Overview of the NHS in Scotland's performance 2010/11

AUDIT SCOTLAND

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Auditor General for Scotland

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Demand for NHS services is increasing at a time when resources are decreasing.

Background

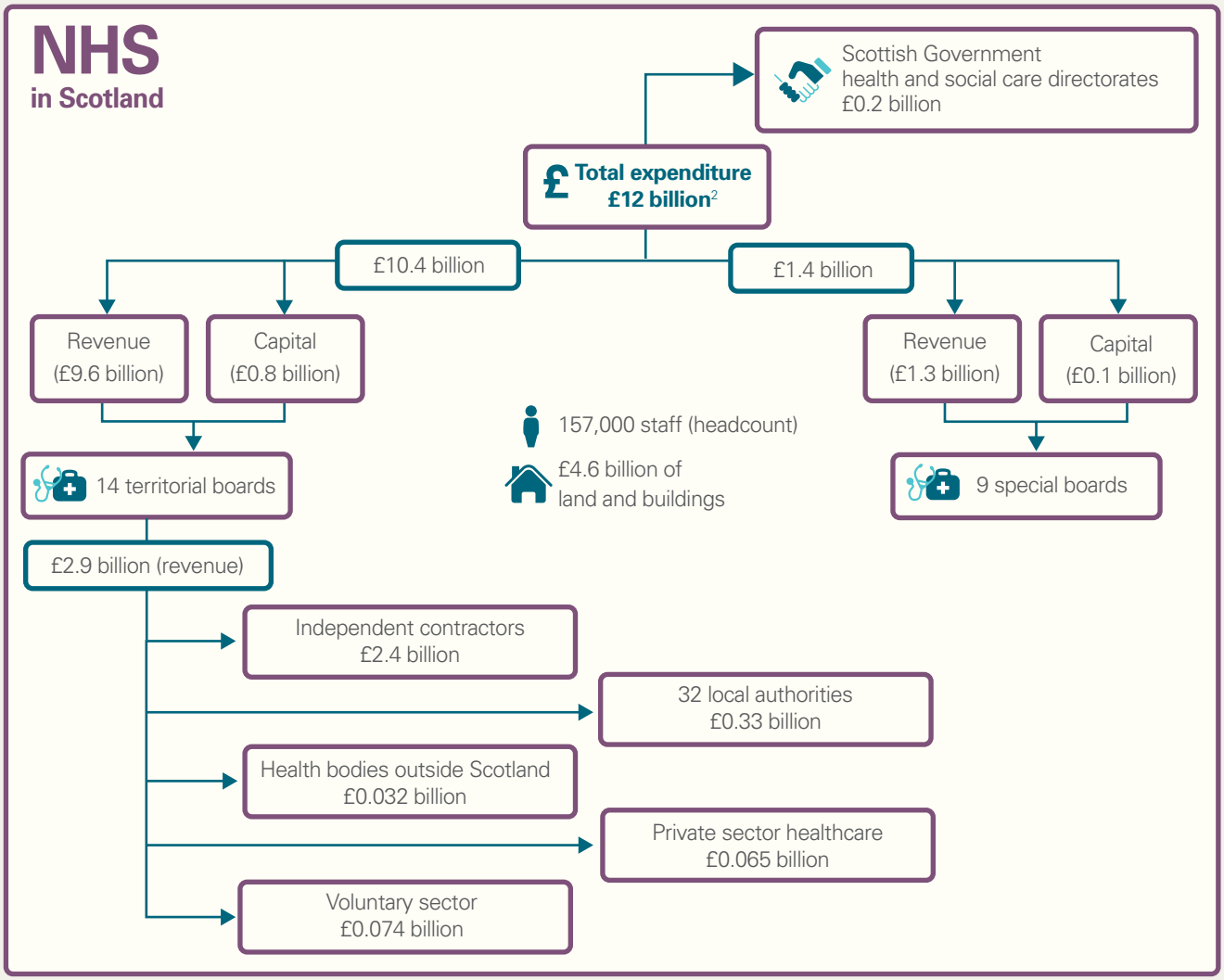
1. This report provides an overview of the performance of the NHS in Scotland in 2010/11 and highlights current and future pressures and risks. The NHS faces pressure relating to a changing population, rising demand and expectations, increasing costs of delivering services, and managing staff reductions. This is at a time when resources are decreasing across the public sector. The Scottish Government allocated £11.5 billion in 2010/11 to the NHS, representing around a third of the total public sector funding.[1] The NHS also received £0.5 billion of income from other sources, including dental charges, building sales, catering, traffic accident compensation and income for patients from England.

2. In total the NHS spent £12 billion in 2010/11 (Exhibit 1).[2] The NHS is Scotland's largest single employer with over 157,000 staff and it owns land and buildings worth over £4.6 billion.[3]

Exhibit 1

Summary of NHS expenditure, 2010/11

NHS bodies spent £11.8 billion in 2010/11.[1] The 14 territorial NHS boards spent £10.4 billion (88 per cent) and the nine special health boards spent £1.4 billion (12 per cent). The Scottish Government health and social care directorates spent £0.2 billion.



Note:
1. We use the term NHS bodies in this report to refer collectively to the 14 NHS territorial boards and nine special NHS boards. For the purposes of this report NHS National Services Scotland and the Mental Welfare Commission for Scotland are referred to as special NHS boards.
2. These figures include total Departmental Expenditure Limit expenditure (that is day-to-day spending and running costs) and Annually Managed Expenditure (that is expenditure that is primarily demand-led, less predictable and needs to be considered on an annual basis). The Scottish Government is responsible for administering the AME budget and has no discretion over how it is spent. The Scottish Government is responsible for providing estimates of AME spending but this requires separate HM Treasury approval.
Source: Audit Scotland, 2011

1 This includes funding allocated to the Scottish Government health and social care directorates and NHS bodies.
2 Of this, NHS bodies spent £11.8 billion and the Scottish Government health and social care directorates spent £0.2 billion.
3 133,000 whole-time equivalents. Information Services Division (ISD) Scotland, 2011.

3. The NHS budget increased in real terms by ten per cent over the five years to 2010/11, with a slight decrease in 2010/11 compared with 2009/10.[4] Although cash funding for the NHS continues to increase, higher inflation means that funding is decreasing in real terms. There has been a 1.4 per cent real-terms decrease in funding between 2010/11 and 2011/12.[5] The Scottish Government's 2011 spending review outlined a 4.2 per cent real-terms decrease in NHS funding in the five years to 2014/15.[6, 7]

4. The financial picture for territorial boards and special boards is different. Special boards have received an average real-terms reduction of three per cent in their 2011/12 revenue budgets. Territorial NHS boards have received an average increase of 1.3 per cent in real terms.

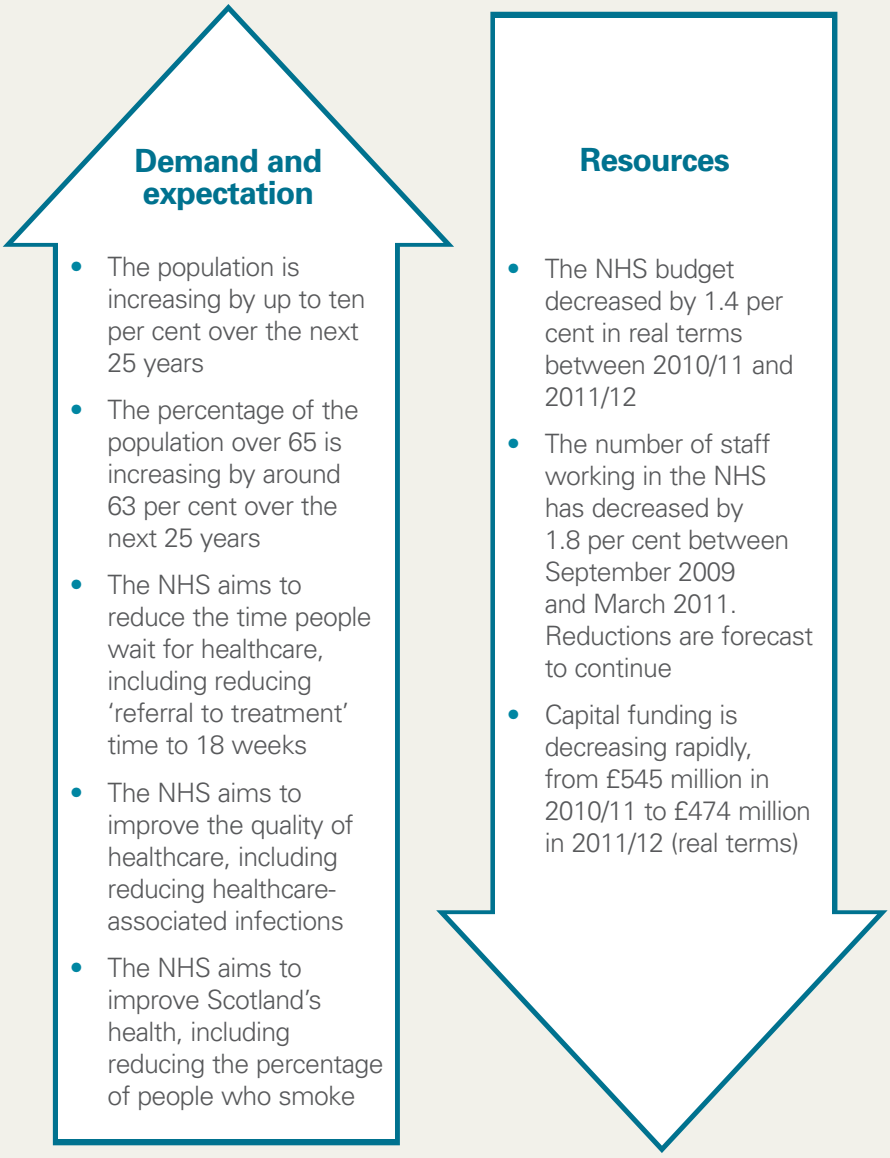
5. Public bodies, including the NHS, are facing increasing pressures and demands, such as responding to the needs of Scotland's changing population, the effects of the recession, and the backlog in maintaining the public sector estate. The most common approaches being taken by public bodies to reduce costs over the next few years are pay restraint and reducing workforce numbers. Many NHS bodies have already reduced staff numbers through recruitment freezes and voluntary severance schemes, with further reductions planned. These pressures combine with increasing public expectations of performance and quality of care and the need to tackle Scotland's health problems (Exhibit 2). This report looks at the implications for the NHS of these competing pressures and performance against targets to improve Scotland's health.

6. The Scottish Government and the NHS aim to improve Scotland's health by reducing the time people wait for treatment, reducing contributors to poor health (such as smoking and alcohol misuse) and improving the quality of healthcare. National performance targets, the *Healthcare*

Exhibit 2

Pressures facing the NHS

Demand for NHS services is increasing at a time when resources are decreasing.



Source: Audit Scotland, 2011

4 These real-term increases represent cash increases of 21 per cent and three per cent respectively. *Scotland's spending review 2011 and draft budget 2012/13*, Scottish Government, 2011.
5 The NHS was the only part of the public sector in Scotland to receive more money than in 2010/11. *Scotland's public finances: addressing the challenges*, Audit Scotland, August 2011.
6 *Scotland's spending review 2011 and draft budget 2012/13*, Scottish Government, 2011.
7 This is a 6.6 per cent increase in cash terms.

Quality Strategy for NHSScotland and the *Efficiency and Productivity Programme* underpin these activities (see Parts 2 and 3).

About the audit

7. This report is based largely on the audited annual accounts and auditors' reports on the 2010/11 audits of the 23 NHS bodies. We also used other sources of information to support our work, including a literature review, published national statistics and interviews with staff from the Scottish Government. This report is in three parts:

- Pressures facing the NHS (Part 1)
- Managing NHS resources (Part 2)
- NHS performance in improving Scotland's health (Part 3).

Key messages

- The overall financial performance of the NHS is good and all NHS bodies met their financial targets, although ten of the 14 territorial boards reported an underlying recurring deficit. Although cash funding for the NHS continues to increase, higher inflation means that overall NHS funding is decreasing in real terms. Territorial boards have received a real-terms increase in funding in 2011/12 but funding for special boards has decreased.
- The NHS has quality, efficiency and productivity strategies aimed at supporting it to work more efficiently and effectively. The NHS continues to find it difficult to quantify productivity due to weaknesses in underlying data and difficulties in linking costs, activity and quality. This is needed to inform how to deliver better health outcomes with the same or fewer resources.
- Healthy life expectancy in Scotland increased by three years for men and over two years for women between 1999/2000 and 2007/08; and rates of deaths from coronary heart disease, stroke and cancer have continued to decrease over the past decade. However, there remain significant health inequalities across Scotland; for example, there are challenges in tackling levels of obesity, smoking, and alcohol and drug misuse. The NHS cannot tackle these challenges alone and needs to work more effectively with other public bodies to make the best use of resources.
- The NHS met three-quarters of the 28 performance targets due for delivery in 2010/11, but performance against these targets varied among individual NHS boards. The NHS has achieved significant reductions in healthcare-associated infections and it is making good progress towards meeting its target to treat all patients within 18 weeks of being referred to hospital. Over 80 per cent of patients who responded to recent surveys were satisfied with the treatment they received from the NHS.

Part 1. Pressures facing the NHS

The NHS faces a number of significant challenges.

Key messages

- The NHS faces pressures relating to a changing population, rising demand and expectations, increasing costs of delivering services and managing staff reductions. This is at a time when resources are decreasing across the public sector.
- Managing the decreasing workforce is challenging and needs to be underpinned by good workforce planning. Between September 2009 and March 2011, staff numbers were reduced by around 2,500 whole-time equivalents (1.8 per cent). Around half of this decrease was due to a reduction in nursing and midwifery staff. The biggest percentage reductions have been in administrative and support services.
- Capital funding is decreasing across the public sector. The NHS plans to use more partnerships with the private sector to build new facilities. It currently has ten large investment projects with a combined value of around £1.9 billion.
- Strong leadership and better partnership working are needed to address the multiple challenges facing the NHS and its social care partners. Some indicators of partnership working, such as reducing delayed discharges from hospital, are showing signs of increased pressure. The Scottish Government is developing new ways of integrating health and social care which are aimed at delivering better coordinated care for patients.

Scotland's changing population means that current ways of delivering services are not sustainable

8. The population in Scotland is projected to rise from 5.22 million in 2010 to 5.49 million in 2020, and to continue to rise to 5.76 million in 2035. This is an increase of ten per cent over this 25-year period.[8] In addition, there are projected changes to different age groups which will affect planning for services:

- The number of people aged 65 and over in Scotland is projected to rise by around 22 per cent over ten years (from 879,000 in 2010 to 1,075,000 in 2020), and by around 63 per cent over 25 years (to 1,431,000 in 2035).
- The number of people aged 75 and over is projected to increase by around 22 per cent by 2020 (from 410,000 to 500,000), and by 80 per cent by 2035 (to 740,000).
- The number of people aged 85 and over is projected to increase by around 39 per cent over ten years and 147 per cent over 25 years.
- The number of children in Scotland aged under 16 is projected to increase by five per cent (from 910,000 to 960,000) between 2010 and 2020. It is then projected to decrease slightly to 940,000 in 2035 (a three per cent increase compared with 2010).

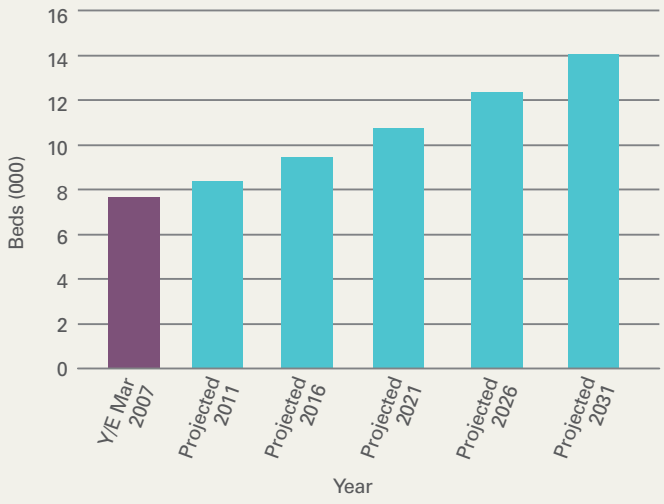
9. The demographic changes will affect the demand for health services in the future. In particular, the growth in the number of older people is likely to increase the number of people living with long-term health conditions.

10. The Scottish Government has reported that the amount spent on health and social care services for older people would need to increase by £3.5 billion by 2031 if the systems remain as they are now (a real-terms increase of 74 per cent from 2008). For example, the number of hospital beds for emergency admissions would need to rise significantly (Exhibit 3).[9]

Exhibit 3

Impact of demographic change on emergency bed numbers, 2007-31, for people aged over 65

The Scottish Government estimates that the number of beds for emergency admissions would need to increase by more than 6,000 (nearly 80 per cent) from 2007 to 2031 if NHS and social care services remain as they currently are.



Source: *Reshaping care for older people: a programme for change 2011-21*, Scottish Government, 2011

8 *Projected Population of Scotland (2010-based)*, National Records of Scotland, 2011.
9 *Reshaping care for older people: a programme for change 2011-21*, Scottish Government, 2011.

11. With the changes to state pension age included, the population of working age is projected to increase from 3.27 million in 2010 to 3.50 million in 2035 (an increase of seven per cent). As a result of demographic changes, the ratio of pensioners to people of working age is expected to increase from the 2010 level of 32 pensioners per 100 people of working age to 38 pensioners per 100 people of working age by 2035. This means relatively fewer people available to deliver public services and to contribute taxes that pay for health and social care.

Staff numbers are decreasing

12. In 2010/11, the NHS in Scotland employed over 157,000 staff (over 133,000 whole-time equivalents) at a cost of £6.1 billion (56 per cent of NHS bodies' revenue expenditure). At 31 March 2011, 19,700 (17 per cent) more staff worked for the NHS than in 2002 but between September 2009 and March 2011 staff numbers decreased by around 2,500 whole-time equivalents (1.8 per cent).[10] Around half of this overall decrease was due to a reduction of 1,261 nursing and midwifery staff. With the exception of unallocated staff, the biggest percentage reductions have been in administrative and support services (Exhibit 4).

13. In line with the Scottish Government's commitment to no compulsory redundancies, these reductions have been achieved through voluntary severance or natural staff turnover.[11] The number of staff leaving the NHS under voluntary severance schemes more than doubled from 157 in 2009/10 to 341 in 2010/11. The total cost of payments in 2010/11 was £15.4 million (Exhibit 5). Most of these staff had been employed by territorial NHS boards. A number of NHS bodies plan further voluntary severance programmes in 2011/12, for example, NHS Greater Glasgow and Clyde forecasts spending £6 million.

14. The Scottish Government requires all NHS bodies to reduce the number of senior managers by 25 per cent by 1 April 2015.[12] It has reported that the number of senior managers decreased by 107 whole-time equivalents (8.1 per cent) in 2010/11, the first year covered by this requirement, and that 89 of the senior managers leaving worked for territorial NHS boards.

15. CIPFA's report *Sharing the gain: collaborating for cost effectiveness* highlights the risks of losing knowledge and experience during periods of change, and the importance of engaging with staff during such periods.[13] NHS bodies need to balance these risks with the potential benefits, opportunities and fresh perspective that can be gained from recruiting new staff.

Exhibit 4

Changes in staff numbers between September 2009 and March 2011
Five staff groups increased, but overall staff numbers decreased by around two per cent.

NHS staff	At 30 September 2009 (WTE)	At 30 September 2010 (WTE)	At 31 March 2011 (WTE)	Percentage change Sept 2009 to March 2011
Medical (hospital, community and public health services)	10,680	10,732	10,697	0.2
Dental (hospital, community and public health services)	641	708	723	12.8
Medical and dental support	1,667	1,811	1,839	10.3
Nursing and midwifery	58,428	57,878	57,167	-2.2
Allied health professions	9,579	9,596	9,511	-0.7
Other therapeutic services	3,326	3,407	3,413	2.6
Personal and social care	763	948	971	27.3
Healthcare science	5,594	5,628	5,571	-0.4
Emergency services	3,704	3,698	3,698	-0.2
Administrative services	26,107	25,887	25,483	-2.4
Support services	14,761	14,411	14,184	-3.9
Unallocated staff	573	261	70	-87.8
All NHS in Scotland staff (excluding GPs and GDPs)	**135,823**	**134,965**	**133,327**	**-1.8**

Notes:
1. GDPs are General Dental Practitioners.
2. Unallocated staff refers to NHS employees who have not been assigned to a staff group since changes to the pay system.
Source: ISD Scotland, August 2011

10 ISD Scotland, 2011.
11 *Public sector pay policy for staff pay remits 2011-12 and 2012-13*, Scottish Government, 2011 and 2012.
12 The Scottish Government issued guidance to NHS boards about which posts should be included in the calculation.
13 *Sharing the gain: collaborating for cost effectiveness*, Chartered Institute of Public Finance and Accountancy, 2010.

Exhibit 5

Voluntary severance, 2010/11

In 2010/11, 341 staff left the NHS and voluntary severance payments totalled £15.4 million.

NHS bodies	Number of people	Cost (£000)
Ayrshire and Arran	21	1,227
Borders	7	87
Dumfries and Galloway	9	382
Fife	-	-
Forth Valley	<5	537
Grampian	31	2,305
Greater Glasgow and Clyde	25	592
Highland	-	-
Lanarkshire	168	6,527
Lothian	26	1,075
Orkney	6	551
Shetland	<5	1
Tayside	5	124
Western Isles	-	-
Total territorial boards	**303**	**13,408**
NHS National Services Scotland	<5	289
Scottish Ambulance Service	<5	15
NHS Education for Scotland	<5	41
NHS 24	10	434
National Waiting Times Centre	6	188
The State Hospital	7	333
NHS Health Scotland	6	649
NHS Quality Improvement Scotland	-	-
Mental Welfare Commission	-	-
Total special boards	**38**	**1,949**
Total	**341**	**15,357**

Source: NHS bodies' financial statements 2010/11

16. NHS bodies have reported to the Scottish Government that they are forecasting a further reduction of 2,388 whole-time equivalent staff (1.8 per cent) during 2011/12 (Exhibit 6, overleaf).[14] NHS bodies project that:

- the largest percentage reduction will be in administrative services (4.3 per cent or 1,101 whole time equivalents)
- there will be a 1.7 per cent reduction (988 whole-time equivalents) in nursing and midwifery staff
- the number of medical and dental staff will increase by 3.4 per cent (455 whole-time equivalents) due to 433 GP trainees being employed by NHS Education for Scotland rather than individual GP practices.

14 *NHS workforce statistics*, Scottish Government, 2011.

Exhibit 6

Projected workforce changes by NHS body, 2011/12

The projected changes in staff numbers vary significantly among NHS bodies.

NHS bodies	Baseline	2011/12 projections		
	31 March 2011	31 March 2012	Change	Percentage change
Ayrshire and Arran	8,640	8,511	-129	-1.5
Borders	2,573	2,466	-107	-4.2
Dumfries and Galloway	3,545	3,434	-111	-3.1
Fife	7,348	7,267	-81	-1.1
Forth Valley	5,229	5,026	-203	-3.9
Grampian	11,522	11,516	-6	-0.1
Greater Glasgow and Clyde	34,332	33,470	-862	-2.5
Highland	7,064	6,871	-193	-2.7
Lanarkshire	9,939	9,762	-177	-1.8
Lothian	18,449	17,715	-734	-4.0
Orkney	471	445	-26	-5.5
Shetland	500	491	-9	-1.8
Tayside	11,425	11,296	-129	-1.1
Western Isles	840	840	-	0.0
Total territorial boards	**121,877**	**119,110**	**-2,767**	**-2.3**
National Waiting Times Centre	1,295	1,275	-20	-1.5
The State Hospital	642	629	-13	-2.0
NHS 24	881	985	104	11.8
NHS National Services Scotland	3,466	3,386	-80	-2.3
Scottish Ambulance Service	4,099	4,035	-64	-1.6
NHS Education for Scotland	608	1,029	421	69.2
Healthcare Improvement Scotland	272	303	31	11.4
NHS Health Scotland	280	280	-	0.0
Total special boards	**11,543**	**11,922**	**379**	**3.3**
Total	**133,420**	**131,032**	**-2,388**	**-1.8**

Note: Increases at NHS 24 reflect changes to structures and staff joining from the Scottish Centre for Telehealth. Healthcare Improvement Scotland (HIS) was established on 1 April 2011 and is responsible for previous functions provided by NHS Quality Improvement Scotland (NHS QIS) and the Care Commission, both of which no longer exist. The increase in staffing for HIS reflects the merging of staff from NHS QIS and the Care Commission. The increase at NHS Education for Scotland is due to 433 GP trainees being employed by NHS Education for Scotland rather than individual practices.
Source: *NHS projected staff in post changes in 2011/12*, Scottish Government, 2011 (There is a difference between the number of staff, at 31 March 2011, shown in exhibits 4 and 6, because the data come from difference sources. The difference is 93 whole-time equivalents, or 0.1 per cent of total staff.)

The NHS implemented a pay freeze in 2010/11

17. Along with other public bodies across Scotland, the NHS implemented a pay freeze in 2010/11 and this continues in 2011/12. However, all staff are entitled to move up their pay scale, unless they reach the top of their pay band. In addition, in line with Scottish Government guidance, NHS workers earning less than £21,000 will receive an increase of £250 in 2011/12. The total cost of both increases for the Scottish public sector as a whole is estimated to be £180 million in 2011/12.[15] The cost to the NHS is likely to be more than £58 million.[16, 17]

18. The number of clinical staff earning over £100,000 has increased by almost two per cent, from 3,003 in 2009/10 to 3,057 in 2010/11.[18] The number of non-clinical staff earning over £100,000 decreased from 65 to 62 over the same period.

It will be important to keep staff motivated at a time of change

19. In Scotland, just over a quarter of employees responded to the 2010 NHS staff survey and most expressed positive views about working for the NHS. However, employee surveys generally achieve response rates of around 50 to 70 per cent.[19] In order to improve the validity of its staff survey, the NHS in Scotland needs to work with local staff partnership forums to help increase the staff response rate.

20. Staff who did respond to the survey were clear what their roles and responsibilities were, and how their work fits with the overall aims of the NHS. Most staff were satisfied with the training they receive, the sense of achievement they get from their work, and with their job security and opportunities to work flexibly. The survey also identified several areas where the NHS could improve, such as consulting staff when changes are made.

21. Sickness absence rates have fallen from 5.25 per cent of working days in 2006 to 4.74 per cent in 2011. The NHS has a national target of four per cent for sickness absence rates. Only five special NHS boards reported sickness absence rates below this target.[20] Six NHS bodies continue to report sickness absence rates higher than five per cent; the remaining NHS bodies report sickness absence rates of between four and five per cent.[21, 22]

The NHS continues to face challenges in developing and maintaining its estate

22. The NHS in Scotland has a significant estate, valued at £4.6 billion, made up of land and buildings, such as hospitals and health centres. In the five years from 2006/07 to 2010/11, NHS capital budgets increased in real terms from £432 million to £545 million. This funding has been used to upgrade existing facilities, construct new buildings and invest in IT, equipment and vehicles. However, the NHS capital budget was reduced by 13 per cent between 2010/11 and 2011/12 to £474 million and will fall further (in real terms) to £215 million by 2014/15.[23] Our 2011 report *Management of the Scottish Government's capital investment programme* stated that the Scottish Government would need to make difficult choices about its investment plans over the period to 2014/15, including the affordability and priority of projects.[24] In January 2010, the Scottish Government established a capital planning group to look at how capital funding is allocated to NHS bodies.

23. The Scottish Government continues to look at alternative sources of financing for a number of NHS projects. Our report in January 2011 identified alternative sources of financing that are available for capital projects, for example transferring money from revenue to capital; the Non-Profit Distributing (NPD) method; and the 'hub' initiative (Exhibit 7, overleaf).[25]

24. The Scottish Government's 2011 spending review stated that although the capital budget for the NHS was being reduced, it would deliver a number of initiatives to ensure capital resources were available for the NHS. In particular, it announced that it would take forward £750 million of NHS capital projects through the NPD model and through the hub initiative, which the Scottish Futures Trust is responsible for supporting.[26]

25. The NHS currently has ten large investment projects, each valued at over £50 million, at various stages of completion. The combined value of these projects is around £1.9 billion. As a result of the spending review decisions, five projects will now be funded through the NPD method and a sixth may also proceed on that basis (Exhibit 8, page 13).

15 *Independent budget review*, Scotland's independent budget review panel, 2010.
16 *Financial scrutiny unit briefing: impact of the Scottish Government pay freeze*, Scottish Parliament, 2011.
17 The NHS accounts for about 32 per cent of the Scottish public workforce and approximately 37 per cent of the NHS workforce earns less than £21,000, compared to 24 per cent of other public sector staff.
18 *Financial statements for the year ended 31 March 2011*, NHS bodies, 2011.
19 http://www.surveylab.co.uk/2011/06/what-is-an-average-survey-response-rate/
20 The five special NHS boards which reported sickness absence rates lower than four per cent in 2011 were the National Waiting Times Centre, NHS Education for Scotland, NHS Health Scotland, NHS National Services Scotland, and NHS Quality Improvement Scotland. The Mental Welfare Commission is not included in these statistics.
21 The six NHS bodies which reported sickness absence rates higher than five per cent in 2011 were NHS Ayrshire and Arran, NHS Fife, NHS Tayside, NHS Forth Valley, The State Hospital and the Scottish Ambulance Service.
22 ISD Scotland, 2011.
23 *Scotland's spending review 2011 and draft budget 2012/13*, Scottish Government, 2011.
24 *Management of the Scottish Government's capital investment programme*, Audit Scotland, January 2011. This report looked at the management of the NHS capital programme and progress of a number of NHS capital projects.
25 *Management of the Scottish Government's capital investment programme*, Audit Scotland, January 2011.
26 *Scotland's spending review 2011 and draft budget 2012/13*, Scottish Government, 2011.

Exhibit 7

Scottish Futures Trust and the use of revenue finance for NHS investment

Scottish Futures Trust (SFT)

- SFT's remit is to examine and develop new financing arrangements for investment and to work in partnership with other public bodies to secure more efficiency from the investment programme.
- SFT is a limited company, wholly owned by Scottish ministers, and established in September 2008.
- SFT's responsibilities in the NHS include oversight of NPD-financed investment and delivery and coordination of the hub initiative (see third column). It is also responsible for advising the Scottish Government about the progress of individual major projects and for support and advice to existing operational Private Finance Initiative (PFI) projects. It also acts as a centre of expertise for investment more widely.

Non-Profit Distributing (NPD) finance for major investment projects

- The NPD model was developed and introduced in Scotland as an alternative to the PFI model.
- Under NPD, a private sector contractor is responsible for financing the project investment. Financing costs are capped and the contractor recovers its costs through annual charges to the public sector for use of the resulting asset.
- So far, contracts for five NPD projects have been signed in Scotland, including the £95 million mental health developments project signed by NHS Tayside in 2010.
- SFT has identified four further large health projects with a combined estimated cost of £547-582 million to be procured as individual NPD projects. See Exhibit 8.
- NPD projects are led by the relevant NHS board. SFT's role is to support the Scottish Government health and social care directorates manage centrally the NPD contract and provide support to procuring NHS bodies.
- Three of the five planned health NPD projects remain at a relatively early stage of development, with no firm dates for construction so far.

Hub initiative

- SFT is leading the hub and expects to take forward around £250 million of health investment projects by this route. These are smaller projects, mainly to support primary care, such as community health centres and doctors' and dental surgeries.
- Five hub territories together cover all of Scotland.[1] In each territory the local community planning partners, including NHS bodies, councils, police, and fire and rescue services will establish a joint venture with a private sector development partner.
- The intention is to allow a strategic, long-term and collaborative approach to planning infrastructure for the delivery of community services in each area. There should also be a strong partnership with private sector suppliers.
- Two joint venture hub contracts were agreed in 2011 for the south-east and north territories. Contracts for the three other territories are due in 2012.
- Public bodies may acquire new projects through the hub using either traditional or private financing.
- Most plans are yet to be confirmed, though SFT estimates that projects could begin between 2012 and 2015.

Note: 1. The five hub territories in Scotland are south-east, north, east-central, west, and south-west.
Source: Scottish Futures Trust, 2011

Exhibit 8

Major capital projects in the NHS valued at over £50 million

The NHS currently has ten capital projects valued at over £50 million each, five of which are now being progressed through NPD.

NHS board	Project	Estimated value (£ million)	Estimated completion	Progress at June 2011
£1,042 million projects financed direct from the capital budget				
State Hospital	Redevelopment	90	2011	Construction
NHS Grampian	Emergency care centre	110	2013	Construction
NHS Greater Glasgow and Clyde	New South Glasgow hospitals and laboratory	842	2016	Construction
£170 million private finance initiative				
NHS Fife	Realignment of services across two existing local general hospitals in Dunfermline and Kirkcaldy	170	2011	Construction
£547-582 million NPD financed projects				
NHS Tayside	Mental health development – Stracathro and Murray Royal	95	2012	Construction
NHS Ayrshire and Arran	Mental Health – development of new inpatient facilities	75	2016	Outline business case being updated
NHS Dumfries and Galloway	Dumfries and Galloway Royal Infirmary refurbishment	141	TBC	Options being assessed
NHS Lothian	Royal Hospital for Sick Children/ Department of Clinical Neurosciences	176-201	TBC	Scope and procurement strategy being developed
NHS Orkney	Balfour Hospital and Kirkwall Dental Centre development	60-70	TBC	Clinical strategy being developed
Method of financing to be decided				
NHS Lothian	Royal Edinburgh Hospital	135	TBC	Options being assessed

Source: Letter from Permanent Secretary to the Scottish Parliament Public Audit Committee providing a progress report on major capital projects, 30 June 2011 and Scottish Government, 2011

26. Because of the change in financing method, some NHS bodies have had to prepare revised business cases for the NPD projects and the timescales for three of these projects are currently uncertain (Exhibit 8). The unforeseen change in financing method created difficulties for one project (Case study 1).

27. Under the hub initiative, nine smaller projects have reached the development stage. These are in the two hub territories where joint venture contracts have been set up, south-east and north. The projects include the Wester Hailes Healthy Living Centre in Edinburgh, Aberdeen Health Village and a number of GP surgeries and day centres, and range in estimated value from £4 million to £16 million each. The first projects are expected to be completed in 2013.

28. Since devolution, some £1.3 billion worth of NHS investment projects – mostly Private Finance Initiative (PFI) projects – will be funded from revenue budgets. Nine NHS boards have existing buildings financed by PFI. The annual cost associated with signed PFI contracts in the NHS in Scotland will increase from £170 million in 2010/11 to £197 million in 2011/12.[27] Each board must pay PFI contract charges from revenue budgets over the lifetime of the contract. Charges are set at the outset of the contract and increase annually in line with inflation.[28] This may put pressure on NHS bodies' revenue budgets.

29. Despite significant capital spending since devolution, the estimated cost of backlog maintenance and repair to the NHS estate remains significant. In 2009, we estimated that over £500 million was needed to address backlog maintenance and repair across the NHS estate.[29] Continued financial pressures over the next few years mean that it may be more difficult to maintain the estate (Case study 2).

Case study 1
Capital projects at NHS Lothian

Early preparatory work had started on the new Royal Hospital for Sick Children and Department of Clinical Neurosciences in NHS Lothian. In 2010, the Scottish Government decided that this project would be financed using the NPD model. Development costs, including enabling works, land purchase and design costs, of £10 million were incurred during 2010/11. Using the NPD model means that these are revenue costs rather than capital.

Source: NHS Lothian annual audit report, 2010/2011

Case study 2
Capital projects at NHS Grampian

NHS Grampian's capital allocation decreased from £28 million in 2010/11 to £7.9 million in 2011/12. However, the board will also receive specific additional funding allocations in 2011/12 to continue specific projects approved in previous years, including an emergency care centre (£41.1 million) and radiotherapy equipment (£10.6 million).

The reduction to the NHS board's core capital allocation means that there is less funding available for the estimated backlog maintenance costs of £124 million (as at April 2011). The board assessed £58 million of the £124 million as 'high' or 'very high' risk. Risks include the need for unplanned investment, as a result of external inspections, to ensure that buildings comply with regulations and avoid the risk of closing buildings.

Source: NHS Grampian annual audit report, 2010/11

The cost of medicines and high-cost medical treatments continues to present financial challenges

30. NHS boards' local delivery plans for 2010/11 and 2011/12 continue to identify financial pressures from increased activity, rising costs and meeting performance targets. NHS boards have highlighted risks associated with the costs of medicines prescribed by GPs and expect these costs to increase by up to eight per cent in 2011/12.[30] The cost of drugs prescribed in primary care in 2010/11 was around £1 billion.[31, 32] Audit Scotland's 2011 report on community health partnerships (CHPs) highlighted that GP prescribing budgets are under pressure with 15 CHPs overspending their prescribing budgets in 2009/10 compared to 12 CHPs in 2008/09.[33]

27 Under PFI, buildings are designed, financed, built and operated by the private sector and made available to the public sector in return for payment of annual charges for their use, usually over a contract period of 25 or 30 years.
28 HM Treasury, 2011.
29 *Asset management in the NHS in Scotland*, Audit Scotland, January 2009.
30 *NHS boards' local delivery plans*, Scottish Government, 2011.
31 These costs refer to the gross ingredient cost.
32 *Prescribing and medicines: prescription cost analysis* 2010/11, ISD, 2011.
33 Where there is more than one CHP in each area, sometimes they jointly manage the GP prescribing budgets or one of the CHPs manages the prescribing budget on behalf of all CHPs. *Community health partnerships*, Audit Scotland, June 2011.

31. NHS boards' financial plans for 2011/12 also identify increasing costs of medicines used in hospitals. Increases vary across boards from nothing to up to 13 per cent. The Scottish Medicines Consortium (SMC) is responsible for issuing advice about new medicines and plans to consider 26 new medicines between October 2011 and January 2012.[34] However, the increasing number of new medicines and uncertainties around cost and volume estimates mean that NHS boards continue to find it difficult to plan for the financial impact of new medicines. To help manage these uncertainties, the SMC introduced 'horizon scanning' in 2005 to assist boards in anticipating changes over the following 12 to 18 months. In addition, the national procurement team within NHS National Services Scotland continues to make progress in identifying cost savings and the number of national contracts for hospital medicines increased from five in 2005 to 67 in 2011.[35] These contracts generated Scotland-wide savings of £8 million in 2010/11 and £5.6 million in the first seven months of 2011/12.[36]

32. National contracts can also assist boards in reducing the costs of medical supplies. For example, Audit Scotland's 2010 report on orthopaedic services reported inconsistencies in procurement methods and costs for purchasing surgical implants, such as artificial hips.[37] At that time, National Procurement estimated that £2 million would be saved each year if NHS boards standardised their purchasing of hip and knee implants.[38]

33. Clinical and medical negligence claims are a recurring pressure. NHS boards meet the costs of such claims by contributing annually to an NHS-wide central fund. The total amount of potential liabilities increased from £279 million at 31 March 2010 to £297 million at 31 March 2011.[39] As a result, payments by boards into the fund to cover these liabilities have increased from £31.3 million in 2009/10 to £61.1 million in 2010/11. NHS boards, the NHS Central Legal Office and the Scottish Government are working together to manage clinical and medical negligence claims. Current changes to the way in which compensation is calculated are aimed to reduce the cost to NHS boards.

Improvements in partnership working are needed to deliver more efficient and effective services

34. Strong leadership is needed to address the pressures facing the NHS and its partners. This will involve managers, clinicians, and elected and non-elected representatives from across the NHS and local government working together with a shared vision about how to improve local services.

35. Since devolution, there has been an increased focus on partnership working between health and social care and across the public sector as a whole. Audit Scotland's 2011 report on CHPs highlighted that joint working could be improved by tackling differences in organisational cultures, planning, and performance and financial management arrangements. It also found that CHPs' governance and accountability arrangements are complex and not always clear.[40]

36. The Scottish Government established a Change Fund of £70 million in 2011/12, which will rise to £80 million in 2012/13 to facilitate NHS boards and councils in working together to improve services for older people. NHS boards and their council partners submitted joint Change Fund applications in February 2011. These applications set out how joint working could contribute to key NHS targets, such as reducing emergency admissions and readmissions among older people. Case study 3 (overleaf) provides an example of one area's plans.

37. Developments in partnership working also include a lead agency arrangement that is being piloted in Highland. This involves one partner delegating responsibility, budgets, staff and assets to the other for services for adults and children (Case study 4, overleaf).

38. The Scottish Government is currently developing plans to improve joint working between the NHS and councils in the delivery of health and social care.

34 *Forthcoming submissions*, Scottish Medicines Consortium, 2011.
35 National contracts are used by all boards to purchase items from a specific supplier and the NHS benefits from reduced costs and time spent negotiating contracts at board level.
36 NHS National Services Scotland, 2011.
37 *Review of orthopaedic services*, Audit Scotland, March 2010.
38 National Procurement was set up in November 2005 as part of the then Scottish Executive's overall Public Procurement Reform Programme and is part of NHS National Services Scotland.
39 These liabilities include all claims outstanding at 31 March, regardless of the year in which they were raised.
40 *Community health partnerships*, Audit Scotland, June 2011.

Indicators of partnership working are showing signs of increasing pressure

39. The Scottish Government aims to reduce the number of people in Scotland who are unnecessarily delayed in hospital. This requires joint action by the NHS and councils and is an indicator of how well these organisations are working together. When national data collection began in September 2000, over 3,000 patients were delayed in hospital, with around 2,000 of these patients delayed for more than six weeks. By July 2011, the total number of delayed discharges had significantly decreased to 722 patients, with 95 of these waiting more than six weeks. But there are indications of pressure as these figures are starting to rise (Exhibit 9).

40. In October 2011, the Cabinet Secretary for Health, Wellbeing and Cities announced that the delayed discharge target will change from six weeks to four weeks by April 2013 and to two weeks by April 2015.[41]

41. The Scottish Government has also set the NHS a target to reduce the number of occupied bed days for patients aged 65 and over who were admitted as an emergency.[42] The NHS target was to reduce the rate of emergency bed days for older people by ten per cent by 2010/11 compared with 2004/05 – by 2009/10, the most recent data available, it had only achieved a 3.5 per cent reduction (Exhibit 10). Although this is an NHS target, it requires action by both the NHS and councils to ensure that there are suitable community services to meet people's needs.

42. The Scottish Government also has a National Indicator to reduce the percentage of people aged 65 and over admitted as emergency inpatients two or more times in a single year. The latest figures show a slight decrease from 5.1 per cent in 2008/09 to 4.9 per cent in 2009/10, although this was slightly higher than the 2006/07 baseline figure of 4.8 per cent (Exhibit 11, page 18). Many initiatives to address this problem were set up using short-term funding rather than from savings released from acute hospitals. These initiatives focus on providing more community-based services but there is often a lack of analysis of the overall effect on costs as a result of service changes.[43]

Case study 3

Change fund plans in Dumfries and Galloway

In 2011, the NHS board and council in Dumfries and Galloway started a five-year change programme that aims to respond to changing demographics and reduced funding. The programme's main aim is to ensure the well-being and independence of members of the community through increased joint working and improved anticipatory care.[1] The programme has received £2.6 million from the Change Fund and £1.9 million from council funds. The Change Fund application identifies three NHS targets (emergency admissions for those aged over 75 years, multiple emergency admissions for those aged over 65 years and the number of anticipatory care plans for high-risk patients) that will be used to measure progress.

Note: 1. Anticipatory care aims to reduce emergency and multiple admissions to hospital.
Source: Dumfries and Galloway Change Fund Submission, 2011

Case study 4

Development of integrated services in Highland

In June 2011, NHS Highland and Highland Council agreed to develop integrated community services for children and adults. The NHS board will be the lead agency for adults, and the council will be responsible for children's services. Implementing this approach includes consideration of support functions, such as finance and information technology; staff governance; patient and public involvement; and clinical governance. The NHS board reports that a system to monitor benefits is being designed, which will include national and local outcomes and performance targets.

This lead agency pilot is not due to be fully implemented until April 2012 and therefore it is too early to comment on the arrangements. However, there are risks to the scale, complexity and timescale of planned changes and these need to be carefully managed.[1]

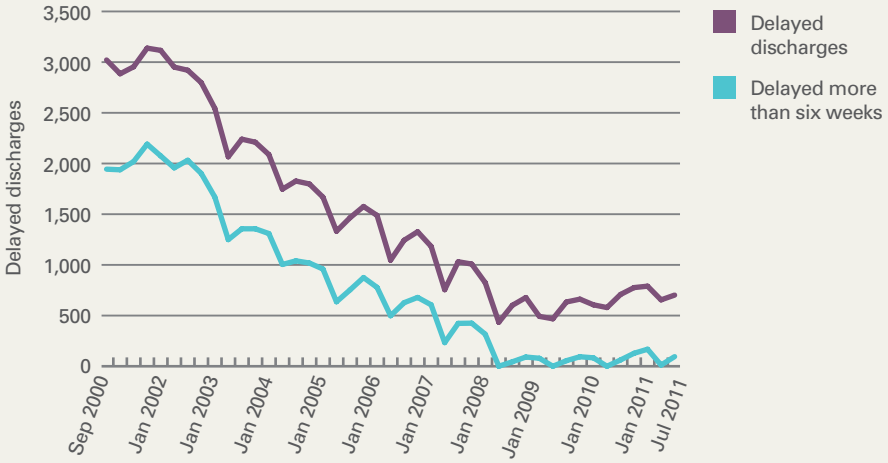
Note: 1. *Community health partnerships*, Audit Scotland, June 2011.
Source: NHS Highland, 2011

41 Scottish Government, 2011.
42 This is one of the national targets for the NHS which are commonly referred to as HEAT targets.
43 *Community health partnerships*, Audit Scotland, 2011.

Exhibit 9

Delayed discharges from acute care in Scotland

Total delayed discharges decreased by around three-quarters between 2000 and 2009 but have since started to rise.

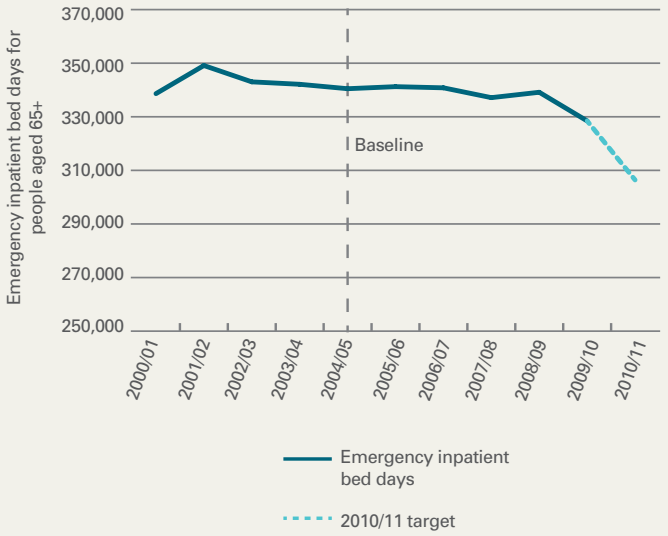


Source: ISD Scotland, 2011

Exhibit 10

Emergency inpatient bed days for people aged 65 and over

Compared with the 2004/05 baseline, by 2009/10 the NHS had achieved a 3.5 per cent decrease in the rate of emergency bed days for people aged 65 and over.

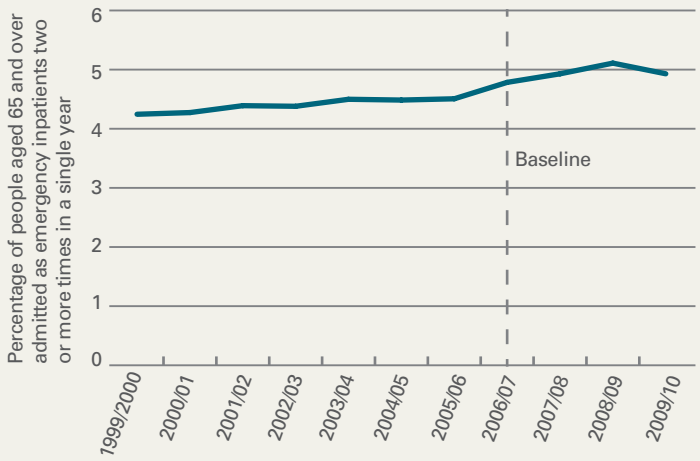


Source: ISD Scotland, 2011

Exhibit 11

Percentage of people aged 65 and over admitted as emergency inpatients two or more times in a single year

Latest published figures indicate a slight recent decrease but admission rates remain higher than the 2006/07 baseline.



Source: ISD Scotland, 2011

Part 2. Managing NHS resources

Overall financial performance is good, but performance varies among NHS boards.

Key messages

- The 2011/12 budget has increased by £232 million in cash terms, but is a real-term decrease due to the impact of inflation. The Scottish Government allocated real-terms increases to territorial boards and real-terms decreases to special boards.
- The overall financial performance of the NHS is good and all NHS bodies met their financial targets, although ten of the 14 territorial boards reported an underlying recurring deficit.
- The NHS reported efficiency savings of £292 million in 2010/11, representing three per cent of revenue funding. This was an increase from £202 million in 2009/10. The level of reported efficiency savings varied across NHS bodies.
- The NHS continues to find it difficult to quantify productivity due to weaknesses in underlying data and difficulties in linking costs, activity and quality. This is needed to inform how to deliver better health outcomes with the same or fewer resources.

43. In Part 2 we set out the financial performance of the NHS. We look at performance against financial targets in 2010/11; how resources have been used; and financial planning for 2011/12.

NHS funding is increasing in cash terms, but decreasing by one per cent in real terms in 2011/12

44. In September 2011, the Scottish Government announced that its budget would fall by £2.6 billion in real terms from £28.3 billion in 2010/11 to £25.7 billion by 2014/15, a nine per cent reduction. The overall decrease is most pronounced in 2011/12, when the budget reduced by £1.7 billion in real terms (5.8 per cent) to £27.4 billion.[44] The Scottish Government reports a cash increase to the NHS budget for 2011/12 following a similar decision by the UK government. This continues a trend of the NHS receiving above-average increases compared to the rest of the public sector in Scotland.

45. Revenue-funding allocations to NHS bodies increased in cash terms by 3.2 per cent (£232 million) in 2011/12. This increase includes the Change Fund (£70 million); funding to help boards meet the cost of the abolition of prescription charges (£57 million); and £24 million for NHS boards below their target funding allocation.[45] As a result, the general increase is only 1.1 per cent (£81 million). Scottish Government funding for 2011/12 assumes that NHS boards will achieve average efficiency savings of 3.6 per cent.

46. The financial picture for territorial boards and special boards is different. Special boards have received an average real-terms reduction of three per cent in their 2011/12 revenue budgets. Territorial NHS boards have received an average increase of 1.3 per cent in real terms in their revenue budgets.

The overall financial performance of the NHS is good, but performance varies among NHS boards

47. The NHS as a whole continues to manage its finances within its total budget. The budget includes funding

Exhibit 12

NHS bodies' expenditure, 2010/11

NHS Ayrshire and Arran, Dumfries and Galloway, Lanarkshire, Shetland and Western Isles reported surpluses totalling £19 million in 2010/11.

	Budget (£ million)	Net expenditure (£ million)	Underspend (£ million)	
Territorial boards	8,957	8,937	20	0.2%
Special boards	1,187	1,176	11	0.9%
Directorate	245	245	-	-
Total	**10,389**	**10,358**	**31**	**0.3%**

Territorial boards	Budget (£ million)	Expenditure (£ million)	Underspend (£ million)	
Ayrshire and Arran, Dumfries and Galloway, Lanarkshire, Shetland, Western Isles	1,968	1,949	19	1%
Borders, Fife, Forth Valley, Grampian, Greater Glasgow and Clyde, Highland, Lothian, Orkney, Tayside	6,989	6,988	1	0.0%
Total	**8,957**	**8,937**	**20**	**0.2%**

Note: Directorate figures are the budget and expenditure incurred indirectly by the Scottish Government health and social care directorates.
Source: NHS boards' 2010/11 financial statements

44 *The 2011-12 Autumn Budget Revision*, Scottish Government, 2011.
45 The NHSScotland Resource Allocation Committee (NRAC) formula calculates a target funding allocation for each NHS board that starts with the number of people resident in each NHS board area, then makes adjustments for the age and gender profile of the NHS board population; their additional needs based on morbidity and life circumstances (including deprivation), and the excess costs of providing services in different geographical areas.

from HM Treasury, the Scottish Government and other sources, for example, for treating patients from outwith Scotland. The main financial target for the NHS is to break even by the end of the financial year to ensure that expenditure is not greater than funding. In 2010/11, the NHS achieved its £10.4 billion revenue target with a small surplus of £31 million (0.3 per cent).[46] All 23 NHS bodies met their revenue and capital financial targets but the performance of individual bodies was very different (Appendix 1).[47]

48. The 14 territorial NHS boards had a combined surplus of £20 million, £19 million of which related to just five boards (Exhibit 12). In addition, NHS Fife and NHS Lothian returned £2.8 million and £2 million respectively to the Scottish Government at the end of 2010/11. These amounts would have increased their surpluses had they been retained by the boards.

49. Funding carried forward by NHS bodies from one year to the next fell from £38 million in 2009/10 to £31 million in 2010/11. The NHS cannot continue to use funding from previous years because the balance is falling and there are changes at a UK level which will make it more difficult to carry forward unspent funding into the following year.

50. The Scottish Government is responsible for managing the NHS budget as a whole and achieving the overall NHS financial target to ensure total expenditure does not exceed funding. The NHS met its overall budget in 2010/11 and all NHS bodies met their individual financial targets. The Scottish Government monitors the financial position of NHS bodies during the year and adjustments may be made in-year. NHS bodies continue to find achieving financial targets challenging and some rely on these in-year funding adjustments. For example, NHS Orkney received £0.8 million of planned additional funding and a further £1.3 million of unplanned funding from the Scottish Government to meet specific cost pressures. This additional funding enabled the board to meet its financial targets.

51. The overall NHS underlying deficit reduced from £39 million in 2009/10 to £12 million in 2010/11, with just under £25 million of this reduction coming from four territorial boards. The net recurring deficit is 0.1 per cent of funding, but ten territorial NHS boards still reported an underlying recurring deficit (Exhibit 13, Case study 5 and Case study 6, overleaf). No special NHS board reported a recurring deficit in 2009/10 or 2010/11.

Efficiency savings helped NHS bodies to break even in 2010/11

52. Efficiency savings are:

- 'providing the same for less' – lower costs of delivery while maintaining service quality
- 'providing more for the same' – improving the quality and/or quantity of service within existing budgets.

53. NHS bodies estimated that they needed to make £309 million efficiency savings in 2010/11 to meet their financial targets. Actual reported efficiency savings were £292 million in 2010/11, representing three per cent of revenue funding. This was an increase from £202 million in 2009/10. All NHS boards have to achieve a two per cent efficiency target over the three years from 2008/09. Appendix 2 shows that all boards met this target except NHS Forth Valley.

54. NHS bodies continue to identify other ways to reduce spend; for example, stopping staff catering subsidies, selling buildings, reducing hospitality and travel, and reducing external training. These examples were identified by NHS bodies in their financial plans for 2010/11 and reported as planned efficiency savings. While these actions reduce expenditure and contribute to achieving financial targets, they do not necessarily demonstrate increased productivity or efficiency.

55. Planned efficiency savings identified in local delivery plans are grouped by areas in the NHS Efficiency and Productivity Programme. Savings from workforce changes and increased clinical productivity were the two largest areas and account for 60 per cent of categorised planned savings in 2010/11 (Exhibit 14). Improvements to clinical services include improving the efficiency of operating theatres, reducing healthcare-associated infections, streamlining discharge processes, and increasing the number of day cases. Workforce savings focus on reducing locum and bank staff costs, reviewing management structures, reducing overtime, and managing sickness absence. Examples of clinical efficiency include reducing the length of hospital stay for patients who have had an operation (Case study 7, page 23).

The NHS continues to find it difficult to quantify productivity

56. Several reports have highlighted the importance of improving productivity in the NHS across the UK as the NHS seeks to provide better health outcomes with the same or fewer resources.[48, 49] The Scottish Government introduced

46 £10.4 billion is the Departmental Expenditure Limit (DEL), which is day-to-day spending and running costs and includes expenditure that is generally more predictable and controllable (Source: Scottish Public Finance Manual).
47 NHS bodies have two financial targets: Revenue Resource Limit (RRL) is the amount of money an NHS board is allocated to spend on day-to-day operations in any one financial year; and Capital Resource Limit (CRL) is the amount of money an NHS board is allocated to spend on capital schemes in any one financial year. NHS boards also received £0.6 billion during 2010/11 for some Family Health Services, which are not included in the RRL.
48 *Spending on Health*, Centre for Public Policy for Regions, June 2010.
49 *Funding and Performance of Healthcare Systems in the Four Countries of the UK Before and After Devolution*, Nuffield Trust, January 2010.

Exhibit 13

Change in recurring surplus or deficit from 2009/10 to 2010/11

The table shows how NHS bodies contributed to the reduction of the underlying NHS recurring deficit from £39 million to £12 million.[1] Ten NHS boards reported an underlying deficit in 2010/11.

NHS board	2009/10 underlying recurring deficit (-) / surplus (£000s)	2010/11 underlying recurring deficit (-) / surplus (£000s)	Contribution to the overall reduction in the underlying recurring deficit (£000s)
Ayrshire and Arran	-	-	-
Borders	-944	-928	16
Dumfries and Galloway	2,641	4,946	2,305
Fife	-995	-1,200	-205
Forth Valley	-8,853	-8,000	853
Grampian	-1,090	-2,020	-930
Greater Glasgow and Clyde	-18,100	-2,000	16,100
Highland	79	56	-23
Lanarkshire	400	500	100
Lothian	-9,000	-4,000	5,000
Orkney	-2,669	-2,890	-221
Shetland	-1,364	-1,300	64
Tayside	-2,576	-1,363	1,213
Western Isles	-1,155	-844	311
Special boards	4,638	6,695	2,057
Total	**-38,988**	**-12,348**	**26,640**

Note: 1. NHS Ayrshire and Arran's underlying financial position did not change between 2009/10 and 2010/11.
Source: NHS bodies' financial returns (signed by each director of finance)

Case study 5

Financial position in NHS Forth Valley

NHS Forth Valley's surplus of £0.053 million in 2010/11 was consistent with its financial forecasts but was achieved on a non-recurring basis as in previous years. To achieve the surplus, the board brought forward £1 million of funding from 2012/13 and borrowed £2.1 million from the Scottish Government. This will be repayable in future years.

Forth Valley Royal Hospital was built using PFI funding at a total cost of £271 million in 2010/11, for the first two of three phases of the development. The new hospital increases the financial challenges facing the board due to ongoing PFI commitments.

Source: NHS Forth Valley annual audit report, 2011

Case study 6

Financial position in NHS Orkney

In 2010/11, NHS Orkney made progress in improving financial monitoring and reporting but has continuing financial pressures. Cost pressures in 2010/11 included unplanned patient expenditure (£1 million) and temporary staffing cover (£0.51 million). The Scottish Government provided non-recurring funding to help the board address its underlying recurring deficit of around £2.8 million. This represents six per cent of total funding (£46 million) for NHS Orkney for the year.

The delayed impact of savings schemes is also contributing to the underlying recurring deficit. These savings schemes are now considered by NHS Orkney to have been too ambitious to fully achieve in one year.

Source: NHS Orkney annual audit report, 2011

Case study 7

Efficiency programme in NHS Borders

Patients having elective major orthopaedic operations were staying longer in hospital in NHS Borders than in other areas. The board used 12 beds to support an enhanced post-surgery recovery programme and has reported early successes. The programme is aimed at supporting rehabilitation and therefore speeding up a patient's recovery after surgery. Before the programme was introduced, 300 patients having a specific operation each year stayed in hospital for an average of 7.7 days; after implementation, 400 patients having the same operation stayed, on average, 3.5 days.

Source: Scottish Government health and social care directorate, 2011

Exhibit 14

Planned efficiency savings, 2010/11[1, 2]

NHS bodies planned to deliver savings of £42 million and £36 million from reducing the NHS workforce and increased clinical productivity respectively.

Efficiency and productivity programme area	2010/11 planned efficiency savings (£000)	% of total classified savings
Workforce	42,087	32
Clinical productivity	36,162	28
Support services	15,307	12
Drugs and prescribing	14,467	11
Procurement	13,229	10
Estates and facilities	9,949	8
Total classified savings	**131,201**	
Unclassified savings	**177,692**	
Total planned savings	**308,893**	

Notes:
1. Unclassified savings are savings planned by NHS Greater Glasgow and Clyde, Lothian and National Services Scotland but local delivery plans submitted by these bodies did not report savings by category.
2. In 2010/11, NHS boards reported achieving £292 million of the £309 million planned savings.
Source: NHS local delivery plans, 2010

The NHSScotland efficiency and productivity programme in 2008 to support the NHS to improve efficiency and productivity. The focus has been on supporting NHS boards to improve benchmarking and to encourage changes to services by using improvement tools and techniques. The first progress report was prepared in June 2010 and the programme was updated in February 2011. The progress report includes examples of good practice, but clearly states that continued effort is required to increase efficiency and productivity.

57. Significant work is still required to develop and implement systems which adequately measure productivity in the NHS in Scotland. Information is needed on activity, costs and quality. While hospital activity data are generally good, they are not sufficient to demonstrate improved productivity. In order to do this, measures of quality need to be applied and cost information needs to improve. For example, Audit Scotland's 2010 report on orthopaedic services concluded that NHS boards need a better understanding of how they use resources if they are to increase productivity without affecting the quality of services.[50]

58. The Scottish Government and the NHS are developing a system to cost patient activity. This is part of an integrated resource framework and aims to link costs to individual patients and increase clinicians' involvement in managing costs. This system is at an early stage of development.

Technology can help boards in responding to financial pressures

59. The Scottish Government published its second NHS eHealth strategy in September 2011.[51] The strategy covers the period 2011 to 2017 and recognises the potential for technology to improve healthcare and efficiency. While the strategy provides examples of progress made under the previous eHealth strategy (Case study 8 and Case study 9), it outlines significant changes planned and required in the future.

60. In 2011, Audit Scotland reviewed the use of telehealth in the 14 territorial NHS boards and concluded that telehealth offers the potential to help NHS boards deliver a range of clinical services more efficiently and effectively.[52, 53] Our report highlighted that experiences of patients and staff involved in telehealth initiatives are broadly positive. The report recommended that NHS boards should consider the use of telehealth when introducing or

50 *Review of orthopaedic services*, Audit Scotland, March 2010.
51 *eHealth Strategy 2011-17*, Scottish Government, September 2011.
52 *A review of telehealth in Scotland*, Audit Scotland, October 2011.
53 Telehealth is the provision of healthcare to patients at a distance using a range of technologies, such as mobile phones, internet services, digital televisions, video-conferencing and self-monitoring equipment.

redesigning clinical services, and that better-quality evaluations are required to provide reliable evidence on the overall effectiveness of telehealth and whether it offers better value for money than traditional patient care.

There is scope for greater consistency in the assumptions used for financial plans

61. In 2010/11, the majority of auditors commented positively on links between NHS bodies' financial and operational plans although auditors of three NHS boards reported the need for improved financial management and reporting processes.[54] Auditors did not report any significant weaknesses in governance arrangements or financial controls in 2010/11.

62. NHS bodies' local delivery plans summarise the assumptions used to inform future financial plans. All bodies make assumptions in the same areas, such as pay rises, inflation and medicine costs. There are differences in the assumptions made by NHS boards due to differing local pressures and how boards manage these. NHS boards need to understand the various assumptions they use to inform financial plans and to help with this they attend a Corporate Finance Network to discuss their approach to setting assumptions.

63. The Scottish Government introduced the NHSScotland Resource Allocation Committee (NRAC) formula in 2009/10 for allocating funding to the territorial boards. The funding changes will be phased in over time to allow boards to plan for any significant differences in their budgets. The funding increases allocated to NHS boards in 2011/12 are aimed at moving boards closer to their target allocation (Exhibit 15). Auditors of three boards identified significant risks to boards achieving their financial plans if the boards' target allocations take longer than expected to be implemented.[55]

Case study 8
The Strathclyde Electronic Renal Patient Record

The Strathclyde Electronic Renal Patient Record (SERPR) was implemented in 2010. It is hosted and managed by NHS Greater Glasgow and Clyde and also involves NHS Lanarkshire, NHS Ayrshire and Arran, NHS Forth Valley, NHS Dumfries and Galloway and the National Waiting Times Centre. SERPR reportedly delivers a number of clinical benefits, including laboratory data for new patients available in 10 to 20 minutes; patient demographics uploaded instantly; reduced reliance on paper case notes; easier and faster data entry for clinical staff; and a unified system across six boards enabling greater information exchange.

Source: *eHealth strategy 2011-17,* Scottish Government, 2011

Case study 9
Using the Emergency Care Summary for scheduled patients

In spring 2010, NHS Lanarkshire ran a pilot project on using an Emergency Care Summary (ECS) in scheduled care. The ECS has been used in emergency care to help clinicians treating patients who need urgent care. The ECS allows clinicians to view basic patient information to help diagnose and treat patients needing urgent care. The objectives were to fully evaluate and capture the benefits and clinical impact from the use of the ECS in managing elective patients in hospitals. Doctors and nurses involved believe that access to this information prevented harm to 23 patients. Pilots have also taken place in NHS Lothian and NHS Tayside to evaluate the potential improvements to patient safety in non-emergency admissions and outpatient clinics. The preliminary results are also positive.

Source: *eHealth strategy 2011-17,* Scottish Government, 2011

54 NHS Ayrshire and Arran, Orkney, Shetland.
55 NHS Fife, Forth Valley and Lothian.

Exhibit 15

Differences between initial 2011/12 funding allocations and NHSScotland Resource Allocation Committee (NRAC) target allocations

No board is receiving its NRAC target share of funding in 2011/12.

NHS board	Initial allocation at start of 2011/12 (£m)	NRAC target allocation for 2011/12 (£m)	Difference (£m)	Difference %
Ayrshire and Arran	575	559	16	2.9
Borders	167	158	9	5.7
Dumfries and Galloway	242	227	15	6.6
Fife	507	519	-12	-2.3
Forth Valley	403	414	-11	-2.7
Grampian	691	726	-35	-4.8
Greater Glasgow and Clyde	1,896	1,834	62	3.4
Highland	485	477	8	1.7
Lanarkshire	816	827	-11	-1.3
Lothian	1,054	1,113	-59	-5.3
Orkney	32	32	-	0.0[1]
Shetland	37	34	3	8.8
Tayside	596	593	3	0.5
Western Isles	58	46	12	26.1
Total	**7,559**	**7,559**	-	**0.0**

Note: 1. The difference is £0.3 million (one per cent), which is zero when rounded to the nearest million.
Source: Scottish Government, 2011

Part 3. NHS performance in improving Scotland's health

Aspects of healthcare have improved but significant health challenges remain.

Key messages

- Healthy life expectancy in Scotland has increased in recent years and rates of deaths from coronary heart disease, stroke and cancer have continued to decrease. However, overall life expectancy in Scotland remains lower than that of most other western European countries and there remain significant health inequalities across Scotland. The NHS and the wider public sector continue to face significant challenges in tackling levels of obesity, smoking, and alcohol and drug misuse. A greater focus on preventative services is needed.
- The NHS met three-quarters of the 28 performance targets due for delivery in 2010/11. Performance against these targets varied considerably among individual NHS boards.
- The Scottish Patient Safety Programme has led to improvements, including continued reductions in healthcare-associated infections. The NHS is also making good progress towards meeting its target to treat all patients within 18 weeks of being referred to hospital.
- Over 80 per cent of patients who responded to recent surveys were satisfied with the treatment they received from the NHS in Scotland. A new standard has been introduced to assess the performance of NHS boards in involving patients and the public.

The Healthcare Quality Strategy provides a basis for the NHS to improve the quality of healthcare

64. In May 2010, the Scottish Government published *The Healthcare Quality Strategy for NHSScotland* which aims to improve the quality of healthcare provided and the healthcare experience for everyone in Scotland. The strategy builds on the previous *Better Health, Better Care* strategy (published in December 2007) and contains several quality ambitions which aim to deliver person-centred, safe and effective healthcare.

65. The Quality Strategy includes a number of priority areas, for example to reduce healthcare-associated infections, and a range of associated interventions which aim to help the NHS achieve its quality ambitions. The Quality Strategy also highlights that a range of national systems need to be developed or improved to help the NHS and its partners to achieve the quality ambitions. These include:

- simplifying the wide range of performance indicators which are used across the NHS
- developing and supporting appropriate IT infrastructure such as standardised patient-management systems
- ensuring that the various strands of governance (financial, clinical and staff) provide NHS boards, government, Parliament and the public with assurance about the quality of healthcare
- communicating clearly and effectively with NHS staff, stakeholders and the public.

The NHS is taking steps to improve prevention and early detection of ill health and to address health inequalities

66. In January 2011, the Scottish Parliament Finance Committee published a report on its inquiry into preventative spending.[56] The Committee recommended that Scotland's public sector should focus more on prevention and early intervention rather than reacting to problems once they have occurred. In his evidence to the Committee, the Chief Medical Officer suggested that significant cost savings could be made for the NHS in Scotland by investing in preventative measures to reduce the future incidence of smoking, obesity and alcohol misuse. Previous Audit Scotland reports – including those on mental health services, and drug and alcohol services – have also emphasised the importance of early intervention and prevention, and identified a lack of investment in these areas.[57]

67. The NHS has taken steps to identify those at risk from ill health at an early stage. In February 2011, it introduced 'Life Begins at 40' as a new service across Scotland which invites all people turning 40 for a health check. In 2011, it also launched a four-year pilot (costing over £3.5 million over the four years) to explore the feasibility of introducing heart check-ups for all people in Scotland over 40. In 2010, the Scottish Parliament's Public Audit Committee welcomed the use of anticipatory care programmes but expressed concerns about whether it is the most effective use of funding for these programmes to be available to all rather than targeted on people in the most deprived areas.[58]

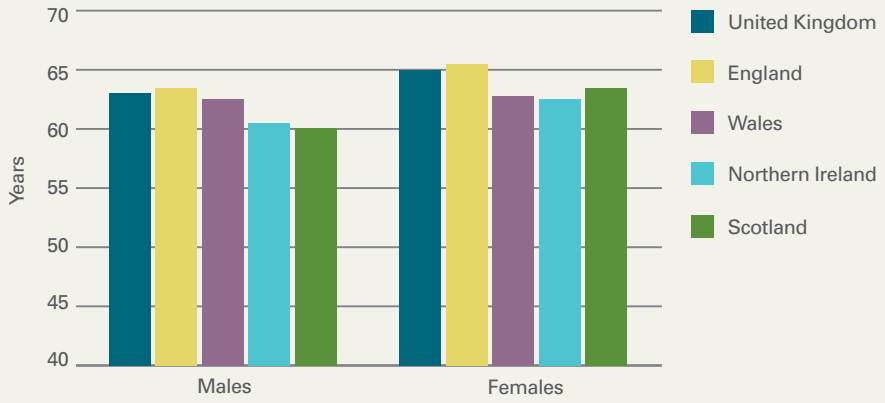
68. Between 1999/2000 and 2007/08, healthy life expectancy in Scotland increased by around three years for men and over two years for women but these figures remain lower than the UK average.[59] In 2007-09, healthy life expectancy among males in Scotland was around three years lower than the UK average, and for females in Scotland it was around 1.5 years lower (Exhibit 16, overleaf). There is large variation in healthy life expectancy within Scotland. In 2007/08, a man living in the most

56 Scottish Parliament Finance Committee report (SP Paper 555), 2011.
57 *Drug and alcohol services in Scotland*, Audit Scotland, March 2009; *Overview of mental health services*, Audit Scotland, May 2009.
58 Scottish Parliament Public Audit Committee report (SP Paper 494), 2010.
59 *Scotland Performs: National Indicators*, Scottish Government, 2011.

Exhibit 16

Healthy life expectancy at birth in the UK, 2007-09

Healthy life expectancy for men in Scotland is lower than in the other UK countries.



Source: Office for National Statistics, 2011

deprived 15 per cent of areas in Scotland could expect to live in good health for 10.5 years less than the national average. The corresponding gap for women was 8.6 years.[60]

69. The most recent figures published by National Records of Scotland indicate that, while overall life expectancy in Scotland has increased, it remains lower than in most other western European countries.[61] Among European Union countries, life expectancy among males was highest in Sweden (79.4 years), 3.6 years higher than in Scotland. Female life expectancy was highest in France (85.0 years), 4.6 years higher than in Scotland.

70. One of the Scottish Government's key priorities is to address inequalities in health outcomes experienced by people living in deprived areas. In its 2008 report *Equally Well*, the Ministerial Task Force on Health Inequalities identified the key actions and interventions which affect healthy life expectancy across Scotland.[62] These include: taking action during children's early years to address future inequalities in health; tackling poverty and increasing employment; providing physical environments which impact positively on people's health and well-being; and tackling the problems associated with alcohol, drugs and violence. These represent major challenges to Scotland as a whole – not just for the NHS – and addressing them will require effective joint working across the Scottish public sector.

71. In 2010, the Ministerial Task Force published a review of *Equally Well* to assess progress to date.[63] The report included examples of shared learning among the eight *Equally Well* test sites but noted that there was not yet a consistent pattern of community engagement when developing local services. Audit Scotland plans to carry out an audit of health inequalities in Scotland during 2012.

72. In May 2010, the Scottish Government announced plans to extend the 'Keep Well' programme, which currently provides health checks in certain areas of high deprivation, to all of Scotland's most deprived communities from 2012. Extending the programme will cost £11 million. The Scottish Government has established a national indicator to reduce mortality from coronary heart disease (CHD) among under 75s in deprived areas. The most recent figures indicate that, in the 15 per cent most deprived areas, the mortality rate decreased from around 110 per 100,000 population in 2006 to around 97 per 100,000 in 2009.[64] The corresponding figures for Scotland as a whole (62 per 100,000 in 2006 and 50 per 100,000 in 2009) indicate that the gap between the national average and the most deprived areas has narrowed slightly.

73. The NHS had a target to increase the number of inequalities-targeted cardiovascular health checks delivered in Scotland during 2010/11. All NHS boards achieved their individual targets of providing increased numbers of these anticipatory care checks which aim to help prevent the development of cardiovascular disease.

Mortality rates from coronary heart disease, stroke and cancer continue to decrease

74. The long-term downward trend in mortality rates from the three biggest causes of premature death in Scotland – CHD, stroke and cancer – has continued (Exhibit 17).

- Between 2000 and 2010, the mortality rate from CHD decreased by around 40 per cent. There was a similar decrease in mortality rate in the most deprived 20 per cent of areas in Scotland but it remained around 15 per cent higher than the national average.
- Between 1995 and 2010, the mortality rate from CHD among under 75s decreased by 60.7 per cent, achieving the Scottish

60 *Scotland Performs: National Indicators*, Scottish Government, 2011.
61 *Life expectancy for areas in Scotland, 2008-2010*, National Records of Scotland, 2011.
62 *Equally Well: Report of the Ministerial Task Force on Health Inequalities*, Scottish Government, 2008.
63 *Equally Well Review 2010*, Scottish Government, 2010.
64 *Scotland Performs: National Indicators*, Scottish Government, 2011.

Government's target of a 60 per cent reduction by 2010.[65]

- The mortality rate from stroke among under 75s decreased by around 59 per cent between 1995 and 2010, meeting the Scottish Government's target of a 50 per cent reduction in premature stroke mortality over this period.[66] This reduction was achieved despite only 39 per cent of stroke patients being admitted to a stroke unit on the day of admission (against a national standard of 60 per cent) and 63 per cent being admitted by the following day (against a national standard of 90 per cent).[67] These national standards relate to the best evidence for positively affecting patient outcomes.

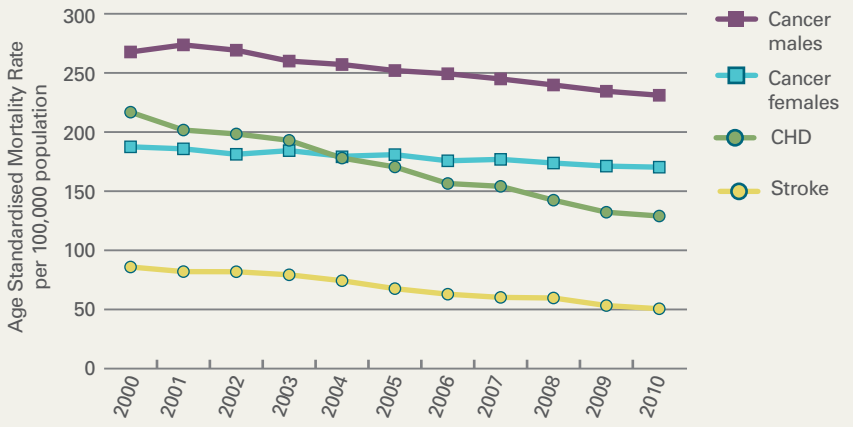
- Overall age-standardised cancer mortality rates in Scotland decreased by about 12 per cent between 2000 and 2010, and mortality rates for all major cancers decreased among both males and females with the exception of lung cancer in females which increased by 11 per cent. Between 1999 and 2009, the number of new cancer registrations increased by about 14 per cent and the number of deaths from cancer increased by around three per cent. These figures reflect the fact that cancer is more common among older people, and the number of older people is increasing.[68]

75. Cancer incidence in Scotland is projected to increase by approximately eight per cent every five years up to 2020, and cancer remains a national clinical priority. In December 2010, the Scottish Government published a report which outlined the progress made since it published *Better Cancer Care: An Action Plan* in 2008.[69] This progress includes: extending the national bowel screening programme to include all territorial NHS boards in Scotland from December 2009; strengthening collaborative working to improve genetic and molecular testing; and achieving the target to treat 95 per cent of all patients within 62 days of being urgently referred following diagnosis with cancer. In its *Spending Review and Draft Budget 2012-13*, the Scottish Government stated that it will invest £30 million and establish new approaches to detecting cancer early.

Exhibit 17

Mortality rates from CHD, stroke and cancer, 2000-10

Mortality rates have continued to decrease, most markedly for CHD and stroke.



Source: ISD Scotland, 2011

Scotland faces significant challenges in tackling obesity

76. Scotland has one of the highest levels of obesity in the world – among OECD countries, only the USA and Mexico have higher levels.[70] In 2010, almost two-thirds of men aged 16-64 and more than half of women in Scotland were classified as either overweight, obese or morbidly obese. Both these figures were over ten per cent higher than in 1995, and over a million adults in Scotland (more than a quarter of the adult population) are obese or morbidly obese. In addition, more than 150,000 children are classified as obese. Obesity levels among adults in Scotland are predicted to exceed 40 per cent by 2030, an increase of more than 50 per cent compared with 2008 levels.[71]

77. Being obese or overweight can increase the risk of developing a range of serious diseases, including type 2 diabetes, hypertension, heart disease, some cancers and premature death. The Scottish Government estimated that the total cost to Scottish society of obesity in 2007/08 was over £457 million.[72]

65 ISD Scotland, 2011.
66 *Stroke statistics update*, ISD Scotland, 2011.
67 *Scottish Stroke Care Audit: 2011 National Report on Stroke Services in Scottish Hospitals*, NHS National Services Scotland, 2011.
68 *Cancer mortality in Scotland*, ISD Scotland, 2010.
69 *Better Cancer Care Progress Report 2010*, Scottish Government, 2010.
70 The Organisation for Economic Co-operation and Development (OECD) produces data on a range of issues affecting the lives of ordinary people across a number of countries.
71 *Scotland's obesity strategy*, Scottish Government, 2010.
72 Ibid.

78. The Scottish Government has taken various steps to tackle obesity, including publishing *Healthy Eating, Active Living* in June 2008 as an action plan to improve diet, increase physical activity and tackle obesity by 2011; setting a national target to reduce the rate of increase in the proportion of children outwith the healthy weight range by 2018; and publishing (with COSLA) a long-term obesity strategy *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight* in February 2010. The strategy states that obesity is not just a health issue and outlines the various actions which central government, local government and the NHS will take to prevent and manage obesity in Scotland. In March 2011, the Scottish Government published an action plan and a set of 16 indicators which it will use to monitor progress in tackling obesity.[73, 74] The action plan includes milestones for achieving specific aspects of the strategy, and the Scottish Government plans to update the indicators every year. The Scottish Government also established a Joint Obesity Ministerial Group to oversee the implementation of the strategy.

79. The Scottish Government has established a national indicator to reduce the rate of increase in the proportion of children with their Body Mass Index outwith a healthy range by 2018. The most recent figures indicate that the average rate of increase started to fall between 2008 and 2009 (9.2 per cent).[75] However, it increased again by 6.6 per cent between 2009 and 2010. Between 2008/09 and 2010/11, the NHS had a target to deliver 6,317 child healthy weight interventions to help tackle obesity. The NHS as a whole delivered 8,406 interventions during this period, and all NHS boards achieved their individual targets.

Indicators of alcohol misuse, drug misuse and smoking have improved but significant challenges remain

80. The number of alcohol-related deaths in Scotland in 2010 was around 1,300 – about the same level as in 2000 but twice as high as in 1990.[76] Levels of alcohol-related hospital admissions in Scotland increased by over a third between 1997/98 and 2007/08 but decreased in both 2008/09 and 2009/10 by around three and seven per cent respectively.[77] Similarly, between 1989 and 2009 there was an approximate threefold increase in the number of men diagnosed with chronic liver disease, and a twofold increase among women.[78] Both figures decreased slightly in 2010 but alcohol misuse remains a significant problem in Scotland.

81. Alcohol misuse costs Scotland an estimated £3.6 billion a year and in 2010 alcohol sales in Scotland were around a quarter higher than in England and Wales.[79, 80] This was the biggest difference ever recorded. The Scottish Government introduced the Alcohol Minimum Pricing Bill in autumn 2011 which proposes a minimum price per unit of alcohol.[81] The Bill aims to improve public health in Scotland by reducing alcohol consumption.

82. The total economic costs of drug misuse in Scotland are estimated to be between £2.6 billion and £3.5 billion a year.[82, 83] In 2006, there were around 55,000 problem drug users in Scotland. The Scottish Government has established a national indicator to reduce this number by 2011, although it has not specified the level of reduction. The NHS will publish 2009/10 figures in December 2011. In 2010, there were 485 drug-related deaths in Scotland, a decrease of 11 per cent compared with 2009.[84] However, this was the third highest total ever recorded and the number of drug-related deaths has increased in six of the past ten years.

83. Smoking in adults decreased gradually from 30.7 per cent in 1999 to 24.2 per cent in 2010 although this was still higher than the Scottish Government's target of 22 per cent by 2010.[85] Despite this decrease, there are still over one million adult smokers in Scotland and around 13,000 smoking-related deaths each year – around a quarter of the total number of deaths in Scotland.[86] In 2010/11, there were around 90,000 successful quit attempts made with the help of NHS smoking cessation services in Scotland, surpassing the NHS target to achieve around 84,000 successful quit attempts.

84. The number of new cases of chronic obstructive pulmonary disease (COPD) in Scotland decreased by over ten per cent among both males and females between 2008 and 2010. Although there is no indication that this reduction was directly linked to the smoking ban which was introduced in Scotland in 2006, there is some evidence that the ban may have reduced the incidence of asthma among children (Case study 10).

73 *Obesity Route Map Action Plan*, Scottish Government, 2011.
74 *Indicators to Monitor Progress of the Obesity Route Map*, Scottish Government, 2011.
75 *Scotland Performs: National Indicators*, Scottish Government, 2011.
76 National Records of Scotland, 2011
77 ISD Scotland, 2010
78 Scottish Public Health Observatory, 2011.
79 *The Societal Cost of Alcohol Misuse in Scotland 2007*, Scottish Government, 2010.
80 Scottish Government, 2011.
81 *Renewing Scotland: The Government's Programme for Scotland 2011-12*, Scottish Government, 2011.
82 *Drug and alcohol services in Scotland*, Audit Scotland, March 2009.
83 *Assessing the Scale and Impact of Illicit Drug Markets in Scotland*, Scottish Government, 2009.
84 *Drug-related deaths in Scotland in 2010*, General Register Office for Scotland, 2011.
85 *Scotland's People Annual report: Results from 2009/10 Scottish Household Survey*, Scottish Government, 2011.
86 Scottish Public Health Observatory, 2011.

Case study 10

Impact of the smoking ban on childhood asthma admissions

Scotland was the first country in the UK to implement a ban on smoking in public places. Prior modelling work and evidence from other countries indicated that such a ban was likely to reduce second-hand smoke exposure, with a consequent reduction in morbidity and mortality from heart disease and other causes.

To assess the impact of the ban on hospitalisations for childhood asthma, researchers at the University of Glasgow used the Scottish Morbidity Record dataset to identify the numbers of admission and deaths attributable to asthma before and after the ban was introduced in March 2006. This study, the first nationwide study anywhere in the world of the impact of smoke-free legislation on childhood asthma, found that admissions fell by 18 per cent following the ban, compared with a five per cent annual reduction in the years before the ban.

Source: *eHealth strategy 2011-17*, Scottish Government, 2011

Healthcare-associated infections and mortality in hospitals are both decreasing

85. Adverse events, such as contracting healthcare-associated infections (HAIs) or experiencing post-surgical complications, are estimated to cost the NHS in Scotland around £200 million a year in extra treatment and lost bed days.[87] One of the Quality Ambitions in *The Healthcare Quality Strategy for NHSScotland* states that people will receive no avoidable harm or injury from the care they receive, and healthcare services will be provided in an appropriate clean and safe environment at all times.

86. In January 2008, the NHS established the Scottish Patient Safety Programme which aims to improve the safety and reliability of hospital care in Scotland.[88] One aim of the programme, which has been implemented in every acute hospital across Scotland, is to reduce the frequency of HAIs.[89] The NHS had two associated targets for delivery in 2010/11:

- reduce all Staphylococcus aureus bacteraemia (including MRSA) cases by 41 per cent between 2005/06 and 2010/11
- reduce the rate of Clostridium difficile infections in patients aged 65 and over by at least 30 per cent between 2007/08 and 2010/11.

87. The NHS achieved its target to reduce the rate of Clostridium difficile infections (a 71 per cent reduction by 2010/11) and although it missed its target to reduce the number of Staphylococcus aureus bacteraemia cases, it achieved a 37 reduction by 2010/11 (Exhibit 18, overleaf).

88. The Scottish Patient Safety Programme also aims to reduce hospital mortality by 15 per cent by December 2012. Hospitals participating in the programme use Hospital Standardised Mortality Ratios to monitor their progress against this target over time.[90] Compared with the 2006/07 baseline, mortality ratios had decreased by around seven per cent during the first quarter of 2011.

89. In his 2010/11 annual report, the chief executive of the NHS in Scotland included further examples of progress towards achieving the key aims of the Scottish Patient Safety Programme, including a range of improvement which reduced the incidence of healthcare acquired infection.[91]

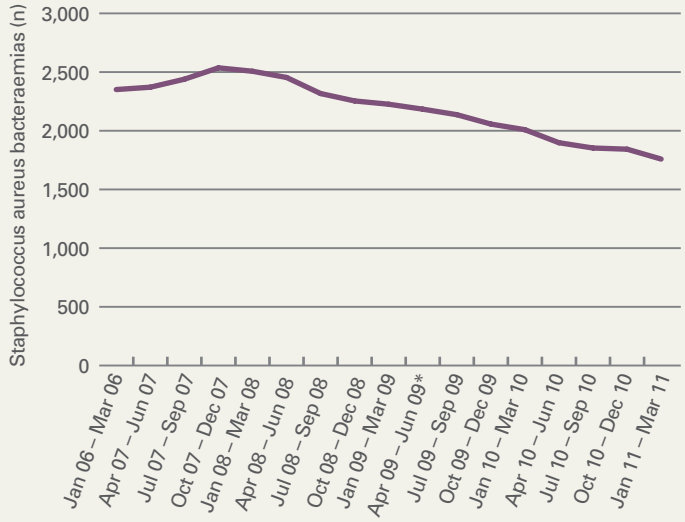
90. The Scottish Government established the Healthcare Environment Inspectorate in 2009 to carry out at least one announced and one unannounced inspection of all acute hospitals across the NHS in Scotland every three years. The inspectorate assesses each acute hospital against the HAI standards which NHS Quality Improvement Scotland (now Healthcare Improvement Scotland) published in 2008. By September 2011, the inspectorate had carried out 36 announced and 30 unannounced inspections of around 40 hospitals in Scotland as well as the NHS National Waiting Times Centre and the Scottish Ambulance Service. In its 2009/10 annual report, the inspectorate stated that most hospitals were generally clean and had good practices for preventing and controlling infection. However, there were some areas which required improvement, including communication between infection control teams and senior management; consistent implementation of standard infection-control precautions; and greater attention to detail in cleaning.

87 *Scottish patient safety programme*, NHS Healthcare Improvement Scotland, 2011.
88 *Scottish patient safety programme*, NHS Healthcare Improvement Scotland, 2011.
89 Some NHS boards have started implementing the programme in community hospitals, and the NHS plans to extend the programme to primary care and mental health services.
90 Hospital Standardised Mortality Ratio is the ratio of the number of deaths in a hospital within a given time period (observed deaths) to the number of deaths that might be predicted if the hospital had the same death rates as a reference population. The calculation includes patients who died within 30 days of admission to hospital and variables are adjusted for a range of factors including each patient's primary diagnosis, age, sex, and number and severity of prior illnesses.
91 *NHSScotland Chief Executive's Annual Report 2010/11*, NHSScotland, 2011.

Exhibit 18

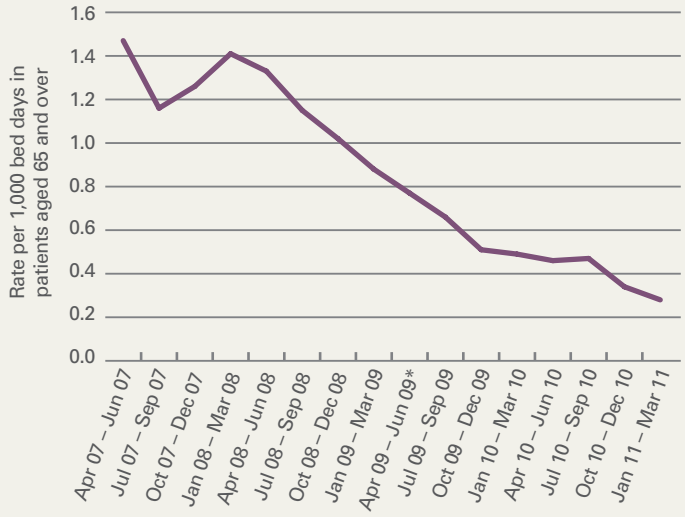
Healthcare-associated infections, 2006 to 2011

The incidence of Staphylococcus aureus bacteraemia has decreased by over a third since 2007/08.



* National Waiting Times Centre data included from April 2009

The rate of Clostridium difficile infections among people aged 65 and over decreased by over two-thirds since 2007/08.



* National Waiting Times Centre data included from July 2008
Source: Health Protection Scotland, 2011

Healthcare Improvement Scotland is also carrying out a programme of inspections to ensure hospitals are complying with the 2002 standards for Care for Older People in Acute Settings.

Admissions to hospital for mental health problems continue to fall but antidepressant prescribing is increasing

91. Mental health is a priority for the Scottish Government and it has established a national indicator to improve mental well-being by 2011.[92] The Scottish Government aims to increase the average score of adults on the Warwick-Edinburgh Mental Well-being Scale but the most recent results (from 2010) show a similar level to the previous year and a slight decrease from the 2006 baseline.[93]

92. In 2009/10, there were around 21,500 admissions to hospital for mental health problems in Scotland, around seven per cent fewer than in 2008/09.[94] This continued the downward trend since 1997/98 when there were over 32,000 psychiatric admissions. The number of psychiatric readmissions within a year of a previous admission decreased steadily from around 4,600 in the year ending December 2004 to around 3,700 in the year ending March 2008. This reduction of around 19 per cent achieved the NHS target to reduce these readmissions by ten per cent by the end of 2009.[95]

93. Prescriptions for mental health medicines, including those used in the treatment of anxiety, depression, Attention Deficit Hyperactivity Disorder (ADHD) and dementia, are increasing in Scotland.[96] Around 4.7 million antidepressant items were dispensed in Scotland during 2010/11, an increase of around eight per cent

92 *Scotland Performs: National Indicators*, Scottish Government, 2011.
93 The Warwick-Edinburgh Mental Wellbeing Scale is a 14-point scale in which individuals respond to questions about their thoughts and feelings. Researchers are then able to measure an individual's mental well-being.
94 *Mental Health (Psychiatric) Hospital Activity Statistics year ending 31 March 2010*, ISD Scotland, 2010.
95 ISD Scotland, 2011.
96 *Prescribing & Medicines: Medicines used in Mental Health*, ISD Scotland, 2011.

from the previous financial year. Recent estimates indicate that daily use of antidepressants among people aged 15 and over increased from around seven per cent in 2001/02 to over 11 per cent in 2010/11. During this period, the number of defined daily doses per 1,000 population increased by over 60 per cent from around 69 in 2001/02 to 113 in 2010/11.

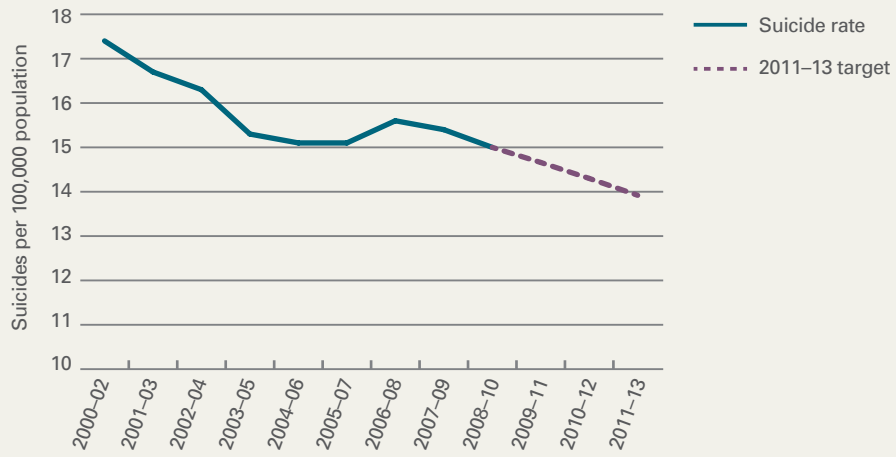
94. There are currently around 80,000 people with dementia in Scotland and this number is expected to double over the next 25 years. In June 2010, the Scottish Government published *Scotland's National Dementia Strategy* which aims to transform dementia services by significantly improving care pathways and strengthening the integration of health and social care services. In June 2011, it published *Standards of Care for Dementia in Scotland* along with a report on the progress made during the first year of the strategy, and in September 2011 it announced that 300 dementia 'champions' will work across the NHS and local authorities to help deliver the required standard of care.[97] To encourage earlier diagnosis and improve the management of people with dementia, each NHS board had a target to increase the number of people diagnosed with dementia by a third between April 2008 and March 2011. The NHS as a whole met this target but three boards did not meet or effectively meet their local targets.[98, 99]

95. In Scotland, suicide is a leading cause of mortality among people under 35. In 2010, there were 781 suicides in Scotland which was around five per cent higher than in 2009. Despite this increase, there was a 14 per cent decrease in suicide rate between 2000-02 (17.4 per 100,000 population) and 2008-10 (15.0 per 100,000 population) (Exhibit 19). The national target is to reduce the rate in Scotland by 20 per cent between 2000-02 and 2011-13. The NHS met its 2010/11 target to deliver suicide prevention training to half of key frontline staff.

Exhibit 19

Suicide rate in Scotland, 2000-02 to 2008-10

The suicide rate decreased by around 14 per cent between 2000-02 and 2008-10.



Source: Scottish Public Health Observatory, 2011

The NHS is making good progress towards meeting the 18 Weeks Referral To Treatment target by 31 December 2011

96. The Scottish Government has established a national indicator and set the NHS a target from December 2011 to treat all inpatients and day cases within 18 weeks of being referred to hospital. This 18-week referral to treatment (RTT) target is the first to consider the patient pathway and encourage joint 'whole-system' thinking across the primary and acute care sectors. Meeting this target was a key pressure facing the NHS in 2010/11. Between January and June 2011, the total number of patients who were treated within 18 weeks of referral increased from 82 per cent to 90 per cent.

97. To determine how long it takes for patients to receive treatment after being referred to hospital, the NHS needs to develop appropriate information systems to track each patient. In June 2011, around three-quarters of patients' information from referral to treatment was able to be linked. NHS boards are currently working with the Scottish Government and ISD Scotland to upgrade their data systems to allow all patients' information to be linked from referral to treatment.

98. To help meet the December 2011 RTT target, the NHS had interim targets to ensure that no day-case patient or inpatient spent longer than nine weeks on a waiting list from 31 March 2011, and no outpatients waited more than 12 weeks for a consultation following referral. In June 2011, less than one per cent of

97 *New measures to improve dementia care*, Scottish Government, 2011.
98 When individual boards delivered over 95 per cent of the difference between the baseline and the target, the NHS considers the target to have been effectively met.
99 NHS Borders, Fife and Orkney.

patients in these categories waited longer than the interim targets.

The NHS has met three-quarters of its 2010/11 performance targets but performance varied among NHS boards

99. The national performance system for the NHS (HEAT) has 47 targets, 28 of which were due for delivery in 2010/11.[100, 101] At November 2011:

- the NHS as a whole had met five national targets and all NHS boards achieved their local targets for these national targets
- the NHS as a whole had met a further 16 national targets but not all boards achieved their local targets
- the NHS as a whole had not met four national targets
- we were unable to determine whether the NHS had met the other three targets as the 2010/11 data were not yet available (Exhibit 20).

100. The targets which the NHS as a whole did not meet were: increasing the percentage of newborn children who are exclusively breastfed; booking GP appointments more than 48 hours in advance; increasing the percentage of GP outpatient referrals which are managed electronically; and reducing the frequency of healthcare-associated infections. Although the NHS did not meet the latter two targets, it has made significant progress in both these areas in recent years.

101. There was variation among individual NHS boards in performance against the national performance targets (Appendix 2). For example:

- The NHS as a whole met the target for at least 80 per cent of 3-5-year-old children to be registered with an NHS dentist, and all boards met this with the exception of NHS Grampian (74 per cent) and NHS Western Isles (54 per cent).
- The NHS had a target to manage 90 per cent of new GP outpatient referrals electronically from December 2010. This target was intended to deliver a faster and more effective referral management process for patients. In January 2011, the NHS managed around 80 per cent of new GP outpatient referrals electronically (a significant increase from around nine per cent in April 2009) and five NHS boards did not meet or almost meet the 90 per cent target (Exhibit 21, page 36).
- At November 2011, NHS Lanarkshire had met the most 2010/11 targets (22 out of 28), and NHS Fife had met the fewest (15).
- No NHS board met its local target to increase the proportion of new-born children exclusively breastfed at six to eight weeks.

The NHS could make further improvements to how it reports performance

102. The chief executive of the NHS in Scotland produces an annual report which comments on performance and the NHS reports its performance against national targets through the Scottish Government website, Scotland Performs. The NHS aims to update this performance information on a monthly basis. Scotland Performs allows the public to access information on how the NHS is performing but there are a number of further improvements the NHS could make to the transparency and timeliness of its performance reporting. These improvements would help patients and the public to better understand how well the NHS is meeting its targets and improving health in Scotland. Such improvements include:

- publishing performance data alongside the relevant targets with clear explanations of whether the targets have been met
- explanations of why targets change between years
- commentary about the quality and timeliness of the data; for example, when data will be available to assess performance against all targets.

103. In addition to national targets, other published measures may be used to assess the health of Scotland's people and the performance of the NHS in Scotland, including:

- Fifteen of the Scottish Government's 45 National Indicators are linked to its strategic objective and national outcome to improve health in Scotland.[102] Some of these indicators relate to issues covered by the NHS national performance targets, including reductions in waiting times, smoking, child obesity and emergency hospital admissions for people aged 65 and over.
- Single Outcome Agreements between Community Planning Partnerships (CPPs) and the Scottish Government which may include a range of health-related indicators. These indicators may correspond to the NHS targets or the health-related national indicators.

100 The HEAT performance management system covers indicators relating to Health improvement, Efficiency, Access to services and Treatment appropriate to individuals.
101 http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance
102 *Scotland Performs: National Indicators*, Scottish Government, 2011.

Exhibit 20

NHS performance against national targets, 2010/11

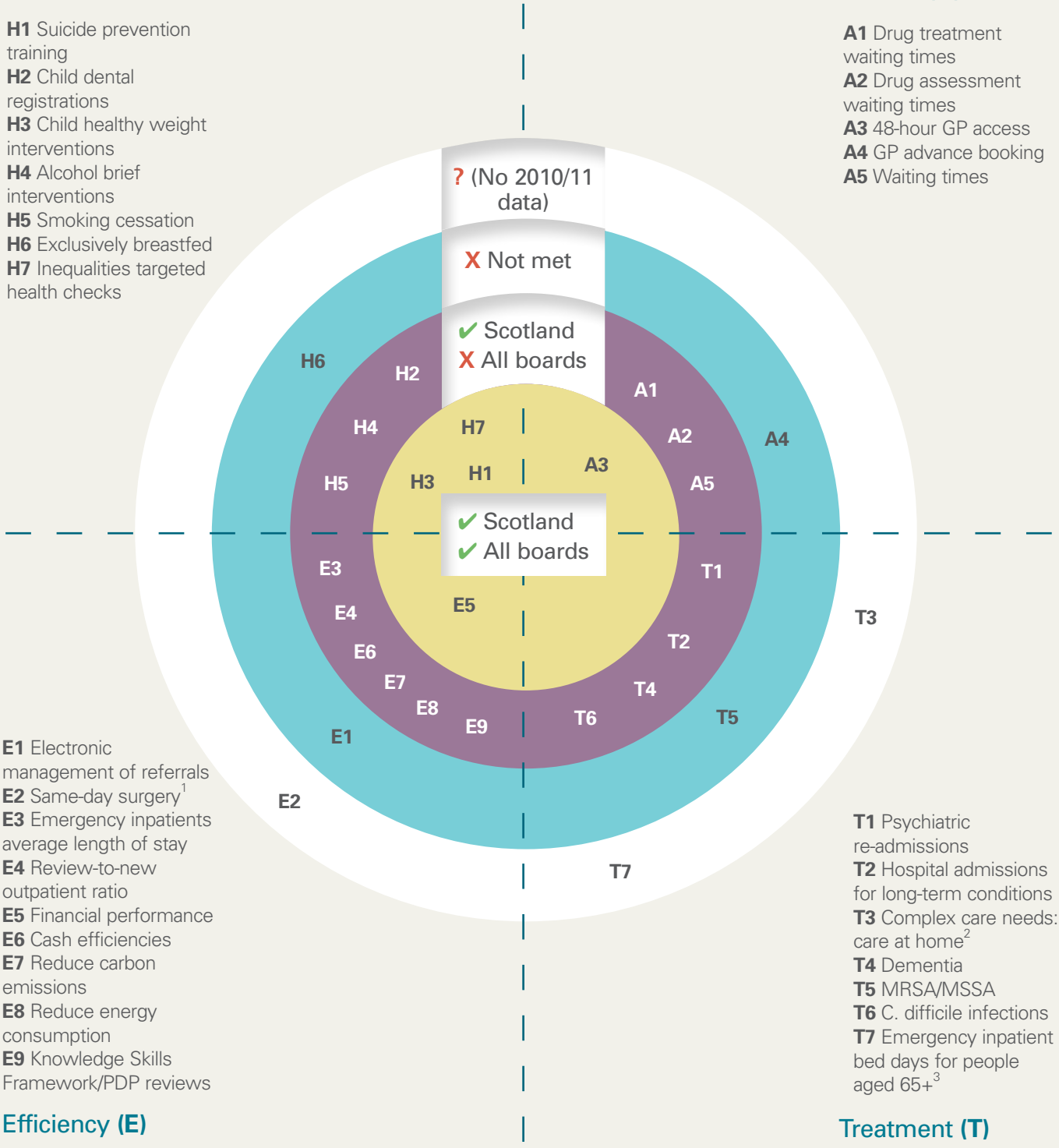
Only five targets were met by the NHS as a whole and by all NHS boards.

Health improvement (H)

H1 Suicide prevention training
H2 Child dental registrations
H3 Child healthy weight interventions
H4 Alcohol brief interventions
H5 Smoking cessation
H6 Exclusively breastfed
H7 Inequalities targeted health checks

Access (A)

A1 Drug treatment waiting times
A2 Drug assessment waiting times
A3 48-hour GP access
A4 GP advance booking
A5 Waiting times



E1 Electronic management of referrals
E2 Same-day surgery[1]
E3 Emergency inpatients average length of stay
E4 Review-to-new outpatient ratio
E5 Financial performance
E6 Cash efficiencies
E7 Reduce carbon emissions
E8 Reduce energy consumption
E9 Knowledge Skills Framework/PDP reviews

Efficiency (E)

T1 Psychiatric re-admissions
T2 Hospital admissions for long-term conditions
T3 Complex care needs: care at home[2]
T4 Dementia
T5 MRSA/MSSA
T6 C. difficile infections
T7 Emergency inpatient bed days for people aged 65+[3]

Treatment (T)

Key ? No data ✔ Target met X Target not met

Notes:
The coding system used here does not directly match the system used by the Scottish Government.
1. E2: Same-day surgery – data only up to December 2010.
2. T3: Complex care needs: care at home – data due to be published in November 2011.
3. T7: Emergency inpatient bed days for people aged 65+ – new data published in December 2011. This is a target for the NHS as a whole.
Source: Scottish Government, 2011

- The Scottish Public Health Network and Observatory (ScotPHO) which publishes information about a range of health outcomes (such as deaths and hospital admissions), health-related behaviour (such as smoking, alcohol intake and drug use) and other factors affecting health (including education and employment).[103]

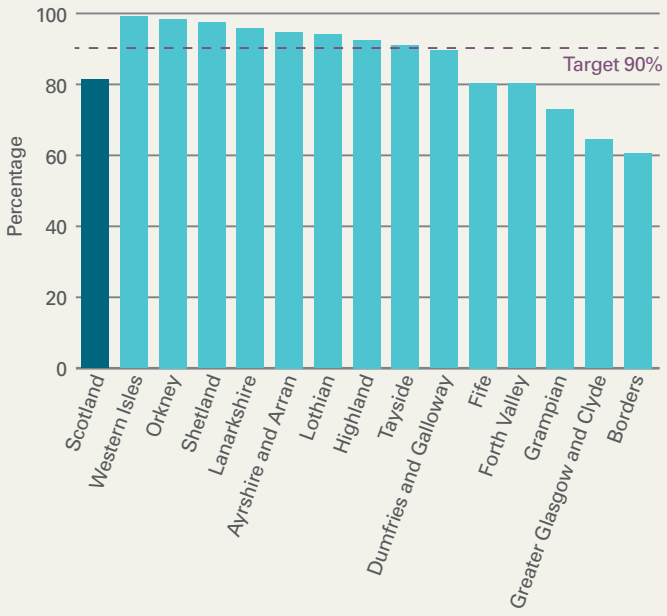
- The Community Care Outcomes Framework which allows NHS and council partnerships to assess local performance and to improve outcomes for users of community care services and their carers. The framework has 16 measures grouped under six themes: satisfaction of services and support; access to right service or support at right time; support for carers; quality of assessment, care planning and review; risk of admission to hospital; and shifting the balance of care. However, these are not routinely reported by local health and social care partnerships.

104. Having such a range of measures makes it difficult to understand how well the NHS and its partners are performing. For example, there are various targets and other indicators of smoking reduction published by the NHS, the Scottish Government and Community Planning Partnerships (CPPs). Some of these indicators are consistent – for example, most CPPs have a local outcome which relates to the NHS performance target or national indicator – but overall the various measures do not present a clear and coherent picture (Exhibit 22).

Exhibit 21

Percentage of GP outpatient referrals managed electronically, January 2011

Performance among NHS boards varies.



Source: Scottish Government, 2011

105. As a number of Audit Scotland reports have indicated previously, the NHS needs to develop a reporting system which brings together the various health-related outcomes and performance measures, and which allows patients and the public to easily understand and interpret the information and to assess how well the NHS is performing. *The Healthcare Quality Strategy for NHSScotland* includes a commitment to simplify and streamline the wide range of performance measures which are used across the NHS and to align the national performance targets with the strategy's ambitions. The NHS has since developed a set of quality outcomes which outline the priorities for improvement to support these ambitions. It is also currently developing a number of associated quality outcome indicators which it will use to monitor and report on longer-term progress towards the quality ambitions and outcomes.

Most patients are satisfied with the NHS and a new standard will assess how well NHS boards involve patients and the public

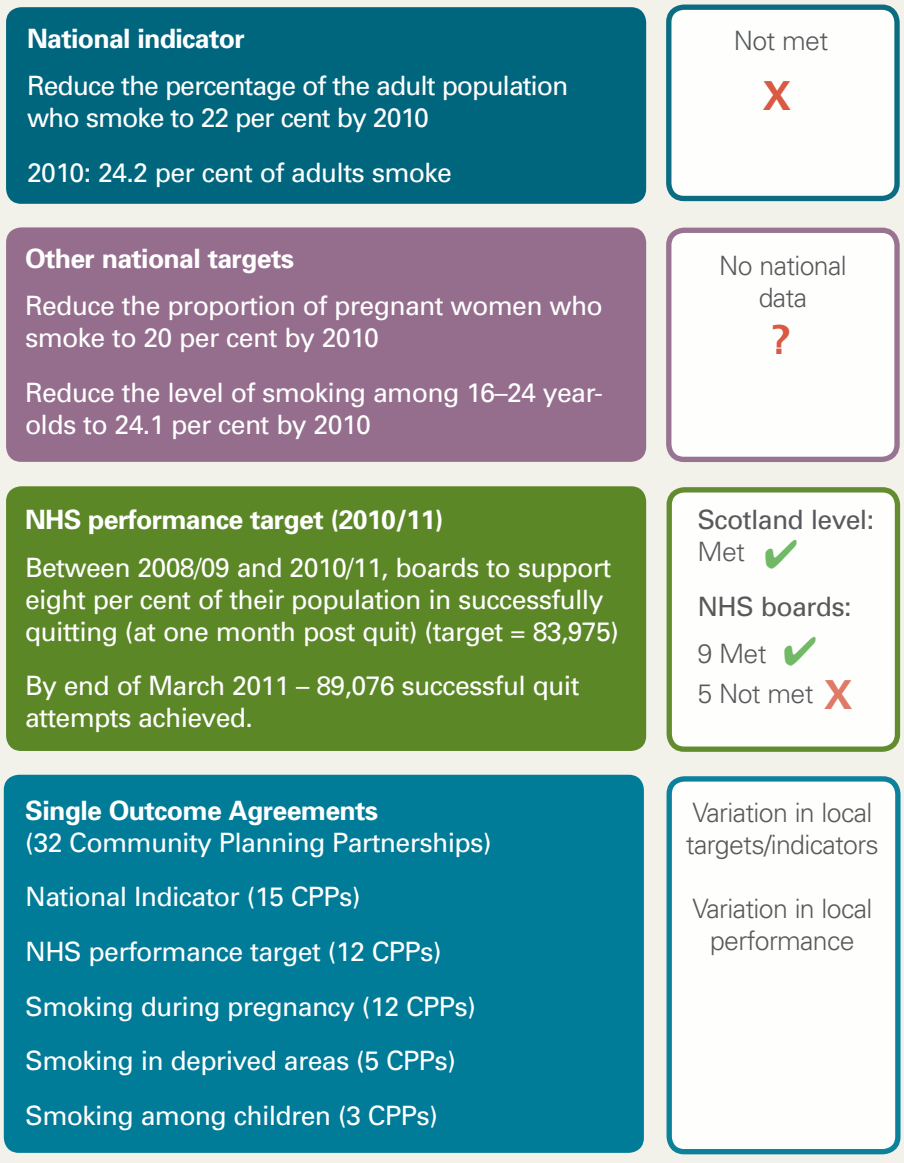
106. Scotland's patient experience programme – Better Together – was established in 2008 to support the NHS in Scotland to deliver high-quality, equitable, patient-centred care. The initial focus of the programme has been on GP services and inpatients. Nine out of ten patients who responded to the first GP survey rated the overall care provided by their GP surgery as good or excellent; only two per cent rated it as poor or very poor. Most patients (85 per cent) who responded to the inpatient survey also rated their overall care and treatment positively (excellent or good) while four per cent rated it as poor or very poor.

103 *Scottish Public Health Observatory*, 2011 http://www.scotpho.org.uk/home/home.asp

Exhibit 22

Measures of smoking prevalence and indicators of smoking reduction

The range of measures do not present a consistent picture of performance.



Source: Audit Scotland, 2011

107. The NHS in Scotland receives around 11,000 complaints each year – less than 0.1 per cent of the total number of patient contacts. In 2010/11, around 63 per cent of complaints related to hospital and community services, around 30 per cent related to family health services (GPs and dental services) and the remaining seven per cent related to special boards such as the Scottish Ambulance Service and NHS 24.[104]

108. The NHS Reform (Scotland) Act 2004 requires NHS boards to involve patients and the public in designing, developing and delivering the healthcare services they provide. In 2005, the Scottish Health Council was established to ensure that boards deliver their Patient Focus and Public Involvement responsibilities. Until 2010, NHS boards produced annual self-assessments but from 2010/11 they assessed themselves against the Participation Standard which the Scottish Health Council published in April 2010.[105] The Participation Standard aims to measure boards' performance in a more systematic and comparable way and assesses how well they:

- focus on the patient; for example, by involving them in discussions about their treatment and care
- take account of the public's views when developing and improving healthcare services.

109. Feedback on the 2010/11 self-assessment process indicated that stakeholders supported the principles and aims of the Participation Standard but wanted a more outcome-focused approach. The Scottish Health Council is working with Healthcare Improvement Scotland to develop this approach. NHS boards will continue to self-assess in 2011/12 and will report formally to the Scottish Health Council in spring 2012 about the outcomes-based approach.

104 *NHS Complaints Statistics*, ISD Scotland, 2011.
105 *Participation Standard*, Scottish Health Council, 2010.

Appendix 1.

Financial performance of NHS bodies, 2010/11

NHS bodies	£000 Revenue resource limit	£000 Revenue resource outturn	£000 Variance under / over (-)	£000 Capital resource limit	£000 Capital resource outturn	£000 Variance under / over (-)
Ayrshire and Arran	644,217	639,199	5,018	22,963	22,962	1
Borders	188,062	188,000	62	5,739	5,734	5
Dumfries and Galloway	269,270	265,061	4,209	16,513	16,511	2
Fife	561,546	561,527	19	20,605	20,603	2
Forth Valley	469,800	469,747	53	287,080	287,080	0
Grampian	786,310	786,261	49	59,753	59,753	0
Greater Glasgow and Clyde	2,184,544	2,183,859	685	162,635	162,634	1
Highland	554,827	554,771	56	28,761	28,761	0
Lanarkshire	917,717	910,096	7,621	30,546	30,545	1
Lothian	1,191,197	1,190,899	298	90,498	90,498	0
Orkney	46,037	46,002	35	2,368	2,340	28
Shetland	52,251	51,790	461	2,111	1,996	115
Tayside	690,746	690,584	162	23,427	23,427	0
Western Isles	70,290	68,941	1,349	4,656	4,611	45
Total territorial boards	**8,626,814**	**8,606,737**	**20,077**	**757,655**	**757,455**	**200**
Mental Welfare Commission	3,781	3,781	0	0	0	0
National Waiting Times Centre	59,460	58,896	564	4,368	4,211	157
NHS 24	63,755	62,681	1,074	1,010	1,010	0
NHS Education for Scotland	428,586	422,699	5,887	1,522	1,493	29
NHS Health Scotland	25,371	24,284	1,087	192	192	0
NHS National Services Scotland	399,080	398,179	901	33,259	33,244	15
NHS Quality Improvement Scotland	19,828	18,808	1,020	122	98	24
Scottish Ambulance Service	203,643	203,597	46	19,484	19,483	1
The State Hospital	41,325	40,999	326	38,650	38,638	12
Total special boards	**1,244,829**	**1,233,924**	**10,905**	**98,607**	**98,369**	**238**
Total	**9,871,643**	**9,840,661**	**30,982**	**856,262**	**855,824**	**438**

Appendix 2.

NHS board performance against national targets, 2010/11

Performance among NHS boards varies.[1]

		NHS boards														
		Scotland	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Health Improvement	Suicide prevention training	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Child dental registrations	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N
	Child healthy weight interventions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Alcohol brief interventions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
	Smoking cessation	Y	N	Y	Y	N	N	Y	Y	Y	Y	Y	N	Y	N	Y
	Exclusively breastfed	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	Inequalities targeted health checks	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Efficiency	Electronic management of referrals	N	Y	N	Y*	N	N	N	N	Y	Y	Y	Y	Y	Y	Y
	Same-day surgery	Due to ongoing issues with the supply of hospital data, ISD has postponed publication (originally intended for September 2011)														
	Emergency inpatients' average length of stay	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N
	Review to new outpatient attendance ratio	Y	Y	Y	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	N
	Financial performance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Cash efficiencies	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Reduce carbon emissions	Y	N	N	Y	N	Y	Y	N	Y	Y	Y	N	Y	Y	N
	Reduce energy consumption	Y	N	N	Y	N	Y	Y	N	Y	Y	Y	N	Y	Y	N
	Knowledge Skills Framework/PDP reviews	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y*	Y

		NHS boards														
		Scotland	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Access	Drug assessment waiting times	Y	Y	Y	Y	N	Y	N	Y	Y	Y	N	Y	Y	Y	Y
	Drug treatment waiting times	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	48-hour GP access	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	48-hour advance booking	N	N	Y	N	N	N	N	N	Y	N	N	Y	N	N	Y
	Waiting times	Y*	N	Y	Y*	Y*	Y*	Y	Y*	Y*	Y	Y*	N	Y	Y*	Y*
Treatment	Psychiatric readmissions	Y	Y*	Y*	Y	Y	Y	N	Y	Y	Y	Y	N	N	N	Y
	Hospital admissions for long-term conditions	Y	Y	N	N	Y	Y	Y	Y	Y*	N	Y	N	Y	Y	N
	Complex care needs: care at home	Data on NHS performance were due to be published on 29 November 2011														
	Dementia	Y	Y	N	Y	N	Y*	Y	Y	Y*	Y	Y	N	Y	Y*	Y*
	HAIs: MRSA/MSSA	N	N	N	Y	N	N	N	Y	N	Y	N	Y	Y	N	N
	C. difficile infections	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
	Emergency inpatient bed days for people aged 65+	Data on NHS performance were due to be published in December 2011														

Key: * means the NHS as a whole or individual boards delivered over 95 per cent of the difference between the baseline and the target, and the NHS considers the target to have been effectively met.

Note 1. Performance against the 2010/11 financial performance and cash efficiencies target is not reported on the Scotland Performs website. Our review of NHS bodies' financial statements confirms that all NHS boards met their financial targets. Performance against the cash efficiencies target has been calculated using the minimum datasets provided by NHS board directors of finance.

Appendix 3.

Glossary of terms

Annual audit report	A final report by an NHS body's auditor on the findings from the audit process.
Annually Managed Expenditure (AME)	Expenditure that is primarily demand-led, less predictable and needs to be considered on an annual basis. The Scottish Government is responsible for administering the AME budget and has no discretion over how it is spent. The Scottish Government is responsible for providing estimates of AME spending but this requires separate HM Treasury approval.
Break-even	Where income equals expenditure.
Cash terms increase/ decrease	The amount of cash compared to previous or future years, before taking into account the effect of inflation.
Clinical governance	Arrangements put in place to ensure safe and effective healthcare.
Community Health Partnership (CHP)	A partnership between health and social care which is 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 which is 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.
Corporate governance	Arrangements put in place to ensure proper use of management and resources.
Cumulative deficit	The excess of expenditure over income built up over more than one year.
Cumulative surplus	The excess of income over expenditure built up over more than one year.
Departmental Expenditure Limit (DEL)	The majority of the budget that covers operating expenditure and running costs. DEL is divided into revenue and capital budgets.
Efficient Government Initiative/Programme	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 SGHD and any planned savings.
Financial statements	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 statement, notes to the accounts and memorandum statements (known as Scottish Financial Returns).

Financial targets	Revenue Resource Limit (RRL) is the amount of money an NHS board is allocated to spend on day-to-day operations in any one financial year. Capital Resource Limited (CRL) is the amount of money an NHS board is allocated to spend on capital schemes in any one financial year.
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.
Healthy life expectancy	The number of years people can expect to live in good health.
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.
Outturn	The final financial position, which could be the actual or forecast position.
Private Finance Initiative (PFI) Public Private Partnership (PPP)	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.
Real-terms increase/ decrease	The amount of funding compared to previous or future years after taking into account the effect of inflation.
Special boards	Organisations providing national support services to territorial boards.
Territorial boards	NHS boards providing hospital and community services to local populations. There are 14 territorial boards, of which three are island boards (NHS Orkney, Shetland and Western Isles).
Underlying deficit	The ongoing financial gap in an NHS board area between the money received to provide health services and the costs of providing these services.

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