Overview of the financial performance of the NHS in Scotland

2003/04

Prepared for the Auditor General for Scotland

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Auditor General for Scotland

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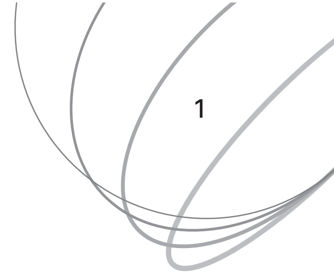

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Summary

Most NHS bodies achieved their financial targets in 2003/04 and there were no qualifications to the annual accounts. But despite significant increases in funding the NHS in Scotland is facing an unprecedented set of challenges over the coming years which will require robust long-term financial and service planning.

Introduction

1. This report provides a financial overview of the NHS in Scotland in 2003/04. It complements our previous overview report on the performance of the NHS and the two reports should be considered together.[1] The annual accounts for 2003/04 cover a year where the NHS was being reorganised into single system structures and trusts were being dissolved in-year. This makes comparisons with previous years difficult.

2. Despite significant increases in funding – from £7.7 billion in 2003/04 to £9.3 billion (in real terms) by 2007/08 – the NHS in Scotland is facing an unprecedented set of challenges over the coming years which will require robust long-term financial and service planning. These include a range of cost pressures such as the UK-wide pay modernisation agenda;[2] rising pension costs; and increasing drug costs. In addition, technical advances in the way in which healthcare can be delivered; changing training requirements for medical staff; and a growing older population all contribute to the need to change the way in which health and related services are delivered. But the fixed costs associated with staffing and property will make it difficult for NHS boards to free-up money for redesigning services.

Main findings

3. The main findings from this financial overview fall into three key areas:

- Financial performance during 2003/04.
- Emerging factors which may affect future financial performance.
- Overall financial stewardship and corporate governance.

Financial performance

4. Most NHS bodies achieved their financial targets in 2003/04 and there were no qualifications to the annual accounts. But four NHS boards – Argyll & Clyde, Lanarkshire, Grampian and Western Isles – overspent their revenue resource limit (RRL). The total overspend from these four bodies amounts to £61.7 million, with the two largest deficits being incurred by Argyll & Clyde NHS Board (£35.4 million) and Lanarkshire NHS Board (£21.2 million).

5. The remaining 11 NHS boards had a combined underspend of £47.5 million. For all NHS boards there is an overall deficit of £14.2 million. This figure is increasing annually, but remains a small percentage (0.2%) of NHS boards' total RRL of £5.8 billion. Three NHS boards – Argyll & Clyde, Grampian and Greater Glasgow – are projecting in-year financial deficits for 2004/05.

Emerging factors that may affect future financial performance

6. NHS bodies are relying on a number of financial strategies to achieve financial balance in future. These include a continuing reliance on non-recurring funding such as capital to revenue transfers and ring-fenced funding; and financial recovery plans which assume that high levels of savings will be made.[3] But achieving the savings targets in some board areas will be challenging. The use of non-recurring funding to achieve financial balance does not affect the underlying cost base. NHS boards generally find it difficult to deliver economies and efficiencies that result in recurring savings which would reduce their cost base.

7. The NHS is also facing external cost pressures such as pay modernisation, increased pension costs and a rising cost of drugs which are set to absorb much of the additional funding going into the NHS. The Scottish Executive Health Department (SEHD) and NHS boards have different estimates of the costs of these pressures. This raises concerns about the robustness of financial planning at both national and local levels. Underestimating these cost pressures will make it harder to achieve financial recovery plans, while overestimating could mean that other service developments are put on hold unnecessarily.

1 *An overview of the performance of the NHS in Scotland*, Audit Scotland, August 2004.
2 The UK-wide pay modernisation agenda includes the new consultants' contract, GMS contract and Agenda for Change. Definitions of these contracts are included in the glossary at Appendix 1.
3 Definitions of types of non-recurring funding are included in the glossary at Appendix 1.

8. This picture of growing pressure means that there is a need for better long-term financial planning which is based on robust cost data in the NHS in Scotland, a better use of performance information, and improved service and workforce planning. This is essential to ensure that the large sums of public money going into the NHS make a real difference to patients and health services.

Financial stewardship and governance

9. No NHS body received a qualified auditor's report on regularity issues for 2003/04. This is an improvement on the previous year when almost all primary care NHS trusts and NHS boards received a qualification because of weaknesses in the system of receipts and payments for family health services.

10. It is too early to assess whether corporate governance arrangements for the new single health systems are working well across Scotland. Auditors will pay attention to this area over the coming year and we will report progress in future overview reports.

Future audit work

11. This report highlights a number of areas where the NHS in Scotland needs to improve. In response to these concerns auditors will monitor and review key business risks such as:

- the effectiveness of financial planning and its links with overall service planning
- corporate governance arrangements in the new single health systems, paying particular attention to the role and accountabilities of the new community health partnerships
- the implementation of and costs associated with pay modernisation.

Part 1. Setting the scene

Introduction

12. This report provides an overview of the main issues arising from the 2003/04 audits of NHS bodies. It is organised into four main parts:

- This introductory chapter outlines recent organisational change in the NHS and provides a commentary on some of the key challenges facing the health service.
- Part 2 (page 9) considers financial performance in 2003/04.
- Part 3 (page 16) highlights emerging factors which may affect future financial performance.
- Part 4 (page 25) reports on financial stewardship and corporate governance.

13. It is important that the financial performance of public services, such as the NHS, is understood by the general public if services are to be truly accountable. It is also important that lay people on NHS boards have a good understanding of the financial position of their boards so that they too can hold managers to account. For these reasons we have attempted to minimise the use of technical terms in this report. But in some places this is unavoidable and we have therefore included a glossary of terms in Appendix 1.

14. This report is in a different format from previous financial overview reports, where we included a section on NHS bodies causing greatest concern. This report features case studies on NHS bodies which are used to demonstrate emerging issues. These case studies are based on final audit reports for 2003/04 which were produced in summer 2004. In addition, Appendix 2 provides the final financial position in 2003/04 for each NHS body.

15. NHS financial performance cannot be considered in isolation from overall performance and service delivery, so this report should be considered alongside our overview report on the performance of the NHS which was published in August 2004.[4] The performance report highlights the range of services the NHS provides and the scale of its annual activity. It also provides information on the extent to which the NHS is achieving national targets in areas such as staff numbers; waiting times for treatment; and survival rates in the clinical priorities of cancer and coronary heart disease.

Reorganisation of the NHS in Scotland

16. In 2003/04 there were 48 NHS bodies in total: 24 trusts, 15 NHS boards, seven special health boards, one NHS body and one independent body.[5 6] Those NHS trusts in existence in 2003/04 were dissolved and all NHS board areas had restructured by

4 *An overview of the performance of the NHS in Scotland*, Audit Scotland, August 2004.
5 A list of all NHS bodies existing during 2003/04 is included at Appendix 2.
6 The Mental Welfare Commission (MWC) is an independent body. Its sponsor department is the SEHD. For the purposes of this report we have referred to the MWC as an NHS body.

1 April 2004.[7] New single system structures are now in place. The accounts for 2003/04 cover a year where these new structures were in transition. Six NHS trusts were dissolved part-way through the financial year 2003/04 and part-year accounts were prepared; the remaining 18 trusts were dissolved at the year end.

17. NHS reorganisation and the dissolution of trusts in-year presents particular challenges in reporting on the financial performance of the NHS:

- We have chosen to comment on the performance of trusts and operating divisions only where appropriate and to highlight longer-term issues.
- It is difficult to make comparisons with previous years, but we have attempted to do so where possible.

Funding and spending in the NHS in Scotland

Funding for the NHS in Scotland in 2003/04

18. The Scottish Parliament voted £5.9 billion for the NHS in Scotland for 2003/04. In addition, the NHS receives income of around £1.8 billion from national insurance contributions, charges for prescriptions and dental treatment and other income generating schemes. The total funding available to the NHS in Scotland in 2003/04 was £7.7 billion (Exhibit 1).

NHS in Scotland spending in 2003/04

19. The money voted by the Scottish Parliament is used to meet the SEHD's spending plan.[8] The SEHD had spending plans for £7.5 billion (Exhibit 1) of which £7 billion was allocated to NHS boards, special health boards and other NHS bodies.

20. Exhibit 1 shows how the NHS in Scotland spent around £7.8 billion during the financial year. NHS boards spent around £6.6 billion and passed most of this on to trusts and operating divisions to pay for hospital and community services and family health services. An additional £0.7 billion was spent by special health boards and other NHS bodies on delivering national services for the NHS. The rest of the money (around £500 million) was spent by SEHD on centrally managed expenditure.

21. This money is allocated to NHS boards in various forms including: an RRL; other funding which is excluded from the RRL, including certain funding for family health services; money to pay for local health councils; other revenue allocations; and a capital resource limit (CRL).

Growth in expenditure

22. Between 2000/01 and 2003/04 expenditure on the NHS in Scotland increased by £1.4 billion to £7.8 billion. By 2007/08 it is set to rise even further to just over £9.3 billion in real terms (Exhibit 2 page 8).[9]

Major challenges affecting the finances of the NHS in Scotland

23. Making sure that these large sums of public money translate into better patient services requires sound planning, good financial management, and effective leadership at national and local level. Much of NHS bodies' spending is fixed as it pays for staff and property. This reduces boards' flexibility in managing their budgets. Ensuring that the new money being invested adds value is even more of a challenge given the scale and pace of change within the NHS, including the recent organisational re-structuring and increased public expectations. Some of the major challenges are outlined in the rest of this section and discussed further in our performance overview report.

Staffing

24. The NHS is a labour-intensive service and is the largest single employer in Scotland. In 2003 it employed 147,500 staff, or 6% of the total workforce in Scotland.[10 11] The NHS in Scotland currently spends around half of its budget on staff, excluding independent contractors such as GPs. There are a number of major changes which affect staffing and present particular challenges for NHS management and clinical practice. These include the:

- European working time directive and ensuring compliance with reductions in junior doctors' hours
- three UK-wide pay modernisation agreements – the consultants' contract, the GMS contract and Agenda for Change
- NHS policies of no compulsory redundancies and a no detriment rule for existing staff whose jobs change. The no detriment rule means that pay and terms and conditions are protected for staff whose jobs change as a result of reorganisation.

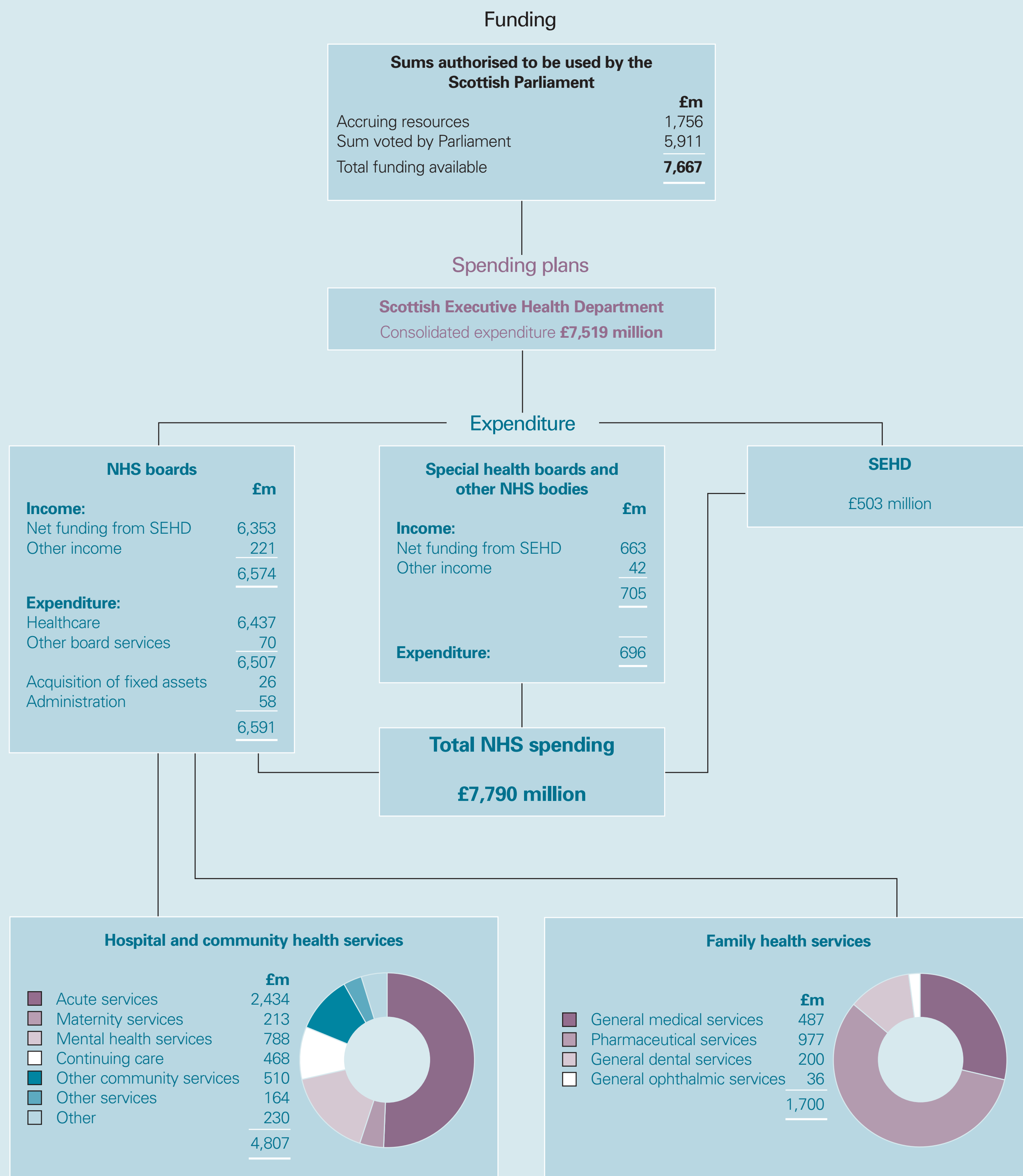
25. In addition, there are national shortages of key staff such as radiologists. Addressing these shortages cannot be met in the short term. It will require a concerted effort to increase the numbers of people training, together with a review of the scope for other staff taking on different tasks. There are also Scotland-wide demographics which

7 NHS trusts were dissolved on 1 April 2004 as a result of The National Health Service Trusts (Dissolution) (Scotland) Order 2004.
8 The Scottish Executive's spending plan for 2003/04 can be found at www.scotland.gov.uk/library5/finance/aesed-00.asp
9 £10 billion in cash terms as outlined in *Building a Better Scotland. Spending proposals 2005-2008*, Scottish Executive, September 2004.
10 *NHS in Scotland Workforce statistics as at 30 September 2003*, ISD, 2003.
11 *Economic activity by gender: Scotland March 1992 to August 2004*, Office for National Statistics, October 2004.

Exhibit 1

How NHS funding was spent in 2003/04

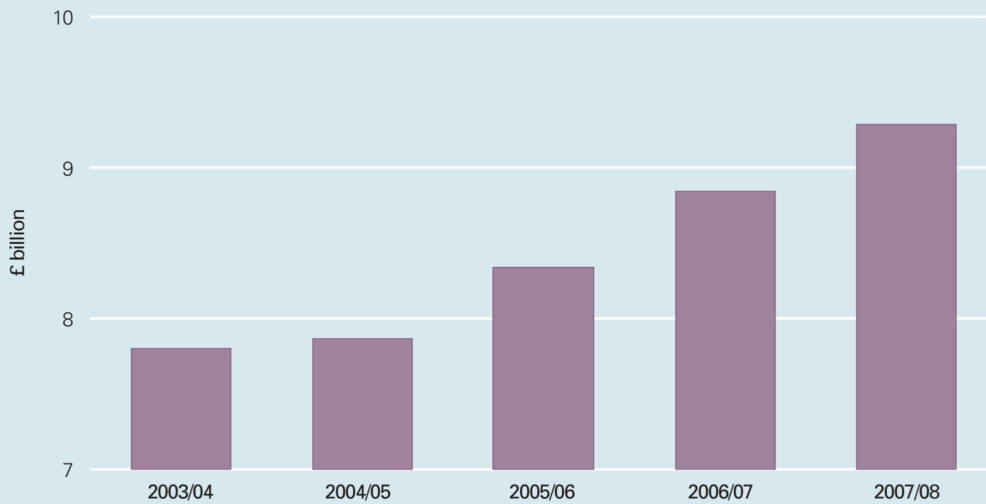
The NHS in Scotland spent around £7.8 billion in 2003/04. NHS boards spent £6.6 billion, special health boards and other NHS bodies £0.7 billion, and £0.5 billion by SEHD.



Source: NHS audited accounts 2003/04

Exhibit 2
Spending in the NHS in Scotland (2003/04 to 2007/08)

Spending in the NHS in Scotland is due to rise from £7.8 billion in 2003/04 to £9.3 billion in 2007/08 (real terms).



Note: Figures for 2003/04 are based on actual expenditure. Figures for 2004/05 to 2007/08 are based on Scottish Executive plans. All figures are quoted at 2003/04 prices.

Source: Audited accounts and SEHD spending plans

will affect recruitment of staff, particularly the declining population in the 16 to 45 age group, reducing the pool of people available to recruit.

Property

26. The NHS in Scotland has assets valued at £3.3 billion resulting in around £265 million being paid in capital charges each year. These capital charges will increase in 2004/05 as a result of the revaluation of the estate which was carried out in 2003/04 and a change in the methodology for calculating capital charges.

Drugs

27. Expenditure on prescription drugs and drugs used in hospitals amounts to around £1.1 billion each year. Prescription drugs costs are rising by around 10% annually adding to the financial pressures which need to be managed.

Redesigning services

28. Technical advances in the delivery of healthcare combined with new medicines mean that many health services which previously could only be provided in hospital settings can now be provided closer to people's homes in community settings – this is contributing to the need to redesign NHS services and for the NHS to work more closely with other agencies. But information is not keeping pace with these changes, so at present it is difficult to demonstrate improvements in productivity or cost-effectiveness. There is now a review of information under way to improve our understanding of what the public is getting for the large amount of public money spent on the NHS.[12]

29. Given that just over 80% of NHS boards' money is already committed to staffing, property and family health services, boards have limited flexibility in the use of existing budgets for redesigning services.[13] Improvements in service efficiency do not necessarily involve extra resources, for example improving the management of outpatient clinics to ensure that more people turn up for their appointments. However, setting up new services may involve double running costs for a transitional period to ensure that there are no disruptions. For example, the move to the new Edinburgh Royal Infirmary involved double running costs of over £17 million while the facilities at the old hospital were wound down. This will be an issue for a number of boards across Scotland as a result of acute services reviews.

12 ISD national data development programme.
13 The 80% committed expenditure is based on staffing, property and family health services costs for Borders NHS Board and Dumfries & Galloway NHS Board.

Part 2. Financial performance in 2003/04

Key messages

Seventeen NHS trusts and 19 NHS boards, special health boards and other NHS bodies achieved their financial targets in 2003/04 and there were no qualifications to the 'true and fair' auditors' opinions.

The combined deficit of the four NHS boards which overspent against their RRLs is £61.7 million. The remaining 11 NHS boards had a combined underspend of £47.5 million. This means that for all NHS boards there is an overall deficit of £14.2 million. This figure is increasing annually, but remains a small percentage (0.2%) of NHS boards' total RRL of £5.8 billion.

The special health boards and other NHS bodies underspent by £12.7 million in total.

The combined financial position for all NHS bodies (NHS boards, special health boards, other NHS bodies) in 2003/04 is an overall deficit of £1.5 million.

The current financial targets need to be reviewed to ensure they are challenging to NHS bodies.

30. This part of the report comments on:

- the financial targets set by SEHD
- how NHS bodies performed against the financial targets in 2003/04
- how useful the targets are in measuring financial performance
- other issues affecting financial performance in 2003/04
- transparency of financial information.

What are the financial targets for NHS bodies?

31. The SEHD has set three financial targets for NHS bodies. They should stay within the:

- revenue resource limit (RRL) – this is the revenue budget allocated for the day-to-day operation of services. Where an NHS body makes savings against its RRL they may be carried forward to the next year. But any overspend has to be repaid from future years' allocations
- capital resource limit (CRL) – this is the budget for net capital investment ie, after any capital receipts have been offset against the total cost of capital
- cash requirement – this is the amount of cash needed to fund the RRL and CRL.

32. NHS boards, special health boards and other NHS bodies must meet all three financial targets. They are expected to manage their finances within their RRL, CRL and cash requirement. All of these targets are set by SEHD.

33. NHS trusts had to meet two financial targets: the RRL and CRL. Both limits were set by their local NHS board.

How did NHS bodies perform against the financial targets?

NHS trusts

Revenue resource limit (RRL)

34. During 2003/04, 17 trusts exactly met their RRL and seven overspent against their RRL. A detailed list of all trusts' performance against the financial targets is included at Appendix 2.

35. The dissolution of trusts part-way through 2003/04 makes comparison with previous years difficult.[14] Six trusts dissolved part-way through the year and became part of their local NHS board. Each of these trusts prepared part year accounts and all six overspent their RRL. These overspends are not failures against the financial targets as final RRLs had not been set for the year. The remaining 18 trusts dissolved on 31 March 2004. Only one of these trusts – Grampian University Hospitals NHS Trust – reported an overspend against its RRL for the year ended 31 March 2004. The remaining 17 trusts reported operating expenditure which exactly matched their RRL.

Capital resource limit (CRL)

36. Of the 18 NHS trusts in existence at 31 March 2004, four trusts reported savings against their CRL and 14 exactly met their CRL. The six trusts which dissolved during the year either exactly met their CRL or did not have a CRL set by their local NHS board.

NHS boards, special health boards and other NHS bodies

Revenue resource limit (RRL)

37. Eleven NHS boards, seven special health boards and one NHS body achieved their RRL target, either meeting this exactly or spending less than the limit. The remaining five NHS bodies overspent against their RRL (Exhibit 3).

38. The combined deficit of the four NHS boards which overspent against their RRLs is £61.7 million. The remaining 11 boards had a combined underspend of £47.5 million. This means that for all NHS boards there is an overall deficit of £14.2 million. This figure is increasing annually, but remains a small percentage (0.2%) of NHS boards' total RRL of £5.8 billion.

39. The special health boards and other NHS bodies underspent by £12.7 million in total. This therefore results in an overall deficit for all NHS bodies (NHS boards, special health boards and other NHS bodies) in 2003/04 of £1.5 million. Details of all NHS boards, special health boards and NHS bodies' performance against their financial targets are included at Appendix 2.

40. Argyll & Clyde NHS Board (£35.4 million) and Lanarkshire NHS Board (£21.2 million) incurred the two largest deficits. Case study 1 (page 12) and case study 2 (page 13) provide further information on each of these deficits and projected deficits for the future. Case study 3 (page 13) focuses on Western Isles NHS Board's failure to meet its financial targets.

Capital resource limit (CRL) and cash requirement

41. Twenty-three out of 24 NHS boards, special health boards and other NHS bodies achieved their CRL target. Western Isles NHS Board exceeded its CRL by £21,000.

42. Twenty-three out of 24 NHS boards, special health boards and other NHS bodies achieved their cash requirement target. Dumfries & Galloway NHS Board exceeded its cash requirement by £257,000 but this relates to a technical adjustment at the year-end and does not represent a failure to meet its financial target.

How useful are the financial targets?

Revenue resource limit (RRL)

43. In recent years the NHS has moved to resource accounting and budgeting to ensure that their accounts can be incorporated into the Scottish Executive resource account. As a result the financial targets for NHS bodies have changed.

14 *Overview of the National Health Service in Scotland 2002/03*, Audit Scotland, December 2003.

Exhibit 3

NHS bodies exceeding their Revenue Resource Limit in 2003/04

Five NHS bodies spent more than their RRL in 2003/04 resulting in a deficit position at the year-end.

NHS board/NHS body	Revenue Resource Limit	Net Resource Outturn	Deficit
	£m	£m	£m
Argyll & Clyde NHS Board	471.282	506.652	(35.370)
Lanarkshire NHS Board	566.930	588.138	(21.208)
Grampian NHS Board	528.634	533.438	(4.804)
Western Isles NHS Board	46.952	47.223	(0.271)
Mental Welfare Commission for Scotland	2.549	2.551	(0.002)
Total			**(61.655)**

Source: Auditors' final reports on 2003/04 audits

44. NHS boards' RRLs are set by SEHD. The initial RRLs are notified early in the financial year but can change a number of times throughout the year as additional money is announced. This can result in a very different figure at the year-end. And in some cases the final RRL is not agreed until after the year end.

45. For example, the SEHD issued 84 changes to the RRL for Dumfries & Galloway NHS Board, 97 to Argyll & Clyde NHS Board's RRL and over 100 changes to Tayside NHS Board's RRL during the course of 2003/04. NHS boards also adjusted the RRLs for their trusts to redirect resources within local NHS systems. While changes to RRLs can help NHS systems by directing additional resources to where they are needed, changes on this scale limit the usefulness of the RRL as a target. The volume of amendments made to the RRL throughout the year also makes financial management difficult for NHS boards. We comment on this later in the report.

46. Auditors for five NHS boards reported that RRL targets were not agreed until mid-July, nearly three months after the end of the financial year.[15] Agreeing a target once the final outturn position is known reduces the likelihood that the target is real or effective.

Cash requirement

47. Under current legislation, NHS boards have a statutory requirement to operate within the cash limit set by SEHD. But under resource accounting, cash limits are no longer advised to NHS boards. A new financial target of operating within the cash requirement has been set for NHS boards. A change in legislation is needed to reflect the change from cash limits to cash requirements under resource accounting.

48. The SEHD should consider reviewing the current financial targets set for NHS bodies.

Other issues affecting financial performance in 2003/04

The revaluation of NHSScotland's estate

49. The NHS in Scotland's estate is revalued every five years. The Valuation Office Agency (VOA) undertook the latest revaluation at 31 March 2004.[16] The revaluation report was originally due to be published in April 2004 but was not issued until June 2004. Part of this delay was due to disagreements over valuation figures between individual NHS boards and the VOA. Several NHS bodies have challenged the valuations supplied by the VOA but have accepted the figures on an interim basis to enable completion of their annual accounts for 2003/04.

50. The auditors of five NHS boards reported that late publication of the VOA report resulted in delays in the audit process. Auditors also reported a number of related issues which delayed the audit process. These included uncertainty over some asset

15 Argyll & Clyde NHS Board, Dumfries & Galloway NHS Board, Forth Valley NHS Board, Tayside NHS Board and Western Isles NHS Board.
16 The Valuation Office Agency (VOA) is an executive agency of the Inland Revenue which values property in England, Wales and Scotland for the purposes of taxes administered by the Inland Revenue.

Case study 1

Argyll & Clyde NHS Board's deficit position for 2003/04 and projected deficit for the future

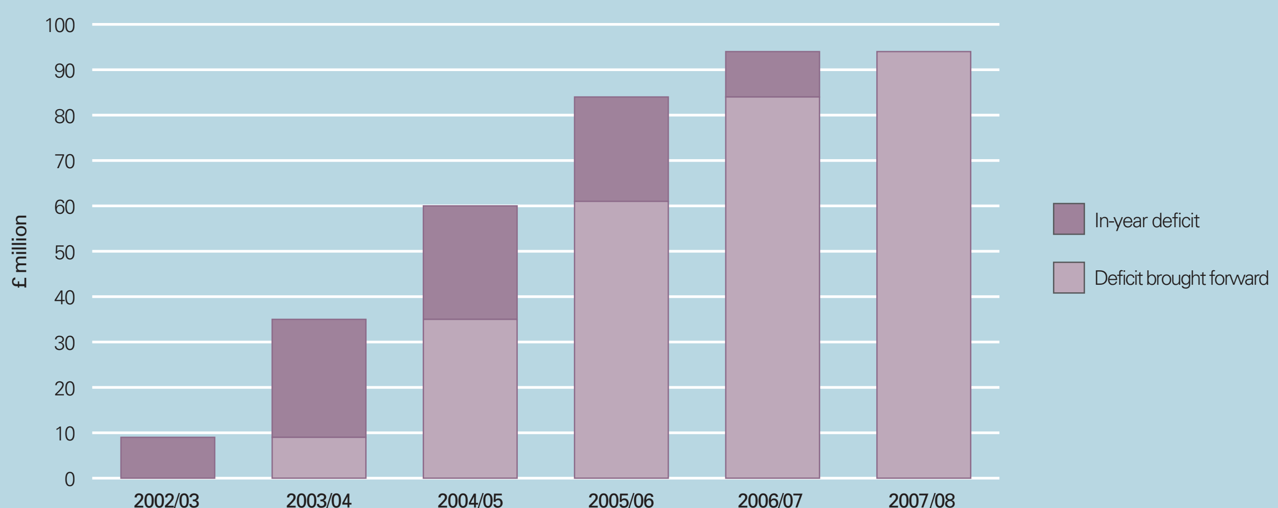
Argyll & Clyde NHS Board has been experiencing financial problems for the past few years. During 2001/02 it identified that the local NHS system was facing an underlying deficit of £6 million and an expert support group was asked by SEHD to review the overall management arrangements. The support group identified a larger underlying deficit, estimated at £25 to £30 million. The board agreed a five-year recovery plan to 2006/07 which aimed to bring its NHS system into recurring financial balance. But our 2001/02 overview report highlighted the auditor's concerns about the risk to the successful delivery of the financial plan. In 2002/03 we reported that although the financial position of NHS Argyll & Clyde had been managed on a system-wide basis, the three trusts all overspent against their RRLs resulting in a total in-year deficit of £9.6 million. In July 2003, the three local trusts were dissolved and a revised five-year financial recovery plan was developed.

The revised five-year financial recovery plan projected an in-year deficit of £22.3 million in 2003/04. The board spent more than planned and its actual in-year deficit was £25.8 million. The board failed to achieve its planned deficit in 2003/04 due to a combination of budget overspends, unfunded cost pressures and a clarification of NHS accounting rules which required the inclusion of a brought forward cumulative deficit of £9.6 million. The board ended the year with a cumulative deficit of £35.4 million.

The auditor for Argyll & Clyde NHS Board has commented that the underlying financial position for 2003/04 may be worse than reported in the board's financial statements. It is estimated that the underlying in-year deficit (excluding the use of non-recurring funding and savings) for 2003/04 is approximately £50 million.

The board has revised its planned in-year deficit for 2004/05 from £17 million to £25 million. The increased planned deficit is a result of the increased cost of pay modernisation and the impact of changes in maternity and surgical service provision. But the current financial recovery plan does not include costs arising from the development of the Clinical Strategy and it is likely that additional funding will be required, in the short term, for this major service reconfiguration.

The board is not expecting to achieve a balanced annual budget until 2007/08, by which time the cumulative deficit will be around £94 million. A summary of the increasing deficit position is set out below. The single largest risk factor for the board is the sustainability of safe, effective and appropriate clinical services, at the same time as addressing the serious financial position.



Source: Auditor's report on the 2003/04 audit of Argyll & Clyde NHS Board

Case study 2

NHS Lanarkshire's underlying financial deficit

During 2002/03, NHS Lanarkshire identified an underlying deficit of £23.8 million (excluding non-recurring funding and savings). A five-year recovery plan was developed, which forecast that NHS Lanarkshire would exceed its RRL for the next three years returning to financial balance in 2006/07.

NHS Lanarkshire's planned in-year deficit for 2003/04 was £16.2 million. The board managed to stay within this target and recorded an actual in-year deficit of £13.9 million. But the auditor reported that considerable effort was required by the board to find the savings required to contribute to this outcome. For example, £4 million was transferred from capital to revenue and a further £3.1 million was saved by carrying vacant staff posts and deferring some non-essential expenditure until future years. After taking into account the £7.3 million deficit brought forward from 2002/03, Lanarkshire NHS Board's cumulative deficit for 2003/04 was £21.2 million.

NHS Lanarkshire's financial recovery plan has now been revised and the projected underlying deficit for 2004/05 is £33.9 million. In order for NHS Lanarkshire to clear both the underlying deficit and the cumulative deficit of £21.2 million brought forward in 2004/05 it needs to make savings and implement other measures totalling £55.1 million. To date the board has identified £13 million from an additional SEHD allocation and capital to revenue transfers.

Source: Auditor's report on 2003/04 audit of NHS Lanarkshire

Case study 3

Western Isles NHS Board's failure to meet its financial targets in 2003/04

The board failed to meet either its RRL or CRL in 2003/04. Although these overspends are small – the RRL was overspent by £271,000 and the CRL by £21,000 – they were incurred after using £397,000 of ring-fenced money, £238,000 of non-recurring funding from the SEHD and deferring the repayment of £150,000 due for financial brokerage received in 2002/03. This means that the underlying deficit was actually £1.1 million.

The board has a five-year financial recovery plan which forecasts that it will break-even in 2004/05 and that by 2006/07 its cumulative deficit will be eliminated. But the auditor has expressed concerns about the board's financial position, and taking the 2003/04 financial position with prior years' performance there are concerns about the sustainability of services within the Western Isles. A number of actions and initiatives are in place to address financial recovery. But a more detailed recovery plan which includes areas of significant cost pressure had not yet been prepared at the end of 2003/04.

Source: Auditor's report on 2003/04 audit of Western Isles NHS Board

categories; difficulties in establishing the nature and extent of downward valuations; and difficulties in determining the historic cost of some assets. The revaluation exercise also identified a number of problems with asset register systems. For example, some systems were found to be poorly maintained and unreliable and could not be easily reconciled to fixed asset balances shown on revaluation reserves.

Transparency of financial performance

Move to single system structures

51. As previously outlined in Part 1 (page 5) all NHS trusts were dissolved by 1 April 2004 and are now part of NHS boards. In most cases the former trusts are now operating divisions of NHS boards. Running the new single NHS systems provides a new challenge for NHS boards as they plan and deliver area-wide services.

52. It will be important for NHS boards to maintain transparency within the new systems. Under the new structures the financial performance of acute and primary care services may be hidden, making it difficult to determine where funding is being spent locally, and whether expenditure and activity are in line with plans. This is particularly important given that, historically, financial deficits have been more common in acute trusts than in primary care trusts.[17]

53. In previous financial overview reports we have identified the number of NHS bodies in financial deficit each year. NHS boards rarely reported a deficit but the number of trusts operating in deficit and the amount of the cumulative deficit has gradually been increasing. Under the new single system structures NHS boards inherit the deficits of their local trusts and will now have to manage these deficits across the board area. An analysis of 2002/03 figures shows that trust deficits have moved to NHS boards in 2003/04, moving some boards into financial deficit positions (Exhibit 4). With all trusts now dissolved more NHS boards may operate at a deficit in the future.

Disclosure within NHS annual accounts

54. The current format of NHS accounts does not disclose some important information about the funding of services, such as the use of non-recurring funding or savings to achieve the financial position. Memorandum statements are used to report spending of certain elements of ring-fenced funding but this is not separately identified in the accounts. In addition, NHS bodies reported capital receipts of around £33 million in 2003/04 but the accounts do not disclose whether this money was reinvested in capital projects or transferred to revenue to support in-year operating expenditure.

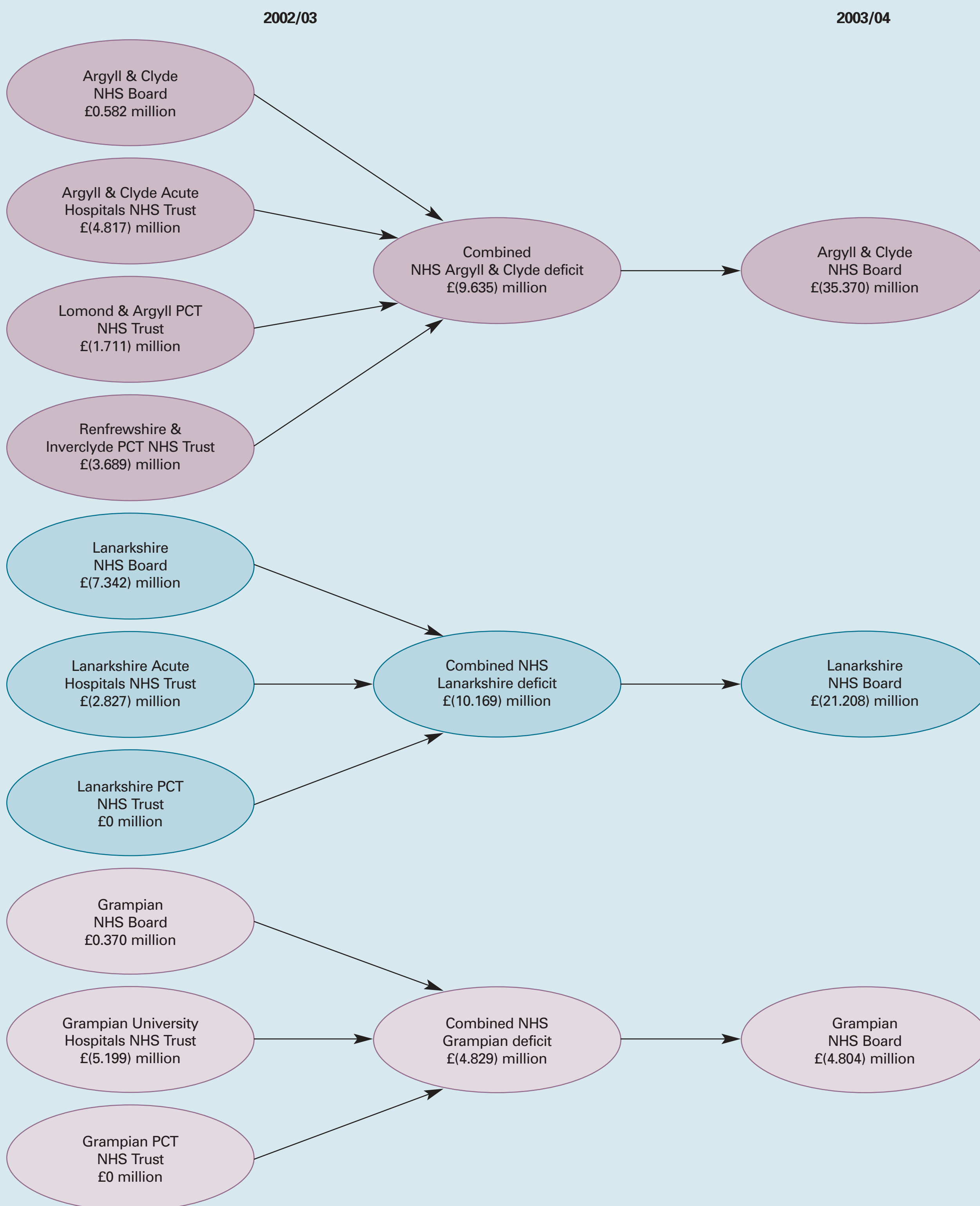
55. In Part 3 (page 16) of this report, we discuss the estimated level of non-recurring funding and use of savings to support operating activities.

17 *Overview of the National Health Service in Scotland 2000/01, 2001/02* and *2002/03*, Audit Scotland.

Exhibit 4

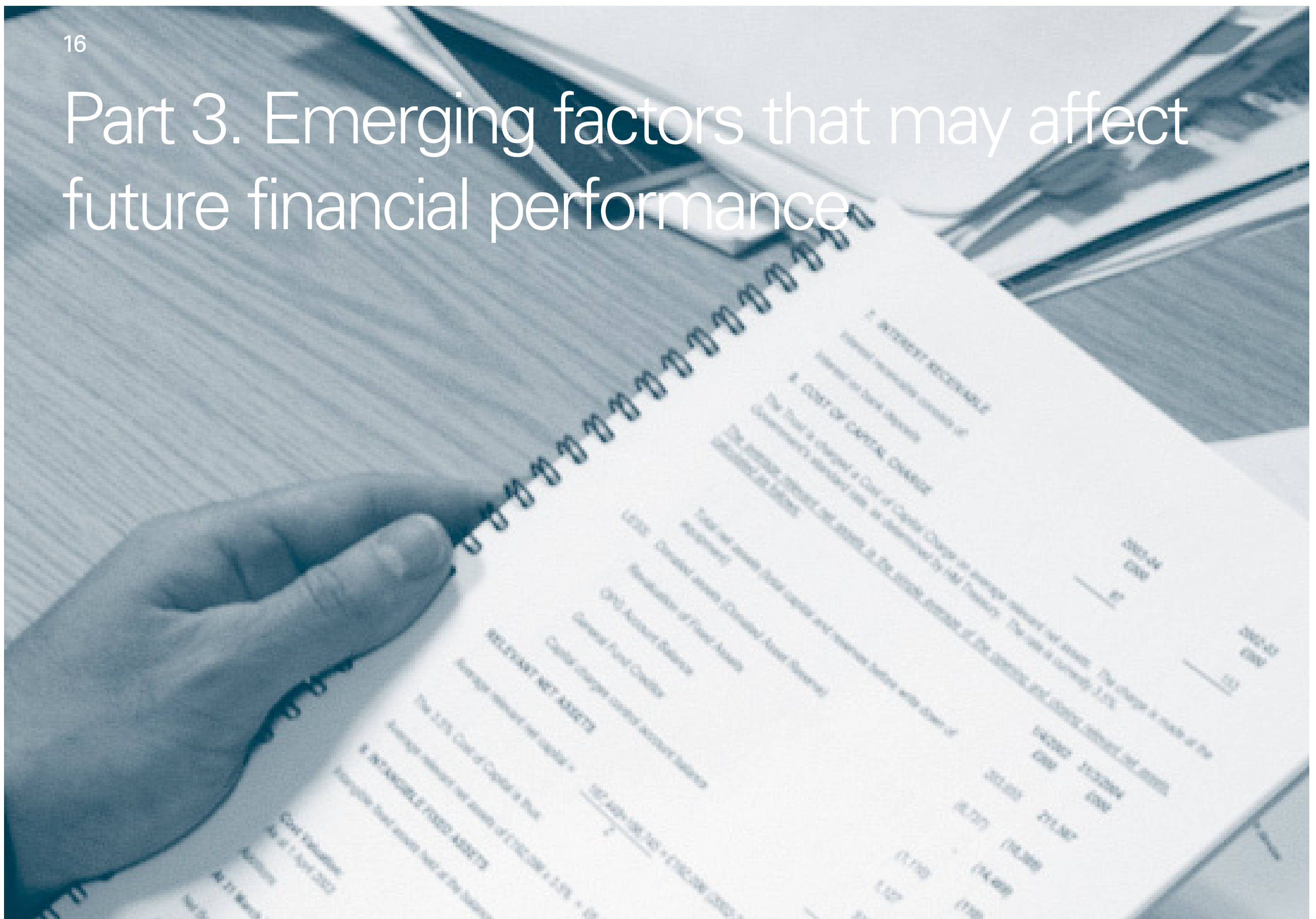
Transfer of deficits from trusts to NHS boards

NHS boards are moving into deficit position as they take in NHS trusts which were previously experiencing financial problems.



Source: Audit Scotland

Part 3. Emerging factors that may affect future financial performance



Key messages

Three NHS boards – Argyll & Clyde, Grampian and Greater Glasgow – are projecting in-year financial deficits for 2004/05.

Funding gaps totalling around £162 million have been identified by seven NHS boards for 2004/05. Of this total, £138 million relates to three NHS boards – Argyll & Clyde, Greater Glasgow and Lanarkshire. The boards have developed financial recovery plans to manage these funding gaps, but there are significant challenges in delivering these plans.

NHS bodies continue to rely on non-recurring funding to achieve financial balance – around £370 million in 2003/04. Using non-recurring funding to support the delivery of operational services does not reduce the cost base and merely stores up potential financial pressures in future years.

A number of NHS boards' financial plans are based on the assumption that savings will be made. But many NHS bodies have failed to meet savings targets in the past adding further risk to the achievement of future financial plans.

The NHS in Scotland is facing major cost pressures over the next few years, from pay modernisation, pension costs and an increasing drugs bill. These cost pressures will absorb much of the additional funding going into the NHS which may affect boards' ability to deliver and redesign services. The SEHD and NHS boards have estimated different costs for each of these pressures. This raises concerns over the assumptions and methodology for estimating costs and over how SEHD and NHS boards work together to plan effectively for the future.

Robust financial management is a challenge for many NHS bodies as RRLs change throughout the year and a number of late allocations of money are ring-fenced or earmarked for specific initiatives.

The emerging issues highlight concerns over the sustainability of current services in some parts of Scotland, particularly where NHS boards are trying to reconfigure local services and manage a number of external cost pressures.

Exhibit 5

Funding gaps identified for 2004/05

Three NHS boards have identified a total funding gap of £138 million for 2004/05.

NHS board	Funding gap identified for 2004/05	Planned expenditure for 2004/05	Funding gap as % of planned expenditure
	£m	£m	%
Argyll & Clyde	45.3	615.6	7.3
Greater Glasgow	58.7	1,163.5	5.0
Lanarkshire	33.9	771.8	4.4
Total	**137.9**		

Note: These funding gaps exclude additional non-recurring funding from SEHD and planned savings.

Source: Auditors' reports on 2003/04 NHS audits

How did NHS bodies achieve financial balance?

56. The majority of NHS bodies achieved their RRL target in 2003/04, but many achieved this in spite of significant financial pressures by redirecting money meant for other purposes to support the delivery of day-to-day services. We have identified a number of emerging themes which may affect the future financial performance of NHS bodies. This part of the report discusses each of these themes:

- Funding gaps in future financial plans.
- Use of non-recurring funding to achieve financial balance.
- Reliance on savings to meet financial plans and the ability to meet savings targets.
- Future cost pressures.
- Financial management.

Projected financial deficits

57. The SEHD expects all NHS bodies in Scotland to achieve financial balance in 2004/05. Twelve of the 15 NHS boards are projecting an in-year balanced position for 2004/05, but NHS Greater Glasgow, NHS Grampian and NHS Argyll & Clyde are forecasting in-year deficits. And two boards have reported that, although they plan to break-even in 2004/05, there is a risk that they may slip into deficit over the next few years. Borders NHS Board's five-year plan is projecting deficits for 2005/06 and 2006/07 with a balanced position in 2007/08, and Dumfries & Galloway NHS Board expects to be in a balanced position for 2004/05 but anticipates that deficits will occur in the following two years unless they take action.

Funding gaps in future financial plans

58. Auditors reported that there are funding gaps at seven NHS boards that total nearly £162 million in 2004/05.[18] Financial recovery plans are in place to manage these gaps, but a continued reliance on 'one-off' funding may undermine the achievability of these plans.

59. Exhibit 5 provides details of the three NHS boards which make up the majority of the £162 million funding gap. These three boards are projecting funding gaps of £138 million in 2004/05. Although the total funding gap is small when compared to the total planned expenditure for these boards it raises concerns about financial stability and the sustainability of local services. To demonstrate how these funding gaps arise we have used Greater Glasgow NHS Board as a case study (Case study 4 page 18).

18 NHS bodies that have identified funding gaps for 2004/05 are Argyll & Clyde NHS Board, Borders NHS Board, Fife NHS Board, Forth Valley NHS Board, Greater Glasgow NHS Board, Lanarkshire NHS Board and Orkney NHS Board.

Case study 4

Greater Glasgow NHS Board's projected funding gap

Greater Glasgow NHS Board is currently projecting an in-year deficit of £4.2 million for 2004/05 and a balanced financial position by the end of 2005/06. But the board has identified a funding gap of almost £59 million for 2004/05, and to achieve the planned deficit position it would need to deliver at least £54.5 million of recurring savings. This represents a considerable challenge. Although savings plans have been achieved in prior years, a large proportion of money has been saved on a non-recurring basis.

The projected 2004/05 financial position for NHS Greater Glasgow is set out below:

	£m	£m
Recurring income	1,080.1	
Recurring expenditure	(1,147.6)	
Underlying recurring deficit		**(67.5)**
Non-recurring income	24.5	
Non-recurring expenditure	(15.7)	
Balance of non-recurring		8.80
2004/05 funding gap		**(58.7)**
Other income sources		
Non-recurring SEHD income		12.6
Corporate savings programme		41.9
Total other income		**54.5**
Projected financial deficit for 2004/05		**(4.2)**

Source: Auditor's report on the 2003/04 audit of Greater Glasgow NHS Board

Exhibit 6

Non-recurring funding used to achieve financial balance in 2003/04

NHS bodies used around £370 million in non-recurring funding to support operational activities in 2003/04.

Non-recurring funding	NHS boards	Special health boards and other NHS bodies	Total
	£m	£m	£m
Capital to revenue transfers*	36.6	0.3	36.9
Capital receipts	33.3	–	33.3
Ring-fenced money	129.2	89.0	218.2
Other non-recurring funding	80.4	2.2	82.6
Total	**279.5**	**91.5**	**371.0**

* SEHD provided the figure for capital to revenue transfers.

Source: Audit Scotland

Using non-recurring funding to achieve financial balance

60. Previous financial overview reports have commented on the extent to which NHS bodies rely on non-recurring funding to achieve financial balance. This remains a problem in 2003/04. It is estimated that NHS boards, special health boards and other NHS bodies relied on around £370 million non-recurring funding in 2003/04.

61. Sources of non-recurring funding identified in 2003/04 are capital to revenue transfers, ring-fenced money for specific initiatives, capital receipts and other non-recurring income. The largest element of non-recurring money used to deliver operational services was £218 million of ring-fenced money which should have been used to deliver specific initiatives (for example, drug and alcohol prevention). This means that some ring-fenced money is being used to support day-to-day operational activities rather than the specific initiatives for which it is intended. These specific initiatives will need to be delivered at some point in the future and NHS boards are simply delaying these projects.

62. A summary of non-recurring funding used across Scotland in 2003/04 is included at Exhibit 6. The majority of this non-recurring funding was passed on to NHS trusts to support their in-year financial position.

63. In addition to the non-recurring funding outlined in Exhibit 6, NHS boards had a balance of £15.9 million outstanding under the financial brokerage scheme at the end of March 2004. This money has been borrowed by boards from the SEHD in prior years and will remain a liability of NHS boards until it is fully paid back. NHS boards paid back £1.9 million in financial brokerage in 2003/04.

64. A number of individual bodies relied on large sums of non-recurring funding to support their financial position in 2003/04 – either to achieve financial balance or to reduce their deficit position – including NHS Lothian, NHS Greater Glasgow, NHS Argyll & Clyde and NHS Fife. While NHS Argyll & Clyde overspent its RRL the other three bodies spent less than their RRL. Case studies 5 and 6 (page 20) provide further details for NHS Lothian and NHS Fife.

65. NHS bodies are relying on a number of financial strategies to achieve financial balance in future. These include a continuing reliance on non-recurring funding such as ring-fenced funding and capital to revenue transfers, although these transfers will not be allowed after 2005/06. The use of non-recurring funding to achieve financial balance does not affect the underlying cost base. NHS boards generally find it difficult to deliver economies and efficiencies that result in recurring year-on-year savings which would reduce the cost base.

Case study 5

NHS Lothian's reliance on non-recurring funding to achieve financial balance

NHS Lothian relied on £44.4 million of non-recurring funding in 2003/04 to achieve financial balance. £21 million was used to support the three trusts, with a further £8.73 million to fund Lothian University Hospitals Trust's deficit on its demise; £8.5 million paid for pan-Lothian review projects aimed at making future savings; and £6 million for increased pay to consultants and part-time workers. This non-recurring support was sourced from the SEHD as brokerage (£13.8 million), capital receipts of £23.4 million and a further £7.2 million from internal sources such as ring-fenced funding and capital to revenue transfers.

It is estimated that around £39.2 million of additional funding that will come from non-recurring sources is needed by the board and its divisions in 2004/05 to support operational activities. The board has recognised that this level of additional support is not considered sustainable beyond 2004/05 and that pan-Lothian projects and operating divisions must achieve their savings targets if NHS Lothian is to return to a balanced position.

Source: Auditor's report on 2003/04 audit of NHS Lothian

Case study 6

NHS Fife's reliance on non-recurring funding

NHS Fife achieved its RRL in 2003/04 through the use of non-recurring funding and other measures. These measures included the late allocation of funds from SEHD to meet in-year cost pressures, savings, and the use of the underspend brought forward from 2002/03. A similar underspend has been carried forward into 2004/05. Non-recurring funding used in-year included capital to revenue transfers and ring-fenced funding, the latter of which meant that some planned initiatives slipped. The board expects that non-recurring funding will continue to play a part in achieving future financial balance.

Source: Auditor's report on 2003/04 audit of NHS Fife

Reliance on savings to meet financial plans and achievability of savings targets

66. The financial recovery plans of six NHS boards are based on making savings to their cost base, and in three cases these savings are substantial.[19] NHS bodies normally plan to make savings from a combination of recurring and non-recurring funds. But making savings from non-recurring funds is only a short-term measure as savings need to be taken out of the recurring cost base.

67. In previous years some NHS bodies have had difficulty in achieving their savings plans, either because they were over ambitious in setting the target or because financial planning had not taken full account of all factors, such as service developments or the cost implications of new initiatives. For example, NHS Argyll & Clyde and NHS Lothian both experienced difficulty in achieving savings targets in the past (Case studies 7 and 8 overleaf) and NHS Greater Glasgow is relying on making savings of nearly £55 million in 2004/05 to meet its financial plan (Case study 9 page 23).

68. A number of other NHS areas have a poor history of achieving savings plans, and this appears to be a particular challenge for boards' acute divisions. For example, the auditor of Fife NHS Board stated in 2002/03 that there was a lack of detailed savings plans. Further audit work carried out in 2003/04 identified that, while savings plans had been developed and implemented in 2003/04, the actual savings made fell short of the target particularly in the board's Acute Division. In NHS Tayside the previous Tayside University Hospitals NHS Trust only achieved £700,000 savings from a £2.3 million target.

Future cost pressures

69. Our recently published performance overview report provided details of the future cost pressures facing the NHS in Scotland and gave details of SEHD's estimated costs. The cost pressures include implementing UK-wide pay modernisation agreements, pension costs and an increasing drugs bill. Together these pressures account for much of the additional funding going into the NHS. This report provides updated estimates for the cost pressures arising from pay modernisation for 2004/05 (Exhibit 7 page 24). As part of the 2003/04 audits we obtained estimated costs for each of the pay modernisation initiatives from the majority of NHS bodies. However, because these estimated costs are not complete and the calculation base may not be consistent we have not included NHS bodies' estimates in this report. The following paragraphs comment further on these estimated costs.

Pay modernisation

70. Since our performance overview report was published the UK-wide negotiations on Agenda for Change have been completed and an agreement reached. The SEHD has now estimated the cost of implementing Agenda for Change as between £130 and £160 million in 2004/05. This estimate includes pay inflation of 3.225%. SEHD has recently provided NHS bodies with a model to calculate the costs associated with the new pay terms and estimated costs from NHS bodies are broadly in line with SEHD's.

71. The SEHD does not anticipate further cost increases to achieve full compliance with the New Deal for junior doctors. But some NHS bodies have estimated additional costs in 2004/05. For the consultants' contract, SEHD's estimated costs have not changed since the performance overview report. NHS bodies have estimated more, although the difference is not significant.

72. SEHD has revised its estimated cost for the new GMS contract upwards since the performance overview report. But NHS bodies' estimates are higher. This may be due to different assumptions and methods in calculating the estimated costs. It highlights a risk in financial planning and management within the NHS in Scotland which will need close monitoring by both SEHD and NHS bodies.

NHS pension costs

73. The future increase in employers' pension contributions is an additional cost pressure for NHS bodies. Employers' contributions to the NHS pension scheme increased from 5.5% to 14% from 1 April 2004 to address a shortfall of £934 million against known liabilities. The NHS Pension Scheme currently has around 118,000 active members and the most recent actuarial valuation reports the scheme's liabilities as £8.1 billion at 31 March 2004. This planned increase in employers' contributions has been recognised in the NHS Pension Scheme's accounts for 2003/04.[20] It is estimated that the additional cost to NHS bodies of these increased employer contributions is at least £226 million. This cost and future costs will be met by SEHD as part of the general uplift in funding.

19 Argyll & Clyde NHS Board*, Borders NHS Board, Forth Valley NHS Board, Greater Glasgow NHS Board*, Lanarkshire NHS Board* and Orkney NHS Board. Those boards marked with an asterisk need to make substantial savings.
20 At the time of writing this report, the NHS Pension Scheme accounts for 2003/04 were still to be audited.

Case study 7

Argyll & Clyde NHS Board's savings plans

Argyll & Clyde NHS Board achieved its planned savings of £13.2 million in 2003/04. But only £6.8 million of these savings were from recurring expenditure. To achieve future savings plans the non-recurring element will have to be found again in 2004/05, and in future years. NHS Argyll & Clyde has historically failed to deliver on financial savings plans. It faces a significant challenge in removing £49 million of recurring costs from its operational cost base by 2007/08. Taking the level of savings required together with the significant organisational changes which are planned and future cost pressures, there is a significant risk that the board will either not achieve its financial targets or will have to significantly redesign services.

Year	Cumulative savings required per recovery plan (£ million)
2004/05	14
2005/06	27
2006/07	42
2007/08	49

Source: Auditor's report on the 2003/04 audit of NHS Argyll & Clyde

Case study 8

NHS Lothian's savings plan

The previous Lothian University Hospitals NHS Trust failed to meet savings plans in the past but the new Division continues to build savings targets into future financial plans. The Trust/Division failed to achieve its savings target of £6 million for 2003/04. The planned savings were based on a recurring cash releasing efficiency savings target of £4.1 million and £1.9 million of unmet savings brought forward from 2002/03. The Trust/Division only achieved savings of £953,000 against its target of £6 million. The £5 million unachieved savings have been carried forward into 2004/05.

The Division has a planned deficit of £5.4 million for 2004/05 and the board has agreed to a one-off allocation of £6 million to meet this deficit. The Division's planned deficit is based on achieving a savings target of £9.5 million. Lothian NHS Board has agreed £2 million in cash releasing efficiency savings funding relief, but this leaves £7.5 million of recurring savings to be achieved in 2004/05.

The previous Trust's performance in achieving savings targets and in managing both its identified and unidentified pressures leaves concerns about the Division's ability to achieve the savings target in 2004/05. The Division's management has commented that the plan is 'extremely challenging' and has noted the need for active management and monitoring if the plan is to succeed.

Source: Auditor's report on the 2003/04 audit of Lothian NHS Board

Case study 9

NHS Greater Glasgow's savings plan for 2004/05

Greater Glasgow NHS Board is forecasting a deficit of £4.2 million for 2004/05. But this means delivering at least £54.5 million of savings. Around £41.9 million of these savings are to be made internally and an additional £12.6 million is expected to come from non-recurring funding from the SEHD.

The board's corporate recovery plan shows the £41.9 million savings to be made in 2004/05. But it only identifies £21.9 million of savings from specific initiatives and £10 million from cross-boundary activity income. This leaves a shortfall of £10 million savings which are still to be identified. And the board's auditor reported that as at June 2004 few detailed and clear action plans had been finalised to realise these savings.

A number of risks to achieving the planned savings have been identified, including:

- pay awards being higher than estimated
- operating divisions not achieving their agreed savings targets
- savings being double-counted at both operational and strategic levels
- the board being unable to negotiate with other West of Scotland NHS boards to obtain the full cost of cross-boundary activity. This will be a particular challenge given the financial deficits faced elsewhere in Scotland.

Source: Auditor's report on the 2003/04 audit of Greater Glasgow NHS Board

Financial management

74. Financial management involves planning, directing and controlling the business to support delivery of the organisation's goals.[21] The SEHD and NHS bodies need to ensure that their current financial management arrangements are sound and that they have sufficiently skilled staff and appropriate systems in place to enable them to meet future challenges. Organisations that have good financial management systems will be better able to redesign and improve services. And good financial management arrangements should also help managers identify where things are going wrong and to respond to them quickly.

75. The Scottish Executive has recently announced record funding for the NHS in Scotland, which will reach £10 billion in cash terms (£9.3 billion in real terms) by 2008. Robust and effective financial management is essential if this extra funding is to deliver improved services.

76. Some of the challenges that NHS bodies are facing make good financial management more difficult. For example, each time the RRL is revised, NHS boards need to amend their financial plans and outturn projections. This limits the effectiveness of financial management systems. Complications can also arise when late allocations of money are made; these allocations may be ring-fenced for specific initiatives, or NHS boards may find it difficult to identify spending opportunities at short notice. Both may lead to poor decision-making and inefficient use of funds.

21 *Effective organisations – A model for financial management in the public service*, The Chartered Institute of Public Finance and Accountancy (CIPFA), May 2004.

Exhibit 7

Estimates of additional costs of pay modernisation initiatives for 2004/05

SEHD estimate the cost of implementing pay modernisation deals at between £234 and £264 million in 2004/05.

	Revised SEHD estimates for pay modernisation costs in 2004/05 £m
Consultants' contract	22
New Deal for junior doctors	–
Agenda for Change	130-160
GMS contract (including out-of-hours)	82
Total	**234-264**

Note: These are in-year costs only. They are not cumulative.

Source: Scottish Executive Health Department

Part 4. Financial stewardship and corporate governance

Key messages

Most NHS boards have planned appropriately for reorganisation but it is too early to comment on how the corporate governance arrangements of the new single systems are working in practice.

There was considerable progress in 2003/04 on payment verification and patient exemption checks for family health services income. As a result, all NHS bodies received unqualified regularity reports in 2003/04.

77. This part of the report discusses:

- Financial stewardship of NHS bodies in 2003/04.
- Corporate governance issues arising in 2003/04.
- Fraud in the NHS.

Financial stewardship of NHS bodies in 2003/04

78. The systems of internal control, which ensure that all expenditure is appropriate and authorised and that proper accounting records are maintained, continue to be of a good standard within the NHS in Scotland. The preparation and audit of accounts were delayed mainly because there were:

- late adjustments to the accounts manuals for NHS trusts and boards by the SEHD
- late publication of the national report on the revaluation of the NHS estate in Scotland.

79. The SEHD acknowledged that these events were affecting the preparation and audit of trusts' annual accounts. It therefore extended the deadline for submitting accounts to 31 July 2004. This affected the preparation and audit of NHS board accounts.

Regularity opinion on the annual accounts

80. Auditors must include an opinion within their audit report on whether expenditure and income shown in the accounts were incurred in accordance with legislation and guidance issued by Scottish ministers.[22] This element of the audit report, which is separate from the 'true and fair' opinion on the financial statements, is known as the regularity opinion.

81. All NHS bodies received unqualified regularity opinions in 2003/04. This is an improvement on previous years when auditors of almost all primary care trusts and NHS boards qualified their regularity opinions in respect of family health services (FHS) expenditure and income. This was due to concerns about payment verification checks covering both patient charges and payments to providers of services. Significant improvements have been made to verification procedures for FHS income and expenditure in 2003/04, which mean that qualified regularity opinions are no longer necessary.

22 This opinion is required by Section 22 (sub-section 1) of the Public Finance and Accountability Act (Scotland) 2000.

Corporate governance

82. The corporate governance issues arising from the 2003/04 audit of NHS bodies include:

- preparing for the move to single system structures
- Fife NHS Board
- Western Isles NHS Board.

Preparing for the move to single system structures

83. It is too early to comment on the governance arrangements of the new single systems. But it is clear that the move to single system working has presented a particular challenge for some of the larger NHS boards. For example, Greater Glasgow NHS Board decided that new ways of working and new organisational structures should be allowed to evolve, and approved transitional arrangements with the aim of introducing its new governance arrangements from October 2004.

Other governance issues arising in 2003/04

84. Corporate governance arrangements in NHSScotland are generally sound but the auditors of two NHS boards have highlighted governance issues which may have affected local performance in 2003/04.

Fife NHS Board

85. In the 2002/03 financial overview report we commented on the financial and operational difficulties that NHS Fife was experiencing, including some corporate governance issues. During 2003/04, the auditor followed up on these issues and found that, while there was evidence of a much more structured and focused approach, further improvements are necessary to improve financial governance. The auditor has also commented that there appeared to have been a weakening of the board's governance framework in 2003/04 following the unification of the three NHS Fife bodies. A number of these concerns have been recognised by Fife NHS Board and have been disclosed in its Statement on Internal Control.

Western Isles NHS Board

86. A review of the board's corporate governance arrangements during 2003/04 identified a number of areas for improvement:

- Work is needed to develop and embed risk management processes.
- Standing Orders, Standing Financial Instructions and the Scheme of Delegation need to be updated to take account of the new board structure.
- Performance management and development systems need to be introduced for all staff.

87. In addition, the board chief executive was off on long-term sick leave during 2003/04 and his contract was terminated in March 2004, while the deputy chief executive retired from office during 2003/04.

88. The board has dealt with, or is actively considering, a number of these issues. The auditor will review the board's response during 2004/05 and consider whether it is operating effectively.

Fraud in the NHS

Primary care payments

89. Family health services (FHS) expenditure covers payments to primary care practitioners (GPs, dentists, opticians and pharmacists). With the exception of GP 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.

90. FHS income and expenditure is accounted for in the accounts of NHS boards and for 2003/04 it is also reported in the accounts of primary care trusts. The Practitioner Services Division (PSD) of NHS National Services Scotland (NHS NSS – previously the Common Services Agency) is responsible for calculating and making payments to FHS practitioners. In 2003/04, the PSD processed approximately 83 million payments to FHS contractors, totalling £1.7 billion. This represents more than 20% of the total expenditure of the NHS in Scotland (see Exhibit 1 page 7).

91. Previous financial overview reports have commented on levels of primary care fraud and on the actions taken by the PSD to improve the control environment. There has been considerable progress in 2003/04 on improving the stewardship function of NHS NSS. Payment verification and patient exemption checks are now made extensively.

92. The Counter Fraud Services Unit (CFS) of the PSD is responsible for checking exemption claims made by patients. During 2003/04, the CFS carried out two exercises to provide estimates of the level of patient exemption fraud and error in pharmaceutical, dental and ophthalmic services. The total estimated fraud and error across Scotland was £15.2 million. This estimate is less than 1% of FHS expenditure. As a result the need for a qualified regularity opinion in respect of FHS income has been removed.

Appendix 1. Glossary of terms

Term	Definition
Agenda for Change	A UK-wide plan to introduce a new pay system for all NHS staff with the exception of doctors, dentists and most senior managers. The new system aims to harmonise conditions of service for staff.
Annual accounts	The annual accounts of an NHS body provide the financial position for a financial year ie, 1 April to 31 March. The format of the annual accounts is set out in NHS accounts manuals and includes financial statements and notes to the accounts.
Asset register	A list of all fixed assets owned by an NHS body, including land, buildings, plant and machinery, IT equipment, vehicles, and furniture and fittings.
Audit report	A final report by an NHS body's auditor on the findings from the audit process.
Break-even	Where income equals expenditure.
Capital charges	The notional revenue costs associated with fixed assets. This includes elements for depreciation and interest.
Capital receipts	Income received from the sale of fixed assets. The main source of capital receipts is from the sale of land and buildings.
Capital resource limit (CRL)	The amount of money an NHS body has to spend on capital schemes in a financial year.
Capital to revenue transfer	Funding transferred from the capital spending programme to be used on revenue, or day-to-day expenditure. This may or may not be associated with a particular capital scheme. There will be no capital to revenue transfers allowed after financial year 2005/06.
Cash limit	This is the amount of cash an NHS body needs to support its operational activities during the year.
Cash releasing efficiency savings (CRES)	CRES is a method of identifying savings in one service and using the money to support provision in another service.
Cash requirement	This is the amount of cash an NHS body needs to support its operational activities during the year.
Consultants' contract	The new pay, terms and conditions negotiated on a UK-wide basis for NHS consultants.
Cost base	The cost of providing day-to-day healthcare services in an NHS board area.
Cumulative deficit	The excess of expenditure over income built up over more than one year.

Term	Definition
Cumulative surplus	The excess of income over expenditure built up over more than one year.
EU Working Time Directive	European legislation which 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 is currently considering whether to amend this provision.
Financial balance	Where income received is equal to expenditure made on an ongoing basis.
Financial brokerage scheme	A central 'bank' of funds which pools together funding not currently required by other NHS boards. NHS boards can borrow from this 'bank' to help implement strategic change initiatives or provide assistance with the implementation of major capital plans. The SEHD established the financial brokerage scheme in January 2003 but withdrew the facility for revenue funding during 2003/04 due to the lack of surplus funds being banked by boards. Financial brokerage remains available for capital funding.
Financial statements	The main statements in the annual accounts of an NHS body. These include: an operating cost statement, statement of recognised gains and losses, balance sheet and cash flow statement. The format of these statements is specified in NHS accounts manuals.
Financial stewardship	Financial stewardship ensures that expenditure is properly incurred and authorised. Proper accounting records are maintained and financial statements are prepared in line with standard accounting practice and relevant guidance.
Funding gap	The difference between the income and expenditure that is needed on a recurring basis to pay for operational activities. This excludes any additional one-off funding received from SEHD and any planned savings.
GMS contract	A new contract for general practitioners (GPs) introduced in April 2004 where GPs receive a lump sum based on a contract. Additional payments are made for services provided over and above those specified in the contract or where they are provided to an enhanced specification.
Historic cost	Transactions are recorded at their original value.
In-year deficit	When the expenditure in a single financial year exceeds the income received.
Memorandum statement	A statement which includes additional financial information but does not form part of the annual accounts of an NHS body.
New Deal for junior doctors	The New Deal is an agreement reached in 1991 between representatives of junior doctors, government and NHS management. It aims to limit the number of hours worked by junior doctors and to improve working conditions.

Non-recurring funds	An allocation of funding for projects with a specific life span, or one-off receipts. This includes capital receipts, capital to revenue transfers and may include ring-fenced funding.
One-off funding	Single payments to achieve financial balance in the short term. This approach does not address underlying deficits.
Outturn	The final financial position, which could be the actual or forecast position.
Qualified audit report	When an auditor is of the opinion that there is a problem with the annual accounts of an NHS body, they can issue a qualified report on the accounts. The qualification may be on the truth and fairness of the accounts, the regularity transactions or both.
Recurring expenditure	Money allocated to NHS bodies on an ongoing basis to provide health services to the local population.
Recurring savings	Savings which require to be made from the cost base each year.
Regularity opinion	Auditors provide an opinion as to whether an NHS body's transactions throughout the year are regular ie, they are in accordance with relevant legislation and guidance issued by Scottish ministers.
Resource accounting	Accruals accounting for government, which plans, controls and analyses expenditure by departmental objectives.
Revenue resource limit (RRL)	The amount of money an NHS body has to spend on day-to-day operations in any one year.
Ring-fenced funding	Funding provided for a specific project or purpose. For example, drug misuse schemes, drug and alcohol prevention, and HIV prevention.
True and fair opinion	Auditors provide an opinion as to whether an NHS body's accounts have been prepared in accordance with all relevant accounting standards, legislation and guidance.
Underlying deficit	The underlying deficit is the gap between recurring income received and the expenditure needed to maintain the current level of health services provided to the local population.
Unqualified audit report	When auditors of NHS bodies are satisfied with the annual accounts they will issue an unqualified audit report.

Appendix 2. Financial performance of NHS areas 2003/04

	Revenue Resource Limit	Revenue Resource Outturn	Variance under/ (over)	Capital Resource Limit	Capital Resource Outturn	Variance under/ (over)
	£000	£000	£000	£000	£000	£000
Argyll & Clyde NHS Board Argyll & Clyde Acute Hospitals* Lomond & Argyll PCT* Renfrewshire & Inverclyde PCT*	**471,282**	**506,652**	**(35,370)**	**8,500**	**7,200**	**1,300**
Ayrshire & Arran NHS Board	**416,122**	**402,573**	**13,549**	**11,907**	**11,907**	**0**
Ayrshire & Arran Acute	183,866	183,866	0	12,381	12,380	1
Ayrshire & Arran PCT	173,557	173,557	0	909	909	0
Borders NHS Board	**124,403**	**124,104**	**299**	**1,917**	**1,917**	**0**
Dumfries & Galloway NHS Board	**180,021**	**174,530**	**5,491**	**2,704**	**2,681**	**23**
Fife NHS Board Fife Acute Hospitals* Fife Primary Care NHS Trust*	**361,517**	**359,151**	**2,366**	**8,549**	**6,833**	**1,716**
Forth Valley NHS Board	**289,557**	**289,165**	**392**	**4,013**	**3,884**	**129**
Forth Valley Acute	125,574	125,574	0	3,002	2,918	84
Forth Valley PCT	127,657	127,657	0	966	966	0
Grampian NHS Board	**528,634**	**533,438**	**(4,804)**	**1,267**	**1,267**	**0**
Grampian University Hospitals	276,847	277,520	(673)	7,226	7,226	0
Grampian PCT	237,424	237,424	0	5,959	5,959	0
Greater Glasgow NHS Board	**1,101,880**	**1,096,870**	**5,010**	**28,513**	**28,513**	**0**
Greater Glasgow PCT	404,397	404,397	0	8,665	8,662	3
North Glasgow	459,510	459,510	0	5,340	5,339	1
South Glasgow	230,568	230,568	0	12,025	12,025	0
Yorkhill Hospital	102,127	102,127	0	2,388	2,388	0

	Revenue Resource Limit	Revenue Resource Outturn	Variance under/ (over)	Capital Resource Limit	Capital Resource Outturn	Variance under/ (over)
	£000	£000	£000	£000	£000	£000
Highland NHS Board	**244,851**	**242,329**	**2,522**	**7,576**	**7,567**	**9**
Highland Acute	103,014	103,014	0	6,012	6,012	0
Highland PCT	123,775	123,775	0	3,787	3,787	0
Lanarkshire NHS Board	**566,930**	**588,138**	**(21,208)**	**572**	**572**	**0**
Lanarkshire Acute	248,884	248,884	0	162	162	0
Lanarkshire PCT	257,497	257,497	0	332	332	0
Lothian NHS Board	**923,381**	**910,174**	**13,207**	**9,912**	**9,912**	**0**
Lothian PCT	303,445	303,445	0	6,344	6,344	0
Lothian University Hospitals*						
West Lothian Healthcare	132,289	132,289	0	3,013	3,013	0
Orkney NHS Board	**25,674**	**25,640**	**34**	**312**	**312**	**0**
Shetland NHS Board	**31,739**	**31,400**	**339**	**2,070**	**1,766**	**304**
Tayside NHS Board	**472,755**	**468,457**	**4,298**	**4,472**	**4,472**	**0**
Tayside PCT	228,165	228,165	0	615	615	0
Tayside University Hospitals	251,854	251,854	0	3,841	3,841	0
Western Isles NHS Board	**46,952**	**47,223**	**(271)**	**1,198**	**1,219**	**(21)**
Total for NHS boards	**5,785,698**	**5,799,844**	**(14,146)**	**93,482**	**90,022**	**3,460**

Note: Trusts marked * dissolved during 2003/04

Special health boards and other NHS bodies

	Revenue Resource Limit	Revenue Resource Outturn	Variance under/ (over)	Capital Resource Limit	Capital Resource Outturn	Variance under/ (over)
	£000	£000	£000	£000	£000	£000
Common Services Agency (Now called NHS National Services Scotland)	**194,795**	**190,385**	**4,410**	**18,416**	**18,416**	**0**
Mental Welfare Commission for Scotland	**2,549**	**2,551**	**(2)**	**0**	**0**	**0**
The National Waiting Times Centre Board	**28,400**	**26,415**	**1,985**	**3,059**	**2,735**	**324**
NHS 24	**38,811**	**37,628**	**1,183**	**2,220**	**2,216**	**4**
NHS Education for Scotland	**206,481**	**203,896**	**2,585**	**25**	**25**	**0**
NHS Health Scotland	**13,969**	**13,934**	**35**	**76**	**11**	**65**
NHS Quality Improvement Scotland	**10,198**	**9,631**	**567**	**37**	**37**	**0**
Scottish Ambulance Service Board	**120,904**	**120,882**	**22**	**17,574**	**17,574**	**0**
State Hospitals Board for Scotland	**26,924**	**24,976**	**1,948**	**2,500**	**2,500**	**0**
Total for special health boards and other NHS bodies	**643,031**	**630,298**	**12,733**	**43,907**	**43,514**	**393**

Overview of the financial performance of the NHS in Scotland

2003/04

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Audit Scotland
110 George Street
Edinburgh EH2 4LH

Telephone
0131 477 1234
Fax
0131 477 4567

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