

OVERVIEW REPORT



Overview of the National Health Service in Scotland

1999/2000

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Overview of the National Health Service in Scotland

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

Auditor General for Scotland

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

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

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

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

The following bodies fall within the remit of the Auditor General

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

Audit Scotland

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Accounts Commission and the Auditor General for Scotland. 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.

Preface

Under the Public Finance and Accountability (Scotland) Act 2000 (the 2000 Act) I assumed responsibility for the audit of NHS Trusts and Health Boards in Scotland with effect from 1 April 2000. The audit of health bodies for the 1999/2000 financial year had been commissioned in advance by the Accounts Commission. The results have been reported to me.

There is an appointed auditor for each health trust and health board in Scotland. In addition to certifying the accounts, auditors must prepare final reports addressed to members of the NHS bodies and to me.

Drawing on the information supplied by auditors, most of which is in their final reports, I have prepared this overview of the main issues arising from the 1999/2000 NHS audits. My report also summarises the results of value for money studies undertaken during the year. The overview has been prepared under section 23 of the 2000 Act, under which I may initiate examinations into the economy, efficiency and effectiveness with which prescribed public bodies have used their resources.

Financial stewardship in the NHS in Scotland generally continues to be of a high standard. I am very grateful to everyone in the NHS in Scotland who has assisted in providing information for this report. I would particularly wish to thank appointed auditors and the staff of Audit Scotland who have worked with me in preparing the overview.

Robert W Black
Auditor General for Scotland
Edinburgh
December 2000

Executive summary

Introduction

- 1 This report provides an overview of the main issues arising from 1999/2000 audits of the National Health Service (NHS) in Scotland's Trusts and Health Boards, and from value for money studies undertaken by the National Audit Office and the Accounts Commission for Scotland.
- 2 Under the terms of the Public Finance and Accountability (Scotland) Act 2000 responsibility for the audit of Trusts and Health Boards transferred from the Accounts Commission for Scotland to the Auditor General for Scotland with effect from 1 April 2000. The 1999/2000 audits of Trusts and Health Boards which had been commissioned in advance by the Accounts Commission were reported after their completion to the Auditor General.
- 3 There is an appointed auditor for each individual Trust and Health Board responsible for conducting and reporting on the local audit. This overview report has been prepared principally from information contained in the local reports, and from national value for money reports.

Exhibit 1: Fundamental principles of public audit

- The independence of public sector auditors from the organisations being audited.
- The wide scope of public audit, that is covering the audit of financial statements, regularity (or legality), propriety (or probity) and value for money.
- The ability of public auditors to make the results of their audits available to the public.

Source: Public Audit Forum 'The Principles of Public Audit', October 1998

- 4 Although my report comments on a number of issues arising in Trusts and Health Boards, overall financial stewardship in the NHS in Scotland continues to be of a high standard. Accounts were presented for audit on time and there were no qualifications on the accounts of any of the 50 Trusts and Health Boards which were subject to audit in 1999/2000. However, it is clear from auditors' reports that Trusts faced significant financial pressures in 1999/2000 and that these will have continued into the current year.
- 5 My report is in two parts. The first relates to matters of a recurrent nature and shows the broader results and trends for the NHS in Scotland as a whole. The second part relates to matters arising during 1999/2000 at individual Trusts and Health Boards or more widely.

Part 1. Annual results and trends

Completion of accounts and audits

- 6 From an accounting point of view, the most significant impact arising from reorganisation of the NHS in Scotland on 1 April 1999 was the reduction in the number of Trusts from 47 to 28 and new arrangements for primary care payments made to GPs, pharmacists, dentists and opticians. Structurally, the 15 Health Boards and seven 'special' Health Boards were largely unaffected by reorganisation.
- 7 The deadlines set by the Scottish Executive Health Department (the Department) for the completion of audits are extremely tight and the performance of Trusts and Health Boards and their auditors in meeting them was commendable. To ensure that similar compliance with deadlines can be achieved in future years it is essential that:

- A timetable for the conduct and completion of the audit should be agreed in advance and the accounts and supporting working papers should be made available to the auditors in accordance with that timetable.
- Guidance and directions on the form and content of the annual accounts should be notified by the Department well in advance of the point at which Trust and Health Board accounts are being prepared for audit.
- Information from the Common Services Agency on primary care payments, essential for the completion of the accounts of Primary Care Trusts and Health Boards, should be made available on a timely basis with full reconciliation of the expenditure reported by the Trusts, Health Boards and the Common Services Agency.

Financial performance

- 8 The Department requires Trusts to achieve three financial targets each year: to break-even; to achieve a rate of return on assets of 6%; and to operate within an External Financing Limit (EFL). In 1999/2000 19 of the 28 Trusts (68%) achieved all these targets compared with 42 of the 47 Trusts (90%) prior to reorganisation in the previous year.
- 9 Eight Trusts failed to break-even in 1999/2000, with total accumulated deficits of £29.8 million at the year end. The remaining 20 Trusts carried forward accumulated surpluses totalling £10.6 million into 2000/2001. This represents an increasing level of deficits over previous years and indicates increasing financial pressures on Trusts.

Exhibit 2: Year end deficits

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

- 10 Eight Trusts also failed to achieve the 6% rate of return on assets in 1999/2000. Seven of these had also incurred deficits. All Trusts achieved the EFL target in 1999/2000.
- 11 In those cases where financial targets were not achieved, and also in those where difficulties were foreseen in achieving targets in future years, most Trusts have prepared recovery plans which set out the action required to achieve or maintain financial stability. But recovery plans are demanding and require the achievement of savings or increases in income which will challenge Trusts. In some cases financial recovery may not be achieved in 2000/2001.
- 12 Most Trusts in Scotland faced significant financial pressures in 1999/2000 with, in many cases, the costs exceeding the level of available resources. These pressures are likely to continue into 2000/2001 and beyond. It is of concern that, by relying on non-recurring income, Trusts can show that financial targets have been achieved in one year yet commence the following year with a deficit in 'trading' terms. Targets are an important element in a financial management framework. But these challenges, taken with the deteriorating ability of Trusts to meet the financial targets required of them, raise questions about the purpose of existing targets. The emerging financial challenges and other structural changes within the NHS mean that it is appropriate for the Department to review the current financial targets.
- 13 The financial target set for Health Boards in 1999/2000 was to remain within a cash limit notified by the Department. All Health Boards reported an underspend against their cash limit in 1999/2000. This does not represent savings, but indicates that cash was not utilised as quickly as planned.
- 14 Although there is clearly a strong relationship between the financial performance of Health Boards and Trusts, the way in which they account for their respective activities precludes the portrayal of the overall financial performance of the NHS as a whole. The Department summarises the financial results of Health Boards and Trusts separately but there is considerable scope to reflect a more comprehensive picture of the NHS in Scotland's overall financial performance. The move towards Resource Accounting in central government may facilitate this.

Clinical and medical negligence

- 15 Clinical and medical negligence concerns the breach of a duty of care by health care practitioners in the performance of their duties in the NHS. Health Boards and Trusts are required to make provision for clinical and medical negligence claims made against them and for which they may be liable.
- 16 At 31 March 2000 Trusts and Health Boards had made provision for negligence totalling £38 million and disclosed contingent liabilities of a further £46.4 million – a combined total of £84.4 million.
- 17 Liabilities for clinical and medical negligence over the past years have been rising at a considerable rate and represent a diversion of resources away from healthcare. Although the level of provision and contingent liability is increasing the actual value of settlements over the past three years has remained relatively constant, at about £4 million.

- 18 A new scheme, the 'Clinical Negligence and Other Risks Indemnity Scheme', mandatory for all Trusts and Health Boards, came into effect on 1 April 2000. The scheme, into which annual contributions are made, provides a pool from which claims are settled. A key aim of the scheme is to encourage health bodies to improve clinical performance and so reduce negligence claims.

Internal financial control

- 19 Directors of health bodies in Scotland are required to sign an internal financial control statement which sets out their responsibilities for internal financial control and confirms that they have reviewed the effectiveness of these controls. Health Board and Trust appointed auditors review the internal financial control statements and provide an opinion. Provided weaknesses in internal control are disclosed in the statement appointed auditors can provide an unqualified opinion on internal financial control. None of the auditors' opinions was qualified in 1999/2000.
- 20 Analysis of the internal financial control statements shows that disclosures of weaknesses were made in most of the 50 NHS bodies in 1999/2000, the first year after reorganisation. The most common were:
- The absence of a fully developed risk management strategy.
 - The absence of a formal fraud and corruption policy.
 - The need to develop IT security policies in respect of services provided under the national IS/IT service provider contract and information management & technology strategies.
 - Limitations in the amount of audit assurance available, particularly in relation to central payroll systems.
 - Weaknesses in the control of payments relating to Family Health Services.
 - The need to update Standing Financial Instructions and schemes of delegation.

Action plans

- 21 The appointed auditors of the 50 health bodies in the NHS in Scotland have all produced reports on their findings. Where they have concluded that action needs to be taken to make improvements in response to their findings, the auditors have agreed or will agree action plans with Health Boards and Trusts. These plans set out the action needed, where responsibility for action rests and a timetable for implementation. I shall ensure that implementation of the action plans is monitored and followed up.

Part 2. Matters arising during the year

Year 2000 compliance

- 22 In the Year 2000 the NHS in Scotland, along with all other organisations worldwide, faced the risk that computers and related systems would be seriously affected by the millennium date change (the Millennium Bug). The NHS in Scotland had prepared for the event and invested some £43 million in ensuring that its services were not disrupted. The NHS in Scotland experienced no significant effect on its services from the threatened Millennium Bug and its healthcare services were fully maintained at the required level.

NHS in Tayside

- 23 As with other parts of Scotland, the NHS in the Tayside area experienced significant organisational change prior to the commencement of the 1999/2000 financial year. While Tayside Health Board achieved its financial target, both Trusts in the area experienced considerable financial difficulties which centred on both in-year and inherited service and cost pressures.
- 24 A Ministerial Taskforce was established in February 2000 to work with Tayside health bodies to deliver an effective financial recovery plan and a cohesive financial and operational strategy. In view of the comments reported by the appointed auditors on the use of resources in the provision of healthcare in Tayside, and the outcome of the Ministerial Taskforce, I intend to report separately on the management and use of resources in Tayside.

Primary care payments

- 25 In 1999/2000 the Common Services Agency assumed responsibility for calculating and making payments to primary care practitioners (ie GPs, pharmacists, dentists and opticians) on behalf of Primary Care Trusts and Islands Health Boards. This involves some 64 million transactions valued at about £1.2 billion.
- 26 A review of these arrangements by the appointed auditor of the Common Services Agency identified critical weaknesses:
- Inconsistencies in post payment verification in relation to all payment streams
 - Insufficient reconciliation between expenditure recorded by the Common Services Agency and health bodies
 - No formally documented disaster recovery test for the GP payments system.
- 27 It is clear from the auditor's report that action is required to ensure that post payment checks are in place for this significant area of NHS expenditure. The Common Services Agency and the Primary Care Trusts need to finalise agreements to ensure that payments are valid and accurate. The Common Services Agency has agreed corrective action and the issues identified from the audit review undertaken will be followed up during 2000/2001.

Employment related matters

- 28 In recent years, health bodies have experienced difficulties in the interpretation and application of regulations relating to senior management remuneration. For pay awards in 1999/2000 health bodies were required by the Department to limit performance pay increases for managers and the overall increase in the pay bill for general and senior managers to prescribed percentage levels. In general, health bodies complied with the requirements.
- 29 The European Union Working Time Regulations provide for minimum rest periods, annual holidays, a limit on the working week and restriction on night work for employees. Most NHS bodies in Scotland did not implement the regulations in full from the effective date in October 1998 and consequently became potentially liable to make certain payments mainly in respect of annual leave entitlements. Consequently, NHS bodies have calculated the value of the potential liability, for the purposes of their 1999/2000 accounts, at a total of £15 million. The Department has established a working party to consider how the costs arising may be met.

Governance

- 30 Health Boards and Trusts are required to ensure good corporate governance through the highest standards of probity and propriety appropriate to the handling of public money. The Government White Paper '*Designed to Care*' extended this role to include clinical governance, which concerns the quality of care in Trusts.
- 31 A review of governance by appointed auditors found that there are generally sound governance arrangements in place in NHS bodies.

Exhibit 3: Areas covered by appointed auditors in reviewing governance arrangements

- The role of the board, including the contributions of non-executives.
- The effectiveness of the audit and remuneration committees
- The organisation's approach to openness
- The board's involvement in the healthcare planning processes
- The governance arrangements for local Health Care Co-operatives
- The board's involvement in the clinical governance framework

Specific value for money findings

- 32 As a result of examinations undertaken during 1999/2000, four main value for money audit reports were published on the NHS in Scotland. Follow up action is planned where appropriate.

The Scottish Ambulance Service: A Service for Life (National Audit Office, December 1999)

This report examined the speed and responsiveness of the emergency ambulance service, their efficient and economic use of resources and their provision of effective pre-hospital emergency healthcare. It concluded that there was scope to improve the responsiveness of accident and emergency ambulance services in Scotland and the impact they have on the healthcare of patients. The Scottish Parliament's Audit Committee took evidence from the Accountable Officers of the Service and of the Department in February and March 2000 and in June 2000 published their report, which emphasised the importance of the Service better matching treatment and speed of response to patients' needs.

A shared approach – Developing adult mental health services (Accounts Commission, October 1999)

The key findings of the examination included:

- The amount of money spent on adult mental health services varied widely across the country. Spending continued to be based on historical patterns, rather than being linked to need.
- 78% (£160 million) of total NHS spending on specialist adult mental health services remained tied up in hospital in-patient beds. This limited the scope for the development of community services.
- The involvement of users and carers in mental health services was better developed than for many areas of health and social care. More attention needed to be paid to involving users in developing their own care plans; and in empowering users and carers to evaluate the quality and effectiveness of services.

Temporary Measures - Managing bank and agency nursing staff (Accounts Commission, February 2000)

The main findings and recommendations from this examination were:

- Nurse banks could be managed more effectively. Most Trusts have more than one nurse bank, and one Trust operates ten nurse banks.
- The development of good IT systems will help Trusts to manage the employment of temporary nursing staff more effectively.
- Trusts could improve their contracts with nurse agencies.
- Effective pre-employment checks, induction and appraisal of temporary nursing staff are required to assure the safety of patients.

A clean bill of health? Domestic services in Scottish hospitals (Accounts Commission, April 2000)

The study found that some Scottish hospitals are not meeting minimum cleaning standards, which can compromise levels of infection control and reduce the quality of the environment for patients.

The report recommended that hospitals can improve cleanliness without incurring costs by having a combination of clear minimum frequencies for specific cleaning tasks and clear output specifications. Domestic service staff should work with infection control teams to minimise the risk of hospital acquired infection.

Introduction

- 1.1 Under the terms of the Public Finance and Accountability (Scotland) Act 2000 (the 2000 Act) responsibility for the audit of NHS Trusts and Health Boards transferred from the Accounts Commission for Scotland to the Auditor General for Scotland with effect from 1 April 2000. Transitional arrangements applied to the audit of 1999/2000 accounts. The audits of Trusts and Health Boards, which had been commissioned in advance by the Accounts Commission, and carried out in accordance with the Commission's Code of Audit Practice were reported to the Auditor General after their completion.
- 1.2 Accounts for 1999/2000 summarising the financial results of Trusts, Health Boards and other specified NHS bodies are prepared by Scottish Ministers for audit by the Comptroller and Auditor General. That work is ongoing and, in due course, the Comptroller and Auditor General will report to the Scottish Parliament and the Parliament in Westminster. Responsibility for the audit of the summarised accounts will transfer to the Auditor General for Scotland, starting with the accounts for the year ending 31 March 2001.
- 1.3 The Accounts Commission appointed auditors to conduct the 1999/2000 audits of Trusts and Health Boards either from commercial accountancy firms or from their own staff (who transferred to Audit Scotland on 1 April 2000). In all cases, appointed auditors also reported to and agreed their findings with individual Trusts and Health Boards. This report, which I present under section 23 of the 2000 Act, has been prepared principally from information contained in reports prepared by appointed auditors at the conclusion of their audits of individual Trusts and Health Boards. Where appropriate, I have supplemented this with other relevant, contextual information. My report covers all the significant issues arising out of the 1999/2000 audits of Trusts and Health Boards.
- 1.4 Although this report comments on a number of issues arising in Trusts and Health Boards, overall financial stewardship in the NHS in Scotland continues to be of a high standard. Accounts were presented for audit on time and there were no qualifications on the accounts of any of the 50 Trusts and Health Boards which were subject to audit in 1999/2000. Generally, it appears that NHS managers coped well with the demanding workload arising from the reorganisation of the NHS in Scotland, which took effect on 1 April 1999. However, it is clear from auditors' reports that Trusts faced significant financial pressures in 1999/2000 and that these will have continued into the current financial year.
- 1.5 My report is in two parts. The first part relates to matters of essentially a recurrent nature and shows, through the annual audit findings at individual Trusts and Health Boards, the broader results and trends for the NHS in Scotland as a whole. The second part relates to matters arising primarily during 1999/2000 either at individual Trusts and Health Boards or more widely.

Part 1. Annual results and trends

This part covers :

- Completion of accounts and audits
- Financial performance
- Clinical and medical negligence
- Internal financial control
- Action plans
- General value for money issues

2 Completion of accounts and audits

Trusts

- 2.1 From an accounting point of view, the most significant impact arising from reorganisation of the NHS in Scotland was the reduction in the number of Trusts from 47 to 28 and the introduction of new arrangements for the administration of primary care payments to GPs, pharmacists, dentists and opticians. A number of the new Trusts operated financial systems inherited from demitting Trusts and had to consolidate the results to produce accounts for 1999/2000. The reconciliation of balances arising from that process in some cases led to a number of adjustments to the accounts presented for audit. Primary Care Trusts and Health Boards also experienced difficulties in preparing their accounts due to the delay in receiving financial information on primary care payments from the Common Services Agency. However, all Trust audits were completed by the 30 June 2000 deadline set by the Scottish Executive Health Department (the Department).

Health Boards

- 2.2 Structurally, Health Boards were largely unaffected by reorganisation. In 1999/2000 there were 15 Health Boards and seven 'special' Health Boards and the deadline set by the Department for completion of these audits was 31 July 2000. By that date 20 sets of accounts had been signed off by the appointed auditors. The accounts of Dumfries and Galloway Health Board and Argyll and Clyde Health Board were signed off by the auditor on 4 August 2000 and 14 September 2000 respectively.
- 2.3 The deadlines set by the Department for the completion of audits are extremely tight and the performance of Trusts and Health Boards and their auditors in achieving the position outlined above was commendable. Exhibit 1 sets out the action required to ensure that a similar performance can be achieved in future years.

Exhibit 1: Action required to achieve audit deadlines

- A timetable for the conduct and completion of the audit should be agreed in advance and the accounts and supporting working papers should be made available to the auditors in accordance with that timetable.
- Guidance and directions on the form and content of the annual accounts should be notified by the Department well in advance of the point at which Trust and Health Board accounts are being prepared for audit.
- Information from the Common Services Agency on primary care payments, essential for the completion of the accounts of Primary Care Trusts and Health Boards, should be made available on a timely basis with full reconciliation of the expenditure reported by the Trusts, Health Boards and the Common Services Agency.

3 Financial performance

- 3.1 The Department requires Trusts to achieve three financial targets each year. They are required to break-even, taking one year with another; to achieve a rate of return on assets of 6%; and to operate within an external financing limit (the 'EFL'). Analysis of the annual accounts of Trusts shows that they experienced significant financial difficulties in 1999/2000.
- 3.2 Overall, in 1999/2000 19 of the 28 Trusts (68%) achieved all three financial targets compared with 42 of the 47 Trusts (90%) prior to reorganisation in the previous year. Exhibit 2 summarises the performance of the 28 Trusts in 1999/2000 and compares results with the 47 Trusts which were in operation in 1998/99.

Exhibit 2: Trust financial target performance

Target	Targets achieved			
	1999/2000		1998/99	
	No of trusts (out of 28)	%	No of trusts (out of 47)	%
Break-even, year on year	20	71	42	90
Rate of return on assets	20	71	45	96
EFL	28	100	45	96

Break-even target

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

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

- deficits reflect a shortfall between the level of expenditure and the availability of income ie, the cost of providing services and the level of service provision exceed the financial resources available
- deficits require to be financed from within the resources available to the Trust and current year deficits have to be repaid from subsequent years' income. By sustaining deficits Trusts are deferring the reductions or changes in services that are required to repay earlier years' overspends and restore financial balance.

3.5 At reorganisation, Trusts' earlier years' surpluses and deficits were eliminated. Consequently new Trusts did not have surplus balances brought forward to absorb deficits in 1999/2000. As indicated in Exhibit 2, eight Trusts failed to break-even in 1999/2000. In total, these Trusts had accumulated deficits totalling £29.8 million as at 31 March 2000. The remaining 20 Trusts, each of which had a surplus to carry forward into 2000/01, had accumulated surpluses totalling £10.6 million. Exhibit 3 shows the position over the past three years.

Exhibit 3: Year end deficits

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

While the increasing level of deficits must be viewed in the context of overall expenditure in the NHS in Scotland of about £5 billion, it provides evidence of mounting financial pressure on Trusts.

3.6 Exhibit 4 details the Trusts that failed to achieve the break-even target in 1999/2000.

Exhibit 4: Trusts with deficits at 31 March 2000

Trust	Deficit at 31/3/2000	Deficit as a % of income
Argyll & Clyde Acute Hospitals	£3.5m	2.5%
Grampian University Hospitals	£2.5m	1.2%
Highland Acute Hospitals	£0.8m	1.0%
North Glasgow University Hospitals	£8.7m	2.3%
Renfrewshire & Inverclyde Primary Care	£1.5m	1.0%
South Glasgow University Hospitals	£2.3m	1.3%
Tayside University Hospitals	£10.0m	5.0%
West Lothian Healthcare	£0.5m	0.4%
	<u>£29.8m</u>	

Note

The position at West Lothian Healthcare is a 'technical deficit' arising from a downward valuation of property. The Trust recognised the impairment in value of a health centre arising from plans to replace the building under a public private partnership arrangement.

3.7 Exhibit 4 shows that Tayside University Hospitals had an accumulated deficit of £10 million at 31 March 2000. Further comment about the position at Tayside is included at Section 9 of this report.

3.8 The two major acute Trusts operating in the Glasgow area (North Glasgow University Hospitals and South Glasgow University Hospitals) reported significant financial deficits in 1999/2000. Similarly, two Trusts in the Argyll and Clyde Health Board area (Argyll & Clyde Acute Hospitals and Renfrewshire & Inverclyde Primary Care) reported deficits. These Trusts, in conjunction with their local Health Boards, are continuing to develop recovery plans aimed at restoring financial balance. The respective auditors will monitor progress during 2000/01 and will report in the context of that year's audit. Based on their findings, the financial position of health bodies operating in these areas may feature as part of my overview report on the 2000/01 NHS audit.

3.9 More generally, individual Trusts' appointed auditors identified the main reasons why Trusts incurred a deficit in 1999/2000. These are shown in Exhibit 5.

Exhibit 5: Main reasons for Trust deficits in 1999/2000

- Financial pressure inherited on reorganisation. Some Trusts inherited 'hidden' deficits eg, predecessor Trusts may have depended on sources of funding to support core services and attain break-even in 1998/99 which were not available to the new Trust in 1999/2000. This problem was compounded in some cases in 1999/2000 by the delay in identifying and quantifying the extent of inherited deficits and the subsequent delay in initiating remedial action to mitigate the effect during the year.
- Non-recurring costs which were specific to 1999/2000 eg, millennium pay, costs associated with ensuring computer systems were Year 2000 compliant and early retirements following reorganisation.
- Increased costs of pharmaceutical products; either general increases in costs arising from EC legislation on packaging or a significant and unexpected increase in the price of generic drugs.
- The requirement to provide in the accounts for the impact of the EU Working Time Regulations (see paragraph 11.8). In some cases, Trusts were able to secure income from their respective Health Boards. As a result, the provision in the Trusts' accounts was not prejudicial to the achievement of financial targets.
- Costs associated with covering staff vacancies by overtime and bank and agency nurses.
- Increased capital charges arising from upward revaluation of property. Increases in the value of fixed assets result in higher capital charges such as at Tayside University Hospitals, where increases in the value of land and buildings resulted in an unbudgeted increase in capital charges of about £1.3 million in 1999/2000.
- Increases in the level of provision for clinical and medical negligence (see Section 4).
- The inability of some Trusts to achieve planned efficiency savings in 1999/2000.
- Unfunded service developments and increased activity, generally. The introduction of new services or the provision of services in excess of planned levels is generally preceded by agreement between the Trust and the Health Board on how new and/or increased levels of service are to be funded. In some Trusts during 1999/2000, appointed auditors reported that changes were introduced before funding had been agreed or where no additional funding was available (eg, Lothian University Hospitals, North Glasgow University Hospitals, South Glasgow University Hospitals, Tayside University Hospitals, Yorkhill).
- Complexity of case mix, leading to higher cost per case than was recognised in the allocation of resources. Trust auditors highlighted a number of cases where actual costs per case were higher than reflected in the allocation of resources. This can arise from treating complex medical conditions or from dealing with more deprived populations.

Many of the above factors also affected those Trusts that achieved break-even in 1999/2000.

3.10 In addition to those cases where Trusts failed to achieve the break-even target, appointed auditors drew attention to a number of cases where Trusts were dependent on non-recurring income to achieve break-even in 1999/2000. Appointed auditors also reported that funding originally earmarked for capital expenditure had been used to support Trusts' revenue positions. In two particular cases (Tayside Primary Care and Yorkhill), they noted that Trusts had anticipated in their 1999/2000 accounts capital receipts due to be available in 2000/01. The Department had approved the treatment of these amounts as revenue in 1999/2000, on the basis of an agreed financial plan which showed how recurring financial balance would be achieved in the future.

Rate of return target

- 3.11 Eight Trusts failed to achieve the required 6% rate of return on average net relevant assets. Exhibit 6 details the Trusts involved, seven out of the eight of which are the same as those included in Exhibit 4 above. The reasons for the failures to achieve the rate of return are similar to those highlighted in relation to the break-even target.

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

Trust	Rate of return (target 6%)
Argyll & Clyde Acute Hospitals	3.3%
Grampian University Hospitals	4.3%
Highland Acute Hospitals	4.5%
Highland Primary Care	5.5%
North Glasgow University Hospitals	2.6%
Renfrewshire & Inverclyde Primary Care	3.0%
South Glasgow University Hospitals	3.7%
Tayside University Hospitals	0.1%

Note

Highland Primary Care failed to achieve the target only due to the impact of the EU Working Time Regulations. The rate of return before accounting adjustments for the Regulations was 6.3%

External financing limit target

- 3.12 The EFL financial target is, in effect, a cash limit on the net external financing for Trusts ie, the amount of borrowing which a Trust is permitted to make. All Trusts achieved the target in 1999/2000.

- 3.13 One appointed auditor reported that payments to creditors were deferred in order to achieve the EFL target. In so doing, the Trust (South Glasgow University Hospitals) did not comply with the CBI code for prompt payment to suppliers. In addition, although not as prevalent as in earlier years, other appointed auditors reported cases where payments were made early in order to achieve the EFL target. While the impact of these early settlements is not significant in cash flow terms and there was no financial risk to the Trusts involved, the practice of early payments should be discouraged.

Future prospects for achieving the financial targets

- 3.14 In those cases where financial targets were not achieved, or where difficulties were foreseen in achieving targets in future years, most Trusts have prepared recovery plans which set out the action required to achieve or maintain financial stability. Individual Trusts' auditors have considered these plans to assess whether they appear to provide a sound basis for the achievement of targets. Appointed auditors have expressed concerns in those cases where elements of the Trust recovery plan are demanding and require the achievement of savings or increased levels of income which represent a significant challenge to the

Trusts in 2000/01. They also highlighted cases where the level of deficit incurred by Trusts in 1999/2000 was so significant that it would not be possible to achieve recovery within 2000/01 (eg, North Glasgow University Hospitals, Tayside University Hospitals).

- 3.15 Many of the factors affecting the achievement of the break-even and rate of return targets in 1999/2000 are likely to continue to have an impact in 2000/01. Other factors likely to lead to additional pressures on Trusts in future years include those set out in Exhibit 7.

Exhibit 7: Additional pressures on Trusts in future years

- **Demography.** Population projections for the next 20 years show an increasing number of people over 65 with a significant increase in the very elderly (over 85). By 2005 it is predicted that one in six of the population will be over 65. This is likely to put significant pressure on all health services.
- **Technological change.** In recent years there have been significant technological advances and it is now possible to treat conditions for which there were previously no treatments available. This includes new drugs, new surgical and radiological treatments and, in due course, gene therapies. Without proper planning, this may lead to financial difficulties.
- **Rising expectations.** There has been a significant shift in the way patients and the public view the health service. This has been reinforced by initiatives such as the Patients' Charter and by the rise of vocal patient groups. Legal challenges to health authority decisions in England (such as the funding for a patient denied beta interferon by a health authority) and media attention on 'postcode prescribing' have also placed pressure on the health service to deliver treatments and services which might not otherwise have been provided at that time.

- 3.16 Overall, it is evident that most NHS Trusts in Scotland faced significant financial pressures in 1999/2000 with, in many cases, the costs exceeding the level of available resources. While it is acknowledged that new resources have been announced for the health service, there are clear indications that these pressures will continue into the current financial year and beyond. It is of concern that, by relying on non-recurring income, Trusts can show that financial targets have been achieved in one year yet commence the following year with a deficit in 'trading' terms. Targets are an important element in a financial management framework. But these emerging challenges, taken with the deteriorating ability of Trusts to meet the financial targets required of them, raise questions about the purpose of existing targets. The emerging financial challenges and other structural changes within the health service mean that it is appropriate for the Department to review the current financial targets.

Health Boards/'Special' Health Boards

- 3.17 The financial target set for Health Boards in 1999/2000 was to remain within a cash limit notified by the Department. The accounts for 1999/2000 show that all 15 Health Boards reported an underspend against their cash limit. This is a continuation of a trend seen in recent years. The 15 Health Boards had total underspends of £19.3 million in 1997/98, £34.6 million in 1998/99 and £37.5 million in 1999/2000. Underspends of cash do not represent savings in the provision of health services but indicate that, for various reasons (eg, delays in the progress of capital projects), cash was not utilised as quickly as had been planned.

3.18 Health Boards may carry forward underspends of up to 1% of the cash limit from one year to another. The six Health Boards which exceeded the 1% cash limit in 1999/2000 were permitted by the Department to carry forward the total value of the underspend into 2000/01. These are set out in Exhibit 8.

Exhibit 8: Health Board underspends in 1999/2000 over 1%

Health Board	Underspend against cash limit	Underspend as % of cash limit
Ayrshire and Arran	£3.4m	1.13%
Argyll and Clyde	£3.8m	1.10%
Dumfries and Galloway	£4.4m	3.32%
Lanarkshire	£6.7m	1.60%
Orkney	£0.4m	1.96%
Shetland	£0.4m	1.05%

3.19 The financial target for 'special' Health Boards is also to remain within a cash limit notified by the Department. All seven 'special' Health Boards achieved that target in 1999/2000.

3.20 Although there is clearly a strong relationship between the financial performance of Health Boards and Trusts, the way in which they account for their respective activities precludes the portrayal of the overall financial performance of the NHS as a whole. The Department summarises the financial results of Health Boards and Trusts separately but there is considerable scope to reflect a more comprehensive picture of the NHS in Scotland's overall financial performance. The move towards Resource Accounting in central government may facilitate this.

4 Clinical and medical negligence

Background

4.1 Clinical and medical negligence is the term given to a breach of a duty of care by health care practitioners in the performance of their duties in the NHS. In this context 'medical' refers to medical and dental practitioners and 'clinical' refers to nursing staff and the professions allied to medicine.

4.2 When medical or clinical negligence claims are lodged against them, health bodies report them to the Central Legal Office. The Central Legal Office assess the likelihood of the claim being successful and advise the health body as to whether to seek a settlement or defend any resulting litigation. The Central Legal Office monitor progress of all cases with individual health bodies and attach a category to each claim in the range of 1 to 3. The higher the category the greater the likelihood of a settlement being paid.

- 4.3 Health Boards and Trusts are required to make provision for medical and clinical negligence claims based on a review of all outstanding and potential claims for which they may be liable. The provision represents the actual cost of outstanding clinical and medical negligence claims where the Central Legal Office and the health bodies concerned have reasonable expectation of making a payment. In addition, all health bodies are required to disclose information on contingent liabilities for clinical and medical negligence claims where no provision has been made in the accounts. These are costs for which there is a possibility rather than a probability of future payment.

Level of claims in 1999/2000

- 4.4 At 31 March 2000 Trusts and Health Boards had made provisions for negligence claims totalling £38 million and disclosed contingent liabilities of a further £46.4 million, a total of £84.4 million. In addition, they utilised £3.5 million of provisions set up in earlier years to settle claims and cancelled provisions of £3.2 million in respect of claims where settlements were not required or were at levels lower than the amount provided (Exhibit 9).

Exhibit 9: Account figures: cost of medical and clinical negligence claims, 1999/2000

	£'000	£'000
Opening Provisions at 1.04.99		
Trusts	11,649	
Boards	<u>12,832</u>	24,481
Utilised in Year		
Trusts	(1,916)	
Boards	<u>(1,602)</u>	(3,518)
Reversed unutilised		
Trusts	(2,004)	
Boards	<u>(1,229)</u>	(3,233)
Arising in Year		
Trusts	10,075	
Boards	<u>10,192</u>	20,267
Closing Provisions at 31.03.00		
Trusts	17,804	
Boards	<u>20,193</u>	37,997
Contingent Liabilities at 31.03.99		
Trusts	12,963	
Boards	<u>21,961</u>	34,924
Contingent Liabilities at 31.03.00		
Trusts	22,727	
Boards	<u>23,677</u>	46,404

4.5 As Exhibit 9 shows, provisions and contingent liabilities across Health Boards and Trusts rose, by £13.5 million (55%) and £11.5 million (33%) respectively over those reported in 1998/99. This is partly due to increases in the:

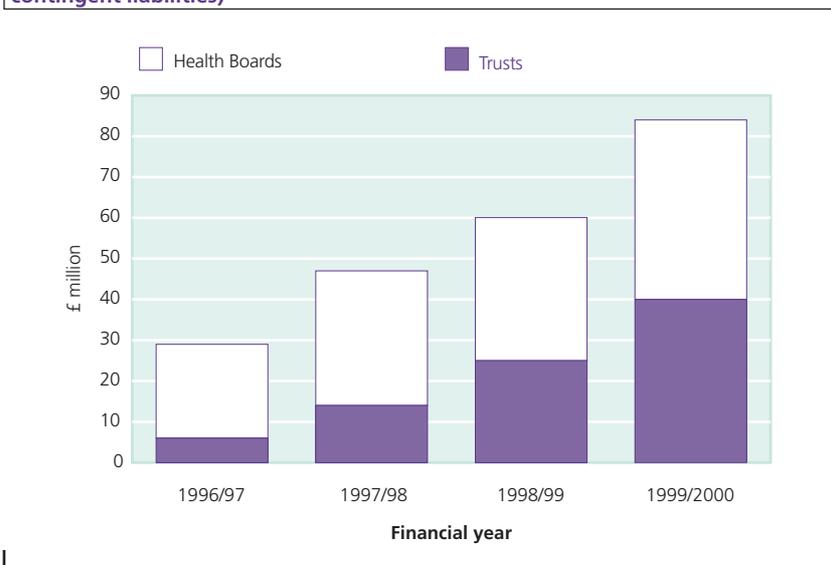
- Total value and number of claims for Trusts.
- Total value attached to previously existing claims for Health Boards, as well as a small number of new claims lodged in 1999/2000. The latter have been assessed at very high values ranging from £0.5 million to £2 million.

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

Rising trend in claims for negligence in Scotland

4.7 Claims are made against the NHS body that was the employer of the health care practitioner at the time the incident occurred. Those arising from incidents prior to the formation of Trusts remain the responsibility of Health Boards. As it can take some years for negligence claims to be lodged, and settled, the majority of claims outstanding are against Health Boards. However, this year the position has almost equalised with claims against Trusts only £3 million (7%) below those reported for Boards, compared with differences between Boards and Trusts of £10 million (28%) and £19 million (59%) in the previous two years. The overall position is shown in Exhibit 10.

Exhibit 10: Clinical and medical negligence claims (total provisions and contingent liabilities)



Trusts

4.8 As shown in Exhibit 10, over the period 1996/97 to 1999/2000 recognised claims against Trusts have increased from £5.6 million to £40.5 million, an increase of over 600%. This rapid increase was to be expected with the transfer of healthcare provision from Health Boards to Trusts. Although Exhibit 10 shows that the rate of increase each year is falling, the value of recognised claims rose from £24.6 million in 1998/99 to £40.5 million in 1999/2000, an increase of 65%. This represents a potentially increasing burden on the financial resources available to the NHS in Scotland.

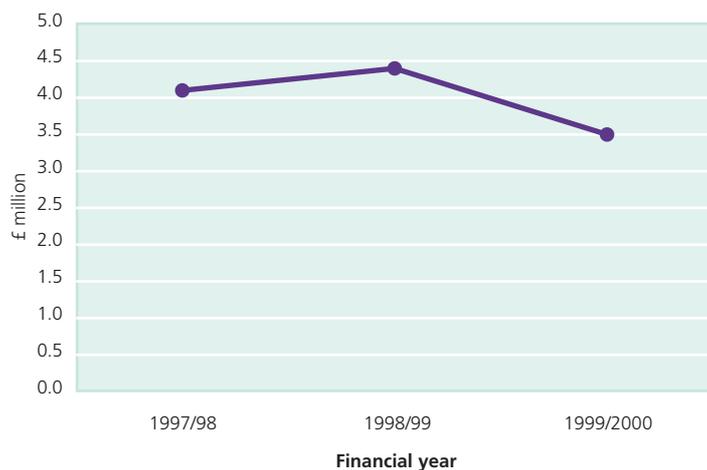
Boards

4.9 The level of recognised claims against Health Boards also increased this year and at a faster rate than reported in the previous year. The level of recognised claims against Health Boards has increased from £34.8 million in 1998/99 to £43.8 million in 1999/2000, an increase of 26% compared to the 6% increase reported between 1997/98 and 1998/99. This is partly due to the Central Legal Office attaching a higher estimated settlement value to some existing claims as well as reporting new claims even though the incidents giving rise to the claims occurred some years ago.

Settlement of claims in 1999/2000 and future funding arrangements

4.10 Liabilities for clinical and medical negligence over the past years have been rising at a considerable rate, as shown in Exhibit 10. These present a major challenge for the health service in Scotland and represent a diversion of resources away from healthcare. However, although the level of provision and contingent liability is increasing the actual value of settlements over the past three years has remained relatively constant. In 1999/2000 the utilisation of the provision was £3.5 million, representing a decrease on the utilisation of £4.4 million in the previous year and £4.1 million in 1997/98 (Exhibit 11).

Exhibit 11: Clinical and medical negligence: use of provisions



4.11 Concerns within the Scottish Executive about the depletion of the fund available and the rising costs of potential negligence claims have led to the establishment of new arrangements for sharing financial risk. The scheme, entitled 'Clinical Negligence and Other Risks Indemnity Scheme' (CNORIS) came into effect on 1 April 2000. The scheme is mandatory for all Trusts and Health Boards and covers settled clinical negligence claims, that is, claims for incidents that occurred after 1 April 2000 or were not reported prior to that date.

- 4.12 Under the CNORIS scheme, members are required to pay annual contributions into the pool based on calculations determined by the scheme managers. The aim being that the overall pool is funded on a 'pay as you go' basis in order that the contributions collected in any one year should be sufficient to meet the expected level of reimbursements from the pool. Contributions to the scheme will take account of a number of factors, including the effectiveness of steps members take, or are taking, to reduce the recognised risk factors and thereby the incidence and cost of claims starting from 1 April 2001 as well as the claims history for each member over time starting from 1 April 2003.
- 4.13 A key aim of the new scheme is to encourage health bodies, through a system of financial incentives, to develop sound risk management procedures and improve clinical performance and so reduce the incidence of clinical negligence claims. A Standards Committee has been established to work with the scheme managers in developing, reviewing and updating the standards for the clinical components of the risk pool. In practice, steps taken, or being taken, by members to reduce the incidence of the liabilities covered by the scheme will be measured against the set of risk management standards developed.

5 Internal financial control

Internal financial control statements

- 5.1 From financial year 1998/99, directors of health bodies in Scotland have been required to sign an internal financial control statement (the 'IFC statement') which sets out their responsibilities for internal financial control and confirms that they have reviewed the effectiveness of these controls.
- 5.2 From 1999/2000, the IFC statement has been amended to include reference to a set of minimum financial control standards specified by the Department under five headings as set out in Exhibit 12.

Exhibit 12: Headings for minimum financial control standards

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

- 5.3 In 1999/2000 the IFC statement was signed by the General Manager/Chief Executive on behalf of the board which hold collective responsibility for internal financial control and is incorporated within the annual accounts of health bodies.
- 5.4 Health Board and Trust auditors are required to review the IFC statement and provide an opinion which takes the form of a 'negative assurance'. Provided weaknesses in internal control are disclosed appropriately in the IFC statement and the statement is not inconsistent with the information arising from the audit, appointed auditors are able to provide an unqualified opinion on the IFC statement. In 1999/2000, none of the auditors' opinions on the IFC statements was qualified.

- 5.5 Analysis of the 1999/2000 IFC statements shows that, across the 50 NHS bodies, additional disclosures were made in most cases. The most commonly occurring issues are set out in Exhibit 13.

Exhibit 13: Most commonly occurring disclosures in IFC statements

- The absence of a fully developed risk management strategy.
- The absence of a formal fraud and corruption policy.
- The need to develop IT security policies in respect of services provided under the national IS/IT service provider contract and information management & technology strategies.
- Limitations in the amount of audit assurance available, particularly in relation to central payroll systems.
- Weaknesses in the control of payments relating to Family Health Services.
- The need to update Standing Financial Instructions and schemes of delegation.

- 5.6 Additional disclosures indicate that not all required procedures and policies were in place as at 31 March 2000 or for the whole of the 1999/2000 financial year. This means that there was exposure to risk in these areas. The delay in implementing the required procedures and policies reflects the competing pressures faced by NHS bodies in 1999/2000, the first year following major reorganisation. Appointed auditors' reports indicate that, in most cases, action has already been taken or is proposed to ensure closer compliance with the minimum financial control standards in 2000/2001.

- 5.7 The IFC statement for all Trusts involved in providing primary care services reflected the weaknesses in control arising from the new arrangements for Family Health Service expenditure. This matter is considered further in Part 2 of this report.

Internal audit

- 5.8 Internal audit in the NHS in Scotland continues to be of a high standard. In most cases there is good liaison and co-operation between internal and external audit and external auditors are able to rely on the work of internal audit, thereby making best use of the overall resources available for audit.
- 5.9 In a small number of cases, appointed auditors considered that there was a need for Trusts to review their internal audit strategy to ensure that the main financial systems (including, where appropriate, Family Health Service systems) are receiving adequate coverage.

Asset registers

- 5.10 In a number of cases, appointed auditors reported weaknesses in Trusts' asset register arrangements. In view of the substantial sums represented by assets, it is essential that there are sound arrangements to safeguard them from loss and to ensure reliable records are available as a basis for capital charges.

Computer systems

5.11 With effect from 1 April 1999, a new contract for the provision of computer services to all NHS bodies in Scotland came into effect. This involves a contract between the NHS and a principal supplier of services, supported by a number of framework agreements between the NHS and other providers of specialist services.

5.12 During 1999/2000 the auditor of the Common Services Agency (CSA) carried out an overview of the arrangements under which this contract is operated. He concluded that the overall arrangements for the contract were satisfactory and in line with good practice. However, the auditor identified a number of issues for consideration by the Contract Management Board of the CSA. Two of the main points related to the specific areas of business continuity and contingency and telecommunications and networking. A detailed action plan has been agreed and the auditor will be following up on the points arising from the review as part of his 2000/2001 audit. An extract from the action plan is shown at Exhibit 14.

Exhibit 14: Extract from action plan

Ref	Recommendation	Importance	Responsibility	Agreed	Audited Body's Comments	Action Date
12.	<p>BUSINESS CONTINUITY/CONTINGENCY</p> <p>Disaster Recovery arrangements for mainframe, mid-range and micro services should be implemented and tested (page 21, para 6).</p>	<i>Critical</i>	CMT Sema Group (& Health Bodies)	Yes	<p>This is in place for mainframe, mid-range and micro services which the NHSIS have deemed to be business critical.</p> <p>Further review may be required with the Health bodies of DR arrangements for Mid range equipment.</p>	Complete and will be monitored twice yearly
13.	<p>TELECOMMUNICATIONS AND NETWORKING</p> <p>A management review of health body telecommunications and networking services should be conducted and a rationalisation programme prepared (page 22, para 7).</p>	<i>Critical</i>	SEHD	Yes	<p>CSA Telecommunications Group and ISSG are currently engaged in this review, and preparing a forward programme. This will be reviewed with Sema, who have also offered network consultancy in this area.</p>	Ongoing

6 Action plans

6.1 The appointed auditors of the 50 health bodies in the NHS in Scotland have all produced reports on their findings. Where the auditors have concluded that action needs to be taken to make the improvements necessary in response to their findings, they have agreed or will agree action plans with respective Health Boards and Trusts which specify the action needed, where responsibility for action rests and a timetable for implementation. As part of my responsibilities for the audit of the NHS in Scotland I shall require that implementation of the action plans is monitored and followed-up by the appointed auditors.

7 General value for money issues

- 7.1 Prior to 1 April 2000, value for money studies of the NHS in Scotland were undertaken separately by the National Audit Office and the Accounts Commission. Under transitional arrangements the work undertaken by the National Audit Office was reported to the Scottish Parliament. Since 1 April 2000 the Auditor General for Scotland has assumed responsibility for undertaking, and where appropriate, reporting on value for money examinations of the NHS in Scotland.
- 7.2 Value for money issues arising during 1999/2000 therefore derive from the work of both the National Audit Office and the Accounts Commission. Due to the different reporting mechanisms the outcome of the National Audit Office's work (on the Scottish Ambulance Service) has already been considered by the Audit Committee of the Scottish Parliament.
- 7.3 The outcome of the main value for money work undertaken on the NHS in Scotland in 1999/2000 is set out in Part 2.
- 7.4 Since 1 April 2000 Audit Scotland value for money examinations will have these features:
 - the potential to improve services to patients
 - the potential for financial savings which can be reinvested in services
 - coverage of both acute and primary care services
 - examinations of major services, where change may be slower or more difficult to achieve, and examinations tackling less prominent services but offering faster improvements.

Part 2. Matters arising during the year

This part covers :

- Year 2000 compliance
- NHS in Tayside
- Primary care payments
- Employment related matters
- Accounting for PFI
- Governance
- Specific value for money findings
- Current value for money examinations

8 Year 2000 compliance

- 8.1 In the year 2000 the NHS in Scotland along with all other organisations worldwide, faced the risk that computer systems, certain medical devices and estate systems would be seriously affected by the millennium date change – a syndrome known as the Millennium Bug. The NHS in Scotland had prepared for the event and invested some £43 million in ensuring that its services were not disrupted. The NHS in Scotland had recognised three broad categories of threat to patients and services: matters that would have an immediate effect on patients (life support equipment etc), matters that would have a very early effect on patients ie, within a matter of hours (critical medical records, essential healthcare equipment and facilities, communications), and matters that would have an effect, but not for a number of days (administrative etc systems).
- 8.2 At the critical dates of 31 December 1999/1 January 2000 the NHS in Scotland experienced no significant effect on its services from the threatened Millennium Bug. Its investment in service continuity planning, system testing and system upgrades undertaken to counter the Millennium Bug ensured that its healthcare services were fully maintained at the required level and no patient was exposed to risk. Since 1 January 2000 no further millennium compliance problems have emerged.

9 NHS in Tayside

- 9.1 As with other parts of Scotland, the NHS in the Tayside area experienced significant organisational change prior to the commencement of the 1999/2000 financial year. Tayside Health Board, in partnership with the two new Trusts (Tayside Primary Care NHS Trust (TPCT) and Tayside University Hospitals NHS Trust (TUHT)) is responsible for leading the development of a financial framework for the provision of healthcare in its area.
- 9.2 While in 1999/2000 Tayside Health Board achieved its financial target, both Trusts experienced considerable financial difficulties. As indicated in Part 1 of this report, TUHT failed to meet the break-even and rate of return targets. Despite the financial pressures, TPCT achieved the targets.
- 9.3 The difficulties faced by the Trusts centre on both in-year and inherited service and cost pressures. Contributory factors included:
- inherited unfunded commitments (from predecessor Trusts)
 - the cost of financing recurring services
 - increased capital charges following estate revaluation
 - budgetary control weaknesses.

- 9.4 A Ministerial Taskforce was established in February 2000 to work with the Tayside health bodies to deliver an effective financial recovery plan for TUHT and a cohesive strategy to address the overall financial and operational difficulties in the area.
- 9.5 In view of the comments reported by the appointed auditors of the Health Board and Trusts in Tayside on the use of resources in the wider provision of healthcare in the area and the outcome of the Ministerial Taskforce, I intend to report separately on the management and use of resources in Tayside.

10 Primary care payments

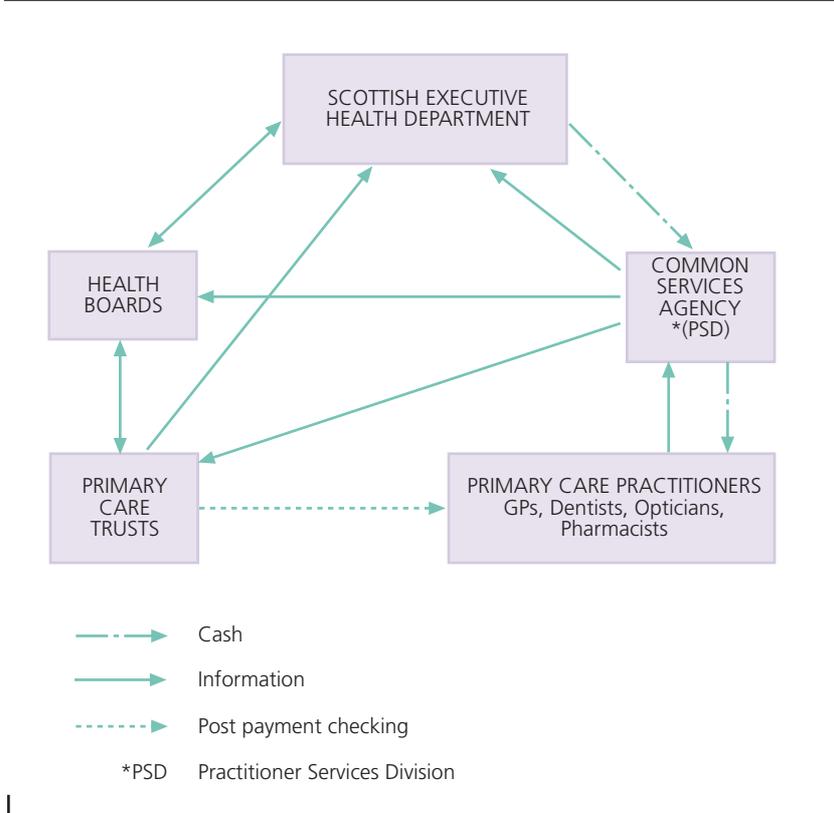
10.1 In 1999/2000, the Practitioner Services Division (PSD) of the Common Services Agency (CSA) assumed responsibility for calculating and making payments to primary care practitioners (ie, GPs, pharmacists, dentists and opticians) on behalf of Primary Care Trusts (PCTs) and Islands Health Boards. These payments (which are also known as Family Health Service (FHS) payments) had previously been made by Health Boards. In 1999/2000 the PSD processed some 64 million transactions with a total value of about £1.2 billion, which represents more than 20% of the total expenditure in the NHS in Scotland. FHS expenditure can represent more than 50% of a PCT's total operating expenditure.

10.2 The respective responsibilities and accountabilities under the new arrangements are complex. In outline:

- the CSA is responsible for cash payments to practitioners
- PCTs co-ordinate FHS payments and are accountable for the related expenditure, which is funded by Health Boards
- Health Boards continue to report FHS income and expenditure for the resident population in their annual accounts
- the responsibility for practice visits to check source documentation supporting claims from contractors rests with PCTs although they may delegate responsibility to the CSA
- PCTs are responsible for the follow up of potential fraud in relation to their FHS practitioners.

Exhibit 15 is a simplified diagram of these arrangements.

Exhibit 15: Outline of the primary care payments system



- 10.3** The revised arrangements for the administration of primary care payments represented a significant undertaking for all parties and involved rationalisation of the sites at which payments are processed, the transfer of staff and changes in accounting and funding systems (including IT systems). Overall, the creation of the PSD as an agency function to process claims and make payments to FHS practitioners represented a major achievement involving the transfer of staff, functions and responsibilities between Health Boards, PCTs and the CSA. Consequently, comments on performance in 1999/2000 must be considered in that context.
- 10.4** As noted earlier, PCTs bear the financial risk involved in respect of the payments made on their behalf but are restricted in their ability to exercise direct control over these activities. It is therefore essential that compensating controls are in place to provide the necessary assurance to PCTs, and Health Boards, in respect of their accounts.
- 10.5** As part of the overall assurance process the CSA engaged a 'service auditor' to report on the payment processes for 1999/2000. Their report, which was circulated within the NHS, concluded that, with the exception of specific areas of weakness, the policies and procedures in place provided reasonable assurance that the control objectives specified by CSA management were achieved during the period covered by the review.
- 10.6** In addition, a review was undertaken by the appointed auditor of the CSA to provide assurances on the standards of governance and financial stewardship for the payments made by the PSD on behalf of the other health bodies. His report was also circulated to all health bodies and concluded that the overall management arrangements were satisfactory but that the divisional

arrangements operated by the PSD in 1999/2000 were incomplete when measured against the minimum financial control standards specified for the NHS in Scotland. The report identified a number of weaknesses of the PSD as 'critical'. In summary these were:

- inconsistencies between offices of the PSD in their approach to post payment verification in relation to all payment streams. In particular, the auditor reported the need for a comprehensive risk-based approach for General Medical Services (ie, services provided by GPs), including targeted and random practice visits. He noted that practice visits may also have implications for clinical governance of General Medical Services. Only limited checks on General Medical Service payments were carried out in 1999/2000
- the necessary reconciliations between expenditure recorded in the accounts of health bodies and those recorded in the CSA's financial ledger were not fully in place during the year, nor were they finalised at the date of the appointed auditor's review report in May 2000. As noted in Part 1 of this report the delay in the availability of information on primary care activity caused difficulties for PCTs and Health Boards in preparing their accounts
- a formally documented disaster recovery test for the General Medical Practitioners payment system had not been performed and there were a range of critical weaknesses in relation to the development and maintenance of software used in the systems.

- 10.7 As indicated in Part 1 of this report NHS bodies considered the impact of the findings of the auditors and made appropriate reference to the weaknesses identified in their Internal Financial Control statements for 1999/2000.
- 10.8 The 'service auditor' also undertook additional work to provide assurance on the year end reconciliations between the information provided to the Trusts and Health Boards and that recorded in the CSA ledger. The necessity for proper reconciliation procedures is of particular importance in view of the impact that relatively small differences or uncertainties in recorded values can have on the attainment of financial targets. Accordingly, the absence of full reconciliations is a serious concern. Agreed positions were only achieved after significant local effort by Trusts and Health Boards and their appointed auditors.
- 10.9 In view of the nature and volume of services, it is clearly impractical for PCTs to authorise all payments in advance. Consequently, a robust system of post payment verification (PPV) checks, including practice visits, is essential. The appointed auditor of the CSA noted that a range of PPV activity is undertaken by PSD covering each of the four service areas. He noted that this was a continuation of predecessor Health Board practice and that, as a result, there are inconsistencies in the operation of post payment checks.
- 10.10 It is clear from auditors' reports that action is required to ensure that adequate post payment checks are in place in relation to this significant area of NHS expenditure. The CSA and PCTs need to finalise agreements for visits to practitioners to ensure that payments are valid and accurate. In addition, management information systems need to be developed so that data on cases where practitioner activity is outside normal levels is available to facilitate and target PPV activity.

10.11 The PSD has agreed that a post implementation review of the transfer of primary care responsibilities will be considered. Overall, the CSA has agreed corrective action in relation to the issues identified from the audit reviews and this will be followed up as part of the 2000/2001 audit.

11 Employment related matters

Senior management remuneration

11.1 In recent years, appointed auditors have reported that health service bodies have experienced difficulties in the interpretation and application of regulations relating to senior management remuneration.

11.2 A circular issued by the Department in September 1999 announced an extension to the pay ranges of general and senior managers employed by Health Boards. Trusts were expected to follow the arrangements closely.

11.3 For pay awards in 1999/2000, health bodies were required to:

- limit performance pay increases for managers to 2.8% for fully acceptable performance and to 6% for demonstrably outstanding performance
- restrict the overall increase in the pay bill for general and senior managers to an increase of not more than 4.3% compared with 1998/99.

11.4 Executive officers at health bodies were required to ensure that remuneration committees were aware of the content of the circular. The circular also required remuneration committees to obtain a variation order from the Department for any payments falling outside the terms of the circular.

11.5 In general, appointed auditors reported that health bodies complied with these requirements in 1999/2000. There were a small number of cases where auditors recommended action to improve local procedures.

11.6 The Department has advised that new arrangements for the pay of senior managers have been introduced from 1 April 2000 which simplify the process and tie pay clearly to achieving results. In addition, the Department has advised that it is reviewing the arrangements for monitoring the achievement of results for senior staff and that it will issue revised guidance in time for the new arrangements to be in place by 1 April 2001.

11.7 Appointed auditors also reported cases where they would have expected payments relating to terms of employment or termination of employment to have been presented in advance to Trusts' remuneration committees for scrutiny and approval. There is also a need to ensure that reports submitted provide full details to the remuneration committee on the reasons why a particular course of action is proposed.

European Union Working Time Regulations

11.8 The EU Working Time Regulations provide for minimum daily and weekly rest periods, annual holidays, a limit on the working week to an average of 48 hours and restrictions on night work for employees. The final regulations for implementation of the requirements of the EU Working Time Directive in the NHS came into force on 1 October 1998.

- 11.9 The Department wrote to health bodies in April 2000 on this matter and advised them to work with their appointed auditors to ensure proper accounting practice was followed.
- 11.10 Most NHS bodies in Scotland did not implement the regulations in full in October 1998. As a result there is a potential liability arising from the entitlement of NHS employees to certain additional payments, mainly in respect of backdated annual leave payments. Consequently, in terms of proper accounting practice, NHS bodies were required to calculate the value of the potential liability and reflect that amount in their 1999/2000 accounts.
- 11.11 The information available from the accounts and appointed auditors' reports indicated that, overall, Trusts and Health Boards have provided for potential liabilities for the EU Working Time Regulations of £15 million. As indicated in Part 1 of this report, this impacted on the financial position of Trusts but, in only one case (Highland Primary Care Trust), did a Trust fail to meet a financial target solely as a result of accounting for the impact of the EU Working Time Regulations.
- 11.12 In some cases, Health Boards have agreed to cover the costs associated with the application of the regulations and 'back to back' arrangements were established where the local Health Board agreed to provide the funding necessary to meet Trusts' potential liability arising from the regulations. In other areas, however, the local Health Board has indicated that if settlement is required by the Trusts the cash impact may be significant and the Board may not have sufficient funds to meet the costs.
- 11.13 The Department has established a working group to consider the matter on a national basis and provide guidance. Final settlements could be more (or less) than that provided in Trusts' accounts.

12 Accounting for PFI

- 12.1 There are a number of Private Finance Initiative (PFI) projects ongoing in the NHS in Scotland.
- 12.2 The auditors of the Lothian University Hospitals Trust reported that the introduction of new guidance on the accounting treatment for PFI transactions required them to reassess their earlier views on accounting for the project at the new Royal Infirmary of Edinburgh. Their earlier views, based on the information and accounting guidance available at that time, was that the PFI transaction would not need to be reflected on the Trust's balance sheet.
- 12.3 Having assessed the scheme with reference to the revised accounting guidance, the overall conclusion of the auditors was that, on practical completion of the new hospital facilities, the fixed asset and the associated finance lease creditor should be included on the Trust's balance sheet. They noted that the 'on-balance sheet' conclusion had arisen solely due to the new accounting guidelines. The auditors emphasised that the change in accounting treatment does not arise from any change in the transfer of risk to the private sector and does not reflect a criticism of the basis on which the contract has been structured.

13 Governance

- 13.1 Governance is a key duty of boards appointed to run Trusts and Health Boards. They are required to ensure good corporate governance through the highest standards of probity and propriety appropriate to the handling of public money. The Government White Paper, *'Designed to Care'* (published in December 1997), extended this role to include a new statutory duty, clinical governance, which concerns the quality of care in Trusts.
- 13.2 *'Designed to Care'* heralded a series of major changes in the structure and management of the NHS in Scotland. New members have been appointed to the boards of the newly created Trusts and a new network, Local Health Care Co-operatives, has been set up. These changes further highlighted the need for governance in the NHS to be re-examined.
- 13.3 A review has been undertaken by appointed auditors which covered:
- the role of the board, including the contribution of non-executives
 - the effectiveness of the audit and remuneration committees
 - the organisation's approach to openness
 - the board's involvement in the healthcare planning processes
 - the governance arrangements for Local Health Care Co-operatives
 - the board's involvement in the clinical governance framework.
- 13.4 The review found that there are generally sound governance arrangements in place in NHS bodies. NHS bodies have been provided with their own local reports and action plans to take forward audit recommendations.

14 Specific value for money findings

14.1 Exhibit 16 summarises the main value for money reports published based on examinations undertaken in 1999/2000 by the National Audit Office and the Accounts Commission.

Exhibit 16: Reports published on 1999/2000 value for money examinations

The Scottish Ambulance Service: A Service for Life	- Published by the National Audit Office - December 1999
A shared approach – Developing adult mental health services	- Published by the Accounts Commission - October 1999
Temporary Measures – Managing bank and agency nursing staff	- Published by the Accounts Commission - February 2000
A clean bill of health? Domestic services in Scottish hospitals	- Published by the Accounts Commission - April 2000

Follow up action is planned where appropriate.

The Scottish Ambulance Service: A Service for Life

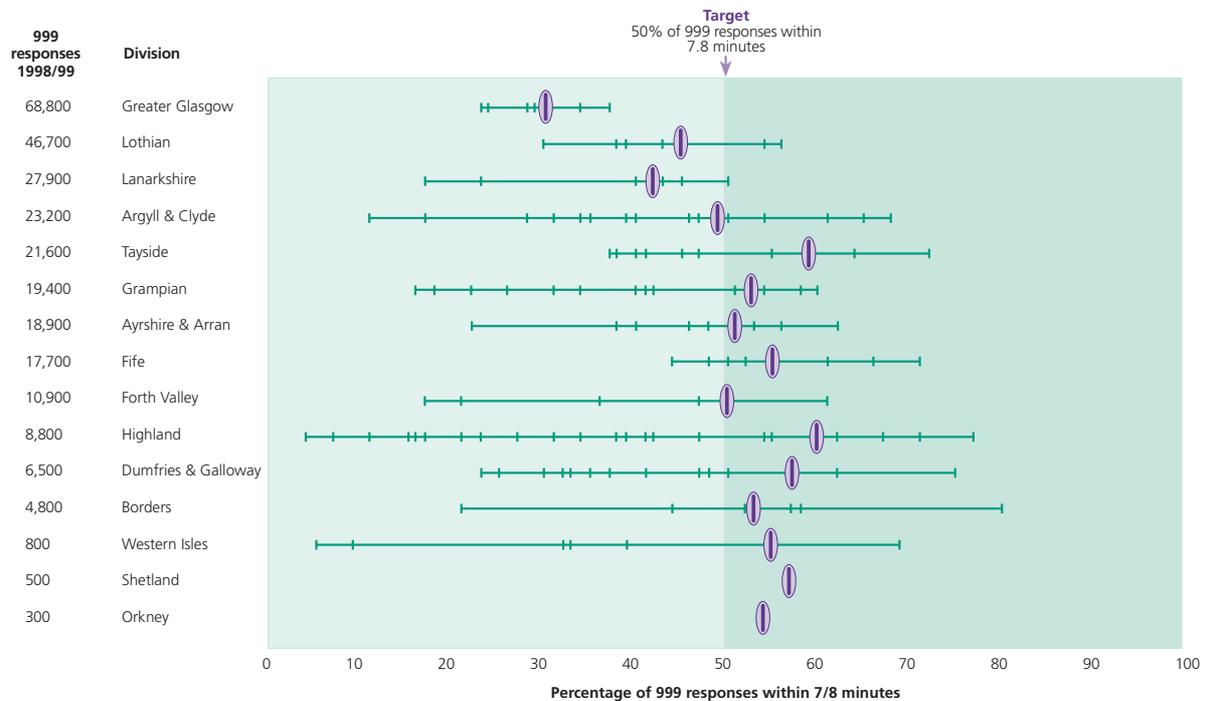
14.2 The Scottish Ambulance Service (the Service) are responsible for ambulance services across Scotland. The Service cost some £93.6 million in 1999/2000 (£86 million in 1998/99). Their emergency services provide pre-hospital clinical care, in some cases advanced life support, while transporting patients to hospital. In 1998/99 the accident and emergency service accounted for nearly four-fifths of the Service's total costs (£67 million) and some 1,720 front line staff and 451 emergency ambulances.

14.3 This report examined in detail the speed and responsiveness of the emergency ambulance service, their economic and efficient use of resources and their provision of effective pre-hospital emergency healthcare. It concluded that there was scope to improve the responsiveness of accident and emergency ambulance services in Scotland and the impact they have on the healthcare of patients (Exhibit 17).

Exhibit 17: Scottish Ambulance Service performance against 999 ambulance response time targets in 1998/99

This exhibit shows that 11 out of the Service's 15 divisions achieved their target to respond to 50% of 999 calls within seven or eight minutes, and many did better. However, the three divisions which did worse against the target are the Service's busiest. They responded to 143,400 999 calls in 1998/99, 52% of all calls.

It shows that there is significant variation around the average, with individual stations within each division achieving comparatively low and high results.



Source: National Audit Office

14.4 On the basis of the National Audit Office report, the Scottish Parliament's Audit Committee examined the performance of the Service in February and March 2000 taking evidence from the Accountable Officers of the Service and of the Department as well as from representatives from Health Boards and a Trust. Committee members also visited several ambulance locations and met staff.

14.5 The Audit Committee published their findings, conclusions and recommendations in June 2000 and emphasised the importance of the Service better matching the most effective and appropriate treatment and speed of response to patients' needs.

14.6 The Department responded to the Audit Committee's report in September 2000.

- **On priority dispatch:** the Department have allocated £100,000 to enable them to commence with the Service an appraisal of priority based systems for dispatching ambulances in response to emergency calls.
- **On variations in reported response times:** the Department has embarked on a comprehensive review of the emergency ambulance service, and an extra £500,000 has been provided in 2000/01 to cover the costs of an additional 20 front-line ambulance staff in Glasgow.

- **On operational efficiency:** the Department confirmed that the Service is committed to monitoring systematically the overall incident service time across Scotland and concerned to introduce improved targets.
- **On clinical aspects:** the Service and its Professional Advisory Group are reviewing the range of treatments provided to ensure that they remain current in terms of best treatment in the pre-hospital care setting.

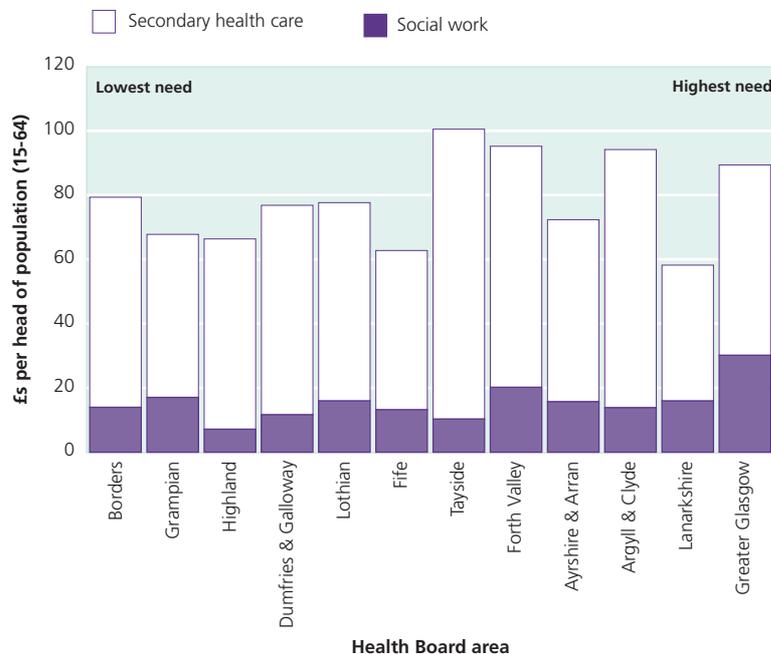
A shared approach – Developing adult mental health services

14.7 It is estimated that around one in four people have mental health problems. Mental health is a priority area for the NHS in Scotland and, more generally, care in the community is a priority for social work, housing and health agencies. A key objective of care in the community is to enable people with mental health problems to live as normal and independent a life as possible in their own homes, or in homely settings, rather than in institutional care. This means moving towards the provision of a range of community-based services that are flexible in meeting individuals' needs.

14.8 The examination of adult mental health services found that no area in Scotland yet has a comprehensive range of social and health care services for adults with mental health problems, two years after the publication by the Scottish Office of the 'Framework for mental health services in Scotland.' Some parts of the country have made progress towards community based care while others are not moving as quickly.

Exhibit 18: Allocating resources to need

Expenditure on specialist adult mental health services does not reflect need.



Notes

- 1 NHS provider costs used to compile this exhibit.
- 2 Because of problems with co-terminosity, social work expenditure was apportioned on the basis of population in each health board area.
- 3 Health boards shown in ascending order from lowest to highest need for mental health services using the morbidity and life circumstances index cited in the Arbutnott report.

Source: Scottish health service costs 1997/98, reports 044, 40LS, 048 and 500R and Accounts Commission Performance Indicators for Social Work 1997/98

14.9 Key findings of the examination included:

- The amount of money spent on adult mental health services varied widely across the country. Spending continued to be based on historical patterns, rather than being linked to need.
- Seventy-eight per cent (£160 million) of total NHS spending on specialist adult mental health services, remained tied up in hospital in-patient beds. This left limited scope for the development of community services.
- The involvement of users and carers in mental health services was better developed than for many areas of health and social care. More attention needed to be paid to involving users in developing their own care plans; and in empowering users and carers to evaluate the quality and effectiveness of services.

14.10 The report highlighted the need for better information to help plan service improvements. Better information is urgently needed on how money is currently spent, and on the impact which existing services are having on the quality of people's lives. This information is needed to plan the basis of the 'community care £' rather than focusing on separate health and local authority budgets. In particular, joint planning in some areas is still being impaired by uncertainty and potential conflict between agencies over how the money released by long stay bed closures is identified and re-invested.

Temporary Measures – Managing bank and agency nursing staff

14.11 The employment of bank or agency nurses costs the NHS in Scotland an estimated £25 million a year. Over 10,000 nurses are thought to be registered with nurse banks, and an average of almost 540 agency nurses are used each day. Bank and agency nursing staff can be a valuable resource, enabling acute and primary care Trusts to provide continuous care and manage unforeseen staff shortages. This form of employment also offers nurses the opportunity to work at times that suit them, keep their skills up-to-date, and earn additional income. However, the study found that there are drawbacks in using temporary staff, not least in ensuring continuity of care for individual patients. The use of temporary nursing staff should therefore be kept to a minimum for both quality and cost reasons. Bank and agency nursing staff should only be used once all other options, such as adjusting staff rotas or asking part-time staff to work extra hours, have been exhausted.

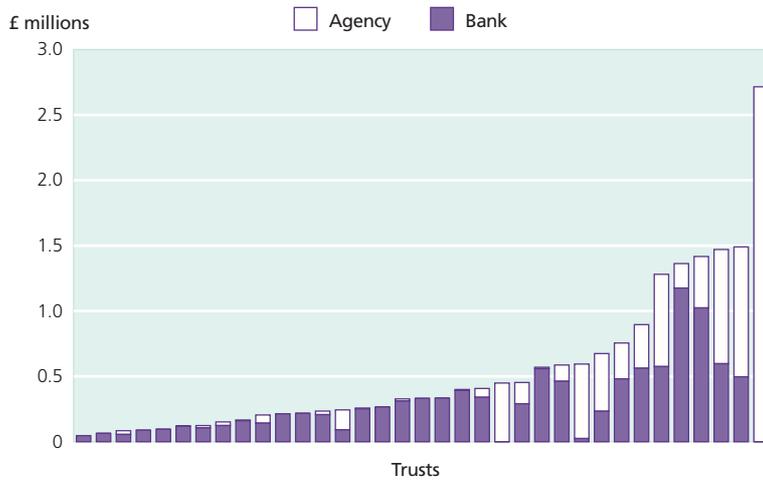
14.12 The main findings and recommendations from this examination were:

- Nurse banks could be managed more effectively. Most Trusts have more than one nurse bank, and one Trust operates ten nurse banks. There is a wide variation across Scotland in how these nurse banks are organised and managed. Merging nurse banks can improve the chances of providing the right temporary nursing staff when required, offers economies of scale, and promotes the sharing of good practice.
- The development of good IT systems will help Trusts to manage the employment of temporary nursing staff more effectively. Only two Trusts use a computerised system to match demand for bank nurses with their availability, skills and experience. Using a computerised system makes it easier to make better matches, and the reasons for requesting a bank nurse can be easily recorded and analysed.

- Trusts could improve their contracts with nurse agencies. Seventy per cent of Trusts use agency nurses, but only one-fifth have contracts with a single agency as their sole provider. The majority of Trusts make ad hoc requests to nurse agencies for temporary staff. This is an expensive option since the commission rates charged by agencies tend to be higher in these circumstances. The report recommended that Trusts put their contracts for agency nurse services out to tender to ensure they get the best possible deal, and suggested that jointly negotiating nurse agency contracts with other Trusts may help to reduce costs.
- Effective pre-employment checks, induction and appraisal of temporary nursing staff are required to assure the safety of patients. Temporary staff, especially agency nurses, may be unfamiliar with the working environment and Trust procedures. The report recommended that when using temporary staff, Trusts must ensure that appropriate vetting procedures are carried out and that nurses are provided with adequate induction and orientation. Formal performance appraisal will also help identify where a temporary nurse is working below the required standards. These quality issues are increasingly important with the establishment of a formal duty of clinical governance in Trusts.

Exhibit 19: Expenditure on bank and agency nursing 1997/98

Some Trusts spend significantly more on bank and agency nursing than others.



Note: Two Trusts have externalised the management of their nurse banks. They are included as "agency" in the above exhibit.

Source: Local audits (n=35)

A clean bill of health? Domestic services in Scottish hospitals

1413 Effective cleaning of hospital wards is essential for the health and safety of both patients and staff, and makes an important contribution to the quality of care patients receive. However, there is a growing perception that standards of cleanliness in hospitals have been declining. Domestic services play a key part in minimising the risk of hospital acquired infections, which have serious consequences for patients and lead to significant costs to the NHS. It is estimated that hospital acquired infection costs the NHS in Scotland around £100 million each year. Domestic services also account for a significant proportion of hospitals' expenditure, around £54 million in 1998/99. Over 8,000 people, about 4,000 whole time equivalents, are employed in this service.

Exhibit 20: Comparison of ward and SCOTMEG frequencies for a selection of tasks

Area of ward	SCOTMEG recommended frequency of full task per week	Percentage of wards complying	Percentage of wards over-cleaning	Percentage of wards under-cleaning
Clean hard floors in bed area	5	34% (57)	56% (93)	10% (17)
Clean soft floors in bed area	5	40.5% (67)	51% (85)	8.5% (14)
Damp clean furniture and fittings in bed area	7	58% (96)	0% (0)	42% (70)
Clean basin, taps and surrounds in bed area	7	57% (95)	5.5% (9)	37.5% (63)
Clean hard floors in sanitary areas	5	26% (43)	66% (111)	7% (11)
Clean basins, WC, baths etc, in sanitary areas	7	52% (85)	18% (30)	30% (50)
Clean dispensers and holders in sanitary areas	7	50% (80)	8% (13)	42% (68)
Clean hard floors in ward offices	5	26% (38)	42% (62)	32% (48)
Clean basin, taps and surrounds in ward utility areas	7	57% (92)	4% (6)	39% (63)

1414 The study found that some Scottish hospitals are not meeting minimum cleaning standards. This can compromise levels of infection control and reduce the quality of the environment for patients. However, while some cleaning jobs were not being done often enough others were being done more often than necessary. The examination also found a wide variation in cleaning costs among hospitals.

1415 The report recommended that hospitals can improve cleanliness without increasing costs by having a combination of clear minimum frequencies for specific cleaning tasks and clear output specifications. Domestic service staff should work with infection control teams to minimise the risk of hospital acquired infection. Other ways in which the quality of cleaning can be improved and costs reduced include: managing staff absence and turnover, overtime hours, shift allowances and productivity payments, and reviewing the work

content of domestic staff. Better management of domestic services will encourage the development of an efficient and more flexible service.

15 Current value for money examinations

- 15.1 Examinations in the NHS in Scotland are currently being conducted on hospital waste management, which concentrates on safety standards and the efficient disposal of waste; and on managing medical equipment, which concentrates on the strategic management of medical equipment, how it is funded and acquired and how it is used and maintained. I intend to publish baseline reports on these topics early in 2001 which will set out the areas where the NHS in Scotland can make improvements.



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