Overview of the performance of the NHS in Scotland 2004/05

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AUDIT SCOTLAND

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Contents

Summary

Introduction

1. This report provides an integrated overview of the performance of the NHS in Scotland. It builds on our 2004 overview reports on performance and financial performance.[1 2]

2. The Scottish Executive has recently published *Fair to All, Personal to Each* and *Building a Health Service Fit for the Future* (the Kerr report).[3 4] These documents restate the priorities for healthcare in Scotland. They also identify the future pressures and trends which will influence the ways in which the NHS in Scotland develops. This integrated overview report complements these publications by providing an independent view of where progress is being made and identifying emerging issues which need to be addressed.

3. The NHS in Scotland spent over £8 billion in 2004/05 representing around a third of the total spend in the public sector. It remains Scotland's largest employer with almost 150,000 staff providing care in community, primary and acute settings throughout the country. The NHS needs to be able to demonstrate how it is using these resources to improve the quality of patient care.

4. The report is organised into six parts: the first three consider performance against targets; the final three parts look at the resources available to the NHS and how they are organised and managed.

- Part 1: progress in relation to health improvement.
- Part 2: outcomes for patients in Scotland's three clinical priorities and healthcare associated infection.
- Part 3: patients' access to healthcare.
- Part 4: planning and development of the NHS workforce.
- Part 5: financial performance and future cost pressures.
- Part 6: structural changes in the NHS in Scotland and the available information to report on performance.

5. The NHS in Scotland is complex. We have tried to minimise the use of jargon and technical terms, but in some places this is unavoidable and we have therefore included a glossary of terms at Appendix 1 (page 42).

1 *An overview of the performance of the NHS in Scotland*, Audit Scotland, August 2004.
2 *Overview of the financial performance of the NHS in Scotland 2003/04*, Audit Scotland, December 2004.
3 *Fair to All, Personal to Each – The next steps for NHSScotland*, Scottish Executive, December 2004.
4 *Building a Health Service Fit for the Future – A National Framework for Service Change in the NHS in Scotland*, Scottish Executive, May 2005.

Summary of key messages

6. Improvements in the quality and availability of treatment are resulting in better clinical outcomes and increased life expectancy for people living in Scotland. But the poor health of some people in Scotland continues to be a problem. This may be as a result of lifestyle choices and life circumstances such as poverty and exclusion.

7. Setting targets is helping to improve outcomes for patients in a number of areas. But the Scottish Executive needs to have a more systematic process for setting targets. For example, it should coordinate targets across the health service and ensure that targets are specific, measurable, achievable, relevant and time-based. When setting targets it should also ensure that it has systems in place to collect data which measure performance against targets.

8. The NHS in Scotland faces significant challenges and cost pressures in the future. To ensure that it can continue to provide sustainable services, it should review and improve financial management and workforce planning.

9. There have been some improvements in activity data collected but a comprehensive picture of NHS activity, costs and quality is still not available and it remains difficult to assess whether the NHS in Scotland is delivering value for money.

Information sources

10. The commentary on financial performance and governance is based largely on auditors' reports on the 2004/05 audits of the 15 NHS boards, nine special health boards and the Scottish Executive Health Department (SEHD).[5] All NHS bodies have received final audit reports for 2004/05 and these are available on Audit Scotland's website. This report also includes published information from sources such as NHS Quality Improvement Scotland (NHS QIS), HM Treasury and Office of National Statistics (ONS). We have also included unpublished data from a report commissioned by Audit Scotland.[6]

11. Parts 1 to 3, which report on the performance of the health service, use a range of sources, including the performance assessment framework (PAF), the Information Services Division (ISD) of NHS National Services Scotland, the General Register Office for Scotland and the Chief Medical Officer. Other information sources are cited throughout the report.

12. We have tried to make this report as current as possible. Some data are updated and published on a quarterly basis by ISD. Where these data have been used, the reference draws attention to the date when it was taken from ISD's website. Some other information used in this report was published prior to 2004 but remains the most up-to-date information available.

13. Throughout the report we have tried to include meaningful comparisons with other countries. But there are significant difficulties in doing this due to differences in health systems and in the way information is compiled. These comparisons must therefore be interpreted with caution.

5 For the purposes of this report, NHS National Services Scotland and Mental Welfare Commission are referred to as special health boards.
6 *European comparators for assessing the performance of Scotland's health system*, Falcon Craig Consulting, May 2005 (unpublished).

Part 1. Health improvement

Key messages

- Measuring performance against health improvement targets is difficult.
- People in Scotland are living longer but these additional years are not necessarily spent in good health.
- The number of smokers in Scotland is falling.
- Alcohol misuse and related problems are on the increase.
- Current trends suggest that drugs targets are not being met.

14. Measuring improvements in health, or progress against health improvement targets, is difficult as they must be measured over time and against a reliable baseline. We have used a variety of data sources in this chapter. But our assessment of progress against some key targets is limited because publication of a key source of information – the Scottish Health Survey, based on 2003 data – was delayed. This was published at the end of November 2005 and its findings are not included in this report.

The SEHD has set targets to tackle the causes of ill health in Scotland

15. Improving Scotland's health is a national priority for the Scottish Executive. Actions for tackling the causes of ill health and health inequalities are set out in the White Paper *Towards a Healthier Scotland* and in *Improving Health in Scotland – The Challenge*.[7 8] The SEHD has set targets to improve Scotland's health; these include targets for reducing smoking and the misuse of alcohol and drugs, and for improving diet and exercise.

16. In 2002, ministers committed to prioritising health improvement by allocating additional funding of £50 million in 2004/05 and £100 million for 2005/06. The Scottish Executive channels the majority of this funding through local authorities and it is being spent on exercise and healthy eating in schools.

People in Scotland are living longer but these additional years are not necessarily spent in good health

17. Life expectancy at birth in Scotland is increasing. On average, there has been an annual increase of around 0.2 years of life for both men and women since the early 1990s.[9] The most recent data (2002-04) show that men and

7 *Towards a Healthier Scotland – A White Paper for Scotland*, The Scottish Office, 1999.
8 *Improving Health in Scotland – The Challenge*, Scottish Executive, 2003.
9 Life expectancy at birth for a particular time period is an estimate of the number of years a new born baby would survive if they were to experience the average age specific mortality rates of that time period throughout their entire life. Therefore, the figures reflect the mortality rates at the particular time period and not the number of years that a baby born in that time period could expect to live, since death rates are likely to change in the future.

Exhibit 1

Life expectancy and healthy life expectancy for men and women in Scotland

Life expectancy at birth for men and women in Scotland has been increasing since the early 1990s. Healthy life expectancy has not kept pace.

Source: *Indicators of Sustainable Development for Scotland: Progress Report 2005*, Scottish Executive, 2005

women in Scotland have a life expectancy of 73.8 years and 79.0 years respectively.[10] But the life expectancy of both men and women in Scotland are below the UK figures of 76.3 years for men and 80.7 years for women.[11]

18. The health gap between the least and most deprived communities in Scotland persists. In 2000–02 life expectancy for men living in the most deprived areas of Scotland was 69.1 years compared with 77.0 years in the least deprived areas. And for women living in the most deprived areas life expectancy was 76.3 years compared with 80.9 years in the least deprived areas.[12 13]

19. To get a better picture of Scotland's health, we need to look at how many years of life, on average, are spent in good health – healthy life expectancy.[14] Although people in Scotland are living longer, they are not spending all those additional years in good health (Exhibit 1).

20. The inequality gap in healthy life expectancy is even greater than for life expectancy. Recent figures show that 30% of people living in the most deprived areas of Scotland have a long-term condition, such as asthma, compared to 12% in the least deprived areas.[15 16] In 2000, for men living in the most deprived areas of Scotland healthy life expectancy was 55.9 years, compared with 73.3 years in the least deprived areas. And for women in the most deprived areas, healthy life expectancy was 61.6 years compared with 72.7 years in the least deprived areas.[17 18]

The number of smokers in Scotland is falling

21. Smoking is the most avoidable cause of premature death in Scotland. Every year, it is estimated that 13,000 people die from smoking-related diseases such as lung cancer, coronary heart disease and stroke. And more than 35,000 people are admitted to hospital each year with smoking-related diseases, costing the NHS in Scotland around £200 million.[19]

10 *Life expectancy by administrative areas within Scotland, 2002-2004*, Registrar General for Scotland, Office for National Statistics, 2005.
11 *Life expectancy at birth by health and local authorities in the United Kingdom 1991-1993 to 2002-2004*, Office for National Statistics, 2005.
12 *Indicators of Sustainable Development for Scotland: Progress Report 2005*, Scottish Executive, 2005.
13 These areas were defined by the 20% least deprived and 20% most deprived postcode sector areas, using the Carstairs Deprivation Index.
14 Healthy life expectancy (HLE) is defined as the number of years people can expect to live in good health. The difference between healthy and total life expectancy (LE) therefore indicates the length of time people can expect to spend in poor health. Definition used by ISD.
15 *Social Focus on Deprived Areas*, Scottish Executive, 2005.
16 Figures relate to 10% of the most deprived areas and 10% of the least deprived areas.
17 *Indicators of Sustainable Development for Scotland: Progress Report 2005*, Scottish Executive, 2005.
18 These areas were defined by the 20% least deprived and 20% most deprived postcode sector areas, using the Carstairs Deprivation Index.
19 *Health in Scotland 2004*, Scottish Executive, 2005 and *Health in Scotland 2003*, Scottish Executive, 2004.

22. The ban on smoking in public places in Scotland will come into effect in March 2006.[20] As well as directly reducing the risk from passive smoking to non-smokers, there is some evidence to suggest a ban will increase the number of smokers who quit and reduce the likelihood of young people starting to smoke.[21]

23. There are targets for reducing the numbers of people who smoke in the following groups:

- adults
- young people
- pregnant women.

In 2003, the SEHD set a revised target to reduce the proportion of adults (aged 16-64) who smoke to 29% by 2010. It monitors progress against this target through the Scottish Health Survey and the annual Scottish Household Survey.

The SEHD set a target of reducing smoking among young people from 14% to 12% between 1995 and 2005, and to 11% by 2010.

The SEHD made a commitment to reduce the proportion of women who smoke during pregnancy from 29% to 23% between 1995 and 2005, and to 20% by 2010.

24. The most recent survey reported that the percentage of all adults (aged 16+) who smoke has reduced to 27%.[22] Although this does not match the target population of 16 to 64-year-olds, the survey indicates that the 2010 target has been met. The SEHD should consider setting a new, more challenging target.

25. The SEHD target is set for 12 to 15-year-olds. But the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), introduced in 2002, monitors the level of smoking among 13 and 15-year-olds.[23]

26. The 2004 SALSUS reports that the number of 13-year-olds who smoke has decreased from 8% to 6% (from 2002 to 2004). The number of 15-year-olds who smoke has also decreased slightly from 20% to 19% between 2002 and 2004. But this does not measure performance against the target.

27. The most recent data show that the proportion of women who smoke during pregnancy has fallen from 26% in 2003 to 23.8% in 2004.[24] This suggests that if current trends continue, Scotland is on course to meet the 2005 target.

Alcohol misuse is increasing

28. The amount of alcohol consumed in Scotland has increased over the past decade and the number of alcohol-related deaths has risen to nearly two thousand in 2003. In 2003/04, over 26,000 people were admitted to Scottish hospitals with an alcohol-related diagnosis. This represents four per cent of all hospital admissions.[25] The *Plan for Action on Alcohol Problems* estimates that alcohol problems cost the NHS in Scotland around £96 million each year.[26]

29. In 2003/04, the SEHD allocated £2.5 million to NHS boards for Drug and Alcohol Action Teams (DAATs) and a further £3 million was distributed for local alcohol action plans.[27] It also allocated £173,000 to NHS National Services Scotland (NSS) for a national alcohol information resource.

30. The SEHD has set a number of targets to reduce the levels of alcohol misuse. These targets refer to weekly sensible drinking levels.[28] But advice on sensible drinking has recently been revised and is expressed in terms of daily consumption to highlight the danger of binge drinking.[29] The SEHD should consider revising targets to reflect current advice on sensible drinking.

20 Smoking, Health and Social Care (Scotland) Act 2005.
21 *Health in Scotland 2004*, Scottish Executive, 2005.
22 *Scotland's People Annual Report: results from the 2003/04 Scottish Household Survey*, Scottish Executive National Statistics Publication, 2005.
23 SALSUS is designed to monitor substance misuse prevalence among 13 and 15-year-olds. It continues the biennial series of surveys used to monitor national trends in Scotland since 1982 for these two age groups and also incorporates items of health, lifestyle and social factors for the first time.
24 Women and Children's Health, ISD, 10/10/05.
25 *Alcohol Statistics Scotland 2005*, NHS National Services Scotland, 2005.
26 *Plan For Action on Alcohol Problems*, Scottish Executive, 2002.
27 Information supplied by the Scottish Executive Health Department, 23/09/05.
28 Weekly limit is 21 units of alcohol for men and 14 units for women.
29 Sensible drinking is defined as a maximum of four units a day for men and three units a day for women. The Scottish Health Survey defines binge drinking as drinking more than twice the sensible daily limit on a person's heaviest drinking day.

Exhibit 2

Daily consumption of alcohol in Scotland compared to England and Wales in 2003

The percentage of people in Scotland drinking above the sensible daily level of alcohol is higher than in England and Wales.

	Percentage who drank more than the sensible daily level on at least one day in the previous week		Percentage who drank more than **double** the sensible daily level on at least one day in the previous week	
	Men	**Women**	**Men**	**Women**
Scotland	44	27	26	10
England	40	22	23	9
Wales	39	22	23	10

Source: *General Household Survey – Great Britain*, Office of National Statistics, 2003

31. The current targets are:

- To reduce the incidence of men (aged 16-64) exceeding the weekly sensible drinking levels from 33% to 31% between 1995 and 2005, and to 29% by 2010.
- To reduce the incidence of women (aged 16-64) exceeding the weekly sensible drinking levels from 13% to 12% between 1995 and 2005, and to 11% by 2010.
- To reduce the percentage of young people (aged 12-15) drinking from 20% to 18% between 1995 and 2005, and to 16% by 2010.

32. Progress against these targets is monitored through the Scottish Health Survey. Other sources of information are available but these are proxy measures only and do not measure the age groups specified in the targets.

33. Figures from NHS NSS indicate that, over the past six years, alcohol-related health problems have been getting worse in Scotland.[30] There has been:

- a 13% increase in the number of patients admitted to hospital with an alcohol-related diagnosis
- a 41% increase in the number of general hospital patients with alcohol-related liver disease
- an 80% increase in the number of patients admitted to general hospital due to harmful use of alcohol
- an 11% increase in the number of people seeing their GP with an alcohol-related problem.

34. Just under half of men in Scotland (44%) and around a quarter of women (27%) exceed the sensible daily limits (four units for men, three units for women).[31] These rates are higher than those in England and Wales (Exhibit 2). The percentage of men who drink more than double the sensible daily limit is also higher in Scotland.

35. The percentage of 13-year-olds drinking on a weekly basis has remained constant, at 13%, since 1996. And the percentage of 15-year-olds who drink regularly has reduced slightly from 36% to 35%.[32] But these data do not measure against the target age group of 12 to 15-year-olds.

30 *Alcohol Statistics Scotland 2005*, NHS National Services Scotland, 2005.
31 *General Household Survey – Great Britain*, Office of National Statistics, 2003.
32 *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report, Smoking, Drinking and Drug Use among 13 and 15-year-olds in Scotland in 2004*, NHS National Services Scotland, 2005.

Current trends suggest that drugs targets will not be met

36. In 2004/05 almost £20 million was spent on drug misuse treatment services. This was in addition to the money used to support DAATs.[33] In 2001, the SEHD set nine national targets as part of its drugs strategy, with three of these targets relating directly to improving health.[34]

Reverse the upward trend in drug-related deaths and reduce the total number by 25% by 2005.

Increase the number of drug users in contact with drug treatment or care services in the community by at least 10% each year to 2005.

Reduce the proportion of drug users who inject, and the proportion of injecting users sharing needles and syringes, by 20% by 2005.

37. The baseline for reducing the number of drug-related deaths was set in 2001 when the total number of deaths was recorded as 332. The most recent figures, published in 2004, recorded 356 drug-related deaths (a rise of 7%).[35] There has been no progress in relation to this target and it is unlikely to be achieved.

38. There has been a rise in the number of users in contact with treatment centres since this target was set in 2001. The target was met in the first year (2001/02) but was not achieved in either of the following years, with annual increases of 0.2% and 8%.[36]

39. The percentage of drug users who inject, and the percentage of those who share needles, have both varied over the past four years. Overall there has not been a consistent reduction in these numbers and this target is also unlikely to be met (Table 1).

Further progress is needed on healthy eating

40. Good nutrition can help reduce the number of people affected by many common diseases, including cardiovascular disease, cancer, diabetes, obesity and osteoporosis. The Scottish dietary targets for 2005 were set in the 1996 *Scottish Diet Action Plan*. In *Improving Health in Scotland: the Challenge,* the Scottish Executive committed to continuing the Diet Action Plan well beyond 2005.[37 38]

41. Performance against dietary targets is difficult to measure due to poor information and imprecise targets. The Scottish Health Survey is the official measure for performance against most of these dietary targets.[39] We comment on two of the targets:

By 2005 the average intake of fruit and vegetables should double to more than five portions per day.

By 2005 more than 50% of women should still be breastfeeding their babies at six weeks.

42. Although it is not the official measure for this target, results from the Health Education Population Survey 2004 show that some progress has been made on the fruit and vegetable target; 33% of survey respondents consumed at least five portions of fruit and vegetables daily compared to 18% in 1996.[40]

43. Only ten of the 15 NHS boards provide data on the numbers of mothers who breastfeed. The most recent data show that in 2004, 36% of mothers were breastfeeding their babies at the time of their six to eight week review. The rate has varied very little over the last three years, and this trend indicates that the target is unlikely to be met.[41]

Table 1

	Users who inject (%)	Users who share needles (%)
2000/01	39	34
2001/02	38	36
2002/03	41	33
2003/04	37	34

Source: Drugs Misuse Statistics Scotland, ISD, 2004

33 Information suppied by the Scottish Executive Health Department, 23/09/05.
34 *Scottish Executive's Annual Report on Drug Misuse 2001*, Scottish Executive, 2001.
35 *Drug related deaths in Scotland*, General Register Office for Scotland, 2004.
36 Drugs Misuse Statistics Scotland, ISD, 2004.
37 *Eating for Health: a Diet Action Plan for Scotland*, The Scottish Office, 1996.
38 *Improving Health in Scotland – The Challenge*, Scottish Executive, 2003.
39 The Food Standards Agency Scotland is also due to publish a report this year reviewing the progress that has been made up to 2003.
40 *Health Education Population Survey 2004*, NHS Health Scotland, 2005.
41 Women and Children's Health, ISD, 10/10/05.

The majority of people in Scotland do not take enough exercise

44. Physical inactivity is one of the most widespread causes of ill health in Scotland. Lack of exercise can lead to increased risk of coronary heart disease (CHD), stroke, cancer and many other health problems. The national physical activity strategy *Let's Make Scotland More Active*, launched in 2003, includes a target that:[42]

Fifty per cent of all adults and 80% of all children meet the minimum recommended levels of physical activity by 2022.[43]

45. Although it is not the official measure for this target, the Health Education Population Survey 2004 indicates that people in Scotland are currently well below the recommended levels for exercise – just over one-third (39%) of adults meet the minimum recommended.[44] And results from a cross national study on health behaviour in school children show that only 38% of 15-year-old boys and 23% of 15-year-old girls in Scotland are meeting the recommended levels. The rates for Scotland are slightly behind those in England (48% for boys and 29% for girls).[45]

42 *Let's Make Scotland More Active*, Scottish Executive, 2003.
43 Minimum levels of activity are 30 minutes per day of moderate physical activity on five or more days per week for adults and one hour per day of physical activity on five or more days per week for children.
44 *Health Education Population Survey 2004*, NHS Health Scotland, 2005.
45 *Health Behaviour in School Age Children: Cross National Study 2001/02*, World Health Organisation, 2004.

Part 2. Clinical outcomes

Key messages

- Death rates from cancer, coronary heart disease and stroke are continuing to fall. If the present trends continue, the Scottish Executive targets are likely to be met.
- Mental health is a clinical priority for the Scottish Executive, but performance monitoring in this area is weak. The main target, which is at best a partial indicator for mental health, is a reduction in deaths from suicide. Recent figures show an increase in the number of deaths from suicide in Scotland.
- NHS boards are putting in place processes to tackle healthcare associated infection. Rates of MRSA remain fairly constant.

Clinical outcomes for cancer are improving

46. Around 26,000 people were diagnosed with cancer in 2002, and in 2004 almost 15,000 people died from cancer.[46] The Scottish Executive committed an additional £25 million revenue funding each year to support its cancer strategy.[47] This has been ring-fenced until the end of 2005/06 after which it will become part of health boards' unified budgets. Further funding has also been invested in cancer services, including £33 million for radiotherapy equipment, £87 million to build a new West of Scotland Cancer Centre, £1 million for a three-year cancer services improvement programme and £1 million recurring support for the Scottish Cancer Research Network. This additional money is only a small part of overall spending on cancer services.

Deaths from cancer are falling

The Scottish Executive has set a target to reduce the number of deaths from cancer in the under 75s by 20% between 1995 and 2010.[48]

47. Latest data show that the death rate has fallen by around 15% from 167.3 (1995) to 142.5 (2004) deaths from cancer per 100,000 population.[49] If this trend continues, Scotland is on course to meet the 2010 target. The reasons for this reduction include improved and earlier diagnosis, better equipment and better drugs to treat cancer.

48. Despite this fall in cancer deaths, the latest comparative data show that Scotland still has more deaths from cancer than Wales, England and Northern Ireland (Exhibit 5, page 13). [50]

46 Cancer statistics, ISD, 21/10/05.
47 *Cancer in Scotland: Action for Change*, Scottish Executive, 2001.
48 *Towards a Healthier Scotland*, Scottish Executive, 1999.
49 Information supplied by ISD, 24/11/05.
50 *Scotland's Population, the Registrar General's Annual Review of Demographic Trends*, General Register Office for Scotland, 2005.

Exhibit 3

Change in death rates for different cancers from 1994 to 2004

With the exception of pancreatic cancer, overall death rates for cancer are falling.

Cancer site	Percentage change over ten-year period		
	Males	Females	Both male and female
Lung	–27.0	+2.8	–14.5
Breast	+68.3	–17.9	–19.7
Prostate	–8.1		
Oesophagus	+6.1	–14.1	–1.0
Ovarian		–3.3	
Stomach	–25.2	–32.6	–27.3
Pancreas	+4.2	+4.4	+4.8
Colorectal	–14.8	–23.2	–18.0
Bladder	–26.6	–12.2	–19.2

Note: A negative percentage indicates a fall in the death rate.

Source: Cancer Statistics, ISD, 2005

49. The most common cancers in Scotland are lung, prostate, and colorectal for males, and breast, lung and colorectal for females. Overall, deaths from lung cancer are falling but it remains Scotland's most common cancer; deaths from lung cancer fell for males between 1994 and 2004, but increased for females. There have also been reductions in deaths from other cancers. The largest falls have been in stomach and colorectal cancer deaths for females, and stomach, lung and bladder cancer deaths for males (Exhibit 3).

More patients are surviving cancer

50. Survival continues to improve for most types of cancer. For patients diagnosed during 1997–2001, 61% of male and 68% of female patients survived to one year after diagnosis and 41% of males and 50% of females survived to five years.[51] Survival for breast cancer, prostate cancer, and bowel cancer has improved significantly. Survival for lung cancer shows little improvement, but lung cancer has one of the lowest survival rates of any cancer.

More needs to be done to reduce inequalities in deaths from cancer

51. Evidence indicates that people living in the most deprived areas of Scotland have the highest risk of cancer, highest death rates and the lowest probability of survival (Exhibit 4 overleaf). Poor diet, lack of exercise, and smoking play a role in higher cancer death rates in the more deprived areas. Later presentation of patients, which leads to later diagnosis, and lower uptake of screening may also be factors.

NHS boards are meeting targets for cancer screening

The Scottish Executive target for cervical cancer screening is for 80% of eligible women to be screened at least once every five years.[52]

52. The latest data show that almost 85% of eligible women had been screened in the previous 5.5 years. In practice, NHS boards invite women for screening every three years and data show that over 79% had been screened in the previous 3.5 years.[53 54] Data collected and reported are for 3.5 and 5.5 years. These do not measure against the target of five years.

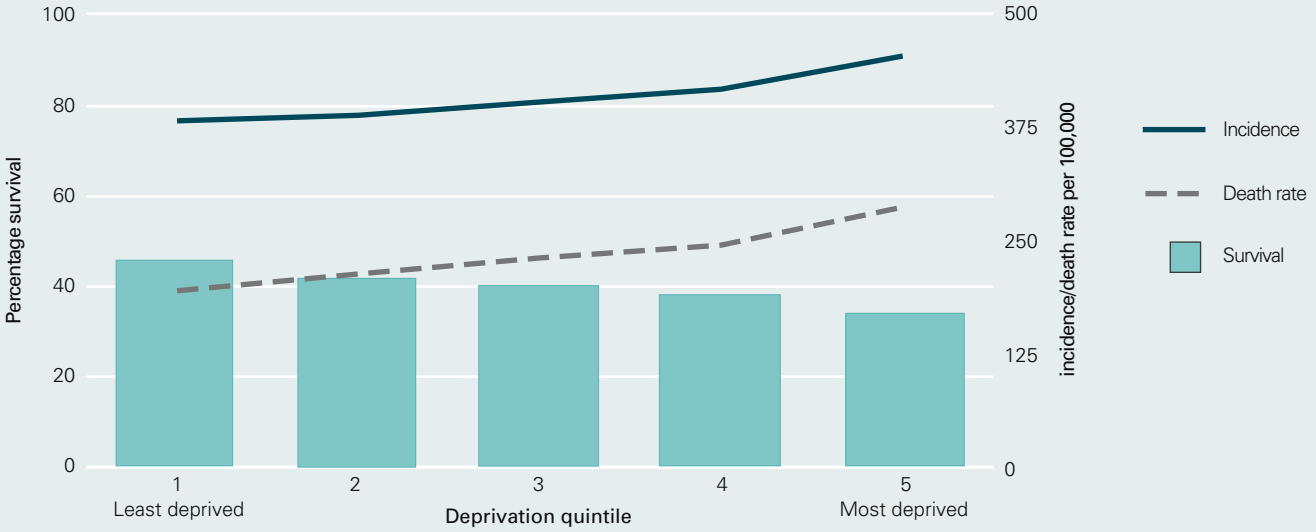
The Scottish Executive target for breast cancer screening is for 70% of eligible women to be screened once every three years.[55]

51 *Trends in Cancer Survival in Scotland 1977 to 2001*, ISD, 2004.
52 All women between the ages of 20 and 60 inclusive.
53 Excludes NHS Lothian.
54 National Screening Programmes, Cervical Screening Uptake statistics, ISD, 11/10/05.
55 Women aged 50-64 years are invited for a routine screen once every three years, and women aged over 64 years are screened three-yearly on request. The breast screening programme is being expanded: the age range for invitation is being extended to include women up to the age of 70. Women over 70 will continue to be screened on request.

Exhibit 4

Cancer incidence,[1] death rate[1] and survival at five years[2 3] by deprivation

People in the most deprived areas of Scotland have higher incidence of cancer, higher death rates and lower survival rates than people in the least deprived areas.



Notes:
1 Age-standardised rates per 100,000 person-years at risk (European standard population).
2 Survival at five years, adjusted for age.
3 Cases diagnosed in 1994 and 1995 do not have five-years' follow-up.

Source: *Trends in Cancer Survival in Scotland 1971-1995,* ISD, 2004

53. All NHS boards have achieved this target, with national average uptake at around 75%. Women living in less deprived areas are more likely to attend breast cancer screening than women from more deprived areas. The uptake rate for the less deprived areas was 82% in 2001/02 compared with 64% in more deprived areas.[56]

54. Following successful pilots in Tayside, Grampian and Fife, the Scottish Executive recently announced that a national bowel cancer screening programme will be rolled out from March 2007. All men and women between the ages of 50-74 will be invited for screening every two years. The screening programme aims to reduce the number of deaths from the disease by 15%.

Clinical outcomes for coronary heart disease and stroke are improving

55. CHD is the second most common cause of death in Scotland. At any one time about 180,000 people suffer CHD symptoms, and last year over 10,000 people died from the disease.[57] But the number of people diagnosed with CHD has been falling over the last ten years.

56. In 2004, stroke accounted for over 6,000 deaths in Scotland.[58] The Scottish Executive's *Coronary Heart Disease and Stroke Strategy for Scotland*, published in 2002, sets out action to prevent more people developing heart disease and stroke and provide better interventions for people with the diseases.[59]

The Scottish Executive has set a more challenging target for reducing deaths from coronary heart disease

The Scottish Executive's target is to reduce the death rate from CHD in the under-75s by 50% between 1995 and 2010.[60]

57. Latest data show the death rate has reduced by around 44% from 124.6 (1995) to 70.3 (2004) deaths per 100,000 population.[61] Due to this success, the Scottish Executive has recently increased the target to 60%. The target will be achieved if the present trend continues.

More people are surviving heart attacks

58. Recent data show that, since 1995, the number of patients discharged from hospital after a heart attack has decreased by 24% in under-75s, but has

56 National Screening Programmes, Breast Screening Uptake, ISD, 11/10/05.
57 *Deaths by sex, age and cause, Scotland, 2004 – provisional figures*, General Registrar for Scotland, 11/10/05.
58 *Deaths by sex, age and cause, Scotland, 2004 – provisional figures*, General Registrar for Scotland, 11/10/05.
59 *Coronary Heart Disease and Stroke in Scotland: Strategy Update*, Scottish Executive, 2004.
60 *Building a Better Scotland: Spending Proposals 2005-2008: Enterprise, Opportunity, Fairness*, Scottish Executive, 2005.
61 Coronary heart disease statistics, ISD, 02/11/05.

Exhibit 5

Age-adjusted death rates by selected cause, 2004

The Scottish death rates for cancer, CHD and cerebrovascular disease (CVD) (including stroke) are higher than in other UK countries for both males and females.

Note: Data are for all ages.

Source: *Scotland's People Annual Report: results from the 2003/04 Scottish Household Survey*, Scottish Executive, 2005

increased by 9% for those over 75.[62] The overall reduction in the number of patients discharged after a heart attack has been offset by a 17% increase in the number of patients discharged after chest pain or angina (under-75s).[63] The reduction in the number of patients discharged after a heart attack may be as a result of fewer patients being admitted to hospital due to earlier investigation and treatment.[64] The number of angiographs carried out in Scotland has increased by 45% since 1995.[65 66]

59. More people are surviving heart attacks. The most recent data show that the percentage of patients surviving for 30 days or more after a first emergency hospital admission for heart attack has increased from 81% in 1995 to 84% in 2003.[67] And the number of revascularisations (coronary artery bypass grafts and angioplasty) has also increased by 78%, from 4,049 in 1995/96 to 7,207 in 2004/05.[68]

60. Despite this significant progress, Scotland needs to do more to close the gap with the rest of the UK. Scottish death rates for CHD remain above the rates for the other countries of the UK for both men and women (Exhibit 5). Recent statistics from the British Heart Foundation show that the premature death rate for CHD for males living in Scotland is 67% higher than in the South West of England; for females the rate is 84% higher.[69]

The target for stroke is likely to be achieved

The Scottish Executive is committed to reducing the death rate from stroke in people under the age of 75 by 50% by 2010.[70]

61. There has been a steady decline in the number of deaths from cerebrovascular disease (which includes stroke) in Scotland and most recent data show the death rate from the disease has fallen by 40% from 37.5 (1995) to 22.5 (2004) deaths per 100,000 population.[71] This target is likely to be achieved if the present trend continues.

62 Coronary heart disease, operations and hospital activity, ISD, 02/11/05.
63 Coronary heart disease, operations and hospital activity, ISD, 02/11/05.
64 *Coronary heart disease and stroke in Scotland: Strategy update*, Scottish Executive, 2004.
65 An angiograph is an X-ray of the heart and blood vessels.
66 Coronary heart disease, operations and hospital activity, ISD, 02/11/05.
67 Coronary heart disease, survival, ISD,10/10/05.
68 Coronary heart disease, operations and hospital activity, ISD, 10/10/05.
69 Coronary heart disease statistics, British Heart Foundation, 2005.
70 *Building a Better Scotland: Spending Proposals 2005-2008: Enterprise, Opportunity, Fairness*, Scottish Executive, 2005.
71 Stroke statistics, ISD, 02/11/05.

62. The number of patients discharged from hospital after a stroke has remained fairly constant over the last ten years at around 24,000. And there has been a steady increase in the survival rate after first emergency hospital admission for stroke in the last ten years, especially in patients aged 45-64 years.[72]

63. As with CHD, other countries in the UK have also made progress in tackling premature death from cerebrovascular disease (including stroke), and death rates in Scotland remain higher (Exhibit 5, page 13).

Mental health is a priority but it is difficult to say if outcomes are improving

64. In Scotland, about one in four adults will experience a mental health problem at some time in their life.[73] This will be severe enough to adversely affect their day-to-day lives, which will in turn impact on family, carers and friends. People with a mental health problem may have contact with the NHS in a number of ways including a consultation with their GP, a specialist community mental health team, or as a hospital outpatient, day patient or inpatient. Around 30% of GP consultations each year are for mental health problems.[74] And in 2003, depression and other affective disorders such as anxiety were in the top five most common reasons for consulting a GP.[75] In 2004/05 NHS boards spent £767 million on mental health services.[76]

The NHS in Scotland lacks information to monitor progress in improving mental health and well-being

65. The Scottish Executive launched the National Programme for Improving Mental Health and Well Being in 2001, with the key aims of raising awareness and promoting mental health and well-being; eliminating stigma and discrimination; preventing suicide; and promoting and supporting recovery. Additional funding of £24 million is being provided to support the programme from 2003 to 2006.

66. Scotland's 'See Me' campaign was launched in 2002 to help challenge and eliminate the stigma around mental illness. Results of the Scottish Executive's second national survey of public attitudes to mental health show that people are becoming more aware – 98% of respondents believe that anyone can suffer from mental health problems.[77]

67. The Mental Health Care and Treatment (Scotland) Act 2003, which came into effect in October 2005, sets out basic principles to ensure people with mental health problems receive effective care and treatment. An additional £17 million was allocated in 2004/05 to support its implementation.[78]

68. But overall performance monitoring on mental health is weak although we understand that the Scottish Executive is developing mental health indicators. The main target currently is a reduction in deaths from suicide and this is, at best, a partial indicator – only around 25% of people who commit suicide have been in contact with mental health services in the year before death.[79]

Suicide rates are increasing

The Scottish Executive has set a target of reducing the suicide rate in Scotland by 20% by 2013.

69. In 2004, 606 people in Scotland committed suicide. If we combine these with deaths from undetermined causes, the total number of deaths classified to these two groups is 835 in 2004 compared with 794 in 2003.[80] Using the latest comparative data available, the Scottish suicide rate of 16 per 100,000 population in 2003 was well above the rate for England and Wales of nine per 100,000 population.[81]

Tackling healthcare associated infection has been identified as a national priority

NHS boards are putting in place processes to tackle healthcare associated infection

70. About nine per cent of patients in Scottish hospitals pick up an infection during their stay, equivalent to at least 10,000 infections a year.[82] According to the NHS QIS national report on healthcare associated infection (HAI), these infections cost the NHS in Scotland around

72 Stroke survival, ISD, 10/10/05.
73 *The fundamental facts... all the latest facts and figures on mental illness*, Mental Health Foundation, 1999.
74 *Our National Health, A plan for action, A plan for change*, Scottish Executive, 2001.
75 General Practice, Practice Team Information, ISD, 10/10/05.
76 NHS audited accounts 2004/05 for NHS boards and special health boards.
77 *Well? What do you think? (2004): The second national Scottish survey of public attitudes to mental health, mental well-being and mental health problems*, Scottish Executive, 2004.
78 *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*, Scottish Executive, 2002.
79 *Safety First: UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, Department of Health, 2001.
80 *Scotland's Population, the Registrar General's Annual Review of Demographic Trends*, General Register Office for Scotland, 2005.
81 www.samaritans.org.uk 10/10/05.
82 *Preventing Infections Acquired While Receiving Healthcare, The Scottish Executive's Action Plan to Reduce the Risk to Patients, Staff and Visitors 2002-2005*, Scottish Executive, 2002.

£186 million every year. They result in slower patient recovery, longer stays in hospitals, delays in discharging patients from hospital and cancelled operations. HAI is a major factor in over 400 deaths each year and a contributory factor in a further 1,300 deaths.

71. In 2001, the SEHD set a target for hospitals, community and primary care health services to meet infection control standards set by the Clinical Standards Board for Scotland (CSBS), now part of NHS QIS. The initial review by CSBS identified a number of areas for improvement.[83] The second review of compliance with these standards was carried out in 2004.[84] This identified that progress is being made but more work is needed particularly in the areas of monitoring and reviewing infection control. The SEHD has made £15 million available over the next three years to protect patients from hospital infections. In addition, a Ministerial HAI Task Force was set up in 2003 to tackle HAI.

The rate of surgical site infections is similar to England and the United States

72. Surveillance of surgical site infections, for example an infection from a surgical procedure such as a hip replacement, has been implemented in all Scottish acute hospitals. Preliminary data on these types of infections indicate rates in Scotland are similar to those in England and the United States.[85]

The rate of MRSA remains fairly constant

73. Recent data show the rate of methicillin-resistant Staphylococcus aureus (MRSA) has remained fairly constant at around 0.15 per 1,000 occupied bed days since 2001.[86] There are wide variations among NHS board areas. However, MRSA is only one of many infections a patient can develop while receiving treatment in hospital, so it is difficult to say whether overall levels of HAI have changed.

83 *Improving clinical care in Scotland: Healthcare Associated Infection: Infection Control*, NHS QIS, 2003.
84 *Healthcare associated infection: Infection Control in NHSScotland: National Progress Report*, NHS QIS, September 2005.
85 *Health in Scotland 2004*, Scottish Executive, 2005.
86 Performance Assessment Framework, Indicator 4.11.01: Rate of MRSA, 10/10/05.

Part 3. Waiting for care

Key messages

- If current trends continue, the Scottish Executive looks on course to meet most 2005 waiting time targets, with the exception of specific targets for cancer treatment. Achieving shorter waiting time targets in the future will be challenging.
- Most primary care services report compliance with the 48-hour access target. But an independent patient survey shows some dissatisfaction with the time taken to get a GP appointment.
- The number of patients who are delayed leaving hospital continues to be a problem in Scotland, although significant progress has been made since 2000 with more than a 50% reduction.

Reducing waiting times is a key commitment

74. In *Our National Health,* the SEHD made a commitment to minimise delays and reduce the time patients have to wait for treatment.[87] To deliver this commitment, it set a number of targets for patients accessing acute and primary care. These commitments have been reinforced in recent years: shorter waiting times were given in *Partnership for Care*; and new targets for 2007 were set out in *Fair to All, Personal to Each*.[88 89] We are currently reviewing strategies aimed at reducing waiting times and our findings will be published in early 2006.

The NHS in Scotland is on course to meet the six month target for patients waiting for inpatient or day case treatment

The SEHD target is to ensure that, by the end of 2005, no patient with a waiting time guarantee waited more than six months for inpatient or day case treatment.

75. There are certain specified circumstances where a patient may not have a waiting time guarantee, for example, where they ask for their admission to be delayed or where, after discussion between a patient and their consultant, the treatment is judged to be low clinical priority. In these situations, patients are assigned Availability Status Codes (ASCs), which means they no longer qualify for a waiting time guarantee. Some of these patients wait longer than the target waiting times.

87 *Our National Health, A plan for action, A plan for change*, Scottish Executive, 2001.
88 *Partnership for Care: Scotland's Health White Paper*, Scottish Executive, 2003.
89 *Fair to All, Personal to Each*, Scottish Executive, 2004.

76. In the quarter up to the end of September 2005, 91% of all patients were treated within six months.[90] At the September 2005 census, 1,249 patients with a guarantee had been waiting more than six months for treatment.[91] There has been a general downward trend during 2005 and if this continues the NHS in Scotland is likely to meet the six month target by the end of the year.

77. There were 109,992 patients on the waiting list on 30 September 2005. The number of patients without a guarantee (35,048) was 12% higher in September 2005 than in September 2004. At the end of 2007, the NHS is changing how it calculates waiting times for inpatient and day case treatment and ASCs will be abolished.[92] A new target is being introduced – no patient will wait longer than 18 weeks by the end of 2007 – which will be challenging for the NHS in Scotland.

The NHS in Scotland is on course to meet the target for waiting for a first outpatient appointment

Partnership for Care pledges that, by the end of 2005, no patient should wait longer than six months for a first outpatient appointment following referral to a specialist by a GP. The SEHD has set a new target that, by the end of 2007, no patient will wait more than 18 weeks.

78. In the quarter up to the end of September 2005, almost 91% of all patients waiting for a first outpatient appointment were seen within six months.[93] The September 2005 census showed that the number of patients waiting more than six months had fallen from 53,579 on 30 September 2004 to 11,854 on 30 September 2005.[94] The NHS in Scotland is on course to meet the six month target by the end of 2005.

79. The total number of patients on the waiting list for a first outpatient appointment has also fallen by more than 20% – from 265,228 on 30 September 2004 to 210,586 on 30 September 2005.[95]

Performance against waiting times targets for coronary heart disease procedures has improved

The SEHD has set specific targets for CHD procedures. It pledged that, by the end of 2004, the maximum wait for angiography would be eight weeks from seeing a specialist. And by the end of June 2004 the maximum wait for cardiac surgery (revascularisation) would be 18 weeks from the time of angiography.

80. Waiting times for angiography have shown signs of improvement, with NHS boards meeting the target in September 2005.[96 97]

81. The cardiac surgery waiting times target was met at September 2005. None of the 815 patients on the waiting list had been waiting longer than the 18-week target.[98] This is the fifth quarterly period that the target has been achieved.[99]

Waiting times targets for cancer treatments are unlikely to be met

The SEHD has set targets for cancer treatments. By the end of 2005, the maximum wait from urgent referral to treatment for all cancers should be two months.

82. Performance against the target is published only for lung, breast, colorectal and ovarian cancers, and melanoma (Table 2).[100] This means it is not possible to assess performance against the target for all cancers. Based on the most recent performance data available (January to March 2005), it is unlikely that this target will be met.

Table 2

Percentage of patients treated within two months of urgent referral	
Lung cancer	71.8
Breast cancer	86.3
Colorectal cancer	47.5
Ovarian cancer	78.9
Melanoma	75.0

Source: Scottish Executive, 2005

The SEHD pledged that, from October 2001, women with breast cancer who are referred for urgent treatment should begin treatment within one month of diagnosis.

90 This includes all patients with and without a waiting time guarantee.
91 Acute hospital care, Waiting times, ISD, 24/11/05.
92 Existing ASCs will be abolished. Low clinical priority and highly specialised treatments will no longer be reasons for excluding patients from the maximum waiting times guarantee. There will be new ways of handling Could Not Attends (CNAs), Did Not Attends (DNAs), and those medically or socially unavailable.
93 This covers patients with a waiting time guarantee only.
94 Acute hospital care, Waiting times, ISD, 24/11/05.
95 Acute hospital care, Waiting times, ISD, 24/11/05.
96 Those with an ASC are not included in this figure.
97 Acute hospital care, Waiting times, ISD, 24/11/05.
98 Those with an ASC are not included in this figure.
99 Acute hospital care, Waiting times, ISD, 24/11/05.
100 Data from the three regional cancer networks, NOSCAN, WOSCAN and SCAN.

Exhibit 6

The number of callers receiving call-back service from NHS 24, January 2004 to August 2005

At least a third of callers to NHS 24 have had to be called back since December 2004.

Source: *Review of NHS 24*, NHS Independent Review team, September 2005

83. This target is not being met. The latest data show that around 80% of women are treated within one month.[101]

Waiting times in A&E units have risen over the past five years

Fair to All, Personal to Each introduced the target that, from the end of 2007, no patient should wait longer than four hours between arriving at an Accident and Emergency (A&E) unit and admission, discharge or transfer, unless there are stated clinical reasons for keeping the patient in the A&E unit.

84. ISD has conducted A&E waiting times surveys since 1995. This year's A&E waiting times survey reports that nine out of ten patients completed their treatment within four hours.[102] The median wait increased between 2000 and 2005 from 74 to 97 minutes.[103] We understand that boards will implement new electronic systems to measure A&E waiting times and outcomes by summer 2006.

Most GP practices meet the target of patients accessing primary care within 48 hours

The SEHD has set a target for access to primary care services. Anyone contacting a GP surgery should have access to a GP, a nurse or other healthcare professional within 48 hours.

85. This is also included within the Quality and Outcomes Framework (QOF) of the new General Medical Services (GMS) contract. The definition of 48-hour access is broader than GP appointments, and includes other services such as nurse-led telephone consultations. In 2004/05, most Scottish GP practices participating in the QOF qualified for, and received, the bonus payments.

86. In a recent UK-wide survey some patients express dissatisfaction about direct access to their GPs. The survey shows that 45% of patients surveyed in Scotland were seen by their GP on the same or next day, compared with 60% in England, 56% in Wales and 51% in Northern Ireland.[104] The survey also found that 30% of patients in Scotland waited four or more days to see their GP, compared with 17% in England.

NHS 24 has to call back too many people

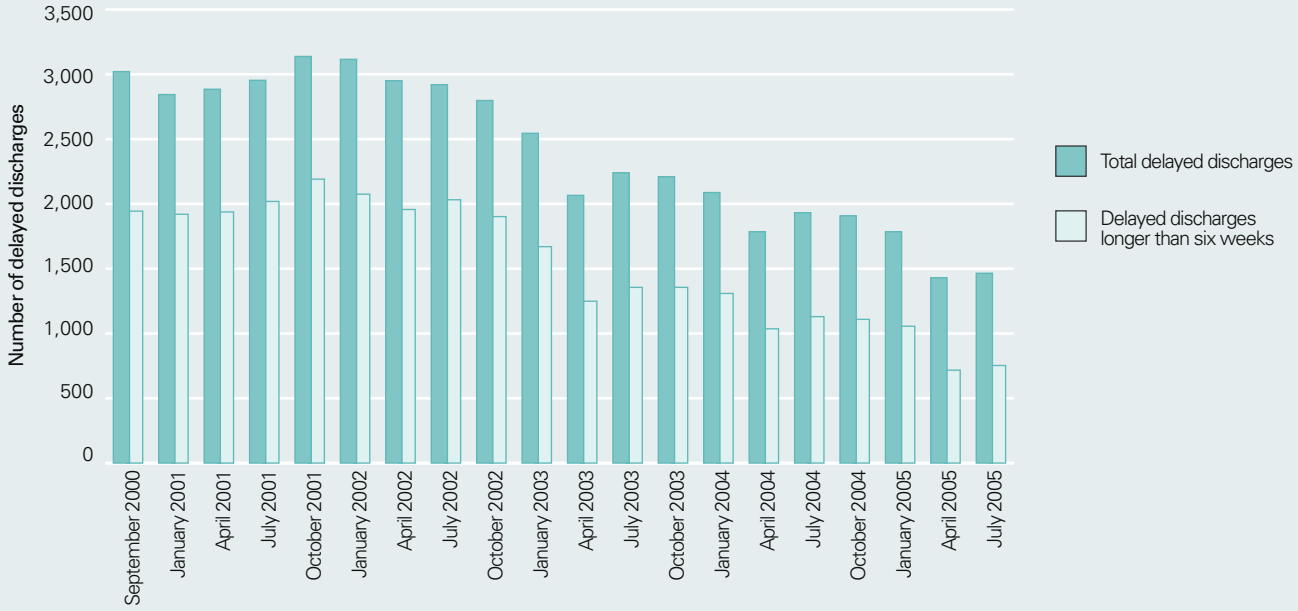
87. NHS 24 was established as a special health board in April 2001. It provides two services to the public: a 24-hour nurse consultation service providing clinical advice and referral; and a health information service offering callers information on specific diseases and conditions as well as advice on local health services.[105]

101 *Health in Scotland 2004*, Scottish Executive, 2005.
102 Accident and Emergency Waiting Times, ISD, 10/10/05.
103 The surveys have been carried out over different periods of time which may affect the reliability of the comparisons.
104 *The Commonwealth Fund International Health Policy Survey* cited in *The Quest for Quality in the NHS, A chartbook on quality of care in the UK*, Nuffield Trust, 2005.
105 *NHS 24 Annual Report and Accounts 2003/04: Helping to make people's lives better*, NHS 24, 2004.

Exhibit 7

Number of patients delayed in hospital, September 2000 to July 2005

The total number of people delayed in hospital and the number delayed for more than six weeks have fallen since a peak in October 2001.



Source: Delayed discharge data, ISD census, 2005

88. An independent review of NHS 24 commissioned by the SEHD reported that call-back is the biggest problem facing the service.[106] NHS 24 has carried out a risk assessment to look at managing the clinical risks involved in the use of call-back. But the use of call-back has accounted for over one-third of all calls from December 2004 until August 2005 (Exhibit 6).[107]

Delays in patients leaving hospital are falling but further work is needed

89. Reducing the number of patients delayed in hospital is a high priority for the SEHD and the 15 delayed discharge partnerships across Scotland.[108] As well as affecting delayed patients and their families, delays in discharging patients can increase the length of time other people wait for hospital treatment or lead to cancelled operations. The main reasons for delay are:

- waiting for community care arrangements or assessments
- waiting for health care arrangements or assessments
- patients exercising their statutory right of choice over their ongoing care.

90. At any one time, about 8% of all hospital beds are occupied by patients who are ready for discharge. And around three-quarters of those who are delayed are aged 75 and over. In addition to the resources that partnerships already use to reduce delayed discharges from their general allocations, the SEHD has targeted £30 million a year until 2007/08 to help tackle the problem.

The number of patients delayed in hospital has fallen significantly since 2000

In 2004, the SEHD set all delayed discharge partnerships a target of reducing the total number of delays by 20% by April 2005.

91. ISD publishes a national quarterly census which measures the number of patients whose discharge from hospital is delayed, and the causes of delay. The most recent census (July 2005) shows that the total number of patients delayed has fallen by over 50% since data were first collected in September 2000. And the number of patients delayed for longer than six weeks has fallen by over 60% (Exhibit 7).[109] Data for April and July 2005 are not directly comparable with previous quarters because some patients have been excluded.[110]

106 'Call-back' refers to calls returned by the nurse to patients who contacted NHS 24 at a time when a nurse was not available to take the call.
107 *Review of NHS 24*, NHS Independent Review Team, September 2005.
108 Local delayed discharge partnerships are made up of representatives from NHS boards and councils. These partnerships are based on NHS board areas.
109 There are two measures for delayed discharge: those delayed for up to six weeks and those delayed for longer than six weeks. Partnerships and the Scottish Executive agreed that a reasonable period to plan and implement a discharge is six weeks.
110 From April 2005, some census data have been disaggregated from the total figures and reported separately. These data relate to patients who are delayed awaiting facilities which do not yet exist, patients whose health circumstances have changed and patients who come under the scope of the Adults with Incapacity (Scotland) Act 2000.

92. The length of time people wait to be discharged once they are fit to leave hospital has also fallen. The average delay has fallen from 80 days in January 2001 to 44 days in July 2005. And the median length of delay has fallen by 45% over the same period, indicating that more serious delays are being dealt with faster.

93. Despite this progress in tackling delayed discharges, it is still a problem. At present, around 1,500 people are waiting to be discharged from hospital. With an expected increase in Scotland's older population, the number of patients who are delayed in hospital is likely to increase unless further action is taken to plan and coordinate services more effectively. Audit Scotland reported on this earlier in 2005.[111]

111 *Moving on? An overview of delayed discharges in Scotland*, Audit Scotland, 2005.

Part 4. Workforce

Key messages

- The NHS in Scotland has set workforce recruitment targets. It is difficult to say whether these targets will be met. But vacancy rates have been rising for consultants and nurses.
- Basic workforce information, such as sickness absence figures, is not available in all NHS bodies. This affects the NHS' ability to manage its workforce and demonstrate savings on efficiency targets.
- Further work is needed to develop regional and national approaches to workforce planning.

94. The NHS is Scotland's largest employer, with 149,896 staff. This represents a small increase (1.6%) in staffing since September 2003.[112]

Good planning and management of the workforce are essential to meet the healthcare needs of Scotland's population.

95. In 2005, the Scottish Parliament's Health Committee reported that strategic planning of the workforce within the NHS in Scotland has been ineffective.[113] The Committee identified two key requirements for the NHS in Scotland. It should:

- have enough trained staff to deliver existing services
- plan for the future, taking account of the age profile of the current workforce, and the need for flexibility to respond to likely changes in the way in which health services will be delivered.

96. The Kerr report emphasises the fundamental importance of linking workforce planning across local, regional and national levels. It highlights that recruitment may be more competitive in the future, raising concerns about rises in staffing vacancies. It also points out the time-lag in training new clinical staff and the effect this may have on meeting current recruitment targets.[114]

Progress against recruitment targets is mixed

97. The Scottish Executive is committed to increasing the number of consultants, nurses and midwives, and allied health professionals (AHPs). However, there are problems with the recruitment targets:

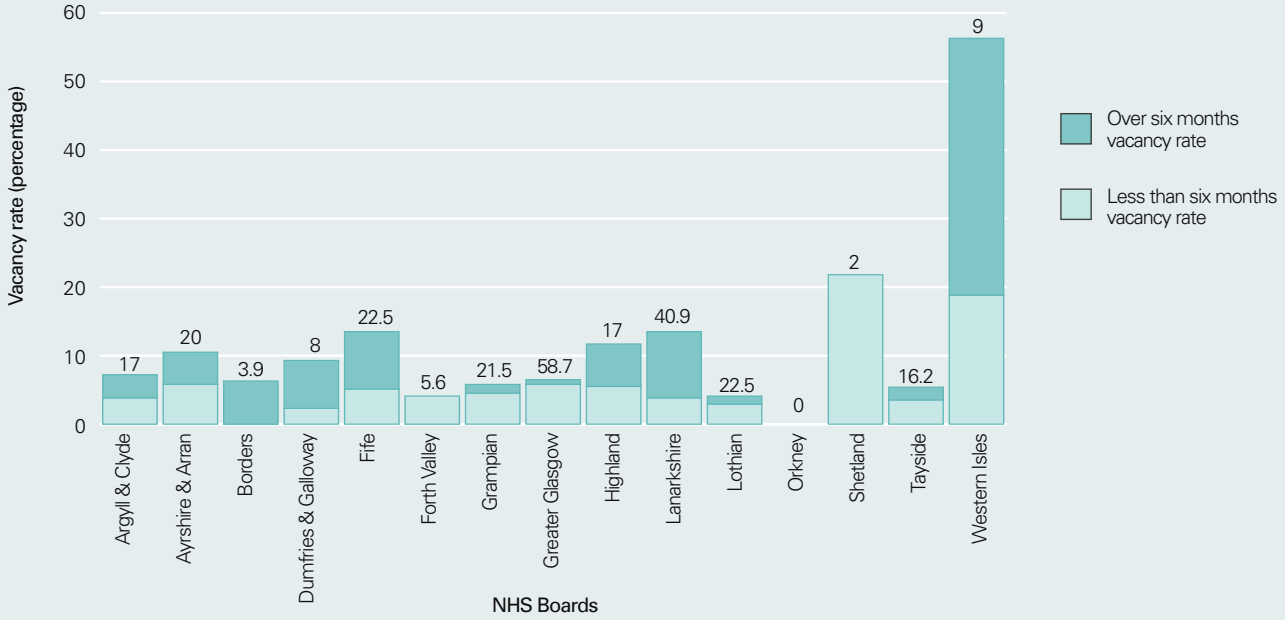
- The targets were set in *A Partnership for a Better Scotland* in 2003 but the definition of headcount was not specified until April 2004 when the SEHD published its *Scottish Health Workforce Plan*.[115] The workforce plan takes the baseline at September 2002.

112 Workforce statistics, ISD, 02/11/05.
113 *Health Committee 2nd Report 2005*, The Scottish Parliament (Paper 275), February 2005.
114 *Building a Health Service Fit for the Future – A National Framework for Service Change in the NHS in Scotland,* Scottish Executive, 2005.
115 *A Partnership for a Better Scotland*, Scottish Executive, 2003.

Exhibit 8

Variation in consultant vacancy rates among NHS boards, 2004

Six NHS boards have vacancy rates of 10% or more.



Note: The numbers at the top of each column indicate the WTE posts vacant.

Source: ISD workforce statistics, 2005.

- Targets are based on headcount rather than whole time equivalent (WTE). It is difficult to know the effect of a headcount target on staffing numbers and service provision. WTE is normally used as a measure for staffing.
- Some specialties and professions have higher vacancy rates than others but the targets do not specify which should be prioritised.
- There are geographical differences in need and the targets do not specify where staff should be located.

The number of consultants has increased but the recruitment target is unlikely to be met

In 2003, the Scottish Executive stated that its aim was to increase the number of consultants in the NHS by 600 by 2006 and to continue to build on that increase thereafter.

98. In June 2005, the NHS in Scotland employed 3,499 consultants (3,282.4 WTE).[116] The number increased by 16 since September 2004, and 196 since 2002. If the current trend continues, the NHS in Scotland is unlikely to meet the target.

99. Consultant vacancy rates are 7.6% of headcount (7.8% WTE), which is up on the previous year (6.6% headcount; 6.8% WTE). There are variations among boards, with six reporting vacancy rates above 10%, and 12 boards carrying vacancies for six months or more (Exhibit 8).

The number of nurses and midwives is increasing but it is difficult to tell whether the recruitment target will be met

In 2003, the Scottish Executive set a target of bringing 12,000 nurses and midwives into the NHS through training, recruitment and retention by 2007.[117]

100. At March 2005, the NHS in Scotland employed 66,086 nurses and midwives (55,687.7 WTE). Of this total, 46,796 (40,027.9 WTE) were registered. This is a net increase of 1,250 registered nurses and midwives since March 2004 and 3,285 since September 2002.

101. The target only refers to those staff coming into the service and does not include those leaving. It is difficult to tell whether the recruitment target will be met as there are no published data on nurses joining the NHS in Scotland. We understand this information will be published during 2006.

102. Registered nurse vacancies in March 2005 were 4.7% WTE – rising from 4.1% WTE the previous year. And the ageing nurse workforce – 11.5% of nurses are over the age of 55 – is likely to result in increased vacancies in future.

116 Workforce statistics, ISD, 02/11/05. These statistics exclude dental specialties as these are not included in the target.
117 The 2004 Workforce Plan specified that the target was for qualified nurses and midwives.

The number of AHPs is increasing

In 2003, the Scottish Executive set a target of increasing the number of AHPs by 1,500 by 2007.[118]

103. In March 2005, the NHS in Scotland employed a total of 10,398 AHPs (8,518.7 WTE). Of this total, 8,535 are qualified. This is an increase of 312 since March 2004 and 804 since September 2002. The WTE vacancy rate in March 2005 was 4.9%. This compares to 5.4% in the previous year. It is difficult to say, currently, whether the NHS is on track to meet this target by 2007.

104. The target does not specify which professions should be recruited. Some have higher vacancy rates than others. There are particular problems in recruiting occupational therapists, radiographers and sonographers.

Not all NHS boards have basic workforce information

105. NHS employers are responsible for the fair and effective management of staff. This is commonly referred to as staff governance. The NHS Reform (Scotland) Act 2004 made NHS employers legally accountable for staff governance, and a *Staff Governance Standard* sets out what this means in practice.[119]

106. The SEHD monitors NHS bodies' progress against the standard through staff surveys every two years and annual reviews of basic workforce information, including:

- sickness absence rates
- turnover rates
- use of bank and agency staff
- staff on temporary and fixed contracts
- the percentage of staff with personal development plans
- the number of disciplinary hearings and grievances.

107. But this basic information, which is needed to manage the workforce effectively, is not routinely available across the NHS in Scotland. For example, not all NHS boards have information on sickness absence and the use of bank and agency staff. And there are a number of different sources of information – ISD workforce statistics, staff governance mandatory statistics and PAF workforce statistics – which are not consistent. NHS bodies and the SEHD are working together to address these issues through the Scottish Workforce Information Standard System (SWISS) project. This aims to link human resources, payroll and other systems to provide a single and accessible source for workforce data from 2006.

NHS bodies do not have the information they need to manage sickness absence

108. Sickness absence in the NHS in Scotland is higher than in many other parts of the public sector – an average of 5.3% (9.6 million hours) of available hours in 15 NHS boards in 2003/04.[120] This may be explained in part by the nature of the work and the need to protect patients. But the NHS needs to actively manage sickness absence, particularly if it is going to achieve the target figure of 4% sickness absence, and the £55 million efficiency savings, anticipated by 2007/08 under the Efficient Government Initiative.[121]

109. At present we do not have a Scotland-wide picture of sickness absence in the NHS. NHS Dumfries & Galloway was unable to supply any information on the hours lost due to sickness absence. And NHS Fife, NHS Greater Glasgow, NHS Highland and NHS Lanarkshire have incomplete or inconsistently collected information.

Spending on bank and agency nurses is over £87 million, but not all NHS boards monitor this

110. NHS bodies use bank and agency nurses to supplement existing staff, cover vacancies and sickness absence and manage peaks in workload. However, not all bodies have full information on the number and costs of bank and agency nurses.

111. In 2002, Audit Scotland recommended that NHS boards review their use of bank and agency nurses in order to manage costs and the potential risk to the quality of patient care.[122] Since then their use has risen by 33%.[123] The biggest growth has been in the use of bank nurses, with a decrease in the number of agency nurses. Latest data show that the NHS in Scotland spent around £61 million on bank nurses and midwives and over £26 million on agency nurses and midwives.[124]

118 *The Scottish Health Workforce Plan 2004* stated that this target related to the headcount of qualified AHPs.
119 *Staff Governance Standard 2nd edition*, Scottish Executive, August 2004.
120 Performance Assessment Framework, 8 June 2005. This information does not include sickness absence for special health boards.
121 *Scottish Executive Efficiency Technical Notes*, Scottish Executive, September 2005.
122 *Planning ward nursing – legacy or design?*, Audit Scotland, 2002.
123 Workforce statistics, ISD, 02/11/05.
124 Workforce statistics, ISD, 02/11/05.

Staff report improvements in working conditions, although many experience violence in the workplace

112. Results from the most recent NHS staff survey show that staff are receiving more training and development opportunities, and that there is a move towards a better work-life balance.[125] But a quarter of respondents report that they have experienced a violent or aggressive incident at work, and one in ten report that they have been bullied or harassed.

Developing regional and national approaches to workforce planning is essential

113. The NHS Reform (Scotland) Act 2004 placed a statutory obligation on boards to have workforce planning arrangements in place. Each board has subsequently produced a baseline workforce profile, intended to inform the production of regional workforce plans by January 2006. NHS board workforce plans are to be completed by April 2006.[126]

114. Two recent Audit Scotland reports have highlighted problems in planning for, and recruiting, pharmacy staff and radiologists.[127] [128] We plan to review nurse workforce planning in 2006, and may carry out a wider review of workforce planning in future.

115. Workforce planning in the NHS is complex and needs to take account of a range of issues including:

- the implications of three recent pay agreements
- changes to the training of junior doctors
- changes in the way in which services will be delivered in the future through the extension of nurses' and AHPs' roles.

New pay agreements are being implemented for most NHS staff

116. Managing the costs and administration of three different pay agreements at the same time has been a significant challenge for NHS bodies. (Costs are covered in Part 5).

117. The three pay agreements are:

- Consultant contract – for all NHS consultants.
- GMS contract – as well as introducing a new system of payment for specific services this also allows GPs to opt out of providing out-of-hours services.
- Agenda for Change – for most non-medical staff, excluding senior managers. This has been complex to implement because of the size of the workforce affected and there has been a delay in full implementation.

It is too early to assess the benefits of the new pay agreements

118. The three pay agreements are designed to secure a more flexible workforce which will meet the present and future needs of the NHS. But work on measuring the benefits of the contracts is at a relatively early stage.

119. The SEHD has recently outlined performance management arrangements for monitoring the benefits.[129] NHS boards were required to submit pay modernisation benefits delivery plans, including measurable indicators, to the SEHD by 30 September 2005. It is therefore too early to have reliable information on the impact of these changes. Audit Scotland will be publishing a report in March 2006 which considers the impact of the consultant contract.

Changes to junior doctors' training will affect future medical workforce needs

120. The number of junior doctors employed by the NHS in Scotland rose by 3.4% between September 2003 and September 2004, and currently stands at 5,197 (5,092.5 WTE). Although no targets have been set for numbers of junior doctors, the SEHD has agreed to increase the number of graduating medical students from around 800 per year to between 950 and 1,000 (subject to review in two to three years' time).[130] The number of medical students trained and the number of junior doctors in training are two of the most significant constraints on future medical workforce capacity.

125 *NHSScotland National Staff Governance Report 2003-04,* The National Staff Governance Working Group, 2005.
126 *National Workforce Planning Framework 2005,* Scottish Executive, August 2005.
127 *A Scottish prescription: Managing the use of medicines in hospitals*, Audit Scotland, 2005.
128 *A review of bowel cancer services: An early diagnosis*, Audit Scotland, 2005.
129 Health Department Letter (2005) 28, *Delivering the benefits of pay modernisation in NHS Scotland,* (1 July 2005).
130 *Review of Basic Medical Education in Scotland: Report and Conclusions – The Response of the Scottish Executive,* Scottish Executive, June 2005.

121. From 1 August 2005, the NHS is implementing a new training programme for junior doctors on a UK-wide basis – Modernising Medical Careers (MMC). This will affect the number of junior doctors available for frontline service delivery as they will spend more time in training. It is anticipated that the impact of this will be felt in the second year of implementation (from August 2006), as trainee doctors will be less available for out-of-hours care than at present.[131] This will affect future workforce planning for both consultants and training grades and, given the time required to train doctors, may put pressure on services.

Redesigning healthcare services will require a more flexible workforce in the future

122. The NHS in Scotland is changing, with more joint working across organisational boundaries, a move away from hospital-based services, and an emphasis on delivering healthcare closer to people in their own communities. The new pay agreements are intended to provide flexibility, although this may be constrained by the no compulsory redundancy policy that exists.

123. In addition, the emphasis on partnership working across the public sector will affect workforce planning in the NHS. The development of Community Health Partnerships (CHPs) has the potential to build on earlier work carried out under the Joint Future Agenda which considered ways of streamlining workforce planning across the health and social care sectors.[132] But significant challenges remain because of the different statutory arrangements in health and local authorities.

131 *Modernising Medical Careers. Report to the Directors of Finance Group*, NHS Education for Scotland, November 2004.
132 *Report of the integrated human resource working group on the human resource implications of the joint future agenda*, Scottish Executive, August 2004.

Part 5. Financial performance

Key messages

- NHS bodies achieved an overall surplus in 2004/05, but the combined cumulative deficit of four NHS boards is getting worse (£91 million).
- The SEHD spent £32 million more than the amount approved for health in the Budget (Scotland) Act 2004. This resulted in a qualified regularity opinion on the Scottish Executive's accounts.
- Funding gaps of around £183 million are forecast for 2005/06. Boards have financial plans to reduce this gap, but a shortfall remains.
- Financial management and planning needs to improve if NHS bodies are to manage their finances properly, respond effectively to cost pressures and provide health services differently in the future.
- The NHS in Scotland faces a significant challenge in meeting savings as part of the Efficient Government Initiative.

Spending on the NHS in Scotland is increasing

The NHS in Scotland spent around £8 billion in 2004/05 and this will rise to £10 billion by 2007/08

124. The NHS in Scotland spent around £8 billion in 2004/05, most of which was spent on direct services. This figure is set to rise to around £10.3 billion by 2007/08.[133]

125. Currently most of this money is spent on staffing (around £4 billion), drugs (over £1 billion), and NHS assets such as hospitals and medical equipment (£301 million). But we cannot tell how much is spent on specific priorities or conditions (such as cancer) as the NHS does not capture financial information in this way.

Spending on healthcare in Scotland is relatively high compared to some other countries

126. In 2003/04 Scotland spent £1,456 per head of population compared to £1,225 in England, £1,345 in Wales and £1,346 in Northern Ireland.[134]

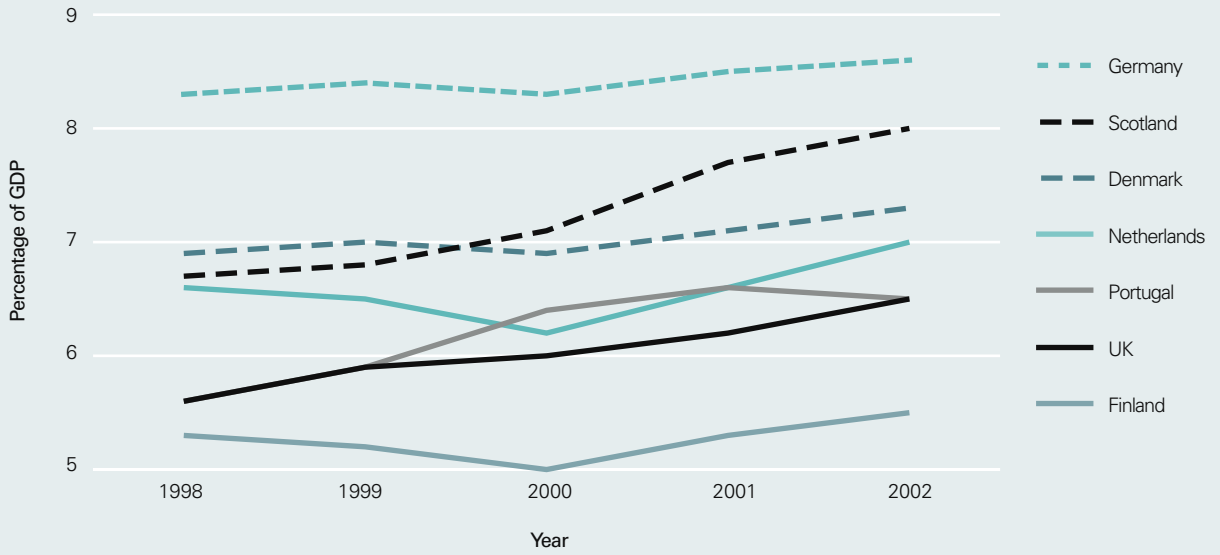
127. During 2005, Audit Scotland commissioned work to estimate Scottish values for health indicators based on experimental health accounts for Scotland compiled using the System of Health Accounts.[135] [136] Data for the UK as a whole are from experimental health accounts compiled by the Office of National Statistics, and this is the

133 *The Scottish Executive: draft budget 2006-07*, Scottish Executive, August 2005.
134 *Public Expenditure Statistical Analysis 2005*, HM Treasury and Office for National Statistics, 2005.
135 *European comparators for assessing the performance of Scotland's health system*, Falcon Craig Consulting, May 2005. (unpublished)
136 The System of Health Accounts (SHA) is a set of internationally comparable health accounts in the form of standard tables.

Exhibit 9

Public expenditure on health as a percentage of GDP, 1998-2002

In 2002, Scotland spent 8% of GDP on healthcare. This was higher than other countries in the benchmarking group, with the exception of Germany.



Source: Falcon Craig Consulting

first time a similar exercise has been attempted for Scotland. It allows us to compare Scotland's expenditure on health as a percentage of Gross Domestic Product (GDP) with a small benchmarking group of countries including Denmark, the Netherlands, Germany, Finland, Portugal and the UK as a whole. Healthcare spending in Scotland, as a percentage of GDP, is higher than the UK and the rest of the benchmarking group with the exception of Germany (Exhibit 9).[137]

128. In parts 1 to 3 of this report we have discussed how the NHS in Scotland is performing against a number of key targets and initiatives. But establishing a relationship between increased level of funding and improved health outcomes is difficult, particularly with limited information on how money is spent.

Most NHS bodies met their financial targets

The SEHD spent more than its budget in 2004/05

129. The SEHD spent £32 million more than the amount approved for health in the Budget (Scotland) Act 2004. This is 0.4% of its £8 billion budget. This is a breach of regulations and has resulted in a qualified regularity opinion on the Scottish Executive's accounts. The overspend was a result of failing to budget accurately for single system working.

NHS bodies in Scotland have to achieve three financial targets

The SEHD sets three financial targets for NHS bodies. They should stay within their:

- Revenue resource limit (RRL) – this is the revenue budget allocated for the day-to-day operation of services. Savings against the RRL may be carried forward to the next year, but any overspend has to be repaid from future years' allocations.
- Capital resource limit (CRL) – the funding that a health body has available for capital programmes.
- Cash requirement – this is the amount of cash needed to fund the RRL and CRL.

130. All NHS bodies achieved their CRL and cash requirement targets in 2004/05.

Four boards overspent their revenue resource limit

131. Eleven of the 15 NHS boards achieved their RRL target, either underspending or breaking even. Their combined underspend was £79.6 million (£47.5 million for 2003/04).

132. The remaining four NHS boards (Argyll & Clyde, Grampian, Lanarkshire and Western Isles)

137 The Scottish GDP includes the onshore-related activities of North Sea oil but excludes activity on the continental shelf.

Exhibit 10

NHS boards exceeding their revenue resource limit (RRL) in 2004/05

Four NHS boards spent more than their RRL.

NHS board	Revenue resource limit 2004/05 (£m)	Net resource out-turn 2004/05 (£m)	Cumulative deficit 2004/05 (£m)	Cumulative deficit 2003/04 (£m)
Argyll & Clyde	527.517	587.009	(59.492)	(35.370)
Lanarkshire	662.595	682.637	(20.042)	(21.208)
Grampian	609.577	620.351	(10.774)	(4.804)
Western Isles	54.041	54.779	(0.738)	(0.271)
Total			**(91.046)**	**(61.653)**

Source: NHS audited annual accounts, 2004/05

overspent against their RRL, with a combined cumulative deficit of £91 million (£61.7 million for 2003/04). This is 1.37% of the total RRL for all NHS boards in 2004/05. The same four boards also overspent against their RRL in 2003/04 (Exhibit 10) and they did not have financial recovery plans agreed with the SEHD during 2004/05. More detail is provided on these NHS boards in case studies 1, 2, and 4 in this part of the report and case study 5 in Part 6 (page 38).

133. This means that the overall deficit for NHS boards is £11.5 million (£14.2 million for 2003/04). This is a slight improvement on 2003/04, representing 0.17% of NHS boards' overall RRL of £6.6 billion (0.2% of £5.8 billion in 2003/04).

All special boards achieved their revenue resource limit targets

134. The special health boards underspent their RRL targets by £22.5 million in total, contributing to an overall surplus for all NHS bodies of £11 million in 2004/05.[138] This is an improvement on the overall deficit of £1.5 million for all NHS bodies in 2003/04. Details of performance against financial targets for all NHS boards and special health boards are given in Appendix 2 (page 45).

NHS bodies achieved balance through a number of financial measures

135. Previous overview reports have highlighted how NHS bodies achieved their RRL targets by using non-recurring funding and making non-recurring savings which do not reduce the operating cost base. This continues to be the case and this part of our report discusses:

- funding gaps occurring in 2004/05 and projected for 2005/06
- how NHS bodies used non-recurring funding to achieve financial balance in 2004/05
- reliance on savings to meet financial plans and the ability to meet savings targets.

Funding gaps at NHS boards have increased since last year

136. We reported in 2003/04 that the SEHD expected all NHS bodies in Scotland to achieve financial balance in 2004/05. At that time, seven NHS boards had forecast funding gaps totalling £162 million for 2004/05, with funding gaps at three boards (Argyll & Clyde, Greater Glasgow and Lanarkshire) making up the majority of this total.[139]

137. In fact, 11 NHS boards had funding gaps totalling nearly £260 million in 2004/05, with seven boards accounting for £252 million of this (Exhibit 11, page 30). The total funding gap may be higher than this; NHS Fife and NHS Western Isles did not provide full information on their funding gaps for 2004/05.

138 For the purposes of this report, 'special health boards' includes the NHS National Services Scotland and the Mental Welfare Commission.
139 A funding gap is the difference between the income and expenditure that is needed on a recurring basis to pay for operational activities, excluding any one-off funding received from the SEHD and planned savings.

Case study 1

NHS Argyll & Clyde's financial performance and planned dissolution

NHS Argyll & Clyde identified a potential in-year deficit of £39.4 million for 2004/05 and planned to use savings and non-recurring income to reduce this deficit to £25.4 million. The actual in-year deficit was £24.1 million, slightly better than forecast, and the cumulative deficit increased to £59.5 million. The board agreed its financial recovery plan in May 2005. The Health Minister announced in May 2005 that, following a period of public consultation, NHS Argyll & Clyde would be dissolved; its services taken over by NHS Greater Glasgow and NHS Highland; and £80 million made available to clear its cumulative deficit. The auditor has commented that it is important that the inheriting boards are made fully aware of the underlying financial position.

Source: Auditor's report on the 2004/05 audit of NHS Argyll & Clyde

Case study 2

NHS Grampian's deficit position and financial recovery plan

NHS Grampian reported a cumulative deficit of £10.8 million in 2004/05. The board used a significant amount of ring-fenced and other non-recurring funding to achieve this position in 2004/05.

NHS Grampian has agreed its budget for 2005/06 and is forecasting to overspend by £8.1 million. The board's financial recovery plan forecasts recurring in-year financial balance by the end of the financial year 2006/07, but this is dependent on using £28 million of non-recurring funding from the sale of assets between 2005 and 2007.

Source: Auditor's report on the 2004/05 audit of NHS Grampian

Case study 3

NHS Lothian relied on non-recurring funding to achieve financial balance in 2004/05

NHS Lothian relied on £39.2 million of non-recurring funding to achieve financial balance in 2004/05, which is an improvement on 2003/04 (£44.4 million). This included:

- £15.8 million capital to revenue transfers
- £15.4 million support from the SEHD
- £8 million carry forward flexibility from 2003/04.

This was used to provide support against overspends in the operating divisions and slippage in achieving anticipated savings from the pan-Lothian review projects. An element was also used to meet the costs of national initiatives, including pay modernisation.

The board plans to reduce its reliance on non-recurring funding to £26.4 million in 2005/06 and this is seen as key to achieving financial balance on an ongoing basis. But to do this, the board must successfully achieve £20.6 million of cash releasing efficiency savings in 2005/06. This will be a major challenge as the board delivered only £6.55 million savings in 2004/05 against a target of £12.75 million. The target for 2004/05 included £5.4 million of savings, which were brought forward from 2003/04.

Source: Auditor's report on the 2004/05 audit of NHS Lothian

Exhibit 11

NHS bodies' funding gaps for 2004/05 and projected funding gaps for 2005/06

NHS bodies had funding gaps of £260 million in 2004/05 and are projecting funding gaps of £183 million in 2005/06.

NHS board	Funding gaps in 2004/05 (£m)	Potential funding gaps for 2005/06 (£m)
Argyll & Clyde	50.0	36.8
Borders	2.3	2.0
Forth Valley	1.8	2.9
Greater Glasgow	58.8	27.9
Grampian	27.1	13.3
Highland	13.8	13.1
Lanarkshire	48.0	26.5
Lothian	26.1	24.0
Orkney	2.4	2.4
Shetland	1.3	1.3
Tayside	28.1	26.2
Western Isles	No data	1.2
Total	**259.7**	**177.6**
NHS Education for Scotland	-	4.6
Scottish Ambulance Service	-	0.05
State Hospital	-	0.85
Total	-	**5.5**
Combined total	**259.7**	**183.1**

Note: These figures are based on 2005/06 financial plans at the beginning of the year, adjusted to remove non-recurring funding and planned savings.

Source: Auditors' reports on 2004/05 audits

Fifteen NHS bodies have identified potential funding gaps for 2005/06

138. Twelve NHS boards are forecasting funding gaps for 2005/06, totalling around £178 million. Three special health boards are also forecasting funding gaps totalling £5.5 million. This gives a total projected funding gap of £183 million (Exhibit 11). Financial plans are in place to reduce the projected funding gaps by £155 million, but a further £28 million of savings need to be made to achieve in-year financial balance.

NHS boards may have used non-recurring measures to reduce funding gaps in 2004/05

139. We have commented in previous overview reports that NHS bodies rely on non-recurring funding to achieve financial balance. Non-recurring funding is a normal part of running the NHS in Scotland, but it should not be used for sustaining day-to-day operating activities in the long term. NHS bodies used £156 million of non-recurring funding in 2004/05. The financial statements do not identify whether this has been used for non-recurring purposes, or to achieve financial balance or reduce deficits. Four NHS boards – Lothian, Greater Glasgow, Lanarkshire and Tayside – accounted for the majority of this sum (£124 million). The figure could be higher, as two NHS boards – Fife and Western Isles – did not provide full information on the level of non-recurring funding used in 2004/05. Case study 3 (page 29) provides further details about NHS Lothian's reliance on non-recurring funding.

140. In previous NHS overview reports, we have highlighted that ring-fenced funding may have been used inappropriately. In 2004/05 the majority of ring-fenced funding was spent appropriately or carried forward to 2005/06.

NHS bodies will not be able to transfer funds from capital to revenue after 2005/06

141. Application of HM Treasury rules mean that NHS bodies will no longer be able to transfer funding from capital to revenue after 2005/06. Those that have relied on this source of non-recurring funding to break even in the past will now need to make additional savings. This will increase what, for some, are already challenging savings targets.

142. At least two NHS boards – Grampian and Lanarkshire – plan to eliminate their cumulative deficits by using proceeds from the sale of surplus assets.[140] The loss of capital to revenue transfers after 2005/06 will make it difficult for boards to use this type of non-recurring income for revenue purposes in the future.

Current savings targets are challenging

143. NHS bodies made savings of over £115 million in 2004/05. Auditors' reports for six NHS boards (Argyll & Clyde, Borders, Forth Valley, Lanarkshire, Orkney and Tayside) identified recurring and non-recurring savings separately. For these six boards, around 50% of the total savings were made on a recurring basis. Making savings on a non-recurring basis is a short-term measure as costs need to be taken out of the operational cost base if boards are to gain any continuing benefit. Case study 4 (overleaf) highlights that although NHS Lanarkshire made substantial savings in 2004/05 most of these were non-recurring; the board will need to make these savings again in 2005/06.

144. We have previously reported that some boards experience difficulties in achieving their savings plans because they were over-ambitious or did not take full account of cost pressures. Financial plans for 14 NHS bodies include savings of around £100 million for 2005/06. Some of the savings plans are challenging and represent a significant increase on the level of savings achieved in 2004/05. For example, NHS Shetland achieved savings of £100,000 in 2004/05, but needs to increase savings to £1.3 million in 2005/06 to balance its budget. NHS Lothian has a savings target of £20.6 million for 2005/06 but it managed to achieve savings of only £6.55 million in 2004/05, around half of its planned savings for that year (Case study 3, page 29).

The NHS in Scotland must contribute to savings required under the Efficient Government Initiative

The NHS in Scotland is expected to contribute to the Scottish Executive's Efficient Government Initiative by making £515 million savings by 2007/08.

145. The Scottish Executive launched its Efficient Government Initiative *Building a Better Scotland* in June 2004.[141] Its latest report on the initiative shows that the NHS in Scotland is now expected to deliver £342 million cash-releasing savings by 2007/08 through a number of initiatives, including £50 million through more efficient procurement, and a further £173 million time-releasing savings by 2007/08, including £55 million by reducing sickness absence to 4%.[142]

140 Profits from the sale of assets will still be able to be used to support revenue expenditure. But when properties are identified as surplus, they must be revalued to market value by the end of the financial year. This may reduce any future profits.
141 *Building a Better Scotland, Efficient Government – securing efficiency, effectiveness and productivity*, Scottish Executive, June 2004.
142 *Scottish Executive Efficiency Technical Notes*, Scottish Executive, September 2005.

Case study 4

NHS Lanarkshire delivery of savings in 2004/05

NHS Lanarkshire delivered savings plans and other actions totalling £48.4 million in 2004/05. This resulted in the board delivering an in-year surplus of £0.4 million. This was a major achievement. But of the £19.8 million savings delivered in 2004/05, only £9.8 million were recurring. The corporate savings plan for 2005/06 has been set at £9.6 million (£3.3 million non-recurring).

The board still has a £20 million cumulative deficit and its financial recovery plan does not forecast recurring financial balance until 2007/08, which means that it will continue to rely on non-recurring savings and funding.

Source: Auditor's report on the 2004/05 audit of NHS Lanarkshire

146. The Scottish Executive has produced efficiency technical notes (ETNs) on how it plans to make savings as part of the Efficient Government Initiative. Audit Scotland was asked to comment on these and did this in May 2005 (cash-releasing savings) and August 2005 (time-releasing savings). In these responses we identified a number of risks in achieving these savings across the public sector (Exhibit 12). Many of the savings identified rely on third parties delivering these savings, for example, NHS bodies, which may face challenges in delivering them. Risk assessments of specified savings need to be carried out to estimate the impact on services.

147. Efficient Government savings should be recurring, against a 1 April 2005 baseline. This will be a challenge for the NHS given the difficulties experienced by some health bodies in delivering recurring savings. A number of the savings identified are national initiatives such as the national shared support services project which is expected to contribute £10 million savings from 2007/08. These national projects are being managed by the SEHD but boards may also have these identified as local savings – leading to a risk of double counting.

The NHS in Scotland continues to face significant cost pressures

148. Cost pressures present another risk to financial plans. The pay modernisation agenda is currently one of the largest cost pressures faced by the NHS. But there are other cost pressures, including changes to the way in which junior doctors are trained, an increasing drugs bill, and the achievement of major policy initiatives and targets such as waiting times. Together these pressures will absorb much of the additional funding going into the NHS.

The new pay agreements remain a cost pressure

149. The additional costs of implementing the new pay agreements are estimated at £271 million for 2004/05 and £291 million for 2005/06 (Exhibit 13, page 34). Some NHS boards are still in the process of estimating the full cost of implementing the new pay agreements. In particular, job matching for Agenda for Change is still under way and implementation has been delayed.

150. NHS boards faced additional cost pressures in 2004/05 as a result of the higher than expected payments made to GPs under the new GMS contract. The new contract has introduced quality achievement payments using the QOF. The SEHD provided additional funding to NHS boards to meet the costs of QOF payments, but this was based on the SEHD's estimate that 80% of GP practices would achieve 80% of the maximum score.

Exhibit 12

Risks associated with identifying and counting savings across the public sector under the Efficient Government Initiative

Audit Scotland has highlighted a number of risks in the methodology for measuring savings in the Scottish Executive's Efficiency Technical Notes (ETNs).

Measurement	Methodology	Eligibility
• Some savings measures are not adequately specified and in some cases information sources or calculation comparisons are unavailable. • A number of ETNs rely on measuring changes in expenditure. Measuring efficiency depends on capturing changes in inputs and outputs, and efficiency savings cannot be measured through changes in expenditure alone. • More information is needed to remove the uncertainty about how and where some of the savings will be realised. • Baselines are not treated consistently across the ETNs and in some cases are inadequately specified. • Adequate systems need to be in place to capture and measure baselines, transaction costs and productivity outcomes. • More information is needed to remove the uncertainty about how and where some of the targeted gains will be realised.	• Guidance covering the definition and identification of efficiency savings is insufficiently developed. • There is a risk of double counting some efficiency gains and associated development costs are largely omitted from savings calculations. • ETNs need to be supported by good project planning and risk management. • The technical notes have adopted 'proxy' measures – these will be more open to challenge and interpretation. • The technical notes incorporate a range of assumptions which are often untested. • Many savings depend on redesign or advances in technology and may require additional investment before savings are realised. It is not clear whether these investment costs are offset from the savings identified. • Savings calculations assume that time released will be 100% productive.	• Some savings are from initiatives started prior to the Efficient Government Plan. These should have the same baseline of 1 April 2005.

Source: Audit Scotland, 2005

Exhibit 13

Additional costs of implementing the new pay agreements in 2004/05 and forecasted costs for 2005/06

The NHS in Scotland spent an additional estimated £271 million on implementing the new pay modernisation agreements in 2004/05 and a further £291 million is forecast for 2005/06.

Pay modernisation	Estimated additional costs in 2004/05 (£m)	Estimated additional costs for 2005/06 (£m)
Consultant contract	31	16
GMS contract	71	69
GMS contract out-of-hours	14	16
Agenda for Change	155	190
Total	**271**	**291**

Source: SEHD, October 2005

The latest data from ISD show that, across all NHS boards, GP practices achieved 92.5% of the maximum score.[143] NHS boards have therefore experienced a funding shortfall; for example, NHS Greater Glasgow had a shortfall of £4.5 million.

151. NHS Borders and NHS Dumfries & Galloway are experiencing additional cost pressures as all GP practices opted out of providing out-of-hours services. This has resulted in additional costs of £1.3 million for NHS Borders and £0.9 million for NHS Dumfries & Galloway. Audit Scotland is planning a review of out-of-hours services across Scotland in 2006.

New training arrangements for junior doctors are likely to be a cost pressure in the future

152. MMC will take several years to implement fully. It is likely to have a significant financial impact as junior doctors will spend less time on frontline service delivery. No estimates are yet available on the long-term financial implications of this. The workforce implications of MMC are discussed in Part 4.

Spending on drugs continues to rise

153. There has been a year-on-year increase in the number and cost of drugs prescribed by GPs. During 2004/05, spending on prescription drugs rose by around 3% to £859 million.[144] This compares to 8% the previous year. The drop in the rate of increase is in part due to the introduction of the Prescription Price Regulation Scheme, which included a 7% price reduction for branded drugs. There is also some evidence of more cost-effective prescribing, with an increase in the percentage of generic drugs prescribed to just over 80%. We discuss cost-effective prescribing in more detail in a report published in 2003.[145]

154. Spending on medicines in hospital is also increasing – it increased by 56% to £189 million in the four years to 2003/04. Our recent report on the use of medicines in hospitals made a number of recommendations on planning and budget setting, and the development of systems which would support cost-effective prescribing in hospitals.[146]

NHS pensions

155. NHS staff and their employers contribute to the NHS Superannuation Scheme, a defined benefit scheme linked to final salary. The scheme, which is administered by the Scottish Public Pensions Agency (SPPA), has 131,200 active members, 28,900 deferred members, and 66,700 pensioners. Its future liabilities are not funded through investments; instead it is a pay-as-you-go scheme, relying on in-year contributions and government grant to meet pension liabilities as they fall due.

143 General Medical Services Quality and Outcomes Framework (QoF) data for Scotland, ISD, 29/09/05.
144 *Update of NHS National Services Scotland Prescribing Information on SHOW*, ISD press release (30/09/05).
145 *Supporting prescribing in general practice: A progress report*, Audit Scotland, June 2003.
146 *A Scottish prescription: Managing the use of medicines in hospitals*, Audit Scotland, July 2005.

156. Full actuarial valuations of the scheme are required to be carried out every five years by statute. The Government Actuary Department (GAD) has been unable to carry out a full actuarial valuation since 1994 because of deficiencies in the pension data provided to it. In subsequent years the GAD has updated the 1994 actuarial valuation to take account of known changes, for example new NHS employees entering the scheme and existing pensioners dying.

157. In July 2005 the GAD identified that errors had been made in the 1999 valuation relating to the estimation of past service liability. The effect of this was that the 2003/04 accounts wrongly show the value of the scheme's liability as £8.1 billion rather than £11.6 billion. But by the time the error was identified, The Budget (Scotland) Act had been passed and there was no scope to increase the budget. As a result, there was an overspend of £843 million against budget in the 2004/05 accounts, resulting in them being qualified by the auditor.

158. Employers' superannuation contributions will not need to increase to meet the increase in the liability. The GAD considers that the calculation of the scheme liability and the contribution rates that employers have to make to meet future pension costs are separate exercises. Employers' contribution rates were increased in 2003/04 due to the introduction of a new calculation methodology and to take account of the increased longevity of the membership.

159. A UK framework for the review of all public sector pensions has been established and the SEHD, SPPA, employers and trades unions will be reviewing the NHS in Scotland scheme by mid 2006. This will address issues of affordability as well as generating scheme specific savings determined by HM Treasury. Audit Scotland will continue to monitor the position on behalf of the Auditor General, and intends to publish a paper on pensions across the public sector in 2006.

Sound financial planning and management arrangements are vital to the financial stability of NHS bodies

160. Our 2003/04 financial overview report highlighted the need for the NHS in Scotland to ensure that its financial management arrangements are sound and that it has sufficiently skilled staff and appropriate systems in place to enable it to meet future challenges.[147] NHS bodies with good financial management arrangements will be better able to redesign and improve services, and managers should be able to identify where things are going wrong and rectify them quickly. This message is reinforced by the drive for service redesign outlined in the Kerr report and the need to deliver significant savings as part of the Efficient Government Initiative.

Some NHS bodies have weaknesses in their financial management

161. The move to single system working has provided boards with an opportunity to harmonise budget setting and control but improvements have been reported in only a few boards.

162. All NHS bodies received an unqualified opinion on the truth and fairness of their annual accounts. But two NHS boards received other qualifications:

- NHS Western Isles – regularity qualification due to a breach of procurement regulations.
- NHS Highland – an 'except for' qualification to the true and fair opinion arising from a difference of view on accounting treatment relating to a Private Finance Initiative contract.

163. A number of other weaknesses in financial management and overall financial control at health bodies and the SEHD were identified by auditors. These include:

- NHS Highland double counted income totalling £1.4 million in respect of out-of-area treatment in its budget. This contributed to a reduction in the forecast surplus for the year from £4 million to £1.2 million.
- NHS Western Isles' financial report to its board in March 2005 showed an in-year surplus of £140,000 but when the annual accounts were finalised, there was an in-year deficit of £400,000. The difference was due to a number of factors including failure to report costs accurately and late adjustments to the accounts.
- NHS Fife forecast a deficit of £0.5 million for 2004/05 in January 2005. But its final out-turn was a surplus of £5.4 million. Four other NHS boards (Greater Glasgow, Highland, Lothian and Western Isles) were unsure of their final out-turn for 2004/05 until after the year-end.

147 *Overview of the financial performance of the NHS in Scotland 2003/04,* Audit Scotland, December 2004.

- The SEHD's overspend was not identified until August 2005, when the consolidated health accounts were prepared. The forecast for revenue expenditure fluctuated significantly between February and August 2005. This varied from an overspend position of £36.2 million to underspends of £90 million and £67.2 million in March and June, and back to an overspend of £35 million in August (the revenue overspend is offset by a £3 million capital underspend). This indicates weaknesses in budget monitoring.

NHS boards have a vital role to play in good financial management

164. NHS boards and committees need to be in a position to challenge constructively the financial and operational information they receive. NHS board members need to understand their body's financial position fully; the *Audit Committee Handbook* states that at least one non-executive director should have recent and relevant financial experience.[148] NHS boards and committees also need regular financial reports which are robust, accurate and easy to understand if they are to oversee their organisation's finances properly. Auditors at some NHS boards have commented that financial reporting needs to improve.[149] The management board at the SEHD also needs to receive better management information, particularly in relation to the forecast year-end position.

NHS bodies must accurately plan and monitor their financial position

165. The Scottish Parliament Audit Committee reported its concerns about the quality of NHS financial information and costs, and whether savings plans were realistic.[150] Accurate forecasting and planning of costs and the year-end position is vital if boards are to develop realistic and robust financial plans and monitor their progress.

166. Planning involves not only identifying income and expenditure in the short, medium and long-term, but also assessing how much financial risk is inherent in the plan and how it will be managed. The reasons for inaccurate planning vary, but can include failure to identify all cost pressures, weaknesses in financial systems and controls, and staff lacking the necessary technical skills.

167. Late allocations from the SEHD or numerous adjustments to RRLs may have made financial planning difficult for some NHS bodies. NHS NES and NHS QIS received late allocations from the SEHD, which were partly responsible for the surpluses reported in 2004/05. NHS Health Scotland experienced an in-year increase of 55% in its RRL, which contributed to its overall difficulties in managing its financial position.

168. Inadequate planning can result in boards or the SEHD failing to take timely action, or taking unnecessary action which may adversely affect the quality of services.

NHS bodies' financial reports and accounts need to be transparent

169. Our 2003/04 financial overview report highlighted that the current format of annual accounts does not disclose some important information about the funding of services, such as the use of non-recurring funding or savings to achieve financial targets.[151] The SEHD has recently updated its monthly monitoring returns for NHS bodies to include non-recurring funding and their use.

148 *NHS Scotland Audit Committee Handbook*, Scottish Executive, 2004.
149 NHS Fife, NHS Greater Glasgow, NHS Lothian, NHS Western Isles, National Waiting Times Centre Board.
150 *Audit Committee 5th report 2005. Overview of the financial performance of the NHS in Scotland 2003/04*, Scottish Parliament, June 2005.
151 *Overview of the financial performance of the NHS in Scotland 2003/04*, Audit Scotland, December 2004.

Part 6. Keeping pace with change

Key messages

- Single system working is taking time to be fully implemented since the abolition of NHS trusts – some NHS boards had interim corporate governance arrangements for at least part of 2004/05. But, overall, NHS boards are making progress in setting up corporate and clinical governance arrangements.
- CHPs are central to the delivery of joined-up health and social care services but there have been delays in implementing them.
- A comprehensive picture of NHS activity, costs and quality is still not available, although some progress is being made. It remains difficult to assess how the NHS is changing and whether it is delivering value for money.
- Public satisfaction with the health service is high, but people feel less involved in decisions about the NHS compared with four years ago.

There have been two major changes to the structure of the NHS in Scotland

170. The structure of the NHS in Scotland has changed significantly over the last two years, including:

- The establishment of single system working, dissolving trusts and developing 15 unified NHS boards. The aim is to remove organisational barriers, and establish shared aims and clear lines of accountability across NHS board areas.
- The development of CHPs to improve collaborative working between primary and acute healthcare, and between health and social care.

171. These changes should support whole system working across primary, secondary and social care. A number of recommendations in the Kerr report may further change how the NHS is structured and services are delivered in future.[152] The Scottish Executive responded positively to the Kerr report in November 2005.[153]

172. Good governance arrangements are essential at a time of structural change. These should cover:

- corporate governance, which includes the arrangements for managing finance and risks
- clinical governance, which covers systems to ensure that healthcare is safe and effective
- staff governance, which includes systems for managing staff fairly and effectively.[154] Staff governance is covered in Part 4.

152 *Building a Health Service Fit for the Future. A National Framework for Service Change in the NHS in Scotland*, Scottish Executive, May 2005.
153 *Delivering for Health*, Scottish Executive, 2005.
154 *Staff Governance Standard for NHSScotland Employees*, Scottish Executive, 2002.

Case study 5

NHS Western Isles' governance arrangements

In 2003/04, the auditor for NHS Western Isles identified a number of areas for improvement in its corporate governance arrangements. The board implemented a revised corporate governance framework in 2004/05. But the auditor identified further weaknesses in her 2004/05 audit report:

- The board breached relevant regulations on procurement when it purchased IT equipment during the year; this led to a qualified regularity audit opinion.
- Robust financial systems were not in place during the year, resulting in poor internal controls, accounting practices and financial reporting.
- The effectiveness of its board committees has been limited, partly due to difficulties in recruiting non-executive directors.
- No clinical governance framework was in place during 2004/05. A clinical governance strategy and clinical audit and effectiveness strategy were drafted, but not finalised or costed, during 2004/05.

Source: Auditor's report on the 2004/05 audit of NHS Western Isles

Some boards had interim corporate governance arrangements for at least part of 2004/05

173. The move to single system working was not immediate and at least six mainland boards operated interim corporate governance procedures for part of 2004/05.[155] The island boards have always operated as single systems.

174. While it is still early to comment on whether the NHS is getting the intended benefits from single system working, some NHS boards are beginning to show improvements. For example, NHS Borders has developed a more consistent view of risks across the board area, introduced clearer lines of accountability and has better information to identify cost savings across the healthcare system.

175. We highlighted concerns about corporate governance in NHS Fife and NHS Western Isles in our 2003/04 financial overview report.[156] NHS Fife has made progress in this area since last year although further improvements are still needed. But NHS Western Isles continues to have serious problems in establishing robust corporate and clinical governance arrangements (Case study 5).

Managing risks needs to improve in some NHS bodies

176. NHS boards need to identify and manage risks that may affect the delivery of patient care. Progress in developing corporate risk management varies across NHS bodies. Auditors at 12 NHS boards commented on this in 2004/05. NHS Borders and NHS Orkney both had adequate risk management arrangements in place. NHS Argyll & Clyde did not have fully developed risk management arrangements in place during 2004/05, and nine boards had risk management arrangements but these did not reflect single system working.[157] NHS Greater Glasgow approved its risk management arrangements in March 2005. All nine special health boards made progress in developing and implementing their risk management arrangements in 2004/05, but NHS 24 and the Scottish Ambulance Service (SAS) need to do more work.

177. One of the key risk areas identified during 2004/05 relates to information management and technology (IM&T) systems. All NHS bodies rely heavily on IM&T systems for their day-to-day activities, and this is likely to increase with developments such as the National eHealth Strategy. Robust disaster recovery plans and business continuity plans are essential if an NHS body is to continue to deliver patient care.

155 NHS Argyll & Clyde, NHS Fife, NHS Greater Glasgow, NHS Lanarkshire, NHS Lothian, NHS Forth Valley.
156 *Overview of the financial performance of the NHS in Scotland, 2003/04*, Audit Scotland, December 2004.
157 NHS Dumfries & Galloway, NHS Fife, NHS Forth Valley, NHS Grampian, NHS Greater Glasgow, NHS Highland, NHS Lanarkshire, NHS Lothian and NHS Western Isles.

178. Auditors in eight NHS boards commented on progress on implementing IM&T strategies.[158] NHS Argyll & Clyde did not have a system-wide IM&T strategy in place throughout 2004/05. The other seven NHS boards' strategies require further development. Auditors also identified that further work is needed to develop and implement IM&T strategies in NHS 24, NHS QIS, and NHS NSS.

179. Audit Scotland is currently undertaking a high-level review of the NHS in Scotland's information needs and IM&T strategy. We will report our findings in 2006.

NHS boards have made progress in setting up clinical governance arrangements

180. In June 2005 NHS QIS published a review of NHS boards' clinical governance and risk management arrangements.[159] This reported that boards are making good progress in developing and implementing structures and processes to ensure that clinical governance and clinical risk management are embedded in single system working. All boards have the basic elements of clinical governance in place and all have established clinical governance committees. But some could not demonstrate clear lines of reporting and accountability for clinical matters in their committee structures. Strategies at several NHS bodies lacked detail about the processes in place to monitor and report clinical performance. And NHS bodies vary in how they developed their clinical risk management strategies: some have divisional strategies in place but no overarching strategy; others have developed an overarching strategy first.

CHPs are not yet fully established

181. The National Health Service Reform (Scotland) Act 2004 established CHPs as committees or sub-committees of a board or joint committees of more than one board. The planned implementation date for CHPs was April 2005, and all NHS boards, except Greater Glasgow, submitted schemes of establishment for their area to the Health Minister for approval in December 2004. NHS Greater Glasgow submitted its full scheme of establishment in April 2005. These proposed the formation of a total of 43 CHPs across Scotland.

182. The Minister has given approval to the schemes submitted by 12 boards. Of these, five have been asked to submit further information or to undertake an early review of their CHPs.[160] The schemes for NHS Orkney and NHS Western Isles have not yet been approved. Proposals for CHPs in NHS Argyll & Clyde are dependent on the final consultation regarding the dissolution of the board and may affect the development of CHPs in NHS Greater Glasgow and NHS Highland. It is anticipated that all CHPs will be established by April 2006.

183. Early indications are that CHPs will operate differently across Scotland to reflect local circumstances. The schemes of establishment differ in the proposed governance, leadership, and reporting structures, as well as in levels of devolved responsibility. But they should all meet a set of core criteria in areas such as finance and accountability. Another consideration will be the relationship between CHPs and community planning partnerships. We will keep this under review and comment in future overview reports.

Performance management in the NHS is changing

184. The NHS in Scotland currently measures and monitors performance against its targets using the PAF. The SEHD has recently announced that it will be replacing PAF with a new system which will require boards to produce local delivery plans. These plans will include a core set of performance measures, and progress against these will be recorded and reported throughout the year. Other developments in performance management in the NHS include setting up a Delivery Group in the SEHD and a review of NHS information and statistics.

185. The aim of the Delivery Group is to monitor local NHS board performance and identify where support or intervention is needed. It will bring together the National Waiting Times Unit, the Centre for Change and Innovation, the Performance Management Division and other units within the SEHD dealing with performance measurement and improvement.

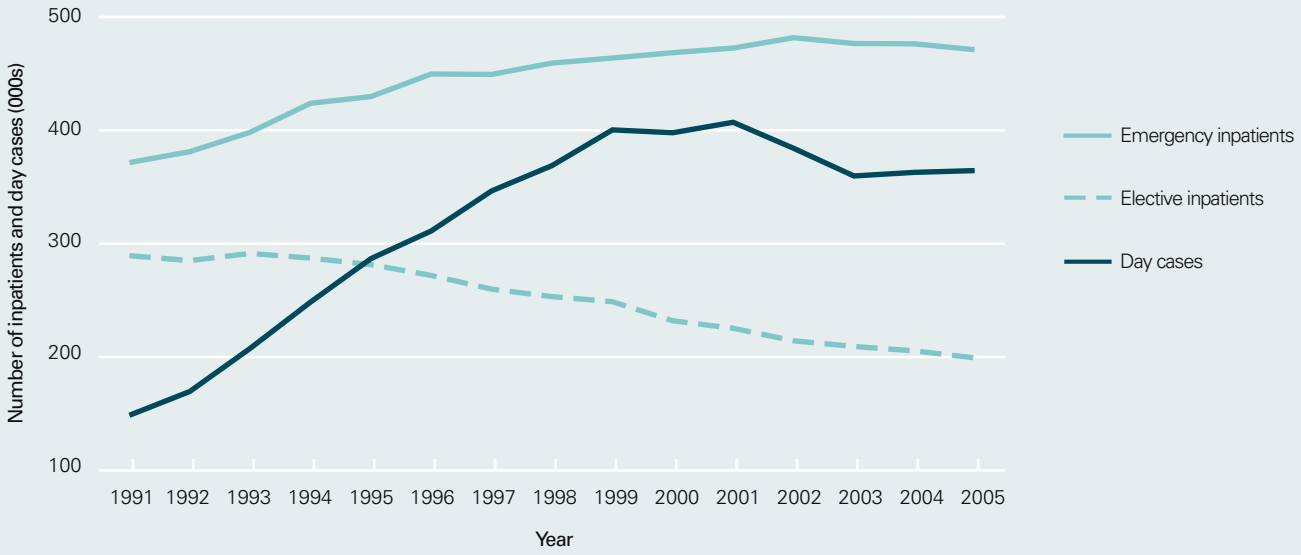
186. A Strategic Review of Health and Care Statistics has been undertaken by the SEHD and ISD during 2004/05. A draft report has been prepared and the SEHD intends to consult with interested parties.

158 NHS Argyll & Clyde, NHS Borders, NHS Fife, NHS Grampian, NHS Greater Glasgow, NHS Lanarkshire, NHS Lothian, NHS Shetland.
159 *Safe and Effective Care: Interim Review of Clinical Governance and Risk Management Arrangements in NHSScotland*, NHS QIS, June 2005.
160 NHS Borders, NHS Dumfries & Galloway, NHS Fife, NHS Greater Glasgow and NHS Lothian.

Exhibit 14

Trends in acute activity, 1991-2005

Elective inpatients continue to fall while the level of emergency admissions and day cases has remained steady since 2003.



Source: Acute hospital care data, ISD, 2005

Comprehensive information on NHS activity, costs and quality is still not available

187. Information has improved in some areas since our last report on the performance of the NHS in Scotland in 2004. For example, more information is available on outpatient clinics led by nurses or AHPs, and GP practice teams. But significant work is still needed to provide robust information on activity, costs and quality to assess whether the NHS is providing value for money.

188. Productivity is an issue currently being considered across the public sector as part of the Atkinson Review.[161] This review reported that improvements were needed in the measurement of health outputs, productivity and quality of treatment. The Scottish Executive is contributing to these developments and has published a response to the review.[162]

Activity data are improving but more needs to be done

189. As we have reported previously, existing measures of activity are not comprehensive. They focus more on hospital care, where fuller information is available, than on healthcare in the community.[163]

190. In recent years the number of elective inpatients has continued to reduce, but the number of day cases and emergency inpatients has remained at a relatively constant level (Exhibit 14). This may be the result of changes in the way healthcare is delivered, with more patients being treated in the community or as outpatients rather than as inpatients or day cases. But it is still not possible to determine the extent to which this is the case.

There has been little change in the balance of spending between acute and community health services

191. The Kerr report recommends a move away from acute hospital based services to community-based healthcare. Spending on hospital services has remained constant at 59% of total NHS spend since 1999/2000. Spending on community services has increased by 1% while expenditure on family health services has fallen by 1% over the same period.[164]

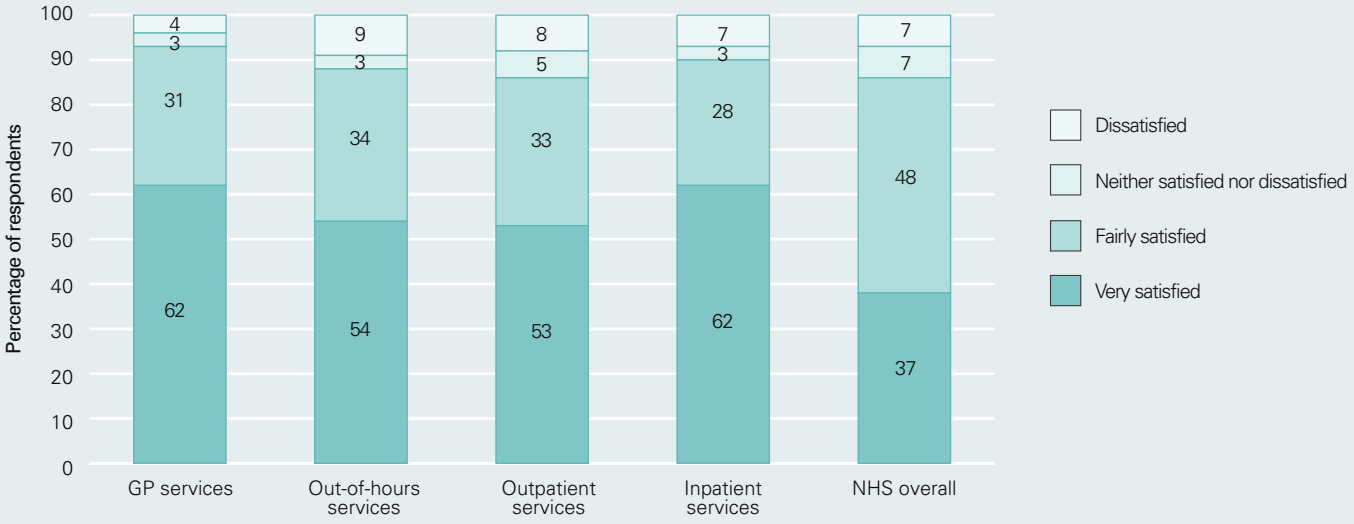
Cost information is better for acute services than for community health services

192. Over the last year the NHS in Scotland has been developing a tariff system mainly to cost cross-boundary patient flows for acute care. This is still at a relatively early stage but it has the potential to be

161 *Atkinson Review: Final Report*, T. Atkinson, 2005.
162 *Implementing the Atkinson Review in Scotland*, Scottish Executive, June 2005.
163 *An overview of the performance of the NHS in Scotland*, Audit Scotland, August 2004.
164 Scottish Health Service Costs 1999/2000 to 2003/04. Figures adjusted to 2004 prices using HM Treasury GDP deflators.

Exhibit 15
Public attitudes to NHS services in Scotland

Overall satisfaction with the NHS is high, with GP services having the highest satisfaction rating.



Source: *Public Attitudes To The National Health Service In Scotland – 2004 Survey*, Scottish Executive, 2004

used more widely to benchmark costs for individual procedures. But there is still a gap in information about the costs of community health services.

193. The NHS in Scotland has benchmarked its costs with English trusts to identify areas for local improvement. This has identified that the cost per inpatient and day case in Scotland is £1,320 compared to the English figure of £1,132 (a difference of 17%). Outpatient costs cannot be adjusted for case-mix nor do we have a Scotland-wide cost. But in Scotland outpatient costs appear to be 20% lower than in England. This benchmarking exercise is a useful development.[165] But to allow better comparison, similar types of hospital such as teaching hospitals, or services such as children's services, should be compared.

Involving patients and the public is essential in developing a patient-led NHS

In 2004, the SEHD set a target for NHS boards to achieve year-on-year improvements in involving the public in planning and delivering NHS services, and in involving patients in decisions about their own healthcare and the development of services.

194. NHS boards now have a duty to involve people in decisions about planning, delivering and improving health services.[166] [167] This duty will also apply to CHPs, which will set up Public Partnership Forums (PPFs) to work with local people.[168]

195. In 2005 the Scottish Health Council was established to promote improvement in the quality and extent of patient focus and public involvement in health services.[169] It will monitor NHS boards' progress in this area and support the development of PPFs. However, it is difficult to say currently how progress in patient and public involvement will be measured.

196. In 2004, the SEHD commissioned a survey of public attitudes to the NHS in Scotland.[170] Of the people who responded, 73% thought that the public had little or no influence over the way that the NHS is run. This has risen from 57% in 2000, suggesting that the public feels less involved in decision-making than it did four years ago.

197. Despite the lack of perceived public involvement in the NHS, the public attitudes survey showed a relatively high level of satisfaction with the NHS in Scotland (85%), although a higher percentage of people reported greater satisfaction with particular services than with the NHS overall (Exhibit 15).

165 NHS Scotland National Benchmarking Project.
166 *Scottish Health Council draft corporate plan, pre-consultation*, Scottish Health Council, 2004.
167 NHS Reform (Scotland) Act 2004.
168 *Community health partnership statutory guidance*, Scottish Executive, 2004.
169 *Scottish Health Council draft corporate plan, pre-consultation*, Scottish Health Council, 2004.
170 *Public Attitudes to the National Health Service in Scotland – 2004 Survey*, Scottish Executive, 2004.

Appendix 1. 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).
Audit report	A final report by an NHS body's auditor on the findings from the audit process.
Availability Status Codes (ASC)	Codes applied to patients who do not have a waiting time guarantee. ASCs may be applied for a number of reasons including when a patient is not available for treatment due to medical or social reasons.
Binge drinking	Drinking more than twice the sensible daily limit.
Break even	Where income equals expenditure.
Capital charges	The notional revenue costs associated with fixed assets. This includes elements of depreciation and interest.
Capital receipts	Funding received from the sale of capital items (items with a value greater than £5,000) including land, buildings and equipment.
Capital resource limit (CRL)	The amount of money an NHS board is allocated to spend on capital schemes in any one financial year.
Capital to revenue transfer	Funding transferred from use on capital spending (ie, items over £5,000) to be used on revenue, or day-to-day expenditure. This may or may not be associated with a particular capital scheme.
Cash-releasing savings	Where a saving is realised because the organisation or function delivers the same service using less money. For example, by delivering support services differently.
Cash requirement	The amount of cash an NHS body needs to support its operational activities during the year.
Clinical governance	Arrangements put in place to ensure safe and effective healthcare.
Community planning partnerships	Multi-agency groups established by each local authority. Their aim is to improve services and the quality of life in the local authority area. There is a statutory duty on NHS boards to participate.
Consultant contract	The new pay, terms and conditions negotiated on a UK-wide basis for NHS consultants.
Coronary heart disease (CHD)	Coronary heart disease is the term used to describe what happens when the supply of oxygen carried in the blood through the heart's blood vessels (coronary arteries) to the heart muscle is blocked or interrupted. This is caused by a build-up of fatty substances in the arteries.
Corporate governance	Arrangements put in place to ensure proper management and use of resources.
Cross-boundary patient flows	Patients treated in an NHS board area other than their resident board.
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.

Family Health Services	Services provided by GPs, dentists, opticians and community pharmacists.
Financial balance	Where income received is equal to expenditure on an ongoing basis.
Financial statements	The main statements in the 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 the NHS accounts manual.
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 the SEHD and any planned savings.
General Medical Services (GMS) contract	A new contract for GPs introduced in April 2004 where they 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.
Gross Domestic Product (GDP)	A commonly used measure of the performance and prosperity of a country. A description of the relevant indicators is found at www.statistics.gov.uk
Healthy life expectancy	The number of years people can expect to live in good health.
In-year financial performance	Result of income compared with expenditure, ignoring any impact of the previous years' financial results.
Life expectancy	Life expectancy at birth for a particular time period is an estimate of the number of years a new born baby would survive if they were to experience the average age specific death rates at that time period throughout their entire life.
Long-term condition	A chronic health problem such as diabetes.
Median	The middle value when numbers are positioned in order from smallest to largest.
Memorandum statement	A statement which includes additional information but does not form part of the annual accounts of an NHS body.
Non-recurring funds	An allocation of funding for projects with a specific life span, or one-off receipts. This includes ring-fenced funding, capital receipts and capital to revenue transfers.
One-off funding	Funding which is provided for one year only.
Operational cost base	The cost of providing day-to-day healthcare services in an NHS board area.
Out-turn	The final financial position, which could be the actual or forecast position.
Private Finance Initiative (PFI)	The UK Government's initiative to encourage the development of private finance in the public sector. PFI is 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.
Qualified audit opinion	When an auditor is of the opinion that there is a problem with the annual accounts of an NHS body, they can issue a qualified report on the accounts. The qualification may be on the truth and fairness of the accounts, the regularity of transactions or both.

Regularity opinion	Auditors provide an opinion as to whether an NHS body's transactions throughout the year are regular, ie they are in accordance with relevant legislation and guidance issued by Scottish ministers.
Resource accounting and budgeting	Accruals accounting for government, which plans, controls and analyses expenditure by departmental objectives.
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.
Ring-fenced funding	Funding provided for a specific project or purpose. For example, drug misuse schemes, drug and alcohol prevention, HIV prevention or one-off income such as capital receipts.
Sensible drinking	A maximum of four units of alcohol each day for men and three units for women.
Stroke	When an area of the brain is deprived of its blood supply for 24 hours or more – usually because of a blockage or burst blood vessel – causing vital brain tissue to die.
Time-releasing savings	Efficiencies which do not release cash but allow frontline services to deliver more or better services with the same money. For example, through reducing sickness absence.
True and fair opinion	Auditors provide an opinion as to whether an NHS body's accounts have been prepared in accordance with all relevant accounting standards, legislation and guidance.
Underlying deficit	The ongoing financial gap in the NHS board area between the money received to provide health services and the costs of providing these services.
Unqualified audit opinion	When auditors of NHS bodies are satisfied with the annual accounts, they will issue an unqualified audit opinion.

Appendix 2. Financial performance of NHS bodies 2004/05

NHS boards

	Revenue resource limit £000	Revenue resource out-turn £000	Variance under/ (over) £000	Capital resource limit £000	Capital resource out-turn £000	Variance under/ (over) £000
Argyll & Clyde NHS Board	527,517	587,009	(59,492)	11,506	10,324	1,182
Ayrshire & Arran NHS Board	508,775	485,874	22,901	8,977	8,977	0
Borders NHS Board	146,873	143,493	3,380	6,372	5,682	690
Dumfries & Galloway NHS Board	212,290	202,835	9,455	3,866	3,858	8
Fife NHS Board	426,864	421,464	5,400	6,807	6,200	607
Forth Valley NHS Board	341,165	340,755	410	5,180	4,951	229
Grampian NHS Board	609,577	620,351	(10,774)	10,487	10,054	433
Greater Glasgow NHS Board	1,280,160	1,268,057	12,103	66,213	66,154	59
Highland NHS Board	302,818	300,980	1,838	5,547	5,335	212
Lanarkshire NHS Board	662,595	682,637	(20,042)	5,888	5,376	512
Lothian NHS Board	956,609	937,043	19,566	7,663	7,577	86
Orkney Islands NHS Board	31,021	30,961	60	1,093	1,055	38
Shetland Isles NHS Board	36,074	36,050	24	2,872	2,794	78
Tayside NHS Board	548,129	543,669	4,460	8,013	7,689	324
Western Isles NHS Board	54,041	54,779	(738)	1,466	1,466	0
Total for NHS boards	**6,644,508**	**6,655,957**	**(11,449)**	**151,950**	**147,492**	**4,458**

NHS special boards

	Revenue resource limit £000	Revenue resource out-turn £000	Variance under/ (over) £000	Capital resource limit £000	Capital resource out-turn £000	Variance under/ (over) £000
NHS National Services Scotland	223,811	219,940	3,871	25,915	25,915	0
Mental Welfare Commission for Scotland	4,298	3,035	1,263	555	368	187
The National Waiting Times Centre Board	33,341	31,740	1,601	3,870	3,806	64
NHS 24	46,788	41,800	4,988	1,468	759	709
NHS Education for Scotland	282,613	274,881	7,732	66	66	0
NHS Health Scotland	17,148	16,701	447	65	32	33
NHS Quality Improvement Scotland	12,105	11,592	513	238	216	22
Scottish Ambulance Service Board	143,492	143,442	50	10,138	10,121	17
State Hospitals Board for Scotland	32,098	30,104	1,994	1,044	1,042	2
Total for special boards	**795,694**	**773,235**	**22,459**	**43,359**	**42,325**	**1,034**

Total for all NHS bodies	**7,440,202**	**7,429,192**	**11,010**	**195,309**	**189,817**	**5,492**

Overview of the performance of the NHS in Scotland 2004/05

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