

NHS in Scotland 2013/14



 AUDITOR GENERAL

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Auditor General for Scotland

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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.

Key facts



Expected real terms reduction in the overall health budget from 2013/14 to 2015/16

0.9%

£274.9 million

Savings made by NHS boards in 2013/14

Real terms increase in NHS boards' revenue budget in 2013/14

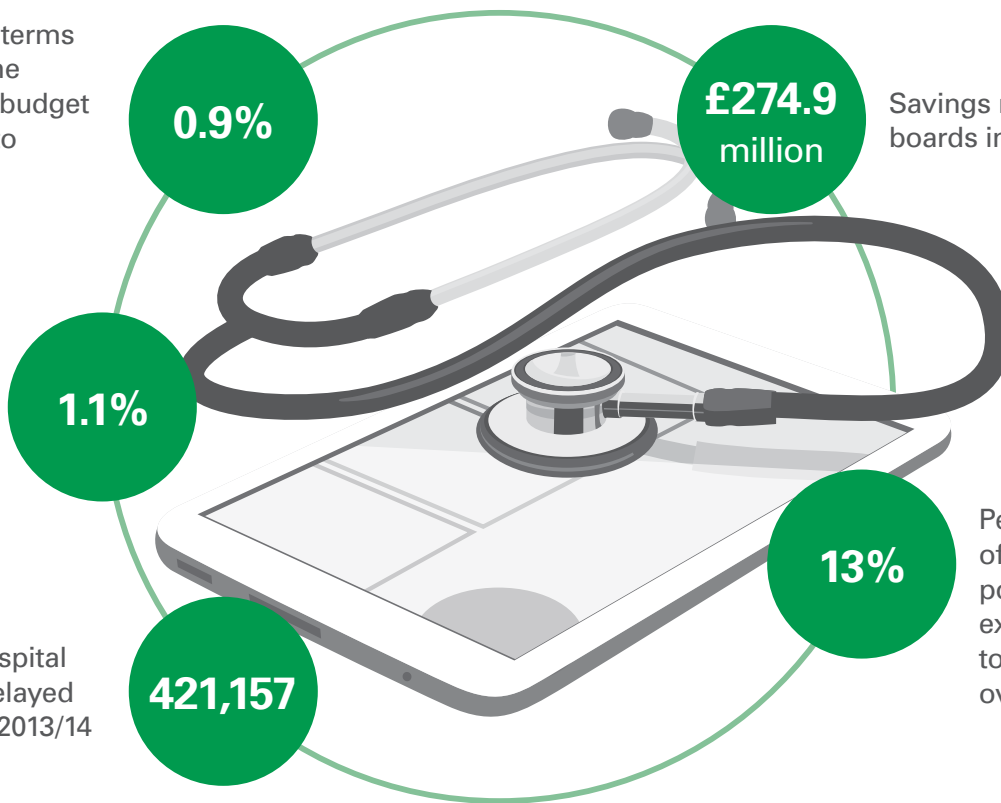
1.1%

Number of hospital days lost to delayed discharges in 2013/14

421,157

13%

Percentage of the population expected to be 75 or over in 2037



Summary



Key messages

- 1** The NHS in Scotland is facing significant pressures at the same time as having to make major changes to services to meet future needs. We found evidence that NHS boards are finding it increasingly difficult to cope with these pressures. NHS boards' revenue budgets increased by just over one per cent in real terms in 2013/14, and smaller real terms increases are planned from 2014/15 onwards. Cost pressures, such as staff pay costs, the growing costs of drugs and other health technologies and rising pension costs, exacerbate this tight financial situation. At the same time, the demands on the NHS are increasing as a result of demographic change, particularly the growing population of elderly and very elderly people; the number of people with long-term health conditions; and people's rising expectations of healthcare.
 - 2** The NHS has made good progress in a number of areas, including improving outcomes for people with cancer or heart disease and reducing healthcare-associated infections. The Scottish Government has set out an ambitious vision for health and social care to enable everyone to live longer, healthier lives at home or in a homely setting by 2020. It will be challenging for the NHS to make the scale of changes required over the next few years, but critical if it is to meet this vision. Progress has been slow and more significant change is needed to move more care into the community. The NHS will not be able to continue to provide services in the way it currently does. Change on this scale will be challenging at the same time as NHS boards are expected to meet demanding targets for hospital care and when budgets are tightening.
 - 3** NHS boards in Scotland delivered a small surplus of £23.4 million against an overall budget of £11.1 billion. All NHS boards met their financial targets, but several boards required additional funding from the Scottish Government or relied on non-recurring savings to break even. Despite significant efforts, the NHS did not meet some key waiting time targets in 2013/14. The current level of focus on meeting waiting time targets may not be sustainable when combined with additional pressures of increasing demand and tightening budgets. There is increasing evidence of 'pinch points' in the complex health and social care system, leading to delays in patients getting the care they need in hospital or the community. NHS boards need a more detailed understanding of current and future patient demand, how they are using their capacity, and how patients move through the system, in order to assess how they can deliver services differently in the future to better match needs.
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Recommendations

The strong focus on meeting annual targets makes it harder to carry out longer-term financial planning. This focus makes it difficult for NHS boards to fund services to meet current needs, at the same time as making the investment required to reshape care in line with the 2020 Vision. NHS boards and their partners need to develop clear plans about how they will deliver sustainable and affordable services to meet future needs, by:

- using population and long-term condition projections to estimate future demand and identify the way that they will provide care that will meet the future needs of the population and achieve the 2020 Vision
- developing detailed and integrated long-term plans for how they will move to those models of care. These should set out the changes needed to spending, workforce, buildings, information technology and other equipment
- developing detailed plans to identify the funding they require to move to new models of care and how they will release and move funding to achieve this. This includes using budget estimates, financial projections, scenario planning and economic modelling
- highlighting any major risks to the Scottish Government to identify what support and action is required at a national level.

NHS boards and their partners need to understand blockages in the way that patients move around the health and social care system and which lead to patients not being able to get care where and when they need it. They need to use this information to better match patient demand with available staff, hospital beds, community services and other resources. The Scottish Government, NHS boards and their partners should:

- improve and maintain data on patterns of demand for, and supply of, community-based health and social care services
- ensure they have access to the necessary skills and technology to:
 - record and analyse patterns of demand, activity and delays by month, week, day of the week and time of day
 - use this data on a real-time basis to make sure that staff and other resources are in place to meet needs
- use modelling techniques to predict patient needs in the short and longer term. They should then use this along with information on available capacity, in order to change how they use staffing and other resources to improve the flow of patients around the system and avoid unnecessary delays.

The NHS is facing significant challenges in making the changes required to achieve the 2020 Vision within the tight financial resources available. These changes need to happen while continuing to provide services to meet the current needs of patients. The Scottish Government should:

- review the current financial and performance targets for the NHS, and the planned indicators for integration joint boards, to ensure they are consistent with, and support the implementation of, the 2020 Vision
 - consider introducing milestones to measure the extent to which boards are moving towards more preventative and community-based care.
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About the audit

1. This report comments on the performance of the NHS in 2013/14 and on its future plans. It is based on our analysis of:

- the audited annual accounts and auditors' reports on the 2013/14 audits of the 23 NHS boards
- NHS boards' Local Delivery Plans (LDPs). These set out their detailed plans and anticipated budget for the next year, and indicative plans for the next three to five years. Boards submit their LDPs to the Scottish Government every year for approval
- monthly Financial Performance Returns (FPRs) that each NHS board submits to the Scottish Government. These provide information about NHS boards' financial performance throughout the financial year
- NHS activity and performance data published by Information Services Division (ISD) Scotland
- an analysis of the demand for healthcare services, the capacity of the NHS to provide services and the flow of patients through the healthcare system. We will publish a briefing paper on this analysis in early 2015.

Part 1

The NHS in Scotland is facing significant pressures



Key messages

- 1** All NHS boards broke even against their revenue and capital budgets in 2013/14, for the sixth year in a row. The NHS boards as a whole achieved an overall surplus of £23.4 million (0.21 per cent of their total revenue and capital budgets of £11.1 billion). All boards except NHS Western Isles met their savings targets, and the NHS as a whole delivered total savings of £274.9 million.
- 2** There are signs that NHS boards are facing increasing difficulty meeting their financial targets, and some are doing this in unsustainable ways. Four boards required additional funding from the Scottish Government to break even, and five continue to rely on high levels of non-recurring savings.
- 3** Despite significant efforts, there are increasing signs of pressure on NHS boards' ability to meet demanding performance targets. The strong focus on meeting waiting time targets may not be sustainable when combined with the additional pressures of increasing demand related to demographic changes and the overall NHS budget starting to decrease in real terms. The effort that NHS boards are putting into meeting challenging financial and performance targets each year makes it more difficult for them to focus on the long-term planning required to achieve the 2020 Vision.

NHS budgets are under pressure

2. The Scottish Government spent £12 billion on health and wellbeing in 2013/14, 35 per cent of total public spending in Scotland.¹ It manages the health and wellbeing budget as a whole, including NHS boards, and sets the national strategy for the NHS in Scotland ([Supplement 1: Overview of financial management in the NHS in Scotland](#)). The current national strategy is set out in the 2020 Vision which aims to provide more preventative and ongoing care at home or in homely settings.²

3. In 2013/14, the Scottish Government allocated £11.1 billion of the total £12 billion budget for health and wellbeing to the 14 territorial NHS boards that serve each area of Scotland and deliver frontline healthcare services, and to the nine special NHS boards that provide specialist and national services ([Supplement 2: Territorial and special boards in Scotland](#)).³

4. Since 2002/03, the Scottish Government's total spending on health (excluding spending on sport and equalities) has increased in real terms (that is, taking inflation into account). Health spending per head of population has decreased

all NHS boards met their financial targets in 2013/14 but some are facing increasing difficulty in achieving them

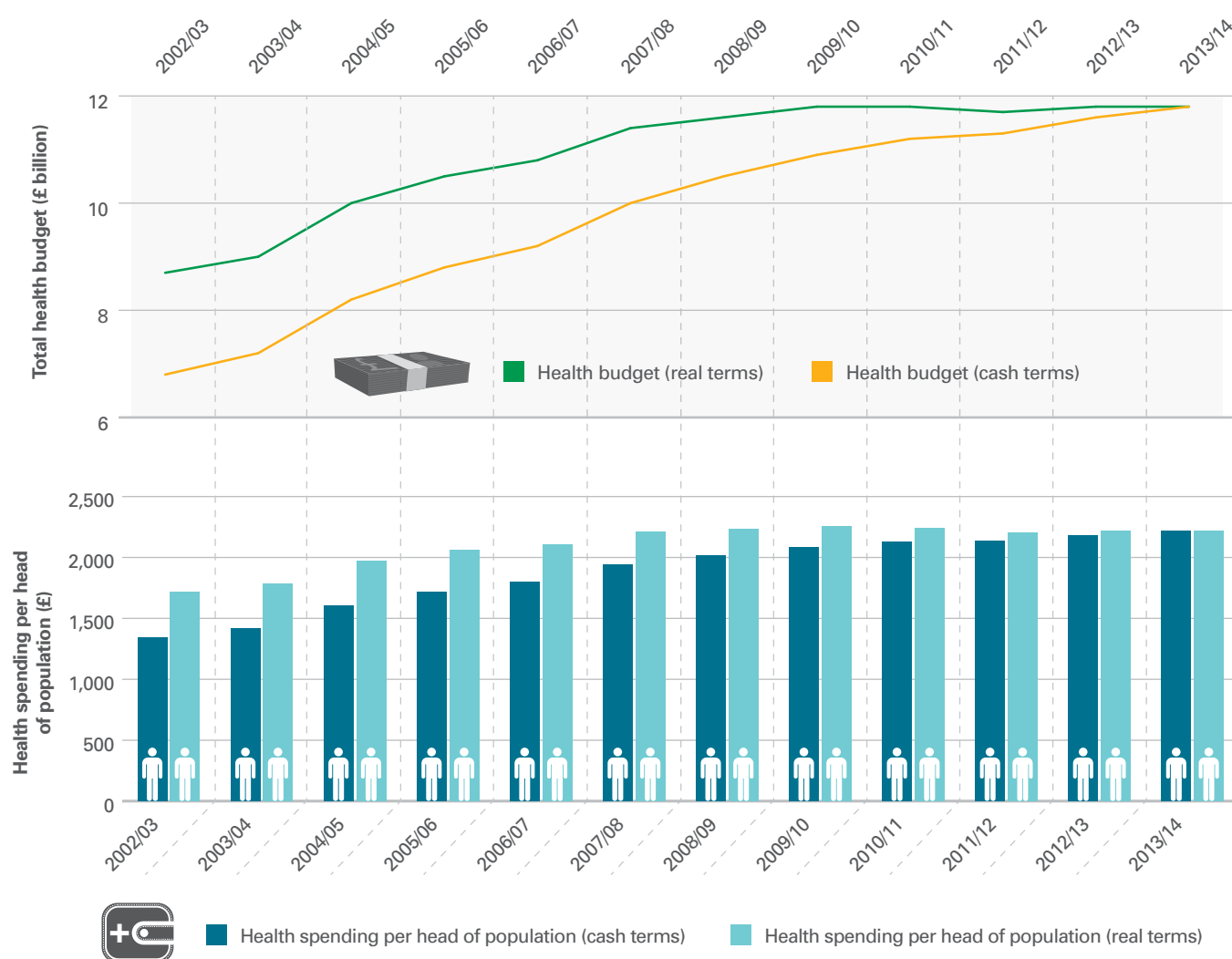
slightly in real terms since 2009/10 ([Exhibit 1](#)). This is due to smaller increases in the budget compared to previous years and an increasing population. The Scottish Government's overall health expenditure is planned to decrease by 0.9 per cent in real terms over the next two years, between 2013/14 and 2015/16:

- the revenue budget is planned to increase by almost 1.0 per cent
- the capital budget is planned to decrease by 53.6 per cent.

Exhibit 1

Actual Scottish health budget, 2002/03 to 2013/14

The health budget continues to have small increases in cash terms. Health spending per head of population has slightly decreased in real terms since 2009/10.



Notes:

1. The overall health budget is the Scottish Government's total spending on health (excluding spending on sport and equalities), including the budgets allocated to the 14 territorial boards and the nine special boards. This includes revenue and capital budgets, and annually managed expenditure.
2. We used 2013/14 as the reference year for calculating real terms figures.
3. 2002/03 was the first year of the current three-year budget-setting arrangements and budget figures from before that year are not directly comparable.
4. Due to an accounting adjustment to the capital budget, the cost of capital charges has been removed from budgets prior to 2010/11.

Source: Scotland's draft budgets: 2007/08, 2008/09, 2009/10, 2010/11, 2011/12, 2012/13, 2013/14 and 2014/15, Scottish Government; and Mid-Year Population Estimates for Scotland, General Register Office for Scotland



5. In 2013/14, the total amount of revenue funding that the Scottish Government provided to boards increased by almost three per cent in cash terms and by just over one per cent in real terms from 2012/13:

- All territorial boards received small real terms increases in their revenue budgets. There was an overall increase of 1.6 per cent in 2013/14.
- Revenue budgets decreased in some special boards, mainly in those that do not provide frontline services. There was an overall decrease of 0.5 per cent in 2013/14.⁴

All NHS boards met their financial targets in 2013/14 but some are facing increasing difficulty in achieving them

6. NHS boards have two financial targets: to break even against both their revenue and capital budgets at the end of the financial year.⁵ This means that NHS boards cannot have a deficit against their budgets at the end of the year. The requirement for NHS boards to break even at the end of every year makes it more difficult to carry out longer-term financial planning. It makes it difficult for NHS boards to balance the funding of services to meet current needs with the investment required to address longer-term issues.

7. Last year, we recommended that the Scottish Government should consider moving away from setting annual financial resource limits for NHS boards to help them plan for the longer term.⁶ From 2014/15, a proportion of funding that the Scottish Government can carry forward each year will be available to the NHS if required (through the budget exchange mechanism). This amount is not fixed and the Scottish Government will decide this on an annual basis.⁷ Although this provides some extra flexibility, it does not provide boards with certainty about the amount of additional funding available to allow them to plan ahead. The Scottish Government is also able to provide some flexibility each year for NHS boards that want to retain a surplus for investment in the following year. NHS boards need to agree this with the Scottish Government in advance. As the Scottish Government needs to balance the health budget as a whole each year, it can only agree this for a small number of boards or for a small percentage of their budgets.

8. All NHS boards broke even in 2013/14, for the sixth year running. There was an overall surplus in the revenue budget of £23.3 million for the whole of the NHS in Scotland. **Supplement 3: Financial performance of NHS boards in 2013/14** shows the budget and outturn figures for 2013/14. This represents only 0.22 per cent of the revenue budget, slightly higher than the 0.16 per cent surplus in 2012/13. NHS boards normally return any surplus against their budgets at the year-end to the Scottish Government. NHS Dumfries and Galloway and NHS Greater Glasgow and Clyde both agreed with the Scottish Government to retain a surplus against their revenue budgets in 2013/14, of £3 million and £10 million respectively. This is to support future non-recurring expenditure in relation to new hospitals that are being built in both these boards.

Four boards required brokerage in 2013/14

9. The Scottish Government can agree to provide an NHS board with additional funding to help it manage changes to planned expenditure, or provide extra money at a time of pressure. This is agreed on the basis that the board provides assurance that it can repay the funds in the coming financial years. This form of additional funding is known as brokerage. The amount of brokerage received by boards in

a year is relatively small compared to their overall budget. This shows that NHS boards are often working to tight budgets with little flexibility for unexpected costs at the end of the year, for example locum costs to cover staff sickness.

10. In 2013/14, four NHS boards received brokerage from the Scottish Government. Brokerage can be helpful in providing some additional flexibility in boards' budgets for unforeseen unexpected financial pressures. However, poor financial management was a major factor in NHS Highland and NHS Orkney needing brokerage in 2013/14. Both boards requested brokerage late in the financial year to help them break even due to overspending on their day-to-day running costs:

- NHS Highland received £2.5 million (0.4 per cent of its revenue budget) to cover pressures associated with overspending on the operating costs for Raigmore Hospital, and costs associated with hiring locum doctors and meeting waiting times targets ([Case study 1, page 13](#)).
- NHS Orkney received £1 million (2.0 per cent of its revenue budget) for additional costs of hiring locum doctors ([Case study 2, page 14](#)).
- NHS 24 received £3.9 million (5.3 per cent of its revenue budget) for the financial implications of delays and ongoing issues in implementing a new IT system. This is likely to have financial implications for the board in future years ([Case study 3, page 15](#)).
- NHS Tayside received £2.85 million (0.4 per cent of its revenue budget) for deferring the sale of property with an anticipated profit of £2 million and associated ongoing maintenance costs. This is the second year running the board received brokerage for this reason.

Three NHS boards faced particular financial difficulties in 2013/14

11. The external auditors have raised concerns about the financial position and financial management in NHS Highland and NHS Orkney, and the financial position in NHS 24. Both NHS Highland and NHS Orkney received brokerage to meet operational cost pressures, but did not identify this need until late in the financial year. Both boards also made high levels of non-recurring savings to help them break even. This is a less sustainable way to meet savings targets than making recurring savings as it means the boards need to find these same savings again in other areas in future years. NHS Highland and NHS Orkney both receive funding allocations from the Scottish Government that are less than that recommended by the national funding formula ([paragraph 13](#)). While this may contribute to their financial pressures, these boards also need to improve their financial management ([Case study 1 and Case study 2](#)). NHS 24 has experienced financial difficulties due to problems implementing a new IT system ([Case study 3](#)). The Auditor General has prepared separate reports on each of these three boards.⁸

Seven boards have ongoing commitments to repay brokerage

12. The Scottish Government has agreed brokerage with eight NHS boards over the past five years, with five of these boards receiving brokerage in more than one financial year ([Exhibit 2, page 12](#)). Seven NHS boards have ongoing commitments to repay brokerage after 2013/14, reducing the amount they will have available to spend on services during this period. For example:

- NHS Orkney has received brokerage on four occasions and its repayment schedule spans a seven-year period. Brokerage was received between

2009/10 and 2011/12 to support implementation of a new clinical strategy and help the board to return to a recurring financial balance. The board repaid £1 million in 2013/14 and has agreed that the balance will be repaid in 2016/17 and 2017/18 to tie in with moving closer to its target funding allocation.

- NHS Highland is due to repay brokerage received in 2013/14 over the next three years.
- NHS Tayside is relying on selling properties to repay the brokerage it has received and to break even in 2014/15. If these property sales do not take place or the proceeds are less than expected, the board might need brokerage again, which could reduce the board's budget in future years.

Exhibit 2

Brokerage provided by the Scottish Government, 2009/10 to 2013/14, and planned repayments to 2018/19

Eight NHS boards have received brokerage over the past five years. Arrangements for repayment can span a number of years.

NHS board	Brokerage by year (£ millions)	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total brokerage by board
Fife	Brokerage			1.11	1.40							2.51
	Repayments				(0.36)	(2.15)						
Forth Valley	Brokerage		2.10	11.00								13.10
	Repayments			(1.55)	(2.57)	(3.57)	(4.41)					
Highland	Brokerage					2.50						2.50
	Repayments						(0.50)	(1.00)	(1.00)			
Lothian	Brokerage				10.00							10.00
	Repayments				(2.00)	(4.00)	(4.00)					
Orkney	Brokerage	1.11	1.01	2.26		1.00						5.38
	Repayments			(0.32)		(1.00)			(3.21)	(0.85)		
Tayside	Brokerage				2.25	2.85						5.1
	Repayments				(0.25)	(4.05)	(0.80)					
Western Isles	Brokerage	3.10										3.1
	Repayments			(0.63)	(0.59)	(0.26)	(0.54)	(0.54)	(0.54)			
NHS 24	Brokerage			0.32	16.58	3.86						20.76
	Repayments							(3.65)	(6.43)	(6.19)	(4.49)	
Total brokerage by year		4.21	3.11	14.69	30.23	10.21						

Notes:

1. Reasons for boards receiving brokerage in 2013/14 are in Case studies 1, 2 and 3, and paragraph 10.

2. Reasons for other boards receiving brokerage before 2013/14 are:

NHS Fife received £1.1 million in 2011/12, and a further £1.4 million in 2012/13, due to overspending in its Acute Operating Division and on GP prescribing, and for costs for some specialist patient treatment outside the Fife area.

NHS Forth Valley received £2.1 million in 2010/11 for financial support. The board received a further £11 million in 2011/12 for costs associated with the implementation of its Healthcare Strategy and to help it break even. The Scottish Government agreed that £1 million of this £11 million brokerage did not require to be repaid.

NHS Lothian received £10 million in 2012/13 to help improve its performance against waiting times targets.

NHS Western Isles received £3.1 million in 2009/10 to support a historical deficit, although it had achieved financial balance for two years.

Source: Health Finance Directorate, Scottish Government

Case study 1

Financial management at NHS Highland



In 2013/14, NHS Highland required brokerage of £2.5 million from the Scottish Government to break even. This was mainly due to an overspend on the operating costs for Raigmore Hospital, and costs associated with hiring locum doctors and meeting waiting times targets. Weaknesses in budgetary control at Raigmore Hospital contributed to a £9.65 million overspend at the hospital in 2013/14, and the board did not meet waiting time targets for inpatients/day cases and outpatients ([Exhibit 5, page 23](#)). Weaknesses in budgetary control at Raigmore Hospital were also highlighted in internal audit reports in 2013 and 2014.

Until February 2014, the board was forecasting that it would break even at the end of the financial year. Finance reports did not sufficiently detail how the board expected to bridge the gap between the ongoing overspend and its forecast break-even position. It was not until close to the end of the financial year that the finance team reported to the board of directors that brokerage from the Scottish Government would be needed to break even.

NHS Highland has increasingly relied on non-recurrent savings to break even in recent years. In 2013/14, it planned to make 67 per cent of its savings on a recurring basis, but it actually only made 38 per cent (£7 million) on this basis. Continued reliance on non-recurring savings may not be sustainable in the longer term.

In 2013/14, NHS Highland also received additional funding of £1 million from Highland Council towards the transitional costs of integrating adult health and social care services. These services had transferred to the board as part of the integration of health and social care in Highland. The cost of delivering adult social care services still poses a financial risk to the board. Highland Council has agreed to provide the board with a further £13.5 million between 2014/15 and 2016/17. This covers the final three years of the partnership agreement between the board and the council for adult health and social care services.

NHS Highland continues to experience financial pressures in 2014/15. At the end of August 2014, it forecast breaking-even at the end of the financial year. This requires it to achieve, by the year-end, a £12.3 million improvement on the financial position projected in August, with £9.9 million of this relating to Raigmore Hospital. This will be challenging for the board and will depend on meeting its savings targets. NHS Highland recognises the significant challenges it faces in identifying and delivering savings. It has established a programme board, chaired by the chief executive and including all executive and operational directors, to oversee the delivery of savings. The programme board is focusing on delivering recurring savings to achieve financial balance.

Source: NHS Highland Annual Audit Report 2013/14 and NHS Highland Board Papers 12/08/2014

Case study 2

Financial management at NHS Orkney



In 2013/14, NHS Orkney required brokerage of £1 million from the Scottish Government to break even. This was largely due to hiring locum doctors to cover vacant medical posts.

Throughout the year, NHS Orkney was reporting an overspend against its revenue budget to its Finance and Performance Committee, and this increased considerably over the second half of the financial year. The board did not have detailed plans for how it was going to bridge the gap between its ongoing overspend position and its forecast break-even position at the year-end, or provide reports to its Board of directors about how it would achieve this. We were informed that officers discussed actions with Board members.

NHS Orkney approached the Scottish Government in February 2014 to request brokerage of £0.75 million. This was later revised to £1 million in March 2014. The Scottish Government has agreed that the board does not need to start repaying the total amount of brokerage received of £4.06 million (including brokerage received in previous years) until 2016/17 ([Exhibit 2, page 12](#)). This is when the board should receive additional funding to take it closer to its target funding allocation ([paragraph 13](#)).

During the audit of the board's 2013/14 annual accounts, the auditor identified a significant error relating to accounting entries associated with the five-yearly revaluation of its land and buildings during 2013/14. Due to a lack of capacity within NHS Orkney's finance team, staff from NHS Fife assisted the board in resolving this issue. The auditor has expressed some concern about the capacity of the finance team, given the pressures facing the board.

In recent years, NHS Orkney has relied on non-recurring savings to break even ([Exhibit 3, page 17](#)). In 2013/14, it achieved £0.42 million recurring savings against a target of £1.03 million (41 per cent of the target). The board's financial plans for 2014/15 also rely on non-recurring savings. It plans to make over 66 per cent of its planned savings on a non-recurring basis due to the non-recurring nature of the pressures facing the board, such as using locum and agency staff until permanent staff are recruited. Taking into account the need to continue to deliver savings and to repay brokerage, the auditor has highlighted that delivering a break-even position in the coming years will be challenging for the board. There are specific pressures that may affect NHS Orkney's ability to achieve the savings required for longer-term sustainability, particularly workforce pressures and associated costs of hiring locum doctors. Between 2012/13 and 2013/14, the board's spending on locum doctors increased by 30 per cent. The board recruited a number of staff to key posts in 2013/14, but it has underlying recruitment problems and has not been able to fill some posts despite several recruitment campaigns. Continued reliance on locum doctors will have a significant impact on its plans to achieve savings.

The Chief Executive asked the board's internal auditor to undertake a detailed review of the board's 2013/14 financial position. This includes an examination of the board's approach to budget-setting and in-year financial management. The review is now complete and the board is developing an action plan.

Case study 3

NHS 24's Future Programme



NHS 24 planned to implement its Future Programme in September 2013. This includes delivering new technology that is central to NHS 24 improving its core telephone and online services for patients. NHS 24 also expected the new application to deliver financial savings. NHS 24 has delayed implementation as it considers that the new application currently developed does not meet its patient safety requirements.

The delay in implementing the new system has led to additional costs being incurred. The total cost of the project to date is £38 million, considerably more than the original business case of £29.6 million. The board has estimated that it will incur further additional costs of £14.6 million between 2014/15 and 2015/16 to achieve an acceptable solution. This includes potential new investment in developing the IT system, the costs of continuing to maintain the current system during the delay, and failing to achieve savings that were expected as a result of the new system.

By the end of 2012/13, the Scottish Government had provided NHS 24 with brokerage of £16.9 million and £0.8 million in revenue funding to fund the Future Programme. The board's financial plan for 2013/14 included agreed brokerage of £1.7 million to support what was planned to be the final year of implementing the Future Programme. Due to the delays and ongoing problems implementing the new IT system, the Scottish Government agreed to provide a further £2.2 million brokerage, taking the total provided in 2013/14 to £3.9 million. NHS 24 was due to repay the brokerage over three years from 2014/15, but the Scottish Government has agreed that this can be postponed to start in 2015/16 ([Exhibit 2, page 12](#)).

NHS 24 has drafted a five-year financial plan for 2014/15 onwards. This projects a break-even revenue position for the first four years of the plan and a small surplus position in year five. The plan has factored in the financial implications of resolving the issues with the Future Programme, and the board will update this on an ongoing basis as the situation evolves. The auditor has highlighted that the achievement of financial targets is likely to remain a high risk for the board given the extent of the issues that need to be resolved and the requirement to repay brokerage in future years.

NHS 24 has kept the Scottish Government informed about the problems with the Future Programme. The board and the Scottish Government jointly commissioned an independent review and NHS National Services Scotland has also recently provided additional support to NHS 24 through contract management and technical specialists. The board is continuing to work with the suppliers of the new IT system on resolving the issues.

The board has ensured that the current IT systems can be maintained in a safe and reliable manner so that services for patients are not affected.

Four NHS boards are still receiving less than their target funding allocation

13. The Scottish Government uses a formula developed by the National Resource Allocation Committee (NRAC) to allocate funding to territorial boards. The formula has been in place since 2009/10, and the Scottish Government is aiming for all NHS boards to be within one per cent of their target allocations by 2016/17. Territorial boards receive an increase in funding each year, however some boards' allocations are below the amount proposed by the formula. Four boards were more than one per cent below their target allocations in 2013/14 and 2014/15:

- **NHS Orkney:** -12.2 per cent (£4.8 million) in 2013/14; -11.1 per cent (£4.5 million) in 2014/15
- **NHS Grampian:** -5.1 per cent (£39.9 million) in 2013/14; -3.7 per cent (£30.2 million) in 2014/15
- **NHS Highland:** -2.2 per cent (£11.3 million) in 2013/14; -2.3 per cent (£12.3 million) in 2014/15
- **NHS Lanarkshire:** -1.5 per cent (£12.7 million) in 2013/14; -1.7 per cent (£15.3 million) in 2014/15.

14. Receiving funding that is below their target NRAC allocation may have contributed to financial difficulties in NHS Highland and NHS Orkney. Both boards broke even in 2013/14 using unsustainable methods, specifically brokerage from the Scottish Government and high levels of non-recurring savings. However, the level of NRAC funding is not the only factor causing financial difficulties at NHS Highland and NHS Orkney. We have identified concerns about financial management at these boards. NHS Grampian and NHS Lanarkshire also received funding allocations of more than one per cent below their target NRAC allocations. NHS Grampian only met two of the eight waiting time targets and the number of its patients with a delayed discharge increased ([Exhibit 5, page 23](#)).

Five boards continue to rely on high levels of non-recurring savings

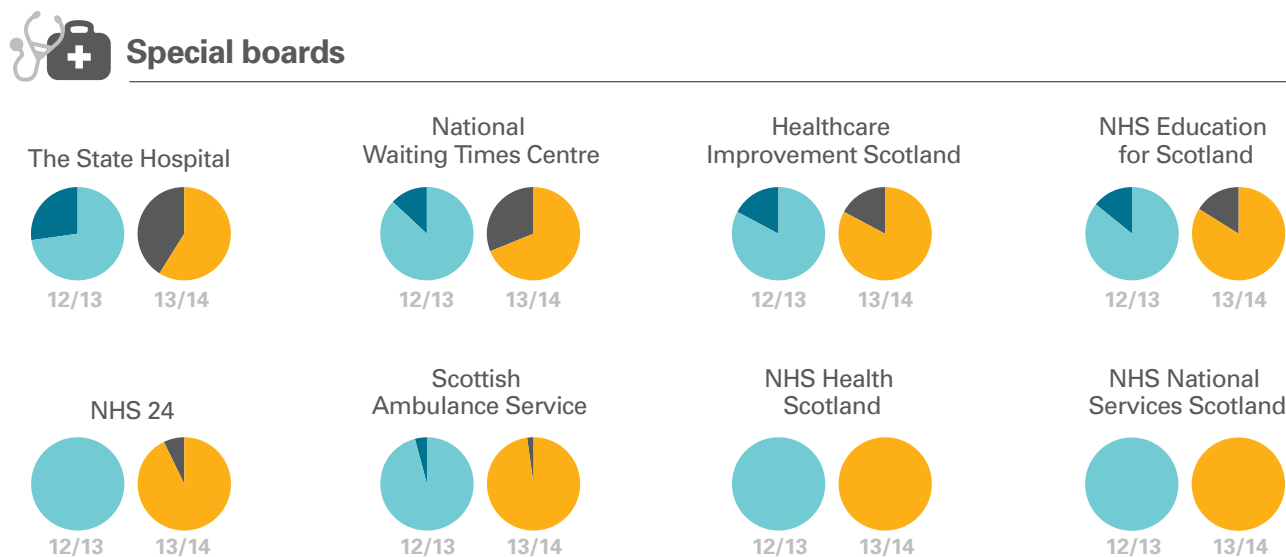
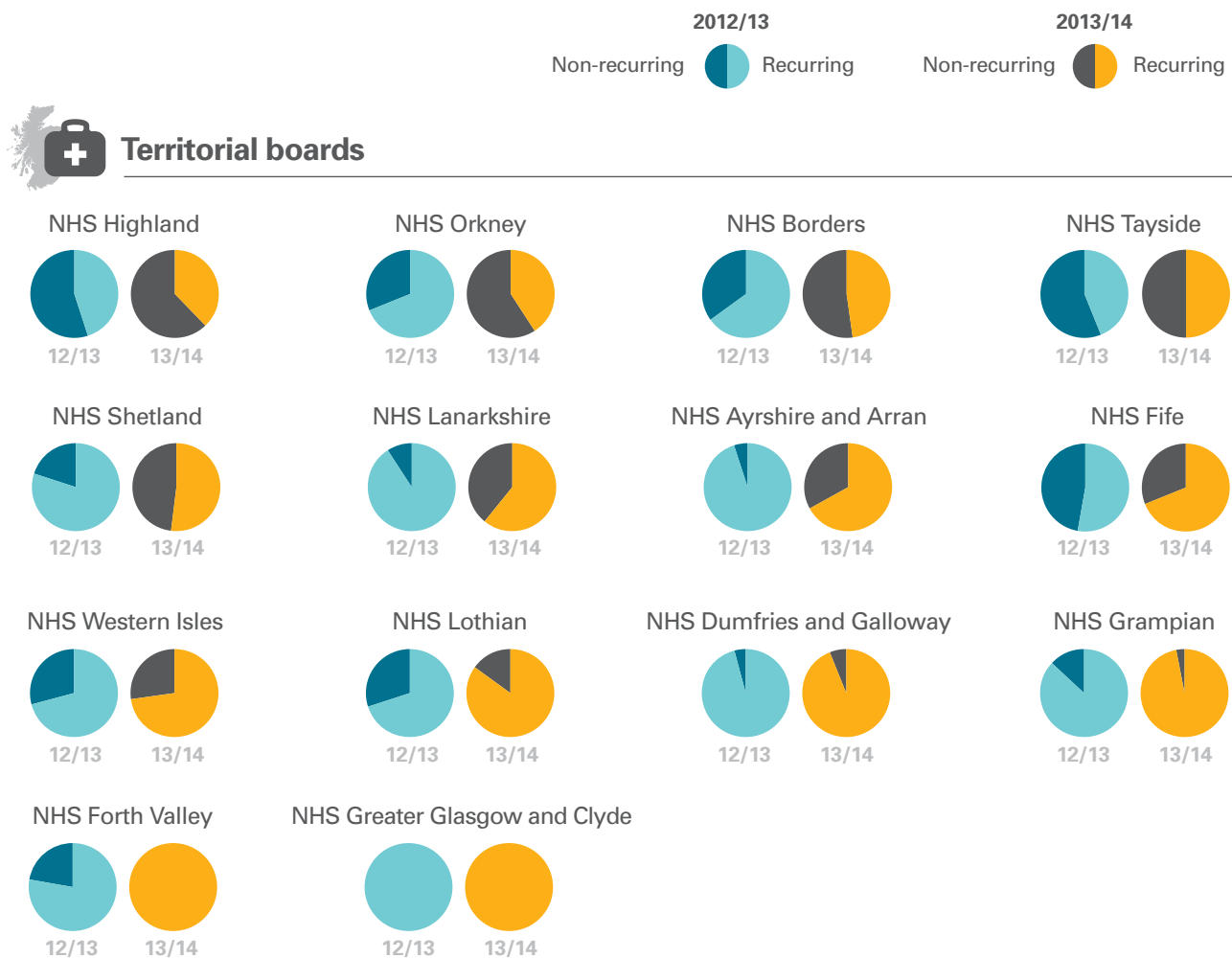
15. Boards are required to make efficiency savings of three per cent against their revenue budgets, and had forecast savings of £267.8 million in 2013/14. The actual savings achieved totalled £274.9 million (£244.7 million by territorial boards and £30.2 million by special boards). All boards met their savings targets, except NHS Western Isles which was £30,000 (1.6 per cent) below its target. NHS boards retain savings made locally as part of their overall financial planning to help balance their budgets.

16. Some boards are still relying on a high percentage of non-recurring savings ([Exhibit 3, page 17](#)). These are savings that are only made for one year, rather than savings that the board will continue to make every year.⁹ It can be appropriate to have some non-recurring savings, but it is important that the majority of savings are recurring to ensure the sustainability of the board's financial position and to reduce the risk of not achieving savings targets in future years. We have highlighted this as a risk in our reports over the last two years and the risk still remains. The area that contributed most to NHS boards' savings was productivity. NHS boards made total savings of £114.1 million in this area against a forecast £102.7 million. However, 26 per cent of these savings were non-recurring, compared with a forecast of 14 per cent. This suggests that these

Exhibit 3

Recurring and non-recurring savings

A number of NHS boards relied on a high level of non-recurring savings in 2013/14 and 11 boards made higher levels of non-recurring savings than in 2012/13.



Source: NHS boards' financial performance returns, March 2014. NHS Orkney updated its savings information in July 2014.



savings were the result of short-term initiatives rather than changing the way that services are provided in order to improve productivity. This is similar to last year, when 28 per cent of productivity savings were non-recurring, higher than forecast. The difficulty NHS boards have achieving recurring productivity savings is another strain on them, and adds to their financial pressures for the coming year.

17. Seven territorial and four special boards had higher overall levels of non-recurring savings in 2013/14 than in the previous year.¹⁰ Five boards reported a particularly high percentage of non-recurring savings:

- NHS Highland (62 per cent)
- NHS Orkney (59 per cent)
- NHS Borders (52 per cent)
- NHS Tayside (50 per cent)
- NHS Shetland (48 per cent).

18. These boards will have to find further savings in future years, on top of the annual savings target. This position is not sustainable, especially since boards are required to continue to make three per cent savings from 2014/15.

19. NHS boards set out their financial projections up to five years ahead in their Local Delivery Plans (LDPs), showing expected funding, projected expenditure and the savings required each year to close the gap between income and expenditure. For 2014/15, NHS boards' detailed financial planning is still limited mainly to the first year of the LDP. Across the NHS:

- six per cent of the required savings for 2014/15 are unidentified
- over two-thirds of the amount of savings are unidentified for the following four years
- five NHS boards have not identified the breakdown of the amount of their savings after 2014/15 (Fife, Forth Valley, Greater Glasgow and Clyde, Lothian and Western Isles).

NHS boards are making less progress than expected on reducing backlog maintenance

20. Further cost pressures arise from the backlog of maintenance required to ensure that hospitals and other buildings are fit for purpose. In 2012, the Scottish Government forecast that the cost of this backlog would decrease by £174 million by 2013, from £948 million to £774 million.¹¹ The actual reduction was £90 million, to £858 million.¹² The high-risk backlog reduced to £96 million, £21 million less of a reduction than anticipated. The significant-risk backlog rose from £265 million to £275 million.¹³ This reflects additional maintenance identified by boards through survey work during 2013 as well as some lack of progress in carrying out backlog maintenance.

21. The level of backlog maintenance decreased in 14 boards and increased in seven.¹⁴ The total increase in the seven boards was £19.9 million of which NHS

Fife had by far the largest increase of £13.5 million. In three of these boards (NHS Borders, NHS Highland and the Scottish Ambulance Service), the backlog had also increased in 2012. The increase of £3.4 million in NHS Highland is a further financial pressure on the board. In four boards, over 50 per cent of the cost of backlog maintenance was classed as high-risk and significant risk: NHS Lothian (84 per cent), NHS Shetland (82 per cent), NHS Tayside (54 per cent) and NHS Ayrshire and Arran (52 per cent).

22. The Scottish Government now forecasts that the majority of high-risk maintenance backlog will be cleared by 2015, one year later than originally planned. The significant-risk backlog is now forecast to decrease to around £150 million by 2017, compared with the previous forecast that it would be cleared by 2016.

The annual financial target for capital spending makes it difficult to plan longer-term projects

23. Capital investment is important in enabling boards to plan and deliver the 2020 Vision, by investing in new healthcare facilities, maintaining and modernising existing facilities that will be required in future, and disposing of those that are no longer needed. The NHS capital budget available to boards fell by 21 per cent between 2012/13 and 2013/14, from £605.5 million to £481.3 million. More than half of this reduction related to accounting adjustments associated with revenue-financed methods, such as Non-Profit Distribution (NPD), which do not affect the capital funds available for boards to spend. The remaining capital budget available to boards reduced by 12 per cent, to £466.4 million.

24. All boards broke even against their capital budgets in 2013/14, but significant movements in their budgets were required during the year to allow them to reach that position ([Exhibit 4, page 20](#)). The Scottish Government manages the capital budget carefully during the year, moving funds from NHS boards that expect delays in their expenditure to those that are able to make use of the funding. This allows the NHS as a whole, and individual boards, to stay within their capital budgets but it makes it difficult to see how well NHS boards have managed their resources. The Scottish Government has increased the proportion of total capital funding that is included in initial allocations each year, although it did not agree final budgets with several NHS boards until after the end of the financial year. NHS boards' annual accounts are still not clear about the extent of, and reasons for, movements in their capital budgets during the year.

25. The annual financial targets for capital budgets, and uncertainty about future budgets, hinders NHS boards' effective planning of capital projects. For example, NHS boards returned around £29 million of capital funding to the Scottish Government during 2013/14. A number of boards that had returned capital funds in previous years received these funds back in 2013/14, and subsequently returned them again. For example, NHS Grampian agreed with the Scottish Government to defer some of its capital budget allocation from 2011/12 and 2012/13, into 2013/14 to help manage the cost of essential backlog maintenance at Aberdeen Royal Infirmary. From 2014/15, the Scottish Government has issued two-year indicative capital allocations to NHS boards to help them manage their capital programmes.

26. The NHS needs the right buildings and facilities to achieve the 2020 Vision and provide healthcare that meets future needs. Over the next four years, the

Exhibit 4

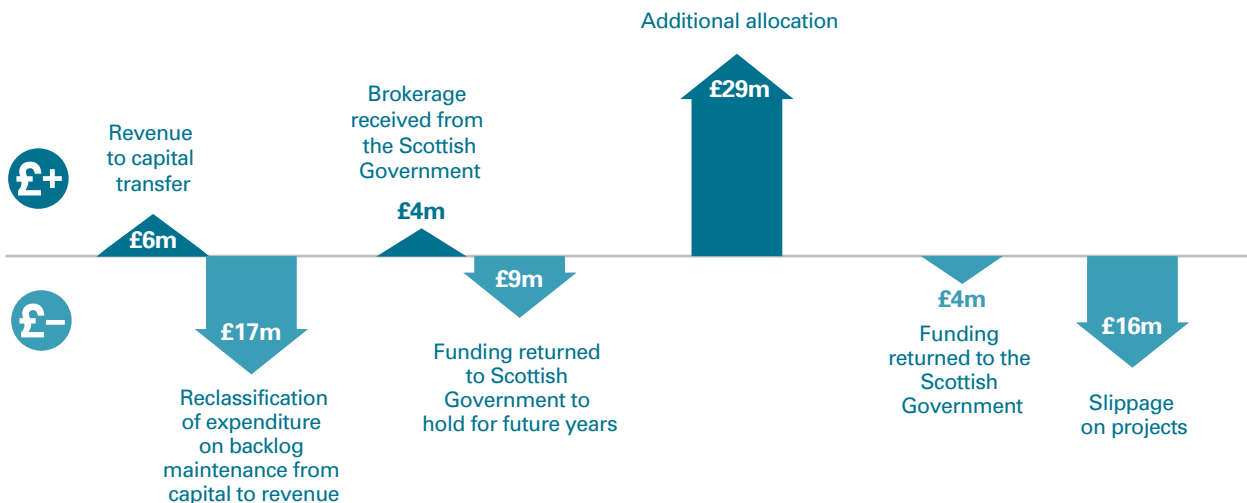
There were significant movements in the NHS capital budget in 2013/14

Both the overall capital budget and the budget available for investment decreased from 2012/13.

	2012/13 £ million	2013/14 £ million	% change
Total capital budget	605.5	481.3	↓ -20.52
Split into:			
Capital provided for investment in board capital programmes	528.1	466.4	↓ -11.68
Capital funded by the Scottish Parliament for accounting treatment for new revenue-financed projects	77.5	14.9	↓ -80.72

There were also significant movements in the capital budget across all boards. These follow a similar pattern to the movements in 2012/13.

Movements in capital budget across boards



Note: The capital budget shown here is represented by the final capital resource limits (CRLs) from the NHS boards' accounts. This differs from the capital budget allocated to the NHS within the Scottish Government Budget due to adjustments, for example for assets donated to the boards.

Source: NHS annual accounts 2013/14 and NHS board allocation letters 2013/14

Scottish Government plans to invest around £330 million in new facilities and other capital projects in the community.¹⁵ This investment is intended to help move towards more community-based and preventative care by April 2017. For example, NHS Forth Valley, Stirling Council and Forth Valley College plan to develop the Stirling Care Village as part of their wider plans to change and improve care for older people. This model intends to combine primary and community healthcare with care for older people, providing joined-up services. GP surgeries, the voluntary sector and other local service providers will also be involved in delivering enhanced services through this model of care.¹⁶

There have been improvements in the quality of healthcare

27. The Scottish Government has set out the national strategy for the NHS in the 2020 Vision and the Healthcare Quality Strategy. These aim to improve the quality and safety of patient care, and health outcomes.¹⁷ The Scottish Patient Safety Programme focuses on improving the safety and reliability of healthcare and reducing harm. For example, a focus on healthcare-associated infections (HAIs) resulted in a 50 per cent reduction in adult patients in hospital with HAIs between 2005 and 2011 (from 9.5 per cent to 4.9 per cent), and rates continue to fall.¹⁸ Health outcomes for some conditions have also improved. Cancer and heart disease are the two main causes of death in Scotland. Between 2003 and 2012, the death rate for all forms of heart disease fell by 38 per cent and the number of people having a heart attack fell by a fifth.¹⁹ The Scottish Government has a policy objective to improve early detection of cancer, which improves outcomes for patients. Between 2010 and 2013, the number of people diagnosed with early stage breast, colorectal or lung cancer increased by 7.5 per cent. Patient satisfaction with hospital inpatient services has also generally increased since 2012.²⁰

Performance against waiting time targets is showing increasing signs of pressure

28. NHS boards are required to meet a number of performance targets that cover health improvement, efficiency, access and treatment (HEAT targets). These aim to ensure that NHS boards focus on making improvements in areas the Scottish Government has identified as priorities, to help to achieve its overall purpose and objectives.²¹ In recent years, the Scottish Government has reduced the number of HEAT targets and has committed to focusing more on outcomes. But the level of performance that boards are expected to achieve has become more challenging at the same time as budgets are tightening. This is making it increasingly difficult for NHS boards to continue to meet HEAT targets.

29. Many of the HEAT targets relate to waiting times. Waiting time targets have reduced over the past ten years and the length of time that people wait has decreased considerably. Some targets have become more challenging for NHS boards recently:

- Delayed discharges – since April 2013, NHS boards have been working to the target that no patient should wait in hospital for more than 28 days from when they are clinically ready for discharge (reduced from 42 days previously). From April 2015, this is due to reduce further, to 14 days. Boards are finding it difficult to meet the current target, with only three boards meeting this at the end of April 2014 ([Exhibit 5, page 23](#)).
- Specialist Child and Adolescent Mental Health Services (CAMHS) – the current target is that 90 per cent of patients should wait no longer than 26 weeks from referral to treatment. This target is due to reduce to 18 weeks from December 2014. Performance against the current target deteriorated between 2012/13 and 2013/14 from 99 to 93 per cent of all patients seen within 26 weeks ([Exhibit 5](#)).
- The treatment time guarantee (TTG) was introduced on 1 October 2012 under the Patient Rights (Scotland) Act 2011. All eligible patients now

have a legal right to receive planned inpatient or day-case treatment within 12 weeks of the treatment being agreed. This is the first time that waiting times have been a legal right and puts more pressure on boards to ensure that all patients are seen within the required time. The TTG has not been met nationally since it was introduced and only five territorial boards met it in March 2014.

30. Last year, we highlighted that the failure to meet some key waiting time targets suggested capacity pressures in boards. Overall, performance against several of these targets deteriorated between 2012/13 and 2013/14, indicating increasing capacity pressures in boards ([Exhibit 5](#)). The Scottish Government has recently lowered the threshold for the A&E target as boards were struggling to meet it. From April 2013, the A&E waiting time target was temporarily lowered from 98 per cent of patients to be seen within four hours to 95 per cent. The 95 per cent target is due to be delivered by the year ending September 2014 and performance data will be published at the end of November 2014.

31. Across Scotland, at the end of March 2014:²²

- Only three of the key waiting time targets were met nationally: the drug and alcohol treatment target (met by all 14 territorial boards), the cancer (decision to treat to first treatment) target (met by 11 territorial boards) and access to CAMHS (met by nine territorial boards). These three targets were also met at the end of March 2013. The 18-week referral to treatment target which was met in at the end of March 2013 was not met at the end of March 2014.
- No territorial board met the outpatient waiting time target; and only three boards met the delayed discharges target (NHS Ayrshire and Arran, NHS Orkney and NHS Shetland).
- Boards are finding it challenging to meet the TTG, four-hour A&E target and cancer (urgent referral to first treatment) target.
- Performance against the targets varied by board. While NHS Orkney met eight of the nine targets and NHS Shetland met seven, NHS Grampian and NHS Lothian met two of the nine targets, NHS Greater Glasgow and Clyde and NHS Highland met three, and NHS Tayside met four.

32. More detailed analysis of performance against these key targets highlights the variability across boards and specialties. For example, most patients waiting longer than the TTG target of 12 weeks at the end of March 2014 were in NHS Lothian and NHS Grampian. More recent information for June 2014 shows that:

- no patients were waiting longer than 12 weeks in any specialty in NHS Forth Valley, NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Orkney, NHS Shetland, and NHS Western Isles
- the three boards with the highest number of people waiting for more than 12 weeks for treatment were NHS Lothian, NHS Highland and NHS Grampian
- the specialties with the highest number of people waiting more than 12 weeks in NHS Lothian were plastic surgery (125 patients), urology (93) and general surgery (49); in NHS Highland it was trauma and orthopaedics (166); and in NHS Grampian it was plastic surgery (133) and ophthalmology (88).²³

Exhibit 5

Performance against waiting time and delayed discharge targets in territorial NHS boards

Performance against some waiting time targets deteriorated in some boards (end of March 2013 to end of March 2014).

Target/ standard	Child and Adolescent Mental Health Services (CAMHS) ¹				Drug and alcohol treatment ²				Referral to treatment (RTT) ¹		Out-patients ¹		Inpatient/day-case treatment time guarantee (TTG) ^{1,3,4}		A&E ¹		Cancer – urgent referral to first treatment ²		Cancer – decision to treat to first treatment ²		Delayed discharges ⁵	
	26 wks		3 wks		18 wks		12 wks		12 wks		4 hrs		62 days		31 days		4 wks					
	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14	'13	'14		
Ayrshire and Arran	✓	✗	✓	✓	✓	✓	↕	✗	✗	✗	✗	↕	↕	↕	✓	✓	✓	✓	✓	✓		
Borders	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	↕	✓	✓	✓	✓	✓	✓	✓	✓	✗		
Dumfries and Galloway	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	↕	↕	✓	✓	✓	✓	✓	✓	✗	✗		
Fife	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗	↕	↕	✓	↕	✓	✓	✓	↕	✗	✗		
Forth Valley	✓	✓	✓	✓	✗	✗	✗	✗	✗	✓	✗	↕	✓	✗	✓	✓	✓	✓	✓	✗		
Grampian	✓	↕	✓	✓	✓	↕	↕	↕	✗	✗	↕	↕	↕	✗	✓	↕	✓	✓	✓	✗		
Greater Glasgow and Clyde	✓	✓	✓	✓	✓	✓	↕	↕	✗	✗	✗	✗	↕	↕	✓	↕	✗	✗	✗	✗		
Highland	✓	–	✗	✓	✓	✓	✗	✗	✗	✗	↕	↕	↕	↕	✓	↕	✓	✓	✓	✗		
Lanarkshire	✓	✓	✓	✓	✓	✓	↕	✗	✓	✓	✗	↕	✓	✓	✓	✓	✓	✓	↕	✗		
Lothian	✓	✗	✓	✓	↕	↕	✗	✗	✗	✗	✗	↕	✓	↕	✓	✓	✗	✗	✗	✗		
Orkney	✓	✓	✓	✓	✓	✓	↕	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓		
Shetland	✓	✓	✓	✓	✓	✓	↕	↕	✓	✓	✓	✓	↕	✗	✓	✓	✓	✓	✓	✓		
Tayside	✓	✗	✓	✓	✓	✓	↕	↕	✗	✗	✓	✓	↕	↕	✓	✓	✓	↕	✗	✗		
Western Isles	✓	✓	✓	✓	✓	✗	✗	✗	✓	✓	✓	✓	↕	↕	✓	✓	✗	✗	✗	✗		
NHS Scotland	✓	✓	✓	✓	✓	↕	✗	✗	✗	✗	✗	↕	↕	↕	✓	✓	✗	✗	✗	✗		

✓ Met
 ↕ Met temporary/interim target
 ✗ Met for over 99% of patients
 ↕ Within 5%
 ✗ Not met

Notes:

1. Data is for month ended 31 March 2013 and 2014. CAMHS data for NHS Highland is not available for March 2014.

The A&E target was 98 per cent at March 2013 and 95 per cent at March 2014.

2. Data for quarter ended 31 March 2013 and 2014.

3. TTG applies to patients added to the waiting list from 1 October 2012 only.

4. TTG incorporates a legal right to treatment, so we have categorised this as met, not met or met for over 99 per cent of patients.

5. Performance against this standard is based on a census at point in time. The delayed discharges data are at the end of April 2013 and 2014.

6. National Waiting Times Board is not included in this table. Four of these targets apply to this board – Referral to treatment (RTT), Outpatients, Inpatient/day case treatment time guarantee (TTG) and Cancer – decision to treat to first treatment. The board met all four of these targets.

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

Demand for outpatient appointments is increasing faster than the number of patients seen

33. NHS boards need to manage demand for outpatient clinics alongside inpatients and day cases. They are finding it difficult to meet the target that new outpatients should be seen within 12 weeks of referral, and none of the territorial boards met the target throughout 2013/14.²⁴ Demand for outpatient appointments has increased over the last three years but the number of people seen has not increased to the same extent. At the quarter ending March 2014:

- the number of people on waiting lists for a new outpatient appointment was 34 per cent higher than at the quarter ending March 2010, increasing from 187,693 to 252,009
- the number of new outpatients seen during the same period increased by only 13 per cent, from 324,403 to 367,259 meaning that the number of people waiting is continuing to increase
- the number of people who had been waiting longer than 12 weeks increased from 157 at the quarter ending March 2010, to 6,754 at the quarter ending March 2014.

34. The increasing number of people waiting over 12 weeks indicates pressure on NHS boards' capacity. For example, the number of procedures carried out in outpatients has more than doubled since 2008/09, to 380,456 procedures in 2012/13. There are risks this pressure will increase as demand continues to grow. This pressure can only be tackled by some combination of:

- increasing the number of new outpatient appointments available, for example by allocating additional staffing and other resources
- further reducing the number of people attending for follow-up appointments (the ratio of follow-up to new appointments has reduced from 2.3 in 2004 to 1.9 in 2013). A new approach is being implemented in hospitals across Scotland to reduce the number of follow-up patients attending orthopaedic clinics ([Case study 4, page 25](#))
- reducing the number of outpatient referrals by moving to other models of care, such as self-management, telehealth and telecare.

Delays in discharging patients are putting pressure on hospital beds

35. Although the overall average (mean) length of stay in hospital has reduced, delays in discharging patients who are clinically ready to leave hospital have been increasing over the last five years, especially during 2013/14. They increased from around 101,500 bed days over the quarter ending April 2013 to 117,800 over the quarter ending April 2014 ([Exhibit 6, page 26](#)).²⁵ In 2013/14, a total of 421,157 bed days were occupied by patients who were delayed, at an estimated cost to the NHS of £78 million.²⁶

36. Most patients who are affected by delayed discharges are aged 75 and over. This reflects their more complex needs and difficulties in organising the community support they need. In April 2014:

- there were 738 patients across Scotland whose discharge was delayed, compared to 564 in April 2013

- 173 patients were delayed for four weeks or more
- the most common reason for delays of four weeks or more was waiting for a place in a care home. Shorter delays (two weeks or less) were mainly due to waiting for community care assessments.²⁷

37. In 2013 and 2014, a number of NHS boards carried out snapshot audits reviewing the healthcare needs of all patients in hospital on one day.²⁸ These found that, for around 25 per cent of patients, there was no clinical reason for them to remain in hospital. Reasons for patients remaining in hospital included: waiting to be reviewed by a consultant; waiting for a place in a care home; and waiting for a social work assessment. NHS boards are using this information to identify areas for improvement, for example focusing on groups of patients at more risk of spending longer in hospital than clinically necessary.

38. While the overall results of the latest NHS inpatient experience survey were positive, the one aspect that was less positive was leaving hospital.²⁹ Fourteen per cent of patients indicated that they had to stay in hospital longer than expected to wait for their care or support services to be organised. Two-fifths of patients experienced a delay on the day they were leaving hospital, mainly

Case study 4



Follow-up care for patients with a fracture has been redesigned

Around 100,000 people a year in Scotland have a fracture that does not require surgery. In these cases, the fracture is left to heal and no follow-up treatment is required. Traditionally, all patients with a fracture were fitted with a cast and would have to return to an outpatient clinic to have the cast removed.

In around 80 per cent of Scottish hospitals, a new approach has been introduced for patients with a fracture that does not require surgery. Patients are treated in A&E and fitted with a removable cast if possible. Patients are provided with information to allow them to self-manage and around 40 per cent do not need to return to hospital for follow-up care. The remaining patients are referred to an orthopaedic clinic. The orthopaedic team is able to follow up around a fifth of these patients by telephone conversation and the remainder of patients attend an orthopaedic outpatient clinic for follow-up.

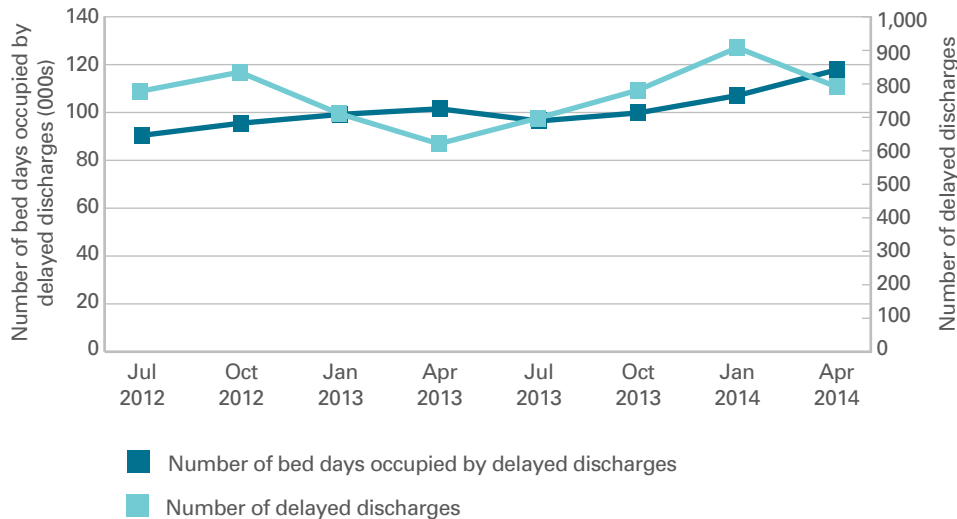
Glasgow Royal Infirmary (GRI) started using this approach in 2011 and was one of the first hospitals to use it. Since it was introduced, referrals from A&E to the orthopaedics department have decreased by over 50 per cent, and it has reduced travel time for patients. GRI has reported that it has improved patient flow in both its A&E and orthopaedics departments. It has reduced the number of orthopaedic patients in A&E who wait longer than four hours, and freed up orthopaedic consultant time to see new outpatient referrals.

Source: Audit Scotland based on information provided by the Quality and Efficiency Support Team (QuEST) at the Scottish Government

Exhibit 6

Number of delayed discharges and occupied bed days, 2012–14

The number of bed days occupied by patients who experience a delayed discharge has been steadily increasing.



Note: The number of delayed discharges refers to all patients who experienced a delay of any length. It excludes 'code 9' patients with complex needs.

Source: ISD Scotland



because they had to wait for medicines, with 16 per cent waiting longer than four hours. Delays in patients being discharged mean that beds are not available to other patients who need them, causing delays and blockages elsewhere in the system. NHS boards need to ensure they have detailed information about discharge times and the reasons for delays to effectively manage patient flows.

39. Some boards, for example NHS Fife, NHS Forth Valley and NHS Lanarkshire, are co-locating staff from the hospital and community, including social work, to coordinate planning for patients' discharge from hospital. Staff in these discharge hubs work with ward staff to identify patients' needs and start planning their discharge as soon as they are admitted to hospital. The aim is to minimise any delays and to ensure patients have sufficient support in the community. In NHS Forth Valley they also provide advice and guidance to hospital staff and GPs, including potential alternatives to admitting people to hospital. We included a case study on the integrated discharge hub in NHS Fife in our A&E report.

40. Our report on reshaping care for older people highlighted how NHS Tayside and Perth and Kinross Council are working together to:

- redesign systems so that patients can be discharged home from hospital as quickly as possible
- provide community-based alternatives to hospital and long-term residential care
- use data to work with GPs to understand how they are using local services and to change how older people receive care and support.³⁰

The NHS puts considerable effort into meeting performance targets

41. The Scottish Government and NHS boards put a great deal of effort into attempting to meet annual waiting time targets. The Scottish Government also provided additional funding for NHS boards. For example, in 2013/14 the Scottish Government provided NHS boards with at least £17 million additional funding during the year to support waiting time targets. This is similar to the additional funding of at least £20 million that it provided in 2012/13.³¹ During 2013/14, NHS boards also received additional funding of £9 million to improve emergency and urgent care, including reducing waiting times in A&E. NHS boards have noted additional workforce costs to provide additional capacity to meet waiting times targets, particularly the TTG. This level of focus on meeting waiting times targets may not be sustainable when combined with the additional pressures of increasing demands related to demographic changes and the overall health budget starting to decrease in real terms.

42. National targets are helpful in targeting areas for improvement in performance. For example, the focus on waiting time targets has led to a considerable reduction in the length of time that people wait for treatment. However, it is becoming more difficult for NHS boards to meet these targets fully. The extent of the effort required to try to meet them makes it more difficult for NHS boards to focus on long-term planning and moving more care into the community. There are risks that too narrow a focus on targets can detract attention from achieving the wider aims.

43. The Scottish Government is reviewing the HEAT framework and aims to have updated guidance for boards by November 2014. It should review whether the current financial and performance targets for the NHS are achievable at the same time as implementing the 2020 Vision for health and social care, within the tight financial resources available. It should consider setting targets for NHS boards that will help them work towards the 2020 Vision, for example introducing milestones to measure the extent to which boards are moving towards more preventative and community-based care.

There is growing evidence of staff pressures

44. The availability of staff is another important factor in NHS boards' capacity to provide patient care. The number of consultants and nursing and midwifery staff in post has increased slightly each year since 2012. Between March 2013 and March 2014, the number of vacancies for nursing and midwifery staff was stable, after increasing the previous year, but the number of consultant vacancies increased significantly ([Exhibit 7, page 28](#)). This may be related to some extent to the increase in the number of consultant posts, and the time lag in filling new posts. However, the number of posts vacant for six months or more almost doubled, from 41 whole-time equivalent (WTE) at 31 March 2013 to 79.2 WTE in March 2014.

45. Of the mainland territorial boards, consultant vacancy rates were highest in NHS Dumfries and Galloway (15.4 per cent), NHS Fife (13.3 per cent), NHS Forth Valley (10.2 per cent) and NHS Grampian (9.9 per cent). With the exception of NHS Dumfries and Galloway, these boards experienced difficulty achieving a number of performance targets in 2013/14 ([Exhibit 5](#)).

46. Many NHS boards have reported difficulties filling medical vacancies in some specialties and some geographical areas, leading to greater use of locum doctors to maintain services. NHS boards' workforce plans comment on a number of factors that are contributing to these difficulties including:

- changes in junior doctor training since the introduction of Modernising Medical Careers in 2005. These changes have led to a reduction in the number of junior doctors available and NHS boards needing more middle grade doctors and consultants
- strong competition among NHS boards for medical staff. This can make it more difficult for smaller boards and more rural areas to compete with larger boards which can offer more opportunities, such as research and development
- difficulty recruiting and retaining staff in some specialties with unattractive working patterns, such as emergency medicine, or where there is a national shortage and greater levels of part-time working, such as paediatrics.





47. These difficulties have an impact on NHS boards' ability to provide services and on their financial position. For example:

- NHS Highland reported that its financial position in 2013/14 was negatively affected by spending on locums. It anticipates that this will continue to be a cost pressure in 2014/15 ([Case study 1](#)).
- NHS Orkney required brokerage from the Scottish Government to help cover increased spending on locum doctors and agency nursing staff ([Case study 2](#)).
- NHS Dumfries and Galloway's spending on locums increased from £6.3 million in 2012/13 to £7.6 million in 2013/14. The board reported that this is due to increased demand and difficulty filling posts.
- NHS Grampian has reported that consultant vacancies in oncology are affecting cancer services, and patients are having to receive treatment in other boards. It has reported significant difficulty recruiting some groups of

Exhibit 7

Consultant, nursing and midwifery workforce, March 2012 to March 2014

The number of vacant consultant posts increased significantly between 2013 and 2014.

	At 31 March 2012 (wte)	At 31 March 2013 (wte)	At 31 March 2014 (wte)	% increase 2012 to 2013	% increase 2013 to 2014
 Consultant staff in post	4,427.7	4,531.6	4,693.6	2.3	3.6
 Consultant vacancies number and rate	167.3 (3.6%)	202.5 (4.3%)	324.8 (6.5%)	21	60.4
 Nursing and midwifery staff in post	56,467.3	57,036.6	58,172.7	1	2
 Nursing and midwifery vacancies number and rate	1,027.9 (1.8%)	1,609.1 (2.7%)	1,637.5 (2.7%)	56.5	1.8

staff, including A&E staff, due to the buoyant labour market, competition for jobs in the local area and a national shortage of staff in certain clinical specialties, including oncology.

- NHS Fife has highlighted vacancies for radiologists and difficulties securing locums, which have had an impact on waiting times for diagnostic tests.
- NHS Ayrshire and Arran has reported that vacancies across medical grades are a challenge to it providing current services and considering its plans for providing services for the future.

48. The NHS spent £128 million on bank and agency nursing and midwifery staff in 2013/14, an increase of 15 per cent since 2012/13. This accounts for 1.3 per cent of total revenue expenditure in 2013/14. Bank nurses accounted for 93 per cent of the spending. However, spending on agency staff increased by 46 per cent, to £9.3 million. This follows a rise of 62 per cent the previous year, reversing the trend of falls in spending on agency nurses since 2008/09.³² Agency staff are likely to be more expensive than bank nurses, and also pose a greater potential risk to patient safety and the quality of care.³³

Spending on private sector healthcare reduced in 2013/14

49. NHS boards use private sector healthcare to provide additional capacity to meet patients' needs or to meet national targets. In December 2013, the Scottish Government issued guidance for NHS boards which states that it expects the vast majority of patients to be treated within the NHS, with the private sector used only to deal with short-term capacity issues.³⁴

50. Total spending on private sector healthcare by the territorial boards fell by 6.9 per cent in real terms between 2012/13 and 2013/14, from £80.3 million to £75.9 million. Spending on private healthcare represented about 0.9 per cent of total spending on hospital and community health services in 2013/14. Spending decreased in eight territorial boards and increased very slightly in three.³⁵ It increased considerably in:

- NHS Shetland: spending increased by 60 per cent, from £116,000 to £186,000
- NHS Highland: spending increased by 40 per cent, from £2.6 million to £3.7 million
- NHS Lothian: spending increased by 12 per cent, from £14.8 million to £16.6 million.

Most boards do not consider integrated performance reports

51. The board of directors in NHS boards need to oversee all aspects of performance, including:

- patient safety and clinical quality
- performance against HEAT targets
- finance
- feedback and complaints from patients and staff.

52. Each aspect of performance is important in ensuring the NHS board is providing high-quality, sustainable care. Considering any one aspect in isolation may mean that the board does not have a full understanding of overall performance; for example, the board may be achieving its HEAT targets but facing increasing financial pressure, or waiting time targets may be met for inpatient and day-case treatment while waiting times for outpatients are growing.

53. An integrated overview of performance, with high-level commentary, helps the board to quickly get an overview of performance. We found that only three boards receive an integrated report bringing together all aspects of performance ([Case study 5](#)).³⁶ A further two consider reports that bring together a range of aspects of performance, but they consider financial performance separately.³⁷ We have previously recommended that NHS boards should avoid considering one aspect of performance in isolation. In our report on the management of NHS waiting lists, we highlighted the importance of NHS boards considering and scrutinising performance against waiting time targets alongside information on how they are achieving that performance. Non-executive directors need access to a range of information in order to allow them to provide effective challenge.³⁸

Case study 5



NHS Greater Glasgow and Clyde uses integrated performance reporting

In April 2011, NHS Greater Glasgow and Clyde established a Quality and Performance Committee (QPC) as a subcommittee of the board. This replaced the Performance Review Group, Health and Clinical Governance Committee and Involving People Committee. The main aim of the QPC is to bring together all areas of governance, quality and performance under one committee to provide an overview.

The QPC considers an integrated quality and performance report. The report brings together data and commentary on the board's performance in relation to quality, patient safety, clinical governance, financial monitoring, performance monitoring, workforce planning and involving people/patients. It highlights any areas where the board is not meeting targets, or on track to meet them. The committee also considers more detailed monitoring reports on some aspects of performance, including a financial monitoring report.

Source: NHS Greater Glasgow and Clyde Annual Audit Report 2011/12 and update from auditor

Part 2

Looking ahead



Key messages

- 1** The overall health budget is planned to reduce by 0.9 per cent in real terms over the next two years. Changes in Scotland's population mean that demand for health and social care will increase significantly over the next 20 years, at the same time as budgets are tightening. The NHS will not be able to continue to provide services in the way it currently does, given the scale of the changes required. It needs to do more to plan for how it will make the changes needed to provide sustainable care for the future.
- 2** Increasing demand is already putting pressure on services. NHS boards need to better understand their demand, capacity and how patients move through the complex health and social care system so that they can match their capacity with current and future needs. They also need to better understand the reasons for delays and blockages in the health and social care system. The Scottish Government has started working with four NHS boards to help them improve patient flow.

the NHS is facing significant pressures at the same time as needing to make major changes to services

The NHS will continue to face increasing pressures

55. Taken together, our audit work has found clear evidence that NHS boards are finding it increasingly difficult to meet their financial and performance targets. All the available evidence suggests that these pressures will increase in future.

56. The Scottish Government's overall health budget (revenue and capital) is planned to decrease by 1.0 per cent between 2013/14 and 2014/15, and to increase by 0.1 per cent between 2014/15 and 2015/16 in real terms. Within the overall health budget:

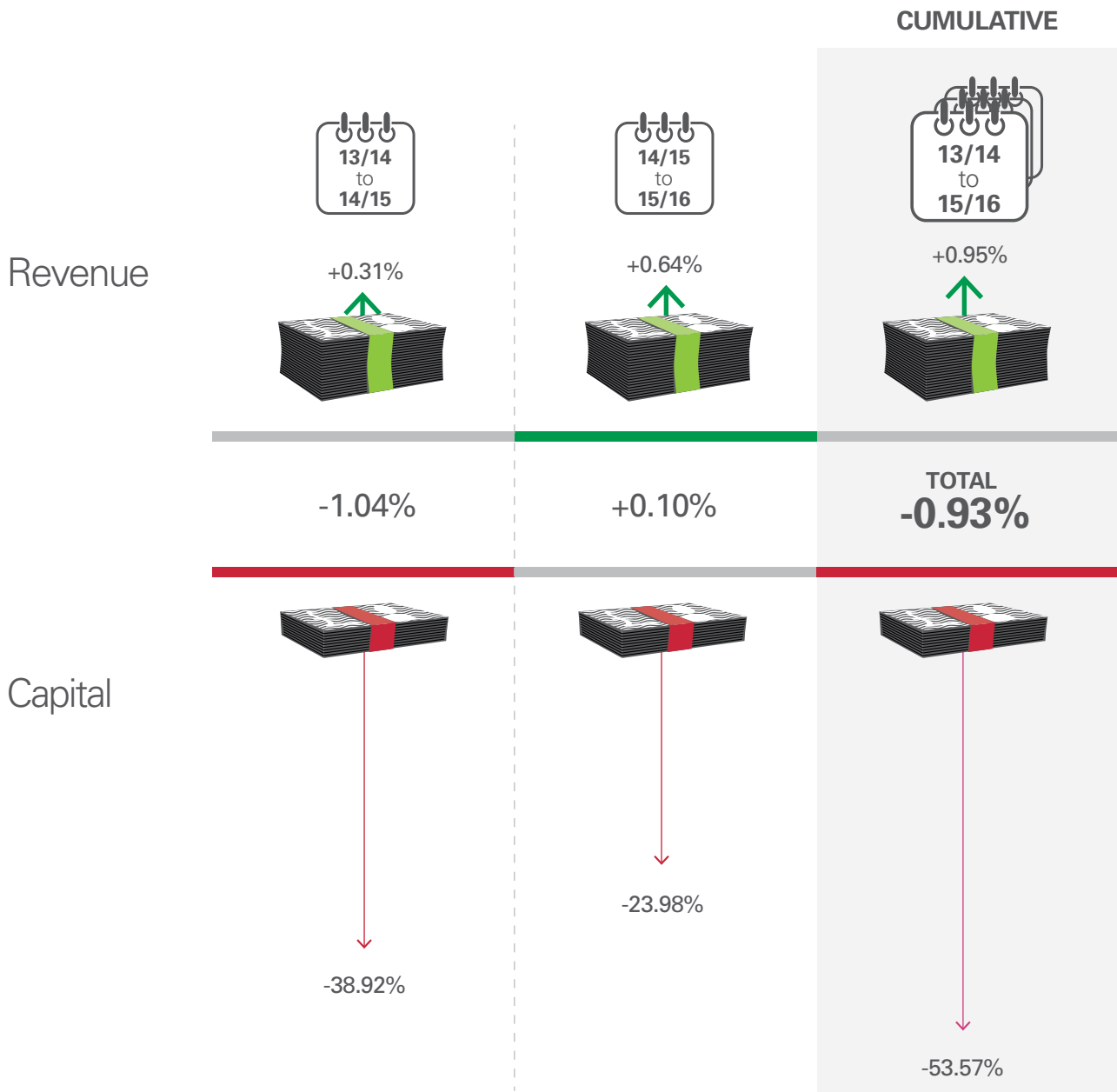
- the revenue budget is planned to increase by 0.3 per cent between 2013/14 and 2014/15, and to increase by 0.6 per cent between 2014/15 and 2015/16 in real terms
- the capital budget is planned to decrease by 38.9 per cent between 2013/14 and 2014/15, and to decrease by 24.0 per cent between 2014/15 and 2015/16 in real terms ([Exhibit 8, page 32](#)).

57. Healthcare inflation in the UK is higher than general inflation, which has an impact on the health budget in real terms. Over the last 20 years, general inflation in the UK averaged just over two per cent a year while health service costs rose by 3.6 per cent a year.³⁹

Exhibit 8

In the next two years, the health budget will decrease by 0.9 per cent in real terms

The larger revenue budget will increase by almost one per cent, while the smaller capital budget will decrease by 54 per cent.



Source: Scottish Government Draft Budgets 2013/14, 2014/15 and 2015/16

58. Longer-term forecasts to 2018/19 by the Office for Budget Responsibility show a real-terms reduction in total UK public sector expenditure of 0.7 per cent in both 2016/17 and 2017/18, before levels are maintained in 2018/19.⁴⁰ Reductions in spending at a UK level will affect the level of funding available in Scotland. The Scottish Government will need to plan for health spending within an overall reducing budget.

Other cost pressures are likely to increase in future years

59. There is likely to be an increase in contribution rates to the NHS Superannuation Scheme during 2014/15. The most recent actuarial funding valuation available for the scheme was at 31 March 2004. A funding valuation was carried out at 31 March 2008 but was suspended by HM Treasury prior to completion. A new funding valuation was carried out in 2013/14 for the scheme as at 31 March 2012 and this will be incorporated in the NHS accounts for 2014/15. Employer contribution rates are expected to increase as a result of this valuation in order to ensure that contributions are large enough to meet the likely future costs of the pension scheme.

60. A number of boards highlighted this as a financial risk in their LDPs. NHS boards have assumed, and are planning for, pensions costs of approximately two per cent of their total pay bill, but the extent of the increase is not yet known. NHS boards will also face further costs due to changes in pension schemes that end the current arrangements under which members and their employers pay lower National Insurance contributions.⁴¹ As a result of these changes, pension scheme members and their employers will no longer pay reduced NI contributions from 6 April 2016.

61. NHS boards have identified other future cost pressures including pay costs, spending on drugs and the availability of new treatments. Staff pay is the largest single item of expenditure for NHS boards, and the Scottish Government has estimated that the pay bill will increase by around £30 million per year from 2014/15 (not including additional pension costs).⁴² NHS boards are working with the Scottish Government to identify how they will fund these cost pressures. NHS boards are considering how they can work together to provide services more efficiently, for example exploring opportunities to provide more services on a regional basis.

Changes in the population are increasing demand

62. Demographic and other changes are increasing the pressures. Scotland's population is ageing ([Exhibit 9, page 34](#)). Between 2012 and 2037:

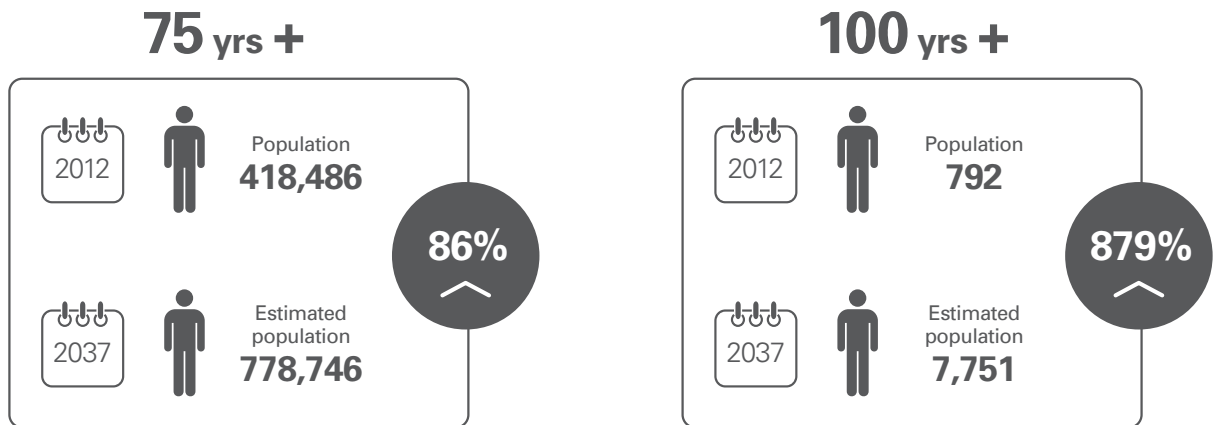
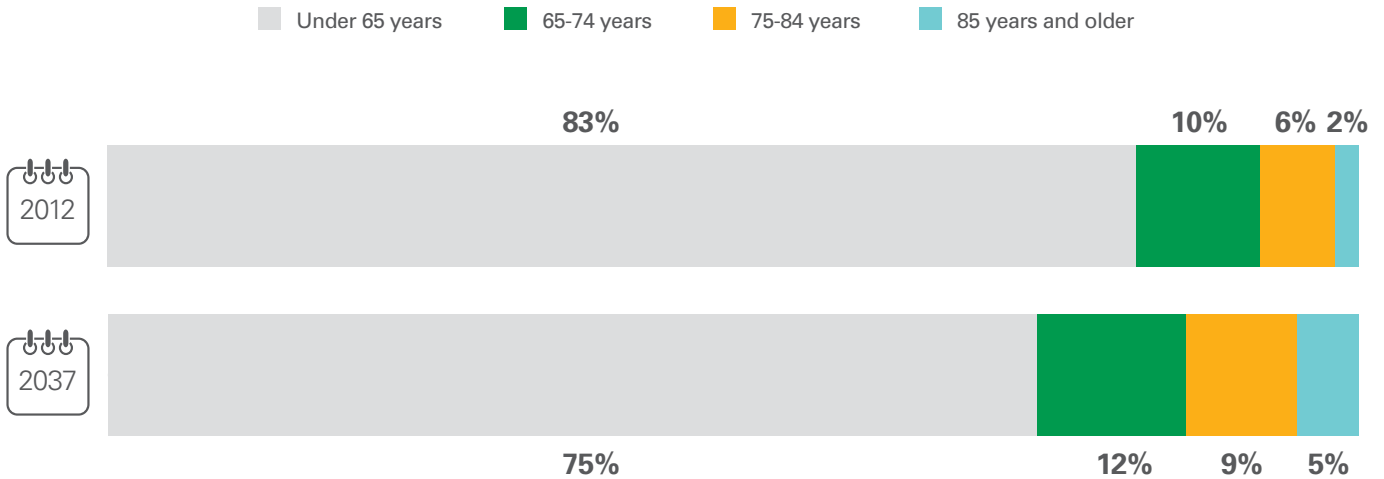
- the percentage of the population aged 65 or over is projected to increase from 17 per cent (925,751 people) to 25 per cent (1,473,158 people)
- the percentage of the population aged 75 or over is projected to increase from eight per cent (418,486 people) to 13 per cent (778,746 people)
- the number of people aged 100 years or older is projected to increase by 879 per cent, from 792 to 7,751.⁴³

63. Older people are more likely to have long-term health problems that require care and, in the absence of good community-based care, that will increase the pressure on acute services. The number of people aged over 65 attending A&E departments increased by 12.6 per cent over the past five years, from 242,677 attendances in 2008/09 to 273,192 in 2012/13. Older people are more likely to be admitted to hospital from A&E: in December 2013, 60 per cent of A&E attendances for people aged over 65 resulted in admission to hospital, compared with 23 per cent of patients aged under 65.⁴⁴

Exhibit 9

Scotland's population is ageing

The percentage of the population aged 75 and over is set to increase considerably over the next 25 years.



Note: Due to rounding, the total percentages add up to 101 per cent.

Source: *Projected Population of Scotland (2012-based)*, National Records of Scotland, 2013



64. The number of people with long-term conditions such as diabetes is increasing, and the number of long-term conditions that an individual may have increases with age. Rates of dementia are also increasing, and the number of people with dementia is estimated to double within the next 25 years.⁴⁵ The number of inpatient and day-case episodes for people aged 65 and over where the patient had a diagnosis of dementia increased by nearly 50 per cent between 2009 and 2013, from 21,524 to 32,205. Older people with dementia generally stay longer in hospital, often due to the need for specialist care that delays their discharge. Around half of long-stay residents in Scottish care homes have a diagnosis of dementia.

65. People's expectations of healthcare are rising in relation to access to services and treatments, and the Scottish Government recognises this as another challenge for the NHS.⁴⁶ For example, the main issues in orthopaedics affecting demand, in addition to an increasing older population, are higher patient expectations and improvements in technology and available procedures. A wider range of procedures are now available and surgeons can carry out more complex procedures.⁴⁷

The Scottish Government has set out its long-term strategy for the NHS but boards do not yet have detailed plans in place

66. Pressures will continue to increase for the foreseeable future. The Scottish Government recognises this, and in 2011 it set out its 2020 Vision, an overarching strategy for achieving sustainable quality in the delivery of healthcare services across Scotland in the context of the challenges facing the NHS.⁴⁸ The overall aim is that, by 2020, everyone is able to live longer, healthier lives at home or in a homely setting. It is an ambitious policy that aims to prevent or improve poor health caused by lifestyle factors, such as smoking, alcohol and lack of exercise, and move towards the NHS providing more care in community settings (**Exhibit 10, page 36**). In May 2013, the Scottish Government set out 12 priority areas for action in the form of a Route Map to the 2020 Vision.

67. The NHS has already made improvements in health outcomes in the Scottish population. The 2020 Vision has the potential to make further improvements in health outcomes and the quality of health and social care. But achieving the vision will require major changes in the way that services are delivered, and a significant shift of resources into more preventative and community-based services. We have highlighted in previous reports that there is a lack of evidence of progress in moving resources and more care into the community.⁴⁹ In 2003/04, 42 per cent of NHS spending for all age groups was on community services; by 2011/12, this had increased to just 44 per cent; and in 2012/13 it reduced to 43 per cent.⁵⁰ Between 2002/03 and 2009/10, council spending in real terms on social care services for older people increased by 37 per cent, from £0.98 billion to £1.35 billion. By 2012/13, this had fallen to £1.29 billion, a four per cent reduction from 2009/10.⁵¹ The reasons for this lack of progress are complex, but achieving the transformation required is made more difficult by the increasing pressures on acute care and by the continuing focus on short-term planning.

68. From April 2016, health and social care services in Scotland will be integrated. The Public Bodies (Joint Working) (Scotland) Act 2014 requires NHS boards and councils to establish new health and social care partnerships. Under these arrangements, NHS boards and councils will be required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. It provides a good opportunity for NHS boards, with their council partners, to redirect resources and move towards more community-based and preventative care. It will be challenging for NHS boards to make the scale of changes required over the next few years, but critical if they are to meet the 2020 Vision. Outcomes are being developed for integrated health and social care, along with integration indicators for the new integration joint boards to report performance against.





69. We have previously recommended that NHS boards need to increase their focus on longer-term financial planning. Without this, there is a risk that they will continue to take a short-term approach to managing the pressures they face, at

Exhibit 10

Aims of the Scottish Government's 2020 Vision for health and social care

The Scottish Government has set out an ambitious policy that will require a considerable move from care in settings like hospitals and care homes to more community-based and preventative care.

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

-  We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.
-  When hospital treatment is required, and cannot be provided in a community setting, day-case treatment will be the norm.
-  Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
-  There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Source: *A Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013

the expense of better options over the longer term. NHS boards need to plan now for making considerable changes to the way they deliver services in the longer term, to ensure they can deliver sustainable, good-quality care to meet future increasing needs. They need to set out how they will reshape services and provide high-quality care with the available funding, staff and other resources. Their longer-term financial planning should consider all the resources they need to provide integrated health and social care services to continue to meet future needs ([Exhibit 11, page 37](#)).

70. LDPs set out how each board plans to deliver the priorities for the NHS in Scotland. They also form the basis for the Cabinet Secretary's annual reviews of each board. In the past, LDPs have focused predominantly on financial planning and meeting HEAT targets for the coming year, rather than demonstrating how boards are planning to meet longer-term aims. For 2014/15, the Scottish Government requires each board to include an improvement and co-production plan in their LDP, outlining the actions the board is taking to deliver the 2020 Vision ([Exhibit 12, page 38](#)). We found that the 2014/15 LDPs include detail about what boards are currently doing but provide little information about how boards will deliver the 2020 Vision in a sustainable way, supported by financial and workforce plans. We would expect there to be more detail in the 2015/16 LDPs about how boards will work with their partners to shift more services into the community as they move towards health and social care integration.

Planning needs to be underpinned by a better understanding of demand, capacity and patient flows

71. Health and social care services form a complex system in which patient flows need to be understood and managed in order to have the right resources available when and where they are needed to meet demand. These resources include the

Exhibit 11

A number of elements of long-term planning should underpin financial plans

Long-term financial planning needs to set out how NHS boards will make the changes needed to meet future needs.

Elements of longer-term planning	Detailed planning required
Future demand for health and social care	<p>Model projected demand for care by taking into account the:</p> <ul style="list-style-type: none"> • numbers of patients/service users expected to need services • demographic profile of the area • complexity of care that people will need. <p>Compare this with current demand and short-term projections.</p>
Models of care	<p>Identify the models of care, and shared objectives for the new health and social care partnerships, required to meet the 2020 Vision and projected future demand for the following:</p> <ul style="list-style-type: none"> • hospitals • community-based care • home-based care • care in the community supported by technology, such as telehealth and telecare.
Workforce requirements	<p>Identify the staff needed to provide these models of care, taking into account:</p> <ul style="list-style-type: none"> • numbers and type of roles • skills mix • training • location. <p>Compare this with the current workforce make-up and location, and short-term projections. Workforce planning needs to be done in collaboration with the Scottish Government, NHS Education for Scotland and training providers, such as colleges.</p>
Location of care	<p>Identify the fixed assets needed to provide models of care in different locations, including the following:</p> <ul style="list-style-type: none"> • buildings (hospitals and community), including the condition of existing buildings and costs of ongoing maintenance, and any new buildings that are required • information technology, including shared access to NHS and social care systems • broadband • transport for patients, service users and staff. <p>Compare this with current assets and short-term projections. Plans need to ensure the infrastructure is in place to support moving more care into the community, while ensuring hospitals are fit for purpose.</p>
Costs and funding	<p>Financial planning to meet future needs by estimating the cost of:</p> <ul style="list-style-type: none"> • providing new models of care and for increased demand • providing more care in the community and in patients'/users' homes • maintaining hospital services in line with future models of care. <p>Use scenario planning with potential financial projections to ensure models of care are affordable and to identify potential funding gaps. Establish plans for redirecting funding from hospitals to community to meet future needs, while maintaining services. This is likely to require double-running costs.</p>

Exhibit 12

LDPs now include improvement and co-production plans

NHS boards are required to set out their priority actions for delivering the 2020 Vision.

Key elements of the plans are that they should:

- be transformational in nature and underpinned by workforce and finance planning
- provide assurance that the five priorities for action set out in *Everyone Matters: 2020 Workforce Vision Implementation Framework* (healthy organisational culture, sustainable workforce, capable workforce, integrated workforce, effective leadership and management) will be taken forward in a planned way
- set out the priority actions the NHS board is taking across patient safety programmes of work, the plans for spread and sustainability and the impact they are having on patient care
- include the approach being taken to ensure that feedback on compliments, concerns, complaints and comments from patients, their families and carers is being actively sought and used to improve services
- set out actions and planned levels of improvement for unscheduled care across the NHS, such as increased anticipatory care and support to help people manage their conditions and medicines, including how hospitals, GPs, community teams, the Scottish Ambulance Service and NHS 24 will work together
- set out the actions the NHS board is progressing with its partners to prepare for health and social care integration.

Source: *NHSScotland 2020 Local Delivery Plan Guidance*, Scottish Government, November 2013

number of hospital beds, outpatient clinics, community services and trained staff. The NHS needs a better understanding of its current capacity, current and future demand, and patient flows, in order to inform the major changes to services that will be required to ensure they are sustainable and meet the long-term needs of the population.

72. We analysed recent trends in healthcare activity, population statistics and rates of conditions, such as diabetes and dementia ([Appendix 1](#) summarises our methodology). We looked at data for the previous five years where this is available and comparable, in order to understand recent trends and identify where pressures are building. This analysis identified some of the main pressures and highlights the complex and interrelated nature of the healthcare system. The degree to which pressures impact on NHS boards, hospitals and specialties varies but include:

- an ageing population and an increase in the number of older people with complex care needs

- more people living with long-term conditions and multiple conditions
- more people seeking emergency and urgent care
- more people being treated in outpatient and day-case settings
- making sure hospital beds and staff are available at the time they are needed
- more people experiencing a delay in their discharge from hospital.

73. We have identified a number of ‘pinch points’ in the system ([Exhibit 13, page 40](#)). These particularly relate to:

- **Hospital beds being available at the time when patients need them.** There has been an increase in the number of patients experiencing delays in being admitted from A&E; and patients are not always cared for in the appropriate ward for their needs, which has an impact on the quality of care they receive (known as boarding). These pinch points are related to how hospitals manage their beds and arrangements for discharging patients.
- **More delayed discharges.** The number of patients delayed in hospital while waiting for services to be available in the community is increasing. This has an impact on the quality of care and outcomes for the patients and it also means that beds are not available for other patients, adding to the pressures on beds ([paragraphs 35 and 36](#)).
- **Increasing demand for outpatient appointments.** Demographic changes, along with improvements in care and more procedures carried out in outpatient clinics rather than on an inpatient basis, have increased demand for outpatient appointments. Demand is increasing at a faster rate than the number of people seen in clinics, meaning that waiting lists are growing and more people are waiting longer ([paragraphs 33 and 34](#)).

Inpatient care is changing and becoming more complex

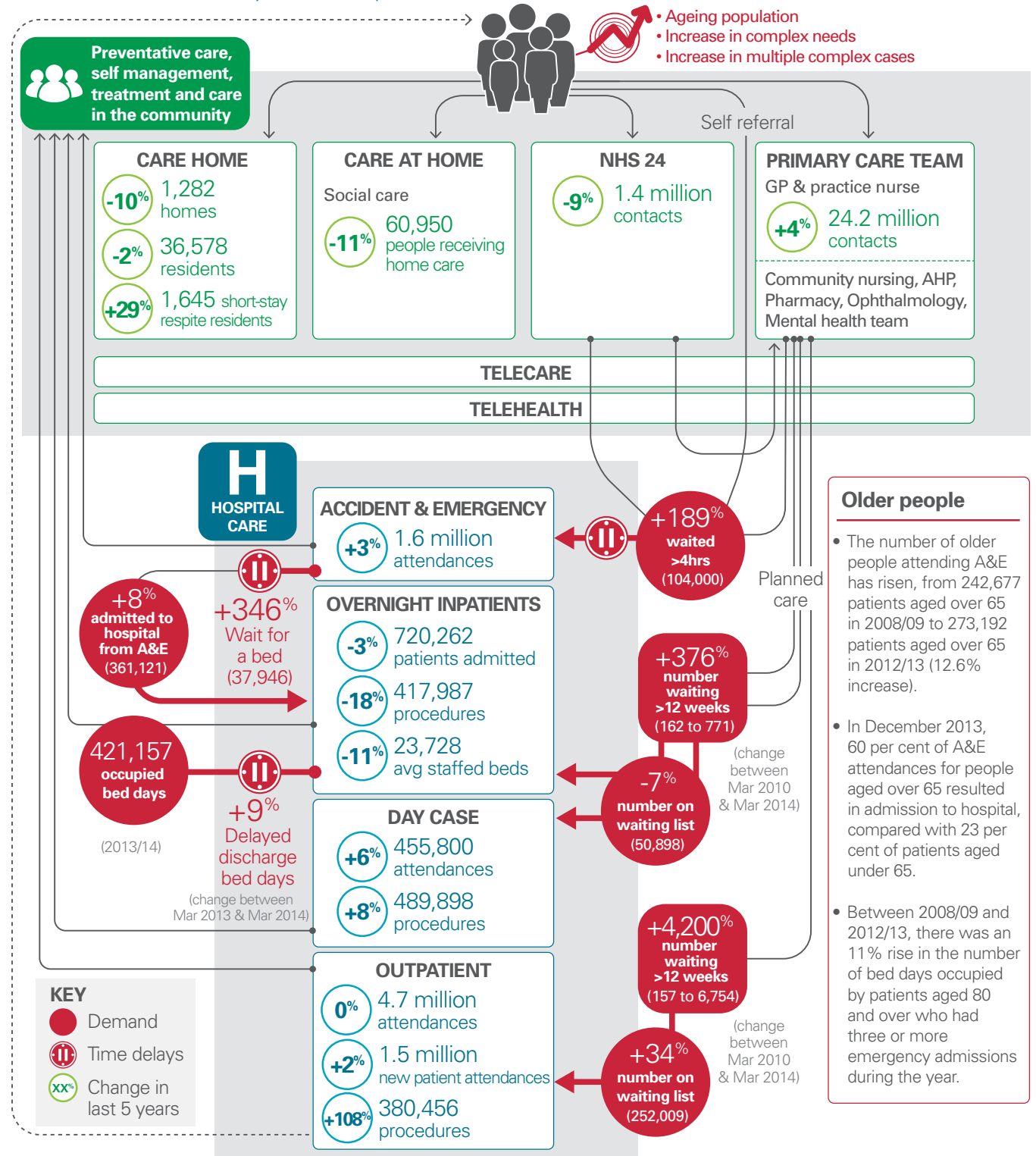
74. In recent years there has been a reduction in elective (planned) inpatient care, as more planned care shifts to outpatients and day cases. The number of patients admitted as emergencies for inpatient care has remained steady and the complexity of these cases has increased. NHS boards need to ensure they have the right number of staffed beds available at the right time to deal with this changing demand. They also need to plan for changes to services in the longer term, including shifting more care into community settings.

75. There has been a reduction in the number of hospital beds across Scotland. Between 2008/09 and 2012/13, the average number of available staffed beds in acute specialties reduced by seven per cent (1,144 beds); the number of acute surgical beds fell by 11 per cent (596 beds); and the number of acute medical beds fell by five per cent (313 beds). The main reason for this reduction is the growth in day surgery as more patients are treated as day cases and outpatients, for example, some eye procedures and diagnostic tests. Between 2008/09 and 2012/13, the number of procedures carried out on an inpatient basis decreased by 18 per cent (418,000 procedures in 2012/13).

Exhibit 13

The NHS is facing increasing pressures from an ageing population and increasing demand

The health and social care system is complex.



76. The average (mean) length of stay for inpatients has also been reducing. Ensuring that patients stay in hospital for no longer than necessary is important, since it helps them stay active, remain independent, and reduces the chance of acquiring a healthcare-associated infection. Between 2008/09 and 2012/13, the average length of stay fell from 7.3 days to 6.5 days for elective (planned) inpatients, and from 3.8 to 3.1 days for emergency inpatients.

77. There is evidence that the complexity of care for patients admitted as emergencies is increasing. There has been a slight growth in the number of days that hospital beds are occupied by emergency admissions for people admitted three or more times during one year (one per cent between 2008/09 and 2012/13). This is more noticeable among older people (aged 80 and over) who are likely to have more long-term conditions and complex needs. Between 2008/09 and 2012/13, there was an 11 per cent rise in the number of bed days occupied by patients in this age group who had three or more admissions during the year. The increase in the older population suggests that this trend will continue unless there are significant shifts to more anticipatory and preventative care in the community.

NHS boards need to improve bed planning and management

78. There are a number of indicators of problems with bed planning and management. The number of people delayed in A&E while waiting for a hospital bed has increased fourfold since 2008/09. This is the most common reason for patients waiting more than four hours in A&E. The reasons for this are complex and linked to beds not being available at the time when they are needed. The day and time that patients are discharged from wards affect the flow of patients throughout the hospital. Attendances at A&E departments are highest on Mondays and Tuesdays. Delays in A&E due to people waiting for a bed in hospital are more likely on these days, since fewer inpatients are discharged at weekends. Discharges from hospital generally take place in the afternoon. Across Scotland, 'wait for a bed' delays for A&E patients are highest at 6pm. The Scottish Government has announced plans to provide more services at weekends and in the evenings to improve the flow of patients and reduce delays. Any knock-on effects in primary and social care should be considered as part of these plans. In our recent report on A&E performance, we highlighted the work that NHS Tayside is doing to improve the quality of care for A&E patients by looking at patient flow ([Case study 6, page 42](#)).

79. Boarding is another indicator that a hospital is not organising its capacity to match demand. This can happen when there are not enough beds available in a particular specialty when patients need them, for example when new patients are admitted as emergencies. Instead, patients are admitted or transferred to a ward of a different specialty. Research has shown that this practice may mean that less specialist care is provided, since staff without the appropriate skills are looking after patients. Boarding can also significantly increase patients' length of stay and contribute to other complications resulting from delayed assessment and treatment, including developing blood clots and healthcare-associated infections.⁵²

80. Boarding used to be more common in winter, when demand traditionally increases due to seasonal infections. Research by the Royal College of Physicians of Edinburgh (RCPE) suggests that it is becoming an all-year problem. In an RCPE survey conducted in May 2012, 80 per cent of respondents reported that boarding now happens all year round in Scottish hospitals; and 71 per cent said that boarding levels in Scotland are high and increasing. The RCPE and the

Case study 6

Improving patient flow in A&E in Ninewells Hospital



Our A&E report identified a number of factors that have helped Ninewells Hospital in NHS Tayside improve the way that patients move through the healthcare system and meet the four-hour waiting time target for A&E. These include:

- having senior clinical decision-makers available at all times, which means that patients get the right type of care quickly
- starting the process of planning for patients to be admitted from A&E early to avoid delays in patients waiting for a bed
- a policy that allows GPs to refer emergency patients directly to wards rather than through A&E first
- a policy of signposting patients attending A&E to other services, such as their GP, where appropriate.

Source: *Accident and Emergency: performance update*, Audit Scotland, May 2014 (Case study 1, pages 35-36)

Scottish Government are examining the extent of boarding in Scottish hospitals, the effect it has on patients, and ways to reduce it. Results from this work should be available in late 2014 or early 2015.

81. The number of emergency admissions over a period of time is reasonably predictable, based on previous activity levels. On a daily and weekly basis, elective admissions can be much more variable than emergency admissions. [Exhibit 14 \(page 43\)](#) provides an example of the pattern of elective and emergency admissions to General Surgery on a daily basis in one of Scotland's district general hospitals, and on a weekly basis in another hospital.

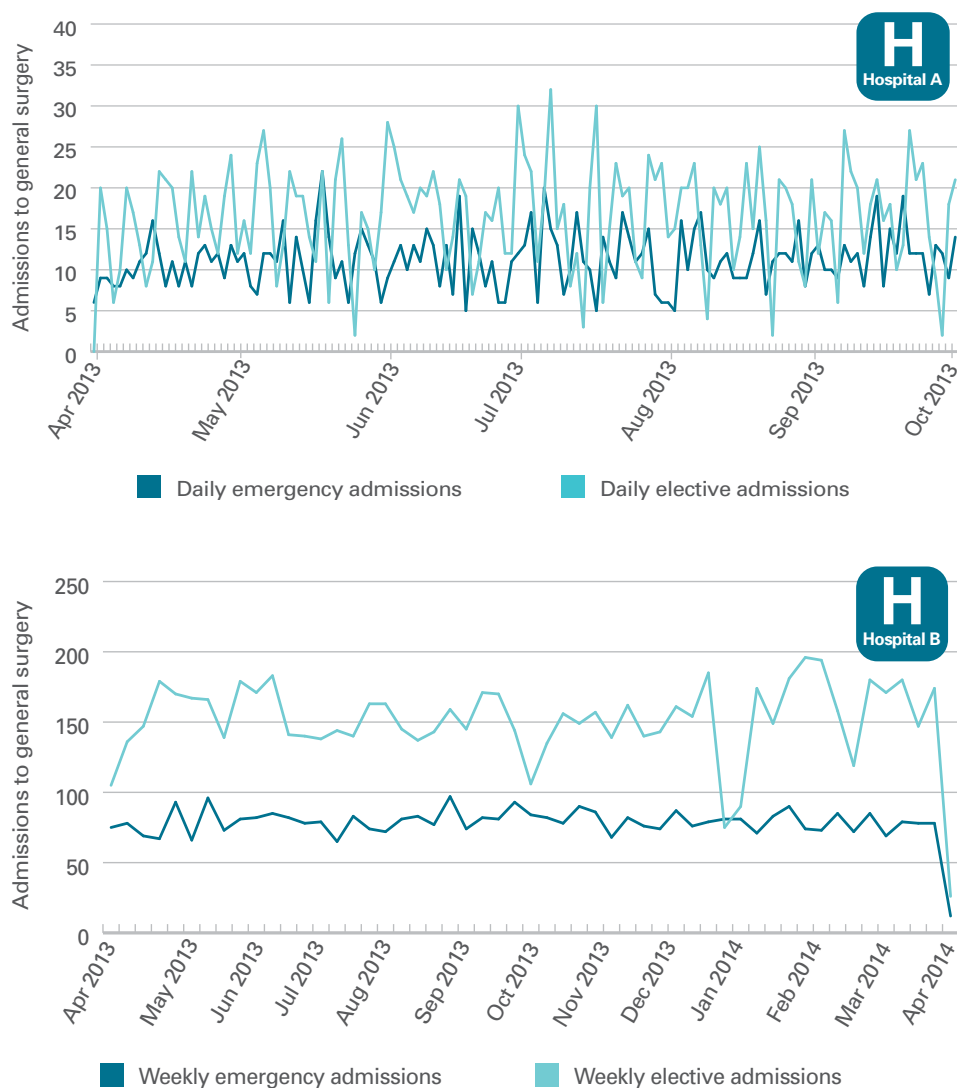
82. NHS boards need to understand the differing patterns of emergency and elective admissions, and actively plan and manage these two flows in a coordinated way. Although the number of emergency admissions is reasonably predictable, the time of day at which patients arrive at hospital is less so. Managing these two flows together means more than ensuring average capacity meets average demand. NHS boards also need to ensure that staffing levels are flexible enough to cope with varying demand, and that sufficient capacity is available at the right time. This means having staff who are trained and equipped to treat increasing numbers of older people with multiple conditions and complex needs.

83. A lot of variation in elective admissions can be due to NHS boards not having sufficient capacity to treat both elective and emergency admissions at the time that patients present. This includes the availability of beds in appropriate wards, sufficient staff with the necessary skills, equipment and access to operating theatres. This can mean having to cancel planned admissions and rearrange for patients to attend at a later date. However, data on the overall proportion of inpatient cases that are cancelled has not been available nationally since October 2012. This is due to changes to NHS boards' electronic systems for managing waiting lists following the introduction of the TTG. In September 2012,

Exhibit 14

Variability in elective and emergency admissions to hospital, 2013/14

Elective admission patterns can be more variable than emergency admissions, both from day to day (Hospital A) and from week to week (Hospital B).



Note: The data is management information from district general hospitals and we have used this for illustrative purposes.

Source: Audit Scotland analysis of NHS demand and capacity

6.9 per cent of inpatient and day-case appointments were cancelled across Scotland. We have previously highlighted that NHS boards need to ensure they are monitoring this locally to understand any problems with capacity and inform how they manage demand.⁵³

84. The Health Foundation worked with NHS trusts in England to look at the relationship between capacity and demand. This was based on the premise that the mismatch between the timing of capacity, such as when staff are available and when patients present to a service, contributes more to delays and inefficiencies than overall levels of demand or resources. Key findings from this work were that using systems improvement methods, such as detailed data

analysis, and bringing together stakeholders and patients across the hospital system to develop an informed understanding of how care pathways really work, can improve patient flow, patient safety and make significant cost-savings.⁵⁴

85. The Scottish Government is working with boards over the next year to help them manage beds better in the short term, including developing a bed-planning toolkit. This will also help them to plan for the number and type of beds required in the longer term, reflecting the new models of care that will be needed. The toolkit will be piloted in 2015 and include scenario planning based on assumptions of demand, admission rates and length of stay, taking into account demographic patterns and more care being provided in the community. Extensive work has also started in 2014 looking at patient flow in boards and the Scottish Government is leading an Outpatients, Primary and Community Care Programme that aims to help NHS boards move more care from hospitals into the community and people's homes.

The Scottish Government is working with NHS boards to improve patient flow




86. As well as having sufficient capacity to deal with demand, NHS boards need to make sure that the flow of patients through the hospital and back into the community is as efficient as possible. The Scottish Government's Quality and Efficiency Support Team (QuEST) is working with four NHS boards to pilot an approach to improve patient flow (NHS Forth Valley, NHS Borders, NHS Greater Glasgow and Clyde, and NHS Tayside), drawing on evidence from the Institute of Healthcare Optimisation in America. This is a significant piece of work looking at individual hospitals within each board area as a whole system, to understand how patients flow through the system, and the factors that can influence this. NHS Forth Valley started testing this approach in 2014, and the lessons learned will be shared with other boards as it is rolled out over the next three years. The Scottish Government will evaluate the pilot as it progresses and also plans to commission an external evaluation.





87. To help improve patient flow and avoid delays in patients getting the appropriate care or being discharged from hospital, the Scottish Government also plans to provide more services at weekends and out of hours. This includes hospital physiotherapy and pharmacy services. An expert group met for the first time in April 2014. The Scottish Government has said there will be no additional funding for this initiative, which will require staff to be available at additional times; instead NHS boards will be expected to make better use of existing resources.

88. Telehealth and telecare offer the potential to care for more people at home or closer to home, supported by technology. This includes things like equipment for people to monitor their own health at home, with their results reviewed by a clinician remotely; and alarms and sensors to help people to stay at home more independently. These innovations support the 2020 Vision of providing care closer to home, potentially improving outcomes for users and avoiding people needing more intensive care in the community or in hospital.⁵⁵ In 2012, the Scottish Government set out its aim that telehealth and telecare will be provided for an additional 300,000 people by March 2015, as a milestone towards achieving the 2020 Vision.⁵⁶ It is focusing on rolling out a number of telehealth and telecare projects at a larger scale than the previous smaller pilots. Both the Scottish Government and the European Union have provided funding for telehealth and telecare projects.

Endnotes



- ◀ 1 The total budget for the Scottish Government's Health and Wellbeing Portfolio includes the budgets for health, sport and equalities.
- ◀ 2 *2020 Vision – Strategic Narrative*, Scottish Government, September 2011.
- ◀ 3 In this report, we refer to NHS National Services Scotland, the Mental Welfare Commission and Healthcare Improvement Scotland as special health boards.
- ◀ 4 Three special boards' revenue budgets increased in 2013/14: National Waiting Times Centre (11.4 per cent), Scottish Ambulance Service (0.1 per cent) and NHS 24 (0.5 per cent).
- ◀ 5 The revenue budget is known as the Revenue Resource Limit (RRL) and the capital budget is known as the Capital Resource Limit (CRL).
- ◀ 6 [NHS financial performance 2012/13 \(PDF\)](#)  Audit Scotland, October 2013.
- ◀ 7 Response from the Scottish Government to the Public Audit Committee, dated 1 August 2014.
- ◀ 8 These reports were prepared under Section 22 of the Public Finance and Accountability (Scotland) Act 2000 and are published on [Audit Scotland's website](#) .
- ◀ 9 Recurring savings are savings that, once achieved, recur year-on-year from that date, for example savings on staff costs as a result of streamlining services. Non-recurring savings only happen once, for example not filling a vacancy on a temporary basis.
- ◀ 10 NHS Ayrshire and Arran, Borders, Dumfries and Galloway, Highland, Lanarkshire, Orkney, Shetland, National Waiting Times Board, NHS 24, NHS Education for Scotland and State Hospital.
- ◀ 11 *Annual State of NHSScotland Assets and Facilities Report for 2012*, Scottish Government, December 2012.
- ◀ 12 *Annual State of NHSScotland Assets and Facilities Report for 2013*, Scottish Government, December 2013.
- ◀ 13 The Scottish Government has defined high-risk backlog maintenance as work that must be addressed as an urgent priority. Significant risk is the next highest priority category of backlog maintenance and requires expenditure in the short term – Correspondence from the Scottish Government to the Public Audit Committee, dated 16 January 2013.
- ◀ 14 Backlog maintenance reduced in (level of backlog at 2013 in brackets): NHS Ayrshire and Arran (£77m), Dumfries and Galloway (£51m), Forth Valley (£13m), Grampian (£159m), Greater Glasgow and Clyde (£167m), Lanarkshire (£57m), Lothian (£96m), Orkney (£9.5m), Shetland (£3.8m), Tayside (£50m), National Waiting Times Centre (£2.6m), NHS National Services Scotland (£2.6m), NHS 24 (£0m) and State Hospital (£0.3m). It increased in NHS Borders (£6.5m), Fife (£70m), Highland (£83m), Western Isles (£3.2m), NHS Education for Scotland (£0.3m), NHS Health Scotland (£0.1m) and the Scottish Ambulance Service (£3.3m). NHS Highland has reported that one reason for its backlog maintenance increasing is that a number of properties transferred from the council to the board in 2012, as part of health and social care integration.
- ◀ 15 *Annual State of NHSScotland Assets and Facilities Report for 2013*, Scottish Government, December 2013.
- ◀ 16 *Outline Business Case for a Care Village in Stirling (A Health & Social Care Partnership Venture)*, NHS Forth Valley, Stirling Council and Forth Valley College, 2 December 2013.
- ◀ 17 *The Healthcare Quality Strategy for NHSScotland*, Scottish Government, May 2010.
- ◀ 18 *Scottish National Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial Prescribing 2011*, Health Protection Scotland, April 2012. Rates of individual HAIs (MRSA and Clostridium difficile) have continued to decrease (Scotland Performs, Scottish Government website).
- ◀ 19 *Heart disease statistics update*, ISD Scotland, January 2014.
- ◀ 20 *Scottish Inpatient Patient Experience Survey 2014*, Scottish Government, August 2014.
- ◀ 21 www.scotland.gov.uk/About/Performance/purposestratobjs 
- ◀ 22 Depending on the target, this may be performance for the month ending March 2014 or for the quarter ending March 2014. The notes in Exhibit 5 give details for each target.

- ◀ 23 ISD Waiting Times Warehouse data, August 2014.
- ◀ 24 The National Waiting Times Board, a special NHS board, met the target for three months in 2013/14.
- ◀ 25 These figures are for standard delayed discharges. They exclude delayed discharges recorded under 'code 9' for patients with complex needs. This includes patients delayed due to waiting for a place in a high-level needs specialist facility where no facilities exist or where an adult may lack capacity under adults with incapacity legislation.
- ◀ 26 ISD calculates the cost of days lost to delayed discharges using a cost per day that excludes costs not incurred by delayed patients, such as costs related to admissions, and allows for the reduced medical and other clinical care that is required for delayed patients. This average cost is around £185 per day.
- ◀ 27 These figures are for standard delayed discharges.
- ◀ 28 These are called Day of Care Surveys.
- ◀ 29 *Scottish Inpatient Patient Experience Survey 2014 Volume 1: National Results*, Scottish Government, August 2014.
- ◀ 30 [Reshaping care for older people \(PDF\)](#)  Audit Scotland, February 2014 (Case study 2, page 30).
- ◀ 31 Scottish Government allocation letters to NHS boards, 2013/14.
- ◀ 32 [NHS financial performance 2012/13 \(PDF\)](#)  Audit Scotland, October 2013.
- ◀ 33 [Using locum doctors in hospitals \(PDF\)](#)  Audit Scotland, June 2010.
- ◀ 34 *Additional 2020 Local Delivery Plan Guidance*, Scottish Government, December 2013.
- ◀ 35 Spending increased slightly in NHS Ayrshire and Arran (1.5 per cent), NHS Tayside (0.7 per cent) and NHS Western Isles (1.3 per cent).
- ◀ 36 NHS Forth Valley, NHS Greater Glasgow and Clyde, and NHS Tayside.
- ◀ 37 NHS Western Isles and NHS 24.
- ◀ 38 [Management of patients on NHS waiting lists \(PDF\)](#)  Audit Scotland, February 2013.
- ◀ 39 Why is health care inflation greater than general inflation? Charlesworth, A., *Journal of Health Services Research and Policy*, June 2014.
- ◀ 40 *Economic and Fiscal Outlook – March 2014*, Office for Budget Responsibility, March 2014.
- ◀ 41 Under the current state pension arrangements, members of the NHS Superannuation Scheme pay a reduced rate of National Insurance (NI). Their employers, the NHS boards, also contribute reduced NI payments on their behalf. This is because it is assumed that the scheme members have opted not to contribute to, or claim, the additional state pension (an additional element paid on top of the basic state pension). Reforms mean the additional state pension will no longer exist and everyone will receive a flat rate basic state pension.
- ◀ 42 *Scottish Government budget 2014/15 – Performance evaluation material for Parliamentary Committees*. Scottish Government, September 2013.
- ◀ 43 *Projected Population of Scotland (2012-based)*, National Records of Scotland, 2013.
- ◀ 44 [Accident and Emergency: performance update \(PDF\)](#)  Audit Scotland, May 2014.
- ◀ 45 *Scotland's National Dementia Strategy*, Scottish Government, 2010.
- ◀ 46 *The Healthcare Quality Strategy for NHSScotland*, Scottish Government, May 2010.
- ◀ 47 [Review of orthopaedic services \(PDF\)](#)  Audit Scotland, March 2010.
- ◀ 48 *2020 Vision – Strategic Narrative*, Scottish Government, September 2011.
- ◀ 49 [Reshaping care for older people \(PDF\)](#)  Audit Scotland, February 2014; [Review of Community Health Partnerships \(PDF\)](#)  Audit Scotland, June 2011; [Overview of the NHS in Scotland's performance 2008/09 \(PDF\)](#)  Audit Scotland, December 2009; [Financial overview of the NHS in Scotland, 2007/08 \(PDF\)](#)  Audit Scotland, December 2008.
- ◀ 50 Audit Scotland analysis of NHS Costs Book data. Spending on community, family health services and resource transfer, as stated in the costs book, has been counted as being spent in the community.
- ◀ 51 Figures in real terms 2012/13 prices. Audit Scotland analysis of Local Financial Return statistics 2002/03 – 2012/13.
- ◀ 52 Royal College of Physicians of Edinburgh press release, June 2012.
- ◀ 53 [Management of patients on NHS waiting lists: audit update \(PDF\)](#)  Audit Scotland, December 2013.
- ◀ 54 *Improving patient flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively*, The Health Foundation, April 2013.
- ◀ 55 [A review of telehealth in Scotland \(PDF\)](#)  Audit Scotland, October 2011.
- ◀ 56 *A National Telehealth and Telecare Delivery Plan for Scotland to 2015*, Scottish Government, 2012.

Appendix 1

Audit methodology



Methodology for analysing demand, capacity and patient flow

To get a better understanding of some of the pressures on NHS services, we carried out data analysis looking at:

- the demand for healthcare services
- the capacity of the NHS to provide services
- the flow of patients through the healthcare system.

This is the first stage of this work and we have presented some high-level findings throughout the report. We will be carrying out further analysis, looking in more detail at hospital and specialty level data and daily activity. We will publish a briefing paper on this analysis in early 2015.

For this report, we looked at the NHS as a whole system. We tried to identify some of the main pressures facing NHS boards and how a pressure in one part of the system can affect another part of the system. We have summarised these pressures in [Exhibit 13 \(page 40\)](#). Throughout the report, we explain some of these in more detail and how this affects patients and services.

In addition to drawing on information from our previous reports, we analysed a range of published data and also requested some bespoke analysis from ISD Scotland. This includes the following data:

- ISD Scotland
 - acute hospital inpatient, day-case and outpatient activity (admissions, discharges, average length of stay, multiple emergency admissions, average number of staffed beds, bed occupancy rates)
 - number of procedures carried out in hospitals
 - waiting times for inpatient and day-case treatment and outpatient clinics
 - hospital workforce numbers and vacancies
 - number of general practice contacts with GPs and practice nurses
 - Quality and Outcomes Framework (QOF) prevalence rates for a number of health conditions
 - number of delayed discharges and occupied bed days
 - care home census
- Scottish Government community healthcare assessments data
- National Records of Scotland population statistics
- Alzheimer Scotland information.

NHS in Scotland 2013/14

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Audit Scotland, 110 George Street, Edinburgh EH2 4LH

T: 0131 625 1500 E: info@audit-scotland.gov.uk 

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