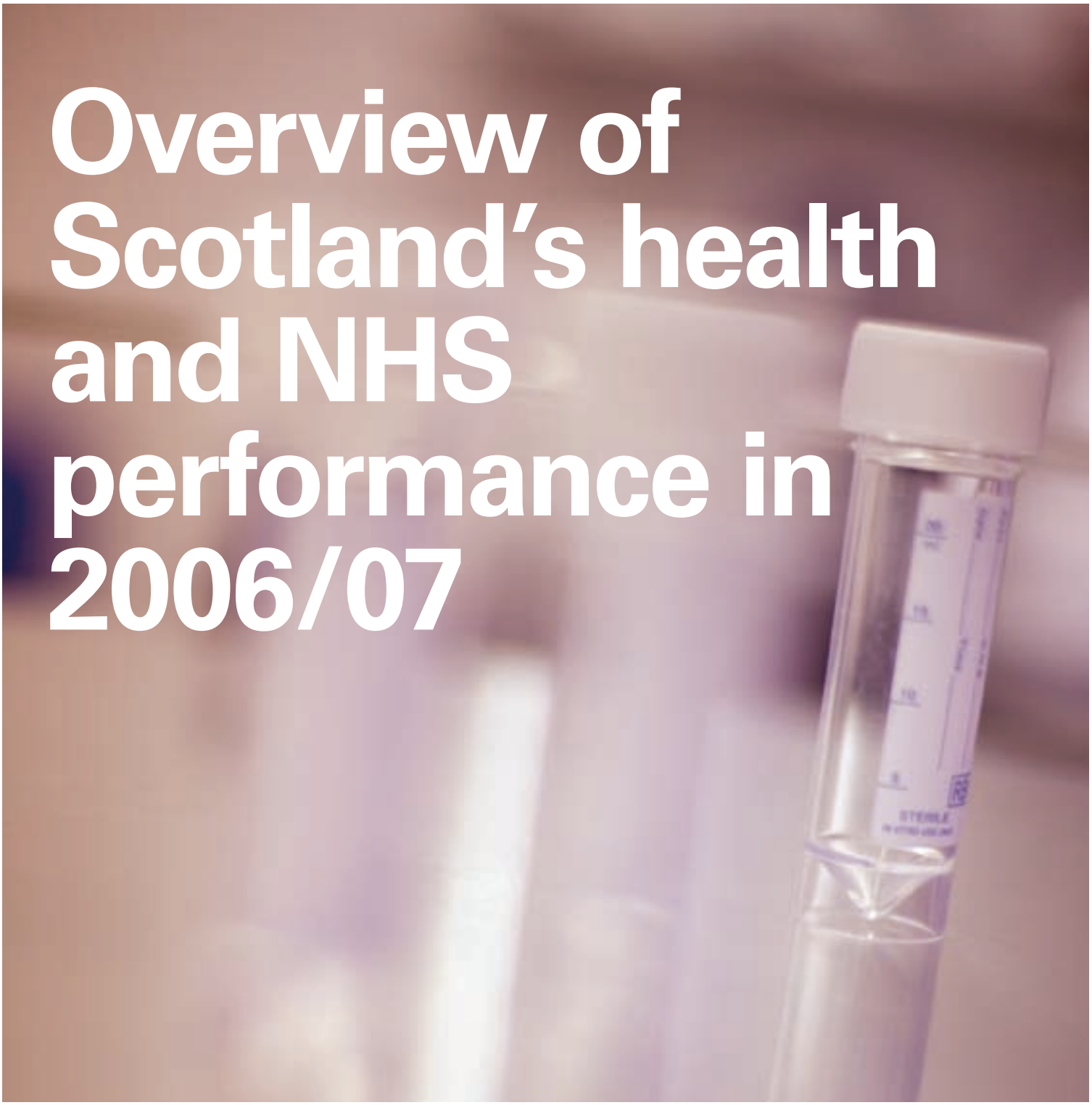
Overview of Scotland's health and NHS performance in 2006/07



AUDIT SCOTLAND

Prepared for the Auditor General for Scotland
December 2007

Auditor General for Scotland

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Contents

Summary

The NHS in Scotland has performed well against the majority of targets, but faces significant future challenges including changes to service delivery and cost pressures.

Introduction

1. This report provides an overview of the health of people living in Scotland and the performance and financial management of the NHS in Scotland.

2. The aim of the Scottish Government is to improve the health and wellbeing of the people of Scotland. This will require efforts by a range of bodies and individuals, not just the NHS. This report focuses on the NHS contribution. Expenditure on the Scottish health service in 2006/07 was £9.4 billion, an increase of 29 per cent since 2001/02 in real terms. There was little change between 2005/06 and 2006/07 (Exhibit 1).

3. The NHS in Scotland faced a number of challenges in 2006/07. NHS boards are continuing to redesign the way services are provided, with the development of Community Health Partnerships (CHPs) and the implementation of pay modernisation contracts. All boards have been assessed against the new clinical governance and risk management standards by NHS Quality Improvement Scotland (NHS QIS) and the Scottish Government has introduced a new performance management framework including targets for boards to achieve.

4. The rest of our report is in four parts:

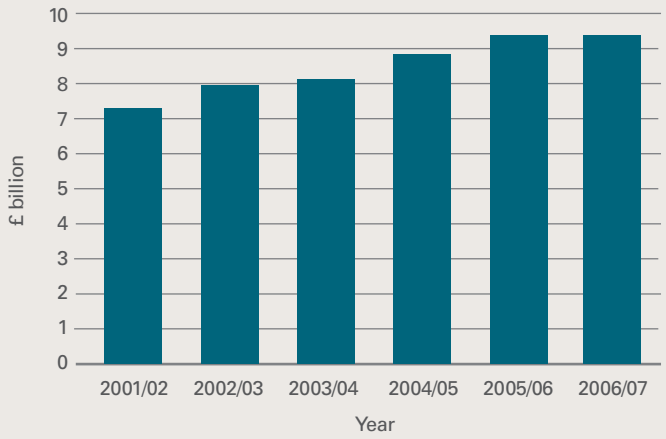
- How healthy are we?
- How is the NHS performing?
- How is the NHS planning for major changes?
- How did the NHS perform financially?

5. As well as providing assurance about how the NHS performed and what it spent during 2006/07, the report contains recommendations for improvement. These are largely aimed at the Scottish Government Health Directorates (SGHD) but may have wider implications for NHS bodies.[1]

Exhibit 1

Gross expenditure on health in Scotland, 2001/02 to 2006/07 (adjusted to 2006/07 prices)

There has been little change in health expenditure over the last two years.



Source: Consolidated resource accounts 2001/02 to 2006/07, adjusted to 2006/07 prices using the HM Treasury GDP deflator

Information sources

6. The commentary on financial performance and governance is based largely on auditors' reports on the 2006/07 audits of the 14 NHS boards, nine special health boards and the SGHD.[2] All NHS bodies have received annual audit reports which are published on the Audit Scotland website.[3] This report also draws on published information from sources such as NHS QIS, HM Treasury, Office of National Statistics (ONS) and the Organisation for European Co-operation and Development (OECD).

7. Parts 1, 2 and 3 of the report, concerning the performance and delivery of the health service, use a range of sources including the Information and Statistics Division of NHS National Services Scotland (ISD), the General Register Office for Scotland (GROS) and the Chief Medical Officer (CMO). Other information sources are cited throughout the report. The information in the report is as current as possible.

8. 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 3.

Summary of key messages

- Mortality rates for key diseases and overall life expectancy are improving, but other public health concerns, including drug and alcohol-related problems and obesity, continue to grow. Significant inequalities in health outcomes remain.
- New performance measures were introduced in 2006/07 and the NHS is performing well against waiting times. However, other areas still need to improve including cancer waiting times, delayed discharges and reducing older people's readmissions to hospital.

1 The Scottish Government is split into directorates. This new structure has replaced the former departmental structure and that means that what was previously the Health Department is now a number of individual directorates.
2 For the purposes of this report, NHS National Services Scotland and the Mental Welfare Commission for Scotland are referred to as special health boards. The Mental Health Tribunal for Scotland Administration is an executive agency and is responsible for laying its own accounts in Parliament, and so is excluded from this report.
3 www.audit-scotland.gov.uk

- The Scottish Government needs to build on the current performance management system for the NHS to be able to report on productivity, cost and quality together. This should fit with wider work on developing outcome measures.

- New ways of delivering services are being developed and implemented throughout the NHS, including CHPs and a move from hospital to community-based services, but there is no evidence that resources are shifting along with these changes. CHPs now need to focus on delivering benefits for patients rather than structures and processes.

- Improvements are needed to the way the benefits of service changes, including CHPs and pay modernisation, are identified, measured and monitored.

- The financial performance of boards improved in 2006/07, with an overall underspend against the revenue budget. Only one board, NHS Western Isles, did not meet a financial target. Continuing cost pressures for the future, including service redesign, pay modernisation and drug costs, reinforce the need for strong financial management.

Recommendations

The Scottish Government should:

- Ensure that information on the performance of the NHS is publicly reported and brings together data on costs, outcomes, targets, productivity, patient satisfaction and experience. It should assess performance against all these elements together to better inform decision-making.

- Ensure the performance management system for the NHS in Scotland fits with wider developments around outcome measures across public services.

- Ensure that the costs and benefits of major changes such as service redesign, pay modernisation contracts and the introduction of CHPs are fully identified.

Boards should aim to be in recurring financial balance and minimise the use of non-recurring income on day-to-day expenditure.

Part 1. How healthy are we?

Mortality rates for key diseases and life expectancy are improving, but inequalities in outcomes remain.

Key messages

- Mortality rates for key diseases and overall life expectancy are improving but inequalities remain.
- Higher levels of deprivation are linked with higher overall mortality and alcohol-related problems.
- Obesity levels continue to rise, and only a third of adults are meeting recommended levels for physical activity.

Overall mortality rates in Scotland are improving but inequalities remain

9. Mortality rates for key diseases such as coronary heart disease (CHD), cerebrovascular disease (CVD) and cancer have decreased over the last ten years. CHD mortality rates have decreased the most, from 208 deaths per 100,000 population in 1997 to 125 deaths per 100,000 population in 2006. The mortality rate for males for cancer remains the highest of the three diseases, but has reduced to 249 deaths per 100,000 population in 2006 (Exhibit 2).

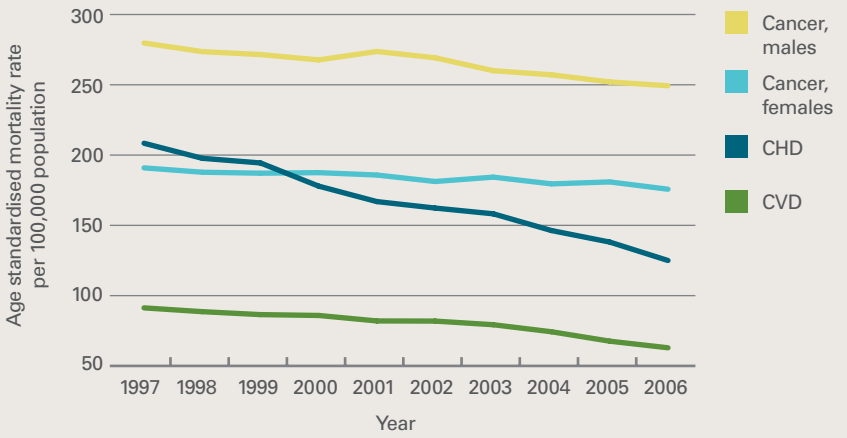
Life expectancy is improving

10. Life expectancy is improving, from 72.1 years to 74.6 years for men and from 77.8 years to 79.6 years for women between 1994-96 and 2004-06. However, it is still lower than the European Union (EU) average: life expectancy for men is almost a year lower than the EU average and almost two years lower for women. The gap between the council areas with the highest and lowest life expectancy

Exhibit 2

Mortality rates for CHD, CVD and cancer from 1997 to 2006

Mortality rates for key diseases are falling.

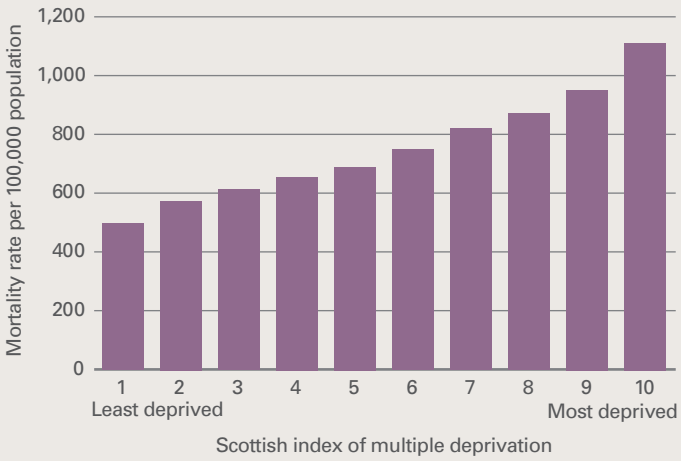


Source: ISD Scotland

Exhibit 3

All-cause age and sex standardised mortality rates, 2005

Mortality rates increase with higher levels of deprivation.



Source: *Measuring Socio-Economic Inequalities in Health: A Practical Guide*, ScotPho, 2007

has not decreased over the last ten years. For men a gap of 7.5 years on average remains between men living in East Dunbartonshire (78.0 years) and Glasgow City (70.5 years).[4]

11. Higher deprivation is related to higher incidence and higher overall mortality for diseases including CHD, CVD and cancer (Exhibit 3).

12. Overall, 34 per cent of all premature deaths can be attributed to deprivation.[5] At a younger age suicide and drug-related problems are more prevalent for people in deprived areas; at an older age key diseases are more prevalent.[6] Alcohol-related discharges from hospital and deaths increase with higher levels of deprivation (Exhibit 4).

13. Mortality rates from chronic liver disease have also risen over the last 20 years, and the increase has been more pronounced for the most deprived areas (Exhibit 5).

14. Drug-related deaths increased by 25 per cent between 2005 and 2006, from 336 to 421. Thirty-eight per cent of these deaths occurred in the NHS Greater Glasgow and Clyde area, which saw an increase in drug-related deaths from 111 to 162.[7]

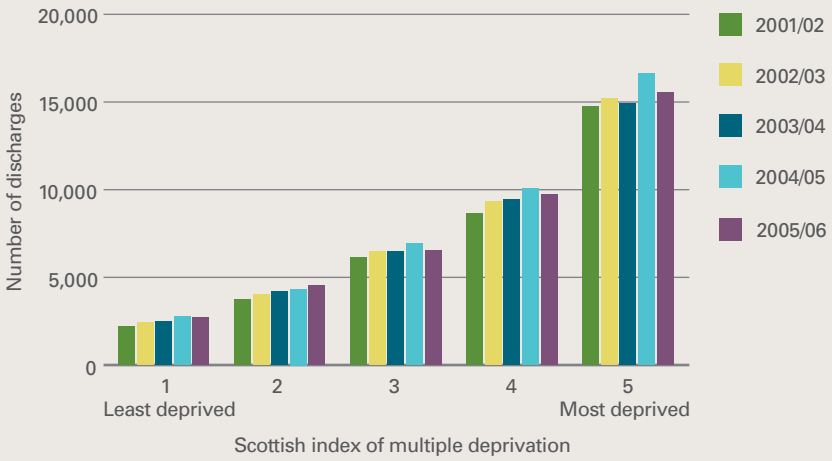
Scotland is ranked behind other countries in many areas of health and wellbeing

15. Obesity continues to be a major public health concern, increasing from 16 to 24 per cent of men aged between 16 and 64, and from 19 to 27 per cent for women between 1995 and 2003.[8] Scotland has the second highest rate of obesity among the

Exhibit 4

General acute inpatient discharges with an alcohol-related diagnosis by deprivation category

Higher levels of deprivation are linked to more inpatient discharges with alcohol-related diagnosis.

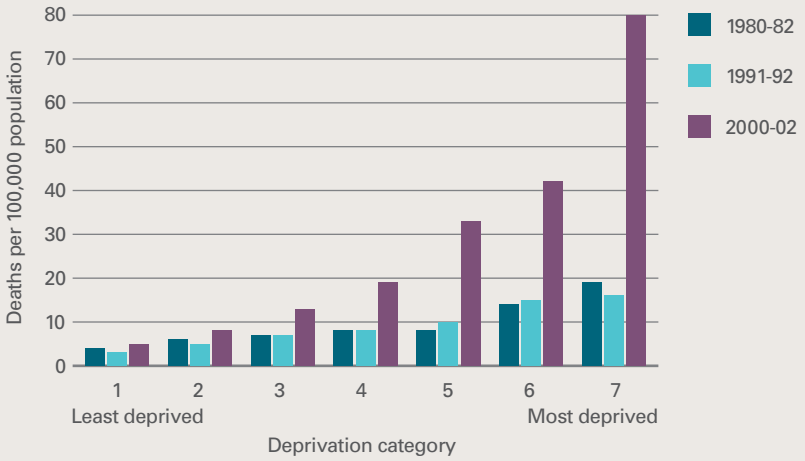


Source: www.alcoholinformation.isdscotland.org

Exhibit 5

Mortality rate for chronic liver disease per 100,000 population, 1980-2002, males

Mortality rates for males with chronic liver disease are increasing the most at higher deprivation levels.



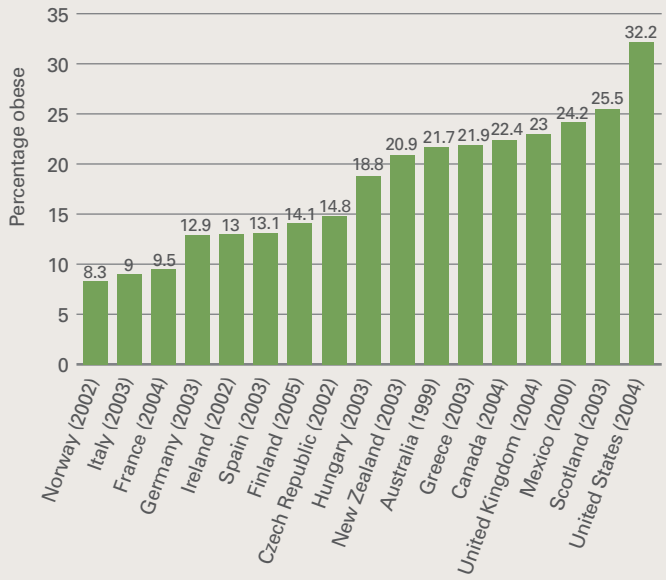
Note: This information uses the Carstairs deprivation index which has seven categories.
Source: ISD Scotland

4 *Life expectancy for administrative areas within Scotland 2004-06*, GROS, September 2007.
5 *Measuring Socio-Economic Inequalities in Health: A Practical Guide*, ScotPho, 2007.
6 *Inequalities in mortality in Scotland 1981-2001*, MRC Social and Public Health Sciences Unit, February 2007.
7 *Drug-related deaths in Scotland 2006*, GROS, August 2007.
8 Obesity is defined as Body Mass Index>30 kg/m^2.

Exhibit 6

Obesity in OECD counties as a percentage of the adult population, aged 15 and over

Obesity levels in Scotland are second only to the USA.

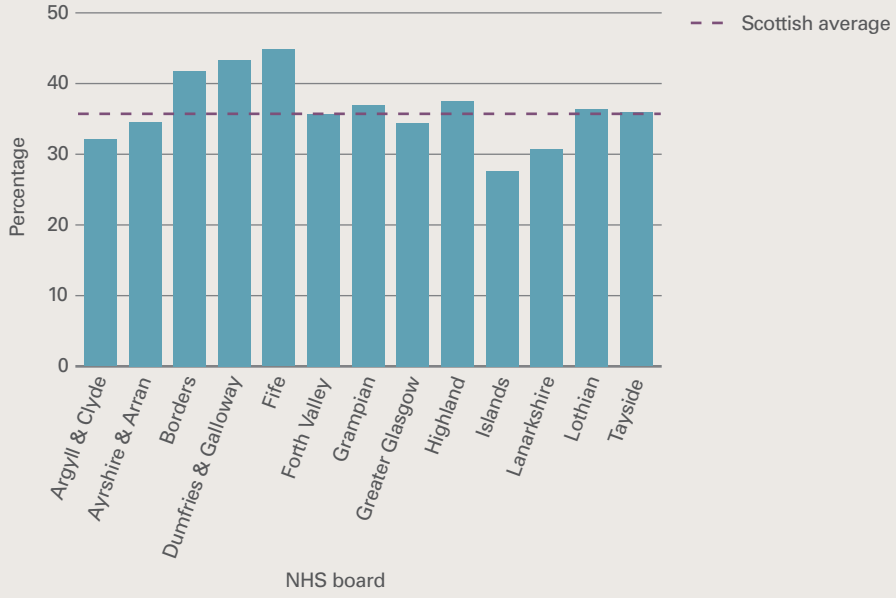


Source: Obesity in Scotland, ScotPho, 2007

Exhibit 7

Percentage of adults aged 16 years and over in Scotland achieving the recommended level of physical activity per week by NHS board, 2003

Only 36 per cent of adults in Scotland are meeting the recommended level of physical activity per week.



Source: Scottish Health Survey 2003

OECD countries, behind only the USA (Exhibit 6).

16. Only 36 per cent of adults in Scotland meet the recommended level of physical activity per week. People in NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Grampian, NHS Highland and NHS Lothian exceed the Scottish average (Exhibit 7).

17. Scotland is ranked 22nd out of 24 in a recent report on the wellbeing of children, with suicide rates, dental health and teenage pregnancy rates contributing to this low ranking.[9]

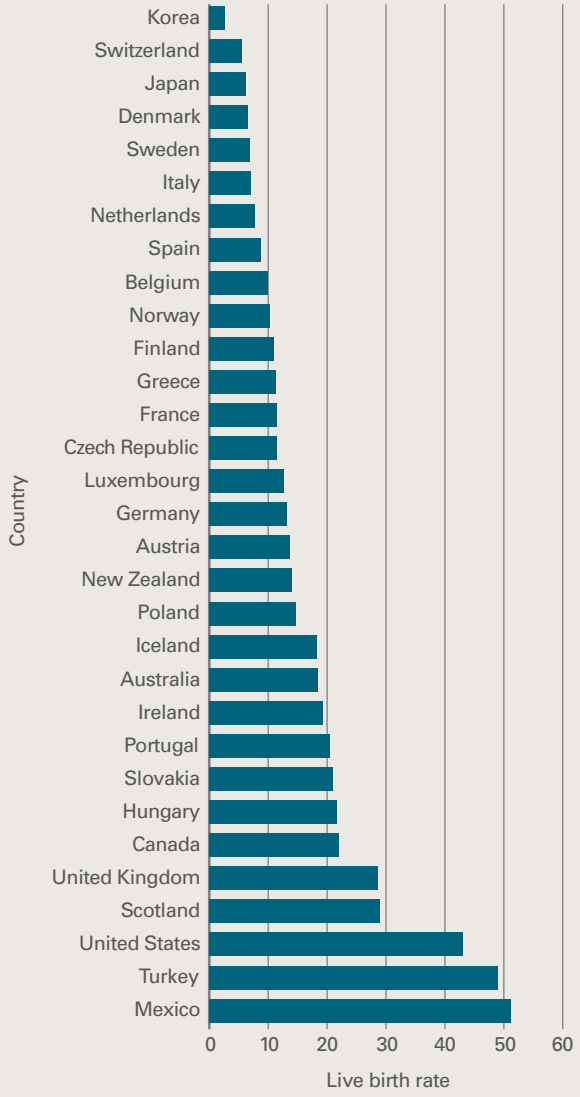
18. The live birth rate for teenage pregnancy in Scotland (and the rest of the UK) is the fourth highest among the OECD countries (Exhibit 8). Within Scotland, NHS Tayside and NHS Dumfries and Galloway have the highest rates of teenage pregnancy, with rates at 70.5 and 67 per 1,000 women aged between 15 and 19 respectively.[10]

9 *Index of Wellbeing for Children in Scotland*, Barnardo's Scotland, July 2007.
10 www.isdscotland.org

Exhibit 8

The number of live births to mothers aged 16-19 years old per 1,000 women of that age

The live birth rate for teenage pregnancy in Scotland is one of the highest of the OECD countries.



Source: *Index of Wellbeing for Children in Scotland*, Barnardo's Scotland, July 2007

Part 2. How is the NHS performing?

Performance against key targets is improving but further work is needed in some areas including cancer waiting times and delayed discharges.

Key messages

- It is still hard to get a complete picture of NHS activity – the best information remains in the acute hospital sector and for consultant-led activity. For example, consultants' outpatient activity shows a downward trend and accident and emergency attendances have increased by 50,000 over the last year. Improvements in data are being made but there are still no measures for productivity.
- Performance against key targets including waiting times is improving, but further work is needed on other targets:
  - 87.3 per cent of cancer patients are treated within the target that all patients with an urgent referral should be treated within 62 days
  - 40 per cent of patients clinically ready for discharge are waiting for more than six weeks
  - elderly readmission rates have declined marginally, but by 2008/09 they need to reduce by 20 per cent from the 2004/05 level.
- New performance measures were implemented, but information on performance is not published for all targets, and is not brought together in an accessible format.
- The Scottish Government needs to build on the current performance management system for the NHS to be able to report on productivity, cost and quality together. This should fit with wider work on developing outcome measures.

Activity levels have been variable as funding for the NHS increases

19. Overall expenditure on health has increased by 29 per cent in real terms between 2001/02 and 2006/07. Total expenditure was £9.4 billion in 2006/07 and is budgeted to increase to over £10 billion in 2007/08.[11] Expenditure on health per head of population continues to be higher in Scotland than in the rest of the UK (Exhibit 9).

20. Activity measures have historically focused on the hospital sector and consultant activity in particular. As services change these measures no longer reflect the full range of activity. There are currently no measures to show the changes in productivity.

21. The increased investment does not appear to be matched by increases in traditional consultant-led activity. For example, there is a downwards trend in consultant-led outpatient total attendances (Exhibit 10).

Exhibit 9

UK spend on healthcare per head of population, 2002/03-2005/06

Scotland spends more on healthcare per head compared to the rest of the UK.

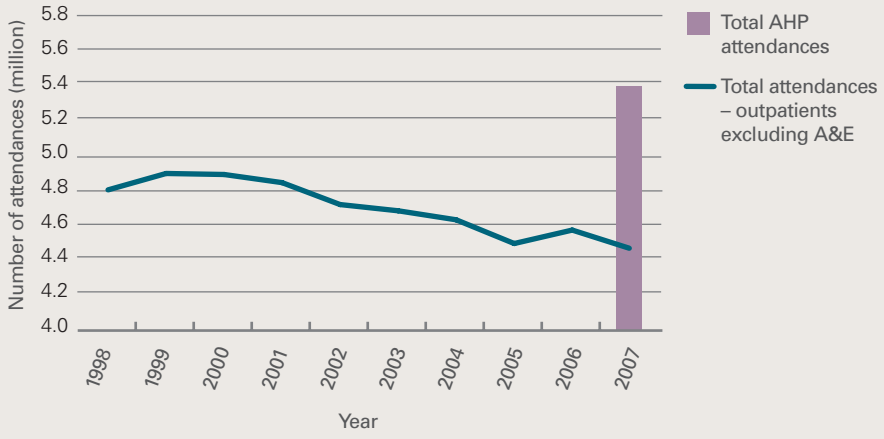
Expenditure on health per head of population				
	2002/03	2003/04	2004/05	2005/06
Scotland	£1,321	£1,451	£1,513	£1,643
England	£1,080	£1,217	£1,347	£1,437
Wales	£1,182	£1,340	£1,435	£1,513
Northern Ireland	£1,198	£1,340	£1,422	£1,549

Source: Public Expenditure Statistical Analysis (PESA) 2007, HM Treasury/Office for National Statistics, May 2007

Exhibit 10

Outpatient (excluding A&E) and Allied Health Professional (AHP) total attendances from 1998 to 2007

Total outpatient attendances are declining, but emerging statistics for attendances with AHPs show that these are higher than consultant-led outpatient attendances.



Note: the 2007 data are provisional.
Source: ISD Scotland

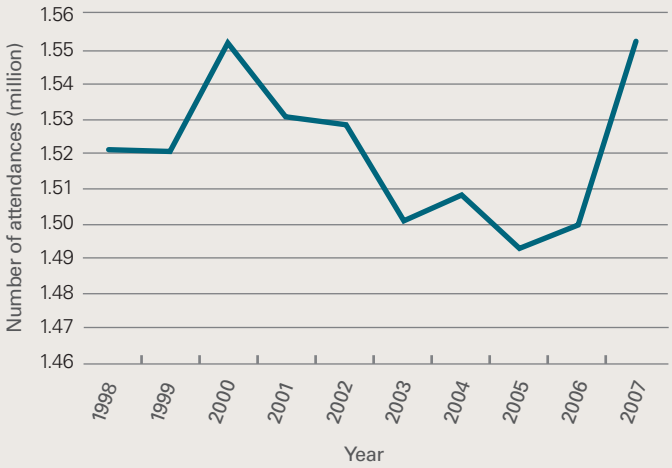
Boards are aiming to eliminate unnecessary repeat visits and this may explain some of the difference – the ratio of new to returning patients has decreased from 2.6 in 1999 to 2.3 in 2007.[12] However, the number of new outpatient appointments also shows a slight downwards trend.[13]

22. The Scottish Government is developing new measures to ensure that all activity is recorded such as the activity of Allied Health Professionals (AHPs). For 2007, total AHP and other technical services attendances were 5.4 million, which is more than consultant-led outpatient attendances. This gives a more complete picture of activity and shows the extent of activity not previously recorded (Exhibit 10). Data development work suggests that nurse-led clinics may account for a further one million outpatient attendances.

Exhibit 11

Total A&E attendances, 1998-2007

A&E attendances have reached their second highest peak in ten years.

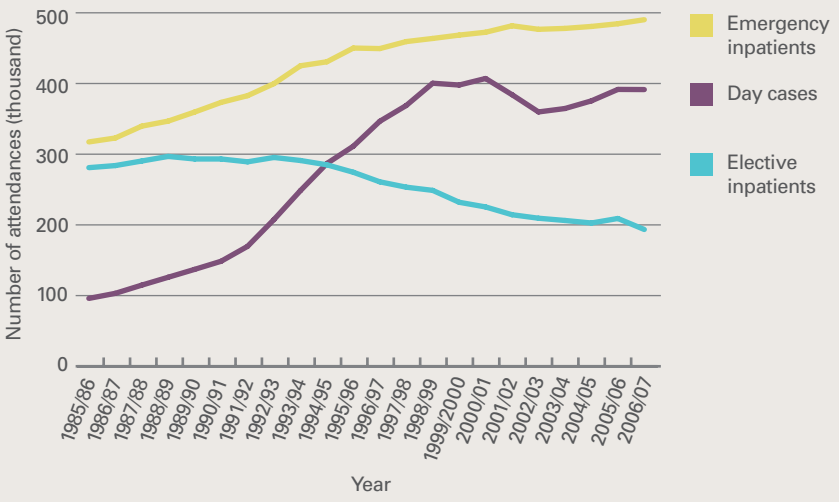


Note: The 2007 data are provisional.
Source: ISD Scotland

Exhibit 12

Total inpatient and day case attendances by type, 1985/86-2006/07

Emergency inpatients and day case attendances have increased over time, but the trend has slowed over the last five years.



Source: ISD Scotland

23. Accident and emergency (A&E) attendances reached their second highest level in the last ten years in 2007. Rates have been increasing for the last two years, following a five-year downward trend (Exhibit 11).

24. Over the last 20 years there has been an increase in emergency and day case activity, but this has levelled out over the last five years. Elective inpatient activity has decreased over the 20-year period but has remained fairly static over the last five years (Exhibit 12).

25. Audit Scotland completed a review of day surgery in 2004 based on a basket of procedures and noted that rates were lower than in England. Between March 2003 and March 2006, day surgery rates have been increasing at about 1 to 1.5 per cent per year. The Scottish Government aims to increase these rates and has estimated a potential efficiency saving of £9.5 million a year.[14] Audit Scotland is undertaking a review of day surgery and will report its findings in 2008.

26. Within primary care, contacts with GPs have remained static over the last three years, with approximately 79 per cent of the practice population seeing a GP in 2005/06 as compared to 78 per cent in 2004/05.[15] The Audit Scotland report on managing long-term conditions noted that for patients with chronic obstructive pulmonary disease the number of contacts with their GPs had decreased, while contact with practice nurses increased. This reflects the wider role that nursing staff are having in the care of patients.[16]

12 www.isdscotland.org
13 www.isdscotland.org
14 *The Planned Care Improvement Programme: Day Surgery in Scotland*, Scottish Executive, 2006.
15 www.isdscotland.org
16 *Managing long-term conditions*, Audit Scotland, August 2007.

27. The number of adult and child dental registrations has declined slightly since 2000, decreasing from 2.73 million to 2.58 million (5.21 per cent fall).[17] The numbers of NHS sight tests and eye examinations slowly increased from 2000 until 2007 when there was a large increase due to the extension of free eye tests to all, increasing from 0.96 million to 1.6 million in one year.[18]

Healthcare associated infection is estimated to cost the NHS £183 million per year

28. According to a study undertaken by Health Protection Scotland between October 2005 and October 2006, 9.5 per cent of patients in acute hospitals and 7.3 per cent in non-acute hospitals had a healthcare associated infection (HAI). The cost of HAI is estimated to be £183 million per year in Scotland.[19] Those specialties with the highest rates were care of the elderly and medicine for both acute and non-acute hospitals and also surgery for acute hospitals.

29. Similar studies have been undertaken in other parts of the UK. A study undertaken in England, Northern Ireland, Wales and the Republic of Ireland between February and May 2006 showed an overall infection rate of 7.6 per cent.[20] It is difficult to make comparisons between the Scotland study and the other studies because of differences in patient case mix, methodology and time period.

30. The Scottish Government has put in place an HAI task force to tackle HAI. The task force has produced a delivery plan stating the actions it is going to take up to March 2008. Also, a target has been included in the 2007/08 health targets to reduce all Staphylococcus aureus bacteraemia (including MRSA) by 30 per cent by 2010.

The Scottish Government introduced a new performance framework for the NHS in 2006/07

31. The NHS developed and implemented new performance measures for 2006/07, with HEAT targets replacing the performance assessment framework (PAF). HEAT has 32 targets, fewer than the system it replaced. These are split into four categories:

- (H) health improvement for the people of Scotland – improving life expectancy and healthy life expectancy
- (E) efficiency and governance improvements – continually improving the efficiency and effectiveness of the NHS
- (A) access to services – recognising patients' need for quicker and easier use of NHS services
- (T) treatment appropriate to individuals – ensuring patients receive high-quality services that meet their needs.

32. Each NHS body must develop a local delivery plan which sets out the HEAT targets and any other local targets the boards are aiming to meet to ensure that the national targets are met. Boards are responsible for measuring performance against the local delivery plans and the results are reported to the Scottish Government.

Performance against targets is improving with some exceptions

33. Performance against HEAT targets is showing improvement in the majority of boards. Appendix 1 provides a full list of all targets and the most recent performance against measures for the whole of Scotland. A selection of the targets is discussed in more detail below.

34. The NHS has been successful in meeting its immunisation targets apart from the measles, mumps and rubella (MMR) immunisation. While uptake is now increasing after a period of decrease, it is still falling short of the 95 per cent target with average performance in the quarter to June 2007 at 92.1 per cent. Only two boards, NHS Dumfries and Galloway and NHS Western Isles, met the target (Exhibit 13, overleaf).

35. Between 2001/02 and 2005/06, there has been a consistent downward trend in the number of suicides.[21] Two more mental health indicators have been added for 2007/08:

- to reduce the annual rate of increase of defined daily dose per capita of anti depressants to zero by 2009/10
- to reduce the number of readmissions (within one year for those who have had a psychiatric hospital admission of over seven days) by ten per cent by the end of December 2009.

36. More indicators for mental health are in development following the publication of *Delivering for Mental Health* by the Scottish Executive in December 2006.[22]

37. In 2006, 25 per cent of the population smoked, showing a decrease since the previous year and continuing a slow downwards trend towards the target of 22 per cent by 2010. The proportion of adults smoking is highest for those living in the most deprived areas in Scotland, at 41 per cent.[23] Smoking has been banned in public places in Scotland since 26 March 2006 but it is too early to assess the impact of this ban.

Sickness absence levels have increased

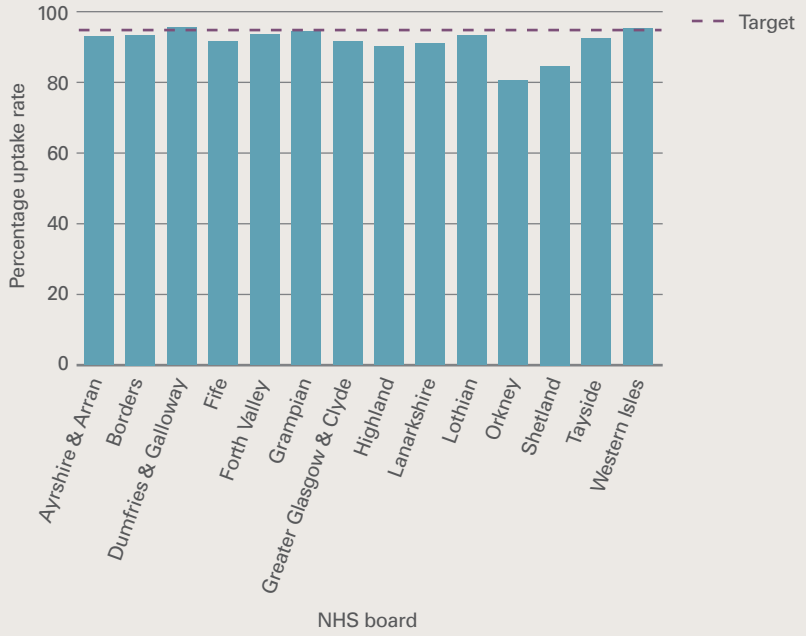
38. At an average of 5.55 per cent, sickness absence rates have worsened

17 www.isdscotland.org
18 www.isdscotland.org
19 *NHSScotland National HAI prevalence survey*, Health Protection Scotland, July 2007.
20 *NHSScotland National HAI prevalence survey*, Health Protection Scotland, July 2007.
21 www.scotpho.org.uk
22 *Delivering for Mental Health*, Scottish Executive, December 2006.
23 *2006 Scottish Household Survey*, Scottish Government, August 2007.

Exhibit 13

MMR uptake rate at 24 months old to quarter ending June 2007, by NHS board

MMR uptake rates are still below the target level of 95 per cent, except in NHS Dumfries and Galloway and NHS Western Isles.

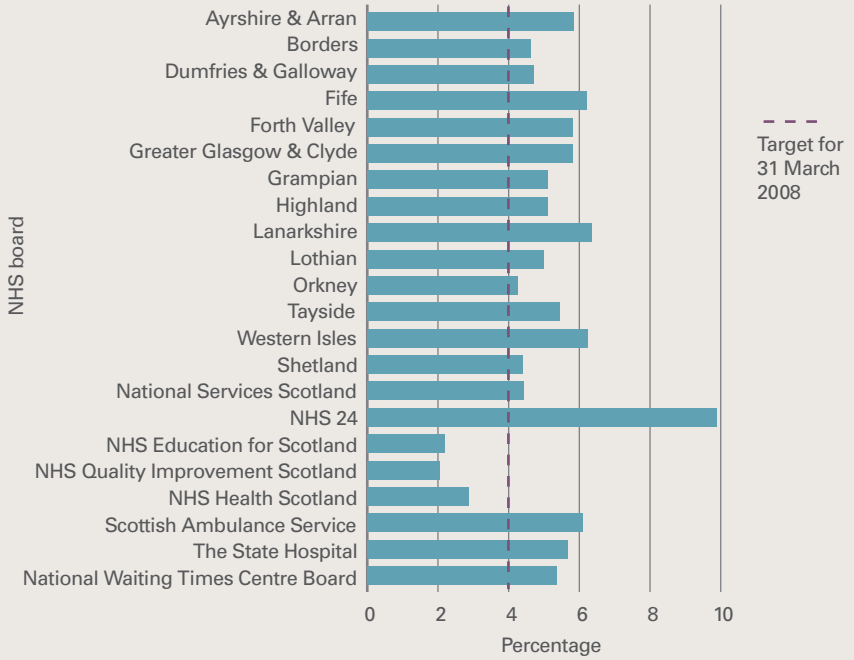


Source: ISD Scotland

Exhibit 14

Sickness absence rate by board, as at 31 March 2007

Sickness absence rates in the majority of boards continue to be high, particularly in NHS 24.



Source: ISD Scotland

since 2005/06 when the average rate was 5.23 per cent. NHS 24 had the highest rate (9.88 per cent) and the majority of boards look unlikely to meet the target of four per cent by 31 March 2008. Only three boards, NHS Education, NHS QIS and NHS Health Scotland, had a rate below four per cent (Exhibit 14). This means the Efficient Government Initiative savings target of £34.5 million has not been met.

The primary care 48-hour access target is generally being met

39. Access targets include waiting times targets. The Scottish Government has a target of access to primary care services, such as GPs or practice nurses, within 48 hours. Performance was measured at 99.4 per cent against the target of 100 per cent in 2005/06.[24] Previously this information was self-reported by GPs through the Quality and Outcomes Framework which determines part of their level of payment. However, since 1 April 2006, there has been a change in contracting arrangements and this information is no longer published.

Ambulance response times to high-priority calls were below target

40. Ambulance response times showed a performance of 55.7 per cent against a target of 64 per cent for responding to Category A (high priority) calls within eight minutes.[25] The Scottish Ambulance Service is undertaking research to get a better understanding of the demand for its services.

Cancer waiting times have improved, but do not yet meet the national target

41. The Scottish Government has set a target that all patients with an urgent referral from their GP for cancer treatment should be treated within 62 days.

42. For the quarter ending 30 June 2007, 87.3 per cent of all cancer patients were treated within the 62 day waiting time. There have been improvements in the percentage of patients with the three main cancers, breast, lung and colorectal, being treated within 62 days,

24 www.isdscotland.org
25 Annual audit report to Scottish Ambulance Service Board and the Auditor General for Scotland 2006/07, PricewaterhouseCoopers.

although performance is still falling short of the target. In the 24 months to June 2007, the percentage of patients being treated within the target timeframe improved as follows:

- For breast cancer, it improved from 80.5 per cent to 97.2 per cent.
- For lung cancer, the improvement was from 76.8 per cent to 86.9 per cent.
- For colorectal cancer, performance improved from 66.8 per cent to 81.3 per cent.[26]

43. The Scottish Government is working with NHS boards to improve their cancer waiting times performance. Cancer performance support teams were created and directed initially to NHS Highland and NHS Forth Valley to improve their poor performance relative to other boards. The support teams also visited NHS Greater Glasgow and Clyde because its size poses particular risks. These teams have helped boards to reduce their waiting times.

44. Following an improvement in the performance of NHS Forth Valley and NHS Greater Glasgow and Clyde, the support teams withdrew from these areas and focused on NHS Lothian and NHS Lanarkshire, which have poorer performance than other boards. The support team remains at NHS Highland. Exhibit 15 shows board performance against waiting times targets for all cancers combined.

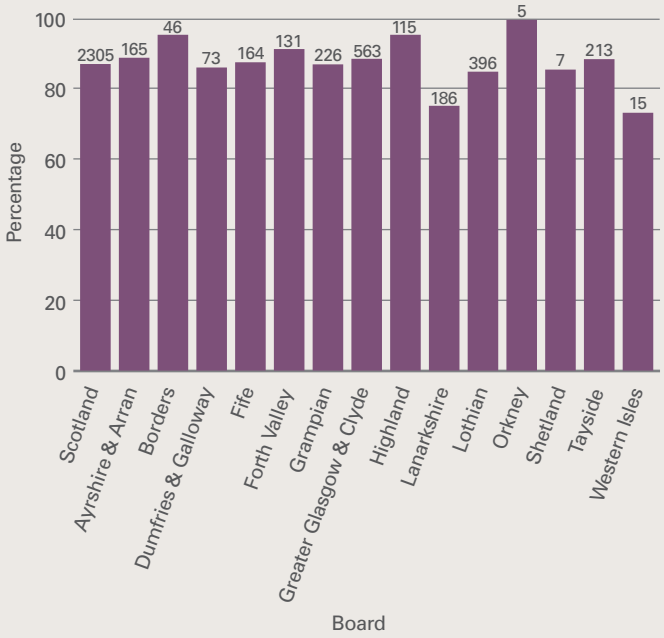
The 18-week target for inpatients has been met

45. For inpatient and outpatient waiting times the targets are that by December 2005 no patient should have been waiting for more than 26 weeks and for more than 18 weeks by December 2007. The national target uses a census measure which provides a snapshot of the number of people waiting to be seen or treated, and how long they have been waiting at the census date. For the 18-week targets that are due for December 2007, the inpatient target has already been met (Exhibit 16).

Exhibit 15

Percentage of patients seen within the target times for all cancers combined for the quarter ending 30 June 2007

NHS boards are still not meeting waiting times targets for cancer, with NHS Lanarkshire and NHS Lothian having poorer performance than other boards.

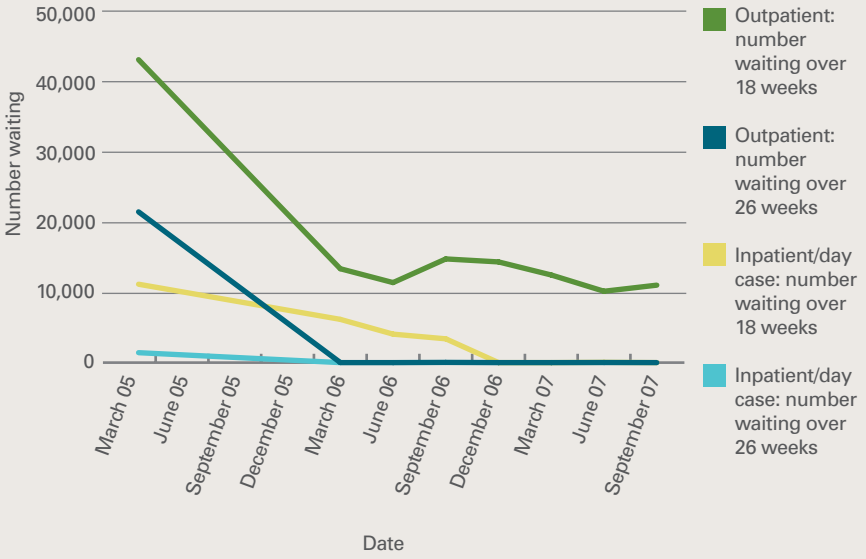


Note: The number at the top of each column represents the number of eligible urgent referrals for that board.
Source: Scottish Government cancer waiting times website

Exhibit 16

NHSScotland performance against 18 and 26-week waiting times targets, March 2005-September 2007

The 26-week waiting times targets have been met, as well as the 18-week inpatient target, which is ahead of the target date.



Source: ISD Scotland

46. Availability status codes (ASCs) are assigned to people if they are medically unfit or unavailable for treatment. The code indicates that the waiting times guarantee does not apply to that patient. The number of patients with an ASC has decreased over time, but they still represent 23 per cent of inpatients and nine per cent of outpatients (Exhibit 17). The Audit Scotland report on tackling waiting times noted that patients with an ASC tended to wait longer.[27]

47. From 1 January 2008, the current ASC system will be replaced with arrangements, known as 'New Ways', that take periods of patient unavailability into account when measuring and reporting waiting times. Abolition of ASCs will present a challenge to NHS boards to meet future waiting times targets. The Auditor General will review how the NHS is applying the new approach during 2008.

Delayed discharges have decreased

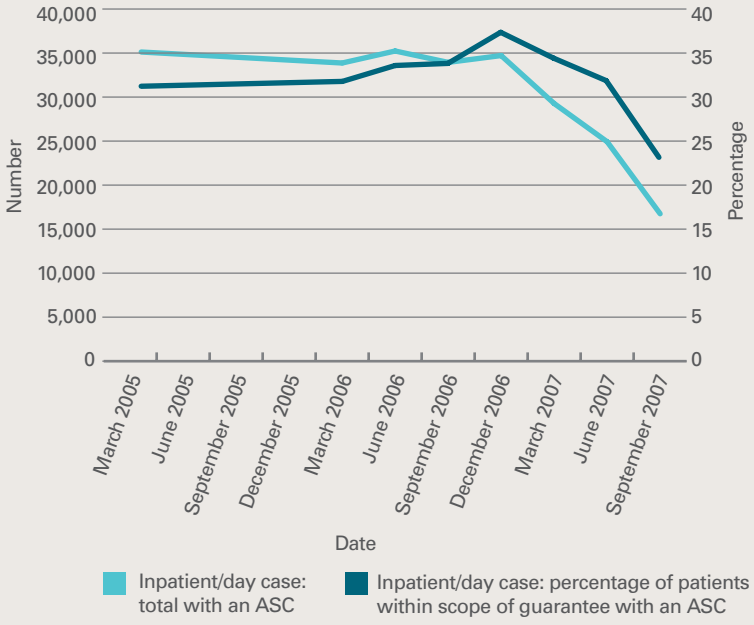
48. At July 2007, of the 1,031 patients clinically ready to be discharged from hospital, 423 had been waiting over the target of six weeks. This compares to 2,162 patients waiting over six weeks when rates were at their highest in October 2001. However, across Scotland over 40 per cent of patients clinically ready to be discharged have been waiting more than six weeks (Exhibit 18). The target for 2007/08 is that no patients should be delayed for more than six weeks.

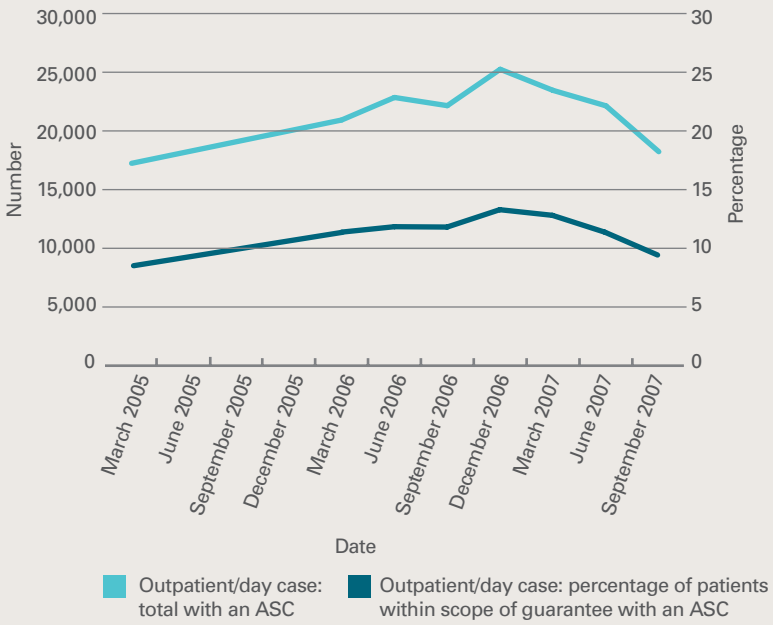
49. A further treatment target is to reduce the percentage of older people (aged 65 and over) who are admitted as an emergency inpatient twice or more in a single year by 20 per cent by 2008/09 from the level in 2004/05.

Exhibit 17

Number and percentage of patients with an ASC, March 2005-September 2007

The number of patients with an ASC has decreased but still represents 23 per cent of inpatients and nine per cent of outpatients.





Source: ISD Scotland

27 *Tackling waiting times in the NHS in Scotland*, Audit Scotland, February 2006.

Performance data, currently available only to March 2006, show a marginal decrease but there is much work to be done to meet the target (Exhibit 19). This is an area where joined-up health and social care is essential.

50. The HEAT targets are intended to improve the performance and accountability of the NHS in Scotland, but there is no publicly available information on performance against the following targets:

- Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15 per cent across a range of indicators, including CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people.
- Ensure that everyone contacting their GP has guaranteed access to a GP, nurse or other healthcare professional within 48 hours.
- Women who have breast cancer and need urgent treatment will get it within one month where appropriate.

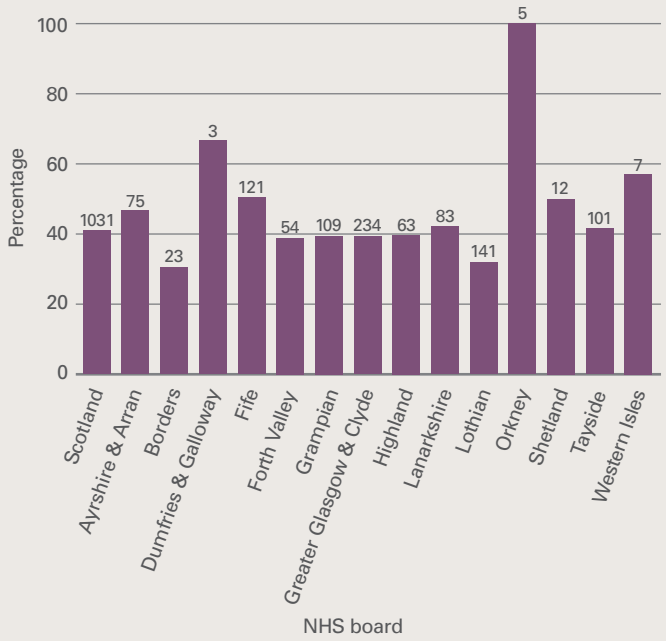
51. The NHS in Scotland does not produce an annual report of its performance against the targets. This means that the public and patients cannot easily get a comprehensive picture of how the NHS is performing. There is also scope to develop the framework further; at present not all the measures are relevant to the target they are supposed to be measuring (for example, target 1.01K in Appendix 1).

52. On 14 November 2007, as part of the budget and spending review, the Scottish Government launched a new outcome-focused approach to performance. This involves setting a single purpose for the Government

Exhibit 18

Percentage of total patients clinically ready for discharge waiting over six weeks, by NHS board, as at July 2007

Over 40 per cent of patients clinically ready to be discharged from hospital in Scotland are waiting longer than six weeks to be discharged.

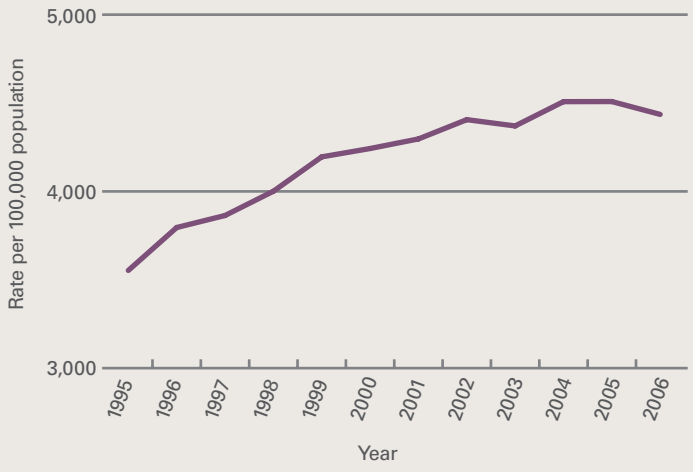


Note: The number at the top of each column represents the total number of patients clinically ready for discharge in each board.
Source: ISD delayed discharge national statistics release

Exhibit 19

Rate per 100,000 population of patients aged 65 and over with two or more emergency admissions within one year, 1995 to 2006

Elderly readmissions have been rising for the last ten years, but reduced slightly in 2006.



Source: ISD Scotland

which is underpinned by five strategic objectives (wealthier and fairer, smarter, healthier, safer and stronger, and greener). These strategic objectives are in turn supported by 15 national outcomes which will be measured through 45 national indicators and targets. All performance management systems across the public sector will be aligned to a single set of priorities.

Several initiatives to improve performance management are in place but need to link to the wider work on outcomes

53. Effective performance relies on the monitoring of information on a range of factors: costs, inputs, outputs and outcomes. The Scottish Government has several initiatives in place or under development to gather this information. However, these initiatives are currently not fully coordinated to allow these factors to be monitored together to give an overall picture of performance.

54. Current national initiatives include:

- reviewing health improvement measures
- developing outcome measures for community care
- developing cost information using NHS tariffs[28]
- contributing to the UK-wide review of productivity measures[29 30]
- exploring the use of programme budgeting to identify true costs of specific services (Case study 1).

55. It is essential that all these initiatives support the wider Scottish Government aims of developing outcome measures across public services.

Case study 1
Programme budgeting

Programme budgeting is designed to identify how healthcare spending is being used, to raise questions about the appropriateness of current patterns of spending and to assess whether changes in spending would represent better value for money. In 2002, the Department of Health initiated the National Programme Budget Project. The project involves mapping all spending to 23 programmes of care based on medical conditions such as mental health, CVD and cancer.

This approach enabled Norwich Primary Care Trust (PCT) to identify programmes, eg mental health, where there were high levels of spending and poor levels of health compared to similar PCTs. This raised questions about whether money was being spent appropriately and whether services were being delivered effectively. Further analyses revealed high spending on hospital care and GP prescribing for people with mental illness.

This information was shared with the public and with clinicians. It encouraged dialogue about the models of mental health services that would best meet people's needs, and options for changing the way services were delivered. This has enabled savings to be made on the prescribing and hospitals budgets, freeing up resources that have been invested in alternatives to hospital admission and medication.

Source: Director of Public Health, York and North Yorkshire PCT

Recommendations

The Scottish Government should:

- Ensure that information on the performance of the NHS is publicly reported and brings together data on costs, outcomes, targets, productivity, patient satisfaction and experience. It should assess performance against all these elements together to better inform decision-making.
- Ensure the performance management system for the NHS in Scotland fits with wider developments around outcome measures across public services.

28 The national tariff sets costs for activity carried out by one NHS board for patients who reside in another board. This would allow each board to compare its cost of providing a particular service against the national standard cost.
29 *Atkinson Review: Final Report, Measurement of Government Output and Productivity for the National Accounts*, HMSO, 2005.
30 *Measuring quality as part of public service output*, strategy following consultation, UK Centre for the Measurement of Government Activity, July 2007.

Part 3. How is the NHS planning for major changes?

New ways of delivering services are being developed throughout the NHS but improvements are needed to the way the benefits from these changes are identified.

Key messages

- New ways of delivering services are being developed and implemented throughout the NHS, including Community Health Partnerships and a move from hospital to community-based services, but there is no evidence that resources are shifting along with these changes. CHPs now need to focus on delivering benefits for patients rather than structures and processes.
- Improvements are needed to the way the benefits of service changes, including CHPs and pay modernisation, are identified, measured and monitored.
- Clinical governance arrangements are adequate in most boards but there is scope for improvement.

The NHS is undergoing a period of service redesign

56. In planning for major changes the NHS needs to focus on ensuring it has good information on costs, workforce and outputs. In previous Audit Scotland reports we have highlighted that the information has not always been good enough, and in the current period of major change it is important that this is addressed.

57. The way services are delivered in the NHS is changing. Recent reports on the NHS, including the Kerr Report *Building a Health Service Fit for the Future*, the Scottish Executive's response *Delivering for Health* and the Government's current consultation *Better Health, Better Care*, have signalled a period of service redesign to shift the balance of care from hospitals to community settings.[31 32 33] This is partly in response to the challenges of an ageing population, which could see a rise of 81 per cent in the number of over 75s between 2006 and 2031, and an increasing number of people with a long-term condition, of whom there are estimated to be one million in Scotland.[34 35] Other reasons for redesigning services are to provide a better quality of care, comply with the European Working Time Directive, make better use of staff and improve waiting times.

58. All boards are reviewing their services. These programmes of change range in size but are significant to the individual boards including NHS Greater Glasgow and Clyde's plans to invest £750 million in acute services, and NHS Dumfries and Galloway which is investing £19 million in redesigning and modernising mental health services. The Scottish Government has recently introduced independent scrutiny panels to review boards' service redesign proposals before they are fully approved.

There is no evidence that resources are shifting to community provision

59. Although boards are redesigning services to provide more locally based care, the analysis of total costs shows that the balance of expenditure between hospital and community services has not yet changed (Exhibit 20). This suggests that resources are not shifting in line with planned changes.

60. The Audit Scotland report on managing long-term conditions, published in August 2007, concluded that there is limited information available to form the basis of decisions about the best use of resources and how to shift the balance of care.[36] There are no targets for this and boards are taking different approaches. There are a number of barriers to moving resources, including the significant amount of resources tied up in secondary care and the need to maintain hospital services during periods of change.

To date Community Health Partnerships have focused on structures and processes and now need to focus on delivering benefits for patients

61. CHPs were developed to help facilitate moving services from acute to community settings.[37] All boards have now created CHPs, with different types of arrangements with councils being developed; for example some CHPs have also incorporated social care into the arrangement making Community Health and Care Partnerships. Five boards have a single CHP covering the whole board area, the majority have two or three CHPs, while NHS Lothian has four and NHS Greater Glasgow and Clyde has ten.

62. CHPs appear to be making slow progress; to date CHPs have focused on structures and processes but they now need to focus their attention on delivering benefits for patients.

63. Auditors, in their annual audit reports, highlighted a number of areas of good practice currently in place at CHPs, together with a number of common challenges that need to be addressed over the next year (Exhibit 21, page 22).

Workforce planning is a key part of service redesign

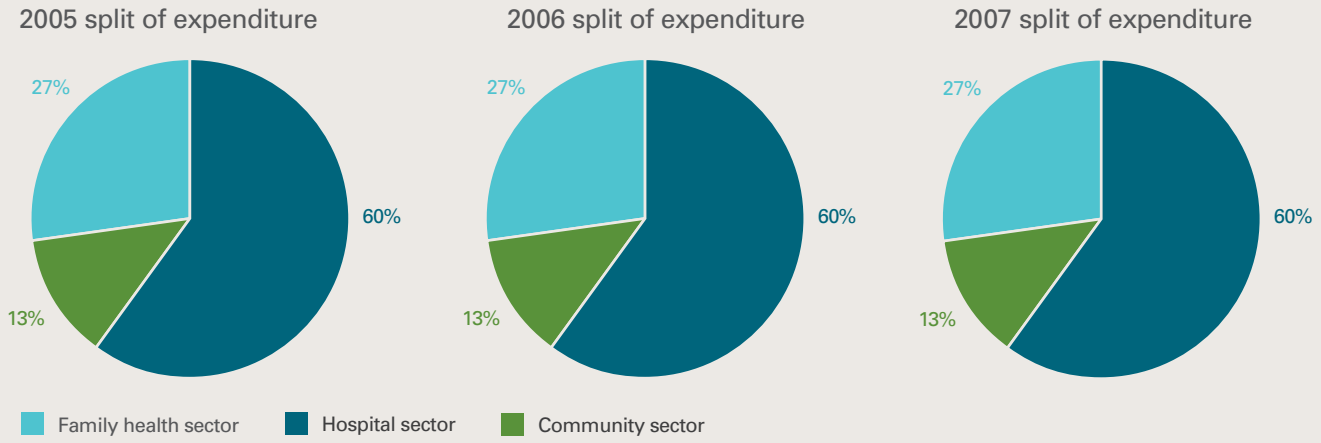
64. Successful redesign of services needs to be supported by having the right number and mix of staff in place. This may include redefining the roles of some staff.

31 *Building a Health Service Fit for the Future*, Scottish Executive, 2005.
32 *Delivering for Health*, Scottish Executive, 2005.
33 *Better Health, Better Care: A discussion document*, Scottish Executive, August 2007.
34 *Projected population of Scotland* (2006 based), GROS, October 2007.
35 *Managing long-term conditions*, Audit Scotland, August 2007.
36 *Managing long-term conditions*, Audit Scotland, August 2007.
37 References to CHPs include community health and care partnerships (CHCPs) and community health and social care partnerships (CHaSCPs).

Exhibit 20

Expenditure by NHS sector, 2005-2007

The split of expenditure among sectors has not changed over the last three years, even though the way services are provided has changed.



Source: ISD

65. The total consultant vacancy rate has fallen from a peak of 7.8 per cent in 2005 to 7.0 per cent in 2006, while the rate for posts vacant for more than six months has remained static over the same time period at 4.2 per cent.[38] Nurse vacancy rates have continued to decrease, falling below three per cent in 2006.[39] Under the new General Medical Services contract GP practices no longer have to provide workforce information.

66. The Audit Scotland report on primary care out-of-hours services highlighted that NHS boards have begun to develop extended roles for NHS staff so that staff such as paramedics and nurses can contribute to the care of patients in the out-of-hours period.[40]

Workforce plans are now being integrated with local delivery plans

67. All boards complete workforce plans, which are now being integrated with other planning documents, including the local delivery plan. In the National Workforce Plan 2006, the Scottish Executive stated that boards should further develop and improve the integration of workforce planning with service planning and financial planning.[41] The plan also noted that a significant challenge for boards has been projecting staffing requirements for the future, and that they were not linking their workforce planning with their Delivering for Health plans.

68. While boards are putting in place strategies and services to shift the balance of care from acute to community care, it is unclear whether they are adequately planning for the financial and human resources to match this shift. Integrating workforce and delivery plans should help.

The use and cost of agency nurses has decreased

69. The use of agency nurses has decreased with an equivalent decrease in costs, but bank nurse numbers and costs have continued to rise (Exhibit 22, page 23). The 2007 Audit Scotland follow-up report on ward nursing emphasised the need to review the appropriate use of bank nurses. The Scottish Government recently wrote to chief executives setting out the improvements needed to meet the recommendations included in the Audit Scotland report, and encouraged the use of national workload and workforce planning tools for nursing and midwifery.[42 43]

Agenda for Change is still being implemented but the impact and benefits have not been adequately measured

70. Pay modernisation in the NHS in Scotland continues, with new contracts for consultants and GPs and changes to out-of-hours working in primary care. Boards have made slow progress with the implementation of Agenda for Change since 2004. Agenda for Change covers most NHS staff and aims to harmonise pay scales and terms and conditions throughout the NHS. Implementation

38 www.isdscotland.org
39 www.isdscotland.org
40 *Primary care out-of-hours services*, Audit Scotland, August 2007.
41 *National Workforce Plan 2006*, Scottish Executive, December 2006.
42 *Planning ward nursing – legacy or design, a follow-up report*, Audit Scotland, January 2007.
43 *Implementation of Nursing and Midwifery Workload and Workforce Planning Tools and Methodologies*, CEL (2007) 06, Scottish Executive, August 2007.

Exhibit 21

Common examples of good practice and future challenges within CHPs

While CHPs have shown a number of good practice features, they still have a significant number of future challenges to face.

Good practice	Future challenges
Established a single management structure in conjunction with the council.	CHPs are not fully accountable for a number of areas of expenditure they manage, therefore they may not be able to bring in the expected improvements.
Integrated performance management with performance measures brought together from the NHS board and the council, and using same performance management techniques as the rest of the organisation.	Multiple lines of monitoring and reporting and a lack of clarity over accountability may lead to a lack of transparency in decision-making.
Council staff given authority to commit NHS board budgets.	Performance measures to meet specific needs and identify service improvements of CHPs are not yet fully developed.
CHP objectives clearly aligned to NHS board, council and social work services plans as well as the community plan.	Information sharing between the board and the council is currently mainly paper-based.
CHP budgets aligned to CHP objectives.	No scheme of delegation in place, therefore there is a risk that accountability for decision-making is not clear.
Joint strategies devised to address poor delayed discharge performance.	Contingency plans detailing how CHP services will be provided if there is a loss of ICT service are not fully defined.
Reviewing possibility of devolving more of budget to CHP level.	No pooled budgets between the board and the council.
CHP general managers fully involved in budget setting process, savings identification and capital planning process.	

Source: Board Annual Audit reports for 2006/07

of the contract began in October 2004. By May 2007, 94 per cent of the workforce across Scotland had moved onto the new pay system.[44] The larger boards are among those behind the national average for progress, while special boards also lag behind due to the number of staff who do not fit national job profiles. Part 4 covers the cost pressures of pay modernisation in more detail.

71. It is unclear whether the full benefits of pay modernisation have been identified and are being monitored. Previous Audit Scotland reports have commented on the weaknesses of benefits realisation plans. The 2006 report *Implementing the NHS consultant contract in Scotland* stated that plans did not yet provide evidence of clear benefits to the NHS and the 2007 report *Primary care out-of-hours services* concluded that plans were not measuring the achievement of the benefits originally set out.[45 46]

Clinical governance arrangements are adequate but scope for improvement remains

72. In October 2005, NHS QIS issued clinical governance and risk management standards for implementation by all NHS boards including special health boards. The standards incorporate the key best value criteria of sound governance and cover the following areas:

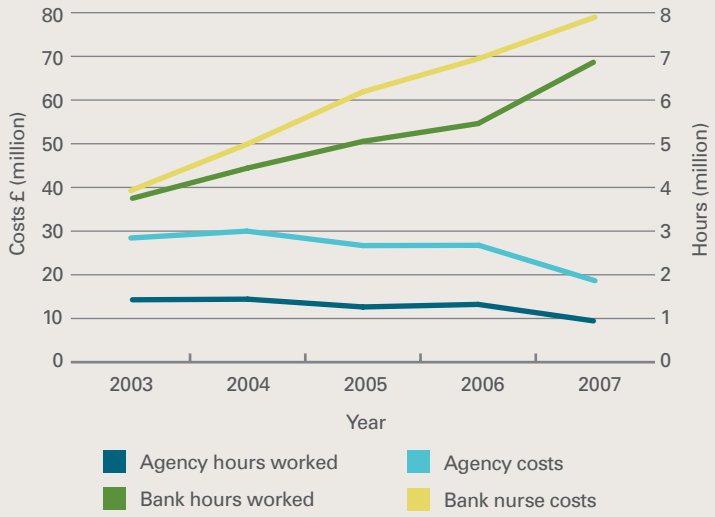
- safe and effective care and services (eg, risk management)
- the health, wellbeing and care experience (eg, access, referral, treatment and discharge)
- assurance and accountability (eg, clinical governance and external communication).

44 Answer to Parliamentary Question: S3W-1184.
45 *Implementing the NHS consultant contract in Scotland*, Audit Scotland, March 2006.
46 *Primary care out-of-hours services*, Audit Scotland, August 2007.

Exhibit 22

Use and cost of bank and agency nurses, 2003-2007

The last five years has seen a reduction in the number of agency hours worked and an equivalent decrease in costs. The number and costs of bank nurses has continued to rise.



Source: ISD Scotland

73. During 2006/07, NHS QIS completed a full assessment of boards' performance against these standards and concluded that most were performing adequately but that there was scope for improvement (Exhibit 23, overleaf). As this was the first year of the standards it was expected that many boards would be at the implementation or monitoring stage of performance, with scope to continue to develop their performance in future years.

74. NHS QIS found that boards had made good progress in some areas including risk management and emergency planning but there were several common areas which posed challenges.[47] These included:

- strategic planning, where boards were found to be not yet fully coordinating strategic activities
- business continuity, an issue which was also reported by local auditors
- information governance, which includes data protection, records management and IT security.

75. NHS Western Isles and NHS Orkney were the poorest performing boards. This is confirmed by auditors' annual reports for these boards, which also identified the need for significant improvements to clinical governance and risk management, and corporate governance.

There have been significant changes in senior management at some boards

76. During 2006/07, a number of boards, including the Scottish Ambulance Service, NHS National Services Scotland, NHS Western Isles and NHS 24, had significant changes in senior positions with interim managers being appointed in some cases. Leadership was seen as a key risk by auditors, with significant senior management changes and vacancies adding to the risk presented by complex and significant future challenges. The 2005 Audit Scotland report on leadership indicated the importance of this issue and the quality of leadership is a key best value criteria.[48]

77. We have reported in previous overview reports on boards' progress with single system working following the abolition of NHS trusts in Scotland. During 2006/07, larger boards continued to make progress with integration, for example NHS Tayside created a new organisational structure at the start of 2006/07 to allow single system working to fully function. In April 2006, NHS Greater Glasgow and NHS Highland took over responsibility for the former NHS Argyll and Clyde and have integrated those functions during the year. Difficulties for the two boards included the use of different financial ledgers, IT systems and governance structures.

Recommendation

- The Scottish Government should ensure that the costs and benefits of major changes such as service redesign, pay modernisation contracts and the introduction of CHPs are fully identified, monitored and measured.

47 *Vital Systems: The health of NHSScotland*, NHS QIS, August 2007.
48 *Leadership development: How government works*, Audit Scotland, November 2005.

Exhibit 23

NHS QIS assessments of NHS board performance against clinical governance and risk management standards

Most boards are performing adequately against the clinical governance and risk management standards but there is scope for improvement.

	Total score	Standard 1 actual score: Safe and effective care and services	Standard 2 actual score: The health, wellbeing and care experience	Standard 3 actual score: Assurance and accountability
NHS Ayrshire and Arran	6	2	2	2
NHS Borders	6	2	2	2
NHS Dumfries and Galloway	6	2	2	2
NHS Fife	6	2	2	2
NHS Forth Valley	6	2	2	2
NHS Grampian	6	2	2	2
NHS Greater Glasgow and Clyde	6	2	2	2
NHS Highland	8	2	3	3
NHS Lanarkshire	6	2	2	2
NHS Lothian	5	2	1	2
NHS Orkney	3	1	1	1
NHS Shetland	7	2	3	2
NHS Tayside	7	2	2	3
NHS Western Isles	3	1	1	1
NHS 24	5	1	2	2
NHS Education Scotland	8	2	3	3
National Waiting Times Centre Board	6	2	2	2
NHS Health Scotland	5	1	2	2
NHS National Services Scotland	6	2	2	2
Scottish Ambulance Service	10	3	3	4
The State Hospital	8	2	3	3

Each standard is scored out of four, with the total score being the scores for each individual standard added together. The score represents the following position of the board in the continuous improvement cycle:

1 – Development stage
2 – Implementation stage
3 – Monitoring stage
4 – Reviewing stage

Source: NHS QIS

Part 4. How did the NHS perform financially?

The financial performance of the NHS in Scotland has improved with an overall revenue underspend of £31 million.

Key messages

- The financial performance of boards improved in 2006/07 with an overall underspend against the revenue budget. Only one board did not meet a financial target.
- Boards are continuing to use non-recurring income to support their revenue position, but this does not represent a large financial risk for most boards.
- Boards face a number of cost pressures. These include potential liabilities arising from equal pay claims, although these are not yet quantified.
- In 2006/07, the NHS reported that it delivered Efficient Government savings of £358 million against a target of £353 million.

The financial performance of the NHS improved in 2006/07

78. Overall the NHS in Scotland underspent against its budget by £98 million in 2006/07. This comprised a revenue underspend of £31 million and an underspend on capital of £67 million (Exhibit 24).

79. NHS boards underspent their annual revenue budgets by £113.2 million (Exhibit 25), while the Scottish Executive Health Department (SEHD) overspent its budget by £80 million. There was a revenue underspend of £31 million for the whole of the NHS.

NHS Western Isles was the only board that failed to meet a financial target

80. The Scottish Government has three financial targets for NHS bodies, which are that they should stay within their:

- Revenue Resource Limit (RRL) – this is the revenue budget allocated for the day-to-day operation of services. Underspends against the RRL, where approved, may be carried forward to the next year.
- Capital Resource Limit (CRL) – this is the funding that a health body has available for capital programmes.
- Cash Requirement – this is the amount of cash that may be drawn down by NHS bodies to fund ongoing operational costs and new capital investment.

Exhibit 24

Overall NHS financial position including the Scottish Executive Health Department, 2005/06 and 2006/07

The NHS in Scotland spent a total of £9,402 million in 2006/07. This resulted in an underspend of £98 million against its overall budget.

NHS in Scotland outturn	2005/06 £ million	2006/07 £ million
Revenue budget	8,651	9,109
Capital budget	305	391
Total budget	**8,955**	**9,500**
Revenue expenditure	8,651	9,078
Capital expenditure	234	324
Total expenditure	**8,885**	**9,402**
Revenue underspend/(overspend)	(0)	31
Capital underspend/(overspend)	71	67
Total underspend/(overspend)	**71**	**98**

Source: Audit Scotland

Exhibit 25

NHS bodies, financial position 2006/07

The total cumulative underspend for all NHS bodies is £113.2 million in 2006/07, an increase of £43 million on 2005/06.

	RRL	Outturn	Cumulative underspend/ (overspend)	Cumulative underspend/ (overspend)
	2006/07 £ million	2006/07 £ million	2006/07 £ million	2005/06 £ million
NHS boards	7,496.7	7,407.6	89.1	45.4
Special boards	993.9	969.7	24.1	24.2
Total	8,490.6	8,377.3	113.2	69.6

Source: NHS board annual accounts

81. The total RRL underspend of £113 million for 2006/07 was made up of an underspend by NHS boards of £89 million and £24 million for the special boards.

82. In 2006/07, only NHS Western Isles did not meet its RRL target although there were no accounts qualifications. This is an improvement on 2005/06 when two boards overspent their RRL (NHS Western Isles and NHS Lanarkshire) and the accounts of NHS Highland were qualified. Appendix 2 provides a position statement for boards' performance against their financial targets.

83. NHS Western Isles has overspent its RRL for the last four years. Its total cumulative deficit now stands at £3.4 million, with an in-year deficit against the RRL of £0.9 million. While NHS Western Isles plans to reduce this deficit in 2007/08, its auditor has expressed concerns that there is a risk that a deficit position will be recorded again. The Auditor General reported to Parliament on these matters in November 2007, under Section 22 of the Public Finance and Accountability (Scotland) Act 2000. A report was also made to Parliament under the same provision on the Mental Health Tribunal for Scotland Administration on its need to improve its governance arrangements.

84. NHS Lanarkshire moved from a cumulative deficit position to a cumulative surplus within 2006/07. The deficit was mainly cleared through the sale of surplus land at the former Law Hospital. This action was planned and had been included within the board's financial plan for a number of years.

Fifteen boards still rely on non-recurring funding to break even but for most this does not represent a major financial risk

85. In previous overview reports we have commented on boards' reliance on non-recurring funding in order to break even and meet their RRL targets. The underlying recurring position of boards identifies the income and expenditure boards must incur every year to provide services, and whether they spend more than they receive (underlying recurring deficit) or vice versa (underlying recurring surplus). This then outlines the level of reliance that boards must place on non-recurring funding in order to make up the deficit position.

86. The NHS in Scotland had an overall underlying recurring deficit of £92 million in 2006/07, representing only one per cent of recurring income. This is a small proportion of the recurring income that boards receive each year. Boards are forecasting this deficit to reduce to 0.28 per cent of recurring income in 2007/08 (Exhibit 26, overleaf).

87. NHS Western Isles and NHS Orkney have recurring deficits of £6.8 million (12.14 per cent of recurring income) and £2.58 million (7.93 per cent) respectively. This is a substantially higher proportion than for other NHS boards and represents a significant risk. Their forecast underlying recurring deficits for 2007/08 also remain relatively high compared to the other boards. We have already noted that NHS Western Isles did not meet its financial targets for 2006/07 and this high underlying recurring deficit highlights the financial difficulty facing the board. The auditors of NHS Orkney reported that at the time of the audit, the board did not have a savings plan in place to address the forecast underlying deficit position.

88. NHS Greater Glasgow and Clyde has the highest deficit of the boards in purely monetary terms, but this represents only 1.26 per cent of its recurring income. This underlying recurring deficit is linked to the board's inheritance of a recurring deficit of £30.5 million relating to the Clyde region. NHS Greater Glasgow and Clyde is receiving transitional funding from the Scottish Government to help manage the deficit, but it acknowledges the difficulties in managing down this deficit and in reducing the transitional funding.

Boards continue to use non-recurring funding to support their revenue position

89. Despite the improved position overall, NHS boards had to use non-recurring funding and non-recurring savings to record an overall surplus. Types of non-recurring income include support from the Scottish Government and proceeds from the sale of assets. Boards continue to use one-off sources of money to meet recurring expenditure; they should be aiming to be in recurring balance and minimise reliance on non-recurring income to pay for day-to-day running costs.

Boards generated a gain of £74 million by disposing of assets

90. In 2006/07, NHS boards disposed of assets with a net book value of £51 million, generating a profit of £74 million.[49] The NHS boards that generated the largest profits on disposal were:

- NHS Greater Glasgow and Clyde (£33 million)
- NHS Grampian (£9 million)
- NHS Lanarkshire (£12 million)
- NHS Lothian (£11 million).

Exhibit 26

NHS bodies underlying recurring deficit /surplus, actual 2006/07 and forecast 2007/08

The NHS in Scotland has an underlying recurring deficit of £92.36 million, representing only 1.02 per cent of recurring income. This is forecast to reduce in 2007/08 to a deficit representing 0.28 per cent of recurring income.

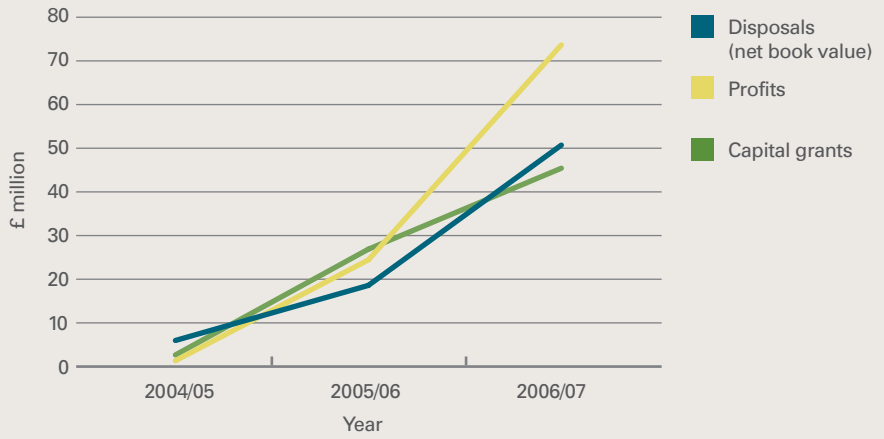
	2006/07 Actual		2007/08 Forecast	
	Underlying recurring deficit (-)/surplus £m	As a % of recurring income	Underlying recurring deficit (-)/surplus £m	As a % of recurring income
NHS Ayrshire and Arran	-0.28	-0.05	0.00	0.00
NHS Borders	-0.50	-0.28	0.20	0.10
NHS Dumfries and Galloway	1.31	0.53	3.99	1.55
NHS Fife	2.40	0.48	-0.90	-0.17
NHS Forth Valley	-2.50	-0.67	0.00	0.00
NHS Grampian	-21.90	-2.75	-6.40	-0.78
NHS Greater Glasgow and Clyde	-30.00	-1.26	-24.80	-0.99
NHS Highland	-8.83	-1.60	-7.20	-1.24
NHS Lanarkshire	-7.20	-0.99	4.90	0.63
NHS Lothian	-18.00	-1.81	-16.00	-1.53
NHS Orkney	-2.58	-7.93	-2.10	-5.87
NHS Shetland	-1.20	-3.75	-1.20	-3.29
NHS Tayside	-7.19	-1.04	3.78	0.52
NHS Western Isles	-6.80	-12.14	-7.00	-11.86
Total for NHS boards	**-103.27**	**-1.27**	**-52.73**	**-0.61**
NHS National Services Scotland	6.40	2.83	11.20	4.70
Mental Welfare Commission for Scotland	0.27	6.81	0.00	0.00
The National Waiting Times Centre Board	2.31	4.13	5.69	7.19
NHS 24	-2.00	-3.98	0.30	0.58
NHS Education for Scotland	5.00	1.46	6.80	1.85
NHS Health Scotland	-0.60	-3.29	-0.46	-2.66
NHS Quality Improvement Scotland	0.01	0.08	-0.03	-0.20
Scottish Ambulance Service Board	0.04	0.02	0.00	0.00
State Hospitals Board for Scotland	-0.54	-1.66	2.35	6.98
Total for special boards	**10.91**	**1.19**	**25.85**	**2.62**
Total for all NHS bodies	**-92.36**	**-1.02**	**-26.88**	**-0.28**

Source: Unaudited returns from the NHS bodies

Exhibit 27

Sale of assets and capital grants, 2004/05 to 2006/07

Profits from the sale of assets have risen to £74 million in 2006/07. Capital grants have also been increasing steadily for three years.



Source: Unified Board Summaries

91. Exhibit 27 shows that the profit from sale of assets has increased significantly over the past three years. 2006/07 was the last year that the profits from the sale of assets could be used to fund revenue expenditure. From 2007/08 these funds will have to be used for capital purposes.

Boards are still able to make capital grants

92. Boards still have powers to make capital grants to other bodies that create or develop assets for their own use for the benefit of the board's residents, for example, contribution to care facilities being developed by the council. These grants have to meet specific criteria as set out in the Scottish Government Capital Accounting Manual. These criteria are that:

- Boards must be able to demonstrate that the recipient body has agreed to use the funding for specific capital purposes.
- Expenditure should meet the definition of capital expenditure as applied by the board.
- Grants should only be used by external bodies for the benefit of the board's residents.

93. All capital grants used in 2006/07 met these criteria according to auditors but some commented that more robust records would have to be maintained in the future. Exhibit 27 shows that the use of capital grants has increased significantly in the past three years. The NHS boards using the most capital grants in 2006/07 were:

- NHS Grampian (£4 million)
- NHS Greater Glasgow and Clyde (£8 million)
- NHS Lothian (£18 million)
- NHS Tayside (£6 million).

94. Using capital grants also allows boards to fund capital assets without affecting revenue resources as these costs are picked up by the other organisation. No assets appear on the boards' accounts so they also avoid paying capital charges.

Boards cited service redesign, pay modernisation, waiting times initiatives and drugs costs as key cost pressures

95. While the level of underlying recurring deficits is small relative to recurring income and is forecast to reduce in 2007/08, the challenge of meeting these forecasts should not be underestimated. Boards continue to face increasing cost pressures and this, combined with reduced flexibility in their use of capital funds, means that the risk of boards not meeting these forecasts is increased. The main cost pressures cited by boards include service redesign, pay modernisation contracts, meeting targets including waiting times, and drugs costs.

Service redesign may have a financial impact

96. Service redesign as envisaged by the Kerr Report was not intended to incur any extra cost to the NHS. However, it is not necessarily cost neutral in the short to medium term and there is no evidence to show that resources are shifting with the balance of care. Many of the cost pressures associated with service redesign are difficult to quantify.

97. The NHS needs to maintain current hospital provision until new services have been put in place. This may cause 'double-running' with sections of old and new services running at the same time. Boards also incur higher depreciation charges on assets that have been designated as surplus to requirements as they have to write down the asset over a shorter period. The Scottish Government has currently funded all accelerated depreciation incurred by boards and provision has been made in the Capital Accounting Manual for 2007/08 for this to continue. Therefore, while boards currently remain unaffected this remains a cost pressure for the Scottish Government.

98. Some boards may need to identify additional savings targets to be able to balance their budgets once the new developments are in place. For example, NHS Forth Valley will need to release additional savings of £2.4 million once the annual charge for the new Larbert hospital is included within its budget.[50]

Pay modernisation is a source of cost pressure for boards

99. Pay modernisation was cited as a cost pressure by most boards. As implementation of Agenda for Change was not complete by March 2007, boards had to make accruals for the amount of back pay still due to be paid to staff. Boards expect that further cost pressures will arise in future years due to incremental increases in pay. This is where, under their previous contract, a member of staff may have been at the top of their pay band, but moved to a new pay band under Agenda for Change and so become entitled to incremental increases in pay again. Boards have also had to estimate the impact of any appeals by staff against their Agenda for Change grading. This could have a financial impact and will need to be managed throughout 2007/08.

Equal pay claims are not yet quantified

100. Equal pay is also an issue for the health service in Scotland. The NHS in Scotland received over 10,000 claims for backdated pay increases arising from the provisions included within the Treaty of Rome and the Equal Pay Directive. All claims have been referred to the NHS's Central Legal Office. However, for 2006/07, auditors reported that they were unable to obtain any estimate of the potential liability being faced by the boards. The auditors accepted this position for 2006/07, with a contingent liability with no value being included in the accounts of all boards affected. However, auditors reported that they would have expected further details to have been available to boards, including a reasonable estimate of each board's liabilities. They encouraged each board to work with the Scottish Government to resolve the matter in advance of the compilation of the 2007/08 financial statements and audit.

Drugs costs have levelled out but are still a cost pressure for boards

101. There has previously been a significant growth in spending on prescribing but this has now levelled out and expenditure has been around £1 billion for the last three years.[51] In 2006/07, some boards noted that drugs costs were lower than anticipated, delivering cost savings. Further savings of £38 million were also delivered through the new pharmacy contract as part of the Efficient Government Initiative.[52] However, boards continue to identify drugs as a cost pressure as new drugs and technologies are introduced, making it difficult for boards to forecast expenditure.

102. Boards also cite waiting times initiatives as a cost pressure. The total amount spent on decreasing waiting times is unknown but boards are facing continual pressure to meet waiting times targets in all areas. This often involves some service redesign or redesign of the patient pathway.

Provisions for clinical and medical negligence claims continue to rise while the cost of settlement decreases

103. NHS boards are setting aside increasing amounts of money to provide for potential clinical and medical claims. Provisions and contingent liabilities for clinical and medical negligence claims have increased over the last three years from £134 million to £208 million (Exhibit 28). The amount set aside and the treatment of each claim within the financial statements depends on the estimated probability of its success, as provided by the Central Legal Office.

Exhibit 28

Clinical and medical provisions and contingent liabilities, 2005-2007

NHS boards are forecasting that increasing amounts will be paid out in clinical and medical claims.

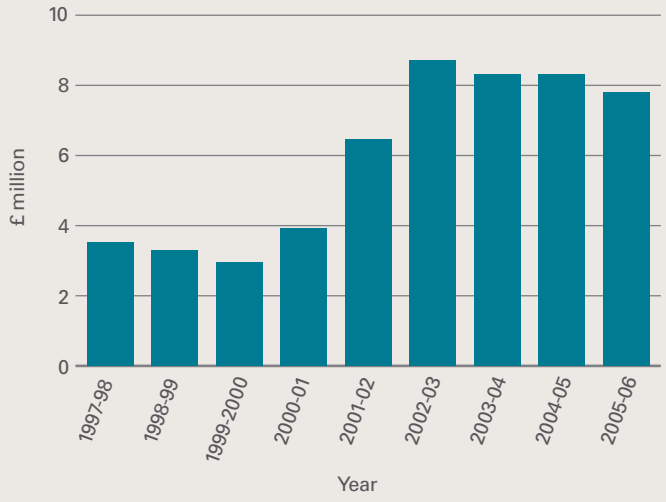
Source: Unified Board Summaries

50 Annual Report to Forth Valley Health Board and the Auditor General for Scotland 2006/07, Scott-Moncrieff.
51 www.isdscotland.org
52 *Efficient Government return*, Scottish Executive, 2007.

Exhibit 29

Cost of settlement of clinical and non-clinical claims 1997/98-2005/06

The amount actually paid out to settle negligence claims has decreased for the last four years, although it has grown significantly over the past nine years.



Source: Answers to parliamentary questions S2W-17415 and S2W-31331

104. Exhibit 29 shows that the amount actually paid out in clinical and medical claims increased nearly three-fold between 1999/2000 and 2003/04 but has decreased since then.

Efficient Government savings targets were reported to be met

105. The Scottish Executive launched its Efficient Government Initiative *Building a Better Scotland* in June 2004. In 2006/07, the NHS reported that it delivered Efficient Government savings of £358 million against a target of £353 million. NHS boards were targeted to make a one per cent recurring efficiency saving, which was a cumulative target of £134 million over two years. The boards reportedly met this target with £137 million of savings over two years.[53]

106. The majority of savings were cash-releasing (81 per cent), while time-releasing savings were 40 per cent below target. This is mainly because boards in total only met 17 per cent of the target to reduce sickness absence. Initiatives where savings were above target were NHS procurement and improved prescribing. This corresponds with a reduction in cost pressure reported by auditors (paragraph 101). A new approach has been developed to shared services, using certain boards to act as pathfinders after the original final business case was not taken forward.

Recommendation

- NHS boards should aim to be in recurring financial balance and minimise the use of non-recurring income on day-to-day expenditure.

53 *Efficient Government return*, Scottish Executive, 2007.

Appendix 1.

Performance against HEAT targets

Identifier	Target Details	Description	Published	Latest performance
1.01.K	Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.	Crude CHD Mortality Rate (per 100,000 population), for people aged under 75, in the 20% most deprived postcode sector areas in Scotland, defined by the Carstairs Deprivation Index.	Not in this format	Not available – data not published in appropriate format
1.02.K	To reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010).	Numbers smoking as a % of relevant (+16 years) population.	Yes – Scottish Household Survey	25% (all Scotland) – 2006
1.03.K	95% uptake target for all childhood vaccinations (ongoing).	MMR uptake rates (% at 24 months old).	Yes – ISD website	92.1% (all Scotland) – June 2007
1.04.K	Reduce suicide rate between 2002 and 2013 by 20%.	Deaths caused by intentional self-harm and events of undetermined intent expressed as a rate per 100,000 population.	Yes – General Register Office for Scotland and ISD website	2002 – 899 deaths 2006 – 765 deaths (15% fall since 2002)
2.01.K	NHS boards to operate within their revenue resource limit; operate within their capital resource limit; meet their cash requirement.	Forecast deficit or surplus for 'End financial year' against total revenue resource limit.	Yes – individual boards' annual reports published on their websites	See Appendix 2
2.02.K	Sickness Absence Rate: 4% by 31 March 2008.	Hours lost due to sickness absence expressed as a percentage of total hours available.	Yes – ISD website	31 March 2007 – 5.55% (all Scotland)
3.01.K	Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours from April 2004.	Percentage coverage of NHS board population, using list sizes for GP practices taking part in Primary Care Collaborative.	No	N/a – data not published
3.02.K	60% of 5-year-old children (primary 1) will have no signs of dental disease by 2010.	Percentage of children aged 0-17 years registered with an NHS dentist.	Yes – ISD website	31 March 2007 – 67.2% of children registered

Identifier	Target Details	Description	Published	Latest performance
3.03.K	No patient with a guarantee should wait longer than six months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.	Number of inpatients/day case patients waiting over six months excluding ASCs.	Yes – ISD website	30 September 2007 – 0 patients waiting over 26 weeks
3.04.K	No patient with a guarantee should wait longer than six months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.	Number of inpatients/day case patients waiting over 18 weeks excluding ASCs.	Yes – ISD website	30 September 2007 – 1 patient waiting over 18 weeks
3.05.K	No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.	Number of inpatients/day cases on waiting list with an ASC.	Yes – ISD website	30 September 2007 – 16,745 patients with an ASC (of a total of 72,244 patients within the scope of the guarantee)
3.06.K	By the end of 2005, no patient will wait longer than six months from GP referral to an outpatient appointment, reducing to 18 weeks from 31 December 2007.	Number of new outpatients (GP/GDP referrals) waiting over 26 weeks excluding ASCs.	Yes – ISD website	30 September 2007 – 138 patients waiting over 26 weeks
3.07.K	By the end of 2005, no patient will wait longer than six months from GP referral to an outpatient appointment, reducing to 18 weeks from 31 December 2007.	Number of new outpatients (GP/GDP referrals) waiting over 18 weeks excluding ASCs.	Yes – ISD website	30 September 2007 – 10,956 patients waiting over 18 weeks
3.08.K	By end 2007, no patient will wait more than four hours from arrival to discharge or transfer for accident and emergency treatment.	The percentage of patients seen waiting no more than four hours from arrival to discharge or transfer for accident and emergency treatment.	Yes – ISD website	September 2007 – 97% (all Scotland)

Identifier	Target Details	Description	Published	Latest performance
3.09.K	By end of 2007, the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.	Number of inpatient/day case patients waiting over 18 weeks.	Yes – ISD website, but data currently under development	Data captured in two sections: 30 September 2007 – number of patients waiting for an outpatient appointment: 485 of total of 2,422; 30 September 2007 – Number of patients waiting for a procedure: 811 out of a total of 4,146
3.10.K	By end of 2007, the maximum wait from admission to a specialist unit to hip surgery, following fracture, will be 24 hours.	Percentage of hip fractures operated on within 24 hours.	Yes – hip fracture audit website	86.3% – 2007 hip fracture audit annual report
3.11.K	Women who have breast cancer and need urgent treatment will get it within one month where appropriate.	Percentage of patients treated within 31 days of diagnosis.	No	Not available – data not published
3.12.K (A)	By 31 December 2005, no patient urgently referred for breast cancer treatment should wait more than two months.	Percentage of patients treated within 62 days of urgent referral.	Yes – Scottish Government website	Quarter ending 31 March 2007: 94.2%
3.12.K (B)	By 31 December 2005, no patient urgently referred for colorectal cancer treatment should wait more than two months.	Percentage of patients treated within 62 days of urgent referral.	Yes – Scottish Government website	Quarter ending 31 March 2007: 81.9%
3.12.K (C)	By 31 December 2005, no patient urgently referred for lung cancer treatment should wait more than two months.	Percentage of patients treated within 62 days of urgent referral.	Yes – Scottish Government website	Quarter ending 31 March 2007: 83.1%
3.13.K	From June 30 2004, the maximum wait from angiography to surgery or angioplasty will be 18 weeks.	Number of angiography patients waiting over 8 weeks excluding ASCs.	Yes – ISD website, but data currently under development. Therefore data is provisional	30 September 2007: 0 patients waiting over eight weeks, out of a total of 798

Identifier	Target Details	Description	Published	Latest performance
3.14.K	From 30 June 2004, the maximum wait from angiography to surgery or angioplasty will be 18 weeks.	Number of revascularisation patients waiting over 18 weeks excluding ASCs (includes angioplasties and coronary artery bypass grafting).	Yes – ISD website, but data currently under development. Therefore data is provisional	30 September 2007: 0 patients waiting over 18 weeks, out of a total of 583
3.15.K	By the end of 2007, patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.	Longest prospective maximum wait for radiology investigation: CT scan.	Yes – ISD website, but data currently under development	30 September 2007: 0 patients waiting over 9 weeks out of a total of 4,093
3.16.K	By the end of 2007, patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.	Longest prospective maximum wait for radiology investigation: MRI scan.	Yes – ISD website, but data currently under development	30 September 2007: 14 patients waiting over 9 weeks out of a total of 5,949
3.17.K	By the end of 2007, patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.	Longest prospective maximum wait for endoscopy investigation: upper GI endoscopy.	Yes – ISD website, but data currently under development	30 September 2007: 37 patients waiting over 9 weeks out of a total of 3,489
3.18.K	By the end of 2007, patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.	Longest prospective maximum wait for endoscopy investigation: lower GI endoscopy (including colonoscopy).	Yes – ISD website, but data currently under development	30 September 2007: 67 patients waiting over 9 weeks out of a total of 5,740
3.19.K	A.11T: By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent. A.13.T: From the end of 2007, no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.	Revascularisation patients waiting more than ten weeks excluding ASCs (includes angioplasties and coronary artery bypass grafting).	Yes – ISD website, but data currently under development	Data captured in different sections. 30 September 2007: – rapid access chest pain clinic: 84 patients waiting over local target out of 984 – valve surgery: 33 patients waiting over 10 weeks out of 113 – other cardiac treatment: 8 patients waiting over 16 weeks out of 540, see also 3.13.K and 3.14.K

Identifier	Target Details	Description	Published	Latest performance
3.20.K	By end 2007, 75% of 999 emergency calls responded to within eight minutes.	Percentage of Category A ('999') calls responded to within eight minutes.	Yes – Scottish Ambulance Service Annual Report on the SAS website	2006/07: 55.7%
4.01.K	Reduce the number of people waiting to be discharged from hospital into a more appropriate care setting by 20% year on year between 2005 and the end of 2008, cutting to a minimum the number of people waiting more than six weeks to be discharged.	The total number of people waiting more than six weeks to be discharged.	Yes – ISD website	31 July 2007: 423 patients waiting over 6 weeks out of a total of 1,031 (33% decrease on 2006) 31 July 2006: 627 (17% decrease on 2005) 31 July 2005: 753
4.02.K	By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient two or more times in a single year by 20% compared with 2004/05.	Rate per 100,000 population (aged 65+) for patients multiply admitted two or more times as an emergency admission.	Yes – ISD website	31 March 2006: rate of 4,436 per 100,000 patients (all Scotland) 31 March 2005: rate of 4,508 (Decrease of 2%)
4.03.K	Cervical screening: a minimum of 80% of women aged 20-60 are screened at least once every five years.	The percentage of women in the 20-60 year old group attending a screening in the last 5.5 years.	Yes – ISD website	31 March 2007: 82.6% (all Scotland)
4.04.K	QIS clinical governance and risk management standards improving.	Number of points achieved (max 12) for three standards within QIS clinical governance and risk management assessment.	Yes – NHS QIS website and interim report	See Exhibit 23 (page 24)

Appendix 2.

Financial performance of NHS bodies 2006/07

NHS boards

	Revenue resource limit	Revenue resource outturn	Variance under/ (over)		Capital resource limit	Capital resource outturn	Variance under/ (over)
	£000	£000	£000		£000	£000	£000
NHS Ayrshire & Arran	573,615	560,615	13,000		23,843	23,843	0
NHS Borders	166,008	163,020	2,988		3,069	3,067	2
NHS Dumfries & Galloway	247,417	233,287	14,130		7,607	7,607	0
NHS Fife	493,625	488,605	5,020		15,479	15,477	2
NHS Forth Valley	386,242	385,652	590		9,154	9,139	15
NHS Grampian	682,161	675,824	6,337		25,130	24,566	564
NHS Greater Glasgow & Clyde	1,921,674	1,894,326	27,348		132,127	129,590	2,537
NHS Highland	492,698	485,869	6,829		14,804	14,368	436
NHS Lanarkshire	765,750	757,789	7,961		9,373	3,231	6,142
NHS Lothian	1,032,897	1,028,263	4,634		42,614	41,977	637
NHS Orkney	34,267	34,128	139		3,591	3,405	186
NHS Shetland	39,561	39,191	370		3,493	2,825	668
NHS Tayside	602,570	599,490	3,080		21,419	17,342	4,077
NHS Western Isles	58,223	61,587	(3,364)		3,795	2,650	1,145
Total for NHS boards	**7,496,708**	**7,407,646**	**89,062**		**315,498**	**299,087**	**16,411**

NHS special boards

	Revenue resource limit	Revenue resource outturn	Variance under/ (over)		Capital resource limit	Capital resource outturn	Variance under/ (over)
	£000	£000	£000		£000	£000	£000
NHS National Services Scotland	291,972	290,272	1,700		34,562	28,820	5,742
Mental Welfare Commission for Scotland	4,023	3,749	274		43	43	0
The National Waiting Times Centre Board	43,454	38,331	5,123		14,141	14,141	0
NHS 24	56,824	54,586	2,238		3,125	1,598	1,527
NHS Education for Scotland	356,408	343,285	13,123		99	99	0
NHS Health Scotland	22,595	22,084	511		50	31	19
NHS Quality Improvement Scotland	15,004	14,857	147		137	137	0
Scottish Ambulance Service Board	169,453	169,321	132		17,028	17,013	15
State Hospitals Board for Scotland	34,122	33,223	899		4,097	4,095	2
Total for special boards	**993,855**	**969,708**	**24,147**		**73,282**	**65,977**	**7,305**
Total for all NHS bodies	**8,490,563**	**8,377,354**	**113,209**		**388,780**	**365,064**	**23,716**

Appendix 3.

Glossary of terms

Accelerated depreciation	Where a board has approved a decision to close a property, the asset must be written down to its net realisable value over the estimated remaining life of the asset. The resulting increase in the annual depreciation charge is known as accelerated depreciation.
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.
Break even	Where income equals expenditure.
Capital charges	The notional revenue costs associated with fixed assets. This includes elements of depreciation and interest.
Capital grants	Payments by boards for securing or improving assets which will benefit the board, or its resident population, even though the assets will not be owned by the board.
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. Capital to revenue transfers ceased from 2006/07.
Cash-releasing savings	Where a saving is realised because the organisation or function delivers the same service with less money. For example, by delivering support services differently.
Cash requirement	This is 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 Health Partnership (CHP)	A partnership between health and social care and responsible for the delivery of a wide range of community health provision including GP services, pharmacy, social care and community nursing.

Community Health and Care Partnership (CHCP)	A partnership between health and social care and responsible for the delivery of a wide range of community health provision including GP services, pharmacy, social care and community nursing. Also responsible for many local social care services, provided by social work staff.
Consolidation	Where a group of entities combine (consolidate) their financial statements into one set of accounts. The Scottish Government's consolidated accounts reflect the consolidated assets and liabilities and the results of all entities within the Scottish Government departmental accounting boundary.
Consultant contract	The new pay, terms and conditions negotiated on a UK-wide basis for NHS consultants.
Corporate governance	Arrangements put in place to ensure proper use of management and resources.
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.
Efficient Government Initiative	A Scottish Executive initiative to increase efficiency across the whole of the public sector in Scotland by delivering the same services with less money or delivering more services with the same money.
Family Health Services (FHS)	Services provided by GPs, dentists, opticians and community pharmacists.
Financial balance	Where income received is equal to expenditure made on an ongoing basis.
Financial 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 Scottish Government and any planned savings.
Financial statements	The main statements in annual accounts of an NHS body. These include: an operating cost statement, statement of recognised gains and losses, balance sheet and cash flow statement. The format of these statements is specified in NHS accounts manuals.
Financial stewardship	Financial stewardship ensures that expenditure is properly incurred and authorised. Proper accounting records are maintained and financial statements are prepared in line with standard accounting practice and relevant guidance.
GMS contract	A new contract for general practitioners (GPs) introduced in April 2004 where GPs receive a lump sum based on a contract. Additional payments are made for services provided over and above those specified in the contract or where they are provided to an enhanced specification.
Governance	The framework of accountability to users, stakeholders and the wider community, within which the organisations take decisions, and lead and control their functions, to achieve their objectives.
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 newborn 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.
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.
Outturn	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. 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.
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.
Section 22 report	Reports produced by the Auditor General for Scotland to draw attention to significant issues concerning public sector bodies. Section 22 reports are only produced for bodies where the Auditor General for Scotland is responsible for securing the audit.
Tariff	A national price list for hospital procedures carried out by one board on behalf of patients who reside in another board area. The national tariff is intended to simplify the process for service level agreements between boards for cross boundary activity.
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 underlying deficit is the ongoing financial gap in the NHS board area between the money received to provide health services and the costs of providing these services.
Unqualified audit opinion	When auditors of NHS bodies are satisfied with the annual accounts they will issue an unqualified audit opinion.

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