Overview of the NHS in Scotland's performance 2008/09

AUDIT SCOTLAND

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Auditor General for Scotland

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Introduction

1. This report provides an overview of the performance of the NHS in Scotland in 2008/09 and examines the financial challenges and risks for 2009/10 and beyond. The NHS in Scotland spent £10.6 billion in 2008/09, representing around a third of the total spend in the public sector of £31.3 billion. It remains Scotland's largest employer, with over 165,000 people providing care in community, primary and acute settings throughout the country.[1]

2. Following a 38 per cent growth in expenditure in real terms between 2001/02 and 2008/09, the NHS in Scotland now faces tighter financial settlements in common with the rest of the public sector.[2] There is likely to be increasing demand for services as the number of older people rises. There is also an increasing number of new health technologies and patients have higher expectations.

3. This report examines the implications for the NHS of the current economic climate and how the NHS is placed to respond to the challenges ahead. The NHS continued to face a number of cost pressures during 2008/09, including the costs of implementing the UK-wide pay modernisation agenda; the increasing costs of drugs and energy; and the cost of fully complying with the European Working Time Directive for junior doctors in training.

Our study

4. Our study is based largely on the audited accounts and auditors' reports on the 2008/09 audits of the 14 NHS boards, nine special health boards and the Scottish Government Health Directorates (SGHD).[3] These bodies collectively make up the NHS in Scotland.[4] We also used other sources of information to support our work, including:

- literature review
- national published statistics
- interviews with staff from the SGHD.

5. All NHS bodies submitted their audited accounts by the deadline of 30 June 2009. The majority of auditors reported that the audit process ran smoothly and that draft accounts and supporting schedules were of a good standard. Annual audit reports are available on Audit Scotland's website. The final financial positions in 2008/09 for the NHS boards and special boards are shown at Appendix 1. For ease of reference, figures in the main body of the report have been rounded. We have tried to minimise the use of technical terms, but in some places this is unavoidable and we have therefore included a glossary at Appendix 2.

6. The rest of this report is organised into three parts:

- Part 1 reports on the implications of the current economic climate for the NHS in Scotland.
- Part 2 considers the challenges for the NHS in a tighter financial climate.
- Part 3 examines the performance of the NHS in 2008/09, including its financial performance.

Key messages

- The NHS faces a challenging period ahead. The NHS received above inflation increases in funding for the last eight years but 2009/10 will be the peak year for public spending. Thereafter, there is likely to be a decrease in funding in real terms across the Scottish public sector. The tighter financial outlook means that the NHS needs to do more to identify efficiencies, understand and improve levels of productivity, review how services are delivered and work more effectively with its partners and patients.
- To continue to meet financial targets and maintain the level and quality of services they provide, NHS bodies need to examine how they deliver services and ensure they make best use of resources. This should be underpinned by accurate and up-to-date information about activity, costs and quality.
- The financial performance of the NHS was good in 2008/09 and all NHS bodies stayed within their budgets. Most NHS bodies relied mainly on recurring income, with only the island boards placing a higher level of reliance on non-recurring income. NHS bodies met their two per cent efficiency savings targets but some may need to exceed this level to achieve financial balance in the future.
- Some of the key indicators of health are showing improvement. However, some indicators continue to remain static or show negative trends, such as those for problems caused by drugs and alcohol misuse and the rate of teenage pregnancies. The NHS as a whole met ten out of 13 national performance targets that were due for delivery in 2008/09.

1 This equates to over 130,000 whole-time equivalent staff.
2 *The Scottish Government's budget 2009: the winners and losers*, Centre for Public Policy for Regions, 2009.
3 Although the Mental Welfare Commission for Scotland is a Commission, constituted under the Mental Health (Care and Treatment) (Scotland) Act 2003, for the purposes of this report we have included financial information on its 2008/09 accounts with our coverage of special health boards.
4 We use the term NHS bodies in this report to refer collectively to NHS boards and special health boards.

Part 1. Implications of the current economic climate for the NHS in Scotland

A reduction in public sector funding and a growing older population are likely to place health services under pressure.

Key messages

- The NHS faces a challenging period ahead. The NHS received above inflation increases in funding for the last eight years but 2009/10 will be the peak year for public spending. Thereafter, there is likely to be a decrease in funding in real terms across the Scottish public sector.
- The next 25 years will see a significant increase in the older population in Scotland and this is likely to place health services under even greater pressure. There is also a growing number of new health technologies and patients have higher expectations.
- The NHS has been able to afford major increases in pay costs over the last eight years due to past levels of funding growth. These increases have been largely used to fund the growth in staff numbers and the implementation of new pay agreements. There are also other new pressures for NHS boards to cope with, including the full implementation of the European Working Time Directive. Equal pay claims remain a potential liability that the NHS is not yet able to quantify.

The recession is having an impact across the public sector

7. In November 2009, the Auditor General reported that the current recession is placing the public sector in Scotland under the greatest financial pressure since devolution.[5] The Scottish Government's latest forecasts show that the current financial year (2009/10) will be the peak year for public spending for some time to come. In the five years to 2013/14, the Scottish Government's budget is predicted to reduce by between £2.1 billion and £3.8 billion in real terms.[6] This will have an effect on all public services, including the NHS. However, in the draft budget 2010/11 the NHS will not be affected as much as other parts of the public sector as it will receive a 0.86 per cent real terms increase in funding compared to, for example, enterprise, energy and tourism, which faces a reduction in funding from £522 million to £458 million.[7]

8. In previous years, the annual NHS overview report has described the finances and performance of the NHS in relation to the ongoing cost pressures it faces. We comment in this report not just on cost pressures within the NHS but also on the operational challenges for the NHS.

Levels of funding for the NHS have been rising rapidly but they are now set to slow down

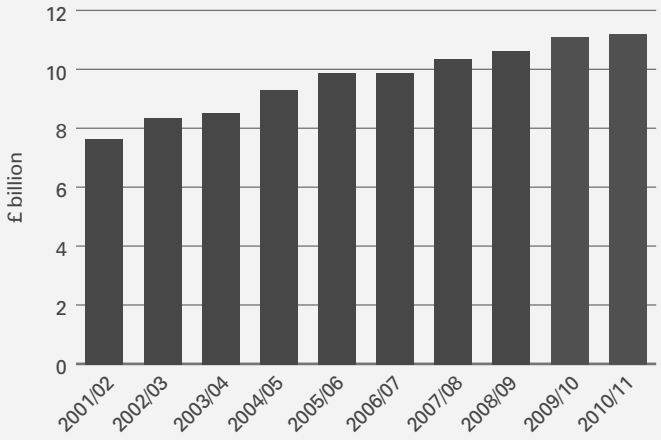
9. The current financial situation places added financial pressure on the NHS. Between 2001/02 and 2008/09, NHS expenditure increased by 38 per cent in real terms – that is, stripping out the effects of inflation over this period (Exhibit 1). These above inflation increases are now drawing to a close, with the draft 2010/11 budget showing a real terms funding increase for the NHS of £96 million, less than one per cent growth.[8]

10. In the past few years the NHS has improved its financial position, with the significant funding increases over the period being an important factor. In 2004/05, four NHS boards had cumulative revenue deficits totalling £91 million. Since then, these boards have recovered their financial positions and all NHS bodies met their three

Exhibit 1

Gross expenditure on health in Scotland, 2001/02 to 2008/09 (adjusted to 2008/09 prices) and budgeted expenditure for 2009/10 and 2010/11

In eight years, the NHS in Scotland has increased its expenditure by more than 38 per cent in real terms, but the increases in budget are expected to be smaller from 2010/11.



Note: The costs for the years up to 2008/09 are adjusted to 2008/09 prices, ie they are increased to strip out the effects of inflation. The costs for 2009/10 and 2010/11 are from the Scottish budget 2010/11.

Source: Consolidated resource accounts. 2009/10 and 2010/11 figures from Scottish budget documents

5 *Scotland's public finances: preparing for the future*, Audit Scotland, November 2009.
6 *The Scottish Government's budget: growth scenarios up to 2013-14*, Centre for Public Policy for Regions, University of Glasgow, April 2009.
7 *Scottish budget: draft budget 2010/11*, Scottish Government, September 2009.
8 Ibid.

financial targets in 2008/09. NHS bodies are now less reliant on non-recurring funding to break even (Part 3).

11. Capital investment in assets in the NHS has more than trebled in cash terms in recent years, from £132.5 million in 2003/04 to £504 million in 2008/09.[9] In response to the current economic climate, the Scottish Government has brought forward £50 million of capital expenditure from the 2010/11 budget to 2009/10. This amount is due to be repaid in 2010/11.

12. NHS bodies are committed to a number of major capital projects that will require significant funding. In June 2009, the Permanent Secretary wrote to the Scottish Parliament's Public Audit Committee with details of major capital projects in the public sector, including a number of projects in the NHS (Exhibit 2).

The financial situation in the public sector will add to the cost pressures facing the NHS

13. While the NHS is in a stronger financial position than for some time, the likely smaller growth in funding in the years following 2009/10 means that NHS bodies will have to make greater efficiency savings to manage within tighter budgets. The Efficient Government Programme requires NHS bodies to make two per cent cash-releasing efficiency savings over the three-year period 2008/09 to 2010/11. Before 2008/09, a one per cent saving was required. We comment on NHS bodies' performance against savings targets in 2008/09 in Part 2.

14. The current economic climate will be a major pressure on the finances of the health service, which has been facing specific cost pressures for some years, which we have commented on previous NHS overview reports. The annual audit reports for NHS bodies for 2008/09 detailed a number of cost pressures for the NHS, including:

- the increasing cost of drugs – between 1996/97 and 2008/09, the cost of prescription drugs more than doubled in cash terms to just over £1.1 billion[10]
- pay modernisation, including Agenda for Change, remained a significant cost pressure in the NHS (paragraph 22)

Exhibit 2

Major capital projects in the NHS with a value in excess of £50 million

Twelve capital projects in the NHS will require expenditure of up to £2.6 billion.

	Estimated capital value £m	Due for completion	Status of project at June 2009
Ayrshire and Arran – mental health	53	Not yet known	Initial agreement
Dumfries and Galloway – Royal Infirmary	36–222	Not yet known	Business case
Fife – general hospital and maternity services	170	2011	In construction
Forth Valley – acute hospital	293	2011	In construction
Greater Glasgow and Clyde– Southern General Hospital	842	2014	Procurement
Grampian – emergency care centre	95	Not yet known	Business case
Lanarkshire – Monklands Hospital	400	Not yet known	Initial agreement
Lothian – Royal Edinburgh Hospital	135	Not yet known	Initial agreement
Lothian – Hospital for Sick Children	148	2012	Business case
Lothian – clinical neurosciences	28–53	Not yet known	Initial agreement
State Hospital – redevelopment	90	2011	In construction
Tayside – mental health	98	2012	Preferred bidder
Total cost (potentially most expensive)	**2,599**	-	-

Note: Since this information was provided to the Public Audit Committee, NHS Dumfries and Galloway has gone to public consultation on three options for service redesign, with an updated range of capital costs of between £144 – 160 million. The consultation is due to finish in January 2010.

Source: *Major capital projects*, Public Audit Committee paper PA/S3/09/13/5, June 2009

9 *Asset management in the NHS in Scotland,* Audit Scotland, January 2009. The 2008/09 figure is from the Scottish Government consolidated accounts.
10 *Prescribing and dispensing costs*, ISD Scotland, October 2009.

- the cost of implementing in full the European Working Time Directive from August 2009 (paragraph 23)
- utilities costs – hospital energy costs increased by 73 per cent between 2004/05 and 2007/08, rising from £41 million to £71 million[11]
- around a third of the NHS estate will require major upgrading within the next three years.[12]

15. From 2009/10, NHS bodies will have to prepare their annual accounts using International Financial Reporting Standards (IFRS) and the changed accounting treatment may affect their reported financial positions. For example, they may have to treat PFI assets differently by bringing them onto the balance sheet. These changes may result in additional expenditure being charged in the boards' accounts but the Scottish Government and HM Treasury have agreed to consider any necessary budgetary amendments to accommodate it.

16. The recession has already affected planned income for some NHS bodies. Some capital programmes are partly reliant on asset sales, which have not yet materialised or resulted in lower receipts than expected. For example, NHS Forth Valley received less than it expected for the sale of part of the Bellsdyke site in 2008/09. The cost of works on the site during the year exceeded the amounts received for the sale of plots of land and the board therefore recorded a loss in its financial statements of £1.47 million. The Bellsdyke development is not expected to be completed until 2014 at the earliest and the board is expecting to achieve an overall gain on disposal of the whole site.

Demographic changes will increase demand for NHS services

17. Life expectancy in Scotland has been rising for a number of years and this is set to continue over the next 25 years. In the period 2008–2033, the number of people over 60 is projected to rise by 31 per cent from 1.02 million to 1.34 million, with a significant increase (84 per cent) in the over 75 age group.[13] Emergency admission rates for older people account for about 40 per cent of all emergency admissions in Scotland and emergency re-admissions of older people have been rising for the last ten years (Exhibit 3). If this trend continues, this will place pressure on the NHS and other services in the future, and highlights the need for the NHS to work effectively with local government.

18. There are also a number of universal financial commitments affecting the NHS. Demographic changes will result in greater demand for free prescriptions and free eye tests. These will result in additional costs, and greater efficiencies are likely to be needed to support them.

19. A ministerial steering group, with representation from the SGHD and the Convention of Scottish Local Authorities (COSLA), is currently undertaking analysis of the resource pressures associated with the growing older population.

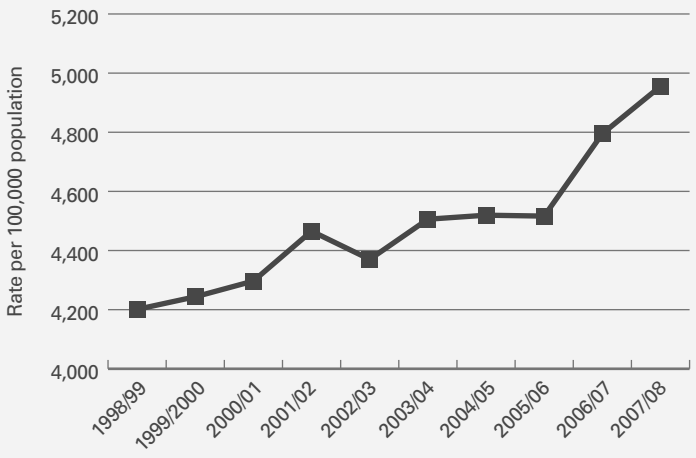
Pay costs have increased due to a growth in staff numbers and recent pay agreements

20. The cost of NHS salaries (excluding those associated with independent contractors such as GPs, community pharmacists, dentists and opticians) has risen in cash terms by more than 60 per cent, from just under £3 billion in 2003/04 to around £5 billion in 2008/09. This large rise in the pay bill has absorbed much of the increased funding for the NHS over the past few years.

Exhibit 3

Rate per 100,000 population of patients aged 65 and over with two or more emergency admissions within one year

The rate of emergency re-admissions has been rising.



Source: ISD Scotland

11 *Expenditure on property overheads by board,* ISD Scotland, October 2009.
12 *Asset management in the NHS in Scotland,* Audit Scotland, January 2009.
13 *Scotland's Population 2008: The Registrar General's Annual Review of Demographic Trends*, General Register Office for Scotland, 2009.

21. Since 2000, the numbers of staff in some of the main staff groups in the NHS have increased significantly (Exhibit 4).

22. Three pay agreements in the NHS have been implemented in recent years: the consultants' contract; the new General Medical Services contract; and Agenda for Change (which is close to being fully implemented). These agreements were introduced during a time of economic growth and large funding increases to NHS bodies but, in conjunction with increased staffing in the NHS, will have long-term cost implications. The pay agreements are intended to: lead to different ways of working; ensure that primary care services support national health policies; and result in greater productivity. That is, achieving more outputs for the same resources or the same outputs for less resources.

Implementing the European Working Time Directive in full may increase the demand for medical locums

23. The impact of the full implementation of the European Working Time Directive may put even more pressure on pay budgets. From August 2009, NHS bodies were expected to fully implement the directive, with junior doctors' hours being reduced from 56 to 48 per week. This may increase demand for locum doctors to cover staffing rota gaps, with a consequent impact on budgets.

24. Four NHS boards (Ayrshire and Arran, Borders, Fife and Lanarkshire) received partial exemptions from the full implementation of the directive for rotas in certain specialties. These exemptions will allow junior doctors in the relevant specialties to work 52-hour weeks rather than 48-hour weeks for up to two years. Audit Scotland is currently examining the use of medical locums and will report in 2010.

Exhibit 4

Increase in number (whole-time equivalent) of selected NHS staff

The number of NHS staff in some of the main staff groups has grown significantly in the last eight years.

	30 September 2000	30 September 2008	% increase
Medical	7,701	10,753	40
Nursing and midwifery	51,292	57,750	13
Allied health professionals	6,956	9,243	33

Source: ISD, Scottish Workforce Information Standard System

Equal pay remains an unquantifiable potential liability

25. Equal pay remains a potential liability that the NHS is unable to quantify. A few NHS trusts in England have settled pay claims for female employees and NHS bodies in Scotland have received similar claims. At 31 March 2009, NHS bodies had received in excess of 12,000 claims and these had been referred for the attention of the NHS Scotland Central Legal Office.

26. The NHS Central Legal Office has stated that claims currently submitted do not provide sufficient detail to allow an estimate to be made of the likelihood of success of the claims or of any financial impact that they may have. An unquantifiable contingent liability was therefore included in the financial statements for NHS bodies where claims have been made. The auditors of 14 NHS bodies included a specific comment on the issue in their 2008/09 audit certificate where they felt that a significant number of cases were pending.

There is a new funding allocation formula for NHS boards

27. The NHSScotland Resource Allocation Committee (NRAC) published a report in 2008 which set out a new formula to calculate the percentage share of annual funding that each board will receive from the SGHD. While the new formula was introduced in 2009/10, the change in boards' share of funding will be phased in over time so that boards should gradually move towards receiving their target share under the NRAC formula. The SGHD has given a commitment that moving to the NRAC targets will not lead to funding cuts for those boards which currently receive a greater share of funding than under the NRAC formula, and an additional uplift will be provided to those boards which currently receive funding at a level below the NRAC formula.

28. The SGHD will recalculate NRAC targets every year to take into account movements such as changes in population in board areas. There is no overall timescale for when funding will match the NRAC target shares for each board. Five boards are currently set to gain additional funding from the new target shares (Fife, Forth Valley, Grampian, Lanarkshire and Lothian). However, given the commitment that there will be no funding cuts for boards that currently receive more than their target share under NRAC, it is hard to see where additional funding will come from in the current economical climate.

Exhibit 5

Initial funding allocations to NHS boards compared to target allocations through the NRAC formula

A number of NHS boards, particularly Lothian, should receive improved funding through the new formula.

	Initial funding 2009/10 £m	Share of initial funding (%)	Share of funding using NRAC targets for 2009/10 (%)	Hypothetical NRAC funding 2009/10 £m	Difference £m
Ayrshire and Arran	557.2	7.69	7.44	539.2	-18.0
Borders	162.2	2.24	2.08	150.8	-11.4
Dumfries and Galloway	232.9	3.21	3.03	219.6	-13.3
Fife	490.3	6.76	6.89	499.4	9.1
Forth Valley	383.9	5.30	5.49	397.9	14.0
Grampian	660.7	9.12	9.47	686.4	25.7
Greater Glasgow and Clyde	1,825.0	25.18	24.47	1,773.6	-51.4
Highland	469.6	6.48	6.28	455.2	-14.4
Lanarkshire	777.4	10.73	11.02	798.7	21.3
Lothian	987.1	13.62	14.50	1,050.9	63.8
Orkney	30.5	0.42	0.42	30.4	-0.1
Shetland	35.9	0.50	0.44	31.9	-4.0
Tayside	578.6	7.98	7.84	568.2	-10.4
Western Isles	56.6	0.78	0.63	45.7	-10.9

Note: Figures have been rounded.

Source: Scottish Government funding allocations February 2009, and NRAC formula funding allocation percentages

29. We have used a hypothetical example to illustrate how the NRAC funding share would have compared to actual initial funding allocations in 2009/10 (Exhibit 5).

Part 2. Operating in a tighter financial climate

The NHS needs to do more to identify efficiencies, understand productivity, review services and work more effectively with its partners.

Key messages

- The tighter financial climate means that the NHS needs to do more to identify efficiencies, understand and improve levels of productivity, review services and work more effectively with its partners. This will be essential for it to continue to meet financial targets and maintain the level and quality of services it provides. In order to do this the NHS needs accurate and up-to-date information about activity, costs and quality.

- NHS bodies have been meeting their efficiency savings targets. Some have had to achieve more than the two per cent required by the SGHD to help them break even and fund new developments. The NHS as a whole has done well to make efficiency savings in some areas, such as procurement, but has made less progress than anticipated in other areas, such as shared support services.

- NHS boards have been engaged in redesigning their services for some time, but significant changes in the balance of care from acute to more community-based services have yet to become evident. NHS boards are, with support from the SGHD, adopting new, leaner approaches to streamlining their services and cutting out unnecessary expenditure.

30. In order to meet the challenges presented by the current economic climate, NHS boards need to address a number of key issues including working more efficiently, increasing productivity and redesigning services around the patient. This chapter examines what boards are doing in these areas and what remains to be done.

Some NHS bodies are having to make significant efficiency savings to help them break even

31. For the most part, the NHS has managed to achieve the necessary level of savings to ensure financial stability in the past few years, although this has been in a period when budgets for health have risen sharply. In 2008/09 NHS bodies reported that they made £149 million of recurring and £43 million of non-recurring efficiency savings (Exhibit 6, overleaf). This is more than the two per cent savings target required by the Efficient Government Programme (£154 million). Some NHS bodies had to make significant savings to help them break even and fund new developments. It is likely that more NHS bodies will need to make greater efficiency savings in the future as budgets are tightened.

32. For 2009/10, NHS bodies have forecast that they will need to make more than £175 million in recurring and £25 million in non-recurring efficiency savings. This presents a significant challenge for many NHS bodies, and their auditors have stated that it will be difficult for some to achieve the required level of savings without any negative impact on the services they provide.

33. In comparison to the rest of the public sector, the NHS performs well overall in efficient procurement. In July 2009, Audit Scotland reported that the NHS had been successful in achieving savings through the introduction of collaborative contracts, generating £54 million savings through more than 150 contracts in the two years to 2007/08.[14]

34. Progress with shared support services in the NHS has been slower than anticipated when the Efficient Government Initiative was launched in 2004.[15] At that time, it was anticipated that developing shared services for finance systems and payroll in the NHS would generate savings of £10 million per year. The programme was relaunched in 2008 and aims to implement shared financial services across the NHS in Scotland. There is some way to go before all NHS bodies are sharing financial services and the full efficiency savings can be achieved. Audit Scotland will report on efficiencies across the public sector in February 2010.

Staff costs make up a significant element of running costs

35. NHS budgets are made up of fixed, committed and variable cost elements. Fixed costs are expenditure that happens regardless of the amount of work an organisation does, such as those related to buildings. Staff costs are an example of committed costs and they make up by far the biggest element in NHS budgets (Exhibit 7, page 13). Variable costs are those costs that change depending on the amount of work an organisation does. For example, if an NHS board performs fewer operations, it will spend less money on medical supplies and equipment.

36. Another example of fixed costs in the NHS are the existing commitments under PFI contracts in NHS accounts that NHS bodies are tied into well into the future. Annual payments, known as unitary charges, are made for the duration of the contract and amount to around £120 million a year at present. Inflation over the next 20 years will significantly increase these commitments although the running costs element would need to be paid irrespective of the funding mechanism used.

37. It is difficult for NHS bodies to make significantly more efficiency savings unless they target the large areas of committed expenditure such as pay costs. The Auditor General for

14 *Improving public sector purchasing*, Audit Scotland, July 2009.
15 *Building a Better Scotland*, Scottish Executive Health Department, November 2004.

Exhibit 6

Efficiency savings made by NHS bodies in 2008/09

Some NHS bodies made significant savings in 2008/09.

	Recurring savings £m	Non-recurring savings £m	Total savings £m
NHS Ayrshire and Arran	10.9	0.0	10.9
NHS Borders	3.3	2.3	5.6
NHS Dumfries and Galloway	4.8	0.0	4.8
NHS Fife	9.4	0.8	10.2
NHS Forth Valley	0.2	3.9	4.1
NHS Grampian	6.1	8.1	14.2
NHS Greater Glasgow and Clyde	50.7	4.0	54.7
NHS Highland	9.9	6.5	16.4
NHS Lanarkshire	3.0	0.1	3.1
NHS Lothian	12.0	8.0	20.0
NHS Orkney	0.9	1.3	2.2
NHS Shetland	0.6	0.2	0.8
NHS Tayside	12.7	3.9	16.6
NHS Western Isles	1.2	0.8	2.0
Total for NHS boards	125.7	39.9	165.6
NHS National Services Scotland	5.3	0.0	5.3
Mental Welfare Commission for Scotland	0.0	0.0	0.0
The National Waiting Times Centre Board	0.8	0.2	1.0
NHS 24	3.7	1.1	4.8
NHS Education for Scotland	8.0	1.3	9.3
NHS Health Scotland	0.4	0.1	0.5
NHS Quality Improvement Scotland	0.3	0.2	0.5
Scottish Ambulance Service Board	3.7	0.1	3.8
State Hospitals Board for Scotland	0.8	0.4	1.2
Total for special boards	23.0	3.4	26.4
Total for all NHS bodies	**148.7**	**43.3**	**192.0**

Note: Figures are rounded. The figures provided are from unaudited returns provided by NHS bodies and do not necessarily correspond with Efficient Government Programme returns to SGHD.

Source: Unaudited returns from NHS bodies, July 2009

Scotland commented in his report on Scotland's public finances that without the flexibility to redeploy or reduce staffing levels or rationalise the assets used to deliver services, public bodies have limited discretion to reduce their costs while maintaining the levels of front-line services they provide.[16]

Exhibit 7

NHS staff costs as a percentage of operating costs in 2007/08

The NHS in Scotland spends around two-thirds of its budget on staff.

	Expenditure £m	Total staff costs £m	Staff cost as % of running costs
Hospital sector	5,086	3,367	66
Community sector	1,193	830	70
Family health sector	2,158	n/a	-
Total operating costs	8,437	n/a	-

Notes: 2007/08 is the latest analysis of these costs available. There is no analysis of staff costs for the family health sector. These health practitioners, such as GPs and dentists, are mainly independently contracted by health boards, ie they are not employed directly by the health board.

Source: Scottish Health Service Costs, ISD Scotland

A better understanding of productivity in the NHS is needed

38. Achieving outcomes in the National Performance Framework can be long-term and is dependent on the delivery of efficient and high-quality services. To help achieve these outcomes and ensure services are delivered efficiently and effectively, there needs to be a sound understanding of the productivity of public services.

39. The information used to measure productivity for the NHS is complex but needs to include activity, costs and quality (Exhibit 8, overleaf). At the UK level, healthcare productivity is thought to be declining – the measure of productivity (healthcare outputs divided by healthcare inputs) showed that productivity in the NHS in the UK fell by ten per cent over the period 1995 to 2006. While healthcare outputs, such as occupied bed days or the number of patients treated grew substantially over this period, inputs rose even more rapidly.[17] Essentially activity increased but expenditure increased even more. These inputs have included significant investment in pay modernisation, service redesign and the infrastructure of the health service.

40. Information on productivity in the health service is only available at the UK level. The Atkinson Review of the measurement of government output and productivity at the UK level made a number of proposals for the development of health output measurement.[18] These included:

- better measurement of activity in primary care
- extending the coverage of output measures to include less tangible outputs from services such as public health campaigns
- extending coverage across the four UK countries to improve output and input measures
- measuring whole courses of treatment rather than individual procedures, for example where patients are undergoing fewer procedures or interventions as a result of improved techniques or technology. This may also increase the quality of care
- adjusting healthcare activity for the quality of the care provided.

41. The NHS in Scotland needs a better understanding of its current use of resources if it is to increase productivity without affecting the quality of services. It must have accurate and up-to-date information about how much it spends on delivering healthcare and whether this is being done economically, efficiently and effectively. This is particularly important during a period of tight resources when the requirement to make efficiency savings is critical. Audit Scotland has highlighted the need for better information in several of its recent reports on the NHS.[19]

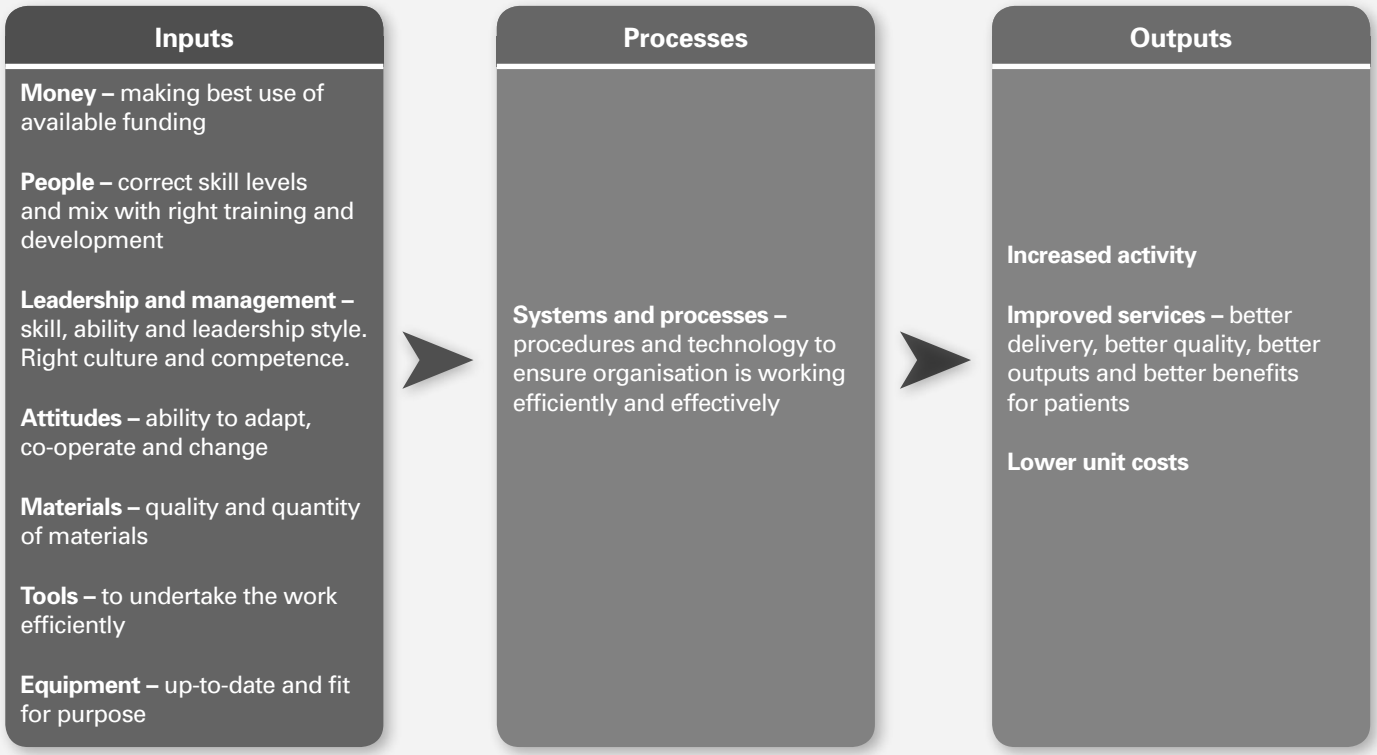
42. In the NHS in Scotland, levels of activity such as the number of inpatients and outpatient episodes are recorded but no measure of quality is applied to these outputs and an understanding of costs is limited. In June 2009, the NHS in Scotland launched an efficiency and productivity programme which aims to support the NHS in achieving efficiency and productivity targets.[20] As part of this programme, seven new indicators have been launched which are aimed at improving productivity by identifying the best performing areas and disseminating good practice to other NHS bodies to reduce variation in performance.[21] The focus of the indicators is, however,

16 *Scotland's public finances*, Audit Scotland, November 2009.
17 *Public Service Productivity: Health Care*, National Statistics, January 2008.
18 *Measurement of Government Output and Productivity for the National Accounts*, Atkinson Review: Final Report, August 2007.
19 *Managing long-term conditions*, Audit Scotland, August 2007; *Asset management in the NHS in Scotland*, Audit Scotland, January 2009; *Drug and alcohol services in Scotland*, Audit Scotland, March 2009; *Overview of mental health services*, Audit Scotland, May 2009; *Information issues identified in recent Audit Scotland reports on the NHS in Scotland*, briefing by the Auditor General to the Public Audit Committee of the Scottish Parliament, June 2009.
20 *NHSScotland Efficiency and Productivity Programme: Delivery Framework*, Scottish Government, June 2009.
21 *Efficiency and Productivity Programme: Better Quality, Better Value indicators*, SGHD, October 2009.

Exhibit 8

Key components of productivity

A wide range of information is needed to be able to analyse productivity.



Source: Audit Scotland

activity, such as pre-operative bed days, rather than productivity, which would also need to take into account the cost and quality of services.

43. The SGHD is working to improve performance and cost information such as the Scottish National Tariff Development, the review of the Scottish Health Service Costs (known as the Cost Book), the development of the Integrated Resource Framework (to support shifting the balance of care) and the National Benchmarking Group. In the NHS in Scotland there is no costing below the level of specialty while in England the NHS is working towards a more detailed level of costing. It is important that the NHS in Scotland develops a more detailed approach to costing if initiatives such as the Integrated Resource Framework are to help NHS bodies to better understand their costs.

Resources are still balanced in favour of the hospital sector

44. In 2005, the then Scottish Executive Health Department adopted a policy, *Delivering for Health*, aimed at providing the majority of care in the community, as locally as possible.[22] This was based on recommendations made in *Building a Health Service Fit for the Future*, also known as the Kerr Report.[23] The policy has a number of strands – a focus on improving health and reducing health inequalities; providing more integrated and targeted care in local settings; reducing hospital admissions; providing systematic support for people with long-term conditions; and allowing patients and carers to have more of a say in what services they receive.

45. There is limited evidence of any large-scale transfer of resources, including money and staff, from secondary to primary care. We have previously reported there was no evidence of a change in the balance of health expenditure to match the move towards more community-based care.[24] Over the period 2004/05 to 2006/07, the split of expenditure between sectors remained hospital services 60 per cent; community services 13 per cent; and family health/GP services 27 per cent. There was little change to this in 2007/08 and no change to the proportion of resources allocated to the hospital sector (Exhibit 9, opposite).[25]

22 *Delivering for Health*, Scottish Executive, November 2005.
23 *Building a Health Service Fit for the Future*, Scottish Executive, May 2005.
24 *Financial overview of the NHS in Scotland 2007/08*, Audit Scotland, December 2008.
25 2007/08 is the latest data available.

46. Measures of activity in the NHS are not comprehensive. In recent years the number of elective inpatients has continued to reduce but the number of emergency inpatients has been rising; day surgery levels have been increasing; and the number of outpatients treated has been falling. This may be the result of changes in the way healthcare is delivered, with more patients treated in the community or at GP surgeries. But it is still not possible to determine the extent to which this is the case.

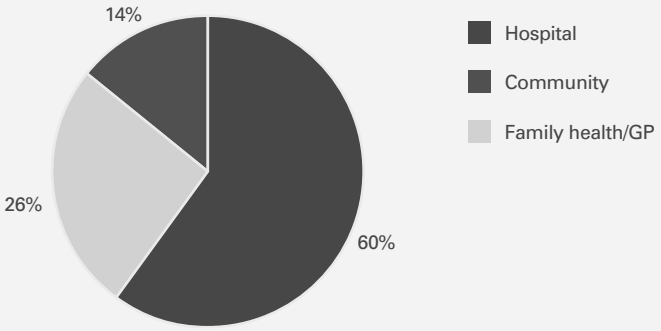
47. Demand for emergency care services is increasing year-on-year across Scotland and this is not consistent with the goal of shifting the balance of care to anticipatory care delivered in a local setting. In 2007/08, there were over 1.6 million attendances at all types of Accident and Emergency (A&E) departments across Scotland.[26] This represents around a six per cent increase from 1.51 million attendances in 2004/05.

48. The work of A&E can have a significant impact on the rest of the hospital. It has been estimated that up to 24 per cent of patients attending A&E are then admitted to hospital as an emergency, which can mean hospitals need to use beds that had been allocated for planned work.[27] This increases the level of resources committed to acute care and makes it more difficult for NHS boards to shift their resources into the community and primary care settings. Audit Scotland is undertaking a review of emergency care and will report its findings in 2010.

Exhibit 9

Expenditure by NHS sector, 2007/08

There has been very little change in the split of expenditure among sectors of the health service, with hospital services accounting for about 60 per cent of spend since 2004/05.



Note: The hospital sector includes the cost of activity carried out in community hospitals.
Source: Scottish Health Service Costs, ISD Scotland

A better understanding is needed of the effectiveness of partnership working

49. Community Health Partnerships (CHPs) and Community Health and Care Partnerships (CHCPs) were established under the National Health Service Reform (Scotland) Act 2004. The goal was to make the link between primary and acute care more seamless, with resources and responsibility for decision-making devolved to local partnerships. Five years on, NHS boards have established 40 CHP and CHCP structures across Scotland but there is still some way to go before health and social care services are fully integrated in this model. A particular area of difficulty has been the open and transparent sharing of budget information to help develop services.

50. Resource transfer from the NHS to local authorities provides an indication of some of the difficulties in reaching agreement on budgets. In 2008/09, NHS boards transferred £312 million to councils to help meet the cost of projects to support people moving out of hospital into more appropriate forms of care in the community.[28] But there have been some difficulties in agreeing this resource transfer which may be an example of the problems boards face in developing their financial relationship with their partners, for example through pooled or joint budgets. The SGHD is working with COSLA to review current arrangements and guidance for resource transfer.

51. There has been little evaluation of the way in which partnership arrangements involving the NHS are working. The SGHD is currently carrying out an evaluation of CHPs, with a report due to be published early in 2010. Audit Scotland will carry out a review of the effectiveness of CHPs next year. We also plan to look at how Community Planning Partnerships are working and will examine the NHS's contribution to the effectiveness of these partnerships and to their Single Outcome Agreements. Together, these reports should provide an overview of partnership arrangements in the NHS, local government and other bodies, and an assessment of how well they are working and whether they are making best use of resources.

26 2007/08 Cost book R044 – Specialty Group Costs – A&E Consultant outpatient attendances. 6.5 per cent of these attendances were follow-up attendances.
27 Information Services Division (ISD) of NHS National Services Scotland's snapshot survey of Emergency Departments in April 2006 found that 6,446 patients were admitted out of 29,280 patients attending an Emergency Department over the seven-day period. A further 677 patients were transferred to other hospital services.
28 Annual accounts of NHS bodies.

Independent scrutiny panels have reviewed decisions to redesign services in some boards

52. Boards are taking different approaches to shifting the balance of care, for example redesigning services within existing budgets, increasing investment or development of primary care, or closing facilities and reinvesting staff and money in community services. *Better Health, Better Care* includes provision for the Scottish Government to establish independent scrutiny panels to examine proposals for major NHS service change.[29] So far, panels have reported on proposals for service redesign in Lanarkshire, Ayrshire and Arran, the Clyde area and Dumfries and Galloway.

53. The first two reports in January 2008, on A&E services in Lanarkshire and Ayrshire and Arran, concluded that the boards had not made adequate cases to reduce the level of services in Monklands Hospital and Ayr Hospital respectively. The boards' original decisions were reversed and the panels concluded that the reversal of the decisions would mean that funds would not be released for the development of other services as the boards had originally planned. The panels, however, also concluded that the boards should examine other ways of making changes to other services, without altering their A&E service provision.

54. The NHS Lanarkshire annual audit report for 2008/09 reported that the retention of three A&E departments in Lanarkshire has affected the level of resource that can be allocated to primary care, which has been historically underfunded. It also noted that Monklands Hospital would require significant investment to maintain its current level of activity and that at an operational level, the board is finding it challenging to staff the three A&E departments.

e-Health is being developed

55. To support service redesign, the SGHD has developed an e-Health strategy aimed at improving healthcare information.[30] There are a number of strands to the strategy but it includes important developments such as the creation of an electronic patient record, and the SGHD is offering greater assistance to NHS bodies around developing business cases for IT projects that demonstrate tangible benefits. Auditors reviewed the IM&T capabilities of NHS bodies during 2008/09, measuring whether they were achieving basic, better or advanced levels of compliance with best value principles. Most were assessed as achieving a basic or better level of compliance.

Some NHS boards are adopting new ways to deliver more efficient services

56. Some NHS bodies are using lean management approaches to streamline the way they provide services and to save money. This approach was developed in the manufacturing sector and uses a variety of business tools to look at processes and identify where improvements can be made. The SGHD's Improvement Support Team is sponsoring a national efficiency programme, in conjunction with a private provider, aimed at delivering service redesign and sustainability while improving performance, quality of care and job satisfaction. Lothian has made the most progress in advancing this approach (Case study 1) and other boards are also progressing lean initiatives.

Case study 1
NHS Lothian's *Lean in Lothian* programme

The *Lean in Lothian* programme was launched in 2006 and provides frontline staff with time, training and management support to make changes in how they do things.

Twelve redesign projects were delivered during 2008/09, leading to a number of improved outcomes, including:

- a ten per cent reduction in Scottish Ambulance Service accident and emergency turnaround times
- an improvement in the information flow of cancer services, leading to achievement of a 62-day cancer waiting time for 96 per cent of cases at the year-end, compared with 91 per cent previously.

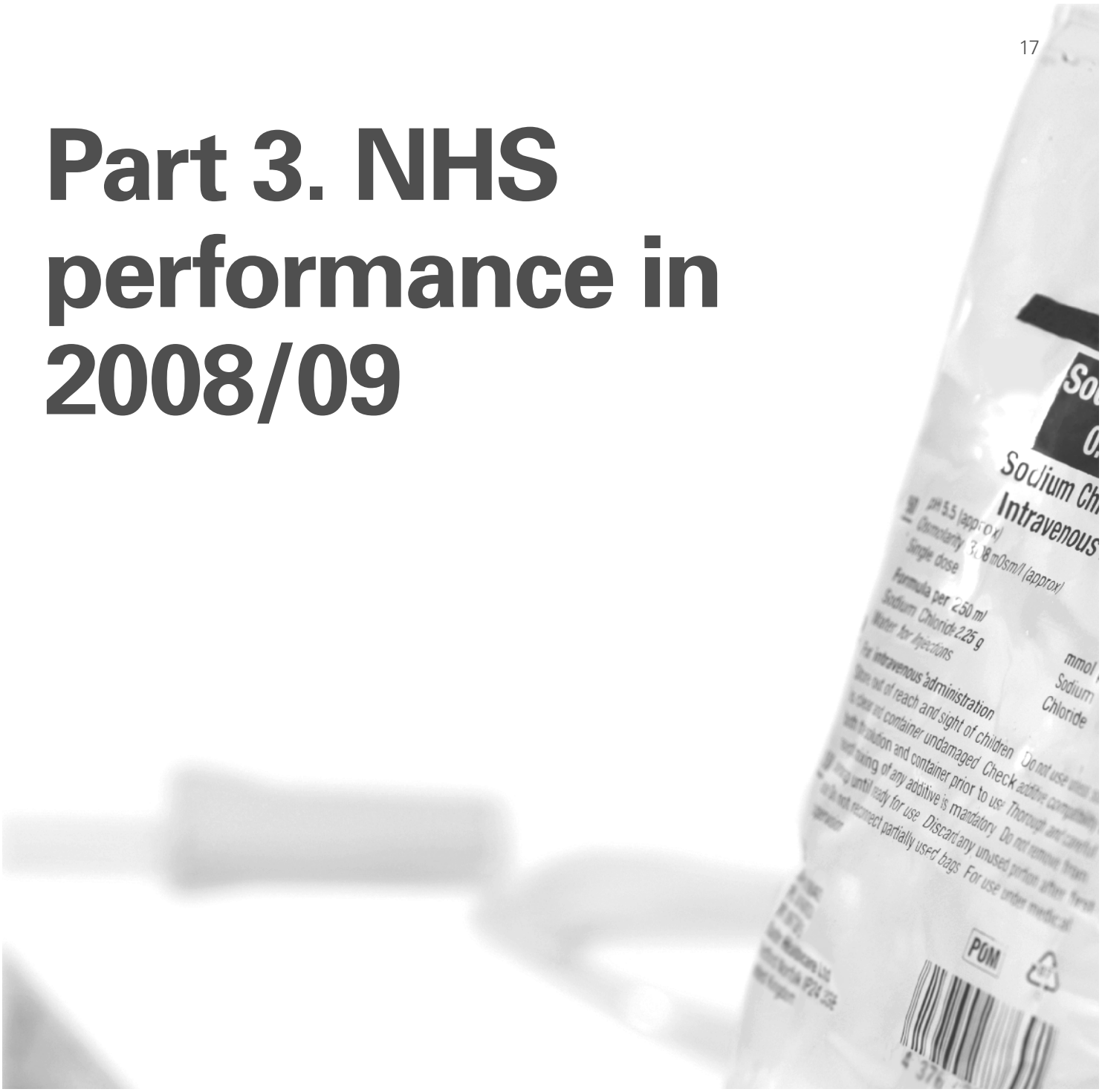
A review of projects undertaken during year two has confirmed that improvements during 2007/08 have been sustained. Other developments during 2008/09 included changes around booking operating theatres and increasing the number of hand surgery operations that can be performed by 110 cases a year.

NHS Lothian has recently introduced its new *5x5x5 programme*. During 2009/10, the programme will focus on NHS Lothian's five most pressing problems and the board has set up five multidisciplinary teams of five people to address these. Each team has been allocated £50,000 to source solutions to the problems.

Source: NHS Lothian annual audit report, 2008/09, other board papers and Scottish Parliament Health and Sport Committee – official report for meeting on 30 September 2009

29 *Better Health, Better Care*, Scottish Government, December 2007.
30 *eHealth Strategy 2008–11*, Scottish Government, August 2008.

Part 3. NHS performance in 2008/09



The financial performance of the NHS was good in 2008/09 but while some indicators of health are showing improvement, others are static or getting worse.

Key messages

- The financial performance of the NHS was good in 2008/09. It spent nearly £10.6 billion and there was a small underspend on the budget. All NHS bodies met their financial targets, including NHS Western Isles, which received brokerage of £3 million to clear its cumulative deficit. Only a small number of NHS boards had a significant reliance on non-recurring income to break even.

- Some of the key indicators of health are showing improvement. The rate of deaths from cancer, coronary heart disease and stroke is declining, the number of AIDS-related deaths is decreasing and suicide rates have been declining. However, some indicators continue to remain static or show negative trends. Problems associated with drug and alcohol misuse continue to rise, the level of teenage pregnancies shows no sign of reducing and there was an increase in the workloads of sexual health clinics.

- The NHS as a whole met ten out of 13 national performance targets that were due for delivery in 2008/09. It failed to meet two targets and one target was dropped before the end of the year. Some NHS bodies need to improve their performance if they are to meet a number of individual targets in their local delivery plans.

Exhibit 10

Overall NHS financial position, including the Scottish Government Health Directorates, 2007/08 and 2008/09

The NHS spent nearly £10.6 billion in 2008/09, with an underspend of £4 million against its overall budget.

NHS in Scotland outturn	2007/08 £m	2008/09 £m
Revenue budget	9,726	10,085
Capital budget	398	508
Total budget	**10,124**	**10,593**
Revenue expenditure	9,702	10,085
Capital expenditure	396	504
Total expenditure	**10,098**	**10,589**
Revenue underspend/overspend (-)	24	0
Capital underspend/overspend (-)	2	4
Total underspend	**26**	**4**

Source: Scottish Government consolidated accounts, 2008/09

The financial performance of the NHS was good in 2008/09 and all NHS bodies met their financial targets

57. The NHS spent nearly £10.6 billion in 2008/09, an increase of £491 million on the previous year. Overall, the NHS in Scotland broke even on its revenue budget, with a small underspend against its capital budget of £4 million (Exhibit 10).

58. NHS bodies overall underspent their annual revenue budgets by £58 million, which was almost entirely balanced by a planned overspend by the SGHD. The underspend by NHS bodies was less than the £76 million underspend in the previous year (Exhibit 11, opposite).

59. All NHS bodies met the three financial targets set by the SGHD, which are that they should stay within their:

- Revenue Resource Limit (RRL) – this is the revenue budget allocated for the day-to-day operation of services. Underspends against the RRL, where approved, may be carried forward to the next year

- Capital Resource Limit (CRL) – this is the funding that a health body has available for capital programmes

- Cash Requirement – this is the amount of cash drawn down by NHS bodies to fund ongoing operational costs and new capital investment.

60. NHS Western Isles brought forward a cumulative deficit of more than £3 million from 2007/08, and in May 2009, the SGHD provided a brokerage arrangement to fund this amount. Under the arrangement, the board will repay this funding over six financial years starting in 2012/13. The board has identified that it needs to continue to address its underlying recurring funding gap and that this is dependent on successfully completing its integrated clinical strategy and delivering savings set out in the current financial recovery plan.

61. NHS Orkney and NHS Shetland relied on non-recurring measures to meet their RRL targets. For both boards, a significant element of these measures was the non-payment of resource transfer to their local council partners. This was done in agreement with the councils, with Orkney keeping £1.8 million and Shetland £0.8 million.

Exhibit 11

Summary of NHS bodies' performance against their revenue resource limit target for 2008/09
NHS bodies underspent their revenue budgets by nearly £58 million in 2008/09.

	RRL £m	Expenditure £m	2008/09 underspend £m	2007/08 underspend £m
NHS boards	8,150	8,106	44	50
Special boards	1,200	1,186	14	26
Total	9,350	9,292	58	76

Note: Figures are rounded to the nearest million.
Source: NHS bodies' annual accounts

Some boards relied on non-recurring income to break even but this was only significant in the island boards

62. We have commented in recent NHS overview reports about NHS bodies' progress in reducing their reliance on non-recurring income. Much of the funding that NHS bodies receive can be classified as recurring income, which is provided to meet ongoing running costs. A sign of good financial health for an NHS body is when its recurring expenditure does not exceed its recurring income. Non-recurring income includes unexpected one-off receipts such as additional funding allocations from the SGHD.

63. In 2008/09, NHS bodies had an underlying deficit of £23 million which was a slight increase on the 2007/08 position when the underlying deficit was around £16 million. NHS boards made a marginal improvement, reducing their combined underlying deficit from around £35 million to £32 million, while special boards reduced their combined underlying surplus from £18.5 million to just under £9 million. The three island boards have the highest underlying deficits (expressed as a percentage of recurring income). NHS Orkney's reliance on non-recurring income is almost ten per cent of its recurring income (Exhibit 12, overleaf).

64. The forecast position for 2009/10 remains similar to 2008/09, with slightly increased reliance on non-recurring funding by NHS bodies. It is important that NHS bodies avoid an over-reliance on non-recurring funding as the tightening financial situation will make this increasingly unsustainable.

Boards make provision for future liabilities in their accounts

65. Most NHS bodies' financial statements include significant accruals, provisions and contingent liabilities. Collectively, these are the setting aside of funds for future events that may be a cost to the NHS body. The amount and the type of funds set aside will vary depending on the likelihood of the event happening.[31]

66. Accruals are funds set aside for events that NHS bodies know will happen. For example, some NHS boards made significant accruals for Agenda for Change payments in 2008/09 because there is a degree of certainty that they will have to pay these amounts. Auditors reported that by the end of March 2009, most NHS bodies had transferred nearly all relevant staff to Agenda for Change. Some NHS boards, however, set aside considerable amounts in their 2008/09 accounts to pay for staff who may be entitled to additional pay. NHS Greater Glasgow and Clyde included nearly £40 million in provisions and accruals, NHS Lothian nearly £25 million and NHS Tayside £14 million.

67. If an NHS body knows an event will happen but is less certain about how much it will cost, it may make a provision, for example the funds NHS bodies set aside to pay for future clinical and medical negligence claims.

68. Where there is less likelihood of an event happening and the NHS body is less certain of whether it will incur a cost, it may make a contingent liability in its accounts. This may or may not have an estimated amount set aside. No figure has been put on the contingent liability for equal pay in the accounts of any of the NHS bodies because there is a degree of uncertainty that NHS bodies will incur any costs (paragraph 26).

69. Accounting estimates and provisions by their nature include a degree of uncertainty, and any under-estimate of costs in 2008/09 could have a significant impact in future years. Pensions are a good example where if amounts set aside are too little, NHS bodies may find it difficult to make payments in future. It is important therefore that the decisions made by NHS managers on the amounts set aside for such provisions are well-informed and fully supported by the board.

31 Accounting standards set clear rules for how and when bodies should use accruals, provisions and contingent liabilities. NHS accounts are prepared in accordance with the Financial Reporting Manual (FReM) issued by HM Treasury. Accounting policies adopted by health boards follow UK generally accepted accounting practice, as applied to the public sector in the FReM to the extent that they are meaningful and appropriate.

Exhibit 12

NHS bodies' recurring deficit/surplus – actual 2008/09 and forecast 2009/10

The three island boards remain those with the largest underlying deficits as a percentage of their recurring income.

	2008/09 actual		2009/10 forecast	
	Underlying recurring deficit (-)/surplus £m	As a % of recurring income	Underlying recurring deficit (-)/surplus £m	As a % of recurring income
NHS Ayrshire and Arran	1.40	0.22	0.00	0.00
NHS Borders	-0.96	-0.47	-0.98	-0.47
NHS Dumfries and Galloway	2.00	0.75	2.17	0.77
NHS Fife	-2.62	-0.49	-1.10	-0.19
NHS Forth Valley	0.00	0.00	-8.90	-2.14
NHS Grampian	-7.80	-0.90	-6.42	-0.72
NHS Greater Glasgow and Clyde	-2.00	-0.08	-14.90	-0.56
NHS Highland	-8.02	-1.41	0.00	0.00
NHS Lanarkshire	3.70	0.46	0.40	0.05
NHS Lothian	-8.00	-0.73	0.00	0.00
NHS Orkney	-3.60	-9.83	-2.50	-6.21
NHS Shetland	-1.85	-5.31	-1.50	-4.18
NHS Tayside	-2.67	-0.35	-0.69	-0.09
NHS Western Isles	-1.50	-2.30	-0.67	-1.00
Total for NHS boards	-31.92	-0.36	-35.09	-0.38
NHS National Services Scotland	0.10	0.03	0.00	0.00
Mental Welfare Commission for Scotland	0.00	0.00	0.00	0.00
The National Waiting Times Centre Board	0.00	0.00	0.00	0.00
NHS 24	0.40	0.71	0.00	0.00
NHS Education for Scotland	8.00	2.03	5.20	1.26
NHS Health Scotland	-0.08	-0.38	0.28	1.41
NHS Quality Improvement Scotland	0.12	0.71	0.15	0.82
Scottish Ambulance Service Board	0.00	0.00	0.00	0.00
State Hospitals Board for Scotland	0.33	0.91	0.56	1.51
Total for special boards	8.87	0.73	6.19	0.48
Total for all NHS bodies	**-23.05**	**-0.23**	**-28.90**	**-0.28**

Note: Figures are rounded

Source: Unaudited returns from NHS bodies, July 2009

70. In previous NHS overview reports we have commented on the level of provisions and contingent liabilities in NHS bodies' accounts for clinical and medical negligence claims. In 2007/08, the NHS paid £14.5 million for these claims, nearly £7 million less than in 2006/07.[32]

Direct elections to health boards will be piloted in 2010

71. Auditors did not raise any significant issues about governance or internal controls in their 2008/09 audit reports on NHS bodies. Audit Scotland is currently reviewing the role of boards in the public sector, including the NHS, and will report its findings in 2010.

72. *Better Health, Better Care* proposed elections to health boards as a way to increase public involvement in the NHS. NHS Fife and NHS Dumfries and Galloway are the two pilot sites for direct elections to health boards. The elections will take place in spring 2010 and the pilots will run for at least two years before an independent evaluation is carried out.

The NHS is meeting some of its national performance targets but there is room for improvement

73. The national performance system for the NHS (HEAT) has 30 targets which support delivery of national outcomes.[33] The NHS met ten out of 13 targets that were due for delivery in 2008/09. Two targets were not met – these related to a reduction of sickness absence to four per cent and all non-medical staff to have personal development plans. The target for reducing the number of older people re-admitted to hospital as an emergency in one year was dropped in November 2008. This target had not been achieved and the overall trend is rising (Exhibit 3, page 7). It has been replaced by one that focuses on emergency bed days for older people. For two others there were no data available to measure performance. The other 14 targets are not due for delivery until 2009/10 or 2010/11. We have previously reported on anti-depressant prescribing and the unlikelihood of meeting this target by 2009/10.[34]

74. Appendix 3 provides a full list of the HEAT targets in 2008/09 and the most recent performance against these measures for the NHS in Scotland as a whole. Some of the targets are discussed in more detail below.

Individual NHS boards need to improve to meet some of their HEAT targets

75. Performance against the HEAT targets presents a national picture but there remains variation in performance at a local level. The degree of variation among NHS boards has reduced for most indicators but the following examples demonstrate that some boards are performing better than others for certain targets.

Urgent cancer referrals

76. The NHS as a whole has met its target for the referral to treatment for urgent cancer referrals (Appendix 3). Most boards are doing well although there remains some variation, with Borders treating more than 98 per cent of referrals within 62 days during 2008/09 while Dumfries and Galloway treated less than 92 per cent (Exhibit 13).

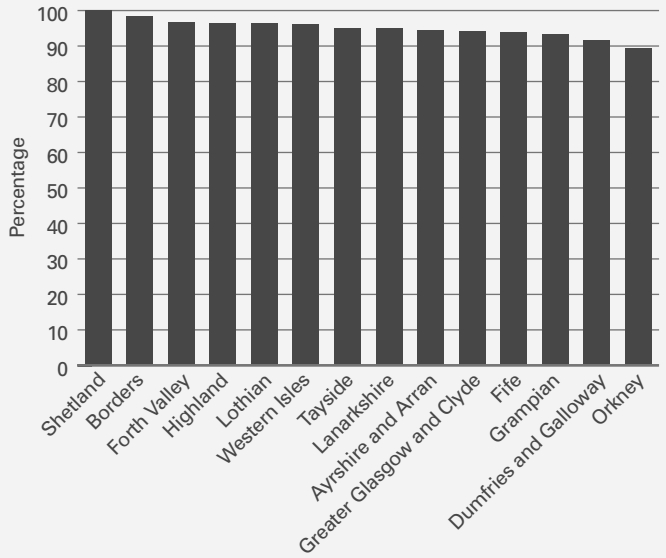
Sickness absence

77. In 2008/09, the NHS as a whole did not meet the HEAT target for sickness absence of four per cent. Few NHS bodies achieved this target although there has been general improvement in performance compared to previous years (Exhibit 14, overleaf).

Exhibit 13

Percentage of urgent cancer referrals treated within 62 days, 2008/09

Performance among NHS boards varies.



Note: Shetland and Orkney only referred 19 and 17 cases respectively.

Source: SGHD

32 Answer to parliamentary question S3W – 22066.

33 The HEAT performance management system covers indicators relating to Health improvement, Efficiency and governance improvement, Access to services and Treatment appropriate to individuals (Appendix 3).

34 *Overview of mental health services*, Audit Scotland, May 2009.

Breastfeeding

78. The HEAT target for increasing the proportion of new-born children who are exclusively breastfed is not due to be met nationally until 2010/11. However, there was wide variation in the levels of breastfeeding among NHS boards in 2008/09. Less than 20 per cent of new-born babies were exclusively breastfed at 6-8 weeks in Ayrshire and Arran and Lanarkshire, while more than 35 per cent were in Lothian (Exhibit 15).

Performance against HEAT targets could be more transparent

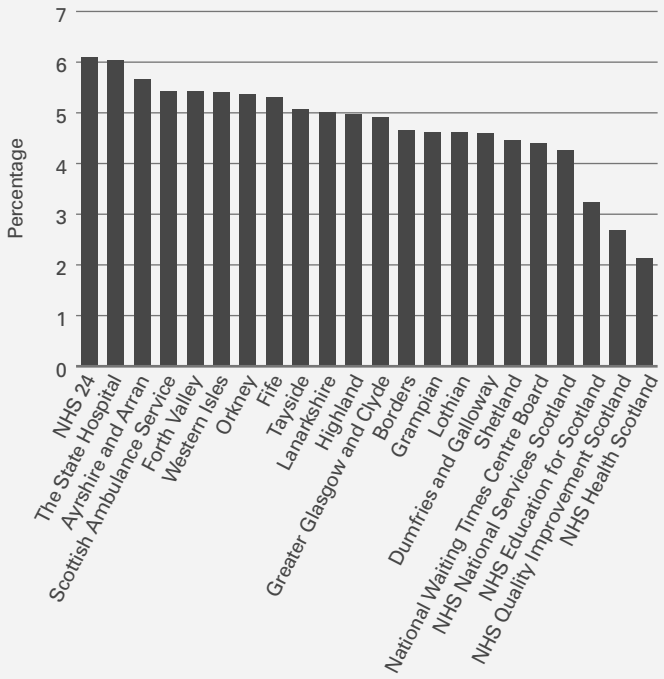
79. The HEAT targets are intended to improve the performance and accountability of the NHS in Scotland, but it is not easy for the public and patients to easily get a comprehensive picture of how the NHS is performing at board level. There is an annual review of each NHS body by the Cabinet Secretary, which is held in public, and the Chief Executive of the NHS in Scotland's annual report comments on performance at a national level. However, there is currently no single publication or website which pulls together how every NHS body is performing against these targets. We have commented in a previous NHS overview report on the need for improved public reporting on individual board performance against the HEAT targets.[35]

80. Some HEAT targets change between years and this makes monitoring trends in performance difficult. Changes and updates to performance targets are understandable as the NHS seeks to build and improve on performance. However, if too many changes are made to performance targets, it becomes harder for the public and other stakeholders to follow changes in performance over time. Of the 30 targets used to measure performance in 2008/09, only 14 were also used in 2006/07, when HEAT was introduced. For 2009/10, ten of the targets used to measure the performance of the

Exhibit 14

Sickness absence rates, 2008/09

Only three special health boards met the four per cent sickness absence target.

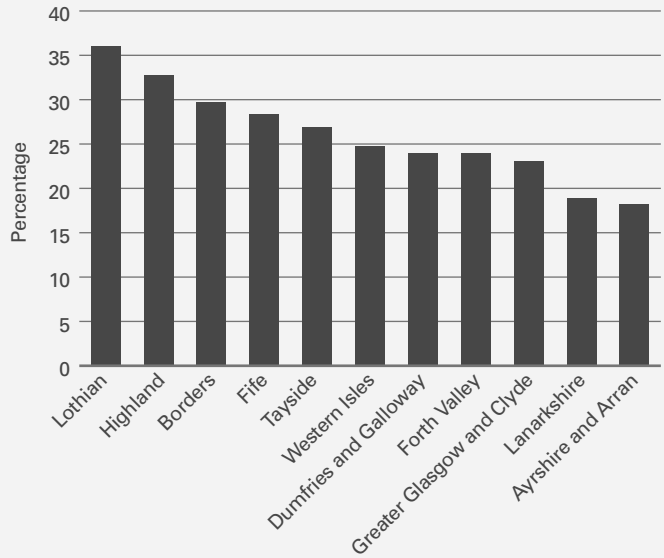


Source: ISD Scotland

Exhibit 15

Percentage of babies exclusively breastfed at 6-8 weeks, 2008/09

Lothian was the best performing NHS board.



Note: There are no data available for Grampian and Orkney as they do not participate in the Child Health Systems Programme Pre-School, and Shetland only recently implemented the system.

Source: ISD Scotland

35 *Overview of Scotland's health and NHS performance in 2006/07*, Audit Scotland, 2007.

NHS in 2008/09 have been changed and two targets, relating to sickness absence and ambulance response times, have been dropped.

Work is under way to align HEAT targets with the National Performance Framework

81. The Scottish Government expects all public sector bodies, including the NHS, to demonstrate how their activities align with the National Performance Framework (NPF). The concordat between the Scottish Government and local government introduced Single Outcome Agreements (SOAs) and a requirement that local community planning partnerships, including NHS boards, would jointly agree and report local priorities within the NPF. Most SOAs mention some of the national NHS performance targets. The NHS is developing HEAT targets to support national outcomes and, at a local level, some HEAT targets may be included in SOAs. NHS boards will need to continue to engage with councils, and other local public bodies to agree priority outcomes and related indicators. Audit Scotland's future studies on CHPs and community planning partnerships will examine this in more detail.

82. The SGHD is working with NHS boards to more closely align the NHS performance management system with the National Performance Framework. From January 2010, the NHS's contribution towards the delivery of the national outcomes will be reported in Scotland Performs.[36] In addition, NHS boards' local delivery plans are now expected to include commentary on how boards are supporting the delivery of their local SOAs, although it is too soon to evaluate the effectiveness of this approach.

Some of the key indicators of health are showing improvements or have stabilised

83. There have been improvements to some key health indicators since we last reported on performance in our 2006/07 NHS overview. Life expectancy has been rising consistently over a number of years and a number of other problem areas are showing signs of improvement. Trends for the three biggest causes of premature deaths – cancer, coronary heart disease (CHD) and stroke – are declining. Suicide rates have been falling and although the number of new HIV cases hit a peak in 2007, increased testing and early diagnosis mean that the number of AIDS-related deaths is also decreasing.

Life expectancy is improving

84. Life expectancy at birth in 2008 was 75.0 years for males and 79.9 years for females.[37] This is an increase of 0.4 years for men and 0.3 years for women since our 2006/07 overview report. Life expectancy rates are projected to continue to rise over the next few years but continue to lag behind the majority of other countries in the EU.[38]

85. A better indicator of improvements in health is healthy life expectancy at birth. In Scotland, this has risen from 65.4 years in 2000 to 67.9 years in 2007 for males, and from 68.6 years in 2000 to 70.2 years in 2007 for females. Life expectancy and healthy life expectancy are lower in more deprived communities.

Death rates associated with cancer, CHD and stroke are declining

86. Since 1998, the rates for the three biggest causes of premature death have been declining. The death rates for CHD and stroke have fallen by 38 per cent and 32 per cent respectively. There has been a 12 per cent fall in death rates for male cancer and a seven per cent fall for female cancer (Exhibit 16).

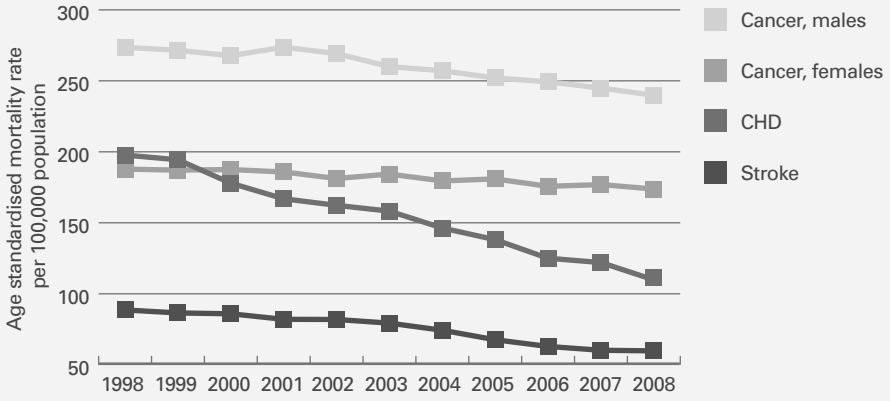
Suicide rates have been reducing overall although there is variation among boards

87. There has been a decrease in suicide rates of ten per cent between 2000–02 and 2006–08, although rates have started to increase (Exhibit 17, overleaf).[39] However, there remain variations in the suicide rates of different NHS boards. In October

Exhibit 16

Death rates for cancer, CHD and stroke, 1998–2008

Death rates have been steadily reducing, most markedly for CHD and stroke



Source: ISD Scotland

36 Scotland Performs is a web-based performance management system which is designed to demonstrate how the Scottish Government is performing against its five strategic objectives, 15 national outcomes and 45 national indicators.
37 Scottish Public Health Observatory (ScotPHO).
38 Ibid.
39 Ibid.

2009, Greater Glasgow and Clyde stated that it was not possible to be confident of achieving the national target to reduce suicide rates by 20 per cent by 2013.[40] Suicide rates in Glasgow have been rising since 2005 and the board believes that high levels of deprivation are one of the main causes of this rise.

The number of AIDS-related deaths has fallen

88. In 2007, 453 new cases of HIV were identified in Scotland and this is the highest annual total of newly identified cases since recording began in 1984. There is, however, a continuing downward trend in AIDS diagnoses and AIDS-related deaths due to a combination of increased testing and early diagnosis, and the provision of high-quality HIV care and therapies. There were 36 reports of AIDS and eight AIDS-related deaths recorded in 2007, representing respectively three-fold and 12-fold decreases since the introduction of effective therapies in 1996.

89. In 2007, 2,668 HIV-infected people were receiving HIV specialist care in Scotland. The majority of people with HIV were in Lothian (967), Greater Glasgow and Clyde (786), Tayside (203) and Grampian (203).[41]

Some indicators continue to show negative trends

90. There continue to be some indicators of health and wellbeing which show negative trends although these are significant issues affecting Scotland and require action from many parts of the public sector, not just the NHS.

Scotland has high levels of drug and alcohol misuse compared to the rest of the UK

91. In March 2009, Audit Scotland published a report highlighting that Scotland has high levels of drug and alcohol misuse compared to the rest of the UK. Drug and alcohol-related death rates in Scotland are among the highest in Europe and have doubled in the last 15 years. Drug and alcohol misuse is a problem across society but people who are likely to be excluded from society and those living in deprived areas are most affected.[42] Up to three in four people using drugs have mental health problems, and up to one in two people with alcohol problems may have a mental health problem.[43]

92. Over the last five years, age standardised rates of alcohol-related general hospital discharges have increased in every age group, with the exception of the under 15 years group which has seen a slight fall. The largest increase in discharge rates was in the 20 to 24 age group (up 36 per cent, from 474 per 100,000 population in 2003/04 to 646 per 100,000 population in 2007/08).[44] Drug-related deaths in Scotland have risen by 36 per cent, from 421 deaths in 2006 to 574 in 2008.[45]

Teenage pregnancy rates have risen slightly

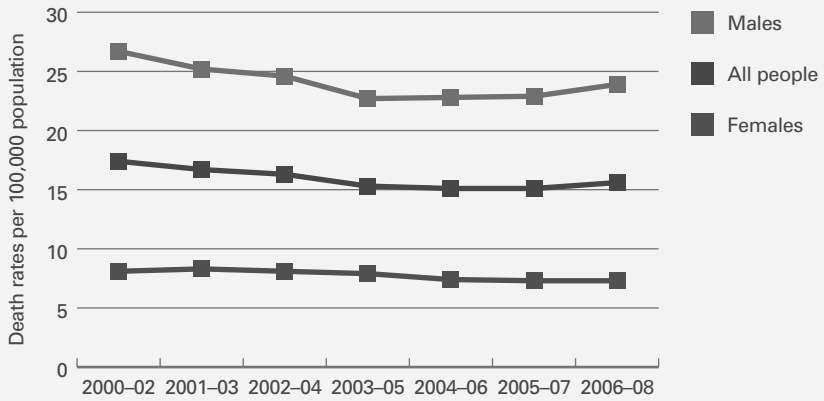
93. Rates of teenage pregnancies have remained fairly stable with just a slight increase. The rate for under 16s remained the same at 8.1 per 1,000 between 2006 and 2007, while there was a slight increase in the rates for under 18s (from 41.5 to 42.4 per 1,000) and under 20s (from 57.9 to 58.6 per 1,000).

94. There is variation among boards in the rate of teenage pregnancies (Exhibit 18, overleaf). NHS Tayside had the highest rate of teenage pregnancy in all three age groups, with a rate per 1,000 of 12.1 for under 16s, 55.3 for under 18s and 74.9 for under 20s. In contrast, NHS Highland had the lowest rate for under 16s at 5.8 per 1000, and NHS Borders had the lowest rates for under 18s (26.7 per 1,000) and the under 20s (45.2 per 1,000). Deprivation has a big impact on rates with areas of

Exhibit 17

Suicide rates per 100,000 population, 2000–02 to 2006–08

Suicide rates have fallen since 2000 but have recently started to increase.



Source: ScotPHO

40 *Public Audit Committee paper,* PA/S3/09/15/2, October 2009.
41 *Scotland's Sexual Health Information*, Health Protection Scotland, 2008.
42 *Drug and alcohol services in Scotland*, Audit Scotland, March 2009.
43 *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems,* Scottish Executive, 2003.
44 *Alcohol Statistics Scotland*, ISD, 2009.
45 General Register Office for Scotland.

highest deprivation recording rates around four times that of the least deprived areas.[46]

Workload in sexual health clinics has grown

95. There was a 16 per cent increase in the workload of sexual health clinics in 2008 compared to the previous year. In 2008, the number of acute sexually transmitted infections diagnosed in clinics in Scotland was 23,171, which represented a very small increase over the previous year (22,906).[47]

Resources have been allocated to dealing with the swine flu outbreak

96. Scotland was the first part of the UK to report the emergence of A(H1N1) swine flu. The ongoing situation is requiring significant time and financial resources from the Scottish Government and NHS bodies, particularly NHS 24 and Health Protection Scotland (part of NHS National Services Scotland). In July 2009, all four UK health ministers announced that outbreak management had moved to the treatment phase, meaning an end to tracing contacts of confirmed cases. In October 2009, the SGHD started a vaccination programme on a priority basis and by 13 November, 61 per cent of people over 65 and 36 per cent of at risk individuals under 65 had received a vaccination.[48] There is a risk of disruption to the work of the NHS, as well as other parts of the economy, due to dealing with the swine flu.

97. The SGHD has assured NHS 24 that it will meet agreed costs to further develop the Scottish Swine Flu Response Centre in anticipation of a higher volume of calls. Around 50 additional WTE call-takers have been recruited, with additional public sector volunteers being trained should the need for further help be required. Ministers have set aside £55 million for swine flu-related costs in the draft health budget for 2010/11.

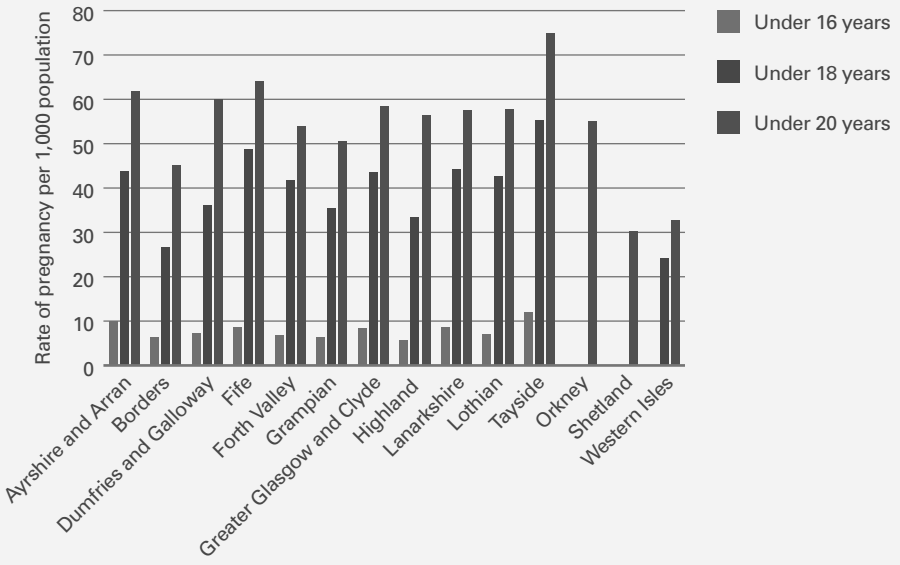
Standards for Healthcare Associated Infections and a new inspectorate have been established

98. A recent national survey of people in Scotland identified that the top two concerns for inpatients centred on hygiene – ward cleanliness and staff hand washing.[49] Clostridium difficile associated disease (CDAD) rates are decreasing overall (Exhibit 19). Other healthcare associated infection (HAI) rates also reduced overall during 2008/09 (Exhibit 20, overleaf).

Exhibit 18

Rate of teenage pregnancy by NHS board, 2007

There are wide variations in the rates of teenage pregnancy across NHS boards, with Tayside having the highest.



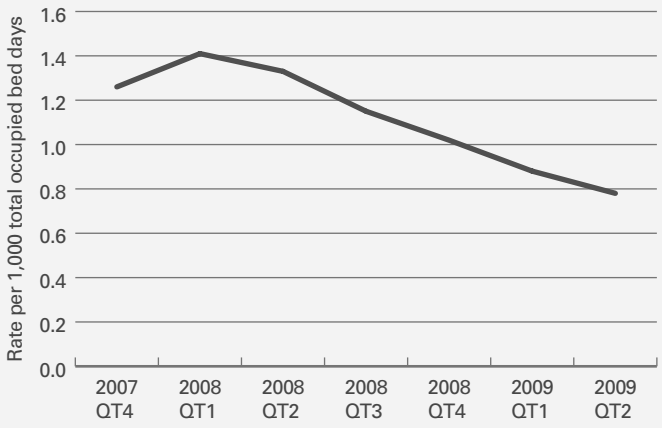
Note: 2007 is the latest year for which data are available.

Source: General Registers of Scotland

Exhibit 19

Clostridium difficile associated disease (CDAD) rates per 1,000 occupied bed days

Rates of CDAD are reducing.



Source: *Health Protection Scotland Surveillance Report 2009*, Volume 43, Number 27

46 ISD.
47 *STI (GUM) data*, ISD, 2009.
48 *Weekly influenza situation report,* Health Protection Scotland, 19 November 2009.
49 *Better Together, Scotland's Patient Experience Programme: Patient Priorities for Inpatient Care report*, Scottish Government, July 2009.

99. However, there remains wide variation in performance across NHS boards in 2008/09. For example, for CDAD, Orkney and Grampian showed the highest rates while Shetland and Western Isles had the lowest (Exhibit 21).

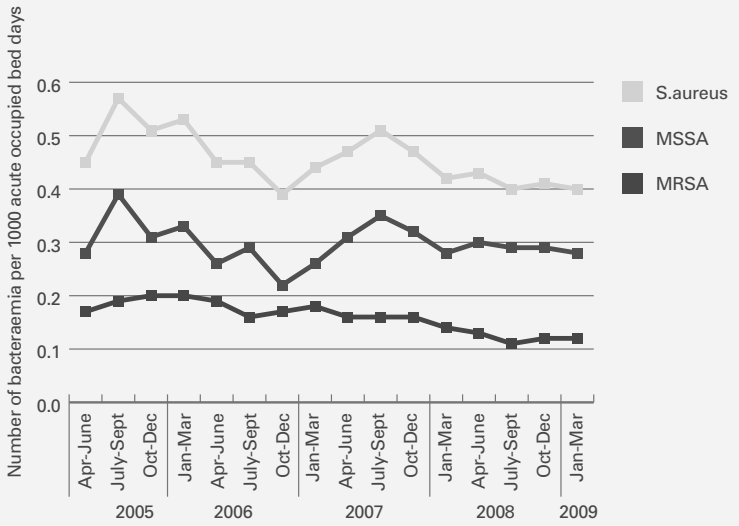
100. NHS Quality Improvement Scotland introduced HAI standards in March 2008 and the Healthcare Environment Inspectorate was established in April 2009. Using risk-based indicators to plan its work programme, the inspectorate will carry out announced and unannounced inspections of every Scottish acute hospital at least once every three years. It will assess compliance against national standards and monitor a variety of measures, including cleanliness and hand washing compliance.

101. Based on observed practice, national compliance with hand washing for NHS staff has increased from 68 per cent in 2007/08 to 93 per cent of 2008/09. Compliance varies between staff groups, with nurses demonstrating the highest levels of hand washing compliance and medical staff demonstrating the lowest rates.[50]

Exhibit 20

HAI rates per 1,000 occupied bed days, 2005/06 to 2008/09

Since 2007, rates of healthcare acquired infections have declined.

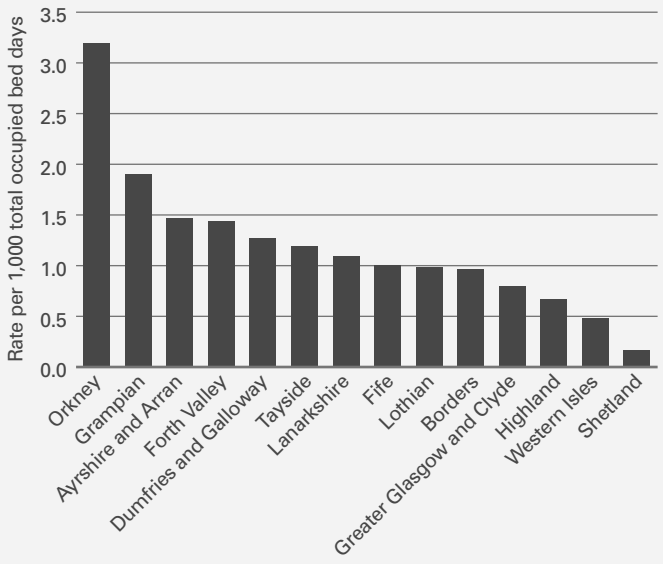


Source: Healthcare Protection Scotland

Exhibit 21

Rates of CDAD by NHS board, 2008/09

There is wide variation among NHS boards in the rates of CDAD.



Source: Health Protection Scotland

50 *National Hand Hygiene NHS Campaign: Compliance with hand hygiene – audit report*, Health Protection Scotland, March 2009.

Appendix 1.

Financial performance of NHS bodies 2008/09

	Revenue resource limit	Revenue resource outturn	Variance under/ over (-)	Capital resource limit	Capital resource outturn	Variance under/ over (-)
	£000	£000	£000	£000	£000	£000
NHS Ayrshire and Arran	618,987	608,975	10,012	30,492	30,490	2
NHS Borders	179,569	179,487	82	6,499	6,495	4
NHS Dumfries and Galloway	261,962	257,478	4,484	8,076	8,075	1
NHS Fife	543,086	540,158	2,928	26,669	26,654	15
NHS Forth Valley	423,973	420,448	3,525	10,101	10,101	0
NHS Grampian	756,339	749,853	6,486	41,801	41,798	3
NHS Greater Glasgow and Clyde	2,046,661	2,046,220	441	123,835	123,758	77
NHS Highland	537,677	537,607	70	25,976	25,935	41
NHS Lanarkshire	854,574	839,679	14,895	34,186	34,160	26
NHS Lothian	1,118,346	1,118,158	188	49,317	49,310	7
NHS Orkney	39,963	39,811	152	3,554	3,519	35
NHS Shetland	44,924	44,534	390	4,023	4,013	10
NHS Tayside	656,114	655,804	310	33,329	33,320	9
NHS Western Isles	67,596	67,587	9	3,767	3,666	101
Total for NHS boards	8,149,771	8,105,799	43,972	401,625	401,295	331
Mental Welfare Commission for Scotland	4,195	4,187	8	300	287	13
National Waiting Times Centre Board	63,294	59,032	4,262	6,576	6,036	540
NHS 24	57,102	57,023	79	1,572	1,546	26
NHS Education for Scotland	406,299	396,978	9,321	437	437	0
NHS Health Scotland	25,579	25,528	51	91	91	0
NHS National Services Scotland	401,378	401,217	161	29,227	28,953	274
NHS Quality Improvement Scotland	18,107	17,991	116	244	240	4
Scottish Ambulance Service Board	188,675	188,650	25	14,151	14,143	8
State Hospital Board for Scotland	35,084	35,083	1	20,753	20,753	0
Total for special boards	1,199,713	1,185,689	14,024	73,351	72,486	865
Total for all NHS bodies	**9,349,484**	**9,291,488**	**57,996**	**474,976**	**473,780**	**1,196**

Source: NHS Bodies' Annual Accounts

Appendix 2.

Glossary of terms

Agenda for Change	A UK-wide plan to introduce a new pay system for all NHS staff with the exception of doctors, dentists and most senior managers. The new system aims to standardise conditions of service for staff.
Annual accounts	The annual accounts of an NHS body provide the financial position for a financial year, ie 1 April to 31 March. The format of the annual accounts is set out in NHS accounts manuals and includes financial statements, notes to the accounts and memorandum statements (known as Scottish Financial Returns).
Annual audit report	A final report by an NHS body's auditor on the findings from the audit process.
Breakeven	Where income equals expenditure.
Brokerage	A facility where the Scottish Government provides money to a health board to enable it to meet its financial target. This money must be repaid in future years.
Capital resource limit (CRL)	The amount of money an NHS board is allocated to spend on capital schemes in any one financial year.
Cash-releasing savings	Where a saving is realised because the organisation or function delivers the same service with less money. For example, by delivering support services differently.
Clinical governance	Arrangements put in place to ensure safe and effective healthcare.
Community Health Partnership (CHP)	A partnership between health and social care and responsible for the delivery of a wide range of community health provision including GP services, pharmacy, social care and community nursing.
Community Health and Care Partnership (CHCP)	A partnership between health and social care and responsible for the delivery of a wide range of community health provision including GP services, pharmacy, social care and community nursing. Also responsible for many local social care services, provided by social work staff.
Consultant contract	The new pay, terms and conditions negotiated on a UK-wide basis for NHS consultants.
Corporate governance	Arrangements put in place to ensure proper use of management and resources.
Cumulative deficit	The excess of expenditure over income built up over more than one year.
Cumulative surplus	The excess of income over expenditure built up over more than one year.
Efficient Government Programme	A Scottish Government initiative to increase efficiency across the whole of the public sector in Scotland by delivering the same services with less money or delivering more services with the same money.

Family Health Services (FHS)	Services provided by GPs, dentists, opticians and community pharmacists.
Financial balance	Where income received is equal to expenditure made on an ongoing basis.
Financial or funding gap	The difference between the income and expenditure that is needed on a recurring basis to pay for operational activities. This excludes any additional one-off funding received from SGHD and any planned savings.
Financial statements	The main statements in annual accounts of an NHS body. These include: an operating cost statement, statement of recognised gains and losses, balance sheet and cash flow statement. The format of these statements is specified in NHS accounts manuals.
General Medical Services (GMS) contract	A new contract for general practitioners (GPs) introduced in April 2004 where GPs receive a lump sum based on a contract. Additional payments are made for services provided over and above those specified in the contract or where they are provided to an enhanced specification.
Governance	The framework of accountability to users, stakeholders and the wider community, within which the organisations take decisions and lead and control their functions to achieve their objectives.
Non-recurring funds	An allocation of funding for projects with a specific life span, or one-off receipts. This can include ring-fenced funding.
One-off funding	Funding which is provided for one year only.
Outturn	The final financial position, which could be the actual or forecast position.
Private Finance Initiative (PFI) Private Private Partnership (PPP)	The UK government's initiatives to encourage the development of private finance in the public sector. A generic term for projects involving both the public and private sectors. The involvement can be to varying degrees and the partnership can take different forms.
Revenue resource limit (RRL)	The amount of money an NHS board is allocated to spend on day-to-day operations in any one financial year.
Underlying deficit	The underlying deficit is the ongoing financial gap in the NHS board area between the money received to provide health services and the costs of providing these services.

Appendix 3.

Analysis of national NHS performance against HEAT targets

The SGHD rated a number of targets as 'effectively delivered' where performance was marginally short of the absolute target. For some targets, such as the cancer waiting times target, the SGHD uses a tolerance level or threshold within which it considers the target to have been achieved. Targets are marked as green if the target has been achieved and red means it has not been achieved.

HEAT target	Progress
Health improvement	
Reduce mortality from Coronary Heart Disease among the under 75s in deprived areas.	Target appears to have been achieved but does not have a clear end point.
80% of all 3 to 5-year-old children to be registered with an NHS dentist by 2010/11.	Target is being met and is due for delivery in 2010/11.
Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.	Target due for delivery in 2010/11.
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.	Target due for delivery in 2010/11.
Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key front-line staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010.	Target due for delivery in 2010/11.
Through smoking cessation services, support 8% of your board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 to 2010/11.	Target due for delivery in 2010/11.
Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.	Target due for delivery in 2010/11.
Efficiency	
Universal utilisation of CHI (Community Health Index).	CHI usage was 97.2 per cent by March 2009 and the target was fully met in July 2009. SGHD considers the target 'effectively delivered'.
NHS boards to achieve a sickness absence rate of 4% from 31 March 2009.	Target not achieved but the position is improving.
NHS boards to ensure that all employees covered by Agenda for Change have an agreed KSF (Knowledge and Skills Framework) personal development plan by March 2009.	Target not achieved but the position is improving.
NHS boards to deliver agreed improved efficiencies for first outpatient attendance Did Not Attend, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011.	Target due for delivery in 2010/11.

NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.	Target achieved.
NHS boards to meet their cash efficiency target.	Target achieved.
To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% from December 2010.	Target due for delivery in 2010/11.
Access	
Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours.	Target achieved.
The maximum wait from urgent referral to treatment for all cancers is 2 months.	Target achieved.
To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland.	Target achieved.
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31 March 2009.	One person was waiting longer than 15 weeks by March 2009 compared to more than 2,500 in April 2008. SGHD considers the target 'effectively delivered'.
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks for inpatient or day case treatment from 31 March 2009.	87 people were waiting longer than 15 weeks by March 2009 compared to more than 1,500 in April 2008. SGHD considers the target 'effectively delivered'.
As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 6 weeks for one of the 8 key diagnostic tests from 31 March 2009.	53 people were waiting longer than six weeks by March 2009 compared to more than 4,500 in April 2008. SGHD considers the target 'effectively delivered'.
NHS boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.	The first part of the target is due for delivery in 2010/11 and the SGHD considers the second part to be 'effectively delivered'.
Treatment	
By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.	Target was removed in November 2008 and has been replaced with a different target for 2009/10. The target was not achieved and the trend is rising rather than reducing.
QIS (Quality Improvement Scotland) clinical governance and risk management standards improving.	No update information available since baseline scores in 2006/07.
Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.	Target due for delivery in 2009/10.
Reduce the number of re-admissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).	Target due for delivery in 2010/11.
To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010.	Target due for delivery in 2010/11.

To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of Chronic Obstructive Pulmonary Disease, Asthma, Diabetes or Coronary Heart Disease, from 2006/07 to 2010/11.	Target due for delivery in 2010/11.
Improvement in the quality of healthcare experience.	There is no information available to measure this indicator.
Increase the level of older people with complex care needs receiving care at home.	There is no information available to measure this indicator.
Each NHS board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.	Target due for delivery in 2010/11.

Overview of the NHS in Scotland's performance 2008/09

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