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Introduction

1 The Department of Health prepares summarised accounts for the NHS in England, which for 2000-2001 covered the:

- 99 health authorities, which spent some £41 billion in purchasing health care and related services from NHS Trusts and other contractors to the health service;
- 40 Primary Care Trusts;
- 356 NHS Trusts, which spent some £31 billion in delivering health care;
- 431 charitable funds held on trust;
- 15 special health authorities; and
- the Dental Practice Board.

Issues covered in my Report

2 This report records the results of my audit of these summarised accounts, and the overall findings from the audits of the underlying health organisations by auditors appointed by the Audit Commission for England and Wales *(paragraphs 2.1 to 2.21).* The separate NHS summarised accounts for Wales and Scotland, including auditors' reports, are laid before the Welsh Assembly and the Scottish Parliament respectively.

3 I also report on the key developments in accounting and internal control *(paragraphs 3.1 to 3.28)*, the overall financial performance of health authorities, Primary Care Trusts and NHS Trusts *(paragraphs 4.1 to 4.21)*, progress in countering fraud *(paragraphs 5.1 to 5.23)*, and on the financial costs facing the NHS for clinical negligence claims together with the latest accounting developments *(paragraphs 6.1 to 6.17)*.

Main findings and conclusions

4 On the basis of my assessment of the work of the appointed auditors, and my audit at the Department of Health, I have given unqualified opinions on all of the 2000-2001 summarised accounts *(paragraphs 1.1 to 1.6)*.

Findings of the Appointed Auditors

5 For the seventh consecutive year, the appointed auditors gave unqualified "true and fair" audit opinions on the accounts of all individual NHS Trusts and health authorities *(paragraphs 2.5 to 2.14)*. They also gave unqualified audit opinions on all of the fifteen special health authorities, the Dental Practice Board and the separate charitable funds held on trust within the NHS.

6 Appointed auditors were also required to express an opinion on the regularity of the activities of health authorities, Primary Care Trusts and special health authorities. Their audit opinions therefore included a statement as to whether "in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them". In all but two cases, they also gave unqualified regularity opinions *(paragraphs 2.10 to 2.14)*.

Developments in accounting and internal control

7 **Changes in the structure of the NHS summarised accounts for 2000-2001**: Primary Care Trusts are to become the lead NHS organisations in assessing need, planning and securing all health services and improving health. For 2000-2001, the first year of their operation, there were 40 Primary Care Trusts, and this increased to 164 in 2001-2002. The main impact on my audit of the 2000-2001 NHS summarised accounts is the inclusion of an additional summarised account for Primary Care Trusts prepared by the Department for my audit.

8 Further restructuring is planned in line with *The NHS Plan* published in July 2000. With effect from 1 April 2002, the existing 95 health authorities will be merged and subsequently replaced, subject to legislation, by 28 strategic health authorities. These new authorities are intended to lead the development of the local health service on the basis of local accountability agreements.

9 The closure of existing health authorities and, again subject to legislation, the establishment of the new strategic health authorities will be significant to my audit of the summarised accounts and to the work of the appointed auditors of the underlying accounts for the 2001-2002 financial year *(paragraphs 3.2 to 3.5)*.

10 **Introduction of the Resource Accounting Manual:** In 1999-2000 the Department of Health, in line with all other central government organisations, adopted a new method of accounting for its activities. This results in the production of annual "resource accounts" on an accruals basis, and replaces the Department's previously cash-based accounts.

11 In producing Resource Accounts, the Department applies the concepts set out in Treasury's Resource Accounting Manual, which interprets UK generally accepted accounting practice for the public sector. Health authorities, Primary Care Trusts, and certain special health authorities fall within the departmental boundary for resource accounting purposes and are consolidated within the Department's accounts. To ensure consistency, Treasury has now directed that such organisations should prepare their own accounts in accordance with the Manual from 2000-2001. This approach has also been reflected in the relevant summarised accounts, where health authorities and special health authorities have restated 1999-2000 balances to reflect the change in accounting basis *(paragraphs 3.6 to 3.9)*.

12 **Extending the remit of the Financial Reporting Advisory Board:** The Board advises Treasury on the development of resource accounting for the central government sector. Thus the accounting policies of health authorities, Primary Care Trusts and certain special health authorities are determined by the recommendations of the Board as incorporated within Treasury's Resource Accounting Manual. With effect from January 2002, the remit of the Board has been extended to oversee NHS Trust accounting *(paragraphs 3.16 to 3.17)*.

13 **The development of corporate governance and statements on the systems of internal financial control:** This is the fourth year for which all NHS organisations have been required to prepare statements on the systems of internal financial control. In response to my comments in my report on the

1998-99 summarised accounts, these statements have now been enhanced to comment on the *effectiveness*, rather than merely the adequacy, of the financial control systems.

14 The Accountable Officers of 20 NHS Trusts, 7 health authorities, and 22 Primary Care Trusts identified weaknesses in their systems for some or all of the financial year and highlighted them in their statements on internal financial control. These additional disclosures indicate that not all of the required policies and procedures were in place for the whole of the 2000-2001 financial year. The Department of Health has informed me that remedial action is being taken in these cases.

15 Statements have been included within the summarised accounts of health authorities, NHS Trusts, Primary Care Trusts and most special health authorities for the first time this year. The Accounting Officer of the Department of Health, drawing on the statements from his Accountable Officers on the underlying individual accounts, drew attention in six summarised accounts to weaknesses in systems or failures to meet all minimum control standards reported by the underlying organisations *(paragraphs 3.18 to 3.28)*

Financial performance of the NHS

16 **Financial Duties:** All health authorities and Primary Care Trusts met the statutory duty to remain within their cash limits in 2000-2001. All but one health authority, which was preparing for a merger, met the departmental requirement to achieve financial balance in resource terms *(paragraphs 4.7 to 4.9)*.

17 The Department considers that no NHS Trust failed its statutory break-even duty in 2000-2001. Nineteen NHS Trusts received an extension to the original period for recovering their cumulative deficits *(paragraphs 4.11 to 4.14)*.

18 NHS Trusts are also subject to two departmental financial duties:

- For the capital cost absorption rate duty, the average return for 2000-2001 was 6.2 per cent, against the target of 6 per cent. Eighteen NHS Trusts failed this duty *(paragraphs 4.15 to 4.17)*;
- Overall, NHS Trusts were £9 million within their external financing limit of £224 million; seven NHS Trusts breached their individual limits by more than £10,000 *(paragraphs 4.18 to 4.19)*.

Fraud

19 The NHS Counter-Fraud Service, formerly the Directorate of Counter Fraud services, is responsible for all work to prevent, detect and measure fraud and corruption within the NHS. It has continued to develop a Risk Measurement Project to measure fraud and "incorrectness" across the main NHS services.

20 By the end of February 2002, the Service had completed five full measurement exercises covering potential patient fraud and two baseline measurement exercises:

The progress made in fraud measurement exercises

Area of measurement	Current status	Fraud measured	Completion date
Pharmaceutical Patient Fraud	Two full measurement exercises completed	1998-1999: £117 million 1999-2000 : £69 million	December 2000
Pharmaceutical Contractor Fraud	First full measurement exercise nearingcompletion	Data currently with statisticians for analysis	-
Dental Patient Fraud	Two full measurement exercises completed	1999-2000 : £40.3 million 2000-2001 : £30 million	January 2002
Dental Contractor Fraud	First baseline measurement exercise completed	Sums found to be 'at risk'* 1999-2000: £59.7 million	January 2002
Optical Patient Fraud	First full measurement exercise completed	1999-2000: £13.25 million	January 2002
Optical Contractor Fraud	Baseline measurement exercise completed	Sums found to be 'at risk'* 1999-2000: £20.9 million	February 2002
GMS Fraud	Baseline measurement exercise nearing completion	Data currently with statisticians for analysis	-
Health authorities and NHS Trusts	Initial work commenced		

NOTE

* The 'at risk' figures quoted are not necessarily fraud; rather they represent sums where it was not possible to establish that no risk existed.

Source: NHS Counter Fraud Service

21 The published results of this work show that measured fraud in the areas of pharmaceutical and dental patient fraud has fallen from £157.3 million to £99 million between the first full measurement exercise and the follow-up exercises. In addition, a further £13.25 million suspected fraud and £80.6 million at risk have been identified by subsequent exercises. The results of the pharmaceutical contractor and fraud in General Medical Services exercises have yet to be finalised *(paragraphs 5.7 to 5.12).*

22 As at March 2001, 484 cases of suspected fraud with an estimated value of £18.3 million had been reported to the Service. Since then, they have received reports on an additional 445 cases, with an estimated value of £17 million *(paragraph 5.14).*

23 In my view, the overall levels are not significant enough to affect my opinions on the accounts and I have therefore given unqualified opinions *(paragraph 5.23).*

Clinical negligence

24 **Total provisions:** provisions for the probable cost of clinical negligence within the NHS amounted to £4.4 billion at 31 March 2001, an increase of £0.5 billion since 31 March 2000. A key cause of this increase was the result of legal developments, which increased awards to fund the costs of future care and therefore required a reassessment of the level of provisions required *(paragraphs 6.3 to 6.7).*

25 **Public Accounts Committee:** The Public Accounts Committee considered my report, *Handling Clinical Negligence Claims in England* (HC 403, 2000-2001), in October 2001. The Department of Health will issue a White Paper in 2002 which will describe its proposals in respect of the reform of clinical negligence *(paragraphs 6.15 to 6.16)*.

Part 1

Basis of my audit

1.1 This part of my report sets out the scope of my audit of the NHS summarised accounts for England 2000-2001, under Section 98 of the National Health Service Act 1977. The separate NHS summarised accounts for Scotland and Wales, including auditors' reports, are laid before the Scottish Parliament and the Welsh Assembly respectively.

1.2 Most of the funding for the health service is provided by the Department of Health. This funding is reported, on a cash basis, in the Appropriation Account for Class II, Vote 1 (hospital, community health, family health and related services, England) and, on an accruals basis, in the Resource Accounts for the Department of Health. Both of these accounts are also subject to my audit. This is the final year of the appropriation accounts, due to the introduction of resource accounting and budgeting.

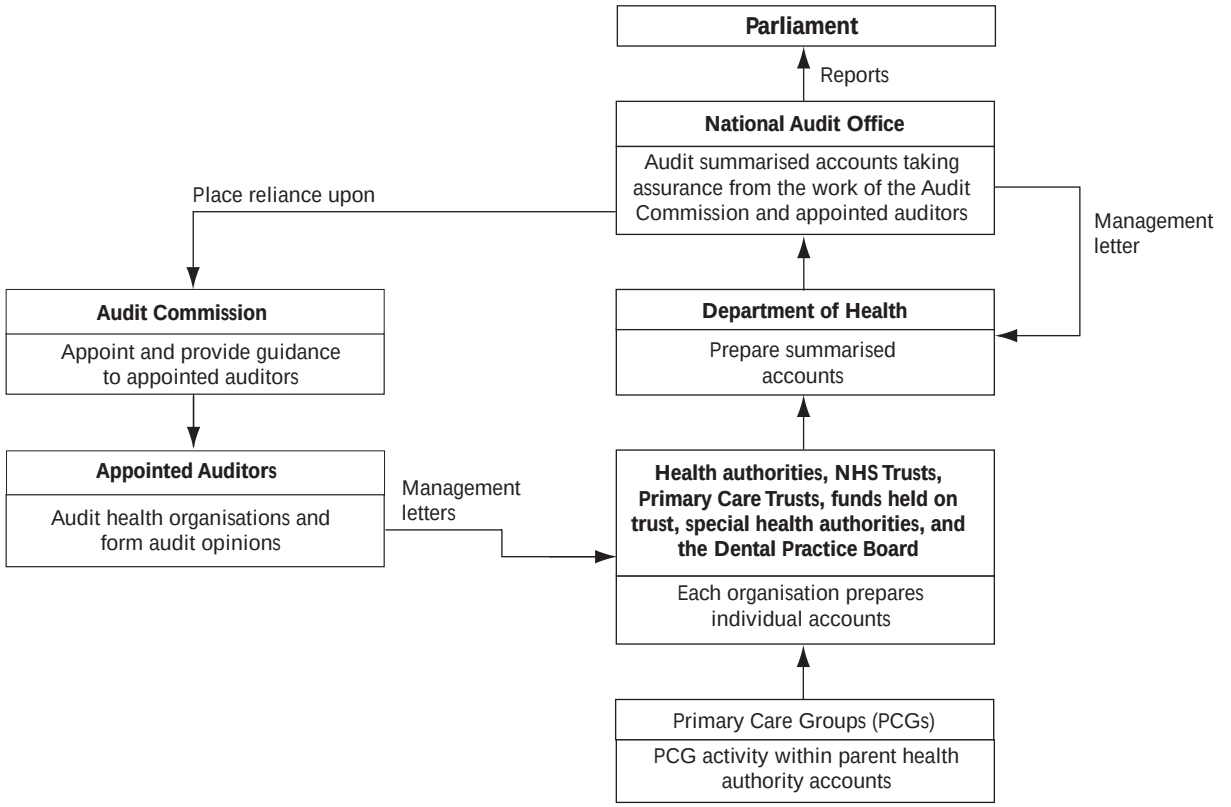
1.3 The NHS summarised accounts presented here record the financial affairs of the:

- 99 health authorities;
- 40 Primary Care Trusts;
- 356 NHS Trusts;
- 15 special health authorities; and
- the Dental Practice Board

to whom these funds are made available.

1.4 The Audit Commission appoints the external auditors to these organisations. These appointed auditors provide an audit opinion on the annual accounts of each body, and the Department of Health summarises these accounts for my audit. **Figure 1** shows the audit arrangements for the underlying and summarised accounts of the NHS in 2000-2001.

1 Audit arrangements in the National Health Service



1.5 The foreword to the NHS summarised accounts describes the basis for their preparation and the background to the individual NHS organisations. My examination of the 2000-2001 accounts included assessing the reliability of the information contained in the audited accounts by:

- reviewing the work of the auditors appointed by the Audit Commission;
- scrutinising their reports and findings; and
- ensuring that acceptable quality control policies and procedures over the appointed auditors' work existed and operated effectively.

1.6 On the basis of my assessment of the work of the appointed auditors, and my audit at the Department of Health, I am able to give unqualified opinions on all of the summarised accounts for 2000-2001.

1.7 I also examine the economy, efficiency and effectiveness with which NHS organisations have used their resources, under section 6 of the National Audit Act 1983. The results of such value for money examinations are published in separate reports made to the House of Commons under section 9 of that Act.

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

- Department of Health: Inpatient and outpatient waiting in the NHS (HC 221, 2001-2002);
- Inappropriate adjustments to NHS waiting lists (HC 452, 2001-2002); and
- NHS Direct in England (HC 505, 2001-2002).
- The Management of Surplus Property by Trusts in the NHS in England (HC 687, 2001-2002).

1.9 In addition, my reports on issues cutting across government departments are also of relevance to the Department of Health and the NHS. Recent relevant reports are:

- Measuring the Performance of Government Departments (HC 301, 2000-2001);
- Purchasing Professional Services (HC 400, 2000-2001);
- Giving confidently: The role of the Charity Commission in regulating charities (HC234, 2001-2002);
- Modern Policy-Making: Ensuring Policies Deliver Value For Money (HC 289, 2001-2002);
- Better Regulation - Making good use of Regulatory Impact Assessments (HC329, 2001-2002);
- Managing the relationship to secure a successful partnership in PFI projects (HC 375, 2001-2002); and
- Joining up to improve public services (HC 383, 2001-2002).

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

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

Part 2

Findings of the appointed auditors

Introduction

2.1 This part of my report summarises:

- the overall findings of the appointed auditors on the accounts of NHS organisations (paragraphs 2.2 to 2.14); and
- findings which led to Section 19 referrals to the Secretary of State and Section 8 reports in the public interest (paragraphs 2.15 to 2.21).

Audit of the 2000-2001 underlying accounts - work of the appointed auditors

The two-part audit opinion

2.2 Auditors of the 99 health authorities, 356 NHS Trusts, 40 Primary Care Trusts, 431 funds held on trust, 15 special health authorities and the Dental Practice Board are required to issue an opinion as to whether the accounts for each individual organisation reflect a true and fair view of its state of affairs as at 31 March 2001 and of its income and expenditure for the year.

2.3 Auditors of health authorities, special health authorities, Primary Care Trusts and the Dental Practice Board are also required to provide a separate assertion about the regularity of the transactions shown in the accounts (see paragraph 2.10 below).

2.4 I examine each of these requirements in paragraphs 2.5 to 2.13.

'True and Fair' view

2.5 For the seventh consecutive year, the appointed auditors gave unqualified opinions that the accounts of all individual NHS Trusts, health authorities and special health authorities reflected a true and fair view of their state of affairs as at 31 March 2001 and of their income and expenditure for the year. They also gave unqualified opinions on the accounts of individual Primary Care Trusts in 2000-2001, their first year of operation. As a result, I was also able to give unqualified opinions on the summarised accounts for NHS Trusts, health authorities, Primary Care Trusts, special health authorities and the Dental Practice Board.

2.6 Part 4 of my report provides analysis of the financial performance of health authorities, NHS Trusts and Primary Care Trusts, and the Department of Health's central financial performance management activities.

Funds held on trust

2.7 NHS Trusts, Primary Care Trusts, health authorities, special health authorities and special trustees have the power to accept, hold and administer any property on trust and are required to prepare separate accounts for these funds. The summarised account for 2000-2001 shows total funds at 31 March 2001 of some £1.7 billion.

2.8 The appointed auditors gave unqualified audit opinions on each of the funds held on trust accounts in 2000-2001. This represents an improvement on 1999-2000 when two accounts received qualified opinions on the grounds of limitation of scope as a result of concerns over systems designed to ensure the completeness of income.

2.9 Following my examination of the account, I have also been able to give an unqualified audit opinion that the summarised account for the NHS funds held on trust presents fairly the state of affairs of the funds at 31 March 2001 and their incoming resources and application of resources.

Regularity opinion

2.10 Health authorities, Primary Care Trusts and selected special health authorities are within the boundary for the Department of Health's Resource Accounts as they receive the majority of their funding directly from the Department. NHS Trusts and the remaining special health authorities are outside the boundary as they receive their main funding either indirectly or from external sources, for example from fees and charges.

2.11 For all special health authorities, and the other accounts included within the Resource Accounts, auditors are required to give a separate "regularity" opinion on whether, in their view, "in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them". Appointed auditors were able to provide unqualified regularity opinions on all but two of the underlying accounts.

2.12 The auditors of the Prescription Pricing Authority and the Dental Practice Board qualified their opinions on the pharmaceutical services and general dental services financial statements. These statements are not separately published, but are incorporated into the summarised accounts of the health authorities.

2.13 The auditors qualified their opinions :

- On the Prescription Pricing Authority: because of the impact of the NHS Counter Fraud Services' calculation of the estimated shortfall of income caused by patients fraudulently evading prescription charges and by unintentional evasion;
- On the Dental Practice Board: because of the Board's probity unit's estimate of the level of inappropriate expenditure, almost half of which was in respect of irregular claims by patients and dentists.

2.14 Despite these qualifications, I have not qualified my overall opinion on the health authorities' or Primary Care Trusts' summarised accounts and discuss this further in part five of my report.

Reports and referrals

2.15 Section 19 of the Audit Commission Act 1998 requires an appointed auditor to refer matters to the Secretary of State if they have reason to believe that an NHS organisation has made a decision which involves, or may involve, unlawful expenditure. As this arrangement is used to give early warning of potential problems, which may not then materialise, these reports are addressed to the Secretary of State and are not published.

2.16 Since my report on the summarised accounts for 1999-2000 (HC 119, 2000-2001), appointed auditors have referred three such matters to the Secretary of State.

2.17 I reported last year that the auditor of Newcastle and North Tyneside Health Authority qualified his opinion due to expenditure incurred on the provision of nursing care in residential homes. The auditor has now issued a referral to the Secretary of State under section 19, concluding that arrangements with three private and voluntary sector bodies to purchase nursing care in residential homes did not comply with applicable statutory authorities. However, the auditor has also noted that the expenditure incurred was capable of being within the powers of the Authority and the Authority has agreed, in discussion with the auditor, to put revised arrangements in place.

2.18 The auditor of the Dental Practice Board also reported his qualification of the General Dental Services account (see paragraph 2.12) in a section 19 referral to the Secretary of State.

2.19 The auditor of Lambeth, Southwark and Lewisham Health Authority issued a section 19 referral regarding a payment in lieu of notice of termination of employment, and concluded that the Authority had made decisions that led to unlawful expenditure of some £46,000. This expenditure, to the extent that it is not recovered, constitutes a loss to the Authority.

2.20 As a result, the Department of Health has asked Lambeth, Southwark and Lewisham Health Authority to seek legal advice on the possibility of undertaking recovery.

2.21 Section 8 of the Act requires appointed auditors to consider whether, in the public interest, they should report on any matter coming to their notice. Since my report last year, no such reports have been issued on those NHS organisations which comprise the summarised accounts in England.

Part 3

Developments in accounting and internal control

Introduction

3.1 This part of my report examines:

- **Changes in the structure of the NHS summarised accounts for 2000-2001** (3.2 to 3.5)
- **Developments in accounting:**
  - introduction of the Resource Accounting Manual (3.6 to 3.9)
  - late funding and deferred income (3.10 to 3.11); and
  - Charities SORP 2000 (3.12 to 3.15);
- **Extending the remit of the Financial Reporting Advisory Board** (3.16 to 3.17);
- **Statements on internal financial control and the development of corporate governance** (3.18 to 3.28).

Changes in the structure of the NHS summarised accounts for 2000-2001

3.2 Section 2 of The Health Act 1999 created Primary Care Trusts. Their role is to become the lead NHS organisations in assessing need, planning and securing all health services and improving health. For 2000-2001, the first year of their operation, there were 40 Primary Care Trusts, and this increased to 164 in 2001-2002.

3.3 The main impact of restructuring on my audit of the 2000-2001 NHS summarised accounts is the inclusion of a separate additional summarised account for Primary Care Trusts which has been prepared by the Department for my audit.

3.4 Further significant restructuring is planned in line with the proposals published by the Government in the NHS Plan in July 2000. With effect from 1st April 2002, the existing 95 health authorities will be merged and subsequently, subject to legislation, replaced by 28 strategic health authorities. These new strategic health authorities are intended to lead the strategic development of the local health service and contribute to the management of the performance of Primary Care Trusts and NHS Trusts on the basis of local accountability agreements. This change in role will also result in a change in the funding mechanisms, whereby:

- the Department of Health will allocate most NHS revenue funding directly to Primary Care Trusts to ensure that the provision of services is matched to the needs of local people;
- the Department of Health will allocate capital funding, to maintain the estate, directly to NHS Trusts and Primary Care Trusts using nationally determined criteria; and
- strategic health authorities will manage the allocation of other capital funding to Primary Care Trusts and NHS Trusts. This will be used to fund strategic change, rather than ongoing maintenance.

3.5 The closure of existing health authorities and the establishment of the new strategic health authorities will be significant to my audit of the summarised accounts and to the work of the appointed auditors of the underlying accounts for the 2001-2002 financial year.

Developments in accounting

Introduction of the Resource Accounting Manual

3.6 In 1999-2000 the Department of Health, in line with all other central government organisations, adopted a new method of accounting for its activities. This results in the production of annual "resource accounts" on an accruals basis, and replaces the Department's previously cash-based accounts. For 1999-2000 and 2000-2001, the Department published both a cash-based appropriation account and an accruals-based resource account.

3.7 In producing resource accounts, the Department applies the concepts set out in Treasury's Resource Accounting Manual, which interprets UK generally accepted accounting practice for the public sector. Health authorities, Primary Care Trusts, and certain special health authorities fall within the departmental boundary for resource accounting purposes and are consolidated within the Department's accounts. To ensure consistency, Treasury has now directed that such organisations should prepare their own accounts in accordance with the Manual from 2000-2001. This approach has also been reflected in the relevant summarised accounts.

3.8 The impacts on the relevant accounts from this year include:

- An operating cost statement replaces the Income and Expenditure Account. Parliamentary funding is not shown as income, but is credited straight to the General Fund reserve. The operating cost statement therefore only shows transactions directly relating to the operating activities of the organisation;
- NHS organisations cannot anticipate parliamentary funding. This means that they cannot account for amounts specifically allocated for the year, but only for the cash received; and
- Other resultant changes have affected the presentation of the cashflow statement, statement of recognised gains and losses, and a number of notes to the accounts.

3.9 Health authorities and special health authorities have restated 1999-2000 balances to reflect the change in accounting basis. The changes to the way the departmental funding is accounted for have affected the net worth of health authorities, who have written out £876 million of debtors from the prior period relating to funding for drugs costs and other funding mechanisms. This is shown as a prior period adjustment in the summarised account for health authorities.

Late funding and deferred income

3.10 During the final quarter of 2000-2001, NHS Trusts received some £200 million additional funding from health authorities and directly from the Department of Health. They arranged for some of this funding to be applied to defined schemes relating to the 2001-2002 financial year.

3.11 The Department recognises that the provision of funding late in a financial year could have an adverse impact on an organisation's ability to plan and control its budget and services in the most effective way, and it aims to minimise such late funding in future years by increasing the proportion of health authority allocations issued in the first half of the year. This will give more time for health authorities to plan spending and will reduce the need for NHS Trusts to treat income received as deferred income.

Charities SORP

3.12 The Charities Commission issued a new Statement of Recommended Practice (SORP) for charities in late 2000, updating previous guidance on financial reporting for charities. NHS organisations have applied this accounting guidance to the reporting of their charitable funds held on trust for 2000-2001.

3.13 The Department has provided guidance on the SORP for NHS charities in the Manual for Accounts, which dictates how trustees should account for their activities.

3.14 A significant impact of the SORP affects the recognition of liabilities. In particular, a charity is now required to recognise a liability when it has committed itself to making a transfer of value to a third party. Future costs cannot be charged to future years' income. The impact of this requirement on individual funds has varied, with some funds finding that their reserves have been greatly reduced. This reduction does not necessarily imply that the fund is having financial difficulties, but can indicate that trustees have undertaken to support projects that may require funds from future charitable donations. The Case Study below shows how the introduction of the SORP has had a significant impact on one charity's reserves.

CASE STUDY

The implementation of the SORP has reduced charity reserves

West Midland Air Ambulance NHS Trust

This Trust's sole activity is to fund the West Midland air ambulance. It is contractually committed to fund the ambulance for ten years. Under the requirements of the SORP, the contractual obligations for future costs have to be recognised in the 2000-2001 accounts. As a result, the Trust's funds have fallen from £4,790,000 at 31 March 2000 to £194,000 at 31 March 2001.

The effect of the SORP is particularly evident in this Trust because it is a single purpose charity, and so practically all of its reserves are committed to this one activity for which a long term contract is in place.

3.15 The summarised account for funds held on trust shows that outgoing resources have increased by 25 per cent since 1999-2000, whilst incoming resources have remained broadly constant. This disparity is due to the change in accounting for commitments in line with the SORP, which has seen grants payable increase by £75 million from £219 million in 1999-2000 to £294 million in 2000-2001.

Extending the remit of the Financial Reporting Advisory Board

3.16 The Financial Reporting Advisory Board to Treasury (FRAB) was set up in April 1996 to advise Treasury on the development of resource accounting for the central government sector. Because health authorities, Primary Care Trusts and certain special health authorities were defined as being within the Department's resource accounting boundary, this effectively meant that their accounting policies were determined by the recommendations of the FRAB as incorporated within Treasury's Resource Accounting Manual. However, the Department remained fully responsible for setting the accounting policies for the NHS organisations which were classified as being outside the resource accounting boundary, most notably the NHS Trusts.

3.17 In my report on the 1998-99 summarised accounts, I raised concerns about the inconsistencies in accounting practice which could arise from exemption of NHS Trusts from the requirements of resource accounting. I am pleased to note that the remit of FRAB has been extended to oversee NHS Trust accounting with effect from January 2002. The extended role for FRAB will help to harmonise accounting policies across the public sector and will facilitate the future development of Whole of Government Accounts.

The development of corporate governance and statements on the systems of internal financial control

3.18 Within both the public and private sectors, there has been a growing focus on corporate governance issues. The NHS has been one of the parts of the public sector which has responded quickly to good practice initiatives and is looking to further develop its corporate governance initiatives.

3.19 Since 1997-98, and ahead of targets set by Treasury, the Department of Health has required all NHS organisations to produce a separate statement on their systems of internal financial control as part of their annual accounts. From 2000-2001, and in response to my comments in my report on the 1998-99 summarised accounts, these statements have been enhanced to comment on the *effectiveness*, rather than merely the adequacy, of the financial control systems.

3.20 The statements prepared by NHS organisations refer to a set of minimum financial control standards specified by the Department in the following areas **(Figure 2)**:

2 Categories of minimum financial control standards

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

Source: Department of Health

3.21 Appointed auditors are required to comment in their opinions on the underlying accounts if they believe that the statement is not consistent with their own knowledge of the relevant NHS organisation. In 2000-2001, the appointed auditors did not qualify their opinions on any NHS organisation's statement on internal financial control. However, the Accountable Officers of 20 NHS Trusts, 7 health authorities, and 22 Primary Care Trusts identified weaknesses in their systems for some or all of the financial year and highlighted them in their statements on internal financial control. The majority of organisations reporting weaknesses were Primary Care Trusts which were in their first year of operation. The most commonly occurring issues are shown at **Figure 3**.

3 Issues in NHS organisations' Statements on Internal Financial Control

- Procedure notes were not in place for all fundamental financial systems;
- The Audit Committee did not review and monitor internal financial control and the implementation of agreed control improvements; and
- The systems in place did not produce wholly reliable financial information and proper accounting records.

Source: Analysis of results of the appointed auditors' work

3.22 These additional disclosures indicate that not all of the required policies and procedures were in place for the whole of the 2000-2001 financial year. The Department advises me that it raises the issues arising from the Statements on Internal Financial Control with the organisations concerned to ensure that action is taken to address any identified shortcomings.

Introduction of statements on internal financial control on the NHS summarised accounts

3.23 Although statements on internal financial control have been included in the underlying accounts since 1997-1998, statements have been included with the summarised accounts for the first time this year. Statements have been prepared for the summarised accounts of health authorities, NHS Trusts, Primary Care Trusts and most special health authorities.

3.24 The Accounting Officer of the Department of Health, drawing on the statements from his accountable officers on the underlying individual accounts, drew attention in six of the summarised accounts to weaknesses in systems or failures to meet all minimum control standards reported by the underlying organisations. Based on the work of the appointed auditors on the underlying accounts, and my own examination, I can also confirm that the various statements in respect of these summarised accounts are consistent with my own knowledge of the relevant NHS organisations.

3.25 There is no departmental or Charities Commission requirement for the NHS charitable funds held on trust to include Statements on Internal Financial Control with their annual accounts. The summarised account for funds held on trust therefore excluded an equivalent statement.

Introduction of statements on internal control

3.26 Treasury issued additional guidance on corporate governance in December 2000, requiring all public sector organisations to expand the statements to cover the whole system of internal control, incorporating such areas as operational and policy making systems. For 2001-2002 and 2002-2003, organisations should report on the progress being made towards achieving the 2003-2004 target of having all significant risks addressed by the statement.

3.27 In parallel, the NHS development of corporate governance this year has resulted in the original minimum control standards being updated and now including three sets of core controls assurance standards for 2001-2002 onwards. These are: governance; financial management; and risk management. The new financial management standard replaces the minimum financial control standards referred to in paragraph 3.21.

3.28 The overall aim of the NHS approach remains to establish mechanisms to prioritise and manage identified risks, and to enable information on both clinical and non-clinical incidents and complaints to be reliably recorded, reported and analysed to determine the underlying causes.

Part 4

Financial Performance of the NHS

Introduction

4.1 The Department monitors the performance of health organisations across a wide range of activities, for example the star ratings for acute NHS Trusts, first published in September 2001. The Department also closely monitors the financial performance of the NHS and this part of my report focuses on the performance of NHS organisations against their financial duties, which are:

For health authorities and Primary Care Trusts

- A statutory duty to remain within their cash limits; and
- A new financial duty to achieve financial balance in resource terms each year;

For NHS Trusts

- breaking even taking one financial year with another. This is the prime financial duty for NHS Trusts;
- absorbing the cost of capital at a rate of six per cent; and
- meeting the external financing limit set by the Department of Health.

Overall NHS Expenditure and Assets

4.2 During 2000-2001, health authorities spent £40.9 billion (1999-2000: £39.3 billion), commissioning primary and secondary healthcare. Primary healthcare refers to family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic practitioners. Secondary healthcare refers to the care provided in hospitals.

4.3 In addition, forty Primary Care Trusts were established in 2000-2001 to commission primary and secondary healthcare, and they reported total spending of £2.3 billion. During 2001-2002, the number increased to 164, and is expected to increase by at least a further 139 in 2002-2003. In line with *The NHS Plan*, Primary Care Trusts will eventually replace health authorities as the lead NHS organisations in assessing need, planning and securing all health services and improving health. Part 3 of my report provides further details of the restructuring of the NHS.

4.4 There were also 356 NHS Trusts in 2000-2001, with total expenditure of £30.8 billion (1999-2000: £28.6 billion) delivering secondary healthcare for the NHS. They received their main funding from health authorities and Primary Care Trusts, but also smaller amounts directly from the Department as well as non-NHS sources.

4.5 In addition, the Department provided funding of £0.9 billion to the 16 special health authorities, including amounts to the NHS Litigation Authority to cover payments under the Existing Liabilities Scheme for clinical negligence. Part 6 of my report provides further details of NHS management arrangements for clinical negligence liabilities.

4.6 The NHS delivered these services with a net asset base of £17 billion **(Figure 4)**.

4 Asset base for the NHS

£ billion	March 2001	March 2000
Fixed Assets	24.2	24.0
Current Assets	5.8	4.9
Total Liabilities	(13.0)	(11.3)
Net Worth	17.0	17.6

Source: NHS Summarised Accounts 2000-2001 for health authorities, Primary Care Trusts, NHS Trusts, special health authorities and the Dental Practice Board

Financial duties

(a) Health Authorities and Primary Care Trusts

4.7 Health authorities and Primary Care Trusts have a statutory duty to remain within their cash limits and a departmental requirement to achieve financial balance in resource terms each year. They are also required to apply the Better Payment Practice Code, which has a target of paying 95 per cent of undisputed invoices within 30 days of receipt of the goods/service or invoice, whichever is the later.

4.8 In 2000-2001, all Primary Care Trusts and health authorities remained within their cash limits, and all but one health authority achieved financial balance. The one exception, Bexley and Greenwich Health Authority, recorded a small overspend of £0.9 million (0.3 per cent of its expenditure limit) in the period leading up to a merger with a neighbouring authority.

4.9 In 2000-2001, 22 per cent of health authorities paid the target level of invoices within 30 days (1999-2000: 13 per cent). The average payment rate was 86 per cent (1999-2000: 84 per cent).

(b) NHS Trusts

4.10 NHS Trusts have three key financial duties, which are explained in the following paragraphs:

- To break even taking one financial year with another;
- To absorb the cost of capital at a rate of six per cent; and
- To meet the external financing limit set by the Department of Health.

Breaking even

4.11 NHS Trusts have a statutory duty to break even, taking one year with another. The legislation does not identify how this should be measured, and therefore the Department established a method, in consultation with the NHS Trusts and their auditors, for measuring whether the NHS Trusts were achieving the duty. This method, which is described in **Figure 5**, took effect on 1 April 1997. In previous periods there were significant differences in financial reporting within the NHS, which made comparison of NHS Trusts difficult, and only since the 1997-98 financial year has there been the necessary stability in the accounting regime to allow appropriate assessment against the break-even duty.

5 The Department has agreed a method for measuring break even

- Where an NHS Trust reports a cumulative deficit, the duty is met if this deficit is recovered within the following two financial years.
- Exceptionally, extensions of up to a total of four years are given to NHS Trusts, for example where recovery over two years would have unacceptable service consequences, and a recovery plan has been agreed with the Department.
- The Department determines break-even to be achieved if an NHS Trust has a cumulative deficit no greater than 0.5 per cent of turnover.

4.12 Based on this definition, no NHS Trust has failed its break-even duty as at 31 March 2001. **Figure 6** shows how this corresponds to the financial position of the NHS Trusts.

6 Analysis of NHS Trusts' financial position showing that no NHS Trust has failed its break-even duty

Number of NHS Trusts with a cumulative deficit in their balance sheet at 31 March 2001	116
Number of NHS Trusts reporting a cumulative deficit since 1 April 1997	90
Number of NHS Trusts with a cumulative deficit since 1 April 1997 in excess of 0.5 % of income	**47**
Of these trusts, at 31 March 2001:	
Number still within year 1 or 2 since incurring a deficit, who therefore have a further 1 or 2 years to achieve break-even	33[1]
Number within year 3 or 4 who were dissolved on 31 March 2001	5
Number within year 3 or 4 who have been granted an extension to their recovery period beyond 31 March 2001	9
Total	**47**

NOTE

1 10 NHS Trusts within the initial period to achieve break-even have been granted extensions to this period to allow for expected impediments to achieving break-even within three years.

4.13 As part of the Department's analysis of financial performance, it identifies those having significant financial difficulties. The number has varied over time **(Figure 7)** but there were 33 at the end of 2000-2001. These NHS Trusts were required to prepare an agreed recovery plan with the appropriate Regional Office of the Department, who will monitor closely the financial progress of that NHS Trust.

7 The number of NHS Trusts with significant financial difficulties at 31 March 2001 is lower than in any of the three preceding years

	2000-2001	1999-2000	1998-1999	1997-1998
Numbers of NHS Trusts regarded by the Department as having significant financial difficulties	33	76	53	78

4.14 The Department indicates in the Foreword to the NHS Summarised Accounts that the improvement in the underlying position is indicative of the NHS benefiting from the Government's spending plans.

Capital cost absorption rate duty

4.15 In line with Treasury requirements across all departments, the Department requires NHS organisations to absorb the cost of their capital at a rate of six per cent of average relevant net assets. This represents a return on the capital employed and funding is set at a level designed to incorporate this charge.

4.16 The average return across NHS Trusts for 2000-01 was 6.2 per cent. The Department allows some tolerance, and considers that only NHS Trusts which have achieved less than 5.5 per cent have failed this duty. On this basis, 18 NHS Trusts were deemed to have failed the duty because they achieved a return of less than 5.5 per cent return (1999-2000: 10 NHS Trusts).

4.17 NHS Trusts can fail their capital cost absorption rate duty because of unexpected but necessary purchases or revaluations of assets. Of the 18 NHS Trusts, 11 failed to achieve this duty for this reason in 2000-2001.

External financing limit

4.18 The Department also sets an external financing limit for each NHS Trust as a way of controlling capital expenditure across the NHS. It represents the difference between what an NHS Trust is authorised to spend on capital items in a year and what it can generate through other resources. An NHS Trust's internally generated resources include:

- depreciation (because matching income is received from the health authority);
- cash proceeds from the disposal of assets; and
- any surplus for the year that remains after the payment of Public Dividend Capital dividends.

4.19 In 2000-2001, NHS Trusts overall were £9 million within the limit of £224 million at a national level. The Department allows some tolerance and considers that only Trusts which overshoot their external financing limit by more than £10,000 have failed this duty. On this basis, seven NHS Trusts, 1.9 per cent, exceeded their individual limits, an improvement on 1999-2000 (eight NHS Trusts, 2.1 per cent). Only one NHS Trust exceeded its limit by more than £100,000 in 2000-2001 (1999-2000: three).

Better Payment Practice Code

4.20 Twenty five per cent of NHS Trusts paid the target level of invoices within 30 days (1999-2000: 19 per cent), while 49 per cent achieved at least 90 per cent compliance (1999-2000: 45 per cent). The average payment rate was 84 per cent (1999-2000: 83 per cent).

4.21 Of the 345 NHS Trusts with comparable data for the two years, 142 (41 per cent) reported a poorer performance in 2000-2001 than the previous year, although in most cases the performance was only marginally poorer. This performance should be seen within the context of the NHS paying some 14 million invoices to external creditors.

Part 5

Fraud

Introduction

5.1 This part of my report summarises:

- Background to countering fraud in the NHS (*paragraphs 5.2 to 5.6*).
- Progress made by the NHS Counter Fraud Service, on the published commitments, including estimation of the cost of fraud and incorrectness in the NHS and achievements in countering fraud (*paragraphs 5.7 to 5.18*).
- Other anti fraud work (*paragraphs 5.19 to 5.20*).
- The impact of fraud on the audit opinions on accounts of the NHS in Wales and Scotland (*paragraphs 5.21 to 5.22*).
- The impact of fraud on my opinion on the summarised accounts (*paragraph 5.23*).

Background to countering fraud in the NHS

5.2 In December 1998, the Department of Health published its fraud strategy, *Countering fraud in the NHS*. It established the NHS Counter Fraud Service (formerly the Directorate of Counter Fraud Services) with a Central Unit within the Department. It has overall responsibility for all work to prevent, detect and measure fraud and corruption within the NHS with particular priority for countering fraud in family health services.

5.3 The NHS Counter Fraud Service has an annual budget of £5.4 million and employs some 115 staff. In addition, health organisations employ a further 400 local counter fraud specialists.

5.4 The fraud strategy gave three published commitments:

- to achieve a 50% reduction in the level of prescription charge evasion by the end of 2002-2003. The Department has to date achieved a reduction of some 41% which is a major step towards achieving this commitment by the end of 2002-2003 (paragraph 5.10);
- to prevent £9 million in contractor fraud and to recover £6 million by the end of 2001-2002. The NHS Counter Fraud Service is not in a position to report progress against the prevention target before April 2002. The £6 million recovery target has been exceeded (Figure 10 and paragraph 5.17); and
- to reduce fraud to an absolute minimum within ten years. The NHS Counter Fraud Service is undertaking a variety of activities, described in this report, to seek to achieve this target (paragraphs 5.19 and 5.20).

5.5 In July 1999, the Public Accounts Committee raised a number of concerns on the efforts made to combat fraud in the NHS. The principal concerns were that:

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

5.6 In my report on the NHS summarised accounts for 1998-99 (HC356, 1999-2000) I examined work undertaken by the Department of Health to prevent, detect and measure fraud in the NHS. In my report on the NHS summarised accounts for 1999-2000, I reviewed the progress made and, this year, I consider the further achievements made against the Department's published commitments and work to address the concerns of the Public Accounts Committee.

Progress made by the NHS Counter Fraud Service on the published commitments

Establishing an overall estimate of the cost of fraud and incorrectness in the NHS

5.7 In order to focus anti-fraud work on key risk areas and to measure achievements in countering fraud, the NHS Counter Fraud Service recognised the need to establish a baseline figure for fraud. To do so, they developed a Risk Measurement Project to accurately measure fraud across all main NHS services by 31 March 2000.

Current position

5.8 **Figure 8** summarises the progress made on each of the separate measurement exercises within the Project:

5.9 This is the first time that such a broad based fraud loss measurement exercise has been attempted and the NHS Counter Fraud Service has encountered problems with the availability of suitable NHS data and has had to develop its methodology as it has progressed. Baseline measurement exercises estimate the percentage of claims that may or may not involve fraud. They are not as accurate as the monetary estimates of fraud and incorrectness to be derived from the subsequent full measurement exercises. The outcomes of these baseline measurement exercises will help to inform how to proceed in full measurement exercises.

5.10 At the time of my last report, the NHS Counter Fraud Service had completed two estimates for the cost of Pharmaceutical Patient Fraud. These indicated that the annual cost to the NHS of patients in England fraudulently evading the prescription charge had fallen from £117 million at November 1998 to £69 million at July 1999. The reduction of £48 million, some 41%, is a major step towards achieving the Department's first published commitment of a 50% reduction by 2002-2003.

8 The progress made in fraud measurement exercises

Area of measurement	Current status	Fraud measured	Completion date
Pharmaceutical Patient Fraud	Two full measurement exercises completed	1998-1999: £117 million 1999-2000: £69 million	December 2000
Pharmaceutical Contractor Fraud	First full measurement exercise nearing completion	Data currently with statisticians for analysis	-
Dental Patient Fraud	Two full measurement exercises completed	1999-2000: £40.3 million 2000-2001: £30 million	January 2002
Dental Contractor Fraud	First baseline measurement exercise completed	Sums found to be 'at risk'[1] 1999-2000: £59.7 million	January 2002
Optical Patient Fraud	First full measurement exercise completed	1999-2000: £13.25 million	January 2002
Optical Contractor Fraud	Baseline measurement exercise completed	Sums found to be 'at risk'[1] 1999-2000: £20.9 million	February 2002
GMS Fraud	Baseline measurement exercise nearing completion	Data currently with statisticians for analysis	-
Health authorities and NHS Trusts	Initial work commenced		

NOTE

1. The 'at risk' figures quoted are not necessarily fraud; rather they represent sums where it was not possible to establish that no risk existed.

Source: NHS Counter Fraud Service

5.11 By the end of February 2002, the NHS Counter Fraud Service had completed five full measurement exercises covering each area of potential patient fraud and two baseline measurement exercises covering dental contractor fraud and optical contractor fraud. A full measurement exercise covering pharmaceutical contractor fraud and a baseline measurement exercise covering fraud in General Medical Services are also nearing completion.

5.12 In respect of dental patient fraud, the NHS Counter Fraud Service has reported a measured reduction in losses from £40.3 million in 1999-2000 to £30 million in 2000-2001. This is a reduction of £10.3 million, some 25%.

Suspected frauds reported to NHS Counter Fraud Services

5.13 Suspected frauds reported to the NHS Counter Fraud Service have been uncovered by a variety of methods, including:

- The Fraud and Corruption Reporting Line initiative;
- The work of the local counter fraud specialists;
- Its own proactive counter fraud exercises; and
- Liaison with health organisations' auditors.

5.14 At the time of my last report, 484 cases of suspected fraud, with an estimated value of £18.3 million had been reported to the NHS Counter Fraud Service. Since then, an additional 445 cases, with an estimated value of £17 million have been reported to the Service.

5.15 The ways in which fraud can be perpetrated against the NHS are numerous. I list a selection of some of the most recent examples of completed cases that the Directorate has dealt with **(Figure 9)**:

9 Some recent fraud cases

- A senior partner of a dispensing general medical practice submitted false invoices and fabricated drugs invoices from fictitious pharmaceutical companies. He pleaded guilty to 49 out of 50 charges of false accounting and obtaining money by deception, with another 1,018 further false accounting offences taken into consideration. He resigned from the practice, was sentenced to prison for three years and nine months and the judge granted a compensation order of some £800,000.
- A nurse submitted falsified time sheets purporting to have worked as a bank nurse for five years. She was charged with 10 counts of obtaining a pecuniary advantage, one of false accounting, one of theft of drugs from the employer and possession of Class C drugs. A further 159 offences involving dishonesty were taken into account. She pleaded guilty to some of the charges. Dismissed following an internal disciplinary hearing, she was also sentenced to 15 months imprisonment. The total value of alleged fraud was £89,000 and the Trust is considering pursuing civil recovery for losses and removal of her nursing registration.
- A businessman, owning and running a number of optical outlets, employed optometrists on a locum basis, paying them by the session. The Health Authority fraud specialist noted high levels of claims and found 1,551 false optical claims being presented for payment. The businessman was charged with 29 offences of false accounting with a further 849 offences taken into consideration. He pleaded guilty to the 29 offences, amounting to some £30,000. He received a 12 months custodial sentence, with compensation of £30,000 to be paid to the Health Authority. A confiscation hearing is to be held for the balance of £75,000.
- An NHS Trust manager authorised timesheets in respect of four relatives who did not work for the Trust. After an investigation by the NHS Counter Fraud Service all five were found guilty of fraud totalling £126,000. The manager was sentenced to three years imprisonment with her co-conspirators receiving six months each. A hearing to confiscate sums related to the crime and return them to the NHS has been arranged.

Source: NHS Counter Fraud Service

Countering fraud in the NHS

5.16 **Figure 10** shows the action that has been taken where fraud has been identified:

10 Actions taken in closed cases

	2001-2002 (to 31 Dec 2001)	2000-2001	1999-2000
Sums recovered	**£4.37 million**	£3.9 million	£0.8 million
Successful prosecutions	**30**	46	21
Civil and disciplinary cases	**33**	74	37

As at 31 December 2001, a further 32 prosecutions were awaiting a court hearing.

Source: NHS Counter Fraud Service

5.17 This means that the Department has met and exceeded the recovery target in its second published commitment to recover £6 million by 2001-2002.

5.18 Section 39 of the Health Act 1999 introduced a sanction of penalty charges for the evasion of pharmaceutical, optical, and dental charges. The penalty charges are five times the value of the prescription plus the charge which should have been paid, up to a maximum of £100. 18,361 of these penalty charges had been applied in respect of evasion of charges in Pharmaceutical Services by 31 December 2001, with a total value of £886,000.

Other anti-fraud work

5.19 The Department's counter-fraud strategy focused on seven generic areas: influencing the development of an anti-fraud culture; deterrence, prevention, detection, investigation, applying appropriate sanctions, and seeking redress. A key part of the strategy was developing the Operational Service, which works as a part of the NHS Counter Fraud Service in implementing the strategy at a local level and providing advice to individual NHS organisations.

5.20 The work of the NHS Counter Fraud Service represents further movement towards achievement of the published commitment to reduce fraud in the NHS to an absolute minimum by 2008. Some recent achievements are described below:

- Development of additional counter-fraud charters with the Royal College of Nursing, the Association of British Dispensing Opticians and with representatives of Patient Groups - a total of more than 400,000 NHS staff and professionals are now covered by such charter agreements;
- Clarification of rules and regulations for primary care contractors, including rules relating to claims for recalled dental attendance, and domiciliary optical visits and sight test optical services in February 2001; new rules regarding conflicts of interest and transparency were introduced in the Health and Social Care Act 2001;
- Introducing additional checks, including point of treatment checks in General Dental Services in November 2000 and point of service checks in General Optical Services in February 2001;
- In the last three years, almost 400 professionally trained and accredited counter fraud specialists have been put in place across the NHS;
- 580 fraud awareness presentations have been delivered to key NHS staff;
- This work has resulted in measured improvements of up to 40% in the numbers of staff understanding the importance of tackling fraud and their roles and responsibilities in this respect;
- There have been 91 successful prosecutions and 143 successful civil legal and disciplinary cases; and
- The NHS Counter Fraud Service has reported a 99% successful prosecution rate - having only lost one case.

Impact of fraud on the audit opinions on accounts of the NHS in Wales and Scotland

5.21 The Auditor General for Wales has qualified his opinion on the 2000-2001 summarised account for health authorities because of a material, but not fully quantified, shortfall in revenue from prescription charges due to the NHS in Wales.

5.22 In the same way, the regularity opinions on the 2000-2001 summarised accounts for the health boards and NHS Trusts in Scotland have been qualified by the Auditor General for Scotland. A limitation was placed on the scope of the opinion due to the absence of a comprehensive framework of post-payment verification covering both patient charges and payments to general medical, dental, ophthalmic and pharmaceutical contractors.

Impact of fraud on my opinions on the summarised accounts

5.23 I considered the impact of the estimated cost of fraud and incorrectness identified by the Service in the context of my audit opinions on the summarised accounts. In my view, although large, the estimated cost of fraud and incorrectness (£112 million, and £80.6 million "at risk") is not significant enough to affect my opinions on the NHS summarised accounts, which account for over £40 billion. I have therefore given unqualified opinions on the accounts.

Part 6

Clinical Negligence

Introduction

6.1 This part of my report:

- Analyses the total potential clinical negligence liabilities for the NHS, drawing together the balances recorded in the different organisations across the NHS (paragraphs 6.3 to 6.7);
- Explains the role of the NHS Litigation Authority and indicates how the administration and accounting for clinical negligence is being transferred to the Authority (paragraphs 6.8 to 6.14); and
- Reports developments since my report *"Handling Clinical Negligence Cases in England"* (paragraphs 6.15 to 6.16).

Background

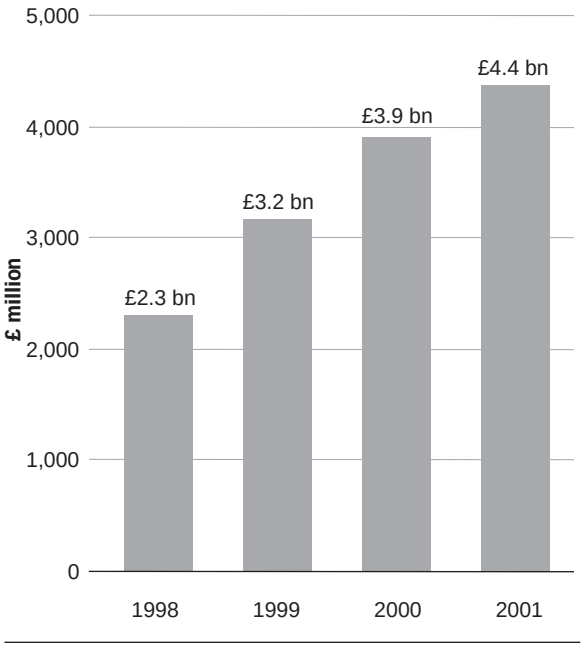
6.2 Clinical negligence is the term given to a breach of a duty of care by health care practitioners in the performance of their duties. Meeting the liabilities for clinical negligence continues to be a major challenge facing the NHS and represents a significant drain on resources away from patient care.

Liabilities and charges for clinical negligence

6.3 In total, the NHS Summarised Accounts show that provisions for the likely cost of clinical negligence amounted to £4.4 billion at 31 March 2001, an increase of £0.5 billion since 31 March 2000.

6.4 **Figure 11** shows that the provisions have continued to grow but that the rate of growth is steadily decreasing. These provisions have been calculated in accordance with Financial Reporting Standard 12, and so reflect the probability of outcome for each individual case. They include actuarially determined estimates for cases that have probably occurred but have yet to be reported to the appropriate authorities. All amounts are discounted by applying the Treasury standard discount factor for the public sector of six per cent, thereby reflecting the net present value of the potential costs.

11 Total provisions for clinical negligence within the NHS continue to increase



6.5 The NHS Litigation Authority reported an increase in new claims, from 2,411 in 1999-2000, to 4,115 in 2000-2001 for the Clinical Negligence Scheme for Trusts. During the year, the Authority closed 1,547 cases (1999-2000: 866). In addition, changes in provisions arise because of revisions of the assumptions applied by the actuaries in calculating estimates.

6.6 Legal developments were a key cause of the size of the increase in provisions observed in 2000-2001. Two significant cases, Wells v Wells and Heil v Rankin have each increased the value of awards, and this has resulted in the Lord Chancellor adjusting the discount rate used in calculating the costs of future care, education and loss of earnings.

6.7 In addition to the provisions for likely costs, NHS organisations have disclosed other possible, but unlikely, costs of clinical negligence. These contingent liabilities, if they crystallised, would add an additional £4 billion, at today's prices, to the NHS liabilities, an increase of £1.1 billion since 31 March 2000. However, the provision of £4.4 billion, shown in **Figure 11** above, includes all liabilities, as at the balance sheet date, which the NHS expected to pay.

Accounting developments

6.8 Each NHS Trust is a separate legal entity and is therefore legally responsible for claims brought against it. The Department's aim is to streamline the claims process and to provide central co-ordination for clinical negligence claim handling.

6.9 The NHS Litigation Authority[1] provides a central focal point for clinical negligence within the NHS, with the aim of ensuring consistency in handling claims. As a first phase of streamlining the management of clinical negligence claims, since 1 April 2000, the NHS Litigation Authority has assumed responsibility for the administration of all negligence cases which occurred prior to 1 April 1995 (funded by the Department under the Existing Liabilities Scheme).

6.10 The NHS Litigation Authority now also accounts for all transactions and balances relating to this scheme, with the relevant NHS Trusts and health authorities reporting, in the notes to their accounts, the liabilities held by the Authority on their behalf. As a result, the NHS Litigation Authority accounts now show the total provisions for the NHS relating to incidents arising prior to April 1995.

6.11 For incidents that have occurred since 1 April 1995, the NHS Litigation Authority has been operating a risk pool, called the Clinical Negligence Scheme for Trusts (CNST). Under this scheme, members pay annual contributions to the NHS Litigation Authority, who administer and settle claims on behalf of the NHS Trust. The contributions are based on the Authority's risk assessment of the individual member, taking account of the claims history and the field in which the NHS Trust operates.

6.12 The NHS Litigation Authority aims to collect enough from contributions to cover the anticipated payments for the financial year. In 2000-2001, the first year of significant payments under the scheme, approximately £157 million was paid to claimants, partly by NHS Trusts and the remainder by the NHS Litigation Authority. Contribution income recorded by the NHS Litigation Authority, since the scheme was established, totalled £119 million.

6.13 To further streamline claims handling, from 1 April 2002, the operation of the Clinical Negligence Scheme for Trusts will change. In particular, all alleged incidents of clinical negligence will be administered and accounted for by the NHS Litigation Authority. Thus, NHS Trusts, health authorities and Primary Care Trusts will remove from their accounts all provisions as at 31 March 2002, and the NHS Litigation Authority will include an appropriate provision for the cases transferred.

6.14 Once this transfer is complete, the NHS Litigation Authority will administer and account for all clinical negligence liabilities. Individual NHS Trusts, health authorities and Primary Care Trusts will continue to report their respective positions in notes to their accounts and will continue to pay contributions into the Scheme. Furthermore, this administrative arrangement will not affect these organisations' duty of care or the legal liability for cases arising.

Public Accounts Committee

6.15 The Public Accounts Committee considered my report, *Handling Clinical Negligence Claims in England* (HC 403, 2000-2001), on 17 October 2001. As I recorded in my report on the summarised accounts for 1999-2000, the Department and the NHS Litigation Authority have been developing initiatives to streamline the claims process and these initiatives had already brought about improvements in the handling of claims. With regard to areas for further improvement, the key recommendations arising from my investigation were:

- **Dealing with outstanding claims:** an action plan should be drawn up with quantified targets and performance measures to address claims that have been open for more than five years;
- **Patients' access to remedies:** alternative ways of satisfactorily resolving small and medium sized claims should be investigated by the various parties involved; and
- **Managing patients' claims:** quantified measures of performance should be developed for the solicitors whom the NHS Litigation Authority instruct or fund and these measures should be incorporated into selection procedures, contracts and monitoring.

6.16 The Department intends to issue a White Paper in the early summer which will describe its proposals in respect of the reform of clinical negligence. Other initiatives taken include:

- The consolidation of management of all claims by transferring responsibility to the NHS Litigation Authority (paragraphs 6.8 to 6.14 above refer);

1 The NHS Litigation Authority is a Special Health Authority, set up under the NHS Act 1977 to adminster clinical negligence and other pooled risk schemes for the NHS.

- "Building a Safer NHS for Patients", which sets out the Government's plans for promoting patient safety following the publication of the report *An Organisation with a Memory* and the commitment to implement it in the NHS Plan;
- Establishment of The National Patient Safety Agency in July 2001, which is implementing and operating the new national system for learning from error and adverse events;
- The issue of additional guidance by the NHS Litigation Authority, strengthening advice on providing apologies and explanations when treatment produces adverse results; and
- Reforming the NHS complaints procedure, following a national evaluation of existing practices.

6.17 I am planning a follow-up study to look at clinical governance in hospitals, and intend to review the implementation of these measures, including the impact they are having in NHS Trusts.