Contents

Index of Figures used in the Report

Executive summary

Introduction and Scope

1 Responsibility for the administration of the National Health Service (NHS) in Wales transferred to the National Assembly for Wales on 1 July 1999. This function is exercised through the five Welsh health authorities, which are responsible for commissioning health services for their local resident populations, and through the NHS trusts in Wales as providers of those health services.

2 The Foreword to the NHS (Wales) Summarised Accounts for 1998-99 describes the basis for their preparation under Section 98 of the National Health Service Act 1977, and the background to the individual NHS organisations in Wales. It details recent NHS reforms, the role of the National Assembly, the stocktake of the NHS in Wales and the application of Financial Reporting Standard 11 (Impairment of fixed assets) to the accounts of NHS bodies. It also gives information on the financial performance of Welsh NHS bodies in 1998-99, and specifically reports on the monitoring of NHS trusts against their financial duties.

3 This is the last report that I shall make to Parliament as Comptroller and Auditor General on the NHS (Wales) Summarised Accounts. From 1999-2000, I will audit these accounts in my capacity as Auditor General for Wales and report on them to the National Assembly for Wales.

Issues covered in this Report

4 This report records the results of my audit examination of the summarised accounts for 1998-99, and the results of the audits of the underlying accounts by auditors appointed by the Audit Commission for England and Wales. I have given unqualified audit opinions to all five of the 1998-99 summarised accounts (paragraphs 2.3 – 2.16). I update several issues raised in my report on the 1997-98 accounts (paragraphs 3.2 – 3.24), including the restructuring of the NHS in Wales (paragraphs 3.2 – 3.8).

5 I comment on the overall financial performance of the NHS in Wales (paragraphs 4.3 – 4.7) and on the underlying performance of the individual health authorities (paragraphs 4.8 – 4.10) and NHS trusts (paragraphs 4.11 – 4.18), and the forecast performance of the NHS in Wales for 1999-2000 (paragraphs 4.19 - 4.22).

6 I consider a range of management and internal control issues, including clinical negligence (paragraphs 5.2 – 5.15), corporate and clinical governance (paragraphs 5.16 – 5.19), fraud (paragraphs 5.20 – 5.23) and human resource management (paragraphs 5.24 – 5.28). In addition, I comment on the progress being made with the introduction of resource accounting and budgeting (paragraphs 6.2 – 6.8), on two important areas of asset management within the NHS in Wales (paragraphs 7.2 – 7.7) and on the cost of primary care drugs (paragraphs 8.2 – 8.6).

Main Findings and Conclusions

Findings of the appointed auditors

7 The auditors appointed by the Audit Commission to undertake the audits of the individual NHS bodies in Wales issued unqualified audit opinions in respect of each body. However, for two health authorities and eight NHS trusts the appointed auditors drew attention to the financial deficits reported by those bodies for the 1998-99 financial year (paragraphs 2.6 - 2.9).

8 The auditors expressed concerns to the Audit Commission about delays in the agreement of recovery plans, and also the difficulties that were being encountered by five trusts following their reconfiguration on 1 April 1999 (paragraphs 2.10 - 2.12). Assembly officials assured me that the actions now being taken to revise recovery plans would address these issues (paragraph 2.13).

Restructuring of the NHS in Wales

9 The NHS in Wales underwent considerable structural change during 1998-99. This included the merger of the four ambulance trusts to form the Welsh Ambulance Services NHS Trust, and the abolition of the Welsh Health Common Services Authority and the Health Promotion Authority for Wales (paragraphs 3.2 - 3.8).

10 The process of reform developed in the January 1998 White Paper "Putting Patients First" continued through 1998-99 and several changes in the administration of the NHS in Wales were implemented under the Health Act 1999. These included the introduction of Health Improvement Programmes as the new mechanisms for determining healthcare requirements within each specific health authority area. The Act also provided for the abolition of both the internal market

within the NHS and the function of GP Fundholding, and established the new Commission for Health Improvement to promote good practice and high-quality care across the NHS in England and Wales (paragraphs 3.9 - 3.16).

11 Two new Financial Reporting Standards have been implemented across the NHS in Wales during 1998-99. These required health authorities and NHS trusts to alter the way in which provisions for liabilities, including those for outstanding clinical negligence claims, are reported (FRS 12), and also the basis of valuation of the NHS estate (FRS 11). The impact of this latter change has been significant, resulting in an exceptional one-off impairment charge within the 1998-99 summarised accounts (paragraphs 3.17 to 3.22).

Financial performance of the NHS in Wales

12 Excluding the impairment charge described in paragraph 11, the NHS in Wales reported a total combined deficit for 1998-99 of some £21.8 million. Within this figure, the five health authorities reported a net deficit of £12.1 million for 1998-99, and an accumulated deficit at 31 March 1999 of £36.7 million. The then 26 NHS trusts in Wales incurred a net £9.7 million deficit for 1998-99, and an accumulated deficit at 31 March 1999 of some £17.2 million (paragraphs 4.3 - 4.7).

13 The reported combined annual financial position of the five health authorities in Wales has deteriorated continually since their establishment in April 1996. Deficits have been reported over the last three years, and a further net deficit is forecast in 1999-2000 (paragraphs 4.8 to 4.10 and paragraph 4.19). Similarly, NHS trusts in Wales reported a net deficit for the fourth year running, and are also forecasting a further deficit in 1999-2000. In 1998-99, fourteen NHS trusts failed to break even, which is one of their three key financial objectives. Indeed, 25 of the 26 NHS trusts failed to achieve one or more of these three objectives (paragraphs 4.11 – 4.18 and 4.20 – 4.22). In the five Appendices to this report, I examine the financial performance of the NHS within each of the five health authority areas in Wales (Appendices A to E).

14 The continuing pattern of annual deficits is also reflected in the supplier payment performance of the five Welsh health authorities, which has improved only slightly since 1997-98. Only 85 per cent of bills were paid within the specified 30-day period (paragraphs 4.24 - 4.25). The supplier payment performance of NHS trusts has declined overall from 78 per cent in 1997-98 to 74 per cent in 1998-99 (paragraphs 4.26 - 4.30).

15 In preparation for the transfer of responsibility for the NHS in Wales to the National Assembly for Wales, a Stocktake Report was prepared at the request of the Secretary of State for Wales by the Welsh Office Policy Unit reviewing the overall financial position of the NHS in Wales. This report concluded that there was no single explanation for the financial problems and that deficits of this nature were not unique to the NHS in Wales. The report noted several of the contributory factors to the underlying operational deficits and made a series of recommendations, including the strengthening of the role of the Assembly's NHS Directorate in ensuring that the monitoring of financial performance is integrated with value for money and the delivery of service priorities (paragraphs 4.31 - 4.39).

The management of risk within the NHS in Wales

Clinical Negligence

16 Outstanding provisions for clinical negligence rose by £17 million during 1998-99 to total over £98 million at 31 March 1999. This figure represents the best estimate of the value of outstanding claims where the health bodies concerned have a reasonable expectation of making a payment. In addition, NHS bodies reported a further £116 million of contingent liabilities at 31 March 1999, where there is a possibility rather than a probability of future payments (paragraphs 5.2 - 5.6).

17 The Welsh Risk Pool has continued to play a leading role in promoting effective risk management across the NHS in Wales. Additional Risk Management Standards are being developed specifically for the health authorities, and the Pool has also established a Risk Manager Network to disseminate best practice between the health bodies (paragraphs 5.10 - 5.15).

Fraud

18 The All-Wales Anti-Fraud Working Group established by the former Welsh Office disseminates examples of best practice in the management of fraud. However, due to resource constraints, no Welsh counterpart to the Directorate of Counter Fraud Services in England has yet been established. In its first year, that Directorate conducted a review of prescription charge evasion in England and reported a loss of some £137 million, including fraud of £95 million – no comparative assessment has been made for Wales (paragraphs 5.20 - 5.23).

Human resource management

19 The recent period of reorganisation and restructuring of the NHS in Wales has placed particular importance on the management of human resources by health bodies. Arrangements for personnel affected by NHS trust reconfiguration remained the responsibility of the NHS trusts themselves and, although guidance was issued by the former Welsh Office, I noted that the terms and conditions of redundancy packages and other arrangements adopted by NHS trusts varied widely (paragraphs 5.24 - 5.26). The implementation of the European Working Times Directive and the additional costs of staffing hospitals over the Millennium period will affect the financial performance of NHS bodies in the 1999-2000 financial year (paragraph 5.27).

Resource Accounting and Budgeting

20 In line with the government-wide Resource Accounting and Budgeting initiative, the Assembly will be required by the Treasury to consolidate the accounts of the five Welsh health authorities into its own annual Resource Account from the 2000-01 financial year. For this consolidation to be possible, changes will be required in the way the heath authorities account for their fixed assets. The appointed auditors will also need to issue a specific regularity opinion on the accounts of the health authorities, in line with best practice, and I note that this is to be made mandatory from the 1999-2000 financial year (paragraphs 6.2 - 6.7).

21 It is likely that the consolidation boundary for the Assembly's resource accounts will be extended over the next few years to include other bodies such as NHS trusts. As Auditor General for Wales, I intend to monitor developments in this area closely (paragraph 6.8).

Asset Management

Public Private Partnerships

22 The implementation of Public Private Partnerships within the NHS in Wales has resulted in some 15 contracts to date, with a total capital cost of some £33 million. The majority of these projects are relatively small, although a new hospital project in Baglan has recently been approved and another in Cardiff is currently under negotiation (paragraphs 7.2 - 7.4).

Use of surplus land

23 The NHS in Wales occupies an estate totalling some 1,100 hectares, with an existing use value of £1.1 billion. Of this, 51 properties covering an area in excess of 260 hectares, with an existing use value of around £96 million are considered surplus to existing NHS requirements. A disposal programme is underway, which is expected to yield some £23 million by 2003. As Auditor General for Wales, I intend to review this area as part of a wider value for money study on the management of the NHS estate (paragraphs 7.5 - 7.7).

Cost of primary care drugs

24 The gross cost of prescribed drugs in Wales in 1998-99 amounted to some £318 million. This was offset partially by patient charge income of some £22 million in the year, giving a net cost to the Assembly of some £296 million. The annual cost of prescribed drugs in recent years has increased at a rate greater than inflation, and the main cost drivers are the number of patients, morbidity rates, the availability of drugs to treat this morbidity and prescribing practices. The Assembly does not have responsibility for the UK-wide pharmaceutical price regulation scheme (paragraphs 8.2 – 8.4).

25 The Assembly Secretary for Health and Social Services has announced the setting up of a 'Task and Finish Group' to consider the scope for improving the efficiency and effectiveness of prescribing in Wales, within the framework of the Assembly's powers and responsibilities. The Group will report in June 2000 and, as Auditor General for Wales, I will review its recommendations as part of my work on the 1999-2000 Summarised Accounts (paragraphs 8.5 – 8.6).

Part 1: Introduction

Background

1.1 During 1998-99, the Welsh Office Health Department was responsible for the administration of the National Health Service (NHS) in Wales. On 1 July 1999 this responsibility was transferred to the National Assembly for Wales (the Assembly), in accordance with the provisions of the Government of Wales Act 1998. In order to support the Assembly in the provision of health services in Wales, the former Welsh Office Health Department has been restructured, and responsibility for the strategic management of the NHS in Wales now rests with the NHS Directorate of the Assembly.

1.2 Administration of the NHS in Wales is exercised through the five Welsh health authorities, which are responsible for purchasing health services for their local resident populations, and through the 16 NHS trusts in Wales (26 trusts prior to reconfiguration on 1 April 1999) as providers of those health services. In addition, the two Special Health Authorities (the Welsh Health Common Services Authority and the Health Promotion Authority for Wales) had specific functions in support of the provision of healthcare within Wales until their abolition on 1 April 1999.

1.3 Cash funding of the NHS during 1998-99 by the Welsh Office was reported to Parliament through the Class XIV, Vote 4 Appropriation Account. Net advances to the five health authorities totalled £2,283 million, and advances of public dividend capital and long-term loans to NHS trusts totalled £78 million.

1.4 The Foreword to the NHS (Wales) Summarised Accounts describes the basis for their preparation under Section 98 of the National Health Service Act 1977, and the background to the individual NHS organisations in Wales. It details recent NHS reforms, the role of the National Assembly for Wales, the Stocktake of the NHS in Wales and the application of Financial Reporting Standard 11 (Impairment of fixed assets) to the accounts of NHS bodies. It also gives information on the health authorities, NHS trusts and the two Special Health Authorities, including a review of their financial performance in 1998-99, and specifically reports on the Welsh Office monitoring of NHS trusts against their financial duties, together with the financial performance of those trusts in Wales in 1998-99.

1.5 The 1998-99 NHS Summarised Accounts for Wales, together with the Foreword to the accounts, were signed by the Accounting Officer on 30 November 1999. The equivalent NHS Summarised Accounts for England and for Scotland are published in separate House of Commons papers, together with my reports on each of them.

1.6 With effect from the 1999-2000 financial year, the responsibility for certifying and reporting on the Summarised Accounts of the NHS in Wales is transferred to the Auditor General for Wales. As Auditor General for Wales, I will report to the National Assembly for Wales. This is therefore the last report that I shall make to Parliament as Comptroller and Auditor General under the National Health Service Act 1977 in respect of these accounts.

1.7 In Part 2 of this Report, I describe in more detail the formation of my audit opinion. The subsequent parts then address current issues affecting financial control and accounting within the NHS in Wales, as follows:

Part 3: Restructuring of the NHS in Wales and other developments;

Part 4: Financial performance of the NHS in Wales;

Part 5: Management and internal control issues, including clinical negligence, corporate and clinical governance, fraud and human resource management;

Part 6: Resource Accounting and Budgeting;

Part 7: Asset management; and

Part 8: Cost of primary care drugs.

1.8 The Appendices to my Report provide more detail about the financial performance of each of the five health authority areas in Wales.

Part 2: Formation of my Audit Opinion

Introduction

2.1 This part of the Report summarises the audit methodology used for my audit of the NHS (Wales) Summarised Accounts. Specifically, it:

- Sets out the basis of my audit (paragraph 2.3);
- Reviews the Audit Commission's summary of findings for 1997-98 (paragraphs 2.4 to 2.5); and
- Outlines the work of the appointed auditors in 1998-99 (paragraphs 2.6 to 2.15).

2.2 On the basis of this work, the audit opinions of the appointed auditors and of my audit of the summarisation process at the Assembly, I am able to give an unqualified opinion on all the NHS (Wales) Summarised Accounts for 1998-99.

Basis of Audit

2.3 Under Section 98(4) of the National Health Service Act 1977, I am required to examine, certify and report on the NHS summarised accounts. My examination of the 1998-99 NHS (Wales) Summarised Accounts included an assessment of the reliability of the information contained in the audited accounts of the individual NHS bodies. As in previous years, National Audit Office staff in Wales undertook this task by reviewing specific areas of work of the auditors appointed by the Audit Commission, scrutinising their reports and discussing their findings with them. My staff also examined the summarisation of the individual underlying accounts by the Assembly's NHS Directorate (responsibility for preparing the 1998-99 accounts of the former Welsh Office has transferred to the Assembly).

Audit Commission annual summary of findings

2.4 In July 1999, the Audit Commission published "A Healthy Balance". This report summarised the financial position of NHS bodies in England and Wales at 31 March 1998 and emphasised the need to achieve financial balance. It also included detail of good practice in financial management within NHS bodies. The report concluded that:

"NHS bodies … face a range of formidable challenges. Generally, they are meeting those challenges well, and …the overall standards of financial management … are consistently high."

Source: "A Healthy Balance", Audit Commission (July 1999)

2.5 In addition, the appointed auditors raised the following themes in their returns to the Audit Commission on the 1997-98 audit cycle:

- The poor financial position of certain health authorities and NHS trusts, and the requirement for Recovery Plans (10 NHS trusts were forecasting a deficit for 1998-99);

- Difficulties in agreeing contracts for the provision of services between health authorities and NHS trusts - this was reported for both the 1997-98 and 1998-99 contract years, and related specifically to trusts within the Dyfed Powys, Bro Taf and Gwent Health Authority areas; and

- On the completion of the Statement on the System of Internal Financial Controls, a number of health authorities and NHS trusts reported that certain specific actions, such as a risk management strategy, had not been in place for the full financial year.

Audit of the 1998-99 underlying accounts

Work of the Appointed Auditors

2.6 In 1998-99, the Audit Commission appointed their arm's length service, District Audit, to undertake the audits of four of the five health authorities, both Special Health Authorities and 21 of the 26 NHS trusts. Two of the leading accountancy firms were appointed by the Audit Commission to audit the remainder.

2.7 Each of the appointed auditors completed their work on the 1998-99 accounts of the individual health bodies in accordance with the timetable prescribed by the Welsh Office Health Department. Unqualified audit opinions were given to each body, although the audit opinions on two health authorities and eight NHS trusts drew attention to those bodies' financial positions.

2.8 The following Table shows the reported and underlying financial positions of each of these ten bodies. The first column shows the actual 1998-99 deficits reported by each body in their annual accounts, whilst the second shows the more important underlying surplus or deficit position after the one-off exceptional effect of the introduction of Financial Reporting Standard 11 is excluded. I set out in more detail the requirements of FRS 11 implementation for NHS bodies in Wales at paragraphs 3.17 to 3.20, and discuss the financial impact of this change in accounting practice at paragraphs 4.3 to 4.5.

2.9 In Part 4 of my Report I set out a more detailed financial analysis of the financial position of the NHS in Wales, and at paragraphs 4.3 to 4.5 explain why in this report I focus on the underlying financial position of the NHS in Wales.

Audit reports highlighting financial performance, 1998-99

Figure 1

Health Body	Reported Surplus/(Deficit) £'000	Underlying Surplus/(Deficit) excluding FRS 11 effects £'000
Bro Taf Health Authority	(291)	(291)
Dyfed Powys Health Authority	(11,492)	(11,492)
Carmarthen and District NHS Trust	(2,592)	(3)
Ceredigion and Mid Wales NHS Trust	(5,412)	19
Llandough Hospital and Community NHS Trust	(4,685)	(2,223)
Llanelli/Dinefwr NHS Trust	(1,279)	(28)
Morriston Hospital NHS Trust	(12,690)	(2,682)
Pembrokeshire and Derwen NHS Trust	(824)	(529)
Powys Health Care NHS Trust	(416)	494
University Hospital of Wales Healthcare NHS Trust	(22,108)	(2,072)

Source: Audit reports, 1998-99 accounts for NHS bodies in Wales

2.10 The main themes identified by the Audit Commission in previous years remain key concerns:

- The ongoing poor financial position and financial standing of certain health authorities and NHS trusts;

- Difficulties in the commissioner/provider relationship of one health authority in contract negotiations with five trusts, following the move to Long Term Agreements; and

- A continuing requirement for additional disclosures of non-compliance within the Statement on the System of Internal Financial Control, in part due to only partial application of these controls by health authorities and NHS trusts in the year.

2.11 In addition, appointed auditors have also raised the following points in their 1998-99 returns to the Audit Commission:

- Several health authorities and NHS trusts had not agreed their required Recovery Plans with the Welsh Office/Assembly, and those that were previously agreed had not been amended following trust reconfigurations;

- The application of the fixed assets impairment review conducted during the year had a significant impact on the financial standing of many trusts (I consider this issue further in paragraphs 3.17 to 3.20 below); and

- Five trusts had already encountered or anticipated problems on reconfiguration. These problems included: the worsening of a cumulative financial position on the merger of two trusts with pre-existing deficits; issues concerning the apportionment of income between specialties within reconfigured trusts; potential large termination payments; and difficulties at one new trust in merging pre-existing financial systems and procedures.

2.12 District Audit told me that although these are issues for the Assembly, they were clear that agreed and sustainable recovery plans are not in place for all NHS trusts, and that the recovery of accumulated deficits is not being recognised in some recovery plans.

2.13 Assembly officials told me that they are taking action in all these areas. Recovery Plans are now being revised between health authorities, NHS trusts and the Assembly, and draft Recovery Plans have been or are being prepared for all the NHS bodies highlighted in Figure 1, and also for those other bodies where emerging deficits have become apparent. Assembly officials have told me that these Recovery Plans are intended to restore financial balance to these NHS bodies.

Reports and Referrals by appointed auditors

2.14 Under Section 8 of the Audit Commission Act 1998, appointed auditors have the discretionary power to make a Public Interest report on any matter affecting the NHS bodies within their purview. No such reports were issued in 1998-99.

2.15 Section 19 of the Audit Commission Act 1998 requires an appointed auditor to refer matters to the Secretary of State if the auditor has reason to believe that an NHS body has made a decision which involves or may involve unlawful expenditure. In 1998-99, no matters were referred to the Secretary of State.

Audit Conclusion

2.16 On the basis of work completed by the appointed auditors, the audit opinions given to the underlying accounts, and following my audit of the summarisation of the underlying accounts by the National Assembly for Wales' Health Directorate, I am able to give unqualified opinions on all of the summarised accounts for 1998-99. I consider further the financial position of those bodies listed above in the Appendices to this Report.

Part 3: Restructuring of the NHS in Wales and other developments

Introduction

3.1 This part of my Report outlines the following recent developments within the NHS in Wales:

- The creation of the Welsh Ambulance Services NHS Trust and the reconfiguration of NHS trusts in Wales (paragraphs 3.2 to 3.4);
- The abolition of the Welsh Health Common Services Authority and the Health Promotion Authority for Wales on 1 April 1999 (paragraphs 3.5 to 3.8);
- Progress and developments under the "Putting Patients First" initiative and the Health Act 1999 (paragraphs 3.9 to 3.16);
- The impact of new Financial Reporting Standards on accounting within the NHS (paragraphs 3.17 to 3.22); and
- The establishment of the National Assembly for Wales, detailing the change in responsibility for the NHS in Wales (paragraphs 3.23 to 3.24).

Creation of the Welsh Ambulance Services NHS Trust

3.2 On 1 April 1998, the four Welsh ambulance trusts merged, along with the ambulance services delivered by the Pembrokeshire and Derwen NHS Trust, to form the single Welsh Ambulance Services NHS Trust.

3.3 In creating this trust, the Secretary of State for Wales extinguished Public Dividend Capital of £10 million and loans of £8 million, and granted new Public Dividend Capital of £10 million and loans of £10 million. The reserves of the former NHS trusts were reset to zero. This included a combined cumulative Income and Expenditure deficit of £0.4 million and a total Revaluation Reserve of £2.1 million. The ambulance function transferring from the Pembrokeshire and

Derwen NHS Trust was excluded from this process and, instead, the value of assets and liabilities relevant to that trust's ambulance function were treated as an in-year adjustment during 1998-99.

NHS trust reconfiguration

3.4 A similar accounting procedure is being applied in the larger reconfiguration on 1 April 1999 of NHS trusts in Wales, which reduced their number from 26 to 16. With Treasury approval, previous practice on reconfiguration has been to reset to zero the brought forward balances on the Income and Expenditure Reserve and Revaluation Reserve, matching the capital structure of the new trust with the net asset position. Where this process results in the removal of cumulative Income and Expenditure deficits, the Assembly has applied to the Treasury for write-off approval. Each case is reviewed to ensure that the decision to reconfigure genuinely improves the provision of services and is not purely a means for "massaging" deficits. Treasury approval is given only if adequate evidence exists to support the decision to reconfigure and demonstrates that an effective recovery strategy is in place in each trust. Any write-offs will be reflected in the 1999-2000 accounts of the former Welsh Office.

Abolition of the Welsh Health Common Services Authority

3.5 Under Statutory Instrument No. 804 of 1998-99, the Welsh Health Common Services Authority was abolished on 1 April 1999 and the property, rights, liabilities and staff of the Authority transferred to the Secretary of State for Wales (and subsequently to the Assembly) and various Welsh NHS trusts and health authorities.

3.6 As the activities of the Authority remain in existence and have passed to these successor bodies, the 1998-99 accounts of the Authority were prepared on a going concern basis. As Auditor General for Wales, I intend to review the transfer of assets and liabilities as part of my audit of the 1999-2000 accounts.

Abolition of the Health Promotion Authority for Wales

3.7 Under Statutory Instrument No. 807 of 1998-99, the Health Promotion Authority for Wales was abolished on 1 April 1999 and the property, rights, liabilities and staff of the Authority transferred to the Secretary of State for Wales (and subsequently to the Assembly).

3.8 As the activities of that Authority remain in existence and have reverted to the Secretary of State, the 1998-99 accounts of the Authority were prepared on a going concern basis. Again, as Auditor General for Wales, I intend to review the transfer of assets and liabilities as part of my audit of the 1999-2000 accounts.

"Putting Patients First" – progress and developments

3.9 The Foreword to the Summarised Accounts describes progress to date on the implementation in Wales of the NHS reforms announced under the National Health Service and Community Care Act 1990, and developed in the January 1998 White Paper "Putting Patients First". Assembly officials told me that this process of reform has continued within the NHS in Wales. These reforms are now being implemented under the Health Act 1999, which received Royal Assent on 30 June 1999.

3.10 One of the major developments from this initiative concerned the introduction of Health Improvement Programmes as a mechanism for driving the health improvement agenda, as well as shaping the delivery of health services in each specific health authority area. These Health Improvement Programmes are intended as three to five year plans of priorities, as agreed by health authorities in conjunction with local authorities, local health groups and NHS trusts, as well as the broader community, including voluntary bodies, employers and users of services. This approach has been introduced from 1999-2000 on an incremental basis, with health authorities and partners initially to produce interim one-year Programmes. For subsequent years substantive Programmes will be developed. This collaborative approach replaces the previous mechanism for the commissioning of health services by reintroducing a strategic planning process.

3.11 One of the purposes of the Health Improvement Programme is to provide a platform for the establishment of Long Term Agreements, being the agreement between the health authority and relevant NHS trusts for the provision of required health services. As Auditor General for Wales, I intend to review progress in this area as part of my audit of the 1999-2000 accounts.

Health Act 1999

3.12 The Health Act 1999 is intended to improve health services by facilitating collaborative working among health bodies and reduce the level of bureaucracy within the NHS. It abolishes the internal market within the NHS, that is the purchaser/provider split, and the function of GP Fundholding. The Act also makes

provision for the establishment of Primary Care Trusts in England and Wales, to be responsible for the commissioning and provision of health services. Assembly officials told me that there are no plans for the development of such trusts in Wales.

3.13 The Act makes a number of changes to the legislative framework of NHS trusts. This includes the simplification of the remuneration of trusts' capital structure. Previously the capital structure consisted of long-term loan and Public Dividend Capital. These were remunerated in two ways: the repayment of long-term loan (principal and interest) in two six-monthly instalments, and the annual payment of a dividend, together adjusted annually to allow a 6 per cent rate of return in total. Under the Act, the capital structure is now wholly Public Dividend Capital, and remuneration simplified to require the annual payment of dividend only. This conversion was completed on 15 March 1999, and is reflected in the 1998-99 Summarised Accounts of the NHS trusts in Wales.

3.14 Further developments under the Health Act 1999 include the placing of a duty of quality on all health authorities and NHS trusts, including the area of clinical governance. The Act also established the Commission for Health Improvement, set up to promote good practice and high-quality care across the NHS in England and Wales. The Commission is answerable to both the Secretary of State for Health and the National Assembly for Wales. Its main functions include:

- The provision of advice and information on the monitoring and improvement of health care at NHS trusts;
- Review of the implementation and adequacy of such monitoring and improvement arrangements;
- Investigating the management, provision or quality of health care at NHS trusts; and
- Reviewing on a national level, particular types of health care provided by the NHS.

3.15 The Commission for Health Improvement will also monitor responses to the findings of the new National Institute for Clinical Excellence, which is tasked with the review of the clinical and cost-effectiveness of new and existing treatments (including drugs) across England and Wales.

3.16 The Health Act 1999 also includes measures designed to control fraud within the NHS, and specifically addresses the evasion of NHS charges for prescriptions, dental treatment or optical services. I consider the issue of fraud within the NHS in Wales further at paragraphs 5.20 to 5.23 of this Report.

Impact of changes in accounting standards

FRS 11: Impairment of Fixed Assets and Goodwill

3.17 The Accounting Standards Board published this Financial Reporting Standard in July 1998, with applicability to all financial statements ending on or after 23 December 1998. It was therefore applicable to the NHS in Wales for the 1998-99 accounts. The purpose of this Standard is to ensure consistency in the reporting of fixed assets and goodwill, and specifically it requires that:

- "fixed assets and goodwill are recorded in the financial statements at no more than their recoverable amount;"
- "any resulting impairment loss is measured and recognised on a consistent basis;" and
- "sufficient information is disclosed in the financial statements to enable users to understand the impact of the impairment on the financial position and performance of the reporting entity."

3.18 The implementation of this new accounting standard within the NHS in Wales posed a considerable logistical challenge. Health bodies in Wales underwent a quinquennial revaluation exercise in 1998-99, with health authorities and trusts needing to incorporate the effects of the resulting adjustments in their 1998-99 accounts within a very tight timescale. The revaluation exercise has historically resulted in a significant decrease to fixed asset values for two main reasons:

- new assets and major capital expenditure items are subject to formal valuations as assets in use for the first time, as opposed to having valuations based on the actual construction cost. Valuation methodology assumes that assets were built in 'ideal' circumstances. However, this is rarely the case, and often the new valuation is lower than the actual construction costs, resulting in a technical impairment; and

- the indices used to determine the net book values of assets in the years between each quinquennial revaluation exercise are compiled on a UK- wide basis, which tends to overstate the values of assets held by health bodies in Wales.

3.19 In the case of specialised buildings such as hospitals, this resulted generally in a reduction in the net asset values reported in each body's balance sheet at 31 March 1999. This reduction (known as an 'impairment review') has had a considerable one-off impact on the 1998-99 summarised accounts of the NHS in Wales. The cost of impairments of fixed assets to health authorities in Wales totalled £35 million. The equivalent figure reported by the NHS trusts in Wales amounted to £272 million. Of this latter amount, £102 million has been written off against the revaluation reserve and the remainder (£170 million) has been charged as an exceptional item on the Income and Expenditure Account.

3.20 In Part 4 of my Report (paragraphs 4.3 to 4.6), I explain in more detail the impact of these impairment charges on the 1998-99 accounts.

FRS 12: Provisions and Contingent Liabilities

3.21 The second Financial Reporting Standard applicable from 1998-99 was FRS 12, which relates to the accounting for provisions and contingent liabilities. The objective of this new standard is to promote consistency in the accounting for provisions and contingent liabilities. A provision is defined as a liability of uncertain timing or amount to be settled by the transfer of economic benefits. If the payment is only a possibility, it is accounted for as a contingent liability. The Treasury issued guidance to all public sector bodies funded by central government on the implementation of FRS 12 in their annual accounts. This guidance requires all health bodies to make appropriate provisions for the anticipated future costs that will be incurred in meeting expected obligations.

3.22 I summarise the impact of this new accounting standard on the accounting for clinical negligence costs within the NHS in Wales in Part 5 of my Report (paragraphs 5.8 to 5.9).

Establishment of the National Assembly for Wales

3.23 Under the Government of Wales Act 1998, the National Assembly for Wales took over the Secretary of State's responsibilities for the National Health Service and for the health of the people of Wales on 1 July 1999. The main functions of the Assembly as regards the NHS in Wales are:

- The administration of the NHS in Wales;
- Holding health bodies to account;
- Monitoring public health;
- Health promotion; and
- Allocating health service resources.

3.24 The Assembly Secretary for Health and Social Services, in consultation with the Health and Social Services Committee of the Assembly, has been responsible since 1 July 1999 for the performance of the above functions.

Part 4: Financial performance of the NHS

Introduction

4.1 This part of my Report examines the financial performance of the NHS in Wales during 1998-99 and summarises:

- A financial overview of the NHS in Wales for 1998-99 (paragraphs 4.3 to 4.7);
- The financial performance of health authorities in Wales (paragraphs 4.8 to 4.10);
- The financial performance of NHS trusts in Wales (paragraphs 4.11 to 4.18);
- The forecast financial performance of the NHS in Wales for 1999-2000 (paragraphs 4.19 to 4.22);
- The NHS supplier payment performance statistics for 1998-99 (paragraphs 4.23 to 4.30); and
- The main findings of the July 1999 "Stocktake" of the NHS in Wales (paragraphs 4.31 to 4.39).

4.2 In the five **Appendices** to this Report, I set out further, more detailed analyses of the financial performance within each health authority's geographic area.

Overview of financial performance of the NHS in Wales, 1998-99

4.3 The five health authorities and the NHS trusts in Wales reported a total combined net deficit in 1998-99 of some £191.8 million. This result comprised a £12.1 million deficit reported by the five health authorities and a £179.7 million deficit by the NHS trusts.

4.4 In paragraphs 3.17 to 3.20 above, I set out the impact of the new FRS 11 accounting standard on the 1998-99 accounts of the NHS in Wales. The overall net deficit for 1998-99 includes fixed asset impairment losses of some £35 million in

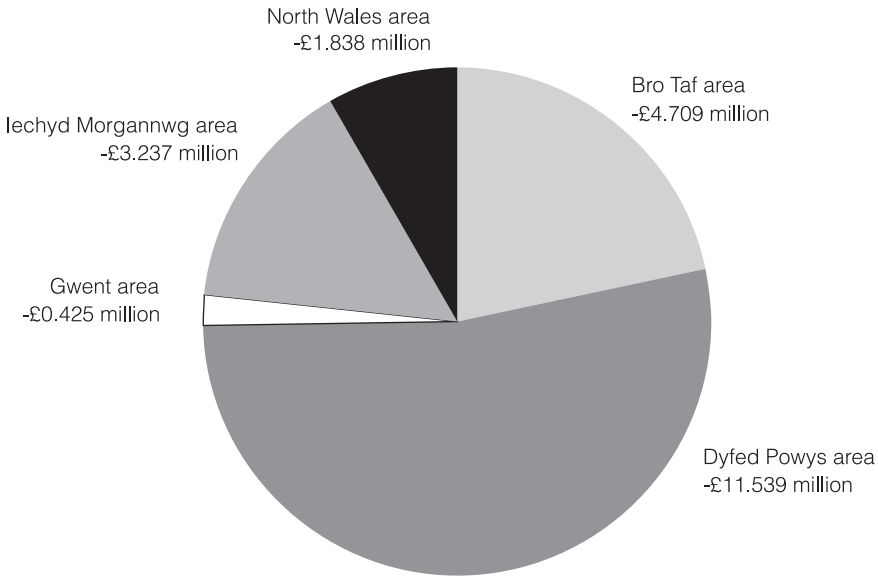
respect of health authorities and £170 million in respect of NHS trusts, arising from the implementation during the year of Financial Reporting Standard 11. This loss had a neutral impact on the financial position of health authorities, as under health authority accounting rules, an equivalent amount was released from the Government Grant Reserve in the year. Assembly officials have considered the effect of the adjustment on the accounts of NHS trusts, and Treasury have agreed to provide funding for that element of the 1998-99 deficit in 1999-2000 in order to neutralise its effect. The position reported in Annex 2 to the Foreword to the Summarised Accounts excludes the charges arising from FRS 11.

4.5 My review below (and in the attached Appendices) of the financial position of NHS trusts in Wales therefore also excludes the exceptional charges arising from the one-off fixed asset impairment review, and focuses on the underlying financial health of each NHS body.

4.6 Had this new accounting standard not been introduced, the net deficit for the 1998-99 financial year would have been some £21.8 million, comprising the £12.1 million deficit reported by the five health authorities and a £9.7 million deficit reported by NHS trusts. This represents an increase in the annual deficit of nearly £2 million (10 per cent) from the 1997-98 result. The following figure illustrates the breakdown of this net operating deficit between the five health authority areas (that is, each health authority together with the NHS trusts within its geographical area), and the wide variations in their relative overall financial positions:

Breakdown of 1998-99 deficit by health authority area

Figure 2



Source: National Audit Office analysis

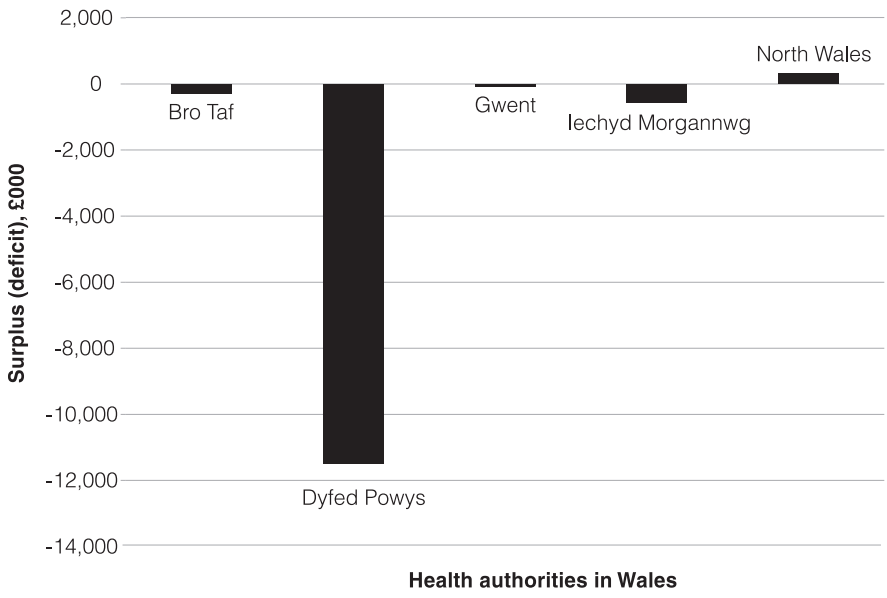
4.7 The five Appendices to this Report examine the performance of each of the areas in Figure 2 (that is, health authorities and NHS trusts) in detail.

Financial performance of health authorities in Wales for 1998-99

4.8 The combined net deficit reported by the five health authorities themselves in the summarised accounts for 1998-99 amounted to £12.1 million. The following figure (Figure 3) illustrates the distribution of that deficit across the five health authorities:

Breakdown of 1998-99 health authorities' surplus/(deficit)

Figure 3



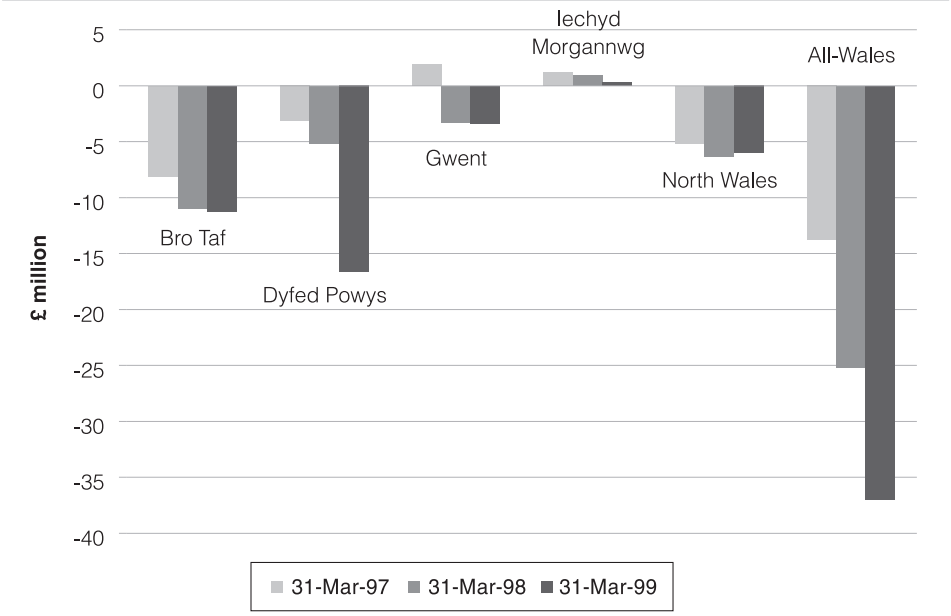
Source: Health Authority published accounts 1998-99

4.9 Figure 4 shows the effect of these 1998-99 results on each authority's cumulative General Reserve at the year-end, together with the all-Wales position.

4.10 The total net deficit of £12.1 million for 1998-99 across the health authorities has increased their accumulated deficit from £24.8 million to £36.9 million at 31 March 1999. The deficits incurred during 1998-99 have followed deficits incurred in previous years, thus worsening an already serious general reserves deficit, as illustrated in Figure 4. The reasons for the deficits are complex and were considered in detail by the July 1999 NHS Stocktake Report. I outline the main conclusions of that report at paragraphs 4.31 to 4.39.

Health authorities' General Reserves, as at 31 March

Figure 4



Source: National Audit Office analysis

Financial performance of NHS trusts in Wales for 1998-99

4.11 Annex 2 to the Foreword to the Summarised Accounts gives details of the financial performance of NHS trusts in 1998-99, including their achievements against the break-even target for the three-year period 1997-98 to 1999-2000. As I noted in my Report last year, the break-even target is defined as the cumulative financial position of a trust over a three-year period, 1997-98 being taken as Year One. In 1998-99, trusts are again therefore only able to report an interim position.

4.12 The reconfiguration of several NHS trusts on 1 April 1999 has effectively reset the cumulative financial position of those NHS trusts to zero, so that 1999-2000 will be the first year of their three-year break-even period. For those NHS trusts which were not reconfigured, achievements against the three-year break-even target will be reported in 1999-2000.

4.13 In 1998-99, the Welsh Office introduced a new financial performance target - the 'Capital Cost Absorption Rate' – which has replaced the 'Rate of Return on Assets' target previously used. The calculation of that statistic included both capital and non-capital items. The purpose of the new approach is to ensure that, taking account of depreciation, trusts absorbed the full cost of their capital. For both the Rate of Return and Capital Cost Absorption Rate, this target was set at

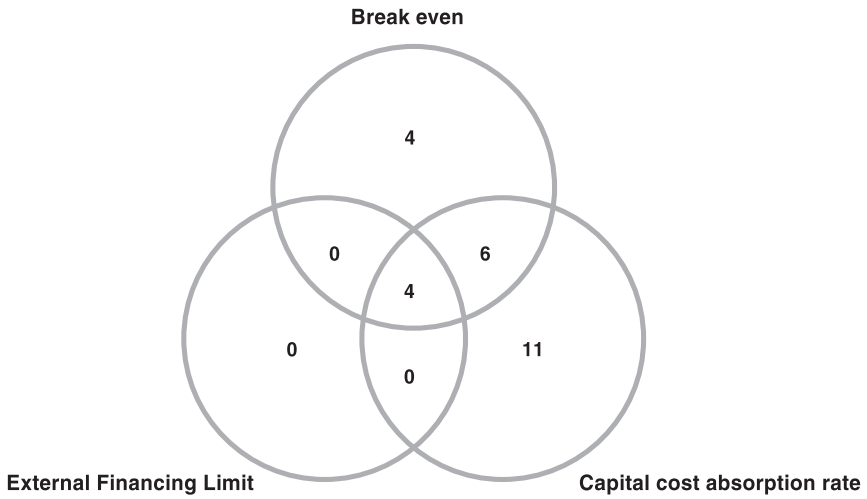
6 per cent. This revised methodology is also being applied by the NHS in England. The estate revaluation exercise has had a material effect in reducing the value of capital assets held, and thus has affected trusts' ability to achieve this target.

4.14 Annex 2 to the Foreword to the Summarised Accounts shows the all-Wales performance by aggregating the results of the underlying NHS trusts. In overall terms, all three financial objectives were failed. The summarised accounts reported a capital cost absorption rate of 6.4 per cent, a deficit of £9.7 million (excluding the fixed asset impairment adjustment) and a marginal overshoot of the External Financing Limit (£0.3 million).

4.15 I note that 25 of the 26 trusts operating in 1998-99 failed to achieve one or more of the three financial objectives set; only the Swansea NHS Trust achieved all three financial objectives (after excluding the impact of the fixed assets impairment review). Four trusts failed all three financial objectives, six trusts failed two and 15 trusts failed one. Taking the objectives individually, 14 trusts failed to break even, 21 failed to meet the exact 6 per cent capital cost absorption rate and four trusts failed to keep within the External Financing Limit.

NHS trusts failing to achieve financial targets

Figure 5



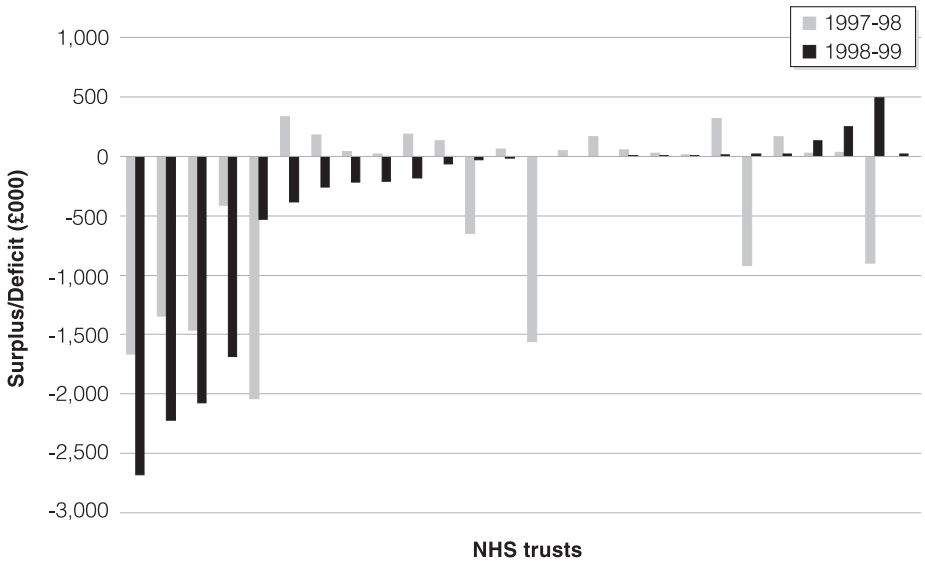
Source: Annex 2, Foreword of NHS (Wales) Summarised Accounts, 1998-99

4.16 In paragraphs 4.11 and 4.12 above, I summarised the changes in the break-even requirement, defined over a three-year period. In terms of their financial performance in 1998-99, 14 trusts failed to break-even, of which seven had previously reported a deficit in 1997-98.

4.17 Figure 6 below shows performance against this objective, charting the surplus/deficit results for 1997-98 and 1998-99 (that is, years 1 and 2 of the rolling three-year period):

Analysis of NHS trusts' surpluses and deficits, 1997-98 and 1998-99

Figure 6



Source: National Audit Office analysis

Note: These results exclude the impact of the FRS 11 fixed asset impairment adjustment.

4.18 The above figure shows the comparative financial performances of all NHS trusts in Wales in 1997-98 and 1998-99 (Welsh Ambulance Services NHS Trust in 1998-99 only). In 1998-99 four NHS trusts incurred deficits in excess of £1.5 million, three of which had incurred large deficits in the previous year. Compared with 1997-98, seven trusts have improved on their surplus/deficit performance, including three trusts which whilst still in deficit in 1998-99 reported significant recoveries in the year. However, the financial performance of 18 trusts, in terms of their surplus / deficit position, has worsened, including seven trusts previously in surplus but now reporting a deficit in the current year. The summarised account shows an increase in the overall annual deficit of NHS trusts in Wales from £9.1 million to £9.7 million in 1998-99.

Forecast financial performance of the NHS in Wales, 1999-2000

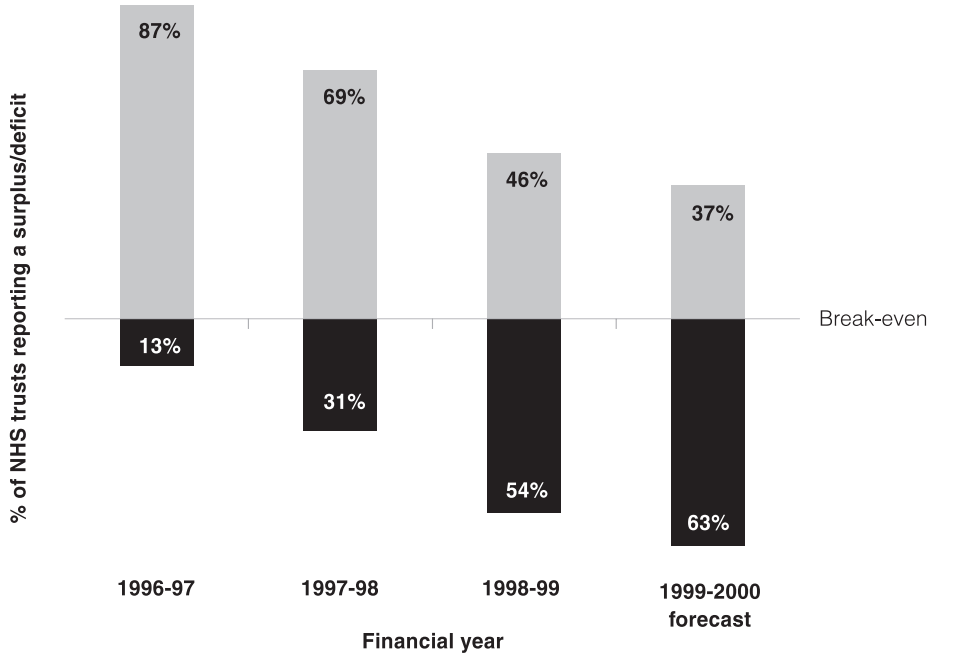
4.19 For 1999-2000, the forecast out-turn position is of concern. Two of the five health authorities are forecasting deficits, with the total net deficit for the year estimated at £8.9 million. This would increase the accumulated net deficit to some £45.8 million at 31 March 2000.

4.20 As regards NHS trusts, the forecast for 1999-2000 is for 10 of the 16 NHS trusts to report deficits totalling some £17.3 million, with individual deficits ranging from £0.3 million to £5.9 million.

4.21 Figure 7 shows the percentage of trusts reporting surpluses or deficits in each of the last three financial years, together with the latest forecast of results for 1999-2000:

Financial performance of NHS trusts, 1996-97 to 1999-2000 (forecast)

Figure 7



Source: National Audit Office analysis

4.22 Taking the forecast deficits for health authorities and NHS trusts together, the total forecast deficit for the NHS in Wales for 1999-2000 is £26.2 million. Specific cost pressures impacting on this forecast position include emergency admissions, high cost treatments, clinical negligence claims, dispensing costs and the implementation of the European Working Times Directive.

Public sector payment policy performance in 1998-99

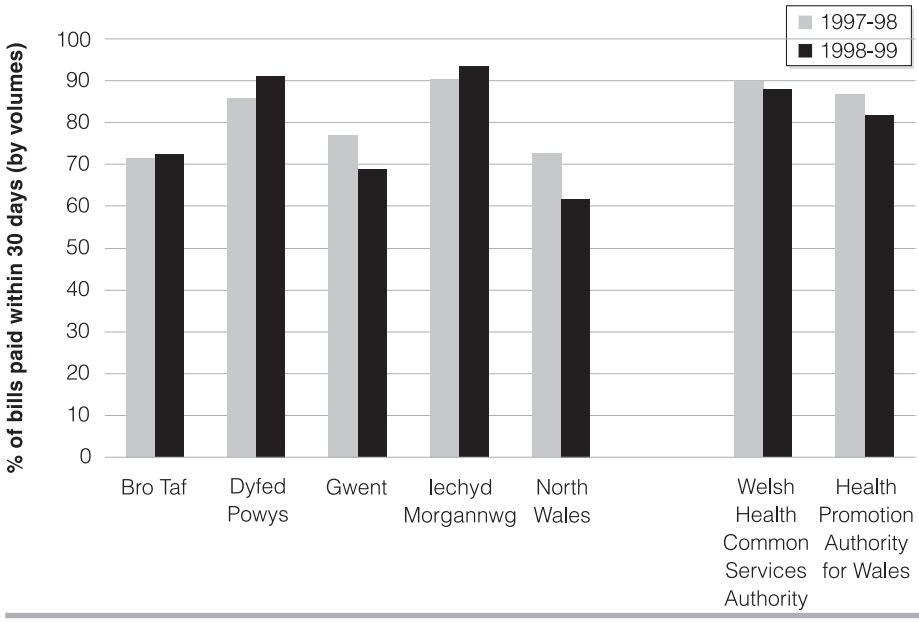
4.23 In common with other public sector bodies, all health authorities and NHS trusts in Wales are required to pay all bills within 30 days of receipt of a valid invoice as specified under the CBI supplier payment code of practice. The performance of each health authority and NHS trust in 1998-99 is given at Annexes 1 and 2 of the Foreword to the Summarised Accounts. Overall, the performance of the health authorities (including the two Special Health Authorities) has worsened since 1997-98. The performance of most of the NHS trusts has generally shown some improvement since 1997-98, but continues to fall well short of paying all bills within 30 days.

Health Authorities

4.24 Figure 8 below illustrates the comparative supplier payment performance of each health authority for both 1997-98 and 1998-99:

Health authorities' supplier payment performance, 1997-98 and 1998-99

Figure 8



Source: Foreword, Annex 1 1997-98 and 1998-99

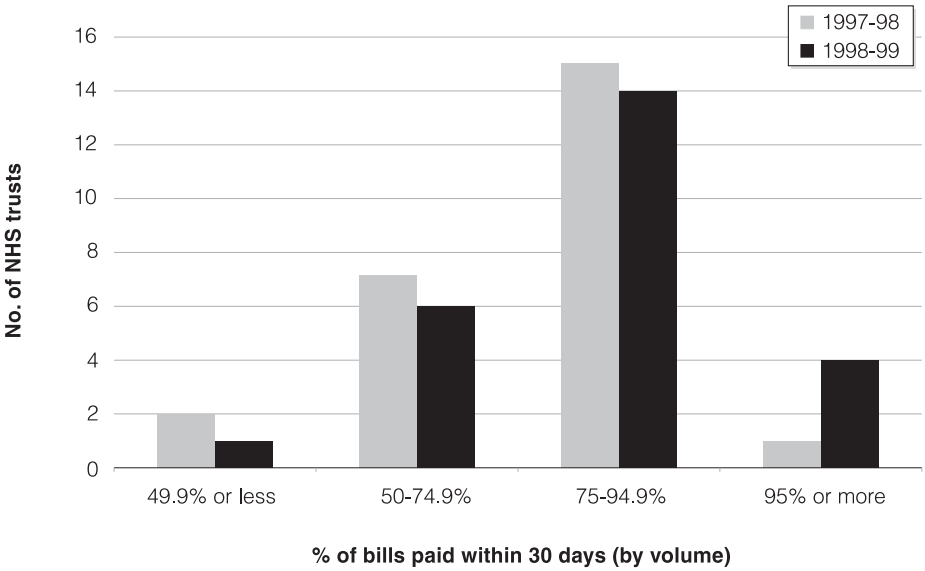
4.25 On the basis of this performance, all the Welsh health authorities failed once again to achieve the prompt payment target. On an all-Wales level, only 85 per cent of bills (1997-98: 83 per cent) were paid within the 30-day period, although these bills represented some 97 per cent by value of payments.

NHS Trusts

4.26 The position with respect to the NHS trusts in Wales is illustrated at Figure 9 below:

Figure 9

NHS trusts' supplier payment performance, 1997-98 and 1998-99



Note: Figure 9 illustrates the comparative performance of NHS trusts in Wales for the financial years, 1997-98 and 1998-99. The four ambulance trusts were reconfigured with effect from 1 April 1998 and these NHS trusts, together with the Welsh Ambulance Services NHS Trust, have been excluded from this graph.

Source: National Audit Office analysis

4.27 The above graph shows that in 1998-99:

- 18 NHS trusts paid more than 75 per cent of bills within 30 days (1997-98: 16 trusts);
- 6 trusts paid between 50 per cent and 75 per cent of bills within 30 days (1997-98: 7 trusts); and
- One trust paid less than 50 per cent within the target period (1997-98: 2 trusts).

4.28 Sixteen trusts improved their payment performance in 1998-99. The performance of nine trusts worsened in the period, with the worst falling to only 26 per cent of bills paid within 30 days. Overall, the prompt payment performance of the NHS trusts declined marginally to 74 per cent (1997-98: 78 per cent), although these bills represented some 76 per cent by value of payments.

4.29 I note that Assembly officials have continued to monitor the supplier payment performance on a monthly basis. However, I am concerned about those nine trusts whose performance has deteriorated during the year. Assembly officials told me that reasons for this declining performance include the impact of GP Fundholder "cost per case" contracts. These involve a much longer lead time before payment to the trust is received, which impacts adversely on the cash flow of each trust, making prompt payment more difficult. Assembly officials consider that the abolition of GP Fundholding during 1998-99 should resolve this issue for future years. Also, the deficit position of many NHS trusts has also contributed to cash management problems. The Assembly offers the facility for short-term loans to help trusts manage their cash flows, and intend that trusts should maximise their use of this facility to assist in the prompt payment of all bills.

4.30 The level of compliance with prompt payment requirements by NHS bodies in Wales will become more significant in future years with the enactment in November 1999 of the Late Payment of Commercial Debts (Interest) Act 1998, giving certain creditors the right to claim interest against the late payment of debt. I note, however, that no such interest payable was recorded in the accounts of the underlying NHS bodies in 1998-99.

NHS Stocktake

4.31 In February 1999, the Secretary of State for Wales announced that a 'Stocktake' of the financial health of the NHS in Wales would be undertaken in response to the financial problems at many health authorities and NHS trusts. The purpose of this review was to provide an analysis of the issues for the National Assembly for Wales, which assumed responsibility for the NHS in Wales in July 1999.

4.32 The report was prepared by the Welsh Office Policy Unit between April and June 1999, under the supervision of a Project Board chaired by the Permanent Secretary. This Project Board included members from the NHS and the Welsh Office Health Department, and was assisted by the Audit Commission. The

Commission's own report "A Healthy Balance", published separately in July 1999, also addressed the problem of financial deficits across the NHS in both England and Wales.

4.33 The Stocktake Report examined the period 1996-97 to 1998-99, and concluded that there was no single explanation for the financial problems existing within the NHS in Wales. The report found that, in the context of pressures faced by all health systems in the developed world, the UK spends a relatively small proportion of national income on health services. Financial deficits were not unique to Wales in the three-year period covered by the report, and a wide range of inter-related national and local factors contributed to these, which the report summarised as follows:

- financial control subordinated to other considerations;
- weak accountability;
- relationships undermined by financial pressure and competition;
- short termism and instability;
- inability to deliver efficiency savings; and
- difficult local service issues.

4.34 The report noted that health authorities have largely financed their deficits by obtaining loans from the Welsh Office and by delaying payments to creditors. The recurring annual deficit in the NHS in Wales was running at £20-25 million, representing 1 per cent of the total NHS budget.

4.35 The Stocktake stated that these deficits could not be ignored for two main reasons:

- "The cash used to finance the deficits will have to be repaid from within present and future NHS income - by sustaining deficits health bodies are simply postponing the reductions or changes in service which will be needed to restore financial balance and repay past debts"; and

- "Deficits reflect an underlying income and expenditure gap which is getting wider, i.e. the cost of staff and facilities in place and the level of treatment being carried out is higher than the resources available".

4.36 The Stocktake Report also noted that, in the view of senior NHS managers, the downsizing of the Welsh Office's staffing devoted to NHS matters between 1994 and 1999 had impaired its ability to tackle the problem of deficits. It reported that the issues involved in tackling deficit problems and delivering a modernisation agenda are all-Wales issues, and that difficult decisions would not be taken locally unless they were supported from the centre.

4.37 The Stocktake Report recommended a stronger role for the Assembly's NHS Directorate, to ensure that the monitoring of financial performance is integrated with value for money and the delivery of service priorities, including the NHS contribution to the better health agenda. Assembly officials confirmed that this strengthening of the NHS Directorate's capacity and expertise was in hand.

4.38 The report noted that the Comprehensive Spending Review had set out the resource framework for the NHS in Wales and concluded that, although this provided for a higher level of year on year growth than in recent years, there was very little flexibility given the growing demands on the NHS each year. One key issue identified by the Stocktake was that capital resources could be freed up to tackle the substantial maintenance backlog and to invest in modern facilities to produce a more streamlined and cost effective service.

4.39 The existing distributions of revenue resources to health authorities in Wales are determined by use of a weighted capitation formula which uses standard mortality ratios as a proxy for health needs. The Stocktake noted that there are deficiencies within the present Welsh formula, including its ability to reflect the social and economic determinants of health. The Health and Social Services Committee of the Assembly has resolved to review the present resource allocation formula within Wales.

Part 5: Management and Internal Control Issues

Introduction

5.1 This part of my Report is concerned with the management of risk in the NHS in Wales. It details developments in:

- The growth and handling of clinical negligence claims (paragraphs 5.2 to 5.15);
- Corporate and clinical governance issues (paragraphs 5.16 to 5.19);
- The progress being made in the detection and prevention of fraud (paragraphs 5.20 to 5.23); and
- Human resource management (paragraphs 5.24 to 5.28).

Clinical Negligence

5.2 Clinical negligence is the term given to a breach of duty by health care practitioners in the performance of their duties in the NHS. In my Reports on the NHS Summarised Accounts for Wales for the last three years, I have commented on improvements in the accounting arrangements and measures taken by the NHS in Wales to manage the risks of clinical negligence. In this Report, I provide an update on the likely future costs of clinical negligence to the NHS in Wales, outline the developments affecting clinical negligence in Wales and consider their potential impact on the Welsh Risk Pool.

Welsh Risk Pool

5.3 The NHS in Wales operates the Welsh Risk Pool, which was managed until 31 March 1999 by the Welsh Health Common Services Authority. Following the Authority's abolition on 1 April 1999, this responsibility transferred to the Conwy and Denbighshire NHS Trust. The Pool membership includes all health authorities and NHS trusts. It is funded by monthly contributions from members, calculated to match anticipated payments in the year. Although strictly a risk-sharing rather

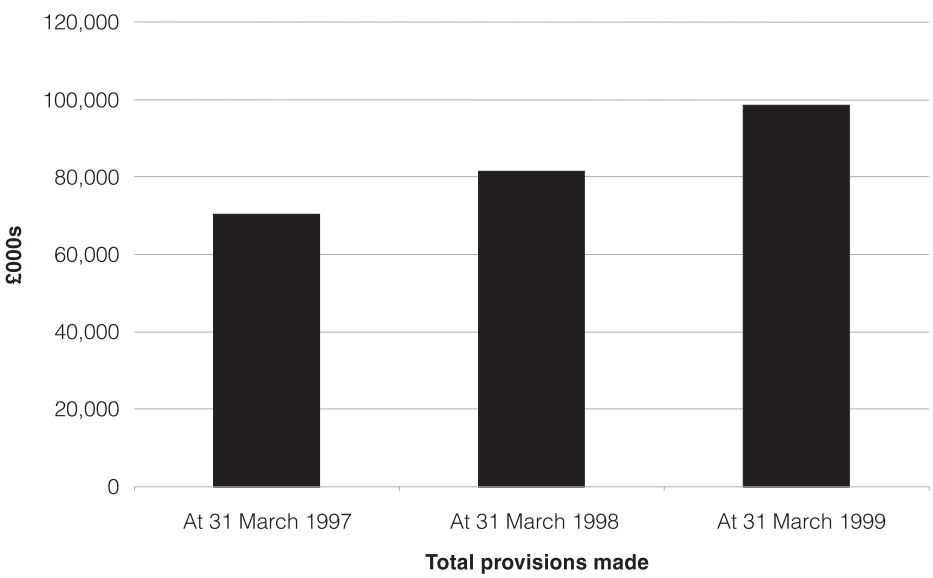
than an insurance scheme, it covers all insurable risks except motor vehicle insurance (but including ambulances), Public Finance Initiative, income generation, and the disruption of business. When a claim is agreed, the health authority or trust involved settles the claim in full and is then reimbursed by the Pool for any amounts paid in excess of £30,000.

Provisions for clinical negligence

5.4 At 31 March 1998, the accounts of the health authorities and NHS trusts recognised outstanding provisions for clinical negligence totalling £81.4 million. At 31 March 1999, this figure had risen to £98.4 million, representing an additional cost to the NHS in Wales during 1998-99 of £17 million (see Figure 10). These provisions represent the best estimate of the actual cost of outstanding clinical negligence claims, where the bodies concerned have a reasonable expectation of making a payment.

Figure 10

The rising costs of providing for future clinical negligence payments

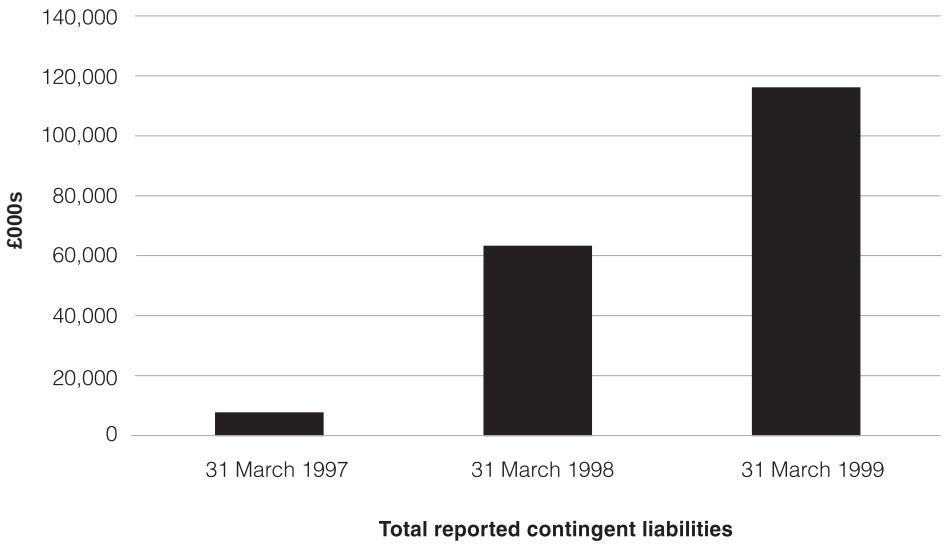


Source: NHS Summarised Accounts for Wales and health authority and trust financial returns, 1997-98 and 1998-99

Contingent liabilities

5.5 In addition, all health service bodies collect information on contingent liabilities for clinical negligence claims where no provision has been made. These are cases for which there is a possibility rather than a probability of future payments. At 31 March 1998, total contingent liabilities were reported at £63 million. This figure rose to £116 million at 31 March 1999 (see Figure 11).

Contingent liabilities **Figure 11**



Source: NHS Summarised Accounts for Wales and health authority and trust financial returns, 1997-98 and 1998-99

5.6 Assembly officials told me that as a result of a House of Lords judgement in July 1998, the calculation of damages in moderate and large-sized claims has increased significantly. This has contributed to the substantial increases in both the level of provisions and reported contingent liabilities.

Incidents incurred but not reported

5.7 Historically, there have been significant delays between the occurrence of the clinical incident and the lodging of any claim against the NHS body. Early identification of potential claims is beneficial, in terms of both risk control and accounting for any potential claims, especially given the timing requirements of the Woolf reforms. The reporting of such events has improved significantly, as evidenced by the increase in value of contingent liabilities. This is partly as a result of the introduction of the Risk Management Standard 3, Adverse Incident Reporting, which requires a trust to have procedures for the reporting of adverse incidents. The Welsh Risk Pool Management Group is also examining options for

an Adverse Incident database, which will also assist in quantifying all adverse incidents as they occur. I welcome these developments, and will monitor progress in this area.

Accounting arrangements

5.8 The Accounting Standards Board issued "Financial Reporting Standard 12: Provisions, Contingent Liabilities and Contingent Assets", in September 1998. This defined a provision as a liability that is of uncertain timing or amount, to be settled by the transfer of economic benefits and requires that the full amount of such provisions must be reported in a body's set of Accounts.

5.9 For 1998-99, health authorities and NHS trusts have reported as provisions only that element of a clinical negligence claim payable by the body itself, that is, excluding any contribution expected from the Welsh Risk Pool. The Pool's transactions are included within the Summarised Accounts of the Welsh Health Common Services Authority. From 1999-2000, the Pool transactions will be included within the account of Conwy and Denbighshire NHS Trust. From 1999-2000, all Pool transactions and balances will be reported within the Summarised Accounts of NHS trusts in Wales.

Developments in the management of risk during 1998-99

5.10 Whilst the core function of the Welsh Risk Pool is to reimburse health authorities and trusts for the costs of litigation, it also plays a leading role in promoting effective risk management across the NHS in Wales. In 1998-99, the Pool's Management Group had intended that all health authorities and trusts would be audited for compliance with Risk Management Standards by their appointed auditors, taking that year as Year One. Pool members were asked to submit completed scores and action plans to address non-compliances by 30 August 1999. However, I note that by 31 January 2000 only ten of the 21 member bodies, including only two of the five health authorities, had submitted their self-assessment scores to the Pool Management Group. For the scheme to be properly effective, the Pool Management Group should ensure that all requirements are clearly understood by the member bodies and their auditors, and take appropriate action against those failing to comply. Similarly, all Pool members should ensure that, in future, they make the necessary submissions to the Pool Management Group on a timely basis.

5.11 In my 1997-98 Report, I commented on a number of issues being developed by the Pool Management Group in its management of risk in the NHS in Wales. This included the proposed introduction of a discounted excess charge as an incentive for members to comply with the Risk Management Standards (the calculation of contributions to the Pool is based in part on claim history). In fact, progress in 1998-99 was slow, and that proposal has yet to be implemented. For this system to be accepted fully by the Pool members, I consider that the self-assessment scores calculated by NHS bodies following completion of the Risk Management Standards checklist must be independently verified. The Pool Management Group is currently considering what mechanisms are available for this purpose. Compliance with the standards in 1999-2000 will now be used as the base year for the discounting of excesses in 2000-01.

5.12 For 1998-99, health authorities were required to complete the Risk Management Standards, given that all but two of the eleven standards were deemed applicable to them. However, given the essential differences between health authorities and trusts, two health authorities had also devised a "Risk Assessment and Management Strategy", which in turn has formed the basis of those bodies' Controls Assurance Statements. Their compliance with both the Risk Assessment and Management Strategy and the Pool's Risk Management Standards was assessed by their external auditors.

5.13 I welcome this co-ordinated approach to the revision of standards, and consider that it should be developed for NHS trusts also. In order to reduce the burden of compliance with standards at trusts, and the audit of that compliance, in terms of completion of both Risk Management Standards and a Controls Assurance Statement (see paragraph 5.19 below), a combined approach is being devised ensuring coverage of all areas.

5.14 In addition, Assembly officials told me that the Management Group of the Welsh Risk Pool is to undertake detailed reviews of a sample of claims for reimbursement to ensure that they are managed by health authorities and NHS trusts in an effective and efficient way.

5.15 An external development impacting on the management of clinical negligence claims are the Woolf reforms of the civil justice system, which came into effect in April 1999. These reforms have introduced new rules for litigation, including pre-action protocols. This relates to the exchange of information on potential clinical negligence cases and imposes a strict timetable for correspondence, requiring a trust to respond formally to a claim within three

months. The court is empowered to impose sanctions for non-compliance with this timetable. Assembly officials expect that these reforms will speed up the process for settlement of clinical negligence claims.

Corporate and clinical governance

Statement on the System of Internal Financial Control

5.16 1998-99 was the second year for which the Treasury has required the annual accounts of all NHS bodies in Wales to include a 'Statement on the System of Internal Financial Control'. In my 1997-98 Report, I commented on the incompatibility of the statement used on the summarised accounts of the NHS in Wales with the statement to be produced for the draft Welsh Office Resource Accounts. A similar inconsistency arose in 1998-99, the summarised account statement again referring to an "appropriate" system of internal financial controls, rather than an "effective" system as required by the current guidance.

5.17 Recent developments, which become effective from 1999-2000 and consolidate the recommendations of the Cadbury, Greenbury and Hampel reports, no longer require comment on the effectiveness of the systems, thereby removing this incompatibility. I will continue to monitor the form of words applied at the underlying account and at the Assembly level to ensure consistency and compliance with the required declaration.

5.18 All the underlying auditors' reports confirmed that the Directors' statements were not inconsistent with the auditors' knowledge of that body. Although an improvement over 1997-98, a majority of underlying bodies continued to report exceptions in 1998-99, including three of the five health authorities and 15 of the 26 trusts. These exceptions included a failure to comply with up to three of the 18 specified minimum control standards or that a particular standard was achieved for only part of the year.

Controls Assurance Statement

5.19 During 1999-2000, all NHS bodies in Wales will be required to produce a new statement on controls assurance covering non-clinical and non-financial areas, to be included within the Annual Report. This statement will be based on a risk management strategy produced by the NHS Executive in England, and currently being adapted in Wales to link to the Welsh Risk Pool's Risk Management

Standards, and is concerned with the identification and prioritisation, management and measurement of key risks. The risk management strategy includes the following areas:

- Business planning;
- Corporate strategy;
- Environmental (property and estates);
- Human resources; and
- Service management.

Fraud

Audit Commission work on fraud and corruption

5.20 The Audit Commission produced an update on fraud and corruption in the NHS in England and Wales, "Protecting the Public Purse" in December 1999. In summary, the update concluded that:

- Whilst the value of detected fraud had increased in 1998-99, much more needed to be done;
- Key areas at risk of fraud included payments for medical services, payroll, income misappropriation and payments to contractors; and
- Progress had been disappointingly slow in many key areas.

Illustration of potential loss: Prescription Charge evasion in England

Figure 12

During 1998-99, the Department of Health in England established the Directorate of Counter Fraud Services as part of the NHS Executive, with responsibility for work on countering fraud and corruption within the NHS. Following a review of prescription charge evasion, the Directorate have reported a loss of £137 million, including fraud of £95 million.

Action taken by the Assembly

5.21 In my Report on the 1997-98 Accounts, I noted that the former Welsh Office had established an All-Wales Anti-Fraud Working Group, whose remit is to develop a fraud strategy. Members of the Group include the Anti-Fraud officers

appointed at each health authority, and the emphasis of the Group's work to date has been to address fraud within the primary care sector of the NHS (that is, prescription, dental and optical services). The Group continues to address the issue of fraud more widely in the NHS, and has disseminated examples of "best practice" in the management of fraud amongst its members, co-ordinating action against fraud across the whole of Wales.

5.22 Assembly officials told me that due to resource constraints, the Assembly has not yet agreed on a central body responsible for the detection and prevention of fraud, similar to the Directorate of Counter Fraud Services that exists in England, although the Assembly works closely with that body and the NHS Executive. The provision of a separate service within Wales is currently under review. Whilst this delay is unfortunate, I welcome any steps taken by the Assembly in identifying the level of fraud within the NHS in Wales, and actions taken to combat fraud. Assembly officials also told me that the Anti-Fraud Working Group recognises the importance of tackling fraud in the secondary care sector (that is, at NHS trust hospitals) and has expanded its remit to consider this area. The Group is currently working with District Audit to develop a fraud strategy for the secondary care sector.

5.23 In my 1997-98 Report, I also noted that the Welsh Office was developing a Losses and Special Payments Register, which was due to be launched on 1 April 1999. This is intended to be a database register of all losses and special payments, and will also detail incidents of potential loss and suspected fraud, representing a significant development in the reporting of fraud in Wales. I note that there was some slippage in the original timetable, and that Assembly officials expect the Register will now be fully operational from 1 April 2000.

Human Resource Management

5.24 The NHS is the largest employer in Wales. Its management of human resources in the face of ever-increasing demand is of particular importance, and this has been especially true during the recent period of significant reorganisation and restructuring. With regard to those bodies dissolved on 1 April 1999, the following steps were adopted:

- On the abolition of the Welsh Health Common Services Authority, those staff not transferring with their function to the new host body were offered re-employment within the former Welsh Office. This helped to minimise the costs of redundancy, and gave employment security to the Authority's personnel; and

- the functions and staff of the Health Promotion Authority for Wales were transferred to the former Welsh Office, and no redundancy costs were incurred.

5.25 Arrangements for personnel affected by the reconfiguration of NHS trusts in Wales remained the responsibility of the NHS trusts themselves. Although the former Welsh Office has issued various circulars to trusts giving guidance on personnel issues, I noted that the terms and conditions for redundancy offered to those staff not allocated employment within the new trust's complement varied between trusts. These included, for example, the periods calculated for compensation for loss of office and for payment in lieu of notice. Arrangements for clawback in the event of the redundant staff being re-employed within the NHS were also treated differently. Given their autonomy, trusts have the authority to determine the terms and conditions for any redundancy package. However, such packages should always be cost-effective and trusts should ensure that they do not result in the betterment of any one individual at the expense of the NHS.

5.26 Certain reconfigured trusts have not accounted for redundancy and associated costs in their 1998-99 accounts, but will report these costs in the 1999-2000 accounts of the reconfigured trust.

5.27 A further human resources issue concerns possible significant increases in staff costs within the NHS in Wales. Two particular issues will affect the NHS during the 1999-2000 financial year:

- The European Working Times Directive, which will have a significant financial impact on the NHS bodies, and especially the NHS trusts. The annual recurrent cost of this has been estimated at £5.5 million, and, dependent on any funding, could have a significant effect on the forecast deficit for NHS trusts in Wales; and

- The costs of staffing NHS trust hospitals over the Millennium period, which may also have a financial impact on the accounts of those bodies.

Suspension of Clinicians

5.28 The treatment of clinicians on suspension, and the disciplinary procedures applying is another human resource issue currently being considered. This is under review by the Department of Health, and the Assembly are contributing to that review. As Auditor General for Wales, I will monitor the outcome of this work.

Part 6: Resource Accounting and Budgeting

Introduction

6.1 This chapter sets out the progress made in the introduction of resource accounting to the NHS in Wales. It examines:

- The requirement to produce a consolidated Assembly Resource Account (paragraphs 6.2 to 6.4);
- The inconsistencies in accounting treatment between NHS accounting practice and that required by the Treasury's Resource Accounting Manual (paragraphs 6.5 to 6.6);
- The introduction of the regularity opinion to the audit opinions at the underlying account level, supporting the opinion to be placed on the Resource Accounts (paragraph 6.7); and
- Future developments in moving toward the 'Whole of Government' accounts (paragraph 6.8).

Requirement to produce a consolidated Assembly Resource Account

6.2 In my Report on the 1997-98 Summarised Accounts, I noted the steps being taken by the former Welsh Office towards consolidating the accounts of the five health authorities within their departmental Resource Account, in line with the government-wide Resource Accounting and Budgeting initiative. I also noted that, for this consolidation to be possible and meaningful, a number of changes in the accounting arrangements for health authorities would be necessary.

6.3 The assets and liabilities of the NHS in Wales became the responsibility of the Assembly on 1 July 1999. For that reason, consolidation of the health authority accounts into the Welsh Office or Assembly Resource Accounts for 1999-2000 would not be possible and the Treasury has provided a dispensation from this requirement until 2000-01.

6.4 The Summarised Accounts of the health authorities in Wales comprise an aggregation, rather than consolidation, of the underlying accounts. Consolidation (involving the removal of all inter-health authority transactions from both the Operating Cost Statement and the Balance Sheet) is required for the Assembly's Resource Account. In order to move towards a full consolidated resource account, the Treasury has agreed that the 1999-2000 summarised NHS accounts should be prepared on a consolidated rather than an aggregated basis.

Inconsistencies in accounting treatment

6.5 In addition to the aggregation of accounts, other issues which have hampered consolidation include the specific accounting treatment at the underlying health authorities in respect of fixed assets. Specifically, this includes:

- the basis of valuation of NHS assets accounted for by health authorities (taking the depreciated replacement cost of an asset), which does not comply with the Resource Accounting Manual; and

- the capital charges regime which operates within the NHS, and which again does not conform with the Resource Accounting Manual.

6.6 Assembly officials told me that these issues will be addressed in health authorities' summarised accounts for 2000-01 to allow consolidation. This will require the further revision of health authority accounting practice, or further disclosure at that level, to ensure compliance with the Resource Accounting Manual.

Regularity opinion

6.7 Under Section 97 (6) of the Government of Wales Act 1998, as Auditor General for Wales I am required to satisfy myself of the regularity of transactions in the Assembly's accounts. In line with best practice, I will provide a specific regularity opinion on the accounts of the Assembly. The appointed auditors of NHS bodies in Wales were not required to give such an opinion on the 1998-99 accounts of underlying NHS bodies, but I note that this is to be made mandatory from the 1999-2000 financial year.

Future developments

6.8 The boundary for consolidation into the Assembly's Resource Account has been set initially to include only the purchaser function of the NHS in Wales, that is, the accounts of the health authorities. In due course, and in support of the Treasury's overall aim to facilitate the production of 'Whole of Government Accounts', the Treasury intends to broaden the consolidation boundary over the next few years to include other bodies such as NHS trusts. As Auditor General for Wales, I will monitor developments in this area closely.

Part 7: Asset Management

Introduction

7.1 At the September 1999 meeting of the Assembly's Audit Committee, the Finance Secretary identified asset management as a key area for attention within the NHS in Wales. In this part of my Report, I comment briefly on two important aspects of asset management:

- The use of Public Private Partnerships (paragraphs 7.2 to 7.4); and
- The use of surplus land within the NHS estate (paragraphs 7.5 to 7.7).

Public Private Partnerships

7.2 The purpose of the Public Private Partnerships (PPP) initiative, which includes the Private Finance Initiative (PFI), is to deliver high quality and cost-effective public services. It involves the investment by private sector companies in the provision and operation of facilities or services for the NHS in Wales in return for financial gain. This financial gain may take the form of either a utility charge from the original service provider or the receipt of fees or rental income from users of the service. A project may involve the provision of revenue or capital facilities.

7.3 The implementation of Public Private Partnerships within the NHS in Wales has resulted in some 15 PFI and PPP deals to date with a total capital cost of £33.1 million. The majority of projects are relatively small, including areas such as energy management, car parking and the provision of sterile services. However, the following table details the more significant PPP projects in Wales:

Significant PPP projects in Wales

Figure 13

Project	Opening date	Capital cost, £ million
University Hospital of Wales and Llandough NHS Trust: Car Park and Concourse development	February 1998	8.0
Gwent Healthcare NHS Trust: Day Surgery and Endoscopy Unit at Nevill Hall Hospital	July 1999	3.3
Pontypridd and Rhondda NHS Trust: Staff residences at the new Royal Glamorgan Hospital	October 1999	3.0
Gwent Healthcare NHS Trust: Chepstow Community Hospital	February 2000	10.0

Source: NHS Directorate of the National Assembly for Wales

7.4 A new hospital in Baglan has been approved, and a further scheme in Cardiff is presently under negotiation.

Use of Surplus Land

7.5 The NHS in Wales occupies an estate totalling some 1,100 hectares, with an existing use value of £1.1 billion. There are some 140 hospitals, 300 health centres and clinics and 80 ambulance stations. When NHS trusts were established, only "active" properties were vested in the relevant NHS trust. Land and property that was not thought to have a long term health service use remained on the books of the health authorities. These properties make up the residual estate and comprise 51 properties covering an area of 264 hectares with an existing use value of some £96 million as at 31 March 1999. Twenty-seven of these properties have been programmed for disposal by the health authorities before 2003 and gross receipts from sales are estimated on an open market value basis at £23 million. The remaining 24 properties, not yet programmed for disposal, have an open market value of £19 million.

7.6 In addition, 18 properties under the ownership of NHS trusts, covering an area of 13 hectares, have also been programmed for disposal between 1999 and 2002. The receipts from sale of these properties are estimated at £3.8 million. Trusts are entitled to retain the first £100,000 from each property sale, and the balance is surrendered to the Assembly.

7.7 The efficient and effective use of the existing NHS estate and, in particular, the generation of sale receipts from the disposal of land and buildings surplus to either current or expected future requirements will be of considerable importance to the Assembly. The Assembly's NHS Directorate is undertaking a review of

procedures and policy in this area, and advice and recommendations will be submitted to the Health and Social Services Secretary for discussion with the Health and Social Services Committee. As Auditor General for Wales, I intend to review this subject in depth as part of a wider value for money review of the management of the NHS estate.

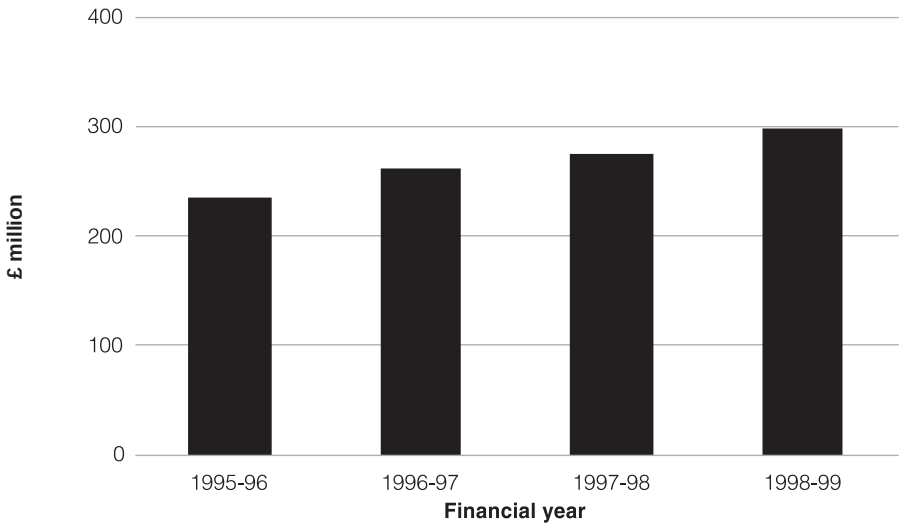
Part 8: Cost of Primary Care Drugs

8.1 In this final chapter of my report, I examine the reasons behind the rising cost of the primary care drugs bill in Wales and note the actions being taken by the Assembly to address this issue.

8.2 The cost of drugs prescribed by GPs and dispensed in Wales in 1998-99 amounted to some £318 million, including the cost of the drugs themselves, container costs, VAT and other expenses, and net of any discounts. This was offset partially by patient charge income of some £22 million in the year, giving a net cost to the Assembly of some £296 million.

Net drugs cost, 1995-96 to 1998-99

Figure 14



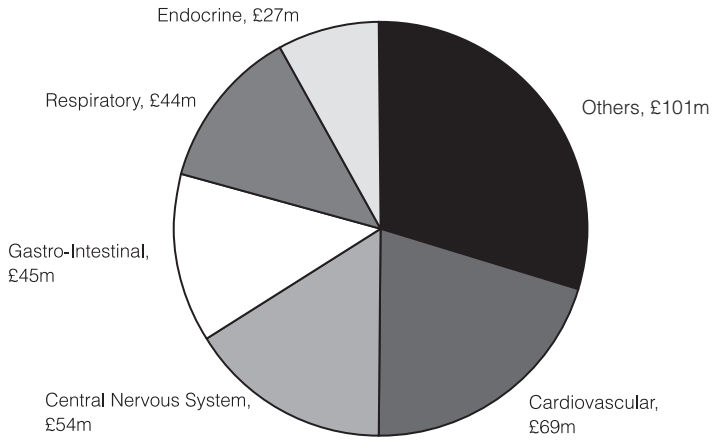
Source: NHS Directorate of the National Assembly for Wales

Figure 14 shows the net cost of drugs in Wales for the years 1995-96 to 1998-99, which has increased consistently over the last four years.

8.3 The main cost element is in respect of the drugs themselves, which has, in recent years, consistently increased at a rate greater than inflation. The major expenditure in terms of class of drugs was incurred in respect of cardiovascular drugs, which cost £69 million in the 1998 calendar year, and central nervous system drugs, costing £54 million in that year. These two classes also showed the largest increases in prescribing compared with 1997, cardiovascular drugs increasing by £8 million (13 per cent) and central nervous system drugs increasing by £7 million (15 per cent). The following table shows the cost of drugs in 1998, by therapeutic class:

Drugs cost per therapeutic class - 1998

Figure 15



Source: NHS Directorate of the National Assembly for Wales

Figure15 shows the spread of drugs costs per therapeutic class as prescribed in calendar year 1998.

8.4 In terms of managing the cost of the primary care drugs bill in Wales, the Assembly regulates patient prescription charges, exemptions and dispensing contractors' fees and allowances for Wales, but does not have responsibility for the UK-wide pharmaceutical price regulation scheme. The main drivers of prescribing costs are the number of patients, morbidity rates, the availability of drugs to treat this morbidity, and prescribing practices. In June 1999, the Welsh Affairs Committee reported on "Health issues in Wales" (HC343-I, 1998-99). The Committee noted the increasing number of effective but expensive drugs becoming available but commented that:

> "rates of prescribing are significantly higher in Wales than in England, even in areas of comparable deprivation."

8.5 Although the annual rate of increase in drug costs has fallen from 10.2 per cent in 1995 to 7.4 per cent in 1998, the Assembly is concerned at the scale of the drugs bill. The Assembly Secretary for Health and Social Services has announced the setting up of a 'Task and Finish Group' to consider the scope for improving the efficiency and effectiveness of prescribing in Wales within the framework of the Assembly's powers and responsibilities. The Group will consider:

- what options the Assembly has to improve the prescribing of drugs and the provision of pharmaceutical services;

- the likely benefits and resources needed to implement these options;
- barriers to implementation and action to overcome such barriers; and
- what information and how to gather it, on the need for prescribed drugs and their contribution to the health and well-being of the people of Wales.

8.6 The Group will report to the Assembly Secretary for Health and Social Services in June 2000. As Auditor General for Wales, I will review their recommendations as part of my work on the 1999-2000 Accounts.

John Bourn
Comptroller and Auditor General
8 March 2000

National Audit Office
23-24 Park Place
Cardiff CF10 3BA

Introduction to Appendices

These Appendices analyse the financial health of each of the five health authorities in Wales, and the NHS trusts that lie within each health authority's operating area, as follows:

Appendix A	**Bro Taf** Health Authority area
Appendix B	**Dyfed Powys** Health Authority area
Appendix C	**Gwent** Health Authority area
Appendix D	**Iechyd Morgannwg** Health Authority area
Appendix E	**North Wales** Health Authority area

The analyses provide further information to support the overall review of the financial performance of the NHS in Wales set out in Part 4 of my Report.

All references to the reported financial performance for the year, and to the accumulated Income and Expenditure Reserves of each body, exclude the exceptional cost of the impairment of fixed assets, as reported in Annex 2 of the Foreword to the Summarised Accounts.

All references to forecast information are based on health authority and NHS trust financial returns for December 1999.

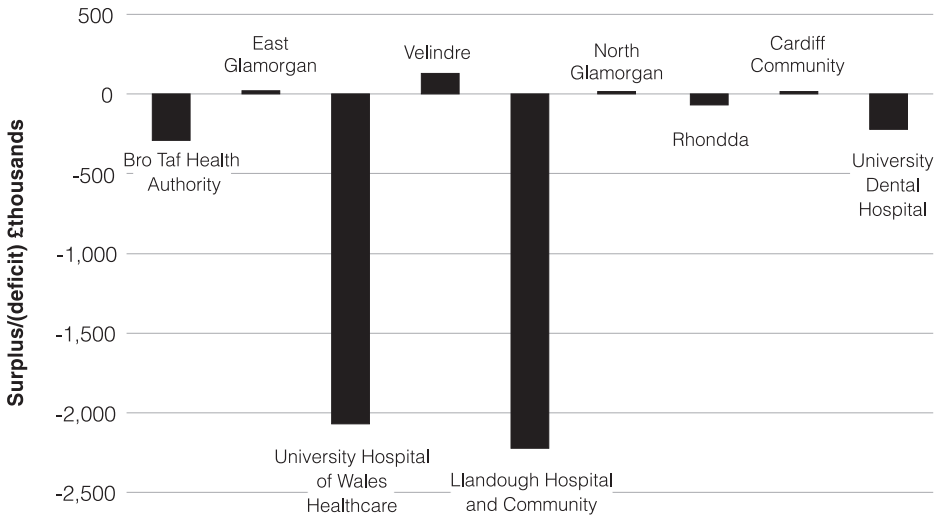
Appendix A

Bro Taf Health Authority area

A.1 For 1998-99, the Bro Taf area reported a total in-year operating deficit of £4.7 million, representing some 21 per cent of the All-Wales deficit. Figure 16 below illustrates the breakdown of this deficit between the health authority and the eight NHS trusts within the Bro Taf area. It highlights the significant in-year deficits generated by the University Hospital of Wales Healthcare NHS Trust and Llandough Hospital and Community NHS Trust.

Financial performance in Bro Taf area

Figure 16



Source: National Audit Office analysis

A.2 The forecast position for this area indicates a serious deterioration in financial performance over the next two years. For 1999-2000, the area is forecasting a deficit of £6.1 million, increasing to £23.5 million in 2000-01 before planned recovery measures are implemented (the worst forecast deficit for a health authority area in Wales for that year). The area's annual deficit is thus forecast to worsen by £17.4 million in 2000-01 unless recovery measures are successfully implemented.

A.3 Much of this forecast increase in deficits is generated from within the health authority itself, which forecasts a deficit of £0.7 million in 1999-2000, rising to a worst case planning deficit of over £14 million in 2000-01. Significant increases in forecast deficits have also been made by the University Hospital of Wales and Llandough NHS Trust (£5.9 million in 1999-2000 and £7.4 million in 2000-01, although this latter figure is planned to reduce to £3.5 million once planned recovery measures are agreed) and North Glamorgan NHS Trust (with forecast deficits of £0.4 million and £1 million over the same period, again prior to recovery measures being implemented).

A.4 There are several reasons for the forecast deficits, and among other cost pressures adding to the forecast deficit in 2000-01 are the full year effect of the commissioning costs associated with the Royal Glamorgan Hospital, activity pressures, high cost drugs, medical negligence costs and a reduction in income as a result of updating the data driving the allocation formula.

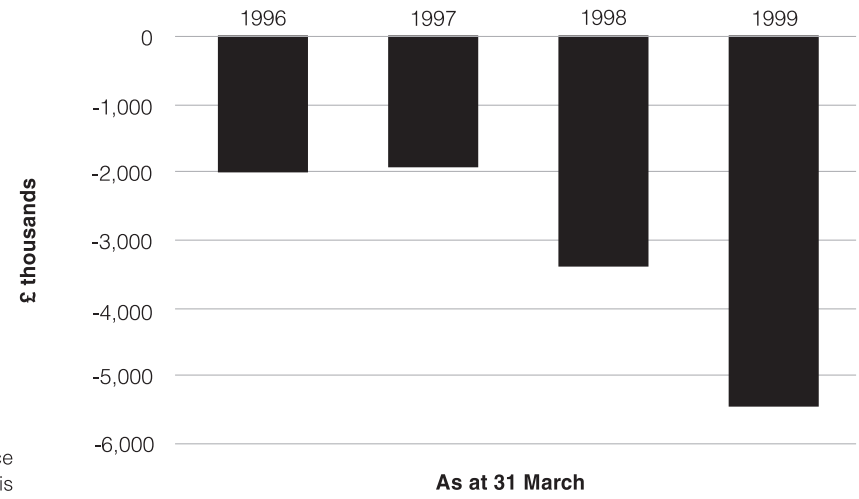
A.5 Following the reconfiguration of NHS trusts in Wales on 1 April 1999, the Bro Taf area now covers five trusts, being Pontypridd and Rhondda NHS Trust, North Glamorgan NHS Trust, Velindre NHS Trust, and the two Cardiff-based NHS trusts which will combine on 1 April 2000 to form the Cardiff and Vale NHS Trust. Only Velindre NHS Trust has reported consistent surpluses over the period since 1996-97, and is forecasting breakeven for 1999-2000. The financial position of the two merging trusts is of particular concern (see paragraphs A.8 to A.11 below).

A.6 I note also that the initial financial requirements of the newly opened Royal Glamorgan Hospital will impact significantly upon the costs of the Pontypridd and Rhondda NHS Trust. This development will be a major challenge to Bro Taf Health Authority in ensuring financial balance in the earlier years and beyond.

A.7 Some £5.1 million of brokerage funding (short-term loans) provided by the Welsh Office to assist trusts within this area remained outstanding at 31 March 1999. I have been informed by the Assembly's officials that there is likely to be an increasing requirement for brokerage for Bro Taf trusts which is forecast at £6.7 million in 1999-2000.

Income and expenditure reserve

Figure 17



Source: National Audit Office analysis

University Hospital of Wales Healthcare NHS Trust

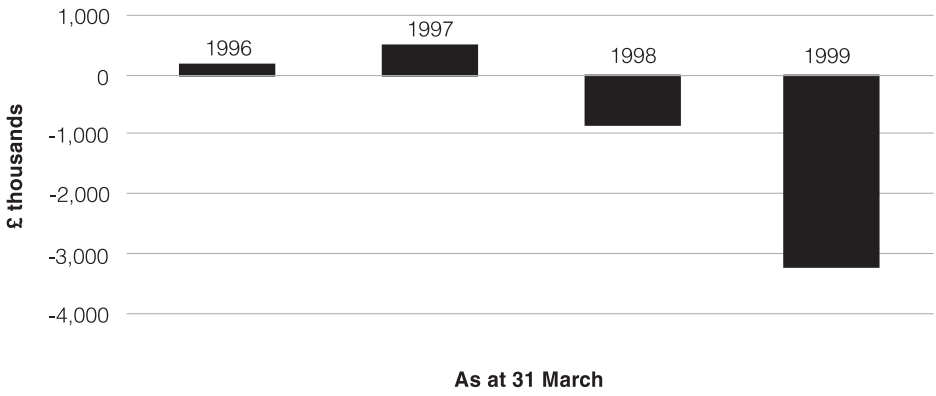
A.8 Since its establishment on 1 April 1995, this trust has incurred significant deficits. For 1998-99, the trust reported a deficit of £2.1 million, and an accumulated deficit in the Income and Expenditure Reserve of £5.5 million at 31 March 1999. During 1997-98, the trust had agreed with the Welsh Office and Bro Taf Health Authority a 'Development and Restructuring Plan', which addressed the forecast deficit of £26.3 million. Savings were identified in this Plan to enable this deficit to be recovered over the three-year period 1998-99 to 2000-01. On 1 April 1999, this trust merged with Llandough Hospital and Community NHS Trust.

Llandough Hospital and Community NHS Trust

A.9 The 1998-99 accounts of this trust detail a number of reasons for its cumulative deficit position of £3.1 million, at 31 March 1999. These include long-standing historic problems such as unfunded cost pressures, income reductions and the underfunding of orthopaedic services which were transferred to the trust on 1 April 1998. The trust's agreed four-year recovery plan included the expectation of a deficit of £1.8 million for 1998-99. However, the trust's actual deficit for the year was £2.2 million.

Income and expenditure reserve

Figure 18



Source: National Audit Office analysis

A.10 The new University Hospital of Wales and Llandough NHS Trust is now forecasting an annual deficit of £5.9 million in 1999-2000, reflecting a significant worsening of its financial position. It was agreed by Assembly officials that an interim one year budget plan should be produced, with a longer term recovery plan tied in with a clinical services strategy to be developed with the Bro Taf Health Authority and the Assembly. A draft plan has been considered by the Assembly and the trust has been asked to reconsider some elements.

A.11 On 2 November 1999, the Assembly's Health and Social Services Secretary announced the final stage of the reconfiguration of NHS trusts in Wales. This merges the University Hospital of Wales and Llandough NHS Trust and the Cardiff Community and Dental Hospital NHS Trust to form the Cardiff and Vale NHS Trust. This trust – which will be the largest in Wales - will become operational on 1 April 2000 and is intended to produce management costs savings of some £0.3 million over three years. Assembly officials told me that they have been closely monitoring the reconfiguration of this trust. Until formal approval is obtained, the trust will continue to forecast pre-recovery deficits. For this strategy to be effective, it is important that the plans are agreed and put in place promptly. As Auditor General for Wales, I intend to monitor closely the progress made by this trust in future years.

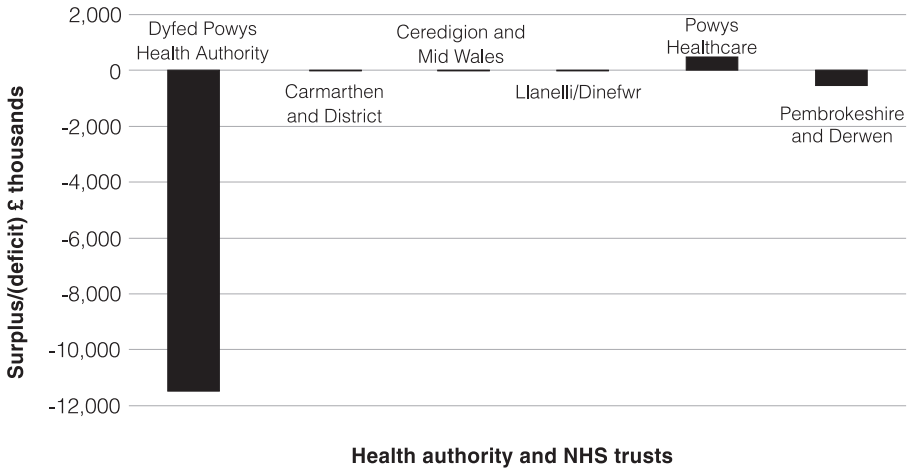
Appendix B

Dyfed Powys Health Authority area

B.1 In 1998-99 the six NHS bodies in the Dyfed Powys area reported a net deficit of some £11.5 million, which represents over half of the all-Wales deficit. The financial health of the Dyfed Powys area has deteriorated over the last three years although, as shown in Figure 19 below, it is the health authority itself which has borne the brunt of the accumulated deficit. This contrasts sharply with the other four health authority areas, where the bulk of the deficits have been borne by individual NHS trusts. The authority has borrowed the additional funds from the Assembly to cover the deficit, and used them to provide non-recurring income to local trusts. Consequently, the recurring deficit will have to be recovered from the trusts (as in other health authority areas), although the deficits are being addressed jointly.

Financial performance in Dyfed Powys area

Figure 19



Source: National Audit Office analysis

B.2 In recent years, Dyfed Powys Health Authority has reported a recurring annual deficit of some £12 million. For 1999-2000, a total deficit of £15.1 million is forecast within the Dyfed Powys area, which is planned to fall to £11.2 million in 2000-01. Each trust has prepared a draft recovery plan to support an overall strategy for the financial recovery of both the health authority and the trusts in the Dyfed Powys area. These plans have yet to be agreed with the Assembly, and their implementation is dependent upon the provision of capital funding from the Assembly.

B.3 The former Welsh Office provided an additional £10 million of brokerage funding during 1998-99, making a total of £12.5 million, to assist the trusts within this area, the whole of which remained outstanding at 31 March 1999. The overall recovery strategy agreed between the health authority and the trusts has set each trust the target of achieving financial recovery by the end of 2002-03. The strategy now includes additional brokerage of £11.6 million in 2000-01, with the requirement for the following year currently under review.

B.4 Dyfed Powys Health Authority has adopted a collaborative approach to the financial recovery of the NHS trusts within its area. Under the agreed recovery plan, the health authority takes responsibility for reporting the cumulative deficit position for the area, whilst the four trusts with deficits have agreed to individual targets for savings over the three-year recovery period:

Dyfed Powys savings targets

Figure 20

NHS Trust	Agreed savings target (£ million)
Carmarthenshire NHS Trust	4.3
Ceredigion and Mid Wales NHS Trust	0.6
Pembrokeshire and Derwen NHS Trust	4.0
Powys Health Care NHS Trust	3.9
Total savings	**12.8**

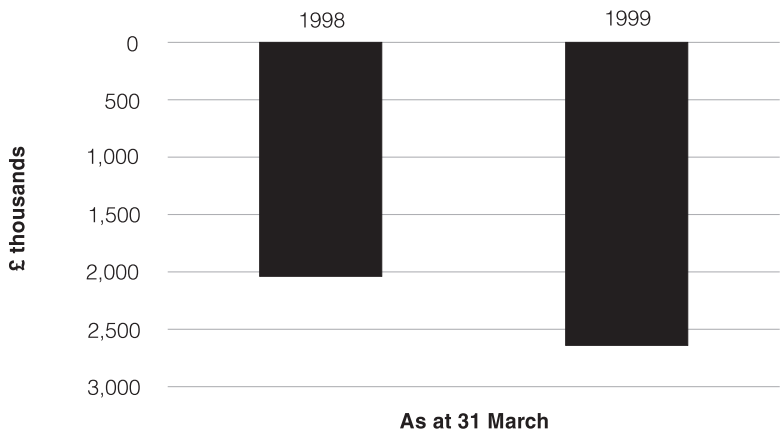
Source: NHS Directorate of the National Assembly for Wales

B.5 Typical measures to achieve these planned savings include general manpower efficiency reductions, site reorganisations, the streamlining of support services and reconsideration of the range and volume of services provided. The recovery plan expects brokerage and other sources of loan funding to be repaid over the following ten to twelve years via a top-slicing mechanism.

B.6 I welcome the adoption of this co-ordinated approach to the challenging and important issue of achieving financial balance within this health authority area. Assembly officials told me that the health authority and three of its trusts are broadly on target to achieve the in-year financial targets set at the beginning of 1999-2000, but that the Carmarthenshire NHS Trust is forecasting a deficit even after allowing for the additional income it is receiving from the health authority. As Auditor General for Wales, I intend to monitor the progress of the plan closely in future years.

Income and expenditure reserve

Figure 21



Source: National Audit Office analysis

Pembrokeshire and Derwen NHS Trust

B.7 Pembrokeshire and Derwen NHS Trust was formed on 1 April 1997 and reported a deficit of some £2 million in its first year of operation. The trust's agreed recovery plan, covering a period of four years, 1998-99 to 2001-02, forecast total revenue cost savings of £1.8 million. In 1998-99, however, the trust incurred a further deficit of £0.5 million. For 1999-2000, a breakeven position is forecast, although this is based on the health authority taking "ownership" of the Dyfed Powys-wide deficit. Pembrokeshire and Derwen NHS Trust has agreed to achieve savings of £4 million over the three-year period as its contribution towards the achievement of financial balance across the whole health authority area. Following a recent tripartite meeting, the trust is developing a recovery plan for agreement with the health authority and Assembly, to be implemented from April 2000,which aims to deliver financial balance by 2002-03.

Appendix C

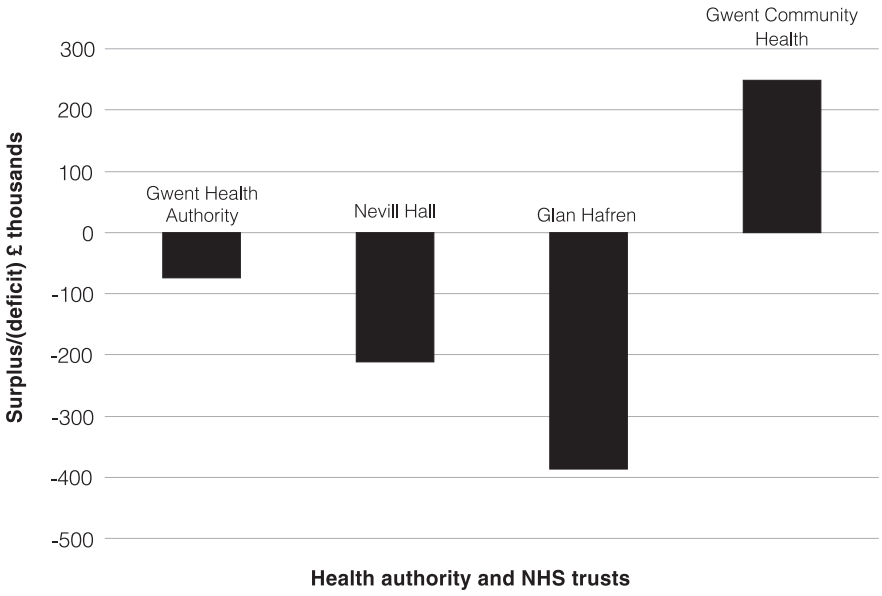
Gwent Health Authority area

C.1 The Gwent Health Authority area reported an overall deficit of £0.4 million for 1998-99 - the smallest in Wales. Each of the three NHS trusts in the area reported negative Income and Expenditure reserve balances, although these resulted primarily from the technical adjustment charge arising from the impairment of fixed asset reviews.

C.2 The three trusts merged to form the Gwent Healthcare NHS Trust. The new trust, together with the Gwent Health Authority, forecasts a break-even position for the 1999-2000 financial year.

Financial performance in Gwent area

Figure 22



Source: National Audit Office analysis

Appendix D

Iechyd Morgannwg Health Authority area

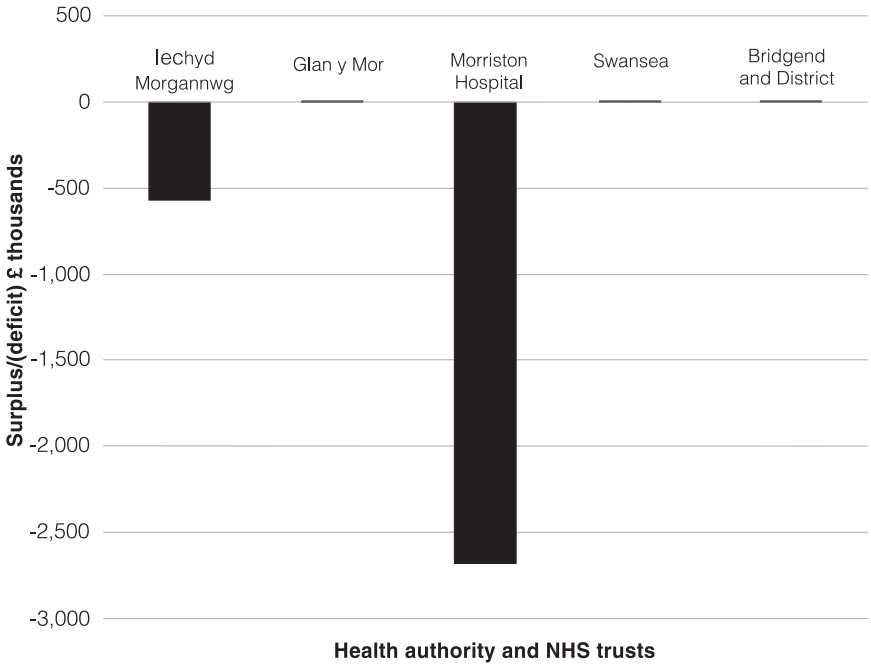
D.1 Overall, the Iechyd Morgannwg Health Authority area reported a net deficit of £3.2 million, of which £0.6 million (19 per cent) was borne by the health authority itself. The audited accounts of the authority showed a surplus of £0.7 million. However, the authority's treatment of GP Fundholder savings repatriated to the authority was not consistent with that adopted by the other four authorities, in that these funds were not recorded in their income and expenditure account.

D.2 I considered that the Summarised Accounts should contain an adjustment of £1.3 million to bring the accounting treatment onto a fully consistent basis. Assembly officials have processed this adjustment, which has resulted in the conversion of the reported surplus of £0.7 million to a deficit of £0.6 million. The authority did, however, manage to achieve a break-even position for the three-year period 1996-97 to 1998-99.

D.3 As shown below, whilst three of the four trusts in this area managed to balance their income and expenditure during 1998-99, Morriston Hospital NHS Trust reported a deficit of £2.7 million - the largest deficit of any trust in Wales.

Financial performance in Iechyd Morgannwg area

Figure 23



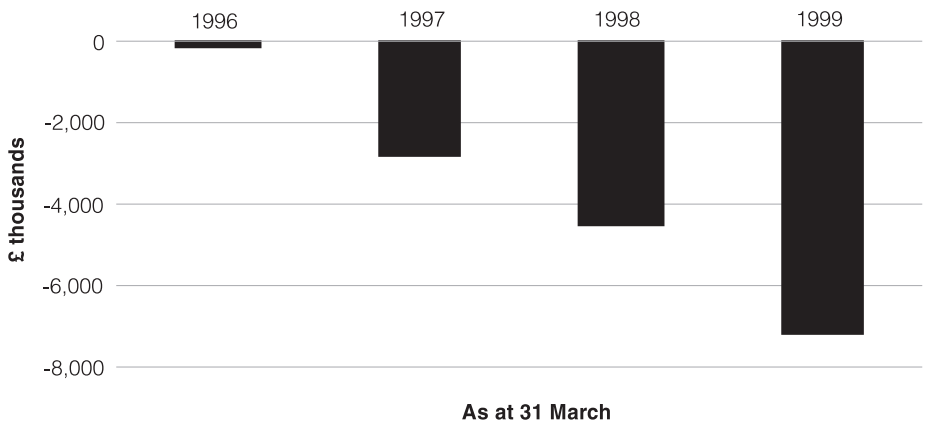
Source: National Audit Office analysis

Morriston Hospital NHS Trust

D.4 I have commented on the financial performance of the Morriston Hospital NHS Trust in my previous three Reports. The deficit for 1998-99 was £2.7 million - an increase of some £1 million on the prior year's reported deficit. At the end of 1996-97, the trust had an agreed recovery plan in place, designed to achieve financial balance over the three-year period 1997-98 to 1999-2000. The trust achieved the target savings in 1997-98, and also made good progress in 1998-99, although with some shortfall on the planned savings. At that stage, the recovery plan had not addressed the accumulated deficit, which at 31 March 1999 amounted to £7.2 million.

Morriston Hospital NHS Trust: Income and expenditure reserve

Figure 24



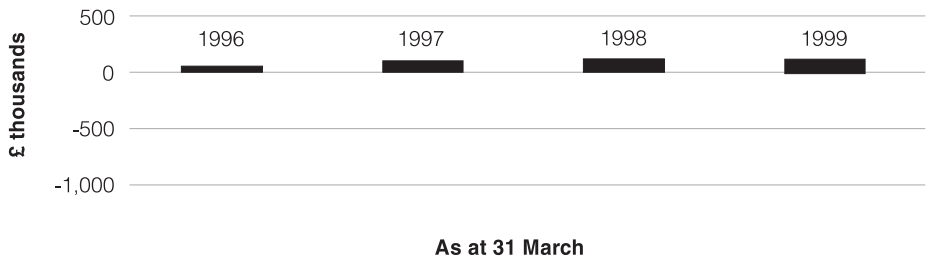
Source: National Audit Office analysis

Swansea NHS Trust

D.5 On 1 April 1999, the Swansea NHS Trust merged with Morriston Hospital NHS Trust. The merger also incorporated the Swansea element of mental health and community functions of the Glan-y-Mor NHS Trust. The Swansea NHS Trust has reported surpluses for each of the last four years.

Income and expenditure reserve

Figure 25



Source: National Audit Office analysis

D.6 In my 1997-98 Report, I noted that the trust expected to agree a revised recovery plan prior to the launch of the new Swansea NHS Trust. Tripartite meetings have been held between the trust, Iechyd Morgannwg Health Authority and the Assembly to facilitate the production of a draft plan, and this draft plan as considered by the Trust's board was received during December 1999.

D.7 For 1999-2000, the Swansea NHS Trust is forecasting a deficit of £2 million (including £0.9 million arising from the costs of the European Working Times Directive). Assembly officials told me that the draft recovery plan is being further developed to address this position and reflect more realistic income assumptions from the Dyfed Powys Health Authority, whose recovery plan requires all trusts providing services to operate within strict financial envelopes. The Trust is confident that it will achieve financial balance by the end of 2000-01, and further tripartite meetings will be held to discuss and examine the updated recovery plan once received.

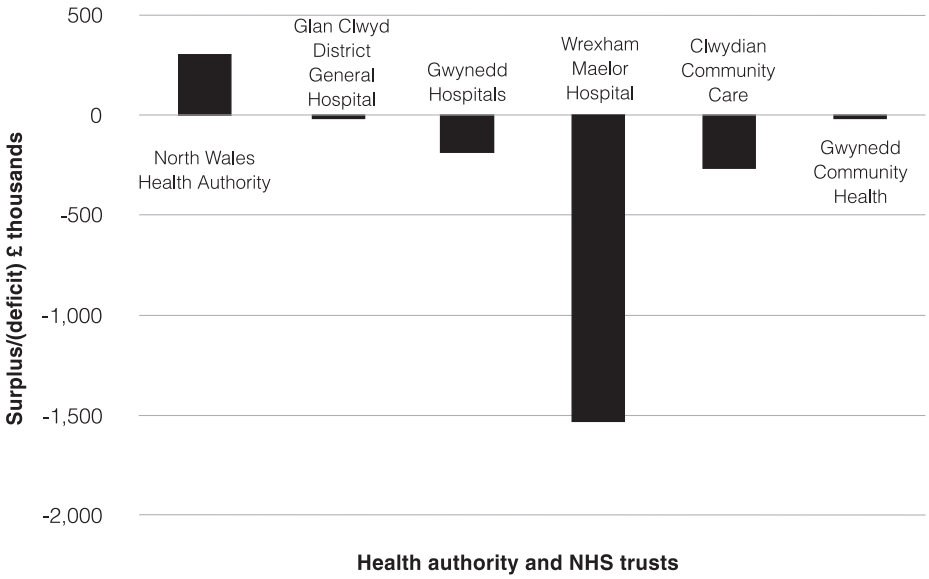
Appendix E

North Wales Health Authority area

E.1 The North Wales Health Authority area differs from the other four areas, in that the health authority itself reported a surplus in 1998-99. This reduced the area-wide net deficit for the year to £1.8 million. Of the five trusts in this area, Wrexham Maelor NHS Trust has incurred the most significant financial difficulties.

Financial performance in North Wales area

Figure 26



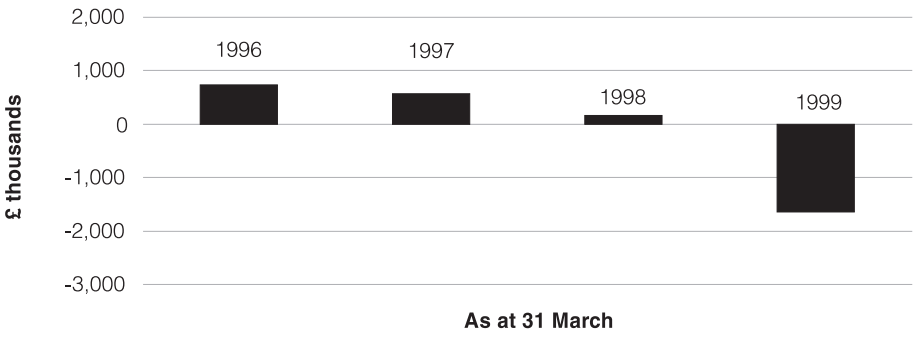
Source: National Audit Office analysis

E.2 In 1 April 1999, the five trusts in this area were reconfigured to form three new trusts - Conwy and Denbighshire NHS Trust, North East Wales NHS Trust and North West Wales NHS Trust. All three trusts have forecast deficits for 1999-2000. However, the trusts anticipate that these deficits will arise from non-recurrent costs (such as redundancy payments arising from the reconfiguration itself) and that the overall position will be recovered in 2001-02. All £3.7 million of brokerage funding which remained outstanding by the health authority at 31 March 1999 has been repaid to the Assembly during the 1999-2000 financial year.

Wrexham Maelor NHS Trust

Income and expenditure reserve

Figure 27



Source: National Audit Office analysis

E.3 Wrexham Maelor NHS Trust forecast a £2.5 million deficit for 1998-99. It had consequently already developed a three-year recovery plan, agreed with the health authority and the Welsh Office, to restore financial balance. The trust's actual 1998-99 deficit of £1.7 million reflected the achievement of Year One of its recovery plan, in part through the use of non-recurring income and savings.

E.4 On 1 April 1999, Wrexham Maelor NHS Trust merged with part of the former Clwydian Community Care NHS Trust to form the North East Wales NHS Trust. This new trust is forecasting a deficit of £3.8 million in 1999-2000, partly because of reconfiguration costs and the impact of the European Working Times Directive. The trust has produced a revised recovery plan. This has been agreed in principle by the Assembly although a significant part of it is subject to public consultation. The trust are providing regular updates on the plan and achievement to date and is now working on a revised recovery plan based on the post- reconfiguration arrangements.