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AUDITOR GENERAL

Mr Paul Gray
Director General - Health and Social Care
Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

1 September 2017

Dear Paul

**NHS in Scotland 2017**

I have pleasure in enclosing the clearance draft of our report on NHS in Scotland 2017. The report comments on the performance of the NHS in Scotland during 2016/17 and the building blocks being put in place to move more care into the community.

I would be grateful if you could confirm by Friday 22 September that you are satisfied with the factual accuracy of the report. The audit team have been liaising with [redacted] during the audit and have arranged to meet with [redacted] to discuss the report on 12 September. Relevant extracts of the report are being issued to individual boards to confirm factual accuracy where they have been specifically mentioned.

In the meantime, if you have any significant issues of fact which require review, the team would be very happy to discuss these. It would be helpful if your office could liaise with [redacted] [redacted]) as soon as possible if there are any issues you wish to raise.

We intend to publish the report on Thursday 26th October 2017 and we will send you a copy of the news release in advance.

Yours sincerely

**Caroline Gardner**
**Auditor General for Scotland**

# NHS in Scotland 2017 - Clearance draft report - Confidential

**Prepared by Audit Scotland**
September 2017

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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# System infographic

Note: This section will contain data from the report highlighting key points made in the report.

# Summary

## Key messages

- Every day the NHS provides vital services to thousands of people across Scotland, with a budget of around £13 billion each year, equivalent to 42 per cent of the overall Scottish budget in 2016/17. At some time in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland employed almost 140,000 staff, treated one in five of the Scottish population in accident and emergency, performed 1.5 million hospitals procedures and conducted an estimated 17 million GP consultations.
- The NHS in Scotland is 70 years old next year. In the intervening decades demographic and health trends have changed significantly and demand for services has increased dramatically. We have reported many times on the challenges facing the NHS including increasing costs, growing demand, and the continuing pressures on public finances. In 2016/17, these challenges continued to intensify. Demand for healthcare services continues to increase and more people are waiting longer to be seen. For example, the number of people waiting for outpatient first appointments increased by 15 per cent in the past year and there was a 99 per cent increase in the number of people waiting over 12 weeks. Scotland's health is not improving and significant inequalities remain, while general practice faces significant challenges, including recruiting and retaining GPs and low morale. In the face of this, NHS staff have helped maintain, and improve the quality of care the NHS provides. Yet there are warning signs that maintaining the quality of care is becoming increasingly difficult. The findings in this year’s report illustrate why the way healthcare is planned, managed and delivered at all levels in Scotland must change.
- The health system is likely to look very different in future years. Health and social care integration marks a significant change in how the different parts of the health and social care system work together and how the Scottish public will access and use services in future years. Yet the scale, complexity, and interdependencies of health and care make achieving this a highly complicated and long-term undertaking. A number of factors provide a positive basis on which to build. Scotland has had a consistent overall policy direction in health for many years and there is broad consensus on the aim that everyone will be able to live longer, healthier lives at home or in a homely setting. A highly committed workforce remains motivated to provide high-quality care and there is a continued focus on safety and improvement. Levels of overall patient satisfaction continue to be high and the Scottish public hold the NHS in high regard. There are also early signs that changes in the way services are planned and delivered are beginning to have a positive impact. For example, delayed discharges have reduced in a number of areas and this provides opportunities for sharing learning across the country.
- There is no simple solution to addressing the issues facing the NHS and achieving the changes required. Previous approaches such as providing more funding to increase

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

## Recommendations

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

**The Scottish Government should:**

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

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

- Develop a capital investment strategy to ensure the NHS Scotland estate is suitable to deliver more regional and community-based services.
- Continue to develop a comprehensive approach to workforce planning that:
  - Reflects forecasts of future staffing and skills requirements to deliver changing models of healthcare provision at regional, local and community level
  - Provides a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training.

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

**The Scottish Government should:**

- Develop a robust governance framework for the delivery of the Health & Social Care Delivery Plan. This should:
  - Provide a more coherent picture of delivery by mapping work currently underway and planned, and the interrelationships between them
  - Move on from statements of intent to developing the specific actions, targets and timescales to deliver all of its work-streams and plans; so as to allow better oversight and progress to be assessed and reported publicly
  - Simplify and make clear the lines of accountability and decision-making authority between the Health & Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, and regional boards, NHS boards and integration authorities

  - Improve transparency by including measures of performance covering all parts of the healthcare system which include indicators of quality of care in addition to indicators of access.

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

**The Scottish Government should:**

- Work with the entire public sector to develop a shared commitment and understanding of their role and inter-relationships in improving public health and reducing health inequalities.

**The Scottish Government, NHS boards and integration authorities, should:**

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

# Introduction

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

1. The NHS in Scotland is 70 years old next year. The NHS was set up in 1948 to provide free healthcare at the point of need. In the intervening seven decades, the range of services it provides, the number of staff it employs, and the Scottish public's demand for its services have all grown considerably. At some point in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland:
    - employed almost 140,000 staff across 14 mainland and island health boards and eight national boards
    - performed 1.5 million procedures in acute hospitals
    - responded to 741,000 accident and emergency incidents
    - conducted an estimated 17 million GP consultations
    - spent £12 billion on delivering healthcare.[1] [2] [3] [4] [5]

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

3. There is general consensus in Scotland that healthcare cannot continue to be provided in the same way but as we have reported previously, more progress needs to be made if transformational change is to happen. To help support this change, this annual overview of the NHS in Scotland focuses on two main areas:
    - In chapter one, we examine how different parts of the healthcare system in Scotland currently perform and why healthcare needs to change.

[1] Overall NHS Scotland workforce summary by staff grouping, ISD Scotland, June 2017

[2] Procedures data is for 2015/16 and provisional (this is the most recent data available); Number and types of procedures carried out by health board, ISD, 2017

[3] Annual Report and Accounts for Year ending 2016/17, Scottish Ambulance Service, 2017

[4] GP consultations data is an estimate based on actual data at 2012/13 from our report, Changing models of care, Audit Scotland, 2016

[5] NHS Consolidated Accounts for financial year 2016/17, Scottish Government, 2017

[6] NHS Scotland Staff Survey 2015 National Report, Scottish Government, December 2015; Scottish Inpatient Experience Survey 2016 Volume 1: National Results, Scottish Government, 2017

- In chapter two, we identify the progress being made and the barriers which urgently need to be overcome to ensure the NHS can continue to provide high-quality care in the future.

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

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

**Exhibit 1**

**How healthcare will look in the future**

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

Graphic showing the following:

- People will be equal partners with their clinicians, working with them to arrive at decisions about their care that are right for them…this might mean less medical intervention, if simpler options would deliver the results that matter to them.
- People will be supported to have the confidence, knowledge, understanding and skills to live well, on their own terms, with whatever conditions they have. They will have access to greater support from a range of services beyond health, with a view to increasing their resilience and reinforcing their whole wellbeing.
- Hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter. Individuals will benefit from more care being delivered in the community, and where possible, at home.
- Everyone will have online access to a summary of their Electronic Patient Record and digital technology will underpin and transform the delivery of services across the health and social care system.

*Source: Audit Scotland using Health and Social Care Delivery Plan, Scottish Government, December 2016.*

5. To achieve this vision, the way that people access and use health and social care services across Scotland will need to change, services will need to be delivered differently, and there will need to be a significant change in how people manage their own health. It is not possible to stop or pause services while these changes are made and the scale of the task should not be underestimated. This is an exceptionally large-scale, complex change involving not just

[7] This vision has its roots as far back as 2000, with the publication of the joint futures agenda. See Reshaping Care for Older People, Audit Scotland, February 2014, Exhibit 3, page 13 for a policy summary.
[8] 2020 Vision: Strategic Narrative, Scottish Government, September 2011.

structural, but also significant culture change, of both public service providers and the public. Attitudes towards the role and responsibilities of the NHS, the way health and social care services are accessed and delivered, the part the rest of the public sector has to play in improving Scotland's health, and how people manage their own health, will all need to change. This can only be achieved by involving, and supporting the Scottish public and NHS and other public sector staff throughout this process. The NHS cannot achieve this vision alone. All parts of the public sector have a role to play, such as housing, sports and education, if the Scottish Government's vision for health is to be realised.

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

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

7. It is not yet clear how planning at each of the different levels will work together in practice. It is important that roles and responsibilities at each level, and how they link together are well defined to ensure:
   - there is clear accountability
   - it is clear how public money is being used
   - the public are easily able to access health and social care services that are joined up effectively.

## Exhibit 2

### Planning levels in the Scottish health system

Multiple planning levels for healthcare are being developed

Note: Finalised graphic will not necessarily be presented hierarchically.

*Source: Audit Scotland*

# Part 1: The NHS in Scotland in 2016/17

## Key messages

- **In 2016/17, the health budget was £12.8 billion, 42 per cent of the total Scottish Government budget. Health funding continues to increase but NHS boards had to make unprecedented levels of savings in 2016/17, at almost £440 million, as operating costs also continue to rise. The lack of financial flexibility, with NHS boards required to break even at the end of each financial year, and long-term planning are barriers to moving more care out of hospitals.**
- **Demand for health services continues to rise but previous approaches of treating more people in hospital are not sufficient anymore. Waiting lists for outpatient first appointments and inpatient treatment increased by 15 per cent and 12 per cent respectively in the past year, and people are waiting longer to be seen. The majority of key national performance targets were not met in 2016/17 and wider indicators of quality suggest that the NHS is beginning to struggle to maintain quality of care.**
- **The overall health of the Scottish population continues to be poor and significant health inequalities remain. Life expectancy is lower than most European countries and improvements have stalled in recent years. Smoking rates have continued to reduce but drug-related deaths increased significantly in 2016/17 and are now the highest in Europe.**
- **General practice is central to changing how health services are accessed and used, yet there are significant challenges. These include difficulties in recruiting and retaining GPs, and low morale.**

## Funding for the NHS continues to increase and accounted for 42 per cent of the Scottish Government budget in 2016/17

8. Health funding is the single largest area of Scottish Government expenditure. In 2016/17, the total Scottish Government health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.8 billion. This accounted for 42 per cent of the overall Scottish Government budget, an increase from 38 per cent in 2008/09.

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

and protection.[9] A significant percentage of territorial health boards' budgets, £5 billion, 45 per cent in 2016/17, is now provided to Integration Authorities to fund primary care and other delegated health services.

10. Between 2015/16 and 2016/17 the overall health budget increased by five per cent in cash terms. Taking into account inflation, the real terms increase was three per cent. This was made up as follows:
    - Revenue funding, for day-to-day spending, increased by 2.4 per cent in cash terms from £12 billion to £12.3 billion, an increase of 0.4 per cent in real terms.
    - Capital funding, for example for new buildings and equipment, increased from £203 million to £522 million, an increase of 159 per cent in cash terms, 154 per cent in real terms. The majority of this increase is due to changes in the way capital funding is accounted for, and excluding this, the real terms increase was 35 per cent.[10]

11. In 2016/17, the NHS budget included £250 million ring-fenced for social care funding for health and social care integration. Although this funding was for social care, it was included in the health budget and NHS boards were required to give this funding directly to Integration Authorities. Without this element of non-health funding, the health revenue budget reduced by 1.6 per cent in real terms between 2015/16 and 2016/17.

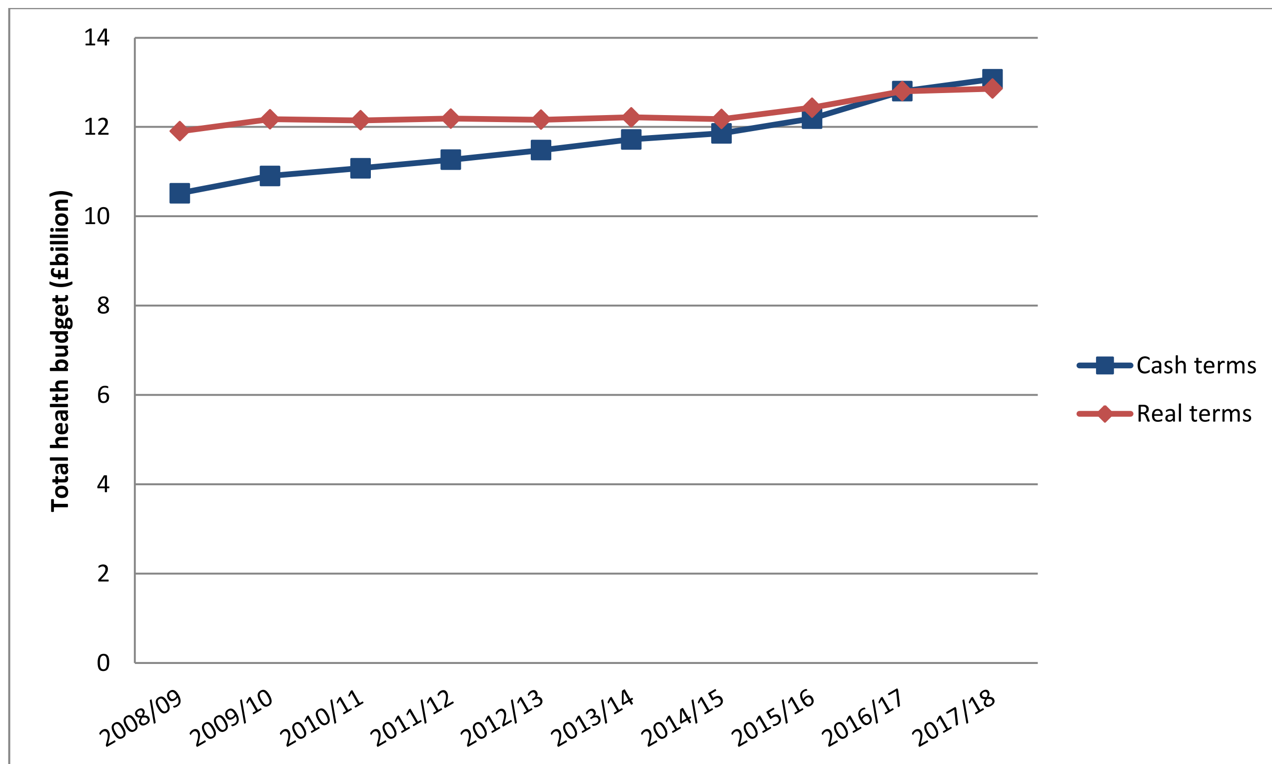
12. Between 2008/09 and 2016/17, the overall health budget increased by 7.5 per cent in real terms [Exhibit 3].[11] This has mainly been driven by funding increases in the most recent five year period and changes in how NHS boards account for capital funding. Revenue funding increased by 5.1 per cent in real terms and capital funding by 8.7 per cent in real terms between 2012/13 and 2016/17.

[9] Revenue and Capital expenditure limits, NHS Consolidated Accounts, Scottish Government, July 2017
[10] Real terms increase excluding accounting changes - source is Draft budget 2016/17: Health and Sport, SPICe Briefing , December 2015
[11] This includes the £250 million social care funding for integration authorities in 2016/17

## Exhibit 3

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

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




*Source: Audit Scotland*

13. The 2017/18 draft health budget is projected to be £13.1 billion, an increase of 2.1 per cent in cash terms, 0.5 per cent in real terms from 2016/17. This is due to an increase in the revenue budget of 3.1 per cent in cash terms, 1.5 per cent in real terms. The capital budget is projected to decrease by almost a quarter, from £522 million to £408 million, a 23 per cent reduction in real terms.[12]

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

14. The Scottish Government allocates most funding to territorial NHS boards according to a formula developed by the NHS Scotland Resource Allocation Committee (NRAC). This is based on a number of factors including population, age and gender profiles and deprivation. Since the formula was introduced in 2009/10, the Scottish Government has been working towards ensuring that by 2016/17, no NHS board would be more than one per cent below their target allocation. In 2016/17, four NHS boards, NHS Grampian, Highland, Lanarkshire, and Lothian, remained more than one per cent below their target allocation, at around 1.5 per cent

[12] Draft budget 2017/18, Scottish Government, December 2016

below parity. Seven NHS boards received more than their target allocation, ranging from 0.3 per cent more in NHS Tayside to 9.4 per cent more in NHS Western Isles.[13] It is anticipated that no board will be more than one per cent below their target funding allocation in 2017/18.

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

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

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

- receiving loans, known as brokerage, and late allocations from the Scottish Government
- transferring money from capital to revenue budgets
- using reserves
- making one-off accounting adjustments, such as releasing surplus holiday pay accruals and insurance rebates.

17. NHS Tayside was the only board to require brokerage from the Scottish Government in 2016/17, receiving £13.2 million. We have prepared a separate report on the 2016/17 audit of NHS Tayside. Three NHS boards, NHS Highland, Orkney, and Western Isles repaid all existing brokerage ranging from £0.5 million to £1 million, and NHS24 repaid £1 million from an existing balance of £20.4 million. NHS24 is scheduled to repay the remaining loan over the next four years.

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

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

[13] Information provided by Scottish Government, July, 2017
[14] NHS Consolidated Accounts, Scottish Government, July 2017

targets are then revised through the year as revenue and capital resource limits change due to additional allocations from the Scottish Government.

19. NHS boards made £439.9 million savings in 2016/17, 3.8 per cent of the total NHS revenue budget. The level of savings made in 2016/17 was unprecedented (Exhibit 4), and was 51 per cent higher than the £291.3 million made in 2015/16. Despite this, the NHS did not meet its original planned savings target of £491.6 million as set out in boards' LDPs, falling short by 11 per cent, £51.7 million.

20. Although the overall target was missed, the majority of NHS boards did meet their individual LDP savings targets in 2016/17. Six territorial boards, NHS Borders, Fife, Forth Valley, Highland, Greater Glasgow and Clyde, and Tayside did not meet their savings targets despite all making higher levels of savings than in previous years. The shortfall ranged from NHS Fife missing its original planned target by £16.9 million (55 per cent), to NHS Greater Glasgow and Clyde which missed its original planned target by £14 million (13 per cent). Of the national boards, NHS Health Scotland was the only board not to achieve its LDP savings target, falling short by three per cent, £32,000.

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

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

- Twelve out of 14 territorial boards predicted that they would still be in a deficit position at February 2017, compared to nine boards in 2015/16.
- Between February and March 2016, NHS territorial boards recovered £41.2 million to move to a year-end surplus position. A year later, they had to recover almost double that amount, £70.9 million, to break even, and ended the financial year with a surplus of £8 million.

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

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

24. The level of savings NHS boards have planned to make has increased significantly over the past five years, increasing by 81 per cent in cash terms, 71 per cent in real terms between 2012/13 and 2016/17. NHS boards make savings in various ways and while they reduce

expenditure and contribute to achieving financial targets, they do not necessarily demonstrate increased productivity or efficiency. Savings are classed as either recurring or non-recurring. The former recur year-on-year from that date, for example savings on costs as a result of providing services in a different way. Non-recurring savings are one-off savings that do not result in ongoing savings after that financial year, for example selling a building or delaying filling a vacant post. The percentage of non-recurring savings made by NHS boards has increased significantly over the past few years (Exhibit 4). Non-recurring savings accounted for 39 per cent of all savings made in 2016/17, almost double the level of five years ago when they accounted for 21 per cent. The percentage of savings made up from non-recurring sources varied widely across the NHS in 2016/17. Among the territorial boards, non-recurring savings accounted for seven per cent of total savings in NHS Forth Valley to 72 per cent in NHS Lothian. In the national boards they ranged from zero in NHS National Services Scotland to 86 per cent in The State Hospital.

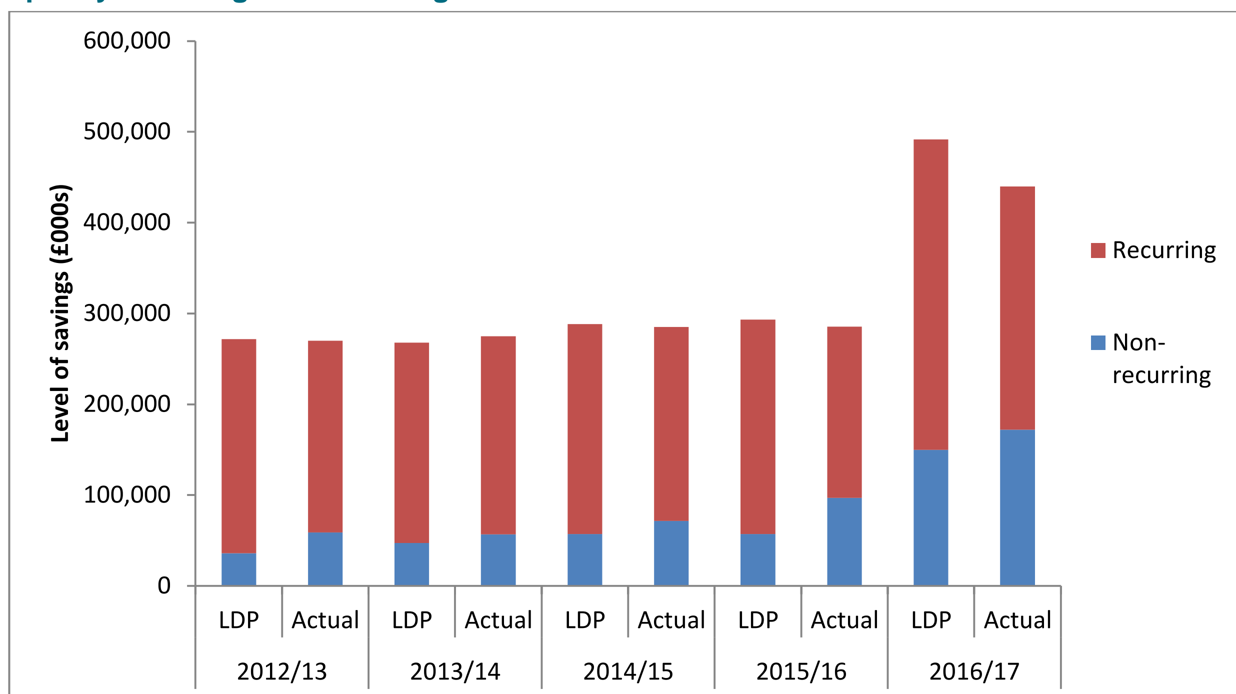
**25.** We have stated previously that increasing reliance on non-recurring savings is unsustainable. This is because:

- it is becoming more and more difficult for NHS boards to identify areas in which they can make one-off savings
- boards that make high levels of one-off savings will have to find more savings in future years as they have less recurring savings to use
- non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.[15]

[15] NHS in Scotland 2016, Audit Scotland, October 2016

**Exhibit 4**

**Overall level of savings projected in LDP and final savings achieved from 2012/13 to 2016/17 split by recurring/non-recurring**




*Source: Audit Scotland*

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

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

27. NHS boards must manage the cost of delivering services within the funding and income they receive. As discussed earlier, this is increasingly challenging for boards to do as costs have

[16] NHS in Scotland 2015, Audit Scotland, October 2015

continued to rise in key areas. Exhibit 5 sets out the main cost pressures boards faced in 2016/17. NHS boards face a high level of fixed costs, for example, staff costs accounted for over half of all revenue expenditure in 2016/17. It is therefore important that NHS boards, Integration Authorities and the Scottish Government work together to ensure:

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

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

**Exhibit 5**

**Cost pressures in 2016/17**

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

- £6.5 billion was spent by NHS boards on staff in 2016/17 (57 per cent of revenue expenditure) and the majority of NHS boards overspent on their pay budget.[17]
- In 2016/17 NHS boards spent £171 million on agency staff, an increase of 81 per cent in real terms over the past five years.[18] Spending decreased, however, by 3.2 per cent between 2015/16 and 2016/17.[19]
- Boards reported spending £139 million on agency medical locums in 2016/17, an increase of 6 per cent in real terms on the previous year.

Backlog maintenance costs have reduced but remain considerable

- £511 million was spent by NHS boards on capital projects in 2016/17, with the majority, £465 million funded by the Scottish Government, and the remaining amount from asset sales and donations.[20]
- 70 per cent of the estate was rated good in 2016/17, a slight increase from 66 per cent in 2015/16. There is wide variation across territorial boards, from 24 per cent of the estate rated good in NHS Orkney to 98 per cent in NHS Borders.
- £887 million total backlog maintenance in 2016/17, a slight decrease from £898 million in 2015/16. There has been a seven per cent increase in the percentage of backlog maintenance classed as significant and high risk, to 48 per cent in 2016/17. There was wide variation across territorial boards, from 21 per cent of all backlog maintenance rated significant and high risk in NHS Ayrshire and Arran to 72 per cent in NHS Lothian and

[17] NHS workforce planning, Audit Scotland, July 2017

[18] NHS Consolidated Accounts, Scottish Government, July 2017

[19] Ibid

[20] Ibid

Tayside. Over half, 56 per cent, of all backlog maintenance was accounted for by three boards, NHS Greater Glasgow & Clyde, Grampian and Tayside.[21]

### Spending on drugs continues to rise

- £1.68 billion was spent on drugs in 2015/16 (£1.26 billion in the community and £420 million in hospitals), an increase of £112 million in real terms (7.1 per cent) from 2014/15.[22]
- Between 2014/15 and 2015/16, spending on drugs in hospitals increased at a higher rate (8.1 per cent in real terms) than spending on drugs in the community (6.8 per cent in real terms).
- In the last five years spending on drugs in hospitals rose by 34.4 per cent in real terms as opposed to a rise of 7.9 per cent in spending on drugs in the community.
- Since 2014/15 the Scottish Government, via the New Medicines Fund (NMF), has provided £183 million additional funding to NHS boards to cover the costs of increasing patient access to treatment for very rare conditions and end-of-life medicines. The fund reduced from £85 million in 2015/16 to £53 million in 2016/17, placing further pressure on boards' drugs budgets. The amount available to boards from the NMF in 2017/18 is not yet known.[23]
- The Scottish Government's Effective Prescribing Programme Board has been in place for two years. It is not yet known what savings have come from effective prescribing activities to date but work on stopping inappropriate prescribing has contributed to reducing the annual increase in volume of community prescribing. Between 2013/14 and 2016/17 the quantity of drugs dispensed in the community increased by around two per cent or less, in comparison to annual increases of between 2.6 and 5.1 per cent between 2008/09 and 2012/13.[24]

### Clinical negligence costs have increased

- The way in which the amount of compensation in personal injury claims is decided has changed in the UK. The cash amount will now be higher which means that the amount boards set aside for claims increased from £323 million in 2015/16 to £582 million in 2016/17.[25]

Note: The final exhibit may be presented differently from the list format above.

[21] Annual State of NHS Scotland Assets and Facilities Report for 2016, Scottish Government, July 2017

[22] 2015/16 is the most recent year figures are available. *Scottish Health Service Costs - drugs*, ISD Scotland, November 2016

[23] The New Medicines Fund is funded from rebate payments from the UK Pharmaceutical Price Regulation Scheme (PPRS). The receipts for Scotland from this scheme have not yet been finalised for 2017/18.

[24] ISD data provided to Audit Scotland, August 2017

[25] The lump sum compensation awarded to victims of life-changing injuries is adjusted according to the interest they could expect to earn by investing it. Courts use a calculation to work this out using a discount rate. The discount rate has been reduced by HM Treasury from 2.5 per cent to minus 0.75 per cent. This reduces the expected value of the future investment, making the cash value of the settlement higher.

*Source: Audit Scotland*

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

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

- staff costs, including the annual one per cent pay uplift, pay rising as staff move up pay scales, the apprenticeship levy, and the impact of the living wage
- increases in spending on hospital drugs of between four and sixteen per cent and increases in GP prescribing costs of between four and nine per cent. The Healthcare Financial Management Association projected spending on drugs in hospitals as a proportion of all hospital costs will rise from 5.4 per cent in 2012/13, to 8.5 per cent in 2019/20 if they continue to grow at the rate they have done over the last four years.[26]
- business rate rises in 2017/18 of between four and 27 per cent and energy increases of upwards of four per cent over the next three years.

**30.** Differences in anticipated funding from the Scottish Government and the cost of delivering services in 2017/18 means NHS boards are planning savings of £445 million. This is less than the planned savings for 2016/17 but still higher than the savings achieved in 2016/17. Case Study 1 gives an example of what these cost pressures mean financially for a territorial board over the next three years.

### Case study 1 - Financial pressures in NHS Grampian

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

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

| | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|
| | £m | £m | £m |
| **New Resources:** | | | |
| Baseline increase in Scottish Government funding | 13.2 | 18.9 | 19.4 |

[26] *Medicines Costs in Scotland*, Healthcare Financial Management Association Briefing, July 2017

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

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

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

31. There is no one indicator of demand for healthcare services. Historically, any analysis of demand has focussed on the acute sector due to a lack of national data on primary and community care. This continues to be the case and makes it difficult to assess overall demand or to better understand changes in demand. Examining a range of different indicators, however, shows that demand is continuing to grow. In particular, demand for outpatient

appointments and planned inpatient and day case treatment have risen significantly in the past five years (Exhibit 6).

**Exhibit 6**

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

Demand for NHS services continues to increase

| | Emergency admissions | Number of procedures | Number of people waiting for first outpatient appointment | Number of people waiting for inpatient and day case treatment | GP consultations |
|---|---|---|---|---|---|
| Five year change | +3.5% | +11.4% | +43.1% | +34.1% | +4.6% |
| 2016/17* | 565,344 | 1,476,055 | 305,746 | 65,960 | 16,974,857 |
| 2012/13 | 546,258 | 1,325,111 | 213,648 | 49,192 | 16,236,010 |
| | A | A | Q | Q | A |

Note 1: A= annual figure Q = Quarter ending March figure

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

*Source: Audit Scotland using Emergency Admissions and bed days by NHS board and Health and Social Care Partnership, 2011/12-2015/16, ISD Scotland, October 2016; Number of procedures performed in acute hospitals by treatment setting, ISD Scotland, October 2016; Acute Activity Quarterly Figures and Table, ISD Scotland, June 2017; Inpatient or Day case Admission: Waiting Times Quarter ending 30 June 2017, ISD Scotland, July, 2017; Changing Models of Health and Social Care, Audit Scotland, March 2016.*

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

Outpatients

- NHS boards see over one million people as outpatients every quarter, and around a third of these are new attendances. Over the past five years, the number of new attendances seen increased by 11 per cent - in the quarter to March 2017, NHS boards saw almost 36,000 more new outpatient attendances than in the quarter to March 2013. However, most of this increase was made at the start of the five year period, and the number seen since then has remained fairly static.
- At the same time, waiting times have increased. The number of people that waited over the standard 12 weeks for their first appointment increased by 300 per cent, from around 21,500 people in the quarter to March 2013 to just over 87,000 people in the quarter to

March 2017. Of these, the number of people that waited over 16 weeks for their first appointment increased ten-fold, from 5,000 to almost 58,000 people.

- The number of people on the waiting list for their first appointment at the census point in March 2017 was almost 306,000 people, a 43 per cent increase, and 92,000 more people waiting than at March 2013. In the past year, the number of people on the waiting list has increased by 39,000, a 15 per cent increase.

Inpatients and day cases

- For planned inpatient and day case treatments, the number of people treated over the past few years has reduced while the length of time people are waiting, and the number waiting, have increased. Around 74,000 people received planned inpatient or day case treatment in the quarter to March 2017, almost 13,900 fewer people (16 per cent less) than the peak in the last five years in the quarter ending March 2014. In the past year, almost 4,800 fewer people were seen – a six per cent reduction.
- Over the same period, waiting times increased. The number who waited over the guaranteed 12 weeks for their treatment increased by 812 per cent, from 1,450 in the quarter ending March 2013 to 13,200 in the quarter ending March 2017. The past year has seen a marked increase in people waiting longer than 12 weeks - an additional 7,500 people waited over 12 weeks between the quarters ending March 2016 and March 2017.
- The number of people on the waiting list rose to almost 66,000 at the census point in March 2017, an increase of 12 per cent from March 2016 and 34 per cent higher than five years ago in March 2013. [27]

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

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

34. National NHS performance targets have been in place in Scotland for over a decade. Previously known as HEAT targets, since 2015 these have been referred to as Local Delivery Plan (LDP) standards. Most LDP standards are measures of access to acute healthcare services, for example, the four hour accident and emergency waiting time standard or the 12 weeks to first outpatient appointment standard. Acute services are only one part of the

[27] Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2017, Information Services Division, May 2017

healthcare system and access is only one measure of the quality of that system. There are a lack of indicators providing information on quality of care, primary care and community care.

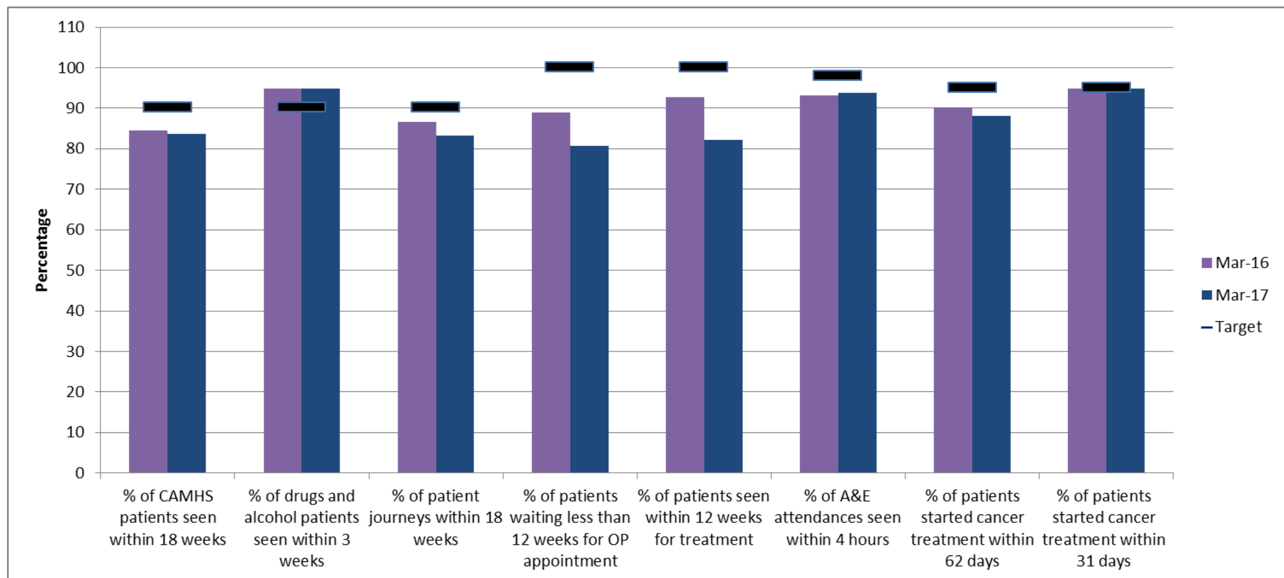
35. The existing measures do not provide a comprehensive, balanced assessment of the performance of our healthcare system. However, performance against LDP standards does indicate the pressure the healthcare system is under. An independent review of the national LDP standards is currently underway and an interim report is due to be published by August 2017.[28]

36. As with last year, NHS Scotland failed to meet seven out of eight key performance standards in 2016/17 (Exhibit 7). Nationally, the NHS met its target of 90 per cent of patients referred for drug and alcohol receiving treatment within 31 days, at 94.9 per cent. The target of 95 per cent of patients starting cancer treatment within 31 days was missed by just 0.1 per cent, the same as in 2015/16. The NHS met its four hour accident and emergency standard in week ending 11 June 2017, the first time since June 2016. Appendix 3 shows performance against the national standards by NHS board. Over the past five years, overall performance has declined in six of the eight key performance standards and remained static in one, with performance only improving against the four hour accident and emergency standard.

**Exhibit 7**

**National performance against key national performance standards, 2015/16 to 2016/17**

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




*Note: CAMHS is Children and Adolescent Mental Health Services*

*Source: Audit Scotland using ISD Scotland data as at August 2017*

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

[28] To update this section when interim report is available

- Performance against the 12-week treatment time guarantee (TTG) for patients waiting on planned inpatient or day case procedures dropped by almost 11 percentage points, from 92.7 per cent in 2015/16, to 82.1 per cent in 2016/17. This means that in 2016/17:
  - 13,200 people were not seen within the 12-week standard, a 131 per cent increase in the number of people who waited over 12 weeks since the previous year.
- Performance against the12-week waiting time standard for first outpatient appointment dropped by over eight percentage points, from 88.9 per cent in 2015/16, to 80.7 per cent in 2016/17. This means that in 2016/17:
  - The number of people on the waiting list increased by 15 per cent, with almost 39,000 more people waiting.
  - Of those on the list, the number of people waiting over 12 weeks increased by 99 per cent, with over 29,400 more people waiting.
  - Of those on the list, the number of people waiting over 16 weeks increased by 109 per cent, with almost 22,700 more people waiting.

Achieving waiting time standards has been a top priority for the Scottish Government and NHS boards for a number of years. Approaches by the Scottish Government include providing additional funding to improve performance against individual standards and providing support teams in NHS boards. NHS boards continue to make extensive efforts to meet the targets. These efforts include redesigning processes and services, recruiting additional staff and using the private sector to increase short-term capacity. In our report, NHS in Scotland 2015, we noted that these approaches may help meet targets in the short-term but do not necessarily demonstrate value for money in achieving the longer-term aims and objectives of the NHS'.[29] Our auditors reported in 2016/17 that NHS boards are increasingly struggling to improve performance against national targets while also achieving financial balance. The continuing effort being put into balancing these two priorities is detracting from the overall strategy of moving more care into the community.

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

38. No single annual assessment is made of the overall quality of care provided by the NHS in Scotland by any organisation. Analysis of a range of measures indicates there were no significant weaknesses in the overall quality of care being provided by the NHS in 2016/17. Positive examples include the following:
    - Inpatient satisfaction is at an all-time high. Ninety per cent of patients rated their care and treatment as good or excellent in 2016.[30]
    - Patient safety indicators continued to improve: between 2007 and 2016, there was a reduction in the hospital standardised mortality ratio of 16.5 per cent, and a 21 per cent reduction in 30-day mortality due to sepsis.[31] [32]

[29] NHS in Scotland 2015, Audit Scotland, October 2015
[30] Scottish Inpatient Experience Survey 2016 Volume 1: National Results, Scottish Government, 2016

- The Nuffield Trust's 2017 report, Learning from Scotland's NHS, found there was a strong culture of continuous improvement in the NHS in Scotland.[33]

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

- in 2016/17, the Scottish Ambulance Service was significantly below its new target of responding to 75 per cent of immediately life-threatening incidents within eight minutes, at 63.8 per cent.[34]
- one in five inpatients surveyed in the national inpatient experience survey in 2016, 20 per cent, said they had experienced problems during their hospital stay, such as infections, sepsis, bed sores or falls. A significant minority, 39 per cent, felt they were not involved in decisions about their care or treatment as much as they would have liked.[35]
- Patient complaints are increasing. Complaints to territorial health boards increased by 29 per cent between 2012/13 and 2015/16 (the most recent year available), to 21,456.[36]
- Recent surveys of staff indicate pressures on maintaining quality of care. A 2017 British Medical Association (BMA) survey of GPs in Scotland found more than nine out of 10 GPs (91 per cent) believe their workload has negatively impacted on the quality of care given to patients. A 2017 survey of nurses and health care support workers by the Royal College of Nursing found that half of respondents in Scotland felt patient care was compromised on their last shift. The main reason respondents gave was a lack of registered nurses and health care support workers.[37]

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

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

[31] The hospital standardised mortality ratio (HSMR) is based on all acute inpatient and day case patients admitted to all specialties in hospital. The calculation takes account of patients who died within 30 days from admission and includes deaths that occurred in the community as well as those occurring in hospitals. HSMR is equal to observed deaths divided by predicted deaths.

[32] Scottish Patient Safety Programme Acute Adult End of Phase Report, Healthcare Improvement Scotland, August 2016

[33] Learning from Scotland's NHS, The Nuffield Trust, July 2017

[34] Annual Report and Accounts for Year ending 31 March 2017, Scottish Ambulance Service, 2017

[35] Scottish Inpatient Experience Survey 2016 Volume 1: National Results, Scottish Government, 2016

[36] NHS Scotland Complaints Statistics 2015/16, ISD NHS National Services, October 2016

[37] Survey of GPs, BMA, 2017; Draft budget 2018-19 submission, RCN, 2017

- Average life expectancy, at 77.1 years for men and 81.1 years for women, is consistently lower than most European countries and has been static since 2012.[38]
- Healthy life expectancy, that is, the number of years a person lives in good health, has remained almost the same since 2009, at 59.9 years for men and 62.3 years for women.[39]
- Overall mortality rates were higher in 2015 and 2016 than in previous years, although it is not yet clear the extent to which there is an emerging trend. Mortality rates from cancer and heart disease remain higher than the rest of the UK. [40] [41]
- The number of drug-related deaths increased by 23 per cent between 2015 and 2016, from 706 to 867, and was double the number of deaths in 2006. Scotland now has the highest drug-death rate in Europe.[42]
- The proportion of adults in Scotland who are current smokers has reduced by five percentage points to 21 per cent between 2008 and 2015.[43]
- The average number of units of alcohol consumed per week for adult drinkers aged 16 and over fell from 16.1 units in 2003 to 12.2 in 2013 and has subsequently stayed at similar levels (12.9 in 2015).[44]

**41.** A recent study by NHS Health Scotland examined the burden caused by various diseases in Scotland. These are measured in disability-adjusted life years (DALYs) with one DALY equal to one lost year of healthy life. The conditions in Scotland causing the greatest loss of healthy life are heart disease, low back and neck pain, and lung cancer. Comparing Scotland with other countries around the world shows that Scotland is less healthy (that is, it has more healthy years lost) compared to countries with similar socio-demographic profiles.[45]

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

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[38] Table 1: Expectation of life, by sex and selected age, Scotland 1861 to 2015, National Records for Scotland

[39] Healthy life expectancy: key points, Scottish Public Health Observatory, December 2016

[40] Table 1: All ages age-standardised death rates for all causes and certain selected causes, Scotland, 1994 to 2016; Age-standardised death rates calculated using the European Standard Population, National Records of Scotland, August 2017

[41] Scotland's Population 2016 - The Registrar General's Annual Review of Demographic Trends, August 2017

[42] Drug-related deaths in Scotland in 2016, National Records of Scotland, August 2017

[43] Scottish Health Survey, Scottish Government

[44] Ibid

[45] The Scottish Burden of Disease Study 2015, NHS Health Scotland, July 2017

- Mortality rates for chronic liver disease in 2015 were nearly twice as high in men than women (19 per 100,000 compared to 11 per 100,000) and stroke rates remain consistently higher for men than women across all age groups.[46]
- Scottish Government research based on the 2011 census found that gypsies/travellers had the worst overall health among ethnic groups, being more likely to report a long-term health problem or disability and more likely to report bad or very bad general health.[47]
- A 2015 Equality Network survey found that 21 per cent of LGBT respondents had personally experienced discrimination or less good treatment in Scotland's healthcare services because of their sexual orientation or gender identity.[48]

**43.** A recent report by NHS NSS noted that while reliable data exists on age and gender in health, there continues to be a lack of data relating to disability, gender identity, religion, and sexual orientation. The report stated that 'without good data on inequalities in health it is impossible to plan and prioritise effective action or to monitor progress towards a more equal society*'* and that 'there is a need to collect equality data to directly improve the care and experience of individual service users*…'.*[49]

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

- are likely to die 8.6 years sooner if female and 12.2 years sooner if male, with the gap in life expectancy increasing as improvements in those living in the least deprived areas outpace those in the most deprived areas[50]
- spend an average of 20.1 years longer in ill health if female, and 21.6 years longer if male[51]
- are most likely to be diagnosed with breast, colorectal and lung cancer at stage 4, the most advanced stage of the disease, whereas those living in the least deprived areas are most likely to be diagnosed at stages 1 or 2[52]

[46] Table 1: Chronic Liver Disease: Deaths rate (EASR) per 100,000 population, for Scotland by gender, calendar years of registration of death 1982-2015, Scottish Public Health Observatory, December 2016; Scottish Stroke Statistics Publication Summary, ISD Scotland, February 2017

[47] Gypsy/Travellers in Scotland: A comprehensive analysis of the 2011 census, Scottish Government, 2015

[48] The Scottish LGBT Equality Report, Equality Network, July 2015

[49] Measuring use of health services by equality group, NHS National Services Scotland, 2017

[50] Scotland's Population 2016 - The Registrar General's Annual Review of Demographic Trends, August 2017

[51] Between 2009 and 2013, the most recent data available, healthy life expectancy among those living in the least deprived areas in Scotland was 72.7 years for men and 74.1 years for women, compared to 51.1 years for men, and 65.3 years for women living in the most deprived areas. Health life expectancy: deprivation deciles, Scottish Public Health Observatory, December 2015.

[52]The highest proportion, 29.4 per cent, of patients living in the most deprived areas were diagnosed at stage 4. Of those living in the least deprived areas, the highest proportion, 28.6 per cent, were diagnosed at stage 2. Detect cancer early staging data: Year 5, Information Services Division, July 2017

- are more than twice as likely to attend A&E, and are slightly more likely to then be admitted to hospital.[53]

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

**45.** Primary care is usually the first point of contact with the NHS and refers to services provided by health professionals in clinics and practices or in a patient's home. General practice is a key part of primary care and is central to the changes needed in how services are accessed and delivered. In 2016 there were 4,913 GPs in Scotland working in 963 practices.[54] Historically, GPs are independent contractors who run their own practices, known as 'partners', or are employed and paid by the partners running a practice. GPs are not normally employed by the NHS board area they work in, although their funding comes from NHS boards.

**46.** No up-to-date national information is available on levels of demand and activity for general practice in Scotland. From projections in our 2016 report, Changing models of health and social care, we estimated the number of GP consultations would increase by 4.6 per cent between 2012/13 and 2016/17, to 17 million consultations.[55] This is equivalent to every person in Scotland visiting their GP at least three times a year. In 2016 the Kings Fund, analysed 177 practices in England (with a total of 30 million patient contacts). They found a 15 per cent increase in the number of consultations between 2010/11 and 2014/15.[56] Therefore it is possible that 17 million is an under-estimate.

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

- The number of GP practices has fallen by three per cent in the past five years, to 963. Consequently, the average practice list size has increased to 5,881, an increase of six per cent. However, there has not been a corresponding increase in the number of GPs, whose numbers have only increased by one per cent in the last five years.[57] This means workload pressures are likely to have increased on the existing workforce.
- Recruitment and retention data is not available nationally, however, a 2017 BMA survey of GPs in Scotland found that 26 per cent of practices had vacancies and of those vacancies, 73 per cent had been open for at least six months.[58] Workforce pressures are

[53] Who attends Emergency Departments, Information Services Division, September 2015

[54] GP Census, ISD NHS NSS, December 2016

[55] Actual data for 2012/13 is from GP Practice Team Information, Information Services Division, October 2013. Data for 2016/17 is estimated using the same projection methods as in Changing models of care, Audit Scotland, March 2016.

[56] Understanding pressures in general practice, The Kings Fund, 2016

[57] GP Census, ISD NHS NSS, December 2016

[58] Vacancy survey shows GP recruitment problems, News Release, BMA, June 2017

likely to continue increasing due to an ageing workforce. A third of all GPs and 42 per cent of GP partners were aged over 50 in 2016, and a BMA survey in December 2016 found that over one-third of GPs planned to retire within the next five years.[59] [60]

- Due to reported recruitment difficulties and other issues such as retiring partners, locum costs, and premises issues, an increasing number of GP practices were taken over by their NHS board in 2016/17 compared to previous years. This means the GP partners running a general practice have handed their practice over to an NHS board and the practice is no longer run by GPs who are independent contractors. In 2016/17, 15 practices were taken over compared to 11 in 2015/16 and four in 2014/15.
- Morale is deteriorating. A BMA survey of GPs in Scotland in December 2016 found that over two-thirds of GPs, 70 per cent, felt they experienced significant work-related stress and 15 per cent felt their stress was unmanageable. More than half, 55 per cent, reported their workload had a negative impact on their commitment to being a GP.[61]

[59] GP Census, ISD, December 2016

[60] Survey shows pressures on GPs in Scotland, News Release, BMA, December 2016

[61] Ibid

# Part 2: Achieving change

## Key messages

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

## The national health and social care delivery plan sets out the main ways the Scottish Government aims to achieve change

**48.** The Scottish Government published a Health and Social Care Delivery Plan (the Delivery Plan) in December 2016 to set out how the 2020 Vision will be achieved. Its aim is to 'increase the pace of improvement and change within Scotland's health and care system'.[62] The Delivery Plan brings together four major existing programmes of work and cross-cutting initiatives:

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

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

[62] Health and Social Care Delivery Plan, Scottish Government, December 2016

49. A significant amount of activity is underway by the Scottish Government, integration authorities and NHS boards to transform the healthcare system in Scotland. In this chapter we identify the building blocks being put in place to move more care into the community. We also examine the main barriers to meaningful progress and the action needed to overcome these.

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

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

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

### Case study 2

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

- Nationally, there are early signs of improvement in delayed discharges. In March 2017 there was an average of 1,338 beds occupied per day by a delayed discharge, 14 per cent fewer days than six months earlier in October 2017.
- Aberdeen Health and Social Care Partnership has made improvements in delayed discharges, with a 22 per cent reduction in the number of people delayed in hospital at the end of the first full partnership year. This was achieved through initiatives such as improving operational processes and the use of intermediate care beds, which allow patients and their families more time to consider care options.
- In East Dunbartonshire the Integrated Care Fund funded the Red Cross to provide transport home from A&E for older people, and provide support to settle them back home. In 2016, 118 people were helped by this service, which avoided unnecessary hospital admissions.
- Edinburgh Health and Social Care Partnership worked with Edinburgh Leisure to develop a 'Fit for Health' physical activity programme, to help people manage their long-term conditions. 78 per cent of participants reported greater wellbeing, including weight loss and improved sleep.

- The Orkney Integrated Authority commissioned NHS Orkney to expand foot care provision through the use of the third sector to provide an alternative service. This has reduced waiting times.

Note: Due to new data requirements and changes to definitions it is not possible to provide comparable Scotland level bed days occupied trend information for the full year of 2016/17.

*Source: Audit Scotland using ISD Scotland data and IAs Annual performance reports*

52. There are still challenges to be overcome in how NHS boards and IAs work together. These include the following:
    - Budget-setting: our report, NHS in Scotland 2016, highlighted there had been difficulties in agreeing IA 2016/17 budgets, mainly due to differences in when local authorities and NHS boards finalise their budgets. This was still the case in 2017/18. Only 14 IAs agreed budgets by March 2017, and these were based on indicative NHS offers.
    - IAs and NHS boards are still developing clinical governance processes.
    - Developing agreed financial reporting timescales: the majority of NHS auditors reported that IAs submitted late financial information to NHS boards for the 2016/17 accounts process. Therefore relevant financial information was not available to boards and auditors at the appropriate time for inclusion in the draft accounts.

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

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

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

54. The concept of realistic medicine was introduced by the Chief Medical Officer in her 2014/15 annual report. A vision and strategy were developed the following year, that by 2025 everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of realistic medicine. Actions set out in the Delivery Plan to achieve the vision include the following:
    - refreshing the Making It Easy health literacy plan to help everyone in Scotland to live well with any health condition they have
    - reviewing the consent process for patients in Scotland - a key element in transforming the relationship between individuals and medical professionals
    - incorporating the principles of realistic medicine as a core component in medical education and into medical professionals' working practice

- commissioning a collaborative training programme for clinicians to help them to reduce unwarranted variation
- developing a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost; and reducing the overall cost of medicine.[63] [64]

A realistic medicine policy team was put in place in early 2017 to take forward these actions. The Scottish Government has yet to set out how it will measure progress in achieving realistic medicine.

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

### Case study 3

#### Realistic medicine activity in NHS Lothian

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

*Source Audit Scotland and NHS Lothian*

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

[63] Health and Social Care Delivery Plan, Scottish Government, December 2016
[64] A formulary specifies the drugs GPs and other prescribers should use for different conditions based on their clinical effectiveness, safety, and cost effectiveness. There are currently ten formularies in Scotland.

- If all NHS boards achieved an average length of inpatient stay in line with those operating in the upper quartile of performance, an estimated 91,444 bed days could be saved annually, equating to £31.4 million.
- Reducing variation from clinical guidelines for day case surgery could potentially save £19.8 million annually.
- Some procedures should only be considered when specific thresholds have been met to ensure that they add value to a patient's outcomes. Reducing the number of these procedures, such as tonsillectomies and minor skin lesions could potentially release almost 21,000 bed days annually, or £39 million.[65]

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

57. It is essential that reliable and comprehensive information is available to support moving more care into the community and to support efforts to manage acute sector demand. We have reported previously that there is a major gap in information about demand and activity for most community health services, including general practice.[66] Two initiatives are underway to try and address this, called 'Source' and LIST.

58. The 'Source' project is a long-term initiative run by the Information Services Division (ISD) of NHS NSS that aims to support integration authorities' strategic planning (IAs) by improving data sharing across health and social care. A database links anonymous individual-level data on health and social care activity (excluding general practice data), costs, and demographic information to enable IAs to understand how individuals, groups of people, and communities interact with services and how resources are being used. Source is designed to be flexible enough to include additional datasets, for example housing and homelessness data and there are plans to include GP data from participating practices in the future.

59. ISD is also providing data and analytical support to IAs through a Local Intelligence Support Team (LIST) initiative. This has placed information specialists from ISD with IAs to build local capacity and capability, facilitate access to national information and expertise, and share initiatives and results across Scotland. Working jointly with the central ISD teams, work is driven by local priorities. Examples of work include:
    - forecasting service demand and impact of service changes
    - examining how individuals and groups move between services, and
    - identifying individuals who most frequently attend accident and emergency departments, to help focus preventative care.

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

[65] Data supplied by Information Services Division, NHS National Services, July 2017. Data is standardised for age, gender, and deprivation.
[66] NHS in Scotland 2016, Audit Scotland, October 2016

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

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

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

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

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

61. As we set out in chapter one, the Scottish Government is attempting a change programme that is exceptionally large in scale, difficult, and long term. It is essential that a robust governance framework is in place to oversee the work.

62. The Health and Social Care Delivery Plan National Programme Board was established to 'provide strategic oversight and operational assurance of the delivery of the Health and Social Care Delivery Plan'.[67] The programme board contains directors from the Scottish Government Health Directorate along with representatives from other policy areas. It met for the first time in April 2017. At August 2017, governance arrangements for how the board will operate were still being developed. These include agreeing the following:

- Lines of accountability and authority with existing governance structures: the current major work programmes have their own governance arrangements, for example health and social care integration has a Ministerial Strategic Group. Decision-making authority and lines of accountability between these existing structures and the Programme Board are not yet clear and there is potential for duplication and lack of clarity about connections to the work of other groups.
- How to assess progress: the Delivery Plan sets out the government's intention to develop a robust, integrated performance framework for the different components of the delivery plan by early 2017. At August 2017, the Scottish Government was still developing this framework. The Delivery Plan does not set out in detail how the changes described in it

[67] Health and Social Care Delivery Plan, Scottish Government, December 2016

will be achieved and many of the actions contained in it are statements of intent rather than actions. Therefore it is important that the performance framework sets out clearly what work is being done and how progress will be measured.

- How to oversee activity: a mapping exercise is currently being carried out of all the work currently underway or planned across the multiple areas of work and programme boards. Completing this exercise will help ensure there is no duplication across workstreams and will allow the Programme Board to prioritise activity and assess the impact of different activities and decisions on other areas.

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

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

64. A financial framework is needed to show how moving more care into the community will be funded, addressing questions such as:
    - What levels of funding are likely to be available in future years, and how does this compare to the likely levels of funding that will be needed in different parts of the system?
    - How will existing funding be spent differently to deliver health and social care in new ways? Where and when will money be spent or stop being spent?

65. Previously we have commented that shifting the balance of care will require either:
    - reducing spending on acute services, such as hospital care, to move funding into the community, or
    - investing more money in the community to develop and establish new models of care while maintaining spending on acute services.

66. Both are not straightforward financially. Community health services need to be capable of looking after patients before resources can be shifted from acute services. This effectively means double-running services, which requires additional funding. The Scottish Government has announced additional funding in the Delivery Plan of £500 million in primary care by 2021. However, it is not clear how much of this will be new investment or reallocated funding from other areas.

67. Currently, there is little indication that the balance of funding between acute and community services will shift in coming years. In 2016/17, NHS boards' funding from integration

authorities was almost exactly the same as the budget they initially provided.[68] Analysis of NHS boards' 2017/18 LDPs shows that only eight territorial boards plan to increase cash funding to their integration authorities between 2017/18 and 2019/20. The Nuffield Trust in their 2017 report, Learning from Scotland's NHS, examined a sample of NHS board LDPs and found little evidence of multi-year plans to move funding and reduce the number of acute beds. Our own analysis of all territorial NHS board LDPs supports this. The majority of 2016/17 LDPs only discussed the current year's funding and only a minority of NHS boards have high-level financial plans for five years. The Ministerial Strategic Group for Health and Community Care is currently considering how it can help integration authorities and NHS boards to shift funding.

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

- how effective community healthcare is in lowering or slowing demand for acute services
- the fact that healthcare needs are not static and will continue increasing as Scotland's population ages
- how effective efforts to improve the health of the Scottish population are. [69]

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

- The level of savings that can be realised from investment in community services - a survey of integration authorities in 2016 by the Health and Sport Committee found only one example in the responses provided of specific savings resulting from investment (North Ayrshire Integrated Joint Board provided a specific example of a £600,000 investment in its care at home reablement service that was estimated to have saved 4,710 acute bed days).[70]
- The level of resources that can be freed up in the acute hospital setting given the high levels of fixed costs involved.
- The extent to which structural redesign, such as increased regional planning and management of health services and using national elective centres, results in delivering more efficient services and financial savings.

**70.** A recent submission by the IJB Chief Finance Officers Group to the Health and Sport Committee on the draft budget 2018/19 stated that 'there is emerging evidence which indicates that the current level of resources is less than that required to meet current cost and

[68] NHS in Scotland 2016, Audit Scotland, October 2016. Comparable 2017/18 data was not available at the time of writing.

[69] Draft Budget 2018-19 Submission to Health and Sport Committee, Scottish Parliament, BMA Scotland, 2017

[70] Health and Social Care Integration Budgets, 2nd Report 2016 (Session 5), Health and Sport Committee, Scottish Parliament, November 2016

demand pressures'.[71] An example cited is a funding gap of £30 million that North Ayrshire Health and Social Care Partnership identified over the next two financial years. North Ayrshire stated in its own submission that 'it is unlikely that transformation alone will bridge the gap, and service reductions within community based, preventative services will be required, which is in direct opposition to what the partnership is seeking to achieve'.[72] The lack of financial flexibility NHS boards have and their limited planning horizons makes it difficult for NHS boards and subsequently, integration authorities to make long-term decisions to redesign health and care services. If the Scottish Government is to achieve its aim of moving more care into the community, it needs to work with NHS boards, integration authorities and local authorities to set out a clear medium and long-term framework for how shifting the balance of care will be funded.

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

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

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

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

- To fully fund NHS boards' capital programmes over the next five years will need investment of £2.8 billion.  It is not known if this level of funding will be available from the Scottish Government, therefore there is the potential for a funding gap.
- No nationally funded projects are currently scheduled after 2019/20.
- The continuing high level of backlog maintenance, £887 million in 2016/17, and the likely future need for investment in primary care facilities mean there is an opportunity to change the type, location, and size of healthcare facilities.

[71] Draft Budget 2018-19 Submission to Health and Sport Committee, Scottish Parliament, CIPFA IJB Chief Finance Officer Section and CIPFA, July 2017

[72] Draft Budget 2018-19 Submission to Health and Sport Committee, Scottish Parliament, North Ayrshire Health and Social Care Partnership, 2017

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

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

**75.** In July 2017 we published the first report in our two-part audit on the NHS workforce, NHS workforce planning: The clinical workforce in secondary care. We found the following:

- Urgent workforce challenges face the NHS in Scotland. These include continuing recruitment and retention difficulties, an ageing workforce, greater use of temporary staff, and the changing demands of an ageing population that is living longer.
- The Scottish Government and health boards have not planned effectively for the long term and responsibility for workforce planning is confused.
- The Scottish Government has not yet adequately estimated what impact increasing and changing demand for NHS services could have on the workforce or skills required to meet this need.

**76.** The Scottish Government aimed to publish a single national workforce plan in early 2017. This became three plans. The first, National Health and Social Care Workforce Plan - Part 1, published in June 2017, covers the NHS workforce.[73] The second plan, covering the social care workforce is due to be published in autumn 2017, and the third, covering primary care is due to be published by the end of 2017. Part 1 is not a detailed plan to address immediate and future issues, rather it is a broad framework to consider future workforce planning challenges. The Scottish Government is likely to find it challenging to provide any more detail in the next two plans. This is due to a lack of national data on the primary care and social care workforces and the fact that integration authorities are still in the early stages of identifying their workforce needs in their areas.

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

- improves understanding of future demand to inform workforce decisions, including carrying out scenario planning on the future population health demand and workforce supply changes
- provides a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups
- sets out the expected transitional workforce costs and expected savings associated with implementing NHS reform; this includes collating transitional costs attached to greater

[73] National Health and Social Care Workforce Plan - Part 1 a framework for improving workforce planning across NHS Scotland, Scottish Government, June 2017

regional and national working, costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.

We will publish a second report on the community-based NHS workforce, including those employed by general practices in 2018/19.

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

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

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

80. Recent work at a national level has set out the Scottish Government's aim to make GPs the lead clinical decision-maker in the community, working with a team from various disciplines. This will involve other professions, such as physiotherapists and nurses taking on some of the current responsibilities of GPs (Case Study 4).[74]

[74] See the National Review of Primary Care Out-of-Hours Services, November 2015; A National Clinical Strategy for Scotland, February 2016; Health and Social Care Delivery Plan, December 2016

**Case study 4**

**Future role of the GP within a wider multi-disciplinary team**

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

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

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

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

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

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

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

81. A range of work is currently ongoing as part of, and related to, the contract negotiations to identify ways to resolve the challenges facing general practice as set out in chapter one. This includes the following:
    - Modelling future demand scenarios to identify workforce requirements for both GPs and the wider primary care workforce.
    - Identifying options for how to plan and manage GP facilities. The Minister is currently considering findings from a working group set up by the Scottish Government and BMA to examine this issue.
    - Additional investment in primary care by the Scottish Government. A £500 million investment in primary care announced in October 2016, included £71.6m to be invested in 2017/18 to improve GP recruitment and retention, stabilise GP pay and make general

practice a more attractive profession. The GP recruitment and retention fund is increasing from £1 million in 2016/17 to £5 million in 2017/18 to fund GP training bursaries, expand the GP returners scheme and increase the GP retainer reimbursement scheme.

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

82. The Community Empowerment (Scotland) Act 2015 (the Act) marked a significant shift in the Scottish Government's expectations of how the Scottish public should be involved in decisions that affect them. NHS boards, integration authorities, and local authorities all have legal duties placed on them by the Act. The Act:

- provides a statutory basis for community planning partnerships and places duties on them for the planning and achievement of local outcomes. NHS boards and integration authorities have a legal duty to participate in community planning.
- means that community groups can make a request to a public body, such as an NHS board, to get involved in trying to make services better. The public body must agree to the request unless there are reasonable grounds for refusing it.
- gives communities greater rights to buy land and to request asset transfers for any land or buildings which a public body owns, or rents from someone else. Public bodies must agree to the asset transfer request unless there are reasonable grounds for refusing it. [75]

83. Proposals to change the way health services are delivered attract considerable attention. As we noted last year, NHS boards can face considerable public and political resistance to proposed changes to local services.[76] The Scottish Government's transformation programme is based on changing the way services are delivered. It is therefore critical that NHS boards and integration authorities are able to do this. This means working with the public to develop a shared understanding and agreement on the need for, and benefits of change, and then to develop and agree ways to provide services differently.

84. NHS boards and integration authorities are working with their local populations in a range of ways. A review of a sample of integration authorities' annual reports for 2016/17 found examples such as a public participation forum in Borders Integration Authority. This meets six times a year to make decisions about local services. East Renfrewshire Integration Authority has held team-building days involving young people, elected members and senior managers. NHS boards are also working with their local populations, for example through media campaigns and involving patient representatives on working groups. The Scottish Government has set up a citizens' panel with 1,200 members of the public from across Scotland to involve people in health policy-making.

85. National Standards for community engagement have been in place since 2005. These were revised in 2016 and are good practice principles for organisations to use when working with communities (Exhibit 8, Appendix 4). It is important that NHS boards and integration

[75] Community Empowerment (Scotland) Act 2015, Scottish Parliament, July 2015
[76] Changing Models of health and social care, Audit Scotland, March 2016

authorities refer to these to ensure their work with the public is meaningful and achieves the desired outcome.

**Exhibit 8**

**National Standards for community engagement**

The national standards are good practice principles designed to support and inform the process of community engagement, and improve what happens as a result

*Source: The National Standards for Community Engagement, Scottish Community Development Centre, September 2016.*

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

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

- Not all NHS boards or integration authorities publish all board and committee meeting papers and minutes on their websites.
- The public are not able to attend committee meetings in many NHS boards.
- Regular data is lacking in some areas of the NHS. For example:
  - information on how many calls the Scottish Ambulance Service deal with and their response times is only published once a year in their annual report.

- Currently no data is published on most aspects of primary care such as how many consultations are undertaken and the types of conditions seen. There is little reliable information on the primary care workforce, for example staff employed by general practices, such as nurses and Allied Health Professionals, such as physiotherapists and podiatrists.
- Public information is lacking in areas such as waiting lists for inpatient and outpatient specialties in NHS boards. Most NHS boards do not publish information on the length of their waiting lists or inform patients of their likely wait to be seen.
- The replacement of the national NHS Scotland staff survey with individual NHS board staff surveys in 2016 means there is now no public or comparable information on the views of NHS staff.

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

**87.** Although public health has traditionally been seen as the domain of the NHS, as little as ten per cent of a population's health and wellbeing is linked to access to healthcare. Factors such as the local environment, housing, transport and employment all affect people's health.[77] It is therefore important that, across all parts of the public sector, there is a shared understanding of, and commitment to, improving the health of the public in Scotland.

**88.** Improving people's health is a key part of the Scottish Government's transformation of health and healthcare. A healthier population is likely to reduce the future burden on health and social care services as fewer people develop conditions stemming from unhealthy lifestyles. Yet it will not be a quick process and may take decades before any meaningful financial savings can be identified. The BMA's submission to the Health and Sport Committee's investigation into the prevention agenda in 2016 illustrates the point. It noted that measures that reduced obesity in children and young adults might not lead to financial savings in health services until they reached middle to older age. This was when weight-related complications would otherwise be more likely to occur.[78]

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

[77] What makes us healthy? The Health Foundation, 2017
[78] Submission on Preventative Agenda, Health and Sport Committee, Scottish Parliament, BMA, 2016

# Appendix 1.

## Methodology

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

91. Our findings are based on evidence from sources that include:
    - the audited annual accounts and auditors' reports on the 2016/17 audits of the 22 NHS boards
    - Audit Scotland's national performance audits
    - NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as indicative spending plans for the next three years
    - activity and performance data published by Information Services Division (ISD), part of NHS National Services Scotland
    - interviews with senior officials in the Scottish Government, professional bodies, and a sample of NHS boards and integration authorities.

92. We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of the NHS is included in Appendix 2.

# Appendix 2.

## Financial performance 2016/17 by NHS board

| Board | Core revenue outturn (£m) | Total savings made (£m) | Non-recurring savings | NRAC: distance from parity |
|---|---|---|---|---|
| Ayrshire and Arran | 743.7 | 25.4 | 20.7% | 0.7% |
| Borders | 220.5 | 8.1 | 62.5% | 2.3% |
| Dumfries and Galloway | 311.1 | 12.8 | 42.9% | 4.6% |
| Fife | 665.6 | 13.8 | 52.2% | -0.2% |
| Forth Valley | 532.5 | 23.8 | 7.4% | -1.0% |
| Grampian | 983.0 | 26.5 | 43.0% | -1.4% |
| Greater Glasgow and Clyde | 2273.7 | 89.8 | 28.3% | 1.6% |
| Highland | 664.4 | 22.1 | 59.8% | -1.5% |
| Lanarkshire | 1204.3 | 45.9 | 19.9% | -1.5% |
| Lothian | 1457.1 | 73.2 | 71.9% | -1.5% |
| Orkney | 52.8 | 2.2 | 46.7% | 0.6% |
| Shetland | 54.8 | 4.2 | 54.5% | -0.9% |
| Tayside | 803.1 | 45.5 | 48.6% | 0.3% |
| Western Isles | 80.1 | 4.0 | 42.5% | 9.4% |
| National Services Scotland | 394.5 | 18.1 | 0.0% | |
| Scottish Ambulance Service | 221.1 | 9.9 | 45.5% | |
| NHS Education for Scotland | 436.0 | 2.6 | 26.0% | |
| NHS24 | 71.6 | 3.3 | 2.3% | |
| National Waiting Times Centre | 65.1 | 4.4 | 10.7% | |
| State Hospital | 32.1 | 1.8 | 86.3% | |
| NHS Health Scotland | 19.1 | 0.9 | 9.1% | |
| Healthcare Improvement Scotland | 27.6 | 1.9 | 61.4% | |

# Appendix 3.

## NHS performance against key LDP standards

| Measure | Child and Adolescent Mental Health Services (CAMHS), patients seen within 18 weeks | Drug and alcohol treatment, patients seen within 3 weeks | Referral to treatment (RTT), patient journeys within 18 weeks | Referral to outpatient appointment, patients waiting less than 12 weeks | Inpatient / day case treatment time guarantee (TTG), patients beginning treatment within 12 weeks | A&E, Patients seen within 4 hours | Cancer referral to treatment, patients beginning treatment within 62 days | Cancer decision to first treatment, patients beginning treatment within 31 days |
|---|---|---|---|---|---|---|---|---|
| | target = 90% | target = 90% | target = 90% | target = 100, interim 95% | target = 100% | target = 98%, interim 95% | target = 95% | target = 95% |
| Ayrshire and Arran | 93.8 | 96.9 | 73.6 | 81.4 | 86.6 | 93.7 | 92.8 | 99.7 |
| Borders | 98.4 | 94.4 | 90.0 | 90.3 | 95.7 | 93.2 | 94.9 | 98.3 |
| Dumfries and Galloway | 100.0 | 97.0 | 89.5 | 91.8 | 86.3 | 93.7 | 96.3 | 96.5 |
| Fife | 84.5 | 96.5 | 89.1 | 95.7 | 91.2 | 95.2 | 80.5 | 97.8 |
| Forth Valley | 99.7 | 98.7 | 79.4 | 82.4 | 63.5 | 97.2 | 89.3 | 96.6 |
| Grampian | 45.2 | 93.1 | 74.5 | 72.6 | 74.3 | 96.1 | 86.2 | 92.2 |
| Greater Glasgow and Clyde | 98.0 | 96.8 | 89.7 | 86.2 | 87.2 | 90.7 | 83.3 | 93.9 |
| Highland | 96.0 | 83.5 | 78.2 | 63.4 | 75.8 | 96.8 | 87.2 | 97.8 |
| Lanarkshire | 87.2 | 99.8 | 78.7 | 83.4 | 66.6 | 90.0 | 95.9 | 96.9 |
| Lothian | 47.8 | 83.4 | 79.1 | 72.8 | 81.4 | 95.7 | 90.6 | 93.6 |
| Orkney | 100.0 | 100.0 | 94.3 | 66.8 | 90.3 | 97.5 | 81.8 | 100.0 |
| Shetland | 100.0 | 77.8 | 84.2 | 67.3 | 98.1 | 97.1 | 94.1 | 100.0 |
| Tayside | 95.2 | 96.5 | 86.7 | 86.3 | 81.2 | 98.6 | 89.6 | 93.1 |
| Western Isles | 100.0 | 93.9 | 95.6 | 95.2 | 100.0 | 99.3 | 85.0 | 100.0 |
| **National Total** | **83.6** | **94.9** | **83.2** | **80.7** | **82.1** | **93.8** | **88.1** | **94.9** |

Green = Standard met

Orange = Standard missed but within 5 percentage points of standard

Red = Standard missed by more than 5 percentage points of standard

# Appendix 4.

## National standards for community engagement - 'how will we know we have met the standards?'

Inclusion:

- The people and groups who are affected by the focus of the engagement are involved at the earliest opportunity.
- Measures are taken to involve groups with protected characteristics (see below) and people who are excluded from participating due to disadvantage relating to social or economic factors.
- Participants in the community engagement process commit to continued two-way communication with the people they work with or represent.
- A wide range of opinions, including minority and opposing views, are valued in the engagement process.

Support:

- An assessment of support needs is carried out, involving all participants.
- Action is taken to remove or reduce any practical barriers which make it difficult for people to take part in engagement activities.
- Access to impartial and independent development support is provided for groups involved in the community engagement process.

Planning

- Partners are involved at the start of the process in identifying and defining the focus that the engagement will explore.
- A clear and agreed engagement plan is in place.
- All available information which can affect the engagement process has been shared and used to develop the community engagement plan.
- Partners agree what the outcomes of the engagement process should be, what indicators will be used to measure success, and what evidence will be gathered.
- The timescales for the engagement process are realistic.
- There are sufficient resources to support an effective engagement process.

Working together

- The roles and responsibilities of everyone involved are clear and understood.
- Decision-making processes and procedures are agreed and followed.
- The methods of communication used during the engagement process meet the needs of all participants.
- Information that is important to the engagement process is accessible and shared in time for all participants to properly read and understand it.
- Communication between all participants is open, honest and clear.
- The community engagement process is based on trust and mutual respect.
- Participants are supported to develop their skills and confidence during the engagement.

Methods

- The methods used are appropriate for the purpose of the engagement.
- The methods used are acceptable and accessible to participants
- A variety of methods are used throughout the engagement to make sure that a wide range of voices is heard.
- Full use is made of creative methods which encourage maximum participation and effective dialogue.
- The methods used are evaluated and adapted, if necessary, in response to feedback from participants and partners.

Communication

- Information on the community engagement process, and what has happened as a result, is clear and easy to access and understand.
- Information is made available in appropriate formats.
- Without breaking confidentiality, participants have access to all information that is relevant to the engagement.
- Systems are in place to make sure the views of the wider community continuously help to shape the engagement process.
- Feedback is a true representation of the range of views expressed during the engagement process.
- Feedback includes information on: the engagement process; the options which have been considered; and the decisions and actions that have been agreed, and the reasons why.

Impact

- The outcomes the engagement process intended to achieve are met.
- Decisions which are taken reflect the views of participants in the community engagement process.
- Local outcomes, or services, are improved as result of the engagement process.
- Participants have improved skills, confidence and ability to take part in community engagement in the future.
- Partners are involved in monitoring and reviewing the quality of the engagement process and what has happened as a result.
- Feedback is provided to the wider community on how the engagement process has influenced decisions and what has changed as a result.
- Learning and evaluation helps to shape future community engagement processes.

*Source: National Standards for Community Engagement, Centre for Community Development, 2016.*

| Finance | |
|---|---|
| Paragraph | Sheet in this workbook |
| 8 | Budget |
| 9 | Accounts - limits' |
| 10 - 12 | Health budgets 08-09 to 16-17' |
| Exhibit 3 | Health budgets 08-09 to 16-17' |
| 13 | Health budgets 08-09 to 16-17' |
| 14 | NRAC |
| 19-20 | Savings - FPRs' |
| 22 | Revenue outturn' |
| 24/exhibit 4 | Savings - FPRs' |
| 30 | Savings - FPRs nonrec' |
| | |

| Performance and demand | |
|---|---|
| Exhibit 6/32 | Outpatients |
| Exhibit 7/37 | Performance |

| Public health | Links to external evidence sources |
|---|---|
| Para 40 | |
| Life expectancy | https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/life-expectancy/life-expectancy-at-scotland-level/scottish-national-life-tables |
| Health life expectancy | http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/key-points |
| Overall mortality | https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp |
| Drug-related deaths | https://www.nrscotland.gov.uk/news/2017/drug-related-deaths-in-scotland-in-2016 |
| Current smokers | http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey/Publications/Supplementary2015 |
| Alcohol consumed | http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey/Publications/Supplementary2015 |
| Para 42 | |
| Chronic liver disease | http://www.scotpho.org.uk/health-wellbeing-and-disease/chronic-liver-disease/data/mortality |
| Stroke rates | http://www.isdscotland.org/Health-Topics/Stroke/ |
| Ethnic groups | http://www.gov.scot/Resource/0049/00490969.pdf |
| LGBT respondents | http://www.equality-network.org/wp-content/uploads/2015/07/The-Scottish-LGBT-Equality-Report.pdf |
| Para 44 | |

| | |
|---|---|
| SIMD Life expectancy | https://www.nrscotland.gov.uk/files//statistics/rgar/16/16rgar.pdf |
| Ill health | http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/deprivation-deciles |
| Cancer | http://www.isdscotland.org/Health-Topics/Cancer/Publications/data-tables2017.asp?id=1958#1958 |
| A & E | http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2015-09-29/2015-09-29-EmergencyCare-Report.pdf? |

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| Savings - FPRs' |
| Savings - FPRs nonrec' |
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| |
| Inpatients and day cases' |
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| |
| Table 1 Expectation of life, by sex and selected age, Scotland, 1861 to 2015 |
| |
| Table 1 - All ages age-standardised death rates for all causes and certain selected causes, Scotland, 1994 to 2016 |
| |
| http://www.gov.scot/Publications/2009/09/28102003/46 |
| |
| |
| Excel file - CLD mortality rates - Scotland overall, and by sex |
| Publication Summary, February 2017 |
| Chapter 4 |
| Page 26 |
| |

| Page 8 |
|---|
| |
| Cancer early staging data |
| Figure 3.1, Page 9 |

Director-General Health & Social Care and
Chief Executive NHSScotland
Paul Gray

T: 0131-244 2790
E: dghsc@gov.scot

Caroline Gardner
Auditor General
Audit Scotland
102 West Port
Edinburgh
EH3 9DN

22 September 2017

Dear Caroline

Thank you for sending me a copy of the clearance draft of your report on the NHS in Scotland 2017.

The report recognises the scale and complexity of our programme of transformational change, but at the same time, the positive basis on which this reform is built. It is clearly crucial that services are maintained as our reform programme is taken forward and I welcome the balanced challenge that is provided in the report.

I understand that feedback relating to points of clarification and factual accuracy has been sent to your team. I would be grateful that this is given due consideration before the final report is published.

Aside from those points, I am satisfied with the overall factual accuracy of the report.

Yours sincerely

Paul Gray

NHS in Scotland 2016/17 – Factual Accuracy –Financial Queries Extract at 21/09/17

| Ref (eg Para No) | Issue/Comments from Scottish Government | Affects (report and/or KMs) | Audit Scotland response/query |
|---|---|---|---|
| Page 6 - KM ( bullet point 1) | Percentage of SG budget. As calculated in 2016 report, this is based on health DEL as a percentage of SG DEL (excluding administration, COPFS, and Scottish Parliament and Audit Scotland). This gives a percentage of 38% in 2008-09 and 43% in 2016-17. | KMs and report | We will clarify the final figures with you once we have finalised the 2016/17 budget figures (see comment below). |
| Page 14 - para 8 | 2016-17 budget is £12.9 billion and comprises resource: £12,352.7 billion, capital: £519.5m and financial transactions: £5m. This is the draft budget for 2016-17 and for consistency with the budgets for all other years in the report, this is the figure which should be referenced. It accounts for 43% of the overall Scottish Government budget.<br><br>The report at present takes the ABR budget for 2016-17, which is a mid-year revision and therefore excludes elements of funding which are part of the totality of health funding (eg transfer of £54 million to the Education and Skills portfolio for nursing and midwifery training). | Chapter KMs and report | In previous years' reports, the budget figure for the year in question has come from the Draft Budget publication for the following year and the Level 3 'Budget' column.<br><br>For example, the 2015/16 health budget figure used in the NHS in Scotland 2016 report was £12.2bn (rounded from £12,188.5). This came from the publication Draft Budget 2016/17, Level 3 (Table 4.03, Column '2015/16 Budget') and was the rounded sum of Total Resource (£11.986) and Total Capital (£202.5). Previous years used the same methodology and the figures up to, and including 2015/16, were confirmed last year in an email from [Redacted] to [Redacted] dated 11/08/16. These figures are not the 'draft budget'- eg, in 2015/16, the Level 1 and 2 tables show the 'draft budget' column, which differs from the 'budget' column also shown and used in Level 3.<br><br>This year's report used the same methodology, using the 2017/18 Draft Budget publication and the Level 3 Column titled '2016/17 Budget'. As discussed between [Redacted] and [Redacted] on 21/09/17, the SG publication this year differs from previous years in that the Level 3 Column used are figures from the Autumn Budget Revision and not the final budget. |

| | | | |
|---|---|---|---|
| | | | Can you possibly provide the 2016/17 budget figures that are comparable to the Level 3 Budget Column normally used? |
| Page 22 – exhibit 5, bullet point 6 | clinical negligence costs do not tie back to Board accounts or the Scottish Government consolidated position. | Report | The source we used for this is from the consolidated NHS accounts - Note 17b CNORIS, line: Provision recognising the NHS Board's liability from participating in the scheme at year end (£582million in 2016/17). |

**Comments on NHS in Scotland 2017**

**Points of Clarification**

The comments below relate to points of clarification on policy or position, and include suggested changes to the language used in the report.

| | **Summary** | **SG Official:** |
|---|---|---|
| | | |
| 1.1 | Page 8 – final bullet point – an overall programme plan was discussed with the Programme board and finalised in August. This maps the work currently underway and details specific actions, targets, timescales and key milestones which are then monitored. Progress is reported against these to the National Programme Board.<br><br>We would ask that you consider reflecting recent progress in recommendation. | [Redacted] (Strategic Change) |
| | | |
| | **Introduction** | |
| | | |
| 1.2 | Page 13 – exhibit 2 – suggest that the graphic is not presented hierarchically. It would be more helpful to present it so that the collaborative nature of planning is reflected. | [Redacted] |
| | | |
| | **Part 1: The NHS in Scotland 2016/17** | |
| | | |
| 1.3 | Page 15 - para 11 - refers to the £250 million for social care as "non-health funding…although this was for social care, it was included in the health budget".<br>This is similar point to last year, where we highlighted that funding for social care being directed to Integration Authorities is an important component of a balanced health and social care system funded through the health budget. Without this funding, costs and pressure would flow into the health system: it is therefore legitimate and appropriate for the funding to come from Health. | [Redacted] |
| | | |
| 1.4 | Page 15 – para 12 – suggests that changes to capital accounting and budgeting have significantly contributed to real terms increase. Trend on capital spend shows this is not rcase. | [Redacted] |
| | | |
| 1.5 | Page 16 – para 13 - states that 'the capital budget is projected to decrease by almost a quarter, from £522 million to £408 million, a 23 per cent reduction in real | [Redacted] |

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| | terms.'<br><br>This is accurate but does not explain why and reflects that Dumfries & Galloway Royal Infirmary, and the Royal Hospital for Sick Children are nearing completion and do not require a full 12 months capital funding. The capital budget is linked to specific projects, so it may be misleading to compare it year on year as with the revenue budget. | |
| | | |
| 1.6 | P17 – para 15 - in the context of financial flexibility, para 15 refers to NHS Boards being required by the Scottish Government to achieve a balanced financial position at the end year. We discussed this point on Tuesday, the flexibility that there currently is and the parameters we are operating in overall that are set by HM Treasury. | [Redacted] |
| | | |
| 1.7 | P17 – para 18 - the introduction of Integration Authorities, and integration generally, also provides a mechanism to rebalance care and spend towards communities and the policy area would not see this as a complication. This might read better as along lines such as these:<br><br>"Previously, NHS boards were responsible for identifying and then making their own savings. Integration has made a new approach possible, where Boards allocate part of their savings targets to IAs along with the budgets they delegate to them. This forms part of the overall savings target of the IA (together with the savings target allocated by Local Authorities with delegated social care budgets) and the IA is able to decide how best to make those savings from its entire pooled budget. '' | [Redacted] |
| | | |
| 1.8 | Page 28 – para 38 – 'No single annual assessment is made of the overall quality of care provided by the NHS is Scotland by any organisation.'<br><br>Health Improvement Scotland is developing a Quality Framework to bring consistency to all their external quality assurance work. The Framework has been designed so that it can be applied locally by service providers to aid self-assessment and service improvement, and nationally for external quality assurance and validation. All HIS external quality assurance activity will be aligned to the Quality Framework to ensure consistency and coherence in their approach to driving improvement in care. | [Redacted] |

| | | |
|---|---|---|
| | Scottish Government published Health & Social Care Standards in June 2017. They apply to the NHS and all services registered with HIS and the Care Inspectorate. These will be taken into account by the Care Inspectorate, HIS and other scrutiny bodies for inspections, quality assurance activity and regulation of services. | |
| | | |
| 1.9 | Page 29 – para 39 – bullet point 3 states that patient complaints are increasing. An increase in complaints is not necessarily an indication of a diminished quality of healthcare and/or services. NHS Boards and organisations welcome and actively encourage feedback, comments, concerns and complaints, as required by the Patient Rights (Scotland) Act 2011.<br><br>The number of complaints we are seeing may reflect a better awareness of how people can give feedback and make a complaint, and confidence that their complaint will be listened to and acted on. Following the publication of the Scottish Public Services Ombudsman Annual Report 2013-14, the then Ombudsman, Jim Martin, told The Scotsman on 7 August 2014 that: “People are less reluctant to complain. They can find their way through the complaints process a lot easier than five or six years ago.”<br><br>Complaints about the NHS are a helpful way of identifying issues and areas in need of change. Acknowledging issues and taking the steps necessary to put things right is a vital part of maintaining and improving the quality and safety of NHS services. | [Redacted] |
| | | |
| | **Part 2: Achieving Change** | |
| | | |
| 1.10 | Page 37 – para 54 – ‘Scottish Government has yet to set out how it will measure progress in achieving realistic medicine.’<br><br>The Health & Social Care Delivery Plan sets out timescales for completing actions to embed realistic medicine. Progress towards achieving actions will be reported regularly to the Delivery Plan Programme Board.<br><br>Once the Realistic Medicine team is in place (recruitment is currently underway), they will develop an annual | [Redacted] |

|  |  |  |
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|  | delivery plan specifically for realistic medicine. It is anticipated that progress will be reported annually in the CMO's report. |  |
|  |  |  |
| 1.11 | Page 39 – para 62 – You met with [Redacted] recently to discuss progress with the Health & Social Care Delivery Plan. An overall programme plan was finalised in August, as noted above (page 8).<br><br>We would ask that you consider updating this paragraph and the corresponding recommendation on page 8 to reflect recent progress. | [Redacted] (Strategic Change) |
|  |  |  |
| 1.12 | Under 'financial framework - from page 40 – 42 – greater focus on role of Integration Authorities – for example how planning for health and social care services should be set out in IA strategic commissioning plans. | [Redacted] |
|  |  |  |
| 1.13 | Page 47 – para 82-85 – Community Empowerment<br>The report does not mention the public involvement duties placed on NHS Boards and integration authorities by section 2B of the National Health Service (Scotland) Act 1978 (as amended by the National Health Service Reform (Scotland) Act 2004) and the Public Bodies (Joint Working) (Scotland) Act 2014.<br><br>The Scottish Government's CEL 4 (2010) Guidance on Informing, Engaging and Consulting People in Developing Health and Community Care Services provides advice and guidance to help NHS Boards fulfil the duties of public involvement set out in the 1978 Act. It also provides information about the role of the Scottish Health Council, which was established to ensure NHS Boards fulfil these duties and to support them to do so effectively.<br><br>Integration Authorities have a range of duties conferred upon them through the Public Bodies (Joint Working) (Scotland) Act 2014, which requires a comprehensive approach to engagement and participation with local communities and other key stakeholders | [Redacted] |
|  |  |  |
| 1.14 | Page 48 – para 86 – The Scottish Government is taking a proactive approach to involving people and communities in developing the future of healthcare, including:<br>• The 'Our Voice' framework developed in partnership with the NHS, CoSLA, and 3rd sector | [Redacted] |

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|---|---|---|
| | representatives to involve people meaningfully in improving health & social care.<br>• Development of the Experience-based Co-Design Methodology with HIS which brings together people accessing support with those who provide it to co-design improvements to services.<br>• National ‘What Matters to You?’ day on 6 June. | |
| | | |
| 1.15 | Page 48 – para 86 – the third bullet point states that there is now no public or comparable information on the views of NHS staff.<br><br>The results of a national Dignity at Work Survey together with national iMatter results will provide a full overview of staff experience which will inform a National Report. This is due to be published in February 2018. | [Redacted] |

**Comments on NHS in Scotland 2017**

**2 - Factual Accuracy**

The comments below relate to inaccuracies in the narrative and figures in the report.

| | Summary | Response received from |
|---|---|---|
| | | |
| 2.1 | Page 6 – bullet point 1 - Percentage of SG budget. As calculated in 2016 report, this is based on health DEL as a percentage of SG DEL (excluding administration, COPFS, and Scottish Parliament and Audit Scotland). This gives a percentage of 38% in 2008-09 and **43%** in 2016-17. | [Redacted] |
| | | |
| | **Introduction** | |
| 2.2 | Page 13 – Exhibit 2 – the three regional planning areas are North, West and East. | [Redacted] (Strategic Change) |
| | | |
| | **Part 1: The NHS in Scotland 2016/17** | |
| | | |
| 2.3 | Page 10 – para 1 – spend figure should refer to £12.9 billion for consistency with references throughout the report to capital and resource spending. | [Redacted] |
| | | |
| 2.4 | Page 14 – para 8 - 2016-17 budget is £12.9 billion and comprises resource: £12,352.7 billion, capital: £519.5m and financial transactions: £5m. This is the draft budget for 2016-17 and for consistency with the budgets for all other years in the report, this is the figure which should be referenced. It accounts for 43% of the overall Scottish Government budget.<br><br>The report at present takes the ABR budget for 2016-17, which is a mid-year revision and therefore excludes elements of funding which are part of the totality of health funding (eg transfer of £54 million to the Education and Skills portfolio for nursing and midwifery training). | [Redacted] |
| | | |
| 2.5 | Page 14 – para 9 – **55%** of the territorial health boards' budgets is now **delegated** to Integration Authorities' control (not 'provided'). | [Redacted] |
| | | |
| 2.6 | Page 14 – bullet point 3 – it is correct that deaths are the highest in Europe, but this was caveated by NRS to recognise variations in data quality. | [Redacted] (Health Improvement) |

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| | Suggested wording:<br><br>'Drug-related deaths increased significantly in 2016/17 and, while there are issues of coding, coverage and under-reporting in some countries, are now the highest in Europe.' | |
| | | |
| 2.7 | Page 15 – para 10-12 – cash and real terms figures should be updated and use 2016-17 Draft budget. | [Redacted] |
| | | |
| 2.8 | Page 16 – exhibit 3 – update in line with correct budget for 2016-17 | [Redacted] |
| | | |
| 2.9 | Page 16 – para 13 – The 2017/18 health budget of £13.1 billion has been approved in parliament so is not a projection. Uplift figures to be corrected in line with 2016-17 budget. | [Redacted] |
| | | |
| 2.10 | Page 17 – para 14 – It has been confirmed that no board is more than one percent below their target funding allocation in 2017/18, so the word 'anticipated' should be removed. | [Redacted] |
| | | |
| 2.11 | Page 17 – para 16 – on capital to revenue transfers it is important to note that there are no net transfers from capital to revenue: these are budget reallocations matching a revenue to capital transfer in another area. | [Redacted]/[Redacted] |
| | | |
| 2.12 | Page 17 – para 16 - brokerage is a means of smoothing funding for Boards and supporting delivery of a balanced position. While this has been provided as repayable financial support, it may be misleading to refer to this as a loan. | [Redacted] |
| | | |
| 2.13 | Page 18 – para 19 – we are unclear on how the 3.8% savings figure is calculated. | [Redacted] |
| | | |
| 2.14 | Page 21 – exhibit 5 – we are not clear on source for agency medical locums spending. | [Redacted] |
| | | |
| 2.15 | Page 22 – bullet point – 6 – clinical negligence costs do not tie back to Board accounts or the Scottish Government consolidated position. | [Redacted] |
| | | |
| 2.16 | Page 24- 29 – statistics are from the first release of statistics. There have been subsequent minor updates. | [Redacted] |
| | | |
| | **Part 2: Achieving Change** | |

| | | |
|---|---|---|
| 2.17 | Page 37 – para 54 - states that 'a realistic medicine policy team was put in place in early 2017'. The realistic medicine policy team is still being set up: the Realistic Medicine Team Leader was appointed in mid July, a clinical lead has just been reported, and recruitment is underway for the remaining posts. | [Redacted] |
| | | |
| 2.18 | Page 39 – para 60 – it is correct to say that SPIRE data will not automatically be linked to the Source data being used by Integration Authorities. However, the Scottish Government is currently exploring ways in which IAs can have access to core GP data for planning purposes. | [Redacted] (Population Health) |
| | | |
| 2.19 | Page 39 – para 62 – the text says the programme board contains directors from the Scottish Government Health Directorate along with representatives from other policy areas'. This is incorrect – other policy areas are not represented.<br><br>The Board includes SG Health & Social Care Directors, NHS Board Chief Executives, NHS Board Chairs, COSLA, SOLACE, and Integration Authority Chief Officer representation, and staff side representation. | [Redacted] (Strategic Change) |
| | | |
| 2.20 | Page 42 – para 73 – we discussed the significant caveat to figure quoted in the first bullet point. The second bullet point states that 'no nationally funded projects are currently scheduled for 2019/20'.<br><br>There are a number of nationally funded projects scheduled for 2019/20 including elective centres, the ambulance replacement programme, the Baird and Anchor, Greenock Health Centre, and Clydebank Health Centre. | [Redacted] |

3 – Suggested Case Studies

Case studies suggested by [Director for Health & Social Care Integration]/HSC Integration Directorate

**Aberdeenshire HSCP - Virtual Community Ward**

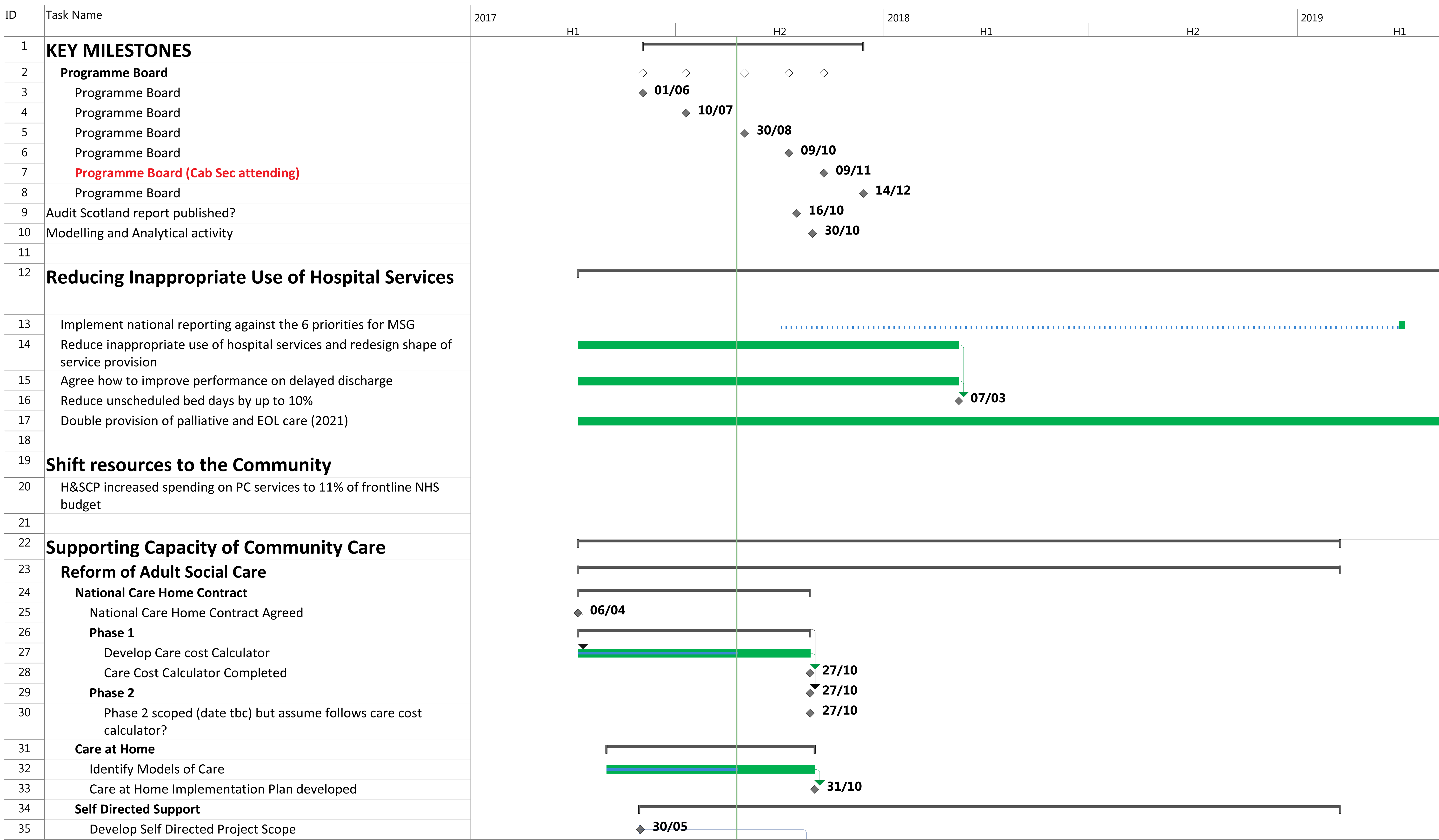
- The Aberdeenshire Health and Social Care Partnership has implemented the Virtual Community Ward (VCW) model which provides a methodology for managing a group within the population who require regular or urgent intervention. Virtual Community Ward has enabled daily multi-disciplinary discussions to take place to ensure that treatment, care and support for the most vulnerable people can be planned in a more preventative way so reducing the need for hospital admission or emergency respite
- The partnership have demonstrated that this approach is leading to a different pathway for many individuals in need of support, maintaining people at home for longer.
- http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0ahUKEwiY16L6hpfUAhXBAsAKHQm6BGsQFgg_MAQ&url=http%3A%2F%2Fcommittees.aberdeenshire.gov.uk%2FFunctionsPage.aspx%3Fdsid%3D90889%26action%3DGetFileFromDB&usg=AFQjCNF_-oUG6FpL-vAqXnDZ_9UINk96MA

Contact : [Redacted]

**Glasgow City HSCP - Intermediate Care/ Discharge to assess**

- In recognition of that acute hospitals are the worst setting in which to assess people's long-term care needs and longstanding problems of older people experiencing delays in hospital, Glasgow City has adopted a 'discharge to assess' policy. The Partnership has introduced nearly 100 intermediate care beds in independent sector care homes. Individuals are is discharged from hospital within 72 hours of being medically fit and in receive an assessment and rehabilitation with the aim of preparing them for a return to their own home, or to alternative care within their local communities.
- Since the introduction there have been reductions in the total number of bed days lost to delayed discharge and the Partnership aims to increase the number of people returning home rather than going to a care home.
- links: http://www.bbc.co.uk/news/health-38879439

Contact: [Redacted]




Project: draft implementation p
Date: Thu 24/08/17

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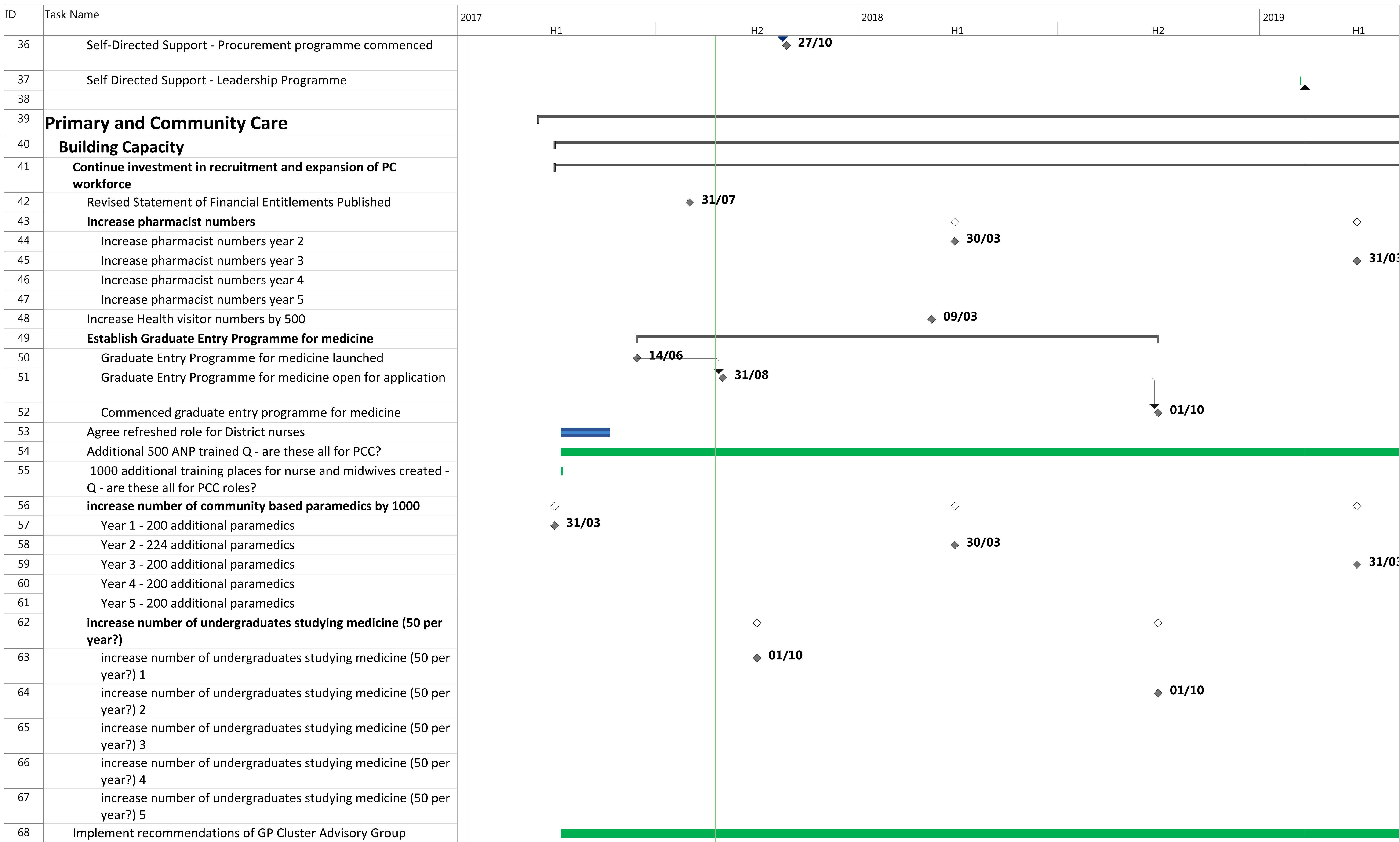
|---|---|---|---|---|---|---|---|---|---|
| Task | | Summary | | Inactive Summary | | Manual Summary | | External Milestone | |
| Completed Task | | Project Summary | | Manual Task | | Start-only | | Deadline | |
| Split | | Inactive Task | | Duration-only | | Finish-only | | Progress | |
| Milestone | | Inactive Milestone | | Manual Summary Rollup | | External Tasks | | Manual Progress | |




Project: draft implementation p
Date: Thu 24/08/17

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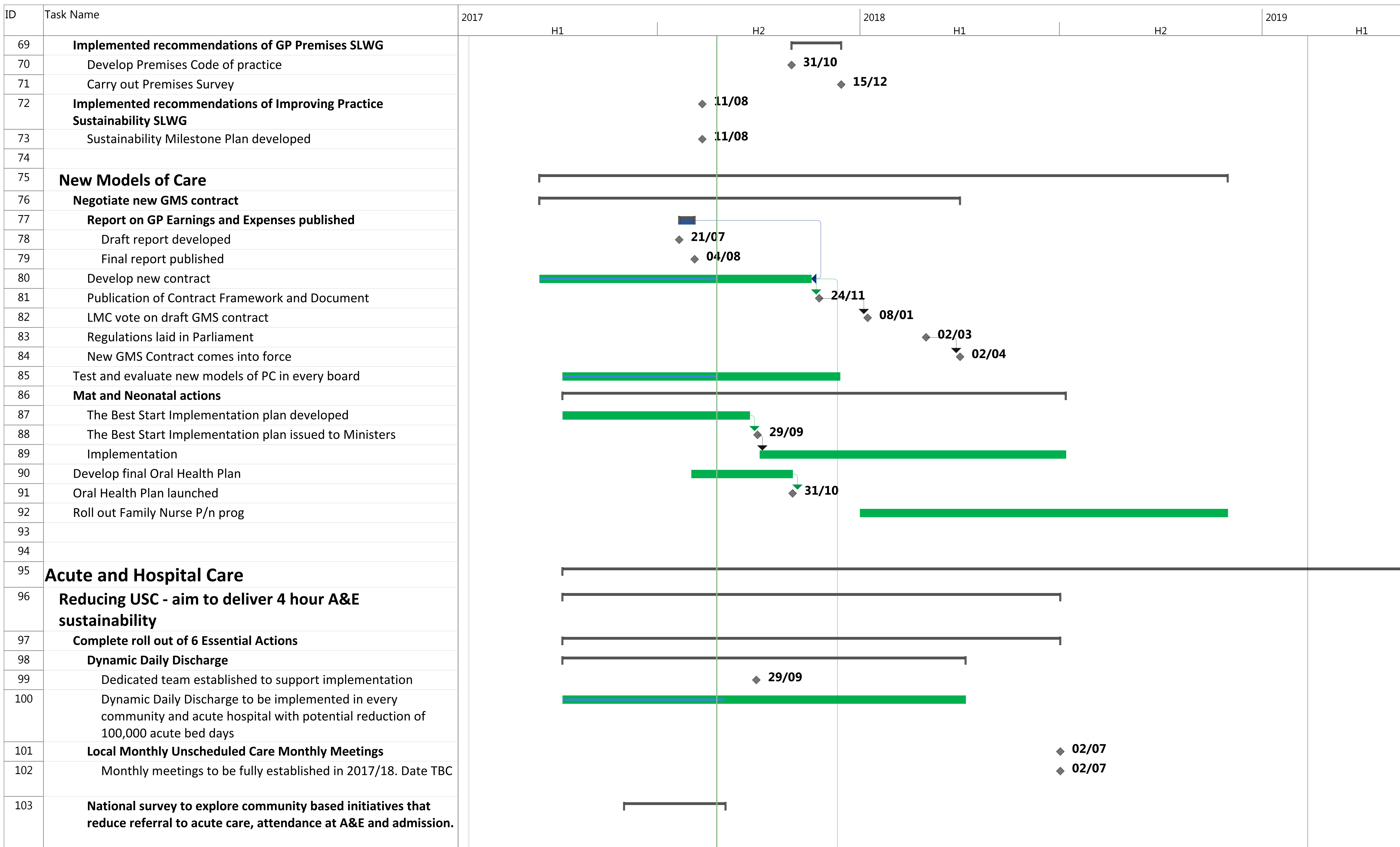
| Task | | Summary | | Inactive Summary | | Manual Summary | | External Milestone | |
| Completed Task | | Project Summary | | Manual Task | | Start-only | | Deadline | |
| Split | | Inactive Task | | Duration-only | | Finish-only | | Progress | |
| Milestone | | Inactive Milestone | | Manual Summary Rollup | | External Tasks | | Manual Progress | |

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| Task | Summary | Inactive Summary | Manual Summary | External Milestone |
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| Milestone | Inactive Milestone | Manual Summary Rollup | External Tasks | Manual Progress |

| ID | Task Name |
|---|---|
| 104 | Survey to be carried out over June |
| 105 | outcomes inform priority actions within Essential Action 6 aligned to partnership working with Hospital, IJB, SAS and third sector colleagues |
| 106 | **Improving Scheduled Care** |
| 107 | **Patient Flow Programme - Increasing national and local capacity to use operations management techniques to improve care for patients** |
| 108 | **Optimising Theatres** |
| 109 | Improve the planning of theatre utilization for emergency and elective work |
| 110 | Extend the pilot work in GRI to other sites with potential reduction of 7,000 acute bed days and reduce waits for emergency surgery |
| 111 | **Reducing pre-admissions** |
| 112 | Improve clinical pathways to reduce levels of elective pre-admissions |
| 113 | Extend pilots from GRI and Borders to other sites with potential to reduce 2,500 acute bed days and significant improvements in cancellations |
| 114 | **Enhanced recovery** |
| 115 | Colorectal laparoscopic enhanced recovery reduced length of stay by 2 days. |
| 116 | Extend pilots to other sites with potential reduction of 6,000 acute bed days. |
| 117 | **Develop approach to refocus on top BADS procedures** |
| 118 | Previous work on BADS (British Association of Day Surgery) procedures helped transform the rate of same day surgery in Scotland |
| 119 | Work is underway to develop resources and approach to refocus on BADS procedures on the new clinical approaches |
| 120 | **Elective Treatment Programme (milestones TBC)** |
| 121 | Elective Treatment Strategy developed |
| 122 | **Inverness** |
| 123 | Inverness Elective Centre Initial Agreement developed |
| 124 | OBC developed |
| 125 | FBC developed |
| 126 | Construction |
| 127 | Patient Occupancy commences |
| 128 | **Aberdeen** |
| 129 | Grampian Initial Agreement developed |
| 130 | OBC developed |
| 131 | FBC developed |



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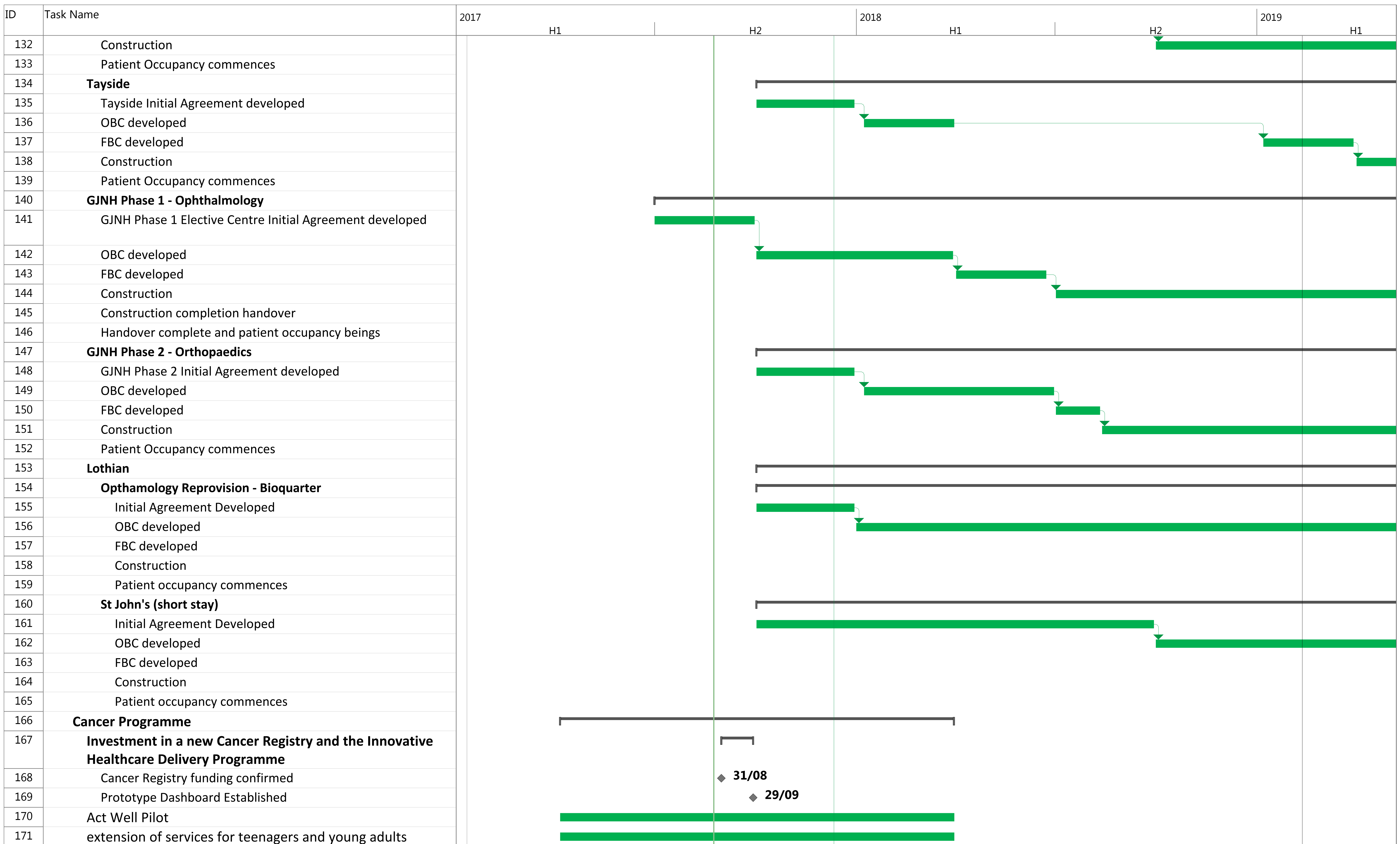


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| ID | Task Name | 2017 H1 – 2019 H1 |
|---|---|---|
| 172 | increasing MRI capacity at the Golden Jubilee Hospital and increasing scopes and diagnostic capacity across NHSScotland | |
| 173 | **Improving Outpatients** | |
| 174 | Outpatient Programme Board and 17/18 workplan established | 02/10 |
| 175 | **Develop infrastructure to underpin modern o/p services** | |
| 176 | Review of statistical definitions of outpatient appointments to support new ways of delivery including Advice Only, Virtual Clinics, Attend Anywhere and Patient Initiated Returns approaches | |
| 177 | Development of clinical requirements and technological systems to support delivery of Advice Only, Virtual Clinics, Attend Anywhere, Patient Initiated Returns and Clinical Decision Support Tools approaches | |
| 178 | Establishment and continuation of speciality redesign collaboration for Trauma and Orthopaedics, Gastroenterology, Dermatology, Ophthalmology , Rheumatology, Cardiology, Respiratory Medicine and Gynaecology. | |
| 179 | **Pursuing efficiencies in outpatient services in 2017/18** | |
| 180 | Targeted engagement with NHS Boards on those specialities with high variance in review to new ratio with potential to deliver up to 15,000 fewer review outpatient appointments | |
| 181 | Specific improvement work in orthopaedics with potential to reduce outpatient appointments by 25,000; and potential for a further 10,000 outpatient reductions in Surgical, Gastroenterology and Rheumatology | |
| 182 | qFIT for colorectal cancers with potential to reduce diagnostic scopes by 7,500 | |
| 183 | **Realistic Medicine** | |
| 184 | **Strengthen relationships between profs and ind** | |
| 185 | Refresh Health Literacy plan | |
| 186 | Review consent process with GMC and make recs | |
| 187 | implement recs | |
| 188 | **Reduce unnecessary cost of medical action** | |
| 189 | incorporate principles of realistic med in med edu | |
| 190 | **develop National Formulary** | 31/07 |
| 191 | National Formulary Planning update | 31/07 |
| 192 | | |
| 193 | | |
| 194 | **Supporting National Priorities** | |

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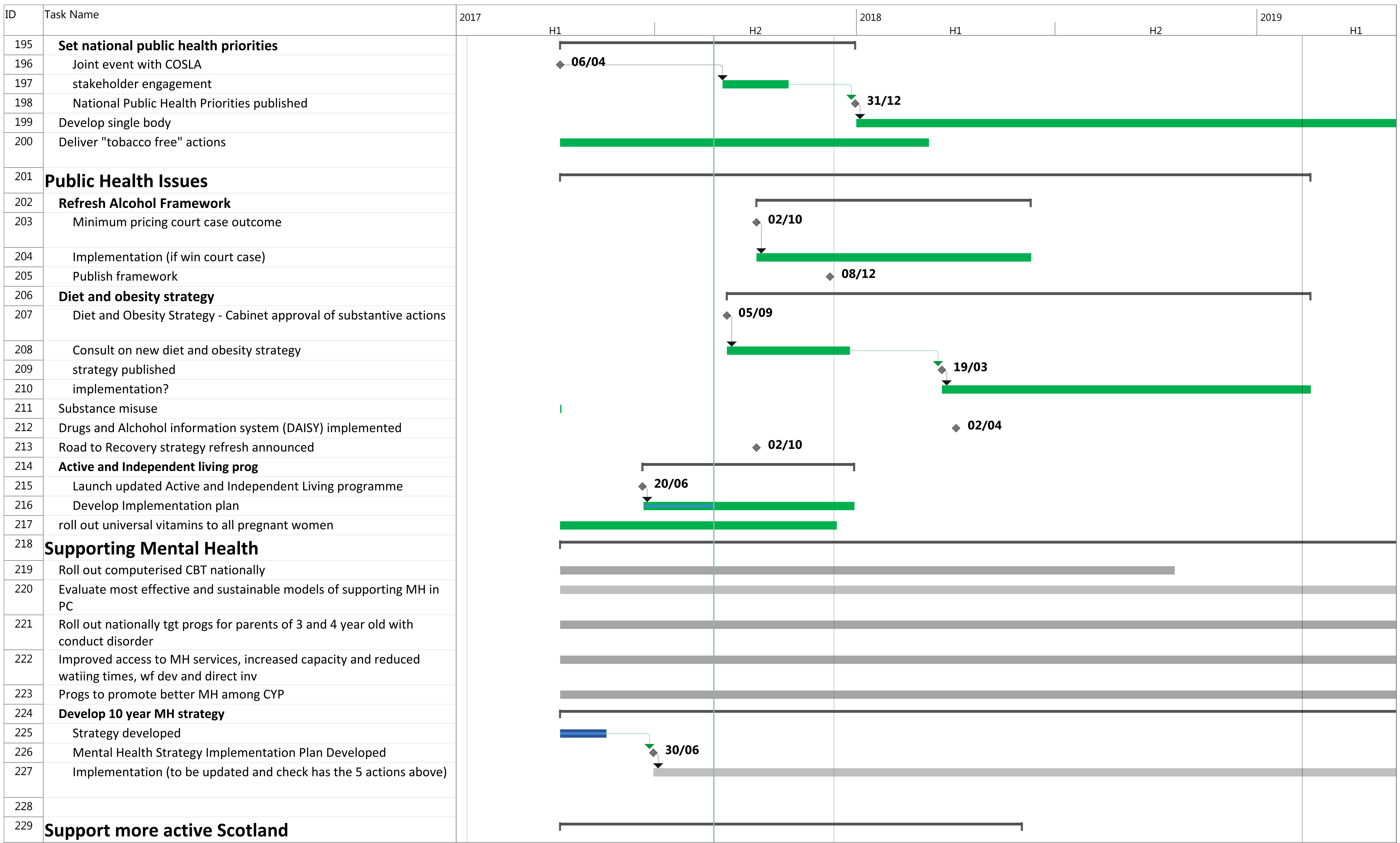
ID
Task Name
2017
H1
H2
2018
H1
H2
2019
H1
195 Set national public health priorities
196 Joint event with COSLA
197 stakeholder engagement
198 National Public Health Priorities published
199 Develop single body
200 Deliver "tobacco free" actions
201 Public Health Issues
202 Refresh Alcohol Framework
203 Minimum pricing court case outcome
204 Implementation (if win court case)
205 Publish framework
206 Diet and obesity strategy
207 Diet and Obesity Strategy - Cabinet approval of substantive actions
208 Consult on new diet and obesity strategy
209 strategy published
210 implementation?
211 Substance misuse
212 Drugs and Alchohol information system (DAISY) implemented
213 Road to Recovery strategy refresh announced
214 Active and Independent living prog
215 Launch updated Active and Independent Living programme
216 Develop Implementation plan
217 roll out universal vitamins to all pregnant women
218 Supporting Mental Health
219 Roll out computerised CBT nationally
220 Evaluate most effective and sustainable models of supporting MH in PC
221 Roll out nationally tgt progs for parents of 3 and 4 year old with conduct disorder
222 Improved access to MH services, increased capacity and reduced watiing times, wf dev and direct inv
223 Progs to promote better MH among CYP
224 Develop 10 year MH strategy
225 Strategy developed
226 Mental Health Strategy Implementation Plan Developed
227 Implementation (to be updated and check has the 5 actions above)
228
229 Support more active Scotland
06/04
31/12
02/10
08/12
05/09
19/03
02/04
02/10
20/06
30/06
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Task
Completed Task
Split
Milestone
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External Milestone
Deadline
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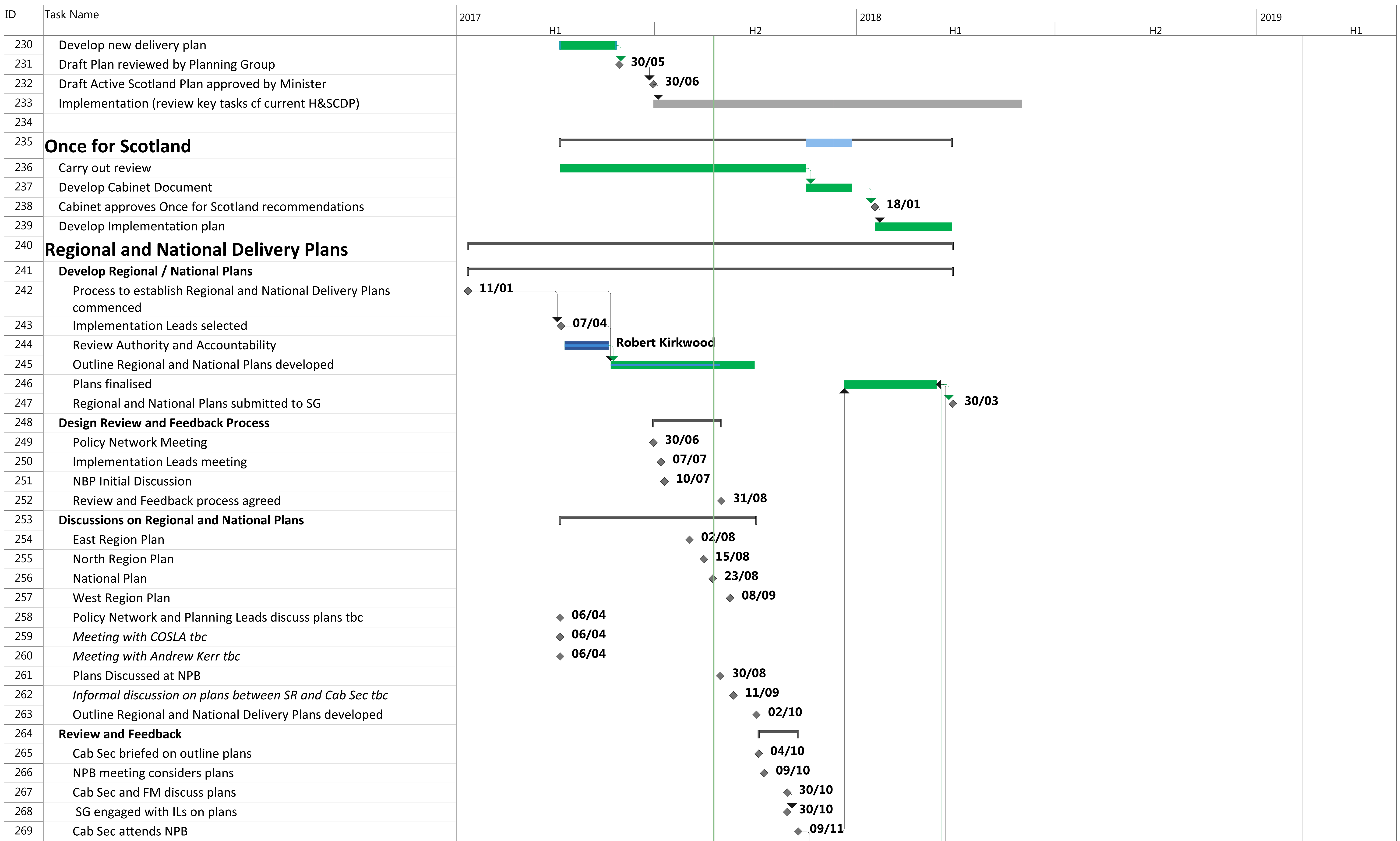


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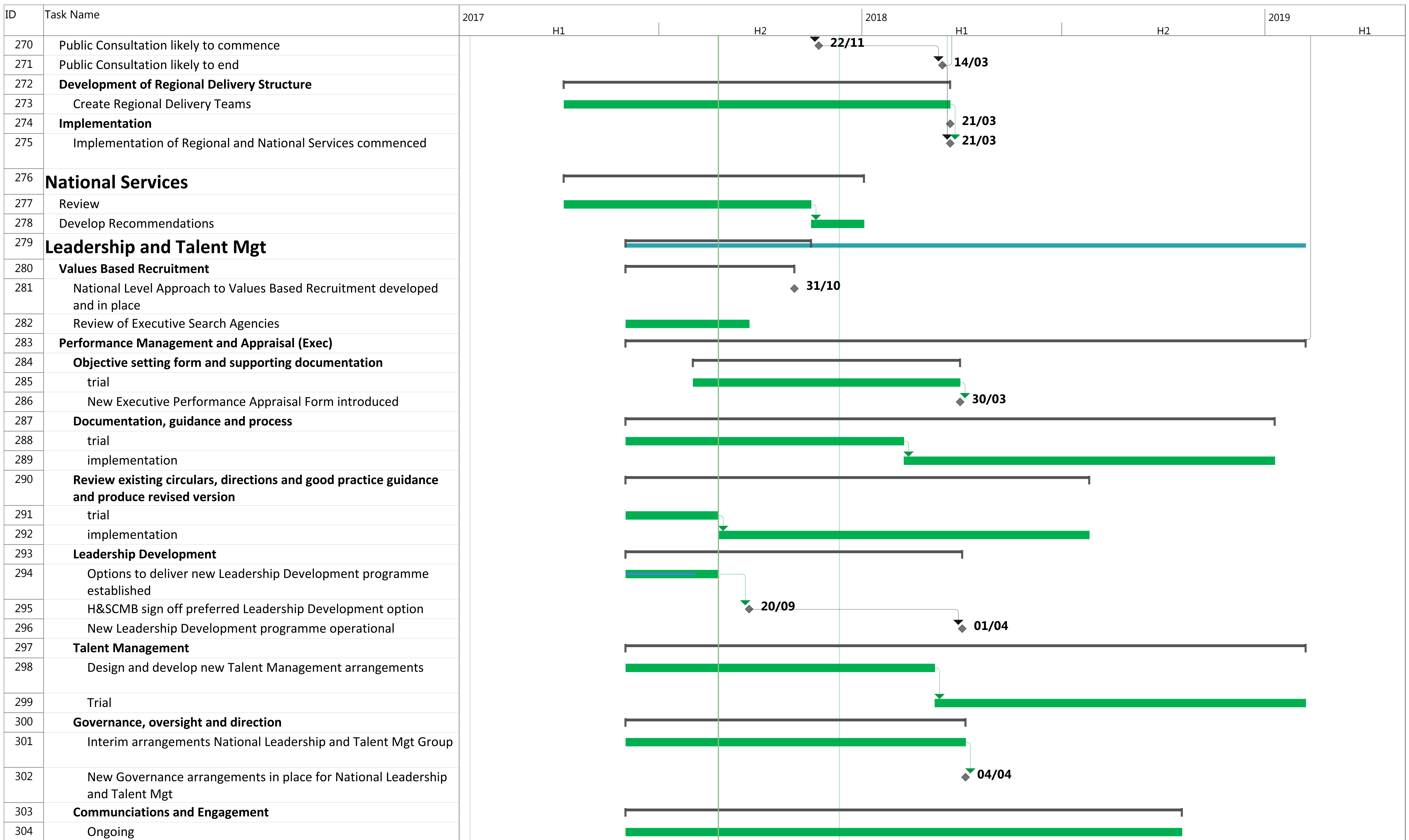


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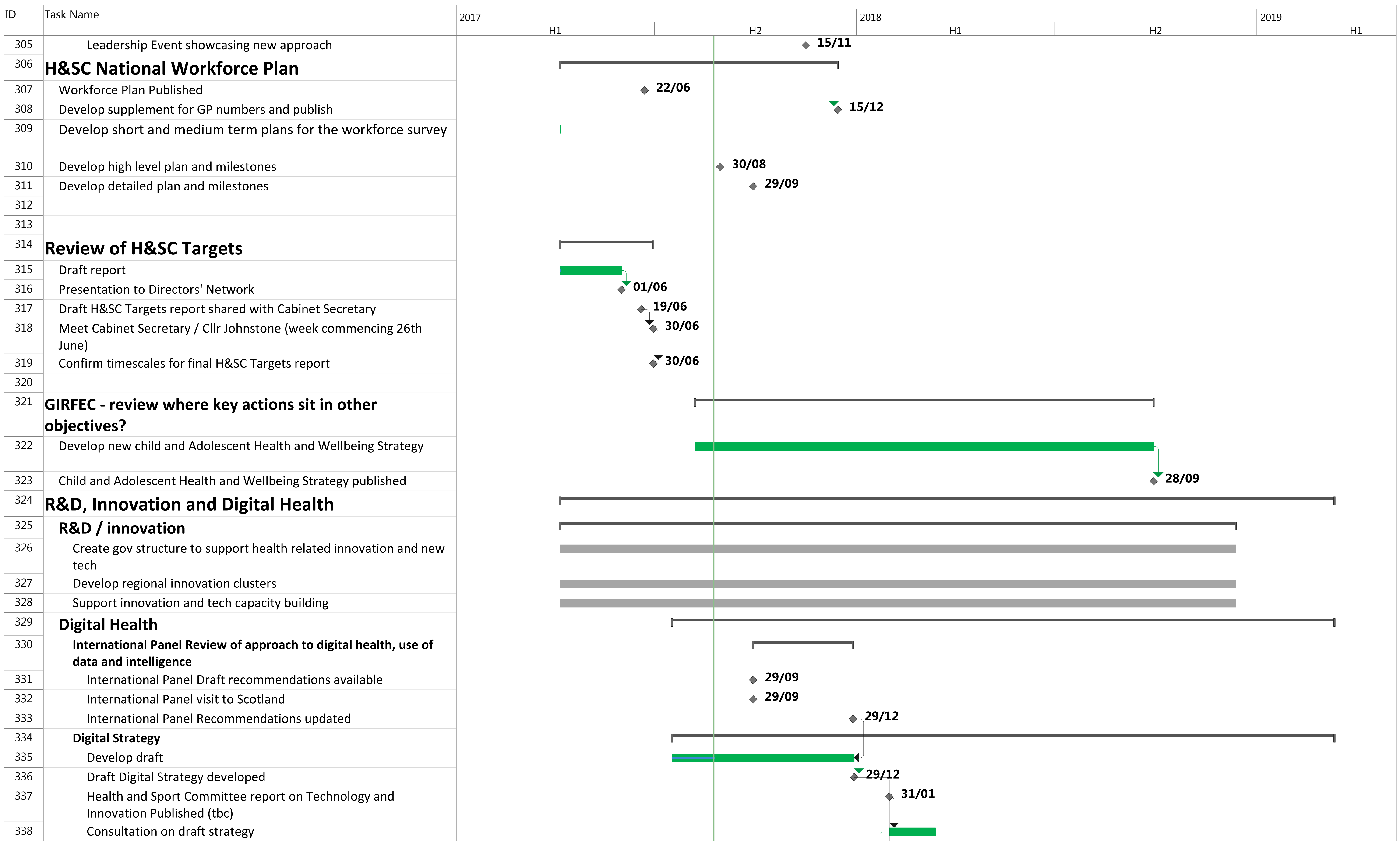


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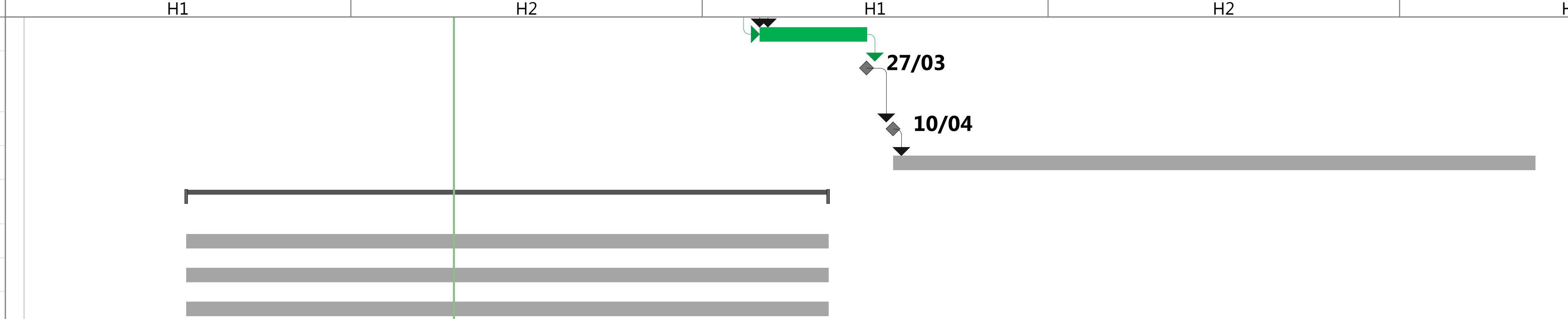
| ID | Task Name |
|---|---|
| 339 | Update Draft |
| 340 | Final agreed and implementation plan developed (Strategic Oversight Group) |
| 341 | Digital Strategy Published |
| 342 | Implementation |
| 343 | **Engagement** |
| 344 | Explore ways in which Our Voice can support engagement |
| 345 | Engagement with delivery partners |
| 346 | Engagement with staff |

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