Scottish Government

NHS Grampian Diagnostic

August 2025

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Background

NHS Grampian ('NHSG') is one of 22 NHS Boards in Scotland, and one of the 14 territorial Health Boards. It works collaboratively in Health and Social Care Integration Partnership with three Integration Joint Boards ('IJBs'): Moray, Aberdeenshire and Aberdeen City, all of which are independent bodies under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (the 'Act'). The IJBs are the decision making body and the legal entity, and the Act requires that NHS bodies and Local Authorities in Scotland work collaboratively together to deliver health and social care services through delivery of an integration scheme that sets out how Health and Social Care Integration is to be planned, delivered and monitored within their local area. These are known as the Health and Social Care Partnerships ('HSCPs').

The North East of Scotland has been experiencing tough economic conditions, particularly with a contraction in the energy sector and increasing pressures on public sector funding. Over the next few years, economic growth is projected to be significantly lower in the North East than many areas in the rest of the UK. Whilst Grampian has a relatively static population size, it has an ageing population with the number of people aged 65 and over growing faster than any other group. On average the elderly require more care, and for longer than other age groups, and this is putting increasing pressure on public services delivered by NHSG, Local Authorities and the IJBs.

NHSG also has a high dependency on temporary staff because of its location, which links to challenges in recruitment, both domestically and internationally. The NHS in Scotland specifically is facing significant financial challenges and, in many areas, it requires transformative change to support wider system pressures and to help achieve national outcomes in population health and health inequalities.

The reported financial performance of the Health Board has deteriorated significantly over the last few years, this along with a number of other concerns has led the Scottish Government ('SG') to escalate the Board to level four on the NHS Scotland support and intervention framework. This indicates that there are '*significant risks to delivery and that tailored support is not producing the required improvements*'.

Context of this report

As a result, SG commissioned an independent professional services firm to undertake a diagnostic report across three areas:

1. to provide a review of 'leadership and governance' arrangements in place at NHSG;
2. to undertake further analysis over and above the work that NHSG has already done to understand the 'drivers of the deficit'; and
3. identifying opportunities for future cost savings or optimisation.

This report sets out the key findings arising from our work and, where appropriate, makes recommendations to support the next stages of financial improvement and recovery.

The key findings and outputs from this report are based on a desktop analysis of data and information provided by NHSG's key representatives, supported by interviews and discussions with NHSG staff.

Background, Context and Summary of Findings (cont.)

Summary of Findings

Across the three pillars of our diagnostic work we have raised a number of findings and recommendations, which are set out in greater detail in the Executive Summary and body of this report. However, we wanted to draw out the key themes that have driven the conclusions of our work and should be considered by SG and the NHSG Board and Chief Executive Team ('CET'), including the incoming Chief Executive Officer.

Leadership and governance

- The leadership at NHSG are under significant pressure, with many competing priorities, and we would recommend that the Board and CET refine and reduce the number of strategic priorities that are currently being tracked and monitored. Transformational change will be needed to address the deficit position and this can only be done by focusing on a smaller number of meaningful key performance metrics to ensure steady progress is achieved in the most critical areas.
- Linked to the above point, we understand that members of the NHSG Management team are working hard to address key priorities. However, there is a perception from external stakeholders that partnership working and engagement is not as effective as it could be – it is felt that limited progress is being made against some critical areas. Following a number of changes, the leadership team at NHSG requires a period of stability to develop a high-performance culture.
- We have identified a number of areas for potential improvement in financial reporting, notably relating to annual budget setting and greater collaboration with HSCPs in relation to service planning to allow better scrutiny of delegated budgeting. There is also an opportunity to strengthen the tone of the supporting analysis of financial reporting both internally and externally to SG.

Drivers of the deficit

- Upon initial assessment of NHSG's work on the drivers of the deficit, we identified that this was not in line with what we would typically expect from analysis of the drivers of the deficit for an NHS organisation. We recommend that SG and NHSG consider undertaking a full and complete analysis of the drivers of the deficit to supplement existing NHSG work, as well as the analysis and findings within this diagnostic report.
- While NHSG's total workforce and Nursing WTE has increased significantly across the historical period (for Health & Care (Staffing) (Scotland) Act ('HCSSA') mandated safer staffing, substantive recruitment to vacancies, increased acuity, changes to care models and changes to the working week), this increase in WTEs does not align with the decrease in total beds and levels of activity that NHSG is experiencing. We recommend an independent review is undertaken of staffing levels across NHSG to validate levels are in line with HCSSA legislative processes.
- Demographic changes are resulting in increased patient acuity and higher non-elective bed demand, while issues with patient flow and delayed discharges have resulted in significant operational pressure. While Grampian has invested in step-up and admission avoidance capacity, there appears to have been a reduction in step-down community beds and care home beds. There are likely opportunities for NHSG to free up any beds that are delayed due to internal blockers. There is a further opportunity for NHSG to continue to develop its community pathways and work collaboratively with the HSCPs/IJBs to release the beds occupied by delayed discharges; thereby enabling the rightsizing of the acute clinical staff base and optimising the use of Bank and Agency spend across both Nursing and Medical staff.
- The delegated budgets accounted for 36.9% of NHSG's total net expenditure in 2024/25, with delegated net expenditure increasing by £153.2 million (a 33% increase) between 2019/20 and 2024/25, primarily driven by increases in the workforce. A lack of clarity on the true drivers of increased delegated expenditure poses an additional risk to NHSG's financial sustainability. We recommend further work is undertaken to understand the drivers of increases in pay costs/WTEs and non-pay costs within the delegated budgets, particularly to understand the impact the increased workforce has had on the overall productivity of the IJBs/HSCPs. NHSG should increase scrutiny on the financial plans and performance reporting of the IJBs/HSCPs and proactively engage with the IJBs/HSCPs to challenge and manage any in-year overspend that may be passed on to NHSG as additional pressures.

Opportunity identification

- We have assessed and benchmarked a broad range of information provided by NHS Grampian to identify credible, incremental, novel, and innovative opportunities for improvement. NHS Grampian has identified £40.0 million of savings as part of its Financial Recovery Plan (FRP). We have been able to identify 27 incremental opportunities on top of the existing savings in the FRP with a total full year effect ('FYE') value of between approximately £14.8m and £26.7m to support further financial sustainability at NHSG. Over time these savings could increase to between £27.8m - £45.7m.

Leadership and Governance: Key Findings

In the table below we have summarised our key findings from the Leadership and Governance work stream. In the body of the report, we have raised a number of recommendations that management at NHSG should consider to address these findings. Over the page we have also set out the areas of good practice we have noted through the course of our work.

Summary of key findings			Page
Strategic prioritisation	**A**	*There is an urgent need to refine and reduce the number of projects and priorities currently being tackled by NHSG. It is difficult to deliver meaningful change in performance in a short period with the current number of action plans and Key Performance Indicators ('KPIs') being reported.*	20
Working with partners	**B**	*There is a disconnect between NHSG's perception of its relationships with partners and how these partners view the organisation.*	21
Delegated decision making	**C**	*The Board should delegate more decision-making and performance management to service leadership teams, giving them autonomy to make improvements within a framework.*	22
Annual budget setting	**D**	*The annual budgeting process incorporates historic unrealised savings. It would benefit from a zero-based budgeting approach and from commencing earlier in the financial year. NHSG would also benefit from greater collaboration with HSCPs on service planning and better oversight and scrutiny of delegated budgeting.*	23
Financial reporting	**E**	*There are opportunities for NHSG to take a more agile approach to financial reporting and monitoring. This should also include a comprehensive summary of IJB financial reporting to the Board to allow better oversight and scrutiny.*	24
Sharing learning	**F**	*It is important that colleagues feel that speaking up results in action being taken. At present, there is a risk that issues and delays with communicating the outcomes of adverse event investigations mean that colleagues will cease to speak out and areas of risk or concern will not be identified and escalated.*	25
Use of risk tolerances	**G**	*Use of "intolerable" risks as part of the Board's risk management methodology could be having unintended negative consequences on how able staff feel to address the challenges facing the organisation.*	26
Visibility of strategic risks, controls and actions	**H**	*Within strategic risk reports to Board Committees, ARC and the Board, there is insufficient visibility of the mitigating actions in place to reduce the risk score of strategic risks. This limits the level of assurance that members can obtain that risks are on the right trajectory.*	27

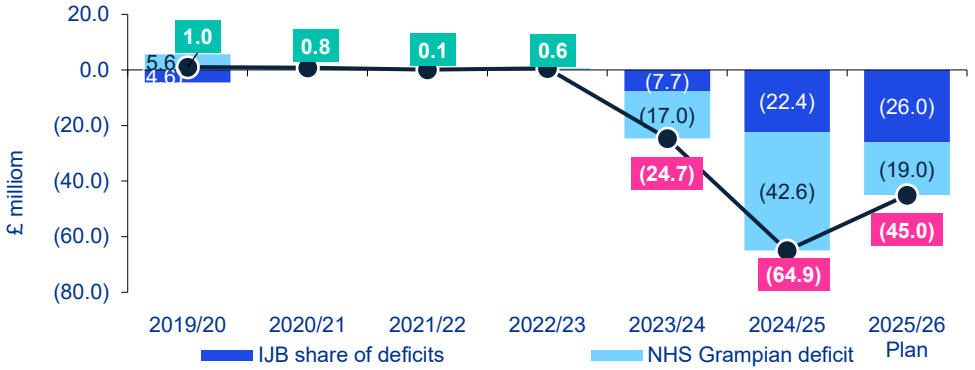
Leadership and Governance: Areas of good practice

Our review noted the following areas of good practice. Please note this list is not exhaustive but highlights some of the key areas we have noted.

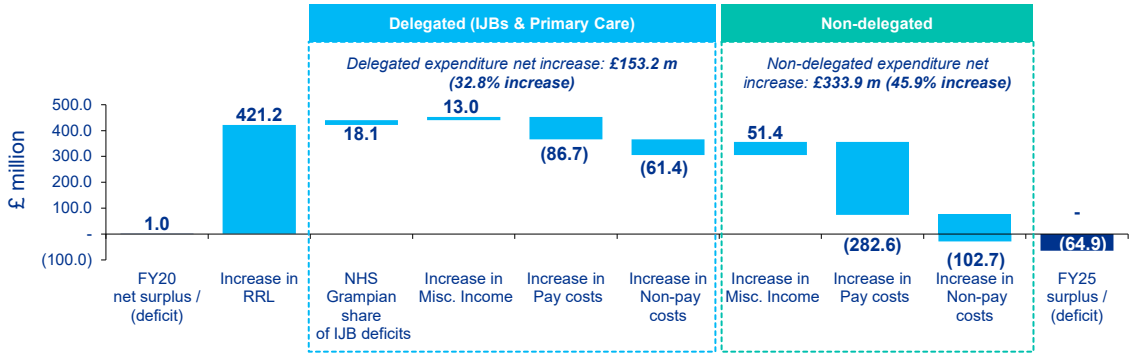
Areas of good practice

- ✓ In view of the Board's challenging financial circumstances, a detailed update on the financial position of NHSG has been provided to each Board meeting over the last 12 months, including progress of the Sustainability and Value Programme.
- ✓ We watched the online recordings of public Board meetings from April 2023 – June 2025 and found that Non-Executive Directors provided challenge and scrutiny to papers presented on a range of issues and with lines of questioning reflecting their differing areas of expertise. This was apparent in relation to the Board's deteriorating financial position with significant challenge around spending controls, budgeting and system-wide planning.
- ✓ A finance update is a standing item at the weekly CET meetings whilst regular meetings have been introduced between the NHSG Chief Executive and Director of Finance, and the Chief Officers of the IJBs to ensure a more collaborative working approach going forwards.
- ✓ The development of an Integrated Performance Assurance and Reporting Framework has improved the clarity of the roles of the Board Committees in managing risk and overseeing delivery of the Board's plan in alignment with strategy.
- ✓ The Baird Family Hospital and ANCHOR Project has remained a regular item on Board agendas over the last two years to ensure oversight and scrutiny on progress of the largest capital construction project ever undertaken by NHSG.
- ✓ An additional IJB update report was introduced to the Board agenda in September 2024 to improve the level of discussion and scrutiny of reporting on activity taking place within the IJBs.
- ✓ As part of its Financial Recovery Framework, the Board completed the Healthcare Financial Management Association ('HFMA') self-assessment tool and has assigned actions with owners and timeframes for each area of the identified improvement plan with progress on actions reported to the Audit and Risk Committee ('ARC').
- ✓ An 'Every Penny Counts' campaign was run in late 2024 to improve awareness at all levels of the organisation of the importance of all colleagues looking for cost savings and efficiencies in processes resulting in a number of initiatives taken forward.
- ✓ Recent internal audits have been focussed on key priorities and areas of risk for the Board including vacancy controls, the Integrated Performance, Assurance and Reporting Framework and the Unscheduled Care Improvement Plan.
- ✓ Strategic risks are aligned to Board Committees for management and oversight with a cycle of in-depth reviews completed for each of the risks within their remit. The controls within strategic risk reports to Committees are assessed for their effectiveness. The CET has scheduled bimonthly meetings to discuss the strategic risk register including review of the intolerable risks on a more frequent basis.
- ✓ The Clinical Governance Committee receives reporting from the Clinical Risk Meeting which highlights complaints and adverse events data as well as updates on the key improvement programmes to address issues or concerns raised.
- ✓ The NHSG Board completed a self-assessment against the Blueprint for Good Governance in October 2023 which resulted in an action plan to address areas of improvement, with agenda items in future seminars aligned to specific actions.
- ✓ In order to improve the system-wide approach to winter planning, the Grampian Operational Escalation System has been strengthened to ensure cross-partnership working with daily calls in place. In addition, a whole system Optimising Flow Group has been stood up to reduce delayed discharges.
- ✓ The Route Map for Change is being developed to support the achievement of the Board's Plan for the Future Strategy in collaboration with partners including the Grampian Area Partnership Forum and Area Clinical Forum as well as the IJBs to ensure buy-in. A Change Board established in November 2024 to oversee implementation of the road map is co-chaired by the Board Deputy Chief Executive and a Chief Officer of one of the IJBs to promote cross-system working.

Financial Assessment & Drivers of the Deficit: Key Findings

Area	Summary of Findings	Recommendations	Page
Summary of Financial Performance	• NHSG's financial statements (as well as internal trial balances) reflect the financial performance of **Non-Delegated financial performance** (NHSG's own core operations) as well as **Delegated budgets** (the three IJBs/HSCPs, Primary Care and Primary Care Prescribing). • NHSG reported a surplus of £1.0 million in 2019/20, before brokerage. This included a risk share contribution to the IJBs deficits of £(4.6) million. This means NHSG's Non-Delegated performance reflected a surplus of £5.6 million in 2019/20. • NHSG's financial performance was supported by the changes to the financial regime during the pandemic and other non-recurrent funding, resulting in NHSG reporting financial breakeven in each of 2020/21, 2021/22 and 2022/23. NHSG received non-recurring financial support of £72.3 million in 2020/21, £84 million in 2021/22 (COVID), £39 million in 2022/23 (COVID and System Pressure Funding) and £29.6 million in 2023/24 (as Sustainability Funding and Misc. income). This has not been normalised in the below analysis. **NHS Grampian surplus / (deficit) before Brokerage**  • NHSG's reported deficit has grown significantly after the Covid-19 pandemic to £(24.7) million in 2023/24 and £(64.9) million in 2024/25. As part of this, NHSG's Non-Delegated financial performance deteriorated to a deficit of £(17.0) million in 2023/24 and to a deficit of £(42.6) million in 2024/25, the remainder relating to NHSG's share of the IJBs' deficits. • NHSG is currently planning a deficit of £(45.0) million for 2025/26. The original NHSG plan submitted to SG included a planned financial deficit of £(68.0) million, which has been revised to the final submission financial plan of £(45.0) million by reducing the projected share of IJB's deficits by £12.0 million and additional one-off savings and technical adjustments of £11.0 million. The plan also assumes receipt of £24.2 million of non-recurrent income from SG and the delivery of £40 million of savings (in addition to above mentioned one-off adjustments), which will be a significant challenge. The plan reflects a Non-Delegated financial deficit of £(19.0) million.	During the fieldwork, NHSG has identified a potential list of non-recurring income and expenses as potential underlying adjustments (see Appendix 4), but these have not been assessed as part of this diagnostic. Further work is recommended to validate these adjustments and update the drivers of deficit analysis to analyse underlying performance. NHSG has successfully delivered in excess of its planned savings target in both 2023/24 and 2024/25, although NHSG's deficit has exceeded plan despite this in both financial years. While a significant proportion of savings where delivered by non-recurrent measures, increases in NHSG's wider expenditure base have outstripped the savings delivered, highlighting either an underlying need for increased financial grip and control to deliver to plan or in year cost pressures arising such as those seen with the IJBs/HSCPs.	Pages 36 to 37

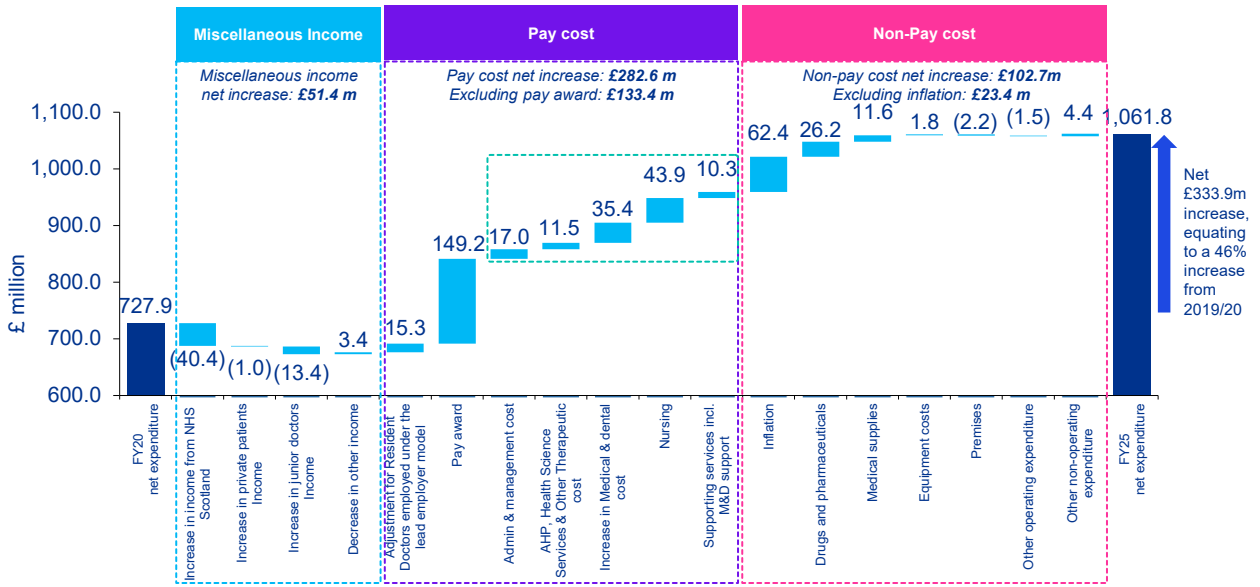
Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
NHSG's Drivers of the Deficit analysis	• The scope of work for this diagnostic report was set based upon an approach of building on NHSG's own analysis and understanding of their drivers of the deficit from work that had already been completed. The intention was to focus on enhancing existing findings and identifying areas for deeper investigation. • Upon initial assessment of NHSG's work on the drivers of the deficit, we identified that while the findings were based on analysis of budget variances and included qualitative evidence of the drivers (supported by analysis), there was no detailed quantification of identified drivers (including inflation and pay awards) and no trend analysis (including on an underlying basis) to explain the decline in financial performance in line with what we would typically expect from analysis of the drivers of the deficit for an NHS organisation. • At the agreement of SG and NHSG, we have therefore adapted our approach to provide analysis of the drivers of the deficit at a summary level for Non-Delegated financial performance and summary analysis of the financial performance of Delegated (i.e IJBs), supplemented by deep dives in nine areas to enhance the understanding of drivers (e.g. Nursing pay costs).	We recommend that SG and NHSG consider undertaking a full and complete analysis of the drivers of the deficit to supplement existing NHSG work, as well as the analysis and findings within this diagnostic report.	Pages 33 to 34
Summary of Non-Delegated and Delegated financial performance	• NHSG's increasing historical deficit of £(64.9) million in 2024/25 has been driven by a combination of both delegated and non-delegated expenditure increases (outstripping increases in Revenue Resource Limit ('RRL')).  • Net Non-delegated expenditure has experienced the most significant increase of £333.9 million (45.9%) across the historical period to a total of £1,062 million in 2024/25, mostly driven by increased pay costs (see overleaf). • Net Delegated expenditure also increased by £153.2 million (32.8%) across the historical period to £619.7 million in 2024/25; this includes an increase in NHSG's share of the IJBs' financial deficits of £17.8 million (to a total of £22.4 million for the 2024/25 financial year). We note that the information within the trial balances reflect an increase of £18.1 million – the value referenced above in the bridge. We note that the difference is due to the way costs and overspends are recorded in the trial balance with some overspends being masked within pay and non-pay costs. We note these differences are immaterial.	N/a	Pages 38 to 43

Source: NHSG Management Information

Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
Summary of key drivers for Non-Delegated financial performance	• Non-delegated total expenditure increased £385.3 million across the historical period to a total of £1,061.8 million in 2024/25, mainly due to impact of pay awards for substantive staff (£149.2) million, non-pay inflation (£62.4) million, recruitment of 1,343 WTEs (13.8% more than 2019/20) and increases in Drug costs and Medical Supplies costs.	N/a	Pages 38 to 41



- Outside of pay awards and inflation, it is the increase in clinical and non-clinical staffing levels that is the primary driver of the increase in the deficit, equating to an increase in expenditure of £133.4 million over the historical period to 2024/25 and accounting for 84% of NHSG's total increase in Non-delegated expenditure (once adjusted for pay awards and inflation).
- Nursing pay costs (including bank and Agency) and Medical and Dental pay costs reflect 70.9% of this total pay cost increase (equating to 65% of the total WTE increase of 1,343 WTEs), which is further set out overleaf.
- The pay award estimate of £149.2 million reflects the impact of pay awards on substantive staff employed by NHSG. We note that Bank costs will have also directly increased due to the impact of pay awards, while Agency spend will also have been indirectly impacted via increased rates over the years. However, these have not been isolated in the bridge analysis due to risk of overstating the impact of pay awards, without adjusting for WTE levels and vacancy rates. It has been, however, estimated that Bank costs may include an impact of up to £6.7 million for increased pay awards.

Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
Non-Delegated increase in WTEs	• Within Non-delegated net expenditure, NHSG's total pay costs have increased by £282.6 million (50.9% increase) between 2019/20 and 2024/25. Excluding the impact of pay awards, pay costs increased by £133.4 million (a 21.7% increase from 2019/20) and corresponds to an increase of 1,343 WTEs (a 13.8% increase). • This is driven by an increase of 651 WTEs within Nursing (a 16.4% increase, which includes 425 substantive WTEs, 257 bank WTEs offset by a reduction of 31 Agency WTEs), 226 WTEs in Medical & Dental (a 17.8% increase), 244 in Administrative Services (a 18.2% increase) and 95 WTEs in Other Therapeutic Staff (a 33.2% increase). • However, NHSG's total bed base has decreased from 1,155 beds in 2022/23 to 1,100 beds in 2025/26, across ARI ("Aberdeen Royal Infirmary"), Dr. Gray's Hospital, Roxburghe House, Royal Aberdeen Children Hospital and Woodend Hospital. This currently includes 119 surge beds. NHSG Management have stated that capacity has increased in virtual beds, Hospital at home, etc. and this trend aligns with national policy shift towards community areas. • While NHSG's Nursing WTEs have increased significantly across the historical period (for HCSSA mandated safer staffing, substantive recruitment to vacancies, increased acuity, changes to care models and changes to the working week), this does not align with the decrease in total beds and levels of activity that NHSG is experiencing. • NHSG Management have stated that an internal review highlighted that NHSG had a 15.7% increase in Nursing WTE for the 5 year period prior to March 2024. Management stated that this was not out of line with changes for the North Region Boards (15.3%), but was greater than the national average (11.8%). Management believes this change is indicative of the impact of recruitment and retention initiatives within this 5 year period to supply a substantive workforce, which can be evidenced by a significant improvement in the vacancy rate. • We note that while there have been recent efforts with the Nursing workforce space that have enabled a shift from Agency to substantive staff, as well as increased Bank (which NHSG Management have stated is required to deliver safe and appropriate care as per HCSSA legislation), further efforts to optimise staff levels could help NHSG unlock savings. To illustrate this, if NHSG were able to reduce the number of bank Nurses to 2019/20 levels (i.e. by approximately 257 Nurses), this would still provide NHSG with a Nursing staff base which will still be 10% higher than in 2019/20 and result in a potential £18.3 million saving.	We recommend an independent review is undertaken of staffing levels across NHSG to validate levels are in line with HCSSA legislative processes given that we cannot reconcile the growth in WTE and concurrent reduction in beds. This may be due to increasing acuity but requires independent peer review.	Pages 38 to 41

Summary of key drivers for Non-Delegated financial performance	• There are a number of areas that have been identified from NHSG's own analysis and from the drivers of the deficit work conducted as part of this diagnostic that are the key drivers of NHSG's deficit, summarised as:
	  • Demographic changes are resulting in increased patient acuity and higher bed demand
	  • A significant number of delayed discharges and issues with patient flow
	  • Use of Agency and Bank staff to address vacancies and difficulties in recruiting
	  • The number of staff working in the Back Office functions has increased by 271 WTEs
	  • Clinical staffing levels have risen significantly, to support HCSSA mandated safer staffing levels (for safer staffing, substantive recruitment to vacancies, increased acuity and changes to care models) and additional beds, along with other factors such as changes to the working week.
	• It is the increase in clinical staffing levels that is the primary driver of the increase in the Non-delegated deficit. Further detail on the other drivers and additional points is set out overleaf and also within the detail of this report.
		N/a	Pages 44 to 53

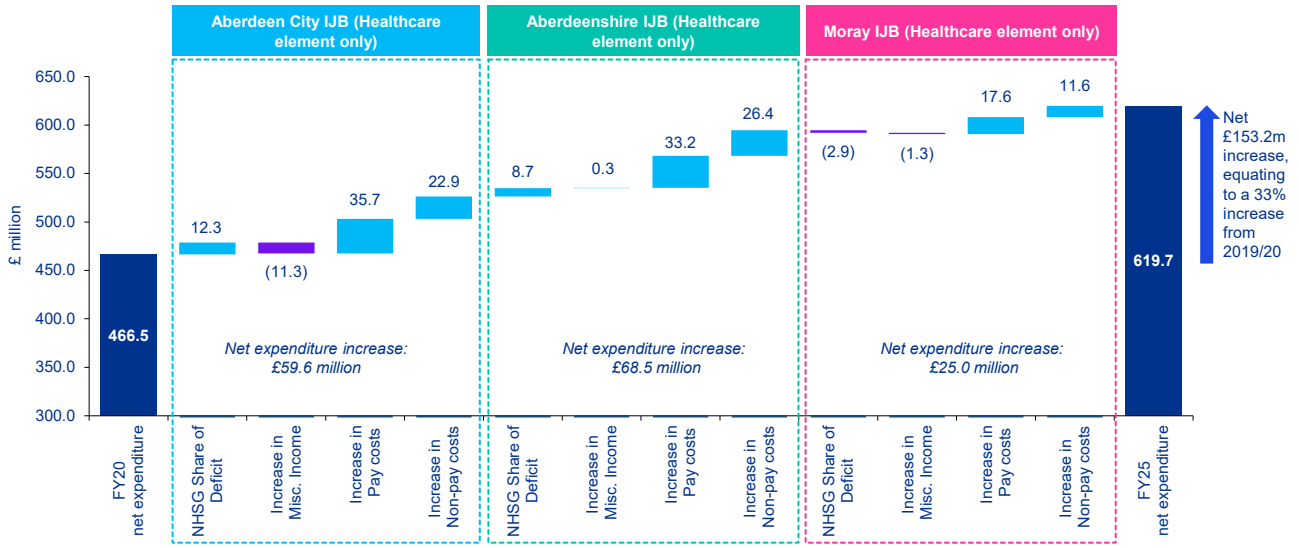
Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
Demographic changes are resulting in increased patient acuity and higher bed demand	• Demographic changes are driving increased patient acuity, adding pressures to non-elective bed days and combined with delayed discharges are also impacting wider activity levels. • Some of the delayed discharges are due to limited capacity in the social care and community sector, while there is also likely going to be an element of operational inefficiencies.	There are likely opportunities for NHSG to free up any beds which are delayed due to internal blockers. There is a further opportunity for NHSG to continue to develop its community pathways and work collaboratively with the HSCPs/IJBs to release the beds occupied by delayed discharges; thereby enabling the rightsizing of the acute clinical staff base and optimising the use of Bank and Agency spend across both Nursing and Medical staff.	Pages 44 to 53
A significant number of delayed discharges beds is creating pressures	• NHSG's total acute bed base (funded and surge beds) has decreased from 1,155 beds in 2022/23 to 1,100 beds in 2025/26 whilst occupied bed days have increased. The bed base currently available includes 119 surge beds (11.3% of total bed base) which require staffing, often via high-cost Agency and Bank staff. • The equivalent number of acute beds currently occupied by delayed discharges is 121. • While Grampian has invested in step-up and admission avoidance capacity, NHS Scotland and Public Health Scotland data indicate a reduction in community hospital beds and care home beds, typically used for step-down care.	NHSG should review the job plans of all consultant surgeons to ensure alignment between capacity and demand. It is noted that the number of surgeons has increased despite a sizeable reduction in activity. The Board should consider the feasibility of annualised contracts for surgical activities.	Pages 44 to 53
Staffing levels have risen to support additional beds (along with other factors)	• NHSG used 651 more Nursing staff (including substantive staff, bank and agency combined) in 2024/25 as compared to 2019/20. We have not undertaken a detailed review of staffing levels as part of this diagnostic, but on the surface it is difficult to reconcile this increase despite the increase in acuity and occupancy. • Similarly, Medical & Dental staff also increased by 226 WTEs (17.8%+) from 2019/20, albeit some of this is due to increase in training posts and investment in business cases.		Pages 44 to 53
Outpateint appointments attended have increased singificantly	• The number of outpatient appointments attended are 39.8% higher in 2024/25, as compared to 2019/20. However, NHSG Management have informed us that waiting lists continue to increase. The increase in outpatient appointments could be driven by how activity is being recorded and needs further work to understand this trend.	We recommend that NHSG undertake further work to understand the drivers of the increase in outpatient appointments. The Health Board should work with Health Improvement Scotland to assess and introduce options to reduce outpatient activity. If the increase in activity is real, there is a significant opportunity to release costs and clinical time, which could be refocused on UEC and patient discharge. Reducing number of outpatient appointments back to 2019/20 numbers could unlock between £10 million to £15 million in savings.	Pages 44 to 53

Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
Other factors impacting clinical staffing levels within NHSG's control	• In addition to staffing additional, unfunded beds, changes in patient acuity are also resulting in an increased staffing level requirement, driven by the mandated 'Common Staffing Method' tools. • There is also evidence that investment in staff numbers (across both Nursing and Medical and Dental staff) are not necessarily aligned to the areas with the highest operational pressures. For example, there have been large Nursing WTE increases in Acute Surgery, Emergency, Unscheduled Care – Urgent and Long-Term Conditions, while the largest increase in Bed Days has been observed in General Medicine. • We note that NHSG Management have stated that additional staffing levels have been driven by the changes in patient models, acuity and treatment complexity over time and that NHSG has adjusted staffing levels to meet the legal obligation to deliver safe and appropriate care, rebasing establishment for each individual area in line with required establishment setting processes (HCSSA legislative process).	NHS Scotland should commission an independent review of nurse WTEs to better understand why they have grown to the degree they have. This may be due to changes in case mix, occupancy, acuity and models of care, but requires further investigation given the considerable cost. This exercise should also help validate current establishment levels, in line with HC&S legislative requirements. A phased 5% reduction (via managed attrition, paused recruitment and realignment of roles where possible) in total number of Medical and Dental WTEs as at 2024/25 could unlock savings of £11.5 million.	Pages 44 to 53
Opportunities to optimise back-office staff numbers	• The total number of staff working in the administrative functions has increased by 271 WTEs (18.3%). Management have stated that this is due to a number of changes, including new services required post Covid such as HEPMA, E-Rostering and other investments. • Our experience across adminsitraitve in the NHS has shown that many of the more junior bands/roles can be automated by leveraging technology. • A significant opportunity exists for NHSG to leverage the latest technology developments (including the use of GenAI tools) to drive efficiency and right-size headcount. • Due to differences in how the staff numbers are coded in the trial balance versus Turas data, it was not possible to benchmark the increase in Administrative WTEs from this report directly with Turas data. However, a high-level benchmarking based on Turas Data only suggests NHSG's administrative services staff base (as reported within Turas Data) has increased by 13.5% between March 2020 to March 2025. This is higher than the Scotland average of 10.7% and is also higher than NHS Tayside *+7.7%*. The growth is, however, lower than observed in NHS Lanarkshire *+16.9%* and NHS Lothian *16.4%* during the same period.	Further work is recommended to understand the drivers of the increase in back office WTEs. NHSG should commission a review of systems, processes and technology in the middle and back office to identify where automation can be employed to reduce staff numbers. A 30% - 40% phased reduction in back-office roles realised by investing in technology, attrition and re-organising internal roles could save £11.7 million - £15.6 million. This will require some investment in technology such as Robotic Process Automation and AI and could take approximately between 12 to 36 months (or beyond depending on pace and attrition rates) to realise.	Pages 44 to 53

Financial Assessment & Drivers of the Deficit: Key Findings (cont.)

Area	Summary of Findings	Recommendations	Page
Delegated financial performance (IJBs and share of financial deficit) The delegated budgets accounted for 36.9% of NHSG's total net expenditure in 2024/25 and lack of clarity on the true drivers of expenditure poses an additional risk to NHSG's financial sustainability.	• Delegated net expenditure has increased by £153.2 million (a 33% increase) between 2019/20 and 2024/25, primarily driven by increases in the workforce/pay costs, the drivers of which need to be understood further. • Total pay costs for delegated budgets have increased by £86.7 million (a 51.3% increase) from 2019/20 to 2024/25, reflecting an increase of 713 WTEs (a 22% increase) – this includes 429 in Nursing, 124 in Administrative Services, 122 in Allied Health Professionals and 80 in Other Therapeutic Staff. This is due to support newly started services – e.g. hospital @home, care home assurance, vaccination services, CTACs. • Delegated non-pay expenditure increased by £61.4 million (gross of inflation) from 2019/20 to 2024/25, primarily in Pharmaceuticals by £21.1 million (20.5% increase) and GMS2 Expenditure, which increased by £24.6 million (27.2% increase). • NHSG had to account for a £22.4 million share of the IJB's deficits as part of the risk share mechanism in 2024/25, putting additional financial pressure on NHSG. The IJB/HSCP overspend is funded in line with the initial budget contribution % (irrespective of the nature of the overspend in the Health or Social care element of the IJB expenditure). 	We recommend further work is undertaken to understand the drivers of increases in pay costs/WTEs and non-pay costs within the delegated budgets, particularly to understand the impact the increased workforce has had on the overall productivity of the IJBs/HSCPs. NHSG should closely monitor performance of the IJBs/HSCPs and proactively engage with the IJBs/HSCPs to challenge and manage any in-year overspend that may be passed on to NHSG as additional pressures. This should include increased scrutiny on financial plans and performance reporting, as well as working collaboratively to develop schemes which can mitigate these risks.	Pages 42 to 43

Opportunity Identification: Key Findings

Area	Summary of Findings	Recommendations	Page
Summary of 2025/26 Financial Recovery Plan ('FRP')	• The original NHSG plan submitted to SG included a planned financial deficit of £(68.0) million, which has been revised in NHSG's revised FRP submission in June 2025 to set out a projected deficit of £(45.0) million for 2025/26, based on £24.2 million of non-recurrent funding from SG, assumed savings of £40.0 million (£10 million of which are planned as non-recurrent) and after adjustments for a revised share of the IJBs/HSCPs deficit/contribution of £26 million (plus other adjustments to the forecast). • At the point of this assessment, £30.9 million of value and sustainability savings had been identified by NHSG as part of its FRP with a further £7.0 million of savings from operational areas and £2.0 million from a further phase of contract leakage review. Our approach, given our agreed scope of work and available timescales, has been to identify incremental opportunities on top of the existing savings in the FRP, but we have not risk assessed or validated the £40.0m of savings that have been identified by NHSG to date.	• We recommend an indepth review of NHSG's FRP to assess the maturity of the individual initiatives, understand progress against plan and readjust delivery forecasts, as appropriate. This will include understanding if in-flight projects can be accelerated to deliver savings sooner.	Pages 54 to 73

Summary of Opportunity identification	• We have identified incremental opportunities over and above the current savings programme, carried out in partnership with NHSG, to produce a detailed and practical list of incremental improvements, offering strategic insight and recommendations to support ongoing financial improvement across key areas such as:
	  • Pay and workforce planning;
	  • Non-pay expenditure;
	  • Clinical productivity;
	  • Procurement;
	  • Estates management; and
	  • Taxation.
	• The resulting long list of opportunities has been validated with key stakeholders to confirm that each was incremental to current savings programmes within NHSG's FRP, feasible within required timelines and viable within the current clinical environment.
	• The resulting list of opportunities represent the validated opportunities that are to be taken forward by the Health Board for further development and delivery.
		• 27 incremental opportunities with a total full year effect ('FYE') value of between £14.8m and £26.7m have been identified to support financial sustainability at NHSG.
		• Over time these savings will increase to between £27.8m - £45.7m as a result of attrition.
		• There are an additional 16 opportunities that due to their complex nature require further exploration to assess the benefits to the Health Board.
			Pages 54 to 73

Opportunity Identification: Key Findings (cont.)

27 incremental opportunities, over and above NHS Grampian's saving programme with a total FYE value of between £14.8m - £26.7m over and above NHSG's current Value & Sustainability Savings programme has been identified to support financial sustainability. Some of these will take time to realise their full potential because NHSG, like other health boards in Scotland, are not allowed to make redundancies. This is different from the NHS in England. When fully realised the proposals below when grown will save an additional £27.8m - £45.7m. An Outpatient redesign programme and ideas widely adopted in England to reduce the indirect tax the NHS pays would save a further £35.6m - £85.6m

Area	Key opportunities	Total Base value (FYE)	Total Stretch Value (FYE)	Full Value (Base)	Pages
Workforce & Pay	✓ Grip and Control improvements ✓ Rightsizing the substantive workforce ✓ Workforce process improvements	£6.6m	£12.8m	£19.6m - £31.7m	56 -58
Non-Pay	✓ Improvements in discretionary spend ✓ Further expansion of the contract leakage programme and improvements in out of area placements	£3.8m	£6.1m	£3.8m - £6.1m	59-60
Procurement	✓ Procurement process improvements including off-PECOS spend and centralising the invoice register	£1.7m	£3.2m	£1.7m - £3.2m	61
Clinical Productivity	✓ Improvement in DNA, cancellation rates and Patient Initiated Returns in outpatients ✓ Improvements in the BADS pathway and Endoscopy Utilisation	£1.9m	£3.2m	£1.1m - £1.5m	62-64
Medicines	✓ Developing clear, evidence-based protocols that support safe and compliant multi-dosing practices. ✓ Reduced HBP ('Hospital Based Prescribing') prescription form to Streamline internal medication supply processes to reduce reliance on hospital based prescriptions	£0.3m	£0.5m	£0.3m - £0.5m	65
Estates	✓ Review and further rationalisation of the estate space, including office space rationalisation and identification of areas with low or unclear usage. ✓ Reduce estate related maintenance costs through Introduction of automated floor cleaners, insourcing of maintenance of small boilers and increasing recycling rates	£0.5m	£0.6m	£0.5m - £0.6m	66-67
Tax	✓ COS review of tax position to establish scope for further savings	£0.1m	£0.4m	£0.1m - £0.4m	68
	Total	**£14.8m**	**£26.7m**	**£27.8m - £45.7m**	
Improvement ideas requiring further development	✓ Workforce redesign and clinical productivity improvements across areas including rostering, unscheduled care and outpatients. ✓ Procurement, Estates and Tax	£35.6m	£85.6m	£35.6m - £85.6m	69-73

02

Leadership & Governance

Summary of Findings – Strategic prioritisation

The following pages outline our findings from interviews with key stakeholders and review of governance documentation presented alongside recommendations to address the issues raised.

A. Strategic prioritisation

There is an urgent need to refine and reduce the number of projects and priorities currently being tackled by NHSG. It is difficult to deliver meaningful change in performance in a short period with the current number of action plans and Key Performance Indicators (KPIs) being reported.

A consistent theme from our interviews was that NHSG is generally good at identifying and describing issues facing services but that this does not easily translate into deliverable actions which are tracked through to completion with the expected versus actual impact on performance being tracked. NHSG has a 10-year strategy, Plan For The Future, but whilst the document itself appears sound and covers the key areas we would expect for the health board, the document or the plans that underpin its delivery were not referenced by interviewees as the guiding documents that NHSG uses to plan its activities that we would normally expect. In the year end “How are we doing?” performance report for 2024/25, 45 of the 100 agreed deliverables for the year had been completed, with the remainder delayed or postponed. Of the 38 KPIs, only a third were meeting the required level of performance to report as “green”. This quarterly performance report is over 60 pages long.

There is only a finite amount of management effort and attention available to tackle the challenges facing NHSG and the prioritisation of these challenges is of paramount importance. We acknowledge that NHSG has already recognised this issue to an extent and is reviewing ways to simplifying reporting. To be successful, any revised approach needs to encompass the following areas:

- A small number of priority issues needs to be identified and agreed upon which will become the CET and Board’s focus until the related performance metric has been achieved. The exact number will be determined by an assessment of management’s delivery capacity.
- These agreed metrics then need to become the focus of management and Board performance reporting, with other metrics monitored by exception based on statistical tolerances. These metrics need to adopted from operational-to-Board level.
- CET and Board members need to hold themselves and each other accountable for focusing review and questioning on these agreed priority issues.
- NHSG’s partners, funders and regulators need to be aware of these agreed priority issues When additional issues requiring attention emerge, a decision then has to be made on which existing priority issue is de-prioritised to create capacity.

Recommendations:

1. CET and Board approve a condensed number of priority areas for delivery and related KPIs.
2. CET and Board focus to remain on these priority areas until performance improvements achieved or decision made to replace the priority area.
3. Agree tolerance parameters for monitoring non-priority KPIs so that they can escalated for attention if they fall outside of these tolerances.

Summary of Findings – Working with partners

B. Working with partners

There is a disconnect between NHSG's perception of its relationships with partners and how these partners view the organisation.

As part of our interviews for this review, there was a clear perception from NHSG's partners that the Board is insufficiently focused on the key issues facing the organisation and there is a perceived lack of progress in tackling these issues. Partners view the NHSG Board as having a sense of helplessness and fatalism in response to the issues it is facing. This links to Finding A and the impact of NHSG trying to tackle too many improvement priorities concurrently as well as Finding G and the unintended impact of characterising risks as "intolerable" . There also appears to be a disconnect between the positive perception NHSG has of its working relationships with its partners and the more nuanced view of the productivity of these relationships from partners.

The level of turnover at the Chief Executive Team level is likely to have impacted the consistency and focus of NHSG's approach to system working. In the last three years, 11 new members have joined the Chief Executive Team and nine members have left. The position of the Director of Strategy is currently vacant. The organisation has had six changes of Chief Executive in the past 10 years, including the incoming new appointee when the current interim retires in autumn. In the period since the pandemic, the organisation has also gone through a move to "Portfolio" management which is now being revised. This adds to the level of internal change the organisation has experienced. From our interviews with NHSG staff and Board members, it is clear that individuals are committed to addressing the issues facing the organisation but this does not align with how partners perceive the Board.

There is a further perception from partners that the focus of the Board is solely related to Acute services and tackling operational issues in this area. This links to the points raised in Finding D and the need for greater collaboration with the IJB and HSCPs on shared service planning and budgeting. It is also reflected in operational performance reporting – the 6-monthly operational performance report to CET contains measures that are all linked to acute services.

Recommendations:

1. The recruitment of a new, substantive CEO presents a crucial opportunity to set the tone for positive collaboration with partners, renewed ways of working and communicating. This should be a key area of focus for the new CEO.

Summary of Findings – Delegated decision making

C. Delegated Decision Making

There are opportunities to increase the level of delegated decision-making and performance management to service leadership teams.

We found from our review of Board governance that the majority of decision-making sits with the Chief Executive Team. One of the motivations for the move to a portfolio management model following the pandemic was the intention to improve delegated decision making, however this has not yet materialised.

This can impact the pace of decision making and results in lost opportunities and benefits within services due to the time it takes to obtain authorisation from the Chief Executive Team. Some service budget holders informed us of a lack of clarity around the framework in which they are empowered to make decisions.

This extends to the Chief Executive Team meetings themselves. Members include Directors that hold NHSG-wide remits plus IJB Chief Officers but also includes the senior leadership from the acute services team. This could lead to some blurring of the lines of accountability between the Executive-level Directors and service level Directors. For example, CET receives an Operational Performance Review pack twice per year. At the CET meeting where this is presented, leads for the different services, who are all members of CET, report on operational performance and key issues. This is different to the performance management approach we would normally expect to see where the leaders of services or divisions would present their own monthly performance reports to an Executive leadership group and be challenged on their delivery and performance.

Recommendations:

1. As part of the move back to service-based leadership teams, clarify the framework in which service leads and budget holders are able to make decisions and where they required sign off from the Chief Executive Team.

Summary of Findings – Financial Governance

D. Annual Budget Setting

The annual budgeting process incorporates historic unrealised savings. It would benefit from a zero-based budgeting approach, greater collaboration with HSCPs on service planning and from commencing earlier in the financial year.

Annual portfolio budgets are based on a historic model which incorporates savings targets from previous years even where these were unrealised. For example, the historic, largely unrealised, savings included within the Women's and Children's Services budget go back to 2011. The approach of not undertaking zero-based budgeting means that each year portfolios are in deficit as soon as the new financial year commences. It was noted in the finance report to PAFIC in May 2025 that unachieved historical efficiency savings were a key reason for overspend in each of the main portfolios.

Greater scrutiny of IJB budgets and potential cost pressures is critical. In the recent past NHSG has been too passive and hands off in relation these delegated budgets. Although these budgets are delegated, the Health Board is ultimately responsible for a proportion of any overspend so it cannot delegate the responsibility completely.

In 2024/25 no provision was included in the Board's budget for IJB overspends as the IJBs had all submitted balanced budgets in line with their statutory requirements at the start of the year. Budget planning for the Board and IJBs has historically been completed separately as a reflection of being separate entities, however as service changes resulting from funding cuts have an impact across the whole system it is important that budget planning is a more collaborative process at both an organisation and service level. This would ensure any resulting pressures are understood across the system and create the conditions where NHSG can undertake greater scrutiny of delegated budgetary spend at an operational level.

Meetings between the Chief Executive Team and IJB Chief Officers have taken place for some time but now take place regularly to ensure more collaborative working. We were also informed of positive day-to-day working relationships at an operational management level with NHSG services and HSCP staff but there are still gaps in the approach to joint service planning and commissioning. It was noted in the October 2024 Board meeting that there is no common approach to 'Finding Balance' between clinical, staff and financial governance and that this process requires proceduralising. Although the need for collaboration in joint planning has been stressed at Board meetings by Executives and Non-Executives over the last two years, a clear process for this is not yet established. For example, the lack of a system-wide approach to impact assessments results in unanticipated strains in other areas of the system, for example cuts to funded care home placements by IJBs results in increased delayed discharge within the acute setting. It is important that decisions are made on a data-driven basis using system wide-data in addition to the information available within individual constituent organisations.

Recommendations:

1. Review the historic savings that are included within annual budgets and consider zero-based budgeting at the start of each year.
2. Start the budgeting process earlier in the year in collaboration with the IJBs to ensure that budgeting forms part of joint planning arrangements and transformation strategies.
3. Work with HSCP partners at an organisational and service level to identify opportunities to undertake greater system-wide service planning including the sharing of important data.
4. NHSG should seek to learn from national best practice regarding the governance and management of delegated budgets.

Summary of Findings – Financial Governance (cont.)

E. Financial reporting

There are opportunities for NHSG to take a more agile approach to financial reporting and monitoring.

Through review of the monthly financial summary, we noted that the messages provided in the reports were largely the same from the July 2024 report all the way through to March 2025. The drivers of financial performance and overspends were consistent throughout the year and the reports delivered largely the same message about these issues month on month. We have also been provided with both a draft and final version of the Update on NHS Grampian Financial Position, 2025/26 Budget and Medium Term Financial Framework (MTFF), which was presented to the April Board meeting. The draft was provided by NHSG to the NHS Scotland Finance Delivery Unit for comment and we note this was provided by NHSG in the spirit of partnership working under Stage 3 support arrangements under the Support and Intervention Framework. We note that there was a significant change of tone in key areas of the report as a result of the comments from the Financial Delivery Unit, including a statement around “it is not possible to return to financial balance over the period of the MTFF” versus “it is not possible to return to financial balance over the period of the MTFF without significant redesign of the whole health and social care system”.

Coupled with this, reporting on Value & Sustainability schemes focused on the small number of “red” rated schemes which did not deliver any of their planned savings but did not provide further details on the larger number of “amber” rated schemes which were under-delivering against their planned targets. We acknowledge that NHSG exceeded its overall savings target for 2024/25 but note that this was achieved through over-delivery against some schemes while other schemes did not deliver any of their planned savings. We also note, however, that this delivery of savings targets comes against a backdrop of a worsening financial position, suggesting either an underlying issue with financial grip and control or in year cost pressures arising such as those seen with the IJBs.

This also extends to the approach to budget monitoring meetings between finance and budget holders. For the larger budgets, these take place monthly. For other smaller budgets, these take place on the basis of the level of financial risk identified in that area. There is no formal process in place which clearly sets out the triggers for a budget changing its risk profile to ensure sufficient oversight in all areas. This presents a risk that adverse movements in lower risk areas are not subject to sufficient review to ensure that they remain an area of less concern and do not become an additional area of overspending.

We also note that detailed financial reporting only includes NHSG spending and does not incorporate detail on spending devolved to the IJB. We understand the legal separation between the two organisations and although the Board cannot control spending within the IJBs, it is responsible for covering a portion of the overspend and there should be increased oversight and scrutiny of IJB costs and expenditure to ensure that there is sufficient awareness of any key budgets under pressure where overspend may be occurring. This could be used to identify areas where additional collaboration may be required to reduce costs within the IJB as well as consider the impact on NHSG. This would improve visibility by the Board of the financial situation at the IJBs throughout the year to reduce the risk of surprises at the year end with the level of overspend the Board is required to cover.

Recommendations:

1. Consider adopting a more exception-based approach to finance reporting, highlighting key changes, deteriorations or improvements from the previous month. A deep dive approach could also be adopted where different areas are prioritised for more detailed analysis in certain months.
2. For Sustainability & Value reporting, consider introducing periodic reporting on “amber” rated schemes which are underperforming to provide additional information on actions being taken to address underperformance.
3. Formalise the budget monitoring process to ensure there is a clear escalation process followed in which smaller budgets exceeding specific triggers result in additional oversight.
4. Include reporting on IJB expenditure within monthly finance reports to ensure that the Board has greater awareness of areas of overspend within IJBs and is able to provide greater scrutiny and challenge.

Summary of Findings – Response to formal concerns raised

F. Sharing learning

It is important that colleagues feel that speaking up results in action being taken. At present, there is a risk that issues and delays with communicating the outcomes of adverse event investigations mean that colleagues will cease to speak out and areas of risk or concern will not be identified and escalated.

It was noted within the 2023/24 Whistleblowing report that there is a need to increase capacity to respond to concerns raised and improve responsiveness. The average time to conclude whistleblowing concerns is significantly above the 20-day target, often taking 50–100 days, with no improvement over the last three years.

In addition, although the Clinical Governance Committee receives reports from the Clinical Risk meeting which highlights the quantity of complaints and adverse events which have arisen during the previous quarter, we found that the number of overdue adverse events requiring a 'level 1' review has increased month on month. The reports noted the actions implemented as a result of HIS recommendations which highlighted delays in the response process, however these actions remained the same between reports, despite the increase in the number of overdue responses. Review and responses overdue by more than 80 days were highlighted as an area of concern by the Clinical Risk Meeting in February 2025.

There is a process in place to complete a learning summary for all adverse events and analysis on overall themes is undertaken, however it is not clear how learnings are triangulated to ensure systematic change and improvements are made where required. A whole system approach to clinical governance was proposed at the May 2025 Board seminar to ensure that learning from audits, complaints, adverse events and risk registers are shared to improve triangulation of data and strengthen the assurance framework. This approach could have positive benefits in terms of more clearly sharing lessons learned for staff across organisational boundaries but this had not yet taken effect at the time of our reporting.

Recommendations:

1. Ensure there is a clear escalation process for overdue level 1 reviews for adverse events.
2. Identify communication mechanisms which can be used to feedback to staff on the learning from adverse events to highlight the impact of reporting them.

Summary of Findings – Strategic Risk Management

G. Use of risk tolerances

Use of "intolerable" risks as part of the Board's risk management methodology could be having unintended negative consequences on how able staff feel to address the challenges facing the organisation.

The Board uses risk tolerances as part of its strategic risk management framework. These provide a useful guide for the target score range of an individual risk and help to highlight to the reader when a risk is outside of this target range and therefore requires further attention. Through our interactions with the Board, we noted an important difference between how these risks are described in written risk reports (as being out with this score tolerance) and how they are described verbally as "intolerable" risks. From our interviews with a range of stakeholders, we found that use of the phrase "intolerable" could be contributing to a feeling that these risks are not within the organisation's control to manage and/or cannot be remediated.

Recommendations:

1. Consider re-visiting the use of risk tolerances, either to change them to target risk score ranges or to introduce an escalating series of operational actions to be taken to address risks which are intolerable to the organisation.

Summary of Findings – Strategic Risk Management (cont.)

H. Visibility of Strategic Risk Controls and Actions

Within strategic risk reports to both Board Committees, ARC and the Board, there is insufficient visibility of the mitigating actions in place to reduce the risk score of strategic risks. This limits the level of assurance that members can obtain that risks are on the right trajectory.

We noted that in the risk papers presented to PAFIC and CGC on the specific risks within their remit, the progress of actions is not clearly tracked, and all actions are not clearly assigned action owners to ensure accountability of completion. In the case of the infrastructure risk, no target dates or action owners were identified to address areas of focus.

In addition, mitigating actions are not clearly aligned to identified gaps in controls. A gap in the control of the Financial strategic risk is noted in relation to budget managers having the ability to commit spend in excess of funding levels to meet operational pressures. It is noted at each update between October 2023 and April 2025 that the development of recovery plans with agreed actions for those Portfolios and Departments which are overspending against budget are not in place for all areas. The lack of progress updates on this action results in insufficient assurance that action plans are in place to reduce the level of risk. A mitigating action or control to address overspends within the IJBs was not included within risk profiles until April 2025 at which point a new control was added around monthly meetings between NHSG Chief Exec Colleagues and IJB Chief officers which was assessed as being effective.

In relation to the risk of the Board's inability to delivery planned and unplanned care, concerns were noted at the March 2024 ARC meeting that there was not a robust action plan in place to address and that the planned bed base review would only be a partial solution. Since March 2024 the risk has been split into separate planned and unscheduled care risks, to better monitor the risks, however it is unclear whether there is sufficient assurance around the current action plans. In November 2024 the Clinical Governance Committee was not assured that the gaps in control identified were being addressed, however acknowledged that work was ongoing. In February 2025 it was highlighted that funding for the second phase of the bed base review has not been secured, however it is still noted as a mitigating action.

The risk register extracts received by ARC Committee do not include the controls or mitigating actions in order to provide assurance to members of appropriate steps to mitigate risks. Specific risks are focussed on at each meeting, however here only the current score and consequence are provided with no update on actions or progress or changes to risk score.

It was noted in the annual review paper presented to ARC in June 2024 on the effectiveness of risk management arrangements that metrics demonstrate there have been some improvements in risk review compliance but little progress regarding action plan compliance. Objectives and priorities for the year were set out, including the development of a Risk Management Strategy, however this is not yet in place and we have not seen that these objectives and priorities have been tracked.

Recommendations:

1. Include strategic risk action plans within risk reporting to CGC, PAFIC and ARC which include a due date, action owner and progress status update to provide committee members with information of actions in place to reduce the risk score or to highlight where no action can be taken.

NHSG's response to formal concerns from external parties

Background and overall assessment

In line with our scope, we have reviewed how NHSG has responded to formal concerns raised by external parties and how these have been addressed through annual delivery plans and other internal reporting mechanisms. The full findings can be found in Appendix 12.

Letters of concern

HIS/NES wrote a joint letter of concern to NHSG on 25 February 2025. This outlined concerns under the headings of leadership and culture, workforce and governance. The leadership and culture section focused on services at Dr Gray's Hospital (DGH), unscheduled care performance at Aberdeen Royal Infirmary (ARI) and the leadership structure for Medical Education. The workforce section focused on the challenges of running safe services with small medical teams which links closely to the issues raised about services at Dr Gray's in the leadership and culture section of the letter. The 25 February 2025 letter built on concerns already raised about the cardiology service at DGH by HIS in a separate letter on 11 April 2024. The governance section then focused on wider concerns about medical appraisal compliance, the influence of the Director of Medical Education role and some specific feedback on medical training programmes. NHSG and HIS/NES met on 19 March 2025 to discuss the points raised in the letter of concern. HIS/NES then wrote a further letter on 21 March 2025 which reflected this conversation and added an additional two areas of concern about risk management and clinical engagement. NHSG then produced a response letter on 1 April 2025 which directly responded to some of the concerns and highlighted that further actions would be identified to address other concerns.

NHSG's response

The Chief Executive Team (CET) at NHSG has been through an exercise to identify an action plan in response to these HIS/NES letters. The HIS/NES concerns were varied – some identified specific issues which could be directly addressed by actions and other areas were broader or more nuanced and therefore an element of judgement is required to identify appropriate mitigating actions. Setting up this action plan was first discussed at the CET meeting on 3 June 2025 and it was created and shared with CET members via Sharepoint in line with the 1 July deadline set by CET. A reporting process was also agreed at the 3 June CET meeting whereby Executive leads will provide action updates in the tracker each Friday from the start of July in time for agenda setting for the next CET meeting. Progress against the tracker will be a standing item on the CET agenda and updates provided by exception of newly implemented actions and those classed as "*not on track*" or "*at risk*".

Overall assessment of the design of NHSG's plans to respond to HIS/NES concerns

The two highest profile and longstanding issues raised in the HIS/NES letters relate to the fragility of cardiology services at DGH and ambulance turnaround/patient flow at ARI. For these areas, significant action plans have been put in place to transform services and address the fundamental concerns raised by HIS/NES. In common with the issues raised in Finding A earlier in this report , the most important factor will be the extent to which these plans are followed through and the expected versus actual impact is measured and any divergence acted upon. For the other areas of concern, actions have been put in place that are designed to address the HIS/NES concerns. There is one exception to this where we have raised a recommendation that further work takes place. This is explained later in appendix 12 of this report.

Additional observations

We have included below a series of observations from our work. These cover areas where multiple stakeholders have raised concerns with us but due to time and scope constraints, we have not been able to undertake a detailed assessment of these areas. We have included them here as indications of where further work may be warranted as we could not ignore the severity of the issues which have been raised.

01. Potential behaviours of some senior clinicians to engage with transformation activities

Interviewees raised concerns about the impact and behaviours of some senior clinicians in certain areas obstructing attempts to address concerns and improve services. A lack of engagement with the case for change and subsequent amendments to ways of working was noted as a contributing factor in the difficulties implementing the attempted move to a portfolio management structure (albeit we were unable to determine if concerns in this specific regard were only limited to clinicians) and other service transformation attempts. However, due to time constraints we have not been able to investigate these matters further, but our interviews suggest there is a cultural barrier to change which will be difficult to overcome without building a shared vision of the future state of services, service delivery and transformation with senior clinicians.

02. Serious adverse events investigation

We have raised a finding in relation to communicating the learning from serious adverse events reporting (SAERs) (**Finding F**). In addition to the issues raised, further concerns have been raised by interviewees about the potential lack of adequately trained staff to manage SAERs and the potential misclassification of the certain major or extreme events (Level 1) as less severe Level 2 or Level 3 events. . This, coupled with issues feeding back on investigation outcomes and learning to those raising incidents and noted in Finding F, could potentially lead to a masking of the care risks to patients through an underreporting of adverse events. A further deep dive review of how SAERs are captured, classified, investigated and reported should be considered by NHSG.

03. Service-level clinical and operational governance

It was outside of our scope of work to test the functioning of service-level clinical and operational governance, with Dr Gray's being given as a key example. Some concerns have been raised through interviews as to the strength of the governance arrangements specifically within Dr Gray's and the consistency with which issues are escalated. A review of the effectiveness of governance at an operational level should be considered.

04. Board effectiveness

We have not raised a specific finding about the effectiveness of challenge and oversight provided by the Board. After watching the recordings of public Board meetings from April 2024 – June 2025, we noted an increase in the level of challenge provided by Non-Executives as NHSG's overall position deteriorated. That being said, this challenge did not extend to consistently tying back areas where interventions had previously been put forward by management but failed to improve performance. We believe this is another consequence of the breadth of challenges which NHSG is trying to tackle concurrently (see Finding A). After a period of time to allow the new CET to get some stability, the arrival of the new Chief Executive represents an opportunity to undertake a broader review of Board Effectiveness.

03

Financial Assessment & Drivers of the Deficit

Summary contents of the analysis and findings from the work on the Financial Assessment and Drivers of the Deficit, setting out the structure of the analysis and how a reader of the report can navigate the contents within this section of the report

Area	Description	Pages
Background, approach and limitations	Summarises the background of this report, the approach and methodology used and key limitations impacting our findings	33-34
Overview of delegated and non-delegated budgets and funding	Outlines the flow of funding from different bodies and how costs impact NHSG – to highlight the nuance between delegated and non-delegated budgets	35
Summary of historical performance	Summarises the overall NHSG performance into delegated and non-delegated performance, which are then analysed separately.	36-37
Summary analysis of non-delegated financial performance	Summary analysis of non-delegated financial performance movements in £ terms and WTE terms. This section also summarises key activity trends at a high level and triangulates with high level workforce changes.	38-41
Summary analysis of delegated financial performance	Summary analysis of delegated financial performance including high level comments on pay and non-pay movements.	42-43
Summary of USC Pathway	Outlines the key findings and recommendations from analysis from the Unscheduled care pathway deep dive.	44-45
Summary of the key drivers of the deficit	Summarises the key drivers of financial performance and underlying challenges in two pages	46-47
The key drivers of the deficit	Expands on the summary of the key drivers of deficit to provide additional narrative and context. These support the analysis and findings from the deep dive areas.	48-53

Summary contents of the analysis and findings from the work on the Financial Assessment and Drivers of the Deficit, setting out the structure of the analysis and how a reader of the report can navigate the contents of the Appendices relevant to this section at the back of this report

Area	Description	Pages
Appendix 4: Non-recurrent adjustments	Provides a schedule of non-recurring funding from Scottish Government, as provided for this report by NHSG.	84-86
Appendix 5: Supporting analysis – reliance on non-recurrent savings	Outlines the reliance of NHSG on non-recurrent savings between 2020/21 and 2024/25.	88
Appendix 5: Workforce Analysis	Highlights the evolution of staffing levels and pay costs, including the financial implications across NHSG functions.	89-90
Appendix 6: Deep dive analysis – Nursing Pay Costs	Provides an overview of the key drivers with a focus on pay cost trend and the underlying reasons for these trends.	92-94
Appendix 6: Deep dive analysis – Medical & Dental Pay Costs	Provides an overview of the key drivers with a focus on the expansion of the workforce in WTE terms and the underlying reasons for these trends.	95-97
Appendix 6: Deep dive analysis – Other Areas	Provides an overview of the key drivers for each of the remaining deep dive sections, including commentary on the underlying reasons for change.	98-106
Appendix 7: Unscheduled Care pathway deep dive	Provides an overview of the key drivers within the Unscheduled Care pathway, including commentary on the underlying reasons for these trends.	108-114
Appendix 9: Outpatient and Theatre Activity	Analyses the activity in day cases, outpatient procedures, outpatient appointments and theatre sessions.	118-121
Appendix 10: Delegated Financial Performance	Summarises the movements in WTEs within the delegated areas of NHSG.	123

Background, approach and limitations

This page summarises the background and approaches used for the Financial Assessment and Drivers of the Deficit analysis, based on the existing work completed by NHSG. Plus, the limitations involved given data and time constraints of this exercise.

1. Background

NHSG reported a significant overspend/deficit of £(65.1) million in 2024/25, which had deteriorated over the previous two years since a breakeven position was reported in 2022/23. This section of the report aims to:

- Summarise the key drivers behind the deterioration in NHSG's financial performance.
- Help identify opportunities to enable sustainable change.

2. Approach and basis of preparation

2.1 Methodology

- This report seeks to build on NHSG's existing work on identification of the drivers of deficit, additional analysis on data provided by NHSG and insights from NHSG's finance team. The primary data source has been annual Trial Balances from 2019/20 to 2024/25.

2.2 Data limitations and Adjustments

- Trial Balance vs. Audited Accounts: The Trial Balances do not fully reconcile with thee audited accounts due to period 13 audit adjustments and how the RRL is recorded within the Trial balances. We note that the residual differences are immaterial and less than £1,000 and have been rounded off in our workings. We understand from NHSG that full reconciliations can be provided, however, these were not deemed necessary for our work.
- A high-level reconciliation between the trial balance and audited accounts has been prepared to ensure confidence in the net expenditure figures (see Appendix 3).
- Revenue Resource Funding (RRL): The RRL in the Trial Balance included Brokerage funding, which distorted the reported deficit.
- A separate file was used to source RRL for analysis.
- Delegated vs. Non-Delegated Budgets: While RRL could not be split between delegated and non-delegated budgets, the Trial Balance allowed us to identify net expenditure for each. This enabled a consolidated-level reconciliation and deeper analysis by cost centre and account type.

2.3 Scope of Analysis

- The report focuses on net expenditure (rather than reported deficit), which includes: Miscellaneous Income; Pay Costs; Non-Pay Costs (including non-operating items).
- Delegated Costs were assumed to include: the three IJB cost centres; Primary Care and Primary Care Prescribing. All other costs were treated as Non-Delegated. Due to the Primary Care and Primary Care Prescribing costs being transferred to the IJBs at year end, these have not been separately analysed.

2.4 Constraints

- Annual vs. Monthly Data: Ideally, a Drivers of Deficit analysis uses monthly Trial Balances, but due to time constraints, annual data was used.
- Pay Cost Breakdown: The Trial Balances did not separate: Base pay; Overtime; Pension costs; Holiday accruals; Sick pay. As a result, pay cost type analysis was not included.
- WTE Information: Our work relies on the accuracy of the average WTE information as provided in the trial balance.

Background, approach and limitations (continued)

This page summarises the background and approaches used for the Financial Assessment and Drivers of the Deficit analysis, based on the existing work completed by NHSG. Plus, the limitations involved given data and time constraints of this exercise.

3. Analytical Approach

3.1 Limitations of Existing Work

- NHSG's existing analysis of deficit drivers focused on performance against in-year budgets. This meant that a typical underlying run-rate (typically used to guide deep dives in a Drivers of the Deficit analysis) was not available.

3.2 Mitigation Strategy

- To address this gap, we conducted a high-level trend analysis using the annual Trial Balances provided. We identified potential areas for deep dives based on the following criteria:
  - Significant increases in net expenditure from 2019/20 to 2024/25
  - Inherently material areas, such as Drug costs
  - Areas already highlighted in NHSG's internal work
  - Areas of strategic interest, as indicated by NHSG, such as Dr. Gray's Hospital

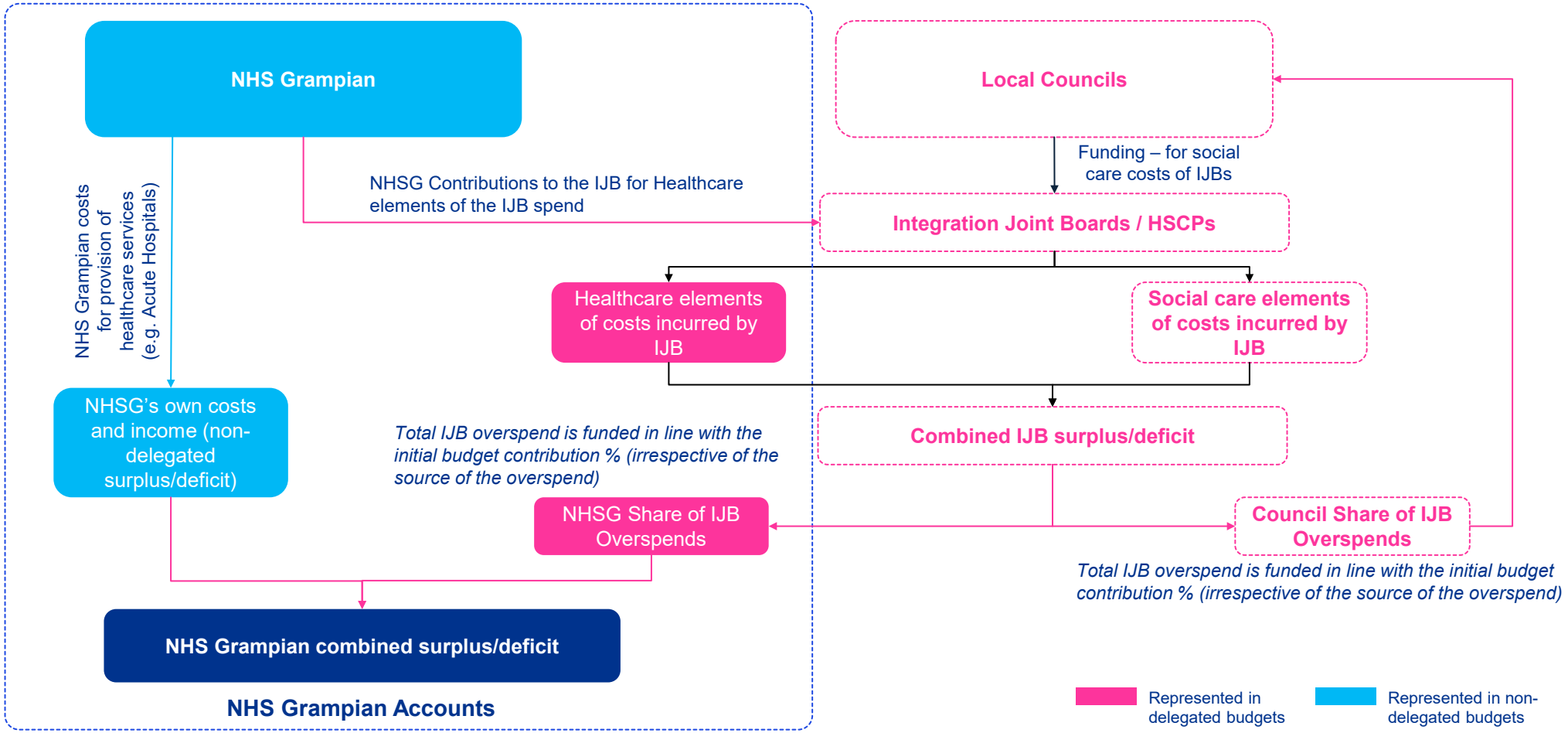
3.3 Selected Deep Dive Areas

- Based on the above criteria, we agreed the following areas for further deep dive analysis with SG and NHSG:
  - Nursing Staff Pay Costs
  - Medical and Dental Pay Costs
  - Dr. Gray's Hospital – Pay Costs
  - Drug Costs
  - Medical Supplies
  - Acute Surgery Division
  - Emergency Services (within Medicine & Unscheduled Care)
  - Long-Term Conditions (within Medicine & Unscheduled Care)
  - AHP Pay Costs

Financial Assessment & Drivers of the Deficit – Overview of Delegated and Non-Delegated budgets and funding

NHSG's consolidated accounts reflect NHSG's spend (Non-Delegated) as well as spend in the IJBs and on Primary Care (Delegated). NHSG accounts for the IJBs' overspends, which presents an additional risk to NHSG's financial position

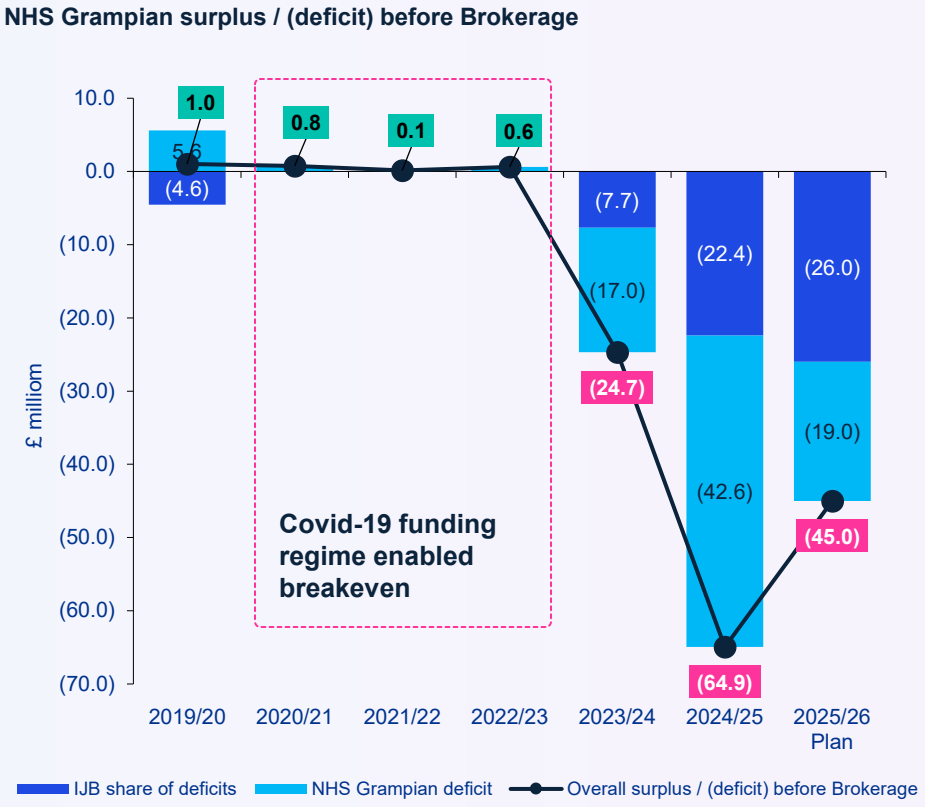
This page outlines the flow of funding from the Scottish Government to NHSG and Local Authorities to the IJBs, illustrating how IJB overspends pose an additional financial risk to NHSG as it reports a share of the IJB deficit (in line with the initial budget contribution %).



Financial Assessment & Drivers of the Deficit – Summary of Historical Performance

NHSG's deficit has grown significantly after the Covid-19 pandemic to £(64.9)m in 2024/25 and is currently projected at £(45.0)m for 2025/26 assuming the delivery of £40m of savings, which is a significant challenge

This page illustrates NHSG's rising pre-brokerage deficits post-pandemic and separates the impact of the share of the IJBs deficits versus NHSG's non-delegated deficits.



Source: NHSG Management Information, including trial balances

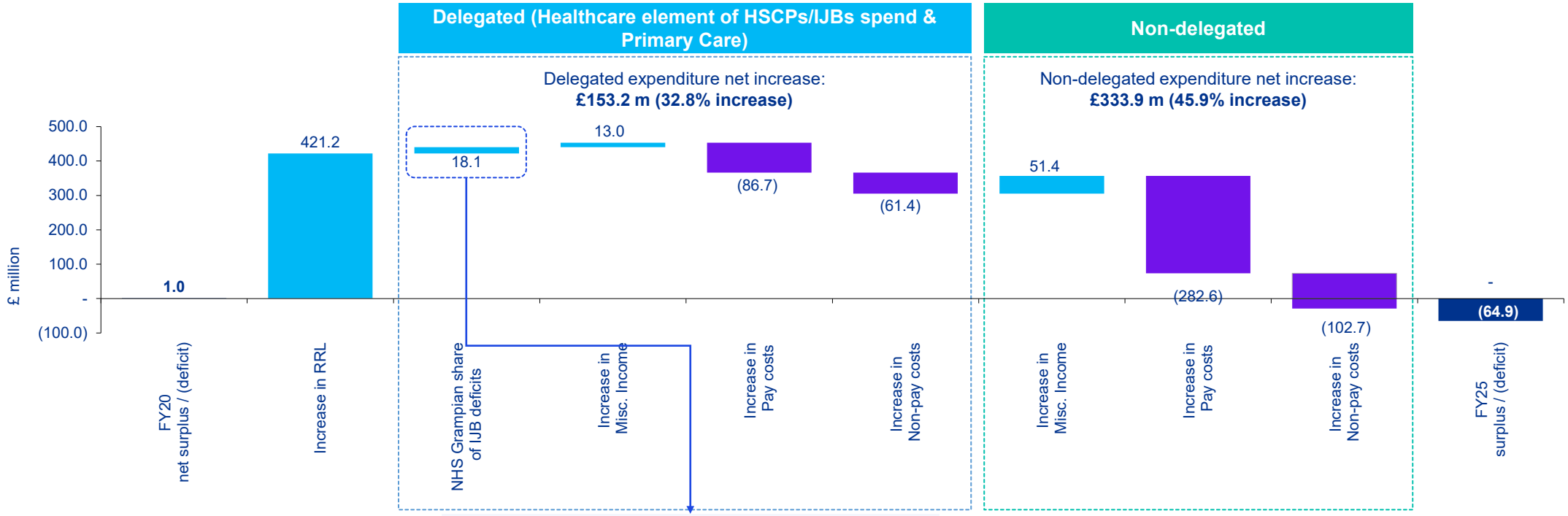
- NHSG's financial statements (as well as internal trial balances) include financial performance of delegated budgets (Primary Care, Primary Care Prescribing and NHSG's share of costs from the three IJBs) as well as non-delegated financial performance (NHSG's own operations). The IJBs are independent bodies and responsible for their own budgets, however, IJB overspends are shared between the local council and NHSG based on the proportion of their contributions (as outlined in the previous page). We understand that NHSG is directly accountable for the non-delegated spends and it is therefore important to assess the non-delegated performance separately from the delegated financials.
- On an overall basis, NHSG reported a surplus of £1.0 million in 2019/20, before Brokerage. This included a risk share contribution to the IJBs of £(4.6) million. This means NHSG's non-delegated performance reflected a surplus of £5.6 million in 2019/20. The non-delegated performance has since deteriorated to a deficit of £(17.4) million in 2023/24 and a deficit of £(42.6) million in 2024/25.
- Delegated deficits (risk share from IJBs) accounted for £(22.4) million (or 35%) of NHSG's overall deficit of £(64.9) million in 2024/25. The additional risk share contributions made to the IJB included £(7.3) million in 2023/24 and £(22.4) million in 2024/25 resulting in overall deficits of £(24.7) million in 2023/24 and £(64.9) million in 2024/25.
- Between 2020/21 to 2022/23, NHSG reported largely breakeven results across both delegated and non-delegated budgets, but this was due to the change in funding regime due to Covid-19 and receipt of additional non-recurrent funding from SG. NHSG received non-recurring financial support of £72.3 million in 2020/21, £84 million in 2021/22 (COVID), £39 million in 2022/23 (COVID and System Pressure Funding) and £29.6 million in 2023/24 (as Sustainability Funding and Misc. income). This has not been normalised in our analysis.
- NHSG is currently planning a deficit of £(45.0) million for 2025/26. The original NHSG plan submitted to SG included a planned financial deficit of £(68.0) million, which has been revised to the final submission financial plan of £(45.0) million by reducing the forecast share of IJB's deficits by £12.0m and additional one-off savings and technical adjustments of £11.0m. The plan also assumes receipt of £24.2 million of non-recurrent income from SG and an increase in the delivery to £40 million of savings (in addition to above mentioned one-off adjustments), which will be a significant challenge. The plan reflects a Non-Delegated financial deficit of £(19.0)m.

During the fieldwork, NHSG has identified a potential list of non-recurring income and expenses as potential underlying adjustments (see Appendix 4), but these have not been assessed as part of this diagnostic. Further work is recommended to validate these adjustments and update the drivers of deficit analysis to analyse underlying performance.

NHSG's increasing historical deficit has been driven by a combination of both delegated and non-delegated expenditure increases outstripping increases in RRL. While Non-delegated expenditure has experienced the most significant net increase, Delegated expenditure has also increased significantly

This page explains the net movement between the reported FY20 surplus to FY25 deficit, breaking the increase down between the delegated and non-delegated performance.

NHSG's deterioration in reported deficit to £(64.9)m in 2024/25 has been driven by net increases in expenditure in both Delegated and Non-delegated expenditure (offset by lower increases in the RRL). Net Non-delegated expenditure has experienced the most significant increase across the historical period to 2024/25 of £333.9m, mostly due to increased pay costs. However, while net Delegated expenditure increased by £153.2m, this includes an increase in NHSG's contribution to IJBs financial deficits of £17.8m from 2019/20.



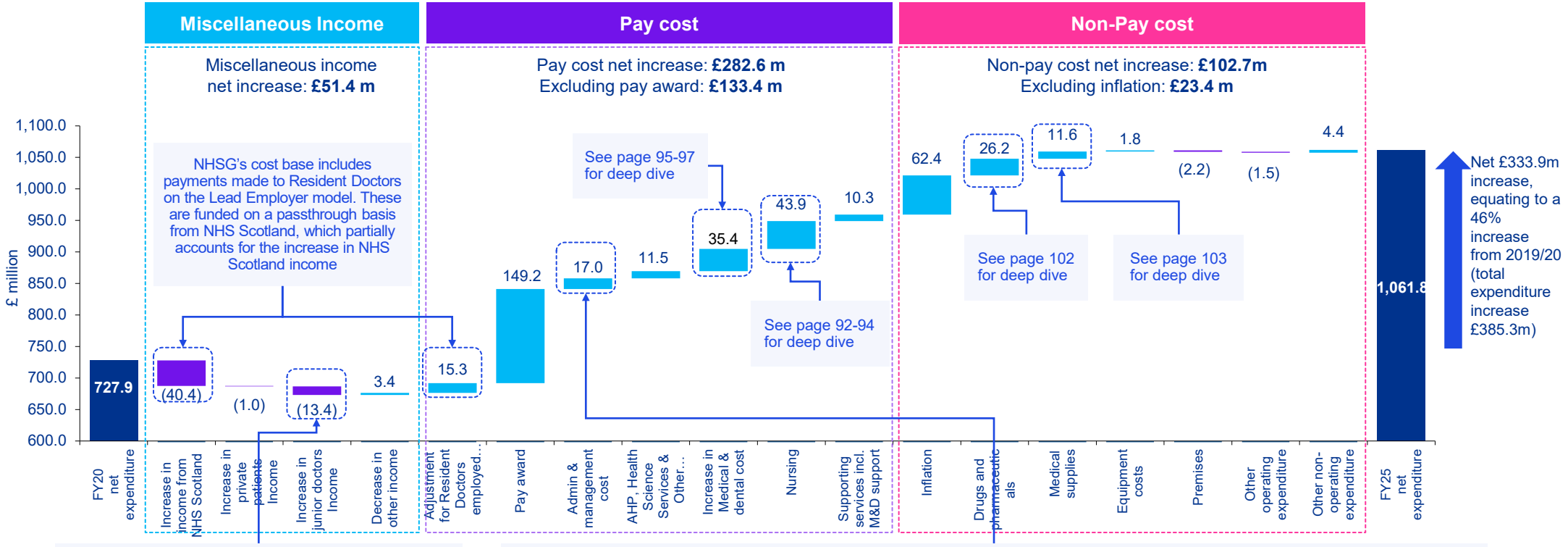
This figure is displayed as £18.1m as reflected in the trial balance. We understand the true increase to be £17.8m. We note that the difference is due to the way costs and overspends are recorded in the trial balance with some overspends being masked within pay and non-pay costs. We note these differences are immaterial.

Source: NHSG Management Information, including trial balances

Financial Assessment & Drivers of the Deficit – Summary Analysis of Non-delegated Financial Performance

Non-delegated total expenditure increased by £385.3m across the historical period to 2024/25, mainly due to impact of pay awards (£149.2)m, non-pay inflation (£62.4)m, recruitment of 1,343 WTEs (13.8% more than 2019/20) and increases in Drug costs and Medical Supplies costs

This page explains the rise in NHSG's net non-delegated expenditure from FY20 to FY25, breaking the increase down into three key elements: miscellaneous income, pay cost and non-pay cost.



Reflects increase in funding for junior doctors from NES – based on a headcount basis. Due to an increasing proportion of resident doctors working LTFT, this is leading to an increase in funding gap of £0.6 m.

A targeted deep dive into Corporate Functions (within Administrative Services) was undertaken in August 2024 – hence this area was not selected for a deep dive in this report.

This reflects an increase of 271 WTEs due to a number of changes for new services required post COVID, including the enhanced vaccination programme, the face fit testing team and other new services such as the regional HEPMA programme hosted in NHS Grampian and the introduction of eRostering. Further work is recommended to understand and validate the drivers of increase in administrative WTEs.

Source: NHSG Management Information, including trial balances

NHSG has a workforce which is 13.8% larger in 2024/25 than in 2019/20; however, theatre sessions, inpatient admissions and outpatient procedures are lower than 2019/20, while outpatient appointments show a significant increase

This page shows a widening gap between workforce investment and service delivery, raising questions about productivity and system efficiency.

- NHSG workforce grew by 18.8%, from 9,758 WTEs in 2019/20 to 11,101 WTEs in 2024-25 most notably in Nursing (651 WTEs across substantive, bank and agency combined, +16.4%) and Medical and Dental Staff (226 WTEs, +17.8%). These increases have been due to additional beds (including surge beds and additional beds in Wards 301/302/401/308, overspill of ED), increased patient acuity requiring greater staffing needs, updated HCSSA mandated safer staffing requirements and investment in training or expansion posts. Along with the impact of pay awards, these investment in staff resulted in an increase of total pay costs of £282.6 million (50.9%+).
- While the number of clinical staff increased and therefore pay costs, several activity metrics declined reflecting a deteriorating productivity challenge:
  - Theatre sessions have fallen by 8.8%.
  - Outpatient procedures have decreased by 3.8%, despite a 39.8% rise in outpatient appointments.
  - Day cases have declined by 11.9%, Inpatient activity declined across all categories, with elective inpatient admissions dropping the most at 21.8%, emergency inpatient admissions have also dropped slightly by 2.3%
- There was, however, an increase in number of bed days by 9% mainly in General Medicine owing to increasing length of stay challenge. In addition, we note that the equivalent of 121 acute beds relate to delayed discharges. Due to delayed discharges and operational pressures, NHSG is staffing an additional 119 unfunded beds. These pressures on beds are impacting wider activity levels (e.g. theatres) and impacting productivity.
- The number of outpatient appointments attended are 39.8% higher in 2024/25, as compared to 2019/20. However, waiting lists continue to increase indicating that further work is required to understand this increase.
- The growing disconnect between workforce expansion, rising pay costs, and shifting activity patterns underscores the urgent need to address productivity, patient flow, and discharge planning. This is further explored in the USC deep dive analysis in Appendix 7 from pages 108 to 114.

WTE Increases by Financial Year	2019/20	2024/25	Difference
Admin & Management	1,484	1,744	260
AHP, Health Science Services & Other Therapeutic	1,200	1,385	185
Medical & Dental	1,267	1,493	226
Nursing	3,966	4,617	651
Supporting Services incl. M&D support	1,841	1,862	21
NHS Grampian Total	**9,758**	**11,101**	**1,343**

Source: NHSG Management Information

Activity Changes by Financial Year	2019/20	2024/25	Difference
Bed Days	57,483	62,678	5,195
Day Cases	44,606	39,306	(5,300)
Outpatient Appointments	957,287	1,338,631	381,344
Outpatient Procedures	35,858	34,506	(1,352)
Theatre Sessions	13,032	11,887	(1,145)

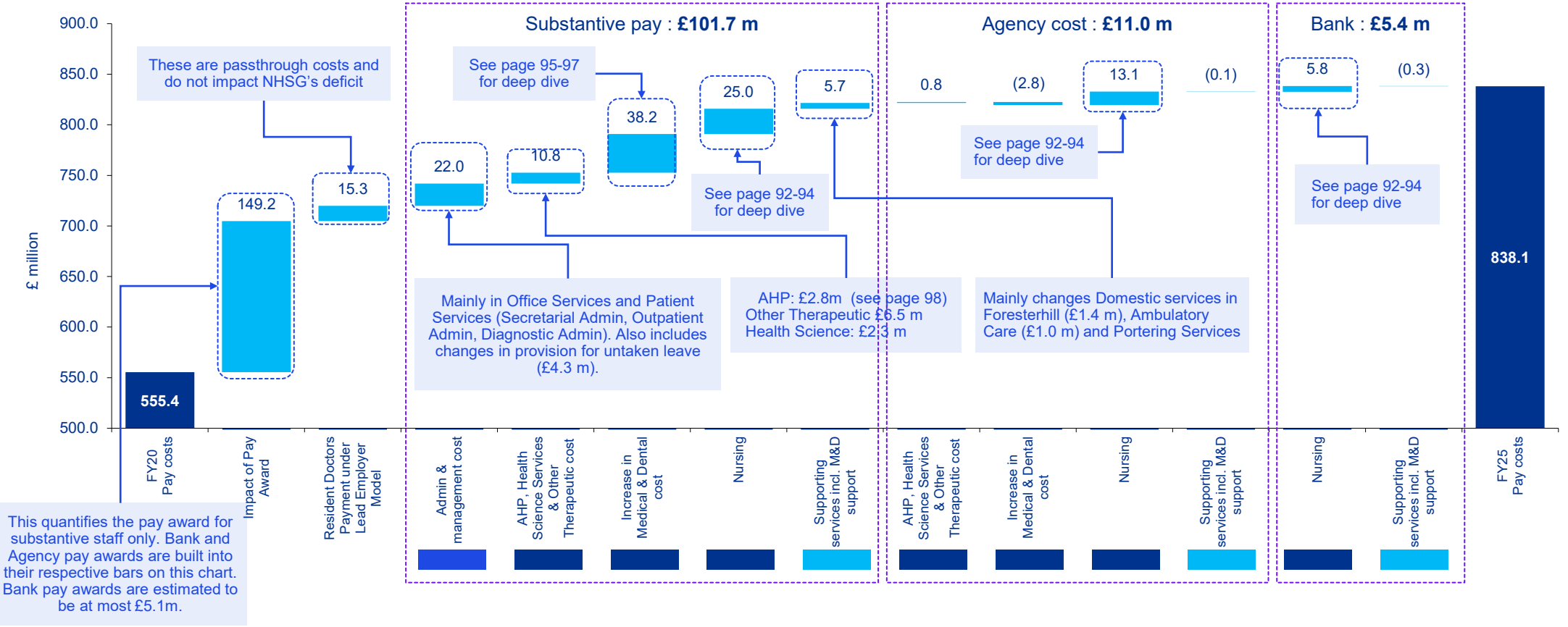
Source: NHSG Management Information

Inpatient Activity Changes by Financial Year	2018/19	2023/24	Difference
Inpatient Admissions - Elective	13,829	10,814	(3,015)
Inpatient Admissions - Emergency	51,183	49,994	(1,189)
Inpatient Admissions - Transfers	19,987	16,232	(3,755)

Source: Public Health Scotland data

Nursing pay costs (including bank and Agency) and Medical and Dental pay costs reflect 70.9% of the total pay cost increase (65% of total WTE increase)

This page details the composition of NHSG's pay cost increases (in £m) from FY20 to FY25 – primarily driven by nursing, medical and dental staff, with substantive pay, agency, and bank costs broken down by service area.

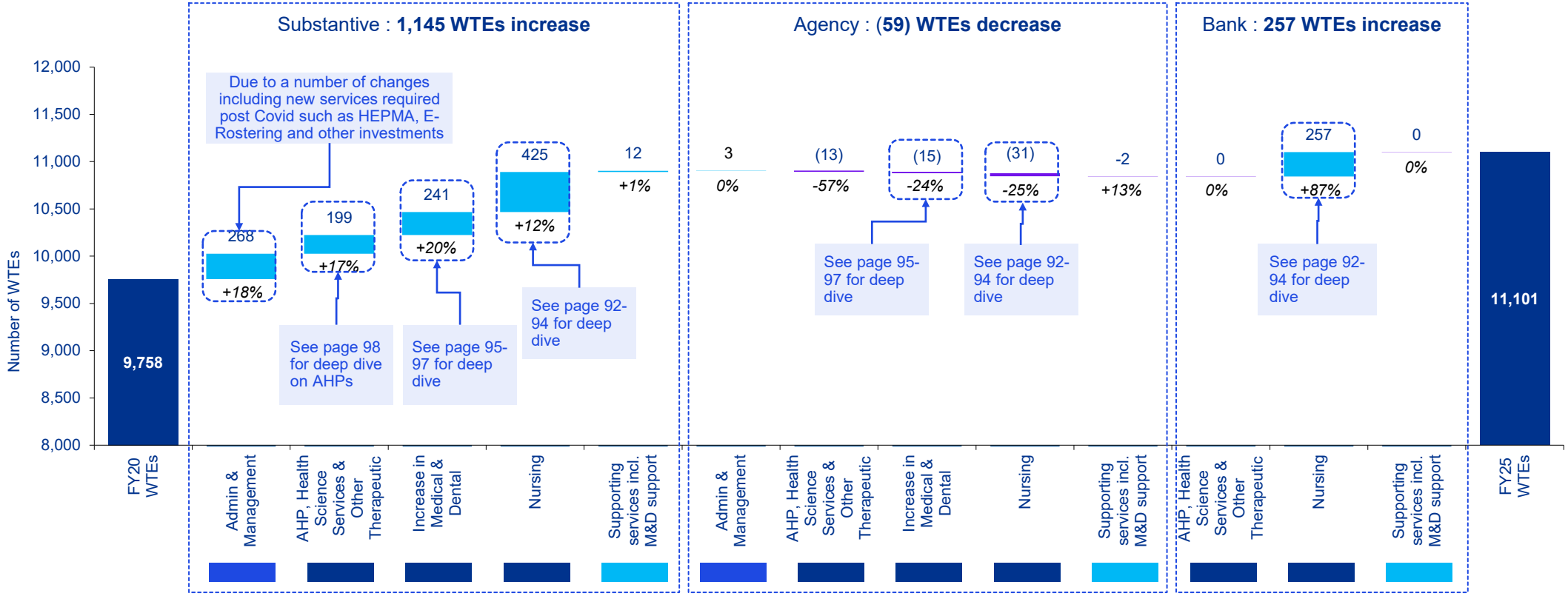


Source: NHSG Management Information, including trial balances

Key: Clinical | Clinical Support | Back Office

Growth in substantive clinical staff is the primary driver of the growth in NHSG's WTEs (76% of the increase), along with a significant increase in Bank Nursing (257 WTEs), partially offset by a reduction of 59 WTEs in Agency

This page details the composition of NHS's pay cost increases (in WTEs) from FY20 to FY25 - primarily driven by nursing, medical, and dental staff, with substantive pay, agency, and bank costs broken down by service area.



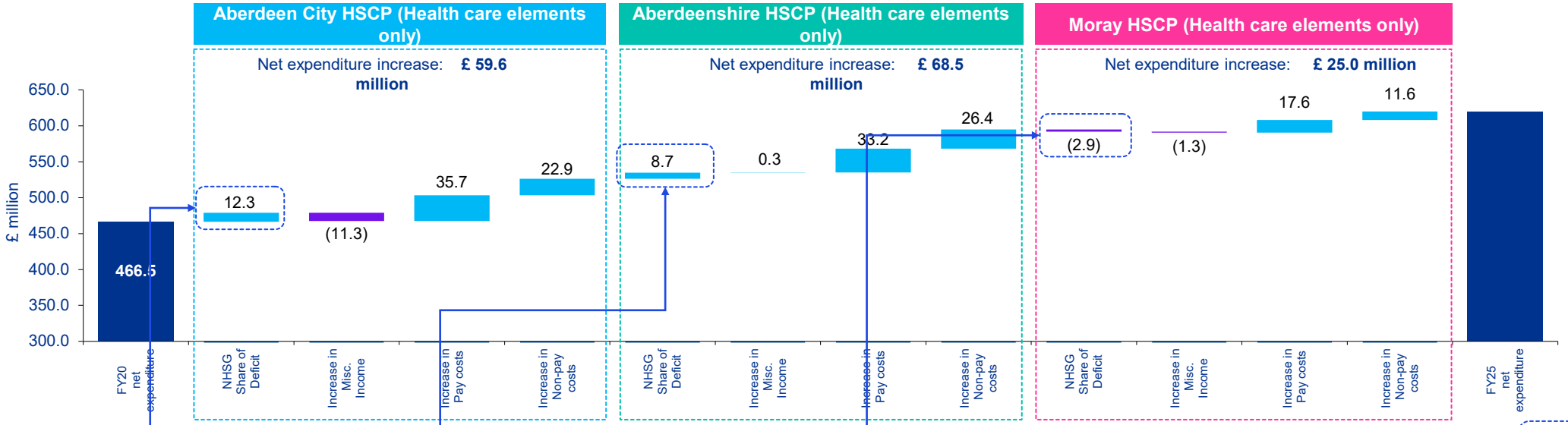
Source: NHSG Management Information, including trial balances

Key: Clinical | Clinical Support | Back Office

In 2024/25, NHSG had to contribute an additional £13.8 m, £6.4 m and £2.2 m to Aberdeenshire, Aberdeen City and Moray deficits as part of the risk share mechanism, putting additional unplanned pressures on NHSG.

This page highlights the financial impact on NHSG from increased Delegated expenditure and its share of the IJBs'/HSCPs' deficits under the risk share mechanism, driven by rising expenditure across local health and social care partnerships.

Between 2019/20 and 2024/25, net Delegated expenditure has increased in Aberdeenshire HSCP by £68.5m, Aberdeen City HSCP by £59.6m and Moray HSCP by £25.0m, primarily due to increases in pay costs. NHS Management have stated that most of these expenditure increases have been funded by new funding sources. It is therefore recommended that further work is done to understand the drivers of these overspends.



Reflects the movement in year end entries to adjust for final IJB spend and share of overspends – however, because some of the overspends are likely baked into the reported spend, it was not possible to reconcile these adjustments to the final share of IJB's overspends (see adjacent table)

IJB Overspends

£ '000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Aberdeen City	-	*No overspends reported - partly due to Covid funding regime*			-	6.4
Aberdeen Shire	3.3				5.4	13.8
Moray	1.3				1.9	2.2
Total	**4.6**	**-**	**-**	**-**	**7.3**	**22.4**

Source: NHSG Management Information

Note: The above table provided by NHSG refers to £7.3m of overspend in 2023/24. NHSG Management have stated this was subsequently updated to a share of deficit of £7.7m

Source: NHSG Management Information, including trial balances

The above numbers, reflected in NHSG's financial statements, includes only the healthcare element of spend under the HSCPs and excludes any social care related spend, except for NHSG's share of deficit.

Delegated net expenditure has increased by £153.2 million since 2019/20, primarily driven by increases in the workforce, which need to be understood further

This page compares the increase in miscellaneous income, pay costs and non-pay costs across the healthcare elements of spend of the three HSCPs/IJBs, Primary Care and Primary Care prescribing from 2019/20 to 2024/25. Increases in WTE and the net pay increase (removing pay awards) is also highlighted. We note that the majority of the Primary Care and Primary Care Prescribing spend is transferred into the IJB/HSCP cost centres at year end. Further work is recommended to understand the movements and drivers of spend in delegated budgets.

NHS Grampian Delegated net expenditure

£ '000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Gross increase	Increase in WTEs	Pay awards	Increase net of Pay Award
Miscellaneous Income										
Aberdeen City	(3,674.4)	(3,612.9)	(4,862.6)	(4,766.9)	(7,683.0)	(14,986.3)	(11,311.8)			1,002.7
Aberdeenshire	(3,891.8)	(3,281.0)	(3,518.5)	(3,940.2)	(4,015.8)	(3,588.9)	303.0			8,959.8
Moray	(2,398.2)	(2,365.7)	(2,389.6)	(2,872.8)	(3,420.7)	(3,659.5)	(1,261.2)			(4,175.4)
Primary Care	(752.8)	(691.3)	(991.6)	(1,126.3)	(1,453.7)	(1,459.3)	(706.5)			(706.5)
Primary Care Prescribing	(7.3)	(11.5)	(5.9)	(4.7)	(5.3)	(3.5)	3.9			3.9
	(10,724.6)	**(9,962.6)**	**(11,768.1)**	**(12,711.0)**	**(16,578.5)**	**(23,697.3)**	**(12,972.7)**	-	-	**5,084.6**
Pay										
Aberdeen City	69,770.8	76,324.1	80,549.4	85,811.1	97,937.3	105,486.3	35,715.6	283	20,250.2	15,465.4
Aberdeenshire	58,901.3	63,527.4	70,011.4	88,488.9	97,202.4	92,052.6	33,151.2	286	18,985.5	14,165.8
Moray	38,286.4	41,079.2	41,937.5	48,914.7	53,567.6	55,931.3	17,644.9	144	11,041.3	6,603.6
Primary Care	1,970.7	1,981.6	1,905.4	2,014.7	2,157.8	2,170.3	199.7	-	483.5	(283.8)
Primary Care Prescribing				-			-	-	-	-
	168,929.2	**182,912.4**	**194,403.6**	**225,229.4**	**250,865.1**	**255,640.5**	**86,711.3**	**713**	**50,760.4**	**35,950.9**
Non-pay										
Aberdeen City	129,521.0	143,136.9	140,266.6	147,545.1	149,864.7	152,451.8	22,930.8			22,930.8
Aberdeenshire	136,235.1	151,302.8	144,556.5	154,224.3	156,222.3	162,652.9	26,417.8			26,417.8
Moray	44,738.4	49,518.4	52,030.5	51,498.7	54,580.3	56,289.0	11,550.6			11,550.6
Primary Care	(1,217.9)	695.4	(561.0)	(888.4)	(704.1)	(711.1)	506.8			506.8
Primary Care Prescribing	7.3	164.8	5.9	4.7	5.3	3.5	(3.9)			(3.9)
	309,283.9	**344,818.3**	**336,298.4**	**352,384.5**	**359,968.5**	**370,686.0**	**61,402.1**			**61,402.1**
Total net expenditure	**467,488.5**	**517,768.2**	**518,934.0**	**564,902.9**	**594,255.1**	**602,629.2**	**135,140.6**			**102,437.5**
Increase in %		*10.8%*	*0.2%*	*8.9%*	*5.2%*	*1.4%*	*28.9%*			
Net movement in Grampian's share of the deficit							18,057.1			
Total increase in net expenditure (as per reported TB)							**153,197.8**			

Source: NHSG Management Information, including trial balances

The 713 WTE increase (a 22% increase from 2019/20) across the Health care budget of the IJBs/HSCPs include an increase of 429 Nurses (23.9% increase), 130 Allied Health Professionals (26.6% increase), 90 Other Therapeutic staff (80.5% increase) and 72 Administrative staff (15.8% increase). This is due to support newly started services (via MDT funding, GMS contract, MH outcomes framework, new responsibilities) e.g. Care Home assurance teams, additional social care staffing. Further work is required to understand the increase behind these WTEs and correlate with activity and capacity changes.

Non-pay costs primarily include 'Internal Audit Recharge Non-Pay' and 'Resource Transfer' entries in the trial balance (roughly 85%). Further work is required to understand the nature and drivers of these costs. Due to the nature of these adjustments, any assumptions to isolate the impact of inflation within non-pay costs would not lead to meaningful results.

Net increase in delegated expenditure, excluding any movements in share of IJB's deficits reflects a 28.9% growth from 2019/20.

After considering the total NHSG share of the IJB deficits, this position is £153.2m, reflecting a 32.8% growth from 2019/20.

High-level analysis of NHSG's activity since 2019 indicates challenges with patient flow and discharge

Pre-attendance/ pre-admission

- Overall activity in primary care has increased, with direct activity increasing by approximately 6% since April 2019, albeit with a reduced percentage of this activity provided by general practitioners.
- The three IJBs/HSCPs report increased usage of virtual wards and hospital at home services, which are primarily oriented at admission avoidance.
- NHSG's care co-ordination centre has seen an increasing number of patients during 2023/24 and 2024/25, despite a reduction in its budget and spending.

Emergency Department

- While overall attendances for NHSG have grown since 2019/20, they are below the levels seen before the covid pandemic. Alongside this, there has been an increase in the number of patients waiting more than four hours to be admitted, transferred or discharged, suggesting challenges with flow.
- While out-of-hours urgent care activity fluctuates significantly by month, its trend since March 2020 is relatively flat.
- Spending on ambulance services has remained flat across the three years, growing by 1% only from 2022/23 to 2024/25 (in 2024/25 values).

Inpatients

- Overall emergency admissions for NHSG are lower than pre-covid, declining from 52.7k spells in 2019/20 to 50.0k spells in 2024/25. Cardiology, Respiratory and Urology have seen significant increases (noting potential changes in coding behaviour).
- Overall occupied bed-days and average length of stay have increased for emergency patients, in particularly at ARI, where it has increased from 3.9 days in 2019/20 to 4.7 days in 2024/25. Bed occupancy at ARI has increased from c.85% to over 100%.
- NHS Grampian data indicate the equivalent of 121 acute beds per day are occupied by patients whose transfer of care has been delayed. We understand there are additional delays in community beds. Flow challenges are impairing the ability to deliver elective care.

Post-discharge

- Within Aberdeen City, there has been a steep reduction in the provision of short-term interim care for adults. Within Aberdeen City, Aberdeenshire and Moray the number of people per 1,000 receiving social care services/support is below the national rate.
- NHS Scotland data indicates that there has been a reduction in community hospital beds, typically used for step-down care.
- Much of the hospital at home and virtual ward capacity provided is oriented towards step-up rather than step-down capacity.
- Since 2009–2010, the number of care home places for individuals aged 65 and over in NHSG has steadily declined from 135 per 1,000 people in this age group to just 92, reflecting both a reduction in capacity and an increase in the >65 population.

Further details are shown in Appendix 7 on pages 108 to 114

Unscheduled care – Recommended next steps

- NHSG has significant challenges with patient flow, with an increasing volume of non-elective activity within its acute beds and corresponding growth in delayed discharges. These challenges are multifactorial and require a co-ordinated, system-wide response, with a programme of short-, medium- and long-term actions. An operational improvement style approach, with a clear focus on depressurising its acute sites, reducing bed occupancy and improving flow, and a targeted set of strategic initiatives would support focus on this challenge across clinical and operational teams.
- These efforts should build on the growth in admission avoidance services, with an additional focus on actions that will improve flow within acute sites and facilitate timely and appropriate discharge, with sufficiently resourced onward support where needed.

Theme	Recommended next steps
Maximising admission avoidance	• Review the staffing model and admission criteria for Hospital at Home and out-of-hours services to identify whether any adjustments could be made to increase their utilisation, noting that both services were underspent in 2024/25. • Work with front-line teams to ensure full awareness of patient navigation routes and available services. • Identify opportunities to link clinical systems across acute and ambulance providers to facilitate swifter patient navigation to the most appropriate service, based on availability. • Continue to develop community pathways and work collaboratively with the HSCPs/IJBs to release beds occupied by delayed discharges.
Evaluation of impact	• Ensure all admission avoidance and discharge support schemes have robust evaluation mechanisms in place to demonstrate their benefits, and to provide a basis for scaling services where these services have had a demonstrable impact on de-pressurising the acute sector
Identification of alternative services to improve flow and outcomes	• Identify the cohorts associated with long lengths of stay within the acute and their characteristics, based on diagnoses codes and length of stay bands (0 days, 1-6 days, 7-13 days, etc.). • Work with clinical teams to identify what services, skills or capacity would need to be in place in out-of-hospital settings to reduce acute activity, and explore the feasibility of standing up identified services.
Acute bed-base configuration	• Consider a short-term reconfiguration of physical acute bed capacity to align this better to current activity, and to improve patient flow by reducing the number of medical outliers.
Post-discharge capacity	• Work with the HSCPs/IJBs to explore opportunities to align onward capacity for patients with complex needs (e.g. dementia and bariatric care), is right-sized and configured for demand within the system, and to reflect the changing demographics of Aberdeen City, Aberdeenshire and Moray.

Summary of the key drivers of the deficit (1)

This section sets out our observations and recommendations regarding financial performance in NHSG including a triangulation with activity (number of bed days) and workforce levels. We also assessed the impact of demographic changes and its implication on admissions (particularly emergency admissions) and length of stay to inform our understanding of the key drivers of deficit. Based on our assessment, we've provided recommended actions for NHSG to pursue.

Area	Summary observations and findings	Recommendations
Demographic changes are resulting in increased patient acuity and higher bed demand	• Demographic changes are driving increased patient acuity, adding pressures to non-elective bed days and combined with delayed discharges which are also impacting wider activity levels. • Some of the delayed discharges are due to limited capacity in the social care and community sector and while there is also likely going to be an element of operational inefficiencies.	• There are likely opportunities for NHSG to free up any beds which are delayed due to internal blockers. **There is a further opportunity for NHSG to continue to develop its community pathways and work collaboratively with the HSCPs/IJBs to release the beds occupied by delayed discharges**; thereby enabling the rightsizing of the acute clinical staff base and optimizing the use of Bank and Agency spend across both Nursing and Medical staff. The quantum of these opportunities are estimated in the following pages. • NHSG should review the job plans of all consultant surgeons to ensure alignment between capacity and demand. It is noted that the number of surgeons has increased despite a sizeable reduction in activity. The Board should consider the feasibility of annualised contracts for surgical activities.
A significant number of delayed discharges beds is creating pressures	• NHSG's total total acute bed base (funded and surge beds) has decreased from 1,155 beds in 2022/23 to 1,100 beds in 2025/26 whilst occupied bed days have increased. This means the system is running "hot". The bed base currently available includes 119 surge beds (11.3% of total bed base), which require staffing, often via high-cost Medical Locum and Nursing Bank staff. The equivalent number of beds currently occupied by delayed discharges is 121, which is highly likely a contributory factor to additional beds being required. • While Grampian has invested in step-up and admission avoidance capacity, NHS Scotland and Public Health Scotland data indicate a reduction in community hospital beds and care home beds, typically used for step-down care.	
Staffing levels have risen to support additional beds (along with other factors)	• NHSG used 651 more Nursing staff (including substantive staff, bank and agency combined) in 2024/25 as compared to 2019/20. We have not undertaken a detailed review of staffing levels as part of this diagnostic, but on the surface it is difficult to reconcile this increase given a reduction in beds despite the increase in acuity and occupancy. • Similarly, Medical & Dental staff also increased by 226 WTEs (17.8%+) from 2019/20, albeit some of this is due to increase in training posts and investment in business cases.	

Summary of the key drivers of the deficit (2)

Area	Summary observations and findings	Recommendations
Other factors impacting clinical staffing levels within NHSG's control	• In addition to staffing additional beds, changes in patient acuity are also resulting in an increased staffing level requirement, driven by the Health and Social Care staffing legislation requirements. • There is also evidence that investment in staff numbers (across both Nursing and Medical and Dental staff) are not necessarily aligned to the areas with the highest operational pressures. For example, there have been large Nursing WTE increases in Acute Surgery, Emergency, Unscheduled Care – Urgent and Long-Term Conditions, while the largest increase in Bed Days has been observed in General Medicine. • We note that NHSG Management have stated that additional staffing levels have been driven by the changes in patient models, acuity and treatment complexity over time and that NHSG has adjusted staffing levels to meet the legal obligation to deliver safe and appropriate care, rebasing establishment for each individual area in line with required establishment setting processes (HCSSA legislative process).	• NHS Scotland should commission an independent review of nurse WTEs to better understand why they have grown to the degree they have. This may be due to changes in case mix, occupancy, acuity and models of care, but requires further investigation given the considerable cost. This exercise should also help validate current establishment levels, in line with HC&S legislative requirements. • **A phased 5% reduction (via managed attrition, paused recruitment and realignment of roles where possible) in total number of Medical and Dental WTEs as at 2024-25 could unlock savings of £11.5 million.**
Opportunities to optimise back-office staff numbers	• The total number of staff working in the Back Office functions has increased by 271 WTEs (18.3%). Management have stated that this is due to a number of changes including new services required post Covid such as HEPMA, E-Rostering and other investments. • Our experience across corporate services in the NHS has shown that many of the more junior bands/roles can be automated by leveraging technology. A significant opportunity exists for NHSG to leverage the latest technology developments (including the use of GenAI tools) to drive efficiency and right-size headcount.	• NHSG should commission a review of systems, processes and technology in the middle and back office to identify where automation can be employed to reduce staff numbers. • **A 30% - 40% phased reduction in back-office roles realised by investing in technology, attrition and re-organising internal roles would save £11.7 million - £15.6 million.** This will require some investment in technology such as Robotic Process Automation and AI and could take approximately 12 to 36 months (or beyond depending on pace and attrition rates) to realise.
Other unplanned cost pressures were not managed via additional recurrent CIP delivery	• A number of other factors impacted NHSG's financial performance included reduction in working week from 37.5 hours to 37 hours (£4.3 million to £4.9 million of cost pressure), national regrading of band 2 health care assistants to band 3 (£2.1 million), increase in Cancer drug costs (£7.2 million), an increase in use of insulin pumps (£1.2 million) and TAVI procedures (£4.1 million). NHSG is also impacted by a higher proportion of Junior Doctors working less than fulltime in the form of lost income (£0.6 million - ££1.9 million). • The cumulative impact of inflation on non-pay spend between 2019/20 to 2023/24 has been estimated at approximately £62.4 million while the funding uplift provided £14.2 million presenting a savings cumulative challenge for NHSG of £48.2 million. The cumulative recurrent savings delivered by NHSG in the same period accounted for £47.0 million leaving a funding gap of £1.2 million which was not bridged.	• The unfunded gap of £1.2 million in the recurrent cost base due to lost savings delivery (during the Covid period) continues to create challenges to the financial sustainability – albeit this is typical across the health sector in the UK. NHSG should include a plan to catch-up on missed savings from prior years to support financial sustainability. • A certain level of unplanned pressures is expected to be absorbed by providers and managed by delivery of saving schemes. NHSG has approximately £19.5 million - £21.4 million of unfunded pressures, which have accumulated without a corresponding funding strategy, (internal or external).

The key drivers of the deficit (1)

Area	Observations and findings	Implications and recommendations
Demographic changes, increased acuity and delayed discharges are impacting activity levels	• NHSG's overall activity declined from 2019/20 levels across the following three years due to the impact of Covid-19, but gradually started to recover from 2022/23. The recovery in some types of activity has been stronger than in others, e.g. the number of outpatient appointments attended are 39.8% higher in 2024/25, as compared to 2019/20. However, NHSG Management have informed us that waiting lists continue to increase. • The increase in outpatient appointments could be driven by how activity is being recorded and needs further work to understand this. • However, the primary activity change impacting NHSG's financial sustainability has been the increase in occupied bed days, which have grown 9% from pre-Covid levels, mostly in General Medicine – where length of stay has deteriorated from 5.7 days in 2019/20 to 18.0 days in 2023/24. NHSG is running 119 surge beds (including 59 in ARI, 10 in DGH and 37 in Woodend) to support the overall increased bed days. • This is partly driven by a change in demographic profile of admissions, where admissions of patients with a higher average age have increased, resulting in a higher proportion of beds being occupied by an older population. As the local population demographic is shifting towards a higher proportion of older patients, patients are presenting with increased comorbidities, resulting in challenges in discharging patients. Further details analysing the USC pathway are discussed in Appendix 7 on pages 108 to 114. • The increase in bed days and length of stay is making it increasingly difficult to admit elective patients. Elective inpatient admission are 22% lower in 2023/24 as compared to 2019/20. Theatre sessions are also 8.8% lower in 2024/25 as compared to 2019/20 despite an increase of 41 WTEs in Medical and Dental and 137 WTEs in Nursing staff in the Acute surgery Division highlighting loss of productivity. • The number of Outpatient Procedures and Day Cases are also 3% and 11.9% lower from 2019/20 despite of significant increase in Medical and Dental and Nursing staff. The number of A&E attendances are also marginally lower than before the pandemic, however, the mix of attendances has shifted to a higher proportion of higher cost Type 1 attendances as compared to Type 3 attendances.	• The increase in length of stay is being driven by a combination of factors including an increase in patient acuity, delayed discharges due to limited capacity in the social care sector and delayed discharges due to inefficiencies. • As a result, NHSG is currently running a total of 119 surge beds (12.3% of funded capacity) which require staffing, often via high-cost Agency and Bank staff. The number of beds currently occupied by delayed discharges is 121 (119 at the end of 2024/25). There are likely opportunities for NHSG to free up any beds which are delayed due to internal blockers. **There is a further opportunity for NHSG to continue to develop its community pathways and work collaboratively with the HSCPs/IJBs to release the beds occupied by delayed discharges**; thereby enabling the rightsizing the acute clinical staff base and optimizing the use of Bank and Agency spend across both Nursing and Medical staff. The quantum of these opportunities are estimated in the following pages. Freeing up capacity held by delayed discharges will also enable NHSG to provide better elective care to its patients, reducing waiting list and proactively reducing acuity of patients by providing the timely care. It will also enable NHSG to utilize resources within Acute Surgery division more efficiently and improve productivity. • We recommend that NHSG undertake further work to understand the drivers of the increase in outpatient appointments. The Health Board should work with CFSD to assess and introduce options to reduce outpatient activity including but not limited to, Patient Initiated Follow Up (PIFU), advice and guidance, and a review of clinical guidelines re: follow up appointments. If the increase in activity is real there is a significant opportunity to release costs and clinical time which could be refocused on UEC and patient discharge. Reducing number of outpatient appointments back to 2019/20 numbers can unlock between £10 million to £15 million in savings. • There is also an opportunity to improve the mix of A&E attendances by undertaking a detailed UEC pathway shift to reduce Type 1 attendances and optimise the staffing model. Options to move separate low acuity elective care and day case activity from the pressure in the main hospitals should also be considered. • A review of consultant job plans in surgical specialties is recommended given the increase in WTE and concurrent reduction in activity.

The key drivers of the deficit (2)

Area	Observations and findings	Implications and recommendations

Increase in number of Nurses in NHSG	• Pay costs for Nurses have increased by £43.9 million (excluding the impact of pay awards) from 2019/20 to 2024/25 – i.e. 651 WTEs (16.4%+). This includes an increase of 425 more substantive nurses (12%+) and 257 more Bank Nurses (87%+) in 2024/25 as compared to 2019/20. We note that NHSG's Bank usage as a percentage of total pay costs is 3.9% against a peer* median of 3.6%.
	• **Key reasons cited by NHSG for the increase in Nurse WTEs include:**
	  • NHSG is running 119 surge beds which need to be staffed. There are also wards running at a higher capacity to their funding (e.g. a Monday to Friday ward being run on weekends as well).
	  • Changes in patient acuity requiring increased staffing levels, as driven by the mandated 'Common Staffing Method' tools.
	  • Successful recruitment to substantive posts against long standing vacant posts and Agency use reduction initiatives.
	  • Increased sickness absence levels and long-term sickness cases.
	  • Reduction in working week from 37.5 hours to 37 hours per week, creating the need to back fill staff (estimated at £4.3m - £4.9m p.a.).
	• There has not been a corresponding increase in activity levels within inpatient admissions, day case procedures, outpatient procedures and theatre sessions. While number of occupied bed days have increased, this is primarily due to challenges in length of stay which are likely resulting from a combination of factors – including delayed discharges. There is also a risk that increases in staffing levels are not in the areas with the highest operational pressures.
		• NHSG have been successful in replacing agency nursing with substantive staff to fill vacancies, as well as increased use of bank.
		• NHSG should employ root cause analysis to inform its approach to reducing delayed discharges, which would in turn reduce nurse expenditure. This is discussed further in the Activity section.
		• Work is also recommended to independently validate if the staffing levels within wards are aligned to the requirements of Heath and Social Care staffing legislation and if there is potential for improvement in terms of standardising patient acuity assessments across different wards (if they aren't standardised already) to identify opportunities to right-size the size of Nursing staff, while also ensuring continued legislative compliance. While there exists an internal check and challenge process (including a review by Chief Nurse in that specific area/Ward) and limited need-based reviews by Nurse Director of Acute Services and Finance team – there is likely going be benefits by undertaking an independent assessment of Common Staffing Method tools inputs and outputs across wards. This can provide immediate savings opportunity by leveraging the increased substantive staff base to reduce spend on Bank. **A 1.75% reduction in Nurse staffing levels driven by a review of HCSSA mandated safer staffing levels can unlock an additional £4.1 million of savings for NHSG.**
		• We note from NHSG Management, however, that a plan to leverage the increase in substantive staff base to further reduce spend on supplementary staff is already being progressed by NHSG's Value and Sustainability Plan. Additionally, NHSG Management have stated that a plan for rebasing establishments and reducing supplementary staffing spend is also within the scope of the Value and Sustainability Plan.

* Peers calculated using publicly available data. Peers are Lothian, Tayside and Lanarkshire.

The key drivers of the deficit (3)

Area	Observations and findings	Implications and recommendations

Increase in the number of Medical and Dental staff	• Pay costs within Medical & Dental have increased by £35.4 million excluding the impact of pay awards, reflecting an increase of 226 WTEs (17.8%+) from 2019/20.
	• **This is due to:**
	  • Increase in number of training posts (116 WTEs) which are partially funded;
	  • Reduction in unfilled vacancies due to successful recruitment to substantive posts (partially offset by a reduction in Agency and Locum) (unfunded);
	  • Additional WTEs to staff escalation capacity rotas (unfunded);
	  • Transfer of services and new business cases (mix of funded and unfunded);
	  • Investment in staff after bed base reviews;
	  • Waiting list initiatives (£2.3 million).
	• The additional number of staff supports the increased activity in outpatients and increase in the number of occupied bed days; however, the number of theatre sessions, day cases and outpatient procedures have decreased indicating potential productivity decline in these areas. This suggests a potential misalignment in investment in staff with areas of operational pressures which can be unpicked by a comprehensive productivity analysis.
	• We note however that use of Medical & Dental Locum has significantly reduced from 2019/20, supported by recruitment to substantive posts.
		• Further work is recommended to undertake a targeted productivity review across key specialties (particularly Acute Surgery) to identify opportunities to improve and optimise activity levels and right-size workforce levels by reducing reliance on Agency and Locum. There may be opportunities to balance staffing with the highest pressures to reduce reliance on Agency, particularly in the FY1 and FY2 doctors.
		• NHSG should continue tightening controls on Medical and Dental Locum use. While there are known vacancies against difficult to recruit areas, NHSG should undertake a review and explore options to rationalise service provision in challenged services.
		• NHSG should explore options to reduce surge beds through service redesign and changes to the UEC pathway and model of care for frailty and end of life care. It may not be possible to reduce escalation beds in the short term given the high occupancy at ARI although it should be possible to reduce this and pressure on the system.

The key drivers of the deficit (4)

Area	Observations and findings	Implications and recommendations
Use of Agency staff	• NHSG's agency and locum usage as a percentage of total pay costs is 3.6%. This is higher than the peer median of 1.6% calculated using publicly available data from Lothian, Tayside and Lanarkshire.	• Were agency costs equal to the peer median, there would be an annual saving of between £7.6 million - £8.5million. Differences in the number of non-standard patient areas and bed base, and specific geographical reasons (e.g. acuity levels, recruitment challenges) mean that the savings opportunity may be smaller. • The use of higher cost rate staff can be reduced through time to hire, sickness reductions, and improved rostering, as outlined in the opportunities identification section.
Optimise back-office staff functions	• We note that the number of staff working in the Back Office functions has increased by 271 WTEs (18.3%) due to a number of changes, including new services required post COVID including the enhanced vaccination programme and the face fit testing team, as well as other new services such as the regional HEPMA programme hosted in NHS Grampian and the introduction of eRostering. • Our experience across adminstrative services in the NHS has shown that many of the more junior bands/roles can be automated by leveraging technology.	• Further work is recommended to understand and validate the drivers of increase in back office/administrative WTEs. From our experience elsewhere we know that a high proportion of these staff are in low paid roles performing administrative work that can be automated and enabled by technology – to evidence this, we know from our national work on the Scaling HR programme for NHS Egland that 50% of the 23,000 people working in HR nationally are employed at Agenda for Change band 3 or 4; similar trends will be true in finance and procurement. • This therefore represents a significant opportunity for NHSG to leverage the latest technology developments (including the use of GenAI tools) to drive efficiency and right-size headcount. A 30% - 40% phased reduction in back-office roles by pausing recruitment against attrition and re-organising internal roles can result in potential saving of £11.7 million - £15.6 million. This will require some investment in technology such as Robotic Process Automation and AI and could take approximately 12 to 36 months (or beyond depending on pace and attrition rates) to realise.
CIP delivery did not bridge the inflation funding gap	• Our analysis suggests the cumulative impact of inflation on non-pay spend between 2019/20 to 2023/24 was approximately £62.4 million. However, based on the funding uplifts reflected £14.2 million presenting a savings cumulative challenge for NHSG of £48.2 million. We note that cumulative recurrent savings delivered by NHSG in the same period accounted for £47.0 million leaving a funding gap of £1.2 million which was not bridged.	• Due to the Covid-19 pandemic, NHSG shifted focus to manage the pandemic and there was limited focus on recurrent savings delivery. However, this is consistent with other healthcare providers across the UK as other organisations reported little to no saving delivery during these years. However, the unfunded gap of £1.2 million in the recurrent cost base continues to create challenges to the financial sustainability. NHSG should include a plan to catch-up on missed savings from prior years to support financial sustainability.

The key drivers of the deficit (5)

Area	Summary observations and findings	Implications and recommendations
Other factors with limited NHSG influence	• Other regulatory changes impacting NHSG include the reduction in working week from 37.5 hours to 37 hours, which creates a pressure in Nursing staff which needs to be backfilled – by overtime, bank or agency. It is estimated that NHSG incurred between £4.3 million to £4.9 million of additional pay costs during 2024/25 due to this change. However, we note that this was only effective from 1 April 2024 and the cost pressure would only relate to 2024/25. While we acknowledge that the reduced working week applies to all AfC staff and not just Nursing staff, we understand that gaps in Nursing working time will directly require back-filling while gaps in other staff groups (e.g. Admin, IT) may not be required to be back-filled. • NHSG Management has reported that national regrading of band 2 health care support workers resulted in significant number moving from band 2 posts to band 3. This was not funded and resulted in a cost pressure of approximately £2.1m. • Increase in Cancer drug costs (gross increase of £7.2 million) due to new medicines and additional lines of treatment, an increase in use of insulin pumps (gross increase of £1.2 million) and costs associated with TAVI procedures (£4.1 million) are creating additional unfunded pressures for NHSG. • NHSG is also impacted by a higher proportion of Junior Doctors working less than fulltime in the form of lost income, additional NHSG costs to cover gaps and related costs (including banding costs). A high level assessment estimates the funding gap to have increased by roughly £0.6 million. However, we understand NHSG has estimated the impact of this to be around £1.9 million.	• In our experience, a certain level of unplanned or unfunded pressures is expected to be absorbed by providers and managed by leveraging income generating options and exploring additional saving opportunities. However, NHSG has approximately £19.5 million - £21.4 million of unfunded pressures which have accumulated without a corresponding funding strategy, (internal or external). NHSG should work collaboratively with the HSCPs/IJBs to explore appropriate and sustainable strategies.

The key drivers of the deficit (6)

Area	Summary observations and findings	Implications and recommendations
Estates maintenance and backlog by right-sizing estate footprint	• Previous work completed in 2024 identified that NHSG has 92 sites which are geographically disbursed and aging. The total area is 321,508 sq.m and there is potential to optimise its use and reduce the size of the estate. There are 33 health centre sites (including 10 in Aberdeen), 18 Clinics (including 11 in Aberdeen) and 17 Community Hospitals. Savings can be generated by reduced maintenance costs and reduced energy costs by 10%. However, challenge will remain due to geographical dispersion and risks to patient access. There is also a significant backlog maintenance spend associated with the ageing infrastructure. • We note that since the outcome of the previous report (referenced above), NHSG has managed to release value from estates by consolidating administrative spaces, with further work on-going to identify opportunities and a plan to release value from clinical areas.	• NHSG should continue to expedite its review of the estate footprint to identify specific opportunities to rationalise and right-size it. This will require an analysis of estate by site including understanding the services being provided on each site (including if any are sub-scale), the estate utilisation, backlog maintenance, maintenance costs, any other liabilities associated with the site (e.g. DBFM (“Design, Build, Finance and Maintain”) contracts). The interventions should be classified as tactical or short term (e.g. closing down a sub-scale service where reasonable alternative service can be provided to patients), medium term (e.g. by renting empty space to cafes or shops) and long term interventions (e.g. by service reconfiguration, redesign and refurbishments of space to optimise utilisation, reducing space requirement by leveraging telemedicine interventions, etc.). • These were quantified previously as a potential £3.2 million to £4.8 million in annual recurrent savings.
NHSG’s share of IJB deficits	• NHSGs funding and costs includes elements of ‘delegated’ funding, which primarily relates to pass-through funding for Healthcare service provision elements of the IJBs/HSCPs. The Social care service provision elements of the IJBs/HSCPs are largely funded by the relevant local council. At the financial year end, the performance of the combined IJB (healthcare and social elements) is assessed and the combined overspend is shared between NHSG and the local council, based on the contribution percentages. • In 2024/25, NHSG had to contribute an additional £13.8 million, £6.4 million and £2.2 million to Aberdeenshire IJBs, Aberdeen City IJB and Moray IJB’s deficits respectively as part of the risk share mechanism putting additional unplanned financial pressure on NHSG.	• NHSG should closely monitor performance of the IJBs and proactively engage with the IJB to prevent and manage any in-year overspend that may be passed on to NHSG as additional pressures. This can include increased scrutiny on financial plans and performance reports prepared by the IJBs as well as to work collaboratively to develop schemes which can mitigate these risks. • Any residual risk of IJB overspends should be considered within NHSG’s own financial governance arrangements to ensure early development of mitigation strategies and saving schemes, as appropriate.

04

Opportunity Identification

Opportunity Identification: Section Summary

27 incremental opportunities, over and above NHS Grampian's saving programme with a total FYE value of between £14.8m - £26.7m over and above NHSG's current Value & Sustainability Savings programme has been identified to support financial sustainability. Some of these will take time to realise their full potential because NHSG, like other health boards in Scotland, are not allowed to make redundancies. This is different from the NHS in England. When fully realised the proposals below when grown will save an additional £27.8m - £45.7m. An Outpatient redesign programme and ideas widely adopted in England to reduce the indirect tax the NHS pays would save a further £35.6m - £85.6m

Approach

- We have identified incremental opportunities, carried out in partnership with NHSG, to produce a detailed and practical list of incremental improvements, offering strategic insight and recommendations to support ongoing financial improvement across key areas such as: Pay and workforce planning, Non-Pay Expenditure, Clinical Productivity, Unscheduled Care, Procurement, Estates Management and Taxation.
- The resulting long list of opportunities has been validated with key stakeholders to confirm that each was incremental to current savings programmes within NHSG's FRP, feasible within required timelines and viable within the current clinical environment.
- The resulting list of opportunities represent the validated opportunities that are to be taken forward by the Health Board for further development and delivery.

#	Opportunity Theme	Page(s)	FYE Base (£m)	FYE Stretch (£m)	Full Value (£m)
1	Workforce & Pay	56 -58	£6.6m	£12.8m	£19.6m - £31.7m
2	Non-Pay	59-60	£3.8m	£6.1m	£3.8m - £6.1m
3	Procurement	61	£1.7m	£3.2m	£1.7m - £3.2m
3	Clinical Productivity	62-64	£1.9m	£3.2m	£1.1m - £1.5m
4	Medicines	65	£0.3m	£0.5m	£0.3m - £0.5m
5	Estates	66-67	£0.5m	£0.6m	£0.5m - £0.6m
6	Tax	68	£0.1m	£0.4m	£0.1m - £0.4m
	Total validated opportunities, excludes the opportunities below that require further exploration		**£14.8m**	**£26.7m**	**£27.8m - £45.7m**
7	Rightsizing Outpatients	71	£10.0m	£15.0m	£10.0m - £15.0m
8	VAT Improvements	72	£25.5m	£70.4m	£25.5m - £70.4m
9	Additional Improvement ideas that require further development (values exclude OPD & VAT)	69-73	£0.1m	£0.2m	£0.1m - £0.2m

Opportunity Identification

Workforce and Pay: Rightsizing substantive workforce

Issue(s)	Root causes
Substantive workforce for nurses and medical & dental staff have grown since 2019/20. • Pay costs for Nurses have increased by £43.9 million (excluding the impact of pay awards) from 2019/20 to 2024/25 – i.e. 651 WTEs (16.4%+). This includes an increase of 425 more substantive nurses (12%+) in 2024/25 as compared to 2019/20. • Pay costs within Medical & Dental have increased by £35.4 million excluding the impact of pay awards, reflecting an increase of 226 WTEs (17.8%+) from 2019/20.	Reasons cited by NHSG include the running of 119 surge beds, changes in patient acuity, as driven by the mandated 'Common Staffing Method' tools, successful recruitment against long standing vacant posts, transfer of services and new business cases, and waiting list initiatives.
The number of staff working in the Back Office/administrative functions has increased by 271 WTEs (18.3%).	Specific reasons include issues with e-rostering system that required a manual workaround using additional administrative staff as well as the implementation of weekly payroll has contributed to the WTE increase.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Digital Back Office Transformation	Pay costs for administrative staff across Band 1-4 was £39.0m in 2024/25. Leveraging technology to support or replace much of the administrative work performed by staff across Bands 1-4 can drive efficiency and generate savings. The use of GenAI tools across HR, finance and procurement can free up staff for more value-add activities. Savings can be made by pausing recruitment against attrition and re-organising internal roles. Assumed 30-40% Band 1-4 reduction over 5 years to align with average staff attrition rate.	£1.2m *(FYE grows each year, to £11.7 in year 5)*	£1.6m *(FYE grows each year, to £15.6m in year 5)*	£11.7m - £15.6m	Short term *(< 1 year)*	
Reduction in substantive nursing levels	Right-size nursing staff through independent validation of staffing levels within wards and alignment to Health and Social Care staffing legislation and potential for standardising patient acuity assessments (if not in place). While there exists an internal check and challenge process (including a review by Chief Nurse in that specific area/Ward) and limited need-based reviews by Nurse Director of Acute Services and Finance team – there is likely going be benefits by undertaking an independent assessment of Common Staffing Method tools inputs and outputs across wards that could lead to a clinically safe staffing reduction. Any reduction must take place gradually through attrition in order to avoid an equal and opposite increase to agency. Savings based upon a 1.8-3.0% reduction in permanent nursing to be realised over 2.5 years based on average staff attrition rate with bank fill rates being reduced first. This would be over and above the current V&S programme of work.	£1.6m *(FYE grows each year, to £4.1m in year 3)*	£3.3m *(FYE grows each year, to £8.2m in year 3)*	£4.1m - £8.2m	Short term *(< 1 year)*	
Job Plan Review and Service Realignment (Surgical)	Full review and realignment of job plans to service requirements of the individual services and reduction of WLIs and additional sessions. Since FY19/20 Acute Surgery Medical and Dental staff has increased by 41 WTE with theatre sessions reducing by 8.8% across ARI and Dr Gray's. Also, under 50% of job plans for FY25/26 are signed off with many rolling over from previous years without change. This could lead to misalignment to service requirements and unnecessary spend to cover under-utilised paid for capacity. Although this opportunity is focused on surgical specialties, this could be extended to medical specialities. It is noted this reduced capacity is driven by unscheduled need.	£0.5m	£1.0m	£0.5m - £1.0m	Short term *(<1 year)*	
Total		**£3.3m**	**£5.9m**	**£16.3m - £24.8m**		

Workforce and Pay: Grip & Control

Issue(s)	Root causes
Non-delegated net cost base increased by £333.9 million mainly due to impact of pay awards (£149.2 million) recruitment of 1,343 WTEs (13.8% more than 2019/20).	Locum and Agency spend across NHSG is 3.6% of total pay. Comparable health boards have a median benchmark of 1.6% of total pay costs. Bank usage across NHSG is 3.9% of total pay spend. Comparable health boards have a median benchmark of 3.6% of total pay costs. Non-clinical to clinical ratio has increased from 11.1% in FY19/20 to 11.6% in FY24/25. This is the equivalent of 38 additional permanent non-clinical staff.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Grip & Control: Bank	Improved Grip and Control for bank staff including looking to make permanent the longest serving agency staff, improve the effectiveness of vacancy control panels including the evidence required for submission. This represents stretch opportunities over and above the current bank reduction programme. To support this opportunity, the Health Board should undertake the recommendation to review the Common Staffing Method tools in the previous section. We note that Management has stated that Grip & Control measures are already included in the V&S plan, this represents a stretch opportunity, that in our experience could be achieved through additional robust, yet clinically safe actions to reduce bank usage.	£0.5m	£1.9m	£0.5m - £1.9m	Short term *(<1 year)*	
Grip and control: stop all non-clinical overtime	Freeze on non-clinical overtime. In FY25 the overtime spend was £3.1m (1.0m in administrative services and £2.1m in support services,. Note: NHSG do have a savings scheme directed at overtime, but it is not a direct ban rather a targeted reduction. The opportunity figure is incremental to that initiative and focused only on administrative services to maintain quality of cleans in the Health Board. It is noted that some overtime in F&E is required for intrusive works planned out with clinical service hours and for emergency repairs and should be considered by appropriate stakeholders.	£0.1m	£0.5m	£0.1m - £0.5m	Short term *(<1 year)*	
Total		**£0.6m**	**£2.4m**	**£0.6m - £2.4m**		

Workforce and Pay: Process Improvements

Issue(s)	Root causes
Non-delegated net cost base increased by £333.9 million mainly due to impact of pay awards (£149.2 million) recruitment of 1,343 WTEs (13.8% more than 2019/20).	Time to hire for new starters is between 42 days and 78 days (depending on role) against a benchmark of 35 days. This is often backfilled with high-cost capacity Sickness rates across NHSG's sickness rates varies between 9.1% and 3.93% depending on the staff group. Overall, the sickness rates are much higher than the NHS Scotland planning target of 4%.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Improved Time to Hire	The current average time from job posting to offer is between 41 and 78 days at NHS Grampian against a target of 35 days and an average time between having a role approved and the person starting work being between 102 and 149 (across Medical and Dental, AHP, Nursing and Midwifery and Therapeutics. This leaves a gap between a gap between a person leaving their role and a new person starting that can lead to shifts being fulfilled with high-cost spend capacity. There is an opportunity to improve time to hire through improved coordination across the Trust, more efficient processes and the use of RPA technology, savings can be made on reduced agency and bank spend through reduction in back filling posts that are recruited to but have not started due to processing issues. It is noted that some roles are not backfilled or are covered by other substantive staff, a conservative approach to value calculation has been taken to account for this but further investigation on that fulfilment rate is required.	£1.4m (5% improvement)	£1.9m (10% improvement)	£1.4m - £1.9m	Short term *(< 1 year)*	
Staff Sickness Improvements	Staff sickness rates in AHPs and Nursing and Midwifery cohorts is above the NHS Scotland target of 4%. Key focus areas for reducing sickness absence include reviewing adherence to Once for Scotland policies, implementing preventative health and wellbeing initiatives, and strengthening active case management with tailored employee support and return-to-work protocols. Clear processes are essential for managing short-term, medium-term, and long-term absences (over 12 months) ensuring consistent and compassionate handling across all cases. It is noted that NHS Grampian's sickness rate is the best in Scotland but still above the 4% target rate, providing an opportunity for improvement.	£1.2m	£2.5m	£1.2m - £2.5m	Medium Term *(1-2 years)*	
Reduced Leaver Overpayments	Reduce leaver overpayments by 75%. In FY25 £140k of overpayments were made, with only £30k repaid as at July 2025. These payments happen mostly due to late notification of termination of contract to finance, who do not stop the final payment in time. Improving understanding and the process around overpayments can reduce this cost.	£0.1m	£0.1m	Short term (<1 year)		
Total		**£2.7m**	**£4.5m**	**£2.7m - £4.5m**		

Opportunity Identification

Non-Pay: Discretionary Spend

Issue(s)could	Root causes
Vehicle Running Costs, which accounted for £3.5m in FY25 spend. A potential saving of up to £1.6m has been identified by optimising fleet utilisation, transitioning to lower-emission vehicles, and centralising fuel procurement.	Elevated costs could stem from an ageing or oversized fleet, underutilisation of vehicles, procurement contracts or a lack of route optimisation. If vehicles are allocated without performance or usage review, leading to inefficiencies.
Training Expenses present a notable opportunity, with £3.0m spent in FY25. While essential for maintaining clinical quality, a closer examination suggests potential over-classification of general staff development costs and inconsistent application of policy. Streamlining this spend through pre-approval processes, digital delivery, and a centralised training function could unlock up to £0.2m in savings.	Training spend appears inflated and could be due to budgets managed locally by individual departments without overarching strategic oversight, leading to duplication of training, varied procurement approaches and unnecessary spend over and above required training levels. Please note, undergraduate teaching is non-discretionary and is excluded

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Vehicle running costs	• Conduct fleet utilisation audits to identify underused or oversized vehicles • Transition to low-emission or electric vehicles where feasible • Implement centralised route planning and fuel procurement via NHS frameworks. • Explore shared fleet services with nearby NHS partners. • Scope: Full NHS Grampian fleet.	£0.4m	£0.7m	£0.4m - £0.7m	Medium Term (1-2 years)	🟡
Training Expenses	• Centralise training approval and procurement through a learning governance board to eliminate duplication and non-essential bookings. • Introduce tiered training prioritisation aligned to strategic workforce development goals. • Transition to default online/virtual delivery for non-hands-on training with mandated e-learning compliance tracking. • Explore regional collaboration for shared training platforms and external provider contracts to achieve economies of scale.	£0.1m	£0.2m	£0.1m - £0.2m	Short Term (<1 year)	🟢
Total		**£0.5m**	**£0.9m**	**£0.5m - £0.9m**		

Non-Pay: Other

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Contract Leakage Phase 2	Following the first phase of the Cognitive Contract Management (CCM) project to address contract leakage at the Health Board, the second set of contracts totalling an additional £40m of addressable spend (spend to review) has been identified. It is recommended that this moves ahead to unlock additional value from contract leakage.	£1.4m	£2.1m	£1.4m - £2.1m	Short term *(<1 year)*	
Contract Leakage: Further Phases	Longer term, there is a further £40m of addressable spend (spend to review) over and above the spend already reviewed in the previous phases. It is recommended that this moves to an additional phase to unlock additional value from contract leakage. Values are based on historic savings when undertaken at other healthcare organisations in the UK, generally between 4% and 6% of contract value.	£1.4m	£2.1m	£1.4m - £2.1m	Short term *(<1 year)*	
Out of Area Placements	NHSG to work with the IJBs to reassess and understand the out of area placement challenges and work to repatriate patients to reduce cost to the Health Board and improve patient experience by bringing care closer to home.	£0.5m	£1.0m	£0.5m - £1.0m	Short term *(<1 year)*	
Total		**£3.3m**	**£5.2m**	**£3.3m - £5.2m**		

Procurement

Issue(s)	Root causes
High volume of non-PECOS spend: 69% of purchasing activity occurs outside the PECOS system	Lack of enforcement of pre-authorisation leading to off PECOS spend.
POs are raised after the purchase is made, bypassing appropriate controls.	Ineffective system grip and control
Only one in five invoices is managed by Procurement; the majority (80%) are left to departments, where invoice handling varies widely in quality and consistency.	Resource constraints to review all invoices coming in leading to incorrect invoicing and over payments.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Non-PECOS purchases	A recent review of purchasing activity revealed that 69% of total spend is occurring outside the PECOS procurement system (approx £448m). Further analysis indicates that 3% (£13m) of this non-PECOS spend could be realistically transitioned onto PECOS. Within this, an estimated 3% to 10% represents avoidable spend or pricing discrepancies against framework agreements. There is an opportunity to drive cost savings by implementing policy and system controls that enforce pre-approval of purchases through PECOS and reduce retrospective ordering practices.	£0.4m	£1.3m	£0.4m - £1.3m	Short term *(<1 year)*	
Management of Invoice Register	Currently, the invoice register holds 2,829 invoices totalling £6.3m, of which only 20% are actively managed by Procurement due to limited capacity. The remaining 80% fall under departmental responsibility, where oversight is inconsistent due to the task being absorbed into already pressured roles. **The following opportunity has been identified:** To implement a centralised function to manage the invoice register, supported by an investment in 3.0 WTE Band 3 staff, to fully manage the register. This model assumes recovery rates of 50% (base case) and 70% (stretch case) applied to outstanding invoice value.	£1.3m	£1.9m	£1.3m - £1.9m	Short term *(<1 year)*	
Total		**£1.7m**	**£3.2m**	**£1.7m - £3.2m**		

Clinical Productivity: Outpatients

Issue(s)	Root causes
High Outpatient Cancellation rates (18%) which leads to underutilisation of planned outpatient capacity and reduces the number of patients seen within existing resources.	Cancellations from patients and hospitals leaving gaps within the clinic templates.
Patient Initiated Return pathways not fully optimised (currently 8%), which lead to inefficient use of capacity where routine follow-ups may be booked unnecessarily, limiting access for new patient appointments.	Inconsistent PIR protocols implementation across the health board

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Improving clinic utilisation	Opportunity to increase outpatient capacity by addressing high cancellation rates and reducing DNA rates, DNA rates are currently c6% and cancellation rates currently at 18%. It is recommended to assess the review the current booking and administrative processes around this to enable fuller utilisation of slot capacity in existing planned time and reducing WLI usage. This will also improve the effectiveness of administrative time through reduction of rebooking cancellations and DNAs.	£0.2m *(canx rate to 10%)*	£0.3m *(canx rate to 5%)*	£0.2m - £0.3m	Medium term *(1-2 years)*	
Increasing Patient Initiated Returns (PIR)	Currently, only 8% of return outpatient appointments are managed via Patient-Initiated Return (PIR) or Open Return (OR) pathways. This presents a significant opportunity to optimise capacity, particularly given the Trust's low New:Return ratio (2.3 vs peer benchmark of 2.9), which indicates available demand to backfill released slots. By increasing the adoption of patient-initiated pathways to a base target of 15% and a stretch target of 20%, the Trust could unlock an estimated £172k–£295k in savings through reduced reliance on Waiting List Initiatives (WLI). Key specialties identified for targeted scaling include: • Dermatology – Aberdeen Royal Infirmary (ARI) and Dr Gray's • Gynaecology – ARI • Rheumatology – ARI and Royal Aberdeen • ENT – Across all hospital sites	£0.2m	£0.3m	£0.2m - £0.3m	Short term *(<1 year)*	
Total		**£0.4m**	**£0.6m**	**£0.4m - £0.6m**		

Clinical Productivity: Outpatients

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Outpatient booking cancellation review	The current cancellation rate in Outpatients stands at 18%, equating to 320,380 appointments. This results in a significant amount of rework due to the need to rebook patients. NHS Grampian should review these cancellation rates to identify and address the underlying causes. By introducing new processes to address these causes and minimise rebooking efforts, it may be possible to reduce staffing requirements of the booking team by between 5 and 15 WTE, depending on the extent of rework involved.	£0.2m	£0.5m	£0.2m - £0.5m	Medium term *(1-2 years)*	
Outpatient booking process review	At present, the current process for booking outpatient appointments is primarily through patient focused booking with some booked post-clinic or pre-booked in urgent cases. There is scope to introduce alternative methods of booking outpatients including Robotic Processing Automation (RPA), implementation of AI tools and/or a choose and book style system to enable patient led booking. This could reduce requirements by between 20 and 40 WTE depending on integration. Please note that this would require further investigation of the current product market and investment to fully realise.	£0.6m	£1.2m	£0.6m - £1.2m	Medium term *(1-2 years)*	
Total		**£0.8m**	**£1.7m**	**£0.8m - £1.7m**		

Opportunity Identification

Clinical Productivity: Theatres

Issue(s)	Root causes (perceived)
High conversion of Day Cases to Inpatient Admissions and underutilisation of Inpatient pathway for BADS-eligible procedures	Inadequate pre-assessment practices with inconsistent application of day case protocols and clear patient selection criteria.
High Endoscopy Cancellation rates across ARI and Dr Gray's	Scheduling inefficiencies, no structured process for analysing and addressing cancellation reasons.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Improvement in Day Case pathways	Opportunity to reduce unnecessary conversion of planned day case procedures to inpatient admissions. For FY24/25, 2,466 procedures were converted from day case to inpatient, representing a 6.3% conversion rate. These unplanned admissions consume inpatient bed capacity, disrupt patient flow, and contribute to increased reliance on Waiting List Initiatives to meet elective targets. There is an opportunity to reduce rates to 3% (base opportunity) and 0% (stretch opportunity).	£0.2m	£0.3m	£0.2m - £0.3m	Medium term *(1-2 years)*	
	Further analysis identified an additional 3,409 procedures (excluding those converted from day case to inpatient as described above) that were eligible for day case delivery under BADS (British Association of Day Surgery) guidelines but were instead carried out as elective inpatient admissions. This represents a missed opportunity to enhance efficiency, reduce bed occupancy, and lower associated costs. A "Day Case by Default" approach could be adopted, whereby procedures are routinely scheduled as day cases unless there is a clinically justified need for inpatient care. Specialties warranting further investigation, based on the highest volume and proportion of day case-eligible inpatient activity, include Medical Specialties, Urology, General Surgery, Gynaecology, Orthopaedics, and Breast Surgery.	£0.3m	£0.4m	£0.3m - £0.4m	Medium term *(1-2 years)*	
Improve Endoscopy Utilisation	The current utilisation rate for Endoscopy is 70% at ARI and 86% at Dr Gray's. There is an opportunity to increase Endoscopy utilisation by reducing cancellation rates (ARI 24%, Dr Gray's 15%) to improve utilisation of substantive capacity and reduce WLIs.	£0.2m	£0.2m	£0.2m - £0.2m	Medium term *(1-2 year)*	
Total		**£0.7m**	**£0.9m**	**£0.7m - £0.9m**		

Medicines

Issue(s)	Root causes
Multi-Dosing - the overall issue with multi-dosing from single-use packs is the significant medicine wastage and inefficiency resulting from rigid adherence to single-use policies, even in situations where the medicine could be safely used for more than one dose or patient. This leads to increased costs and avoidable environmental impact, particularly in high-volume settings such as ophthalmology and anaesthetics.	The root cause lies in the lack of nationally agreed clinical guidance or protocols that support multi-dosing, combined with infection control concerns and regulatory caution. In many cases, the default to single-use is driven by perceived safety risks, absence of validated processes, and medicolegal concerns, rather than clinical necessity or evidence-based practice.
Excessive use of HBP (Hospital Based Prescriptions) within the hospital setting leads to delays in patient access to medication, inefficiencies in discharge processes, and increased workload for both hospital and primary care teams. It often results in disorganised prescribing responsibility and poor continuity of care.	The overreliance on HBP is primarily driven by unclear discharge prescribing pathways, where medicines can be found in the community

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Multi-Dosing from Single-Use Packs	Developing clear, evidence-based protocols that support safe and compliant multi-dosing practices in appropriate clinical areas. This includes conducting clinical risk assessments to identify where multi-dosing can be safely implemented, such as in ophthalmology, anaesthetics, or routine injections without compromising patient safety. To fully realise the opportunities presented by multi-dosing, a significant upfront investment in comprehensive training programmes is essential. These programmes should equip staff with the knowledge and skills necessary to adhere to the new protocols, understand the clinical risks involved, and confidently implement multi-dosing practices.	£0.1m	£0.1m	£0.1m - £0.1m	Short Term *(<1 year)*	
Reduced reliance on HBP prescriptions	Streamline internal medication supply processes to reduce reliance on prescriptions, ensuring that necessary medications can be provided directly through hospital systems where appropriate. Enhance coordination between secondary care and primary care to minimise unnecessary transfers of prescribing responsibility. Monitor and audit HBP usage trends regularly to identify departments with high usage and implement targeted interventions. Explore electronic solutions to reduce manual processing and delays, improving the efficiency and appropriateness of medication supply and reducing the reliance on HBPs.	£0.2m	£0.4m	£0.2m - £0.4m	Short Term *(<1 year)*	
Total		**£0.3m**	**£0.5m**	**£0.3m - £0.5m**		

Estates

Issue(s)	Root causes
• Ageing estate portfolio (50% of the buildings are over 50 years old) with growing maintenance backlog of £202.7m as of Apr 2024.	• Limited capital investments over time, many key components of building infrastructure unchanged since installation.
• Estate space is not fully optimised, limiting opportunities for reductions in associated property costs.	• The rationalisation of building space is ongoing, while further opportunities remain present to consolidate services and achieve office space reduction.

Opportunity name	Countermeasure description	Opportunity **Base** (FYE, £m)	Opportunity **Stretch** (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Estate rationalisation and closure of sites	Further rationalisation of the estate space, including office space rationalisation and identification of areas with low or unclear usage. Currently a total area of 19,652 sqm has been identified for closure/disposal, resulting in reduction of operational maintenance, energy, water, cleaning and rates related cost. *Note: Savings are gross and do not include the one-off £50k removal and set-up costs for the properties be to demolish. The savings are high-level estimates, a detailed analysis of the property costs will be necessary to confirm the actual savings that can be achieved upon closure. For example, estimation of costs related to the actual works required to physically separate the utility supplies, ensuring that the remaining sites can continue to function seamlessly.*	£0.3m	£0.4m	£0.3m - £0.4m	Medium term *(1-2 years)*	
Installation of photovoltaic (PV) solar panels	Reduce electricity consumption by installing integrated photovoltaic (PV) solar panels on the flat roofs. Feasibility studies indicate that 5 sites are available for installation, requiring an initial investment of £1.7m, with projected annual savings of £114k and payback periods ranging from 6 to 29 years. The Mathew Hay Building, Aberdeen Royal Infirmary site offers the highest potential, with an anticipated reduction in energy costs of **£82k** per annum, upfront investment of **£0.5m** and payback period of 6 years. The stretch option includes all 5 sites if full investment is obtained. Note that the savings here are predicated on securing capital funding for this programme.	£0.1m	£0.1m	£0.1m - £0.1m	Medium term *(1-2 years)** *Payback 23 years*	
Total		**£0.4m**	**£0.5m**	**£0.4m - £0.5m**		

Estates (cont.)

Issue(s)	Root causes
• Maintenance is primarily focused on fixed and compliance tasks rather than preventative care, with 50% currently being reactive, high-cost maintenance.	• Working with a constrained and time limited (annual) funding framework results in a “break-fix” approach prioritising repairs of failed assets, rather than strategic asset management of whole-life costing.
• High estate operational cost driven by outdated infrastructure, resulting in higher than average.	• Older facilities demand increased time for cleaning and other soft facility maintenance and pose major cost barriers to sustainability upgrades and renewable energy transition.

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Reduce estate related maintenance cost: • Introduction of automated floor cleaners • Insource maintenance of small boilers • Increase recycling rates	**Various maintenance related opportunities:** • Implement robotic cleaning systems for the corridors to reduce pay expenditure on domestic (cleaning) services. Potential to save ~1 Band 2 WTE, opportunity is limited to Emergency Care Centre and excludes the older buildings which have irregular layouts and smaller spaces. • Bring the small boiler replacement activities in house by filling two Band 5 vacancies and reduce contractor’s labour related cost. • Improve recycling rates at the low-performing sites by addressing them individually and increase recycling rates up to 35%. The proposed reductions are based on savings of £31 per unit of waste.	£0.1m	£0.1m	£0.1m - £0.1m	Medium term *(1-2 years)*	
Total		**£0.1m**	**£0.1m**	**£0.1m-£0.1m**		

Opportunity Identification

Tax

Issue(s)	Root causes
There are ways in which the VAT recovery position for NHSG can be improved.	

Opportunity name	Countermeasure description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
COS review	The independent professional services fimr performed a review of the 2023/24 accounts payable transactions and secured VAT savings of £0.5m. In our view, with more time and access to invoices, we would expect to achieve additional savings of £0.25m - £0.4m over and above the £0.5m identified and secured for the Board.	£0.1m	£0.4m	£0.1m - £0.4m	Short Term *(<1 year)*	
Total		**£0.1m**	**£0.4m**	**£0.1m-£0.4m**		

Additional opportunities with further investigation required (cont.)

Ideas for Development	Idea description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Workforce Planning: Improved rostering practices	E-Rostering has only partially been implemented across NHSG, with significant delays with national business systems integration preventing the full roll out to all areas. Improved rostering practices beyond this can have the effect of reducing temporary staff. **Medical** • The number of staff that can be on annual leave at any one time varies. Breaches are not monitored and managed centrally. **Nursing and AHPs** • Each rota has annual leave headroom of 15.75%, with a tolerance range of 14.25-17%. For the first three months of the year (Apr-Jun) there were 36 breaches of this range. **Fixed Shift Patterns** • Compliance with the Flexible Working Policy be regularly reviewed, particularly in relation to the use of fixed shift patterns. While fixed patterns can be appropriate, they should only be agreed upon where they align with the operational requirements of the service (i.e., roster requirements). Therefore, it is possible for teams to maintain a high proportion of fixed shifts while remaining policy compliant, provided these patterns support service delivery needs. • In areas where fixed shift patterns are in place and agency staff are also utilised, NHS Grampian should continue to review these patterns for efficiency. This ensures that workforce planning remains both cost-effective and aligned with service demands.	TBC	TBC	TBC	Short Term *(<1 year)*	
Workforce Planning: Implement Annualised Job Plans	Annualised job plans involve agreeing a set number of programmed activities or hours to be delivered over the course of a year, rather than evenly across each week, allowing clinicians to flex their workload in line with seasonal demand, on-call commitments, or personal development needs. This approach supports improved work-life balance, better alignment with service pressures, enhanced efficiency, and reduced reliance on locums or overtime, while enabling time for research, teaching, or leadership responsibilities.	TBC	TBC	TBC	Medium term *(1-2 Years)*	

Additional opportunities with further investigation required (cont.)

Ideas for Development	Idea description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Unscheduled Care: Maximising admission avoidance	Review admission criteria for Hospital at Home and out-of-hours services to identify whether these could be adjusted to increase their utilisation, noting that both services were underspent in 2024/25. Work with front-line teams to ensure full awareness of patient navigation routes and available services. Identify opportunities to link clinical systems across acute and ambulance providers to facilitate swifter patient navigation to the most appropriate service, based on availability.	TBC	TBC	TBC	Short Term *(<1 year)*	🟢
Unscheduled Care: Evaluation of impact	Ensure all admission avoidance and discharge support schemes have robust evaluation mechanisms in place to demonstrate their benefits, and to provide a basis for scaling services where these services have had a demonstrable impact on de-pressurising the acute sector	TBC	TBC	TBC	Short Term *(<1 year)*	🟢
Unscheduled Care: Identification of alternative services to improve flow and outcomes	Identify the cohorts associated with long lengths of stay within the acute and their characteristics, based on diagnoses codes and length of stay bands (0 days, 1-6 days, 7-13 days, etc.). Work with clinical teams to identify what services, skills or capacity would need to be in place in out-of-hospital settings to reduce acute activity, and explore the feasibility of standing up identified services.	TBC	TBC	TBC	Short Term *(<1 year)*	🟡
Unscheduled Care: Acute bed-base configuration	Consider a short-term reconfiguration of physical acute bed capacity to align this better to current activity, and to improve patient flow by reducing the number of medical outliers.	TBC	TBC	TBC	Short Term *(<1 year)*	🟡
Unscheduled Care: Post-discharge capacity	Work with **the HSCPs/IJBs** to explore opportunities to align onward capacity for patients with complex needs (e.g. dementia and bariatric care) is right-sized and configured for demand within the system, and to reflect the changing demographics of Aberdeen City, Aberdeenshire and Moray.	TBC	TBC	TBC	Medium term *(1-2 years)*	🔴

Additional opportunities with further investigation required (cont.)

Ideas for Development	Idea description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Clinical Productivity: Rightsizing Outpatients	The number of outpatient appointments attended are 39.8% higher in 2024/25, as compared to 2019/20. However, NHSG Management have informed that waiting lists continue to increase. If NHSG reduce the outpatient activity to FY19/20 levels, this is equivalent to c.80 FTE Consultant positions that can be utilised to support elsewhere. We recommend that NHSG undertake further work to understand the increase in outpatient appointments and associated costs (including whether they are in the right areas and are necessary) and their limited impact in reducing waiting lists. This should include assessing options to reduce PIFU, improve advice and guidance options, update clinical guidelines on follow up appointments, etc. to release significant savings and clinical time which could be refocused on UEC and discharge.	£10.0m	£15.0m	£10.0m - £15.0m	Medium term *(1-2 years)*	
Medicines: Shorter TTO Packs	NHSG can implement more flexible and clinically appropriate discharge supply policies. This includes enabling tailored TTO durations (currently 14 days) based on clinical need, with clear guidance and decision support embedded into prescribing systems. Improving discharge communication workflows with primary care can help shorten the supply buffer currently required. Pharmacy teams can also support prescribers with training and awareness on the benefits of shorter TTOs in reducing waste. It should be noted that any scheme that simply shifts internal costs to primary care may not generate savings to NHSG and may result in higher system costs overall. Therefore, further analysis should be undertaken to identify the opportunity only for those patients that need 7 days' supply on discharge. It should exclude patients who require 14 days supply or who may be at risk of unplanned care or readmission.	TBC	TBC	TBC	Short Term *(<1 year)*	
Social Care: Service Review	Due to the pass-through nature of the budget, social care was not able to be reviewed during this diagnostic outside of publicly available information and as such. a review into the current spend within at home social care is required. It is noted that at present, Aberdeenshire IJB are undertaking a review of Home Care following a £1.3m overspend in FY24/25 for Home Care and ARCH services.	TBC	TBC	TBC	Short Term *(<1 year)*	

Additional opportunities with further investigation required (cont.)

Ideas for Development	Idea description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Tax: VAT Improvements	There is an opportunity for NHSG to realise significant VAT savings through implementation of a subsidiary company. Setting up this subsidiary would be subject to changes in policy by Scottish Government.	£25.5m	£70.4m	£25.5m - £70.4m	Medium term *(1-2 Years)*	
Procurement: Reduction of bespoke implants	Bespoke implants are currently ordered across multiple theatre sub-specialties, often without consistent clinical justification or standardised governance. In FY25, the introduction of a clinical justification form within Orthopaedics delivered verified savings of £66k by strengthening oversight and ensuring appropriate use. **The following opportunity has been identified:** Extend the implementation of this form to other surgical sub-specialties to standardise the approval process for bespoke implant purchases. There is opportunity to ensure value-based procurement and support improved outcomes for patients.	TBC	TBC	TBC	Medium term *(1-2 Years)*	
Procurement: Implementation of National Frameworks	A review of procurement activity highlights that out of 44 national frameworks, 15 have not been assessed locally due to limited procurement resource. Among these, 7 frameworks indicate potential price savings, however these need to be validated through local detailed analysis. For example, one single recent framework reviewed turned into a £30k cost avoidance. By enabling local analysis of the remaining 15 frameworks, there is potential to unlock further cost savings. The realisation of savings is contingent on securing short-term procurement capacity to accelerate review of outstanding frameworks.	TBC	TBC	TBC	Medium term *(1-2 Years)*	

Additional opportunities with further investigation required (cont.)

Ideas for Development	Idea description	Opportunity Base (FYE, £m)	Opportunity Stretch (FYE, £m)	Year 5 – Opp (FYE, £m)	Time to Implement	Complexity
Estates: Paper towel replacement	Replacement of paper towels with hand dryers. **Upfront and Operating Costs -** While hand dryers involve upfront installation costs (purchase and wiring) and ongoing electricity usage, they eliminate the recurring costs of purchasing, storing, and disposing of paper towels. Over time, dryers can partially offset paper towel spend – not eliminate it entirely but help reduce the volume significantly. Switching to electric hand dryers could reduce paper towel costs by 20–40%, depending on how widely and effectively the change is implemented across appropriate areas. **Savings Breakdown** (Estimates):Total Paper Towel Spend (example): £900,000 **Applicable areas for dryers**: Likely non-clinical areas (admin buildings, staff toilets, some outpatient spaces) – typically **30–50% of usage**. It is noted that hand dryers are not suitable for IPC areas. NHS Grampian have switched to hand dryers in some non-clinical areas but further work to understand installation cost vs actual of deployment to the wider estate is required.	£0.1m	£0.2m	£0.1m - £0.2m	Medium term *(1-2 years)*	
Estates: Advertising on sites	Utilising the digital screens in the main concourse at the Foresterhill site for commercial advertising may provide additional income for the estate. This opportunity is currently in the early stages of development and the estimated extra revenue will depend on engagement with advertising companies, as well as factors such as footfall, the types of items permissible for advertisement and the agreed revenue share.	TBC	TBC	TBC	Short Term *(<1 year)*	

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Appendices

Appendix 1 : Glossary

Glossary

Abbreviation	Definition
A&E	Accident and Emergency
AFC	Agenda for Change
AHP	Allied Health Professionals
AI	Artificial Intelligence
ARC	Audit and Risk Committee
ARCH services	Active Resident in Care Homes
ARI	Aberdeen Royal Infirmary
BADS	British Association of Day Surgery
CCM	Cognitive Contract Management
CEO	Chief Executive Officer
CET	Chief Executive Team
CGC	Clinical Governance Committee
CIP	Cost Improvement Programme
COS	Contracted Out Service
CSM	Clinical Services Manager
DBFM	Design, Build, Finance and Maintain
DDIT	Doctors and Dentists in Training
DGH	Dr Grays Hospital
ED	Emergency Department
ENT	Ear, Nose, Throat
FRP	Financial Recovery Plans

Abbreviation	Definition
FY	Financial Year
FYE	Full Year Effect
GenAI	Generative Artificial Intelligence
GPs	General Practitioners
HBP	Hospital Based Prescribing
HCSSA	Health & Care (Staffing) (Scotland) Act
HFMA	Healthcare Financial Management Association
HR	Human Resources
IJBs	Integration Joint Boards
KPIs	Key Performance Indicators
LTFT	Less Than Full Time
M&D	Medical & Dental
MIUs	Minor Injuries Units
NES	NHS Education for Scotland
NHSG	NHS Grampian
OR	Open Return pathways
PAFIC	Performance Assurance, Finance and Infrastructure Committee
PCIF	Primary Care Improvement Fund

Glossary (cont.)

Abbreviation	Definition
PECOS	Professional Electronic Commerce Online System
PIFU	Patient Initiated Follow Up
PIR	Patient-Initiated Return
PV	Photovoltaic
RN	Registered Nurses
RRL	Revenue Resources Limit
SAERs	Serious adverse events reporting
SG	Scottish Government
TB	Trial Balance
TTOs	To Take Outs (medications)
UEC	Urgent and Emergency Care
USC	Unscheduled Care
UTCs	Urgent Treatment Centres
VAT	Value-added Tax
WLI	Waiting List Initiatives
WTEs	Whole Time Equivalents

Appendix 2: Meeting Log

Appendix 2 – Meeting Log

Meeting Log

NHSG Stakeholders	Role/ Department	Governance Review	Opp ID & DoD	Date(s) Consulted		
				Governance Review	Opps ID & DoD	Follow ups
Dr Hugh Bishop	Medical Director	✓	✓	11 June	11 June	
Paul Bachoo, Geraldine Fraser and June Barnard	Acute Senior Triumvirate	✓	✓	11 June	12 June	26 June
Sarah Irvine	Deputy Director, Finance	✓	✓	***Recurring Meetings Held on Every Monday***		
Matthew Toms & Karen Alexander	Booking Team		✓		17 June	
Lorraine Scott, Cathy Young, Matthew Toms, Pam Milliken and Carrie Stephen	Transformation and PMO		✓		18 June	
Alan Wilson	Director of Infrastructure	✓	✓	18 June	26 June	27 June, 4July
Judith McLenan and Fiona Mitchellhill	Mental Health Division		✓		19 June	3 July
Jennifer Yeomans and Kirsty Martin	Procurement Team		✓		19 June	30 June
Lynn Morrison	Director of AHPs	✓	✓	26 June	24 June	
June Brown	Executive Director, Nursing	✓	✓	26 June	24 June	
Stuart Stephen, Cameron Matthew, Vanessa Sandison, Alasdair Pattison, Sue Swift	Operational Service Budget holders	✓	✓	24 June	1 July	
David Pfelger	Director, Pharmacy		✓		23 June	
Gavin Payne and Garry Kidd	Facilities and Estates		✓		2 July	3 July
Steven Lindsay	Employee Director and Chair of Grampian Area Partnership Forum	✓		30 June		
Mark Burrell	Chair, Area Clinical Forum	✓		2 July		
Alex Stephen	Director, Finance	✓	✓	25 June	27 June	***Recurring weekly meetings held on every Thursday***

Appendix 2 – Meeting Log

Meeting Log (cont.)

NHSG Stakeholders	Role/ Department	Governance Review	Opp ID & DoD	Date(s) Consulted		
				Governance Review	Opps ID & DoD	Follow ups
Alison Evison	Chair, NHS Grampian	✓		2 July		
Derick Murray	Chair, NHSG Audit & Risk	✓		1 July		
Sandy Riddell	Chair, NHSG PAFIC	✓		1 July		
Colin McNulty	Senior Nurse Manager		✓		27 June	
Vanessa Sandison	Divisional Director		✓		4 July	
Adam Coldwells	Chief Executive Officer	✓		7 July		
Fiona Mitchellhill Leigh Jolly Judith Proctor	Health & Social Care Partnership Chief Officers: Aberdeen City Aberdeenshire Moray	✓		10 July		
Jim Savege	Chief Executive, Aberdeenshire Council	✓		8 July		
Angela Scott	Chief Executive, Aberdeen City Council	✓		7 July		
Karen Greaves	Chief Executive, Moray Council	✓		23 July		
Simon Watson Eddie Docherty Emma Watson	Medical Director – Director of Safety, HIS Director of Quality Assurance and Regulation, HIS Executive Medical Director, NES	✓		2 July		
Linda Downie Robert Lockhart	Co-Chair Grampian GP Sub-Committee Co-Chair Clinical Area Forum	✓		1 and 10 July		
Michael Dickson	Chief Executive, Scottish Ambulance Service	✓		2 July		
Scottish Government	Health and Social Care Finance			***Recurring Meetings Held on Every Thursday***		

Appendix 3:
Reconciliation between reported numbers and trial balance

Reconciliation between reported numbers and trial balance

Reconciliation between reported performance and trial balance						
£ 'million	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Revenue resource limit						
RRL - as per audited accounts	**1,139.0**	**1,311.1**	**1,386.6**	**1,338.7**	**1,489.0**	**1,599.5**
Adj for FHS non-discretionary allocation (in TB but nc	56.8	65.4	66.3	71.1	76.3	82.3
Adj for Donated Assets Income (not in TB but in RRL	(1.4)	(1.1)	0.0	0.0	0.0	0.0
RRL to reconcile with Trial balance	1,194.4	1,375.5	1,452.9	1,409.8	1,565.3	1,681.8
Surplus / (deficit)						
Overall surplus / (deficit) before Brokerage	1.0	0.8	0.1	0.6	(24.7)	(64.9)
Adj for Brokerage funding / (repayment)	(1.0)	0.0	0.0	0.0	24.8	65.2
Overall surplus / (deficit) including Brokerage	0.0	0.8	0.1	0.6	0.1	0.3
Net Expenditure						
Net expenditure to reconcile with Trial balance	1,194.4	1,374.7	1,452.7	1,409.2	1,565.2	1,681.5
Net expenditure as per TB	1,194.4	1,374.7	1,452.7	1,409.2	1,565.2	1,681.5
Unreconciled differences	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**

Source: NHSG Management Information, including trial balances

Appendix 4:
Non-recurrent adjustments

Non-recurrent adjustments – from NHSG data (1 of 3)

NHSG have identified the below non-recurrent items as potential underlying adjustments. This report has not assessed the validity and completeness, or the appropriateness of the identified underlying adjustments. Further work is therefore recommended for NHSG to enable updating the drivers of deficit work on an underlying basis, which incorporates a validated list of underlying adjustments.

NHS Grampian - Non Recurring Funding (Table 1/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Waiting Times - Elective Activity per AOPs - (75%)	8,093	-	-	-	-	-
Family Nurse Partnership Programme Funding	728	842	-	-	-	-
Waiting Times - Cancer & Diagnostic	1,803	-	-	-	-	-
£20m Tariff Reduction to Global Sum 2018-19	(1,841)	-	-	-	-	-
£20m Tariff Reduction to Global Sum 2019-20	(1,818)	-	-	-	-	-
e-Health Strategic Fund	1,679	-	-	-	-	-
NDC Top Slice	(1,573)	-	-	-	-	-
CSO - Support for Research Infrastructure	5,281	1,537	-	-	-	-
£20m Tariff Reduction to Global Sum 2018-19 - reversal	1,841	-	-	-	-	-
£20m Tariff Reduction to Global Sum 2019-20 - reversal	1,818	-	-	-	-	-
Scottish Trauma Network	2,433	-	-	-	-	-
Shingles, Rotavirus, Seasonal Flu and Childhood Flu 2019	1,359	-	-	-	-	-
Financial Flexibility - recovery of surplus	(3,000)	-	-	-	-	-
Transfer from NHS Grampian to GJHN for Stracathro activity	(1,400)	-	-	-	-	-
PET - Local	1,387	1,317	-	-	-	-
PET - National	(782)	(822)	-	-	-	-
Non Core Expenditure - Depreciation	(23,491)	-	-	-	-	-
NSD Topslice	(4,509)	-	(4,222)	-	-	-
Golden Jubilee Foundation top slice 2019-20 Boards SLA's	(1,173)	-	-	-	-	-
National VC Service	427	427	427	-	-	-
Additional funding for elective activity	1,320	-	-	-	-	-
Infrastructure Support	2,000	1,100	7,350	2,489	-	-
Reversal of allocation ref. 712 (Financial Flexibility - recovery of surplus)	3,000	-	-	-	-	-
Covid-19 - Integration Authority funding	-	4,982	-	-	-	-
eHealth Strategic Allocation	-	1,595	-	-	-	-

NHS Grampian - Non Recurring Funding (Table 2/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Social Care Sustainability - Tranche 2	-	2,491	-	-	-	-
CSO support for Health Innovation	-	590	615	-	-	-
NSS Riskshare	-	(5,396)	-	-	-	-
2020/21 PfG - Local Improvement Fund (ADP)	-	1,102	-	-	-	-
NHS Research Scotland infrastructure	-	3,763	-	-	-	-
SLA Children's Hospices Across Scotland (Year 4/5)	-	(592)	(584)	-	-	-
COVID-19 Q1-4 Funding Allocation	-	49,064	-	-	-	-
Mental Health Strategy Action 15 Workforce - First Tranche	-	1,455	-	-	-	-
NoS Regional eHealth Lead (HEPMA)	-	5,963	-	-	-	-
Covid-19 additional funding for GPs	-	1,968	-	-	-	-
Redesign of Urgent Care	-	972	974	-	-	-
NoS Regional eHealth Lead - reverses alloc. ref. 420	-	(5,963)	-	-	-	-
North of Scotland HEPMA	-	5,963	-	-	-	-
Social Care- Additional Covid Funding	-	4,048	-	-	-	-
GJNH - Top slice adjustment - Boards SLA's	-	(461)	(693)	-	-	-
Adult social care winter plan	-	11,261	-	-	-	-
PCIF balance	-	5,759	-	-	-	-
Action 15 Balance	-	1,526	-	-	-	-
Depreciation	-	(23,461)	(24,509)	-	-	-
HEPMA	-	(3,000)	-	1,500	-	-
Covid-19 Q1-4 Allocation - tranche 2	-	16,408	-	-	-	-
Community Living Change	-	2,011	-	-	-	-
Further Integration Authority Support	-	9,521	-	-	-	-
Annual leave additional accrual	-	4,800	-	-	-	-
Pay Award - 1% Increase	-	1,792	-	-	-	-

Source: NHSG Management Information

Non-recurrent adjustments – from NHSG data (2 of 3)

NHS Grampian - Non Recurring Funding (Table 3/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
£500 Thank You Payments - NHS	-	8,482	-	-	-	-
£500 Thank You Payments - PSD	-	1,824	-	-	-	-
AfC Pay Award Accrual Funding	-	5,471	-	-	-	-
Mental Health Recovery & Renewal (CAMHS & PT)	-	-	3,202	-	-	-
RMP 3 Elective Care	-	-	7,790	-	-	-
Type 2 Diabetes / Adult Weight Management	-	-	539	560	-	-
Test & Protect	-	-	10,621	-	-	-
Covid & Extended Flu Vaccinations	-	-	4,031	-	-	-
Q1 Covid Funding	-	-	7,576	-	-	-
Integrated Primary and Community Care	-	-	768	499	-	-
Local development aligned with DHAC Strategy	-	-	1,595	1,864	-	-
Aberdeen Health Village - Unitary Charge	-	-	1,203	-	-	-
Drug tariff reduction	-	-	(5,927)	(7,398)	-	-
General Dental Sevices element of the Public Dental Service	-	-	6,495	-	-	-
Further General Covid Funding 2021/22	-	-	14,322	-	-	-
Nurse Director Support for Care Homes	-	-	1,372	-	-	-
Covid and Extended Flu Vaccinations	-	-	17,588	-	-	-
ADP Programme for Government 2021-2022	-	-	1,678	-	-	-
RMP4 Elective Care Activity	-	-	7,410	-	-	-
CSO support for NHS Research Scotland infrastructure	-	-	5,520	2,782	-	-
Regional HEPMA Funding	-	-	1,500	-	-	-
Multi-disciplinary teams	-	-	1,969	-	3,397	-
Additional Band 2-4 Staffing	-	-	1,461	-	-	-
GP Practices – Sustainability Payment	-	-	1,473	-	-	-
Positron Emission Tomography Scans	-	-	1,444	1,535	-	-

NHS Grampian - Non Recurring Funding (Table 4/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Positron Emission Tomography Scans - Adjustment	-	-	(891)	(920)	-	-
Diabetic Technologies	-	-	1,593	-	-	-
Further 2021-22 Covid-19 Funding	-	-	60,873	-	-	-
Mental Health Recovery Renewal - Facilities Projects	-	-	1,461	-	-	-
Additional Covid-19 funding	-	-	1,291	-	-	-
Additional Covid funding	-	-	4,907	-	-	-
Additional Operational Pressures	-	-	2,793	-	-	-
Annual Leave Buy Back and Accrual	-	-	3,000	-	-	-
NSS Payments on Behalf - Pandemic Stock 21-22	-	-	7,985	-	-	-
Urgent and Unscheduled Care Collaborative	-	-	-	3,500	-	-
Test & Protect - Tranche 1	-	-	-	3,978	-	-
Unitary charge	-	-	-	3,592	-	-
Funding for Bands 2-4	-	-	-	2,931	-	-
Children's Hospices Across Scotland	-	-	-	(684)	-	(682)
Covid-19 Funding Envelopes 22-23	-	-	-	23,400	-	-
NSD Riskshare	-	-	-	(3,870)	-	-
National Video Conferencing	-	-	-	427	427	227
Nursing support for Adult Social Care	-	-	-	1,372	-	-
Return of funding	-	-	-	(26,987)	9,000	-
ADP tranche 2 allocation of National Mission	-	-	-	1,074	-	-
New Medicines Funding - additional funding	-	-	-	4,884	-	-
Pay Awards 22-23	-	-	-	40,300	-	-
GJNH - Top Slice Adjustment - Board SLAs	-	-	-	(1,026)	-	-
System Pressures	-	-	-	15,200	-	-
ADP - Tranche 3 National Mission	-	-	-	1,337	-	-

Source: NHSG Management Information

Non-recurrent adjustments – from NHSG data (3 of 3)

NHS Grampian - Non Recurring Funding (Table 5/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
SG Funded POB - PPE	-	-	-	2,136	-	-
Core RRL - IAS17/IFRS16 Reduction	-	-	-	(4,967)	-	-
Reduction in Core RRL (Depreciation Switch)	-	-	-	(24,510)	(24,500)	(24,500)
One-off Payment - Pay Award	-	-	-	-	7,987	-
New Medicines Funding	-	-	-	-	9,738	-
Mobile scanner and endoscopy	-	-	-	-	3,502	-
Cancer Waiting Times - pathway improvement	-	-	-	-	1,070	-
New Medicines	-	-	-	-	14,606	-
ADP / NM Tranche 1 & AfC	-	-	-	-	3,021	-
NSD Risk-share	-	-	-	-	(4,955)	-
Digital Health & Care Strategic Fund	-	-	-	-	1,544	1,492
23-24 Mental Health Outcomes Framework	-	-	-	-	5,240	-
CSO Support for NRS Infrastructure	-	-	-	-	5,789	-
Multi-Disciplinary Teams (reverse 110)	-	-	-	-	(3,397)	-
Urgent & Unscheduled Care	-	-	-	-	3,173	-
Collaborative & Clinical Care Support	-	-	-	-	1,372	-
Maternity Moray Service	-	-	-	-	1,550	-
ADP/NM Tranche 2	-	-	-	-	1,161	-
Childhood Flu Vaccine costs delivered during winter 2023/24	-	-	-	-	1,107	-
Logistics Services Charge Top Slice 2023/24	-	-	-	-	(1,713)	-
GJNH Core top slice adjustment - Boards SLAs	-	-	-	-	(2,332)	-
Agenda for change/Pay Award Uplift funding gap	-	-	-	-	2,114	-
Health Consequentials/sustainability funding 2023/24	-	-	-	-	14,610	-
National Treatment Centres - Top Slicing for activity	-	-	-	-	(1,280)	-
National Treatment Centres - Activity Cost	-	-	-	-	1,280	-

NHS Grampian - Non Recurring Funding (Table 6/6)						
Funding Allocation	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
2023/24 PPE Usage	-	-	-	-	1,160	-
Infrastructure Support (Capital to Rev)	-	-	-	-	1,981	-
Sustainability Payments	-	-	-	-	6,000	-
Core RRL - IAS17/IFRS 16 Reduction	-	-	-	-	(3,972)	-
Core RRL - IFRS 16 Interest	-	-	-	-	1,176	-
Financial Brokerage 2023/24	-	-	-	-	24,800	-
Non Pay Reforms	-	-	-	-	-	19,490
New Medicines (PPRS)	-	-	-	-	-	22,316
Collaborative Care Home Support Teams	-	-	-	-	-	1,372
NSD- Non-Recurring Risk Share Top-Slice	-	-	-	-	-	(5,459)
NSS- Logistics Top-slice	-	-	-	-	-	(1,995)
Dr Grays	-	-	-	-	-	3,000
NHS Research Scotland Infrastructure Funding 24/25	-	-	-	-	-	5,616
Waiting Times - Endoscopy and diagnostics	-	-	-	-	-	3,342
AfC Reform Costs (Share of £30m)	-	-	-	-	-	2,923
Planned Care Recovery funding - £30m	-	-	-	-	-	3,245
Shingrix Vaccination Programme	-	-	-	-	-	2,177
Child Flu LAIV vaccines	-	-	-	-	-	1,036
Planned Care Recovery funding - £30m of £100m for 3years	-	-	-	-	-	1,493
2024-25 Brokerage	-	-	-	-	-	65,200
IAS 17 Lease Payments	-	-	-	-	-	(4,233)
Lease Interest	-	-	-	-	-	1,139
Capital to Revenue	-	-	-	-	-	4,113
GMS Uplift - non-recurring	-	-	-	-	-	7,203
Total of items listed above	**-6,418**	**118,339**	**156,000**	**44,998**	**84,656**	**108,515**
Total of individual funding items between £(1)m and £1m	7,755	15,592	26,973	12,416	12,655	7,508
Total Non Recurring Core Funding	**1,337**	**133,931**	**182,973**	**57,414**	**97,311**	**116,023**

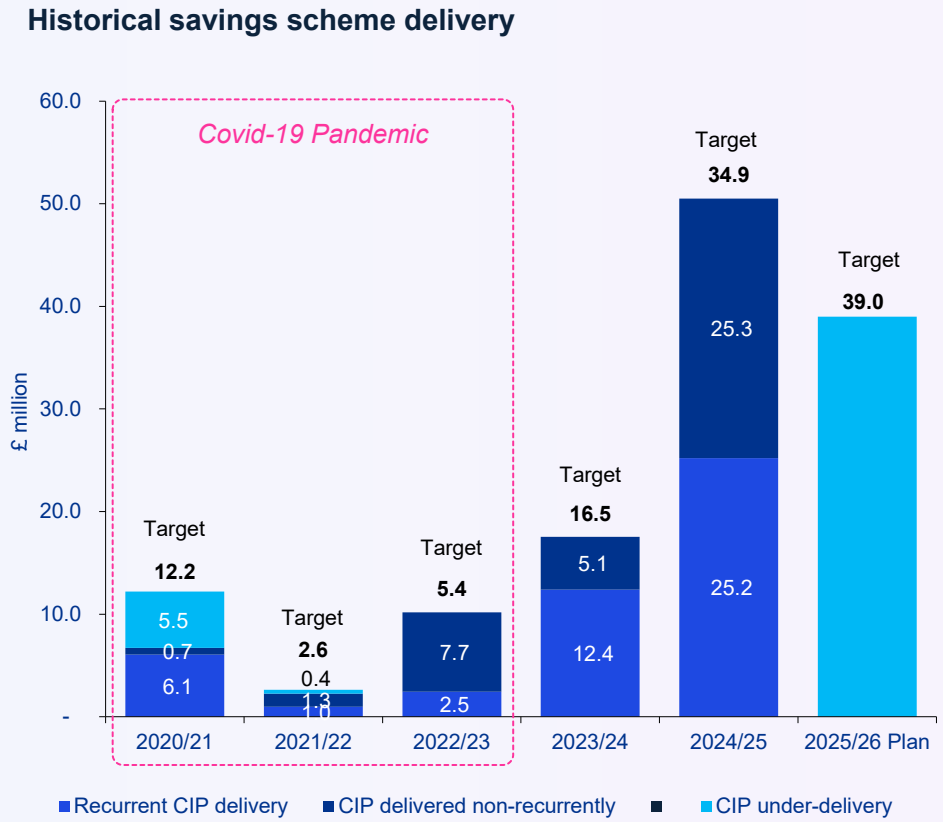
Source: NHSG Management Information

Appendix 5:

Supporting analysis to Financial Assessment & Drivers of the Deficit

Limited recurrent savings delivered between 2020/21 to 2023/24 did not bridge the funding gap and have contributed to the deficit

This page aims to set out NHSG's reliance on non-recurrent savings between 2020/21 and 2024/25, as well as the challenge in 2025/26 plan.



Source: NHSG Management Information

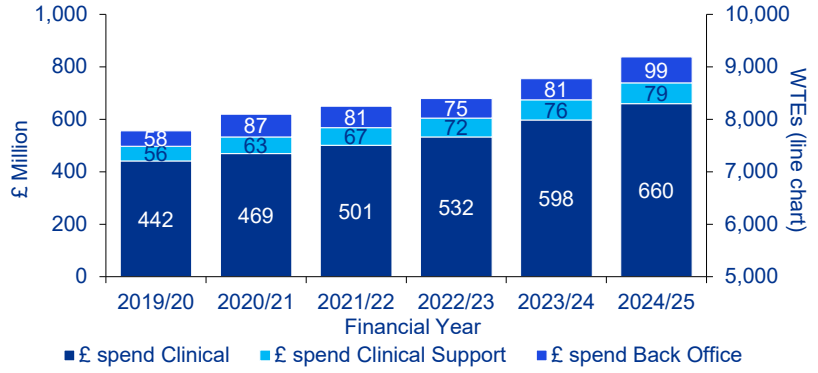
- **NHSG has exceeded its planned total savings target in each of the last three financial years:**
  - 2022/23 – £10.2 million reported as delivered versus target of £5.4 million
  - 2023/24 – £17.5 million reported as delivered versus target of £16.5 million
  - 2024/25 – £50.5 million reported as delivered versus target of £34.9 million
- However, a significant proportion (41% in 2023/24 and 50% in 2024/25) have been delivered non-recurrently in the last two financial years.
- While NHSG has successfully delivered in excess of its planned savings target in both 2023/24 and 2024/25, NHSG's deficit has exceeded plan despite this in both financial years. Given a significant proportion of savings where delivered by non-recurrent measures, increases in NHSG's wider expenditure base have outstripped the savings delivered highlighting the need for increased financial grip to deliver to plan.
- Limited delivery of recurrent savings during the pandemic and immediately after in 2023/24 and 2024/25 (noting that a total of £50.5 million of savings where delivered in 2024/25) has therefore contributed to the deterioration of NHSG's financial deficits. While the shortfall in recurrent delivery has been met with delivery of non-recurrent savings, this creates pressures in subsequent years.
- The impact of under delivery in recurrent savings was mitigated due to the Covid-19 funding regime. However, NHSG's under delivery of recurrent savings by £4.1 million in 2023/24 continues to create pressures in subsequent years.
- The total saving target for NHSG in 2024/25 was £34.9 million, with the target for recurrent schemes being £22.0 million, (reflecting approximately 3% of the non-delegated net expenditure). NHSG met this target in 2024/25 by delivering £25.2 million recurrent savings (overall delivery of £50.5m savings).
- NHSG's cost base had continued to increase between 2020/21 to 2022/23 due to inflation and other factors. However, limited savings targets and delivery during this period meant NHSG's financial sustainability became reliant on the additional funding provided in this period being recurrent.
- Due to the Covid-19 pandemic, NHSG shifted focus to manage the pandemic and there was limited focus on recurrent savings delivery. However, this is consistent with other healthcare providers across the UK as other organisations reported little to no saving delivery during these years.
- For 2025/26, NHSG has a savings target of £39.0 million, which is significantly higher than savings delivery in recent years, underpinning the challenge for the 2025/26 plan.

Recent growth in WTEs has slowed, but is still reflecting an increase year on year across clinical as well as non-clinical staff areas

This page provides an overview of how NHSG's staffing and pay costs have evolved from 2019/20 to 2024/25, highlighting trends in workforce expansion and the financial implications across clinical, support, and administrative functions.

- Pay costs have increased in the Clinical functions by £218.5 m (£117.2 m excluding pay awards) accounting for 77.3% of the increase from 2019/20 to 2024/25. This largely corresponds to the growth in WTEs, with Clinical function WTEs increasing by 1,060 WTEs and accounting for 78.9% of all WTE growth from 2019/20 to 2024/25. These are largely due to increased training posts, staffing additional beds, recruitment against open vacancies and increased staffing under safer staffing act.
- Back office pay costs increased by 70.8% from 2019/20 to 2024/25. The number of WTEs in Back-office functions increased from 1,479 WTEs in 2019/20 to 1,852 WTEs by 2021/22. However, these declined to 1,699 WTEs in 2022/23 before gradually increasing to 1,750 WTEs by 2024/25. This is due to a number of changes including new services required post COVID including the enhanced vaccination programme and the face fit testing team and other new services such as the regional HEPMA programme hosted in NHS Grampian and the introduction of eRostering. Further work is recommended to understand and validate the drivers of increase in back office WTEs.

NHSG Workforce - Pay Spend vs WTEs



Source: NHSG Management Information, including trial balances

Clinical, Clinical Support and Back office pay costs summary

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Increase	Pay Award	Net Increase	Net increase %
Spend (£ million)										
Clinical	441.6	469.5	501.1	532.3	597.9	660.1	218.5	101.3	117.2	*49.5%*
Clinical Support	55.8	63.0	67.4	72.3	76.1	78.9	23.0	28.9	-5.8	*41.3%*
Back Office	58.0	87.3	81.3	75.0	80.7	99.1	41.1	19.0	22.0	*70.8%*
Total	**555.4**	**619.8**	**649.7**	**679.6**	**754.6**	**838.1**	**282.6**	**149.2**	**133.4**	***50.9%***
Clinical		*6.3%*	*6.7%*	*6.2%*	*12.3%*	*10.4%*				
Clinical Support		*12.8%*	*7.0%*	*7.4%*	*5.2%*	*3.7%*				
Back Office		*50.5%*	*-6.9%*	*-7.8%*	*7.6%*	*22.8%*				
Total		***11.6%***	***4.8%***	***4.6%***	***11.0%***	***11.1%***				
WTEs										
Clinical	6,474	6,916	7,185	6,986	7,266	7,534	1,060		1,060	*16.4%*
Clinical Support	1,805	1,945	1,977	1,912	1,857	1,816	11		11	*0.6%*
Back Office	1,479	1,683	1,852	1,699	1,728	1,750	271		271	*18.3%*
Total	**9,758**	**10,544**	**11,014**	**10,598**	**10,851**	**11,101**	**1,343**		**1,343**	***13.8%***
Clinical		*6.8%*	*3.9%*	*-2.8%*	*4.0%*	*3.7%*				
Clinical Support		*7.7%*	*1.7%*	*-3.3%*	*-2.9%*	*-2.2%*				
Back Office		*13.8%*	*10.1%*	*-8.2%*	*1.7%*	*1.3%*				
Total		***8.1%***	***4.5%***	***-3.8%***	***2.4%***	***2.3%***				

A number of changes including new services required post COVID including the enhanced vaccination programme and the face fit testing team and other new services such as the regional HEPMA programme hosted in NHS Grampian and the introduction of eRostering

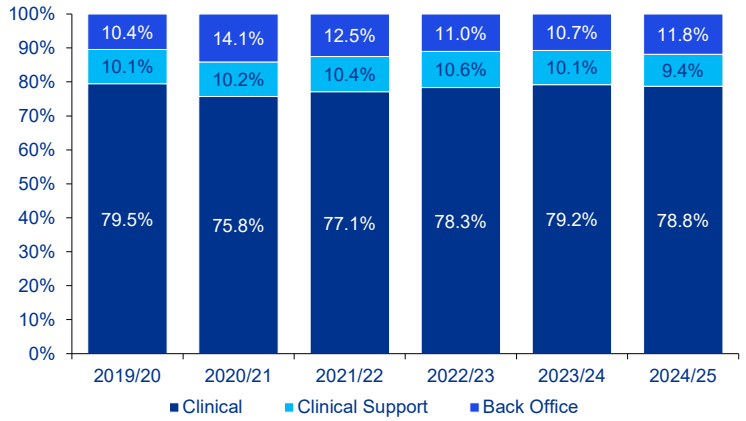
Post Covid surge capacity, additional waiting lists, recruitment against vacant posts and increased staffing against safer staffing act and increase in training posts

Appendix 5 - Supporting analysis to Financial Assessment & Drivers of the Deficit

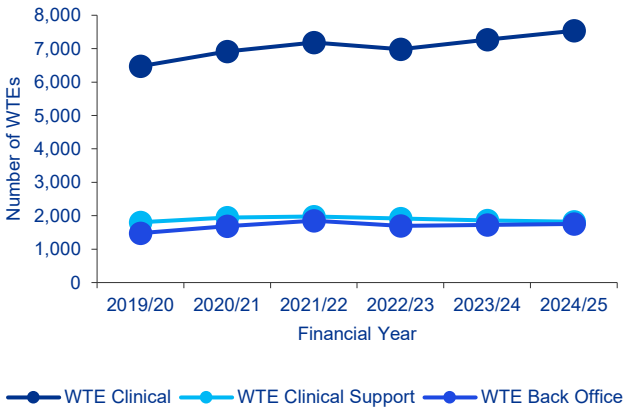
Cost per WTE for all staff groups has been increasing, due to the impact of pay awards and a disproportionate increase in hiring higher cost staff

This page analyses the change in proportion of £ spend and WTEs by business areas (clinical, clinical support and back office) and the WTE progression and cost per FTE from 2019/20 to 2024/25.

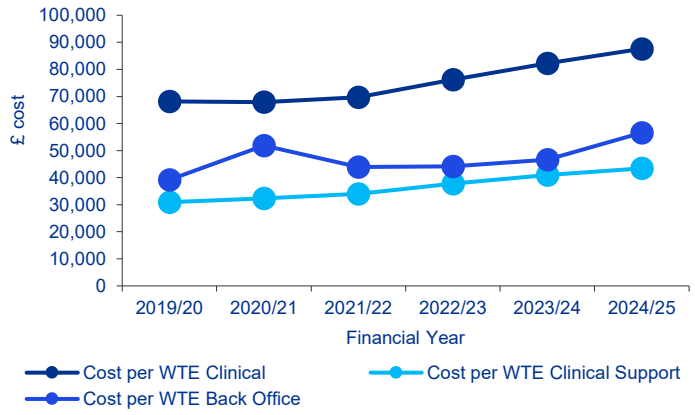
Proportion of £ spend by Business Area



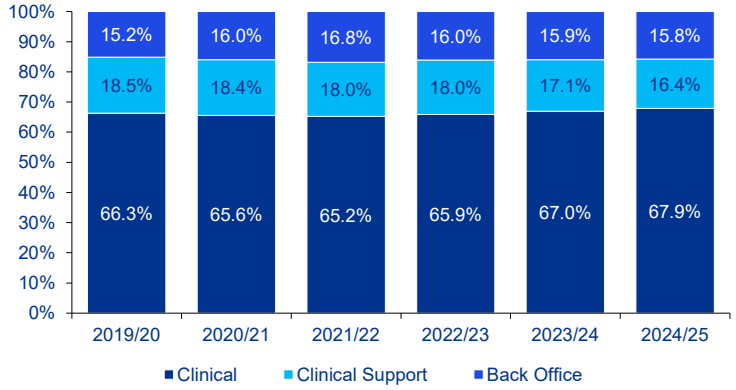
WTE Progression (2019/20 to 2024/25)



Cost per WTE



Proportion of WTEs by Business Area



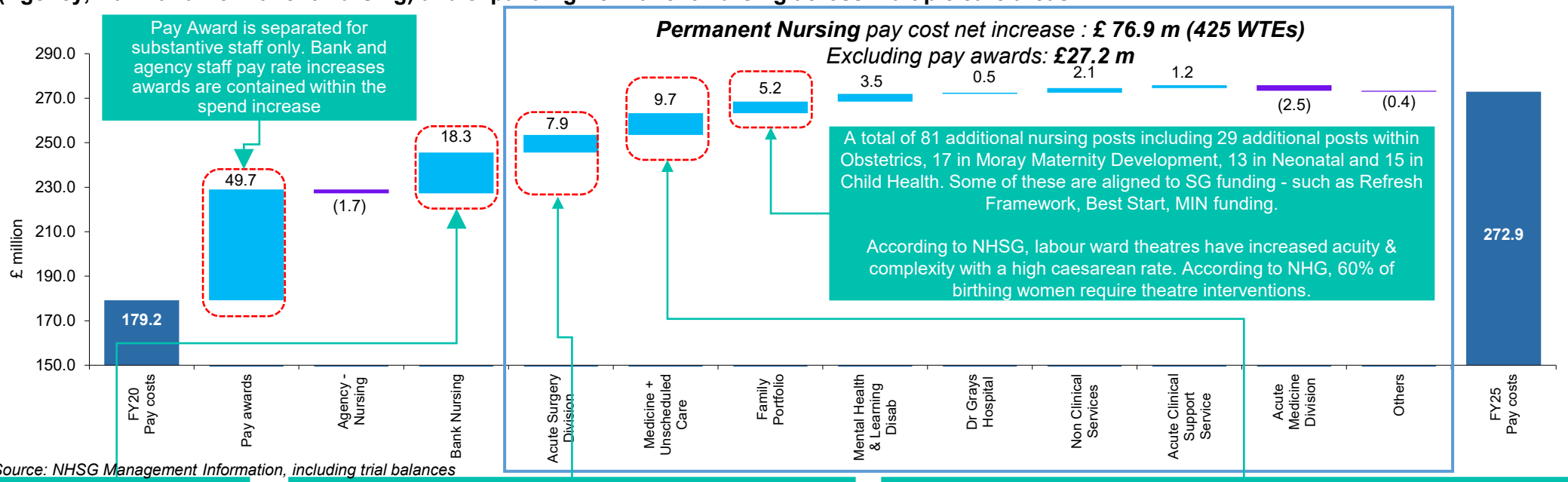
Cost per WTE						
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Clinical	68,216	67,886	69,747	76,188	82,289	87,619
Clinical Support	30,930	32,370	34,064	37,817	40,956	43,423
Back Office	39,213	51,883	43,889	44,117	46,669	56,598
NHS Grampian	**56,922**	**58,780**	**58,993**	**64,122**	**69,542**	**75,497**

Appendix 6:

Deep dive analysis to Financial Assessment & Drivers of the Deficit areas

Pay awards, increase in Bank usage and increases in substantive staff in Medicine and Unscheduled Care, Acute Surgery divisions, Family Portfolio and Mental Health have led to a £76.9m increase in Nursing pay costs

This page provides an overview of the key drivers behind the rise in nursing pay costs from FY20 to FY25, focusing on workforce expansion by type (Agency, Bank and Permanent Nursing) and expanding Permanent Nursing across multiple care areas.



Source: NHSG Management Information, including trial balances

HCSSA mandated safer staffing levels, surge capacity pressures, and sickness absence – primarily in Medicine and Unscheduled Care, Mental Health and Learning Disability, Acute Surgery Division and Dr. Gray's Hospital have been cited by NHSG as the reason for **additional 257** Bank Nurse staffs.

Addition of 137 additional nurses. According to NHSG, this is driven by hiring against vacancies, increased patient numbers, including surge beds and new emergency clinics.

The 2024 CSM found a 44 WTE shortfall which led to a new patient assessment and admission methods resulting in emergency clinics in Urology, General Surgery and Vascular.

In response to rising emergency cases in some surgical specialties, new methods for patient assessment and admission have been implemented, leading to the establishment of emergency clinics in Urology, General Surgery, and Vascular.

Addition of 288 WTEs, including 92 in Emergency, 119 in Unscheduled – Urgent (mainly Cardiology and medical specialty wards) and 78 in Long Term Conditions (mainly Respiratory medicine).

NHSG Management has reported that there are consistently up to 49 surge beds in use daily cross the portfolio, which need to be staffed. The portfolio also opened three new wards since 2020 which required additional substantive staff.

Additionally, HCSSA mandated safer staffing levels are driving increased staffing requirements while gaps due to vacancy and turnover of staff, which had been filled by agency and bank nursing, are now being replaced by substantive recruitment after funded establishment amendments.

Notes:
Others include OPERATIONAL PROVISIONS , PUBLIC HEALTH ,PHARMACY SERVICES, CENTRALLY,MANAGED DENTAL SERVS, CANCER PERFOMANCE TEAM, ACUTE PERFORMANCE + GOV,TRANSFORMATION TEAM, ACUTE SECTOR MANAGEMENT

Safer staffing levels, surge capacity pressures and sickness absence are cited by NHSG as the reason for increased Bank Nurse use

This page analyses Bank nursing pay cost trend by cost centres and highlighting the percentage change and WTEs over years. Commentary on the underlying explanations of these increases is also listed below.

Nursing pay - bank nursing by cost centres									
		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Increase	*Increase %*	Increase in WTEs
1	Medicine + Unscheduled Care	2,682,909	2,953,309	4,221,470	6,797,430	8,366,403	9,718,721	7,035,812	***162.2%***	**114**
2	Mental Health & Learning Disab	3,293,285	3,144,555	3,292,400	4,693,982	6,166,255	8,088,896	4,795,611	***45.6%***	**65**
3	Acute Surgery Division	2,400,989	2,062,864	2,593,483	4,205,413	5,357,114	6,003,507	3,602,519	***50.0%***	**50**
4	Dr Grays Hospital	826,817	803,891	741,295	1,039,438	1,831,164	2,358,066	1,531,249	***85.2%***	**20**
	Family Portfolio	1,365,382	1,391,235	1,545,455	1,984,538	2,314,038	2,171,430	806,048	***-41.0%***	**5**
	Acute Clinical Support Service	754,800	492,379	827,663	1,307,835	1,456,621	1,555,217	800,418	***6.0%***	**11**
	Operational Provisions	533,146	1,293,924	1,322,622	1,338,621	2,851,130	1,076,822	543,676	***2.0%***	**3**
	Others	774,775	595,146	664,084	391,846	11,410	-10,747	-785,522	***-201.4%***	**-12**
	Bank Nursing	**12,632,102**	**12,737,303**	**15,208,471**	**21,759,101**	**28,354,135**	**30,961,914**	**18,329,811**	***45.1%***	**257**

Source: NHSG Management Information, including trial balances

1

NHSG Management has reported that this is due to changes in the Emergency Department and Acute Medical Initial Assessment areas which have led to increased staffing needs – which are filled by a mix of agency and bank staff.

NHSG Management has reported that sickness absence remains an issue and continues to deteriorate, particularly in long-term cases.

There have also been additional ward areas that have opened since 2020, adding 56 beds, requiring bank nurses to facilitate recruitment.

There are also 8 overspill beds in use, with funding for only 6 on weekdays. Further staffing requirements are driven by current initiatives aim to improve patient flow and safety in ambulances.

2

NHSG Management has reported that this increase is to comply with legislation on safe staffing levels amidst rising patient acuity and demand, as well as the use of surge beds. Continuous Interventions (CIs) have increased from a norm of 30-35 WTEs to a peak of 49 WTEs across the site.

This rise is linked to deteriorating physical environments, more adverse events, and higher RIDDOR reportable injuries among staff. Staff sickness stands at 9.6%, primarily due to mental health issues, which is notably higher than the NHSG average.

In May, a civil contingency was activated to seek mutual aid due to high clinical demand and acuity at the RCH site, necessitating additional bank staff to ensure safe hospital operations.

3

NHSG Management has reported that this is to cover short and long-term sick leave or maternity leave, as well as to provide extra support. Bank is the preferred option for filling any unfilled shifts.

Utilizing supplementary staff ensures safe staffing levels, in accordance with the Health and Care Staffing Act.

4

NHSG Management has reported that HCSSA & use of common staffing method has meant increased use of supplementary staffing to ensure appropriate staffing levels in all clinical areas.

Reduction in working week hours (£4.3 - £4.9 million) and re-grading of band 2 nurses to band 3 (£2.1 million) has created additional pressures for NHSG

This page outlines the financial impact of structural workforce changes in NHG's nursing staff, including reduced working hours and regrading of Band 2 nurses.

Nursing pay cost by bands

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Increase	Increase in WTEs	Pay award	Net increase	*Net increase %*
Agency - Nursing	9,380,465	4,041,800	6,128,930	11,508,366	13,348,274	7,723,021	-1,657	-31	N/A	-1,657	*-17.7%*
Bank Nursing	12,632,102	12,737,303	15,208,471	21,759,101	28,354,135	30,961,914	18,329,811	257	N/A	18,329,811	*145.1%*
Permanent Nursing	157,234,818	184,224,429	192,896,498	191,275,131	208,977,311	234,168,753	76,933,935	425	N/A	76,933,935	*48.9%*
Permanent Nursing - Band 2	19,536,808	21,918,170	26,201,548	16,653,180	5,145,528	4,683,373	-14,853	-527	4,703,999	-19,557	*-76.0%*
Permanent Nursing - Band 3	8,419,560	11,625,024	11,917,691	19,343,402	34,193,735	40,214,456	31,794,897	637	4,693,951	27,100,946	*377.6%*
Permanent Nursing - Band 4	2,384,502	7,036,194	2,909,855	3,537,463	4,594,900	3,546,843	1,162,341	20	1,029,198	133,142	*48.7%*
Permanent Nursing - Band 5	63,070,751	71,858,788	76,249,524	71,592,113	75,228,022	86,820,302	23,749,551	107	18,968,774	4,780,777	*37.7%*
Permanent Nursing - Band 6	34,201,546	36,222,449	39,441,679	42,834,114	49,190,860	54,884,825	20,683,279	127	10,760,379	9,922,900	*60.5%*
Permanent Nursing - Band 7	22,002,513	27,226,950	27,058,259	28,186,256	30,611,929	33,070,952	11,068,438	58	7,178,055	3,890,383	*50.3%*
Permanent Nursing - Band 8A	4,532,915	5,091,656	5,213,256	4,872,627	4,941,046	5,571,667	1,038,751	-6	1,297,478	-259	*22.9%*
Permanent Nursing - Band 8B	1,326,589	1,231,594	1,710,619	1,980,328	2,548,885	2,701,246	1,374,657	10	480,183	894,474	*103.6%*
Permanent Nursing - Band 8C	1,342,733	1,472,159	1,596,909	1,582,077	1,422,767	1,269,668	-73	-3	393,592	-467	*-5.4%*
Permanent Nursing - Band 8D	317,118	476,618	491,350	390,892	618,154	779,517	462,399	2	122,934	339,466	*145.8%*
Other Permanent Nursing	99,783	64,827	105,808	302,680	481,486	625,904	526,121	1	59,165	466,956	*527.3%*
Total	**179,247,386**	**201,003,532**	**214,233,899**	**224,542,599**	**250,679,720**	**272,853,688**	**93,606,303**	**651**	**49,687,708**	**36,621,609**	***52.2%***

Source: NHSG Management Information, including trial balances

NHSG Management has reported that national regrading of band 2 nurses resulted in significant number of nurses moving from band 2 posts to band 3. This was not funded and resulted in a cost pressure, albeit offset by an associated reduction in band 2s

We note that Band 3 Nurses cost £2,979 more p.a. than Band 2 Nurses in 2024/25 – re-grading 714 staff from Band 2 to Band 3 quantifies into an impact of £2.1 m.

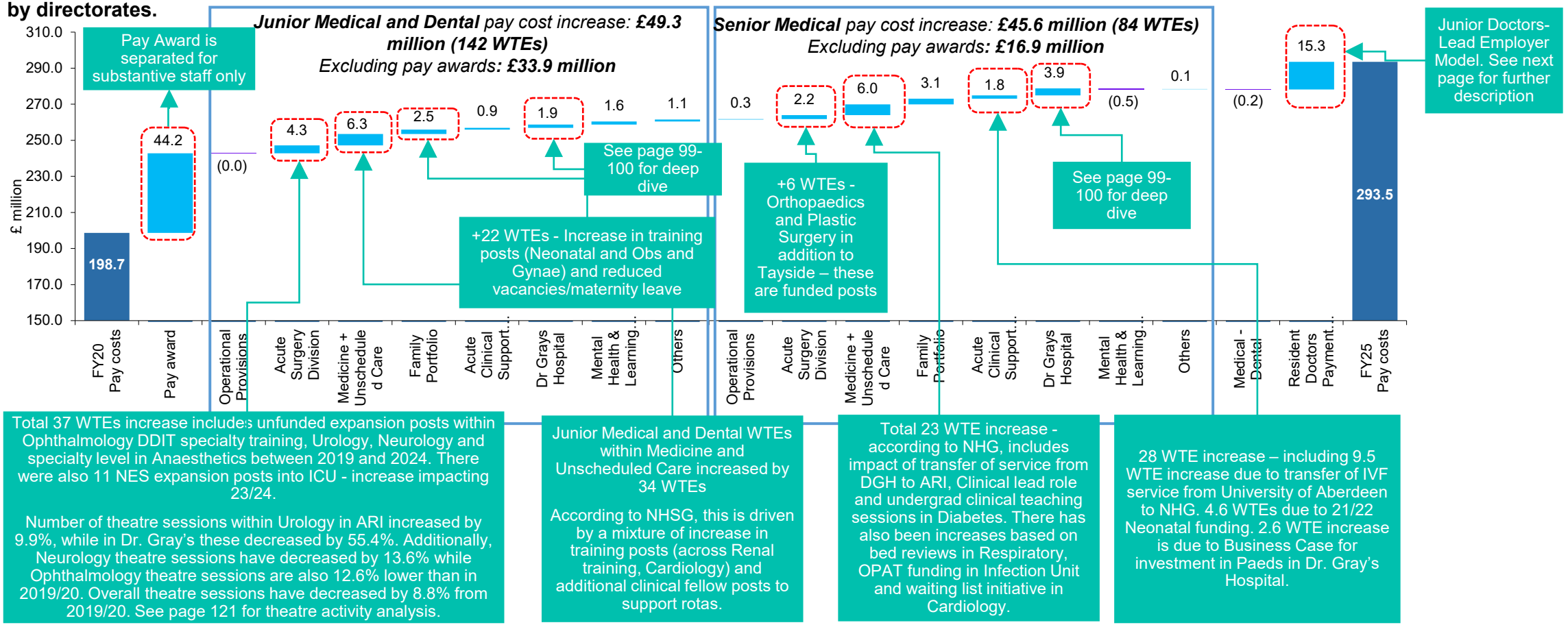
We note that the AfC working week hours reduced from 37.5 hours a week to 37 hours in 2024/25, creating a gap in available staff time time for all AfC staff, including Nursing. For the Nursing staff group, however, this gap needed to be funded by additional substantive staff, bank, agency or use of overtime.

Based on the pay cost of £320.3 m in 2023/24, the value of 0.5 hours lost is estimated at £4.3m. (i.e. £4.3m = £320.3m x 0.5/37.5)

We note that NHSG has estimated the actual impact of this change in terms of additional backfill, overtime and Bank use at £4.9 m.

Medical and Dental pay costs increased due to training posts, recruitment to vacancies and additional posts to support rotas

This page provides an overview of the key drivers behind the rise in Medical & Dental pay costs from FY20 to FY25, focusing on workforce expansion by directorates.



Total 37 WTEs increase includes unfunded expansion posts within Ophthalmology DDIT specialty training, Urology, Neurology and specialty level in Anaesthetics between 2019 and 2024. There were also 11 NES expansion posts into ICU - increase impacting 23/24.

Number of theatre sessions within Urology in ARI increased by 9.9%, while in Dr. Gray's these decreased by 55.4%. Additionally, Neurology theatre sessions have decreased by 13.6% while Ophthalmology theatre sessions are also 12.6% lower than in 2019/20. Overall theatre sessions have decreased by 8.8% from 2019/20. See page 121 for theatre activity analysis.

Junior Medical and Dental WTEs within Medicine and Unscheduled Care increased by 34 WTEs

According to NHSG, this is driven by a mixture of increase in training posts (across Renal training, Cardiology) and additional clinical fellow posts to support rotas.

Total 23 WTE increase - according to NHG, includes impact of transfer of service from DGH to ARI, Clinical lead role and undergrad clinical teaching sessions in Diabetes. There has also been increases based on bed reviews in Respiratory, OPAT funding in Infection Unit and waiting list initiative in Cardiology.

28 WTE increase – including 9.5 WTE increase due to transfer of IVF service from University of Aberdeen to NHG. 4.6 WTEs due to 21/22 Neonatal funding. 2.6 WTE increase is due to Business Case for investment in Paeds in Dr. Gray's Hospital.

Notes:

1. Junior Medical – Others includes: NON-CLINICAL SERVICES, PUBLIC HEALTH, CENTRALLY MANAGED DENTAL SERVS, PHARMACY SERVICES, SERVICE PURCHASING, ACUTE PERFORMANCE + GOV,ACUTE MEDICINE DIVISION

2. Senior Medical – Others includes: NON-CLINICAL SERVICES, PUBLIC HEALTH,CENTRALLY MANAGED DENTAL SERVS, PHARMACY SERVICES, RETAINED NCARE, ACUTE MEDICINE DIVISION, ACUTE PERFORMANCE + GOV

Source: NHSG Management Information, including trial balances

Agency and Locum posts have decreased from 2019/20 while substantive posts in Specialty Registrar (91 WTEs), Consultants (58 WTEs) and Foundation Year 1 and 2 (64 WTEs) have increased

This page provides a breakdown of medical and dental pay cost increases across staff grades, to allow identification of staff groups with significant changes.

Medical and Dental Pay cost by type

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Increase	Increase in WTEs	Pay Award	Net increase	*Net increase %*
Junior Medical	**97,810,092**	**94,543,059**	**102,640,539**	**109,491,785**	**129,392,241**	**147,128,814**	**49,318,723**	**142**	**15,371,972**	**33,946,751**	***50.4%***
Junior Doctors - Lead Employer	49,262,073	43,544,839	47,050,862	48,310,671	55,099,222	64,538,290	15,276,217	0	0	15,276,217	*31.0%*
Foundation Yr1/2	10,256,806	11,640,685	13,309,383	15,283,723	19,467,003	21,502,290	11,245,483	64	4,084,479	7,161,004	*109.6%*
Specialty Registrar (STR)	32,284,980	34,974,318	37,900,798	40,807,455	49,104,828	57,000,480	24,715,500	91	11,014,229	13,701,271	*76.6%*
Agency Locum	4,809,291	2,623,494	2,760,672	4,277,559	5,112,371	3,116,704	-1,692,587	-5	0	-1,692,587	*-35.2%*
NHS Locum	1,081,086	1,563,535	1,224,588	536,549	393,868	660,305	-420,781	-9	206,927	-627,709	*-38.9%*
Other Junior Medical	115,854	196,188	394,235	275,828	214,950	310,745	194,890	2	66,336	128,554	*168.2%*
Medical - Dental	**473,217**	**1,614,739**	**559,602**	**615,271**	**602,159**	**465,891**	**-7,326**	**-1**	**185,662**	**-192,988**	***-1.5%***
Senior Medical	**100,376,689**	**101,409,487**	**109,570,565**	**118,006,362**	**129,637,371**	**145,933,467**	**45,556,778**	**84**	**28,636,740**	**16,920,039**	***45.4%***
Consultant	77,730,341	81,917,996	89,130,215	94,614,820	101,387,566	116,956,416	39,226,076	58	24,606,486	14,619,590	*50.5%*
Specialty Doctors	4,228,534	4,947,368	5,634,265	6,314,495	7,795,163	9,863,153	5,634,619	33	1,675,784	3,958,834	*133.3%*
Agency Locum	11,032,499	6,629,926	7,161,365	8,146,728	10,204,090	8,710,576	-2,321,924	-10	0	-2,321,924	*-21.0%*
Practitioners	691,548	834,404	1,167,234	1,691,503	1,924,589	2,434,886	1,743,337	11	392,097	1,351,241	*252.1%*
Associate Specialist	2,069,619	1,794,872	1,479,208	1,224,838	1,197,260	1,645,128	-424,491	-7	374,890	-799,381	*-20.5%*
NHS Locum	3,702,481	4,322,462	4,059,836	5,243,089	6,307,690	5,505,086	1,802,605	-0	1,360,966	441,640	*48.7%*
Other Senior Medical	921,666	962,459	938,441	770,889	821,014	818,223	-103,443	-1	226,517	-329,960	*-11.2%*
Total	**198,659,998**	**197,567,285**	**212,770,707**	**228,113,418**	**259,631,772**	**293,528,173**	**94,868,175**	**226**	**44,194,374**	**50,673,802**	***-52.2%***

Source: NHSG Management Information, including trial balances

FY1/2 costs includes payments made to Resident Doctors on the Lead Employer model – these were £49.3 m in 2019/20 and £64.5 m in 2024/25. These are funded on a passthrough basis from NHS Scotland, which partially accounts for the increase in NHS Scotland income.

Net of the passthrough Lead Employer costs, FY1/2 pay costs increased by £11.2 m from 2019/20 to 2024/25.

Increase in FY1 and FY2 WTEs were largely attributable to Acute Surgery, Dr. Gray's Hospital, Long Term Conditions, Mental Health Divisions, Emergency and Unscheduled – Urgent.

Acute Surgery reflected an increase of 25 WTEs.

Other increases in cost are within acute women and children - 25 WTEs increase. This is due increase in neonatal posts based on 21/22 neonatal funding and increase in posts within obstetrics and gynaecology.

Mental Health Directorate reflected an increase of 15 WTEs due to increased patient needs. Within Emergency - £2.0 m and only 6 WTEs increase for balancing clinical fellow posts needed to support rotas as well as MH Central directorate - £1.8 m and 15 WTEs increase due to increase in mental heath activities.

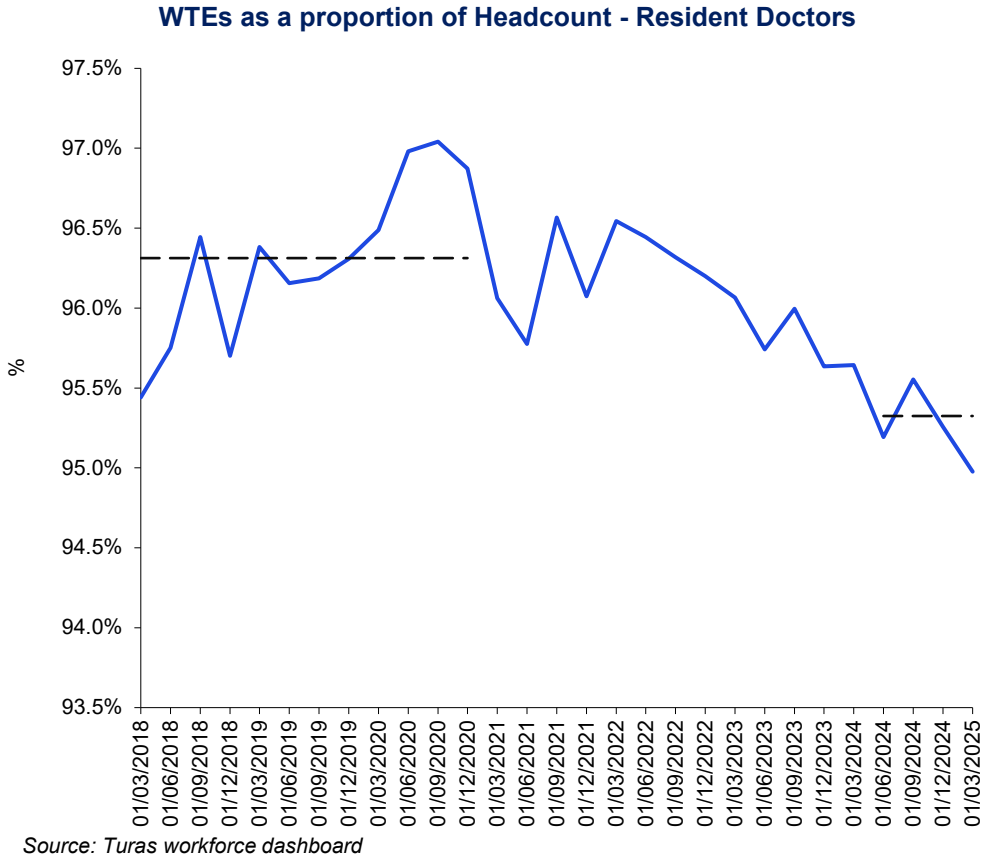
Increase in Consultants primarily in Anaesthetics; ITU (6 WTEs), Child Health Medical (8 WTEs), Foresterhill Radiology (6 WTEs), Cancer Services (4 WTEs), Cardiology (4 WTEs), Diabetes (6 WTEs), Gynaecology (4 WTEs).

Pathology and Infection unit also reflected an increase of 3 WTEs each. Other services with 2 WTE increase each were observed in Renal Service, Neonatal, Neurology and Breast.

Some of the Increases are because of OPAT funding (Infection Unit), bed review (respiratory), to reduce waiting times (Cardiology) and opening of additional 402/3 ward in 2020. Other additional WTEs are primarily due to transfer of services (e.g. IVF) and recruitment to vacant posts

Increasing proportion of Resident doctors working less than full-time is partially contributing to a deteriorating financial deficit

This page highlights a funding misalignment caused by changes in working patterns among Resident Doctors, which has increased staffing costs without corresponding adjustments in fundings.

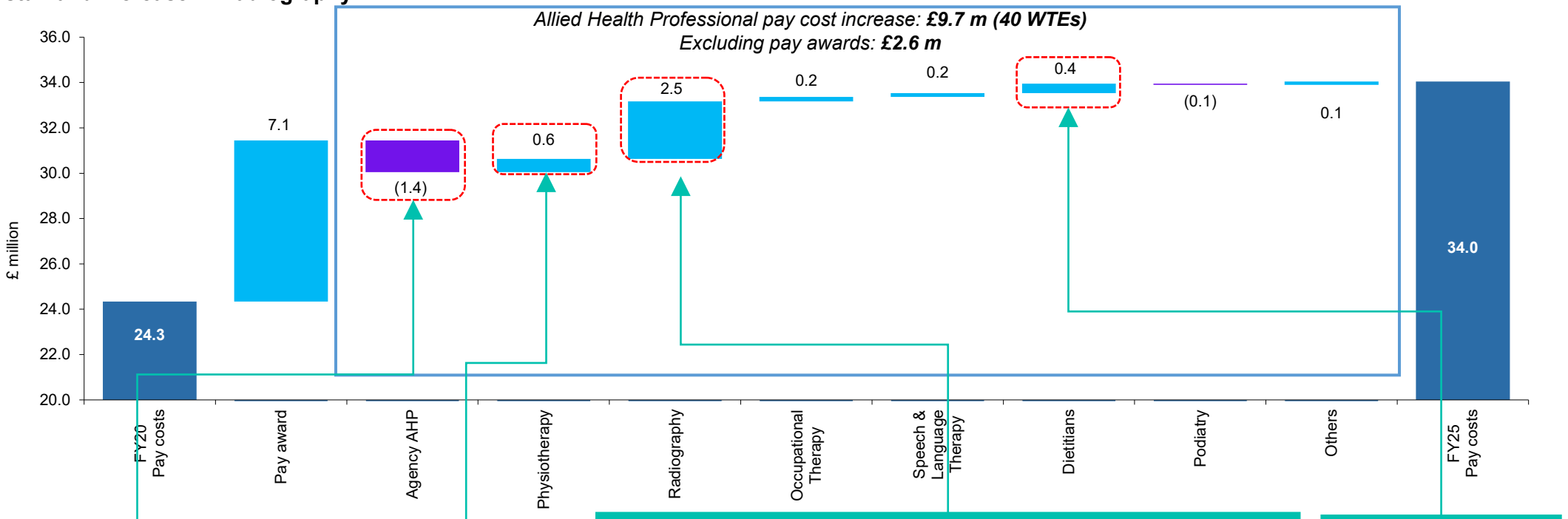


Source: Turas workforce dashboard

- According to NHSG Management, NHSG receives funding from NES on Resident Doctor trainees based on a headcount basis, rather than a WTE basis.
- Due to an increase in the proportion of Resident Doctors working less than fulltime, NHSG has to fill gaps by employing additional staff without corresponding funding from NES.
- Data from Turas suggests that the gap between WTEs and Headcounts has increased in the recent quarters, as compared to before and during the Covid-19 pandemic, providing support to the hypothesis.
- The WTE to Headcount ratio has declined from 96.3% (averaged across March 2018 to December 2020) to 95.3% (averaged across June 2024 to March 2025). This 1% decrease, if applied to the total NES Junior Doctors Income in 2024/25 (£36.5 million) translates to an increase in funding gap of of approximately **£0.6 m** (including a 50% uplift for banding costs) which is potentially unfunded.
- However, an internal assessment by NHSG estimates the impact of lost income associated with less than fulltime working to be **£1.9 million.**

Allied Health Professional Pay costs increased primarily within Radiography due to WLIs

This page outlines the drivers behind increased Allied Health Professional pay costs by type from FY20 to FY25, highlighting the reduction in Agency staff and increase in Radiography.



Source: NHSG Management Information, including trial balances

13 WTEs reduction due to Agency Reduction Programme

Additional 6 WTEs of Physiotherapists

NHSG Management has reported that this is mainly due to acute clinical support service (£2.4 m and 25 WTEs):

Reorganisation of the plain film radiography service in 2023 which involved substantial pay protection elements. Increased use of Waiting List Initiatives (WLIs) since 2020 for Ultrasound, MRI and CT. These are funded retrospectively by the Scottish government. 2 Band 8a sonographers were added in 2022 through recurring Scottish government funding.

There was further investment by NHSG into MRI 7 day working announced in Nov 2023 and 3.6 band 6 WTEs & 3 band 3 WTEs were hired. There was also use of locum sonographers for several periods (2021-2022 and 2023/24 till present).

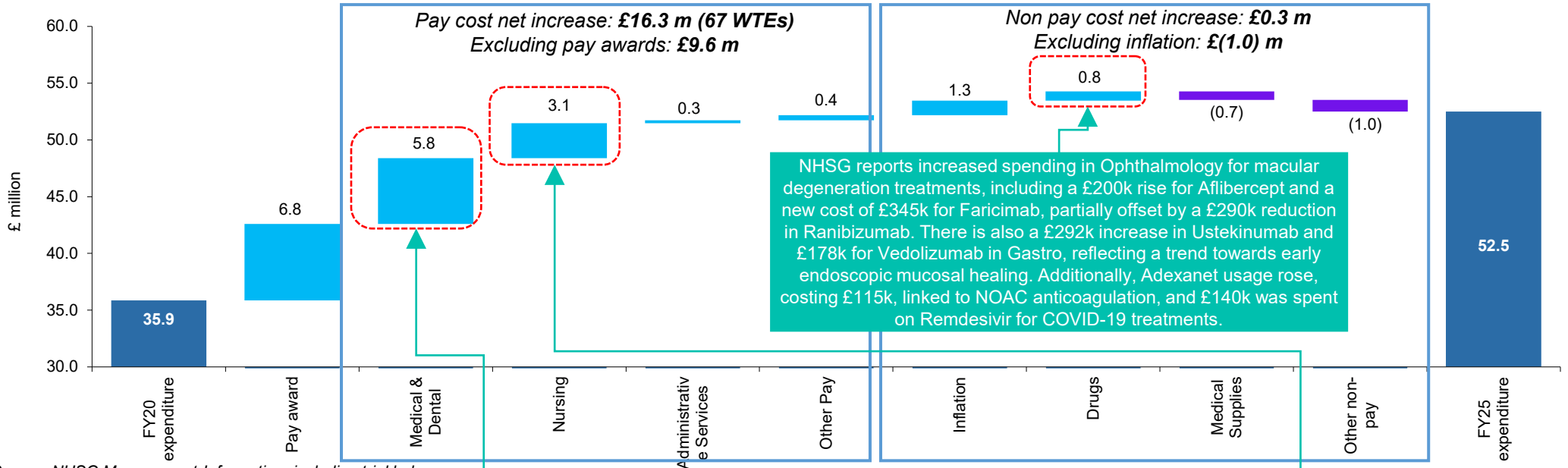
Additional recruitment of 9 WTEs, within Dietetics – Acute.

Notes:

1. Others includes: ORTHOTIST, ORTHOPTISTS, UNI STAFF - AHP'S, AHP TRAINING/ADMIN ,PROSTHETISTS, MULTI SKILLED/THERAPIES, ART THERAPISTS, SECONDEE- AHP'S, PROV OF SERV - AHP'S, PROV OF SERV - OTHER THER

Dr Gray's Hospital Medical & Dental and Nursing pay costs have surged due to rises in DDIT, locums and capacity issues

This page outlines cost pressures at Dr. Gray's Hospital driven by pay and non pay from FY20 to FY25. Unpicking reasons leading to significant increases in medical & dental and nursing pay costs.



NHSG reports increased spending in Ophthalmology for macular degeneration treatments, including a £200k rise for Aflibercept and a new cost of £345k for Faricimab, partially offset by a £290k reduction in Ranibizumab. There is also a £292k increase in Ustekinumab and £178k for Vedolizumab in Gastro, reflecting a trend towards early endoscopic mucosal healing. Additionally, Adexanet usage rose, costing £115k, linked to NOAC anticoagulation, and £140k was spent on Remdesivir for COVID-19 treatments.

Source: NHSG Management Information, including trial balances

NHSG reports that the rise in the number of Doctors and Dentists in Training (DDIT) is attributed to the increase in national training posts, with 27 DDIT positions available in April 2019 and 40 DDIT positions available in March 2024. This results in a net increase of 13 positions. In 2019, there were 3 vacancies, whereas in 2024, there are 8 vacancies. These are partially funded by NES. While these positions remain unfilled, the rotas are based on these figures, necessitating coverage through Clinical Fellows, locums, and other means - these pressures are not funded.

Increased use of Medical Locum (6 WTEs) – mainly in General Medicine due to increase in vacancies with element linked to new posts in 21/22 agreed to ensure safe delivery of services. Other increases are in A&E Consultants due to impact of dual site working agreed to remove need for locums. Resulted in vacancies filled with Consultants working across ARI and DGH. Part of increase due to EPAs required to reflect travel time.

HCSSA & use of common staffing method led to increases in use of supplementary staffing to ensure appropriate staffing levels in all clinical areas.

Covid backlog and increased system pressures have led to the higher use of surge capacity, which is unfunded & required supplementary staffing.

High sickness absence in some areas (which is still shown in average WTE) requiring to be covered. Slight reduction in substantive WTE reflects vacancy, and maternity leave also requiring to be covered by agency and bank nursing.

Notes:

1. Other pay includes: OTHER THERAPEUTIC, HEALTH SCIENCE SERVICES, SUPPORT SERVICES, ALLIED HEALTH PROFESSIONALS, MEDICAL & DENTAL SUPPORT, PERSONAL & SOCIAL CARE,OTHER PAY

2. Other non-pay includes: ADMINISTRATION, EQUIPMENT, ANCILLARY, TRANSPORT, MAINTENANCE, PROPERTY,SERVICE AGREEMENT PATIENT SERV

Increase in pay costs in Nurses is primarily in Bank and Agency, while in Medical and Dental Pay Locum Consultants accounted for the biggest increase in pay costs

This page provides an expansion of Nursing and Medical & Dental by staff type to highlight increases in WTEs and net increases, excluding pay awards.

Dr Gray Hospital - Nursing pay

	Net increase	Increase in WTEs	Pay awards	Net increase
Permanent Nursing	4,018,210	9	3,542,432	475,778
Bank Nursing	1,531,249	20	0	1,531,249
Agency - Nursing	1,079,764	14	0	1,079,764
Total	**6,629,223**	**42**	**3,542,432**	**3,086,791**

Source: NHSG Management Information, including trial balances

Dr Gray Hospital - Medical & Dental pay

	Increase	Increase in WTEs	Pay awards	Net increase
Senior Medical	**5,697,680**	**16**	**1,815,324**	**3,882,356**
Agency Locum Consultant	2,514,354	6	0	2,514,354
Practitioners	1,018,183	3	126,252	891,931
Consultant	759,617	-3	1,357,022	-597,405
Specialty Doctors	945,754	7	73,575	872,179
NHS Locum	714,720	3	167,582	547,138
Associate Specialist	142,922	0	90,892	52,030
Junior Medical	**2,676,790**	**12**	**772,788**	**1,904,002**
Specialty Registrar (STR)	1,706,762	7	383,353	1,323,408
Foundation Yr1/2	1,273,827	5	369,848	903,980
Agency Locum	-349,590	0	0	-349,590
NHS Locum FY1/2	45,791	0	19,587	26,204
Total	**8,374,470**	**0**	**2,588,112**	**5,786,358**

Source: NHSG Management Information, including trial balances

The bulk of WTE increase in Dr. Gray's Nursing is within Bank and Agency reflecting local challenges within Dr. Gray's Hospital.

Increase of 21 WTEs across Bank and Agency are within the Surgical Wards and Surgical Theatre Specialties while 12 WTEs increased in Medical Specialties. We note that permanent Nurses decreased by 8 WTEs in the Surgical Ward and Surgical Theatre Specialties.

Pay Award numbers are estimated for substantive staff only. While Bank rates also increase directly with Pay awards and Agency rates increase indirectly, these have not been isolated due to risk of overstating the impact of pay award.

6 WTEs are in General Medicine and 5 WTEs are in General Surgery.

This is driven by increase in number of training posts and increase in vacancies. (1 vacancy within 12 posts in 2019 vs 4 vacancies within 16 posts in 2024). Also, additional staff are required to ensure clinical safety.

Increase of 5 WTEs are in General Medicine, 3 WTEs in Anaesthetics, 3 WTEs are in Orthopaedic Medical Staff and 2 WTEs are in General Surgery due to vacancies and approval of funded new posts.

Increase of 3 WTEs in A&E due to impact of dual site working and travel time.

Increase in agency use due to on call requirement . Highest increase is since in General medicine due to vacancies.

Increase in specialty doctors due to new posts approval as past for 21/22 budget setting process to ensure safe service.

Posts are also agreed as part of ambulatory care service development bid from 22/23 service pressure funding.

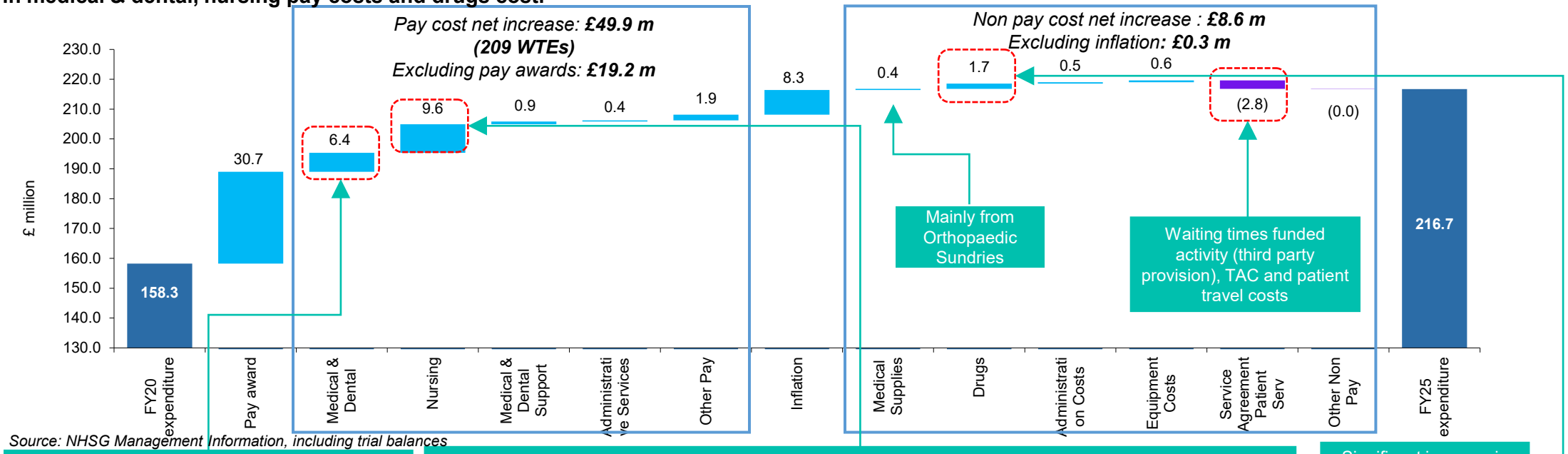
Notes:

1. Other pay includes: OTHER THERAPEUTIC, HEALTH SCIENCE SERVICES, SUPPORT SERVICES, ALLIED HEALTH PROFESSIONALS, MEDICAL & DENTAL SUPPORT, PERSONAL & SOCIAL CARE,OTHER PAY

2. Other non-pay includes: ADMINISTRATION, EQUIPMENT, ANCILLARY, TRANSPORT, MAINTENANCE, PROPERTY,SERVICE AGREEMENT PATIENT SERV

Addition of 137 Nursing and 41 Medical Staff is driving an increase in pay costs – these are to support unfunded capacity as well as to support rota compliance, while number of theatre sessions have decreased

This page outlines cost pressures within Acute Surgery division, driven by pay and non pay from FY20 to FY25. Unpicking reasons leading to increase in medical & dental, nursing pay costs and drugs cost.



Source: NHSG Management Information, including trial balances

Increase of 41 WTES with highest increase in Medical & Dental WTEs under ITU (16 WTEs). NHSG reports 11 NES expansion posts in 23/24 and additional junior doctors are required due to changes in wards during COVID.

Second highest increase under Anaesthetics (12 WTEs) due to combination of locum and non-complaint rota costs according to NHSG.

Increased need in medical & dental across all other areas due to funded posts to reduce waiting times.

Increase of 137 WTEs including 50 Bank Nurses and 114 Substantive Nurses, partially offset by a reduction of 26 Agency Nurses. Highest increase in Orthopaedics which increased by 36 WTEs across Aberdeen Royal Infirmary and Woodend elective. This is due to additional beds from surge capacity (6 unfunded beds) being filled partly by bank and substantive staff.

20 WTEs increase is due to successful recruitment against long standing RN vacancies and additional fundings from Scottish government. 14 additional nurses have been recruited to support Ophthalmic Emergencies in Ward 203. This is funded 'Monday to Friday' Ward but is opened every other weekend on an unfunded basis.

10 WTEs have been increased in Ambulatory Care and 20 WTEs in ITU, while Neurology has 13 more WTEs. There are also 12 more nurses in Urology. Key driver of Nursing staffing levels (including spend on Agency & bank nursing) is ensuring supplementary staff having special skills and to support additional surge capacity.

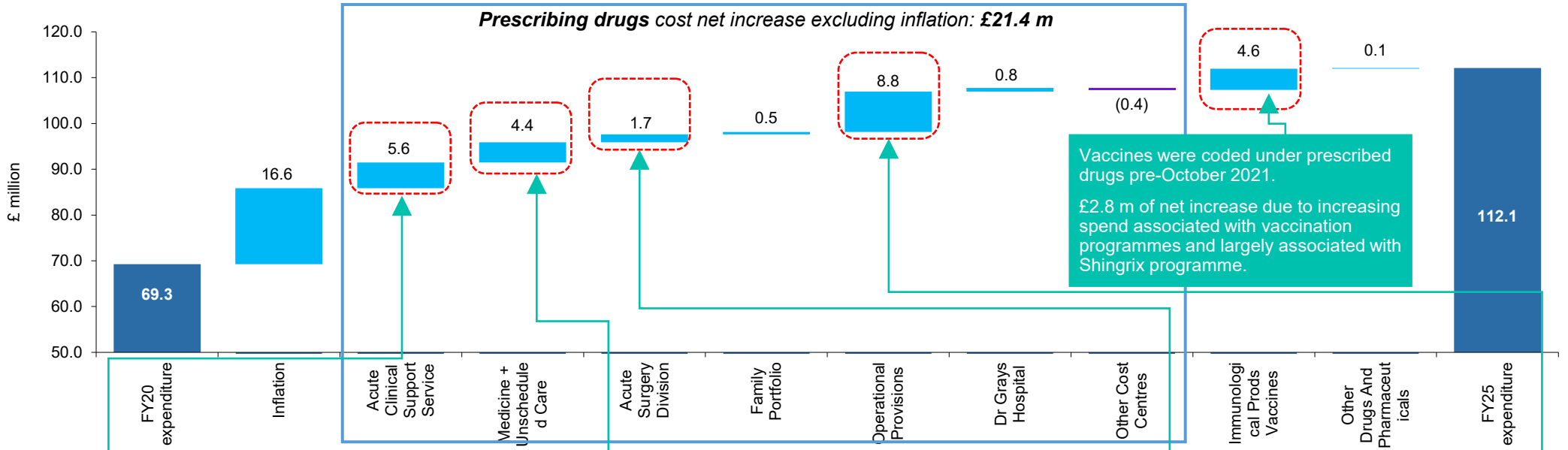
Significant increase in drug cost within Neurosurgery. Raise in plasma spend driven by global supply challenges through covid.

Treatment options for MS continuing to grow with significant budgetary impact due to high cost of treatments.

Notes:
1. *Other pay includes: HEALTH SCIENCE SERVICES, OTHER THERAPEUTIC, SUPPORT SERVICES, ALLIED HEALTH PROFESSIONALS, OTHER PAY*
2. *Other non-pay includes: ANCILLARY, MAINTENANCE, TRANSPORT, PROPERTY COSTS*

Cost of Prescribed Drugs increased due to new medicines and treatment pathways within Cancer services and Long Term Conditions

This page examines the underlying drivers of rising prescribed drug costs from FY20 to FY25, linking them to evolving treatment protocols, new medications, and demographic pressures across directorates.



Source: NHSG Management Information, including trial balances

Primarily relates to increase in Cancer services cost (£7.2 m) due to new medicines, medicine used in combination and additional lines of treatment (third, fourth line or more) and new adjuvant treatments etc. Highest spend on Pembrolizumab with approx. £2m increase.

Immunology drug costs (£0.2 m) increased due to global supply challenges in Plasma products.

Primarily due to increase in drug cost for Long Term Conditions (£1.8 m) including Gastroenterology (*use of drugs in patients with Crohn's disease or Ulcerative Colitis has increased and with new drugs licensed for use);* Rheumatology (*More aggressive treatment at earlier stage and new treatment pathways, alongside with growth in patient numbers*); Dermatology (*increasing patients*); Respiratory Medicine *(increasing spend associated with Cystic Fibrosis drugs).*

Virtual Capacity and Infection Unit in Unscheduled – Urgent division accounts for (£1.3 m) of increased cost due to ward holding area for COVID treatments and high-cost antibiotics (e.g.: Dalbavancin) which could reduce length of stay in hospital.

Primarily due to increase in Neurosurgery due to higher cost of treatments. There is a significant increase in plasma spend driven by global supply challenges through COVID.

Ophthalmology- surgery drug cost also continued to increase due to rising incidence of macular degeneration in the aging population. Growing licence extensions also impacted any biosimilar savings offset by introduction of new drugs.

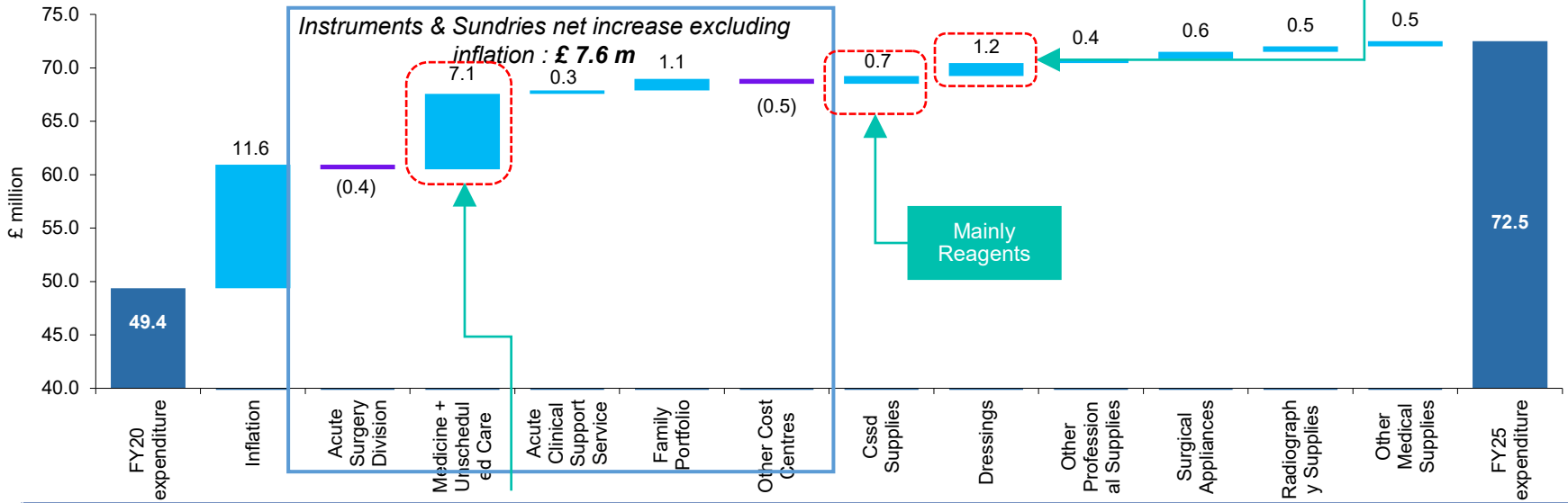
NHSG Management stats that movement in Operational provisions reflects changes within P13 adjustment – these are "grossing up" adjustments required for audit and not true expenditure.

1. Other cost centres includes: MENTAL HEALTH & LEARNING DISAB, NON CLINICAL SERVICES, PUBLIC HEALTH, CENTRALLY MANAGED DENTAL SERVS, PHARMACY SERVICES,ACUTE PERFORMANCE + GOV, ACUTE MEDICINE DIVISION, ACUTE SECTOR MANAGEMENT

2. Other drugs and pharmaceuticals includes: CARDIOVASCULAR SYSTEM, CYLINDER RENTALS, EAR NOSE OROPHARYNX, EYE, GASTRO-INTESTINAL SYSTEM, MALIGNANT DISEASE IMMUNOSUP, OBS GYNAE URINARY TRACT, OTHER DRUGS PREPARATIONS, PARAMEDIC DRUGS, PREPARATIONS USED IN DIAGNOSIS

Cardiology supplies (TAVI), Insulin Pumps and consumables within Renal Services and Endoscopy are driving the increase in cost of Medical supplies

This page examines the underlying drivers of rising medical supplies cost from FY20 to FY25, expanding trend analysis within Medicine and unscheduled care into functional areas.



Medical Supplies - Medicine + unscheduled care

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	Gross Increase	Inflation	Net increase	*Net Increase %*
Long Term Conditions	2,712,673	3,477,257	3,518,817	3,664,797	4,800,960	6,234,465	3,521,792	620,882	2,900,910	*29.8%*
Renal Service	566,613	579,566	600,220	889,087	1,380,279	1,782,215	1,215,601	163,599	1,052,002	*114.5%*
Diabetes	881,860	1,422,270	958,539	924,248	1,232,760	2,133,921	1,252,061	163,128	1,088,933	*42.0%*
Endoscopy	506,397	575,902	865,789	881,691	1,023,558	1,191,614	685,218	136,254	548,964	*35.3%*
Other Long Term Conditions	757,803	899,519	1,094,269	969,770	1,164,363	1,126,715	368,912	157,901	211,011	*-51.3%*
Unscheduled - Urgent	3,919,551	4,611,416	5,565,102	6,584,358	9,716,667	9,377,240	5,457,689	1,180,757	4,276,932	*39.2%*
Cardiology	3,598,283	4,211,516	5,157,567	6,189,199	9,297,216	8,885,107	5,286,824	1,121,186	4,165,638	*46.9%*
Other Unscheduled - Urgent	321,268	399,900	407,535	395,159	419,451	492,133	170,865	59,571	111,294	*-46.8%*
Other	467,094	532,425	620,136	629,220	659,180	728,680	261,586	92,968	168,617	*-44.0%*
Total	**7,099,318**	**8,621,098**	**9,704,056**	**10,878,374**	**15,176,807**	**16,340,385**	**9,241,067**	**2,146,913**	**7,094,154**	***30.2%***

Largely due to cost pressure associated with insulin pump increased use.

Under long term conditions, cost increases have largely been within renal service, diabetes and endoscopy.

NHSG management has reported that renal service medical supplies have increased due to cost of procurement driven by Brexit.; diabetes due to increased usage of insulin pumps and endoscopy due to changes in guidance on kit used and national contract costs

Under Medicine and unscheduled care, cost increase has largely been within unscheduled urgent – cardiology.

According to NHSG, this was due to increased demand and activity relating to the mobile Modular Cath laboratory. Expenditure on TAVI devices and Mitral clips have also surged significantly.

There has also been expansion in eligibility for treatment and number of patients meeting clinical criteria.

Notes:

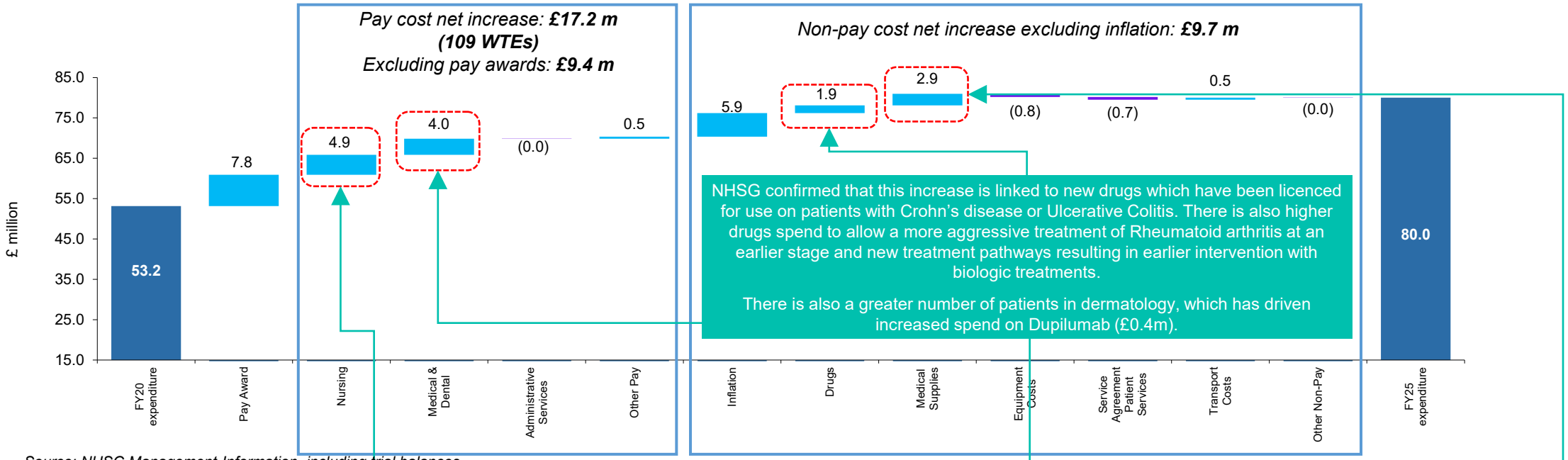
Other cost centres includes: DR Gray's HOSPITAL, NON CLINICAL SERVICES, MENTAL HEALTH & LEARNING DISAB, PUBLIC HEALTH, ACUTE PERFORMANCE + GOV,PHARMACY SERVICES, OPERATIONAL PROVISIONS, CENTRALLY MANAGED DENTAL SERVS ,TRANSFORMATION TEAM, SERVICE PURCHASING, ACUTE MEDICINE DIVISION,ACUTE SECTOR MANAGEMENT

Othe medical supplies includes AUDIOLOGY SUPPLIES OTHER MEDICAL SUPPLIES, INCONTINENCE PADS, DIETETICS SUPPLIES, OCCUPATIONAL THERAPY SUPPLIES , PHYSIOTHERAPY SUPPLIES, PODIATRY SUPPLIES SPEECH THERAPY SUPPLIES

Source: NHSG Management Information, including trial balances

Increased staff in Respiratory Medicine, Diabetes, Renal Service and Gastroenterology along with increased cost of medical supplies and drugs is driving cost increases in Long Term Conditions

This page outlines the cost pressures in managing long-term conditions (within Medical and unscheduled care) from FY20 to FY25, driven by expanded staffing and increased spending on new treatments and medical supplies across key specialties.



NHSG confirmed that this increase is linked to new drugs which have been licenced for use on patients with Crohn's disease or Ulcerative Colitis. There is also higher drugs spend to allow a more aggressive treatment of Rheumatoid arthritis at an earlier stage and new treatment pathways resulting in earlier intervention with biologic treatments.

There is also a greater number of patients in dermatology, which has driven increased spend on Dupilumab (£0.4m).

Source: NHSG Management Information, including trial balances

70 new nurses have been hired, of which 56 in respiratory medicine, 11 in Gastroenterology, 8 in Renal service. Activity (Bed days) within Respiratory medicine and Renal Service has increased by 20.1% and 26.8% respectively, while Gastroenterology has declined marginally by 4% from pre-Covid levels.

Bank usage has increased in some areas since 2020 due to higher vacancy rates and maternity leave, alongside a need for more beds. The pandemic caused staffing shortages in Non-Invasive Ventilation and Level 2 care, impacting budgets. Post-COVID, the demand for staffing has resulted in more wards opening, with bank nurses temporarily filling roles. Additionally, higher patient acuity has necessitated more nursing support due to increased falls and complex conditions, compounded by rising sickness absence, resulting in additional substantive staff being recruited.

A total of 22 WTE increase, including 9 in Diabetes 6 in Renal Service and 3 in each of Gastroenterology and Respiratory Medicine. NHSG confirmed an increases largely attributable to the number of training posts, recruitment to vacant posts, increases in medical ACT funded sessions for undergraduate teaching and impact of new wards / surge capacity.

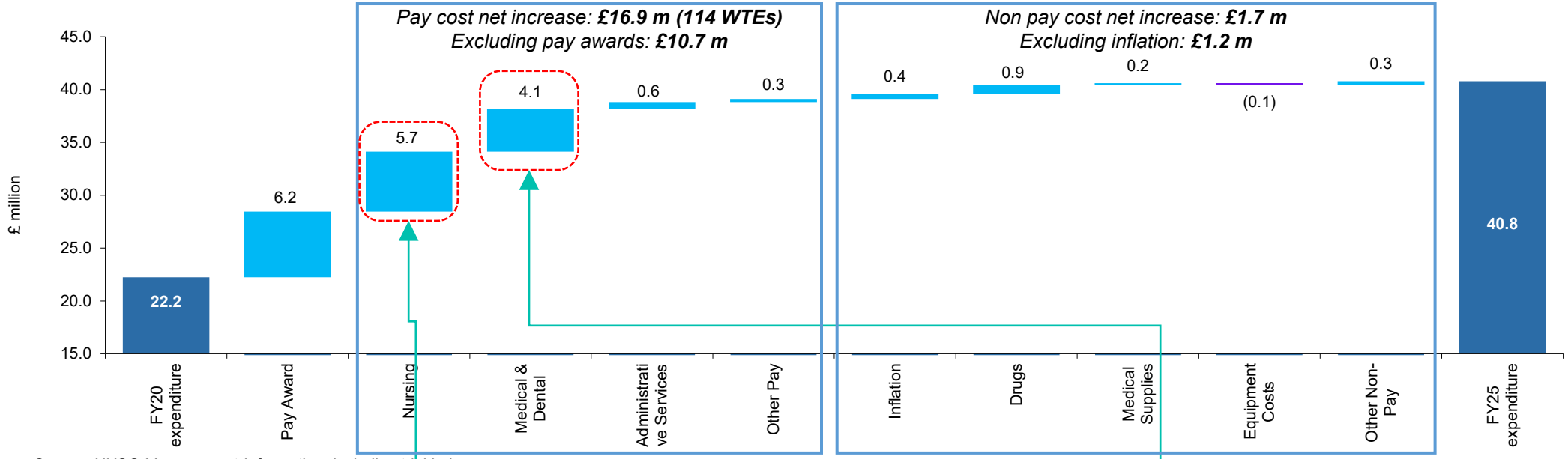
NHSG confirmed that this has been driven by waiting list activity and increased demand for procedures, particularly in Endoscopy and Renal Service.

Notes:

1. *Other pay includes: ADMINISTRATIVE SERVICES, MEDICAL & DENTAL SUPPORT, HEALTH SCIENCE SERVICES, ALLIED HEALTH, PROFESSIONALS SUPPORT SERVICES, OTHER THERAPEUTIC, OTHER PAY*
2. *Other non-pay includes: ADMINISTRATION, ANCILLARY, MAINTENANCE, PROPERTY COSTS*

A 44% increase in Nursing WTEs (92) and increase in medical & dental costs (by £4.1 m) is driving Emergency cost increase, while A&E attendances and admissions are comparable to pre-pandemic levels

This page analyses cost movements within Emergency (within Medical and unscheduled care) by pay and non pay. This is further explored within the Urgent and Emergency Care pathway section. However, since the UEC pathway covers areas in addition to Emergency, the numbers on this page and in that section will not directly reconcile.



Source: NHSG Management Information, including trial balances

Increase of 92 WTEs in Nursing (44% increase) cited by NHSG due to successful recruitment against vacancies plus the support required for additional beds opened since 2020. This includes 25 Bank Nurses and 4 Agency Nurses. NHSG also confirm recent over-recruitment to support the development of the team and reduce the reliance on Agency nursing. Changes to patient acuity have also necessitated additional nursing support. Many of these recruits are at higher bands with an increase of 6 WTEs in band 5 and 7 in band 6.

The re-grading of band 2 nurses to band 3 is also cited by NHSG as an additional cost pressure.

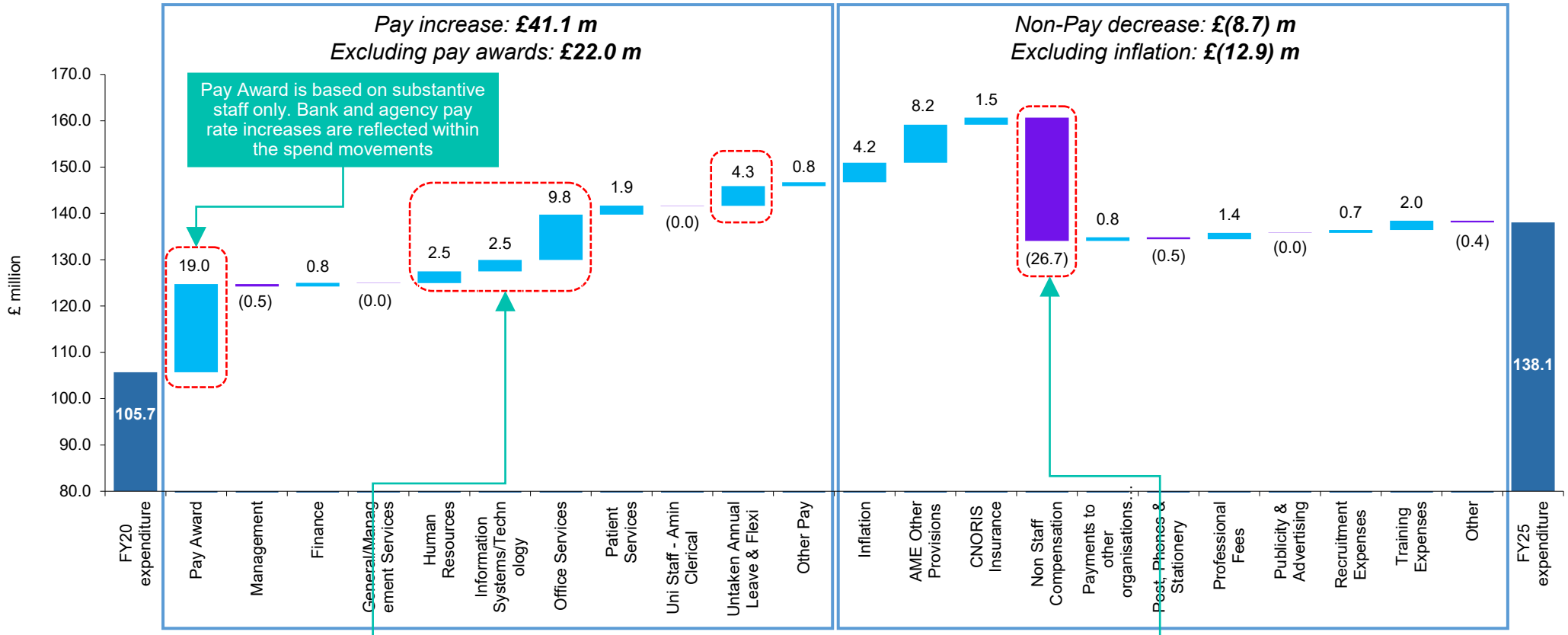
Medical and Dental costs are driven by an increase in Foundation Doctor WTEs – there are five additional Year 2 doctors across Acute Medicine and A&E. There is also an additional two agency locum consultants within Acute Medicine.

Within A&E, there is an additional spend of £573k on Senior Medical Consultants, despite no recorded increase in WTEs, and an increase in spend of £889k for Specialty Registrars despite a reduction of two WTEs. Given the timelines of this report, we were not able to investigate this further.

Notes:
1. Other pay includes: MEDICAL & DENTAL SUPPORT, SUPPORT SERVICES, OTHER PAY, HEALTH SCIENCE SERVICES, ALLIED HEALTH PROFESSIONALS
2. Other non-pay includes ADMINISTRATION, ANCILLARY, MAINTENANCE, PROPERTY, TRANSPORT COSTS

Back Office Costs have increased by £32.4m, driven by increases in staff pay partially offset by a significant fall in non-pay costs. Almost half of the pay increase is driven by the impact of the annual pay award

This page provides an overview of the key drivers behind changes in Back Office costs, including pay and non-pay aspects.



Source: NHSG Management Information, including trial balances

Due to a number of changes including new services required post COVID including the enhanced vaccination programme and the face fit testing team and other new services such as the regional HEPMA programme hosted in NHS Grampian and the introduction of eRostering.

This refers to payments under the CNORIS risk share scheme, which is a national risk share scheme covering the cost of any medical negligence of employer liability claims. This reflects the movement in the accounting adjustments required made up of the annual CNORIS charge plus the annual provision required. This is not the total cost of negligence for one year.

Appendix 7:
Unscheduled care pathway deep dive

Spending across the USC pathway has increased since 2022/23, with growing deficits in particular within acute services

- The high-level cost baseline shows the spending and variances divided across the following stages of the unscheduled care (USC) pathway:
  - Pre-attendance/Pre-admission;
  - Emergency department activity (including UTCs/MIUs);
  - USC-related inpatient care;
  - Support post-discharge.
- Cost data are shown for 2022/23, 2023/24 and 2024/25. Within the time available, the intention is not to align perfectly every cost line, but rather to create a sufficient, indicative view to generate discussion on opportunities for improvement.
- The cost baseline is supplemented by selected key performance indicators and narrative collected during interviews and from other available sources. It is recognised that within NHSG there is a range of different models deployed across the different partnerships in both physical and mental health.
- Using the baseline, we set out recommended next steps for addressing the increase in USC spending across NHSG.

Numbers are inflation-adjusted to show 2024/25 values

Source: NHSG Management Information

USC spending is increasing at variable rates across the pathway, but more so in the pre-attendance/pre-admission segment of the pathway

- Spending has increased the most in the Pre-attendance/Pre-admission segment, reflecting increasing investment in admission avoidance services.
- Within the Emergency Department and the Inpatients/ Discharge segments of the pathway, spending has increased at rates greater than the increase in overall A&E attendances and emergency admissions.
- The Post-discharge segment has seen the smallest increase in spending over the years in question.

	Pre-attendance/ Pre-admission	Emergency Department	Inpatients	Post-discharge	Total
2022/23	£24.6m	£61.0m	£194.1m	£21.1m	£300.8m
2023/24	£27.1m	£64.3m	£201.5m	£20.3m	£313.2m
2024/25	£28.2m	£64.7m	£208.0m	£20.8m	£321.7m

Numbers are inflation-adjusted to show 2024/25 values

Source: NHSG Management Information

Budget variances are most significant in the Emergency Department and Inpatients/Discharge segments of the pathway

- Overall deficits are driven by overspending in the Emergency Department and Inpatients/ Discharge segments, despite annual increases in budgets within these areas.
- Much of the overspending relates to escalation capacity within Aberdeen Royal Infirmary and Dr. Gray's Hospital.
- Of note, the budgets related to hospital at home and out-of-hours services were underspent in 2024/25, which may indicate an opportunity to optimise these services to further reduce acute activity.
- The smaller deficits in the Pre-attendance/Pre-admission and Post-discharge segments likely reflect the access criteria for these services rather than actual demand.

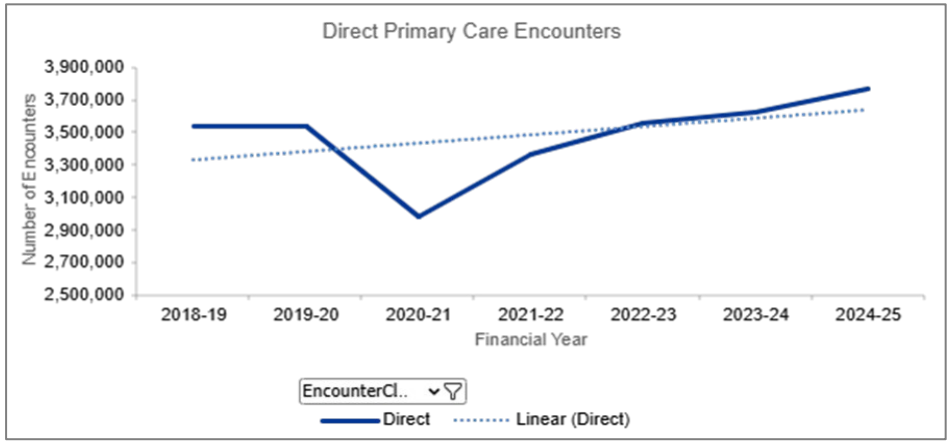
	Pre-attendance/ Pre-admission	Emergency Department	Inpatients	Post-discharge	Total
2022/23	£(1.0)m	£(4.8)m	£(15.8)m	£1.3m	£(20.3)m
2023/24	£1.8m	£(7.6)m	£(22.9)m	£0.8m	£(27.9)m
2024/25	£(0.1)m	£(8.4)m	£(20.0)m	£0.3m	£(28.2)m

Numbers are inflation-adjusted to show 2024/25 values

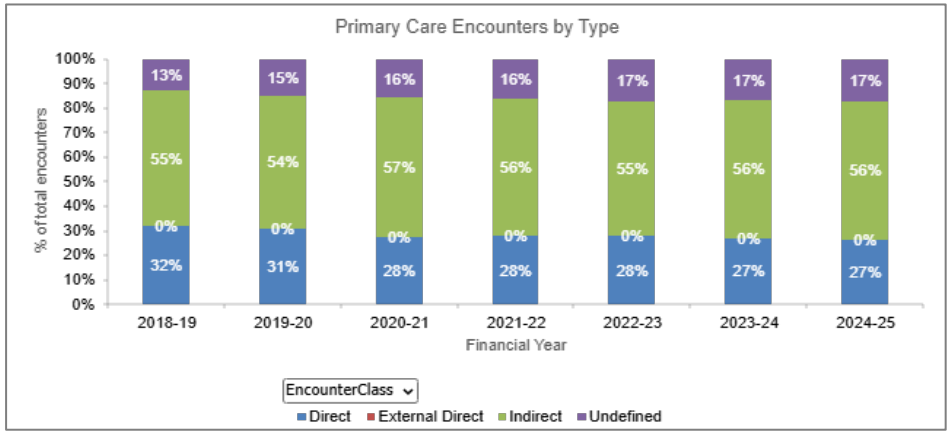
Source: NHSG Management Information

Pre-attendance/Pre-admission – NHSG is investing more in admission avoidance services for its population

- NHSG has developed a range of admission avoidance services. Its hospital at home services are primarily focused on admission avoidance, in line with the national programme targeted at increasing its usage. Spending on hospital at home services has increased from £622k in 2022/23 to >£2.1m in 2024/25 (inflation adjusted).
- Overall direct primary care activity has increased by c.6% in the NHSG area since 2019/20, albeit with a lower percentage of this activity being provided by general practitioners. Continued access to primary care is being enabled by the extension of alternative roles.
- While models differ across each IJB, we understand that out-of-hospital teams frequently work together in a multi-disciplinary team approach to support admission avoidance, e.g. the enhanced community support huddle in Aberdeen City.
- NHSG has a higher number of community beds than other regions, with GPs able directly to admit to some of these beds to avoid acute admissions. In addition, these beds are often used for palliative care, again helping to avoid acute admissions.
- There has been a strong focus on medicines management and reducing polypharmacy, which contributes to c.16.5% of non-elective admissions. Spending on the PCIF Pharmacotherapy service has grown from £2.4m in 2022/23 to over £3m in 2024/25.
- We understand there is limited join-up across information acute, community and ambulance information systems, which if addressed would provide a further basis for optimising admission avoidance services.
- While we have excluded community mental health services from the cost mapping, we note that spending on these services has increased from £17m in 2022/23 to £19.2m in 2024/25, with much of the increase associated with adult and older age people's community services.



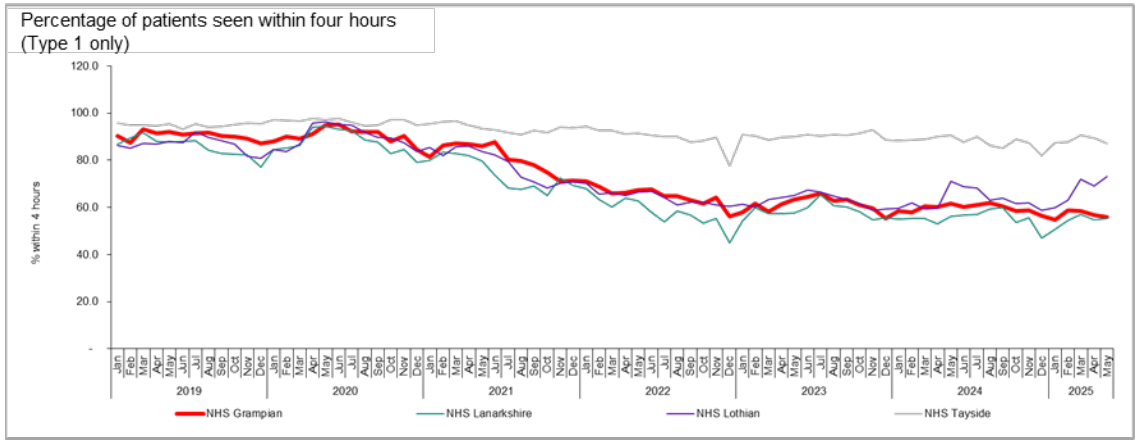
Source: Public Health Scotland data



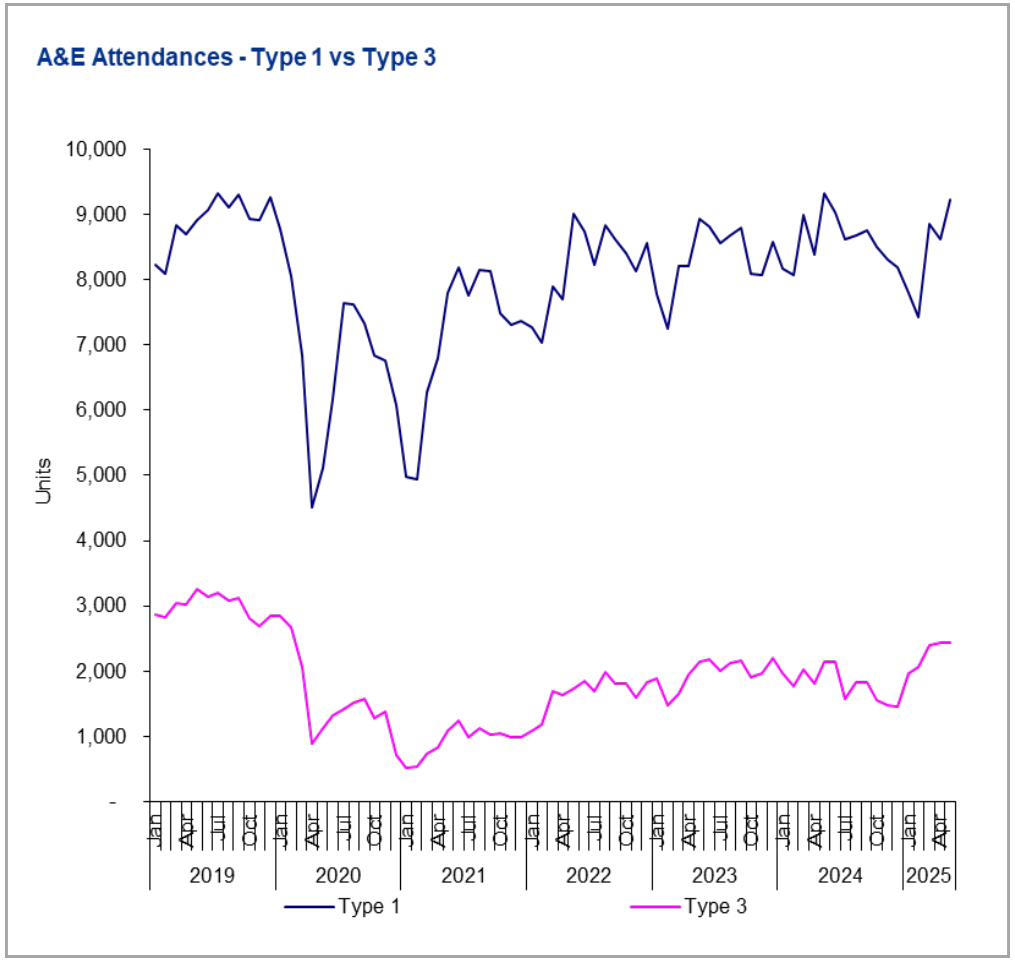
Source: Public Health Scotland data

Emergency Department – attendances have not returned to their pre-covid levels, but achievement of the four-hour target is falling

- Activity mix has shifted towards higher cost type 1 activity. In 2019/20, 75.2% of NHSG's A&E activity was Type 1. This was 82.1% in 2024/25.
- While similar trends were seen in comparable health boards as well, NHS Lothian has gradually recovered the Type 3 attendances to near pre Covid-19 numbers. NHS Lothian's proportion of Type 1 attendances in 2024/25 was 84.2%, which is marginally higher than the proportion in 2019/20 of 82.8%.
- There has been a steady decrease in percentage of patients seen within four hours in general across Scotland. For NHSG, it started at above 80% in 2019 but dropped to below 60% by 2023 and remained low through 2025 while we could see slight improvement in other health boards from Jan 2025.
- This reflects an increasing inefficiency in the ability to see patients within A&E, even with the recruitment of additional medical staff.



Source: Public Health Scotland data



Source: Public Health Scotland data

Inpatients – admissions have also not reached pre-covid levels, although non-elective activity and delayed discharges have increased

- Inpatient activity by specialty has declined by 2.3% between 2018/19 and 2023/24, with the most significant drop observed in Accident and Emergency, where activity fell by 89.4%. Inpatient admissions overall have also decreased slightly by 6%.
- When broken down by age group, admissions for children aged 0–14 increased by 9%, whereas the 65–79 age group saw a 3% rise.
- In contrast, admissions declined across other age groups, including a 7% decrease in the 80+ age group—an unexpected trend given the broader observation that emergency patients are aging.
- Meanwhile, the average daily number of occupied beds in NHSG has risen sharply in the post-pandemic period, owing to increasing acuity and delays in patient discharges. The share of non-elective activity has increased over time, reducing capacity for elective care.
- This suggests that the current backlog is not driven by overall increases in activity, but rather a combination of challenges, including:
  - A reduction in the acute bed base from 2019;
  - Increases in patient acuity;
  - Reductions in onward care capacity.
- Mental health inpatient beds face similar challenges with discharges patients into care homes or support accommodation.

Inpatient activity by specialty

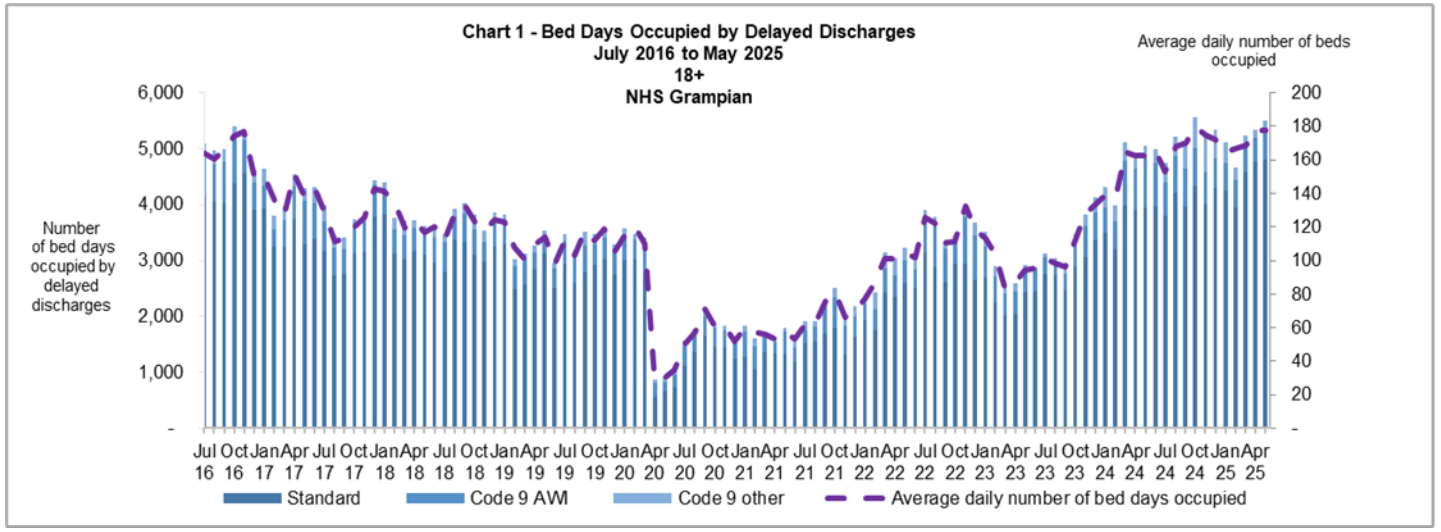
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	% chg
Emergency							
General Medicine	14,063.0	14,493.0	13,986.0	14,125.0	14,071.0	15,039.0	7%
General Surgery	7,436	7,778	6,644	6,871	7,070	7,073	-5%
Paediatrics	5,200	5,620	3,741	5,515	5,905	5,703	9.7%
Trauma and Orthopaedic Surgery	3,220	3,197	3,150	3,364	3,662	3,523	9.4%
Geriatric Medicine	4,004	3,494	2,870	3,330	3,014	2,786	-30%
Cardiology	1,575	1,590	1,725	1,935	1,915	1,955	24.1%
Urology	1,525	1,960	1,565	1,770	1,690	1,985	30.2%
Respiratory Medicine	1,405	1,410	1,508	1,765	1,815	1,878	33.7%
Accident & Emergency	2,529	2,983	1,030	1,200	475	267	-89.4%
Others	10,226	10,125	8,528	9,538	9,654	9,785	-4.3%
Total	51,183	52,650	44,747	49,413	49,271	49,994	-2.3%

Source: Public Health Scotland data

Inpatient admissions by age

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	%chg
Emergency							
0-14	6,656	7,143	4,876	6,770	7,350	7,284	9%
15-39	8,584	8,703	7,516	7,578	7,469	7,643	-11%
40-64	13,205	13,536	12,005	12,277	12,126	12,627	-4%
65-79	12,388	12,626	11,041	12,479	12,533	12,786	3%
80+	10,370	10,660	9,310	10,297	9,843	9,691	-7%
Total	51,203	52,668	44,748	49,401	49,321	50,031	-2%
Total Inpatient	**65,041**	**66,044**	**51,699**	**58,508**	**59,564**	**60,864**	**-6%**

Source: Public Health Scotland data

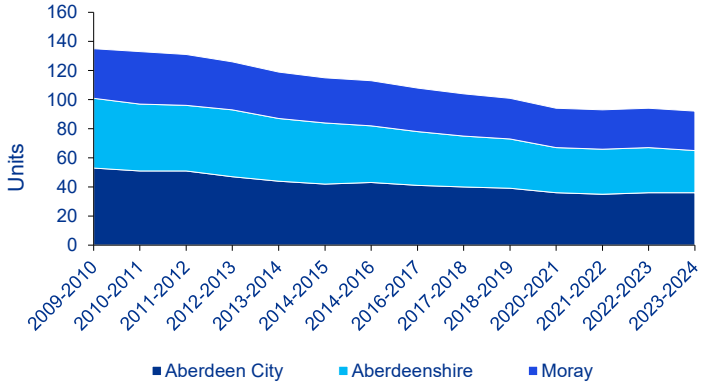


Source: Public Health Scotland data. Includes community beds

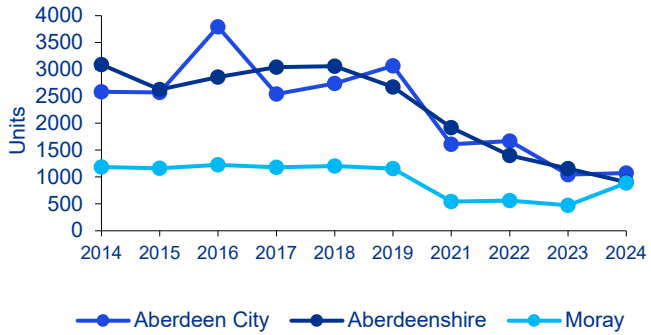
Post-discharge – a reduction in care home places per capita further hampers patient flow

- A key factor contributing to delayed hospital discharges is a reduction in the available care home spaces per capita. Since 2009–2010, the number of care home places for individuals aged 65 and over in NHSG has steadily declined—from 135 per 1,000 people in this age group to just 92.
- This is driven by a combination of a growing >65 population and a reduction in the number of care home beds available.
- This reduction has led to fewer admissions into social care homes, with Aberdeenshire experiencing the most significant decrease. Notably, the number of discharges from care homes has fallen at a faster rate than admissions, indicating that more individuals are remaining in care homes for longer periods.
- There have also been some reductions in community beds, e.g. a reduction in 30 beds at Rosewell House.
- Limited onward care capacity has had a knock-on effect on hospitals across Grampian, making it increasingly difficult to discharge patients who are medically fit to leave, but who have care needs.

Care Home Places per 1,000 population aged 65+



Number of Admissions to social care homes in NHS Grampian



Number of Admissions, Discharges and Deaths and Net staying

	2014	2015	2016	2017	2018	2019	2021	2022	2023	2024
Aberdeen City										
Number of Admissions	2,582	2,573	3,794	2,545	2,737	3,068	1,608	1,669	1,045	1,075
Number of Discharges	2,169	2,153	3,193	2,038	2,188	2,410	994	1,050	425	569
Number of Deaths	448	425	486	494	617	554	650	458	521	479
Net staying	-35	-5	115	13	-68	104	-36	161	99	27
Aberdeenshire										
Number of Admissions	3,092	2,629	2,856	3,044	3,058	2,672	1,920	1,398	1,158	905
Number of Discharges	2,397	2,011	2,104	2,361	2,295	1,943	1,050	661	556	403
Number of Deaths	642	651	655	704	759	661	848	744	579	524
Net staying	53	-33	97	-21	4	68	22	-7	23	-22
Moray										
Number of Admissions	1,188	1,164	1,226	1,183	1,207	1,159	542	560	473	890
Number of Discharges	957	923	960	973	967	937	289	257	237	604
Number of Deaths	217	249	274	242	230	258	241	254	237	258
Net staying	14	-8	-8	-32	10	-36	12	49	-1	28
Total Net staying	**32**	**-46**	**204**	**-40**	**-54**	**136**	**-2**	**203**	**121**	**33**

Source: Public Health Scotland data. Note: Data for 2019-2020 & 2020 not available and therefore excluded from above tables and graphs

Appendix 8:

Mapping of cost groupings to USC pathway

Mapping of cost groupings to USC pathway

Segment	Cost Grouping
Pre-admission/Pre-attendance	• Community Beds (60%) • Community Treatment and Care • Flow Navigation Centre • Hospital at Home (60%) • PCIF • Virtual Capacity – Respiratory (60%) *Note: community mental health services have not been included in this scope of this mapping.*
Emergency Department	• Acute ED • Ambulance • Mental Health USC Team • Out-of-hours Services • UTC (MIU)
Inpatients	• Acute In-patient Discharge • Mental Health & Learning Disabilities - IP Wards • Specialty Wards
Post-discharge	• Discharge to Assess/Rehab Beds • Community Beds (40%) • Hospital at Home (40%) • Virtual Capacity – Respiratory (40%)

Appendix 9:
Outpatients and theatres

Day case activity in NHSG has decreased and not recovered to pre-pandemic levels, presenting an opportunity to optimise day case mix

- Day case activity in NHSG has decreased by 11.9% across both ARI and Dr Gray's Hospital from 2019/20 to 2024/25. At Dr. Gray's Hospital, the decrease in day case activity is most significant in Gastroenterology, General Surgery, Urology and Ophthalmology. While Medical Oncology day cases have decreased, these have been more than offset by increases in Clinical Oncology.
- There has been a sharp decrease in Trauma and Orthopaedic Surgery day cases within Dr. Gray's Hospital in 2024/25, however, this is due to Orthopaedic unit being shut down in May 2025 due to an internal assessment of staffing levels and safety concerns.
- Similarly, within ARI, day cases have declined in Ophthalmology, Cardiology, Gynaecology, ENT and Oral and Maxillofacial Surgery. There is an opportunity for NHSG to optimise the mix of day cases to recover operational efficiency to Covid-19 levels. Fewer Outpatient Procedures and Day cases could lead to deterioration in patient's conditions and result in subsequent pressures in Acute Care or Theatres.

Daycase activity by site

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Aberdeen Royal Infirmary	23,858	12,172	18,359	20,053	18,166	22,700	-4.9%
Dr Grays Hospital	9,039	5,512	6,583	6,060	5,821	7,298	-19.3%
Royal Aberdeen Childrens Hosp	3,230	1,928	2,595	2,960	4,230	4,329	34.0%
TAC Healthcare Group Ltd	-	-	214	2,397	2,288	1,577	N/A
Woodend General Hospital	2,379	541	1,195	1,433	1,787	1,482	-37.7%
Aberdeen Community Health & Care	3,285	826	3,085	2,765	2,210	-	-100.0%
Others	2,815	1,489	1,698	2,043	1,850	1,920	-31.8%
Total	**44,606**	**22,468**	**33,729**	**37,711**	**36,352**	**39,306**	**-11.9%**

Source: NHSG Management Information

Aberdeen Royal Infirmary - Day cases by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Gastroenterology	4,787	3,026	4,077	3,743	3,510	6,014	25.6%
Urology	5,658	4,125	5,432	5,880	5,925	5,793	2.4%
General Surgery (excl Vascular, Maxillo	3,187	1,402	2,110	2,189	1,804	3,187	0.0%
Ophthalmology	3,834	1,123	2,792	3,321	1,971	2,410	-37.1%
Cardiology	1,943	1,034	1,706	1,864	1,769	1,727	-11.1%
Gynaecology	1,177	234	326	694	746	777	-34.0%
Pain Management	736	276	756	560	508	748	1.6%
Ear, Nose & Throat (ENT)	680	98	129	233	164	292	-57.1%
Oral and Maxillofacial Surgery	352	35	79	127	107	144	-59.1%
Others	1,504	819	952	1,442	1,662	1,608	6.9%
Total	**23,858**	**12,172**	**18,359**	**20,053**	**18,166**	**22,700**	**-4.9%**

Source: NHSG Management Information

Dr Grays Hospital - Day cases by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Gastroenterology	2,027	1,582	1,723	1,595	982	1,533	-24.4%
General Surgery (excl Vascular, M	2,057	788	877	736	619	1,470	-28.5%
Medical Oncology	1,170	922	1,041	1,069	1,056	1,134	-3.1%
Clinical Oncology	385	465	586	580	737	951	147.0%
Urology	1,258	860	821	798	757	841	-33.1%
Ophthalmology	707	188	313	221	248	69	-90.2%
Trauma and Orthopaedic Surgery	376	144	356	250	351	5	-98.7%
Haematology	246	130	293	365	477	476	93.5%
Gynaecology	265	158	154	102	134	308	16.2%
Others	548	275	419	344	460	511	-6.8%
Total	**9,039**	**5,512**	**6,583**	**6,060**	**5,821**	**7,298**	**-19.3%**

Source: NHSG Management Information

The number of outpatient procedures has recovered, but is still marginally lower than pre pandemic

- Outpatient procedures in NHSG have decreased marginally by 3.8% from 2019/20, although activity in Woodend General Hospital reflected a 43.2% decrease. Dr Gray's Hospital also had a 11.8% decrease in Outpatient procedures primarily due to closure of Orthopaedic unit due to safety concerns. Other hospitals reflected an increase in outpatient procedures activity, mainly in ARI where activity increased by 23.2%.
- Within ARI, outpatient procedures decreased in Immunology, Haematology, General Surgery and ENT, while Ophthalmology procedures increased significantly.
- Outpatient procedures in Dr. Gray's decreased for General Surgery, Gynaecology and Trauma and Orthopaedics while Ophthalmology procedures increased. We note that Senior Medical staff in Dr. Gray's Medical Division increased by 13 WTEs (29% increase).
- Fewer Outpatient Procedures and Day cases could lead to deterioration in patient's conditions and result in subsequent pressures in Acute Care or Theatres.

Outpatient procedures activity by site

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Aberdeen Royal Infirmary	16,305	14,148	17,411	20,943	20,746	20,080	23.2%
Woodend General Hospital	8,807	2,100	5,930	5,616	5,257	5,006	-43.2%
Dr Grays Hospital	4,584	2,343	3,570	4,358	3,738	4,043	-11.8%
Aberdeen Community Health & Care \	806	312	749	937	1,222	1,195	*48.3%*
Aberdeen Maternity Hospital	491	269	547	516	751	860	*75.2%*
Aberdeen Dental School	-	133	445	519	501	583	*338.3%*
Others	4,865	1,159	1,478	1,999	2,030	2,739	-43.7%
Total	**35,858**	**20,464**	**30,130**	**34,888**	**34,245**	**34,506**	-3.8%

Source: NHSG Management Information

Aberdeen Royal Infirmary - Outpatient procedures by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	*% chg*
Ophthalmology	5,440	5,926	7,722	8,480	9,583	9,714	*78.6%*
Gynaecology	4,803	4,257	4,759	4,592	5,065	4,942	*2.9%*
Clinical Oncology	1,398	835	1,507	5,141	3,973	2,744	*96.3%*
Dermatology	1,607	1,547	2,398	1,998	1,313	1,814	*12.9%*
Immunology	605	366	286	370	419	425	*-29.8%*
Haematology	1,091	529	288	136	165	167	*-84.7%*
General Surgery (excl Vascular, Maxil	218	259	233	197	166	137	*-37.2%*
Ear, Nose & Throat (ENT)	385	16	-	1	15	14	*-96.4%*
Medical Oncology	712	396	192	2	2	1	*-99.9%*
Others	46	17	26	26	45	122	*165.2%*
Total	**16,305**	**14,148**	**17,411**	**20,943**	**20,746**	**20,080**	*23.2%*

Source: NHSG Management Information

Dr Grays Hospital - Outpatient procedures by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	*% chg*
Ophthalmology	1,048	377	520	1,113	719	1,871	*78.5%*
Ear, Nose & Throat (ENT)	1,603	629	1,102	1,235	1,290	1,007	*-37.2%*
GP Other than Obstetrics	497	122	424	444	463	523	*5.2%*
Orthodontics	-	79	143	162	305	457	*478.5%*
Gynaecology	514	408	422	701	325	131	*-74.5%*
Trauma and Orthopaedic Surgery	708	709	912	653	535	51	*-92.8%*
General Surgery (excl Vascular, M	183	17	42	43	96	1	*-99.5%*
Others	31	2	5	7	5	2	*-93.5%*
Total	**4,584**	**2,343**	**3,570**	**4,358**	**3,738**	**4,043**	*-11.8%*

Source: NHSG Management Information

Number of outpatient appointments attended has grown by 39.8%, while waiting list continues to grow

- Total outpatient appointments attended in NHSG increased by 39.8 %, primarily in ARI. While all other hospitals have an increase in outpatient appointment activity (attended), there is a decrease in activity at Royal Cornhill Hospital and Woodend General Hospital. Abeerdeen Royal Infirmary has increased by 40.7% and Dr. Gray's has increased by 13.6%, where the greatest increase in % is within General Nursing. However, NHSG Management have informed us that outpatient waiting lists continue to increase.
- The increase in outpatient appointments could be driven by how activity is being recorded. We recommend that NHSG undertake further work to understand the drivers of the increase in outpatient appointments. The Health Board should work with Health Improvement Scotland to assess and introduce options to reduce outpatient activity including but not limited to, Patient Initiated Follow Up (PIFU), advice and guidance, and a review of clinical guidelines re: follow up appointments. If the increase in activity is real there is a significant opportunity to release costs and clinical time which could be refocused on UEC and patient discharge. Reducing number of outpatient appointments back to 2019/20 numbers can unlock between £10 million to £15 million in savings.

Outpatient appointment activity by site

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Aberdeen Royal Infirmary	371,195	400,696	518,865	470,522	506,058	522,288	*40.7%*
Royal Cornhill Hospital	131,840	128,624	138,546	116,481	94,271	93,448	*-29.1%*
Dr Grays Hospital	79,090	65,815	73,873	73,822	83,910	89,815	*13.6%*
Aberdeen Community Health & Care \	50,149	22,646	36,385	46,548	47,338	58,437	*16.5%*
Woodend General Hospital	66,222	39,389	50,187	53,101	55,075	57,886	*-12.6%*
Domiciliary Location	25,115	34,961	44,574	44,308	46,595	56,141	*123.5%*
Royal Aberdeen Childrens Hosp	40,431	32,294	38,184	42,276	49,474	55,661	*37.7%*
Aberdeen Maternity Hospital	52,664	51,286	55,094	55,358	56,130	54,975	*4.4%*
Others	140,581	78,526	153,927	228,249	305,917	349,980	*149.0%*
Total	**957,287**	**854,237**	**1,109,635**	**1,130,665**	**1,244,768**	**1,338,631**	***39.8%***

Source: NHSG Management Information

Aberdeen Royal Infirmary - Outpatient appointment by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Clinical Oncology	21,514	35,077	50,648	69,585	76,216	75,831	*252.5%*
Ophthalmology	40,031	25,000	38,426	42,041	40,500	42,732	*6.7%*
Gastroenterology	24,731	19,378	22,652	26,209	28,818	28,979	*17.2%*
General Surgery (excl Vascular, M	22,372	17,224	23,705	26,328	26,002	26,379	*17.9%*
Dermatology	29,121	11,807	24,854	26,547	25,961	25,543	*-12.3%*
Haematology	21,963	23,981	28,530	22,190	21,918	21,840	*-0.6%*
Trauma and Orthopaedic Surgery	3,518	10,057	16,519	18,719	20,453	21,744	*518.1%*
Acute Medicine	5,904	1,742	2,501	4,730	18,904	20,348	*244.6%*
Accident & Emergency	565	6,720	14,038	13,349	18,169	19,477	*3347.3%*
General Nursing	101	6,889	9,549	6,760	9,215	10,131	*9930.7%*
Occupational Therapy	25	170	405	503	578	492	*1868.0%*
Others	201,350	242,651	287,038	213,561	219,324	228,792	*13.6%*
Total	**371,195**	**400,696**	**518,865**	**470,522**	**506,058**	**522,288**	***40.7%***

Dr Grays Hospital - Outpatient appointment by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Physiotherapy	6,532	4,416	4,153	2,152	4,159	11,112	*70.1%*
General Nursing		528	3,699	4,000	5,560	6,771	*1182.4%*
Anaesthetics	5,791	3,705	4,893	5,482	5,926	6,556	*13.2%*
General Surgery (excl Vascular, M	3,234	1,996	3,575	4,521	6,066	6,426	*98.7%*
Obstetrics Ante-Natal	6,002	5,613	5,804	5,604	5,926	5,539	*-7.7%*
Ophthalmology	5,012	4,318	4,990	5,883	6,035	5,227	*4.3%*
Electrocardiography	6,400	4,191	5,529	5,131	6,079	5,059	*-21.0%*
Trauma and Orthopaedic Surgery	5,388	5,335	7,170	7,480	7,943	5,008	*-7.1%*
Dermatology	5,378	3,469	5,127	4,944	4,801	4,922	*-8.5%*
General Psychiatry (Mental Illness)	24	42	47	17	756	1443	*5912.5%*
Orthodontics	5	223	299	371	445	692	*13740.0%*
Others	35,324	31,979	28,587	28,237	30,214	31,060	*-12.1%*
Total	**79,090**	**65,815**	**73,873**	**73,822**	**83,910**	**89,815**	***13.6%***

Source: NHSG Management Information

Source: NHSG Management Information

The number of theatre sessions continues to remains lower than pre-pandemic levels, even when Grampian has more Consultants

- Total theatre sessions are 8.8% lower than in 2019/20 while the number of senior medical staff WTEs is 9.2% higher than 2019/20 reflecting an opportunity for NHSG to right-size theatres or improve theatre productivity and efficiency.
- Theatre activity has decreased across both ARI and DGH and is generally lower across most specialties.

Aberdeen Royal Infirmary - Theatre activity by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Urology	1,086	1,085	1,129	1,258	1,187	1,194	9.9%
General Surgery	1,428	784	964	1,098	1,049	1,044	-26.9%
Plastic Surgery	688	448	555	655	797	846	23.0%
Ophthalmology	831	372	763	769	676	726	-12.6%
Gynaecology	834	254	456	718	692	672	-19.4%
NeuroSurgery	565	379	419	407	475	488	-13.6%
Breast Surgery	354	196	386	422	458	486	37.3%
Cardiac Surgery	450	322	349	322	369	437	-2.9%
Vascular Surgery	400	330	389	361	373	419	4.8%
Ear, Nose & Throat	552	152	226	268	261	315	-42.9%
Others	722	320	535	643	647	747	3.5%
Grand Total	**7,910**	**4,642**	**6,171**	**6,921**	**6,984**	**7,374**	**-6.8%**

Source: NHSG Management Information

Theatre activity by site

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
Aberdeen Royal Infirmary	7,910	4,642	6,171	6,921	6,984	7,374	-6.8%
Woodend Hospital	1,824	703	1,412	1,702	1,846	1,601	-12.2%
Dr Grays Hospital	1,928	1,101	1,209	898	976	1,362	-29.4%
RACH	862	546	671	629	991	1,029	19.4%
Aberdeen Maternity	508	506	507	512	515	521	2.6%
Grand Total	**13,032**	**7,498**	**9,970**	**10,662**	**11,312**	**11,887**	**-8.8%**

Source: NHSG Management Information

Dr Grays Hospital - Theatre activity by specialty

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	% chg
General Surgery	506	162	130	125	225	463	-8.5%
Gastroenterology	521	428	487	405	218	400	-23.2%
Gynaecology	124	82	97	56	97	266	114.5%
Urology	213	149	110	91	79	95	-55.4%
Trauma and Orthopaedics	320	201	239	139	248	13	-95.9%
Ophthalmology	102	44	76	55	46	22	-78.4%
Others	142	35	70	27	63	103	-27.5%
Grand Total	**1928**	**1101**	**1209**	**898**	**976**	**1362**	**-29.4%**

Source: NHSG Management Information

Appendix 10:
Delegated financial performance

The bulk of the WTE growth has been between 2021/22 and 2023/24, with significant growth in Aberdeenshire IJB between 2021/22 to 2022/23 which needs to be understood in the context of overall service provision

Delegated WTE breakdown (i.e. IJBs plus Primary Care)

		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	FY20-FY25 Variance	% Variance
WTE	Aberdeen City IJB	1,402	1,437	1,477	1,574	1,623	1,685	283	20.2%
	Aberdeenshire IJB	1,158	1,174	1,224	1,475	1,531	1,444	286	24.7%
	Moray IJB	654	659	688	790	810	799	144	22.1%
	Primary Care	30	30	27	28	30	29	0	-1.2%
	Primary Care Prescribing	0	0	0	0	0	0	0	0.0%
	Total	**3,244**	**3,300**	**3,416**	**3,867**	**3,993**	**3,957**	**713**	**20.2%**

Source: NHSG Management Information, including trial balances

Appendix 11:
Position against External Recommendations

Position against external recommendations

There are six off track items and two at risk items from the HIS and NES recommendations with four of them linked to the Dr Gray's Cardiology escalation. The HIS recommendation for more appraisers deliver a minimum of 10 appraisals a year by 31 July 2025 has been classed as rejected. NHS Grampian's current position is that "*10 per appraiser not fully achievable with current cohort. If mandated will reduce overall number of appraisals and will require increased spend on GPs. Work to agree position re number of appraisals per appraiser underway*".

Source of recommendation	Number of recommendations	Complete	On track	Not on track	Rejected	No status
SG re RTC DGH Cardiology HIS escalation	17	8	5	4	-	-
HIS/NES Chief Execs Letter	29	13	12 (2 at risk)	2	1	1
Total	**46**	**21**	**17**	**6**	**1**	**1**

At Risk or Not on Track HIS/NES Chief Executive Actions

Topic	Action	Response to	Target Date	Status
INTEGRATION OF 3 PRIORITISED ACUTE SERVICES	Hold Stakeholder workshops for collaborative design of phased plan	HIS/NES Chief Execs Letter	by 30 April'25	At Risk
CLINICAL ENGAGEMENT	The Cardiology, Orthopaedics and Endoscopy integration work streams described in section 3 above have senior medical leadership and access to senior medical advisors, with a direction to engage fully with clinical teams in both ARI, Dr Gray's and primary care in designing the preferred model.	HIS/NES Chief Execs Letter	23 April 2025	At Risk
PORTFOLIO REVIEW REPORT	Newly formed acute triumvirate will lead a rapid review of management structures across clinical services with an acute footprint, to be completed by the end of June. This will simplify accountability and responsibility for clinical, staff, financial and corporate governance and provide clear lines of escalation for issues that service management teams cannot resolve or deem to be high risk.	HIS/NES Chief Execs Letter	30 June 2025	Not on Track
INTEGRATION OF 3 PRIORITISED ACUTE SERVICES	Immediate actions to be implemented and phased plan produced for a fully integrated single acute service	HIS/NES Chief Execs Letter	30 June 2025	Not on Track
INTEGRATION OF 3 PRIORITISED ACUTE SERVICES	Hold Stakeholder workshops for collaborative design of phased plan	HIS/NES Chief Execs Letter	by 30 April'25	At Risk
REDUCE WAITS IN EDs and AMBULANCE STACKING	Implement actions to reduce occupancy levels	HIS/NES Chief Execs Letter	Awaited	

Not on Track HIS Cardiology Actions

Topic	Action	Response to	Target Date	Status
CARDIOLOGY	Integrate ARI and DGH cardiology waiting lists by end of June 2025	SG re RTC DGH Cardiology HIS escalation	30 June 2025	Not on Track
CARDIOLOGY	DGH CLINICAL GOVERNANCE: Secure honorary contract for external reviewer	SG re RTC DGH Cardiology HIS escalation	04 July 2025	Not on Track
CARDIOLOGY	DGH CLINICAL GOVERNANCE: Screen of cases highlighted by clinical lead and any additional cases from QIAT Team	SG re RTC DGH Cardiology HIS escalation	31 May 2025	Not on Track
CARDIOLOGY	DGH CLINICAL GOVERNANCE: Any additional individual reviews commissioned	SG re RTC DGH Cardiology HIS escalation	30 June 2025	Not on Track

Appendix 12:
NHSG's response to formal concerns from external parties

NHSG's response to formal concerns from external parties

Status of NHSG's identified actions as at 1 July

Below we have provided an update on the status of the actions in the CET tracker as at 1 July. These actions have been identified by NHSG in response to the concerns raised in the letters from HIS/NES. They are therefore an interpretation of how to respond to the concerns raised by HIS/NES. On the following pages we have provided an assessment of the **design** of the actions to address the concerns raised in the 25 February 2025 HIS/NES letter and 11 April 2024 HIS letter, as well as additional points raised in the 21 March 2025 HIS/NES letter. As part of this work, we have also considered whether there are any gaps in NHSG's response where there is a lack of actions to respond to identified concerns. Our work found there are no areas where a concern raised by HIS/NES does not have a corresponding action.

Status of NHSG identified action

Source	Total number of actions identified by NHSG in response to the letter	Status of actions identified by NHSG as at 1 July 2025				
		Complete	On track	Not on track	Rejected	No status
11 April 2024 HIS letter re: DGH Cardiology	**17**	8	5	4	-	-
25 February and 21 March 2025 HIS/NES Chief Executives' Letter	**29**	13	12 (2 at risk)	2	1	1
Total	**46**	**21**	**17**	**6**	**1**	**1**

The full list of off-track recommendations or those without an updated status can be found in Appendix 11. The key point to note is that whilst plans to address the concerns raised about the cardiology service have been put in place, a number of these actions are not on track. This is reflected in project reporting which highlights key risks and issues but further links to Finding A in our report about the risk of delayed delivery of these actions due to the volume of challenges being tackled simultaneously by NHSG.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership and governance		
Concerns around effectiveness of current leadership arrangement	NHSG's response has been to re-introduce an Acute leadership team, with a Chief Officer plus Acute Medical Director and Acute Nurse Director. We confirmed that this change had come into effect at the time of our fieldwork for this report and the findings of our interviews as part of this review suggest that this is expected to have a positive impact on the clarity of leadership arrangements. This triumvirate has been tasked with reviewing the wider management structure within acute services with the aim of "providing accountability and responsibility for clinical, staff, financial and corporate governance and provide clear lines of escalation for issues that service management teams cannot resolve or deem to be high risk". This action to undertake a review was still in progress at the time of writing our report although we reviewed a timeline for the Acute Sector Leadership Team Transition. A survey has been issued to capture existing governance and reporting arrangements and the new governance arrangements are due to go live in August. A review of the Acute Sector Leadership Team management structure is due to take place between September and November. The process for conducting this review has therefore been agreed but we have not been able to review any outputs from this in terms of planned changes due to timing. This action also links to Finding C in our report about the impact of moving to and now revising the Portfolio leadership structure and the need to revisit decision-making structures.	**Yes** but the identification of further work from the Acute Sector Leadership's team review will be key to ensuring that concerns raised are fully addressed.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership, culture and workforce		
Concerns around the cardiology and trauma & orthopaedics services at DGH. For cardiology, this also includes concerns around governance, executive oversight and it being run as a single-handed service.	There are project initiation documents (PIDs) for the Integration of Acute Pathways (IAP) in these two services which outline the steps which will be taken to create a single service across the DGH and ARI sites. NHSG has separately identified endoscopy as a similarly fragile service as well as a separate integration plan for clinical administration across these three pathways. IAP PIDs for these two additional services have been created as well. These PIDs include outcomes to be achieved in three, six and 12 month horizons and cover areas such as introducing a single governance arrangement for each service, investigation and improvement plans for immediate patient safety and quality of care concerns, a single process for managing referrals, waiting lists and delivery of care and maximising scheduled care opportunities (to reduce preventable unscheduled presentations). Each of these identified outcomes has a stated benefit and the metric or evidence that will be used to measure the achievement of these outcomes. These documents appear to be well designed to address the concerns raised by HIS/NES. Milestone reports are provided to CET. For trauma and orthopaedics (T&O), endoscopy and Administrative Services, the programmes are reporting good progress as at 7 July, although all programmes are highlighting capacity risks for staffing having the time to deliver this transformation work. We note that management are reporting delays with the implementation of the cardiology project plan which could delay the planned changes taking effect. The delay to the cardiology workstream is linked to the need to establish the conditions for change with clinicians. A workshop with cardiology clinicians, which has already been completed for T&O and endoscopy, is scheduled for 31 July and therefore the overall vision for the revised service model and high-level implementation plan for the remainder of the financial year is not yet in place for cardiology. This is highlighted as risk to the progress of the cardiology IAP workstream.	**Yes**. Whilst the establishment of the cardiology IAP project is positive, we note that this is the key programme designed to address concerns raised about cardiology by HIS on 11 April 2024 as well as the re-iterated concerns from the 25 February 2025 letter. There has therefore been a significant gap between the concerns being raised and this project initiating.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership, culture and workforce		
Queries around the safety and quality monitoring of cardiology services in Moray and across NHSG, and how HIS concerns were being shared with staff.	An initial response was provided by NHSG to HIS in May 2024 which outlined the mechanisms in place to monitor the Moray and NHSG-wide cardiology service. Any plans to change these processes are linked to the wider ongoing review of the Acute Services governance structure which is covered in the "leadership and governance" on the previous page. NHSG's response to HIS in May 2024 confirmed the initial letter and final response would be shared with cardiology service and DGH leadership. The sharing of this information was referenced by contacts as part of our interviews which provides confirmation that this took place.	**Yes** – subject to the outcome of the Acute Sector Leadership's team governance and reporting review noted on the previous page.
Concerns around omissions of care within cardiology at DGH	The cardiology Clinical Lead reviewed 22 cases identified as being of concern with an associated adverse outcome in response to the 2024 HIS letter. One of these cases has since been referred to an external reviewer. This external reviewer was still in the process of being appointed at the time of our fieldwork, but the patient has now been contacted under Duty of Candour requirements. An additional action has been identified for the cardiology Clinical Lead to screen cases and identify any further cases which require referral to the external assessor. The cardiology Clinical Lead has not been involved in the care of DGH patients and is therefore independent and objective of the individual cases whilst having the required specialist knowledge to perform this review. The cardiology Clinical Lead has not identified any further adverse events which need to be raised in these cases. As a further control, the Executive Medical Director is due to meet with the cardiology Clinical Lead to satisfy himself on the basis of the conclusions in the 22 cases to discuss whether any additional adverse events need to be reported.	**Yes** but further actions will need to be identified based on the outcome of the external reviewer's report. **Recommendation:** Identify any additional actions required or lessons learned exercise which should be performed based on the outcome of the external reviewer's report.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership and culture		
Concerns around the reprovision of consultant led maternity care at DGH	NHSG's response to HIS/NES highlighted that the Target Operating Model (TOM) in place for Moray Maternity Services only covers the service development up to planned C-sections. The Phase 2 Plan which would allow delivery of the full Model 6 consultant led service was in development. We were provided with Moray Maternity Services Bi-Monthly Progress Report for May-June 2025. This highlights that the Phase 2 TOM was under development and that progress was being made through workforce planning introduction of cell salvage for caesarean sections and the expansion of criteria for planned caesarean sections. Development of this TOM will continue throughout the year and progress is reported directly to Scottish Government. The actions take in this area therefore appear to be designed to address the concerns raised, noting that work is ongoing to fully design how this service will run. HIS/NES raised additional concerns about Neonatal care at DGH in their 25th February letter which were noted as still outstanding in their 21 March letter. The Executive Medical Director had further direct email correspondence with HIS/NES after this date and outlined the specific support in place at DGH for neonatal emergencies, the additional training that had taken place for staff at DGH around management of neonatal pneumothorax and the selection of low-risk c-section patients in the initial phase of offering the procedure at DGH which contributed to addressing the concerns raised about Neonatal care under current maternity model at DGH.	**Yes**.
Concerns around the clarify of the medical leadership structure for education	NHSG has provided an organisational chart which sets out the position of the two Directors responsible for Medical Education and confirms they report directly to the Executive Medical Director. The CEO NHSG clarified the reporting lines that have been in place for a number of years in a letter on 1 April confirming that both Directors of Medical Education report directly to the Executive Medical Director.	**Yes**

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership and culture		
Concerns around ambulance turnaround and patient flow at ARI	There are two overarching actions that form NHSG's response to this concern. The first is implementing the recommendations raised by Centre for Sustainable Delivery (CfSD) and the second is implementing actions to reduce occupancy levels. We have assessed each of those actions in turn. ***Implementing CfSD recommendations***: There were seven recommendations raised in the CfSD report. NHSG has created an Unscheduled Care Improvement Progamme Development Plan Gantt Chart. This maps to the seven CfSD recommendations and outlines how each will be delivered through individual tasks. At the time of our review in July 2025, the majority of the initial set up actions had been completed, such as agreeing the revised structure for the Unscheduled Care Improvement Programmes which is supported by a revised Terms of Reference. Other actions were ongoing and planned to take place over the summer and onwards to the end of 2025. This includes action to support the recommendation to move to a "ground-up" improvement culture and making improvements to data on demand, capacity, activity and queues. The action plan also includes the establishment of a series of Delivery and Project Groups. The focus of these individual groups was decided after a workshop on 20 February 2025 with 60 participants from across the health and social care system. This workshop's aim was to identify ways to implement the CfSD recommendation to improve flow and therefore ambulance turnaround times in the short, medium and long term. From a short term (6 month) perspective, the following four programmes were identified as priorities: • Expansion of the Flow Navigation Centre into an Urgent Care Hub • Review of processes for front door assessment and differentiation of patients • Reducing Acute occupancy pressure by improving discharge workflows and processes • Improving system flow using Discharge without Delay principles. ***(continued…)***	**Yes** but we are unable to comment on the extent of the expected impact of the actions in reducing ambulance turnaround times.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership and culture		
Concerns around ambulance turnaround and patient flow at ARI	***(continued…)*** A Project Group has been set up for each of these four areas. These are multi-disciplinary groups which report to either the Upstream or Downstream Delivery Groups and then onwards to the Unscheduled Care Programme Board. At the time of our review, these Groups had been established and their membership agreed. Detailed work to identify the key improvement actions to be delivered by each Group was still ongoing at the time of our fieldwork in July 2025. NHSG's impact assessment of the planned improvement for ambulance turnaround times is mixed. The weekly average turnaround time (90th percentile) for February 2025 was 03:45:03. This is forecast to reduce over the year to 03:04:00 in March 2026. There is however still an expected spike in turnaround time to 04:14:00 in December 2025. These projected figures were submitted as part of NHSG's 2025/26 Whole System Improvement Plan in March 2025 and therefore do not reflect the impact of planned pathway changes. At the time of our fieldwork, NHSG has been asked to resubmit a refined plan to Scottish Government to align to the c.£3m initial funding available for unscheduled care improvement initiatives. To maximise the impact of this funding, performance trajectories (including ambulance turnaround times) will be re-forecast to identify the initiatives with the greatest impact. We are therefore not able to assess the extent to which the implementation of the CfSD recommendations outlined above are expected to impact on key patient flow measures.	**Yes** but we are unable to comment on the extent of the expected impact of the actions in reducing ambulance turnaround times.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Leadership and culture		
Concerns around ambulance turnaround and patient flow at ARI (cont)	Implementing actions to reduce occupancy levels: NHSG has produced a plan for "Hospital at Home" as part of the 2025/26 Whole System Plan. This plan looks to increase the amount of care which can be provided outside of the acute hospital setting, therefore reducing the occupancy level of inpatient beds, either through avoiding admissions or speeding up discharges. This plan sets out the current "Hospital at Home" provision across the three HSCPs, how each HSCP plans to increase this provision in 2025/26 and the funding that is required to achieve this. We note that Government feedback on these plans is still awaited pending the outcome of this review, hence there is no due date recorded for this action. The plan itself includes a clear assessment of the number of beds and/or the additional capacity which could be created and we note the positive collaboration with Aberdeen City and Aberdeenshire in terms of opening up Aberdeen City beds to Aberdeenshire residents (the latter being the HSCP with the high number of delayed discharges). NHSG's impact assessment of increasing the Hospital at Home service shows a mixed picture. There were 165 delayed discharges in January 2025 and this number is expected to be reduce down to 106 by March 2026. There is however still an expected spike of 202 delayed discharges in December 2025. These projected figures were submitted as part of NHSG's 2025/26 Whole System Improvement Plan in March 2025 and therefore do not reflect the impact of planned pathway changes. At the time of our fieldwork, NHSG has been asked to resubmit a refined plan to Scottish Government to align to the c£3m initial funding available for USC improvement initiatives. To maximise the impact of this funding, performance trajectories (including delayed discharges) will be re-forecast to identify the initiatives with the greatest impact. We are therefore not able to assess the extent to which the implementation of the CfSD recommendations outlined above are expected to impact on key patient flow measures.	**Yes** but we are unable to comment on the extent of the expected impact of the actions in reducing occupancy levels.

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Governance		
Concerns around the deferral of medical appraisals due to a lack of appraiser capacity	A series of actions have been identified to increase compliance with medical appraisals. These are being monitored by the Appraisal Team and reported to the internal Appraisal and Revalidation meetings. The key actions relate to increasing appraisal capacity by 10%. At time of our fieldwork, capacity had been increased by around 7% with the addition of 13 new appraisers. The Executive Medical Director has also emailed all relevant staff to highlight the need to spread appraisals throughout the year and reduce the peak of activity in February/March. The target is to reduce appraisals completed in Q4 by 30% and progress against this will be monitored by the Appraisal Team. We also confirmed that no 5A exemptions were issues due to lack of appraiser capacity in 2024/25, in line with what was reported to NES in June 2025 and that those doctors who received a 5A exemption in 2023/24 were appraised for both years in 2024/25.	**Yes**
Concerns around the Medical Education training environment and the influence of the Director of Medical Education role	NHSG recognised that it was an oversight that the NHS Grampian Medical and Dental Education Governance Group (MDEGG) was stood down as part of the pandemic response but was not re-convened. This has now been addressed and the group has been re-established and a meeting calendar agreed. From review of the membership for the Group, we confirmed this included the Executive Medical Director and Acute Sector Medical Directors, the two Directors of Medical Education and the Post-Graduate Education Quality Manager. There is also representation from Portfolio Medical Directors, the University, NES, SAS and the Area Clinical Forum (ACF). The Directors of Medical Education are also seeking to include a Resident Doctor Lead to ensure the voice of Resident Doctors is present in the meetings. Both Directors of Medical Education have also confirmed to us as part our fieldwork that with the re-establishment of Medical and Dental Education Governance Group, they have access to appropriate forum to influence medical education discussions.	**Yes**

NHSG's response to formal concerns from external parties

HIS/NES concern	Commentary	Are NHSG's actions appropriately designed to address the concerns raised?
Governance		
Concerns around the General Practice medical training programme	NHSG confirmed they have facilitated further visits from the GP training scheme and no further concerns have been raised as a result of this visit and that NES do not plan to visit again. The Post Graduate Director of Medical Education confirmed that review of the data from the most recent trainee surveys did not raise any areas of concern. Another element of the HIS/NES concern relates to triangulating intelligence on the training environment. The re-establishment of MDEGG is intended to act as a forum to formally triangulate multiple sources of intelligence around this which currently happens through the Directors of Medical Education via their review of data and involvement in different groups. MDEGG will report into the Staff Governance Committee to provide assurance on the findings and actions from its work around medical training and education.	**Yes**
Focus of risk management activities on achievable actions	This point links to **Finding H** in our report where further improvements could be made to the risk management process.	See Finding H.
Clinical engagement		
Concerns around the ways in which clinicians are engaged in the design of services for the future	This links to an observation point raised in our report which requires further investigation in terms of potential barriers to engagement with senior clinicians. Additional actions have been identified as part the CET action plan. These include a weekly meeting between the ACF Chair and CET, with a quarterly review date to assess the impact of this. There have also been additional clinical members identified for the Strategy Change Board and underlying project groups as well as the clinical engagement included in the IAP approach documents. We also note the Unscheduled Care Improvement Programme includes multiple mechanisms for engaging with the clinical workforce, both through the initial set up of the response to the CfSD report and as part of ongoing project boards.	**Yes -** but we note that the issues raised in relation to clinical engagement are much more intangible, potentially cultural, and pervasive in nature than other concerns raised. It is therefore likely that ongoing review of this area will be required to identify additional actions required as wider improvement programmes continue.