Overview of the National Health Service in Scotland

2002/03

Prepared for the Auditor General for Scotland

December 2003

AUDIT SCOTLAND

Auditor General for Scotland

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

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

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

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

The following bodies fall within the remit of the Auditor General:

- departments of the Scottish Executive eg the Health Department
- executive agencies eg the Prison Service, Historic Scotland
- NHS boards and trusts
- further education colleges
- Scottish Water
- NDPBs and others eg Scottish Enterprise.

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

Contents

Summary

Introduction

1 This report provides an overview of how the NHS in Scotland is organised and of the main issues arising from the 2002/03 audits of NHS boards and trusts. The report is organised into four parts. Part 1 sets out how the NHS in Scotland is organised, how it is financed and how it manages its performance. Part 2 of the report is concerned with financial stewardship and corporate governance in the NHS. Part 3 of the report reviews the financial performance of the NHS in 2002/03 while Part 4 reviews those NHS bodies where financial health is of greatest concern. A summary of the financial performance of each NHS area is included at Appendix 3.

Setting the scene

2 The NHS is a large and complex organisation but is essentially organised into three tiers.

- The Scottish Executive Health Department (SEHD) has overall responsibility for health policy and the administration of the NHS in Scotland. It sets the strategic aims and priorities for the NHS in Scotland, establishes the framework for the planning and delivery of health services, including the allocation of resources, and monitors the financial and other performance of NHS bodies.

- The 15 NHS boards in Scotland are primarily responsible for the protection and improvement of the health of their resident populations. SEHD established unified boards in September 2001 so as to promote shared decision-making and better collaborative working. Unified boards are responsible for developing a single local health plan which addresses the health priorities and healthcare needs of the resident population, for allocating resources to address local priorities and for the performance management of the local health system.

- NHS trusts provide patient services on the Scottish mainland. The 13 primary care trusts (PCTs) deliver primary, community and mental health services, including family health services (FHS). The 14 acute trusts[1] are responsible for the delivery of acute and chronic care health services, including medical care, surgery and diagnostic services. In line with the Scottish Executive's vision for the health service in the 21st century, SEHD has required NHS boards to bring forward proposals, by April 2004 at the latest, to dissolve trusts.

In addition, 14 special health boards and other NHS bodies provide clinical, technical, advisory and administrative services on a national basis.

3 The Scottish Parliament annually determines the total resources which are made available to SEHD to fund the NHS in Scotland. For 2002/03, the Scottish Parliament voted SEHD gross expenditure limits of £7,533 million. SEHD made net

1 There is also the West Lothian Healthcare NHS Trust which is a mixed trust providing both acute and primary care services.

provisions of £6,113 million to NHS boards and £601 million to special health boards and other NHS bodies during 2002/03. Some 87% of the money made available to NHS boards was by way of a formula based allocation which takes into account the share of the population living in each NHS board area, the age structure of the population, levels of deprivation and the proportion of the population living in remote and rural areas. SEHD also spent approximately £185 million itself on a variety of services.

4 NHS boards determine how to spend the formula based allocation in accordance with their local health plans and the healthcare needs of the local population. In 2002/03, NHS boards spent £5,832 million on healthcare of which £4,268 million (73%) was on health and community care and £1,564 million (27%) was on family health services. Some 89% of NHS board expenditure was in the form of advances to trusts operating in the board's geographic area. Including income received from other sources, acute trusts spent £3,074 million (49% of total trust expenditure) in 2002/03, and PCTs £3,182 million (51%). The largest single element of trust expenditure was on staff costs, representing 46% (£2,849 million) of total trust expenditure.

Financial stewardship and corporate governance

Completion of accounts

5 Although the report comments on a number of issues arsing in NHS boards and trusts, overall financial stewardship in the NHS in Scotland continues to be of a good standard. The audits of all NHS trust and NHS health board accounts were completed within the deadlines set. There were no qualifications to the 'true and fair' opinions provided by auditors in relation to the 54 trusts, health boards and special health boards subject to audit in 2002/03.

6 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 NHS bodies incurred or applied expenditure and income incurred in accordance with legislation and guidance issued by Scottish Ministers. Similar to previous years, however, in 2002/03 the appointed auditors for four PCTs and seven NHS boards qualified their audit opinion on the regularity of FHS expenditure. The appointed auditors for 13 PCTs and 14 NHS boards also qualified their audit opinion on the regularity of FHS income. Paragraphs 10-13 of the Summary explain the reason for the qualifications in more detail.

Financial and internal controls

7 External auditors found that the key financials systems and controls 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. A number of trusts, however, experienced wide variances between actual and budgeted expenditure, indicating that scope remains to improve budgetary control arrangements across NHS bodies.

8 Since 2001/02, accountable officers of health bodies have been required to prepare a statement of internal control (SIC) confirming how the body has implemented adequate systems of control. The SIC covers financial, operational and compliance controls and risk management. The SEHD recognised that it would take time for health bodies to put in place all the necessary risk management and review processes and so it allowed trusts and boards to adopt one of two types of SIC. Thirteen trusts, four NHS boards and four special boards adopted the preferred SIC in 2002/03 indicating that a sound system of control was in place throughout the year which complied with Scottish Executive guidance. The SEHD has now set a target for all NHS bodies to adopt the preferred form of SIC for 2003/04.

9 The planned integration of NHS boards with trusts is likely to result in a period of uncertainty and upheaval as systems are integrated, and staff responsibilities and reporting lines and accountabilities are bedded in. It is important during this transitional period, that senior officers and board members are clearly engaged with baseline budgets so as to give them a clearer understanding of the underlying cost base of the new organisations, and to monitor closely outturn against budgets.

Fraud in the NHS

10 NHS bodies are responsible for taking all practicable steps to prevent and detect the occurrence of fraud and other irregularities. Auditors reported that general arrangements at trusts and NHS boards for the prevention and detection of fraud appeared to be satisfactory during 2002/03.

11 A significant source of potential fraud and irregularity in the NHS is in relation to FHS activity. Practitioner fraud may occur where claims are submitted for services or prescriptions which have not been legitimately provided. Patient fraud may occur where patients falsely claim entitlement to free prescriptions and other services. NHS boards and trusts need to ensure that only properly valid claims

are paid and that only valid exemptions from patient charges are granted. During 2002/03, the NHS incurred FHS expenditure of £1.6 billion and received income of £100 million.

12 Since April 1999, the Practitioner Services Division (PSD) of the Common Services Agency (CSA) has been responsible for making payments to primary care practitioners on behalf of PCTs and island NHS boards. Previous NHS overview reports have highlighted the efforts made by the CSA to improve the overall control environment at PSD and to introduce a robust framework of payment verification. While the auditor for the CSA reported a number of positive developments on the previous year, a comprehensive framework of payment verification did not operate throughout 2002/03. As a result, the auditors for four PCTs and seven NHS boards qualified their regularity audit opinions in respect of FHS expenditure. The CSA estimates that, overall, 3% to 8% of claims from practitioners may be fraudulent, representing some £40 million to £100 million per annum.

13 The Counter Fraud Services (CFS) unit of the CSA is responsible for checking that patients who claim exemption or remission from charges are entitled to do so. Based on a sample of claims, the CFS estimated that invalid exemptions might have amounted to £12.6 million across Scotland in 2002/03. Because the method of sampling meant that CFS could not split accurately the understatement of income between individual trusts and NHS boards, the auditors for 13 PCTs and 14 NHS boards qualified their regularity audit opinions in respect of NHS income. The most common form of invalid claim for exemption from payment was from patients claiming they were in receipt of income support.

14 The CSA has made significant progress in 2002/03 to improve its overall control environment and to introduce a robust framework of payment verification. Further improvements are, however, necessary if auditors are to avoid qualifying their opinion on the regularity of expenditure and income in the accounts of PCTs and NHS boards. In particular, it is important that CFS's sampling of patients' exemption claims is statistically robust so that the level of invalid exemptions granted can be estimated for each PCT and NHS board.

Corporate governance arrangements

15 Auditors referred in their final reports on the 2002/03 audits of NHS bodies to a number of key aspects of corporate governance:

- unified boards have made satisfactory progress to establish their committee structures, and board and committee meetings are occurring on a regular basis. There are encouraging signs that a more co-operative approach is being taken to the management of each local health area
- a number of NHS bodies have yet to fully develop and implement adequate arrangements for the identification and management of risk
- the Performance Assessment Framework (PAF) is a comprehensive performance management framework for the NHS in Scotland which was introduced in 2002. Auditors report that most health boards have found the PAF indicators to be helpful in reviewing and assessing their performance
- individual NHS boards propose different management structures for the new, integrated organisations which will result from the dissolution of trusts. The auditors of NHS Borders reported on a number of important lessons to be learned from the integration of local trusts which would be of value to other NHS areas planning integration.

Financial performance in 2002/03

Changes to format of accounts

16 2002/03 saw the introduction of a revised format of accounts for NHS boards and trusts intended to contribute to greater consistency and to allow a better picture of the overall financial performance of the NHS to be gained. The most significant changes to the format of the accounts were the replacement of the Income and Expenditure Account with an Operating Cost Statement (OCS), and the creation of a General Fund. The OCS discloses the net operating costs of an NHS board or trust. Net operating costs are then compared to the Revenue Resource Limit (RRL) set by SEHD for NHS boards and special health boards, and by NHS boards for trusts. The RRL is the resource budget for ongoing operations.

17 The revised financial framework also resulted in changes to the financial targets for the NHS in Scotland. The statutory breakeven target remains and is now interpreted as requiring trusts to remain within the RRL. Trusts are also required to operate within a Capital Resource Limit (CRL) which applies to in-year capital expenditure. NHS boards are also required to operate within their RRL and CRL, but they must also operate within an overall Cash Requirement.

Financial performance in 2002/03

18 During 2002/03, four trusts reported savings against their RRL, five reported excesses against their RRL and 19 exactly matched their RRL. The total savings were £0.2 million and the total excesses were £18.2 million. This compares to 25 trusts which achieved breakeven in 2001/02 under the previous financial regime. During 2002/03, eight trusts reported savings against their CRL, 16 exactly matched it and four exceeded their CRL.

19 Of the five trusts which exceeded their RRLs in 2002/03, three are within NHS Argyll and Clyde. This is a reflection of the current financial and operational difficulties being experienced within NHS Argyll and Clyde. Paragraphs 31-33 of the Summary set out the financial position of NHS Argyll and Clyde in more detail.

20 The accounts for 2002/03 show that 14 NHS boards and nine special health boards and other NHS bodies either met or made savings against their RRL. Lanarkshire NHS Board exceeded its RRL by £7.3 million. A significant contributory reason for the overspend was expenditure associated with the repatriation of patients domiciled in Lanarkshire from NHS Glasgow to NHS Lanarkshire. All NHS boards, special health boards and other NHS bodies operated within their CRLs and Cash Requirements except one special health board, which exceeded its CRL by £0.1 million.

21 The achievement of financial targets remains a challenge for NHS bodies. Auditors identified three main tools which enabled RRLs to be met during 2002/03:

- the re-routing of underspends within NHS systems
- the use of non-recurring funding streams
- the use of cash releasing efficiency savings.

22 The re-routing of underspends between trusts was successfully applied in NHS Tayside and shows the benefits that co-operative working can bring to the management of NHS finances. However, the fact that this re-routing of underspends was necessary at all, is indicative of the financial pressures which continue to face NHS bodies. There is still a need to identify and address underlying recurring deficits if financial balance is to be achieved in the foreseeable future. While it is currently clear when budgets are re-allocated between trusts, there is a risk that under the proposed single tier NHS system, such transparency will be lost, and that the reasons for underlying recurring deficits in particular services or directorates may not be identified and addressed.

23 Previous NHS Overview reports have commented on the extent to which NHS bodies have relied on non-recurring funding to achieve financial balance. Auditors estimated that in 2002/03, trusts generated £266 million non-recurring funding, some 4.4% of the total funding of trusts. Several different types of non-recurring funding can be identified. In some cases, for example SEHD's funding of specific initiatives, NHS bodies can form a reasonable expectation that some funding will be received annually, although its level and purpose may not be known in advance. In such cases, earmarked income should be matched to specific expenditure needs and thereby offer no assistance in achieving a balanced, recurring budget.

24 In other cases, for example the disposal of surplus property, the non-recurring funding is a genuine one-off, never to be repeated. While these sources of funding can be used to alleviate in-year deficits, it is important that NHS bodies do not depend upon these as a recurring funding source when planning to achieve year-on-year financial balance.

25 Many NHS bodies have developed financial recovery plans which include the implementation of cash releasing efficiency savings. It is important that NHS bodies continue to review the way in which services are provided and to seek efficiency savings whenever possible. At the same time, the extent to which NHS bodies can continually make efficiency savings is finite without impacting on the quality of service provided. The auditors of several NHS bodies have concerns about the ability of NHS bodies to deliver savings plans and thus, the viability of financial recovery plans.

Future cost pressures

26 Over the next three years, the Scottish Executive is committed to spending significantly more resources on the NHS in Scotland. Planned expenditure is expected to increase from £6.7 billion in 2002/03 to £8.5 billion in 2005/06 (£7.9 billion at 2002/03 prices). The additional expenditure is expected to contribute to improved patient services and healthcare. During 2002/03, auditors reported that many trusts experienced significant cost pressures arising from the New Deal for junior doctors, nationally agreed pay awards, the introduction of the EU Working Time Directive and increases to employers' National Insurance and superannuation contributions. Many PCTs also experienced significant cost pressures arising from increased GP drugs prescribing.

27 The SEHD does not know precisely the implications of future cost pressures. It is clear, however, that the introduction of new contracts for the employment of consultants and for the provision of General Medical Services, together with the recruitment of substantial numbers of new staff, will consume much of the additional funding being made available. It will be important that the NHS in Scotland is able to demonstrate that this expenditure is translated into improved healthcare.

NHS bodies where financial performance is of greatest concern

28 The 2001/02 NHS overview report highlighted that many NHS areas would continue to face financial difficulties and remain dependent on sources of non-recurring income to achieve breakeven. Auditors expressed concerns about the ability of three specific trusts to achieve financial balance in the future. The auditor of Fife NHS Board also raised significant concerns in 2002/03 over the ability of local trusts to meet planned savings targets.

Lothian University Hospitals NHS Trust (LUHT)

29 The Trust has met all of its financial targets since its inception in 1999 through the application of non-recurring funding and the implementation of cash releasing efficiency plans. During 2001/02, a pan-Lothian review team was created to work with and support LUHT in the production of an effective and deliverable financial recovery plan for the trust.

30 Since the review team announced its findings in January 2002, LUHT has produced a number of iterations to its five-year plan. Its March 2003 financial plan forecast a cumulative shortfall of nearly £180 million in the five years to 2007/08. LUHT subsequently worked with Lothian NHS Board to produce a financial plan which forecast a balanced financial position for 2003/04 and a significantly reduced shortfall in each of the remaining four years of the plan. As at 30 September 2003, however, LUHT reported an adverse variance of £6.6 million against its budget for 2003/04.

NHS Argyll and Clyde

31 During 2001/02, NHS Argyll and Clyde found that it faced a significant underlying deficit of over £6 million. A five-year recovery plan was agreed to bring the NHS area back into recurring and sustainable financial balance. Argyll and Clyde Acute Hospitals NHS Trust (ACAHT) has had a recurring deficit since its inception. The financial performance of ACAHT was seen as a key factor in determining whether the recovery plan is achieved.

32 During 2002/03, the financial position of NHS Argyll and Clyde was managed on a system wide basis. Argyll and Clyde NHS Board and all three local trusts reported an overspend against their RRLs, with the total excess being £9.6 million. ACAHT's share of the excess against its RRL was £4.8 million. Without the available non-recurring income, the recurring operational deficit across NHS Argyll and Clyde could have been as high as £31.4 million.

33 In July 2003, the local trusts were formally dissolved and NHS Argyll and Clyde completed a fundamental review of its finances to support the development of a new financial recovery plan. The plan forecasts that recurring financial balance will be achieved in 2007/08. It assumes less reliance on non-recurring income, but does not include any potential costs arising from service reviews. Nor does it explain how excesses against RRLs in 2002/03 or subsequent years will be recovered. The auditor considers that NHS Argyll and Clyde's cumulative deficit could reach £60–70 million by 2007/08 and may be irrecoverable.

Grampian University Hospitals NHS Trust (GUHT)

34 During 2001/02, GUHT recorded an in-year deficit of £5.2 million. GUHT prepared a financial recovery plan, but the appointed auditor concluded that it was not possible to determine whether the initiatives being taken would ensure the long-term viability of the trust.

35 In 2002/03, GUHT recorded an excess of expenditure of £5.2 million against its RRL of £260.2 million. The excess relates wholly to the accumulated deficit brought forward from 2001/02. This performance was achieved as a result of brokerage funding from SEHD of £3.4 million and non-recurring support from Grampian NHS Board of £2.1 million. The auditor notes that without the brokerage and non-recurring financial support, GUHT would have exceeded its RRL irrespective of the brought forward deficit. GUHT has agreed a plan which will enable it to repay the brokerage to SEHD and recover its accumulated deficit by the end of 2005/06. However, the trust needs to address a number of significant issues and cost pressures if financial recovery is to be achieved.

NHS Fife

36 During its financial planning for 2002/03, the NHS Fife system identified an underlying financial deficit of £9.6 million spread across Fife NHS Board, Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust. SEHD asked NHS Fife to develop a five-year recovery plan which was then extended to ten years. In 2002/03, Fife NHS Board and both trusts achieved their RRLs. The trusts' RRL targets were only achieved through the use of £9.6 million non-recurring funding.

37 In March 2003, the chief executive of Fife NHS Board asked the appointed auditor to review financial monitoring and the recovery planning process within the Fife NHS system. The review found several aspects of good financial management but also scope for improvement. NHS Fife has welcomed the auditor's report and is taking action to address its findings.

General conclusions

38 The NHS in Scotland is undergoing considerable change. It is reorganising its structure and its management arrangements at the same time as significant additional funding is being provided. Against this background, the NHS faces persistent financial pressures, not least from increasing staffing costs and the rising cost of healthcare.

39 Overall financial stewardship in the NHS continues to be of a good standard though non-recurring funding is still being relied upon to support recurrent expenditure and to achieve financial balance.

40 Unified boards now have a crucial role in promoting a more joined-up approach to the management of NHS systems. There is encouraging evidence that the new arrangements are taking shape, and that joint working is occurring across the NHS and between the NHS and other external agencies. There is also an opportunity for NHS boards to learn valuable lessons from those NHS systems which have successfully integrated their trusts.

41 It is important that, as a result of restructuring, transparency is maintained within the NHS and individual NHS boards to enable a clear view of the complex operational and financial activity which will continue in place to support the delivery of healthcare in Scotland. This is not only to support sound and open accountability, but also to enable a clear view of the healthcare benefits resulting from the major additional resources being placed at the disposal of the NHS in Scotland.

Part 1. Setting the scene

Background

1.1 The NHS was established in 1948 with the aim of providing a comprehensive system of health care that was free to all at the point of delivery. Initially, it was expected that demand for the NHS would decline as illnesses were cured. An ageing population, however, and expensive new technology and drugs have meant that successive governments have increased public spending on healthcare. Since its creation then, the NHS has undergone a number of organisational changes to improve its management and administration, and to make the best use of finite resources. A limited range of patient charges has also been introduced.

1.2 Today, the NHS throughout the UK employs over one million staff and spends some £60 billion annually. In Scotland, the NHS employs 130,000 staff and had a gross budget for 2002/03 of £7.5 billion. This part of the report explains how the NHS in Scotland is organised and funded, and how its performance is managed.

How the NHS in Scotland is organised

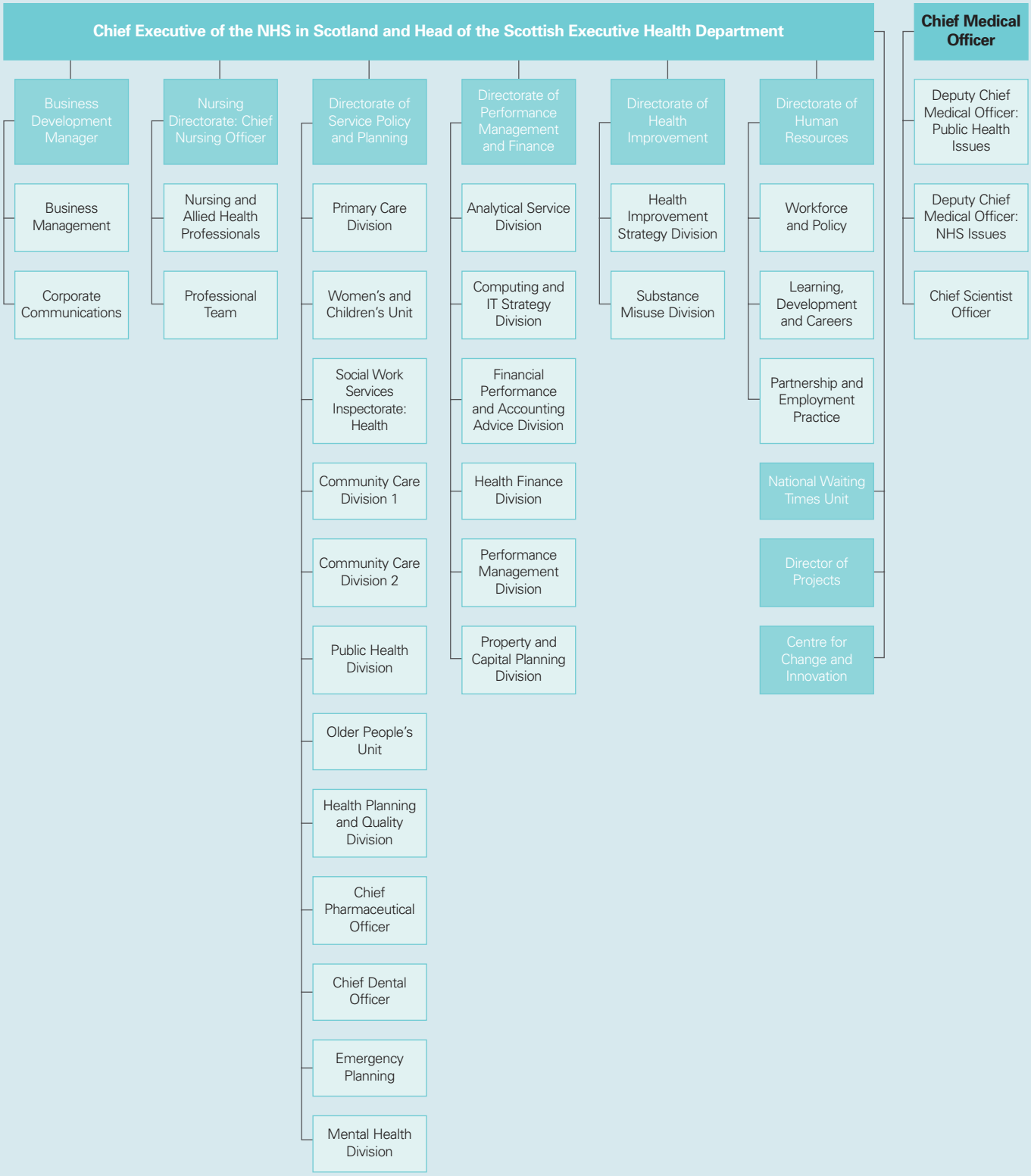
1.3 The NHS in Scotland is a large and complex organisation but is essentially organised into three tiers. The Scottish Executive Health Department (SEHD) is responsible for national policy and direction; NHS boards are responsible for local health planning and improvement; and NHS trusts are responsible for the delivery of hospital and primary care services. In addition, special health boards and other NHS bodies provide clinical, technical, advisory and administrative services on a national basis.

The Scottish Executive Health Department

1.4 SEHD has overall responsibility for health policy and the administration of the NHS in Scotland. The organisation of SEHD (Exhibit 1) reflects its role in the management of the NHS:

- to set strategic aims and priorities for the NHS in Scotland, to establish the framework for the planning and delivery of health services, including the allocation of resources, and to disseminate this to NHS bodies
- to monitor the financial and other performance of NHS bodies through the medium of regular performance returns and review meetings, and to act where performance diverges significantly from plan
- to issue guidance to NHS bodies on a wide range of issues, eg clinical, managerial, financial and human resources, including corporate governance arrangements.

Exhibit 1: The organisation of SEHD



Note: The Chief Medical Officer is the Scottish Executive's principal medical adviser, and as such has direct access to the Scottish Ministers.

Source: Scottish Executive Health Department

1.5 The Scottish Ministers are, overall, accountable to the Scottish Parliament for the activities of the NHS system in Scotland. The head of SEHD is also chief executive of NHSScotland. As accountable officer, he is directly accountable to the Scottish Parliament for financial propriety and regularity, and for achieving best value from the resources allocated to SEHD and to NHSScotland. In practice, the accountable officer is held personally responsible for departmental systems and procedures, for the effectiveness of SEHD's monitoring and review of the NHS, and for the guidance issued to NHS bodies.

NHS boards

1.6 The 12 mainland and three island NHS boards in Scotland are corporate bodies under the control of boards appointed by the Scottish Ministers. The National Health Service (Scotland) Act 1978 defines an NHS board as a body corporate consisting of a chair appointed by the Scottish Ministers and such numbers of other members so appointed as the Scottish Ministers think fit. NHS boards are primarily responsible for the protection and improvement of the health of their resident populations (Exhibit 2). NHS boards are responsible for managing their day-to-day affairs without detailed oversight from Ministers and SEHD.

NHS trusts

1.7 NHS trusts are also corporate bodies under the control of boards appointed by the Scottish Ministers. The National Health Service and Community Care Act 1990 defines NHS trusts as bodies corporate having a board of directors consisting of a chair appointed by the Scottish Ministers and executive and non-executive directors. Similar to NHS boards, NHS trusts are responsible for managing their day-to-day affairs without detailed oversight from Ministers and SEHD. The primary responsibility of NHS trusts is the provision of high quality patient care. Under the 1997 White Paper *'Designed to Care – Renewing the National Health Service in Scotland'* two types of trust were envisaged [2].

1.8 Primary care trusts (PCTs) are responsible for delivering primary, community and mental health services including GP services, community pharmacists and opticians, community nurses, midwives and therapists. While PCTs provide some hospitals services, the efforts of PCTs are largely directed to providing health services either in patients' own homes or in homely settings in the community. As such, PCTs have developed local health care co-operatives as part of their internal structures, drawing on GPs, clinical and nursing staff to develop a multi-disciplinary approach to delivering local community care. PCTs are also required to foster close relationships with local authorities to develop, for example, joint approaches to care for the elderly. The organisation of a typical PCT is shown in Exhibit 3.

1.9 Acute trusts comprise groups of hospitals with responsibility for the delivery of acute and chronic care for a range of health services including medical care, surgery, diagnostic services, A&E services and longer-term rehabilitation. In addition to their main role in delivering patient care, acute trusts play a vital role in the education and training of health service staff, and in the pursuit of clinical and related research. Several acute hospitals have, therefore, developed close links with the medical faculties of the universities of Aberdeen, Dundee, Edinburgh and Glasgow. The organisation of a typical acute trust is shown in Exhibit 4.

Developments affecting the organisation of NHS boards and trusts

1.10 Following publication in December 2000 of the Scottish Executive's plan for the future of the NHS in Scotland *'Our National Health: A plan for action, a plan for change'*, in September 2001 unified NHS boards were established in all 15 health board areas. In the case of the 12 mainland health board areas, these new, unified NHS boards replaced the separate board structures of health boards and trusts to form a local health system, with a single governing board responsible for improving the health of the local population and delivering the healthcare they require. Under the current arrangements, trusts remain as legal entities within the local NHS system and retain their existing operational autonomy. Trust management teams have, however, replaced trust boards, although management teams still have non-executive membership.

1.11 Unified boards are accountable to Ministers and SEHD for the financial and operational performance of the local NHS system. They provide strategic leadership and direction for the system as a whole and explain the plans and actions of the local NHS system to the public and other local stakeholders. Trust chairs and chief executives, together with the chief executive of the NHS board, are members of the unified board so as to promote shared decision-making and better collaborative working. Local authority elected members and NHS staff

2 'Designed to Care' intended that within the geographical boundary of most mainland NHS board areas there would one primary care trust and one acute trust. In total, however, 13 primary care trusts and 14 acute trusts were established in Scotland. Two primary care trusts operate within the geographic boundary of Argyll and Clyde while, due to its size, three acute trusts serve the Greater Glasgow area. There is also one mixed trust within the Lothians which provides both primary care and acute services. Orkney NHS Board, Shetland NHS Board and Western Isles NHS Board deliver patient care in addition to their health protection and improvement roles without the need for trusts.

Exhibit 2: NHS board health improvement functions

Monitoring and assessing the population's health and well-being
This function includes:
- assessing and understanding the health status of the local population
- developing an understanding of the determinants of good and poor health and how these operate in local areas through local needs assessments.

Developing healthy public policy
This function includes:
- involving front-line staff, the public and local interest groups in developing policies and plans to improve health and reduce inequalities
- providing health input to the policy development process in local and national agencies.

Detecting and preventing disease and disability
This function includes:
- ensuring the adequate provision and uptake of personal preventative health services which promote health and well-being
- targeting preventative health services on communities and groups at higher risk of ill health.

Maximising the health impact of services
This function includes:
- developing partnerships with local communities, service users and their carers so that they can become active partners in planning and evaluating health and other services, particularly through the community planning process
- developing new ways of working with other agencies and extending the traditional role of health professionals to improve health.

Protecting the population from hazards which damage their health
This function includes:
- managing outbreaks of communicable diseases and major exposures to toxic hazards by ensuring their early detection, proper investigation and effective control.

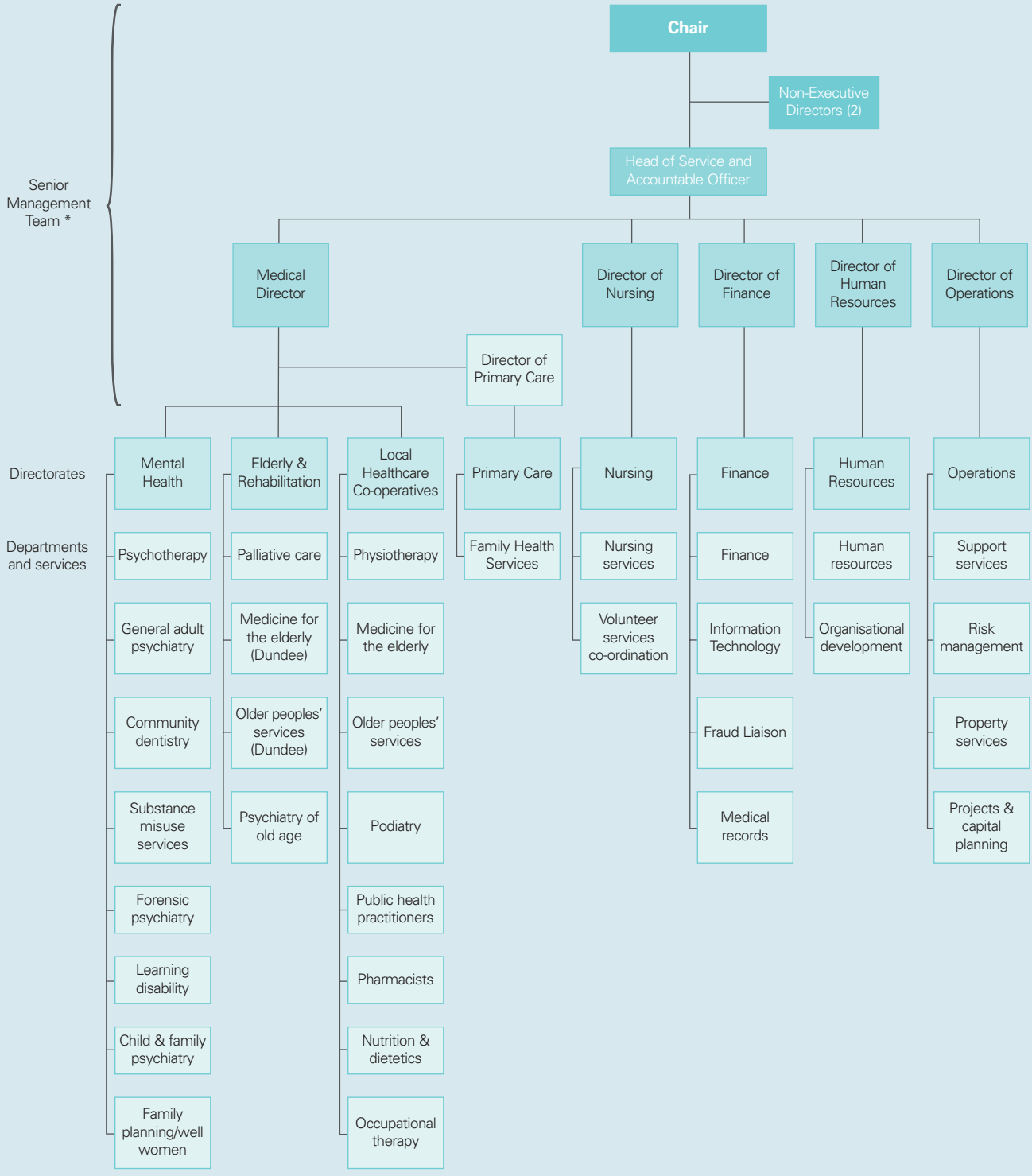
Supporting the development of personal skills necessary for health and well-being
This function includes:
- targeting disadvantaged and high-risk groups to prevent and alleviate health-damaging behaviour
- encouraging the development of skills and practice which promote positive health and well-being.

Strengthening community action for health
This function includes:
- increasing equality of opportunity and access to those who are disadvantaged through, for example, disability, personal circumstances, geographical location, ethnicity and age
- consulting and actively involving members of the community in improving their health through the use, for example, of community development methods.

Carrying out research to develop health improvement
This function includes:
- reviewing, developing and applying the findings of published research together with local learning to inform health planning and to strengthen local health improvement programmes on an on-going basis
- working to monitor and evaluate the components of the NHS board's health improvement strategy, and their combined impacts.

Source: *Health Improvement Self Assessment Instrument*, SEHD January 2003

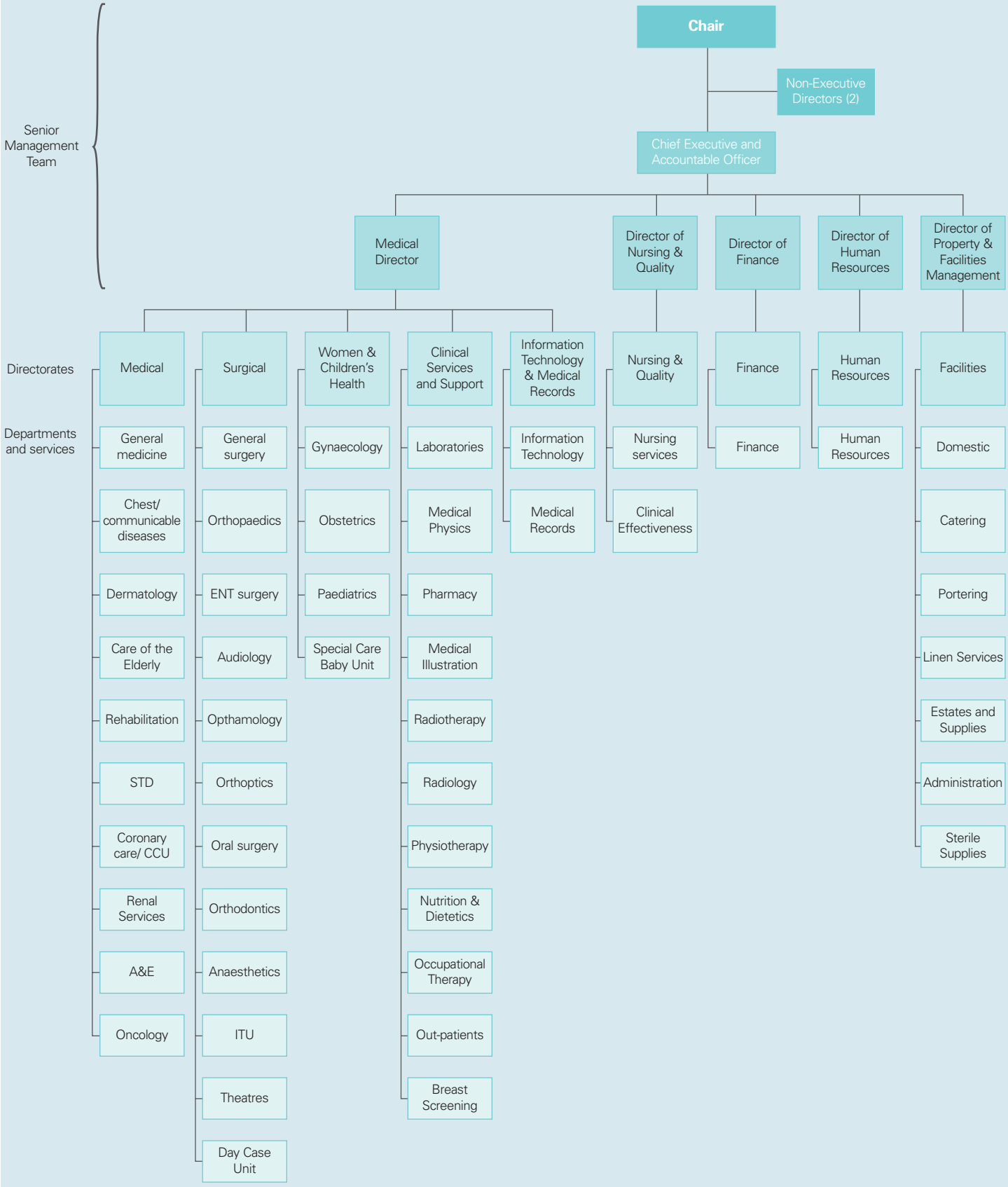
Exhibit 3: The organisation of a typical primary care trust



* except for the Director of Operations

Source: Tayside Primary Care NHS Trust

Exhibit 4: The organisation of a typical acute trust



Source: Highland Acute Hospitals NHS Trust

representatives are also often members of the unified board so as to promote better joint working. The functions of the unified NHS board comprise:

- **strategy development**, including the development of a single local health plan which addresses the health priorities and healthcare needs of the resident population
- **resource allocation** to address local priorities in accordance with individual boards' strategic objectives
- **implementation** of the local health plan
- **performance management** of the local NHS system, including risk management.

1.12 Scotland's Health White Paper *'Partnership for Care'*, published in February 2003, set out the Scottish Executive's vision for the health service in the 21st century. It emphasised the importance of the patient in service delivery and for devolving financial and management authority to the frontline. It concluded there was a need to remove unnecessary organisational and legal barriers to support the development of integrated, decentralised healthcare services. SEHD, therefore, intends that it will legislate to remove the powers relating to trusts. It has required NHS boards to bring forward proposals, by April 2004 at the latest, to dissolve trusts.

Special health boards and other NHS bodies

1.13 Special health boards and other NHS bodies provide clinical, technical, advisory and administrative services on a national basis. They normally comprise a board appointed by Ministers and employ their own staff, manage their own budgets and receive the majority of their funding via SEHD. The board has overall responsibility for establishing the overall strategic direction of the organisation within a policy and resources framework set by Ministers. The chief executive is responsible for the day-to-day operations and management of the body and is overall accountable to the Scottish Ministers and the board for its performance. Appendix 1 provides further details on the 14 special health boards and other NHS bodies in Scotland.

Funding the NHS in Scotland

Expenditure in 2002/03

1.14 The Scottish Parliament annually determines the total resources which are made available to SEHD to fund the NHS in Scotland. For 2002/03, the Scottish Parliament voted SEHD gross expenditure limits of £7,533 million, including £527 million for capital investment. Some £6,309 million (84% of the total gross expenditure limit) was to be provided from the Scottish Consolidated Fund (itself funded largely from grant voted to The Scotland Office by the Westminster Parliament), while the remainder was to come from income received, including prescription and dental charges and National Insurance contributions.

1.15 Of the funding available in 2002/03, SEHD made net provisions of £6,113 million to NHS boards and £601 million to special health boards and other NHS bodies. SEHD also spent approximately £185 million[3] itself on a variety of services, including training and education, research and other national projects, and grants to voluntary organisations. SEHD's provision of funds to NHS boards comprise three main elements, a formula-based allocation, a demand-led indicative allocation, and a ring-fenced allocation for specific initiatives (Exhibit 5).

1.16 It is for NHS boards to determine how to spend the formula based allocation in accordance with their local health plans and the healthcare needs of the local population. In 2002/03, NHS boards spent £5,832 million on healthcare of which £4,268 million (73%) was on health and community care and £1,564 million (27%) was on family health services. Some 89% of NHS board expenditure was in the form of advances to trusts operating in the board's geographic area. Including income received from other sources, acute trusts spent £3,074 million (49% of total trust expenditure) in 2002/03, and PCTs £3,182 million (51%). The largest single element of trust expenditure was on staff costs, representing 46% (£2,849 million) of total trust expenditure. Exhibit 6 provides more details on NHS expenditure in 2002/03.

Expenditure over time

1.17 The total level of resources devoted to the NHS in Scotland has increased since 1999/2000. Exhibit 7 shows that the Scottish Executive expects that expenditure on the NHS will increase by an average of over 6% per annum in real terms between 1999/2000 and 2005/06. In September 2002, the Scottish Executive announced[4] that an additional £2.7 billion would be invested in the NHS in the three years to 2005/06. Amongst other things, the additional investment is to be used to[5]:

- develop and deliver health improvement action, in partnership with other departments and local government

3 Subject to the 2002/03 audit of the Scottish Executive Consolidated Resource Account
4 *Building a Better Scotland: Spending Proposals 2003-2006: What the money buys,* Scottish Executive, September 2002
5 *Scottish Executive Draft Budget 2004/05,* Scottish Executive, September 2003

Exhibit 5: How SEHD funds NHS boards

There are three main elements to the funding of NHS boards by SEHD.

- **Unified budget**. The unified budget is allocated to cover expenditure on hospital and community health services, general medical services (GP support and team costs) and the cost of drugs dispensed. Allocations to individual NHS boards are determined by reference to a formula developed in 1999 by a steering group chaired by Sir John Arbuthnott. The Arbuthnott formula takes into account the share of the population living in each NHS board area, the age structure of the population, levels of deprivation and the proportion of the population living in remote and rural areas. In implementing the Arbuthnott formula, SEHD recognised that it would not be appropriate to reduce the level of funding for any NHS board whose share of resources was higher than their target share determined through the allocation formula. Instead, all NHS boards receive a standard increase in funding so that they benefit from the substantial growth in NHS expenditure. Those NHS boards whose target share is above their current share of resources receive a higher rate of increase in funding. SEHD expects that most NHS boards will reach their target share of funding in 2005/06. Capital funding is also determined with reference to the Arbuthnott formula, although adjustments are made to provide additional funds to NHS board areas with specialist teaching centres. In 2002/03, the unified budget comprised 87% of the total allocations to NHS boards.

- **Family health services non-discretionary budget**. Expenditure under this heading covers payments to family practitioners based on the number of patients seen and prescriptions dispensed. As this expenditure is demand led, it is not appropriate for NHS boards to be allocated sums based on the Arbuthnott formula. Instead, allocations are only indicative and expenditure is met by an equal non-discretionary funding allocation. In 2002/03, the family health services non-discretionary budget comprised 10% of the total allocations to NHS boards.

- **Ring-fenced budgets**. So as to ensure that NHS boards spend appropriate amounts on particular initiatives, SEHD can ring-fence some of the funds allocated to NHS boards. Typical examples of ring-fenced allocations include support to Drug Action Teams, HIV prevention measures and GP out-of-hours services. In 2002/03, ring-fenced allocations comprised 3% of the total allocations to NHS boards.

Source: Audit Scotland

Exhibit 6: How NHS funding is spent 2002/03

Sums authorised to be used by the Scottish Parliament

	£m
Resources other than accruing resources:	6,309
Accruing resources:	1,225

Scottish Executive Health Department

NHS boards

	£m
Income:	
Net funding from SEHD	6,113
Other income	124
	6,237
Expenditure:	
Health Care	5,832
Administration	68
Capital allocations to trusts	263
Other Expenditure	42
	6,205

Special health boards and other NHS bodies

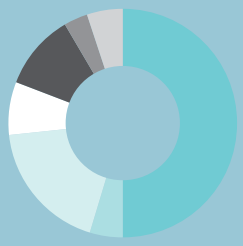
	£m
Income:	
Net funding from SEHD	601
Other income	30
	631
Expenditure:	646

Other expenditure by SEHD:

£185 million

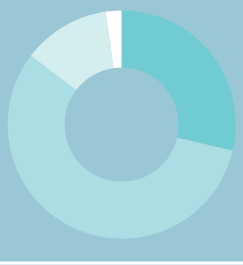
Hospital and Community Care

	£m
Acute services	2,135
Maternity services	198
Mental health services	798
Continuing care	319
Other community services	458
Other services	144
Other	216
	4,268



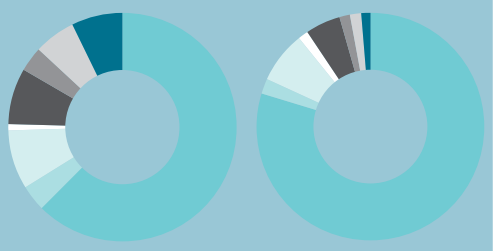
Family Health Services

	£m
General medical services	448
Pharmaceutical services	887
General dental services	194
General ophthalmic services	35
	1,564



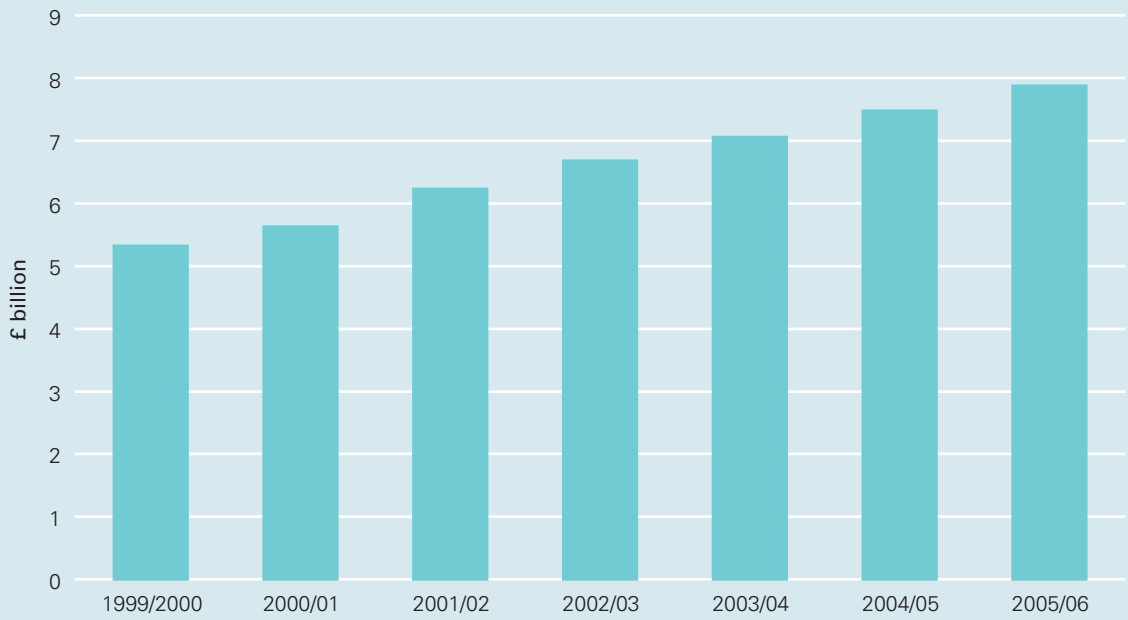
Trusts

	Acute £m	Primary Care £m
Income:		
Host NHS board	2,690	2,893
Income from activities	83	117
Other income	98	106
Capital allocations from NHS boards	221	42
	3,092	3,158
Expenditure:		
Clinical services	1,921	2,535
Hotel services	113	68
Other services	257	234
Transport, T&S	28	46
Premises	244	158
Cost of capital	108	48
Other	181	51
Capital investment	222	42
	3,074	3,182



Source: Audit Scotland

Exhibit 7: NHS expenditure over time



Note: Figures for 1999/2000 to 2001/02 are based on actual expenditure. Figures for 2002/03 to 2005/06 are based on plans. All figures are at 2002/03 prices.

Source: Audit Scotland

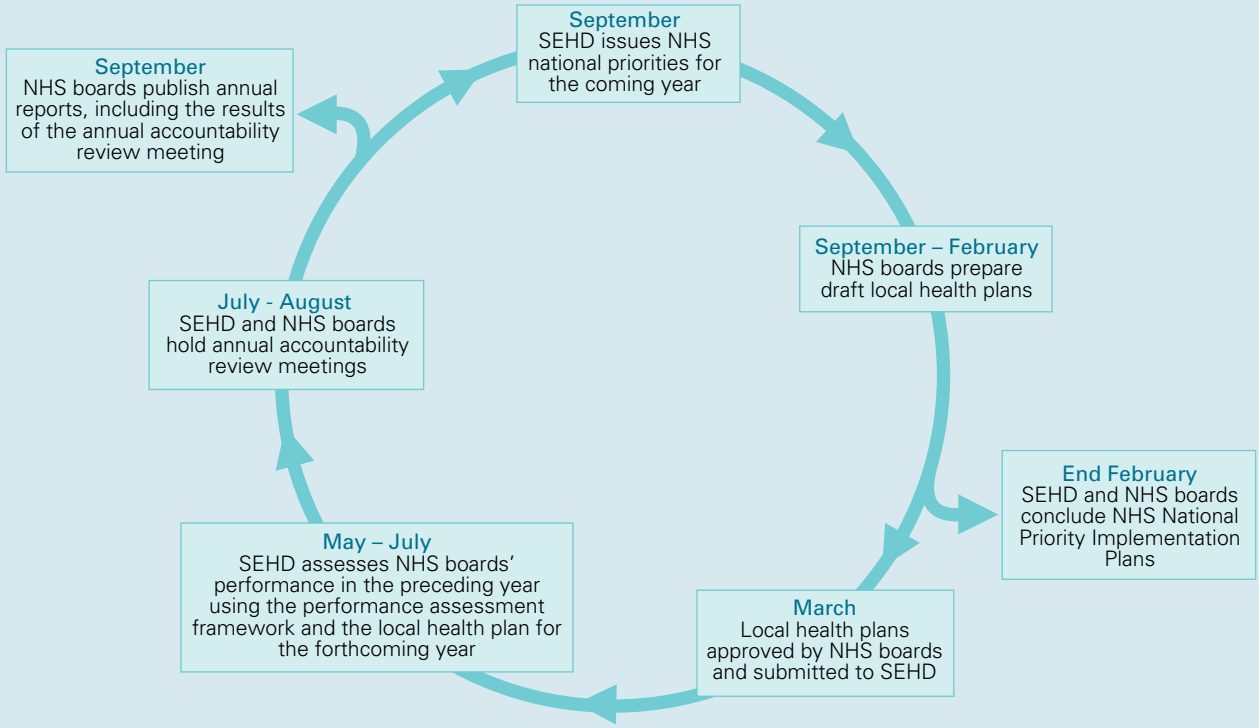
- continue to support the drive for reform within the NHS in Scotland through the Centre for Change and Innovation
- invest in the improvement of the treatment of coronary heart disease, stroke, cancer and mental illness
- treat additional hospital cases as outpatients, day cases or inpatients
- train an additional 10,000 nurses and 1,500 midwives, and increase the total number of consultants by 600
- improve the patients' experience of the NHS by investing at least £250 million in hospitals, primary care facilities and IT
- invest £30 million a year to provide 1,000 community places for people leaving hospital.

Performance management and reporting in the NHS

1.18 The overall responsibilities of the Scottish Ministers and the chief executive of NHSScotland requires there to be robust procedures for the management and reporting of performance of local health systems. The performance management and reporting system in place is intended to form part of the accountability cycle of NHS boards to the Scottish Ministers and to the public. It comprises:

- the setting of strategic objectives and national priorities for the NHS as a whole (the current aims, objectives and targets of the NHS in Scotland are set out in Appendix 2)
- the annual preparation of local health plans
- the monitoring of the financial and other performance of local health systems by SEHD through the medium of regular performance returns and the Performance Assessment Framework
- the holding of annual accountability review meetings between SEHD and each NHS board where past performance and future priorities are discussed and agreed
- the publication by NHS boards of annual reports on their activities and performance.

Exhibit 8: Performance management in the NHS



Source: Health Department Letter HDL (2002) 73, SEHD, October 2002

The performance management cycle is shown in Exhibit 8.

Performance assessment framework

1.19 SEHD introduced revised performance assessment and accountability arrangements with effect from 2001/02. 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 national health priorities
- reinforce and support the role of unified NHS Boards in managing the performance of their local NHS systems
- enable NHS Scotland to account systematically for its performance, both locally and through the Scottish Executive, to the Scottish Parliament and to the public.

1.20 The performance assessment framework is designed to encompass a set of quantifiable measures, indicators and qualitative assessments to 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. It also provides a systematic background for continuing discussions between SEHD and NHS boards about performance, and as a basis for discussion at the annual accountability review meetings held each summer between SEHD and NHS board senior managers.

Part 2. Financial stewardship and corporate governance

2.1 Financial stewardship is about how bodies put in place systems of internal control to ensure that all expenditure is properly authorised and incurred, and how they maintain proper accounting records and prepare financial statements which provide a true and fair view of their financial position. Corporate governance is concerned with structures and processes for decision-making, accountability, control and behaviour at the upper levels of an organisation. This part of the report covers:

- completion of accounts and audits
- systems of internal control
- fraud in the NHS
- corporate governance.

Completion of accounts and audits

2.2 Overall financial stewardship in the NHS in Scotland continues to be of a good standard. All trust accounts and the majority of NHS board accounts, were presented for audit within the timetable set by SEHD. There were no qualifications to the 'true and fair' opinions provided by auditors in relation to the accounts of any of the 54 trusts, NHS boards, special health boards and other NHS bodies subject to audit by the Auditor General in 2002/03.

2.3 In a few cases, auditors reported that draft accounts and supporting schedules were not prepared on time or to the required standard for audit. This was largely due to unfamiliarity following the introduction of resource accounting and a revised format of accounts for NHS bodies (see Part 3). In the main, however, the preparation of accounts and supporting schedules was conducted to a high quality. The audits of all 28 NHS trusts were completed by the deadline of 30 June 2003. Similarly, the audits of all NHS boards, special health boards and other NHS bodies were completed by the deadline of 31 July 2003.

Regularity assertion

2.4 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'.

2.5 My overview reports in 2000/01 and 2001/02 highlighted that the appointed auditors of all PCTs and all NHS boards had qualified their regularity assertion in respect of Family Health Services (FHS) expenditure and income. This was due to the absence of a comprehensive framework of payment verification checks covering both patient charges and payments to those providing the services. In 2002/03, the appointed auditors for four PCTs and seven NHS boards qualified their audit opinion on the regularity of FHS expenditure. The appointed auditors for 13 PCTs and 14 NHS boards qualified their opinion on the regularity of FHS income. FHS expenditure and income are

considered further at paragraphs 2.15 to 2.23.

Systems of internal controls

Budget setting and monitoring

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

2.7 External auditors found that the key financial systems in place at trusts and NHS boards were, generally, of a good standard. Weaknesses identified and reported are addressed through action plans agreed locally with the audited body and followed up by the auditors.

2.8 The majority of auditors concluded that arrangements in NHS trusts and boards for setting budgets and monitoring performance were generally adequate and operated soundly. A number of trusts, however, experienced wide variances between actual and budgeted expenditure, indicating that scope remains to improve budgetary control arrangements across NHS bodies in Scotland. Exhibit 9 shows typical examples identified by auditors of examples where there is scope for improvement.

Statements on internal control

2.9 Since 2001/02, accountable officers of health bodies have been required to complete a statement on internal control (SIC) confirming how the body has implemented adequate systems of control including financial, operational and compliance controls, and risk management, and how it has reviewed their effectiveness. The SIC 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, providing weaknesses in internal controls 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. In 2002/03, none of the auditors' opinions on trust and NHS board SICs were qualified.

2.10 The SEHD recognised that it would take time for health bodies to put in place all the necessary risk management and review processes. As in 2001/02 therefore, it allowed trusts and boards to adopt one of two types of SIC for 2002/03 – the preferred SIC indicating that the body is satisfied that it had in place a sound system of control in place throughout the year which complied with Scottish Executive guidance, or an alternative form of SIC which included a description of planned work required to achieve full compliance.

2.11 Four NHS bodies adopted the preferred SIC in 2001/02. The remaining trusts and NHS boards reported that processes were still being developed but were expected to be implemented by March 2003. For 2002/03, 13 trusts, four NHS boards and four special health boards adopted the preferred SIC. In addition, a number of other health bodies indicated that the necessary risk management and review processes were in place as at 31 March 2003, although they were not in place throughout the year.

2.12 The most common issues which health bodies disclosed in their SICs as requiring further attention include the introduction of risk management and information technology strategies, controls over FHS income and expenditure streams, and the attainment of CNORIS level 1 accreditation (see paragraphs 2.28-2.30). In some cases, these issues were first identified in 1999/2000. SEHD has now set a target for all NHS bodies to adopt the preferred form of SIC for 2003/04.

Fraud in the NHS

Prevention of fraud and irregularity

2.13 NHS bodies are responsible for taking all practicable steps to prevent and detect the occurrence of fraud and other irregularities. Auditors may act as a deterrent to fraud through their audit activities but they do not have a duty to prevent or detect it. They are, however, required to report suspected fraud to the audited body and, if necessary, to the police. As part of the Code of Audit Practice, NHS auditors are required to review and assess arrangements for the prevention of fraud. They must also plan their audits so that there is a reasonable expectation of detecting material misstatement arising from fraud or irregularity. Auditors will consider, amongst other things, procedures for ordering goods and services, supervisory checks by line managers, the segregation of duties, the existence of appropriate financial operating procedures and whether there is an effective internal audit function.

2.14 Auditors reported that general arrangements at trusts and NHS boards for the prevention and detection of fraud and irregularity appeared to be satisfactory during 2002/03. NHS bodies are required to notify their auditor of all closed cases of identified fraud during the financial year. Returns for 2002/03 show that there were 19 closed cases of fraud each valued at less than £2,000, with a total value of £11,000. There were a further 14 closed cases in excess

Exhibit 9: The scope for health bodies to improve budgetary control

- Budgets should use realistic estimates of expected financial positions rather than reflect 'worst case' scenarios. This would help minimise wide fluctuations being reported to Finance Committees and Boards.
- Areas of financial risk tend to be reflected early in forecasts, but potential underspends are often not reflected until realised. This approach may appear prudent but has an impact upon initial plans, which only becomes apparent as forecast deficits reduce throughout the year.
- Financial budgets and monitoring reports should include a clear statement of the assumptions underlying forecasts and the action that will be required if the assumptions vary.

Source: Auditors' final reports on the 2002/03 audits

Exhibit 10: Family health services contractor systems

General medical practitioner services
Payments to general medical practitioners mainly comprise a capitation payment based on the number of people registered with the GP, plus claims made for items of service or treatments carried out. GPs may also receive additional payments, for example the rural practices travelling allowance. PSD makes monthly payments to GPs based on patient lists (GPs are asked to confirm the accuracy of the list each quarter) and on the basis of claims received.

Dental practitioner services
PSD pays dentists monthly comprising capitation payments for registered child patients, continuing care payments for registered adult patients and on the basis of claims received for services provided. Item of service claims are the biggest element of dentists' remuneration. The dentist is paid the value of work done less any amount he has received directly from the patient.

Pharmacist services
Chemist contractors comprise dispensing pharmacies, dispensing doctors and appliance suppliers. Payments to chemist contractors are almost entirely based on the value of prescriptions dispensed plus a fee for each item dispensed. Contractors provide prescription forms to PSD once or twice a month. PSD makes an advanced payment comprising 90% of the number of items received times the average price per item paid to the contractor in the previous month. The remainder of the payment is made up of the final calculation of the cost for the previous month.

Ophthalmic services
High street ophthalmic contractors provide sight tests and issue NHS optical vouchers to eligible patients under general ophthalmic services. Dispensers, who are not necessarily ophthalmic contractors and who are not required to be a dispensing optician, provide glasses. Most adults normally pay in full for sight tests except for those aged 60 and over, those who are exempt under the NHS Low Income Scheme and those who have, or are at risk to, particular medical conditions. The NHS pays for sight tests and provides optical vouchers to purchase glasses to certain categories of patients including children under 16, those aged 16-18 in full-time education, complex lens wearers and those who are exempt from paying under the NHS Low Income Scheme. PSD pays ophthalmic contractors for NHS work provided on the basis of claims received and reimburses dispensers for the value of optical vouchers.

Source: Audit Scotland

of £2,000, with a total value of £92,000. Typical cases of reported fraud included the misappropriation of £3,000 from the sale of welfare foods. A pharmacist was able to defraud a PCT of £15,000 by overstating the quantity of items dispensed (see below).

Primary care payments

2.15 Family Health Service (FHS) expenditure comprises payments to primary care practitioners (GPs, dentists, opticians and pharmacists) in respect of services rendered. With the general exception of general medical services, most patients make a contribution towards the cost of these services unless they are exempt, for example because they are in receipt of income support. Although FHS expenditure and income is accounted for in the accounts of PCTs and NHS boards, the Practitioners Service Division (PSD) of the Common Services Agency (CSA) has been responsible for calculating and making payments to primary care contractors since 1999/2000 (Exhibit 10). In 2002/03, FHS expenditure amounted to £1,594 million from approximately 76 million transactions processed. FHS income amounted to £103 million.

2.16 There are two main sources for potential fraud and irregularity in relation to FHS activity:

- **practitioner fraud** – where claims are submitted for services or prescriptions which have not been provided to valid patients and/or were not provided for valid reasons.

- **patient fraud** – where patients knowingly claim entitlement to free prescriptions and other services to which they are not entitled, resulting in an under-recovery of income from patients' charges.

Practitioner fraud

2.17 Payments to primary care contractors represent 48% of the expenditure of PCTs and islands NHS boards. They need, therefore, to be able to ensure that only properly valid claims are paid and that accurate and timely prescribing management information is generated so as to monitor expenditure against budgets. In 2001/02, PSD and PCTs/island NHS boards agreed Partnership Agreements detailing their respective responsibilities for the processing, payment and verification of primary care payments (Exhibit 11).

2.18 Previous NHS overview reports have highlighted the efforts made by the CSA to improve the overall control environment at PSD and to introduce a robust framework of payment verification which complies with the requirements of the Partnership Agreements. Significant progress was made in 2002/03, although there is still scope for improvement. In particular, the service auditor (appointed by the CSA to annually review PSD's policies and procedures in providing processing and payment services) found:

- PSD's regional centres issued letters to patients seeking confirmation of treatment received from GPs in relation to all NHS areas in 2002/03 except one. The Dumfries and Galloway GP sub-committee did not agree to letters being issued.

- there was a lack of level 3 and 4 checks in respect of payments to pharmacists. PSD issued reports on the results of level 2 checks only in respect of the first six months of 2002/03.

- high value dental treatment requires the prior approval of a dental advisor. PSD did not check that the approval was obtained when the claim for payment was subsequently received. Prior approval was not obtained in all instances.

- there is scope for PSD to improve the administration of user access to the underlying computer systems.

2.19 That said, the appointed auditor for the CSA reported a number of positive developments on the previous year, including:

- the NHS is now more fully involved with setting the scope of the work of the service auditor

- the respective responsibilities of the CSA, PSD and PCTs in regard to payment verification checking are more clearly understood

- more payment verification checking is being undertaken across all payment streams, although in certain areas, payment verification checks have either not been fully implemented or not reported in a timely manner

- the CSA has put in place measures to ensure that the service auditor's recommendations are acted upon and reported in a timely manner.

2.20 The Counter Fraud Services[6] (CFS) unit of the CSA is responsible for pursuing contractors who are suspected of claiming fees for treatment or services which may be fraudulent or in violation of regulations. During 2002/03, the CFS identified losses to FHSs of £134,000, and assisted in the recovery of £54,000 from practitioners who

Exhibit 11: Responsibilities for FHS payment verification

PSD has prime responsibility for making payments to primary care contractors and for carrying out payment verification checks. There are four payment verification levels of testing.

- Level 1 – Comprising 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 by Level 1 checks, trend analysis or risk assessment.
- Level 3 – Where issues are identified for further investigation which may include letters being sent to patients asking them to confirm the treatment claimed for was received, or the examination of patient records.
- Level 4 – Where practice visits may be made on a random and targeted basis so as to examine patient records or where patients are given further examination, for example by the Scottish Dental Reference Service.

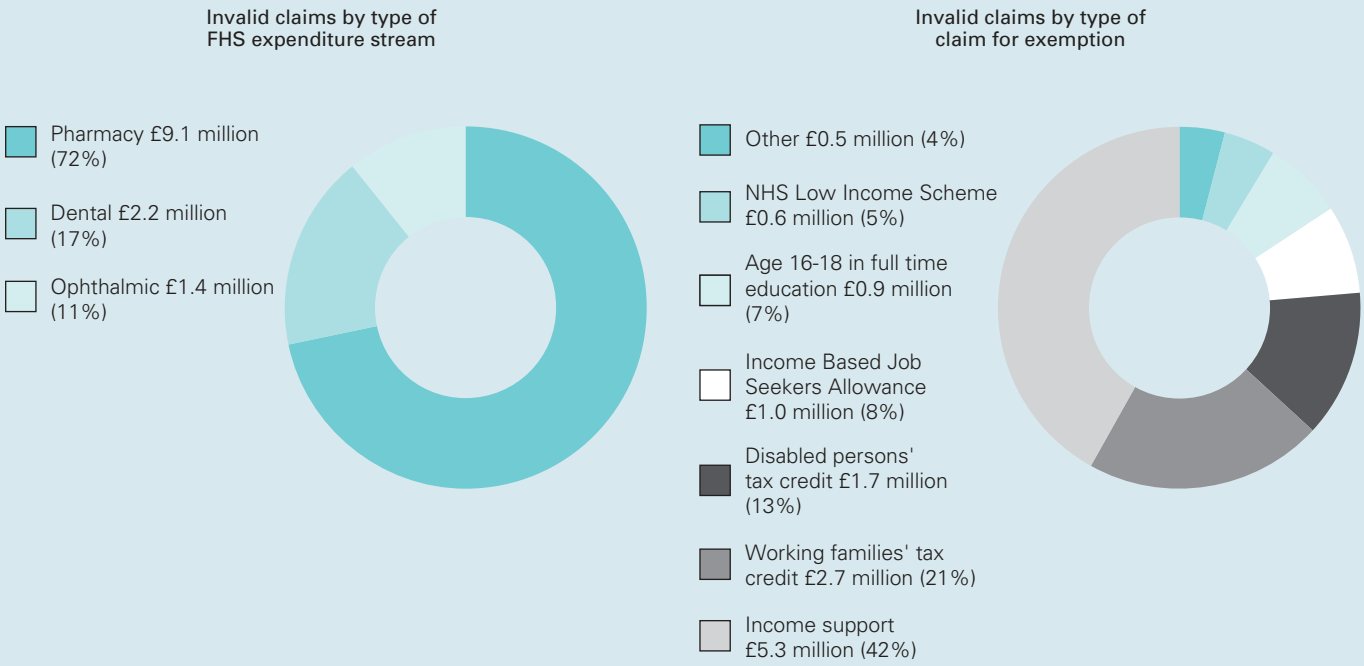
PSD is also required to notify the PCT/island NHS board and the CFS unit of CSA if fraud is suspected.

The Partnership Agreements make clear that PCTs/island NHS boards also have responsibility for implementing policies and procedures which contribute to the proper control of payments made. In particular, PCTs/island NHS boards are expected to:

- have in place procedures to analyse payment and post-payment information, develop a programme of practice visits in conjunction with PSD and investigate suspected practitioner fraud
- review outliers or unusual prescribing or dispensing patterns and carry out initial investigations based on prescribing and dispensing information provided by PSD
- review the outcome of PSD's payment verification work and agree actions where further investigations are indicated
- inform the CFS should any of the above raise suspicion that fraud is being perpetrated against the NHS.

Source: Audit Scotland

Exhibit 12: Invalid claims for exemption or remission from patient charges



Source: Counter Fraud Services

made false or inappropriate claims. It also identified annual savings of £616,000, almost six times that identified in 2001/02, in respect of fraudulent or inappropriate claims by family health practitioners. The CFS estimates that, overall, 3% to 8% of claims from practitioners may be fraudulent, equivalent to between £40 million to £100 million per annum.

2.21 Despite the significant improvement during 2002/03 in the level of payment verification work carried out, a comprehensive framework of payment verification did not operate throughout the year. As a result, the auditors for four PCTs and seven NHS boards, including the three island NHS boards, qualified their regularity audit opinions in respect of FHS expenditure. In the remaining PCTs, however, trusts reviewed local arrangements for the verification, evaluation and reporting of payment verification checks, and for monitoring PSD's progress towards implementing an effective payment verification system. The appointed auditors for these trusts were able to take assurance from the additional work carried out and issued unqualified regularity opinions on FHS expenditure.

Patient fraud

2.22 Under the Partnership Agreement between the CSA and PCTs/island NHS boards, the CFS is also responsible for checking that patients who claim exemption or remission from charges are entitled to do so. During 2002/03, the CFS undertook checks on 25,000 exemption claim forms. Based on the 17,000 forms where it could form an opinion on the validity of the exemption claimed, CFS concluded that 3.2% of claims for exemption or remission from pharmacy, dental and ophthalmic charges were invalid. The CFS estimates that invalid exemptions might have amounted to £12.6 million across Scotland in 2002/03 based on its extrapolation of the error rate. There is, therefore, a potential understatement of income receivable in the accounts of PCTs and NHS boards equal to that amount. Claims for exemptions from prescription charges made up over two-thirds of the total estimated understatement. The most common form of invalid claim for exemption from payment was from patients claiming they were in receipt of income support (Exhibit 12).

2.23 CFS selected exemption claims forms from batches from NHS board areas across the year. The cases were not, however, selected in a statistically robust way and some NHS areas may only have been covered once or twice during the year. As a result, the CFS could not split accurately the understatement of income between individual trusts and NHS areas. In the absence of trust level information on patient charges, there were no satisfactory alternative audit procedures that auditors could adopt to form an opinion on the regularity of FHS income. As a consequence, the auditors for 13 PCTs and 14 NHS boards qualified their regularity audit opinions in respect of FHS income. The auditor for Grampian Primary Care NHS Trust and Grampian NHS Board did not qualify his regularity audit opinion on FHS income on grounds of materiality.

Exhibit 13: Example of how NHS areas are approaching joint working

One of SEHD's objectives for the creation of unified NHS boards was that it would promote shared decision-making and better collaborative working between the host NHS board and their local trusts. The following shows how a more collaborative approach is being taken at NHS Glasgow.

- Close working between trusts and board in relation to the monitoring and planning of waiting times.
- The formation of an Acute Services Review Steering Group involving cross-system representation to guide the redesign of hospital services in the Glasgow area.
- The establishment of a Glasgow-wide property committee, covering estates and facilities management.
- A prescribing group, led by the PCT, but with strong pan-Glasgow involvement, examining the scope for efficiency savings in the prescribing of drugs.
- A Glasgow-wide team to address issues surrounding junior doctors and their working patterns.
- The planned development of a West of Scotland-wide approach to agency and bank nursing, with the intention of moving towards a single agency contract to reduce competition between trusts and boards.

Source: Auditors' final reports on the 2002/03 audits

Corporate governance

2.24 Under the Code of Audit Practice, auditors have a responsibility to review and report on the corporate governance arrangements in place at public bodies. During 2002/03, auditors referred in their final reports on the 2002/03 audits of NHS bodies, to four key aspects of corporate governance:

- the role of boards and their committees following the introduction of unified NHS boards in September 2001
- risk management arrangements
- how NHS bodies are using the Performance Assessment Framework to manage their performance
- how NHS bodies are planning for the dissolution of trusts.

The auditor of the National Waiting Times Centre Board also made important points about corporate governance arrangements at that body.

NHS boards and their committees

2.25 As part of the process of establishing new unified structures, SEHD expected all NHS boards to review their committee structures in order to determine the most effective arrangements for the discharge of the business of the local NHS system as a whole. NHS boards appear to have made satisfactory progress during 2002/03 to establish their committee structures. Most NHS bodies have established a core of essential committees such as Finance and Audit, Clinical Governance and Pay and Remuneration. But in addition, a number of NHS bodies have also established other committees to address a variety of functions, such as service redesign and to monitor performance against the performance assessment framework.

2.26 Auditors reported that unified board and committee meetings are occurring on a regular basis. Board meeting away days are often held in alternate months and attendance at board and committee meetings is generally high. There are also encouraging signs that a core reason for the establishment of unified boards, to enable a more co-operative and joint approach to the management of the local health area, is beginning to be realised. Exhibit 13 shows how NHS Glasgow is approaching joint working.

2.27 I have previously reported to Parliament on the financial and operating difficulties, and serious failures in corporate governance, experienced at NHS Tayside. Since my original report on the NHS in Tayside[7] and the subsequent investigation by the Scottish Parliament's Audit Committee, the auditor has continued to review corporate governance arrangements in Tayside. She reports that 2002/03 was a settled period during which Tayside NHS Board's committees met regularly and have been well attended. The committees have considered comprehensively relevant business and have reported on that work timeously. Officers and directors of the local trusts continue to participate in both trust and NHS

7 *National Health Service bodies in Tayside* Report by the Auditor General for Scotland, AGS/2001/03, March 2001

board committees, thus ensuring an integrated approach to the strategic direction of NHS Tayside and its holding to account.

Risk management

2.28 NHS bodies face a wide variety of risks, ranging from the failure to achieve strategic objectives to the risk of providing medical care which falls short of professional standards. Successful risk management is dependent on the thorough investigation of the nature and extent of the risks to which an organisation is exposed, the allocation of responsibility at a senior level for the analysis and management of key risks, and having appropriate responses to address each risk when it is encountered. An effective risk management system embedded within the governance framework of an organisation should be able to anticipate risk, assess current safeguards, plan improvements and monitor and review outcomes. Auditors continue to report that a number of NHS bodies have yet to fully develop and implement adequate arrangements for the identification and management of risk.

2.29 It is vital that NHS bodies manage risks which arise from their clinical activities, including claims for medical and clinical negligence. SEHD introduced the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) in April 2000 with the aim of encouraging health bodies to develop sound risk management procedures, to improve clinical performance and so reduce the incidence of clinical negligence claims. The scheme requires trusts and NHS boards to pay an annual contribution to a pool from which negligence claims are settled. Discounts on the amount of contribution an individual NHS body is required to make is dependent on the attainment of three specified standards of risk management[8]:

- **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.

2.30 Auditors reported that 21 trusts, three NHS boards and three special health boards had achieved CNORIS level 1 by March 2003 (corresponding figures as at 31 March 2002 were ten trusts, one NHS board and one special health board). Some trusts and the majority of NHS boards have, however, opted to suspend the process of seeking accreditation, in light of the impending integration of trusts with NHS boards. Each time reorganisation takes place, the NHS bodies concerned have to re-apply for CNORIS accreditation. No NHS body has achieved level 2 accreditation, although a number expect to be assessed during 2003/04.

Performance management

2.31 The Performance Assessment Framework (PAF) represents a comprehensive performance management framework for NHSScotland with which to assess health improvements, clinical outcomes and service standards alongside good financial management. Since summer 2002, SEHD has used the performance data generated through the PAF as a means to hold NHS bodies to account.

2.32 Auditors report that most NHS boards have found the PAF indicators to be helpful in reviewing and assessing their performance. One NHS body found that the indicators provide more robust measures of performance than previous performance measurement systems, although another considered there was a balance to be struck in achieving high performance against a particular PAF indicator and the cost of achieving that high performance. Exhibit 14 shows how Lothian NHS Board has aligned the PAF to its local health plan monitoring process.

2.33 The current indicators contained in the PAF are primarily focused on patient care and are thus principally for the use of trusts and NHS boards. SEHD is working with a number of special health boards to develop more appropriate performance assessment indicators for use by these bodies.

Planning the reorganisation of the NHS

2.34 SEHD intends that the dissolution of trusts will lead to greater devolved financial and management authority to the frontline and more integrated healthcare services. Ministers approved the dissolution of trusts in NHS Borders and NHS Dumfries and Galloway with effect from 31 March 2003. Since April 2003, the further integration of trusts was achieved in NHS Argyll and Clyde and NHS Fife. Six of the remaining eight mainland NHS areas submitted proposals to SEHD for the dissolution of trusts by August 2003. These trusts are either

8 In July 2003, SEHD announced that, following the formation of NHS Quality Improvement Scotland (NHS QIS), the CNORIS risk management standards will be integrated with the NHS QIS Generic Clinical Governance Standards. SEHD expects that the combined standards will be established by April 2004. NHS QIS will be responsible for overseeing the standard setting and accreditation process.

Exhibit 14: How Lothian NHS Board uses the PAF

- Each lead director is responsible for monitoring progress against the local health plan, including performance against the PAF and the Scottish health plan.
- The NHS Lothian board co-ordinates actions to be taken against the PAF through the Performance Assessment Framework Steering Group. Membership of the Group comprises all executive members of the board. The Steering Group is responsible for identifying the underlying factors affecting the performance of NHS Lothian, and agreeing action plans to improve performance. Each member of the Group is responsible for implementing the action plans within their own areas of responsibility.
- The action plans break down responsibilities for delivering improvements within PAF across the individual trusts and Lothian NHS Board. The action plans also translate criteria for success identified within the PAF into objectives to be achieved.
- The Lothian NHS Board assistant director of finance is responsible for monitoring progress against action plans. Once SEHD makes available PAF data through its website, the assistant director of finance will report to the Performance Review Committee every six to eight weeks.

Source: Auditor's final report on the 2002/03 audit

in the process of, or have now completed, consulting with staff and other key stakeholders on their proposals.

2.35 Individual NHS boards propose different management structures for the new, integrated organisations. Some boards propose a straightforward approach of replacing trusts with operating divisions having the same scope and functions. Alternative approaches are to set up either a single unified operating division covering the whole NHS area, or to have a number of operating divisions organised on a geographical basis responsible for delivering all healthcare services in their area. The auditors of Borders NHS Board reported a number of important lessons to be learned from the integration of local trusts which would be of value to other NHS areas planning integration (Exhibit 15).

2.36 A significant issue emerging from the reorganisation of the NHS in Scotland is the compatibility of financial systems currently in use across boards and trusts. Many of these systems are at the end of their useful lives, are no longer being supported and are often not compatible with other systems in use. It is likely that many unified organisations will wish to introduce new financial systems. Such a move, at a time of dissolution and unification, may mean a temporary loss of financial control and will place additional pressure on finance staff. The timing of the introduction of new financial systems and the move to shared financial services will need careful planning to ensure that resources are available and in place to deliver effective financial control and stewardship.

National Waiting Times Centre Board

2.37 The Scottish Executive's targets for the NHS in Scotland include the setting of maximum periods a patient should have to wait for treatment. In June 2002, SEHD purchased the former HCI hospital in Clydebank (now renamed the Golden Jubilee National Hospital) and established the National Waiting Times Centre Board (NWTCB) as a special health board. The NWTCB is responsible for ensuring the effective operation of the National Hospital to assist in the management of waiting times for NHS patients requiring treatment. During the period to 31 March 2003, the NWTCB treated 9,300 patients, some 85% more than the targeted number of procedures it was expected to perform.

2.38 Despite this operational success, the auditors identified several areas where the NWTCB needs to improve its corporate governance, risk management and performance management arrangements (Exhibit 16). While recognising that the NWTCB is a relatively new organisation, I will be expecting the auditors to examine NWTCB's progress in these matters as part of the 2003/04 audit.

NHS Fife

2.39 During 2002/03, SEHD asked NHS Fife to prepare a financial recovery plan because it was reporting that, during financial planning, it had identified an underlying annual financial deficit of almost £10 million. Fife NHS Board and both local trusts achieved their

Exhibit 15: Lessons learned from the integration of trusts in NHS Borders

The Minister for Health and Community Care gave formal approval for NHS Borders to proceed with its proposals for the integration of its two constituent trusts with Borders NHS Board in September 2002. The new organisation came into being on 1 April 2003. The following sets out how NHS Borders tackled the integration process, what worked well and its observations from its experiences.

Logistics of change

A project manager was appointed with overall responsibility for the integration process and to ensure that all governance and administrative arrangements were properly dealt with.

NHS Borders saw the integration of management and support services as a key priority. As a result, the human resources and financial planning functions were integrated at an early stage of the process. With only one acute and one primary care unit, the clinical structure remains similar to that which existed prior to integration.

The seven-month timescale from the date of Ministerial approval for integration was seen as critical to the success of the move to the single NHS Borders organisation. The timescale allowed NHS Borders to consider fully how best to achieve integration and to put in place its new management arrangements.

The new NHS Borders chief executive was appointed in November 2002. Other senior management appointments were made shortly thereafter. The prompt appointment of the chief executive provided a focus to drive the integration process.

What worked well

NHS Borders considers the following approaches to have benefited the process.

- Each area of integration was given an overall lead officer. This approach helped to ensure that the whole range of skills and experience of the senior management team were used. Their knowledge in different areas was shared.
- The staff partnership forum was actively involved at an early stage and greatly assisted the integration process.
- NHS Borders had a very pro-active chairman supporting the integration process until appointment of the chief executive.
- The NHS board, the acute trust and PCT worked together to respond to the financial pressures and subsequent planning and recovery process.

Observations from the NHS Borders experience

- NHS Borders did not receive any formal guidance from SEHD on how to manage the transition process. The main problems encountered were connected with statutory accountability arrangements during the transition period.
- The use of common terminology is very important as different interpretations can be put on words and terms used across NHS organisations. Terminology was seen as particularly important in areas such as team titles.
- The roles and responsibilities of non-executive directors and chairs of associated committees should have been more clearly defined at an earlier stage in the process.
- Formal arrangements in relation to staff contracts could have been more fully considered.
- Accommodation arrangements were an important part of ensuring that staff felt they were part of a new team.
- The development of a checklist covering all areas of the integration process would have been a useful tool.
- Despite the 'no detriment' provisions and assured job protection, there has still been some anxiety among staff.
- The process of integration did not stop when the new organisation was established in April 2003. Steps for greater integration are likely to still be taking place in two-years time.

Source: Auditor's final report on the 2002/03 audit

Exhibit 16: Areas where NWTCB needs to improve its corporate governance and other arrangements

Corporate governance

- NWTCB did not have a formally constituted board with non-executive directors in the period up to 31 March 2003.
- A local health plan, or equivalent, detailing strategic objectives was not in place for 2002/03. A plan has been developed for 2003/04.
- Management had not implemented rigorous budgets that were matched by equivalent formally documented income levels.

Risk management

- NWTCB has yet to apply for CNORIS level 1 accreditation.
- The board did not have in place, in 2002/03, the clinical governance committees specified in NHS guidelines. The required committees have now been established.

Performance management

- A formal performance management framework was not in place in the period up to 31 March 2003.
- The current financial system is insufficient to provide the budgetary control information required by the organisation.
- NWTCB does not have formal policies and procedures in place in relation to medical records and patient confidentiality.

Source: Auditor's final report on the 2002/03 audit

Exhibit 17: Auditor's findings on corporate governance in NHS Fife associated with its financial management

In February 2003, the chief executive of Fife NHS Board asked its appointed auditor to review financial monitoring and the recovery planning process within the NHS Fife system. The auditor also commented on specific aspects of corporate governance associated with the financial management of NHS Fife:

- NHS Fife has taken positive steps to improve corporate working, including the establishment of a Joint Executive Team, a Finance Review Group to monitor delivery of the financial recovery plan, and a Fife NHS Reviews Group Project to look at specific areas for savings. The auditor reported, however, that there remains a sense of territorialism within the system. The identification of action points and the creation of review groups to follow up specific areas of service actively did not work effectively or to timetable. There is also scope to improve the working of the Joint Executive Team.
- the auditor reported concern over the lack of vision and commitment in some quarters, thereby impairing the ability of the NHS Fife system to display proper strategic direction and corporate working. In particular, because of concern about its ability to achieve financial recovery, the auditor expressed reservation regarding the likely pace of implementation of NHS Fife's Right for Fife strategy.
- the auditor considered there is scope to improve communication through the preparation of detailed savings action plans, better alignment of the preparation of financial reports with the timing of meetings of boards and management teams, and for recovery plans to be updated to reflect variations from the planned financial position.

Source: NHS Fife's auditor's report *Financial Monitoring and Recovery Planning*, July 2003

financial targets for 2002/03, although the trusts experienced difficulty in achieving expected savings. As a result, at the request of the chief executive of Fife NHS Board, the appointed auditor reviewed financial monitoring and the recovery planning process within the NHS Fife system. The auditor's findings on financial control and financial management are set out in more detail in Part 4 of the report. The auditor also commented on specific aspects of corporate governance in the NHS Fife system associated with its financial management (Exhibit 17).

2.40 In July 2003, the chief executives of Fife NHS Board and both trusts reported to the NHS Fife audit committee that they were moving matters forward by:

- shifting from a financial reporting system focusing on in-year variance in the three separate organisations to one looking at trends over time, treating the NHS in Fife as a single entity

- with staff involvement, building a new common finance function supporting both the two operating divisions in Fife established as a result of the recent integration of the trusts with Fife NHS Board, and the whole NHS Fife system

- clarifying the role of the Joint Executive Team, Strategy Implementation Groups and Executive Champions, to lead the creation of a single corporate culture replacing any competitive hangovers which exist.

Part 3. Financial performance in 2002/03

3.1 The Scottish Executive announced, in May 2001, its intention to review the existing financial framework for NHSScotland[9]. The Scottish Executive's aim was to simplify the flow of resources from SEHD to NHS boards and down to trusts, thus allowing greater flexibility for financial planning over the longer 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 to be gained. This part of the report:

- explains the changes to the financial regime and the new format of accounts for NHS bodies which was introduced with effect from 2002/03
- sets out the new financial targets for the NHS in Scotland
- reviews performance against these targets in 2002/03
- comments on the current and potential future cost pressures which the NHS is facing.

Changes to the format of accounts

3.2 The SEHD established a group consisting of senior finance staff from the Department, NHS boards and trusts to review the financial regime of the NHS in Scotland. As well as taking into account the organisational and operational changes within the NHS arising from *'Our National Health: A plan for action, a plan for health'* the review group was also to take cognisance of the introduction of resource accounting and budgeting to the public sector. The review group's remit was to put forward proposals to establish, as appropriate, a revised financial regime which reflected the new NHS environment, maintained and ensured robust financial controls and which was transparent and easily understood. The SEHD agreed the review groups' recommended changes to the financial regime in October 2001. It committed to introduce the new regime with effect from 2002/03 (Exhibit 18).

3.3 The effect of these changes to the NHS financial regime is a change to the format of accounts for all NHS boards, special health boards and trusts. The most significant of these changes are the introduction of:

- an Operating Costs Statement (OCS) which replaces the Income and Expenditure Account. The OCS discloses the net operating costs of an NHS board or trust.
- a General Fund, which replaces the Retained Surplus/(Deficit) Carried Forward and Capital Reserves.

3.4 The OCS fundamentally changes the disclosures for, and the definition of, income. Under resource accounting, funding for patient services is regarded as part of the *taxpayers' equity*, not as a source of income. In accordance with the principles of resource accounting,

9 *Rebuilding our National Health Service*, Scottish Executive, May 2001

Exhibit 18: Changes to the NHS financial regime

The replacement of Public Dividend Capital (PDC) with a General Fund
When trusts were first established, the value of the net assets of the new organisation were matched in the Balance Sheet by an equal amount of PDC. This reflected the principles of the internal market which then applied to the NHS. Trusts were required to repay a portion of the PDC annually, along with a dividend, to SEHD. The system was administratively complicated and could be difficult to understand. In order to simplify the system and to improve consistency between trusts and NHS boards, from 2002/03 outstanding PDC balances were included within a General Fund.

The abolishment of External Financial Limits (EFL)
EFLs were also created at the inception of trusts. They were used as a mechanism for funding capital expenditure within trusts without the need for direct allocations from SEHD and were associated with the independence and autonomy of trusts. They were also administratively complicated and could be difficult to understand.

The SEHD to allocate capital to NHS boards for onward allocation to trusts in accordance with a national capital allocation methodology
Prior to 2002/03, SEHD allocated the majority of capital funds to trusts through the EFL. In order to enhance consistency between NHS boards' and trusts' accounting arrangements, SEHD now allocates capital funds to NHS boards as part of their capital resource limit. NHS boards are responsible for allocating capital funds to trusts.

The requirement for trusts to repay their capital charges to SEHD
Capital charges are made up of two elements: depreciation to reflect the wearing out of an asset; and a 6% return on net assets intended to replicate the principal and interest payable if the asset was purchased from borrowings. Prior to 2002/03, NHS boards repaid their capital charges to SEHD through a charge on their Income and Expenditure Account. Trusts retained their depreciation for expenditure on fixed assets (controlled through the EFL mechanism) and repaid their 6% return to SEHD in the form of a PDC dividend. In order to enhance consistency between NHS boards' and trusts' accounting arrangements, trusts now also repay their capital charges as a charge on their Income and Expenditure Account.

The SEHD to revise their monitoring arrangements to monitor NHS boards as a whole
Prior to 2002/03, NHS boards and trusts individually submitted monitoring returns to SEHD detailing their actual and forecast expenditure. Unified NHS boards were created in 2001. Trusts remain as separate statutory bodies, at least until their expected formal integration with boards over the next year or so. Because unified boards are accountable for the local NHS system as a whole, SEHD now requires each NHS board to submit one monthly monitoring return, reporting the consolidated financial performance of the NHS board and its constituent trusts.

Source: *The Revised Financial Framework: Practical Implementation,* SEHD HDL 2002(9), March 2002

SEHD's funding of NHS boards is now reflected not as income credited to the Income and Expenditure Account, but as a credit to the General Fund. For trusts, the credit to the General Fund is the funding received from its host and other NHS boards.

3.5 There is no change to the accounting treatment of expenditure, but the format of disclosures within the OCS differs from that of the previous Income and Expenditure Account. Instead of presenting a surplus or deficit of income over expenditure (as in the previous Income and Expenditure Account), the OCS simply calculates the Net Operating Cost for the year and then compares this against a Revenue Resource Limit set by SEHD for NHS boards and special health boards, and by NHS boards for trusts.

3.6 Because SEHD's funding is not treated as income, NHS boards are no longer permitted to accrue the balance of their allocation for the year (ie, that which has yet to be drawn down). An unwelcome consequence of this, is that a number of Balance Sheets, as at 31 March 2003, showed that NHS boards were in a negative equity situation, ie their liabilities exceeded their assets. In reality, by the time accounts are finalised, most NHS boards have drawn down funding from SEHD to meet the liabilities disclosed at the financial year end.

New financial targets for the NHS in Scotland

3.7 In previous years, NHS boards and special health boards were expected to contain the cash consequences of their ongoing operations and capital investment within a cash limit notified by SEHD. NHS trusts had to meet three financial targets. These were:

- to break even on the Income and Expenditure Account taking one year with another (as required under the National Health Service and Community Care Act 1990)
- to achieve a 6% pre-interest return on relevant assets, ie the surplus on the Income and Expenditure Account before interest receivable and PDC dividends payable should equate to at least 6% of relevant net assets
- to remain within the External Financing Limit.

3.8 Trusts still have a statutory obligation to break even taking one year with another. However, as a result of the replacement of the Income and Expenditure Account with the OCS, the statutory breakeven target is now interpreted as requiring trusts to remain within a Revenue Resource Limit (RRL) agreed with their host and other NHS boards. The RRL is the resource budget for ongoing operations. In the case of PCTs, the RRL excludes the FHS Non Discretionary Budget because payments to primary care contractors are dependent on the demand for services. Trusts are also required to stay within a Capital Resource Limit (CRL) which applies to in-year capital expenditure and is set by local NHS boards. In addition, although trusts no longer have a specific cash target in the form of the External Financing Limit, they are not expected to accumulate cash balances. Excess balances should be returned to the host NHS board.

3.9 NHS boards and special health boards are also required to operate within an RRL and CRL set by SEHD but have an additional financial target, the Cash Requirement. The Cash Requirement is a financing requirement to fund the cash consequences of ongoing operations and new capital investment.

Performance against financial targets in 2002/03

3.10 An excess of resource outturn against the RRL means, for the NHS body concerned, that the costs of providing services and the level of service provision exceeded the financial resources available for the year. Savings against the RRL may be carried forward to the next year but excesses have to repaid from subsequent years' resources. In other words, the NHS body is expected to contain expenditure not only within the RRL set for that year, but also to make good any overspend in the previous year.

Trusts' financial performance

3.11 During 2002/03, four trusts reported savings against their RRL, 19 exactly met their RRL and five exceeded their RRL (Appendix 3). The total savings were £0.2 million and the total excesses were £18.2 million. The five trusts which did not achieve the RRL target are shown in Exhibit 19.

3.12 The excess against RRL experienced by Lanarkshire Acute Hospitals NHS Trust is largely the result of a deficit originally created in 2000/01 through a technical accounting entry to revalue downwards certain properties which were planned for sale but had minimal value. The trust expects to clear the deficit in 2003/04 with the sale of other valuable surplus land as part of its land property strategy. The amount by which Grampian University NHS Trust exceeded its RRL is equivalent to its brought forward deficit from 2001/02. All three trusts within NHS Argyll and Clyde exceeded their RRLs. This is a reflection on the current operational and financial difficulties being experienced within NHS Argyll and Clyde. The financial position of Grampian University Hospitals NHS Trust and NHS Argyll and Clyde is discussed in greater detail in Part 4 of the report.

Exhibit 19: Trusts exceeding their Revenue Resource Limit

	Revenue Resource Limit (£000)	Net Resource Outturn (£000)	Excess against RRL (£000)
Argyll and Clyde Acute Hospitals NHS Trust	163,412	168,229	4,817
Grampian University Hospitals NHS Trust	260,234	265,433	5,199
Lanarkshire Acute Hospitals NHS Trust	235,388	238,215	2,827
Lomond and Argyll Primary Care NHS Trust	76,086	77,797	1,711
Renfrewshire & Inverclyde Primary Care NHS Trust	130,365	134,054	3,689

Source: Audit Scotland

3.13 During 2002/03, eight trusts reported savings against their CRL, 16 exactly met their CRL and four exceeded their CRL. The total savings were £0.4 million and the total excesses were £0.7 million. Three-quarters of the overspend against the CRL was due to the advanced planned purchase of medical equipment by Lothian University Hospitals NHS Trust.

NHS Boards' and special health boards' financial performance

3.14 The accounts for 2003/03 show that 14 NHS boards and nine special health boards and other NHS bodies either met or made savings against their RRL. Exhibit 20 shows those boards which exceeded their RRLs.

3.15 Lanarkshire NHS board exceeded its RRL by £7.342 million. A significant contributory reason for the overspend was expenditure associated with the repatriation of Lanarkshire patients from NHS Glasgow to NHS Lanarkshire. NHS Lanarkshire is currently negotiating for the transfer of £4.0 million funding from NHS Glasgow for these patients. NHS 24 exceeded its RRL due to the accrual of expenditure associated with the planned development of two Contact Centres. NHS Education for Scotland exceeded its RRL largely due to its requirement to increase pension contributions in respect of staff formerly employed by the National Board for Nursing, Midwifery and Health Visiting for Scotland.

3.16 All 15 NHS boards and 11 special health boards and other NHS bodies, except one, operated within their CRLs and Cash Requirements. The National Waiting Times Centre Board exceeded its CRL by £0.1 million because of the need to upgrade medical and other equipment following the purchase of the Golden Jubilee National Hospital.

How RRL targets were achieved

3.17 The achievement of financial targets remains a challenge for NHS bodies. Appendix 3 summarises the 2002/03 financial outturn of all NHS boards and trusts, including the steps taken to achieve RRL targets. Auditors identified three main tools which enabled RRLs to be met during 2002/03:

- the re-routing of underspends within NHS systems
- the use of non-recurring funding streams
- the use of cash releasing efficiency savings.

Re-routing of underspends within NHS systems

3.18 The principle behind the formation of unified NHS boards in September 2001 is that they should enable a more joined-up approach to the management of the local NHS system to be taken. Trusts should work in partnership with other trusts and interested parties in the area rather than in isolation. The joint approach to the management of NHS finances enabled at least one trust to achieve its RRL in 2002/03. At NHS Tayside for example, a £6.7 million underspend at the PCT enabled funding to be returned to the NHS board. This enabled Tayside NHS Board to transfer £5.7 million to, and increase the RRL of, the acute trust.

Exhibit 20: NHS boards and special NHS boards exceeding their Revenue Resource Limit

	Revenue Resource Limit (£000)	Net Resource Outturn (£000)	Excess against RRL (£000)
Lanarkshire NHS Board	540,965	548,307	7,342
NHS 24	26,211	27,167	956
NHS Education for Scotland	185,898	186,846	948

Source: Audit Scotland

Exhibit 21: Examples of non-recurrent funding used by NHS bodies 2002/03

- **Funding for specific initiatives**
  SEHD provides ring-fenced funding to NHS boards, for example, for the development of Drug Action Teams. Such funding is usually forwarded to trusts. SEHD monitors that ring-fenced funding is spent on the purposes for which it was given via regular returns to it.
- **Use of contingencies and other reserves**
  NHS boards do not always commit immediately all the financial resources they expect to receive. Additional funding is provided to trusts during the course of the year, for example, in light of cost pressures that arise. Other reserves include deferred income and surpluses carried forward from previous years.
- **Receipts from the sale of land and property**
  NHS bodies are expected to identify and dispose of land and property which are surplus to requirements. In 2002/03, SEHD normally reduced the RRL for the value of any profit on disposal made such that there was a neutral effect on outturn against RRL. In a few exceptional cases, however, the profit on disposal was made available to the NHS body to support recurring activity without a reduction in the RRL. From 2003/04, the net book value of disposals will be deducted from capital expenditure charged against the CRL, and any profit or loss on disposal will be charged against the RRL.
- **NHS financial brokerage scheme**
  SEHD introduced the NHS brokerage scheme in January 2003. It enabled NHS boards to obtain advance funding from a 'bank' established from funds not currently required by other NHS boards with which to implement strategic change initiatives or to provide assistance with the implementation of major capital plans. SEHD withdrew the facility for NHS boards to obtain revenue funding from the scheme in 2003/04 because of a lack of funds being 'banked'. Financial brokerage for capital funds remains available.
- **Capital to revenue transfers**
  Under NHS accounting rules, expenditure associated with a building or other property is treated as revenue expenditure if it does not give rise to an increase in the value of that property. NHS boards are able to make capital to revenue transfers, with consequential adjustments to the RRL and CRL, of up to 20% of the total capital allocation given to them.

Source: Audit Scotland

3.19 The NHS Tayside approach shows the benefits that co-operative working by unified boards can bring to the management of NHS finances. However, the fact that this re-routing of underspends was necessary at all, is indicative of the financial pressures which continue to face NHS bodies. There is still a need to identify and address underlying recurring deficits if financial balance is to be achieved in the foreseeable future. It is currently clear when budgets are re-allocated between trusts. But there is a risk that, under the proposed single tier NHS system, such transparency will be lost and that the reasons for underlying recurring deficits in particular services or directorates may not be identified and addressed.

Non-recurring funding streams

3.20 Previous NHS overview reports have commented on the extent to which NHS bodies have relied on non-recurring funding to achieve financial balance. Auditors estimated that in 2002/03, trusts generated £266 million non-recurring funding, some 4.4% of the total funding of trusts. Several different types of non-recurring funding can be identified (Exhibit 21). In some cases, for example SEHD's funding for specific initiatives, NHS bodies can form a reasonable expectation that some funding will be received annually, although the level of funding and the purpose for which it is to be spent may not always be known in advance. In other cases, for example the disposal of surplus property, the non-recurring funding is a genuine one-off, never to be repeated.

3.21 In January 2003, SEHD introduced a new type of non-recurring funding, the NHS financial brokerage scheme. The scheme enabled NHS boards to obtain advance funding from a 'bank' established from funds not currently required by other NHS boards with which to implement strategic change initiatives or to provide assistance with the implementation of major capital plans. Applications for revenue funding were only to be accompanied by a robust financial plan demonstrating why the resources were needed, that recurring financial balance would be achieved, and how and when any resources advanced would be repaid from future budget allocations. SEHD agreed to advance funds only if this led to in-year financial balance in the year in which the application was made. In order to pump-prime the scheme, SEHD used central funds to provide brokerage of £13.2 million to five NHS boards in 2002/03.

3.22 SEHD withdrew the facility for NHS boards to obtain revenue funding from the brokerage scheme in September 2003 because of a lack of funds being 'banked'. NHS boards are still, however, able to obtain capital funds from the brokerage scheme. SEHD also intends to provide repayable advances in allocations to NHS boards where it had previously agreed to advance revenue resources from the brokerage scheme.

Cash releasing efficiency savings

3.23 Many NHS bodies have developed financial recovery plans aimed at restoring the body to recurring financial balance. Most of these plans include the implementation of cash releasing efficiency savings. Savings plans can range from relatively small-scale efficiency reviews, eg the provision of laundry services, to more fundamental reviews of how patient services are delivered. It is important that NHS bodies continue to review the way in which services are provided and to seek efficiency savings whenever possible. At the same time, the extent to which NHS bodies can continually make efficiency savings is finite without impacting on the quality of service provided. The auditors of several NHS bodies have concerns about their ability to deliver savings plans and thus, the viability of financial recovery plans.

Validity of targets

3.24 While the revised financial framework is intended to enhance the transparency of NHS financial performance, a number of auditors commented on the usefulness of the Revenue Resource Limit as a financial target. SEHD's initial notification of the RRL to each NHS board and special health board is subject to change throughout the financial year. SEHD, for example, issued 89 amendments to Argyll and Clyde NHS Board updating the initial RRL. The amendments added £25 million to the initial RRL, taking it to £435 million overall.

3.25 Auditors reported that the RRL of a number of NHS boards and trusts was only finalised after the year-end. Some trusts appeared to have difficulties agreeing an overall RRL where several NHS boards were involved. Setting the RRL after the year-end does not accord with the primary reason for setting a target in the first place, ie to provide a challenging, yet achievable, target for operational management to aim for. Agreeing a target once the final outturn position is known reduces the likelihood that the target is real or effective.

Future cost burdens

3.26 Over the next three years, the Scottish Executive is committed to spending significantly more resources on the NHS in Scotland. Planned expenditure is expected to increase from £6.7 billion in 2002/03 to £8.5 billion in 2005/06 (£7.9 billion at 2002/03 prices). The additional expenditure is expected to contribute to improved patient services and healthcare.

3.27 During 2002/03, auditors reported that many trusts experienced significant cost pressures arising from the New Deal for junior doctors, nationally agreed pay awards, the introduction of the EU Working Time Directive, and increases to employers' National Insurance and superannuation contributions. The average number of staff increased by 3.3% during the year to 105,000 whole time equivalents, but staff costs increased by 10.3% to £2.8 billion. Many PCTs also experienced significant cost pressures arising from increased GP drugs prescribing. The following paragraphs highlight some of the more significant cost pressures which NHS bodies will face over the next few years. These cost burdens are likely to consume much of the additional funding being made available to the NHS.

Staff related cost burdens

New Deal for junior doctors

3.28 The New Deal is an agreement reached in 1991 between representatives of junior doctors, government and NHS management. It aims to limit the number and intensity of the hours worked by junior doctors, and to improve their working conditions. Its objective is to improve the quality of patient care through having safe, well looked after and properly trained doctors. The need to reduce junior doctors' hours of work is driving programmes to modernise and re-engineer the delivery of hospital services.

3.29 From 1 August 2003, no junior doctor should have to work more than 56 hours a week, or 72 hours including on-call time. NHS trusts are responsible for implementing junior doctors' shift rosters which are New Deal compliant. If junior doctors work beyond the permitted threshold, trusts have to pay salary enhancements for the additional time worked. The additional amount is payable not only to the individual working the extra time, but also to each doctor on their shift roster. Junior doctors' hours will be further reduced from August 2004 with the phased introduction of the EU Working Time Directive[10]. By 2009, no junior doctor should have to work more than 48 hours a week.

3.30 The financial consequences of New Deal arise from the need to pay salary enhancements and to recruit additional junior doctors so that compliant shift rosters can be established. SEHD sees service redesign as being key to the successful implementation of the New Deal. It has been encouraging trusts to look at new ways of working and to produce compliant rosters through the introduction of new roles and responsibilities.

3.31 SEHD does not know the cost of implementation of New Deal or how many additional junior doctors have been recruited as a result. Between March 2001 and March 2003, the number of junior doctors employed in the NHS in Scotland increased from 4,160 to 4,751. During the same period, the number of junior doctors whose shifts were in compliance with the New Deal increased from 35.1% to 57.5%. If it is assumed that half the increase in junior doctor numbers was due to implementation of compliant shift rosters, then its full implementation would require the recruitment of an additional 560 junior doctors and cost an extra £25 to £30 million per annum. By August 2003, 83% of junior doctors worked New Deal compliant shift rosters.

New terms and conditions of employment together with additional staff

3.32 *'Agenda for Change'* is the UK health departments' plan to introduce a new pay system for all NHS staff, with the exception of doctors and dentists and some senior managers. Subject to further staff ballots to be held by a number of staff organisations, SEHD expects that the new system will be implemented across Scotland with effect from October 2004. The new system aims to harmonise conditions of service for staff. Staff will receive an annual pay increase, plus an annual increment for staff not on the maximum pay point for their grade. The new pay system will also allow for consideration of the need to award salary enhancements in high cost areas, and to retain staff in posts where there is competition from outside the NHS. SEHD has selected one NHS board, one trust and two special health boards to pilot the new pay system prior to planned full introduction.

3.33 The UK health departments also intend to introduce new contracts of employment for consultants. In summary, the new contracts offer a higher starting salary, progression through a stepped scale of pay thresholds based on performance, and additional recognition for on-call and out-of-hours working. Implementation of the EU Working Time Directive will have an impact on the number of consultants' hours worked. The NHS's current cost projections indicate increases of 8% to 15% in average consultant earnings arising from the basic contractual committments required of consultants. Employers also have the discretion to agree extra committments with consultants, subject to individual job planning

10 The EU Working Time Directive (93/104/EC) sets a maximum 48-hour working week averaged over a reference period and provides for minimum rest periods and annual paid holidays. The UK's regulations putting into effect the Directive came into force in October 1998. Staff can opt out of the 48-hour limit on their working week but the EC are currently considering whether to amend this facility. The EU Working Time Directive has significant implications for the NHS in Scotland in respect of junior doctors' and consultants' staff costs.

exercises to be carried out with those consultants opting for the new contract between now and its introduction in April 2004. In October 2003, a majority of consultants in Scotland voted to accept the new contract.

3.34 In addition to the introduction of new contracts, SEHD also intends for the NHS in Scotland to recruit an additional 10,000 nurses, 1,500 midwives and 600 consultants in the three years to 2005/06. The new contracts and additional staff will add significantly to the costs of NHSScotland. SEHD estimates that the NHS salary bill, inclusive of employers' National Insurance and superannuation contributions, may increase by £264 to £309 million per annum over the next three years as a result of these initiatives.

Increased employers' superannuation contributions

3.35 Most staff employed in the NHS in Scotland are members of the NHS Superannuation Scheme for Scotland. Contributions are credited to the Exchequer and the balance in the account is deemed to be invested in a portfolio of Government Securities. The Government Actuary assesses the pension cost every five years. The most recent actuarial valuation of the scheme, covering the five-year period to March 1994, identified a shortfall of £934 million to be met by future contributions from employing authorities. As a result, employers' contributions increased from 4% to 5.5% of total pensionable salaries with effect from April 2002. Employers' contributions will increase further to 7% with effect from April 2005. It is estimated that the increase in superannuation contributions from April 2005 will cost the NHS in Scotland an extra £35 to £40 million per annum based on 2002/03 staff numbers and salary costs. Further increases in employers' superannuation contributions may be necessary when the 1999 full actuarial valuation is published.

New General Medical Services contract

3.36 Payments to general medical practitioners currently mainly comprise a capitation payment based on the number of people registered with the GP plus claims for items of service or treatments carried out. In June 2003, GPs across the UK voted for a new contract which will bring far-reaching changes to NHSScotland.

3.37 The new contract will reduce the number of GP claims for payment. Instead, GP practices will receive a lump sum based on a contract setting out the services to be provided. It will be for GP practices to decide how to use the payments received, for example, the number of practice nurses they employ. NHS boards will make additional payments if the GP practice provides more services, or the same level of service set out in the contract to an enhanced specification. Extra payments will also be made if quality standards are achieved.

3.38 SEHD expects that the new GMS contract will be introduced with effect from April 2004. It anticipates that resources for general medical services will increase by £36 million in 2004/05, and by £100 million in 2005/06 compared to 2003/04 levels.

Non-staff related cost burdens

GP prescribing costs

3.39 In 2002/03, the cost to the NHS in Scotland of prescription drugs dispensed by community pharmacists and dispensing doctors was £773 million, up 10% on the previous year. The total number of prescriptions dispensed was up 5% to 70 million. In common with previous years, drugs used to treat cardiovascular disease and mental health problems accounted for most of the increase in costs (£50 million). The cost to the NHS of prescribed drugs has more than doubled in real terms since 1987/88.

3.40 Most PCTs experienced difficulties in 2002/03 in staying within their prescription drugs budgets. In June 2003, Audit Scotland published a performance audit report examining how the NHS had improved the quality and cost of primary care prescribing since 1999. The report found that:

- the volume and costs of medicines prescribed is affected by a variety of factors, including general costs and volume inflation such as an ageing population, the impact of national prescribing guidelines, the use of new, more expensive drugs and increased patient awareness.

- PCTs have made some efficiency savings since 1999 through, for example, greater use of generic drugs, the substitution of premium-priced products with cheaper standard alternatives, less use of medicines considered to be of limited value, and more use of established therapies over less well-established, newer medicines. Although challenging to achieve, there is scope for further efficiency savings of £14 million.

- the implementation of national prescribing guidelines can improve the quality of patient care but has significant cost implications. The NHS needs to consider the cost of new guidelines alongside other priorities for service development.

3.41 Despite the improvement already made, Audit Scotland concluded that NHSScotland could take further action to manage prescribing more effectively and influence prescribers' prescribing

choices. In particular, there is a need for NHS boards to further develop area-wide prescribing strategies, to manage better repeat prescriptions and for greater sharing of good practice. Further work is also needed to make the most of computerisation in improving the quality and efficiency of prescribing. SEHD is taking action to address the report's findings.

Joint Future Agenda

3.42 The Joint Future Agenda is intended to support better joint working, primarily between health bodies and local authorities, to deliver better services to community care groups. In October 2000, the then Minister for Health and Community Care announced the intention to establish joint resourcing and joint management of community care services to older people.

3.43 SEHD required NHS bodies and local authorities to develop initial Local Partnership Agreements (LPA) by April 2002. The LPA was to set out agreed management structures and arrangements, identifying the resources to be included and confirming whether budgets were to be aligned, ie funds were to be held within the separate budgets of the agencies involved, or pooled, ie the total budget was to be held by one of the partner agencies. NHS bodies and local authorities were also to prepare an action plan, by April 2003, setting out how joint development priorities and plans, joint governance and accountability arrangements and a joint performance management framework were to be agreed. A final LPA, setting out in more detail an agreed financial framework for the operation of the joint management arrangements, was also to be prepared by this date.

3.44 Although still at an early stage, the NHS in Scotland is likely to devote significant sums to the Joint Future Agenda. The auditor of one NHS area indicated that the NHS's share of the aligned health and social work community care budget for 2003/04 was £32 million for joint resourcing. If this figure was replicated across all health areas, the NHS could be spending £350 million to £450 million per annum under the joint management of community care services.

3.45 In some cases, joint management should lead to efficiencies, for example, through single service or locality management services. It may also lead to inflexibilities for the NHS, for example, by restricting the scope to meet cash releasing efficiency targets from budgets already committed to joint services, or to shift resources between budget heads to meet in-year cost pressures. The Joint Future Agenda also raises important issues for how public agencies work together and concerning the accountabilities for public expenditure. Audit Scotland is, therefore, considering how best to include this area in its forward programme of performance audit studies.

Outlook for 2003/04

3.46 At the time of preparing this report, considerable uncertainty remains around the projected financial position of NHS systems. Auditors reported that many NHS boards had not finalised their 2003/04 budgets by the end of June 2003. In turn, this means that trusts had not been notified of their RRLs for the year, or were able to finalise their own budgets. On the basis of funding agreed so far, many trusts were projecting a potential shortfall between funding and planned expenditure. In order to address these shortfalls, trusts are focusing on the implementation of savings plans and reducing new cost pressures.

Part 4. NHS bodies where financial health is of greatest concern

4.1 The 2001/02 NHS overview report highlighted that, based on their draft financial plans for 2002/03, many NHS areas would continue to face financial difficulties and remain dependent on non-recurring income or savings plans to achieve break-even. Auditors expressed concerns about the ability of three specific trusts to achieve financial balance in the future.

4.2 NHS boards are either working towards or have already achieved the integration of trusts. And those who have yet to achieve integration are generally working in a more co-operative and joint manner in the financial management of the NHS area. Nevertheless, because the overall financial prospects for each NHS area are dependent on the finances of its constituent parts, the financial health of trusts is still important. The following paragraphs outline the 2002/03 financial performance and longer-term financial prospects of the NHS bodies highlighted in the previous NHS overview report. In addition, in his report on the 2002/03 audit of Fife NHS Board, the auditor raised significant concerns about the ability of the local trusts to meet planned savings targets.

Lothian University Hospitals NHS Trust

4.3 Lothian University Hospitals NHS Trust (LUHT) has met all its financial targets since its inception in 1999 through the application of non-recurring funding and the implementation of cash releasing efficiency savings. The trust received £40.2 million of non-recurring income (10.5% of total income) during 2001/02.

4.4 During 2001, a pan-Lothian review team was created to work with and support LUHT in the production of an effective and deliverable financial recovery plan for the trust. The review team's report, in January 2002, estimated that LUHT would experience a shortfall between income and expenditure of £95 million in the four-year period 2002/03 to 2005/06. The shortfall was associated with five key business cases in the course of implementation, including the development of the new Royal Infirmary of Edinburgh (RIE) and the Anne Ferguson Building. NHS Lothian's then extant financial recovery plan showed that further savings plans, the use of capital receipts arising from the sale of the old RIE site and other measures would result in savings of £55 million over the four-year period. An NHS Lothian-wide strategic change initiative was intended to deliver the other £40 million savings required.

4.5 Since the review team announced its findings in January 2002, LUHT has re-examined its financial projections and produced a number of iterations to its five-year financial plan. The trust's five-year plan to 2006/07, dated May 2002, showed a projected cumulative deficit over the period of £11.7 million. Cumulative deficits in the first three years were to be offset by surpluses in years four and five. The financial plan was, however, dependent on NHS Lothian providing £9.4 million in 2003/04 and £14.8 million per annum thereafter, through a combination of non-recurring support and savings from specific projects, to allow the full

Exhibit 22: LUHT's March 2003 financial plan projected funding gaps

	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000	2007/08 £000
Category 1 costs	25,337	27,191	27,927	28,648	29,169
Category 2 costs	2,956	3,069	3,016	3,340	4,344
Category 3 costs	11,390	12,653	12,533	12,587	12,580
Total	**39,683**	**42,913**	**43,476**	**44,575**	**46,093**
Trust savings plans	(2,627)	(3,728)	(9,548)	(10,548)	(10,548)
Projected funding gap	**37,055**	**39,185**	**33,928**	**34,027**	**35,545**

Source: Auditor's final report on the 2002/03 audit of LUHT

commissioning of the new RIE and the Anne Ferguson Building. In his final report on the 2001/02 audit, LUHT's external auditor considered there was a risk that the financial plan may not be deliverable, and that the projected cumulative deficit may be higher.

4.6 In 2002/03, LUHT had a net resource outturn of £406.5 million against its RRL set by Lothian NHS Board of £406.6 million. During the year, the trust received £64.6 million of non-recurring income, equivalent to almost 18% of total income. The most significant elements of non-recurring funding received included Lothian NHS Board's provision of £16.9 million to fund non-recurring double running costs associated with the commissioning of the new RIE, and £14.2 million capital to revenue transfers also in respect of non-recurring expenditure. Income from Lothian NHS Board also included £8.2 million non-recurring funding to support the underlying recurring financial deficit for 2002/03. Given its significance, LUHT's management team now monitors non-recurring income on a monthly basis.

4.7 The trust began reviewing its May 2002 financial plan in November 2002. The revised plan, dated March 2003, identified three categories of cost pressure:

- **Category 1** – where LUHT is seeking confirmation that these pressures will be fully funded. The trust intends, where possible, not to commit expenditure on these pressures without first having an agreed funding source
- **Category 2** – where costs are regarded as entirely unavoidable and a funding source has yet to be identified
- **Category 3** – where the pressures are without a funding source and LUHT intends either to prevent the pressure or to provide funding by re-prioritising resources.

4.8 The March 2003 financial plan identified that LUHT's projected funding gap, excluding receipt of agreed brokerage funding, was now significantly greater than that indicated in the May 2002 plan. The March 2003 plan forecast a cumulative shortfall of nearly £180 million in the five years to 2007/08 (Exhibit 22). The plan was subject to a number of assumptions, including:

- savings of £7.5 million arising from the implementation of changes to the delivery of care of the elderly services are generated in full and from the start of 2006/07
- the cost of planned national uplifts, such as the new consultants' contracts, routine pay awards and the implementation of Agenda for Change, are fully funded
- savings identified following the pan-Lothian review are achieved in full.

4.9 There are four main reasons why the projected funding gap identified in the March 2003 financial plan differed from that set out in the May 2002 plan:

- reductions in the anticipated costs of pressures identified in the May 2002 plan totalling £10.1 million over the five years to 2007/08

Exhibit 23: Adjustments to take LUHT's March 2003 financial plan into balance

	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000	2007/08 £000
Projected funding gap (March 2003 plan)	(37,055)	(39,185)	(33,928)	(34,027)	(35,545)
NHS Lothian funding	8,554	9,194	10,570	11,133	11,133
Other NHS bodies funding	2,640	2,940	3,240	3,330	3,330
Specific initiatives funding	2,317	2,317	2,317	2,317	2,317
Hospital Information System savings	-	500	1,000	1,500	1,500
Risk tolerances	7,646	7,619	7,533	7,533	7,533
Cash releasing efficiency savings (CRES)	4,000	8,000	12,000	16,000	20,000
Brokerage	5,598	6,244	-	-	-
Deferred income	2,000	-	-	-	-
Capital receipts	4,300	-	-	-	-
Reinvestment of CRES	-	(2,000)	(4,000)	(6,000)	(10,000)
Final position	**-**	**(4,371)**	**(1,268)**	**1,786**	**268**

Source: Auditor's final report on the 2002/03 audit of LUHT

- increases in the anticipated costs of pressures identified in the May 2002 plan totalling £54.3 million in the period to 2007/08. The main cost increases arise from the introduction of shift rotas for junior doctors which are compliant with the EU Working Time Directive, and the costs of cancer drugs and medical equipment

- new pressures identified since the preparation of the May 2002 plan totalling £92.8 million in the period to 2007/08

- the exclusion, on the grounds of prudence, of savings and other income previously included in the May 2002 plan which LUHT could not guarantee. These include savings of £1.6 million in 2003/04, rising to £2.5 million recurring by 2005/06, generated from the introduction of an improved Hospital Information System, and £9 million receipts from the disposal of land at the old RIE site which are contingent on the appropriate planning permission being granted.

4.10 LUHT has subsequently worked with Lothian NHS Board to reduce the level of the projected funding gap. By June 2003, discussions had progressed, enabling LUHT's management team to approve a balanced financial position for 2003/04 (Exhibit 23). The auditor has reported that the LUHT director of finance's professional view is one of concern about the challenges the assumptions in the plan present to the trust.

4.11 The auditor considers that, on the basis of the financial information available to him, the implementation of components of LUHT's financial plan represent a significant management challenge. As such, there remains a substantial risk that the outturn projected in the financial plan will not be achieved. The auditor considers the achievement of the five-year plan will be conditional on whether:

- the trust is able to achieve cash releasing efficiency savings in addition to those already identified under the pan-Lothian review process

- savings from the introduction of the Health Information System can be secured, despite the project being behind schedule

- the trust can remove or successfully manage recognised cost pressures

- in collaboration with Lothian NHS Board, LUHT can secure the anticipated increase in income from non-Lothian NHS bodies.

4.12 Since March 2002, the various reiterations of LUHT's financial plans have resulted in widely different forecast financial positions. The latest financial plan forecasts that LUHT will achieve a balanced financial position for 2003/04. However, LUHT reported an adverse variance of £6.6 million against its budget in the period from April to September 2003. The reasons for the overspend include the implementation of the New Deal for junior doctors, double running costs associated with the opening of the new RIE, and the under-achievement of cash releasing efficiency savings.

NHS Argyll and Clyde

4.13 During 2001/02, NHS Argyll and Clyde identified that it faced a significant underlying deficit of over £6 million. It subsequently agreed a financial recovery plan covering the five years to 2006/07 designed to bring the NHS area into recurring and sustainable financial balance. The external auditor considered there were a number of risks to the successful delivery of the plan. These included: that the costs of future key strategic challenges, such as acute services reconfiguration, were not included in the plan; that Argyll and Clyde Acute Hospitals NHS Trust (ACAHT) was required to deliver £2.7 million savings in 2002/03; and that there were limited contingency funds available to meet unfunded cost pressures likely to be experienced in 2002/03.

4.14 The financial performance of ACAHT was seen to be a key factor in determining whether the recovery plan is achieved. Since its inception, the trust has had a recurring deficit. ACAHT has received recurrent funding to alleviate these deficits but has, nevertheless, relied on non-recurring monies to manage other in-year pressures. During 2001/02, Argyll and Clyde NHS board provided ACAHT with 'one-off' non-recurring funding of £7.0 million. This enabled the trust to report an operational surplus, but was insufficient to enable it to clear its accumulated deficit which stood at £1.7 million at 31 March 2002.

4.15 In September 2002, at the request of the chairman of Argyll and Clyde NHS Board, the Minister for Health and Community Care announced the appointment of an expert support group to assist in resolving long-standing managerial issues within the local health structure. Following receipt of the support group's findings in December 2002, a new interim management team replaced the chief executives of Argyll and Clyde NHS Board and all three trusts in the area.

4.16 During 2002/03, the financial position of NHS Argyll and Clyde was managed on a system-wide basis. Argyll and Clyde NHS Board and all three local trusts reported an overspend against their RRLs, with the total excess being £9.6 million. This was despite the application of non-recurring income such as disposal receipts, capital to revenue transfers and slippage in the use of ring-fenced monies. The interim management team calculated that, without this non-recurring funding, there was a recurring operational deficit of £31.4 million across NHS Argyll and Clyde in 2002/03.

4.17 ACAHT's share of the excess against its RRL was £4.8 million (RRL £163.4 million). The excess relates to the deficit of £1.7 million brought forward from 2001/02 plus an excess of £3.1 million during 2002/03. The 2002/03 excess is primarily due to increased patient activity combined with a number of unavoidable cost pressures and unachieved cost reduction targets. In particular, due to increased patient activity, ACAHT was unable to achieve planned savings on the use of agency and bank staff. There were, therefore, significant overspends against budget on medical and nursing pay. Expenditure on drugs and medical supplies was also in excess of budgets as a result of increased patient activity.

4.18 In July 2003, the local trusts in Argyll and Clyde were dissolved, in-line with SEHD's proposals for a single tier health system. As part of the move to the new organisation, NHS Argyll and Clyde completed a fundamental review of its finances to support the development of a new financial recovery plan. The plan forecasts that recurring financial balance will be achieved in 2007/08. The plan assumes less reliance on non-recurring funding but does not include any potential costs arising from service reviews, such as the future provision of maternity services and general surgery. Nor does it indicate how excesses against revenue resource limits in 2002/03 or subsequent years will be recovered. Overall, however, because of the comprehensive nature of the financial review which underpinned it, the auditor considers the current plan is more robust than previous financial recovery plans. That said, the auditor considers that NHS Argyll and Clyde's cumulative deficit could reach £60 to £70 million by 2007/08 (approximately 10% of annual funding) and may be irrecoverable.

4.19 NHS Argyll and Clyde's financial plan for 2003/04 projects a planned system deficit of £22.3 million, excluding £5 million non-recurring funding which is expected to be generated. The plan is dependent on achieving recurrent savings of £13.2 million. The auditor has commented that NHS Argyll and Clyde has a history of not meeting savings targets, and real cost reductions of this scale would be daunting for any NHS system.

4.20 NHS Argyll and Clyde is developing its financial governance framework to support the delivery of the new financial recovery plan. It is important that managers in the new organisational structure have clear responsibilities and are held accountable for achieving agreed financial plans. In this respect, the establishment of a multidisciplinary Financial Recovery Group of senior officers reporting through the Senior Executive Group to the Finance Committee is a significant development.

Grampian University Hospitals NHS Trust

4.21 During 2001/02, Grampian University Hospitals NHS Trust (GUHT) was able to eliminate its cumulative deficit and reduce its in-year deficit to £5.2 million as a result of Grampian NHS Board's provision of 'one-off' additional funding. GUHT prepared a financial recovery plan (as part of a wider NHS Grampian Action Plan to address a number of issues facing the unified board) which envisaged that the trust would incur in-year deficits over the next two years but would break even in 2004/05. The financial recovery plan contains a number of measures designed to contain and reduce costs. A consultants' review of the recovery plan in September 2001, however, reported that a number of key risks existed to GUHT achieving the plan. These included that planned savings and cost reductions appeared ambitious, and that an income source had yet to be identified to meet the costs of achieving waiting list targets.

4.22 In his final report on the 2001/02 audit, GUHT's auditor concluded that it was not possible to determine whether the initiatives being taken would ensure the long-term viability of the trust. The auditor noted that the NHS Grampian Action Plan indicated that GUHT was operating at around 10% above the levels suggested by funding availability. In the auditor's view, the achievement of the trust's £4.5 million planned deficit for 2002/03 was dependent on a number of factors, including planned asset sales or other funding to address cost pressures. In order for GUHT to achieve financial balance in the medium to long-term, Grampian NHS Board needed to specify clearly the level of funding to be made available to the trust and the nature and levels of healthcare services it expected to be delivered.

4.23 In 2002/03, GUHT had a net resource outturn of £265.4 million against its RRL set by Grampian NHS Board of £260.2 million. The £5.2 million excess against the revenue resource limit wholly relates to the deficit brought forward from 2001/02. This performance was achieved, however, as a result of SEHD approving brokerage funding of £3.4 million and Grampian NHS Board providing non-recurring support of £2.1 million. The auditor notes that without this brokerage and non-recurring support, GUHT would have exceeded its RRL for 2002/03 irrespective of the brought forward deficit.

4.24 The 2003/04 RRL for NHS Grampian is £540 million, an increase of almost 8% on the 2002/03 limit. While this is a substantial increase, much of the extra funding is likely to be incurred on increased staff costs including employers' superannuation and National Insurance contributions, pay awards and modernisation of terms and conditions of service. NHS Grampian has produced a balanced financial plan for 2003/04, but this is dependent on the achievement of £5 million efficiency savings and the use of £12.1 million income from the sale of surplus assets. In the auditor's view, therefore, GUHT faces significant financial challenges in 2003/04 and beyond.

4.25 GUHT has agreed a plan which will enable it to repay the brokerage to SEHD and to recover its accumulated deficit by the end of 2005/06. As part of its discussions with SEHD over the plan, GUHT also reviewed the initiatives in the NHS Grampian Action Plan to ensure they will secure long-term financial viability. GUHT's director of finance has identified a number of significant issues that NHS Grampian needs to address if financial recovery is to be achieved:

- NHS Grampian will face an on-going challenge to avoid above inflation price increases and make efficiency savings from an already low cost organisation, while continuing to meet the demand for healthcare

- NHS Grampian needs to refine the nature and level of activity it expects to be delivered by secondary care services and how it will invest in those services. A planned performance template has been designed to help identify the levels of healthcare services to be delivered and the resources required, but the template needs further refinement

- there is concern about the lack of change proposals being presented to the trust's Savings Programme Project Board. More needs to be done to introduce changes which will contribute to the high level of cost reduction demanded by the financial pressures facing the trust

- there is a need for NHS Grampian to realign itself to meet increased costs arising from the new consultants' and General Medical Services contracts and the EC Working Times Directive.

NHS Fife

4.26 During its financial planning for 2002/03, the NHS Fife system identified an underlying financial deficit of £9.6 million spread across Fife NHS Board, Fife Acute Hospitals NHS Trust (FAHT) and Fife Primary Care NHS Trust (FPCT). As a result, SEHD asked NHS Fife to develop a five-year financial action plan, later extended to cover the ten-year period to 2011/12. The three NHS bodies worked together to produce the action plan, building on earlier financial recovery plans, the ongoing work of the Fife NHS Review Group project and individual recovery planning at each body.

4.27 Both trusts achieved their RRL targets in 2002/03 despite experiencing difficulty in achieving their overall savings targets of £3 million. The auditor reported that the trusts used £9.6 million non-recurring income in 2002/03 to assist in the achievement of RRL targets. Sources of non-recurring income included £2.2 million net revenue support from Fife NHS Board, £1.7 million capital to revenue transfers and £2.2 million accumulated surpluses brought forward. SEHD also provided both trusts, via Fife NHS Board, with £8.0 million non-recurring income. This money was ring-fenced to fund specific initiatives and was not used to support the recurring financial position.

4.28 In 2002/03, Fife NHS Board underspent against its RRL of £322.7 million. The £3.0 million underspend was largely due to the late return by trusts of unspent, ring-fenced budgets.

4.29 In his final report on the 2002/03 audits, the auditor made three fundamental points about the non-recurring funding received.

- The significant funding provided to both trusts to support new initiatives, future developments and to cover bridging costs while services are developed is of a short-term nature. Specifically in relation to FPCT, the ability of the trust to take forward future developments and initiatives, and to secure the transfer of services to new community settings or arrangements, depends upon the scope for further cash releasing cost reductions, the level and range of services provided and from service redesign arising from the implementation of the Right for Fife strategy.[11]
- Initiative monies should be matched with specific expenditure needs and should offer no assistance in achieving a balanced recurring budget.
- While both trusts received additional revenue support funding to alleviate in-year deficits, future planning to achieve financial balance year-on-year should not depend upon this as a recurring funding source.

4.30 NHS Fife's financial planning for 2003/04 also identified a significant financial imbalance. This was largely the result of unmet savings targets from the previous year, increased prescribing costs, the full-year effect of pay awards and the dependency in 2002/03 on non-recurring funding not expected to be available in 2003/04. NHS Fife did not produce for approval its final financial plans for 2003/04 until after 31 March 2003 so as to ensure that the financial position could be fully considered. Fife NHS Board, therefore, made an interim allocation of funds to the trusts pending the further consideration of savings proposals for 2003/04 and beyond. The board approved a management plan setting out the savings proposals in July 2003. In view of the late finalisation of the 2003/04 financial plan, together with the trusts' past difficulties in securing recurring savings, the auditor has significant concerns about the ability of the trusts to meet the necessary savings targets.

4.31 In March 2003, at the request of the chief executive of Fife NHS Board, the appointed auditor reviewed financial monitoring and the recovery planning process within the NHS Fife system. The review found several aspects of good financial management, but also scope for improvement (Exhibit 24). NHS Fife has welcomed the auditor's report. The action being taken to address its findings is that set out in paragraph 2.40.

11 'Right for Fife' is NHS Fife's plan to modernise acute and primary care health services in the region. The Minister for Health and Community Care approved the plan in December 2002. The overall approach is integrated and covers Mental Health, Learning Disability, Elderly Care, Children and Community/Primary Care as well as acute. A key element of the plan proposes that the Queen Margaret Hospital, Dunfermline and Victoria Hospital, Kirkcaldy will both continue to provide a range of services. Victoria Hospital will become the specialist acute in-patient centre.

Exhibit 24: Financial monitoring and recovery planning in NHS Fife

In February 2003, the chief executive of Fife NHS Board asked its appointed auditor to review financial monitoring and the recovery planning process within the NHS Fife system. The auditor's key findings were:

- *Financial monitoring and reporting*. Budget holders receive timely financial information, including variance analysis. The style, content and degree of detail contained in finance and activity reports vary. For FAHT, the report provides a good summary of the financial position and activity levels. There is, however, scope for both Fife NHS Board and FPCT to enhance financial reporting by incorporating projected outturns in the budget performance and financial summary statements. There is also scope to consider the timing of FAHT's board and trust management team meetings so that they coincide with the availability of up-to-date and accurate financial outturn information. Overall, there is a need to reduce the significant variance in the reporting time-frames operated by all three bodies which can lead to a delay in the reporting of the NHS Fife financial system as a whole.

- *Outturn projections*. The methodology applied by both Fife NHS Board and FAHT to forecast projected outturns is well-documented and reasonably robust. Financial forecasts are, however, largely a linear projection of trends and there is scope for greater use of judgement. There is also scope for greater detailed input from budget holders and directorates in the forecasting of outturn at FPCT. The reporting of outturn projections of the Fife-wide financial position is inconsistent.

- *Cash releasing efficiency savings*. All three NHS Fife bodies were expected to achieve cash releasing efficiency targets in 2002/03. While budget-holders in Fife NHS Board and FPCT monitored outturn against budgets which were reduced to reflect agreed savings, the auditor was unable to identify clear and specific plans setting out how these savings targets were to be achieved. Only FPCT reported detailed progress against the targets to the trust management team.

- *Financial recovery planning*. Each health body identified savings for inclusion in the recovery plan. Only FAHT prepared a detailed, risk-assessed and aligned action plan capable of being used as a focus for management and for monitoring purposes. On a Fife-wide basis, various review groups were tasked with identifying specific savings, but a lack of detailed action plans resulted. The financial recovery process involved the three directors of finance. Greater involvement of their deputes could have helped identify the likelihood of successful implementation of some of the savings proposals.

Source: NHS Fife's auditor's report *Financial Monitoring and Recovery Planning*, July 2003

Appendix 1. Special health boards and other NHS bodies in Scotland

Special health boards

National Waiting Times Centres Board * – Established in July 2002 following SEHD's purchase of the former HCI hospital at Clydebank for the NHS. The Centre's prime role is to increase the capacity and activity of NHSScotland so as to help reduce the time people wait for treatment. It helps, in particular, by treating patients who have been waiting longest.

NHS 24 * – Established in April 2001. Provides a nurse-led advice, referral and health and healthcare information service through a network of contact centres, including an improved and more appropriate response to 999 callers who do not require the immediate despatch of an ambulance. The service is currently available in the Grampian and Greater Glasgow area and is expected to be available to the whole of Scotland by the end of 2004.

NHS Education for Scotland * – Established in April 2002, bringing together the National Board for Nursing, Midwifery and Health Visiting for Scotland, the Post-Qualification Education Board for Health Service Pharmacists and the Scottish Council for Postgraduate Medical and Dental Education. NHS Education for Scotland promotes best practice in the education and lifelong learning of all NHSScotland staff through educational development, quality assurance of educational provision, facilitation of continuing professional development and the management of educational programmes.

NHS Health Scotland * – Established in April 2003 bringing together the Health Education Board for Scotland and the Public Health Institute for Scotland, NHS Health Scotland is the national focus for health improvement in Scotland. Responsible for delivering health improvement programmes to a wide variety of audiences and stakeholders working to improve Scotland's health, empoying knowledge about health and its determinants in a way that infuences policy and practice to improve health in Scotland. It is also expected to play a key role in the successful implementation of programmes of health improvement.

NHS Quality Improvement Scotland * – Established in January 2003, bringing together the Clinical Standards Board for Scotland, the Clinical Resource and Audit Group, the Health Technology Board for Scotland, the Nursing and Midwifery Practice Development Unit and the Scottish Health Advisory Service. NHS Quality Improvement Scotland is expected to co-ordinate the work of Scotland's clinical effectiveness organisations through the development of a national strategy for improving the quality of patient care. It also advises NHSScotland on the clinical and cost-effectiveness of new and existing health technologies.

Scottish Ambulance Service * – Provides accident and emergency and non-emergency services to the people of Scotland from a total of 152 locations. A&E ambulance crews are trained in pre-hospital care and life-saving techniques and to respond to 999 calls and other requests for emergency ambulances. The Patient Transport Service provides transport to people to, and from, hospitals, clinics and day centres who do not require an emergency service but whose medical condition still generates a need for ambulance transport.

State Hospitals Board for Scotland * – Provides secure psychiatric care to patients who, because of mental illness, have dangerous, violent or criminal propensities. At any one time, care is provided to some 250 patients (some 70% of whom suffer from schizophrenia and around half have multiple diagnosis) by 550 staff organised in multi-disciplinary teams.

Other NHS bodies

Common Services Agency * – Supports NHSScotland through providing and co-ordinating essential national and regional services, including the Scottish National Blood Transfusion Service, the Scottish Centre for Infection and Environmental Health, the collation and publication of health statistics, the provision of specialist legal and procurement services and the payment of family health practitioners.

Mental Welfare Commission for Scotland * – Responsible for protecting people who may, by reason of mental disorder (including learning disabilities and dementia), be incapable of protecting themselves or their interests adequately. Work includes visiting people in hospital and in the community, investigating cases of deficiency in care or treatment and providing information and advice.

Scottish Hospital Trust * – Distributes the incomes and endowments transferred to it among NHS boards, trusts and the State Hospitals Board for Scotland. Under the Public Appointments and Public Bodies etc (Scotland) Act 2003, the Scottish Hospital Trust is to be dissolved, although this will not take effect until a commencement order is made.

Non-Departmental Public Bodies sponsored by SEHD

Executive NDPBs

Scottish Commission for the Regulation of Care * – Established in April 2002. Responsible for the regulation of care services including care homes for adults, residential care for children, childminding, care at home, fostering and adoption agencies, nurse agencies and independent healthcare services.

Scottish Hospitals Endowment Research Trust * – Receives and holds endowments, donations and bequests and makes grants from these funds to promote medical research in Scotland.

Scottish Medical Practices Committee – Responsible for ensuring there is an adequate number of GPs providing general medical services in Scotland. Under the Public Appointments and Public Bodies etc (Scotland) Act 2003, the Scottish Medical Practices Committee is to be dissolved, although this will not take effect until a commencement order is made.

Advisory NDPBs

Scottish Advisory Committee on Distinction Awards – Advises the Scottish Ministers on which consultants working in the NHS in Scotland should receive distinction awards in recognition of outstanding professional work.

Scottish Advisory Committee on the Medical Workforce – Advises the Scottish Ministers on all matters relating to medical workforce planning in Scotland, other than matters relating to terms and conditions of service.

* The accounts of these bodies are subject to audit by the Auditor General for Scotland or auditors appointed by the Auditor General for Scotland under the Public Finance and Accountability (Scotland) Act 2000.

Appendix 2. Aims, objectives and targets of the NHS in Scotland

Aim:	To improve the health and the quality of life of the people of Scotland and deliver integrated health and community care services, making sure there is support and protection for those members of society who are in greatest need.
Objective 1:	Work towards a step change in the life expectancy for Scots, particularly disadvantaged members of the community, including children and older people.
Targets	• Achieve a 50% reduction in death from coronary heart disease in people under 75 between 1995 and 2010. • Achieve a 20% reduction in death from cancer in people under 75 between 1995 and 2010. • Achieve a 50% reduction in death from cerebrovascular disease (stroke) in people under 75 between 1995 and 2010. • Achieve a reduction in smoking from 35% to 33% between 1995 and 2005 and to 31% by 2010. • Achieve a reduction in the incidence of adults exceeding weekly drinking limits for men from 33% to 31% between 1995 and 2005 and to 29% by 2010 and for women from 13% to 12% between 1995 and 2005 and to 11% by 2010.
Objective 2:	Ensure that health care providers provide swift and appropriate access to integrated health care, covering primary, community and acute care.
Targets	• Ensure access to a GP, nurse or other health care professional within 48 hours by April 2004. • No patient should wait longer than 26 weeks for a new outpatient appointment by the end of 2005. • No patient should wait longer than 2 months from urgent referral to treatment for all cancer cases by the end of 2005. • No patient should wait more than 6 months from diagnosis for inpatient treatment by the end of 2005.
Objective 3:	Improve the patient's experience of services provided by the NHS.
Targets	• Bring 12,000 nurses and midwives into the NHS by 2007. • Develop a national framework for improving the quality of clinical care by April 2004. • All hospitals to have made significant progress towards Clinical Standards Board for Scotland standards on infection control and clean hospitals by April 2003 and to make further progress each year thereafter.
Objective 4:	Improve services for older people, at home and in care settings.
Targets	• Progressively enable a greater number of older people to live and be cared for in their own homes in each year to March 2006. • Ensure by 2005 that all those with unmet need for free personal care are identified and receive the services they need.

Source: *The Scottish Executive Draft Budget 2004-05*, September 2003

Appendix 3. Financial performance of NHS areas 2002/03

	Revenue Resource Limit £000	Revenue Resource Outturn £000	Variance under/ (over) £000	Capital Resource Limit £000	Capital Resource Outturn[12] £000	Variance under/ (over) £000
Argyll and Clyde NHS Board	435,462	434,880	582	10,773	10,514	259
Argyll and Clyde Acute Hospitals NHS Trust	163,412	168,229	(4,817)	2,951	3,057	(106)
Lomond and Argyll Primary Care NHS Trust	76,086	77,797	(1,711)	1,800	1,800	0
Renfrewshire and Inverclyde Primary Care NHS Trust	130,365	134,054	(3,689)	5,763	5,763	0
Ayrshire and Arran NHS Board	381,281	375,645	5,636	7,384	7,245	139
Ayrshire and Arran Acute Hospitals NHS Trust	169,648	169,648	0	6,014	6,060	(46)
Ayrshire and Arran Primary Care NHS Trust	163,774	163,774	0	1,207	1,170	37
Borders NHS Board	109,720	109,394	326	2,775	2,735	40
Borders General Hospital NHS Trust	43,568	43,568	0	1,569	1,563	6
Borders Primary Care NHS Trust	49,514	49,514	0	1,166	1,047	119
Dumfries and Galloway NHS Board	159,753	157,442	2,311	1,863	1,863	0
Dumfries and Galloway Acute and Maternity Hospitals NHS Trust	62,476	62,476	0	1,782	1,782	0
Dumfries and Galloway Primary Care NHS Trust	74,330	74,330	0	81	81	0
Fife NHS Board	322,731	319,753	2,978	7,117	6,891	226
Fife Acute Hospitals NHS Trust	117,382	117,382	0	4,701	4,616	85
Fife Primary Care NHS Trust	156,048	155,970	78	2,190	2,190	0
Forth Valley NHS Board	269,363	269,363	0	7,753	7,656	97
Forth Valley Acute Hospitals NHS Trust	113,898	113,898	0	3,586	3,476	110
Forth Valley Primary Care NHS Trust	125,045	125,045	0	4,349	4,369	(20)
Grampian NHS Board	500,108	499,738	370	20,664	20,522	142
Grampian University Hospital NHS Trust	260,234	265,433	(5,199)	16,108	16,108	0
Grampian Primary Care NHS Trust	224,860	224,860	0	4,403	4,403	0
Greater Glasgow NHS Board	1,034,677	1,022,542	12,135	41,611	41,218	393
North Glasgow University Hospitals NHS Trust	439,360	439,360	0	18,941	19,935	6
South Glasgow University Hospitals NHS Trust	214,533	214,533	0	9,079	9,079	0
Yorkhill NHS Trust	81,924	81,921	3	4,327	4,327	0
Greater Glasgow Primary Care NHS Trust	372,527	372,502	25	6,806	6,754	52

12 The NHS board CRL is the cumulative position for the NHS area and should not, therefore, be added to the individual constituent trust' CRLs.

	Revenue Resource Limit £000	Revenue Resource Outturn £000	Variance under/ (over) £000	Capital Resource Limit £000	Capital Resource Outturn[12] £000	Variance under/ (over) £000
Highland NHS Board	222,063	221,621	442	9,751	9,749	2
Highland Acute Hospitals NHS Trust	93,827	93,827	0	4,799	4,799	0
Highland Primary Care NHS Trust	110,510	110,510	0	4,924	4,924	0
Lanarkshire NHS Board	540,965	548,307	(7,342)	8,305	8,305	0
Lanarkshire Acute Hospitals NHS Trust	235,388	238,215	(2,827)	3,988	3,988	0
Lanarkshire Primary Care NHS Trust	239,295	239,295	0	4,350	4,330	20
Lothian NHS Board	747,875	739,491	8,384	142,063	142,063	0
Lothian University Hospitals NHS Trust	406,578	406,501	77	137,110	137,635	(525)
Lothian Primary Care NHS Trust	251,990	251,990	0	2,476	2,476	0
West Lothian Healthcare NHS Trust	119,468	119,468	0	1,954	1,954	0
Orkney NHS Board	23,813	23,813	0	537	537	0
Shetland NHS Board	30,205	29,931	274	1,638	1,538	100
Tayside NHS Board	443,176	438,846	4,330	6,845	6,845	0
Tayside University Hospitals NHS Trust	232,613	232,613	0	5,870	5,870	0
Tayside Primary Care NHS Trust	215,379	215,379	0	872	872	0
Western Isles NHS Board	44,713	44,512	201	1,143	1,144	(1)

NHS Argyll and Clyde

NHS Argyll and Clyde provides health services to a population of 421,000. Most of the population live in densely populated urban areas (some of which have very high levels of illness), but a considerable number also live in remote and rural areas.

Argyll and Clyde NHS Board underspent against its Revenue Resource Limit (RRL) of £435.5 million in 2002/03 by £0.6 million. The underspend relates to slippage on cancer services projects and will be carried forward to 2003/04. The Board also remained within its Capital Resource Limit (CRL) and achieved its Cash Requirement Target of £455.0 million.

Argyll and Clyde Acute Hospitals NHS Trust exceeded its RRL of £163.4 million for 2002/03 by £4.8 million. The excess relates to a £1.7 million deficit carried forward from 2001/02 plus £3.1 million incurred in 2002/3, mainly as a result of increased patient activity, cost pressures and unachieved cost reduction targets. The trust also exceeded its CRL by a small amount.

Lomond and Argyll Primary Care NHS Trust exceeded its RRL of £76.1 million for 2002/03 by £1.7 million. Net operating costs increased by £7.5 million (8.4%) during 2002/03, mainly as a result of increased family health service costs (£3.7 million) and staff costs (£3.9 million). The Board also provided the trust with £3.9 million non-recurrent funding for a variety of development and in-year cost pressures. SEHD also approved a £1.3 million capital to revenue transfer. The trust met its CRL.

Renfrewshire and Inverclyde Primary Care NHS Trust exceeded its RRL of £130.1 million for 2002/03 by £3.7 million. Net operating costs increased by £13.1 million (8.5%) during 2002/03, mainly as a result of increased family health service costs. The Board also provided the trust with £4.6 million non-recurrent funding for a variety of development and in-year cost pressures. SEHD also approved a £0.5 million capital to revenue transfer. The trust met its CRL.

During 2002/03, the financial position of NHS Argyll and Clyde was managed on a system-wide basis. The local trusts were dissolved in July 2003. Further details on NHS Argyll and Clyde's financial plans are at paragraphs 4.13 to 4.20 of the main report.

NHS Ayrshire and Arran

NHS Ayrshire and Arran provides health services to a population of 377,000. The age structure of the population is similar to the rest of Scotland, with an increasing number of elderly people. Levels of illness and deprivation are above the Scottish average and are relatively high.

Ayrshire and Arran NHS Board underspent against its RRL of £381.3 million in 2002/03 by £5.6 million. Some £3.7 million of the underspend relates to specific allocations, which it was not possible to utilise in 2002/03, and other earmarked funds, some of which are held on behalf of the local trusts. SEHD has given approval for the remaining underspend to be carried forward to support the 2003/04 revenue position. The Board also remained within its CRL and achieved its Cash Requirement Target of £384.0 million.

Ayrshire and Arran Acute Hospitals NHS Trust remained within its RRL of £169.6 million during 2002/03. This was achieved through utilisation of its £1.0 million accumulated surplus brought forward from the previous year and as a result of slippage on approved revenue developments. The trust's net costs during the year increased by £15.1 million compared to 2001/02. Some two-thirds of the increase was due to increased staff costs. This was mainly as a result of pay awards, increased employer's superannuation contributions, increased agency costs and increases due to junior doctors (New Deal) and in respect of the low payment agreement. The trust marginally exceeded its CRL.

Ayrshire and Arran Primary Care NHS Trust also remained within its RRL of £163.8 million during 2002/03. This was achieved through utilisation of its £1.0 million accumulated surplus brought forward from the previous year and of £1.0 million deferred income. Ayrshire and Arran NHS Board also provided £0.8 million non-recurring funding. The trust's net costs during the year increased by £17.2 million compared to 2001/02. Some two-thirds of the increase was due to increased family health services costs, in particular, drug-prescribing costs. Staff costs also increased due to pay awards, increased employers' superannuation contributions and in respect of the low payment agreement. The trust also remained within its CRL.

NHS Ayrshire and Arran's financial plans for 2003/04 identifies a planned balanced financial position. The plan recognises a range of cost pressures, the most significant of these being pay related increases of around £15.2 million, and prescribing cost pressures of around £7.5 million. The financial plan also recognises an underlying recurrent deficit of £3.2 million for the acute trust. This is to be managed through the Board's provision of £2.3 million non-recurring funding (sourced from the carry-forward of unspent balances from 2002/03 and through property sales) and through £0.9 million efficiency savings. The primary care trust will also receive £2.3 million on a non-recurring basis and is expected to make £0.9 million efficiency savings. The auditor considers that both trusts will face significant financial challenges in 2003/04 and beyond.

NHS Borders

NHS Borders provides health services to a population of 106,000. Borders has the highest proportion of elderly people in its population of any health area in Scotland. It also has a high proportion of people living in remote and rural areas, although levels of morbidity and deprivation are among the lowest in Scotland.

Borders NHS Board underspent against its RRL of £109.7 million in 2002/03 by £0.3 million. The underspend is a result of underspends by both trusts (£0.65 million returned to the Board as reductions in RRLs), brokerage received (£0.4 million) and expenditure slippages (£0.7 million), offset by a £1.4 million overspend in unplanned activity. The Board also underspent by a small amount against its CRL and achieved its Cash Requirement Target of £113.7 million.

Borders General Hospital NHS Trust and Borders Primary Care NHS Trust both remained within their RRLs (£43.6 million and £49.5 million respectively) during 2002/03. This was achieved through utilisation of accumulated surpluses brought forward from the previous year (£0.1 million and £0.8 million) and use of deferred income (£0.8 million). In common with many trusts, both Borders General Hospital NHS Trust and Borders Primary Care NHS Trust faced cost pressures during the year arising from the EU Working Time Directive, the New Deal for junior doctors and drugs cost increases. Both trusts also remained within their CRLs.

During 2001/02, the three health bodies produced a financial recovery plan to address NHS Borders' underlying financial deficit of approximately £2.5 million. Following the integration of the three health bodies and the dissolution of the two trusts in April 2003, the joint plan was updated in May 2003. The current recovery plan shows financial balance for each of the five years to 2007/08, except 2003/04, where a deficit of £0.3 million is forecast.

The plan is, however, dependent on NHS Borders achieving savings targets of £4.2 million over the next five years and receiving £4.0 million brokerage over the three years to 2005/06 (with repayment due in 2006/07 and 2007/08). NHS Borders considers that savings in management costs of over £0.4 million in 2003/04 will arise from the integration of trusts and has identified further savings of £0.3 million. The external auditor notes, however, that most of the other easily identifiable savings have now been made. The SEHD has also yet to formally approve the additional brokerage sought.

NHS Dumfries and Galloway

NHS Dumfries and Galloway provides health services to a population of 148,000. The proportion of elderly people in the population is high, but levels of ill health and deprivation are below the Scottish average.

Dumfries and Galloway NHS Board underspent against its RRL of £159.8 million in 2002/03 by £2.3 million. The underspend is to be carried forward to 2003/04 to fund future cost pressures and specific purposes and slippage in other projects. The Board also remained within its CRL and achieved its Cash Requirement Target of £158.1 million.

Dumfries and Galloway Acute and Maternity Hospitals NHS Trust and Dumfries & Galloway Primary Care NHS Trust both remained within their RRLs (£62.5 million and £74.3 million respectively) during 2002/03. This was achieved through utilisation of accumulated surpluses brought forward from the previous year (£0.7 million and £0.3 million). Both trusts also remained within their CRLs.

The acute trust's net costs during the year increased by £4.2 million compared to 2001/02. Some two-thirds of the increase was due to increased staff costs mainly associated with the EU Working Time Directive and New Deal for junior doctors. The primary care trust's net costs during the year increased by £9.3 million compared to 2001/02. This was mainly due to increased staff costs and increased prescribing costs, in particular drugs costs. The increasing cost of drugs is being addressed in conjunction with GPs. This includes the development of an antibiotic strategy which aims to reduce antibiotic prescribing and, where clinically appropriate, substituting cheaper medications.

The three separate health organisations operating within Dumfries and Galloway were fully integrated in April 2003 with the dissolution of the two trusts. The auditor considers that NHS Dumfries and Galloway took a well-structured approach to managing the integration process while working to ensure that financial balance was achieved. The new, integrated body's five-year financial plan for the period 2003/04 to 2007/08 forecasts a balanced position, but recognises that significant risks exist in relation to the costs of prescribing, the new GP contract and waiting time pressures on elective activity.

NHS Fife

NHS Fife provides health services to a population of 350,000. The age structure of the population is close to the national average, and levels of ill health and deprivation are generally below the national average.

Fife NHS Board underspent against its RRL of £322.7 million for 2002/03 by £3.0 million. This was largely the result of the late return by trusts of unspent budgets. The Board also had a slight underspend against its CRL and achieved its Cash Requirement Target of £329.4 million

Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust both remained within their RRLs (£117.4 million and £156.0 million respectively) during 2002/03. This was achieved through the use of £9.6 million non-recurring income used to support the recurrent financial position. Both trusts also remained within their CRLs.

Further details on NHS Fife's financial position are contained in paragraphs 4.26 to 4.31 of the main report.

NHS Forth Valley

NHS Forth Valley provides health care services to a population of 279,000. The age structure of the population is close to the national average, and although there are some areas of deprivation, the general morbidity and deprivation of the area are below the Scottish average.

Forth Valley NHS Board remained within its RRL of £269.4 million for 2002/03. The Board also remained within its CRL and achieved its Cash Requirement Target of £274.5 million.

Forth Valley Acute Hospitals NHS Trust and Forth Valley Primary Care NHS Trust both remained within their RRLs (£113.9 million and £125.0 million respectively) for 2002/03. This was achieved through utilisation of accumulated surpluses brought forward from the previous year (£0.8 million and £0.3 million) and through £1 million financial brokerage provided to support the trusts while savings targets are being delivered. The acute trust also remained within its CRL but the primary care trust exceeded its CRL by a small amount.

The acute trust's net costs during the year increased by £11.2 million compared to 2001/02. Some 70% of the increase was due to increased staff costs mainly through pay awards, increased employer's superannuation contributions, increased agency costs and increases due to the New Deal for junior doctors and in respect of the low payment agreement. The primary care trust's net costs during the year increased by £12.1 million (8.3%) compared to 2001/02. Some 71% of the increase can be attributed to increased Family Health Service expenditure, in particular pharmaceutical services and dental services, and increased staff costs.

NHS Forth Valley's financial plan for 2003/04 identifies a planned balanced financial position. The plan identifies a number of risks mainly arising from increased staff costs, the unpredictability of prescribing costs and the delivery of the Royal Scottish National Hospital retraction savings. The plans also include an assumed level of financial brokerage of £2.5 million and a capital to revenue transfer also of £2.5 million.

The agreement between SEHD and NHS Forth Valley requires the repayment of financial brokerage in 2006/07. NHS Forth Valley expects that receipts from the disposal of property will compensate for the reduced availability of funding resulting from the need to repay brokerage. In order to achieve financial stability after the brokerage period, NHS Forth Valley needs to realise annual savings of £5.6 million from 2005/06 onwards. This is to be achieved through a continuing series of best value reviews and costed savings targets. The auditor considers that the achievement of identified savings will be key to longer-term financial recovery, and that NHS Forth Valley faces significant financial challenges in 2003/04 and beyond.

NHS Grampian

NHS Grampian provides health care services to a population of 526,000. The proportion of elderly people is below the Scottish average and levels of morbidity and deprivation are among the lowest in Scotland.

Grampian NHS Board underspent against its RRL of £500.1 million in 2002/03 by £0.4 million. The Board also had a slight underspend against its CRL and achieved its Cash Requirement Target of £514.0 million.

Grampian University Hospitals NHS Trust exceeded its RRL of £260.2 million for 2002/03 by £5.2 million. The excess wholly relates to the deficit brought forward from 2001/02. The trust, however, received brokerage of £3.4 million from SEHD and was also reliant on non-recurrent funding of £2.1 million from the Board. Net costs increased £31 million during the year on 2001/02, about half of which was due to increased staff costs arising from the New Deal for junior doctors and pay awards. The trust achieved its CRL.

Grampian Primary Care NHS Trust remained within its RRL of £224.9 million during 2002/03. To achieve the target, the trust utilised its £3.9 million surplus brought forward from the previous year. The most significant cost pressure faced during the year was from increased expenditure on drugs. The trust remained within its CRL.

Further details on NHS Grampian's future financial plans are contained in paragraphs 4.21 to 4.25 of the main report.

NHS Greater Glasgow

NHS Greater Glasgow provides health care services to a population of 991,000. The proportion of elderly people is slightly below the Scottish average but there are very high levels of morbidity and deprivation.

Greater Glasgow NHS Board underspent against its RRL of £1,034,677 million in 2002/03 by £12.1 million. The underspend includes income deferred by trusts of £6.4 million in relation to projects not fully completed in the year. The deferred income will be used in 2003/04 to match expenditure incurred. The balance of £5.7 million relates to Board projects and reserves not fully utilised by 31 March 2003 but in progress for completion in 2003/04. The Board also underspent against its CRL and achieved its Cash Requirement Target of £1,048 million.

North Glasgow University Hospitals NHS Trust remained within its RRL of £439.4 million during 2002/03. This was as a result of achieving savings of £4.0 million from cost improvement and savings plans. The Board also provided additional non-recurring funding. During the year, the trust encountered recurring cost pressures totalling £8.7 million. The trust funded these pressures from a number of non-recurring actions, including vacancy management, slippage in projects and capital to revenue transfers. However, as the recurring cost baseline was not reduced, the trust will carry these pressures forward to 2003/04. The trust remained within its CRL.

South Glasgow University Hospitals NHS Trust remained within its RRL of £214.5 million during 2002/03. The Board provided the trust with additional recurring funding during the year to address its previous reliance on non-recurring income. As a result, the trust did not need to implement any additional cost improvement programmes during 2002/03. It did, however, pursue existing recovery plans relating to Gynaecology and Laboratories Rationalisation, in order to deliver internal cost savings for service enhancements elsewhere. The trust remained within its CRL.

Yorkhill NHS Trust had a slight underspend against its RRL of £81.9 million during 2002/03. This was achieved as a result of the trust realising savings of £0.9 million from its cost improvement plan. A major factor in the trust's achievement of the financial target was also the high level of vacancies experienced. Staff cost savings of £0.9 million allowed pharmacy and other cost pressures to be offset. The auditor considers that the over-riding pressure in 2003/04 will be to control non-staff costs if staff vacancies are filled. The trust remained within its CRL.

Glasgow Primary Care NHS Trust also had a marginal underspend against its RRL of £372.5 million during 2002/03. The trust incurred prescribing costs which were £4.0 million in excess of forecasts. This cost increase was funded through a number of non-recurring sources including use of reserves, savings and reduced capital charges, and income from bank interest. The trust had a slight underspend against its CRL.

SEHD increased its 2003/04 funding for the Board by £67.4 million compared to the previous year. This was approximately £11.1 million less than the Board expected, reflecting a decrease in the Greater Glasgow population. The decrease in population meant that the Board moved from a position of being below its Arbuthnott target share of resources to being above target. This resulted in the Board receiving the standard increase in funding with no further Arbuthnott increase.

The Board is committed to a Glasgow-wide balanced recurring budget by 2004/05. The Board plans to achieve this through improved working practices and efficiency savings linked to the NHS Greater Glasgow acute services review. The estimated additional recurring funding to achieve financial balance is around £22.9 million, assuming that the trusts also deliver efficiency savings of around 2% to 3%. After taking account of increased funding, trust efficiency savings, and inflation and other cost commitments, the Board's financial plan for 2003/04 indicates a recurring over-commitment of around £23.0 million. To address this shortfall, the Board has identified a number of non-recurring funding measures. These include delaying the introduction of the new consultants' contract (£4.0 million), disposal of land (£14.0 million) and slippage in various capital schemes (£5.0 million).

All four Greater Glasgow trusts are likely to face challenging financial situations during 2003/04 and to be reliant, to a greater or lesser extent, on non-recurring income. Each trust has prepared savings plans designed to achieve savings totalling some £7.0 million. The trusts recognise that one of the key areas where new cost pressures arise is through unfunded developments. The Greater Glasgow NHS Board Performance and Resource Monitoring Group will, therefore, approve any significant new or emerging trust developments. Arising from implementation of the Arbuthnott formula and the resulting lower than anticipated level of increase in funding for NHS Greater Glasgow, the Group will also comprehensively review financial plans for future years.

NHS Highland

NHS Highland provides health care services to a population of 209,000. NHS Highland faces considerable extra costs due to the need to make health services accessible to people living in remote and rural areas. The proportion of elderly people is above average, while levels of morbidity and deprivation are generally below the Scottish average.

Highland NHS Board underspent against its RRL of £222.1 million in 2002/03 by £0.4 million. The target was achieved largely as a result of SEHD's approval for a £2.8 million capital to revenue transfer. The Board intends to repay this amount to its capital allocation over a three-year period from the proceeds of planned property disposals. The Board also achieved its CRL and Cash Requirement Target of £228.8 million.

Highland Acute Hospitals NHS Trust and Highland Primary Care NHS Trust both remained within their RRLs (£93.8 million and £110.5 million respectively) during 2002/03. This was achieved through the implementation of efficiency savings. The Board was also able to provide the trusts with additional funding of £3.6 million following its capital to revenue transfer. In common with many trusts, both Highland Acute Hospitals NHS Trust and Highland Primary Care NHS Trust faced cost pressures during the year arising from the New Deal for junior doctors and drugs cost increases. Both trusts also remained within their CRLs.

NHS Highland's financial plans for 2003/04 forecast a balanced financial position. The plans assume £4.7 million cash releasing efficiency gains across all three bodies. Identified cost pressures include the New Deal for junior doctors, the Low Pay Agreement, consultants' contracts, overspends on prescribing and drug costs, and, in respect of the primary care trust, overspends on mental health and learning disabilities services. Both trusts acknowledge that achieving the budget will be a challenge.

NHS Lanarkshire

NHS Lanarkshire provides health care services to a population of 561,000. It has one of the lowest proportions of elderly people of any health area, but suffers from high levels of morbidity and deprivation.

Lanarkshire NHS Board exceeded its RRL of £541.0 million for 2002/03 by £7.3 million. This was largely as a result of cost pressures faced by both trusts, increased activity, and because of expenditure associated with the repatriation of Lanarkshire patients from NHS Glasgow to NHS Lanarkshire. NHS Lanarkshire is negotiating for the transfer of £4.0 million funding from NHS Glasgow for these patients. The Board achieved its CRL and its Cash Requirement Target of £548.4 million.

Lanarkshire Acute Hospitals NHS Trust exceeded its RRL of £235.4 million for 2002/03 by £2.8 million. This relates to the deficit brought forward from 2001/02. The deficit was originally created in 2000/01 through a technical accounting entry to revalue downwards certain properties which were planned for sale but had minimal value. The deficit was reduced in 2001/02 and 2002/03 through the sale of valuable surplus land at Hairmyres and Bellshill as part of the trust's overall land property strategy. The trust expects to clear the deficit in 2003/04 with the further sale of land at Hairmyres. The trust achieved its CRL.

Lanarkshire Primary Care NHS Trust achieved its RRL of £239.3 million for 2002/03. The trust marginally underspent against its CRL.

The achievement of financial targets is now being managed on a pan-Lanarkshire basis. In June 2002, a Performance Review Group was established with responsibility for monitoring the performance of NHS Lanarkshire together with

any actions required to correct variances. The Group has identified an underlying recurring deficit within NHS Lanarkshire of £23.8 million. It has developed a five-year plan to address the deficit and to achieve long-term financial and clinical sustainability. The plan forecasts that Lanarkshire NHS Board will exceed its RRL for each of the three years from 2003/04 (reaching a peak deficit of £16 million in 2004/05) but will thereafter return to financial balance.

In 2002/03, the deficit was minimised by making recurring savings of £4.7 million, capital to revenue transfers of £6.9 million, and use of £5.8 million non-recurring income. SEHD also advanced £5.3 million in respect of expected receipts from land sales (repayable in 2003/04 and 2004/05 when land is sold by the primary care trust).

Because the non-recurring actions implemented in 2002/03 will not result in savings in subsequent years, NHS Lanarkshire intends to address the underlying deficit through stabilisation actions totalling £20.5 million and use of development monies. Stabilisation actions include best value and shared service reviews, the centralisation of corporate functions and other cash releasing efficiency initiatives.

NHS Lothian

NHS Lothian provides health care services to a population of 784,000. The proportion of elderly people is below the national average. Levels of morbidity and deprivation are also significantly below the national average but not as low as in some areas.

Lothian NHS Board underspent against its RRL of £747.9 million for 2002/03 by £8.4 million. The underspend largely relates to slippage on projects to be carried forward to 2003/04, a technical gain on sale of property of £3.9 million by Lothian Primary Care NHS Trust and a £1.5 million contingency balance. The Board also achieved its CRL and its Cash Requirement Target of £760.0 million.

Lothian University Hospitals NHS Trust achieved its RRL of £406.6 million for 2002/03. The trust, however, was dependent on £64.6 million of non-recurring income and faces significant financial challenges in the future. Further details on the trust's future financial plans are contained in paragraphs 4.3 to 4.12 of the main report. The trust marginally overspent against its CRL due to the advanced planned purchase of medical equipment due to be funded from the 2003/04 capital resource.

Lothian Primary Care NHS Trust achieved its RRL of £252.0 million for 2002/03. During the year, the trust realised gains on sale of property of £23.0 million and received £32.0 million non-recurring funding. Of this, £5.5 million was utilised to support clinical services expenditure. Underlying recurring expenditure therefore exceeded recurring income. The trust has developed a financial recovery plan aimed at eliminating its reliance on non-recurring income support by 2005/06. The trust achieved its CRL.

West Lothian Healthcare NHS Trust achieved its RRL of £119.5 million for 2002/03. During the year, the trust received £12.0 million non-recurring funding of which the Board provided £1.5 million to meet budget overspends in the surgical directorate and on family health services. The trust has a financial recovery plan aimed at returning it to recurring financial balance by 2006/07. The trust achieved its CRL.

NHS Lothian's financial plans for the five-years to 2007/08 forecast a small annual surplus. The plan is, however, dependent on the realisation of savings from strategic changes to service delivery and the agreed financial plans at each of the trusts being achieved.

Orkney NHS Board

Orkney NHS Board provides health services to a population of 19,000. The proportion of elderly people is higher than the Scottish average but levels of morbidity and deprivation are substantially below average.

Orkney NHS Board achieved both its RRL of £23.8 million and its CRL in 2002/03, and its Cash Requirement Target of £22.9 million. The RRL was achieved as a result of the implementation of a series of cost and savings measures designed to alleviate the £0.8 million deficit which was forecast in December 2002. The measures included SEHD's approval of £0.2 million brokerage funding.

The Board's financial plan covering the period 2003/04 to 2007/08 forecasts a surplus of £0.7 million at the end of the five years. The plan is dependent on cumulative savings of £2.5 million and receipt of £2.0 million further brokerage in 2003/04 and 2004/05. Brokerage will be repaid over the following three years.

Shetland NHS Board

Shetland NHS Board provides health services to a population of 23,000. The proportion of elderly people is among the lowest of any health area and levels of morbidity and deprivation are very low compared to the Scottish average. Shetland NHS Board underspent against its RRL of £30.2 million in 2002/03 by £0.3 million. It also underspent against its CRL, and its cash requirement was £0.6 million below the £29.6 million limit set by SEHD. Outturn against the targets includes a £0.9 million capital to revenue transfer.

The Board's financial plans for 2003/04 forecast a balanced financial position. Financial pressures include increased drugs expenditure, clinical vacancies resulting in high locum costs and the high cost of individual unplanned treatments.

NHS Tayside

NHS Tayside provides health care services to a population of 389,000. The proportion of elderly people is well above the national average. Levels of morbidity and deprivation are very close to the Scottish average.

Tayside NHS Board underspent against its RRL of £443.2 million for 2002/03 by £4.3 million. The underspend was largely the result of Tayside Primary Care NHS Trust returning to the Board £6.7 million in respect of slippage on various specifically funded initiatives and other budget underspends, and a similar return of £2.7 million by Tayside University Hospitals NHS Trust. This was offset by the Board providing an additional £5.7 million non-recurring funding to the acute trust to address in-year cost pressures. The Board expects that the £4.3 million underspend will be carried forward to 2003/04. The Board achieved its CRL and its Cash Requirement Target of £443.3 million.

Tayside University Hospitals NHS Trust achieved its RRL of £232.6 million for 2002/03. As noted above, this was largely achieved through the Board providing an additional £5.7 million non-recurring funding, and through the trust's utilisation of £1.6 million reserves. Cost pressures included increased nursing pay as a result of increased activity and use of agency nurses to fill employment gaps, the Low Pay Agreement, medical and price inflation in theatre supplies, and above inflation increase in drugs expenditure. The Trust achieved its CRL.

Tayside Primary Care NHS Trust achieved its RRL of £125.4 million for 2002/03. This was due to the utilisation of £2.3 million brought forward surpluses and deferred income from 2001/02, SEHD's provision of an additional £4.4 million to fund impairments on fixed assets and accelerated depreciation, and £4.2 million capital to revenue transfer. The Trust achieved its CRL.

NHS Tayside's financial plans for 2003/04 forecast a balanced financial position. This is dependent on the successful implementation of savings plans and the management of in-year pressures.

Western Isles NHS Board

Western Isles NHS Board provides health services to a population of 27,000. The proportion of elderly people is among the highest of any health area. It also has high levels of morbidity and deprivation.

The Board underspent against its RRL of £44.7 million in 2002/03 by £0.2 million. The target was achieved after the Board took action to address a potential overspend of £1.0 million identified during the course of the year, mainly associated with increased locum and prescribing expenditure and greater capital charges. Action included SEHD's approval for £0.5 million capital to revenue transfer and a £0.5 million underspend on ring-fenced specific initiatives. The Board had a slight overspend against its CRL but met its Cash Requirement Target of £41.0 million.

SEHD has required the Board to produce a financial recovery plan to return it to financial balance. The plan requires the Board to make savings of £1.0 million during 2003/04. The Board is still to identify how and where these savings are to be realised.

Overview of the National Health Service in Scotland

2002/03

Audit Scotland
110 George Street
Edinburgh EH2 4LH

Telephone
0131 477 1234
Fax
0131 477 4567

www.audit-scotland.gov.uk ISBN 1 904651 21 6 AGS/2003/12