AUDITOR GENERAL

OVERVIEW REPORT

Overview of the National Health Service in Scotland

2001/02

PREPARED BY AUDIT SCOTLAND

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Overview of the National Health Service in Scotland

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

Auditor General for Scotland

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Executive summary

Introduction

1. This report provides an overview of the main issues arising from the 2001/02 audits of NHS trusts and health boards, and from the performance audit work undertaken since the previous overview report.

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 good standard. In a number of cases, auditors reported significant improvements in the preparation of accounts, often following the implementation of recommendations arising from the 2000/01 audits. This resulted in more effective and efficient audits and is to be encouraged. The majority of NHS trust and NHS health board accounts were presented for audit on time and all audits were completed within the deadlines set. There were no qualifications to the 'true and fair' opinions provided by auditors in relation to the accounts of the 52 trusts, health boards and special health boards subject to audit in 2001/02.

3. The Public Finance and Accountability (Scotland) Act 2000 requires auditors to include within their audit report 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 Scottish Ministers. Similar to the 2000/01 accounts, however, auditors' regularity opinions were qualified in respect of the 2001/02 accounts of all primary care trusts and health boards. The auditors concluded that 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 found that the key financial systems in place at trusts and health boards were, generally, of a good standard. The majority of auditors concluded that arrangements in NHS trusts and boards for setting budgets and monitoring performance were, generally, adequate and operated soundly. In a small number of trusts and boards there was some scope to improve budgetary control arrangements.

5. 2001/02 was the first year in which public sector bodies were required to complete a Statement of Internal Control (SIC). The SIC requires health bodies to implement adequate systems of internal control including financial, operational and compliance controls and risk management, and to review their effectiveness. The scope of the SIC is wider than that of the previous Statement of Internal Financial Control. Two trusts, one health board and one special health board reported that they had all the risk management and review processes fully in place during 2001/02. The remaining 26 trusts and 22 health boards and special health boards reported that processes were still being developed but were expected to be implemented by March 2003.

6. While the disclosure requirements of the new SIC are wider, it is still disappointing to note that a number of cases were identified where NHS bodies have yet to address control weaknesses first identified in 1999/2000. In particular, some trusts have only recently approved a risk management strategy, and a number have yet to attain Level 1 of the Clinical Negligence and Other Risks Indemnity Scheme. It is important that health bodies act promptly to address these issues.

Financial performance in 2001/2002

7. Trusts were required to achieve three financial targets during 2001/02. The primary financial target for trusts was to break-even taking one year with another although, as in previous years, trusts were also expected to achieve a rate of return on assets of 6% and to operate within an external financing limit (the 'EFL'). The number of trusts achieving financial targets in 2001/02 improved compared to 2000/01 (Exhibit 1). Twenty-four of the 28 trusts achieved all three targets in 2001/02, five more than the previous year.

Exhibit 1: Trust financial target performance

	Targets achieved	
	2001/02	**2000/01**
Target	Number of trusts (out of 28)	Number of trusts (out of 28)
Break even, year-on-year	25	20
Rate of return on assets	26	22
EFL	27	27

Source: Audit Scotland

8. Three trusts failed to break even and had accumulated deficits totalling £13.2 million as at 31 March 2002 (which includes a £6.3 million technical deficit at one trust arising from a downward revaluation in 2000/01 of properties in connection with a Private Finance Initiative project). By comparison, eight trusts failed to break even in 2000/01 and had accumulated deficits totalling £53.9 million. The remaining 25 trusts had accumulated surpluses as at 31 March 2002 totalling £31.8 million (£22 million in 2000/01) giving an overall net surplus for trusts as at 31 March 2002 of £18.6 million (net deficit of £31.9 million in 2000/01). In overall terms, the accumulated position therefore improved in 2001/02.

9. There has been a clear overall improvement in the financial position of boards and trusts. However, at least part of the improved financial results can be attributed to Ministers deciding in September 2001 to divert £90 million not used elsewhere in the health budget to support front-line patient care. Simply based on the figures shown in their accounts, 15 trusts would not have been able to achieve break-even without the additional funding provided. Whilst it is reasonable to assume that these bodies would have taken steps to attempt to break-even without additional funding, the one-off funding does not represent a long-term solution to the financial problems faced by NHS bodies. The future prospects of health bodies achieving financial balance are considered later in the report.

10. The financial targets set by the Scottish Executive Health Department (the Department) for health boards and special health boards in 2001/02 were to operate within a Revenue Resource Limit, a Capital Resource Limit and their cash requirements. Health boards and special health boards were largely successful in meeting these targets.

Health boards achieved all three of their financial targets, except one which had a slight overspend against its Revenue Resource Limit (equivalent to 0.2% of the Revenue Resource Limit set). Similarly, only two special health boards reported slight overspends against their Revenue Resource Limits.

Accounting for clinical negligence

11. 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 negligence claims since 1 April 2000 are settled. The amount of the contribution is dependent on a number of factors. The Department intends that discounts on contributions will be available in future years to trusts and health boards which achieve specified standards of risk management.

12. External auditors reported that ten trusts, one health board and one special health board in Scotland achieved Level 1 accreditation (the lowest standard of risk management of the CNORIS scheme which focuses on corporate ownership of risk through effective policies and procedures) by 31 March 2002. Since then, a further nine trusts have achieved Level 1 accreditation.

13. Health boards and trusts are still required to make provisions for negligence claims where there is a reasonable expectation of making a payment, and to recognise as contingent liabilities those claims where there is a possibility rather than a probability of future payment. At 31 March 2002, trusts and health boards had made provisions for negligence claims totalling £53 million and disclosed contingent liabilities of a further £61 million – a combined total of £114 million (2000/01: £95 million). They also settled claims of £8 million from provisions set up in previous years, and reversed provisions of £7 million in respect of claims where settlements were not required or were at levels lower than the amount provided for.

14. The Department has recently completed a review of the basis on which health bodies reflect negligence claims in their accounts. The review concluded that there was a wide variation in the way individual health bodies handled negligence claims but that, overall, the system seemed to be working well. In August 2002, the Department's audit committee concluded that these variations would need to be investigated before any decision to issue guidance on a

standardised approach to accounting for clinical negligence claims could be made. The Department is currently taking this work forward.

Scottish Executive Health Department

15. As a result of the introduction to central government of resource accounting in 2001/02, the Department produced financial statements on an accruals basis for inclusion in the Scottish Executive's Core Departments' Resource Accounts. A consolidated Scottish Executive Resource Accounts, incorporating executive agencies', health boards' and special health boards' income and expenditure was also produced. The audits of these accounts were completed on 18 December.

Part 2: Matters arising during the year

Primary care payments

16. 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. This is a very significant area of expenditure for NHSScotland. In 2001/02 PSD processed approximately 76 million transactions (60 million in 2000/01), with a total net value of £1,336 million (£1,263 million in 2000/01). This is more than 20% of the NHS expenditure in Scotland.

17. 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. As part of the 2001/02 external audit of the CSA, the appointed auditor conducted a follow-up review of conclusions and recommendations made in previous years, to determine PSD's progress in enhancing its control framework. The review concluded that PSD had tackled areas of concern which had been identified previously, and that it continues to make progress in enhancing its overall control environment. There is, however, scope for the CSA to further improve its control systems and to develop key performance indicators and management information to monitor and identify outlying medical and ophthalmic payments.

18. The CSA has also made significant efforts to introduce and embed a robust framework for payment verification covering both patient charges and payments to contractors. A partnership agreement was introduced in 2001/02 between the CSA and each primary care trust detailing their respective responsibilities for processing, payment and verification of primary care payments. Although the external auditor reported that, as at December 2001, the extent of payment verification

checks was not yet in line with the full requirements of the partnership agreements, the CSA considers further progress has been made since this date. In addition, the CSA's Fraud Investigation Unit continued its work in pursuing contractors and patients suspected of improper activity in claiming fees or payment exemptions respectively.

19. The CSA continues to make progress in improving its overall control environment and in introducing robust payment verification checks. It is important, however, that further progress is made if auditors are to avoid qualifying their opinion on the regularity of expenditure and income in respect of the 2002/03 accounts of primary care trusts. This is an area which must be pursued vigorously.

Revised accountability arrangements

20. In September 2001, unified NHS boards in each of the current health board areas replaced the separate board structures which had hitherto existed in health boards and NHS trusts. NHS trusts have, however, retained their separate legal status and operational responsibilities but with streamlined management arrangements. The Department expects that the revised accountability arrangements will help contribute to improved financial management in NHS bodies.

21. As part of their 2001/02 audits, appointed auditors examined the establishment and operation of the new boards against the Department's requirements for revised accountability arrangements. Several auditors reported that the new arrangements, although at an early stage, appear to be working well. There are, however, some aspects of the new arrangements where further consideration needs to be given. In particular, there is a need to clarify the respective responsibilities where trust boards continue to exist alongside unified boards.

22. The creation of unified boards is being implemented alongside revised performance assessment and accountability arrangements being introduced with effect from 2002/03. The performance assessment framework is designed to encompass a set of quantitative measures, indicators and qualitative assessments which will provide an aggregate picture of the performance of a local NHS system. The creation of unified boards and the new performance assessment arrangements represent a major development in holding local NHS systems to account for their performance.

Future prospects for achieving financial balance

23. In September 2002, the Scottish Executive's spending proposals for 2003/04 to 2005/06 '*Building a Better Scotland*' announced that an additional £2.7 billion would be invested in the NHS in Scotland over the three-year period, bringing planned annual expenditure to £8.6 billion by 2005/06. Many NHS areas will have to deliver improved healthcare for their local populations, and will continue to face financial difficulties in 2002/03 and remain dependent on non-recurring income or savings plans to achieve financial break-even.

24. There will still, therefore, be a requirement for NHS boards to prepare balanced budgets and to manage prudently the finances of the local NHS area in accordance with clearly identified priorities and plans. The auditors of most NHS trusts and boards reported that draft financial plans for 2002/03 forecast that break-even will be achieved. But in three specific trusts, auditors expressed concern about the ability of trusts to deliver their financial plans. In particular, an expert support group, appointed in September 2002 to help resolve long-standing managerial issues within NHS Argyll and Clyde, found a potential finanical shortfall of between £25 million and £30 million in the local NHS system in 2003/04 if no action was taken. As a result, in December 2002, the chief executives of Argyll and Clyde NHS Board and all three trusts agreed to stand down and were replaced by an interim management team.

NHS Tayside

25. In September 2001, the Department and Tayside NHS reported the action that was being taken in response to the Scottish Parliament's Audit Committee's report on its investigation into the management and use of resources by the NHS in Tayside.

26. The auditor's final reports on the 2001/02 audits of the Tayside health bodies confirmed that the NHS in Tayside was taking the action that it said it would. In particular, NHS Tayside has introduced a number of developments in respect of new accountability arrangements, and financial planning and monitoring. The auditor also reported that, whilst a number of mechanisms had been put in place to ensure effective monitoring and reporting of Tayside University Hospitals NHS Trust's financial position, it will still be a challenge for the trust and for NHS Tayside as a whole to secure break-even in 2002/03.

Performance audit findings

27. Since the previous overview report, Audit Scotland has sought to develop and implement a performance audit programme which is consistent with the Auditor General's strategic statement issued in August 2001 outlining the range of reports the Auditor General would produce.

28. During the past year, Audit Scotland produced one baseline report on ward nursing. The Auditor General also responded to requests from the Scottish Ministers for Audit Scotland to undertake reviews of the retention of both human organs at Scottish hospitals and the management of waiting lists. Baseline reviews in the NHS in Scotland are currently being undertaken on outpatients, hospital catering and the management of community equipment. Audit Scotland also expects to publish, in 2003, full performance audit reports on hospital cleaning, GP prescribing and medical equipment.

General conclusions

29. Overall financial stewardship in the NHS continues to be of a good standard. In 2001/02 the financial performance of trusts improved relative to 2000/01 but this was achieved, at least in part, through an additional £90 million which the Department provided to health boards during the year. Trusts continue to face significant financial pressures. Significant extra funding is to be made available to the NHS in Scotland in the period 2003/04 to 2005/06. The additional resources are also expected to contribute to significant improvement in patient services but there is no guarantee that health bodies will find it any easier to balance their books.

30. The role of unified boards will be crucial to achieving successful financial equilibrium of the NHS in Scotland. The new arrangements appear to be working well at this early stage. It is also clear that the revised performance assessment framework will have a key role in holding local NHS systems to account for their performance. In particular, the Department will need to ensure that its performance assessment framework is sufficiently developed to be able to identify the healthcare improvements being provided with the additional funds.

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 2001/02 audits of trusts and health boards and re-examines significant issues which featured in my overview report on the 2000/01 NHS audits.

1.2 My report is in two parts. The first part relates to matters essentially of a recurrent nature, and results and trends for the NHS in Scotland as a whole. The second part relates to matters arising primarily during 2001/02.

Part 1: Annual results and trends

This part covers:

- completion of accounts and audits
- corporate governance and budgetary controls
- financial performance in 2001/02
- accounting for clinical and medical 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 good standard. The majority of NHS trust accounts, and all NHS health board accounts, were presented for audit on time. There were no qualifications to the 'true and fair' opinions provided by auditors in relation to the accounts of any of the 52 trusts, health boards and special health boards subject to audit in 2001/02.

2.2 In a number of cases, auditors reported significant improvements in the preparation of accounts, often following the implementation of recommendations arising from the 2000/01 audits. This resulted in a more effective and efficient audit and is to be encouraged. In a few cases, the audits of primary care trusts were subject to some delay because of problems experienced in reconciling Family Health Service payments and expenditure to information provided by the Common Services Agency and to health board records. This, however, did not compromise the completion of the audit and the audits of all 28 trusts were completed by the deadline of 30 June 2002. Similarly, the audits of all 15 health boards and nine special health boards were completed by the deadline of 31 July 2002.

Regularity assertion

2.3 The Public Finance and Accountability (Scotland) Act 2000 requires auditors to include within their audit report an opinion as to whether, in all material respects, expenditure and income shown in the accounts was incurred or applied in accordance with applicable enactments and guidance issued by Scottish Ministers. This element of the audit report, which is separate from the 'true and fair' opinion on the financial statements, is known as the 'regularity assertion'.

2.4 Similiar to the 2000/01 accounts, the appointed auditors for all primary care trusts and all health boards 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 payment verification covering both patient charges and payment to those providing the services.

2.5 Significant effort continues to be put into the design and implementation of post-payment verification checks at the Practitioner Services Division of the Common Services Agency. However, not all elements of the framework were in place during 2001/02. In the absence of such a framework, there were no satisfactory audit procedures which the appointed auditors could adopt to form an opinion as to whether the associated expenditure and income was incurred in accordance with relevant enactments and guidance. In view of the limitation in the scope of their work, appointed auditors for all primary care trusts and all health boards have 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 Section 7 of this report.

3 Corporate governance and financial controls

Financial systems and controls

3.1 A key requirement of any public sector body is to operate sound financial systems and controls. Sound financial systems can both contribute to the prompt production of accurate accounts and help reduce the risk of fraud or corruption. Sound financial systems also contribute towards good corporate governance by supporting managers and members in the consideration of budgets and in monitoring financial outturn.

3.2 External auditors found that the key financial systems in place at trusts and health boards were, generally, 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.

3.3 The majority of auditors concluded that arrangements in NHS trusts and boards for setting budgets and monitoring performance were generally adequate and operated soundly. In a small number of trusts and health boards, however, auditors concluded there was some scope to improve budgetary control arrangements. Exhibit 2 shows typical examples identified by auditors where there is scope to enhance budgetary control.

Exhibit 2: The scope for health bodies to improve budgetary control

Issue of concern	Audit recommendation
■ Meetings between budget holders and managers are not formally recorded.	■ Meetings should record detailed reasons for over or under spends.
■ Action plan points resulting from budget meetings between finance teams and Clinical Directorates not recorded.	■ Action plans should be documented to demonstrate that budget variances are actively monitored and corrective action taken.
■ Underlying financial data is not always comparable across NHS bodies.	■ A financial planning and reporting framework should be developed to ensure the completeness and comparability of underlying financial data across all NHS bodies.
■ Lack of a framework for regularly reviewing and managing the use of resources.	■ Health boards and trust boards should review financial reports on a regular basis.

Source: Auditors' final reports on audits

3.4 In September 2001, unified NHS boards were established in all 15 health board areas to replace the separate board and trust structures which had previously existed. Auditors reported that the new arrangements appear to have contributed to enhanced budgetary control and financial monitoring. This matter is considered further in Section 8 of this report.

Statements of Internal Control

3.5 Since 1998/99 accountable officers of health bodies have been required to complete a statement on internal financial controls confirming that the effectiveness of internal financial controls had been reviewed. Following the publication of the Turnbull Committee Report '*Internal Control: Guidance for Directors on the Combined Code*' in September 1999, public sector bodies are now required to produce a Statement of Internal Control (SIC) with effect from the 2001/02 accounts. The SIC requires public bodies to implement adequate systems of internal control including financial, operational and compliance controls, and risk management, and to review their effectiveness. Exhibit 3 shows the business processes which public

bodies should consider reviewing to ascertain the effectiveness of systems of internal control.

Exhibit 3: Processes which may be reviewed to ascertain the effectiveness of systems of internal control

- Procedures for identifying the organisation's objectives and key risks.
- The development of a control strategy and risk management policy.
- The allocation of risk ownership.
- The role of the organisation's audit committee or other relevant committees.
- Involvement and role of internal audit.
- Procedures for ensuring that aspects of risk management and internal control are regularly reviewed and reported on.
- Systems used to ensure compliance with specific regulations or procedures laid down by central departments.
- Details of monitoring procedures for subsidiary bodies.
- Monitoring of progress with current initiatives and compliance with extant external requirements.

Source: *'Corporate Governance: Statement of Internal Control'*, Scottish Executive Finance Guidance Note No. 2001/13

3.6 The SIC is signed by the chief executive of each NHS trust and health board as accountable officer, and is incorporated within the accounts. Auditors are required to review the SIC and to provide an opinion which takes the form of 'negative assurance'. This means that, provided weaknesses in internal control are disclosed appropriately in the SIC and the statement is not inconsistent with information arising from the audit, appointed auditors are able to provide an unqualified opinion on the SIC. Auditors review the statement to assess whether it complies with extant guidance and to ensure that it is not inconsistent with other information that they are aware of from their audit. In 2001/02, none of the auditors' opinions on trust and health board SICs were qualified.

3.7 It was recognised that not all health bodies would have in place all the risk management and review processes they considered necessary throughout 2001/02. Trusts and boards could, therefore, adopt one of two acceptable forms of the SIC for the 2001/02 accounts. The preferred SIC is where the body is satisfied that it has a sound system of control which has been in place throughout the year and complies with the Scottish Executive's guidance. However, because some trusts and boards may need to do further work before all relevant risk

management and review processes are fully in place, they could use an alternative form of SIC which included a description of planned work required to achieve full compliance.

3.8 Two trusts, one health board and one special health board reported that they had all the risk management and review processes fully in place during 2001/02. The remaining 26 trusts and 22 health boards and special health boards reported that processes were still being developed but were expected to be implemented by March 2003.

3.9 Because the scope of the SIC is wider than that of the Statement of Internal Financial Control, the overall number of disclosures relating to internal controls and review processes increased slightly in 2001/02 compared to 2000/01. The most commonly occurring issues disclosed in 2001/02 are set out in Exhibit 4. Disclosures in the SIC indicate controls which are not yet operational or were not operational throughout the year. This means that those health bodies making these disclosures were exposed to risk in these areas.

3.10 While the disclosure requirements of the new SIC are wider, it is still disappointing to note that a number of cases were identified where NHS bodies had yet to address control weaknesses first identified in 1999/2000. In particular, some trusts have only recently approved a risk management strategy, and a number have yet to attain Level 1 of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS).

3.11 It is important that health bodies implement and maintain sound systems of internal control that support the achievement of organisational policies, aims and objectives. Auditors will continue to review the progress made by health bodies in complying with the Scottish Executive's guidance on internal controls and the action taken in response to audit recommendations concerning internal control weaknesses. Where action has not been taken or has been slow, these bodies will feature in that year's overview report.

Exhibit 4: The most common disclosures in statements of internal control

- **The absence of a fully developed risk management strategy and risk control procedures**. A risk management strategy is essential for identifying the risks that a business faces and mitigating principal risks to the achievement of the organisation's policies, aims and objectives.
- **The need to develop Information Technology security policies** in respect of services provided under the national service provider contract; and information management and technology strategies.
- **Continuing control weaknesses relating to the processing of certain Family Health Service payments**. Family Health Service payments involve the Common Services Agency making payments to primary care contractors (GPs, dentists, pharmacists and opticians) on behalf of primary care trusts. This is a significant area of expenditure for the NHS in Scotland and this matter is considered further in Section 7 of this Report.
- **Critical issues remaining to be addressed regarding a fully developed post-payment verification framework for Family Health Service payments**. Post-payment verification (PPV) procedures are essential for the verification of claims for services provided by primary care contractors. PPV procedures also check that prescriptions were issued to valid patients for valid reasons. These matters are considered further in Section 7 of this Report.
- **CNORIS risk management standards and criteria at Level 1** are still being implemented with a view to external assessment. The implementation of CNORIS standards is essential if health bodies are to manage effectively risk associated with clinical and medical procedures. See Section 5 of this Report.
- **'Whistleblowing' policies which comply with the requirements of the Public Interest Disclosure Act 1998 still to be implemented**. The Act, which came into force in July 1999, provides protection from dismissal and intimidation to employees who make disclosures in the public interest.

Source: Audit Scotland

Computer systems

3.12 The Common Services Agency (CSA) manages IS/IT service provider contracts on behalf of NHSScotland. This involves a main contract between the NHS and a principal supplier of services, supported by a number of framework agreements between the NHS and other providers of specialist services.

3.13 During 1999/2000, the appointed auditor of the CSA carried out an overview of the arrangements under which the contract for the provision of computer services to all NHS bodies in Scotland is operated. The CSA's appointed auditor followed up the

recommendations arising from the 1999/2000 audit as part of the following year's audit. The auditor reported there had been progress in disaster planning and recovery planning. 'Scenario testing' had also enhanced the level of preparedness of both the service provider and NHSScotland to respond to a disaster situation.

3.14 During 2001/02, the internal audit consortia responsible for the review of the IT service provider completed a progress review of recommendations arising from the earlier audits. This report concluded that good progress had been made in the implementation of the agreed actions. Although a number of performance improvement opportunities were identified, there has been no requirement to disclose weaknesses in the statements of internal control of NHS bodies in Scotland.

3.15 The external auditor for the CSA has reported that both the CSA and the IT service provider have now taken action on the internal audit consortia's recommendations in respect of organisation and asset protection. The auditor has emphasised, however, that it is essential that further improvement is made in relation to business continuity arrangements and communications infrastructure. The external auditor will continue to monitor progress in these areas in future years.

Information Technology

3.16 Information technology (IT) is important to the ability of health organisations to meet their objectives and to allow the effect of activities to be measured. Health organisations are highly dependent on the use of IT, including its use for processing and disseminating financial, medical and patient information. It is important, therefore, that NHS bodies have in place sound systems to manage IT risk through disaster recovery plans and other measures so as to ensure business continuity.

3.17 A number of external auditors have already reported that IT systems have been examined. The auditor of one trust reported that it would face a significant risk of loss of patient information if IT systems were unavailable for more than 48 hours, and made a number of recommendations designed to improve business continuity and disaster recovery. This important topic will be considered in greater detail in subsequent NHS overview reports.

4 Financial performance in 2001/02

4.1 In December 2000, the Scottish Executive Health Department (the Department) published *'Our National Health Service: A plan for action, a plan for change'*, its plan for the future of the NHS in Scotland. The Department provided guidance to NHS chairs and chief executives on the detailed implementation of the Health Plan in May 2001 in *'Rebuilding our National Health Service'*. A key commitment given in *'Rebuilding our National Health Service'* was to review the existing financial framework for NHSScotland with a view to simplifying the flow of resources, thus allowing greater flexibility for financial planning over the long term. The revised financial regime was also expected to contribute to greater consistency between NHS board and trust accounts so as to allow a better picture of the overall financial performance of the NHS area to be gained.

Trusts

4.2 In previous years 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'). In July 2001, the Department announced changes to the financial reporting and monitoring requirements for health bodies for the year 2001/02. The Department considered that the break-even target was the primary financial target for trusts, although both the 6% rate of return and the EFL remained as targets for the year.

4.3 The number of trusts achieving financial targets in 2001/02 improved compared to 2000/01 (Exhibit 5). Twenty-four of the 28 trusts achieved all three targets in 2001/02, five more than in the previous year.

Exhibit 5: Trust financial target performance

	Targets achieved	
	2001/02	**2000/01**
Target	Number of trusts (out of 28)	Number of trusts (out of 28)
Break even, year-on-year	25	20
Rate of return on assets	26	22
EFL	27	27

Source: Audit Scotland

Break-even target

4.4 Trusts are required to break-even, taking one year with another. Any surplus achieved can be carried forward to facilitate achievement of the target the following year, but if deficits are carried forward, achievement of the target in the subsequent year requires a higher level of surplus.

4.5 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, ie, the cost of providing services and the level of service provision exceed the financial resources available for the year
- accumulated deficits have to be repaid from subsequent years' income. Deferring the reductions or changes in services that are required to repay earlier years' overspends and restore financial balance may result in continuing in-year deficits.

4.6 Three trusts did not achieve the break-even target in 2001/02 (Exhibit 6). The auditors of these trusts reported that the main reasons for not achieving the target included:

- failure to achieve targets set locally for Cost Reducing Efficiency Savings
- higher than anticipated inflation in drugs costs
- cost pressures arising from the regrading of medical secretaries, the

implementation of the New Deal for Junior Doctors and upgrading of accommodation for doctors

- decontamination of equipment.

Exhibit 6: Trusts with cumulative year-end deficits as at 31 March 2002

Trust	Retained deficit at 31/3/02	Deficit as % of income	Retained deficit at 31/3/01
Argyll & Clyde Acute Hospitals	£1.7m	1.0	£3.0m
Grampian University Hospitals	£5.2m	2.1	£4.9m
Lanarkshire Acute Hospitals[1]	£6.3m	2.2	£12.7m
Highland Acute Hospitals	–	–	£2.7m
North Glasgow University Hosptials		–	£9.5m
Renfrewshire & Inverclyde Primary Care	–	–	£1.1m
South Glasgow Univeristy Hospitals	–	–	£4.1m
Tayside University Hospitals	–	–	£15.9m
	£13.2m		£53.9m

[1] The position at Lanarkshire Acute Hospitals NHS Trust is a 'technical deficit' arising from a downward revaluation of £14.9 million, in 2000/01, of properties in connection with a Private Finance Initiative project. The trust recognised the reduction as the properties became non-operational due to the development of new hospitals under the Private Finance Initiative. The trust forecasts that it will clear this deficit by March 2003.

Source: Audit Scotland

4.7 The three trusts had accumulated deficits totalling £13.2 million as at 31 March 2002 compared with the eight trusts which failed to break even in 2000/01 and which had accumulated deficits totalling £53.9 million. The remaining 25 trusts had accumulated surpluses as at 31 March 2002 totalling £31.8 million (£22 million in 2000/01) to carry forward into 2002/03. The overall net surplus for trusts as at 31 March 2002 is therefore £18.6 million (net deficit of £31.9 million in 2000/01). Exhibit 7 shows the position over the past five years.

Exhibit 7: Year-end surpluses and deficits

	Trusts with cumulative surpluses at year-end		Trusts with cumulative deficits at year-end		Overall value of cumulative surpluses or deficits
Year ended 31 March	Number of trusts	Total value of surpluses at year end (£ million)	Number of trusts	Total value of deficits at year end (£ million)	(£ million)
2002	25 (out of 28)	31.8	3 (out of 28)	13.2	18.6 surplus
2001	20 (out of 28)	22.0	8 (out of 28)	53.9	31.9 deficit
2000	20 (out of 28)	10.6	8 (out of 28)	29.8	19.2 deficit
1999	42 (out of 47)	83.3	5 (out of 47)	21.9	61.4 surplus
1998	44 (out of 47	100.3	3 (out of 47)	5.8	94.5 surplus

Source: Audit Scotland

4.8 It is pleasing to note this overall improved financial position and that the deficits which remain are small in relation to the income of each trust and to the total NHS budget for 2001/02. However, at least part of the improved financial results can be attributed to Ministers deciding in September 2001 to divert £90 million not used elsewhere in the health budget to support front-line patient care. The 'one-off' package consisted of:

- £66.9 million allocated between health boards on the basis of 1.5% of each board's annual budget
- £11.0 million earmarked for hospitals and health centres to help prepare for winter pressures
- £10.8 million specifically for the purpose of clearing the accumulated deficit outstanding at Tayside University Hospitals NHS Trust

- £1.3 million allocated to Greater Glasgow Health Board to help clear accumulated deficits at North Glasgow University Hospitals NHS Trust and South Glasgow University Hospitals NHS Trust.

4.9 The Department expected health boards to use their share of the £90 million to eliminate accumulated deficits at trusts. After that, health boards were free to use the additional funding for any other purpose which met their health care priorities and plans. Auditors reported that trusts used £41.3 million to eliminate accumulated deficits brought forward from 2000/01. The auditors also reported that a further £21.0 million was used to: fund projected in-year deficit; support recurring activity; and to tackle specific initiatives such as waiting list reductions.

4.10 The availability of the extra resources was of great benefit to trusts. Appendix A shows that, simply based on the figures shown in their accounts, 15 trusts would have been unable to break-even during 2001/02 without this extra 'one-off' funding. It does not, of course, automatically follow that the 15 trusts listed in Appendix A would have been unable to achieve break-even in 2001/02 without additional funding. It is reasonable to assume that these trusts would have taken steps to implement efficiency savings and reduce costs so that in-year surpluses could have resulted which would have been used to help reduce accumulated deficits. However, it is clear that the one-off funding does not represent a long-term solution to the financial problems faced by NHS bodies. Underlying financial pressures remain which need to be addressed.

4.11 Auditors also reported that, as in previous years, a significant number of trusts relied on non-recurring funding to achieve financial targets in 2001/02 without taking steps to fully balance the costs of recurrent activity with recurrent income. Many trusts anticipate that further difficulties in achieving financial equilibrium may be expected within the next few years. The future prospects for the financial performance of the NHS in Scotland are considered in Section 9 of the report.

Rate of return target

4.12 During 2001/02, the Department continued to monitor trusts' performance against the 6% rate of return target. Trusts were required to report performance in their annual accounts (including reasons for non-achievement of the target) but, providing that break-even was achieved, trusts were not required to take action if the 6% rate of return was not achieved.

4.13 Borders General Hospitals NHS Trust (4.5%) and Grampian University Hospitals NHS Trust (5.9%) were the only two trusts which failed to achieve the 6% rate of return on assets target in 2001/02, compared with six in the previous year. The reasons for these failures to achieve the rate of return are similar to those highlighted in relation to the break-even target. The Department did not require Borders General Hospitals NHS Trust to take action as a result of not achieving the 6% target because it achieved break-even taking one year with another.

4.14 The rate of return target requires trusts to achieve an operating surplus which is intended to represent a charge for the use of capital assets including buildings and other equipment. From 2002/03, as part of the introduction of resource accounting and budgeting across the public sector, trusts will be required to repay to the Department their capital charges in a similar way to that currently undertaken by health boards. Trusts will include a 6% charge on assets as a direct cost in their accounts. As such, trusts will no longer be required to achieve a 6% rate of return target in terms of the operating surplus to be achieved, but they will be required to break-even after the 6% charge is accounted for.

External financing limit (EFL)

4.15 The EFL target is, in effect, a cash limit on the net external financing for trusts ie, the amount of borrowing which a trust is permitted to make. Fife Primary Care NHS Trust narrowly missed by less than £7,000 to achieve its EFL. The Department accepts that it is difficult for trusts to manage its cash limit precisely and therefore permits a £10,000 tolerance around the EFL. All other trusts achieved the target in 2001/02.

4.16 As part of the revised financial framework for the NHS, with effect from 2002/03 the Department no longer requires trusts to remain within an EFL. Instead, in order to enhance consistency between health boards' and trusts' accounting arrangements, funds for capital expenditure are to be allocated to NHS boards rather than directly to trusts through the EFL. NHS boards will receive capital funds as part of their Capital Resource Limit which will then be allocated to trusts in the same way as for revenue funds.

Health boards/special health boards

4.17 In previous years, the financial target for health boards was to remain within a cash limit notified by the Department. Health boards were expected to contain the cash consequences of their ongoing operations and capital investment within this limit. In 2001/02, as

part of the introduction of resource accounting and budgeting across the public sector, health boards were also required to remain within a separate Revenue Resource Limit providing a resource budget for ongoing operations, and a Capital Resource Limit providing a resource budget for new capital investment.

4.18 The accounts for 2001/02 show that all 15 health boards operated within their cash requirement and Capital Resource Limit. Argyll and Clyde NHS Board had a slight overspend of £74,000 (equivalent to 0.2% of its Revenue Resource Limit of £411.7 million). All other health boards were within their Revenue Resource Limits. The total revenue resource underspend amounted to £38.6 million. Health boards are able to carry the underspend forward to 2002/03 to fund on-going activities and other developments.

4.19 The financial targets for special health boards for 2001/02 were the same as for health boards, and only two special boards reported slight overspends against their Revenue Resource Limits. All special boards remained within their Capital Resource Limits and cash requirement targets.

5 Accounting for clinical negligence

Background

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

5.2 The Department introduced the Clinical Negligence and Other Risks Indemnity Scheme (‘CNORIS’) in 2000 amid concerns about the rising costs of potential negligence claims and the depletion of the central fund available to finance certain settlements. The scheme has two principal 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, improve clinical performance and so reduce the incidence of clinical negligence claims.

5.3 Health boards and trusts are required to make a provision for negligence claims, based on a review of all outstanding and potential claims for which they may be liable. With the introduction of

CNORIS, trusts and health boards pay an annual contribution to provide a pool from which negligence claims since 1 April 2000 (including claims from employees for industrial injuries) are settled. The contribution is dependent on a number of factors, including the steps taken by the health body to reduce recognised risk factors; and the level of excess payment each body is prepared to pay for each claim settled. CNORIS meets the balance of any settled claim above the agreed excess.

5.4 The provision represents the actual cost of outstanding clinical negligence claims where the CLO and the health bodies concerned have reasonable expectation of making a payment. In addition, all health bodies are required to disclose information on contingent liabilities for clinical negligence claims where no provision has been made in the accounts. These are costs for which there is a possibility rather than a probability of future payment.

CNORIS risk management standards

5.5 The Department intends that discounts on contributions will be available in future years to trusts and health boards which achieve specified standards of risk management. The standards are based on three levels:

- **Level 1** which focuses on corporate ownership of risk through effective policies and procedures
- **Level 2** which seeks evidence of implementation and addresses operational issues
- **Level 3** which necessitates a high degree of integration of risk management into the culture and activities of NHS bodies, and requires evidence of the existence of dynamic risk management systems.

5.6 The Department has not set specific targets of when it expects trusts and health boards to attain each of the levels in the scheme, although it is to review this in the light of changes shortly to be introduced to the standards expected to achieve Level 1. External auditors reported that ten trusts, one health board and one special health board, in Scotland, achieved Level 1 accreditation by 31 March 2002. As at 31 March 2002, the other 18 trusts had yet to attain Level 1 status or had been audited by CNORIS scheme managers but had not met some of the criteria required for accreditation. Since then, a further nine trusts have achieved Level 1 accreditation.

Level of claims in Scotland in 2001/02

5.7 As at 31 March 2002, trusts and health boards had made provisions for negligence claims totalling £52.6 million and disclosed contingent liabilities of a further £61.2 million. In addition, they utilised £7.8 million of provisions set up in previous years to settle claims, and cancelled (reversed) provisions of £6.9 million in respect of claims where settlements were not required or were at levels lower than the amount provided for (Exhibit 8).

Exhibit 8: Accounting for clinical negligence

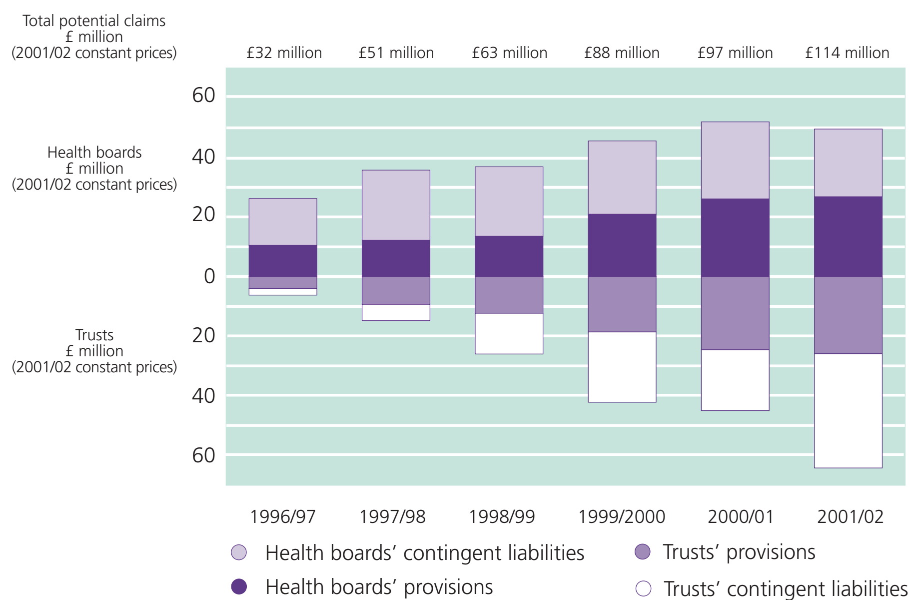
	£'000	£'000
Opening provision at 1/04/01		
Trusts	23,889	
Boards	28,068	51,957
Utilised in year		
Trusts	(4,006)	
Boards	(3,819)	(7,825)
Reversed unutilised		
Trusts	(4,229)	
Boards	(2,704)	(6,933)
Arising in year		
Trusts	10,214	
Boards	5,181	15,395
Closing provision at 31/3/02		
Trusts	25,868	
Boards	26,726	52,594
Contingent liabilities at 31/3/01		
Trusts	19,977	
Boards	25,348	45,325
Contingent liabilities at 31/3/02		
Trusts	38,423	
Boards	22,763	61,186

Source: Audit Scotland

The trend in claims for negligence in Scotland

5.8 Claims are made against the NHS body that was the employer of the health care practitioner at the time the incident occurred. Those arising from incidents prior to the formation of trusts remain the responsibility of health boards. Accordingly, because it can take several years for negligence claims to be lodged and settled, in previous years the majority of potential claims (provisions and contingent liabilities) outstanding were against health boards. In 2001/02 the gap between health boards and trusts reversed, with potential claims against trusts now representing 57% of the total potential negligence claims of £114 million outstanding against NHS Scotland (Exhibit 9).

Exhibit 9: Potential clinical negligence claims (total provisions and contingent liabilities)



Source: Audit Scotland

5.9 Exhibit 9 shows that there has been a continual increase in real terms in the level of potential claims against trusts since 1996/97. Whilst in earlier years a rapid increase was to be expected with the transfer of healthcare provision from health boards to trusts, it is of some concern that the rate of increase shows little sign of slowing down.

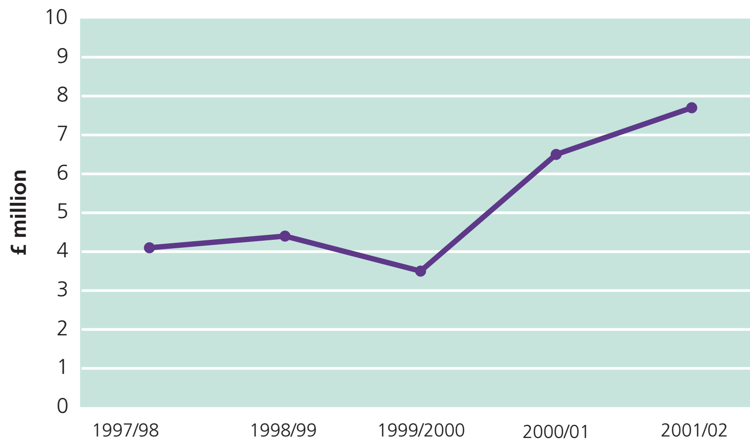
5.10 The overall increase in negligence claims in 2001/02 is largely due to an increase in contingent liabilities. A significant reason for the overall increase in contingent liabilities in 2001/02 is due to Lothian University Hospitals NHS Trust changing its method of estimating contingent liabilities to bring it more into line with most other trusts that assess contingent liabilities on the basis of guidance issued by the CLO. Lothian University Hospitals NHS Trust recognised contingent liabilities in respect of clinical negligence amounting to £2.7 million in its 2000/01 financial statements. The corresponding figure for 2001/02 was £16.2 million. Even without the increase for Lothian University Hospitals NHS Trust however, the trend in clinical negligence provisions and contingent liabilities in trusts is still upwards and now exceeds that for health boards.

5.11 The level of recognised claims against health boards also increased in real terms in the period 1996/97 to 2000/01. 2001/02 was the first year in which claims decreased compared to the previous year. A reduction in the number and value of recognised claims against health boards might be expected because, with the exception of the three island health boards and the special health boards, health boards are no longer responsible for the direct delivery of healthcare provision.

5.12 2001/02 also saw a rise in actual payments made by the NHS in Scotland to settle negligence claims for the second year in succession after a period of some stability (Exhibit 10). Since 1996/97 the number of claims which are settled each year has remained broadly constant and averages around 150. The average cost per settlement has, however, been more prone to variation, from a low of £25,000 in 1997/98, to a high of £42,000 in 2001/02. The Department estimates that 5% of the claims which are settled each year account for 60% of total expenditure. The Department considers that a minor fluctuation in the number of large settlements in excess of £1 million will, therefore, have a marked effect on the overall costs of settlement.

5.13 Although small in comparison to the total level of expenditure within NHSScotland and the overall accounting provisions, the settlement of clinical negligence claims still represents a diversion of resources away from healthcare. It is important that trusts and health boards act promptly to put in place the risk management standards envisaged under CNORIS so as to minimise clinical negligence claims. In the meantime, it is important for future planning that health bodies recognise the continuing upward trend and the possibility of significant costs under these claims.

Exhibit 10: Clinical negligence settlements



Source: Audit Scotland

5.14 Following its consideration of the Auditor General's 1999/2000 overview report, the Scottish Parliament's Audit Committee recommended that the Department reassess the basis on which health bodies reflect negligence claims in their accounts. The Auditor General's 2000/01 overview report noted that, after consultation with Audit Scotland, a review was under way.

5.15 The review found that in an examination of cases settled over a two-year period the actual payments made represented 99.7% of the value of the provision for negligence claims in the annual accounts. The review concluded that there was wide variation in the way individual health bodies handled negligence claims but that, overall, the system seemed to be working well. In August 2002, the Department's Audit Committee concluded that these variations would need to be investigated before any decision could be made on the issuing of guidance on a standardised approach to accounting for negligence claims. The Department is currently taking this work forward.

6 Scottish Executive Health Department

6.1 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 11.

Exhibit 11: Scottish Executive Health Department: aims and objectives

Aim

To improve the health and quality of life of people in Scotland and deliver integrated community care services, making sure there is support and protection for those members of society who are in greatest need.

Objectives

- To work towards a step change in life expectancy for Scots, particularly disadvantaged members of the community, including children and older people.
- To ensure that health care providers provide swift and appropriate access to health care, covering primary, community and acute care.
- To improve the patient's experience of the services provided by the NHS.
- To improve services for older people, at home and in care settings.

Source: *'Building a Better Scotland'*, Scottish Executive spending proposals 2003-2006, September 2002

6.2 The introduction to central government of resource accounting with effect from the 2001/02 accounts means that the Department is no longer required to produce cash accounts. In 2001/02, therefore, the Department produced financial statements on an accruals basis for inclusion in the Scottish Executive's Core Departments' Resource Accounts. A consolidated Scottish Executive Resource Accounts, incorporating executive agencies', health boards' and special health boards' income and expenditure was also produced.

6.3 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 that for individual trusts and health boards. The audits of the 2001/02 Scottish Executive Core Departments' Resource Accounts and Scottish Executive Consolidated Resource Accounts were completed on 18 December 2002.

Part 2: Matters arising during the year

This part covers:

- primary care payments
- new accountability arrangements
- future prospects for achieving financial balance
- NHS in Tayside
- performance audit reviews.

7 Primary care payments

Practitioner Services Division

7.1 The Practitioner Services Division (PSD) of the Common Services Agency (CSA) has been responsible for calculating and making payments to primary care contractors on behalf of primary care trusts (PCTs) and island health boards since 1999/2000. In 2001/02 PSD processed approximately 76 million transactions (60 million in 2000/01), with a total net value of £1,336 million (£1,263 million in 2000/01). This is more than 20% of the NHS expenditure in Scotland.

7.2 Responsibilities and accountabilities for primary care payments are complex (Exhibit 12):

- primary care trusts are accountable for the related expenditure but the CSA makes payments to practitioners on behalf of primary care trusts

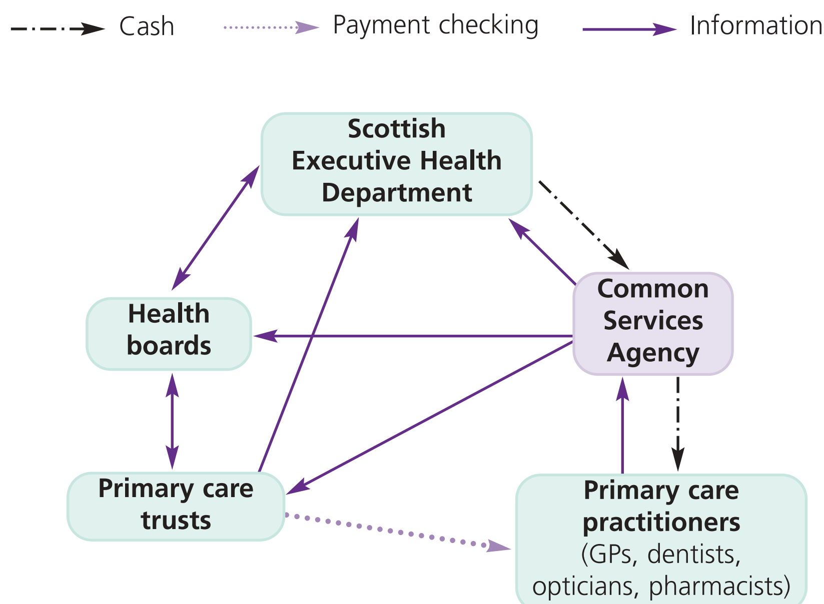
- the CSA requisitions cash from the Department drawn from health boards' allocations to enable payments to be made

- health boards continue to report primary care income and expenditure for the resident population in their annual accounts. They do not, however, exercise direct control over the drawdown of funds by the CSA

- the responsibility for practice visits (to GPs) to check source documentation supporting claims from contractors rests with PCTs, although they may delegate responsibility for payment verification to the CSA

- PCTs are responsible for the follow-up of potential fraud in relation to their contractors and patients.

Exhibit 12: Outline of primary care payments system



Note that although PCTs are responsible for payment checking, in practice it is delegated to the CSA's Practitioner Services Division to perform.

Source: Audit Scotland

7.3 The different responsibilities and accountabilities are such that it is essential that compensating controls are in place to provide assurance to health boards and PCTs that expenditure was legal. As part of the overall assurance process, the CSA engage a 'service auditor' to review the policies and procedures employed by the CSA in providing processing and payment services. The service auditor's annual report for 2001/02 concluded that, with the exception of particular areas of weakness, the policies and procedures in place provided reasonable assurance that the control objectives specified by management were achieved.

7.4 Since 1999/2000, the CSA has made considerable efforts to address a number of deficiencies in the control processes operated by PSD as highlighted by the service auditor and the externally appointed auditor. The CSA has acted to improve the overall control environment at PSD and to introduce a robust framework for payment verification covering both patient charges and payments to contractors. The 2001/02 external audit of the CSA involved a review of progress achieved in responding to areas of concern highlighted in previous years' audits.

7.5 As agreed with the CSA, in June 2002, the reports arising from this work were circulated to all NHSScotland bodies involved in this area and to their external auditors.

Practitioner Services Division: progress update

7.6 As part of the 2001/02 external audit of the CSA, the appointed auditor conducted a follow-up review of conclusions and recommendations made in previous years, to determine PSD's progress in enhancing its control framework. The review, which took into account the service auditor's work in this area, concluded that, in 2001/02, PSD had made progress in tackling areas of concern which had been identified previously. There was, however, still scope for further improvement and a need for the CSA to address a number of control weaknesses assessed by the service auditor of being 'high' risk. In addition, there continues to be concern about the accuracy and timeliness of prescribing information.

7.7 Exhibit 13 shows the appointed auditor's main findings arising from her 2001/02 review, including how the CSA has responded to areas of concern previously highlighted and where further action is warranted. Since the auditor reported, the CSA considers that both the accuracy and timeliness of prescribing information has improved. The CSA intends to issue progress reports to PCTs and health boards detailing the further action being taken.

Exhibit 13: CSA's response to previous concerns relating to PSD controls

Issues of concern identified in 2001/01	Auditors' findings in 2001/02 (recommendations for further action in bold)
Overall control environment and processes	
1. The service auditor identified a number of significant continuing control weaknesses including 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 service auditor identified a number of 'high' risk control weaknesses: including those relating to disaster recovery and business continuity plans for business-critical systems; segregation of duties and users' access rights; formal change management and testing; and monitoring of key security breaches. The service auditor also recorded that: a review of masterfile amendments is evidenced for all streams except for general dental services; disaster recovery plans for general pharmacy services and general dental services remain outstanding; and some Business Continuity Plans had not been updated since December 1999. While back-up procedures for pharmacy systems are now documented, they do not specify arrangements for on-site storage and there is no documentary evidence to confirm that daily back-up tasks are carried out. While progress has been made towards implementing systems procedures and training guides, a comprehensive set of procedural instructions has yet to be developed. **Management must address controls which have had an unsatisfactory test result when reviewed by the service auditor. Efforts should be directed in accordance with the level of risk associated with each control objective.** **Comprehensive procedural instructions should be developed and made available to staff involved in payment processing.**
Identification and evaluation of risks and control objectives	
2. Comprehensive PSD risk register using the CSA's common format still being developed.	The CSA has identified through its business planning processes risks pertinent to PSD. Risks are now incorporated in a risk register. **There is a need to clarify how risks identified as part of the business planning process are managed through the development of systems of internal control.**
3. 'Partnership Agreement' between the CSA and PCTs describing all aspects of the service to be provided by CSA not yet finalised.	A comprehensive Partnership Agreement was agreed and implemented during 2001/02. Regular regional team meetings with PCT representatives are now an established part of the overall framework of communication and control. The degree to which all aspects of the Agreement have been fully implemented varies, depending on the trust, payment stream and regional centre involved.

The Partnership Agreement should be fully implemented for each payment stream; regional centre of PSD; trust. Where implementation of agreed protocols proves unworkable, PSD should work with trusts to find appropriate solutions and the Agreement should be updated accordingly.

Information and communication

4. 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.

5. As a result, 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 processing of pharmacy payments on the new computerised system returned to the normal lead time of two months by November 2001.

Overpayments arising from estimated payments had diminished from £2.5 million at 31 March 2001 to approximately £0.12 million at 31 March 2002.

There remain concerns about the accuracy and timeliness of prescribing management information provided to PCTs, and forecasting does not always accord with local projections. This may hinder management control and treasury management arrangements in-year at PCT and health board level.

PSD should work with PCTs to address the concerns surrounding the accuracy and timeliness of prescribing management information, including forecast information.

6. Internal audit had concerns about certain aspects of the control features of the computerised processing system.

Satisfactory action has been taken in a number of areas to address the control weaknesses identified by the internal auditor. The CSA is still taking action in relation to disaster recovery and as regards the activation of the auditing and management information functions within the computerised system.

7. No progress had been made on the development of key performance indicators for medical and ophthalmic payments streams and supporting information systems to ensure regular monitoring.

The development of key performance indicators and supporting management information systems is still ongoing.

Key performance indicators and related management information should be developed to monitor and identify outlying medical and ophthalmic payments.

Source: Audit Scotland

7.8 Payments to primary care contractors represent one fifth of the expenditure of the NHS in Scotland. PCTs, therefore, need to be able to rely on the CSA that only properly valid claims are paid and that they receive accurate and timely prescribing management information which can be used to monitor expenditure against budgets. The CSA continues to make progress in enhancing its overall control environment. Nevertheless, there is still scope for the CSA to further improve its control systems and to develop key performance indicators and management information to monitor and identify outlying medical and ophthalmic payments.

Practitioner Services Division: payment verification

7.9 Payment verification checks are an essential part of the control framework for payments to primary care contractors. Since 1999/2000, the CSA has strived to introduce procedures for ensuring the regularity of payments made, including visits to contractors, routine management and internal audit checks of processed information and special investigations of those practitioners' claims where there are concerns.

7.10 The 2000/01 audit of the CSA highlighted the progress made to date by PSD and where further action was still required. For 2001/02, the appointed auditor carried out a follow-up review of the CSA's post-payment verification procedures. The auditor found that the CSA had made progress, including the implementation of Partnership Agreements with PCTs, but some action was still outstanding from 2000/01 (Exhibit 14).

Exhibit 14: CSA's response to previous findings relating to post-payment verification

Issues of concern identified in 2001/01	Auditors' findings in 2001/02 (recommendations for further action in bold)
1. A Fraud Investigation Unit (FIU) was established in July 2000. As at March 2001, procedures still had to be formalised in a number of areas and a service level agreement had yet to be agreed with the Benefits Agency.	The FIU had commenced checks in respect of patient exemption claims under a range of exemption categories. These checks are in addition to those performed by PSD regional teams on exemptions claimed due to age, medical conditions and prepaid certificates. However, FIU had experienced some problems with the implementation of these checks and the level of checking is not yet in line with the intended level. For example, the FIU was required to contact patients directly where they claimed to have a tax credit exemption because the Inland Revenue does not have the facility to undertake the initial confirmation check. Pharmacy exemption checking was strictly limited in 2001/02 because the payment system was still being updated. **Levels of patient exemption claim checking should be as stated in the Partnership Agreement.**
2. During 2000/01 there was no formal agreement in place between PSD and PCTs detailing responsibility for payment verification and the level of testing to be undertaken. As a result, there were inconsistencies between offices in the operation of payment checks and only the Edinburgh Processing Centre participated in GP practice visits.	A formal agreement is now in place between PSD and all PCTs detailing their respective responsibilities for the processing, payment and verification of primary care payments. The CSA has made significant effort to introduce and embed the payment verification checks as stated in the Agreement. However, the extent of checking continues to vary depending on the primary care payment stream, the PSD regional office or the PCT involved. As at 31 December 2001, GP practice visits had been made by the Edinburgh and Aberdeen Processing Centres and further visits were planned. **Robust post-payment verification procedures for pharmaceutical services should be introduced in accordance with the Partnership Agreement. Payment verification checks for ophthalmic services should be conducted and reported throughout the year, as informed by the risk management exercise. GP practice visits should be conducted systematically in accordance with the Partnership Agreement.**
3. 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.	The comprehensive review of risks had yet to be concluded at May 2002. As such it does not inform current verification processes with respect to identifying higher risk payment streams, the level of testing required, and the effectiveness of validation checks. The comprehensive review of risks for each primary care stream should be completed and applied as appropriate to the checks on payments and patient exemption claims.

4. 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.	Detailed procedures for the utilisation of management information have yet to be developed. The provision of management information on general medical services and summaries of the results of certain payment verification checks was provided quarterly to trusts in accordance with the Partnership Agreement, although staff shortages led to some temporary delays in the dispatch of information. **Detailed procedures should be drafted for the compilation and reporting of general medical services management information. Reports should be issued on a timely basis.**

Source: Audit Scotland

7.11 Partnership Agreements that are now in place between PSD and all PCTs detail the respective responsibilities of PSD and trusts for the processing, payment and verification of primary care payments. The Partnership Agreement sets out a payment verification protocol detailing the levels of testing which should be applied to each of the four primary care payment streams. These can be summarised as:

- **Level 1** – routine pre-payment checks on the accuracy of information input to the system from the original claim
- **Level 2** – a sample of claims may be subject to further scrutiny, triggered through Level 1 checks, trend analysis or risk assessment
- **Level 3** – patient confirmation letters may be sent, or medical records may be subject to examination
- **Level 4** – medical records subject to examination on a random basis.

7.12 The auditor reports that the CSA has made significant efforts to introduce and embed the payment verification checks as stated in the Partnership Agreement. However, the extent of checking varies depending on the primary care payment stream, the PSD regional office or the PCT concerned. The auditor reported that, as at December 2001:

- no Level 3 or 4 checking had commenced in respect of pharmaceutical services
- limited Level 1 and 2 checks only had been reported for general

ophthalmic services. Checking had been confined to some trusts only and only in respect of payments up to September 2001

- GP practice visits, conducted under Level 3 and 4 checks, only covered some trusts. The Glasgow Regional Centre had yet to carry out any GP practice visits.

7.13 Since December 2001, the CSA considers it has made further improvements to its payment verification checks. In particular, all three regional centres completed their programmes of random GP practice visits by 31 March 2002. Regional centre staff also carried out targeted visits where necessary. In the CSA's view, it therefore complied with the terms of its Partnership Agreements. In addition, the CSA carried out further ophthalmic checking during 2001/02 and intends that these checks will be conducted throughout subsequent years.

Fraud Investigation Unit

7.14 The Fraud Investigation Unit (FIU) was established as part of the CSA in July 2000 to pursue contractors who are suspected of claiming fees for treatment or services which may be fraudulent or in violation of regulations. The FIU also investigates fraud committed by patients using services provided by primary care contractors. During 2001/02, the FIU achieved its full staffing complement of 15 and continued its investigation of those contractors suspected of improper activity. It also commenced checks as to the validity of patient exemption claims in a number of areas, including those patients claiming to be in receipt of income support, working families' tax credit and disabled persons' tax credit.

7.15 The FIU reported in its annual report for 2001/02 that it identified annual savings of £110,000 in respect of fraud or inappropriate claims by family health practitioners. The FIU also identified losses to family health services of £101,000 and made recoveries amounting to £21,000 from practitioners who made false or inappropriate claims. Recoveries of £11,000 were also made from patients evading NHS charges. During the year, the FIU investigated 42 referrals concerning contractors of which 30 were still on-going at 31 March 2002.

7.16 During 2001/02, however, the FIU encountered some problems in the implementation of its checking of patient exemption claims, and the level of checking was not yet in line with that intended in Partnership Agreements. For example, the FIU was required to contact patients directly where they claimed to have a tax credit exemption because the Inland Revenue does not have the facility to undertake the initial

confirmation check. Pharmacy exemption checking was strictly limited in 2001/02 because the payment system was still being updated. The Prescription Pricing Authority[1] was also unable to commence bulk checking in 2001/02 in respect of patients on the NHS Low Income Scheme.

Post-Implementation Review Group

7.17 The 2000/01 NHS Overview report noted that a Post-Implementation Review Group had been established in March 2001 to consider whether the expected benefits to NHSScotland arising from the transfer of payment and administration responsibilities to the CSA are being realised.

7.18 The Post-Implementation Review Group published its report in December 2001. The overall conclusion was that the transfer of functions had been successfully achieved, although it was recognised that circumstances had posed some particular difficulties and challenges. The report included a number of caveats, and identified that it would have been helpful to have agreed baselines and outcomes in order to measure the impact of change and the achievement of planned improvements.

8 Revised accountability arrangements

8.1 In May 2000, the Minister for Health and Community Care commissioned a review of the roles, functions and accountabilities of the different parts of the NHS system. The aim of the review was to streamline the strategic decision-making process and promote a greater degree of partnership and collaboration between the individual components of the system. The results of that review were used to inform the development of *'Our National Health: A plan for action, a plan for change'*.

8.2 A principal change arising from the Health Plan was to establish, in September 2001, unified NHS boards in each of the current health board areas to replace the separate board structures which had hitherto existed in health boards and NHS trusts. NHS trusts have, however, retained their separate legal status and operational responsibilities but with streamlined management arrangements and fewer non-executive directors (Exhibit 15).

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[1] The Prescription Pricing Authority is a special health authority within the NHS. It administers the NHS Low Income Scheme on behalf of the Department for Health for England, the Scottish Executive Health Department and the National Assembly for Wales. The scheme provides income related help with health costs for people who are not exempt or automatically entitled to help with NHS charges, but who nevertheless have difficulty in paying for the costs of NHS prescriptions, dental and ophthalmic charges; travel to hospital for NHS treatment; and NHS wigs and fabric supports.

Exhibit 15: Revised accountability arrangements

- Each unified board is responsible for developing a single health plan to address the needs of the local population.
- As boards of governance, unified boards have responsibility for the implementation of the local health plan.
- Unified boards determine how resources are allocated between their component health boards and trusts to meet strategic objectives.
- Unified boards are accountable to Ministers and the Department for the financial and operational performance of the local NHS system as a whole.
- The chief executives of health boards and trusts are members of the unified board so as to promote shared decision making and better collaborative working across the local NHS system. There is, however, no line management relationship between a board chief executive and a trust chief executive.
- As designated accountable officers, chief executives remain directly answerable to the Scottish Parliament for propriety and regularity of financial transactions under their control and for achieving best value from the use of resources provided.

Source: *'Our National Health: A plan for action a plan for change'*, Scottish Executive Health Department, December 2002

8.3 The Department expects that the revised accountability arrangements will help contribute to improved financial management in NHS bodies. As part of their 2001/02 audits, appointed auditors examined the establishment and operation of the new boards against the Department's requirements for revised accountability arrangements. Several auditors reported that the new arrangements, although at an early stage, appear to be working well. In particular:

- there has been a high attendance of non-executive members at meetings of the unified boards
- the introduction of local authority representatives as members of the unified board was seen as beneficial, particularly when dealing with issues such as community planning and delayed discharge of patients
- the creation of a finance committee at two unified boards (Argyll and Clyde NHS Board and Lothian NHS Board) has contributed towards an increased corporate approach being taken towards financial matters, including the preparation of financial recovery plans

- there is evidence that the new arrangements have contributed towards joint working between NHS bodies and other agencies. For example, Tayside NHS Board is working with the local PCT and the local authorities to take forward an innovative project, Care Together, aimed at integrating better health and social care services in the area.

8.4 A number of other auditors, however, commented on aspects of the new arrangements where further consideration needs to be given. In particular, there is a need to clarify the respective responsibilities where trust boards continue to exist alongside unified boards. Concern has also been expressed about the amount of time spent by non-executive members preparing for and attending board and committee meetings (Exhibit 16).

Exhibit 16: Areas where the revised accountability arrangements require further consideration

- The role of audit committees in cases where the unified boards have agreed that the individual trusts should also maintain their own audit committees.
- The non-statutory position occupied by unified boards and the potential difficulties that this presents for the members of trust boards regarding cross-accountabilities, particularly in regard to their statutory duties for their own body. This is particularly relevant for NHS health areas which have significant financial difficulties.
- While the new arrangements have had the desired effect of enhancing the level of co-operative working, it has also resulted in an increase in the amount of time consumed in attending committee meetings and the volume of reading and preparation has risen commensurately. The auditor of one health board highlighted the onerous level of commitment that increasingly is being demanded of non-executive board members.

Source: Audit Scotland

8.5 The creation of unified boards is being implemented alongside revised performance and accountability arrangements. The new performance assessment and accountability arrangements were introduced with effect from 2002/03. The objectives of the system are to:

- support and encourage sustained improvement in the performance of NHSScotland by focusing on key measures in relation to health priorities

- reinforce and support the role of unified NHS boards in managing the performance of their local NHS systems

- enable NHSScotland to account systematically for its performance both locally and through the Scottish Executive to the Scottish Parliament and to the people of Scotland

8.6 The performance assessment framework is designed to encompass a set of quantitative measures, indicators and qualitative assessments which will provide an aggregate picture of the performance of a local NHS system. The framework analyses overall performance using seven broad headings or fields each with their own success criteria and measures of specific aspects of performance (Exhibit 17). The performance assessment framework provides a systematic background for continuing discussions with NHS boards about performance, and was used during the summer of 2002 as a basis for discussion at the annual accountability review meetings between the Department and NHS board senior managers.

Exhibit 17: The areas covered by the performance assessment framework

- Health improvement and reducing inequalities
- Fair access to health services
- Clinical governance, quality and effectiveness of healthcare
- The patient's experience
- Involving the public and communities
- Staff governance
- Organisational and financial performance and efficiency

Source: *'Rebuilding our National Health Service'*, Scottish Executive Health Department, May 2001

8.7 The creation of unified boards and the new performance assessment arrangements represent a major development in holding local NHS systems to account for their performance. Auditors will be expected to monitor the implementation of the new arrangements across Scotland and report on their effectiveness in the coming years.

9 Future prospects for achieving financial balance

9.1 In September 2002, the Scottish Executive's spending proposals for 2003/04 to 2005/06, *'Building a Better Scotland'*, announced that an additional £2.7 billion would be invested in the NHS in Scotland over

the three-year period, bringing planned annual expenditure to £8.6 billion by 2005/06. *'Building a Better Scotland'* outlined how the additional funds were to be invested over the period (Exhibit 18).

Exhibit 18: How the planned additional funding for NHSScotland is to be used

- A Centre for Change and Innovation will be established to support the drive for reform within NHSScotland.
- Investment is to be made in the treatment of coronary heart disease, stroke, cancer and mental illness, utilising the latest technologies.
- Provision will be made to treat additional hospital cases as outpatients, day cases or inpatients.
- An additional 10,000 nurses and 1,500 midwives are to be trained and the total number of NHS consultants is to increase by 600.
- At least £750 million is planned to be invested in buildings and IT.
- £20 million per annum is to be invested to provide 1,000 community places for people leaving hospital and to reduce waiting times imposed by delayed discharges.
- £125 million per annum is to be invested on personal and nursing care for the elderly.
- NHS 24 is to be rolled out across Scotland giving swift access to advice and assistance.
- At least £36 million is to be invested to modernise and improve GP and dental facilities.
- Funding will be provided to allow large increases in staffing levels and to improve the recruitment and retention of NHS frontline staff.
- A wider role for nurses will be developed to get the full benefit of their skills and to enable the release of doctors to focus where their skills are needed.

Source: *'Building a Better Scotland'*,
Scottish Executive spending proposals 2003/04 to 2005/06, September 2002

9.2 These increased levels of funding for the NHS are intended to assist in reforming and modernising the health service in Scotland. But the additional funding will not necessarily solve the financial problems faced by the NHS. An ageing population and technological advances in the treatment of conditions for which there were previously no treatments available will continue to have financial implications for the NHS. New EC regulations, such as that affecting the transportation of clinical waste, and other directives may represent increased costs without there being a clear, direct link to improved

patient care. And, while NHS boards will no doubt welcome the extra resources to be made available, it is clear they will have to deliver improved health care for their local populations in return.

9.3 Consequently, there will still be a requirement for NHS boards to prepare balanced budgets and to manage prudently the finances of the local NHS area in accordance with clearly identified priorities and plans. Auditors have reported that draft financial plans for 2002/03 indicate that many NHS areas will continue to face financial difficulties and remain dependent on non-recurring income or savings plans to achieve financial break-even. While the auditors of most NHS trusts and boards reported that draft financial plans for 2002/03 forecast that break-even will be achieved, in three specific cases auditors highlighted issues which represent a risk to future financial balance.

Lothian University Hospitals NHS Trust

9.4 Lothian University Hospitals NHS Trust (LUHT) provides acute health, paediatric and community services to the 700,000 resident population of Lothian. In addition, it provides secondary and tertiary acute care services to the wider population of the south east of Scotland and certain highly specialised services on a national basis.

9.5 The trust has achieved all of its financial targets since its inception in 1999. However, the external auditors have reported each year that the trust has had an underlying recurring deficit. Financial targets have only been achieved through the application of non-recurring funding and the implementation of cash releasing efficiency savings. For example, in 2001/02 Lothian NHS Board provided the trust with £9.9 million non-recurrently to offset LUHT's cumulative recurring deficit position. Some £8 million of the additional funding was used to help fund the commissioning of two new buildings, the Anne Ferguson Building at the Western General Hospital and the first phase of the new Royal Infirmary of Edinburgh (RIE). The trust also implemented a manpower plan expected to yield recurring savings of £3.3 million.

9.6 Since October 2001, NHS Lothian has been responsible for ensuring that robust and balanced financial plans are prepared by local NHS bodies to support the achievement of local health plans. Given LUHT's financial position and its likely impact on the projected financial position of the local health area, a pan-Lothian team was created during 2001 to 'work with and support the trust in the production of an effective and deliverable financial recovery plan for the trust which will result in a sustainable five-year financial plan across the trust and NHS Lothian to underpin the local health plan, to meet both national and locally agreed strategic objectives and targets'.

9.7 The pan-Lothian review team estimated that LUHT would experience a shortfall between income and expenditure of £95 million over the four-year period from 2002/03 to 2005/06 associated with five key business cases currently in the course of implementation. The key business cases included the development of the new RIE and the Anne Ferguson Building, and the introduction of an improved Hospital Information System and Picture Archiving and Communication System. The pan-Lothian review team concluded that a number of key assumptions associated with the business cases affecting funding, savings and efficiency improvements etc were not as robust as they should have been. In addition, there had been considerable change since most of the business cases had been approved and, as a result, certain of the assumptions were no longer valid.

9.8 The pan-Lothian review found that LUHT had developed a financial recovery plan to address a significant element of the affordability gap. The trust expected that the introduction of further savings plans, the use of capital receipts arising from the sale of the old RIE site and other measures would result in savings amounting to some £55 million over the four-year period. The balance of the savings requirement of £40 million was to be addressed through a NHS Lothian-wide strategic change initiative. NHS Lothian has identified six initiatives to affect strategic change, including the redesign of acute and primary care services, the better integration of support services and improved manpower planning. Each of these projects is being led at chief executive level and the achievement of significant progress, within the timescales set, will be key to NHS Lothian securing clinical stability and financial equilibrium.

9.9 Lothian NHS Board approved the pan-Lothian review findings in January 2002. Since then, LUHT has produced a number of iterations to its five-year financial plan covering the period 2002/03 to 2006/07 (Exhibit 19). The latest five-year financial plan, submitted to the Department in May 2002, shows a projected cumulative deficit over the period of £11.7 million, with cumulative deficits in the first three years being partly offset by surpluses in years four and five. The financial plan is, however, dependent on NHS Lothian providing LUHT with £9.4 million in 2003/04, and £14.8 million thereafter, to allow the full commissioning of the new RIE and the Anne Ferguson Building. The financial plan also highlights that a pan-Lothian strategic change fund has been established to assist in the delivery of these two projects and other strategic change initiatives which are expected to result in recurrent savings in the longer term. The external auditor, however, considers there is a risk that the financial

plan may not be deliverable, and therefore, the potential deficit may exceed the levels projected.

Exhibit 19: Lothian University Hospitals NHS Trust five-year financial plan

1. LUHT's five-year financial plan covering the period 2002/03 to 2006/07 produced in February 2002 identified a projected deficit for year one of £27.1 million. This was in addition to the net deficit of £0.9 million facing the trust summarised through the work of the pan-Lothian review team.
2. Following Lothian NHS Board's request for a revised financial plan showing a balanced position, in accordance with the Department's requirements, LUHT reported, in March 2002, that further work had resulted in the forecast deficit being reduced to £16 million for 2002/03. The financial plan indicated that trust expenditure would significantly exceed income in 2002/03, with future years showing a significantly worse position.
3. Subsequent to this, a number of meetings were held between LUHT and Lothian NHS Board which resulted in the trust identifying further savings, and which ultimately allowed the health board to submit to the Department a financial plan showing a balanced position. The savings plan identified a recurring saving of £25.6 million by 2006/07, but noted in the intervening period that LUHT would require from Lothian NHS Board non-recurring funding of £80 million to allow the trust to cumulatively break-even.
4. At the instigation of NHS Lothian, LUHT submitted a revised five-year plan to the Department in May 2002 following further work between it and Lothian NHS Board. The plan projected a residual net deficit over the five-year period to 2006/07 of £11.7 million. Years one to three identify a projected cumulative deficit of £15.1 million, and years four to five a cumulative surplus of £3.4 million. The financial plan is, however, dependent on Lothian NHS Board providing the trust with non-recurring income of £9.4 million in 2003/04 and £14.8 million thereafter, in respect of additional investment required to allow the full commissioning of the new RIE and Anne Ferguson Building. The financial plan is also dependent on the use of a pan-Lothian strategic change fund to finance strategic change initiatives which are expected to yield recurring savings in the longer term.

Source: Audit Scotland

Argyll and Clyde Acute Hospitals NHS Trust

9.10 NHS Argyll and Clyde is responsible for the delivery of acute services, primary care and care of the elderly for a population of 420,000 in an area of 2,800 square miles, ranging from Argyll in the north to Greenock and Paisley in the south.

9.11 During 2001/02, a significant underlying deficit of over £6 million was identified across the NHS Argyll and Clyde area.

In February 2002, all four local health bodies agreed a financial recovery plan covering the five years to 2006/07 designed to bring the health area into recurring and sustainable financial balance, and setting challenging targets for all three trusts. The external auditor considers there are a number of risk areas which may impact on the successful delivery of the plan including:

- all three Argyll and Clyde trusts have identified recurring deficits which will require both continued application of rigorous financial control measures and a more strategic change in service delivery
- the financial plan anticipated a balanced financial position at 1 April 2002 across the three trusts. The 2001/02 audited accounts show a combined cumulative deficit of £1.2 million was carried forward
- the costs of future key strategic challenges, such as acute services reconfiguration and the redesign of maternity services, which are not currently provided in the plan
- Argyll and Clyde Acute Hospitals NHS Trust (ACAHT) is required to deliver £2.7 million savings in 2002/03, including the non-recurrent use of £0.7 million from its winter planning contingency
- additional, as yet unfunded, cost pressures have been identified in 2002/03 in areas such as waiting lists, anaesthetics and junior doctors' accommodation.

9.12 Argyll and Clyde NHS Board considers that the plan will, in the short term, significantly curtail service development across NHS Argyll and Clyde. NHS Argyll and Clyde has established contingency arrangements which provide a framework to address any variations from the financial plan. There are, however, limited contingency funds available. Taken together with previous financial problems which have been experienced by trusts in the area, this means that it is essential that Argyll and Clyde NHS Board and trusts implement comprehensive arrangements for prioritising and allocating resources from contingency funds, and for monitoring performance against savings targets.

9.13 One of the key factors which will determine whether the recovery plan is achieved is the financial performance of ACAHT. Since its inception the trust has had a recurring deficit. Although recurrent funding has been put in place to alleviate these deficits, the trust has nevertheless still had to rely on non-recurring monies to manage

other in-year pressures. The reliance on uncertain non-recurring funding has impacted on overall financial planning at ACAHT and management decision making, particularly over the allocation of non-recurring funds between funded service developments and existing recurring cost pressures.

9.14 During 2001/02, Argyll and Clyde NHS Board provided ACAHT with 'one-off' non-recurring funding of £7.0 million including £3.0 million for the purpose of clearing its accumulated deficit. The additional funding enabled the trust to report an operational surplus for the year of £1.3 million, but was insufficient to clear the accumulated deficit from previous years which now stands at £1.7 million. For 2002/03 the trust is required to deliver recurrent and non-recurrent savings amounting to £2.7 million. ACAHT's savings plans commit it to a number of actions which, in the auditor's view, may impact on patient services such as reducing agency nurse and locum doctor costs (expected to provide some £1.3 million of the planned £2.7 million savings). The auditor considers that the trust has had difficulty in the past in achieving efficiency savings.

9.15 The auditor for NHS Argyll and Clyde has reported, however, that the new governance and accountability arrangements have helped establish joint working across the local health area. A key development has been the setting up of a finance committee of the unified board to review and monitor the performance of each local NHS organisation against financial plans and budgets.

9.16 Nevertheless, it is clear there are still concerns between the local health bodies, particularly surrounding the overall financial position. The Minister for Health and Community Care announced on 26 September 2002 that an expert support group had been appointed following a request from the chairman of Argyll and Clyde NHS Board for assistance in resolving long-standing managerial issues within the local health structure.

9.17 The support group presented its conclusions to Argyll and Clyde NHS Board on 16 December. Its main findings included:

- lack of strategic direction and clarity of goals for the NHS in Argyll and Clyde
- loss of confidence and reputation giving clinicians the perception that the system is incapable of making decisions
- mistrust and blame culture instead of team work

- a “them and us” culture at certain levels between trusts and the board
- ineffective relationships with local authority and planning partners, clinicians, MSPs and other stakeholders
- a lack of shared understanding over strategic direction and the true financial position which comprises a potential shortfall of between £25 million and £30 million in 2003/04 if no action was taken
- some evidence of robust planning but actually little implemented in practice
- little has changed in the wake of previous attempts to create a cohesive team approach.

9.18 As a result, the chief executives of Argyll and Clyde NHS Board and all three trusts in the area have agreed to step down. A new interim management team has been appointed to tackle the strategic and opertional challenges which remain.

Grampian University Hospitals NHS Trust

9.19 Grampian University Hospitals NHS Trust (GUHT) was established in April 1999 following the merger of Aberdeen Royal Hospitals NHS Trust, parts of Grampian Healthcare NHS Trust and parts of Moray Healthcare NHS Trust. The trust provides acute care to patients from a wide area including the whole of Grampian and the islands of Orkney and Shetland. It also provides some services to the residents of Highland and Tayside as well as to the offshore oil industry. The trust serves a population in excess of 575,000.

9.20 GUHT began 2001/02 with an accumulated deficit of £4.9 million and initially budgeted for an in-year deficit of £6 million. During 2001/02, the trust received ‘one-off’ additional funding of £5.6 million from Grampian NHS Board, which enabled it to eliminate the cumulative deficit and to reduce the 2001/02 actual in-year deficit to £5.2 million. NHS Grampian has prepared an action plan which is intended, *inter alia*, to address the financial viability of the trust (Exhibit 20).

Exhibit 20: Action taken to address financial issues at GUHT

The NHS Grampian Action Plan was devised to address a number of issues facing the unified board. The plan, approved by the health board and both trusts' boards in June 2001, consists of two parts:

- Part 1 consists of the Grampian University Hospitals NHS Trust Waiting List Numbers Action Plan, the Grampian University Hospitals NHS Trust Financial Recovery Plan and the Grampian Primary Care NHS Trust Financial Viability Plan
- Part 2 comprises the NHS Grampian Modernisation, Redesign and Redevelopment Programme. This is a ten-year plan to make the most effective use of funding allocated to NHS Grampian, including the appropriate application of additional resources to be provided by the Department in the immediate future.

Initiatives currently being progressed under the NHS Grampian Modernisation, Redesign and Redevelopment Programme include:

- A review of all planned and yet to be executed NHS Grampian developments
- A review of primary and community service provision focusing on location, clinical infrastructure and service viability
- A review of targeted acute services with a focus on modernisation and re-design, building on best practice
- An evaluation of the plan for central Aberdeen hospital sites and progress with these plans.

Source: Audit Scotland

9.21 A key part of the NHS Grampian action plan is the GUHT Financial Recovery Plan. The financial recovery plan envisaged that the trust would incur in-year deficits of £6 million in 2001/02, £4.5 million in 2002/03, £2.5 million in 2003/04 and break-even the year after. Some of the actions taken by GUHT to meet the target deficit in 2001/02 included:

- the introduction of tighter controls over drug spend, with protocols having to be followed before expensive drugs can be used
- the establishment of a vacancy control committee to provide approval before any post can be filled
- changed authorisation thresholds to ensure the involvement of more senior staff in the ordering process
- investigation by management of all areas of expenditure to identify action to reduce costs.

9.22 Consultants appointed to review the trust's financial recovery plan reported in September 2001 that a number of key risks existed to GUHT achieving its recovery plan, including:

- the possibility that, after March 2002, expenditure in excess of £1.3 million may be required to meet waiting list targets and no income has been identified to specifically fund this initiative
- proposed savings in 2002/03 of £3.9 million are ambitious and heavily dependent on cost savings arising from the closure of a hospital site which are difficult to quantify due to the need to provide the same services at an alternative location
- cost reductions resulting from the NHS Grampian redesign of services of £3.4 million, rising to £4.3 million, need to be achieved in 2002/03 and 2003/04 to meet the required planned in-year deficit reductions.

9.23 The external auditor has concluded that it is not possible, at this stage of the NHS Grampian Modernisation, Redesign and Redevelopment Programme, to determine whether the initiatives being taken will ensure the long-term financial viability of GUHT. The NHS Grampian Action Plan states that GUHT is operating at around 10% above the levels suggested by funding availability.

9.24 In the auditor's view, achievement of the trust's £4.5 million planned deficit for 2002/03 is dependent on a number of factors including planned asset sales or other funding to address costs pressures and the maintenance of waiting lists/targets within national limits, and resourced using current funding levels. The auditor considers that if the trust is to achieve a break-even position in the medium to long-term, it is necessary to specify the level of funding to be provided by Grampian NHS Board and the nature and levels of activity of healthcare services to be delivered by the trust.

9.25 While GUHT reporting a deficit of £5.2 million in 2001/02, the auditor has concluded that GUHT and Grampian NHS Board actively monitored the trust's financial recovery plan during the year and that there is effective health leadership, corporate working and governance within NHS Grampian. The trust has agreed, in principle, with the Department a plan for the elimination of accumulated deficits after it has achieved an annual break-even position. GUHT, overseen by Grampian NHS Board, is also reviewing whether the initiatives identified in the NHS Grampian Action Plan will ensure the long-term viability of the trust.

10 NHS in Tayside

10.1 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%). This led the Auditor General to publish a report, in March 2001, on the financial and operating difficulties faced by NHS bodies in Tayside.

10.2 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's report conclusions included:

- 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 one former trust over the development of cancer and renal services and the filling of staff vacancies
- there was an urgent need to restore confidence in Tayside Health Board so that it could lead the Tayside trusts and other partners forward to deliver healthcare improvements
- annual accountability reviews between the Department and Tayside health organisations failed to address financial issues adequately and there was a need for more robust systems for monitoring financial performance of NHS bodies.

10.3 In September 2001, the Department and the NHS in Tayside responded to the Audit Committee's conclusions and recommendations, stating that action being taken to address the Audit Committee's findings included:

- the establishment of a Tayside Health Board Finance and Resource Committee to hold NHS Tayside bodies to account in respect of financial planning and 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 appointments

- the establishment of a Staff Partnership Forum in each trust and the health board to ensure input to NHS Tayside governance.

10.4 The auditors' final reports on the 2001/02 audits of the Tayside health bodies indicate that a number of developments in respect of new accountability arrangements, financial planning and monitoring, and financial results for 2001/02 have taken place since the response to the Audit Committee's report. In particular, the auditor reported that the establishment of a unified NHS Tayside board and its supporting committee structures has had the desired result of further enhancing the level of co-operative working in Tayside.

10.5 The auditor also reported that, whilst a number of mechanisms have been put in place to ensure effective monitoring and reporting of TUHT's financial position, break-even in 2001/02 was only achieved through the use of non-recurring income and other savings. In particular, the Department provided TUHT with £15.9 million non-recurrently to clear its accumulated deficit. The auditor considers that it will be a challenge for TUHT and NHS Tayside to secure break-even again in 2002/03. Further details of the auditor's findings in relation to NHS Tayside are provided in Exhibit 21.

Exhibit 21: Auditor's findings in relation to NHS Tayside

Accountability arrangements

1. Tayside NHS Board was established in September 2001 to replace the separate board structures which had hitherto existed in Tayside Health Board, TUHT and Tayside Primary Care Trust (TPCT). The board is intended to form a local health system with responsibility for improving the health of the local population. The overall purpose of the unified NHS Board is to ensure the efficient, effective and accountable governance of the local NHS system, and to provide strategic leadership and direction for the system as a whole.
2. Membership of Tayside NHS Board consists of the chair and vice-chair; the chief executives of Tayside Board and TUHT, plus two other executive directors and seven non-executive directors, including representatives of the three local authorities, the chairs of both TUHT and TPCT, one university representative and a staff representative. Officers and directors of the trusts, including non-executive directors, are now participating in a series of committees of the NHS board, thus ensuring an integrated approach to the strategic direction and accountability for the NHS in Tayside. At the same time, the trusts have maintained much of their previous committee structures (including their own Audit, Remuneration and Clinical Governance Committees. TPCT also has a Finance and Resources Committee) reflecting the separate legal status of the trusts. In addition, Staff Partnership Forums have been established in Tayside NHS Board and both trusts to ensure input into NHS Tayside governance.
3. The auditor reports that, while this has had the desired result of further enhancing the level of co-operative working in Tayside, it has also resulted in an increase in the amount of time spent preparing for and attending committee meetings. The level of commitment demanded is largely a manifestation of the revised governance arrangements arising from the Department's requirements, but the auditor notes that the Tayside NHS Board has also established four committees over and above the mandatory standing committees. The auditor recommends that it would be timely to review these committees after they have been in operation for a full year to ensure that the level of time invested in them is appropriate to service requirements.

Financial planning and monitoring

4. In light of the significant financial difficulties encountered by TUHT, in 1999/2000 the trust reached an agreement with NHS Tayside and the Department to implement a recovery plan to enable it to be in a position whereby, by 31 March 2003, the underlying surplus of income over expenditure before interest would be equivalent to 6% on net assets. As at 31 March 2001, TUHT had an accumulated shortfall against the 6% return of £16.7 million, and an accumulated deficit of £15.9 million. The financial plan for NHS Tayside required the trust to return a shortfall against the 6% return of £4.0 million in 2001/02. To achieve the financial plan and combat cost pressures, TUHT assessed that a package of £6.0 million of additional income and cost reduction initiatives was required in the year.
5. The auditor reports that a number of mechanisms have been put in place to ensure effective monitoring and reporting of TUHT's financial

position. At trust level review of financial performance remains a standing item for TUHT's board and is always subject to close scrutiny. Responsibility to ensure budgetary provision exists for any proposed appointment has been devolved to the trust's clinical service groups (replacing the Vacancy Control Committee) and is monitored quarterly.

6. On a NHS Tayside level:
   - there is a corporate financial report showing the financial position of all three Tayside health bodies which is subject to timeous scrutiny within each of the respective organisations
   - the Joint Management Forum has been replaced by the Tayside Joint Clinical Board in order to secure greater clinical input to its business
   - Tayside NHS Board has established a Finance and Resources Standing Committee. The chairman of TCPT chairs the committee and membership is drawn from the board, both trusts and representatives of the Area Staff Partnership Forum. One of the Committee's functions is to hold to account the chief executive, heads of service, directors of finance and other officers of NHS Tayside in respect of financial planning and performance
   - implementation of the Tayside Acute Services Strategy (agreed August 2001) is monitored by all three Tayside health bodies.
7. The auditor reported that the unified board and the boards of both trusts have monitored closely financial performance.

Financial results for 2001/02

8. TUHT achieved a significant level of recurring and non-recurring income and savings in 2001/02 and, following a collaborative approach to the management of available resources within NHS Tayside, achieved break-even for the year. Break-even by TUHT was thus achieved one year earlier than planned. However, TUHT only achieved break-even through the use of non-recurring income and savings of £6.5 million. There will still be a challenge for TUHT and NHS Tayside to secure break-even again in 2002/03.
9. TUHT's accumulated deficit as at 31 March 2001 was eliminated as a result of the Minister for Health and Community Care's announcement in September 2001 to make available an extra £90 million to clear accumulated deficits across the NHS in Scotland. The additional £15.9 million income cleared the accumulated deficit and resulted in a 14.6% return on net assets. Adjusting for the impact of additional funding, TUHT achieved a 6% return on net assets.
10. Although TPCT received non-recurring income of £8 million in 2001/02, it recorded a retained deficit for the year of £3.3 million. This deficit can be largely attributed to an accelerated depreciation charge arising from a revaluation of assets declared surplus. Nevertheless, TPCT carried forward a net surplus at 31 March 2002 of £0.5 million, and also achieved a 6% return on net assets.

Source: Appointed auditor's final reports on the 2001/02 audits of NHS Tayside bodies

11 Performance audit reviews

11.1 Since the previous overview report, Audit Scotland has sought to develop and implement a performance audit programme which is consistent with the Auditor General's strategic statement, issued in August 2001, outlining the different range of reports the Auditor General would produce. Audit Scotland produced one 'baseline report' during the year on ward nursing (Exhibit 22). The Auditor General also responded to requests from the Scottish Ministers for Audit Scotland to undertake reviews of the retention of human organs at Scottish hospitals (Exhibit 23) and the management of waiting lists (Exhibit 24).

11.2 Reviews in the NHS in Scotland are currently being undertaken on outpatients, hospital catering and the management of community equipment. 'Baseline reports' on each of these topics will be published in 2003. A full performance audit report on hospital cleaning is to be published shortly. Full performance audit reports will also be published in 2003 on GP prescribing and medical equipment, the latter following on from a 'baseline report' published in March 2001.

Exhibit 22: Ward nursing

During 2001/02, NHS trusts incurred staff costs of some £1.2 billion in respect of the 43,000 nurses and midwives working in Scottish hospitals. Except for some specialised areas, little detailed guidance exists for the appropriate level of nurse staffing. The baseline audit was undertaken to establish the extent to which significant variation existed in the staff establishment of wards and how any variation affected the costs and quality of patient care. The audit covered registered and unqualified nurses in a selection of hospital wards in all 28 trusts across Scotland.

Key findings of the study included:

- managing nurse staffing is complex. Nurse managers need high-quality, timely information on nurse deployment, costs, patient casemix and quality of care. However, there is significant variation in the availability of information at trust and ward level, limiting the availability of trusts to establish whether their use of nursing staff is cost-effective.
- there is inadequate workforce planning in Scottish trusts. In particular, there is a lack of integrated planning and few dedicated staff supporting workforce planning. Working for Health, the new Scottish Executive Health Department Workforce Development Action Plan, provides the basis for the better planning of human resources across NHSScotland.
- the baseline audit showed significant unexplained variation in the number and costs of nurses at trust and ward level, including the proportion of expenditure incurred on registered nurses, the grade mix and on the use made of bank and agency nursing.
- there is no single measure of quality or outcome of care available for trusts to use alongside cost information to assess the cost-effectiveness of nurse staffing levels. Trusts commonly collect proxy measures of the quality of nursing and midwifery care, including accidents to patients, but there is a need to develop quality of care measures which focus on continuous improvement as well as service failures.

The baseline report makes a series of recommendations for workforce planning and the calculation of ward establishments, and for the investigation of variations in the numbers and costs of nurses at ward level. The report emphasises the requirement for an agreed set of measures addressing the quality of care being provided by nursing staff, and provides recommendations for improving management information to assist in the effective use of nursing resources. Audit Scotland intends to undertake a follow-up audit to establish what improvements have been made, including the extent to which the national Workforce Development Action Plan has been implemented.

Source: Audit Scotland

Exhibit 23: Organ retention validation review

Following on from the Alder Hey enquiry in England, the Minister for Health and Community Care announced, in September 2000, the formation of an independent review group to review post-mortem practice in Scotland. As part of the work of the review group on the retention of organs at post-mortem, trusts were asked to provide information about the number of organs retained at post-mortem.

In response to a request from the Minister, the Auditor General instructed Audit Scotland to undertake an exercise to validate the information provided by the trusts. In addition, Audit Scotland was asked to:

- examine reasons for retention
- provide a breakdown of hospital and procurator fiscal post-mortems
- review the systems to record all materials held (including tissue blocks and slides)
- discuss findings with the review group and parents' support groups to give them an opportunity to comment on the shortcomings of existing systems and the way forward.

The Audit Scotland review aimed to establish the number of organs retained after post-mortem and the robustness of hospital information systems, so that trusts can respond comprehensively and accurately to any queries from relatives about the location of organs and tissues which had been kept.

Audit Scotland visited all pathology departments and tested their systems for tracking retained organs. The main findings were:

- procedures vary from trust to trust, but all hospitals can produce the required information
- nearly 11,000 organs are being held in Scottish hospitals
- all hospitals now use new consent forms which require permission for organ retention as well as for post-mortem.

As a result of the review, Audit Scotland recommended that the Scottish Executive should:

- ensure that disposal of organs is carried out consistently and sensitively
- draw-up clear guidelines for post-mortems undertaken on behalf of procurators fiscal
- consider the future role of museum collections and their long-term maintenance.

Source: Audit Scotland

Exhibit 24: Review of the management of waiting lists in Scotland

In December 2001, the First Minister asked the Auditor General to undertake a review of the management of NHS waiting lists across Scotland. The Auditor General instructed Audit Scotland to examine:

- the arrangements for placing patients on waiting lists
- the monitoring of lists and the way in which these are kept up to date
- the extent to which trusts are consistently applying central guidance from the Information and Statistics Division (ISD) of the Common Services Agency in recording waiting list information
- whether trusts had taken any action in managing lists which resulted in inappropriate delays to treatment.

Audit Scotland found no evidence of systematic or deliberate irregularities in the management of waiting lists. However, there were a number of areas where a more consistent approach was required.

In particular, Audit Scotland identified that acute trusts needed to ensure that:

- all patients were placed on waiting lists
- patients' waiting time guarantees would not be lost by having their treatment reclassified from inpatient or day case to outpatient
- the deferred list should be used in a consistent manner across Scotland.

Audit Scotland also found different practices among PCTs in the recording of waiting lists. PCTs need to improve data collection and monitoring, and the validation of information to ensure that patients are treated equally across Scotland.

More generally, there was a need for trusts to:

- provide clearer information to all patients, and the public more generally, on waiting lists and times
- ensure that all patients understand their waiting list status and the implications of the use of the deferred waiting list and guarantee exception codes
- have in place sufficiently rigorous monitoring systems that provide early warnings of patients who may be at risk of breaching waiting time guarantees
- identify services under pressure and put in place formal policies and procedures to deal with these situations.

The report recommends a number of actions for trusts, NHS boards, the Department and ISD in order to improve practice in managing waiting lists and to standardise data recording. In response to the recommendations, the Department has developed an action plan for all trusts and boards including consideration by ISD of the implications for changing computer systems and administrative arrangements used to record waiting list information. The Department intends to introduce, as soon as possible, a single waiting list for everyone waiting for inpatient and day case treatment and to abolish deferred waiting lists.

Source: Audit Scotland

Appendix A

Effect of 'one-off' funding received from the Scottish Executive Health Department

Trust	**Retained surplus/(deficit) 2001/02 £'000**	**'One-off' funding received**		**Retained surplus/(deficit) (less 'one-off' funding) £'000**
		To eliminate accumulated deficits £'000	**To support in-year pressures and developments £'000**	
Argyll & Clyde Acute Hospitals	(1,717)	3,035	–	(4,752)
Ayrshire & Arran Acute	1,022	–	2,892	(1,870)
Ayrshire & Arran Primary Care	852	–	1,069	(217)
Borders General	116	–	1,727	(1,611)
Borders Primary Care	797	–	–	797
Dumfries & Galloway Acute and Maternity	741	–	1,015	(274)
Dumfries & Galloway Primary Care	278	–	190	88
Fife Acute Hospitals	1,005	–	875	130
Fife Primary Care	1,153	–	375	778
Forth Valley Acute Hospitals	782	–	2,736	(1,954)
Forth Valley Primary Care	258	–	–	258
Grampian Primary Care	3,897	–	–	3,897
Grampian University Hospitals	(5,199)	4,914	652	(10,765)
Greater Glasgow Primary Care	2,469	–	–	2,469
Highland Acute Hospitals	68	2,744	–	(2,676)
Highland Primary Care	154	–	–	154
Lanarkshire Acute Hospitals	(6,261)	–	–	(6,261)
Lanarkshire Primary Care	1,497	–	950	547
Lomond & Argyll Primary Care	401	–	–	401
Lothian Primary Care	3,892	–	1,950	1,942
Lothian University Hospitals	356	–	4,900	(4,544)
North Glasgow University Hospitals	2,684	9,491	–	(6,807)
Renfrewshire & Inverclyde Primary Care	81	1,077	–	(996)
South Glasgow University Hospitals	102	4,092	–	(3,990)
Tayside Primary Care	510	–	–	510
Tayside University Hospitals	49	15,900	–	(15,851)
West Lothian Health Care	13	–	1,650	(1,637)
Yorkhill	8,561	–	–	8,561
Totals	**18,561**	**41,253**	**20,981**	**(43,673)**

Appendix B

Financial position within health board areas at year end

Health Board	2001/02 Variance against Revenue Resource Limit (over)/under £'000	2000/01 Retained surplus/ (deficit) £'000	NHS Trust	2001/2002 Retained surplus/ (deficit) £'000	2000/01 Retained surplus/(deficit) £'000
Argyll & Clyde	(74)	(7,208)	Argyll & Clyde Acute	(1,717)	(3,035)
			Renfrewshire & Inverclyde	81	(1,077)
			Lomond & Argyll Primary Care	401	429
Ayrshire & Arran	5,036	(4,199)	Ayrshire & Arran Acute	1,022	590
			Ayrshire & Arran Primary Care	852	593
Borders	203	(5,936)	Borders General	116	608
			Borders Primary Care	797	13
Dumfries & Galloway	1,582	(969)	D & G Acute and Maternity	741	2,215
			D & G Primary Care	278	203
Fife	2,110	(4,333)	Fife Acute Hospitals	1,005	904
			Fife Primary Care	1,153	1,383
Forth Valley	1,179	(3,459)	Forth Valley Acute	782	631
			Forth Valley Primary Care	258	12
Glasgow	7,672	(10,665)	N Glasgow University Hospitals	2,684	(9,491)
			S Glasgow University Hospitals	102	(4,092)
			Greater Glasgow Primary Care	2,469	5,684
			The Yorkhill	8,561	2,362
Grampian	1,837	3,843	Grampian University Hospitals	(5,199)	(4,914)
			Grampian Primary Care	3,897	2,807
Highland	856	(1,541)	Highland Acute Hospitals	68	(2,744)
			Highland Primary Care	154	127
Lanarkshire	2,667	5,536	Lanarkshire Acute Hospitals	(6,261)	(12,661)
			Lanarkshire Primary Care	1,497	1,229
Lothian	10,214	2,674	Lothian University Hospitals	356	41
			Lothian Primary Care	3,892	10
			West Lothian Healthcare	13	0
Orkney	328	(511)			
Shetland	293	(350)			
Tayside	4,151	(832)	Tayside University Hospitals	49	(15,852)
			Tayside Primary Care	510	2,116
Western Isles	567	(1,029)			
Totals	**38,621**	**(28,979)**		**18,561**	**(31,909)**

Appendix C

NHS external auditors 2001/02

NHS trust	Auditor
Argyll & Clyde Acute Hospitals NHS Trust	Chief Auditor, East Kilbride
Ayrshire & Arran Acute Hospitals NHS Trust	Chief Auditor, East Kilbride
Ayrshire & Arran Primary Care NHS Trust	Chief Auditor, East Kilbride
Borders General Hospital NHS Trust	Scott Moncrieff
Borders Primary Care NHS Trust	Scott Moncrieff
Dumfries & Galloway Acute and Maternity	Chief Auditor, East Kilbride
Dumfries & Galloway Primary Care NHS Trust	Chief Auditor, East Kilbride
Fife Acute Hospitals NHS Trust	Henderson Loggie
Fife Primary Care NHS Trust	Henderson Loggie
Forth Valley Acute Hospitals NHS Trust	Chief Auditor, East Kilbride
Forth Valley Primary Care NHS Trust	Chief Auditor, East Kilbride
Grampian Acute Hospitals NHS Trust	Chief Auditor, Inverness
Grampian Primary Care NHS Trust	Chief Auditor, Inverness
Greater Glasgow Primary Care NHS Trust	PriceWaterhouseCoopers
Highland Acute Hospitals NHS Trust	Blueprint Scotland
Highland Primary Care NHS Trust	Blueprint Scotland
Lanarkshire Acute Hospitals NHS Trust	Scott Moncrieff
Lanarkshire Primary Care NHS Trust	Scott Moncrieff
Lomond and Argyll Primary Care NHS Trust	Chief Auditor, East Kilbride
Lothian University Hospitals NHS Trust	KPMG
Lothian Primary Care NHS Trust	KPMG
North Glasgow Hospitals NHS Trust	PriceWaterhouseCoopers
Renfrewshire and Inverclyde Primary Care Trust	PriceWaterhouseCoopers
South Glasgow Hospitals NHS Trust	PriceWaterhouseCoopers
Tayside Primary Care NHS Trust	Chief Auditor, Edinburgh
Tayside Hospitals NHS Trust	Chief Auditor, Edinburgh
The Yorkhill NHS Trust	PriceWaterhouseCoopers
West Lothian Healthcare NHS Trust	KPMG

Argyll & Clyde Health Board	Chief Auditor, East Kilbride
Ayrshire & Arran Health Board	Chief Auditor, East Kilbride
Borders Health Board	Scott Moncrieff
Dumfries & Galloway Health Board	Chief Auditor, East Kilbride
Fife Health Board	Henderson Loggie
Forth Valley Health Board	Chief Auditor, East Kilbride
Grampian Health Board	Chief Auditor, Inverness
Greater Glasgow Health Board	PriceWaterhouseCoopers
Highland Primary Health Board	Blueprint Scotland
Lanarkshire Primary Health Board	Scott Moncrieff
Lothian Health Board	KPMG
Orkney Health Board	PriceWaterhouseCoopers
Shetland Health Board	Blueprint Scotland
Tayside Health Board	Chief Auditor, Edinburgh
Western Isles Health Board	Chief Auditor, Edinburgh
Clinical Standards Board for Scotland	Scott Moncrieff
Common Services Agency	Chief Auditor, Edinburgh
Health Education Board for Scotland	KPMG
Health Technology Board for Scotland	Scott Moncrieff
Mental Welfare Commission	KPMG
NHS 24	Chief Auditor, East Kilbride
Scottish Ambulance Service	Chief Auditor, Edinburgh
Scottish Council for Post Graduate Medical and Dental Education	Scott Moncrieff
The State Hospital	Chief Auditor, East Kilbride

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