AUDITOR GENERAL

OVERVIEW REPORT

Overview of the National Health Service in Scotland

2000/01

PREPARED BY AUDIT SCOTLAND

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AGS/2001/10

Overview of the National Health Service in Scotland

A report to the Scottish Parliament by the Auditor General for Scotland

Auditor General for Scotland

The Auditor General for Scotland is the Parliament's watchdog for ensuring propriety and value for money in the spending of public funds.

He is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management.

He is independent and not subject to the control of any member of the Scottish Executive or the Parliament.

The Auditor General is responsible for securing the audit of the Scottish Executive and most other public sector bodies except local authorities and fire and police boards.

The following bodies fall within the remit of the Auditor General:
- departments of the Scottish Executive eg the Health Department
- executive agencies eg the Prison Service, Historic Scotland
- NHS boards and trusts
- further education colleges
- water authorities
- NDPBs and others eg Scottish Enterprise.

Audit Scotland

Audit Scotland is a statutory body set up in April 2000, under the Public Finance and Accountability (Scotland) Act 2000. It provides services to both the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

Executive summary

Introduction

1. This report provides an overview of the main issues arising from the 2000/01 audits of NHS trusts and health boards, and from the performance audit work undertaken since the previous overview report. This year's report also includes reference to the audit arrangements for the NHS summarised accounts and the Scottish Executive Health Department (the Department).

Part 1 Annual results and trends

Completion of accounts and audits

2. Although the report comments on a number of issues arising in trusts and health boards, overall financial stewardship continues to be of a high standard. The majority of accounts were presented for audit on time and there were no qualifications to the 'true and fair' audit opinions on the accounts of the 51 trusts, health boards and special health boards subject to audit in 2000/01. Most trust and health board audits were completed by the deadlines set by the Department.

3. This year is the first in which auditors were required to include a specific opinion on the regularity of transactions. In broad terms they concluded that the income and expenditure shown in the accounts were in accordance with legislation and guidance issued by the Scottish Ministers. However, for primary care trusts and most health boards, auditors' regularity opinions were qualified because they were unable to obtain sufficient evidence to be satisfied that primary care expenditure and income (relating to GP, dentist, optician and pharmacy services) were incurred and applied in accordance with enactments and guidance. Other important matters relating to primary care payments are considered in more detail later in the report.

Corporate governance and financial controls

4. External auditors generally found that the key financial systems in place at trusts and health boards were of a good standard. Weaknesses identified and reported are addressed through the action plans agreed locally with the trust or health board and followed up by the auditors.

5. Health bodies in Scotland are required to prepare an internal financial control statement (the 'IFC statement') in which they confirm that the effectiveness of the internal financial controls have been reviewed. Auditors review the IFC statement and provide an opinion. Provided weaknesses in internal control are disclosed appropriately in the IFC statement and it is not inconsistent with information arising from the audit, auditors are able to provide an unqualified opinion. In 2000/01, none of the auditors' opinions on trust and health board IFC statements was qualified. However, while the overall number of disclosures in 2000/01 has reduced substantially, it is disappointing that a number of cases were identified where action has yet to be taken to address control weaknesses first disclosed in 1999/2000.

6. Internal audit in the NHS in Scotland continues to be of a high standard. There is good liaison and co-operation between internal and external audit and appointed auditors are able to rely on the work of internal audit, thereby making best use of the overall resources available for audit.

Financial performance in 2000/01

7. In 2000/01 the Department required trusts to achieve three financial targets: to break-even, taking one year with another; to achieve a rate of return on assets of 6%; and to operate within an external financing limit (the 'EFL'). The trusts' 2000/01 annual accounts show that, as in previous years, difficulties were experienced in achieving these targets.

Exhibit 1: Trust financial target performance

	Targets achieved	
	2000/01	**1999/2000**
Target	No. of trusts (out of 28)	No. of trusts (out of 28)
Break-even, year on year	20	20
Rate of return on assets	22	20
EFL	27	28

Source: Audit Scotland

8. Eight trusts failed to break-even in 2000/01 and had accumulated deficits totalling £53.9 million at 31 March 2001 (which includes £12.7 million relating to a technical deficit arising from property revaluations in 2000/01 at a particular trust). By comparison, the eight trusts which failed to break even in 1999/2000 had accumulated deficits totalling £29.8 million. The remaining 20 trusts had accumulated surpluses totalling £22 million (£12.3 million in 1999/2000) giving a net deficit for trusts of £31.9 million in 2000/01 (£17.5 million in 1999/2000). In overall terms, the accumulated position therefore deteriorated in 2000/01.

9. The financial target set by the Department for health boards and special health boards in 2000/01 was to remain within a cash limit. The 2000/01 accounts show that all 15 health boards operated within their cash limits and consequently reported an underspend against their cash limit, a continuation of a trend in recent years. The total value of cash underspends was £37.3 million. Underspends of cash do not represent savings in the provision of health services but indicate that cash was not utilised as quickly as had been planned. Two of the eight special health boards failed to remain within their cash limits, but by very small amounts.

10. The financial regimes operating in health boards and trusts, while linked, have significant differences which make it difficult to establish the overall financial performance of the board area. The Health Plan, '*Our National Health*', recognises the different accounting bases in operation and indicates that a review of the financial regime would be undertaken. Proposals have been put forward by the Department which, if implemented, are intended to achieve greater consistency between board and trust accounts and therefore allow closer comparison of financial performance in NHS board areas.

11. In September 2001, the Health Minister announced additional funding of £90 million for NHSScotland. These additional funds are intended to alleviate the financial pressures on trusts by reducing deficits accumulated to 31 March 2001. But the additional funds are non-recurring and trusts will need to continue monitoring their financial position closely and ensure that plans to secure financial balance are pursued rigorously. NHSScotland should ensure that the additional funds are applied to reduce the £53.9 million accumulated deficits and monitor the outcome to establish how the balance of the £90 million additional funding has been applied.

12. It is clear from auditors' reports that trusts continued to face mounting financial pressures in 2000/01, with the net deficits for trusts increasing from £17.5 million in 1999/2000 to £31.9 million in 2000/01. Immediate pressures have been alleviated by the Health Minister's decision to provide additional funding of £90 million. But many trusts will be challenged by new and continuing pressures on their budgets in the current and future years which may result in a continuation of deficits at individual trusts in the new unified NHS board areas.

Accounting for clinical negligence

13. Concerns about the rising costs of potential negligence claims and the depletion of the central fund available to finance settlements led to the establishment of the Clinical Negligence and Other Risks Indemnity Scheme ('CNORIS') on 1 April 2000. Trusts and health boards now pay an annual contribution to a financial pool from which claims can be met. The amount of the contribution is dependent on a number of factors including the steps taken to improve and maintain risk management arrangements.

14. Health boards and trusts are still required to make provision for negligence claims based on a review of all outstanding and potential claims for which they may be liable. At 31 March 2001 trusts and health boards had made provisions for negligence of £50 million and disclosed contingent liabilities for a further £45 million – a combined total of £95 million (1999/2000: £86 million).

15. Following its consideration of the 1999/2000 overview report, Parliament's Audit Committee noted the reasonably constant level of claim settlement in Scotland and recommended that the Department reassesses the basis on which negligence claims are reflected in accounts. This review is under way and may lead to a reduction in the level of provisions in future years' accounts.

Scottish Executive Health Department

16. Historically, the Health Department has prepared aggregated, summarised accounts for health boards and trusts, and summary accounts for each of the special health boards. Following the introduction of the Public Finance and Accountability (Scotland) Act 2000 this requirement has changed. The Department now prepares aggregated summarised accounts for health boards and trusts. The summarised health board accounts and the special health board accounts provide the basis for the input to the Scottish Executive Consolidated Resource Account. These audits are not yet complete and will be reported in due course. In future years, the intention is for the audit timescale to be advanced to enable all major NHSScotland issues arising from audit to be addressed within the overview report.

Part 2: Matters arising during the year

Primary care payments

17. Since April 1999 the Practitioner Services Division (PSD) of the Common Services Agency (CSA) has been responsible for payments to primary care contractors (GPs, pharmacists, dentists and opticians) on behalf of primary care trusts and island health boards. In the first year of operation following the transfer of responsibilities (1999/2000), a number of critical deficiencies in the control processes were highlighted by internal and external audit. This is a very significant area of activity and expenditure for NHSScotland. In 2000/01, PSD processed approximately 60 million transactions, valued at £1,263 million. This is more than 20% of total NHS expenditure in Scotland.

18. The 2000/01 audit revealed progress had been achieved in a number of important areas. However, serious concerns remained to be addressed in relation to the system for making payments to dispensing contractors and the supply of prescribing information.

19. While progress has been achieved in planning payment verification procedures, there was no formal agreement in place during the year between PSD and primary care trusts detailing responsibility for payment verification and the level of testing to be undertaken. Consequently, inconsistencies in the operation of payment checks across Scotland remained with only a limited number of GP practice visits in 2000/01.

20. Arising from its consideration of the 1999/2000 overview report, Parliament's Audit Committee recommended that developments in this area be progressed as a matter of urgency. The establishment of the Fraud Investigation Unit and a partnership agreement which includes a payment verification protocol are important developments in ensuring robust and consistent payment verification procedures. These initiatives should be pursued urgently.

NHS in Tayside

21. The Auditor General's report on the NHS in Tayside presented to Parliament in March 2001 examined the background and the factors contributing to the financial and operating difficulties in the health service in Tayside together with the action being taken by management.

22. On the basis of the report, Parliament's Audit Committee took evidence and considered the management and use of resources by the NHS in Tayside. The Audit Committee was critical of past financial stewardship and governance but was content with the action being taken and indicated its intention to continue to monitor the financial management and performance of the NHS in Tayside.

Performance Audit findings

23. The Auditor General's strategic statement on public audit in Scotland was published in August 2001 outlining the direction and priorities for public audit over the next three years. To help support democratic scrutiny, the statement outlined three types of reports which the Auditor General would produce: performance reports (which could be either 'baseline reports' providing a snapshot of recent performance or full performance reports examining whether performance is improving over time); reports on particular issues of concern to Parliament where there is evidence of poor management; and overview reports of financial stewardship and governance which look at sectors as a whole and which highlight issues requiring particular attention from managers and auditors in ensuing years.

24. Since the previous overview report, Audit Scotland has produced four performance 'baseline reports' on the NHS in Scotland on waste management in hospitals, medical equipment, outpatient services and supplies management.

25. In June 2000 Parliament's Audit Committee published findings, conclusions and recommendations arising from its examination of the performance of the Scottish Ambulance Service. The Department responded to the Audit Committee's report in September 2000. Since then, at the Committee's request, the Department provided in January 2001 and in July 2001 reports on progress on the appraisal of the case for priority based dispatch and more general developments affecting the Service.

26. Performance reviews in the NHS in Scotland are currently being undertaken on ward nursing, hospital cleaning and GP prescribing. Follow up on the latter has been delayed because of difficulty in obtaining up to date information from the CSA.

General conclusions

27. Overall financial stewardship in the NHS continues to be of a high standard. But trusts continue to face significant financial pressures and it is not clear the extent to which the additional £90 million NHS funding provided in September 2001 will avoid deficits in the current and future financial years. In light of the significance of primary care payments, the performance of the Common Services Agency in managing its payment arrangements is crucial to NHSScotland and the availability of prescribing data and payment verification need to be enhanced urgently.

Introduction

1.1 This report relies mainly on information in reports prepared by the external auditors appointed by the Auditor General at the conclusion of their audits of individual trusts and health boards, supplemented with other relevant information. My report covers all the significant issues arising out of the 2000/01 audits of trusts and health boards and re-examines significant issues which featured in my overview report on the 1999/2000 NHS audits. My report this year also includes reference to audit arrangements for the NHS summarised accounts and the Health Department.

1.2 The first part relates to recurrent, general issues and the results and trends for the NHS in Scotland as a whole. The second part relates to matters arising primarily during 2000/01.

Part 1: Annual results and trends

This part covers:

- Completion of accounts and audits
- Corporate governance and financial controls
- Financial performance in 2000/01
- Financial position under the new Health Plan
- Accounting for clinical negligence
- Scottish Executive Health Department

2 Completion of accounts and audits

2.1 Overall financial stewardship in the NHS in Scotland continues to be of a high standard. The majority of accounts were presented for audit on time and there were no qualifications to the 'true and fair' opinions provided by auditors in relation to the accounts of any of the 51 trusts, health boards and special health boards subject to audit in 2000/01.

2.2 In some cases trust audits were slightly delayed because draft accounts and supporting schedules presented for audit were not prepared to an acceptable standard or in accordance with agreed audit timetables. Primary care trusts experienced difficulties in preparing their accounts due to the delay in receiving financial information on Family Health Service activity from the Common Services Agency. More generally, trusts experienced problems in agreeing balances due to and from other NHSScotland bodies. Despite these difficulties, 26 of the 28 trust audits were completed by the 30 June deadline and the others were completed by 16 July 2001.

2.3 In 2000/01 there were 15 health boards and 8 special health board audits. The auditors had signed 21 sets of accounts by the deadline of 31 July 2001 and the remainder were signed off within two days.

Regularity opinion

2.4 The Public Finance and Accountability (Scotland) Act 2000 introduced a new requirement from 2000/01 for auditors to include within their audit report an opinion as to whether, in all material respects, the expenditure and income shown in the accounts were incurred or applied in accordance with applicable enactments and guidance issued by the Scottish Ministers. This element of the audit report is separate from the 'true and fair' opinion on the financial statements.

2.5 For all primary care trusts and most health boards, the external auditors concluded that the evidence available to them in connection with expenditure and income relating to Family Health Services (which involves services provided by GPs, dentists, opticians and pharmacists) was limited due to the absence of a comprehensive framework of post payment verification covering both patient charges and payment to those providing the services. In the absence of such a framework, there were no satisfactory audit procedures which the auditors could adopt to form an opinion as to whether the associated expenditure and income were incurred in accordance with relevant enactments and guidance. In view of the limitation in the scope of their work, auditors qualified their opinion on the regularity of

expenditure and income. This issue and other matters relating to Family Health Service activity are considered further in Part 2 of this report.

2.6 At the Common Services Agency, the auditor qualified the regularity element of the audit opinion on an issue relating to the allocation of staff to pay ranges. This was outwith the direct control of the Agency and is considered in more detail in Part 2 of this report.

3 Corporate governance and financial controls

Financial systems and controls

3.1 External auditors generally found that the key financial systems in place at trusts and health boards were of a good standard. Weaknesses identified and reported are addressed through the action plans agreed locally with the trust or health board and followed up by the auditors.

Internal financial control statements

3.2 Health bodies in Scotland are required to prepare an internal financial control statement (the 'IFC statement') in which they confirm that the effectiveness of the internal financial controls has been reviewed. The IFC statement was amended in 1999/2000 to include reference to a set of minimum financial control standards specified by the Department under the headings set out in Exhibit 1.

Exhibit 1: Headings for minimum financial control standards

- The control environment
- Identification and evaluation of risks and control objectives
- Information and communication
- Control processes
- Monitoring and corrective action

Source: Scottish Executive Health Department

3.3 The IFC statement is signed by the Chief Executive as Accountable Officer and is incorporated within the annual accounts.

3.4 The IFC statement was amended for 2000/01 to include a statement confirming that the Accountable Officer is aware of the requirements of the Turnbull Committee Report '*Internal Control: Guidance for Directors on the Combined Code*' published in September 1999. This Code extends the requirement to cover all controls, including financial, operational, compliance and the management of risk. The Accountable Officer was also required to confirm that reasonable steps were being taken to implement the guidance for the year ended 31 March 2002.

3.5 Auditors are required to review the IFC statement and provide an opinion which takes the form of a 'negative assurance'. This means that provided weaknesses in internal control are disclosed appropriately in the IFC statement and the statement is not inconsistent with information arising from the audit, auditors are able to provide an unqualified opinion on the

IFC statement. In 2000/01, none of the auditors' opinions on trust and health board IFC statements was qualified.

3.6 Analysis of the 2000/01 IFC statements show that the overall number of additional disclosures by Accountable Officers reduced significantly compared to 1999/2000. The most commonly occurring issues disclosed in 2000/01 are set out in Exhibit 2. Additional disclosures indicate that not all required procedures and policies were in place as at 31 March 2001 or for the whole of the 2000/01 financial year. This means that those health bodies making these disclosures were exposed to potential risk in these areas.

Exhibit 2: Examples of disclosures in 2000/01 IFC statements

- The absence of a fully developed risk management strategy
- The need to develop information technology systems security policies and information management and technology strategies
- Continuing control weaknesses relating to the processing of certain Family Health Service payments
- The absence of a fully developed payment verification framework for Family Health Service payments

Source: Audit Scotland

3.7 While the overall number of disclosures in 2000/01 has reduced substantially compared with 1999/2000 it is disappointing that a number of cases were identified where NHS bodies had yet to address control weaknesses first disclosed in 1999/2000. This is a matter that auditors will continue to review in 2001/02. The Accountable Officer of Tayside University Hospitals Trust, due to the financial difficulties faced by the Trust, was unable to confirm that the minimum control standards relating to the effective, efficient and economical use of resources were fully in place throughout the financial year. The overall position at this Trust is considered more fully in Part 2 of this report.

3.8 Control issues relating to the administration of Family Health Service expenditure affected the IFC statement for all trusts involved in providing primary care services. This issue is considered further in Part 2 of this report.

Internal audit

3.9 Internal audit in the NHS in Scotland continues to be of a high standard. There is good liaison and co-operation between internal and external audit and external auditors are able to rely on the work of internal audit, thereby making best use of the overall resources available for audit.

Computer systems

3.10 During 1999/2000 the auditor of the Common Services Agency (CSA) reviewed the arrangements under which the contract for the provision of computer services to all NHS bodies in Scotland is operated. This involves a contract between the NHS and a supplier, supported by a number of agreements involving providers of specialist services. The auditor concluded that the overall arrangements for the contract were satisfactory and in line with good practice, but identified a number of issues for consideration by the CSA.

3.11 The CSA's auditor followed up these issues as part of the 2000/01 audit, and reported that there has been progress in disaster planning, recovery planning and testing. 'Scenario testing' had been performed at the service provider's principal site. This has enhanced the level of preparedness of both the service provider and NHSScotland to respond to a disaster situation. However, issues relating to disaster recovery arrangements, in particular telecommunications infrastructure, require further action. NHSScotland has established the Scottish Telecommunications Advisory Group (STAG) and this should provide a suitable forum to address telecommunication and networking needs.

3.12 Overall, the auditor acknowledged the progress made but stressed the need for progress to be maintained in this important area. An action plan, requiring action on the part of the CSA and in some cases the Department, has been agreed.

'Whistleblowing' policy

3.13 The Public Interest Disclosure Act 1998 which came into force in July 1999 provides protection from dismissal and intimidation to employees who make disclosures in the public interest. It applies to workers who disclose information about malpractice or maladministration where they consider it is in the public interest to do so.

3.14 Auditors in most cases reported that health bodies have either introduced a policy or are taking steps to develop appropriate procedures. In cases where health bodies had yet to consider the introduction of a 'whistleblowing' policy, the auditors recommended that early action is taken.

4 Financial performance in 2000/01

Trusts

4.1 Under the financial regime in 2000/01 trusts were required to achieve three financial targets: to break-even, taking one year with another; to achieve a rate of return on assets of 6%; and to operate within an external financing limit (the 'EFL'). The annual accounts of trusts show that, as in previous years, difficulties were experienced in achieving these targets in 2000/01.

4.2 In 2000/01, 19 of the 28 trusts achieved all three targets, which is similar to the performance achieved in 1999/2000. Exhibit 3 summarises the performance of the 28 trusts in 2000/01 compared with the results in 1999/2000.

Exhibit 3: Trust financial target performance

	Targets achieved	
	2000/01	**1999/2000**
Target	No. of trusts (out of 28)	No. of trusts (out of 28)
Break-even, year on year	20	20
Rate of return on assets	22	20
EFL	27	28

Source: Audit Scotland

Break-even target

4.3 Trusts are required to break-even, taking one year with another. Any surplus achieved can be carried forward to help achieve the target the following year. If deficits are carried forward, achievement of the target in the subsequent year requires a higher level of surplus. Under the Health Plan, '*Our National Health*', the break-even position (taking one year with another) will become the primary financial target within NHSScotland.

4.4 Financial deficits are therefore important and represent a serious problem for two key reasons:

- in-year deficits reflect a shortfall between the level of expenditure and the availability of income, that is the costs of providing services exceed the financial resources available
- accumulated deficits have to be repaid from subsequent years' income, that is current year costs must be reduced or income increased to repay earlier years' overspends and restore financial balance.

4.5 As indicated in Exhibit 3, eight trusts failed to break-even in 2000/01. These trusts had accumulated deficits totalling £53.9 million as at 31 March 2001. By comparison the eight trusts which failed to break-even in 1999/2000 had accumulated deficits totalling £29.8 million. The remaining 20 trusts had accumulated surpluses totalling £22 million (£12.3 million in 1999/2000) giving a net deficit for trusts of £31.9 million (£17.5 million in 1999/2000). Exhibit 4 shows the position over the past four years.

Exhibit 4: Year end cumulative deficits

	Trusts with cumulative deficits at end of year	
Year ended	**No. of trusts**	**Total value of deficits at the year end**
31 March 2001	8 (out of 28)	£53.9 million
31 March 2000	8 (out of 28)	£29.8 million
31 March 1999	5 (out of 47)	£21.9 million
31 March 1998	3 (out of 47)	£5.8 million

Source: Audit Scotland

4.6 Exhibit 5 details the trusts that did not achieve the break-even target in 2000/01.

Exhibit 5: Trusts with cumulative year-end deficits

Trust	Retained deficit at 31/3/2001	Deficit as % of income	Retained deficit at 31/3/2000
Argyll & Clyde Acute Hospitals	£3.0 m	1.9%	£3.5 m
Grampian University Hospitals	£4.9 m	2.2%	£2.5 m
Highland Acute Hospitals	£2.7 m	3.3%	£0.8 m
Lanarkshire Acute Hospitals[1]	£12.7 m	6.5%	–
North Glasgow University Hospitals	£9.5 m	2.4%	£8.7 m
Renfrewshire & Inverclyde Primary Care	£1.1 m	0.7%	£1.5 m
South Glasgow University Hospitals	£4.1 m	2.2%	£2.3 m
Tayside University Hospitals[2]	£15.9 m	7.2%	£10.0 m
West Lothian Healthcare	–		£0.5 m
	£53.9 m		**£29.8 m**

1 The position at Lanarkshire Acute Hospitals NHS Trust is a 'technical deficit' arising from a downward revaluation of properties by £14.9 m. The Trust recognised the reduction as the properties became non-operational due to the development of new hospitals under the Private Finance Initiative.
2 The overall position at Tayside is considered in Part 2 of this report.

Source: Audit Scotland

4.7 Trusts' auditors identified the main reasons why deficits were incurred in 2000/01. These are shown in Exhibit 6.

Exhibit 6: Main reasons for trust deficits in 2000/01

- Slippage in planned cost reduction programmes, principally in clinical and medical services.
- Overspends on budgets. This reflects the cost of drugs and surgical equipment and general activity levels, such as medical and surgical activity, rehabilitation etc.
- Increasing demands on community services due to earlier discharges from hospital and increasing expectations from service users.
- Cost pressures arising from pay awards to speech therapists, the implementation of the 'New Deal' for junior doctors and intensity payments to medical consultants.

Source: Audit Scotland

Many of the above factors also affected those trusts that achieved break-even in 2000/01.

4.8 There were a number of cases where trusts were dependent on non-recurring income to achieve break-even in 2000/01. Because of this, trusts with underlying operating deficits were able to achieve break-even. This remains a significant issue for NHSScotland.

Rate of return target

4.9 Six trusts failed to achieve the required rate of return on assets, compared with eight in the previous year. Exhibit 7 details the trusts involved. The reasons for the failures to achieve the rate of return are similar to those highlighted in relation to the break-even target.

Exhibit 7: Trusts with a rate of return of less than 6%

Trust	Rate of return (target 6%) 2000/01	Rate of return (target 6%) 1999/2000
Grampian University Hospitals	4.6%	4.3%
Highland Acute Hospitals	3.0%	4.5%
Highland Primary Care	5.8%	5.5%
North Glasgow University Hospitals	5.1%	2.6%
South Glasgow University Hospitals	4.1%	3.7%
Tayside University Hospitals	2.8%	0.1%

Source: Audit Scotland

External financing limit

4.10 The EFL target is a cash limit on the net external financing for trusts, that is the amount of borrowing permitted or repayment of loans required. With the exception of Renfrewshire and Inverclyde Primary Care Trust, where the auditors reported that the Trust failed to achieve its EFL by a small amount, all NHS trusts achieved the target in 2000/01.

4.11 Although not as prevalent as in previous years, there were cases where payments were made early in order to achieve the EFL target. For example, Fife Primary Care Trust and Lanarkshire Primary Care Trust made payments of £1.32 million and £1.76 million respectively in March 2001 in relation to PAYE and NI deductions when payment was not due until April 2001.

Health boards/special health boards

4.12 The financial target for health boards in 2000/01 was to remain within a cash limit notified by the Department. The accounts for 2000/01 show that all 15 health boards operated within their cash limits and consequently reported an underspend against their cash limit, a continuation of a trend in recent years. The 15 health boards had total cash underspends of £19.3 million in 1997/98, £34.6 million in 1998/99 and £37.5 million in 1999/2000. In 2000/01 all 15 health boards had underspends, the total value being £37.3 million. Under-spends of cash do not represent savings in the provision of health services but indicate that, for various reasons (for example, delays in the progress of capital projects), cash was not utilised as quickly as had been planned.

4.13 Health boards may carry forward underspends of up to 1% of the cash limit from one year to another. The seven health boards which exceeded the 1% cash limit in 2000/01 were permitted by the Department to carry forward the total value of their underspends into 2001/02. These are set out in Exhibit 8.

Exhibit 8: Health board cash underspends over 1% in 2000/01

Health board	Underspend against cash limit	Underspend as % of cash limit
Ayrshire & Arran	£3.8 m	1.18%
Dumfries & Galloway	£1.5 m	1.05%
Lanarkshire	£7.6 m	1.67%
Lothian	£7.2 m	1.12%
Orkney	£0.2 m	1.1%
Shetland	£0.4 m	1.6%
Western Isles	£0.7 m	1.85%

Source: Audit Scotland

4.14 The financial target for special health boards is also to remain within a cash limit notified by the Department. Two of the eight special health boards failed to remain within their cash limits, but by very small amounts.

5 Financial position under the new Health Plan

The Health Plan

5.1 In December 2000 the Department published '*Our National Health: A plan for action, a plan for change*', its plan for the future of the NHS in Scotland. Implementation of the plan includes changes in key roles and responsibilities within NHSScotland which are summarised in Exhibit 9.

Exhibit 9: The Health Plan: changes to key roles and responsibilities

In each of the 15 NHS health board areas there will be a single unified NHS board which, in the 12 mainland NHS health board areas will replace the separate board structures of the existing NHS health boards and NHS trusts.

The new NHS boards are expected to form a single health system, with single governing boards responsible for improving the health of their local populations and delivering the healthcare they require. NHS boards will be expected to provide strategic leadership and have overall responsibility for resource allocation, implementation of a Local Health Plan and performance management of the local NHS system. Unified NHS boards will be accountable to the Department and the Scottish Ministers.

In their local areas local authorities should have a strong voice on the new NHS boards and there should be staff membership on the new NHS boards, nominated by local Staff Partnership Forums.

NHS boards are expected to forge effective links with patients, staff, local communities and excluded groups so that their needs and views are put at the heart of the design and delivery of local health services.

In each NHS board area, the existing separate Health Improvement Programmes and Trust Implementation Plans should be replaced by a single comprehensive document – a Local Health Plan.

Each NHS board will be responsible for developing a single Local Health Plan to address the health improvement, health inequalities and healthcare needs of the local population. The system is intended to streamline NHS planning, will form an integral part of local authority Community Plans and will link to local authority homelessness strategies.

NHS trusts will retain their existing operational and legal responsibilities within the local health system but with streamlined management arrangements and fewer non-executive directors. Chairs and Chief Executives of NHS trusts will sit on the new unified NHS boards and be held jointly accountable for the performance of the local health system.

NHS trusts will remain as legal entities within the local NHS system and will retain their existing operational autonomy. Trust Chief Executives will continue as Accountable Officers. Their role, and that of Trust Chairs, as non-executive members of unified NHS boards will be to reinforce the corporate governance of the local NHS system as a whole.

A new Performance and Accountability Framework for the NHS in Scotland will be developed.

The framework is intended to include clearer, more objective and broad based measures against which to assess all parts of the system and to provide a more systematic means of holding it to account.

Source: '*Our National Health: A plan for action, a plan for change*', Scottish Executive Health Department, December 2000

Revised financial framework

5.2 The financial regimes of health boards and trusts, while linked, do have significant differences which make it difficult to establish the financial performance of the overall board area.

In 2000/01 trusts had overall net deficits totalling £31.9 million. Health boards had overall retained 'deficits' totalling £29 million, yet were underspent in cash terms by £37.3 million. The financial position, albeit on different bases, across health boards and trusts is set out in Appendix A.

5.3 The Health Plan recognises the different accounting bases and indicates that a review of the financial regime would be undertaken. Final proposals have now been put forward by the Department. The Department has advised that, if implemented, the proposals will achieve greater consistency between board and trust accounts and allow better consideration of the NHS board financial performance.

Future prospects for achieving financial balance under the new arrangements

5.4 In September 2001, the Health Minister announced additional funding of £90 million for NHSScotland, consisting of:

- £68 million for health boards, to be allocated to trusts in 2001/02
- an additional £11 million to clear Tayside University Hospitals NHS Trust's remaining deficit
- £11 million for health boards to help prepare for winter pressures.

Exhibit 10: Health Minister's funding package

	Additional health board funding £'000	Additional funding to eliminate deficits £'000	Winter pressures £'000	Total additional funding £'000
Argyll & Clyde Health Board	5,411	0	947	6,358
Ayrshire & Arran Health Board	4,806	0	841	5,647
Borders Health Board	1,372	0	240	1,612
Dumfries & Galloway Health Board	1,993	0	349	2,342
Fife Health Board	4,129	0	722	4,851
Forth Valley Health Board	3,245	0	568	3,813
Grampian Health Board	5,566	0	974	6,540
Greater Glasgow Health Board	12,287	1,296	2,150	15,733
Highland Health Board	2,860	0	500	3,360
Lanarkshire Health Board	6,645	0	1,163	7,808
Lothian Health Board	8,452	0	1,479	9,931
Orkney Health Board	263	0	46	309
Shetland Health Board	294	0	51	345
Tayside Health Board	5,020	10,832	878	16,730
Western Isles Health Board	529	0	92	621
Common Services Agency	2,000	0	0	2,000
Health Education Board for Scotland	100	0	0	100
The Scottish Ambulance Service	1,600	0	0	1,600
The State Hospital	300	0	0	300
Totals	**66,872**	**12,128**	**11,000**	**90,000**

Source: Scottish Executive Health Department

5.5 These additional funds are intended to alleviate the financial pressures on trusts by reducing deficits accumulated to 31 March 2001. The additional funds are non-recurring and trusts will require to continue monitoring closely their financial position and ensure that plans to secure financial balance are pursued rigorously.

5.6 Other factors likely to lead to additional pressures on all trusts in future years include those set out in Exhibit 11.

Exhibit 11: Additional pressures on the NHS in future years

Demography. Population projections for the next twenty years show an increasing number of people over 65 with a significant increase in the very elderly (over 85). By 2005 it is predicted that one in six of the population will be over 65. This is likely to add to the pressure on all health services.

Technological change. In recent years there have been significant technological advances and it is now possible to treat conditions for which there were previously no treatments available. This includes new drugs, new surgical and radiological treatments and, in due course, gene therapies. Without proper planning, this may lead to financial difficulties.

New Deal for Junior Doctors. In December 1999 a new contract for doctors in training was introduced, structured to impose cost penalties on trusts which maintained training posts deemed to be non-compliant with the New Deal limits on hours of work and rest. The reduction of junior doctors' hours is being phased, in the first instance on a grade by grade basis. On 1 August 2001 it became a contractual requirement for Pre Registration House Officers (PRHOs) to work a maximum of 56 hours a week and to work the appropriate intensity according to their shift pattern. This will apply to the other two training grades – Senior House Officers (SHOs) and Specialist Registrars (SpR) – from August 2003. Most trusts appear to be meeting the initial target of 56 hours for PRHO grades and will now turn their attention to reaching compliance for SHO and SpR grades. Any delays in securing compliance for these staff would ultimately result in significant increases in staffing costs, particularly as pay band multipliers increase incrementally through to December 2003. Auditors report that there may also be additional capital expenditure for trusts in meeting the minimum requirements laid down by the New Deal in terms of accommodation and catering.

Changes in the regulations for the transportation of clinical waste. European Directive 95/55/EC required member states to transport clinical waste in rigid containers, and not flexible bags. Member states were expected to adopt the Directive from 1 January 2000 but the UK was granted a two year relaxation to the rule. As a consequence of having to adopt the Directive from 1 January 2002, trusts will have to reconfigure existing arrangements for the transport of clinical waste. This is likely to create an additional financial burden on trusts. The Department estimates the cost to be in the region of £85 million over the next 10 years based upon current operational practice and circumstances, although there may be scope for reduction in this figure.

Joint working. Much of government policy now involves NHSScotland working in partnership with other agencies to meet objectives and targets to varying timeframes. This may have two major effects: staff time required to undertake the planning and implementation stages and pressure to introduce new services, or change the way services are provided and resourced.

Employee related costs. Issues such as the ongoing impact of the European Union Working Time Directive and new on-call arrangements for consultants are likely to put pressures on NHS finances.

Source: Audit Scotland

6 Accounting for clinical negligence

Background

6.1 Clinical negligence is the term given to a breach of duty of care by health care practitioners in the performance of their duties in the NHS.

6.2 When negligence claims are lodged against them, health bodies report them to the Central Legal Office (the CLO). The CLO assess the likelihood of the claim being successful and advise the health body on whether to seek a settlement or defend any resulting litigation.

6.3 Concerns within the Department about the rising costs of potential negligence claims and the depletion of the central fund available to finance certain settlements led to the establishment of the Clinical Negligence and Other Risks Indemnity Scheme ('CNORIS') on 1 April 2000. The new scheme is mandatory for all trusts and health boards and has been developed by the Department, in partnership with an appointed scheme manager.

6.4 The scheme has two aims: to provide cost-effective claims management and financial risk pooling arrangements for all trusts and health boards, and to encourage health bodies to develop sound risk management procedures and improve clinical performance and so reduce the incidence of clinical negligence claims.

6.5 Health boards and trusts are still required to make provision for negligence claims lodged prior to 1 April 2000, based on a review of all outstanding claims for which they may be liable.

6.6 Trusts and health boards pay an annual contribution (premium) to a financial pool from which an element of negligence claims can be met. The contribution is dependent on a number of factors, including the steps taken by the health body to improve and maintain its risk management arrangements and the amount each body is prepared to pay (the excess) on settlement before accessing the CNORIS pool. In future years, discounts on contributions will be available to those trusts and health boards that meet, and continue to comply with, independently set and assessed standards for risk management.

6.7 Trusts and health boards are still required to make a provision for clinical negligence claims that the CLO assess as likely to result in a settlement. Once settlement has been agreed, the amount is matched by a debtor in the trusts' accounts reflecting amounts due from the CNORIS pool.

Level of claims in Scotland in 2000/01

6.8 At 31 March 2001, trusts and health boards had made provisions for negligence claims totalling £49.6 million and disclosed contingent liabilities of a further £45.4 million. In addition they utilised £6.5 million of provisions set up in previous years to settle claims and cancelled (reversed) provisions of £3 million in respect of claims where settlements were not required or were at levels lower than the amount provided (Exhibit 12).

Exhibit 12: Accounting for clinical negligence

	£'000	£'000
Opening provision at 01.04.00		
Trusts	17,804	
Boards	20,203	
		38,007
Utilised in year		
Trusts	(4,526)	
Boards	(2,007)	
		(6,533)
Reversed unutilised		
Trusts	(1,163)	
Boards	(1,853)	
		(3,016)
Arising in year		
Trusts	11,956	
Boards	9,206	
		21,162
Closing provision 31.03.01		
Trusts	24,071	
Boards	25,549	
		49,620
Contingent liabilities at 31.03.00		
Trusts	23,319	
Boards	24,660	
		47,979
Contingent liabilities at 31.03.01		
Trusts	19,977	
Boards	25,410	
		45,387

Source: Audit Scotland

6.9 As Exhibit 12 shows, provisions across health boards and trusts rose by £11.6 million (31%) but contingent liabilities fell by £2.6 million (5.4%) over those reported in 1999/2000. This is mainly due to increases in the:

- total value of claims for trusts
- total value attached to previously existing claims for health boards, as well as a number of new claims lodged in 2000/01.

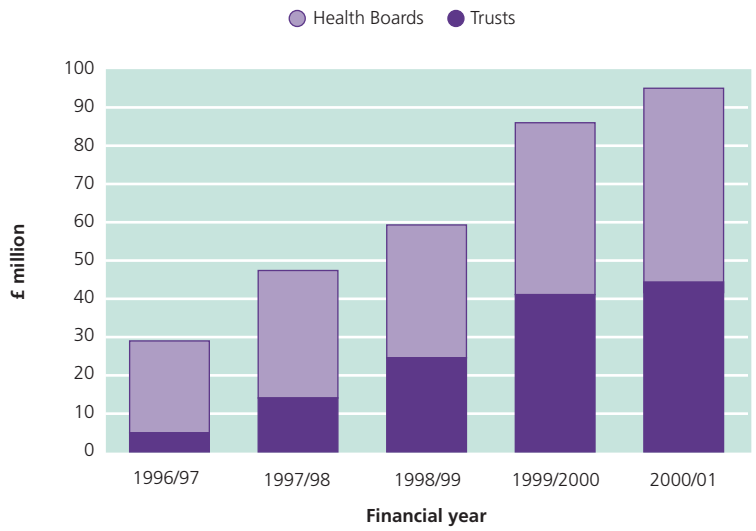
6.10 The figures relate only to negligence claims reported to the CLO. There is no liability recognised for the costs of incidents that had not been reported by the balance sheet date but which might lead to claims in future years. On the basis that it takes several years from the date of reporting an incident to reaching settlement, the majority of cases will have been disclosed as either a contingent liability or provided for in advance of the requirement to settle.

The trend in claims for negligence in Scotland

6.11 Claims are made against the NHS body that employed the health care practitioner at the time of the incident. Those arising from incidents prior to the formation of trusts remain the responsibility of health boards. As it can take some years for negligence claims to be lodged and settled, the majority of claims outstanding are against health boards. This year the gap between

health boards and trusts has widened with claims against trusts £6.9 million (14%) below those reported for health boards, compared with differences between boards and trusts of £3 million (7%) and £10 million (28%) in the previous two years. The overall position is shown in Exhibit 13.

Exhibit 13: Clinical negligence claims (total provisions and contingent liabilities)



Source: Audit Scotland

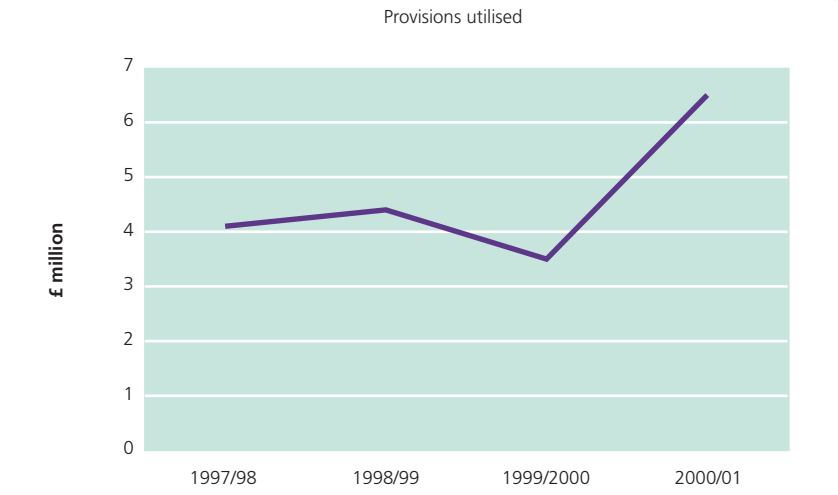
6.12 Between 1996/97 and 2000/01 recognised claims against trusts increased from £5.6 million to £44 million. This rapid increase was to be expected with the transfer of healthcare provision from health boards to trusts. Exhibit 13 shows however that the rate of increase appears to have stabilised with the value of recognised claims against trusts rising by £2.9 million in 2000/01, an increase of 7% (65% in 1999/2000).

6.13 The level of recognised claims against health boards increased from £44.8 million in 1999/2000 to £51 million in 2000/01, an increase of 14% compared to the 26% increase reported between 1998/99 and 1999/2000. This is partly due to the CLO attaching a higher estimated settlement value to existing claims.

6.14 Notwithstanding the increase in the actual level of payments made, it appears that the rate of increase in claims for clinical negligence may be reducing. The CNORIS scheme, by providing for a reduction in cost for bodies which are able to demonstrate good risk management practices, is intended to alleviate the financial burden on NHSScotland.

6.15 Exhibit 13 has shown how liabilities for clinical negligence appear to be levelling off after rising at a considerable rate. Exhibit 14 shows that there has been an increase in the actual level of payments made by the NHS in Scotland to settle clinical negligence claims.

Exhibit 14: Clinical negligence: settlements



Source: Audit Scotland

6.16 These settlements present a challenge for the health service in Scotland and represent a diversion of resources away from healthcare. In 2000/01 the utilisation of the provision was £6.5 million, compared with £3.5 million in the previous year (Exhibit 14). But this must be viewed in the context of total expenditure within NHSScotland and the overall value of the accounting provisions.

6.17 Following its consideration of the Auditor General's 1999/2000 overview report, the Scottish Parliament's Audit Committee referred to the reasonably constant level of settlement in Scotland and recommended that the Department reassesses the basis on which health bodies reflect negligence claims in their accounts. Following consultation with Audit Scotland, this review is under way and may lead to a reduction in the level of accounting provisions in Scotland in future years. Ultimately, of course, this is a policy matter for NHSScotland. Auditors will assess the effect of changes to accounting provisions.

7 Scottish Executive Health Department

7.1 In line with all departments of the Scottish Executive, the Scottish Executive Health Department (the Department) is required to account for the sums approved by the Scottish Parliament to fund its activities in pursuit of its agreed aims and objectives, as set out in Exhibit 15.

Exhibit 15: Scottish Executive Health Department: aims and objectives

Aim
To improve the health and quality of life of people in Scotland

Objectives
- To provide a modern, high quality, responsive NHS in Scotland and to develop new approaches to speed treatment and shorten waiting times
- To improve the health of the people of Scotland by preventing illness; by encouraging and maintaining healthier lifestyles; and by tackling inequality
- To deliver person-centred health and community care and to work in partnership with the people who deliver health and social care.

Source: Scottish Executive Health Department

7.2 In 2000/01, the Scottish Executive departments were required to produce departmental cash accounts as well as financial statements on an accruals basis, for inclusion in the Scottish Executive's Core Departments' Resource Account. A consolidated Scottish Executive Resource account, incorporating Executive Agencies, health board and special health boards' expenditure, is also produced.

7.3 Since the production of consolidated accounts requires the underlying accounts to be audited first, the timescale for the preparation, audit and publication of these accounts is later than for trusts and health boards. Any major findings from these audits will be reported with the relevant accounts.

7.4 Historically, the Department has prepared aggregated, summarised accounts for health boards and trusts, and summary accounts for each of the special health boards. Following the introduction of the Public Finance and Accountability (Scotland) Act 2000 this requirement has changed. The Department prepares aggregated summarised accounts for health boards and trusts. The summarised health board accounts and the special health board accounts provide the basis for the input to the Scottish Executive Consolidated Resource Account. As stated above, these audits for 2000/01 are not yet complete. In future years, the intention is for the audit timescale to be advanced to enable all major NHSScotland issues arising from audit to be addressed within the Auditor General's overview report.

7.5 The timing of the consolidation exercise as it currently stands poses a significant challenge to both the Department and its auditors. Any delays or issues affecting the underlying accounts can impact adversely on this timescale. To enable the production of consolidated accounts, it is particularly important to ensure that inter-NHSScotland balances are agreed by both parties and that consistent accounting policies are adopted across the NHS. This was not always the case in 2000/01, and considerable effort was required by the Department to ensure that disclosures were made

accurately and on a consistent basis. It is therefore important that the individual trusts and health boards comply fully with the NHS accounting requirements.

Accounting for pension costs

7.6 In 1999, the Government Actuary's report recommended that employers' contributions to the NHS in Scotland superannuation scheme should be increased from 4% to 5.5% with effect from 1 April 2002 and to 7% from April 2005.

7.7 The Department will fund health bodies for the increased cost arising from April 2002 onwards. However to comply with accounting standards, health bodies had to reflect an increased charge in their 2000/01 accounts. Trusts created a liability for the additional charge and a debtor for funding due from their local health boards. In turn, health boards created a liability for the additional charge and a debtor for funding due from the Department.

7.8 The trusts and health boards have complied with the technical accounting requirements. Overall, funding of the order of £44 million over two years will be required to meet the cost arising from the increase in employers' contributions. The Department has indicated that this will require to be met from the uplifts in the unified budgets.

Part 2: Matters arising during the year

This part covers:

- Primary care payments
- NHS in Tayside
- Employment related matters
- Performance Audit findings
- Current Performance Audit reviews

8 Primary care payments

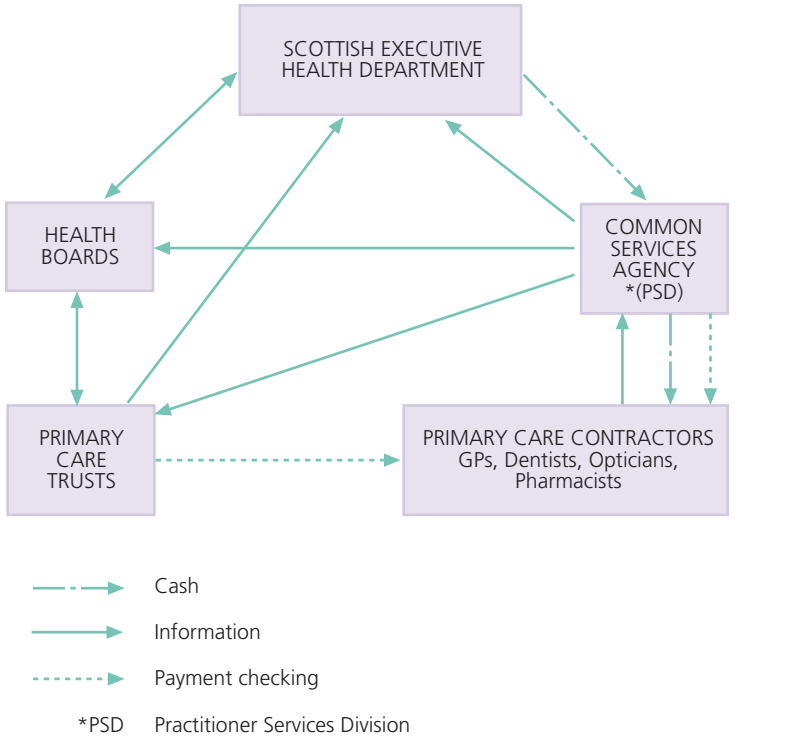
Practitioner Services Division

8.1 Since April 1999 the Practitioner Services Division (PSD) of the Common Services Agency (CSA) has been responsible for payments to primary care contractors (GPs, pharmacists, dentists and opticians) on behalf of primary care trusts and island health boards. In the first year of operation following the transfer of responsibilities (1999/2000), a number of critical deficiencies in the control processes were highlighted by internal and external audit. This is a very significant area of activity and expenditure for NHSScotland. In 2000/01, PSD processed approximately 60 million transactions, valued at £1,263 million. This is more than 20% of the NHS expenditure in Scotland.

8.2 Responsibilities and accountabilities for primary care payments are complex:

- The CSA is responsible for cash payments to contractors.
- Primary care trusts are accountable for the related expenditure, which is funded by the health boards.
- Health boards continue to report primary care income and expenditure for the resident population in their annual accounts.
- The responsibility for practice visits (to GPs) to check source documentation supporting claims from contractors and verification checks rests with primary care trusts although they may delegate responsibility to the CSA.
- Primary care trusts are responsible for the follow up of potential fraud in relation to their contractors.

Exhibit 16: Outline of the primary care payments system



Source: Audit Scotland

8.3 The CSA requisitions cash from the Department drawn against health boards' allocations and makes payments direct to the contractors on behalf of the appropriate primary care trust. It also provides information to both health boards and trusts for budgetary control purposes.

8.4 Primary care trusts bear the financial risk involved in the making of payments on their behalf but are restricted in their ability to exercise direct control over these activities. Health boards also face financial risks in that they do not exercise direct control over the drawdown of funding. It is essential, therefore, that compensating controls are in place to provide assurance to health boards and primary care trusts in respect of their accounts.

8.5 As part of the overall assurance process, the CSA engaged a 'service auditor' (Ernst & Young) to report on the payment process and issued a copy of the service auditor's report for 2000/01 to all primary care trusts and health boards. Their report concluded that, with the exception of particular areas of weakness (see paragraph 8.11), the policies and procedures in place provide reasonable assurance that the control objectives specified by management were achieved.

8.6 The 2000/01 external audit of the CSA involved a review of progress achieved. It concentrated on two key areas highlighted in the 1999/2000 overview report:

- procedures to reconcile expenditure recorded in the Agency's ledger to cash amounts drawn down from the Department on behalf of health boards

- payment verification procedures, including GP practice visits.

8.7 As agreed with the CSA, the reports arising from this work were circulated to all NHSScotland bodies involved in this area and their external auditors in May 2001.

Practitioner Services Division: progress update

8.8 The 1999/2000 audit of the management arrangements within PSD involved a review of the Division's framework of control and concluded that although the CSA's overall management arrangements were satisfactory, divisional arrangements operated by PSD were incomplete.

8.9 The 2000/01 review revealed that progress had been made in a number of important areas. In particular:

- material issues identified in 1999/2000 relating to the provision of payment information to primary care trusts had largely been resolved. Delays had arisen, however, in the provision of prescribing information (see paragraph 8.10)

- control weaknesses identified by the service auditor in 1999/2000 were being addressed by the Agency and significant improvements in the level of control operated had been achieved in a number of areas

- there had been a significant improvement in the level of control exercised over the payment information issued to NHSScotland

- the scope of the service audit had been extended to include the processes for reconciling payment information and the drawdown of funds from the Department.

8.10 Serious concerns required to be addressed, however, in relation to the largest of the payment streams ie, the payment of dispensing contractors and the supply of prescribing information.

- The implementation of a new computerised processing system contributed to a three month delay to the normal timetable for the determination and provision of 'actual' payment information.

- Arrangements were introduced to pay all dispensing contractors on time using a system of estimated advances. The basis of estimation used resulted in monthly advances initially being overpaid by an average level of 5%. The methodology used to calculate advances was revised in year in consultation with NHSScotland and contractor representatives. The CSA's external auditor reported that there is a level of risk inherent in paying external contractors on an estimated basis for an advance period of five months. Of particular concern is the difficulty in the recovery of any overpayments made to contractors that may have subsequently ceased trading (the auditor was informed that at the time of reporting (August 2001) the exposure to potential losses was less than £100,000).

- Internal audit still has concerns about certain aspects of the control features of the new computerised processing system.

8.11 Other areas where significant improvement was still required were also identified:

- The service auditor identified a number of continuing control weaknesses which, in the view of the CSA's external auditor, were significant. These include inconsistent evidencing of review of masterfile amendments, the need to update Business Continuity Plans and insufficient documentation and evidencing of back-up procedures for pharmacy systems.

- The scope of the service auditor's work for 2000/01 continued to exclude the nature and extent of work undertaken in relation to practice visits.

- The form of the original 'Partnership Agreement' between the CSA and primary care trusts remained under discussion in 2000/01. Crucially, therefore, partnership agreements which comprehensively describe all aspects of the service to be provided were not in place between PSD and primary care trusts during the year.

8.12 Robust information systems are necessary for financial control but are also essential for operational management within primary care trusts. GP prescribing represents around a quarter of the expenditure of primary care trusts. The Accounts Commission report '*Supporting Prescribing in General Practice*', issued in September 1999, contained a number of recommendations which, if implemented, could benefit patients and generate annual savings of in the region of £26 million from a drugs budget of £575 million in 1998/99. Primary care trusts have a key role in encouraging GPs to improve prescribing and to control costs. This is dependent on good financial information.

Practitioner Services Division: payment verification

8.13 The 1999/2000 audit of PSD highlighted that a range of payment verification activity was undertaken but that this activity was largely a continuation of procedures inherited from health boards. As a result, there were a number of inconsistencies between offices in the operation of payment checks. The audit also highlighted that the development of comprehensive risk based post payment verification systems for General Medical Services (GMS), incorporating targeted and random practice visits at GP premises, remained at an early stage. Processes to identify payment trends and outliers were not yet fully established and only the Edinburgh Processing Centre had carried out practice visits.

8.14 The 2000/01 review revealed that some progress has been made.

- Checks performed on the validity of patient claims for exemption were extended to cover all payment streams and payment centres in March 2001 (checks performed prior to March were limited and inconsistent).

- The Fraud Investigation Unit (FIU) was established in July 2000 and the development of the work of the Unit should make a significant contribution to the prevention and detection of patient and contractor fraud within NHSScotland. The FIU published its first annual report in September 2001 setting out its early achievements.

8.15 During 2000/01, however, there was no formal agreement in place between PSD and primary care trusts detailing responsibility for payment verification and the level of testing to be undertaken. As a result, the inconsistencies between offices in the operation of payment checks remained and only the Edinburgh Processing Centre participated in GP practice visits during 2000/01. A total of 75 practice visits were conducted by the Edinburgh Processing Centre in 2000/01 (45% in the Lothian Primary Care Trust area), compared to 30 in 1999/2000.

8.16 The CSA auditor also reported that:

- a comprehensive review of the risks arising from all primary care payment streams and the nature of payment verification necessary to combat those risks had yet to be completed

- in relation to general medical payments, detailed procedures had not yet been developed for the utilisation of the management information system to identify and target 'outlier' practices.

8.17 A range of corrective action is needed in response to the work of both the service auditor and external audit. The CSA's auditor recommended that the Board of the CSA (through the Audit Committee) monitors progress in relation to reducing delays in the supply of prescribing information and the implementation of a robust system of payment verification for all payment streams.

Current position

8.18 The Department has advised that there is now an agreed (and signed) partnership agreement in place with primary care trusts which includes a payment verification protocol. The protocol proposes a programme of payment verification which includes, as one element, targeted practice visits supplemented by a small random sample to provide assurance on the overall level of control and standards of administration.

8.19 Arising from its consideration of the Auditor General's 1999/2000 overview report, the Scottish Parliament's Audit Committee recommended that developments in this area be progressed as a matter of urgency. Following the general consultation with Audit Scotland envisaged by the Committee, Audit Scotland indicated that the CSA's proposals were reasonable but that it would be for the external auditors to assess the implementation and effectiveness of the arrangements in practice. The establishment of the FIU and a payment verification protocol are significant developments but steps should be taken to expedite the introduction and development of payment verification systems.

8.20 A Post Implementation Review Group, attended by representatives of the CSA, the Department and primary care trusts, has been established to consider whether the expected benefits to NHSScotland of the transfer of payment and administration responsibilities are being realised. The Department has advised that the Group's report will become available in December 2001. In addition, PSD intends establishing a group to monitor implementation of payment verification proposals.

9 NHS in Tayside

9.1 In 1999/2000 Tayside University Hospitals NHS Trust (TUHT) recorded the largest deficit (£10 million) of any individual trust and produced the lowest rate of return (0.1%) compared with the 6% target set by the Department. In recognition of the financial problems being experienced by the NHS in Tayside, in February 2000 the Minister for Health and Community Care established a taskforce to assist and support health service managers in Tayside. The Auditor General's report on the NHS in Tayside, which was presented to the Scottish Parliament in March 2001, examined the background, the factors contributing to the financial and operating difficulties in the health service in Tayside and the action being taken in response to the taskforce's findings.

9.2 On the basis of the Auditor General's report, the Scottish Parliament's Audit Committee considered the management and use of resources by the NHS in Tayside. Between April and June 2001, the Audit Committee took evidence from the Accountable Officers of the two Tayside Trusts, Tayside Health Board and the Scottish Executive Health Department as well as the former chairs of TUHT and Tayside Health Board, the former chief executive of the NHS in Scotland and former senior staff from the predecessor Trusts in Tayside which existed prior to NHS reorganisation in April 1999.

9.3 The Audit Committee concluded that:

- there was sufficient evidence of serious financial problems to merit action by the Accountable Officers and there were failures within the Tayside health system in both formal reporting and investigation to establish the true financial position
- there was a breakdown of financial and management control at the former Dundee Teaching Hospitals NHS Trust (the predecessor of TUHT) over the development of cancer and renal services and the filling of staff vacancies
- there is an urgent need to restore confidence in Tayside Health Board as an effective team which can lead the Tayside Trusts and other partners forward to deliver healthcare improvements and to progress the Tayside Acute Services Review
- the Department failed to ensure that fundamental performance and management issues were addressed. Annual accountability reviews between the Department and Tayside health organisations failed to address financial issues adequately and there is a need for more robust systems for monitoring financial performance of NHS bodies.

9.4 The Department and the NHS in Tayside broadly accepted the conclusions and recommendations of the Audit Committee's report in August 2001. The Department maintained that financial monitoring arrangements highlighted the emerging difficulties and that appropriate action was taken as soon as the Department became aware of difficulties. However, the Department acknowledged that there were lessons to be learned. Action being taken to address the Audit Committee's findings includes:

- the establishment of a Tayside Health Board Finance Resource Committee, chaired by the Health Board vice-chairman and including both Trust chairmen to hold NHS Tayside bodies to account in respect of

financial planning and performance. A new Corporate Financial Report incorporating the financial position of all three NHS bodies has also been developed to report financial performance

- the continuation of a Joint Management Forum comprising senior staff from the Health Board and Trusts as well as staff representation to consider all health issues, including financial recovery, on a corporate basis

- the continuation of a Vacancy Control Committee within TUHT to ensure that budgetary provision exists for any proposed new staff appointment

- the establishment of a Staff Partnership Forum in each Trust and the Health Board to ensure input to NHS Tayside governance

- the establishment by the Department of an expert group to support and advise NHS boards in managing changes in the configuration of services and to advise the Department of the appropriateness of local configuration. The Department also intends to provide guidance, training and support to local NHS leaders to enable them to involve the public effectively in the management of changes to local services

- the introduction of a new Performance Assessment Framework from October 2001 for the new NHS boards which is intended to provide a broader picture of operational performance over time and which will be used as the basis for the annual accountability review meetings with the Department. Specific to NHS Tayside, the Department has advised that it is holding more regular meetings with Tayside health bodies to review progress reports on the financial position, both prospectively, and in respect of ongoing financial performance.

9.5 The Audit Committee expressed itself content with the action being taken and indicated its intention to continue to monitor the financial management and performance of the NHS in Tayside.

10 Employment related matters

Senior management remuneration

10.1 The Department issued new mandatory pay arrangements from 1 April 2000 for senior managers within the NHS in Scotland. These cover the posts of senior management staff including Chief Executives, Executive Directors, other Directors (including Medical Directors) and all senior managers whose posts have been evaluated by the Central Evaluation Committee at a specific level.

10.2 Under the new executive pay arrangements:

- the pay and terms and conditions of service for the executive group in NHS trusts were brought under Ministerial Direction from 1 April 2000

- all posts covered by the arrangements are subject to evaluation by the Central Evaluation Committee (CEC), which is responsible for the management, maintenance and integrity of the job evaluation process

- the pay ranges will be reviewed annually

- there will be guaranteed progression through the pay range subject to the fully acceptable performance of the individual

- a model contract has been introduced.

10.3 Auditors have reported that, in general, health bodies have taken appropriate action to ensure compliance with the new guidance for senior management remuneration. An issue arising from the audit of the Common Services Agency is summarised in the following paragraph.

10.4 The Common Services Agency's accounts include payroll costs of £6 million relating to executive directors and senior managers. The CSA's internal auditors reported in April 2001 that although all relevant staff had been transferred to the Professional/Managerial Transitional Arrangements, none of the Agency's executive directors or senior managers had been assessed by the Central Evaluation Committee and assimilated into the executive pay arrangements. The external auditor therefore qualified her opinion on the regularity assertion but highlighted that individual members of staff had not been overpaid and that the Agency has not disregarded or misinterpreted the regulations.

11 Performance Audit findings

Introduction

11.1 The Auditor General published a strategic statement on public audit in Scotland in August 2001. The aim of the strategic statement was to outline the direction and priorities for public audit over the next three years and to provide a framework within which Audit Scotland, as the service provider, could formulate its corporate plan. To help support democratic scrutiny, the statement outlined three types of reports which the Auditor General would produce:

- performance reports. These could be either 'baseline reports' providing a snapshot of recent performance with guidance if appropriate on 'what works best'; or full performance reports examining whether performance is improving over time and naming public bodies which demonstrate continuing shortfalls in performance.

- reports on particular issues of concern to the Parliament where there is evidence of poor management

- overview reports of financial stewardship and governance which look at sectors as a whole and which highlight issues requiring particular attention from managers and auditors in ensuing years.

11.2 Since the previous overview report, Audit Scotland has produced four 'baseline reports' on the NHS in Scotland. Auditors were also asked to review progress made by health bodies in implementing agreed recommendations arising from previous value for money examinations undertaken by the Accounts Commission. This work is continuing and significant issues arising will feature in the next overview report on the NHS.

11.3 The 'baseline reports' were on waste management in hospitals (see Exhibit 17); medical equipment (see Exhibit 18); outpatient services (see Exhibit 19); and supplies management (see Exhibit 20).

Exhibit 17: Waste management in Scottish hospitals

The disposal of hospital waste costs the NHS in Scotland about £8 million a year. Of this, some £6 million is spent on the disposal of clinical waste with the remainder incurred on the disposal of domestic waste made up of the same type of items found in waste from any household. The effective management of hospital waste is essential for the health and safety of patients, staff and the general public. This 'baseline report' examined the handling, segregation and disposal of hospital waste at a sample of 21 trusts and sought to identify and promulgate good practice and the scope for potential savings.

Key findings of the study included:

- General safety standards are high, although there were occasional examples of poor practice in regard to staff training and staff compliance with safety standards. There was also significant variation between trusts in the standard of monitoring of uplift and disposals of waste. Several examples of good practice were found amongst trusts including waste management issues being covered in appropriate induction and staff training programmes and use of single handling systems where waste bags are tied and tagged at point of origin and placed in a wheeled bin without need for further handling.

- The unit cost of waste disposal depends on the contract price that has been negotiated with the contractor. Glasgow trusts have jointly negotiated a contract which runs until 2005, and a consortium comprising 22 trust and two island boards recently negotiated a ten year contract which is expected to reduce clinical waste disposal costs. Given the long term nature of these contracts there is limited opportunity for further savings in the unit cost of disposal at least in the short term.

- Greater scope for reducing the costs of clinical waste disposal exists by reducing the volume of clinical waste produced. Clinical waste costs about £300 per tonne more to dispose of than domestic waste so it is important for costs control reasons that domestic waste is not mixed in with clinical waste and disposed of in a much more expensive way than is necessary. The study found that within acute hospitals there was a three-fold variation in the amount of clinical waste produced for each staffed bed, in two trusts there was no segregation of domestic waste from clinical waste and there was poor segregation of waste by staff in a number of trusts that did have a segregation policy. An estimated £1 million could be saved if all trusts achieved the standard of segregation achieved by the best.

- Clinical waste includes 'sanpro' waste, ie, items used for the disposal of urine, faeces and other bodily secretions and excretions but which do not contain identifiable human tissue and blood. Most sanpro waste is produced by primary care trusts but if there is no infection risk from sanpro, then such waste may not need to be classified as clinical waste and may be disposed of safely in other ways. Over £1 million could be saved if sanpro was reclassified. A number of pilot formal risk assessments should be undertaken at primary care trusts to establish whether sanpro waste from certain hospitals or types of patients could be treated as domestic waste.

- Trusts have a responsibility for clinical waste right through to its final disposal. They therefore need to know that the amounts uplifted and properly disposed of are the same. In addition there is a need to monitor safety issues (for example needle stick injuries). There was a considerable variation amongst trusts in the information gathered and the monitoring use made of this information.

The 'baseline report' made a number of recommendations including the basic information trusts should collect to improve their monitoring of waste management issues. Many of the recommendations can be implemented by trusts individually but some will require joint working and coordination from bodies such as the Clinical Waste Steering Group and the Property Environment Forum Executive. Audit Scotland intends to carry out a follow-up audit in about 18 months time to establish what action has been taken and what improvements have been achieved.

Source: Audit Scotland

Exhibit 18: Equipped to care

Medical equipment is essential to patient care. Failing to ensure that the right medical equipment is available when required and used properly is increasingly likely to result in poorer patient care and extra costs through litigation. This 'baseline report' considers the strategic management of medical equipment in the NHS trusts in Scotland, its funding and acquisition, its use and how it is maintained.

Key findings of the study included:

- The strategic importance of medical equipment, the need for clear leadership and the implications for clinical governance, highlight the need for overall responsibility to be taken at trust board level. But overall responsibility for the management of medical equipment was not always clear, in some trusts there was no obvious board involvement and in many trusts there was no overall policy for medical equipment particularly policies covering the standardisation of equipment. In addition, management information regarding medical equipment is not often considered at board level meaning that trust boards are not able to establish clear priorities for medical equipment based on sound information.

- Across Scotland, expenditure on new and replacement medical equipment is failing to match depreciation and trusts are not replacing items of medical equipment when they come to the end of their useful lives. The Scottish Executive has taken action to address the problems due to systematic under-investment including increased funding for specific types of medical equipment and changing accounting rules in order to ensure that monies allocated for capital are not used to reduce trust deficits.

- Ensuring that medical equipment is available at the right place at the right time, together with properly trained staff, is essential for good patient care. Most trusts lacked adequate information systems for monitoring the use of medical equipment and tracking the location of individual items. No formal documented training policies existed at more than 40% of trusts. Similarly, many trusts do not appear to have formal policies covering who can use the equipment, and who has the authority to decide on which item of equipment should be used.

- There are marked variations between trusts in maintenance expenditure as a percentage of the value of their equipment. There are also differences between trusts about the quality of maintenance including, for example, the accreditation of in-house maintenance departments under a recognised quality standard, the number of suppliers used and the approach to planned preventative maintenance. Clinicians, however, generally reported that they were satisfied with response times in the event of equipment failure and that interruptions to service were rare.

There is room for improvement in the management of medical equipment particularly concerning the use of management information and reporting systems. Audit Scotland will undertake a follow-up study during 2001/02 and will investigate whether improvements have been achieved in practice. The follow-up study will include an analysis of the age and condition of a sample of types of equipment and trusts' arrangements for the replacement of existing equipment.

Source: Audit Scotland

Exhibit 19: Mind the gap

More people encounter secondary care in an outpatient clinic setting than in any other – 4.8 million in 1999/2000. The cost of outpatient attendances in 1999/2000 was approximately £296 million, representing 11% of total hospital running costs. In order to manage the outpatient system as a whole, managers require robust data and sound information upon which to base their decision-making and performance monitoring.

The report covers the following main areas:
Data issues. In order to do work on benchmarking, trusts need good data collection systems and electronic clinical communications. However, there are concerns about the adequacy of the data. Firstly, in terms of the data 'gaps' – some data are not mandatory, and other data are not collected at all. Secondly, there can be problems with definitions and coding errors, making data quality a further issue. Finally, there is still room for improvement regarding the adequacy of the method of data production. Extending the use of IM&T to ensure effective data collection and management would help improve matters. Despite the importance of outpatient services, there is only limited information available to measure their performance.

Waiting times. Recent initiatives at a national level have sought to set maximum waiting times for certain groups of patients. However, the report shows that there has been an overall increase in waiting times for a first outpatient appointment, from 8% of referrals waiting more than 18 weeks in June 1998, to 15% of referrals in December 2000. To assess the length of time patients wait to be seen at a hospital clinic, trusts need information about waiting times for each stage of the process. This would allow them to review any areas where delays are occurring and plan services accordingly to help minimise delays.

Attendance rates. Non-attendance at clinics is a widespread problem, since it brings a significant financial burden to the NHS and can also affect the patients' health. Across all specialty groupings in Scotland (1999/2000), the average 'did not attend' (DNA) rate is 11%. An estimated 161,000 new outpatients in Scotland therefore fail to attend their appointment. Based on an average total cost of attendance of £63, DNAs accounted for approximately £10 million in 1999/2000. Trusts should be able to review DNA rates by clinic and patient type, to identify how best to address problems and ensure that there are no operational factors contributing to DNA rates.

Cost effective use of resources. Outpatient clinics represent approximately 11% of total hospital running costs. Trusts need information regarding the relative costs of different types and locations of clinics to ensure that the most effective mix of services is provided. As would be expected the total costs of outpatient attendances varies between specialties. However, of greater interest is the substantial variation in costs between peer groups. For example, within the ENT speciality, the total costs per attendance for acute trusts vary from £34 to £60; and direct costs per attendance for acute trusts vary from £18 to £42. These cost variations highlight the need for trusts to undertake benchmarking in order to address any underlying problems or reasons for the variations.

Source: Audit Scotland

Exhibit 20: In good supply?

Supplies are the largest area of NHS expenditure after staff pay with the NHS in Scotland spending an estimated £600 million each year on goods and services. Supplies covers a wide range of goods such as uniforms, surgical gloves and infusion devices, and services as diverse as catering and medical equipment repairs. Supplies management is important to trusts in ensuring that staff have access to the equipment, goods and services they need to treat patients.

The report found that:

- basic management information is not routinely available, making it very difficult to manage supplies effectively by performance monitoring expenditure and usage levels
- despite the existing national contracts, there is disagreement about which supplies should be purchased at local, regional or national levels
- national contracts are not treated as mandatory and are often undermined by trusts negotiating directly with suppliers
- more needs to be done to exploit the benefits that IT has to offer not only to those responsible for procurement but also those responsible for the use of supplies.

Despite a range of reports and initiatives over the last 20 years, the management of supplies in the NHS in Scotland remains fragmented and does not demonstrate good value for money. Effective management of supplies will depend on strong leadership both nationally and locally – it cannot be left solely to operational managers. Given the strategic importance of supplies, and the opportunities that exist to improve value for money, Audit Scotland will work with the service on the development and piloting of performance indicators in 2002/03. Audit Scotland will follow up their implementation along with other recommendations and produce a follow up report in 2004. At this stage the performance indicators should be available across Scotland; this will provide a clear picture for the first time of where and how value for money can be improved.

Source: Audit Scotland

Ambulance Service

11.4 As reported in the 1999/2000 overview report, in June 2000 the Scottish Parliament's Audit Committee published their findings, conclusions and recommendations arising from their examination of the performance of the Scottish Ambulance Service. The Department responded to the Audit Committee's report in September 2000.

- **On priority dispatch:** the Department allocated £100,000 to enable them to commence with the Service an appraisal of priority based systems for dispatching ambulances in response to emergency calls.
- **On variations in reported response times:** the Service had embarked on a comprehensive review of the emergency ambulance service, and the Department had provided an extra £500,000 in 2000/01 to cover the costs of an additional 20 front-line ambulance staff in Glasgow.
- **On operational efficiency:** the Department confirmed that the Service was committed to monitoring systematically the overall incident service time across Scotland and concerned to introduce improved targets.
- **On clinical aspects:** the Service and its professional Advisory Group were reviewing the range of treatments provided to ensure that they remain current in terms of best treatment in the pre-hospital care setting.

11.5 Since then, at the Audit Committee's request, the Department provided in January 2001 a report on progress to date with the appraisal of the case for priority based dispatch and in July 2001 a more general update on developments affecting the Service.

- **On priority dispatch:** the Service is considering the case for emergency call prioritisation alongside proposals to reduce from eight to three the number of operations control rooms and investment in new computer systems to support emergency controllers including improved mapping and vehicle location systems. The Service has confirmed that in densely populated parts of Scotland responding to non-life threatening calls more slowly than at present would release resources which could be used to provide a faster response to life-threatening calls. The Department and the Minister for Health and Community Care have now invited the Service to take its proposals for improving its operations rooms' functions and prioritising its emergency service response to the next phase. The Department's funding for the Service in 2001/02 includes the start-up costs attached to operations rooms' proposals and priority based dispatch although it is expected that the Minister would wish the Service to phase in operations rooms' changes and to carry out some modelling of the categorisation experience in Scotland before approving the introduction of priority based dispatch.

- **On variations in reported response times:** the Department's funding for the Service in 2001/02 includes an additional £700,000 to cover the costs of an extra 26 front-line emergency ambulance staff for Glasgow. In June 2001 the Service provided to the Department a case for investment in additional staff in various ambulance stations across Scotland where working time pressures are most acute. The Department is currently considering the business case.

- **On operational efficiency:** the Service and Department concluded that it would be inappropriate to set targets for the amount of time spent at the scene of an incident but the Service has been undertaking systematic monitoring and reporting of incident service time across Scotland since January 2001. Performance indicators covering each element of incident service time are to be incorporated into the Service's revised Performance Assessment Framework.

- **On clinical aspects:** the Service's Health Plan to 2005/06 includes plans to develop in 2001/02 clinical performance standards and indicators in the fields of: chest pain, trauma, paediatric care, diabetic care, chronic obstructive pulmonary disease, and patient report form completion and accuracy.

Current Performance Audit reviews

11.6 Reviews in the NHS in Scotland are currently being undertaken on ward nursing and a 'baseline report' on this topic will be published in 2002.

11.7 Work is also being undertaken on GP prescribing. Publication of a full performance audit report, following up findings from the previous study published in 1999, has been deferred to 2002 because of delays in obtaining up to date information from the CSA (see section 8 of this report).

11.8 Follow up work on the 'baseline report' on hospital cleaning ('*A clean bill of health? Domestic services in Scottish hospitals*', published in April 2000) will also lead to a full performance report.

Appendix A

Financial position within health board areas at year end[1]

Health Board	2000/01 Retained surplus/(deficit) £'000	1999/2000 Retained surplus/(deficit) £'000	NHS Trust	2000/01 Retained surplus/(deficit) £'000	1999/2000 Retained surplus/(deficit) £'000
Argyll & Clyde	(7,208)	(1,687)	Argyll & Clyde Acute Renfrewshire & Inverclyde Lomond & Argyll Primary Care	(3,035) (1,077) 429	(3,521) (1,518) 190
Ayrshire & Arran	(4,199)	(182)	Ayrshire & Arran Acute Ayrshire & Arran Primary Care	590 593	588 386
Borders	(5,936)	(4,011)	Borders General Borders Primary Care	608 13	500 44
Dumfries & Galloway	(969)	110	D & G Acute and Maternity D & G Primary Care	2,215 203	2,501 155
Fife	(4,333)	(3,680)	Fife Acute Hospitals Fife Primary Care	904 1,383	553 673
Forth Valley	(3,459)	(3,853)	Forth Valley Acute Forth Valley Primary Care	631 12	464 27
Greater Glasgow	(10,665)	(11,132)	N Glasgow University Hospitals S Glasgow University Hospitals Greater Glasgow Primary Care Yorkhill	(9,491) (4,092) 5,684 2,362	(8,706) (2,263) 567 1,736
Grampian	3,843	2,281	Grampian University Hospitals Grampian Primary Care	(4,914) 2,807	(2,540) 733
Highland	(1,541)	(1,615)	Highland Acute Hospitals Highland Primary Care	(2,744) 127	(808) 92
Lanarkshire	5,536	4,505	Lanarkshire Acute Hospitals Lanarkshire Primary Care	(12,661) 1,229	407 686
Lothian	2,674	888	Lothian University Hospitals Lothian Primary Care West Lothian Healthcare	41 10 0	30 1,167 (486)
Orkney	(511)	115			
Shetland	(350)	(252)			
Tayside	(832)	(2,739)	Tayside University Hospitals Tayside Primary Care	(15,852) 2,116	(9,939) 745
Western Isles	(1,029)	(480)			
Totals	**(28,979)**	**(21,732)**		**(31,909)**	**(17,537)**

[1] Because the basis for accounting applied in health boards differs from that applied in trusts, it is not appropriate simply to add board and trust surpluses and deficits. As indicated in paragraph 5.2 of the report, significant differences in the financial regimes for boards and trusts make it difficult to establish the financial performance of the overall board area.

Appendix B

NHS external auditors 2000/01

NHS Body	Auditor
Argyll & Clyde Acute Hospitals NHS Trust	PricewaterhouseCoopers
Ayrshire & Arran Acute Hospitals NHS Trust	PricewaterhouseCoopers
Ayrshire & Arran Primary Care NHS Trust	Chief Auditor, East Kilbride
Borders General Hospital NHS Trust	KPMG
Borders Primary Care NHS Trust	Chief Auditor, Edinburgh
Dumfries & Galloway Acute and Maternity Hospitals NHS Trust	Chief Auditor, East Kilbride
Dumfries & Galloway Primary Care NHS Trust	KPMG
Fife Acute Hospitals NHS Trust	Scott-Moncrieff
Fife Primary Care NHS Trust	Scott-Moncrieff
Forth Valley Acute Hospitals NHS Trust	Chief Auditor, Glenrothes
Forth Valley Primary Care NHS Trust	Chief Auditor, Glenrothes
Grampian Primary Care NHS Trust	Ernst & Young
Grampian University Hospitals NHS Trust	KPMG
Greater Glasgow Primary Care NHS Trust	Chief Auditor, Glasgow
Highland Acute Hospitals NHS Trust	Scott Oswald
Highland Primary Care NHS Trust	Scott Oswald
Lanarkshire Acute Hospitals NHS Trust	Scott-Moncrieff
Lanarkshire Primary Care NHS Trust	Chief Auditor, East Kilbride
Lomond and Argyll Primary Care NHS Trust	KPMG
Lothian Primary Care NHS Trust	KPMG
Lothian University Hospitals NHS Trust	PricewaterhouseCoopers
North Glasgow University Hospitals NHS Trust	PricewaterhouseCoopers
Renfrewshire and Inverclyde Primary Care NHS Trust	PricewaterhouseCoopers
South Glasgow University Hospitals NHS Trust	PricewaterhouseCoopers
Tayside Primary Care NHS Trust	Henderson Loggie
Tayside University Hospitals NHS Trust	Chief Auditor, Glenrothes
The Yorkhill NHS Trust	PricewaterhouseCoopers
West Lothian Healthcare NHS Trust	KPMG
Argyll & Clyde Health Board	Chief Auditor, Glasgow
Ayrshire & Arran Health Board	Chief Auditor, Glasgow
Borders Health Board	Chief Auditor, Edinburgh

Dumfries & Galloway Health Board	Chief Auditor, Glasgow
Fife Health Board	Chief Auditor, Glenrothes
Forth Valley Health Board	Chief Auditor, Glenrothes
Grampian Health Board	Ernst & Young
Greater Glasgow Health Board	PricewaterhouseCoopers
Highland Health Board	Scott Oswald
Lanarkshire Health Board	Chief Auditor, East Kilbride
Lothian Health Board	Chief Auditor, Edinburgh
Orkney Health Board	Scott Oswald
Shetland Health Board	Ernst & Young
Tayside Health Board	Henderson Loggie
Western Isles Health Board	Chief Auditor, Inverness
Clinical Standards Board for Scotland	Scott-Moncrieff
Common Services Agency	Chief Auditor, Edinburgh
Health Education Board for Scotland	Scott-Moncrieff
Health Technology Board for Scotland	Scott-Moncrieff
Mental Welfare Commission for Scotland	Scott-Moncrieff
Scottish Ambulance Service Board	KPMG
Scottish Council for Post Graduate Medical and Dental Education	Scott-Moncrieff
The State Hospital	Chief Auditor, Glenrothes

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