

**National Audit Office
Report of the Comptroller and Auditor General**

**NHS (Scotland) Summarised Accounts
1998-99**

Confidential

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**The full accounts, from which this Report is taken, are published by the Stationery Office at
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Part 1: Basis of my audit

1.1 It is my duty under legislation¹ to examine, certify and report on the NHS summarised accounts for Scotland. This part of my report sets out the scope of my audit of those accounts for 1998-99.

1.2 The health service in Scotland is funded largely by the Scottish Executive Department of Health and is reported, on a cash basis, in the Appropriation Account for Class XIII, Vote 4 (Hospital, Community Health, Family Health, Other Health Services and Welfare Food, Scotland). The Mental Welfare Commission is funded through Class XIII, Vote 6 (Scottish Executive: administration). Both Appropriation Accounts are also subject to my audit. The summarised accounts record, largely on an accruals basis, the financial affairs of the Health Boards, NHS Trusts and other health bodies to whom these funds are made available.

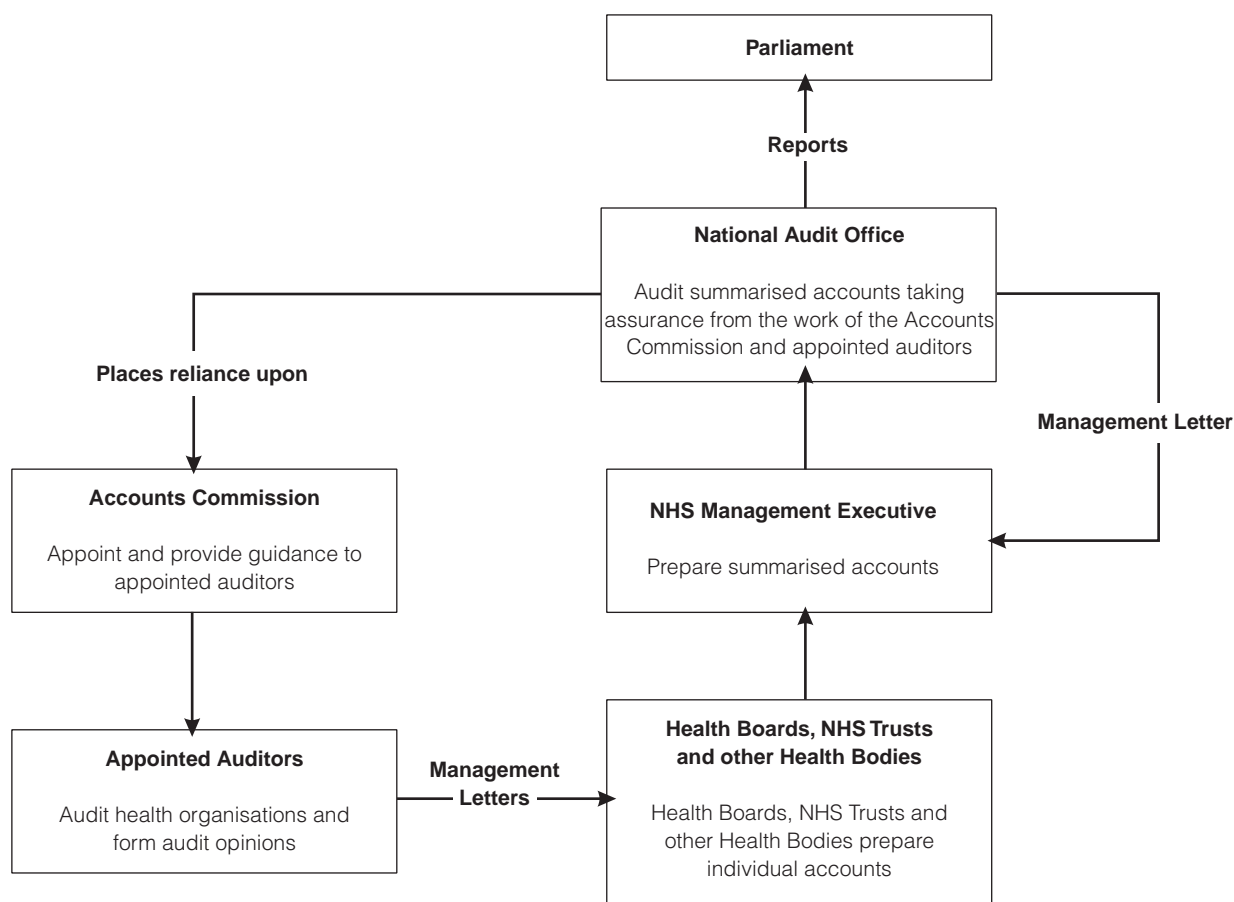
1.3 As of 1 April 1995, the Accounts Commission for Scotland took over responsibility for securing the external audit of NHS bodies in Scotland. For 1998-99, the Commission's directly employed teams carried out some 31 per cent of these audits, the remainder being undertaken by seven leading audit firms in the private sector. These appointed auditors provide an audit opinion on the annual accounts of each health organisation, and the NHS Management Executive summarise these accounts for my audit. Figure 1 shows the audit arrangements for the underlying and summarised accounts of the NHS during 1998-99.

1.4 The Foreword to the Scottish NHS summarised accounts describes the basis for their preparation and the background to the individual NHS organisations in Scotland. My examination in 1998-99 included an assessment of the reliability of the information contained in the audited accounts of the individual NHS bodies, undertaken by reviewing the work of the appointed auditors and scrutinising their reports. I also checked the preparation of the summarised accounts, from the individual accounts, by the NHS Management Executive.

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

¹ Section 86 of the National Health Service (Scotland) Act 1978, as extended by Schedule 1 to the Mental Health (Scotland) Act 1984 for the State Hospital and by Section 2 (8) (c) of the Mental Health (Scotland) Act 1984 for the Mental Welfare Commission.

Figure 1 Audit arrangements in the National Health Service in Scotland



1.6 I also examine the economy, efficiency and effectiveness with which NHS organisations in Scotland utilised their resources during 1998-99, under section 6 of the National Audit Act 1983. The results of such value for money examinations are published in separate reports made to the House of Commons and, from 1 July 1999, the Scottish Parliament under section 9 of that Act. My most recent reports on health issues are:

- The NHS in Scotland: Making the Most of the Estate (HC 224, February 1999)
- The Scottish Ambulance Service: A Service for Life (SE/1999/54, December 1999);

- Progress on National Audit Office Reports on Scottish Matters (SE/1999/55, December 1999), which detailed progress on reports on cataract surgery and the NHS estate.

1.7 In Part 2 of this report, I describe in more detail the findings of the auditors appointed by the Accounts Commission for Scotland. The remaining parts of my report address:

- Part 3: Developments in accounting and internal control;
- Part 4: Financial performance of the Scottish NHS;
- Part 5: Clinical and medical negligence;
- Part 6: Employment termination settlements.

Impact of devolution

1.8 The Public Finance and Accountability (Scotland) Act 2000 provides for the appointment of an Auditor General for Scotland and the establishment of a new public sector audit agency, Audit Scotland. With effect from 1 April 2000, the Auditor General will assume responsibility for the audit of the individual NHS bodies from the Accounts Commission and will oversee the completion of the audits for the year ended 31 March 2000. Responsibility for the audit of the summarised accounts will transfer to the Auditor General for Scotland starting with the accounts for the year ending 31 March 2001.

Part 2: Findings of the auditors appointed by the Accounts Commission for Scotland

Introduction

2.1 This part of my report discusses the overall findings of the appointed auditors on the accounts of Scottish NHS organisations (paragraph 2.2), summarises other work and findings by the appointed auditors (paragraphs 2.3 to 2.4), and draws attention to their value for money work (paragraph 2.5).

Overall findings

2.2 As a result of reorganisation of the NHS, the number of NHS Trusts decreased from 47 to 28 with effect from 1 April 1999. In 1998-99 the appointed auditors gave unqualified opinions on the accounts of each of the forty-seven out-going Scottish NHS Trusts, and of each of the Health Boards and other health bodies. While they commented on a number of issues, the auditors noted that overall financial stewardship within the NHS had continued to be of a high standard. They also noted that the demanding workload arising from moves towards reorganisation at the end of 1998-99 had been managed well. The Accounts Commission's Annual Report for 1999 provides a summary of the issues raised. I have dealt with the main issues in later parts of my report: failure to fully meet the requirements for statements of internal financial control (Part 3); weaknesses in arrangements to tackle fraud, in particular through post-payment verification checks (Part 3); failures to meet financial targets (Part 4); and remuneration issues (Part 6).

Section 104A reports

2.3 Section 104A of The Local Government (Scotland) Act 1973 (as amended), requires an appointed auditor to report to the Controller of Audit, if the auditor has reason to believe that a Scottish NHS body has made a decision which involves, or may involve, unlawful expenditure. The Controller is required, in turn, to send a copy of the report to the Accounts Commission and the Secretary of State.

2.4 The Controller of Audit has issued no Section 104A reports since I issued my report on the summarised accounts for 1997-98 (HC 444, 1998-99).

Accounts Commission Value for Money Work

2.5 The Annual Report of the Accounts Commission also summarises their value for money work in the NHS. My staff liaise closely with them so that, taken together, our studies avoid overlaps and add value. During 1998-99, the Commission undertook 3 studies and produced 6 reports:

Studies undertaken

- Medical Equipment;
- Waste Management;
- Bank & Agency Nursing.

Reports published

- Care in the Balance: Evaluating the Quality and Cost of Residential and Nursing Home Care for Older People;
- A Matter of Trust: Guidance on Trust Reorganisation;
- Full House: Theatre Utilisation in Scottish Hospitals;
- The Implementation of Evidence-based Healthcare in Scottish Health Boards;
- Supporting Prescribing in General Practice;
- A Shared Approach: Developing Adult Mental Health Services.

Part 3: Developments in accounting and internal control

Introduction

3.1 This part of my report outlines key developments in accounting and internal control within the Scottish NHS covering resource accounting (paragraphs 3.2 to 3.9), internal controls (paragraphs 3.10 to 3.14), measures to combat fraud (paragraphs 3.15 to 3.20) and impact of the millennium threat (paragraph 3.21 to 3.23).

Resource accounting and budgeting

3.2 I have worked closely with the NHS Management Executive and the Treasury to address general issues involved in resource accounting, and the specific issues, which relate to the NHS in Scotland.

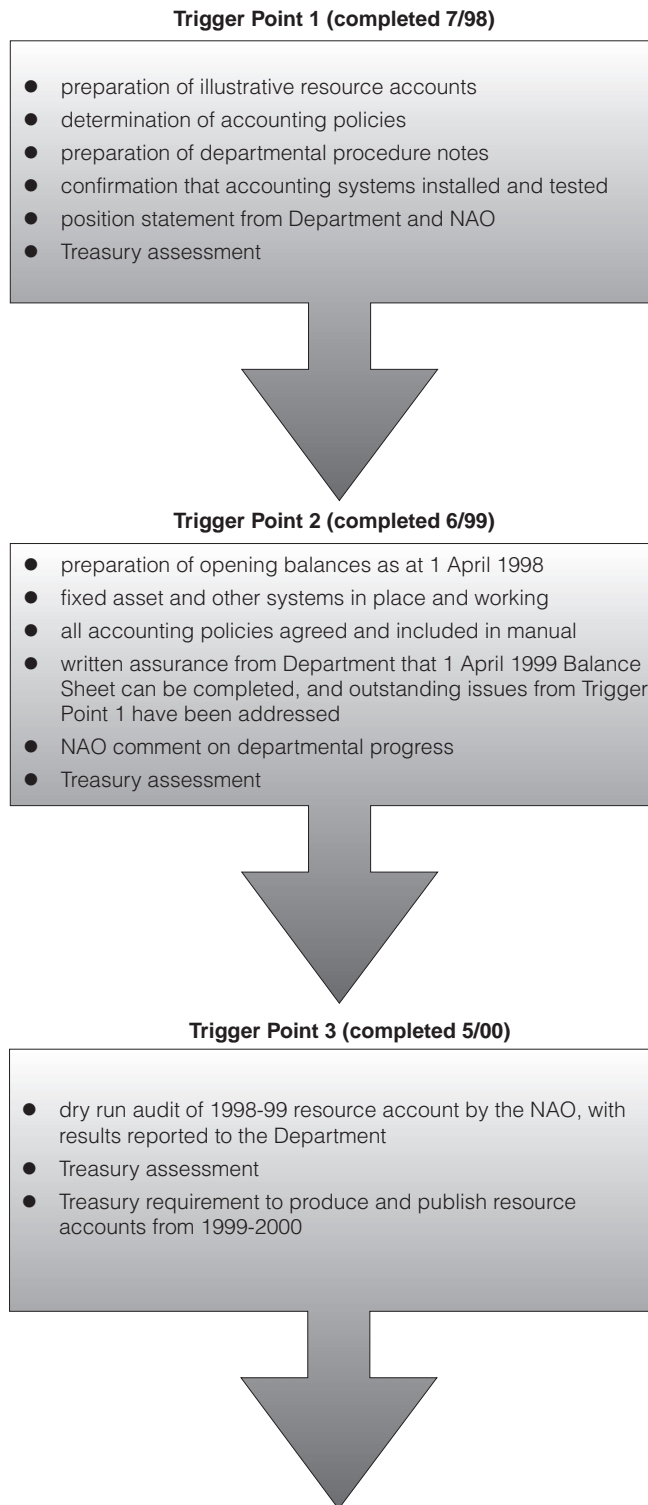
3.3 To help ensure successful implementation, the Treasury identified a number of "Trigger Points" for the overall resource accounting project. As each Trigger Point is reached, the Treasury assess a Department's progress towards implementation, take any corrective action and decide whether the target for implementation is still viable. Figure 2 below sets out the key features of each Trigger Point.

3.4 The Scottish Executive passed Trigger Point 1 on 10 July 1998, and subject to the resolution of a number of outstanding issues was allowed to proceed to Trigger Point 2 which was itself completed in June 1999.

3.5 No significant issues remain from the audit work carried out by my staff on the opening balance sheet, and consolidation of Health Board Accounts was audited for the first time at Trigger Point 3.

3.6 It is important that these, and other accounts underlying the consolidated departmental resource account use accounting policies which are consistent with those set out in the Resource Accounting Manual. To help ensure this in February 1999 the NHS Management Executive produced a new Accounts Manual for Health Boards and other health bodies.

Resource accounting trigger points **Figure 2**



3.7 Trigger Point 3 consisted of an assessment of the results of the National Audit Office's audit of Scottish Executive's dry run accounts for 1998-99. My staff received core departmental resource accounts in November 1999 but all the information relating to the consolidation of the Health Boards and health bodies accounts was not received until mid-February 2000.

3.8 Trigger Point 3 was effectively completed in May 2000 and Resource Accounts for the Scottish Executive will be produced for 1999-00. The production of the accounts is expected to be earlier than for Trigger Point 3 by using Consolidation packs for Health Boards to provide data in a consistent format directly comparable with the consolidation process for the whole Scottish Executive.

3.9 From 1999-00, the accounts of Health Boards and other health bodies will be both consolidated into the resource account and included in the summarised accounts. However, for organisations outside the resource accounting boundary, such as NHS Trusts, the summarised accounts will be the only account produced showing the national position. I am working closely with the NHS Management Executive to assess the impact of Resource Accounting requirements on the future of the NHS Summarised Accounts for health organisations, with the aim of minimising the audit burden on these bodies whilst maintaining public accountability.

Internal controls in the NHS

3.10 In December 1992, a Committee chaired by Sir Adrian Cadbury produced a Code of Practice relating to the management and control of companies. This recommended that the board of directors should report on the companies' system of internal financial control. To the extent that the proposals could be applied to central government bodies, in 1994 the Treasury issued a "Code of Best Practice for Board Members of Public Bodies" (since revised by the Cabinet Office and reissued in January 1997 as "Guidance on Codes of Practice for Board Members of Public Bodies"). The Treasury's DAO (GEN) 13/97 letter requires all departments, agencies and NDPBs to provide a statement by the Accounting Officer on the system of internal financial controls, to be provided for the first time alongside 1998-99 accounts.

3.11 General Managers and Chief Executives are required to sign a statement that sets out:

- their responsibilities in respect of internal financial control;

- the limitations of internal financial control;
- the extent of assurance which internal financial control can provide;
- the appointed officers' responsibility for reviewing the effectiveness of the system of internal financial control;
- their confirmation that the requirements have been met or action taken, or proposed, to correct weaknesses in the system of internal financial control.

3.12 From the 1998-99 accounts appointed auditors were required to form a separate audit opinion on whether Directors have provided the required disclosures on internal financial control, and whether the Directors' comments are not inconsistent with their audit findings. The Accounts Commission has issued guidance on the form of opinion.

3.13 The appointed auditors drew attention to NHS bodies which did not comply fully with the requirements of the statement and several bodies made additional disclosures to this effect in their Statement of Directors' Responsibility in Respect of Internal Financial Control. The most commonly occurring issues were:

- the absence of a formal fraud and corruption policy;
- review of risk assessment and management incomplete at 31 March 1999;
- deficiencies in internal control, including internal audit arrangements;
- weaknesses in arrangements at Health Boards for primary care payment checking;
- weaknesses in tendering procedures.

3.14 Examples of these failures included:

- The Mental Welfare Commission did not include a statement of internal financial control in their financial statements for the year 1998-99 but will do so in their 1999-2000 accounts;

- The auditors of the Glasgow Dental Hospital and School NHS Trust and Stobhill NHS Trust had qualified their audit opinions on internal financial controls, due to failures to disclose that these Trusts had not adopted a fraud and corruption policy;
- The auditors of the Western General Hospital NHS Trust also qualified their audit opinion due to failure to disclose the inadequacy of internal audit coverage of the main financial systems, because the Trust did not have a fully revised set of “Financial Operating Procedures” and because they had not adopted a fraud and corruption policy;
- Argyll and Bute NHS Trust commissioned special internal and external audit reports due to an unexpected deterioration in the Trust’s in-year financial position. The findings of these reports pointed to weaknesses in financial management and reporting control and verification of fixed assets, stock balances and debtors and that action agreed on weaknesses identified in previous audit reports had not occurred. The Chief Executive stated that action had been taken in relation to issues relating to the 1998-99 accounts and that remaining issues were being prioritised and actioned accordingly by successor Trust Lomond and Argyll Primary Care Trust to ensure that proper financial control is established and maintained.

Measures to combat fraud in the NHS

3.15 Expenditure by the NHS is vulnerable to fraud in a number of different guises including the fraudulent claiming of exemption from charges, and fraudulent claims made by practitioners in respect of services completed. The Scottish Executive Department of Health current estimate, based on figures provided by the Department of Health, is that prescription fraud alone may cost the NHS in Scotland up to £10 million every year. The Accounts Commission’s annual Report contains statistics for frauds detected in the year, but these specifically exclude prescription fraud. A total of 79 frauds amounting to £253,000 were detected.

3.16 Before the latest reorganisation of the NHS in Scotland, Health Boards were responsible for primary care expenditure comprising payments to GPs, pharmacists, dentists and opticians and for conducting post-payment verification checks on this expenditure and investigating frauds. The Common Services

Agency provided data for both patient and family health service practitioner fraud, while frauds relating to General Ophthalmic Services and General Medical Services were investigated on the basis of information held by Health Boards.

3.17 A number of the appointed auditors reported that, due to staff shortages and other competing pressures, planned post-payment verification exercises at some Health Boards did not take place or were not completed in 1998-99. These weaknesses are acknowledged in the disclosures made by some Health Board General Managers in their Statement of Directors' Responsibility in respect of Internal Financial Controls.

3.18 From 1 April 1999, responsibility for the administration of primary care payments transferred to the Common Services Agency. Primary Care Trusts and Island Health Boards are now accountable for this expenditure and responsible for undertaking post-payment verification. However, the appointed auditors have identified potential problems in these arrangements in that:

- some Primary Care Trusts may have insufficient resources to carry out post-payment verification;
- the new payments system to be introduced by the Common Services Agency, and which is intended to produce reports highlighting where post-payment procedures may be best directed was unlikely to be operational until February 2000.

3.19 In 1998 the Department of Health in England set up a new unit within the NHS Executive, the Directorate of Counter Fraud Services, which has overall responsibility for all work to counter fraud and corruption within the NHS in England. The Directorate has specific targets including a 50% reduction in prescription charge evasion by 2002-3. In Scotland, the NHS Management Executive announced its intention in November 1999 to establish a Central Counter-Fraud Unit in the Common Services Agency within the next few months which will investigate fraud by both patients and family health practitioners. It will also seek recovery of money wrongly claimed by patients or practitioners or NHS charges evaded.

Objectives of the unit as set out in the draft outline proposals include:

- Developing a pilot system which will identify and significantly reduce fraudulent exemption claims from patients using the information available from the pharmacy, dental and ophthalmic systems;
- Developing the capability to provide, on behalf of Primary Care Trusts and Island Health Boards, a national programme of counter-fraud action for contractor fraud.

3.20 There are also several counter-fraud initiatives at various stages of planning or completion including the following:

- “Point of Dispensing” checks were introduced in October 1998, following a publicity campaign earlier in the year informing the public that they must show proof of exemption when handing over their prescriptions for dispensing. During the first half of 1999, there has been an increase of around 1% in the number of prescriptions on which charges have been collected by pharmacists, compared with 1998. There has also been an increase of 30% in the number of pre-payment certificates being bought by patients;
- The National Health Service (Penalty Charge) (Scotland) Regulations 1999 introduced penalty charges with a current maximum of £100 or 5 times the unpaid charge, whichever is the lesser. A penalty charge will be levied where post payment checks confirm that the patients have evaded charges on NHS prescriptions or dental treatment, or claimed eligibility for free NHS treatment or benefits to which they are not entitled;
- Amendments to Regulations are currently being drafted for introduction in 2000. These will for the first time give the NHS Tribunal, which is the ultimate disciplinary body for family health service practitioners, a specific power to inquire into cases of fraud involving practitioners;
- The Common Services Agency’s Practitioner Services Division is to introduce an ophthalmic reference service in March 2000 along the lines of their existing dental reference service which has proved an important tool in helping detect NHS fraud by dentists.

Impact of the Year 2000 Problem

3.21 In common with all other businesses and services, the NHS endeavoured to ensure that no serious computer malfunctions would result from the millennium date change.

3.22 An independent assessment concluded that the “NHSiS has shown clear leadership and direction in the management of its year 2000 projects. Progress to ensure that risks are identified and managed appropriately and timeously is evident.” In the event, no problems of any significance were encountered.

3.23 The total (estimated) cost of implementing the year 2000 schemes for the financial years 1997-98 to 1999-2000 was £45 million against the earlier estimate of £56 million. This cost is made up of £22.2 million for schemes to upgrade or replace systems/equipment; £17.4 million for project manpower; and £5.7 million central costs for national IT systems.

Part 4: Financial performance of the Scottish NHS

Introduction

4.1 This part of my report looks at the financial performance of Health Boards (paragraphs 4.2 to 4.5), other health bodies (paragraphs 4.6 to 4.7) and NHS Trusts (paragraphs 4.8 to 4.23), the effects of the revaluation exercise (paragraphs 4.24 to 4.32), management costs (paragraphs 4.33 to 4.34) and compliance with the CBI prompt payment code (paragraphs 4.35 to 4.38), and at the action taken by the NHS Management Executive to monitor their performance and address problems arising.

Health Boards

Financial performance

4.2 Health Boards have one statutory financial duty - to ensure that net expenditure does not exceed their cash limit. In 1998-99 all 15 Boards met this target with an aggregate underspend of £34.5 million which represents 0.91% of total cash limits.

4.3 The Summarised Account of Health Boards for 1998-99 shows a surplus of £13 million (1997/98 £1 million) representing 0.28% of total expenditure. The accumulated deficit fell from £28 million at 31 March 1998 to £15 million.

4.4 Within the overall surplus of £13 million reported by Health Boards, six Boards incurred a deficit and two Health Boards had deficits in excess of £1 million: Ayrshire and Arran (£1.8million) and Greater Glasgow (£2.0million). The deficit reported by Ayrshire and Arran Health Board arose principally from the utilisation, during 1998-99, of cash balances accumulated in previous years. Greater Glasgow Health Board's deficit occurred mainly as a result of their decision to write-off GP Fundholders' funds in 1998-99.

4.5 Two Boards had surpluses in excess of £5 million. Lanarkshire Health Board had a £7.7 million non-recurring surplus, which arose as a result of a combined slippage in the Board's planned activities and the late allocation of funds from the Management Executive which could not be spent in the year. Lothian

Health Board were given special dispensation by the Management Executive to carry forward higher than normal cash balances to meet planned additional expenditure in 1999-2000.

Surplus/Deficit of Health Boards for 1998-99

Figure 3



Health Boards ranked by surplus/(deficit) in 1998-99.

Other Health Bodies

4.6 The five other health bodies (the Health Education Board for Scotland, Mental Welfare Commission, Common Services Agency, State Hospitals Board for Scotland and the Scottish Council for Postgraduate Medical and Dental Education) also met their cash limit target with an aggregate underspend of £6.4 million, or 2.5 % of their total cash limits.

4.7 The Common Services Agency underspent its cash limit by £6.0 million (4.8%) but was given dispensation to carry forward £5.44 million to fund major initiatives in 1999-2000.

NHS Trusts

Financial Performance

4.8 The foreword to the summarised accounts describes the financial duties of NHS Trusts in Scotland, the financial monitoring of Trusts by the NHS Management Executive, and the outturn against the financial duties for 1998-99. In summary, NHS Trusts in Scotland are subject to 3 financial performance targets – an external financing limit, a 6% rate of return on operating surplus and they are required to break-even taking one year with another.

4.9 The retained deficit for NHS Trusts in Scotland changed from a £15.2 million surplus in 1997-98 to £28.2 million deficit in 1998-99, representing 0.9 per cent of total turnover. Following transfers of debit balances from other reserves totalling £1.6million, an accumulated surplus of £61.4 million has been carried forward (£91.3 million in 1997-98).

4.10 The reduction in the accumulated surplus was due to a combination of factors, but mainly arose from technical adjustments relating to valuation adjustments on old NHS property.

4.11 Eighteen Trusts reported deficits for the year but had a sufficient accumulated surplus to achieve the break-even target. As in 1997-98, five Trusts failed to meet one or more of the three targets set in 1998-99 (see figure 4).

NHS Trusts failing to achieve one or more financial targets

Figure 4

| Trust | Surplus/ (deficit) in year £'000 | % of income | Cumulative surplus/(deficit) at 31.3.99 £'000 | EFL Achieved | Rate of Return |
|---|---|----------------|--|-----------------|-------------------|
| Argyll and Bute | (1,210) | 3.5 | (1,112) | No | 3.1% |
| Stobhill | (3,144) | 5.1 | (1,272) | No | 5.1% |
| Central Scotland Healthcare | (70) | 0.1 | (430) | Yes | 6.0% |
| Greater Glasgow Community and Mental Health Services | 319 | 0.2 | (5,111) | Yes | 6.0% |
| Highland Communities | (13,641) | 0.25 | (14,026) | Yes | 6.0% |

Break-Even

4.12 The five Trusts shown above all failed to meet the break-even target in 1998-99 (3 in 1997-98), although one of these did generate a surplus in year (2 in 1997-98). Two of the five (Central Scotland Healthcare and Greater Glasgow Community and Mental Health Trust), failed this target for the second year in succession mainly as a result of losses arising from the disposal of assets in previous years.

4.13 The largest deficit in year was at Highland Communities Trust. The Trust reported an operating surplus for the year but the effect of a downward revaluation of property of £9.8 million and loss on disposal of fixed assets, following the introduction of a PFI scheme, resulted in an overall retained deficit for the year of £13.6 million. This deficit has been written off as part of the reconfiguration of the Trusts on 1 April 1999.

4.14 In the case of four Trusts, Victoria Infirmary, Law Hospital, Hairmyres and Stonehouse and Central Scotland Healthcare, the NHS-ME waived all or part of their public dividend capital dividend in the year. In one case, the Victoria Infirmary Trust, this was done as part of an agreed recovery plan to put the Trust back into cumulative surplus and enable it to achieve its break-even target. In the other three cases, the reduction in dividend was done for administrative reasons arising from a change in asset values impacting on capital charges, and did not affect the Trusts' ability to meet their financial targets.

External Financing Limit

4.15 Each year the Management Executive set external financing limits (EFLs) for each Trust in order to control capital and revenue expenditure. The ME rigorously monitor these targets and adjust them to reflect changing circumstances. In 1998-99 Trusts achieved an overall £91.2 million against a limit of £94.2million (£77.8 million in 1997-98).

4.16 The main contributor to the undershoot was the Argyll and Bute National Health Trust. The Trust had a target to increase cash in-year by £2.0 million but overspent their external financing limit by £3 million. The difficulties resulted from fundamental weaknesses in financial management, noted in Section 3.14.

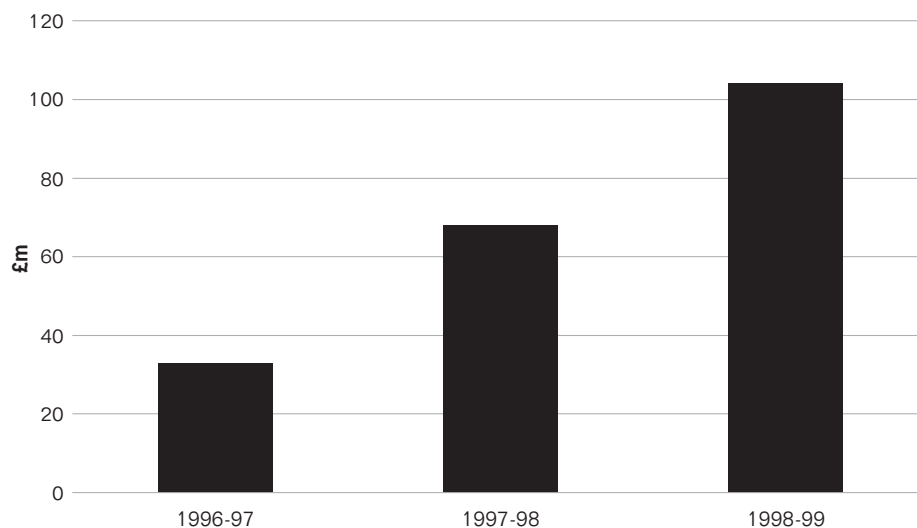
4.17 In the last 4 years capital expenditure by NHS Trusts in Scotland has fallen from nearly £200 million to just under £130 million. This reduction in capital expenditure together with cash from asset sales, capital to revenue transfers and asset transfers between Trusts has resulted in large cash balances being accumulated by some Trusts. As [Figure 5](#) below shows, cash balances rose from £33million at 31 March 1997 to £104 million at 31 March 1999, an increase of more than 200% in 2 years.

4.18 Of the 47 Trusts, 10 held more than half of the cash, some £60 million, between them, with each of these Trusts holding in excess of £3 million. These bodies accumulated high cash balances either as a result of asset sales or because capital charges recovered significantly exceeded the level of capital expenditure.

4.19 Although the Management Executive had the power under the NHS (Scotland) Act 1978 to bring these cash surpluses back into the centre, by setting a higher level of public dividend payable by each Trust, in practice they have been reluctant to do this because higher dividends could impact on Trust's financial targets and put individual Trusts into deficit.

**Increase in cash held by
the Trusts from 1996-7
to 1998-99**

Figure 5



4.20 As part of the NHS Trust reconfiguration, the financial structuring of the Trusts was reviewed. The NHS Management Executive reviewed the level of excess cash in each Trusts' bank accounts at the end of the 1998-99 financial year, and recovered £41.6 million from Trusts as a repayment of loans prior to writing off old Trust debt. Excess cash was defined as being anything in excess of 4% of turnover or £4 million whichever was lower, based on the opening cash balances at the reconfigured Trusts.

4.21 Since the introduction of the Health Act 1999 in April of that year, the Management Executive is able to direct Trusts to place 'excess' cash in Paymaster General (PGO) Accounts rather than leave them in commercial accounts. The level of 'excess' will be adjudicated by the Management Executive who are currently working on producing guidance in this area. Some Trusts have already acted in the spirit of the new guidance by placing funds at PGO. The public sector then obtains the benefits of these funds.

Rate of return

4.22 Although this is not a statutory target, the Management Executive set Trusts the target of achieving a 6% rate of return, in line with a general public sector target set by the HM Treasury. Two Trusts failed to meet the 6% rate of return (3 in 1997-98) – Argyll and Bute and Stobhill.

Effect of targets on management actions

4.23 The method by which the targets are calculated can encourage poor quality financial decisions on the part of the Trusts in order to meet them. The appointed auditors have reported various instances of Trusts making payments with no obvious immediate benefit which, in their professional opinions, were made solely to meet financial targets. These can include settling PAYE/NI liabilities early or bulk purchases of stock at year-end. The figures compiled by the Accounts Commission indicate that the value of the most common manipulations is, however, falling.

Revaluation of NHS Property

1998-99 Accounts

4.24 The revaluation of Health Board assets resulted in a write-down of £11 million, in both 1998-99 and 1997-98. A total of £109.8 million was written off NHS Trust assets in 1998-99 (£50.9 million in 1997-98). These relate mainly to hospital closures or are as a result of Trusts entering into Private Finance Initiative contracts and rationalising their service provision. In addition, much of the £19.5 million loss on disposal of property relates to properties which have fallen out of use and been demolished. The summarised account details the individual Trusts and amounts involved.

4.25 In the financial year the Treasury has approved the write off of £47.5 million in public dividend capital and £54.4 million in long-term loans relating to the above assets (£24.6 million of public dividend capital and £33.9 million in long term loans in 1997-98).

4.26 A national revaluation of all NHS property in Scotland was carried out at 1 April 1999, with the exception of The Health Education Board for Scotland which was revalued at March 1998. The valuations were required for the Trust reconfiguration including the transfer of assets from Health Boards to Primary Care Trusts, and will give up to date values for Health Boards' and other health bodies' assets for resource accounting and will also facilitate the capital charging of Health Bodies in occupation of National Health Service properties in Scotland from 1999-2000. Disclosure of the revaluations was made in the 1998-99 Accounts but as the revaluations were not finalised, no adjustments were made. The effects will be reflected in the 1999-2000 accounts.

4.27 Recognising the specialist nature of most of the properties within the Estate, Trusts predominantly used the Depreciated Replacement Cost basis of valuation. However, in the revaluation exercise a substantial number of properties were valued on an open market basis having been declared surplus to requirements or closed and unoccupied, greatly reducing their carrying value.

4.28 The accounting standard FRS11 came into force for accounting periods ending after 23 December 1998. The FRS requires that impaired assets are written down to their "recoverable" amount in the balance sheet. Impairment can result, for example, from obsolescence, damage or other changes in the operation of the business. Any change in circumstance indicating that the carrying value of the fixed assets may not be recoverable should trigger an impairment review e.g. the identification of property as closed and unoccupied. Although there was a significant write down of properties in health bodies' accounts for 1998-99, there were still health bodies, some with negative revaluation reserves balances, carrying asset valuations at 31 March 1999 significantly in excess of the new valuations. This may suggest that FRS 11 was not consistently applied across all health bodies.

Health Boards

4.29 The 1999 revaluation, which takes account of asset transfers between Health Boards and NHS Trusts, has indicated a downward revaluation/reduction in assets for six Health Boards (£7.1 million) and an upward revaluation for the remaining nine (£5.8 million). Two of the Health Boards with a downward revaluation have insufficient balances in their revaluation reserve against which to offset the decrease in valuation. Greater Glasgow Health Board is showing a negative balance in its reserve of £17.8 million as at 31 March 1999. To comply with UK GAAP, these Boards should charge the negative balances, where they relate to permanent diminutions in asset values, through their Income and Expenditure Accounts in 1999-00 to effect the downward movement.

Other Health Bodies

4.30 Two of the other health bodies are affected by the revaluation: the Common Services Agency (decrease of £6.7 million) and the State Hospital for Scotland (increase of £1.5 million). The reduction in value of £6.7 million for Common Services Agency represents a 18.2% fall in net book value of land and buildings shown in their March 1999 accounts.

NHS Trusts

4.31 The restructuring of the NHS in Scotland with effect from 1 April 1999 resulted in a decrease in the number of Trusts from 47 to 28. There is a need for transparency between the old and new trusts when stating opening balances of the new trusts, with any write-offs of fixed assets and originating public capital being separately identified.

4.32 Of the forty-seven NHS Trusts, seventeen show a downward revaluation (£78 million) and the remaining thirty an upward revaluation (£126.8 million). Ten Trusts have either a negative or insufficient balance on their revaluation reserve against which to offset the downward valuation and a further three Trusts have negative revaluation reserves in excess of their increase in revaluation (See Figure 6). Had the Trusts not been reorganised, the charge to the Income and Expenditure Account that would have been required to effect the revaluations and write-off any negative revaluation reserve balances would have been £121.7 million. The opening balances for the new Trusts will reflect the valuations as at 1 April 1999.

Revaluation of NHS Trusts **Figure 6**

| NHS Trusts | Revaluation | Revaluation Reserve 31/3/99 | Total |
|---------------------------------------|---------------|-----------------------------|----------------|
| Central Healthcare | £(23,951,000) | £(9,478,000) | £(33,429,000) |
| Grampian Healthcare | £(7,648,500) | £(21,736,000) | £(29,384,500) |
| Edinburgh Healthcare | £(3,329,500) | £(22,946,000) | £(26,275,500) |
| Borders General Hospital | £(2,343,000) | £2,310,000 | £(33,000) |
| Ayrshire & Arran Community Healthcare | £(3,373,000) | £(2,501,000) | £(5,874,000) |
| Angus | £(564,500) | £(3,350,000) | £(3,914,500) |
| Royal Infirmary of Edinburgh | £(7,657,500) | £3,901,000 | £(3,756,500) |
| Law Hospital | £(4,174,000) | £1,273,000 | £(2,901,000) |
| Kirkcaldy Acute Hospital | £(11,958,000) | £10,980,000 | £(978,000) |
| Highland Communities | £(2,895,500) | £2,148,000 | £(747,500) |
| East & Midlothian | £637,000 | £(6,904,000) | £(6,267,000) |
| Stobhill | £3,527,000 | £(9,158,000) | £(5,631,000) |
| North Ayrshire & Arran | £408,000 | £(2,932,000) | £(2,524,000) |
| Total | £(63,322,500) | £(58,393,000) | £(121,715,500) |

Management Costs

Health Boards

4.33 In 1996 the Management Executive set Boards a target of reducing their management costs per weighted head of population to £10 by the end of 1998-99. The inability of the smaller Health Boards to achieve the target on an individual basis led to the target being accepted as an all Scotland one. [Figure 7](#) shows that steady progress has been made towards the target at national level.

Management Costs of Health Boards

Figure 7

| Health Boards | 1995-96 | 1996-97 | 1997-98 | 1998-99 |
|---|---------|---------|---------|---------|
| Management cost per weighted head of the population | £13.98 | £12.23 | £11.06 | £10.77 |

NHS Trusts

4.34 The definition of management costs upon which the NHS Trusts in Scotland base their calculations was revised in April 1998. These are now expressed as a percentage of total income for 1998-99. The current average is 4.6% (4.0% in 1997-98), although there are significant variations within this. Southern General Hospital NHS Trust had the lowest management costs as a percentage of total income (1.4%) and Glasgow Dental Hospital NHS Trust the highest (9.24%).

CBI Prompt Payment Code

4.35 The Health Board and NHS Trust Accounts Manuals require that Health Boards and Trusts endeavour to comply with the CBI prompt payment code by processing supplier invoices without unnecessary delay and in a timeous manner. Treasury guidance set a target of no less than 95% of undisputed bills to be paid within 30 days. Dumfries and Galloway Community Health NHS Trust was the only Trust or Health Board to achieve this target.

4.36 Of the fifteen Health Boards, Fife Health Board failed to disclose their payment performance and Tayside and Western Isles only partially complied with the recommended disclosure. The average percentage of invoices paid within 30 days for the remaining Health Boards was 78.4% by value and 69.7% by volume.

4.37 Less than half the NHS Trusts complied fully with the recommended disclosure, some Trusts failing to disclose their payment performance and others using different payment performance criteria. The average percentage of invoices paid within 30 days for the NHS Trusts disclosing the relevant information was 79% by value and 78% by volume. Falkirk and District Royal Infirmary paid less than half their invoices, both by value and volume, within 30 days.

4.38 The Late Payment of Commercial Debts (Interest) Act 1998 establishes a statutory right to interest on commercial debts as of 1 April 1999. Unless the vendor or purchaser agree their own terms for settling overdue payments, the provisions of the Act come into force 30 days after the invoice. In future, in view of the poor payment performance of the majority of the NHS Trusts and Health Boards, actual or contingent liabilities may arise that will require recognition or reporting in the entity's financial statements.

Part 5: Clinical and medical negligence

5.1 This part of my report:

- Provides background information on clinical and medical negligence (paragraphs 5.2 to 5.3);
- Potential costs to the NHS in Scotland of clinical and medical negligence (paragraphs 5.4 to 5.7);
- Developments in funding negligence claims and improving the quality of clinical care (paragraphs 5.8 to 5.16);
- Accounting arrangements (paragraphs 5.17 to 5.22);
- Clinical Governance (paragraphs 5.23 to 5.25).

Background

5.2 Clinical and medical negligence is the term given to a breach of a duty of care by health care practitioners in the performance of their duties in the NHS. Medical refers to medical and dental practitioners and clinical refers to nursing staff and those in the professions allied to medical.

5.3 In my report on the NHS summarised accounts for Scotland for 1996-97 (HC 692 1997-98), I described the arrangements adopted by the NHS Management Executive in Scotland to account for and finance the costs of medical and clinical negligence claims. In my report on the 1997-98 accounts I welcomed the improvements in disclosure required by Boards in order to show the costs of negligence claims separately in the accounts and the requirement for separate disclosure of any contributions from the Medical and Dental Defence Union in order to show the full cost of negligence claims. I also referred to inconsistencies in the calculation of provision for clinical and medical negligence and contingent liabilities when comparing Boards with Trusts and also when comparing bodies within each group.

Level of Claims in 1998-99

5.4 At 31 March 1999 Trusts and Boards had made provisions for negligence totalling £24.8 million and disclosed contingent liabilities of a further £34.9 million. In addition, they utilised £4.4 million of provisions set up in earlier years to settle claims and cancelled provisions of £1.1 million in respect of claims where settlements were not required.

5.5 As Figure 8 shows, provisions and contingent liabilities across Health Boards and Trusts rose by £5.1 million (26 per cent) and £8.2 million (31 per cent) respectively over those reported in 1997/98. This is partly due to increases in the:

- number of Health Boards and Trusts complying with Management Executive guidance on the accounting treatment for clinical and medical negligence claims;
- total value and number of claims for trusts.

5.6 Claims are made against the NHS body that was the employer of the health care practitioner at the time the incident occurred. Those arising from incidents prior to the formation of NHS Trusts remain the responsibility of Health Boards. As it can take some years for negligence claims to be lodged, and settled, the majority of claims outstanding are against Health Boards. In the previous two years I have reported that recognised claims against NHS Trusts have more than doubled. This rapid increase was to be expected now that all mainland healthcare providers are NHS Trusts. The value of recognised claims rose again from £13.5 million in 1997-98 to £24.9 million in 1998-99, an increase of 84 per cent. This confirms a potentially increasing burden on the financial resources available to the NHS in Scotland.

5.7 The level of recognised claims against Health Boards also increased but at a much slower rate. The rise in 1998-99 from £33 million to £35 million was only 6 per cent.

| Account Figures: Cost of Medical And Clinical Negligence Claims, 1998-99 | Figure 8 | £'000 | £'000 |
|---|---|---------------------|---------|
| | Opening Provisions at 01.04.98 | | |
| | Trusts ^a | 8,494 | |
| | Boards | <u>11,200</u> | 19,694 |
| | Utilised in Year | | |
| | Trusts | (2,081) | |
| | Boards | <u>(2,334)</u> | (4,415) |
| | Reversed unutilised | | |
| | Trusts | (354) | |
| | Boards | <u>(815)</u> | (1,169) |
| | Arising in Year | | |
| | Trusts | 5,869 | |
| | Boards | <u>4,781</u> | 10,650 |
| | Closing Provision at 31.03.99 | | |
| | Trusts | 11,928 | |
| | Boards | <u>12,832</u> | 24,760 |
| | Contingent Liabilities at 31.03.98 | | |
| | Trusts | 5,052 | |
| | Boards | 21,630 ^b | 26,682 |
| | Contingent Liabilities at 31.03.99 | | |
| | Trusts | 12,963 | |
| | Boards | 21,961 ^b | 34,924 |

^a Includes a prior year adjustment of £2.2 million in respect of change in accounting treatment of contributions from the MDDU from net to gross disclosure.

Source: Summarised Accounts for Scotland for 1998-99

^b Includes all contingencies (mostly medical and clinical negligence) other than £2.1 million for a building claim 1997-98.

Funding claims

5.8 When medical or clinical negligence claims are lodged against them, health bodies report them to the Central Legal Office of the Scottish Health Service. The Central Legal Office assess the likelihood of the claim being successful and advise the health body as to whether to seek a settlement or defend any resulting litigation. The Central Legal Office monitor progress of all cases with individual health bodies. The methods used for funding claims differ for medical and clinical negligence.

a) Medical Negligence

5.9 In 1990, The Scottish Executive introduced a scheme to assist health bodies in Scotland to meet the cost of large damage awards and legal expenses arising from successful medical negligence claims. The scheme is funded from a reserve held on behalf of the NHS Management Executive by the Medical and Dental Defence Union. Access to the fund is dependent on the size of an award relative to the Health Board's financial allocation or the NHS Trust's annual level of income.

5.10 The employing health bodies are responsible for meeting the costs of awards that are less than 0.15 per cent of their allocation/expected annual income or £450,000, whichever is the smaller. Once above that threshold the body may access the reserve funds, but still remain responsible for meeting the first 25 per cent of the amount claimed against the reserve. Further safety nets exist to protect employing bodies against really large awards or a substantial accumulation of awards in any one financial year so that the reserve fund will meet the excess where:

- for any one award where the employing body's contribution exceeds 0.3 per cent of their allocation/income figure;
- total payments by employing authorities on all awards in any one financial year exceed 0.5 per cent of their allocation/income figure.

5.11 Once a settlement is reached, the Central Legal Office advises the employing body of the amounts to be paid. The latter then notifies the NHS Management Executive of the amount they wish to reclaim. Once checked and agreed by the NHS Management Executive, the sum is then transferred from the Medical and Dental Defence Union reserve to the employing body. In 1998-99, five payments totalling just under £1.9 million were made from the reserve. As at 31 March 1999, the remaining balance held by the Medical and Dental Defence Union amounted to some £2.4 million.

5.12 Concerns that the current reimbursement arrangements could quickly exhaust the reserve led the Scottish Executive to set up a Review Group to undertake a comprehensive review of the current arrangements for reimbursing health bodies. The Review Group recommended the establishment of new financial "pools" to fund the costs of larger claim settlements, to be funded by a system of levies on Trusts and Boards. Ministers accepted the recommendation and new arrangements will be brought in from 1 April 2000.

5.13 A key aim of the new arrangements is to encourage Trusts through a system of financial incentives or penalties that encourage sound risk management procedures and improved clinical performance and so reduce the incidence of clinical negligence claims. Four major objectives have been set for the new scheme:

- improve the quality of patient care;
- maximise the incentive for trusts to implement and improve cost effective clinical risk management and claims management;
- minimise the cost of clinical negligence by reducing the incidence of negligence;
- spread the financial risk from large claim settlements across all Trusts.

In addition, an important element of the scheme is that it must complement and facilitate the development of other initiatives to improve clinical standards and performance, and risk management procedures in general and on the newly introduced clinical governance requirements, future work of the Clinical Standards Board for Scotland, and the Controls Assurance Statements as required in Trusts' Annual Accounts and Reports in particular.

5.14 Membership in the financial risk pool "scheme", which will cover both clinical and certain non-clinical risks will be mandatory for all NHS Trusts and Health Boards, the State Hospital and Ambulance Service Boards for Scotland and all other Special Health Boards and the Common Services Agency. Contributions will be set in part on the Members' effectiveness in establishing and operating appropriate risk management procedures and a new Standards Committee will be established. The latter will assist in setting the risk management standards against which performance will be assessed and contributions set.

5.15 For the first year no account will be taken of the Member's previous claims history or risk management performance. However, contribution calculations for subsequent years will take account of the Member's performance in establishing and operating risk management procedures. For the clinical negligence component of the scheme, it is initially proposed to use the standards adopted in England for their Clinical Negligence Scheme for Trusts. Standards that are unique to Scotland will be developed in time.

b) Clinical Negligence

5.16 In previous years I have reported the absence of central arrangement for funding clinical, as distinct from medical, negligence claims. Health bodies must meet the full costs of such claims from their own resources. In future, however, these claims will also be covered by the revised central funding arrangements.

Accounting for negligence

5.17 Trusts are required to show the total costs of clinical and medical negligence claims separately in their income and expenditure account, the level of provision at 31 March and the level of contingent liabilities. Whilst Boards are required to disclose the level of provision, there is no requirement to show the total costs of medical and clinical negligence separately.

5.18 In my report on the 1996-97 summarised accounts, I recommended that the costs of medical and clinical negligence should be shown separately by Health Boards, and that any contributions from the central reserve – in 1998-99, £1.9 million – should be disclosed in order to show the full cost of negligence claims. The latter recommendation has been implemented for the 1998-99 accounts. Health Boards and Trusts now provide gross for negligence claims disclosing any contributions from the Medical and Dental Defence Union separately as income. However, no action has yet been taken to implement my recommendation that Health Boards show the total costs of medical and clinical negligence separately in their income and expenditure account.

5.19 In my report on the 1997-98 summarised accounts, I noted that inconsistencies in the calculation of provisions for negligence and contingent liabilities were still arising due to some Boards and Trusts failing to comply with the Management Executive's guidance. Matters have improved but some inconsistencies are still arising. For example, last year I reported that Fife Health Board did not include such provisions in its accounts. Although the Board has made some provision in the 1998-99 account, my review concludes that the level of such provision is understated by some £0.7 million. Of this £0.4 million is due to the Board's failure to comply with the ME's guidance which states that provisions should be gross of any contributions due from the Medical and Dental Defence Union. The appointed auditors have made specific reference to the need 'to develop further the reporting of clinical and medical negligence provisions in line with the guidance contained in the Health Board Accounting manual'.

Incidents incurred but not reported

5.20 In my report on the 1996-97 summarised accounts, I noted that there could be a considerable delay between an incident occurring and a negligence claim being lodged. Neither Health Boards or NHS Trusts made any provisions for the cost of incidents that had not been reported by the balance sheet date but which might lead to claims in future years. The Central Legal Office considered that it was not possible to estimate future claims arising from current activity with sufficient certainty to make a provision or merit disclosure in the accounts of individual Boards or NHS Trusts.

5.21 In their report on the summarised accounts 1996-97, the Committee of Public Accounts concluded that accounting for clinical negligence in all NHS organisations should comply with FRS 12 for provisions and contingent liabilities for the year ended 31 March 1999. This should include an estimate of potential liability in respect of incidents that may have occurred but for which no claim has yet been received. Such an estimate would be based on a financial model supplemented by a review of known events at each location.

5.22 The Scottish Executive have been developing a model to assist in the identification of 'incidents incurred but not yet reported'. My review of their findings for Health Boards indicates that 60 per cent of settled cases were reported to the CLO within one year of the incident occurring and that 90 per cent were reported within three years. Given that it takes several years from the date of reporting an incident to reaching settlement, the majority of cases will have been disclosed as either a contingent liability or provided for in advance of the requirement to settle. On this basis the ME conclude, and I agree, that there is not a material under-statement in the accounts in respect of 'incidents incurred but not yet reported'.

Clinical Governance

5.23 The White Paper, *Designed to Care*, announced the Government's intention to introduce clinical governance into the NHS in Scotland. Clinical governance makes quality of care an integral part of the NHS governance framework and from 1 April 2000 the corporate governance of all NHS bodies will encompass both financial and quality issues. A key purpose of clinical governance is to support clinical staff in improving quality of care. It will also ensure that wherever possible poor performance is identified and addressed.

5.24 The board of each NHS body has responsibility for clinical governance which will mean major implications for the way in which they conduct their business. Issues relating to the quality of clinical care will feature much more prominently on their agendas forming a complimentary and equal strand alongside financial and probity issues in their accountability. In addition to the structures it develops to deliver clinical governance, each Trust board is required to establish a Clinical Governance Committee, the status of which will be commensurate with that of the Financial Audit Committee.

5.25 Trust boards will be required to include a specific section in their annual report giving a full account of their activities related to clinical governance. The proposed Clinical Standards Board for Scotland will produce an annual report outlining its assessment of the position of the NHS in Scotland in relation to quality of clinical care.

Part 6: Employment termination settlements

Settlements

6.1 This final section of my report examines issues relating to employment termination settlements for NHS Trusts.

6.2 Previously, the NHS Management Executive did not have powers to control termination payments by NHS Trusts in Scotland. With a view to the restructuring of NHS Trusts from 1 April 1999 the Committee of Public Accounts urged the Executive to seek powers to ensure that this did not lead to irregular settlements. The NHS Management Executive obtained general powers of direction for Ministers in the Health Act 1999.

6.3 With the planned reduction in the number of Trusts from 47 to 28 from 1 April 1999, the Directorate of Human Resources of the Management Executive was charged with initiating a selection process for the appointment of Chief Executives and Executive Directors of the new Trusts, and the consideration of early retirement and redundancy. There were seventeen cases of Early Retirements due to the reconfiguration of the Trusts - five Chief Executives and twelve Executive Directors. Ministerial approval was given for the costs of the Early Retirement Scheme to be met by the Management Executive. The summarised accounts for NHS Trusts in 1998-99 show a charge of £2.8 million for "Compensation for loss of Office".

6.4 The Scottish Executive Audit Unit examined the Early Retirement Scheme and found that the Scheme was "handled in a controlled manner. The justification for the Early Retirement cases was clearly documented and approved in principle at Ministerial level and proper consideration was given to minimising the cost of the Early Retirement Scheme to the Exchequer".

6.5 There was one instance of an overpayment of a lump sum award of about £15,000 and an on-going overpayment of pension of approximately £500 per month. This overpayment has now been recovered from SOPA and the monthly pension corrected.

John Bourn
Comptroller and Auditor General
19 July 2000

National Audit Office