to rise and performance against targets is declining

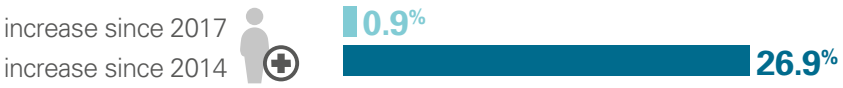
34. The number of people waiting for first outpatient and inpatient appointments continued to increase in the past year while elective and emergency admissions declined. Exhibit 6 (page 17) shows trends across indicators of demand and activity for acute services.

Exhibit 6

Indicators of demand and activity for acute services in 2017/18

Demand for secondary care services

305,754 patients waiting for first **outpatient** appointment in March 2018

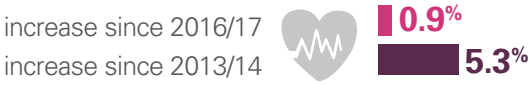


72,837 patients waiting for first **inpatient** appointment in March 2018

Activity

149,424 elective admissions in 2017/18

593,531 emergency admissions in 2017/18



1,418,667 new outpatient apppointments in 2017/18

2,814,883 return outpatient apppointments in 2017/18

1,434,118 procedures in 2017/18

453,731 daycase patients in 2017/18

6.2 days average length of hospital stay in 2017/18

Source: Annual Acute Hospital Activity and Hospital Beds - Year ending March 2018, ISD Scotland, 25 September 2018; New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2018, August 2018; Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2018; ISD Scotland, September 2018.

Trends in demand and activity need to be better understood

35. The Scottish Government and NHS need to better understand these patterns of demand and activity. For example, the overall number of people waiting for their first outpatient appointment continued to increase in 2017/18, but the number of new and return outpatient appointments NHS boards carried out declined over the same period.[23,24] It is not possible from national published data to tell whether the increase in the number of people waiting is:

- an actual rise in demand
- being caused by reductions in capacity, with boards seeing fewer patients than previously
- a combination of both these factors.

Similarly, the number of elective admissions declined by 9.7 per cent between 2016/17 and 2017/18.[25] It is difficult to tell if this is due to reduced demand or because NHS boards lack the capacity to undertake as many procedures. There is also wide variation across NHS boards.

36. Changes in demand and activity can be caused by a variety of factors. These include public expectations, levels of referrals from GPs and other healthcare professionals, availability of staffing, and winter pressures such as flu and adverse weather. It is important that NHS boards and integration authorities fully understand the reasons behind changes in demand and activity to plan services effectively both in the short term and in the longer term.

37. There continues to be a lack of public data on important areas of the healthcare system. The focus remains on acute hospitals and there is limited public data on primary care, for example the number of people seeking GP consultations, and the reasons for referrals on to secondary care. This makes it difficult to assess overall demand or better understand changes in demand and plan how to meet it.

Declining performance against national standards indicates the stress NHS boards are under

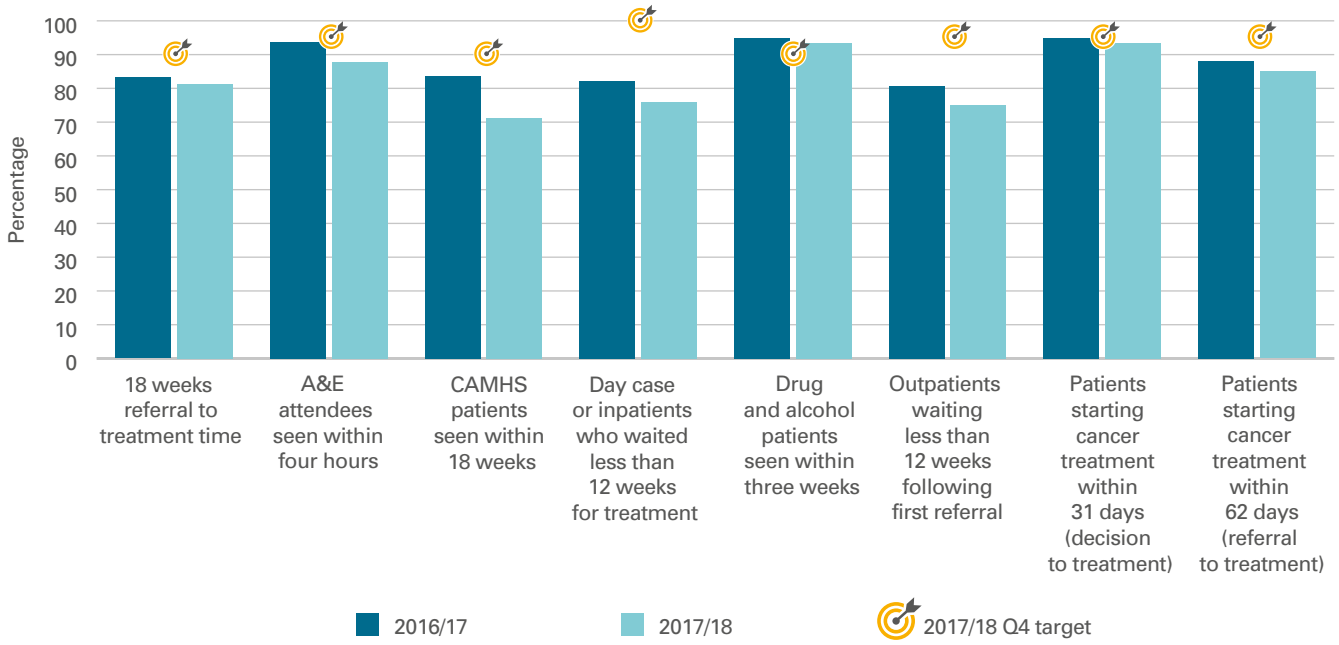
38. The NHS met only one of eight key national performance targets in 2017/18, for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within 21 days (Exhibit 7, page 19). Nationally, the target of 95 per cent of patients starting cancer treatment within 31 days was missed by one and a half percentage points. No boards met all eight targets. NHS Western Isles met six indicators, while NHS Lothian did not meet any targets. NHS Grampian, Greater Glasgow and Clyde, Highland, and Tayside each met one target. Appendix 3 shows performance against the national standards by NHS board.

39. Performance declined against all eight key national targets between 2016/17 and 2017/18. The greatest reduction was in performance against Children and Adolescent Mental Health Services' (CAMHS) patients seen within 18 weeks, where performance dropped by 12.4 percentage points, from 83.6 per cent in 2016/17 to 71.2 per cent in 2017/18. We published our report examining CAMHS in Scotland in September 2018.

Exhibit 7

NHS Scotland performance against key national performance standards 2016/17 to 2017/18

NHS Scotland met one key performance standard in 2017/18.



Notes:
1. CAMHS is Children and Adolescent Mental Health Services.
2. Figures are for month/quarter/census point ended March 2018 (Appendix 3).

Source: See Appendix 3 for sources

40. The number of people waiting over 12 weeks for their first outpatient appointment or planned inpatient procedure continued to increase in 2017/18:

- In the final quarter of 2017/18, 93,107 people waited more than 12 weeks for their first outpatient appointment, an increase of six per cent on the previous year. The number of people who waited more than 12 weeks has increased by 215 per cent in the last five years. People waiting more than 16 weeks increased by 13 per cent between 2016/17 and 2017/18, and by 558 per cent over the last five years.

- People waiting more than 12 weeks for an inpatient or day case procedure increased by 26 per cent between 2016/17 and 2017/18 to 16,772 people, and by 544 per cent over the last five years.[26]

41. NHS boards are working with the Scottish Government to implement a range of initiatives aimed at improving access and waiting times, such as the Scottish Access Collaborative. This was set up by the Scottish Government in October 2017 to improve waiting times for patients waiting for non-emergency procedures. However, 2017/18 annual audit reports of NHS boards indicated that financial pressures will continue to have a detrimental impact on performance. NHS boards need to balance quality of care, performance targets, and financial targets. A continuing focus on meeting targets in the acute sector makes it harder to achieve the longer-term aim of moving more funding and services into the community.

The NHS is managing to maintain the overall quality of care, but it is coming under increasing pressure

42. The Scottish Government has three Quality Ambitions for the NHS in Scotland–that the NHS is safe, person-centred, and effective. It does not comprehensively assess and report on these ambitions. Healthcare Improvement Scotland (HIS) is currently rolling out a new Quality of Care approach which involves a more comprehensive assessment of quality.[27]

43. Analysis of a range of measures indicates there are positive examples, including:

- Ninety per cent of patients responding to the 2018 inpatient survey rated their care and treatment as good or excellent, similar to the 2016 survey. Ninety-one per cent of people were positive about their experience of hospital staff, a slight increase since 2016.[28]

- some patient safety indicators improved: the hospital standardised mortality rate decreased by 9.2 per cent between 2013/14 and 2017/18, and C-Diff Infection rate decreased by 0.1 to 0.27 infections per 1,000 occupied bed days between 2016/17 and 2017/18.[29,30]

44. We reported last year that the wide range of pressures facing the NHS may be beginning to affect the quality of care staff are able to provide. This concern remains in 2017/18. For example:

- the percentage of patients rating the quality of care provided by their GP practice as positive has declined from 90 per cent in 2009/10 to 83 per cent in 2017/18. Only 58 per cent of respondents who received treatment in the last 12 months felt they were given the opportunity to involve the people that mattered to them.[31]

- SAB infections, including MRSA, remained relatively static between 2017 and 2018 but remain above the national standard.[32]

- there have been specific concerns about some services. For example, a 2017 HIS inspection of adult health and social care services in Edinburgh rated a majority of quality indicators as weak or unsatisfactory; and an independent inquiry into mental health services in NHS Tayside is under way.[33,34]

45. A key indicator of the quality of care is the extent of serious adverse events happening in hospitals and other healthcare settings. As part of its review of NHS governance in 2017/18, the Scottish Parliament's Health and Sport Committee identified that there was no common definition of a serious adverse event and that there is no national reporting of the frequency of, and learning from, these events. The Committee recommended that a standard definition and national reporting be developed.[35] HIS published a revised national framework in July 2018 to improve consistency in this area.[36]

The NHS workforce is crucial to the future of the NHS but faces significant challenges

46. The NHS depends on having the appropriate number of staff, in the right place, with the appropriate skills. Overall staff levels in the NHS in Scotland are at their highest level ever, with 139,918 whole-time equivalent (WTE) staff employed as at March 2018. This is a 0.3 per cent increase on the previous year. But NHS boards continue to face major workforce challenges (Exhibit 8, page 22).

Withdrawing from the European Union will create additional challenges

47. EU withdrawal has the potential to significantly affect the NHS. It has been difficult to assess the scale of the risk, particularly in terms of workforce as data on the nationality of employees is not routinely collected, and there is still significant uncertainty about what form EU withdrawal will take. Some figures are available:

- General Medical Council data shows that 5.9 per cent (1,177 people) of doctors working in Scotland obtained their primary medical qualification in a non-UK European Economic Area (EEA) country.[37]

- The Scottish Government has estimated that there are 17,000 non-UK EU nationals working in health and social care in Scotland (4.4 per cent of the total health and social care workforce).[38]

NHS boards are working with the Scottish Government to identify how many of their current workforce are non-UK EU citizens.

48. The NHS is already experiencing an impact on recruitment:

- A 2018 British Medical Association (BMA) survey of members across the UK found that 57 per cent of respondents reported a decline in applications for positions in their departments from non-UK nationals since the 2016 vote to leave the European Union.[39]

- The Nursing and Midwifery Council reported that during 2017/18, there was an 87 per cent decrease in the number of nurses and midwives from non-UK EEA registering to work in the UK compared to the previous year.[40]

- In addition, if there is a loss of mutual recognition of professional qualifications between the EU and the UK, it will be more difficult for qualified staff from the EU to work in Scotland.

49. Changes to rules and regulations may also have a significant effect on the NHS. For example, medicine and medical equipment may be more expensive and it may take longer to access essential medical supplies. This includes imported products with limited lifespans, such as radioisotopes that are used to treat cancer. Increases in the price of food due to trade tariffs or additional custom checks will also have an impact on the NHS. Our briefing *Withdrawal from the European Union: Key audit issues for the Scottish public sector* sets out key questions that all public bodies should be asking themselves in the five months to EU withdrawal.

Exhibit 8
Workforce pressures in the NHS

Vacancy rates

Consultants
2013/14 6.5% → 2017/18 7.5%

Allied health professionals
2013/14 3.9% → 2017/18 4.4%

Nursing and midwifery
2013/14 2.7% → 2017/18 4.5%

GPs
2015 22% → 2017 24% (number of practices reporting a vacancy)

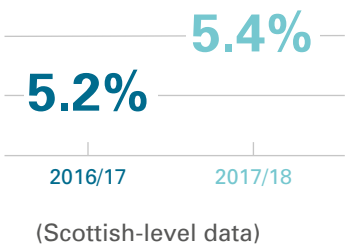
Percentage of vacancies open long term

60% of consultant vacancies open at least six months

30% of nursing and midwifery and AHP vacancies open three months or more

27% of filled GP vacancies took more than six months to fill

Sickness absence

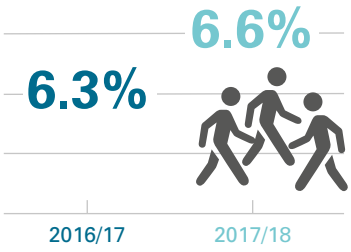


(Scottish-level data)

4% NHS Shetland was the only territorial board to meet the national target

5.8% NHS Fife had the highest sickness absence rate among the territorial boards

Staff turnover



2017 staff survey

46% responded that they could meet all conflicting demands on their time at work

34% responded that there are enough staff to do their job properly

65% believed it is safe to speak up and challenge the way things are done if they have concerns about the quality, negligence or wrongdoing by staff

29% have experienced emotional or verbal abuse from a patient or the public

Note: The 2017 staff survey included some social care staff, who made up a small proportion of the overall total.

Sources: Audit Scotland using ISD Scotland workforce data, June 2018 and *Health and social care staff report 2017*, Scottish Government, March 2018. *Primary Care Workforce Survey Scotland 2017*, Scottish Government, March 2018

Part 2

What needs to change?

Key messages

1 Changing how healthcare services are accessed and delivered is a long-term, complex undertaking. Successfully achieving it will bring real benefits to patients, NHS staff, and the wider public. A number of key elements are critical to success, including clarity about the scale of the challenge, effective leadership, involving stakeholders in planning and decisions, and clear governance.

2 Leaders play a crucial role in developing and delivering change. There is evidence that the NHS is struggling to recruit and retain the right people, and ensure they have the time and support they need.

3 The healthcare system needs to become more open. People need to be able to take part in an honest debate about the future of the NHS. There is a lack of information on:

- how the NHS is performing and the difference it is making to people's lives
- how health funding is used and the impact it has on people
- how much health funding is likely to be required, and available, over the medium to longer term
- the progress being made towards achieving the Scottish Government's 2020 Vision.

4 The overall governance of the NHS needs to be clarified for NHS staff as well as the public. Roles and responsibilities for each planning level need to be explicit and lines of accountability well defined. NHS boards need better support to govern and challenge effectively.

an urgent focus on the elements critical to success is needed

50. There are many reasons why the way in which health services are accessed and delivered in Scotland needs to change. The significant financial, workforce, and demographic pressures facing the NHS, as set out in Part 1, are undoubtedly key drivers, but there are also many positive reasons for change. The Scottish Government's vision for healthcare sets out multiple benefits:

- the Scottish public will benefit from services that are more joined up, tailored, and delivered closer to home. For more complex care needed at hospitals, there will be quicker access and shorter stays

- healthcare staff will have more time to provide high-quality, personalised care
- the wider public sector will benefit from a population that is healthier and takes more responsibility for their own health
- as a result of all of the above, the healthcare system should also become more efficient by reducing the costs of delivering services and improving processes.

51. Achieving these benefits, however, is incredibly challenging. These changes need to happen at the same time, while also continuing to deliver high-quality services on a day-to-day basis. It involves:

- significant organisational and cultural change
- developing and then introducing new ways of working
- designing, delivering, and using new digital technology.

52. It is therefore essential that all the elements needed for successful change are in place. This chapter focuses on the key elements that need addressed if the Scottish Government is to achieve its 2020 Vision.

A clear understanding is needed of the scale of the challenges facing the NHS and the options for addressing them

53. Transforming how health services are delivered and achieving the Scottish Government's vision of delivering more care in the community are long-term projects. They require planning over the short, medium and longer term. An essential part of this is to understand:

- how much funding is likely to be required in the medium to long term
- what funding is likely to be available over the same period.

Where there is a mismatch between what is available and what is required, then options can be developed involving NHS staff, the public and politicians.

54. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework* ('the framework'). This is an important step in enabling an open debate about the scale of the financial challenges ahead and the potential options for dealing with the impact this will have on delivering services.

55. The framework covers the period 2016/17 to 2023/24 and has four main sections:

- health and social care expenditure–setting out current expenditure and historical expenditure trends in health and social care, and historical activity growth and trends in productivity
- future demand for health and social care–including drivers of demand growth and an estimate of the future increases in health spending required
- future shape of health and social care expenditure–setting out how shares of health funding will be re-distributed across different parts of the system in future years

- reforming health and social care–identifies five specific areas of activity (shifting the balance of care, regional working, public health and prevention, Once for Scotland, and annual savings plans) that will contribute to the reform of health and social care delivery.

56. The financial framework focuses on 'frontline' NHS board expenditure, comprising the 14 territorial NHS boards and four of the national boards (NHS 24, Golden Jubilee Hospital, State Hospital and the Scottish Ambulance Service), and local government net expenditure on social care. The framework sets out a 'do nothing' position. This takes into account estimated expenditure growth caused by factors such as demand and pay and prices and sets out that health and social care resource expenditure in 2023/24 would need to be £20.6 billion. This is more than the projected resource funding availability of £18.8 billion over the same time period. The framework sets out the three main ways in which the Scottish Government plans to bridge the gap:

- efficiency savings–a one per cent efficiency requirement across health and social care
- savings arising from shifting the balance of care–this includes A&E, inpatients and outpatients
- additional savings–from regional working, public health prevention, and back office efficiencies.

A remaining gap of £159 million is identified which is expected to be addressed over the period to 2023/24.

57. The projected funding figures set out in the framework are based on the Scottish Government receiving additional funding from the UK Government of £3.3 billion due to increased funding for the NHS in England (known as Barnett resource consequentials). It is not yet known how the UK Government plans to fund increases in English health expenditure and the options chosen may affect the amount available to the Scottish Government.

58. Alongside the publication of the health and social care financial framework, the Cabinet Secretary announced recently that NHS territorial boards will no longer be required to break even at the end of each financial year. Instead, they will be required to break even every three years. This should provide NHS boards and integration authorities with greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care. It also makes it even more important that NHS boards plan their finances over a medium to longer-term period. Traditionally, NHS boards have taken a short-term approach to financial planning with most of their financial plans covering three years or less. This continued to be the case in 2017/18. The main reasons given by NHS boards for this are the current uncertainties around the implications of regional planning and the national health financial framework. The Scottish Parliament's Health and Sport Committee reported in 2018 that it 'did not accept an inability to undertake longer-term financial planning exists'.[41]

59. As we showed in Part 1, the NHS estate is likely to require more investment than is likely to be available. This makes it more urgent to identify how the type, location, and size of healthcare facilities need to change as more services are delivered in the community. We recommended in our *NHS in Scotland 2017*

report that the Scottish Government, in partnership with NHS boards and integration authorities, should develop a capital investment strategy to ensure the NHS Scotland estate is appropriate for delivering more regional and community-based services.[42] This will help the Scottish Government and NHS boards engage and involve the public in agreeing how the NHS estate will develop. The Scottish Government is developing a national health capital investment plan, scheduled for completion by the end of the financial year 2018/19.

There is a need to ensure effective leadership is in place with the time and support to deliver change

60. Effective leadership is critical to achieving successful change. Leaders need to drive change and improvement, involve staff and the public in developing a common vision and work with partners to deliver it. But they also require a skilled and cohesive team to support them and strong sponsorship from the top. Health and social care integration has changed the context in which NHS boards operate and has also increased the number of effective leaders required across Scotland.

61. The Scottish Government has recently developed a new approach to leadership and succession planning. This includes developing a talent management scheme to identify future leaders and introducing values-based recruitment to ensure new appointments share the values of the organisation, in addition to skills and experience.

62. There are indications that finding effective leaders and support teams is becoming more difficult:

- The NHS Greater Glasgow and Clyde chief executive position required two recruitment rounds to fill.
- The Scottish Borders Integration Joint Board chief finance officer role was vacant from October 2017 until recently. This has now been filled through a one-year secondment from NHS Lothian.
- The chief executive position in NHS Orkney has been an interim appointment since January 2018 and a recruitment exercise has only recently taken place.
- NHS Highland has experienced significant turnover in non-executive members, with six new members in 2017/18. This has led to challenges in ensuring members have the skills, experience and training required to fulfil their role.
- There is an increasing number of joint posts across NHS boards. For example:
  - The chief executive and director of finance in NHS Grampian are now also the chief executive and director of finance in NHS Tayside
  - The director of finance for the Golden Jubilee National Hospital is also the interim director of finance for the Scottish Ambulance Service.
- Increasing regional planning has created additional responsibilities for senior leadership teams.
- Key support functions such as finance and human resources are also experiencing vacancies in many boards. Twelve boards reported vacancies in their finance team and 11 boards reported vacancies in their HR team.

- The NHS workforce is ageing, and chief executive positions at NHS Grampian, Highland, and Tayside will become vacant due to retirement. The chief executive at NHS Borders is also due to retire at the end of April 2019.

- Only 62 per cent of respondents to the 2017 national health and social care staff survey felt that the senior managers responsible for the wider organisation were sufficiently visible. 64 per cent of respondents had confidence and trust in the senior managers responsible for their wider organisation.[43]

63. NHS board chief executives and senior teams are responsible for the delivery of critical day-to-day services as well as leading the changes to how services are accessed and delivered in their boards. This places significant demands on senior leadership teams. To successfully plan and deliver the whole-scale changes that are required takes time and capacity.

NHS governance arrangements are confusing and non-executive directors need more support

The overall governance of the NHS needs to be clarified

64. The arrangements for NHS planning are complex. There are now multiple planning levels from small localities through to national planning (Exhibit 2 in our report *NHS in Scotland 2017* describes these). Last year we said that it was not yet clear how planning at each of the different levels would work together in practice. This remains the case:

- Lines of accountability for health and social care integration are still not universally clear. Auditors highlighted issues in some areas in 2017/18 relating to the need for greater clarity to avoid duplicating governance arrangements, managing overspends in integration authorities, and ownership of performance management.

- Regional plans have not yet been published so it is not clear how roles and responsibilities between NHS boards will work within the regions or where accountability and decision making will lie for service planning, delivery, and performance.

- There is no public information on the progress of national planning initiatives, such as Once for Scotland (delivering services and functions more efficiently at a national level).

- It is not clear to what extent the public, staff, and NHS boards have been involved in some decisions to change how services are accessed and delivered. For example, the Scottish Government has decided to develop regional elective centres across Scotland to carry out procedures such as knee and hip replacements. This will change how people access services, but the decision was taken before regional plans were developed.

65. As new planning layers have been created, none have been removed. This multiplicity of levels and lack of clarity over their roles means NHS governance is confusing. If the different planning levels are to work together effectively and the public is to easily understand what each part of the system is intended to do, governance arrangements must be clear and robust. This means that roles and responsibilities are explicit, and lines of accountability are well defined. For example, the roles and responsibilities of NHS boards have changed with the

introduction of Integration Authorities and will continue to change as regional and national planning develops further. It is important to ensure that the roles and responsibilities of NHS boards in this new context are clear.

66. The Scottish Government, working with NHS boards and integration authorities, should clearly set out the key decisions that need to be made in planning how to deliver services and why. This would help ensure:

- decisions are made at the right level, are coherent and fit with existing policies and plans
- there is clear accountability for delivering outcomes
- NHS staff and the public have the opportunity to make their voice heard.

67. To ensure the multiple planning levels can operate effectively, it is also essential that lines of accountability and levels of scrutiny within the Scottish Government's Health and Social Care Directorate are clear and robust. There is scope to improve these. The directorate is led by the Director General of Health and Social Care, who is also the Chief Executive of NHS Scotland. The Chief Executive is responsible for the day-to-day performance of the NHS and for implementing Scottish Government health policies. The Director General is responsible for holding the NHS to account for its performance and how well it has implemented Scottish Government policies. The Director General is also the chair of the directorate's Assurance Board which holds the directorate to account for its performance. The challenges facing the health and care system make this dual role ever harder.

68. There is also scope to increase independent scrutiny of the directorate. In the Auditor General for Scotland's report *The 2017/18 audit of the Scottish Government Consolidated Accounts*, the Auditor General highlighted the important role of non-executive directors in ensuring effective scrutiny and challenge within the Scottish Government.[44] The report found that, across the Scottish Government, scrutiny and challenge was not as effective as it needed to be. Within the Health and Social Care Directorate, only one non-executive director provided independent challenge in 2017/18 as a member of the directorate's Assurance Board.

Boards need better support to challenge and govern effectively

69. Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively, and to give the public confidence in the NHS. There is evidence that not all boards are operating effectively. Our forthcoming report, *Health and Social Care Integration: Update on progress,* will examine the effectiveness of governance arrangements in integration authorities.

70. Boards are made up of executive members, including the chief executive and other senior managers, and non-executive members. These include staff representatives and members of the public appointed through a competitive recruitment process. The board is responsible for:

- ensuring the organisation delivers its functions in accordance with the Scottish ministers' policies
- the strategic and financial leadership of the organisation

- holding the chief executive and senior management to account.

71. Board members need to have an appropriate level of knowledge, skills, and expertise to do their role effectively. But there is no consistent approach across the NHS to ensuring this. For example:

- Skills gap analysis–not all NHS boards have identified the range of skills and expertise among board members and areas where training or additional expertise may be needed.

- New member induction–in a 2018 survey of board members by the Scottish Parliament's Health and Sport Committee, only 61 per cent of respondents agreed there is adequate induction for board members.[45]

- Training and development–most NHS boards have training and development programmes for board members, but these are often ad-hoc. Less than half (48 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee agreed there was adequate training.[46]

- Performance assessment–not all NHS boards do one-to-one annual appraisals. If these do take place, it is not always clear how formal these are, for example, if it is an informal discussion or a structured appraisal. There is no standard approach across the NHS to assessing the performance of board members.

72. The majority (63 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee in 2018 thought their board had the right skills, knowledge and expertise. However, a third thought their board only partly had the right skills, knowledge and expertise.[47] NHS boards are complex organisations in a continually changing environment and without appropriate support, boards cannot fulfil their role effectively.

Scrutiny arrangements need to be improved across the NHS

73. Through our audit work we have identified areas for improvement:

- Financial and performance reporting–there are examples of financial reporting to boards that was too lengthy or not easily understandable, or too high-level and did not provide enough information for board members to be able to scrutinise. Performance reporting did not always provide appropriate detail on the reasons for performance or planned actions to improve targets.

- Accessibility and transparency–the language used in reports can often contain acronyms and technical information that is not explained and can be difficult for lay people to fully understand. Agenda items are often for noting with no discussion required and board minutes do not always provide a clear picture of the level of scrutiny that took place in meetings. Board papers are not always easy to find on board websites.

74. The majority of board members who responded to the 2018 survey (87 per cent), felt that members of their board always or mostly challenged advice, opinions and information presented. However, 13 per cent disagreed. Almost one in five (17 per cent), reported that their board only sometimes or hardly ever sufficiently holds the chief executive and senior management team to account for the operational management of the organisation and the delivery of agreed plans to time and budget.[48]

75. The Scottish Government is carrying out a range of work aimed at strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance. Case study 1 sets out the scope and key findings from the pilot in NHS Highland.

Case study 1

Scottish Government corporate governance review of NHS Highland

A review team was set up which included the chair of NHS Greater Glasgow and Clyde and a non-executive director from Healthcare Improvement Scotland. The team developed a framework for assessing governance based on sources of evidence that included codes of conduct from other bodies, academic literature, and lessons learned from successes and failures from across the UK public sector. The review included desk research, face to face interviews with current and previous, board members and other stakeholders, and observation of board meetings.

The review made a number of recommendations to the board, including the need to:

- develop a clear strategic plan for the board, and a planning cycle
- make sure appropriate reporting methods are in place
- agree shared expectations of the roles and responsibilities of board members and clarify the relationship between the board and the Executive Team. Develop an induction programme and map existing board member skills against the future requirements
- develop a governance map, setting out remits of committees and how they relate to one another. Develop guidance on writing board papers, including protocol for ensuring confidentiality and making sure papers are circulated five days ahead of meetings. Minutes should include an action plan
- make sure there is a shared understanding of best practice in assessing and managing risk, and the operation of the finance and audit committees. The chair and chief executive should attend the Audit Committee and there should be an external review of the existing internal audit services
- develop an engagement strategy, including clearly defining the roles and responsibilities of board members in supporting this
- consider external support to help resolve recent issues. Develop protocols for board members to raise concerns. Reconsider having board members sitting on operational groups.

Source: Audit Scotland using Corporate Governance in NHS Highland report, Scottish Government, May 2018

The Scottish Government and the NHS need to become more open

76. If efforts to transform the NHS are to be successful there must be a shared understanding of why change is needed. There must also be broad agreement between the public, politicians, NHS staff, NHS boards, integration authorities, and the Scottish Government about:

- the scale of the challenge
- the options for what needs to happen
- how changes will be implemented.

There is currently no common agreement on these areas. If health and care services are to change to meet the needs of Scotland's people, then the NHS and the Scottish Government must become more open. People need access to information if they are to have an honest debate about the future of the NHS and get involved in designing services to meet their needs.

77. In our report, *NHS in Scotland 2017*, we stated that 'open and regular involvement with local communities about the NHS is needed to develop options for delivering services differently.'[49] People are closely invested in their local health services, and there continue to be many examples of public and political opposition to attempts by NHS boards to change how services are delivered. This suggests that local communities are still not being involved appropriately in planning changes to services.

There is still no overall picture of how the NHS is performing and the difference the NHS is making to people's lives

78. In previous years we have commented that existing national NHS performance measures do not measure the quality of care across the whole healthcare system, focusing mainly on access to the acute sector. It is important that wider performance measures are developed to provide a clear picture of how the system as a whole is working.

79. The Scottish Government commissioned an independent review of targets and indicators in health and social care in Scotland. This reported in November 2017 and recommended that the Scottish Government move to a system of indicators and targets which allow improvements across a whole system of care to be tracked.[50] The Scottish Government has not yet made progress on the recommendations.

80. The availability of public information on performance has improved with the introduction of the NHS Performs website, which shows information on indicators such as A&E performance and hospital deaths, at hospital, NHS board, and national-level.[51] However, the range of data is limited and focuses on the acute sector. Another positive development is the uptake in the use of Care Opinion, an independent website which allows patients and the public to publicly share their stories and experiences of health services across Scotland. All NHS boards in Scotland are now using Care Opinion and NHS staff are able to view stories and respond.

Better information is needed on how the NHS uses funding to support change

81. Health funding in Scotland is the single largest area of Scottish Government expenditure. The Scottish public need to know what this funding is being used for and what it is achieving.

82. There is no easy-to-understand, summarised public information available on health funding and what it is spent on. There is information on parts of the system, but they do not provide a comprehensive picture or provide information that is easy to access.

83. There is also no public information on how the health funding system works, for example:

- How much funding, and the type of funding, the Scottish Government allocates to NHS boards throughout the year, and how NHS boards then allocate this to integration authorities.
- What the Scottish Government expects NHS boards to spend funding on and how NHS boards prioritise expenditure.
- How the Scottish Government monitors how NHS boards use funding and whether they are achieving the outcomes the Scottish Government wants.

84. Since June 2018, the Scottish Parliament has received a monthly update on boards' financial position. This includes their year-to-date position against budget and the expected outturn at year-end.[52] The reports also indicate which NHS boards may require brokerage to break even at the financial year-end. This is a helpful step forward in providing information that the public and MSPs can use to scrutinise financial performance. There is, however, room for improvement to make the information more helpful. For example, in the June 2018 report, eight NHS boards were projecting that they would not break even at year-end, but only four boards indicated that they might require brokerage.[53] It is not clear from the information presented why the remaining four boards do not expect to require brokerage or why the boards indicating they may need brokerage do not expect to identify additional savings.

The Scottish Government is making progress with the Health and Social Care Delivery Plan but public reporting is needed

85. The Health and Social Care Delivery Plan sets out an ambitious set of actions to achieve the 2020 Vision. A number of key actions have been achieved, including putting in place a new national GP contract in April 2018 and publishing national public health priorities in June 2018. Work is also under way across a range of other areas, including increasing paramedic and health visitor numbers, developing new elective centres, and establishing a new national public health body.

86. Significant progress still needs to be made, however, to achieve the 2020 Vision. In a number of areas, including those where actions have been achieved, implementation and embedding is likely to take a number of years and progress is often dependent on other actions being achieved. For example, the success of the new GP contract is dependent on resolving issues such as premises costs and increasing the number of GPs and others, such as pharmacists and paramedics, to develop multidisciplinary teams. Progress has also been slower than planned in some areas; for example the publication of the national public health priorities were over a year later than the target date. This is partly due to

the complexity and scale of the changes. Successfully achieving the actions in the Delivery Plan will require staff, public, and political buy-in and involvement.

Detailed workforce planning is overdue

87. All three parts of the Health and Social Care National Workforce plan have now been published, with the final part on the primary care workforce published in April 2018.[54] As with part one, parts two and three largely focus on what needs to be done to plan for the future, rather than on setting out what the medium to longer-term workforce will look like. In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[55] The National Workforce Plan does not provide this information. We will be undertaking an audit of primary care workforce planning in 2018/19.

Reporting on progress towards the Scottish Government's 2020 Vision needs to be made public

88. Progress towards achieving the Delivery Plan is reported to the Scottish Government's Health and Social Care Delivery Plan Programme Board every six weeks. This board is responsible for the strategic oversight and operational assurance of the delivery of the Delivery Plan. There is scope to improve the monitoring and reporting of progress:

- There is no public reporting of progress. Programme Board minutes are made public but agendas and papers, including progress updates, are not published.
- An integrated performance framework covering all elements of the Delivery Plan has not yet been developed. The Delivery Plan states that this would be produced by early 2017. As we reported in our *NHS in Scotland 2017* report, the Delivery Plan does not set out in detail how the changes described in it will be achieved and many of the actions in it are statements of intent rather than actions.[56] It remains important that the performance framework sets out clearly what work is being done and how progress will be measured.
- In the overall progress reports provided to the Programme Board it is not always clear whether current progress is as expected, or why expected progress has not been made. Where completion dates have been delayed, these are not always clearly labelled as delayed, despite some activities slipping by more than a year from the planned target date.
- The public and politicians cannot fully hold the Scottish Government to account or get involved in changing how health care services are accessed and delivered if they do not know what:
  - activities are being undertaken
  - progress is being made towards achieving these
  - challenges are being faced in achieving the Delivery Plan actions.

Endnotes

1 *NHS Scotland Workforce Information - Overall trend*, ISD Scotland, June 2018.

2 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.

3 *Acute Hospital Activity and NHS Beds Data Release*, ISD Scotland, June 2018.

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Appendix 1

Audit methodology

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 2017/18 and why immediate action is needed.

Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2017/18 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 and a range of other key stakeholders.

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 37).

Appendix 2

Financial performance 2017/18 by NHS board

Board	Core revenue outturn (£m)	Total savings made Annual Audit Report (£m)	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	779.5	24.8	41%	-1.0%
Borders	223.9	8.3	66%	1.3%
Dumfries and Galloway	327.5	22.6	74%	2.8%
Fife	683.6	22.5	58%	-1.0%
Forth Valley	547.1	24	28%	-1.0%
Grampian	1,003.6	27.7	34%	-0.9%
Greater Glasgow and Clyde	2,349.2	122.4	57%	1.8%
Highland	693.2	35	71%	-0.7%
Lanarkshire	1,239.4	36.1	23%	-1.0%
Lothian	1,512.2	23.5	40%	-0.9%
Orkney	55.6	1.3	83%	5.1%
Shetland	56.8	4.7	49%	3.0%
Tayside	820.6	46.8	64%	-1.0%
Western Isles	82.1	3.5	30%	15.1%
Healthcare Improvement Scotland	28.2	2	68%	
National Services Scotland	416.6	18.2	0%[1]	
National Waiting Times Centre	66.2	4.5	23%	
NHS 24	71.7	2.4	26%	
NHS Education for Scotland	444.4	8	76%[1]	
NHS Health Scotland	19.4	0.3	100%	
Scottish Ambulance Service	235.4	8.7	51%	
State Hospital	32	1.8	90%	

Notes: 1. These figures are from Month 13 Financial Reporting Return to the Scottish Government. 2. NRAC is the NHS Scotland Resource Allocation Committee.

Appendix 3

NHS performance against key LDP standards in 2017/18

Measure	18 weeks referral to treatment time	A&E attendees seen within four hours	CAMHs patients seen within 18 weeks	Day case or inpatients who waited less than 12 weeks for treatment
	standard = 90%	standard = 95%	standard = 90%	standard = 100%
Ayrshire and Arran	78.6	90.8	98.2	85.2
Borders	86.7	89.5	48.2	84.5
Dumfries and Galloway	84.0	90.3	89.9	77.7
Fife	79.1	94.6	67.7	87.6
Forth Valley	83.4	83.4	48.0	56.1
Grampian	65.5	94.1	48.7	64.0
Greater Glasgow and Clyde	89.3	86.7	88.7	78.7
Highland	81.7	96.0	82.9	65.0
Lanarkshire	82.1	90.0	71.4	62.6
Lothian	74.6	75.4	65.1	79.3
Orkney	98.9	95.9	94.7	95.9
Shetland	81.8	94.4	94.7	94.2
Tayside	71.9	98.0	40.7	73.6
Western Isles	91.7	97.7	94.7	100.0
National total	**81.2**	**87.9**	**71.2**	**75.9**

Key Green = Standard met
Red = Standard missed

Measure	Drug and alcohol patients seen within three weeks	Outpatients waiting less than 12 weeks following first referral	Patients starting cancer treatment within 62 days (referral to treatment)	Patients starting cancer treatment within 31 days (decision to treatment)
	standard = 90%	standard = 95%	standard = 95%	standard = 95%
Ayrshire and Arran	98.6	85.0	87.3	97.4
Borders	89.3	91.7	95.7	100.0
Dumfries and Galloway	95.6	90.4	94.9	96.6
Fife	95.9	93.6	86.2	97.4
Forth Valley	98.4	84.6	79.7	97.0
Grampian	91.0	63.4	76.7	87.2
Greater Glasgow and Clyde	94.5	74.5	81.3	92.7
Highland	86.8	80.7	81.4	93.2
Lanarkshire	99.4	84.8	96.5	99.2
Lothian	79.9	66.2	87.2	91.1
Orkney	100.0	62.5	91.7	100.0
Shetland	100.0	80.7	100.0	100.0
Tayside	87.3	70.7	86.5	92.5
Western Isles	91.7	88.9	88.9	100.0
National total	**93.5**	**75.1**	**85.0**	**93.5**

Sources:

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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 2018; ISD Scotland, June 2018

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NHS in Scotland 2018

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