

National Audit Office
Report of the Comptroller and Auditor General

NHS (England) Summarised Accounts
1998-99

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Contents of Report of the Comptroller and Auditor General

	Page
Summary and conclusions	R1
<hr/>	
Part 1: Basis of my audit	R9
<hr/>	
Part 2: Findings of the appointed auditors	R12
Introduction	R12
Overall findings	R12
Findings which led to Section 19 referrals and Section 8 reports	R14
Audit Commission work on the millennium date change	R15
Audit Commission work on financial performance	R15
Audit Commission work on fraud and corruption	R15
Audit Commission value for money work	R15
<hr/>	
Part 3: Developments in accounting and internal control	R17
Introduction	R17
Deferred implementation of Financial Reporting Standards 11 and 12	R17
Accounting for the revaluation of land and buildings	R20
Accounting for "back-to-back" provisions	R20
Implementation of resource accounting	R21
Introduction of statements on internal controls in the NHS	R24
The millennium date change	R25
<hr/>	
Part 4: Financial performance of the NHS	R28
Introduction	R28
Health authorities	R28
NHS Trusts	R33
Overall financial position by geographical area	R37

Part 5: Fraud in the NHS	R38
Introduction	R38
Scope of my work	R38
Developments in the role of the Directorate of Counter-Fraud Services	R39
Prevention and detection	R40
Commentary on the Directorate of Counter-Fraud Services' methodology	R41
The impact of fraud on my opinion on the summarised accounts	R44

Part 6: Clinical negligence	R45
Introduction	R45
Background information	R45
Liabilities and charges for clinical negligence disclosed in 1998-99	R47
Incidents incurred but not reported	R47
Accounting developments and consistency issues	R49
Developments in improving the quality of clinical care	R51

List of Figures

	Page
Figure 1 Audit arrangements in the National Health Service	R10
Figure 2 Resource accounting trigger points	R22
Figure 3 The financial performance of health authorities in 1998-99	R31
Figure 4 Health authorities with serious financial problems - 1997-98 to 1998-99	R33
Figure 5 NHS Trusts with serious financial problems - 1997-98 to 1998-99	R36
Figure 6 Geographical areas with underlying in-year deficits of over £10 million	R37
Figure 7 Costs of clinical negligence in 1998-99	R48
Figure 8 Problems with the consistency of disclosure between NHS accounts	R50

Summary and conclusions

Introduction

1 The NHS Executive prepare summarised accounts for the NHS covering, mainly, the £34 billion spent by 100 health authorities in purchasing health care and related services from NHS Trusts and other contractors to the health service; and the £26 billion spent by 402 NHS Trusts in delivering health care.

2 My report records the results of the audit examination of these summarised accounts by the National Audit Office, and the overall findings from the audit of the individual health organisations by auditors appointed by the Audit Commission for England and Wales.

3 I also report on the key developments in accounting and internal control within the NHS, the overall financial performance of health authorities and NHS Trusts, progress in countering fraud in the NHS, and on the financial costs facing the NHS for clinical negligence claims together with the latest accounting and quality of care developments.

4 The NHS summarised accounts for Scotland and for Wales are published in separate House of Commons papers, along with my reports on them.

Main findings and conclusions

Findings of the Appointed Auditors

5 For the fifth consecutive year the appointed auditors gave unqualified opinions on the accounts of all individual NHS Trusts and health authorities. On the basis of the work of the appointed auditors, I consider that accounting and financial controls across the NHS continue to be generally sound, although, as might be expected from an operation of this complexity and scale, a number of issues have emerged from audit work which need action by the NHS Executive. I welcome the NHS Executive's responses to the issues raised by the appointed auditors.

6 On funds held on trust within the NHS, the number of underlying accounts qualified by the appointed auditors has continued to drop significantly. Accordingly, I have issued an unqualified audit opinion on the summarised account.

Developments in Accounting and Internal Control

7 The Accounting Standards Board issued two Financial Reporting Standards (FRSs) which applied to the 1998-99 accounts. FRS 11 requires both temporary and permanent impairment losses to be recognised in the financial statements and FRS12 redefined the basis for identifying and accounting for provisions and contingent liabilities. The NHS Executive asked Treasury for approval to defer both of these standards on the grounds that they would adversely affect NHS Trusts' ability to meet their statutory break even duty and that the work required to enable full compliance would create operational difficulties. Treasury gave dispensation for 1998-99 but ruled that these accounting standards be implemented for the 1999-2000 financial year. The Audit Commission advised their appointed auditors not to qualify the audit opinions on the 1998-99 underlying accounts of health authorities and NHS Trusts provided there was disclosure of the reasons and the potential impact of non-compliance.

8 At the request of the NHS Executive the District Valuer of the Inland Revenue carried out prospective valuations for 1 April 2000 of NHS land and buildings and reported his findings in June 1999. I informed the NHS Executive that the timing of the valuations required the financial statements to be adjusted for these post balance sheet events in accordance with UK Generally Accepted Accounting Practice (UK GAAP). In January 2000 the NHS Executive obtained Treasury dispensation to allow them to depart from UK GAAP to remain in line with the current proposals for mid-year revaluations under resource accounting.

9 The 1998-99 accounts also show a large increase in the amount of provisions that health authorities have agreed to specifically fund on behalf of NHS Trusts. These "back-to-back" provisions are mainly in respect of clinical negligence liabilities not covered by separate departmental schemes and they vary significantly between NHS bodies. The impact on the overall financial NHS surplus or deficit is neutral but some NHS Trusts have improved their financial position at the expense of health authorities. From 1 April 1999 health authorities will agree funding arrangements for all NHS Trust provisions that are not due to be reimbursed from central schemes. I will continue to monitor these arrangements and the extent to which these and similar financial relationships between NHS Trusts and health authorities impact on proper accountability.

10 I am concerned with the number of areas where the NHS has departed from generally accepted accounting practice. My staff have discussed these matters with the NHS Executive and in light of the difficulties the NHS had in applying the Financial Reporting Standards, the NHS Executive propose that, subject to

assurances on a number of practical matters, future NHS accounting should be overseen by the Financial Reporting Advisory Board. I welcome this proposal, which, if implemented, will help harmonise accounting policies across the public sector and will be of benefit to the future development of "Whole of Government Accounts".

11 Health authorities and several of the special health authorities form part of the Department of Health's resource account. The third milestone, "Trigger Point 3" is the completion of the dry-run resource account for 1998-99 and Treasury set autumn 1999 as the original deadline for all departments. Treasury subsequently revised the deadline for the Department of Health to March 2000 because of its unique size and the nature of the consolidation. My audit work on Trigger Point 3 at the time of my report was still on-going and preliminary results indicate problems with systems that produce the balance sheet figures for the core Department. I am still assessing the impact of these and advising the Department on corrective action.

12 Over the past few years, the NHS Executive have taken positive steps to improve governance in the NHS. The NHS Executive required NHS organisations to include a directors' statement on internal financial control in their 1997-98 annual accounts, a year ahead of the majority of the public sector and in advance of Treasury guidance. However, in my view, the NHS Executive have adopted a statement expressed in weaker terms than other departments and agencies, and I have recommended that the NHS Executive should strengthen their requirement in line with the rest of the government sector. The NHS Executive intend to bring the wording of their standard into line with other departments from 1 April 2000.

13 All the appointed auditors of NHS Trusts and health authorities gave unqualified opinions on the statements of internal financial controls. The number of additional disclosures from directors stating that one or more of the minimum control standards had not been met has reduced substantially from the previous year. I welcome the improvements indicated by the statements on internal financial controls together with the developments on wider controls assurance and additional reporting arrangements established for 1999-2000.

14 Throughout 1998 and 1999, the NHS worked on their preparations for the year 2000 date change. In particular, in the months prior to the date change, NHS organisations continued to monitor the compliance of software, equipment and devices, and the NHS Executive produced a range of guidance on associated issues. Over the millennium period NHS bodies reported relatively few incidents to the central NHS reporting centres. The incidents affected relatively minor systems and

the NHS Executive considered that none of the incidents affected patient services or safety. I welcome the effort undertaken by the NHS to deal with and substantially avoid this potentially serious problem.

Financial Performance of the NHS

15 Health authorities are funded on a cash basis. They receive funds in the year when the actual payments are to be made and their statutory duty is for net payments not to exceed their cash limits. In 1998-99, all health authorities achieved this statutory duty. However, their financial reporting is on an accruals basis and 48 health authorities recorded a deficit in year where liabilities arising in the year will require the NHS to make cash payments in future years. The same number of health authorities recorded a deficit in 1997-98. The 1998-99 summarised account for all the 100 health authorities shows that together they achieved an aggregate surplus of £18 million, but also reported an accumulated deficit at the end of 1998-99 of £698 million. However at the end of the second quarter of 1999-2000 the forecast in-year deficit was £80 million.

16 The health authorities summarised account indicates that had FRS 11 been implemented in 1998-99 an estimated additional £53 million would have been charged to the income and expenditure account for the year in respect of the downward revaluations of fixed assets. However the NHS Executive inform me that there would have been no effect on their in-year surplus as, through the financing arrangements, health authorities would have been able to recognise an equal amount of additional funding. The NHS Executive also obtained Treasury dispensation not to reduce the values of land and buildings in the financial statements for the District Valuer's reports completed three months after the financial year-end. The NHS Executive has been unable to quantify the effect on the health authorities' summarised account.

17 For NHS Trusts, 1998-99 represents the second of a rolling three-year (by exception five-year) period over which performance against their primary financial target to break even "taking one financial year with another" will be measured. As such, it is not possible to state the number of NHS Trusts who met this statutory financial objective in 1998-99, but 98 Trusts did report a retained deficit for 1998-99. Twenty Trusts failed one or more of the two remaining financial targets set for them (the capital cost absorption rate and the external financing limit). In total, the retained deficit fell from £104 million to £36 million indicating that the overall financial position of the 402 NHS Trusts improved significantly. At 31 March 1999 NHS Trusts had cumulative surpluses totalling

£215 million, which compares with £209 million as at 31 March 1998. However at the end of the second quarter of 1999-2000 the forecast in-year deficit was £117 million.

18 The NHS Trusts' summarised account indicates that had FRS 11 been implemented in 1998-99 an estimated additional £366 million would have been charged to the income and expenditure account for the year in respect of the downward revaluations of fixed assets. The NHS Executive also obtained Treasury dispensation not to reduce the values of land and buildings in the financial statements for the District Valuer's reports completed three months after the financial year-end. The NHS Executive have estimated that the impact of these valuation reports would have been further charges of about £750 million to the income and expenditure accounts. Due to the dispensation the NHS Executive have not estimated the impact on the balance sheet figures. The NHS Executive have informed me that the funding mechanism for 1999-2000 has been adjusted to the extent necessary to protect NHS Trusts' finances from an adverse impact from this loss.

19 At the end of 1998-99, the NHS Executive assessed that 18 health authorities and 53 Trusts were in serious financial difficulties (in that, after adjustments for one-off items, they have deficits which exceed the lower of £1 million or 1% of turnover). Regional offices of the NHS Executive continue to work with these organisations to restore them to a sound financial position.

Fraud in the NHS

20 The Directorate of Counter-Fraud Services have overall responsibility for all work to counter fraud and corruption within the NHS with particular priority for countering fraud in the Family Health Services. The Directorate have three specific targets:

- to achieve a 50% reduction in the level of prescription charge evasion by 2002-2003;
- to prevent £9 million in contractor fraud and to recover £6 million by 2001-2002; and
- to reduce fraud to an absolute minimum within ten years.

The Directorate are developing a Risk Management Project to measure fraud and incorrectness across the main services in the NHS. Initially the Directorate had a target date of March 2000 for the completion of eight separate measurement exercises. Due to the complexity of the undertaking, the Directorate have not yet completed any of the exercises. The Directorate have informed me that they plan to complete some of these exercises by May 2000 and report on the overall level of fraud and incorrectness in the NHS early in 2001.

21 The methodology is most advanced for measuring fraud and incorrectness from prescription charge evasion. I examined the methodology, and statistical samples used, and I am satisfied that it provides a sound basis for estimating the likely levels of fraud and incorrectness in this area. However the accuracy of the estimates is dependent on the reliability of the information against which the checks are made. One source of information used for checking free prescription entitlements and other health benefits is whether the claimant is in receipt of a social security benefit. However I have reported for several years on the unacceptable level of fraud and error in the social security benefits system. The effect of not allowing for these errors is to understate the overall level of fraud and incorrectness in the NHS measurement exercises. I recommend that the Directorate work closely with the Benefits Agency if fraud in the NHS is to be reduced to an absolute minimum.

22 From April 1999, the NHS Executive implemented a number of measures to prevent and deter prescription fraud, in particular point of dispensing checks for non age-related exemptions and the criminalisation of the act of fraudulently evading prescription charges. The Directorate therefore completed two measurement exercises before and after April 1999. The results of the first exercise from November 1998 indicated an estimated annual loss to the taxpayer of £137 million (+/- £15 million) from non age-related prescription charge evasion. The second exercise for July 1999 indicated that the estimated non age-related annual loss had been reduced to £92 million (+/- £12 million). The preventative and deterrent measures adopted will be factors in the reduction although it is not possible to separate these from other causes.

23 Part of the strategy to develop an "anti-fraud culture" throughout the NHS has been the introduction of the Counter-Fraud Operational Service which consists of a team in each NHS region, a national mobile team and from April 2000 two specialist teams for dental fraud and pharmaceutical fraud. Also each individual NHS body will have a Local Counter-Fraud Specialist who will receive specific accredited training, and the Directorate are carrying out a series of fraud awareness presentations.

24 Since April 1999, the Directorate have asked NHS organisations to report suspected frauds to them and 239 cases with a total estimated value of £14 million have been reported to date. These represent a large increase from the detected fraud figures previously reported by the Audit Commission and the Directorate are currently investigating these cases. The Directorate are also developing a “whistleblowing” initiative, which will enable staff and professionals to report suspected cases of fraud and corruption confidentially and a separate hotline to enable members of the public to report suspected cases of fraud to the Directorate.

25 I considered the impact of the reported levels of fraud and incorrectness in the context of my audit opinion on the summarised account of health authorities. In my view, the overall levels of fraud and incorrectness reported are not significant enough to affect the true and fair view of the accounts and I have therefore given an unqualified opinion on the accounts. From my examination of the measurement of prescription exemption fraud I identified that the Directorate will need to undertake further work to develop suitable methodologies for other exercises such as procurement fraud where the nature of transactions susceptible to fraud and incorrectness is substantially different. Overall I welcome the range of initiatives introduced by the Directorate of Counter-Fraud Services to tackle fraud and I will continue to monitor progress on the important work to establish the actual level of fraud within the health service.

Clinical Negligence

26 The reported liability for clinical negligence continues to increase within the NHS, with total potential liabilities of £2.4 billion disclosed in the accounts at 31 March 1999, an increase of £0.6 billion from the previous year. In addition there is the cost of clinical incidents which have occurred but have not been reported by the balance sheet date. The latest information from the Clinical Negligence Scheme for Trusts suggests that incidents since April 1995 are being reported earlier than previously predicted. This implies that the liability for incidents incurred but not reported may now be below my 1996-97 estimate of £1 billion.

27 The accounting for clinical negligence is complex and is split between several different accounts. I identified several problems with consistency between NHS accounts, arising from different measurement methods and accounting information being prepared at different points in time. The NHS Litigation Authority implemented the Financial Reporting Standard on Provisions (FRS 12) in 1998-99 although, with Treasury approval, the rest of the NHS deferred implementation until 1999-2000. The NHS Executive have subsequently issued

guidance on the application of FRS 12 that includes a formal reconciliation process to address these consistency problems. The application of FRS 12 will change the basis of measurement of all provisions which I consider will provide the NHS with better information on the total cost of clinical negligence incidents.

28 Since my last report work has continued on improving the system for handling claims and minimising the risk of negligence happening in the first place, and includes a number of measures taken forward from the consultation document "A First Class Service: Quality in the NHS". The Woolf reforms came into effect in April 1999, and the protocols introduced set out the information to be exchanged before court proceedings and a timescale for that exchange. A duty of quality of care on NHS bodies was established for the first time in the Health Act 1999, and the National Institute for Clinical Excellence and the Commission for Health Improvement have been fully established. In October 1999 the Health Select Committee issued their report on procedures related to adverse clinical incidents which included a range of recommendations. NHS Trusts have continued to be assessed against the clinical risk standards of the NHS Litigation Authority and new controls assurance statements are under development that will build on those standards.

29 I welcome the developments in this area and support the range of initiatives being taken to improve the systems and reduce the risks of negligence happening in the first place. It is however still early days for these initiatives and for assessing what impact they will have on the future liabilities of the National Health Service in respect of clinical negligence claims. I will report in future years on the level of claims, together with the progress being made by the Department of Health and the NHS Executive on their initiatives.

Part 1: Basis of my audit

1.1 Section 98 of the National Health Service Act 1977 requires me to examine, certify and report on the NHS summarised accounts for England. This part of my report sets out the scope of my audit of the NHS summarised accounts for 1998-99.

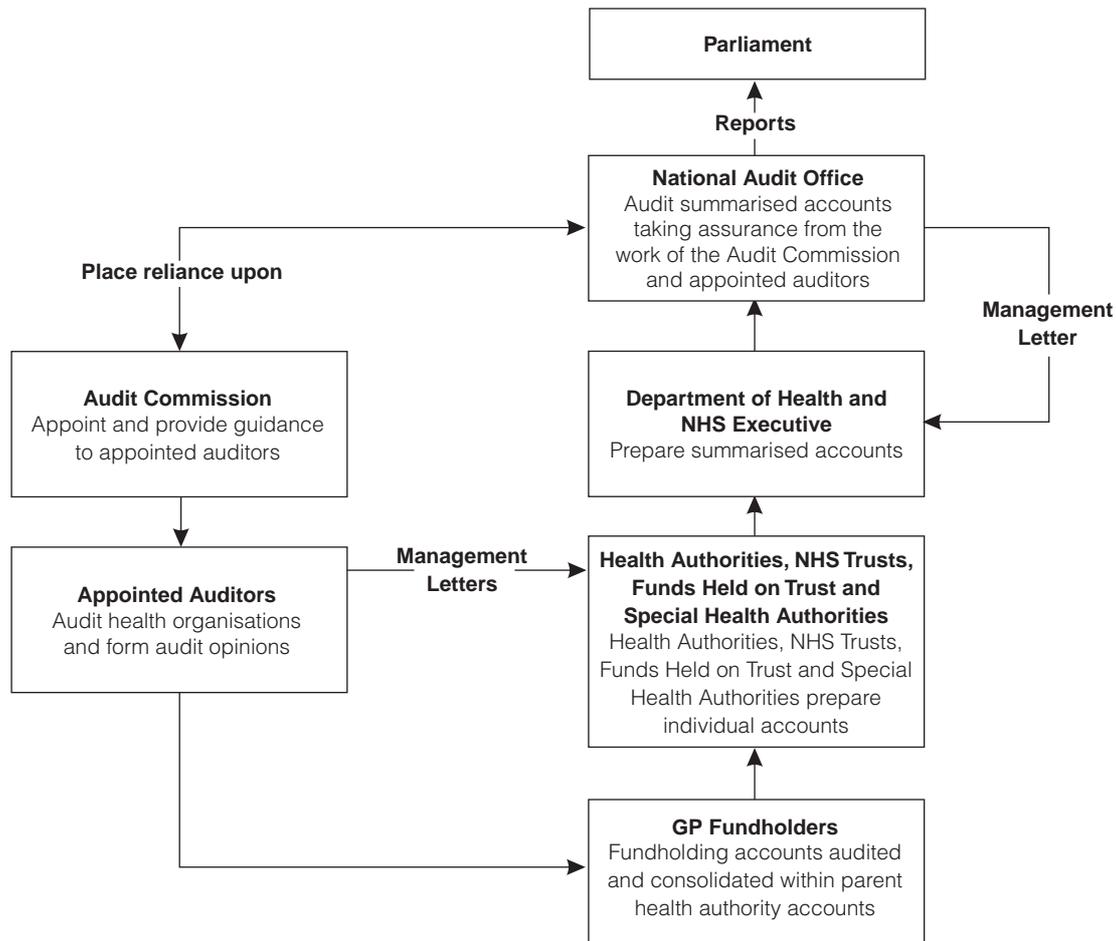
1.2 Most of the funding for the health service is provided by the Department of Health and is reported, on a cash basis, in the Appropriation Account for Class XI, Vote 1 (hospital, community health, family health and related services, England), which is also subject to my audit. The summarised accounts record, largely on an accruals basis, the financial affairs of the health authorities, special health authorities, the Dental Practice Board and NHS Trusts to whom these funds are made available.

1.3 The Audit Commission is responsible for appointing external auditors to all health authorities, special health authorities and NHS Trusts. For 1998-99, District Audit had approximately 70 per cent of these appointments and seven leading audit firms had the remainder. These appointed auditors provide an audit opinion on the annual accounts of each health organisation, and the Department of Health and the NHS Executive summarise these accounts for my audit. Figure 1 shows the audit arrangements for the underlying and summarised accounts of the NHS.

1.4 The foreword to the NHS summarised accounts describes the basis for their preparation and the background to the individual NHS organisations in England. My examination of the 1998-99 accounts included assessing the reliability of the information contained in the audited accounts of the individual NHS organisations and checking the summarisation of the individual underlying accounts by the Department of Health and the NHS Executive. The reliability of the underlying accounts was assessed by reviewing the work of the auditors appointed by the Audit Commission, scrutinising their reports and findings and ensuring that acceptable quality control policies and procedures existed and operated effectively.

1.5 On the basis of my assessment of the work of the appointed auditors, and my audit at the Department of Health and the NHS Executive, I am able to give unqualified opinions on all of the summarised accounts for 1998-99.

Figure 1 Audit arrangements in the National Health Service



1.6 I also examine the economy, efficiency and effectiveness with which NHS organisations have used their resources, under section 6 of the National Audit Act 1983. The results of such value for money examinations are published in separate reports made to the House of Commons under section 9 of that Act. I have recently completed a study of particular relevance to this volume of summarised accounts, examining corporate governance and financial control arrangements at NHS trustee bodies, and my report is due to be published this spring.

1.7 My other recent reports on issues affecting the NHS in England are:

- The PFI Contract for the new Dartford and Gravesham Hospital (HC 423, 1998-99);

- The Management of Medical Equipment in NHS Acute Trusts in England (HC 475, 1998-99);
- The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England (HC 230, 1999-2000); and
- Inpatient Admissions and Bed Management in NHS Acute Hospitals (HC 254, 1999-2000).

1.8 In part 2 of this report, I describe in more detail the findings of the appointed auditors. The remaining parts of my report address current issues concerning financial control and accounting within the NHS, namely:

- Part 3: Developments in accounting and internal control;
- Part 4: Financial performance of the NHS;
- Part 5: Fraud in the NHS; and
- Part 6: Clinical negligence.

Part 2: Findings of the appointed auditors

Introduction

2.1 This part of my report summarises:

- the overall findings of the appointed auditors on the accounts of NHS organisations (paragraphs 2.2 to 2.6);
- findings which led to Section 19 referrals to the Secretary of State and Section 8 reports (paragraphs 2.7 to 2.10); and
- the Audit Commission's work on the millennium date change, financial performance, fraud and corruption and value for money (paragraphs 2.11 to 2.15).

Overall findings

2.2 For the fifth consecutive year in 1998-99, the appointed auditors gave unqualified opinions on the accounts of all individual NHS Trusts, health authorities and special health authorities. However, in 14 cases, auditors drew attention to the financial health of the Trust or other matters of concern. Part 4 of my report provides further analysis of the financial performance of health authorities and NHS Trusts and the action taken by the NHS Executive.

2.3 Each year appointed auditors summarise their audit findings for analysis by the Audit Commission. Based on the audit of 1998-99 accounts, the Commission concluded that this was another year of achievement for the NHS. However the Commission also concluded that the NHS needs to:

- apply professionally recognised accounting standards on a timely basis where practicable;
- ensure further improvement in the overall financial position of health authorities and NHS Trusts;
- continue the drive against fraud and corruption; and

- manage planned structural changes, such as the development of primary care groups and the introduction of primary care trusts, in such a way that it does not adversely affect the financial management of the NHS.

2.4 In response to the points raised by the appointed auditors, the NHS Executive informed me that:

- they apply professionally recognised standards in NHS accounts as soon as is practical and in agreement with the Treasury. For the three recent and complex accounting standards the NHS Executive considered that the one year delay in their application was necessary while the NHS Executive put in place a whole package specially dealing with the NHS context, to ensure that financial discipline is maintained, Treasury rules are observed and patient care is undamaged. Part 3 of my Report comments further on this issue;
- they continue to seek improvement in the financial position of health authorities and NHS Trusts;
- a range of measures have been introduced as part of the strategy to develop an “anti-fraud culture” throughout the NHS. Part 5 of my Report (paragraphs 5.9 to 5.12) sets these out in detail; and
- the Department and the NHS fully recognise the need to manage planned structural changes in a way that does not affect adversely the financial management of the NHS. On 1 April 1999, 481 primary care groups came into being with the aim of developing and delivering better health services for their communities.

2.5 NHS Trusts, health authorities and special trustees have the power to accept, hold and administer any property on trust and are required to prepare separate accounts for these funds. The summarised account for 1998-99 (page 69) shows total funds at 31 March 1999 of some £1.8 billion. The appointed auditors gave qualified opinions on 4 of the 490 funds held on trust accounts in 1998-99, a significant improvement on 1997-98 when 47 accounts were qualified. In one other case, the auditors drew attention to other matters of concern.

2.6 Given the small number of accounts which were subject to qualified audit opinions I have been able to give an unqualified audit opinion on the summarised account for the NHS funds held on trust. I welcome the significant reduction in the number of qualified opinions.

Findings which led to Section 19 referrals and Section 8 reports

2.7 The Audit Commission Act 1998 draws together a number of pieces of legislation relating to the functions of the Audit Commission. Section 19 requires an appointed auditor to refer matters to the Secretary of State if the auditor has reason to believe that an NHS organisation has made a decision which involves, or may involve, unlawful expenditure. As this arrangement is used to give early warning of potential problems, which may not then materialise, these reports are addressed to the Secretary of State and are not published. Since my report on the summarised accounts for 1997-98 (HC 382, 1998-99), appointed auditors have referred two such matters to the Secretary of State which concerned:

- the severance agreement and house purchase made to an employee by an NHS Trust; and
- the early retirement arrangements for the chief executive of an NHS Trust.

2.8 The NHS Executive has taken legal action in both cases. For the first case, the NHS Executive has instructed the NHS Trust to obtain specialist legal advice on the prospects of recovering unlawful payments. In the second case, the legal advice available to the NHS Executive is that the NHS Trust acted within its powers. The NHS Executive, therefore, believe that there is no basis for seeking recovery.

2.9 Section 8 of the Audit Commission Act requires appointed auditors to consider whether, in the public interest, they should make a report on any matter coming to their notice. One report has been issued since my report on the summarised accounts for 1997-98 (HC 382, 1998-99), which concerned payments by Leeds Health Authority and Leeds Community NHS Trust to a management consultancy firm over a six-year period. The auditors concluded that:

- the work to be carried out by the consultancy firm was inadequately specified and that the appointment was made without competition;
- there were significant weaknesses in the financial control exercised by senior management; and
- there were clear examples of poor value for money.

2.10 The events described in this report took place between 1991 and 1997 and involved payments of some £1.43 million. As the appointed auditor noted, in recent years a much higher profile has been given to corporate governance and

standards of internal control in the NHS. On the specific issue of consultancy advice, the NHS Executive issued detailed guidance on good practice in 1996. Improvements have also been made to standing orders at the NHS bodies concerned, with guidance on the employment and use of management consultants circulated to all relevant managers.

Audit Commission work on the millennium date change

2.11 In June 1998, the Audit Commission published a management paper, "A Stitch in Time", which reported on the action being taken by local government, the NHS and the emergency services to tackle the risks associated with the millennium date change. Since then the Audit Commission has published two updates, the most recent of which, "Time Waits for No One", was published in November 1999. I comment on this further in paragraphs 3.27 to 3.35 of my report.

Audit Commission work on financial performance

2.12 In June 1999, the Audit Commission published a management paper "Achieving a Healthy Balance", which looked at key influences affecting the financial performance of NHS Trusts and health authorities in England and Wales. I comment on financial performance further in my report in part 4.

Audit Commission work on fraud and corruption

2.13 The Audit Commission published its report "Protecting the Public Purse" in December 1999, which stated that the amount of detected fraud in 1998-99 amounted to some £4.7 million. This was an increase of £2.1million on the previous year. The Audit Commission also reported that there had been a tenfold increase in the levels of fraud detected in GP services, from £121,000 to £1,282,000. However, detected fraud in NHS hospital and community care Trusts decreased slightly from £1.3 million to £1.1 million. As the Public Accounts Committee noted in July 1999 (HC 128, 1999-2000) the figures for detected fraud are still very low compared to the likely level of fraud in the system. I comment further on fraud and corruption in part 5 of my report.

Audit Commission value for money work

2.14 In addition to the work of its appointed auditors on the accounts of NHS organisations, the Audit Commission also undertakes value for money work. My staff liaise closely with the Audit Commission so that, taken together, our studies

avoid overlap and add value. I also undertake joint studies with the Audit Commission, for example we have a study underway on education and training of the clinical non-medical workforce.

2.15 Since my last report on the summarised accounts for 1997-98 (HC 382, 1998-99), the Audit Commission has published the following reports on national studies:

- Children in Mind: Child and Adolescent Mental Health Services (September 1999);
- Critical to Success: The Place of Efficient and Effective Critical Care Services Within the Acute Hospital (October 1999);
- Forget Me Not: Mental Health Services for Older People (January 2000); and
- United They Stand: Co-ordinating Care for Elderly Patients with Hip Fracture (February 2000).

Part 3: Developments in accounting and internal control

Introduction

3.1 This part of my report examines:

- the decision to defer the implementation of accounting standards – FRS 11 and 12 (paragraphs 3.2 to 3.10);
- accounting for the revaluation of land and buildings (paragraph 3.11);
- accounting for “back-to-back” provisions (paragraphs 3.12 and 3.13);
- the implementation of resource accounting by the Department of Health (paragraphs 3.14 to 3.21);
- the introduction of statements of internal financial control within the NHS (paragraphs 3.22 to 3.26); and
- the work undertaken by the NHS to manage the millennium date change (paragraphs 3.27 to 3.35).

Deferred implementation of Financial Reporting Standards 11 and 12

3.2 The accounts of NHS organisations are required by Treasury to comply with UK Generally Accepted Accounting Practice, the accounting and disclosure requirements of the Companies Act and all relevant accounting standards issued or adopted by the Accounting Standards Board, in so far as they are appropriate to the NHS and are in force for the financial year for which the accounts are to be prepared. In respect of the 1998-99 accounting year, the Board issued two new standards, Financial Reporting Standard (FRS) 11 – Impairment of Fixed Assets and Goodwill and FRS 12 – Provisions, Contingent Liabilities and Contingent Assets.

3.3 The Board first set out their proposals in these areas in Discussion Papers published in April 1996 and November 1995 respectively. These were followed by the exposure drafts - Financial Reporting Exposure Drafts (FREDs) 14 and 15 - both issued in June 1997. The NHS Executive and Treasury took advantage of the consultation period to provide their comments on the drafts to the Board. FRS 11 was issued in July 1998 and became effective in respect of financial statements relating to accounting periods ending on or after 23 December 1998. FRS 12 was issued in September 1998 for financial statements relating to accounting periods ending on or after 23 March 1999. Both of these standards should have been applied to the 1998-99 accounts of the NHS, for them to fully comply with UK Generally Accepted Accounting Practice (UK GAAP).

3.4 FRS 11 requires that all impairment losses in the value of assets should be recognised immediately in the financial statements, whether impairment is expected to be temporary or permanent. Impairments fall into two categories:

- where the impairment was due to the loss of economic benefits, such as physical damage to the asset, then the loss of value is required to be taken to the income and expenditure account; and
- where the impairment was caused by a fall in prices, the FRS allows the reduction in value to be taken against previous upward revaluations, as recorded in revaluation reserves on the balance sheet. If, however, the previous upward revaluations in respect of the specific asset are not sufficient to cover the loss, the remaining loss has to be charged to the income and expenditure account.

3.5 Existing NHS accounting practice allowed the majority of losses on revaluation of assets to be charged against the revaluation reserve, even where the losses in value exceeded the previous upward revaluations. As a result, several NHS organisations carry “negative” balances within their revaluation reserves. Implementation of FRS 11 would therefore have led to a higher charge to the income and expenditure account than existing NHS accounting practices. The impact would therefore have been to reduce surpluses or increase deficits for the individual NHS Trusts.

3.6 FRS 12 redefines the basis for identifying and accounting for provisions and contingent liabilities. The FRS gives criteria for recognition of these liabilities and for the methods that can be used to calculate the associated accounting

estimates. To implement the standard, NHS organisations would have needed to review all legal claims, in particular for clinical negligence, and establish for each claim their forecast outcomes, probabilities and expected date of settlement.

3.7 In December 1998, the NHS Executive requested approval from the Treasury to defer the implementation of both FRS 11 and FRS 12. The reason was that the two standards would have had significant implications for NHS organisations, namely:

- the impact of the FRSs, particularly FRS 11, on the income and expenditure account would adversely affect NHS Trusts' ability to meet their statutory break even duty in a year when such costs had not been reflected in the funding process. They believed that this could negate the financial discipline at NHS Trusts and influence the funds assigned to patient care; and
- the level of work required to enable full implementation of the standards would create operational difficulties for NHS bodies.

3.8 The Treasury decided in May 1999 that the NHS need not implement the standards for the 1998-99 financial year. The Treasury gave dispensation for 1998-99 but ruled that the standard must be implemented for the 1999-2000 financial year. The Audit Commission expressed concern that failure to comply promptly with accounting standards undermined the accounting process in the NHS. However, they did not believe that qualification of the audit opinions on the underlying accounts of health authorities or NHS Trusts was necessary, provided that there was full disclosure of the reasons as well as the potential impact of non-compliance. I set out the impact on the financial statements of health authorities and NHS Trusts in paragraphs 4.7 and 4.23.

3.9 The NHS Executive have issued guidelines on how FRS 11 (December 1999) and FRS 12 (August 1999) are to be applied to NHS accounts. On FRS 11, guidance sets out how to identify impairments, the accounting treatment and how NHS Trusts could apply for additional flows of funds from their commissioners to offset major impairment losses. The NHS Executive have also commissioned a review of the valuation method used by the District Valuer to ensure that it is still appropriate.

3.10 In light of the difficulties the NHS had in applying these Financial Reporting Standards, the NHS Executive propose that, subject to assurances on a number of practical matters, future NHS accounting should be overseen by the Financial Reporting Advisory Board to the Treasury. The Board was set up in April 1996 and has overseen the development, in conjunction with the Treasury, of the Resource

Accounting Manual, which is used as the basis for departmental resource accounts. I welcome this proposal which, if implemented, will help harmonise accounting policies across the public sector and will be of benefit to the future development of "Whole of Government Accounts".

Accounting for the revaluation of land and buildings

3.11 At the request of the NHS Executive, the District Valuer of the Inland Revenue carries out prospective valuations of NHS land and buildings at five-yearly intervals. The most recent prospective valuation related to 1 April 2000. In order for the valuations to be used for setting capital charges, the NHS Executive required that these valuations were completed and agreed by 18 June 1999 with a suitable index applied to obtain 1 April 2000 values. As the unindexed valuations were likely to relate to events before the 1998-99 balance sheet date, I informed the NHS Executive that under UK GAAP the NHS accounts were required to be adjusted for these post balance sheet events. Current proposals for resource accounting will allow a departure from UK GAAP, to avoid the need for mid-year revaluations to be reflected in the opening balances for the year of account. In January 2000 therefore the NHS Executive obtained Treasury dispensation to allow them to depart from UK GAAP and remain in line with the resource accounting proposals. I further comment on the financial impact for health authorities and NHS Trusts in paragraphs 4.8 and 4.24.

Accounting for "back-to-back" provisions

3.12 Before 1998-99, NHS Trusts adopted different approaches to recover the costs of provisions included in the balance sheet in respect of future liabilities that were not funded by separate departmental schemes. Some NHS Trusts entered agreements whereby their commissioning health authorities would specifically fund part of their provisions, mostly in respect of provisions for clinical negligence liabilities. At 31 March 1998, these "back-to-back" provisions totalled £9.3 million. From 1 April 1998, the NHS Executive adopted a policy of recommending "back-to-back" provisioning for all NHS Trusts. As a result, by 31 March 1999, "back-to-back" provisions had risen to £82 million. However, the "back-to-back" provisions agreed varied significantly. In their 1998-99 accounts, 36 health authorities disclosed no such arrangements with NHS Trusts, while the amounts provided by other authorities ranged from £3,000 to £3,656,000.

3.13 The NHS Trusts which agreed "back-to-back" provisions improved their financial position as they recognised funding for their future expenses. The health authorities which agreed to specifically fund provisions increased their liabilities

to the detriment of their own financial position. The impact on the joint financial surplus or deficit of the NHS as a whole is neutral, although this arrangement increases the current resources available to spend at the NHS Trusts whilst the liability of the health authority will need to be funded in future years. From 1 April 1999 it became mandatory for health authorities to agree funding arrangements for all NHS Trust provisions not reimbursed from central schemes. I will continue to monitor these arrangements and the extent to which these and similar financial relationships between NHS Trusts and health authorities impact on proper accountability.

Implementation of resource accounting

3.14 In my report on the 1997-98 NHS summarised accounts (HC 382, 1998-99), I described the development of resource accounting and the progress made by the Department of Health and the NHS Executive against a series of "Trigger Points" set by Treasury. The key features of each Trigger Point are shown in figure 2.

Achievements against Trigger Point 1

3.15 The Department of Health passed Trigger Point 1 on 31 March 1998. However, Treasury noted that the Department had not yet fully developed some key systems, for example to support the analysis of expenditure by departmental aims. The Treasury also stressed that they would have liked the Department to have made more progress in developing a system for consolidating underlying data.

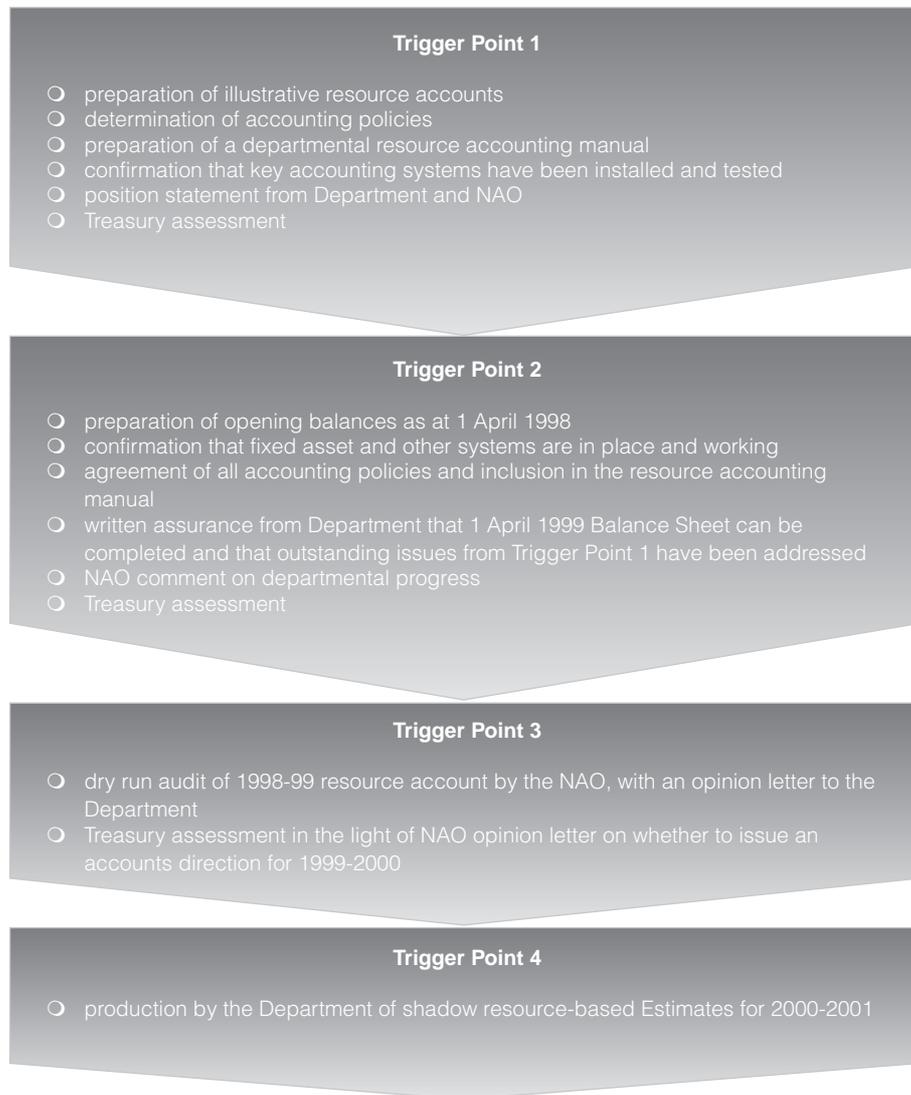
Achievements against Trigger Point 2

3.16 The deadline for achievement of Trigger Point 2 was 30 June 1999, on which date Treasury gave the Department approval to progress to Trigger Point 3.

3.17 As agreed with Treasury, I provided specific comments at Trigger Point 2 on:

- the quality of the departmental balance sheet as at 1 April 1998;
- the adequacy of the Department's fixed asset system;
- the adequacy of other systems; and
- the Department's accounting policies.

Figure 2 Resource accounting trigger points



3.18 My main concerns were that:

- five out of seven balance sheet components were materially misstated;
- it was not possible to determine whether all assets were correctly entered onto the system for recording fixed assets or whether the system provided all the information required under resource accounting;
- the Department was unable to introduce a robust system to provide me with documentation in support of the statement of the use of resources analysed by departmental objectives (Schedule 5); and
- accounting policies adopted by individual health authorities were not fully compliant with the Resource Accounting Manual.

3.19 Treasury permission for the Department of Health to progress to Trigger Point 3, was subject to the Department addressing these specific issues.

Achievements against Trigger Point 3

3.20 The deadline for Trigger Point 3 was originally set for autumn 1999 for all government departments. However, Treasury agreed a revised target of March 2000 for the Department of Health, because of the unique scale and nature of the consolidation between the core Department, health authorities and agencies. The scope of my work for Trigger Point 3 has been that of a full audit of the dry-run account, although the accounts themselves are non-statutory. The audit has been designed to assess the ability of the Department of Health to construct financial statements on an accruals basis and to help solve problems before the Department produce their first live resource account.

3.21 My work on Trigger Point 3 at the time of my report was still on-going and I will report to the Department at the end of March 2000 providing an audit opinion and report on the same basis as for a statutory audit. My preliminary results have identified problems with systems that produce the balance sheet figures at the core Department and I am still assessing the impact of these. I will be advising the Department on actions that can be taken to overcome these problems. After my opinion and report are issued Treasury will consider my opinion and report and assess whether to issue an accounts direction to the Department to produce a full statutory account for 1999-2000.

Introduction of statements of internal financial control in the NHS

3.22 In my report on the 1997-98 summarised accounts (HC 382, 1998-99), I noted the introduction of a requirement for most NHS organisations to include an audited directors' statement on internal financial control. The statement confirms that:

- the organisation has an appropriate system of internal financial control in line with NHS Executive guidance;
- the minimum control standards laid down by the NHS Executive have been in existence within the organisation throughout the financial year; and
- appropriate disclosures have been made where the organisation does not comply with the required standard.

3.23 The NHS implemented statements of assurance on systems of internal financial control a year ahead of the majority of the public sector and in advance of Treasury guidance. However, the statements for NHS bodies are differently worded from that required by the Treasury with the statements referring to the existence of "appropriate" controls whereas other government departments and agencies refer to "effective" controls. In my view, the NHS Executive have adopted a statement expressed in weaker terms than other government departments and agencies, and I have recommended that the NHS Executive should strengthen their requirement in line with the rest of the government sector. The NHS Executive will continue to use this assurance statement for the 1999-2000 accounts of NHS bodies, but intend to bring the standard into line with other departments from 1 April 2000.

3.24 I reviewed the results of the annual data collection exercise co-ordinated by the Audit Commission from the returns of individual appointed auditors. All health authorities and NHS Trusts produced a statement of internal financial control for 1998-99 and all appointed auditors were able to give unqualified opinions on the statements.

3.25 However, for 12 of the 100 health authorities and 71 of 402 NHS Trusts the statements had additional disclosures from directors stating that one or more of the required minimum control standards had not been met. In 11 cases, the relevant NHS Trusts also had a non-standard audit opinion on their financial statements. The number of NHS organisations which reported that not all of the

minimum standards were in place has reduced substantially from the previous year. Several of these NHS organisations also reported that the standards were met partway through the financial year.

3.26 The NHS Executive has been working on developing a controls assurance framework to cover risk management and organisational controls within a further and more extensive control statement. In November 1999 the NHS Executive published 18 new “organisational” control standards, including some which complement the internal financial controls. Examples include standards on risk management, information management and technology, and contracts and contractor controls. In their 1999-2000 Annual Reports, Chief Executives on behalf of their boards, will be required to confirm that their NHS Trust or health authority has performed a baseline assessment against the standards and has developed prioritised action plans to manage risk. Overall, I am satisfied that proper financial controls have been established across health authorities and NHS Trusts and I welcome these further developments.

The millennium date change

3.27 Throughout 1998 and 1999, the NHS worked on their preparations for the year 2000 date change. The NHS Executive monitored the readiness of all NHS healthcare organisations, working through its Regional Offices, with a central team that included independent consultants, working in collaboration with the Audit Commission. Regional Offices assessed each NHS Trust and health authority through regular monitoring returns supplemented by other information.

3.28 In June 1999, the Committee of Public Accounts took evidence from the Chief Executive of the NHS on the progress of NHS bodies towards meeting the September 1999 deadline. This required Chief Executives to ensure that all parts of the NHS were fully prepared, with compliant equipment or effective contingency plans in place (NHS (England) Summarised Accounts 1997-98 - HC 128, 1999-2000). The NHS Executive told the Committee that all but four NHS Trusts had made satisfactory progress and that they were taking action to help the bodies most at risk of not meeting that deadline. The Committee also noted that the NHS Executive had made the Chief Executive of each health organisation personally responsible for dealing with the millennium threat.

3.29 In my report “The Millennium Threat: Are We Ready” (HC 871, 1998-99), I stated that all NHS Trusts and health authorities had achieved “blue” status by 21 October 1999, which meant that no risk had been identified of material disruption to the infrastructure processes due to the millennium date change. Each

NHS Trust and health authority Chief Executive was personally required to approve and sign a completion report stating that their systems were either year 2000 compliant or that effective contingency plans were in place. NHS organisations were also required by this date to have final, detailed and robust plans in place to ensure service provision over the millennium period dealing with all foreseeable contingencies.

3.30 In the months prior to the end of the millennium, NHS organisations continued to monitor their position, in particular to ensure that compliance of software, equipment and devices was not compromised by activities such as software upgrades, changes in configuration or repairs. In addition, the NHS Executive produced a range of guidance on associated issues such as prescribing medicines around the millennium, a booklet for registered nurses, midwives and health visitors on potential problems, supply chain assurances, human resource issues and possible year 2000 computer viruses.

3.31 In November 1999, the Audit Commission published their third update on the management paper on addressing the millennium date change, entitled "Time Waits for No One". The report concluded that health authorities and NHS Trusts had continued to make good progress in their preparations throughout 1999 and that the organisations previously identified as "preparing less well" were no longer giving cause for concern. However, in spite of the good progress made the Audit Commission recommended that it was vital that the NHS continued to treat the project with high priority as well as apply lessons learnt to future management challenges.

3.32 Over the millennium period, the NHS Executive, NHS Estates and the Medical Devices Agency operated central reporting and co-ordination centres. The centres logged significant incident reports and issued urgent technical alerts and warnings to advise NHS organisations of problems that affected them. NHS bodies reported 55 incidents relating to the year 2000 date change. Most incidents affected relatively minor systems, for example several cases were reported of systems displaying incorrect dates and two reports indicated problems with accessing data records. The NHS Executive reported that none of the incidents affected patient services or safety and that all the incidents had been dealt with by staff at the organisations concerned, with assistance from suppliers as necessary.

3.33 The NHS Executive estimate that some £350 million has been spent over three years preparing for the millennium date change. The main areas of expenditure have related to information management and technology systems, human resources, medical devices, operational continuity and the supply chain.

3.34 The NHS Executive recognise that there have been a number of additional benefits from the expenditure, including better identification and control of assets, improvements in disaster recovery and contingency planning, and assistance in achieving the controls assurance requirements.

3.35 I welcome the effort undertaken by the NHS to deal with and substantially avoid this potentially serious problem.

Part 4: Financial performance of the NHS

Introduction

4.1 This part of my report looks at the financial performance of health authorities and NHS Trusts. In particular, I examine:

- the action taken by the NHS Executive to monitor the financial position of health authorities and address any problems identified (paragraphs 4.2 to 4.19);
- the financial duties of NHS Trusts, their financial performance, the monitoring by the NHS Executive, and action taken to address any problems identified (paragraphs 4.20 to 4.31); and
- the overall financial position by geographical area (paragraphs 4.32 and 4.33).

Health authorities

Financial performance

4.2 1998-99 was the third year of the operation of the 100 health authorities in England. Paragraph 10 of the Foreword to the summarised accounts notes that, in 1998-99, all health authorities achieved their statutory financial duty of ensuring that net expenditure did not exceed their cash limit.

4.3 In total, health authorities reported an in-year surplus for 1998-99 of £18 million (compared to a deficit of £8 million in 1997-98) and an accumulated deficit at the year-end of £698 million (compared with £717 million at 31 March 1998). However, at the end of the second quarter of 1999-2000 the forecast in-year deficit was £80 million.

4.4 As at 31 March 1999 the balance sheet for the summarised account of health authorities included:

- long term creditors and liabilities for pension and clinical negligence costs of £385 million (1997-98 £316 million); and

- net current liabilities of £313 million (1997-98 £404 million), i.e. health authorities' short term liabilities of creditors and overdrawn bank balances exceeded their current assets in the form of stocks, debtors and cash by this amount. This includes £187 million of creditors in relation to GP fundholder savings. The NHS Executive have issued guidance on the treatment of these savings requiring former GP Fundholders to seek agreement with their Primary Care Group on how savings should be deployed within the Primary Care Group setting.

4.5 As I noted in my report on the 1997-98 summarised accounts (HC 382, 1998-99), it is important, in interpreting the key financial information in the summarised accounts, to note the impact on the financial statements both of the way in which health authorities are funded and the level of liabilities which the health authorities inherited on 1 April 1996.

- **Funding** - health authorities are funded each year on a cash basis from the Class XI, Vote 1 Appropriation Account. Cash allocations are designed to meet each health authority's expected cash requirement in the year, hence the statutory duty of health authorities not to exceed their cash limit. This cash-based system of funding, however, means that health authorities do not receive funding in the year to cover longer-term liabilities, such as provisions for future clinical negligence costs. These liabilities must nevertheless be recorded on a health authority's balance sheet. As a result, health authorities are likely to carry significant liabilities in their balance sheets, which are not matched by funding assets. Cash funding to meet the longer term liabilities will still be required when the liabilities are due to be settled.

- **Inherited liabilities** – health authorities inherited an adjusted opening deficit of £471 million from predecessor bodies on their inception in April 1996, representing opening current liabilities and provisions for future liabilities and charges.

4.6 FRS 11 was published in July 1998, to be effective for accounting periods ending on or after 23 December 1998. Part 3 of my report discusses the background to the approval by Treasury of deferral of the need to apply this FRS and the reasons for the delay in compliance.

4.7 As disclosed on page 22 of the health authority account, had FRS 11 been implemented in 1998-99, it is estimated that an additional £53 million would have been charged to the income and expenditure account for the year in respect of the downward revaluations of fixed assets. However the NHS Executive inform me

that, through the financing arrangements for capital charges, the health authorities would have been able to recognise an equal amount of additional funding so that there would have been no effect on their in-year surplus.

4.8 Part 3 of my report also outlined the NHS Executive's decision to seek Treasury dispensation not to account in line with UK GAAP for revaluations by the District Valuer as adjusting post balance sheet events. The District Valuer's reports on the estimated values of NHS properties as at 1 April 2000 were finalised at the end of June 1999. Given the dates for which the values were to be estimated (i.e. April 2000), an index was applied to the values to forecast the values as at 1 April 2000 for individual health authorities. The NHS Executive have been unable to quantify the overall change in the total value of land and buildings as the data they have received from the District Valuer is incomplete and may include retained estate which was disposed of around the end of the financial year.

4.9 However in view of the timing of the District Valuer's work, it is reasonable to assume that much of the change in value related to events which had occurred prior to the balance sheet date of 31 March 1999. Under UK GAAP the changes in value, where material, should therefore have been treated as adjusting post balance sheet events. However, in January 2000, Treasury gave a dispensation to the NHS, allowing them to retain the previous basis of valuations in their accounts for 1998-99. The rationale for this dispensation was to keep NHS accounting in line with the latest proposals for resource accounting in central government.

4.10 Figure 3 gives an indication of the relative financial performance of health authorities, by analysing surpluses and deficits as reported in their accounts, as a percentage of each health authority's income in 1998-99.

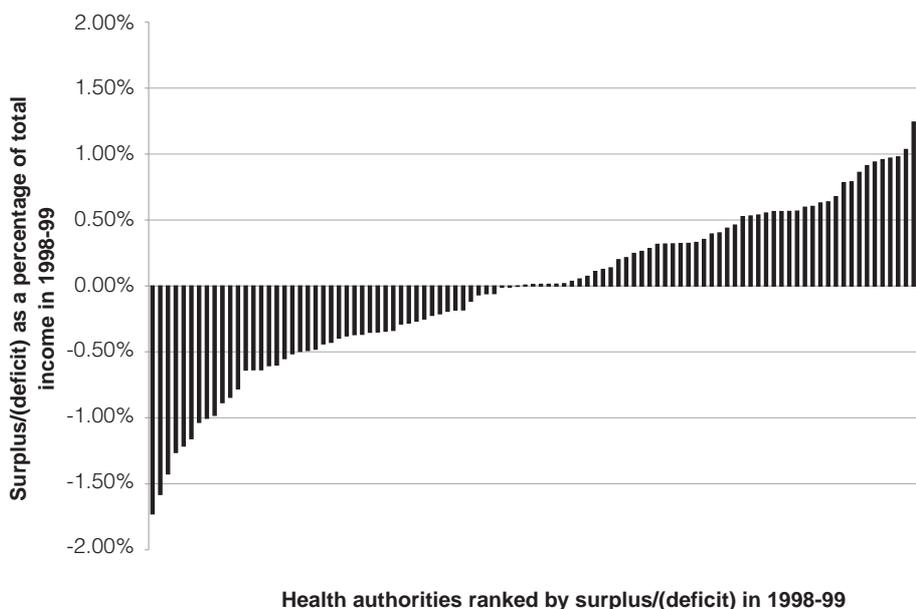
- 48 of the 100 health authorities reported a deficit in the year, the same as in 1997-98; and
- 88 of the 100 health authorities reported an accumulated deficit as at 31 March 1999, compared with 86 as at 31 March 1998¹.

¹ The analysis is not adjusted to reflect results that would have been reported under full compliance with UK GAAP requirements.

The financial performance of health authorities in 1998-99

Figure 3

Figure 3 shows that 48 health authorities reported an in-year deficit in 1998-99 on an accruals basis.



Source: Health authority accounts for 1998-99.

4.11 In addition to health authorities’ statutory duty to remain within their cash limit, the NHS Executive set them income and expenditure targets (paragraph 9 of the Foreword). A key target for 1998-99 was that all health authorities should break even, on an accruals basis, except where there were deep-seated problems that could not be resolved in a single year.

4.12 Health authorities are also set targets relating to their “recurrent” financial position (i.e. after stripping out one-off elements of income and expenditure). The key target was that they should be in recurrent financial balance by 1 April 1999, except where there were deep-seated problems that could not be resolved in a single year. Recovery of accumulated deficits after that point would largely depend upon when liabilities represented by the deficits needed to be settled, if at all.

4.13 The public sector payment performance target aims to pay 95% of invoices within 30 days. In 1998-99 only 13% of health authorities achieved the public sector payment performance target, with only 38% achieving more than 90%. As stated in paragraph 14 of the Foreword, the low level of compliance by health authorities may become more significant in 1999-2000 as legislation on the statutory right to claim interest on late debt, enacted in November 1998, comes more fully into effect. There has been a slight deterioration on 1997-98 performance when 17% of health authorities met the target.

Monitoring and action by the NHS Executive

4.14 The NHS Executive, through its eight regional offices, monitors the financial position of each health authority. The regional offices take account of “non-recurrent” factors within a health authority’s reported financial position in order to assess the underlying picture, for example special assistance funding from the NHS Executive centrally or from the NHS Executive regional office. As a result, the NHS Executive do not consider that in-year and cumulative deficits and identified future liabilities disclosed in a health authority’s accounts are in themselves an indication of financial problems in all cases.

4.15 Paragraph 11 of the Foreword notes that, at the end of 1998-99, the NHS Executive considered that a total of 18 health authorities were experiencing serious financial problems (defined as being an underlying deficit of more than the lower of 1 per cent of income or £1 million). This is an improvement over 1997-98 when 29 health authorities experienced serious financial problems.

4.16 The NHS Executive’s regional offices identified a number of factors contributing to the financial difficulties experienced by health authorities (paragraph 11 to the Foreword). The main factors identified were:

- over-performance on contracts with providers, leading to additional recurrent expenditure;
- in-year and recurrent cost pressures due to factors such as drug costs; and
- problems, which result from historical patterns of health services in the area which can only be resolved by restructuring.

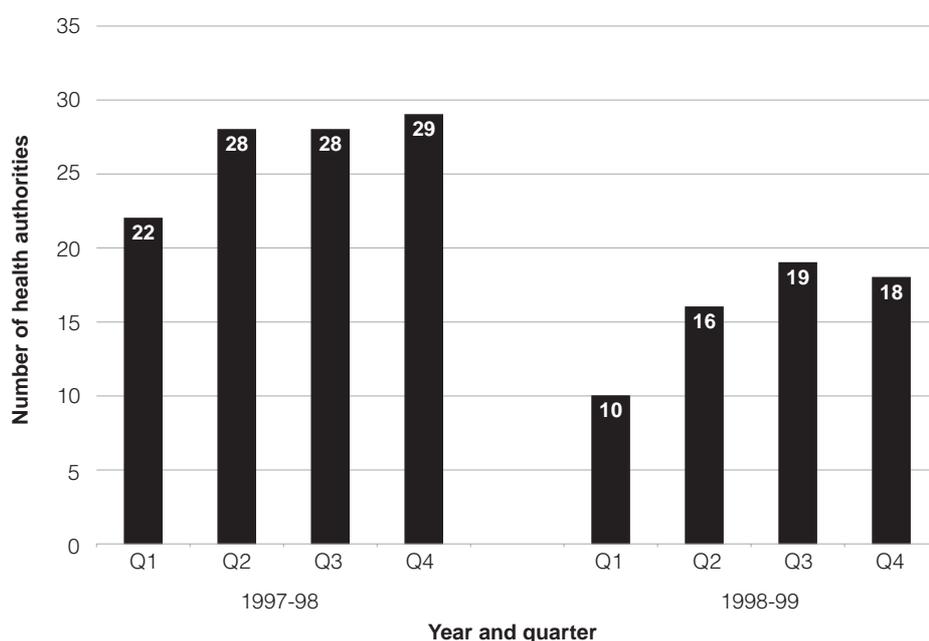
4.17 My analysis of the regional offices’ monitoring information indicates that a further factor was overspending on the part of GP fundholders within the health authority area. Eight of the health authorities experiencing serious financial difficulties gave this as a reason. However, the abolition of GP Fundholding means that this will not be a recurrent problem.

4.18 Paragraphs 12 and 13 of the Foreword describe the action taken by the NHS Executive in cases where they believed that the financial performance of a health authority indicated that there was an underlying recurrent problem. These health authorities were required to prepare recovery plans; the appropriate regional office agreed these plans and monitored their implementation.

4.19 The NHS Executive summarise their assessment of health authorities' underlying financial positions each quarter. Figure 4 below sets out the number of health authorities classified as experiencing serious financial problems, by quarter, from the first quarter of 1997-98 to the fourth quarter of 1998-99.

Health authorities with serious financial problems - 1997-98 to 1998-99

Figure 4



Source: NHS Executive monitoring data

NHS Trusts

NHS Trusts' financial duties

4.20 The Foreword to the summarised accounts gives details of the financial duties of NHS Trusts (paragraph 17), in particular explaining the definition of the duty to break even “taking one financial year with another”. This definition was clarified by the NHS Executive in July 1997 so that, from 1997-98 onwards, NHS Trusts are required to report performance over a run of years, with a start date of 1 April 1997. The duty to break even is the primary financial duty of NHS Trusts. The two remaining financial duties of NHS Trusts are the capital cost absorption rate (which replaced the target rate of return in 1998-99) and the external financing limit.

4.21 In my report on the 1997-98 summarised accounts (HC 382, 1998-99), I noted that the NHS Executive had still to issue guidance to Trusts which would clarify how they should deal with their accumulated surplus or deficit as at 31 March 1997. The Audit Commission also voiced concerns about inconsistencies in the approach adopted by different regional offices of the NHS Executive. In 1998-99, the continuing lack of guidance and evidence of inconsistencies suggests that some Trusts budgeted, and therefore set prices, to recover past deficits. The NHS Executive established a national working group to consider this further and issued guidance on accumulated deficits in June 1999. I welcome the issue of this guidance but note that it does not deal with the treatment of accumulated surpluses.

Financial performance of NHS Trusts

4.22 In total, the in-year deficit fell from £104 million at 31 March 1998 to £36 million at 31 March 1999. This indicates that the overall financial position of the NHS Trusts improved significantly in 1998-99. However at the end of the second quarter of 1999-2000 the forecast in-year deficit was £117 million.

4.23 As noted in paragraphs 3.2 to 3.10, compliance with FRS 11 was deferred for NHS organisations. Page 48 of the NHS Trusts account discloses that, had the FRS been applied, the estimated impact of asset impairments on the income and expenditure account would have been £366 million, changing the in-year deficit of £36 million to £402 million. In the absence of adjustments to funding, the impact would have been to reduce the accumulated surplus from £215 million to a deficit of £151 million.

4.24 As set out in paragraph 3.11, the NHS Executive decided to seek Treasury dispensation not to account in line with UK GAAP for revaluations by the District Valuer as adjusting post balance sheet events. The NHS Executive estimate that the changes in the values of land and buildings reported by the District Valuer would have had an impact, after utilising available revaluation reserves, of around £750 million additional charges on the income and expenditure account. Because the NHS was not required to comply with FRS 11 for this year's accounts, the NHS Executive have not prepared an estimate of the impact on the balance sheet figures. The NHS Executive have informed me that the funding mechanism for 1999-2000 have been adjusted to the extent necessary to protect NHS Trusts' finances from an adverse impact from this loss, which has arisen primarily through accounting adjustments rather than any real financial loss.

4.25 In total 98 NHS Trusts reported a retained deficit for 1998-99, of which the NHS Executive considered 57 to be material (paragraph 24 of the Foreword). Table 2 of the Foreword lists the four Trusts with the largest deficits, expressed as a percentage of income, together with details of the factors which the NHS Executive consider to be the underlying cause. At 31 March 1999, 115 NHS Trusts had cumulative deficits, which totalled £291 million. This compares with 126 NHS Trusts with an accumulated deficit totalling £304 million at 31 March 1998².

4.26 As paragraph 22 of the Foreword notes, since this is the second year of a three-year period (or in exceptional circumstances, a five-year period) for assessing NHS Trusts' performance against the break even objective, it is not yet possible to indicate how many NHS Trusts are on target to meet this objective. I note that an in-year deficit for NHS Trusts is forecast for 1999-2000. The NHS Executive inform me that they are working closely with NHS Trusts to ensure that their statutory financial duties are met.

4.27 Table 1 in the Foreword summarises the performance by NHS Trusts against the remaining two financial duties: 97% met the capital cost absorption rate and 96% met the external financing limit, after adjusting for technical factors. In total, 20 Trusts failed one or more of the two remaining financial duties, and paragraph 28 of the Foreword outlines the reasons.

4.28 The public sector payment performance target aims to pay 95% of invoices within 30 days. In 1998-99 only 17% of NHS Trusts achieved the target, with only 41% achieving 90% or above. As stated in paragraph 31 of the Foreword, the low level of compliance by NHS Trusts may become more significant in 1999-2000 as legislation on the statutory right to claim interest on late debt, which was enacted in November 1998, comes more fully into effect. There has been a slight improvement on the 1997-98 performance when 16% of NHS Trusts met the target.

4.29 Page 53 of the NHS Trusts' summarised account discloses that £14,000 was paid by NHS Trusts in interest on late debt in the five month period since the legislation came into force. Although the amount involved is not yet significant, I recommend that the NHS Executive should carefully monitor the payment performance of NHS organisations to ensure that the performance improves significantly and that public funds for patient care are not wasted unnecessarily on interest on late debt.

² The analysis is not adjusted to reflect results that would have been reported under full compliance with UK GAAP requirements.

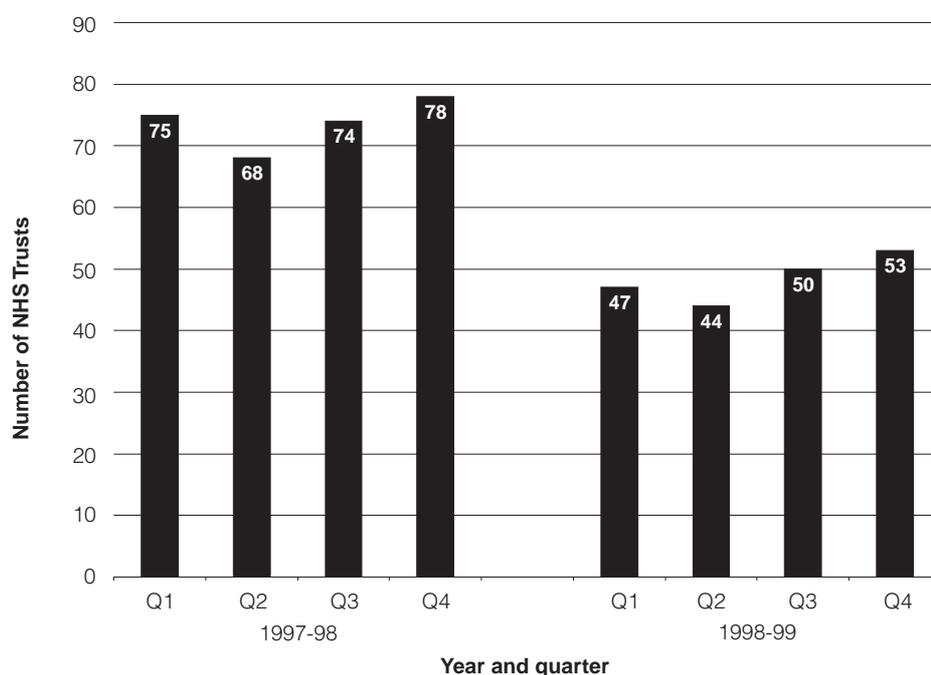
Monitoring of NHS Trusts by the NHS Executive

4.30 Paragraphs 18 to 20 of the Foreword summarise the way in which the NHS Executive agrees business plans with NHS Trusts and monitors their performance, and outlines the steps which the NHS Executive take when they consider that Trusts have underlying financial difficulties.

4.31 The NHS Executive identifies those Trusts which they consider to be in serious financial difficulty each quarter. By the final quarter of 1998-99, the total number of NHS Trusts assessed by the NHS Executive as facing serious in-year financial difficulties stood at 53. Figure 5 below sets out the number of NHS Trusts facing serious in-year financial difficulties from the first quarter of 1997-98 to the last quarter of 1998-99.

NHS Trusts with serious financial problems - 1997-98 to 1998-99

Figure 5



Notes: 1. On 1 April 1998, 15 of the 78 NHS Trusts were either merged or dissolved, which partly explains the reduction to 47 in the first quarter of 1998-99.

2. On 1 April 1999, 10 of the 53 NHS Trusts were also merged or dissolved.

Source: NHS Executive monitoring data

Overall financial position by geographical area

4.32 This is the second year that the NHS Executive have reported the financial position of geographical areas, taking account of the financial performance of both purchaser and provider bodies. The analysis combines health authorities with the main NHS Trust providers to give an overall picture of the state of the local “health economy”. This is done after stripping out the effects of one-off items of income and expenditure in order to get a fairer picture of an area’s underlying financial position. The total underlying deficit for each health economy is calculated by adding together the health authority’s recurrent income and expenditure deficit, the income and expenditure surpluses and deficits of NHS Trusts located within that health authority’s boundary and any non-recurrent funds for London NHS Trusts.

4.33 At the end of 1998-99, this monitoring identified four geographical areas with underlying in-year financial deficits of over £10 million compared with seven at the end of 1997-98. Figure 6 sets out the details of the areas concerned. Three out of the four areas relate to London health economies and are listed on the basis that they received non-recurrent funds. The NHS Executive’s regional offices continue to work with NHS Trusts and health authorities to develop, agree and monitor implementation of recovery plans.

Geographical areas with underlying in-year deficits of over £10 million

Figure 6

Figure 6 shows the geographical areas with underlying in-year financial deficits of over £10 million and excludes the non-recurrent income provided in 1998-99 to some London NHS Trusts.

Geographical Area	As at 31 March 1999	As at 31 March 1998
Camden and Islington	✓	✓
Ealing/Hammersmith/Hounslow	—	✓
East London and City	✓	✓
Lambeth/Southwark/Lewisham	✓	✓
Leeds	✓	✓
Merton/Sutton/Wandsworth	—	✓
West Surrey	—	✓

Source: NHS Executive monitoring data

Part 5: Fraud in the NHS

Introduction

5.1 In my report on the NHS (England) Summarised Accounts for 1997-98 (HC 382, 1998-99), I described some of the issues surrounding fraud in the NHS and the strategy to tackle the problem announced in the White Paper “Countering fraud in the NHS”, published by the Department of Health in November 1998. This section of my report deals with the implementation of this strategy and with the results of the work undertaken to date.

5.2 Since my last report, the Committee of Public Accounts have published a report highlighting their own concerns in this area (HC 128, 1999-2000). In particular, they were concerned:

- about the lack of an estimate of the overall level of fraud in the NHS;
- that the level of detected fraud at £2.6 million was very low, compared to the stock of fraud in the system of over £150 million; and
- that there were some two million more people registered with GPs in England than the resident population and that this may to some extent be the result of fraudulent claims by GPs.

5.3 They also stressed the need for the Directorate of Counter-Fraud Services (the Directorate) to liaise closely with Treasury and the Social Security Benefit Fraud Inspectorate and other experts to share best practice and to ensure a rigorous approach.

Scope of my work

5.4 In looking at fraud in the NHS I have:

- reviewed the development to date of the role of the Directorate (paragraphs 5.5 to 5.8);
- commented on the Directorate’s initiatives to help prevent and detect fraud (paragraphs 5.9 to 5.12); and

- reviewed the methodology and practice related to the first fraud measurement exercise i.e. prescription charge evasion fraud, which was based on data from November 1998 and July 1999 (paragraphs 5.13 to 5.28).

Developments in the role of the Directorate of Counter-Fraud Services

5.5 The Department of Health strategy document “Countering fraud in the NHS” announced the establishment of the Directorate of Counter-Fraud Services as a Directorate within the NHS Executive and gave their staff overall responsibility for all work to counter fraud and corruption within the NHS with particular priority for countering fraud in Family Health Services. The Directorate have responsibility for developing policy and strategy and for all operational work to counter fraud and corruption alongside the responsibilities held by health authorities and NHS Trusts. They are also responsible for the provision of advice, guidance and the monitoring of standards.

5.6 The strategy document also gave three published commitments:

- to achieve a 50% reduction in the level of prescription charge evasion by 2002-2003;
- to prevent £9 million in contractor fraud and to recover £6 million by 2001-2002; and
- to reduce fraud to an absolute minimum within ten years.

5.7 In carrying out their function, the Directorate are building on the efforts to counter fraud made by, amongst other bodies, the Fraud Investigation Unit of the Prescription Pricing Authority and the Probity Unit of the Dental Practice Board.

5.8 The initiative taken by the Department of Health in the establishment of the Directorate is a positive step to coordinate and enhance anti-fraud activities in the NHS.

Prevention and detection

5.9 In order to help to prevent and detect fraud, the Directorate are aiming to develop an “anti-fraud culture” throughout the NHS. A key part of the strategy has been the development of the Counter-Fraud Operational Service, which came into operation slightly later than planned, in December 1999. The Service comprises a total complement of 56 officers, with a team in each NHS region and a national mobile team. Two specialist teams for dental fraud and pharmaceutical fraud will be established by April 2000. They will work alongside a Central Directorate Unit in implementing strategies at a local level and providing advice to individual NHS bodies.

5.10 In addition, each individual NHS body will have a Local Counter-Fraud Specialist who has overall responsibility for the detection and prevention of fraud. The Directorate will ensure that each of these individuals attends an accredited counter-fraud training course at its own Training Centre of Excellence. The Directorate have also carried out a series of fraud awareness presentations across the NHS and will meet with all local professional committees of GPs, pharmacists, dentists and opticians in 2000 to deliver the same message. The target is for all health authority specialists to be trained by March 2000 and all NHS Trust specialists to be trained by March 2001.

5.11 Since April 1999, the Directorate have asked NHS organisations to report suspected frauds to them as they become aware of them. 239 cases with a total estimated value of £14 million have been reported to date. The Directorate are currently investigating around 200 fraud suspects, which includes 36 administrators, 18 external contractors, 25 GPs, 9 hospital doctors and surgeons, 22 nursing staff, 24 dentists, 16 opticians and 27 pharmacists. This represents a considerable achievement, since the levels of detected fraud reported by the Audit Commission amounted to only £2.6 million in 1997-98 and £4.7 million in 1998-99. The Directorate and the Audit Commission published a Memorandum of Understanding in August 1999 outlining how they will work together to exchange information on fraud and corruption and produce clear guidelines for the interaction of auditors and counter-fraud specialists.

5.12 Finally, as part of the effort to reduce the level of fraud which remains undetected, the Directorate are developing a “whistleblowing” initiative, which will enable staff and professionals to report suspected cases of fraud and corruption confidentially. A separate hotline will enable members of the public to

report suspected cases of fraud to the Directorate. The start of this initiative has been delayed from September 1999 to April 2000 to ensure that operational resources are in place to handle the cases that are reported.

Commentary on the Directorate of Counter-Fraud Services' methodology

5.13 Much of the early work of the Directorate has focused on developing a sound methodology for the measurement of fraud. This exercise has consisted of two main projects:

- the definition of fraud; and
- the estimation of levels of fraud in each of the eight target areas referred to in paragraph 5.17 below.

Definition of fraud

5.14 The Directorate have adopted as their definition of fraud a concept based on civil case law, being whether a person knowingly or recklessly obtains resources to which they are not entitled. The Directorate's evaluation aims to mirror the test of a civil law burden of proof – the balance of probabilities – on a case-by-case basis.

5.15 This analysis leads the Directorate to identify three categories of cases. If the Directorate encounter a case where the facts show that the person is not entitled to resources, and according to the balance of probabilities the mental element of knowledge or recklessness needed to meet the definition of fraud is present, this case is classified as "fraud". Where the mental element is not deemed to be present, then it is classified as "incorrect". Where a case complies with the relevant legislative processes, this case is classified as "correct".

Measurement

5.16 In order to measure achievement against the stated targets for prescription charge evasion, the Directorate recognised the need to establish a baseline figure for fraud in this area. To this end, they developed a Risk Management Project, which has the declared aim of accurately measuring fraud and incorrectness across all main services in the NHS, not just prescription fraud, by 31 March 2000.

5.17 The Directorate identified the following eight separate measurement exercises within the Risk Management Project:

- prescription exemption – patients;
- prescription exemption – contractors;
- prescription exemption – effect of point of dispensing checks;
- dental services – contractors and patients;
- optical services – contractors and patients;
- General Medical Services;
- procurement fraud – NHS Supplies; and
- fraud in health authorities and NHS Trusts.

5.18 Separate target dates were set for each of the exercises within the overall target of March 2000. Due to the complexity of the undertaking, none of these eight exercises have yet been completed. The Directorate now plan to complete some of these exercises by May 2000 and to report on the overall level of fraud and incorrectness in the NHS early in 2001.

Sampling

5.19 In order to establish the estimated level of fraud and incorrectness throughout the NHS, the Directorate have developed a sampling methodology which they have applied to the exercise on prescription charge evasion.

5.20 As part of my review, I examined the sampling methodology used and am satisfied that it provides a sound basis for estimating the likely level of fraud and incorrectness in the area of prescription charge evasion. However, the Directorate will need to undertake further work to develop suitable methodologies for other exercises such as procurement fraud where the nature of transactions susceptible to fraud and incorrectness is substantially different from prescription charge evasion.

Assessment of individual cases

5.21 As described in paragraph 5.15 above, the methodology requires officers to determine whether, on the balance of probabilities, an individual transaction is fraudulent, incorrect or correct. In general, I am satisfied that the processes adopted by the Directorate enable this judgement to be made accurately.

5.22 The methodology for evaluating the individual transactions is different for each type of measurement exercise. I have examined the process for those exercises relating to prescription exemption claims. There are essentially two stages to this process.

5.23 Firstly, data is checked against the records of another relevant government body in an attempt to determine the accuracy of the exemption status claimed. The processes of cross-checking with benefits data and the subsequent extrapolation of these results rely on the accuracy of the databases against which checks are made. However, I have reported that around 10% of the payments in the social security benefits system are potentially incorrect. It would therefore be appropriate, in my view, to consider the estimates calculated by the Directorate alongside these error estimates. Similarly, there may be other errors in systems against which the Directorate cross-checks exemptions claimed on the basis of age and these errors would flow through into the estimates made by the Directorate. The effect of not allowing for these errors is to understate the overall level of fraud and incorrectness in the NHS measurement exercises. I recommend that the Directorate work closely with the Benefits Agency if fraud in the NHS is to be reduced to an absolute minimum.

5.24 The second stage in the checking process applies to those cases where exemption has not been proven through cross-checking data. In these cases, the Directorate carry out field visits to the patients, which seek to confirm exemption through interview and checking with documents held by the individuals themselves.

5.25 I reviewed a sub-sample of the cases which the Directorate used in the prescription exemption exercises for November 1998 and July 1999. I am satisfied that the methodology described in Directorate documents was followed accurately.

Results of the work

5.26 The Directorate are using the sampled cases to produce an estimate of the overall level of fraud and incorrectness for each type of measurement exercise. The results of the prescription exemption exercise for November 1998 indicate an estimated loss to the taxpayer of £137 million (+/- £15 million). This estimate does not refer to cases where the patient has claimed exemption for reasons related to age, for which an estimate is not yet available. The estimate comprises fraud of £95 million and incorrectness of £42 million. The July 1999 estimate shows a reported loss of £92 million (+/- £12m) comprising fraud of £59 million and incorrectness of £33 million.

5.27 The figures quoted in paragraph 5.26 mean that the loss to the taxpayer through prescription exemption fraud and incorrectness where the exemption claimed does not relate to age may have reduced by £45 million or 33% between the November 1998 exercise and the July 1999 exercise. Measures taken by the NHS Executive are likely to have had a strong deterrent effect against potential fraudsters, in particular the introduction of point of dispensing checks implemented in April 1999 for non age-related exemptions and the criminalisation of the act of fraudulently evading prescription charges. The effect of these and other measures taken is not separately identifiable from other potential reasons for the reduction in losses.

The impact of fraud on my opinion on the summarised accounts

5.28 I have considered the impact of the reported levels of fraud and incorrectness in the context of my audit opinion on the summarised account of health authorities. In my view, the overall levels of fraud and incorrectness reported are not significant enough to affect the true and fair view of the accounts and I have therefore given an unqualified opinion on the accounts.

Part 6: Clinical negligence

Introduction

6.1 This part of my report:

- provides background information on clinical negligence (paragraphs 6.2 to 6.5);
- compiles the total clinical negligence liabilities and charges for the NHS from the separate figures disclosed in the 1998-99 summarised accounts (paragraphs 6.6 and 6.7);
- discusses clinical incidents that may have occurred, but for which no claims have yet been received (paragraphs 6.8 to 6.10);
- considers accounting developments affecting the treatment of clinical negligence and the need for consistency between NHS accounts (paragraphs 6.11 and 6.12); and
- sets out developments in improving the quality of clinical care aimed at minimising future costs of clinical negligence claims (paragraphs 6.13 to 6.20).

Background information

6.2 Clinical 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. The liabilities for clinical negligence are a major challenge facing the NHS and represent a drain of resources away from patient care.

6.3 Claims for clinical negligence are made against the relevant NHS Trust or health authority that was the employer of the health care practitioner at the time the incident occurred. To assist in meeting the cash impacts of large clinical negligence claims there are three separate funding schemes:

- the Existing Liabilities Scheme, which provides assistance with the cost of claims for clinical negligence incidents which arose before 1 April 1995. Under the scheme the health authority or NHS Trust pays the first £10,000 of

any such justified claim, plus 20 per cent of the cost between £10,000 and £500,000. The remainder is paid from central funds provided by the Department of Health;

- the Clinical Negligence Scheme for Trusts is a membership scheme administered by the NHS Litigation Authority to provide support for clinical negligence claims in respect of incidents occurring after 1 April 1995. Nearly all NHS Trusts are now members and each Trust can choose from a range of excesses and higher thresholds, which along with discounts for risk management will determine their contribution levels. The Trust will be reimbursed 80 per cent of any settled claim between the excess and the higher threshold and the full amount over the higher threshold; and
- the Ex-Regional Health Authorities Scheme, which covers the liabilities of the hospitals and other services formerly managed at a regional level, which had been assumed by regional health authorities prior to their abolition in April 1996. The NHS Litigation Authority has taken over the responsibility for these claims.

6.4 The accounting and disclosure of the cost of clinical negligence is spread across the summarised accounts. In my report on the NHS summarised accounts for 1997-98 (HC 382, 1998-99) I brought together the various liabilities and charges accounted for or noted by NHS organisations to show that the overall potential liabilities facing the NHS, as disclosed in the accounts at 31 March 1998, was £1.8 billion. In addition I reported that the costs of clinical incidents which have occurred but have not been reported by the balance sheet date could amount to a further £1 billion. In paragraphs 6.6 to 6.7, I have set out the comparable figures for this year.

6.5 In September 1998, the Accounting Standards Board issued Financial Reporting Standard 12 "Provisions, Contingent Liabilities and Contingent Assets". I noted in my 1997-98 report that I expected that the standard would provide the framework for improving the way in which this type of provision and contingency is accounted for and disclosed in NHS accounts. However, while the NHS Litigation Authority has applied the standard to their 1998-99 accounts, NHS Trusts and health authorities have deferred the application of FRS 12 until 1999-2000³, as explained in Part 3 of this report.

³ In both Wales and Scotland, NHS Trusts and health authorities/health boards have applied FRS 12 to their 1998-99 accounts.

Liabilities and charges for clinical negligence disclosed in 1998-99

6.6 In total the NHS summarised accounts show:

- gross charges to the income and expenditure accounts of over £1 billion, an increase of almost £0.4 billion or 58 per cent on 1997-98;
- gross provisions of £2.4 billion, an increase of £0.6 billion or 36 per cent from 31 March 1998; and
- net contingent liabilities of £435 million, an increase of £59 million or 16 per cent from 31 March 1998.

Figure 7 below shows how the total clinical negligence liabilities and charges have been compiled from the separate figures disclosed in the 1998-99 summarised accounts.

6.7 The gross provisions represent the potential liabilities within the NHS, although the £2.4 billion total excludes the additional liabilities relating to incidents incurred but not reported (see paragraphs 6.8 to 6.10). About £0.4 billion of the £0.6 billion increase in reported liabilities from March 1998 is due to the recognition of additional claims under the Existing Liabilities Scheme, and arises, in part, from the better reporting and disclosures within the accounts. The remaining £0.2 billion is mainly from the new claims arising from the Clinical Negligence Scheme for Trusts although an element is due to the increase in the provisions set aside for existing claims.

Incidents incurred but not reported

6.8 In practice, there can be significant delays between a clinical incident occurring and a claim for clinical negligence being made against the NHS. There are numerous reasons for a delay to occur including the time it can take for a patient to realise the effects of a clinical incident.

Costs of clinical negligence in 1998-99

Figure 7

Charge to income and expenditure account	1998-99 £ million	1997-98 £ million
NHS Trusts	122	85
Health Authorities	79	48
NHS Litigation Authority (Ex-RHA scheme)	18	11
National Blood Authority	2	–
Net Total	221	144
NHS Trusts' anticipated reimbursements	402	191
Health authorities' anticipated reimbursements	410	318
Gross Total ¹	1,032	653
	31 March 1999	31 March 1998
Provisions and Contingent Liabilities	£ million	£ million
NHS Trusts	210	169
Health Authorities	196	165
NHS Litigation Authority (Ex-RHA scheme)	65	60
National Blood Authority	2	–
Total Net Provisions ²	473	394
NHS Trusts' anticipated reimbursements	750	421
Health authorities' anticipated reimbursements	1,187	943
Total Gross Provisions	2,410	1,758
Net Contingent Liabilities		
NHS Trusts ³	268	240
Health Authorities	166	133
National Blood Authority	1	3
Total Net Contingent Liabilities ³	435	376

Notes: 1. The amounts charged to expenditure by NHS Trusts and health authorities are net of anticipated reimbursements from the Existing Liabilities Scheme and the Clinical Negligence Scheme for Trusts. Adding in the anticipated reimbursements from the central schemes, as disclosed in the notes to the accounts, (note 23, page 61 and note 4, page 26) shows the total charge to the NHS for 1998-99.

2. The net provisions represent health organisations' best estimate of their share of negligence claims viewed to have a 50 per cent likelihood or more of being settled. The anticipated reimbursements from central schemes are noted in the NHS Trusts and health authorities summarised accounts (note 14, page 58 and note 11, page 31).

3. Contingent liabilities are disclosed in the summarised accounts for those claims considered to have less than 50 per cent likelihood of settlement. The figures are net of potential reimbursements. The figures for NHS Trusts are part of the total contingent liabilities disclosed in note 22, page 61, 1998-99 £283 million (1997-98 £262 million).

Source: Summarised Accounts for NHS England for 1998-99

6.9 At present neither health authorities nor NHS Trusts make any provisions for the likely cost of clinical incidents which have not been reported by the balance sheet date but which may lead to claims in the future. In my report on the summarised accounts for 1996-97 (HC 923, 1997-98) I estimated that outstanding liabilities relating to such incidents could amount to £1 billion. The estimate was based on an analysis of delays carried out by the NHS Executive in conjunction with the Medical Protection Society Limited and Willis Corroon Limited. In practice, the accounts for 1997-98 and 1998-99 have shown that the amounts incurred in those two years under the Existing Liabilities Scheme for incidents before April 1995 alone have amounted to over £1.1 billion.

6.10 However, the latest information suggests that, under the Clinical Negligence Scheme for Trusts, incidents are being reported earlier than previously predicted, and that estimates for unreported cases for this scheme and the Existing Liabilities Scheme at the end of March 1999 are likely to be below the previous estimate of £1 billion. I am working with the NHS Executive to incorporate an estimate of all incidents incurred but not reported into the summarised accounts for the NHS, so that the full extent of the liability is quantified and built into future funding estimates for the NHS.

Accounting developments and consistency issues

6.11 As I set out in part 3 of my report, the NHS Executive requested approval from the Treasury to defer the implementation of FRS 12 to their accounts until 1999-2000. The main impact on the accounting for clinical negligence at NHS Trusts and health authorities will be to change the basis of measuring the provision. Under FRS 12 the provision will be the probable value of all the claims discounted from their expected date of settlement to their present value. In contrast the current policy provides in full for all the claims considered to have a 50 per cent or more likelihood of settlement. In addition FRS 12 requires that the provisions are accounted for gross, with the amounts due in reimbursements included in debtors, and greater disclosure of the timing of settlements.

6.12 In 1998-99 the different methods of measuring clinical negligence provisions and the timing of such measurement has resulted in several problems with achieving consistency of disclosure between different summarised accounts and with the underlying accounts. The problems with the consistency of disclosure between NHS accounts are summarised in Figure 8.

Figure 8 Problems with the consistency of disclosure between NHS accounts

Problems identified	Impact	Actions taken or being taken for 1999-2000
The NHS Litigation Authority applied FRS 12 to their accounts in 1998-99, unlike health authorities and NHS Trusts.	The NHS Litigation Authority's account has disclosed a different figure, for the value of reimbursements due to Trusts from the Clinical Negligence Scheme for Trusts, from that shown in the NHS Trusts' summarised account.	All underlying accounts and the summarised accounts will apply FRS 12 for 1999-2000.
The quality of information from underlying accounts on non-compliance with FRS 12 was poor. The NHS Executive therefore found it difficult to establish the full impact of non-compliance with FRS 12 on the summarised accounts.	In the 1998-99 summarised accounts the NHS Executive have made rough estimates of the impact of FRS 12. The estimates were made by assuming that the probability of settlement for: <ul style="list-style-type: none"> ■ claims within provisions averaged 75 per cent; and ■ claims within contingent liabilities averaged 25 per cent. The estimates do not include the impact of discounting the provisions.	Non-compliance with FRS 12 will not be an issue in the 1999-2000 accounts.
The NHS Litigation Authority's own published account applied FRS 12 to the claims which they had received by 31 March 1999. However, the NHS Litigation Authority's liability under the Clinical Negligence Scheme for Trusts includes all incidents that have occurred up to the balance sheet date that are likely to result in a transfer of economic benefit, rather than just reported cases.	The NHS Executive and the NHS Litigation Authority agreed to adjust the summarised account to show the liabilities for all known incidents up to the time when the Accounting Officer signed the accounts. At 31 March 1999 the expected discounted value of cases under the Clinical Negligence Scheme for Trusts totalled £271 million, but when the Accounting Officer signed the accounts the total had increased to £418 million (note 9 page 196).	I am in discussion with the NHS Litigation Authority and the NHS Executive on how to develop the NHS Litigation Authority's account to fully show the value of not only the incidents recorded but also a likely estimate of incidents incurred but not yet reported.
As part of the audit of the NHS Litigation Authority, the appointed auditor tried to match the amounts recorded at Trust level, as due from the NHS Litigation Authority. The appointed auditor found discrepancies in almost all cases. These discrepancies were mostly due to timing differences.	The underlying NHS Trust accounts are inconsistent with the underlying account for the NHS Litigation Authority.	I have raised the problem of ensuring consistency between NHS accounts and the NHS Executive have agreed that a formal reconciliation process between the NHS Litigation Authority and NHS Trusts is to be adopted from 1999-2000.
My examination of the NHS Trusts and health authorities accounts also revealed that a number of bodies have failed to disclose any contingent liabilities, where values would have been expected. Also the amounts recoverable from departmental schemes have varied widely across NHS bodies.	Contingent liabilities have almost certainly been understated and a few NHS Trusts have not correctly applied the accounting guidance issued by the NHS Executive.	The application of the guidelines issued by the NHS Executive in respect of FRS 12 should increase consistency between NHS accounts.

Source: Summarised Accounts for NHS England for 1998-99

Developments in improving the quality of clinical care

6.13 In December 1999, the Committee of Public Accounts reported on the NHS (England) Summarised Accounts 1997-98 (HC 128, 1999-2000). The Committee concluded that, where clinical negligence has occurred, the aim must be to ensure that the system for dealing with cases is cost-effective, quick, efficient, fair and humane. The Committee considered that the real issue was how to minimise the risks of negligence happening in the first place.

6.14 The report noted work in three key areas:

- wide consultation by the then Secretary of State about options for improving the system of handling claims for compensation;
- developments made by the NHS Litigation Authority; and
- a range of policy initiatives to improve standards.

6.15 At the time of my report, work on improving the system of handling compensation claims was still on-going. In October 1999 the Health Select Committee issued their report on the procedures related to adverse clinical incidents and outcomes in medical care (HC 549, 1998-99). The Committee considered that it was vital that the NHS complaints procedure is made more open and transparent and that the system is seen to be fair and independent. Their recommendations included that the Department of Health should issue guidelines to NHS regional offices, health authorities and NHS Trusts giving clear advice as to which adverse incidents should be reported, to whom and when, and that the Department of Health should review the issues and publish a consultation document on the possible introduction of no-fault compensation within the NHS.

6.16 The exchange of information for clinical negligence and other civil cases within the NHS has been revised in line with the Woolf reforms to the civil justice system, which came into effect on 26 April 1999. The reforms introduced a new protocol that has to be followed on the exchange of information before court proceedings. The courts now treat the protocol standards as normal pre-action conduct and can impose sanctions for non-compliance. This should speed up the time taken to resolve clinical negligence claims, although the reduced time allowed for the NHS to respond to a claim letter may increase the costs of investigation.

6.17 The NHS Litigation Authority encourage the members of the CNST scheme to meet clinical risk management standards by offering discounts on their membership contributions. There are three levels of achievement, which are awarded after independent assessment. By February 2000, 263 NHS Trusts had reached the first standard, entitling them to a 10% discount; 31 NHS Trusts had reached level two, qualifying them for a discount of 20%; and a further one NHS Trust had reached level three, entitling them to a 25% discount.

6.18 In my report on the summarised account for 1997-98 I outlined the measures announced in the NHS Executive's consultation document "A First Class Service: Quality in the NHS" aimed at ensuring fair access to effective, prompt, high quality healthcare wherever a patient is treated in the NHS and enhancing standards. The key developments since my report are:

- the establishment of the National Institute for Clinical Excellence and the agreement of their first year's programme;
- the establishment of a duty of quality of care on health authorities, Primary Care Trusts and NHS Trusts as part of the Health Act 1999;
- the development of the NHS Performance Assessment Framework, with high-level performance indicators being set across a range of areas, including clinical effectiveness. The indicators are to be used to compare local performance with similar localities, to assess reasons for variations and identify scope for improvements;
- the establishment of the Commission for Health Improvement which commenced its work in November 1999. The Commission has a number of functions, including the independent scrutiny of NHS organisations to improve the quality of service, support for NHS organisations in tackling clinical service problems, monitoring the implementation of national service frameworks and guidance issued by the National Institute for Clinical Excellence and monitoring measures to reduce unacceptable variations in service provisions; and
- the publishing of the first national survey of NHS patients in October 1999.

6.19 The NHS Executive are also working on extending the controls assurance statements beyond financial controls to wider organisation controls and risk management. The overall aim is to establish mechanisms to prioritise and manage

the identified risks and enable information on both clinical and non-clinical incidents and complaints to be reliably recorded, reported and analysed to determine underlying causes and enable lessons to be learned from past experience. In November 1999 the NHS Executive published 18 control standards and related criteria, including those for overall risk management systems containing the criteria for incident reporting and follow-up. The NHS Executive in conjunction with interested parties, are intending to further develop the framework to incorporate standards for measuring risks associated with clinical systems. It is intended to achieve this through enhancing and incorporating the existing NHS Litigation Authority standards for the Clinical Negligence Scheme for Trusts. The NHS Executive plan to combine these standards from 2000-2001.

6.20 It is still early days for these initiatives and for assessing what impact they will have on the future liabilities of the NHS in respect of clinical negligence claims. I will report in future years on the level of claims, together with the progress being made by the Department of Health and the NHS Executive on their initiatives.

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29 March 2000

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