

NATIONAL HEALTH SERVICE REORGANISATION ACT 1973

NATIONAL HEALTH SERVICE ACT 1977

HEALTH SERVICES ACT 1980

HEALTH AND SOCIAL SERVICES AND SOCIAL SECURITY ADJUDICATIONS ACT 1983

HEALTH AND SOCIAL SECURITY ACT 1984

NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

HEALTH AUTHORITIES ACT 1995

NATIONAL HEALTH SERVICE ACT 1999

Summarised Accounts of Health Authorities, Primary Care Trusts and NHS Trusts in England, of the Dental Practice Board and Special Health Authorities providing central services in England, and of Funds Held on Trust by Health Authorities, Primary Care Trusts, NHS Trusts, Special Health Authorities and Special Trustees in England, for the year ended 31 March 2002 together with the Report of the Comptroller and Auditor General thereon. (In continuation of House of Commons Paper No. 766 of 2001-2002)

Presented pursuant to NHS Act 1977 c.49, s.98(4)

NHS (England) Summarised Accounts 2001-2002

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Summary and Conclusions

Introduction

- 1 The Department of Health (the Department) prepares summarised accounts for the NHS in England, which for 2001-2002 covered the:
 - 95 health authorities, which commission health care and related services from NHS Trusts and other contractors to the health service;
 - 164 Primary Care Trusts, which commission and deliver health care;
 - 318 NHS Trusts, which deliver health care;
 - 398 charitable funds held on trust;
 - eighteen 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 key conclusions from the audits of the underlying health organisations by auditors appointed by the Audit Commission for England and Wales (*paragraphs 2.1 to 2.28*). 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 corporate governance and accounting (*paragraphs 3.1 to 3.39*), the overall financial performance of health authorities, Primary Care Trusts and NHS Trusts (*paragraphs 4.1 to 4.35*), progress in countering fraud (*paragraphs 5.1 to 5.41*), and on the financial costs facing the NHS for clinical negligence claims and other provisions (*paragraphs 6.1 to 6.19*).

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 2001-2002 summarised accounts apart from those of the NHS Appointments Commission.

Findings of the Appointed Auditors

- 5 The appointed auditors gave unqualified "true and fair" audit opinions on the accounts of all the underlying organisations, except the NHS Appointments Commission, where they could not identify all the expenditure properly chargeable. I qualified my opinion on the relevant summarised account for the same reason (*paragraphs 2.6 to 2.10*).

- 6 Appointed auditors were also required to express an opinion on the regularity of the activities of health authorities, Primary Care Trusts and several special health authorities. In all but five cases, they gave unqualified opinions (*paragraphs 2.13 to 2.17*).
- 7 The appointed auditor issued a report in the public interest on NHS organisations comprising the Bedfordshire Shared Service operation managed by Bedfordshire and Luton Community Trust because of a breakdown in financial control. Action has been taken to regain control and the accounts of the constituent organisations have been prepared and audited for 2001-2002 (*paragraphs 2.23 to 2.28*).

Developments in corporate governance and NHS accounting disclosure

- 8 **Changes in the structure of the NHS summarised accounts:** the 95 health authorities were abolished and re-established as 28 new health authorities on 1 April 2002. They were renamed as strategic health authorities from 1 October 2002 with amended functions. These changes will impact on my audit of the summarised accounts and the work of the appointed auditors of the underlying accounts for the 2002-2003 financial year (*paragraphs 3.2 to 3.6*).
- 9 **The development of corporate governance and statements on internal control:** NHS organisations were required to prepare statements on internal control for the first time in 2001-2002. Although NHS bodies have made considerable progress in implementing the Treasury's requirements, successful implementation and embedding of effective risk management arrangements across all key activities within the complex and dynamic NHS environment is challenging. In general, the statements received from the underlying organisations indicate that they plan to have the necessary actions in place by the beginning of 2003-2004, thereby fully complying with Treasury requirements. However, the Department recognises that this requires extensive effort by each of the underlying organisations during 2002-2003 if this aim is to be achieved (*paragraphs 3.7 to 3.17*).
- 10 **Developments in NHS accounting disclosures:** 2001-2002 is the first year in which the NHS summarised accounts include disclosures on senior staff salaries and pensions in line with Treasury guidance, although a significant number of staff in underlying organisations have withheld their consent to disclose such information, including some 50 Chief Executives who have exercised their right to withhold consent to disclosure (*paragraphs 3.18 to 3.20*). In addition, the Department has made new enhanced disclosures required by Financial Reporting Standards on derivatives and other financial instruments, and retirement benefits (*paragraphs 3.26 to 3.29*).
- 11 **Extending the remit of the Financial Reporting Advisory Board:** With effect from January 2002, the remit of the Board was extended to oversee NHS Trust accounting and therefore NHS Trusts now follow the Resource Accounting Manual, apart from divergences such as not accounting separately for research and development expenditure and excluding assets under construction from the cost of capital charge, which are formally accepted by the Board (*paragraph 3.30*).

12 The future of the NHS summarised accounts. The Department initiated a consultation exercise in June 2002 on their proposals to remove the dual accounting burden on NHS charities (*paragraphs 3.31 to 3.34*). Proposals have been made to modernise the audit arrangements for the special health authorities and the Dental Practices Board, and specifically to transfer responsibility for these audits to me (*paragraphs 3.35 to 3.37*). I shall assess the impact of the proposed foundation trusts on the NHS summarised accounts once the draft legislation to establish them has been produced (*paragraphs 3.38 to 3.39*).

Financial performance of the NHS

- 13** In 2001-2002, the NHS overall is reporting a £71 million revenue underspend. This is in the context of overall health care commissioned of £43.3 billion (*paragraph 4.7*).
- 14 Financial Duties:** All health authorities and Primary Care Trusts met the statutory duty to remain within their cash limits in 2001-2002. Two health authorities and four Primary Care Trusts only achieved financial balance in resource terms after being provided with unplanned support and four health authorities failed their capital resource limit duty by more than the Department's £50,000 de minimus limit (*paragraphs 4.8 to 4.13*).
- 15** The Department assessed 46 out of the 318 NHS Trusts (14.5 per cent) as managing significant financial difficulties by the end of 2001-2002. The strategic health authorities involved are working closely with these NHS Trusts, and where necessary other NHS organisations within the health economy, to ensure that action plans are implemented that address the causes of the difficulties (*paragraphs 4.17 to 4.18*).
- 16** No NHS Trust failed its statutory duty to break-even taking one year with another in 2001-2002 (*paragraphs 4.14 to 4.16*).
- 17** NHS Trusts are also subject to three departmental financial duties:
- To absorb the cost of capital at a rate of six per cent - the average return for 2001-2002 was 6.1 per cent. Seventeen NHS Trusts failed this duty (*paragraphs 4.19 to 4.21*);
 - To meet the external financing limit set by the Department - overall, NHS Trusts were £6.1 million within their external financing limit of £370 million, but five NHS Trusts breached their individual limits by more than £10,000 (*paragraphs 4.22 to 4.23*);
 - To stay with the Capital Resource Limit set by the Department - two NHS Trusts failed this duty by more than the Department's £50,000 de minimus limit (*paragraph 4.24*).

Fraud

- 18** The Department established the NHS Counter Fraud Service (the Service) in 1999, with the remit to counter fraud within the NHS, with particular priority for Family Health Services. This remit has subsequently been extended to counter fraud and corruption within the Department as well. The Service has direct responsibility for developing policy and strategy to counter fraud and corruption, including providing advice and guidance to the Department and the NHS, and setting appropriate standards (*paragraphs 5.2 to 5.5*).
- 19** Determining a realistic estimate for fraud was one of the main tasks the Department set the Service. It has not yet established estimates for all areas of NHS expenditure, though it has calculated estimates for most areas within Family Health Services. The estimates indicate that fraud costs the NHS some £118 million per year within these expenditure streams, and in areas where they have undertaken a second measurement exercise, fraud appears to be reducing (*paragraphs 5.6 to 5.13*).
- 20** The specific contribution made by the Service in tackling fraud is not easily measurable, and the reductions in the level of fraud are likely to be due to a combination of factors, including initiatives implemented by the Service. Nevertheless, I commend the progress the Department and the NHS, driven by the Service, have made in reducing fraud within Family Health Services, and in developing an anti-fraud culture within the NHS (*paragraphs 5.36*).
- 21** The Service, which becomes a special health authority in 2003, should undertake the measurement exercises to estimate losses through fraud across the whole NHS. The Department spent some £11.9 billion on Family Health Services in 2001-2002, and the estimates show approximately one per cent of this expenditure is lost to fraud and corruption. There are no estimates yet for the level of fraud over the remaining £41.2 billion of NHS and Departmental expenditure (*paragraphs 5.9*).

Clinical negligence and provisions

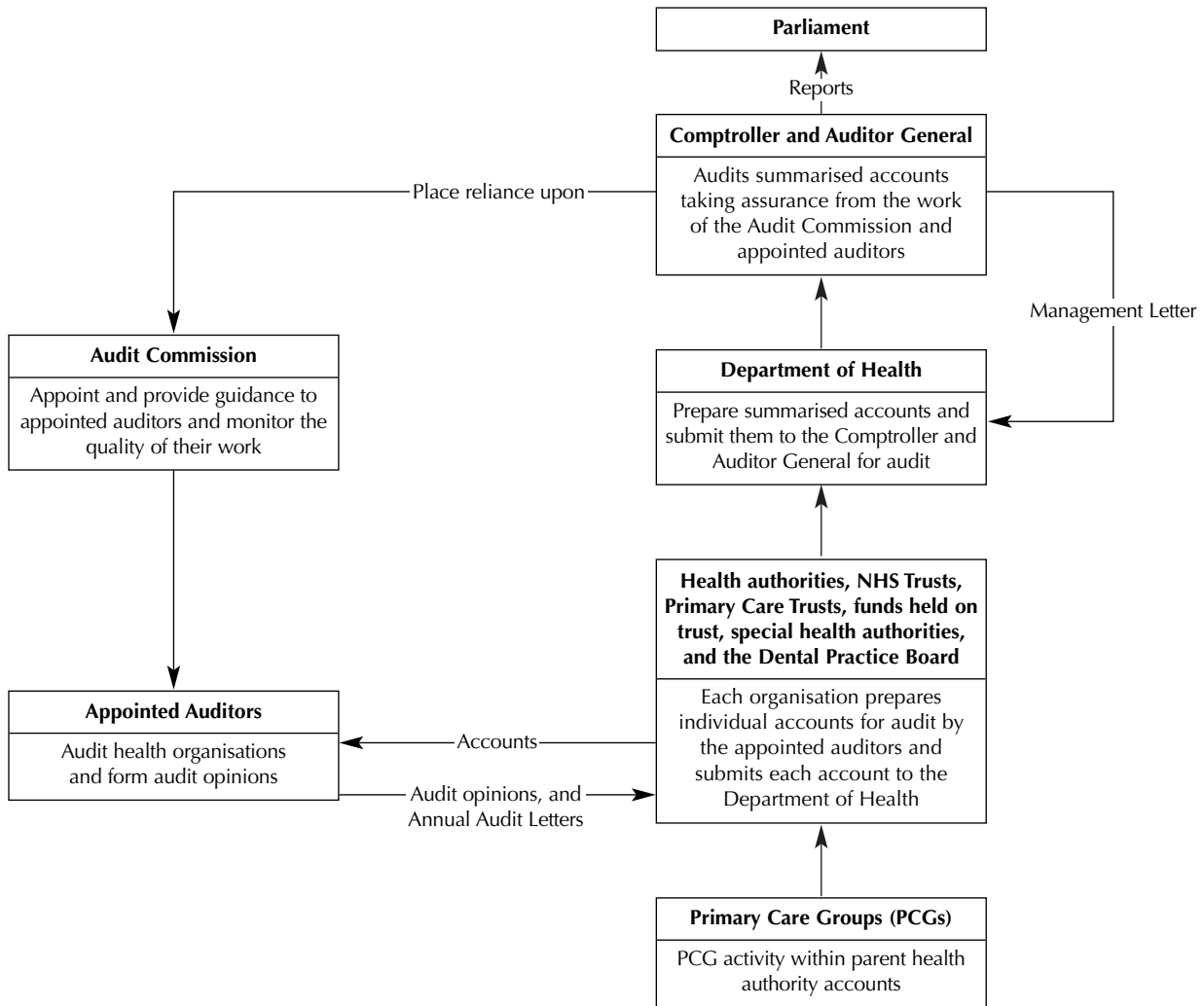
- 22** The NHS paid out some £446 million to settle clinical negligence claims in 2001-2002, an increase of 7.5% over 2000-2001 (*paragraph 6.6*). Provisions for the probable future cost of clinical negligence within the NHS amounted to £5.25 billion at 31 March 2002, an increase of £0.85 billion since 31 March 2001. A key cause of this increase was revised assumptions by actuaries in calculating the level of provisions required (*paragraphs 6.7 to 6.10*). Of the £5.25 billion, some £0.51 billion is expected to be paid out in 2002-2003. The increase in the expected amount to be paid is indicative of the reducing average time taken to settle clinical negligence claims (*paragraph 6.11*).
- 23** In addition, NHS bodies included provisions within their accounts totalling some £790 million, mainly to cover pensions to former Directors and staff (£382 million) and other legal claims (£114 million) (*paragraphs 6.17 to 6.19*).
- 24** **Public Accounts Committee:** The Department of Health responded to the Public Accounts Committee report *Handling Clinical Negligence Claims in England* in October 2002 and plans to issue a report which will describe its proposals in respect of the reform of clinical negligence (*paragraphs 6.14 to 6.16*).

Part 1

Introduction

- 1.1 This part of my report sets out the scope of my audit of each of the National Health Service summarised accounts for England 2001-2002. 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 is reported on an accruals basis within the Department's Resource Account, which is also subject to my audit. The Resource Account for 2001-2002 was laid before the House of Commons on 30th January 2003 [HC 363, 2002-2003].
- 1.3 These summarised accounts show how the bodies funded by the Department have used their resources:
- 95 health authorities;
 - 164 Primary Care Trusts;
 - 318 NHS Trusts;
 - 18 special health authorities; and
 - the Dental Practice Board.
- 1.4 The Department also prepares a summarised account for the NHS funds held on trust which covers the operations and total funds held by 398 individual NHS charities.
- 1.5 The Audit Commission appoints the external auditors to these organisations under the Audit Commission Act 1998. These appointed auditors provide an audit opinion on the annual accounts of each body, and the Department summarises these accounts for my audit. I am required under section 98(4) of the National Health Service Act 1977 to certify each of the summarised accounts and lay copies of them, together with my report on them, before both Houses of Parliament. **Figure 1** shows the audit arrangements for the underlying and summarised accounts of the NHS in 2001-2002.
- 1.6 The foreword to the NHS summarised accounts describes the basis for their preparation and the background to the individual NHS organisations in more detail. My examination in 2001-2002 included assessing the reliability of the information contained in the audited underlying 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.
- 1.7 On the basis of this work, and my audit of the processes adopted by the Department of Health, I am able to give unqualified opinions on all but one of the summarised accounts for 2001-2002. I have qualified my opinion of the NHS Appointments Commission on the grounds of limitation of scope, as explained in paragraph 2.6 of my report.
- 1.8 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 laid before the House of Commons under section 9 of that Act.
- 1.9 Since my report on the 2000-2001 NHS summarised accounts [HC766, 2001-2002], I have published the following reports on issues affecting the NHS in England:
- Facing the Challenge: NHS Emergency Planning in England [HC 36, 2002-2003];
 - The PFI Contract for the redevelopment of West Middlesex University Hospital [HC 49, 2002-2003];
 - Innovation in the National Health Service - the acquisition of the Heart Hospital [HC 157, 2002-2003]; and
 - Ensuring the effective discharge of elderly patients from NHS Acute Hospitals [HC 392, 2002-2003].

1 Audit arrangements in the National Health Service



Source: National Audit Office

1.10 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:

- PFI refinancing update [HC 1288, 2001-2002];
- Tackling pensioner poverty: Encouraging take-up of entitlements [HC 37, 2002-2003];
- The Invest to Save Budget [HC 50, 2002-2003];
- Using call centres to deliver public services [HC 134, 2002-2003];
- Safety, quality, efficacy: regulating medicine in the UK [HC 255, 2002-2003]; and
- PFI Construction Performance [HC 371, 2002-2003].

1.11 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 corporate governance and NHS accounting practice;
- Part 4: Financial performance of the NHS;
- Part 5: Fraud; and
- Part 6: Clinical negligence and provisions.

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 2.18); and
- Findings which led to one Section 19 referral to the Secretary of State and one Section 8 report in the public interest (paragraphs 2.19 to 2.28).

Audit of the 2001-2002 underlying accounts - work of the appointed auditors

The two-part audit opinion

- 2.2 Auditors of the bodies covered in the summarised accounts 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 2002 and of its income and expenditure for the year.
- 2.3 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 from health authorities, Primary Care Trusts or NHS Trusts, or from external sources, for example from fees and charges.
- 2.4 For those accounts included within the boundary for the Department's Resource Accounts, auditors are required by the Audit Commission's Code of Audit Practice 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".

2.5 I examine each of these requirements in paragraphs 2.6 to 2.17.

'True and Fair' view

- 2.6 The appointed auditors gave unqualified opinions that the accounts of all individual NHS Trusts, Primary Care Trusts, health authorities and all but one special health authority reflected a true and fair view of their state of affairs as at 31 March 2002 and of their income and expenditure for the year. As a result, I was also able to give unqualified opinions on the summarised accounts except that related to the NHS Appointments Commission.
- 2.7 In that case, the appointed auditor found that not all the costs associated with the NHS Appointments Commission's activities had been properly reflected in the accounts. He was unable to quantify the extent of the understatement and therefore qualified his audit opinion on the grounds of limitation of scope.
- 2.8 This first year of the Commission's activities was transitional with NHS Regional Offices reducing their appointments duties and the Commission building up its capacity. The Commission's accounts reflected only the costs of appointments work it undertook, and did not include all the expenditure relating to work associated with the appointments process carried out in NHS Regional Offices during the financial year, which was included within the Department's own accounts.
- 2.9 In addition, the Commission worked closely with the Department of Health throughout the year, sharing staff, offices and other facilities at the Department's premises. No charge was made to the Commission by the Department for the provision of these resources.
- 2.10 I therefore qualified my opinion on the summarised account of the NHS Appointments Commission for the same reasons.

Funds held on trust

- 2.11 Health authorities have the power under section 90 of the National Health Service Act 1977 to accept, hold and administer any property on trust for all or any purposes relating to the health service. Section 11 of the NHS and Community Care Act 1990 extends this power to NHS Trusts, and equivalent powers were bestowed on PCTs in section 7 of the Health Act 1999. Separate accounts are prepared for each of these funds. The summarised account for 2001-2002 records total funds held at 31 March 2002 to be some £1.68 billion (2000-2001: £1.74 billion).
- 2.12 The appointed auditors gave unqualified audit opinions on each of the funds held on trust accounts in 2001-2002, apart from those of Berkshire Healthcare NHS Trust where the appointed auditor qualified his audit opinion due to limited controls over income from voluntary donations. As the amounts involved are not significant enough to affect the readers' understanding of the summarised account, I have not qualified my opinion on the funds held on trust summarised account.

Regularity opinion

- 2.13 Appointed auditors were also able to provide unqualified regularity opinions on all but five of the underlying accounts.
- 2.14 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 because of the:
- impact of the estimated shortfall of income caused by patients fraudulently evading prescription charges and by unintentional evasion on the pharmaceutical services financial statement;
 - Dental Practice Board's estimate of the level of inappropriate expenditure, almost half of which was in respect of irregular claims made by patients and dentists.
- 2.15 These statements are not separately published, but are incorporated into the summarised accounts of the health authorities. I examine the issue of fraud further in Part five of my report.
- 2.16 In addition, appointed auditors qualified their regularity opinion on three Primary Care Trusts whose accounts were prepared under the Bedfordshire shared services arrangement. I refer to this arrangement further in paragraph 2.23 below.

- 2.17 As the amounts involved are not significant enough to affect the readers' understanding of these accounts, I have not qualified my overall opinion on the health authorities' or Primary Care Trusts' summarised accounts.

Accounts production

- 2.18 In their reports to management, the appointed auditors also drew attention this year to delays in producing underlying accounts, and a reduction in the quality of those accounts and supporting working papers. Some of these problems resulted from the significant restructuring of the health sector, which I refer to further in Part 3 of my report. For example, first year accounts have had to be prepared for some 125 newly created Primary Care Trusts and five new special health authorities established during 2001-2002.

Reports and referrals

Referrals to the Secretary of State

- 2.19 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.
- 2.20 Since my report on the summarised accounts for 2000-2001 (HC 766, 2001-2002), appointed auditors have referred one such matter to the Secretary of State.
- 2.21 The auditor of the Dental Practice Board reported his qualification of the General Dental Services account (see paragraph 2.14) in a section 19 referral to the Secretary of State.
- 2.22 The Dental Practice Board acknowledges the concerns raised by the auditor and has put in place procedures designed to actively monitor and seek to address the levels of inappropriate expenditure incurred.

Reports in the public interest

2.23 Section 8 of the Audit Commission Act 1998 requires appointed auditors to consider whether, in the public interest, they should report on any matter coming to their notice. Since my last report, one such report has been issued, on 31 May 2002, to:

- Bedfordshire and Luton Community NHS Trust;
- Bedfordshire Health Authority;
- Bedford Primary Care Trust;
- Bedfordshire Heartlands Primary Care Trust; and
- Luton Primary Care Trust.

2.24 The report concerned a shared services operation managed by Bedfordshire and Luton Community Trust, which provides financial services to the above organisations. It identified deficiencies in the arrangements to maintain adequate systems of financial control and to keep proper accounting records. No shared service provider option appraisal had been performed, there had been limited assessment of risks, project management was insufficient and there was evidence of poor leadership.

2.25 Despite warnings of the risks and the breakdown in arrangements in the appointed auditor's management letters in 1999-2000 and 2000-2001, effective action was not taken at the time by the health authority or the community trust.

2.26 A recovery plan was eventually put in place from November 2001 by Bedfordshire Shared Services Executive (equivalent to a board of Directors and comprising representatives of all organisations within the shared service arrangement). As a result, the organisations concerned and the appointed auditors had to undertake significant additional work to ensure the annual accounts for 2001-2002 presented a true and fair view. Even then, the appointed auditor qualified his regularity opinion on the accounts of the three Primary Care Trusts. This was because expenditure on services purchased on behalf of the individual trusts by a 'Joint Commissioning Agency' staffed by local authority officers was not covered by a formal agreement under section 31 of the Health Act 1999, as required by Regulation 9 of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 1999 (SI 2000/617).

2.27 The Department initiated a project to provide assurances about performance for the 2002-2003 year end and focus attention on this fundamental area of financial control and governance. The project was piloted in the Thames Valley Strategic Health Authority area and includes a questionnaire for organisations to review their current position and take action if necessary.

2.28 The tool has been distributed to all strategic health authorities, who have been asked for assurances about their NHS organisations based on the outcomes of the questionnaire, and made available more widely to shared services organisations. A Finance Governance Manual is also being produced, incorporating good practice in producing service level agreements and a model agreement. The national shared services pilots will be adopting this model.

Part 3

Developments in Corporate Governance and NHS Accounting Disclosure

Introduction

3.1 This part of my report examines:

- **Restructuring of the NHS and the impact on the NHS summarised accounts for 2001-2002** (paragraphs 3.2 to 3.6);
- **Developments in Corporate Governance:**
 - The introduction of Statements on Internal Control (paragraphs 3.7 to 3.9);
 - Progress made (paragraphs 3.10 to 3.17).
- **Developments in NHS accounting practice and disclosure:**
 - Senior staff salary and pension disclosures (paragraphs 3.18 to 3.20);
 - The implementation of new Financial Reporting Standards (paragraphs 3.21 to 3.29).
- **Extending the remit of the Financial Reporting Advisory Board** (paragraph 3.30); and
- **The future of the NHS summarised accounts** (paragraphs 3.31 to 3.39).

Restructuring of the NHS and the impact on the NHS summarised accounts for 2001-2002

- 3.2 The NHS continues to be subject to significant restructuring following the Department of Health's "NHS Plan: A Plan for Investment, A Plan for Reform" (Cm 4818-1) published in July 2000. The existing 95 health authorities were abolished from 1 April 2002. They were replaced by 28 new health authorities whose boundaries reflect their local and regional government areas.
- 3.3 These authorities became strategic health authorities from 1 October 2002 with amended functions. They will create a strategic framework for the delivery of the NHS Plan locally. They will secure local annual agreements with, and performance management of,

Primary Care Trusts and NHS Trusts, build capacity within the local healthcare system and act to support performance improvement.

- 3.4 The final summarised account for health authorities has therefore been prepared for 2001-2002. From 2002-2003, there will be a summarised account covering the strategic health authorities.
- 3.5 In line with the NHS Plan, Primary Care Trusts have become the lead NHS organisation in assessing need, planning and securing all health services and improving health. The number has increased from 40 in 2000-2001, the first year of their operation, to 164 in 2001-2002, and again to 304 during 2002-2003.
- 3.6 The aims of the NHS Plan are to decentralise power in the NHS and strengthen the regulation of health professions. This process has partly resulted in an increase in the number of summarised accounts presented for my audit this year. In 2001-2002, five new special health authorities were established for which the Department prepared summarised accounts, covering the National Clinical Assessment Authority, the NHS Appointments Commission, the National Patient Safety Agency, the National Treatment Agency and the Retained Organs Commission. Taken together with the mergers of other NHS organisations, a total of 18 special health authority summarised accounts were presented for my audit this year.

Developments in Corporate Governance

Introduction of Statements on Internal Control

- 3.7 In December 2000, the Treasury issued guidance requiring all public sector organisations to prepare a statement on internal control from 2001-2002, to provide assurances about the management of risk to each organisation in meeting its key objectives. Organisations are required to have all their risk management processes in place before 1 April 2003 to fully comply with Treasury requirements.

- 3.8 To enable the Department of Health's Accounting Officer to provide such a statement on each of the summarised accounts, he needs assurances from the Accountable Officer of each underlying NHS organisation that they, in turn, have effective systems of internal control in place to manage the key risks to meeting their objectives.
- 3.9 To achieve this aim, the Department issued three core control assurance standards, focusing on governance, financial management and risk management, for each underlying organisation to achieve, which would assist the Accountable Officers in gaining assurances about their systems of internal control. **Figure 2** sets out the key criteria that NHS organisations have to consider when establishing systems of internal control under these core standards. The core standards are supported by 18 other control assurance standards introduced in 1999-2000 and covering a wide range of operational activities.

2 The Department's key criteria for internal control

Core Standards	Key Criteria
Governance	<ul style="list-style-type: none"> ■ Clear accountability arrangements; ■ Key objectives and outcomes to meet stakeholders needs; ■ Processes to achieve objectives and deliver outcomes; ■ Improve performance from monitoring and review; ■ Independent assurances on effectiveness of systems;
Financial Management	<ul style="list-style-type: none"> ■ Define and approve financial objectives; ■ Clear lines of financial accountability; ■ Audit Committee overview of governance; ■ Formally adopted and promulgated financial instructions; ■ Financial risk management processes in place; ■ Effective internal control systems; ■ Adequately resourced and trained finance function; ■ Regular reports on financial performance; ■ Annual assurance from internal audit; ■ Demonstrate achievement of key objectives.
Risk Management	<ul style="list-style-type: none"> ■ Clearly defined responsibilities; ■ Clearly defined risk management strategy; ■ Effective structure to support risk management processes; ■ Appropriate risk management training for employees; ■ Independent assurance on effectiveness of risk management system.

Progress made

- 3.10 For 2001-2002, each underlying NHS organisation was required to include a statement on internal control as part of its accounts, in line with target dates agreed in the accounts production timetable. The Department planned to analyse these statements in order to monitor progress in implementing risk management processes and to identify actions that underlying organisations need to address in future years. Using the information contained in the statements, together with opinions provided by the appointed external auditors, the Department would then be able to compile the statements on internal control for each of the summarised accounts.
- 3.11 By 28 November 2002, the date the Accounting Officer signed each summarised account, the Department had received all 598 statements from the 596 underlying organisations - the Prescription Pricing Authority and Dental Practice Board were required to prepare a separate statement for their services and administration accounts. The Department's analysis was completed in January 2003, and the Accounting Officer was able to sign each statement on internal control on 23 January 2003. I am satisfied that these reflect the Department's analysis.
- 3.12 The Department's analysis identified that:
 - 46 statements claimed to have fully complied with Treasury requirements;
 - 407 statements claimed to have partially complied with Treasury requirements; and
 - statements were prepared by 145 underlying organisations that were dissolved on 31 March 2002.
- 3.13 In their statements, underlying organisations identified 1,827 actions that they planned to carry out to enable them to fully comply with the Treasury requirements. The Department's analysis categorised these actions across a range of headings, such as risk management and performance management and benchmarking, and identified the following key actions:
 - improve training in the assessment and management of risks to the delivery of key operational objectives;
 - develop risk registers to show the link between risks, management of risk and the impact on achieving key operational objectives;
 - develop and implement indicators, including those relating to risk indicators, to allow management to benchmark and measure performance in achieving targets; and
 - introduce procedures providing independent reviews of risks and actions to support management assurances.

Source: *The Department of Health*

3.14 Also, the auditors of each underlying body have a duty to assess whether the statements on internal control are consistent with their knowledge of the organisation and whether statements are misleading or incomplete. An analysis by the Audit Commission of returns from the appointed auditors identified the following key business risks which could impact on the levels and standards of patient care and planned service developments:

- the number and scale of new initiatives and the NHS Plan;
- changes in organisational and sector structure;
- staff retention; and
- indicators allowing organisations to measure delivery against targets.

3.15 The identification of these risks, together with the key actions identified as required by the underlying organisations and the Department, need to be viewed within the context of significant NHS structural change. As some organisations cease operations and new ones are formed, there is the potential for risks not to be fully identified or managed. It is therefore important for organisations to manage effectively the effects of the change process on corporate governance.

3.16 The Department has recognised the need for guidance and training on managing risk and, over the last five years, has supplied roadshows, training and seminars and is developing a national programme to assist underlying organisations with risk management awareness and internal control training requirements. The Department established the Controls Assurance Support Unit in October 2000 to provide support in facilitating the production of standards, training and guidance. The Unit is developing key performance indicators for each of the controls assurance standards.

3.17 Although NHS bodies have made considerable progress in implementing the Treasury's requirements, successful implementation and embedding of effective risk management arrangements across all key activities within the complex and dynamic NHS environment is challenging. In general, the statements received from the underlying organisations indicate that they plan to have the necessary actions in place by the beginning of 2003-2004, thereby fully complying with Treasury requirements. However, the Department recognises that this requires extensive effort by each of the underlying organisations during 2002-2003 if this aim is to be achieved.

Developments in NHS Accounting Disclosures

Senior Staff Salary and Pension Disclosures

3.18 During 1999-2000, the Treasury introduced revised disclosure requirements for salaries and pensions for central government organisations. This stemmed from the application of the recommendations of the Greenbury Committee, which reported to Parliament in 1995. Whilst the recommendations relate to the disclosure of information about directors of companies listed on the stock exchange, central government policy is to adopt best practice in the private sector.

3.19 Therefore since 2000-2001 the Department of Health, in line with all other central government organisations, has sought to increase the level of detail disclosed in the accounts. However, in order to comply with the provisions of the Data Protection Act 1998, employers are required to obtain the prior consent of the individuals concerned before such data can be disclosed in the published accounts.

3.20 For 2001-2002, the summarised accounts of each special health authority provide details of aggregate emoluments and pension entitlement of the chief executive, the most senior employees and Advisory Board or non-executive directors. For the accounts of the health authorities, NHS Trusts, Primary Care Trusts and Funds Held on Trust, such disclosure is made only in the underlying accounts given the scale of the information. I note that senior staff in a significant number of underlying organisations, including eight special health authorities, have exercised their right to withhold consent to disclosure, and this is reflected in the notes to the summarised accounts. Some 50 chief executives in underlying bodies also exercised their right to withhold their consent to disclose their salary details.

Adoption of United Kingdom Generally Accepted Accounting Practice

3.21 Treasury requires the accounts of NHS organisations that are within the resource accounting boundary to comply with the Resource Accounting Manual, in so far as it is appropriate for the NHS. This is based on United Kingdom Generally Accepted Accounting Practice as amended for the public sector context (including the accounting and disclosure requirements of the Companies Act and all relevant accounting standards issued or adopted by the Accounting Standards Board).

FRS 11: Impairment of Fixed Assets and Goodwill

3.22 FRS 11 was implemented in the NHS summarised accounts for the first time in 1999-2000. It introduced a requirement to distinguish between reductions in the value of assets which arise because of genuine loss of economic benefit (for example when an asset has been physically damaged) and those attributable to changes in market prices. In my report on the 1999-2000 accounts, I noted that reductions in asset value due to loss of economic value were charged to the Income and Expenditure accounts and all other losses against existing related revaluation reserves.

3.23 To avoid this approach leading NHS trusts to accumulate cash balances, and thus divert money from patient care, the Department introduced revised funding arrangements. This meant that for losses in value attributable to real loss of economic value, funds would flow in a circular fashion around the NHS, as:

- Health authorities provided NHS Trusts with funds to cover their impairment losses;
- NHS Trusts used these funds to repay public dividend capital to the Department of Health; and
- The Department of Health passed the funds to the health authorities to cover the additional payments they had to make to NHS Trusts.

3.24 In the 2001-2002 NHS Trusts summarised account some £500 million of public dividend capital was repaid to the Department of Health for the first time, relating to 1999-2000 and 2000-2001 economic impairments. This allows the Department to complete the circular flow of funds to account for the effects of implementing FRS 11.

3.25 During 2001-2002 the NHS applied two Financial Reporting Standards (FRSs) which increased the level of detailed disclosures regarding assets and liabilities used in its organisations.

FRS 13: Derivatives and Other Financial Instruments: Disclosures

3.26 FRS 13 has been effective for accounting periods ending since March 1999 for companies with capital instruments listed on the stock exchange and aims to provide an overview of the main financial risks concerning an organisation's financial assets and liabilities and how these have been addressed. During 2001-2002 the Treasury confirmed that FRS 13 applies to all central government departments and agencies, and NHS bodies.

3.27 As a result of my audit the Department has included the appropriate disclosures in the 2001-2002 NHS summarised accounts. These show that the risks associated with movements in interest rates and transactions in foreign currencies are insignificant due to the type of transactions which the NHS undertakes.

FRS 17: Retirement Benefits: Disclosures

3.28 FRS 17 was issued in November 2000 and will be implemented in three separate tranches, not fully replacing previous generally accepted accounting practice until the 2003-04 financial year. One of the major impacts of the standard is the requirement to introduce a valuation of pension scheme assets at market value, instead of actuarial value. The results of this change should be disclosed in the accounts, together with the immediate recognition of scheme surpluses or deficits. However, under the standard, employers whose staff contribute to schemes, such as the NHS Pension Scheme, are exempt from providing these details because it is not possible for individual NHS organisations to identify their share of the underlying scheme liabilities. The NHS Pension Scheme produces a separate resource account for my audit and this account provides the latest valuation of the liabilities of the scheme. The NHS Pension Scheme Resource Account for 2001-2002 was laid before the House of Commons on 30th January 2003 [HC 319, 2002-2003].

3.29 In line with the standard, NHS organisations are required to provide more details on the pension scheme arrangements in place and the assets and liabilities arising from the employer's retirement obligations, and these details are provided in the notes to the 2001-2002 summarised accounts.

Extending the remit of the Financial Reporting Advisory Board

3.30 I reported last year that the Treasury's Financial Reporting Advisory Board (FRAB) would oversee NHS Trust accounting with effect from January 2002. The Department has worked with the FRAB to prepare for NHS Trusts a list of agreed accounting practices divergent from the Resource Accounting Manual, to reflect fundamental differences between NHS Trusts and Government Departments. My audit of the 2002-2003 summarised account for NHS Trusts will take account of this new context.

The future of the NHS summarised accounts

Planned cessation of the Funds Held on Trust summarised account

- 3.31 Over 450 NHS organisations currently administer charity funds in England and Wales, including health authorities, NHS Trusts, Primary Care Trusts, special health authorities, and special trustees who have powers to receive new funds and incur expenditure. At present most of these charities are required to prepare two sets of accounts. In accordance with Section 98 of the National Health Service (NHS) Act 1977, one set is sent to the Department of Health who use these to prepare the Funds Held on Trust summarised account for my audit. The other set is sent to the Charity Commission as required by the Charities Act 1993.
- 3.32 When the provisions of the NHS Act 1977 came into force, NHS trustees were exempted from the duty to routinely send accounts to the Charity Commission. However since 1996 the funds have been brought fully within the scope of the monitoring activities of the Charity Commissioners, and so the accounting burden is duplicated.
- 3.33 The Department proposes to remove the requirements in the NHS Act 1977 to remove the requirement to submit accounts for funds held on trust to the Secretary of State for Health or the National Assembly for Wales, for them to be summarised for my audit or that of the Auditor General for Wales, and presented to Parliament or the National Assembly for Wales. Individual accounts will, however, continue to be submitted to the Charity Commission. In addition, audit appointments for individual funds would continue to be made by the Audit Commission rather than the Trustees. This recognises that although the funds have been derived from voluntary donations, they are administered by public bodies.
- 3.34 The Department initiated a three-month consultation exercise in June 2002 on their proposals to remove the dual accounting burden using the Regulatory Reform Act 2001. Subject to appropriate legislative changes being made, the Department proposes that the final summarised account for Funds Held on Trust will be prepared and presented for my audit for the 2002-2003 financial year.

Planned transfer of the audit of special health authorities to the C&AG

- 3.35 Section 11 of the NHS Act 1977 provides for the Secretary of State for Health to establish special health authorities "for the purpose of performing any functions which he may direct the body to perform on his behalf, or behalf of a health authority". The NHS Act deals separately with the Dental Practices Board, although it is analogous to a special health authority, as it was formed from an organisation already in existence. Section 98 of the NHS Act 1977 provides for the Audit Commission to appoint auditors to audit the special health authorities and the Dental Practice Board, and for the Department to prepare for my audit the summarised accounts of these organisations.
- 3.36 Proposals have been made to modernise the audit arrangements for these bodies and specifically to transfer responsibility for these audits to the Comptroller and Auditor General. This would simplify and speed up the audit process.
- 3.37 HM Treasury issued a consultation document in December 2002. Assuming the change takes place, it is expected to take effect from the 2003-2004 financial year. One of the consequences would be that individual audited accounts would be addressed to and laid before Parliament, and there would be no requirement for the Department to prepare summarised accounts for these bodies.

NHS Foundation Trusts

- 3.38 In November 2002, as part of the Queen's Speech, the Department announced that it would establish NHS Foundation Trusts as locally owned public benefit organisations, modelled on co-operative societies and mutual organisations. Their primary purpose will be to provide health and health-related services for the benefit of NHS patients and the community, on the basis of clinical need and according to national standards, and they will be subject to inspection by the Commission for Healthcare Audit and Inspection. Details on proposals are set out in *A Guide to NHS Foundation Trusts* published by the Department in December 2002. This document invites preliminary applications, subject to criteria laid down by the Department, from acute and specialist NHS Trusts that were successful in gaining three stars in the July 2002 NHS Performance Ratings. Subject to legislation, the first NHS Foundation Trusts will be established from April 2004.
- 3.39 I shall assess the impact of these new bodies on the summarised accounts, and their audits, once the draft legislation has been produced.

Part 4

Financial Performance of the NHS

Introduction

4.1 This part of my report summarises:

- Overall NHS Expenditure and assets (paragraphs 4.2 to 4.6);
- Overall NHS financial performance (paragraph 4.7);
- Achievement of financial duties (paragraphs 4.8 to 4.24);
- Monitoring of financial performance (paragraphs 4.25 to 4.30); and
- Better Payment Practice Code performance (paragraphs 4.31 to 4.35).

Overall NHS Expenditure and Assets

- 4.2 During 2001-2002, health authorities and Primary Care Trusts spent some £43.3 billion commissioning primary and secondary healthcare (**Figure 3**), mainly from NHS Trusts and Primary Care Trusts.
- 4.3 In line with *The NHS Plan*¹, Primary Care Trusts 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 318 NHS Trusts in 2001-2002, with total expenditure of £31.8 billion (2000-2001: 356 NHS Trusts with expenditure of £30.8 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.

3 £43.3 billion of health care was commissioned by health authorities and Primary Care Trusts

	Primary Care £ billion	Secondary Care £ billion	Total £ billion
Health authorities	9.4	20.4	29.7
Primary Care Trusts	3.5	11.9	15.4
Total 2001-2002	12.9	30.4*	43.3*
Total 2000-2001			40.7

NOTES

* these figures exclude transactions between health authorities and Primary Care Trusts.

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.

Source: Summarised accounts for health authorities and Primary Care Trusts.

- 4.5 In addition, the Department provided funding of £0.8 billion to the 18 special health authorities and the Dental Practice Board (2000-2001: £0.9 billion to 15 special health authorities and the Dental Practice Board), including amounts to the NHS Litigation Authority to cover payments 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 £17.2 billion (**Figure 4**), which has decreased by £0.4 billion since March 2001.

¹ *The NHS Plan: A Plan for Investment A Plan for Reform (Cm 4818-1, July 2000)*

4 Asset base for the NHS

	March 2002 £ billion	March 2001 £ billion	March 2000 £ billion
Fixed Assets	25.9	24.4	24.0
Current Assets	5.3	6.2	6.6
Total Liabilities	(14.0)	(13.0)	(10.4)
Net Worth	17.2	17.6	20.2

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

Overall NHS financial performance

4.7 In 2001-2002, the NHS overall is reporting a £71 million revenue underspend. This is in the context of overall health care commissioned of £43.3 billion (paragraph 4.2).

Achievement of Financial duties

Financial requirements

4.8 Each health organisation has a number of financial duties, both statutory and Departmental (**Figure 5**).

Health Authorities' Performance

Cash limits, revenue resource limits and financial balance

4.9 In 2001-2002, all health authorities achieved their statutory financial duty to remain within resource and cash limits. With the exception of two health authorities, all others achieved the departmental financial balance measure. The two exceptions: Brent and Harrow Health Authority and Cornwall and the Isles of Scilly Health Authority required unplanned support of £3,900,000 and £524,000 respectively.

Capital resource limits

4.10 All but four health authorities achieved their capital resource limit duty within the Department of Health's £50,000 de minimus limit: Bexley, Bromley and Greenwich Health Authority (£3,050,000), East Sussex, Brighton and Hove Health Authority (£174,000), Bedfordshire Health Authority (£105,000), and North Cheshire Health Authority (£65,000) did not.

Significant financial difficulties

4.11 As part of the Department's analysis of financial performance, it identifies those organisations managing significant financial difficulties. The number has varied over time, but there were 30 (31.6% of the 95 health authorities) at the end of 2001-2002. Comparative figures are provided in **Figure 6**. In the Foreword to the NHS Summarised Accounts, the Department noted that

5 Financial duties

Health authorities and Primary Care Trusts	NHS Trusts
Statutory	
<ul style="list-style-type: none"> ■ remain within cash limits (paragraphs 4.8 and 4.11) ■ contain expenditure, measured on an accruals basis, within approved revenue resource limits (paragraphs 4.8 and 4.11). ■ contain expenditure measured on an accruals basis, within approved capital resource limits (paragraphs 4.9 and 4.12). 	<ul style="list-style-type: none"> ■ break even taking one financial year with another (paragraph 4.13).
Departmental	
<ul style="list-style-type: none"> ■ achieve financial balance without the need for unplanned financial support (paragraphs 4.8 and 4.11). ■ apply the Better Payment Practice Code (paragraph 4.36) 	<ul style="list-style-type: none"> ■ absorb the cost of capital at a rate of six per cent (paragraph 4.18). ■ not to exceed the external financing limit set by the Department of Health (paragraph 4.22). ■ contain expenditure measured on an accruals basis, within approved capital resource limits (paragraph 4.24). ■ apply the Better Payment Practice Code (paragraph 4.31).

the 2001-2002 financial position was influenced greatly by significant increases in prescribing costs. The Department planned for a 10.7% rise in resources for the primary care drugs bill in their budgets. National schemes, such as the Maximum Price Scheme and Pharmaceutical Price Regulation Scheme, are in place to bring savings to the NHS drugs bill. Health authorities overall recorded a small underspend.

6 Health authorities assessed as managing significant financial difficulties

	01-02	00-01	99-00	98-99	97-98
Proportion assessed as managing significant financial difficulties	31.6	11.1	28.3	18.0	29.0

Source: Department of Health

Primary Care Trusts' Performance

Cash limits, revenue resource limits and financial balance

4.12 In 2001-2002, all Primary Care Trusts achieved their statutory financial duty to remain within resource and cash limits. With the exception of four Primary Care Trusts, all others achieved the departmental financial balance measure. The four exceptions required unplanned support: Bexley Primary Care Trust (£691,000), Dartford, Gravesham and Swanley Primary Care Trust (£1,363,000), Greenwich Primary Care Trust (£1,330,000) and Maidstone and Malling Primary Care Trust (£983,000).

Capital resource limits

4.13 All Primary Care Trusts achieved their capital resource limit duty within the Department's £50,000 de minimus limit.

NHS Trusts' Performance

Breaking even

4.14 The legislation does not specify how the statutory duty to break even, taking one year with another, should be measured. The Department therefore bases its assessment on a method agreed in consultation with the NHS Trusts and their auditors (Figure 7).

7 The Department of Health's 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 can be 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.

4.15 Based on this definition, no NHS Trust failed in its break-even duty as at 31 March 2002. However, 50 incurred an in-year deficit (2000-2001: 39 NHS Trusts), ranging from £1,000 to £11.5 million. Nineteen deficits were not classed as significant by the Department, being less than 0.5% of turnover. The NHS Trusts with the largest in-year deficits as a percentage of income are shown in Figure 8 overleaf.

4.16 NHS Trusts with in year deficits are required to prepare an agreed recovery plan with the appropriate Regional Office of the Department, who will monitor closely their financial progress.

Significant financial difficulties

4.17 The Department noted that 46 out of the 318 NHS Trusts (14.5 per cent) were managing significant financial difficulties by the end of 2001-2002 (33 out of 356 in 2000-2001). The number has varied over time and comparative figures are provided in Figure 9.

9 NHS Trusts assessed as managing significant financial difficulties

	01-02	00-01	99-00	98-99	97-98
Proportion assessed as managing significant financial difficulties	14.5	9.3	20.2	13.2	18.4

Source: Department of Health

4.18 In the Foreword to the 2001-2002 NHS summarised accounts, the Department observed that, whilst not directly impacting on NHS Trusts in the same way as primary care, the 2001-2002 financial position was influenced by significant increases in prescribing costs. The Department acknowledged that there are some trusts managing significant financial issues and considers that modernisation of service delivery and changed management structures, together with the significant increases in the overall resources made available to the NHS, will support the process of financial recovery.

8 The five NHS Trusts with the highest deficits as a percentage of income

NHS Trust	Deficit for the year £ million	In-year deficit as a percentage of income
West Hertfordshire Hospitals NHS Trust	11.5	6.6
East Berkshire Community Health NHS Trust	1.2	4.7
Somerset Partnership NHS and Social Care Trust	1.8	4.6
Sussex Weald and Downs NHS Trust	2.3	4.3
Bedford Hospitals NHS Trust	3.1	4.1

Source: Accounts of individual NHS Trusts

Capital cost absorption rate duty

- 4.19 In line with Treasury requirements across all government 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. Funding for the NHS is set at a level which takes account of this charge.
- 4.20 The average return across NHS Trusts for 2001-2002 was 6.1 per cent (2000-2001: 6.2 per cent). The Department considers that only NHS Trusts achieving less than 5.5 per cent fail the duty and 17 failed on this basis (2000-2001: 18 NHS Trusts).
- 4.21 Of these NHS Trusts, 15 failed to achieve the duty because of unexpected but necessary purchases or revaluations of assets in line with Treasury requirements. The other two failed for technical accounting reasons.

External financing limit

- 4.22 The Department also sets an external financing limit for each NHS Trust as a way of controlling cash spending 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.
- 4.23 In 2001-2002, NHS Trusts were £6.1 million within the national limit of £370 million (2000-2001: £9 million within the national limit of £224 million). The Department considers that only Trusts which exceed their individual limits by more than £10,000 have failed this duty. On this basis five, or 1.6 per cent, did so, an improvement on 2000-2001 (seven NHS Trusts, 1.9 per cent).

Capital resource limit

- 4.24 Two NHS Trusts failed their capital resource limit duty by more than the Department of Health's £50,000 de minimus limit: East and North Hertfordshire NHS Trust (£9,985,000) and Bury Health Care NHS Trust (£52,000).

Monitoring of financial performance

NHS performance ratings ("Star Ratings")

- 4.25 The Department has developed a series of performance measures for NHS Trusts, and in July 2002, it published Star Ratings for all NHS Trusts in England based on performance achieved during 2001-2002. For the first time, ratings were given for ambulance trusts, acute NHS Trusts with specialist services and indicative ratings for mental health trusts.
- 4.26 NHS Trusts were assessed across four main areas:
- nine key targets, including waiting lists, financial performance, cancellation of operations and cleanliness;
 - clinical indicators that measured the clinical quality of care;
 - patient indicators, to measure how well patients are treated; and
 - staff indicators, as an indication of management of staff.
- 4.27 NHS Trusts which consistently reported the required levels of performance were awarded the maximum three stars. NHS Trusts which performed well overall, but had not reached consistently high standards, were given two stars. NHS Trusts with one or zero stars performed worse than expected against some key targets.
- 4.28 The financial performance of an organisation was primarily judged by looking at the extent to which the 2001-2002 outturn varied from the agreed plan. The extent to which the position is being supported by unplanned funding was also considered by the Department.
- 4.29 Twenty eight NHS Trusts 'significantly underachieved' and 21 'underachieved' their financial management targets. Of those which significantly underachieved, none achieved three stars, eight were awarded two stars, 13 one star and the other seven zero stars.

4.30 Primary Care Groups and Primary Care Trusts were the subject of a separate publication, describing their performance against a range of indicators. As they are relatively new NHS organisations, Primary Care Trusts will receive their first overall 'star' ratings in 2003, based on their performance during 2002-2003.

Better Payment Practice Code performance

Creditor payment performance

4.31 NHS organisations are also required to apply the CBI's 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.

4.32 The Department of Health uses the percentage of invoices paid within target, by number of invoices rather by value of invoices. This is because one or two high value payments could otherwise distort the results.

4.33 In 2001-2002, the average performance across all NHS organisations is 84.4%. This performance should be seen within the context of the NHS paying over 15 million invoices per year to external creditors. Comparative figures are provided in **Figure 10**.

4.34 The Foreword to the NHS summarised accounts notes that Department's Regional Offices worked with health authorities, Primary Care Trusts and NHS Trusts to improve Better Payment Practice Code performance. The percentage of organisations achieving target performance remains below 30 per cent.

4.35 To improve performance further, the Department will continue to work with NHS bodies to restore and achieve a level of payment performance consistent with Government Accounting regulations and the Better Payment Practice Code. The Department expects payment performance to improve through increased investment in information technology and the continued rollout of the shared services initiative.

10 NHS Performance against the Better Payment Practice Code

	Health Authorities	Primary Care Trusts	NHS Trusts
	% paid within target, by number of invoices	% paid within target, by number of invoices	% paid within target, by number of invoices
2001-2002	84.4%	82.0%	84.6%
2000-2001	86%	82%	84%
	% paid within target, by value of invoices	% paid within target, by value of invoices	% paid within target, by value of invoices
2001-2002	87.7%	88.5%	85.2%
2000-2001	91%	89%	85%

Target = 95% of invoices paid within 30 days

Source: NAO analysis of accounts of individual NHS organisations

Part 5

Fraud

Introduction

5.1 This part of my report summarises:

- The role of the NHS Counter Fraud Service (paragraphs 5.2 to 5.5);
- Measurement of fraud within the NHS (paragraphs 5.6 to 5.13);
- NHS Counter Fraud Service targets (paragraph 5.14);
- How the NHS Counter Fraud Service has countered fraud (paragraphs 5.15 to 5.35);
- The creation of a special health authority (paragraphs 5.36 to 5.38);
- Impact of fraud on my audit opinions for the NHS summarised accounts and Department of Health Resource Account (paragraphs 5.39 to 5.40);

Background

The NHS Counter Fraud Service

5.2 The NHS is vulnerable to fraud in a number of different guises. Essentially, these are:

- Fraud committed by patients and customers using NHS services, for example by claiming exemption from prescription charges without entitlement;
- Fraud committed internally or by contractors, such as dentists, general practitioners, and opticians claiming for payments to which they are not entitled;
- Fraud committed by those providing services or materials to the NHS, such as drugs, staff and equipment.

5.3 The Department of Health recognised during the mid 1990s that there was an unacceptable level of fraud within the NHS, and it published a strategy to combat fraud in 1998, *Countering Fraud in the NHS*. This established the NHS Counter Fraud Service ("the Service"), which had the remit:

"To have overall responsibility for all work to counter fraud and corruption within the Department of Health and the NHS with particular priority for countering fraud in Family Health Services. To have direct responsibility for developing policy and strategy and for all operational work to counter fraud and corruption alongside that which is proper to Health Authorities and NHS Trusts. Here the responsibility of the Director of the NHS Counter Fraud Service will involve advice, guidance and the setting and monitoring of appropriate standards."

5.4 The Service has two distinct divisions:

- The Central Unit provides the strategic direction, revises policy and systems, undertakes the risk assessment and measurement exercises, and oversees the NHS-wide counter-fraud activities;
- The Operational Service consists of national and regional counter-fraud teams throughout England and Wales. These teams detect and investigate alleged fraud within the NHS and that perpetrated by contractors or patients, and seek to apply sanctions where fraud is believed to be present.

5.5 At the local level, all NHS bodies employ an accredited Local Counter-Fraud Specialist. These specialists undertake counter-fraud activities in NHS Trusts and Primary Care Trusts and from October 2002 strategic health authorities, in accordance with the NHS Counter Fraud and Corruption Manual (paragraph 5.28).

Measuring fraud

5.6 The Public Accounts Committee considered fraud within the NHS in 1999-2000, and found it "unsatisfactory that the Department of Health lacked a realistic estimate of the overall level of fraud"². The Department responded that determining a realistic estimate of fraud was "one of the main reasons behind the creation of the NHS Counter Fraud Service" in 1999.

- 5.7 The Service recognised that there was a need to establish the extent of fraud within the NHS in order to focus resources effectively. It identified eight risk areas within its original priority of family health services expenditure, and then embarked on a series of measurement exercises to estimate the level of fraud within these areas, by analysing statistical samples of transactions.
- 5.8 The Service has not yet established estimates for all areas of NHS expenditure, although estimates have been calculated for most areas within Family Health Services. **Figure 11** details the expenditure streams it identified as being at risk of fraudulent activity, together with the latest estimates of fraud, where calculated. Measurement exercises are not undertaken every financial year for each category, but aggregating the latest figures suggests that the NHS is potentially losing some £118 million through fraud each year.
- 5.9 Family health services expenditure in 2001-2002 amounted to some £11.9 billion, and the Service's analysis suggests that fraud accounts for one per cent of this expenditure. The Department and the NHS spent a further £41.2 billion on the provision of healthcare and other Departmental objectives³. There is not sufficient data to extrapolate the measured fraud over the remaining expenditure, and so there is a need to extend the measurement programme to cover remaining areas of departmental expenditure.
- 5.10 In those areas where a second measurement exercise has been completed, the results indicate success in reducing fraudulent activity over time (Figure 11), and represent significant progress against the original targets set by the Department for reducing fraud in key areas (paragraph 5.14).
- 5.11 The Service has encountered difficulties in determining the levels of fraud in some areas. Records kept by pharmacists and General Practitioners, for example, have not allowed the Service to fully estimate fraud within those areas of expenditure. Thus there is no estimate available for fraud within General Medical Services (General Practitioners), and further work was not undertaken because of changes being made in General Practice. Instead, insight into areas of risk gained by the Service will be used to strengthen processes in the development of Personal Medical Services contracts for GPs. Likewise, the Service has not been able to establish an estimate for fraud within all pharmaceutical contractor expenditure streams because of the paucity of underlying data. Instead, it has completed analyses of fraud within two areas:

11 Estimates of fraud by expenditure stream within Family Health Services, health authorities and NHS Trusts

Risk Area	Latest Estimate of fraud*
Pharmaceutical patient fraud	1999-2000: £69m (1998-1999: £117m)
Pharmaceutical contractor fraud	1999-2000: £8.5m (1998-1999: £9.5m)
Dental patient fraud	2000-2001: £30m (1999-2000 £40.3m)
Dental contractor fraud	No full estimate available**
Optical patient fraud	2000-2001: £10.2m (1999-2000: £13.3m)
Optical contractor fraud	No full estimate available**
General Medical Services fraud	No estimate available (paragraph 5.11)
Health authorities and NHS Trusts	An initial pilot risk measurement study was conducted on payroll and recruitment, procurement and telecommunications. This information will help in the design of a measurement exercise.

NOTES

- * The estimates of fraud relate to the year in which the transactions examined occurred. Comparatives are given in areas where more than one exercise has been completed.
- ** Measurement exercises were started, but operational difficulties in obtaining accurate and reliable data have prevented an estimate being obtained. Instead, the Service has a baseline on which further work will be undertaken to reach an accurate assessment of fraud.

Source: NHS Counter Fraud Service

³ Source: Department of Health Resource Account 2001-2002.

- **Double income:** when a patient is exempt from the prescription charge, the Prescription Pricing Authority pays a fee to the dispensing pharmacist. Fraud can arise if the patient pays for a prescription, and the pharmacist then alters the form to indicate an exemption was claimed. In this way, the pharmacist receives two payments for the same transaction. The latest estimated losses due to this fraud are £7 million per annum, which is a reduction of £1 million from the previous estimate.
- **Prescribing advice to care homes:** care homes can contract with individual pharmacists to provide advice on medication for patients or residents. Fraud can occur, for example, when pharmacists claim for medication that they have not prescribed. The Service has estimated fraud to be between £1 million and £1.5 million.

5.12 I recognise that difficulties in obtaining reliable information, as indicated in paragraph 5.11, have presented practical barriers to estimating fraud, and that the Service is continually considering how it can overcome these barriers. There is still a significant amount of work needed to reach an overall estimate of fraud, and the completed estimation exercises have taken a considerable time. The Service operates to a high degree of accuracy (99 per cent confidence level), which requires sample sizes of several thousand transactions for each exercise, although factors outside the Service's control have contributed to the length of time taken to gain accurate and robust estimates. For example, data cleansing is required to ensure patient details are correct; and delays can be caused by awaiting responses from outside agencies and confirmation from patients receiving services.

5.13 Whilst the Service has pursued initiatives to speed up the process, such as agreeing a service level agreement with the Department for Work and Pensions specifying response times, it should consider what additional steps can be made to obtain an overall estimate of fraud across the NHS as a matter of priority.

Progress against targets for reducing fraud

5.14 When the Service was established, it inherited two targets relating to prescription charge fraud which had arisen from the Department's 1997 Efficiency Scrutiny of prescription fraud. The 1998 Comprehensive Spending Review set these targets as Public Service Agreement Targets. In addition, the Department has published its overall aim of reducing fraud to an absolute minimum within ten years. **Figure 12** details these targets and the progress reported by the Department against those targets.

Tackling fraud

5.15 The Service's strategy to meet its overall aim of reducing and maintaining fraud at a minimum level consists of seven objectives:

- The creation of an **anti-fraud culture**;
- Maximum **deterrence** of fraud;
- Successful **prevention** of fraud which cannot be deterred;
- Prompt **detection** of fraud which cannot be prevented;
- Professional **investigation** of detected fraud;
- Effective **sanctions**, including appropriate legal action against people committing fraud;
- Effective methods for seeking **redress** in respect of money defrauded.

Creation of an Anti-fraud culture

5.16 The creation of an anti-fraud culture within the NHS was a primary aim of the Service. To this end, the Service has implemented a number of initiatives to raise awareness of individual responsibility of NHS staff, including:

12 Progress by the Department against their fraud reduction targets

Target

Reduce by 50 per cent evasion of prescription charges by patients by the end of the year 2002/03

Within prescription fraud perpetrated by NHS contractors, to prevent £9 million in fraud and to recover a further £6 million by the end of the year 2001/02

Reduce fraud to an absolute minimum by 2008

Progress against target

On course to achieve. The two measurement exercises on pharmaceutical patient fraud (Figure 11) show a reduction in fraud of £48 million, which represents a reduction of 41 per cent up to 1999-2000. The next measurement exercise is scheduled for 2003.

Achieved. By the end of 2001/02, prevention savings of £9.3 million had been secured, and £7.5 million had been recovered⁴.

Not measurable, although significant success appears to have been achieved - this remains the continuing aim of the Department, and will be the objective of the new Special Health Authority.

- Induction programmes for new staff to emphasise responsibilities;
- Fraud awareness seminars to NHS staff throughout the country;
- Specific training for key staff, such as directors of finance;
- Contracts of employment for certain key staff contain a clause relating to those individuals' responsibilities;
- Each NHS organisation employs a local counter-fraud specialist, and it is their responsibility to spread good practice;
- Publicity, such as a quarterly newsletter, *Protecting Our NHS*, to spread good practice and advertise its work

5.17 Internal surveys undertaken by the Service have shown a growth in awareness amongst NHS staff regarding their individual and collective responsibilities for countering fraud. For example, following fraud awareness seminars in 2000-2001, 74 per cent of participants recognised that countering fraud was their individual responsibility, compared to 34 per cent in the previous year.

Deterrence

5.18 The Service ensures that its activities are widely advertised within the NHS. The media regularly report successful actions, and this can act as a deterrent. Professional regulatory bodies add their support to the publicity. The presence of local counter-fraud specialists and Service personnel throughout the NHS also act as a deterrent. **Case study 1** provides an example of where fees claimed from the NHS fell following revisions made by the Service to how dentists claimed "Recalled Attendance" fees.

Case study 1: a drop in claims for dental fees followed a change to claims process

As a result of an investigation, the Service revised the arrangements for General Dental Services Recalled Attendance fee claims, requiring self-certification. Following this change, claims dropped from £14.3 million in 1998-99 to £9.1 million in 2001-2002.

Source: NHS Counter Fraud Service

Prevention

5.19 Whilst the development of an anti-fraud culture helps deter fraud, there is also the need to prevent the opportunities for fraudulent activity. To this end, the Service helps to shape policy and improve systems. For example, before new schemes are implemented by the Department, the Service considers inherent risks of fraudulent activity, and systems of financial control are developed accordingly.

5.20 For existing schemes, when fraud occurs or a risk is identified, then the Service reviews systems and directs appropriate changes to systems. For example, changes have been made to prescription forms to reduce error and fraud, and point of dispensing checks for entitlement for exemption have been introduced. If a patient does not sign the declaration on the back of the form, then the Prescription Pricing Authority now assumes that the patient was not entitled to a free prescription, unless the patient is under 16 or over 60, and does not pay the exemption fee to the pharmacist. If patients do not provide evidence of exemption to the dispensing pharmacist, then the form is annotated accordingly by the pharmacist and will be targeted by the Authority's Pharmaceutical Fraud Team. Statistics indicate a considerable success in combating losses from pharmaceutical patient charge evasion.

Detection

5.21 Although the direct actions of the Service staff, local counter-fraud specialists and internal audit have detected instances of fraud, it is reliant on NHS staff and contractors reporting suspicions of fraud. The development of an anti-fraud culture, supported by the establishment of reporting mechanisms, such as the Service's *Fraud And Corruption Reporting Line*, have provided the mechanism for bringing such suspicions to the attention of the trained specialist investigators.

5.22 In the 18 months since inception, the Service has received some 460 calls to the Fraud and Corruption Reporting Line which have resulted in 271 referrals to the regional investigation teams.

5.23 The Service also undertakes exercises to identify potential outliers in NHS reimbursement claim patterns. This can result in investigation of individual contractors and changes to claim procedures, such as amending claim forms. **Case study 2** provides an example of a fraud being detected from analysis of unusual claim profiles.

Case study 2: analysis of individual claims can detect fraud

Monitoring of dentists' claims identified an unexpected high level of claims for complex extractions and sedations by one dentist. The Service investigated the suspicion of overclaiming and, in August 2001, the dentist was arrested and records were seized. He was later convicted of offences of false accounting and deception, and was sentenced to 3 months in prison and ordered to repay costs of £14,000 within 28 days.

The Service has recently formed a specialist Dental Fraud Team to review dental cases, which will make recommendations for revisions to policy and procedures.

Source: NHS Counter Fraud Service

Investigation

5.24 The Service has dedicated local operational teams, whose work includes investigation. These teams have the power to interview NHS staff under caution when investigating allegations, and it has memoranda of understanding with law enforcement agencies, which provide for the Service to investigate cases. The police are involved only where it is necessary to use their powers of search, arrest or detection. The memoranda allow for the Department's Solicitors Branch to prosecute in place of the Crown Prosecution Service. The Service has sought these arrangements to enable it to investigate fraud in the most efficient and effective way.

Case study 3: Investigation of alleged fraud by the Service secured conviction

A finance manager at an NHS Community Trust defrauded the NHS of £125,000 by adding four family members to the payroll, and claiming for hours that they did not work. Following an internal inquiry, the case was passed to the Service for investigation. The Service established that signatures had been forged on timesheets, and that claims had been made when one person had not even been in the UK. The proof collected by the Service was sufficient to secure criminal convictions for the five defendants, who each received custodial sentences.

Source: NHS Counter Fraud Service

Sanctions and redress

5.25 Since the creation of the Service in 1999 to October 2002, 135 prosecutions for alleged fraud have been completed, with all but three resulting in conviction.

5.26 A recent initiative implemented by the Service is to gain redress for fraudulent activity through the use of *parallel sanctions*: the application of various sanctions, individually or collectively, to seek redress. As well as pursuing a criminal prosecution, civil action is taken to recover losses incurred by the NHS. **Case study 4** demonstrates how the NHS has recovered losses from a convicted general practitioner, gaining reparation from his pension.

Case study 4: applying parallel sanctions redresses losses incurred by the NHS

A senior dispensing GP operated two surgeries in Dorchester. His practice partner raised concerns regarding financial irregularities that resulted in a joint investigation being conducted with the Service and Dorset Police. The GP had claimed for 4,000 exempt prescriptions from the Prescription Pricing Authority since 1994, of which only around 15 per cent were genuine. The GP had engineered the deception by commissioning a Dorchester printing company to produce blank invoices in the names of nine pharmaceutical companies, seven of which were fictitious. Investigators retrieved 1,054 completed invoices representing false transactions; the GP had grossly exaggerated the purchase and supply of drugs and medical equipment. The GP pleaded guilty to the 14 offences of obtaining money by deception and 36 counts of false accounting, and received a custodial sentence of over three years.

The court found that the doctor had benefited to the sum of £799,000. A confiscation hearing was held in June 2001. He was ordered to repay £88,000 within three months and the remaining £711,000 was recovered from his pension.

Source: NHS Counter Fraud Service

5.27 Since its inception, the Service has pursued 186 civil and disciplinary sanctions, recovering in excess of £11.7 million. The Service has signed memoranda of understanding with professional staff associations and regulatory bodies across the NHS. By March 2002, more than 400,000 staff and contractors were covered by such agreements, as well as 113 patient groups and all NHS regulatory bodies. These provide a framework for concerted sanctions; for example, professional regulatory bodies have agreed to support the consistent development and application of appropriate disciplinary processes and the imposition of appropriate sanctions, and such support is regularly advertised.

Local counter-fraud specialists

- 5.28 Each NHS organisation is required by the Secretary of State to put procedures in place to counter fraud, which include the appointment of local counter-fraud specialists. The Service provides the specialists with training in counter-fraud work. The training courses are accredited by the Institute of Criminal Justice Studies, and all prospective specialists are subject to propriety checks.
- 5.29 The specialists' role encompasses both reactive work, such as data collection for fraud investigations and appearing as witnesses in criminal cases, and proactive work, such as providing fraud awareness seminars. The Service supports these specialists, providing operational support, as well as carrying out quality inspections. The local specialists form an integral part of the NHS' efforts to combat internal fraud.
- 5.30 During my review, NHS staff raised two issues of concern regarding the local counter-fraud service:
- The cost of external provision of counter-fraud services can range from £180 to £400 per day. There was a suggestion that, in some cases, cost may be acting as a disincentive to NHS Trust and PCT management for referring suspicions.
 - There is a wide variation between NHS bodies in the status of counter-fraud specialists. Also conflicting pressures from the separate roles of a nominated specialist can limit activities at certain times. For example, a finance staff member may not be able to devote time to this role during the accounts preparation period, and a specialist needs the support to be able to tackle fraud effectively. The audit committee is an integral component for monitoring losses to fraud and counter-fraud measures within an organisation, and so the local counter-fraud specialist must have sufficient standing within an organisation to be able to report freely to the committee. Equally, the Committee should ensure adequate coverage throughout the period.
- 5.31 The Service is working with NHS bodies to seek solutions to these issues, whilst reiterating their duty for investigating suspicions of fraud. It plans to carry out a review of the current level of service provision in 2003, which will include undertaking a range of pilot studies in 2003-2004 to evaluate different models of local specialist provision.

Success of the NHS Counter Fraud Service

- 5.32 The measurement exercises indicate that fraud within family health services has fallen since the Service was established. The specific impact of the Service's individual initiatives for tackling fraud described above, are not easily measurable, with the reductions likely to be due to a combination of factors. Nevertheless, I commend the progress the Department and the NHS, driven by the Service, have made in reducing fraud within family health services, and in establishing an anti-fraud culture within the NHS.
- 5.33 Whilst the Service has begun to make a difference in its aim to minimise fraud, it is still at an early stage of its ten-year strategy. The Department informs me that it is due to undertake an exercise in 2003 to evaluate its impact to date in reducing fraud, and I will report findings in my report on the 2002-03 summarised accounts.

The role of external auditors

- 5.34 The prevention and detection of fraud are statutory responsibilities of the management of the NHS bodies, and not the external auditors. However, external auditors still have a role in countering fraud. The Audit Commission Code of Audit Practice requires all auditors of NHS bodies to consider whether the audited body has put in place adequate arrangements to maintain proper standards of financial conduct, and to prevent and detect fraud and corruption.
- 5.35 Based on their assessment of local risks, auditors may undertake specific audits, including reviews of IT systems and data-matching exercises. The Audit Commission's National Fraud Initiative (NFI) matches payroll data to local authority data on housing benefits, as well as a range of other data, with a view to identifying matches which could be evidence of fraud. The Initiative has previously focused on local government but, for NFI 2000, the matching exercise was extended to cover the NHS in the London region. **Case study 5** provides some examples of how potential fraud was identified through checking whether NHS staff are in receipt of housing benefits. For NFI 2002, the Audit Commission will undertake the data-matching across the whole of the NHS.

Case study 5 : data matching can identify potential fraud

A London Borough achieved significant success by investigating matches between NHS payrolls and housing benefit claims. These identified overpayments of benefits involving a wide range of NHS staff. Several prosecutions will result from the false information provided by claimants. Examples include:

- A doctor who fraudulently claimed £49,000 of housing benefit whilst being employed by the NHS received an 18 months suspended sentence.
- A staff nurse who allegedly claimed £3,000 of housing benefit - prosecution is pending
- A careworker who claimed £83,000 of benefits is awaiting prosecution.

Source: Audit Commission National Fraud Initiative 2000 (published 2002)

Special health authority

- 5.36 The Secretary of State for Health has established a new special health authority in accordance with Section 11 of the NHS Act 1977⁵ with the responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the NHS. The Counter Fraud and Security Management Service will become fully operational on 1 April 2003, and will act at arms length from the Department.
- 5.37 The new body has a remit to counter fraud within the Department as well as within the NHS, and should allow counter-fraud activities to extend beyond the original priority of fraud within family health services. This will also provide the Department with an ideal opportunity to develop a set of comprehensive targets for the reduction of fraud across all areas of the Department and the NHS.
- 5.38 The Department should set this organisation new targets to succeed the expired Public Service Agreement targets, which are measurable and encompass all risk areas across the NHS. These targets should be in percentage terms, rather than absolute values, thereby more easily demonstrating the relative success of the efforts to counter fraud.

Impact of fraud on my audit opinions

- 5.39 Measurement exercises undertaken to date by the Service suggest that fraud within family health services is some £118 million per annum. Total expenditure for these services for 2001-2002 was £11.9 billion, compared to overall departmental expenditure of £53.1 billion (Department of Health Resource Account 2001-2002). The Department set the Service an original priority of tackling fraud within family health services. Operational experience has since shown that significant losses to fraud and corruption are also being incurred in other sectors of the NHS, with 38 per cent of live cases being investigated occurring in non-primary care.
- 5.40 I consider that the estimated losses through fraud do not distort the truth and fairness of the NHS summarised accounts nor the departmental Resource Account for 2001-2002, and I am therefore able to give an unqualified opinion with respect to regularity. I will, however, continue to monitor the extent of fraud within the Department and the NHS, and consider my opinion in this regard annually.
- 5.41 The financial reporting arrangements in Wales and Scotland differ to those in England. The accounts of the individual health authorities in Wales, and the health boards and Primary Care Trusts in Scotland, have each been qualified on grounds of regularity because there is no separate organisation for handling dental claims and so the fraud in this area directly affects the accounts of those bodies. As a result the summarised accounts for health authorities in Wales have been qualified on grounds of regularity, as have the accounts for the Scottish Executive, where Summarised Accounts are no longer prepared.

Part 6

Clinical Negligence and provisions

Introduction

6.1 This part of my report :

- Outlines the role of the NHS Litigation Authority in administering clinical negligence claims, and the amounts paid out in 2001-2002 (paragraphs 6.2 to 6.6);
- Analyses the total potential clinical negligence liabilities for the NHS, drawing together the balances recorded in the different organisations within the NHS (paragraphs 6.7 to 6.11);
- Highlights developments since the Public Accounts Committee report "*Handling Clinical Negligence Claims in England*" (paragraphs 6.12 to 6.13);
- Explains how the administration and accounting for the Clinical Negligence Scheme for Trusts transferred to the NHS Litigation Authority (paragraphs 6.14 to 6.16);
- Reviews the Department's use of other provisions for liabilities in the summarised accounts, including those for restructuring costs such as redundancy and early retirement (paragraphs 6.17 to 6.19).

Clinical negligence

Background

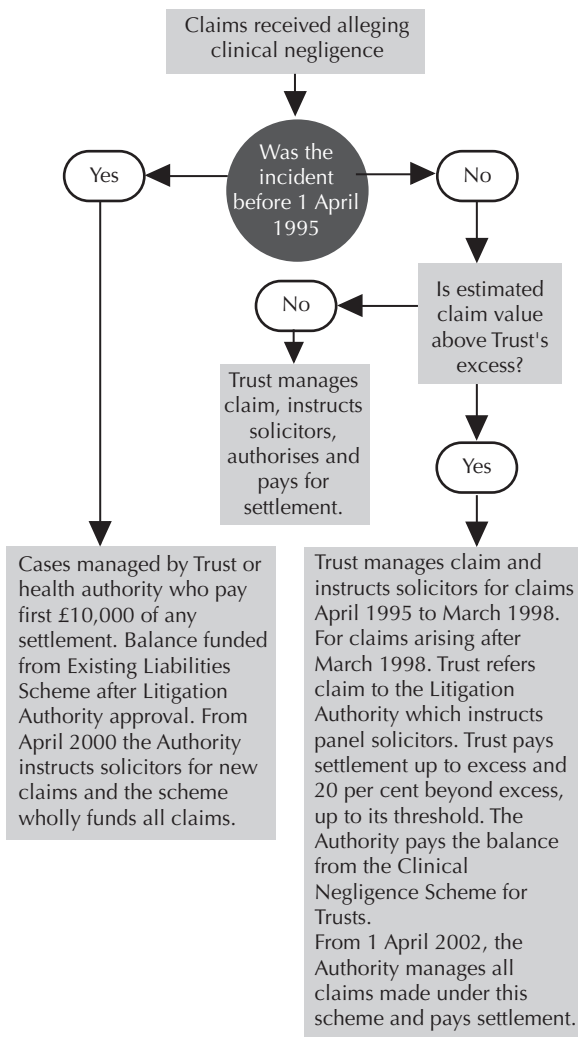
- 6.2 Clinical negligence is the term given to a breach of a duty of care by healthcare practitioners in the performance of their duties. Meeting the liabilities for clinical negligence continues to be a major challenge facing the NHS and represents a significant drain on resources away from patient care.
- 6.3 Until 1989, individual practitioners were responsible for claims for clinical negligence against them. Practitioners in England insured themselves against the potential costs through the Medical Defence Union, the Medical

Protection Society and the Medical and Dental Defence Union of Scotland. In 1990, the NHS took over responsibility for all outstanding and future clinical negligence claims involving medical and dental staff employed by health authorities.

- 6.4 When NHS Trusts were established from 1991, they became liable for their own claims whilst health authorities remained responsible for claims relating to earlier incidents. Their role is to undertake the initial investigation and assessment of adverse medical incidents. The NHS Litigation Authority⁶ ("the Authority") provides a central focal point for managing clinical negligence claims within the NHS, to ensure consistency in handling such claims. The extent of the Authority's involvement in dealing with a particular claim depends on its scale, and when it arose (**Figure 13 overleaf**).
- 6.5 Under the Clinical Negligence Scheme for Trusts risk pool, NHS Trusts and other member organisations pay annual contributions to the Authority, which administers and settles claims on their behalf. The contributions are based on the Authority's risk assessment of the individual member organisation, taking account of the claims history and the field in which the organisation operates. Each NHS Trust agreed an excess figure with the Authority and pays out amounts below this amount and twenty per cent beyond excess, up to its threshold.
- 6.6 The Authority collects sufficient annual contributions from each NHS Trust to cover the anticipated Clinical Negligence Scheme for Trusts payments for the financial year with any shortfall or excess being adjusted in the following year. In 2001-2002, the Authority paid out £83 million under the Clinical Negligence Scheme for Trusts, and collected contributions of £41 million from NHS Trusts. In 2001-2002, the Authority paid out some £430 million for all clinical negligence schemes and NHS Trusts paid out some £16 million to settle clinical negligence claims (**Figure 14 overleaf**).

⁶ The NHS Litigation Authority is a Special Health Authority, set up under the NHS Act 1977 to administer clinical negligence and other pooled risk schemes for the NHS.

13 The main funding avenues available to NHS bodies to meet clinical negligence settlements in 2001-02



Source: The National Audit Office

14 Total paid out by NHS organisations on clinical negligence claims

	2001-2002 £ million	2000-2001 £ million
NHS Litigation Authority		
Clinical Negligence Scheme for Trusts	83	23
Ex-Regional Health Authority Scheme	4	7
Existing Liabilities Scheme	343	228
NHS Litigation Authority total	430	258
NHS Trusts		
Clinical Negligence Scheme for Trusts (and Existing Liabilities Scheme for 2000-2001)	16	157
Total paid out by NHS organisations on clinical negligence claims	446	415
Clinical Negligence Scheme for Trusts contributions to NHS Litigation Authority from NHS Trusts	(41)	(50)

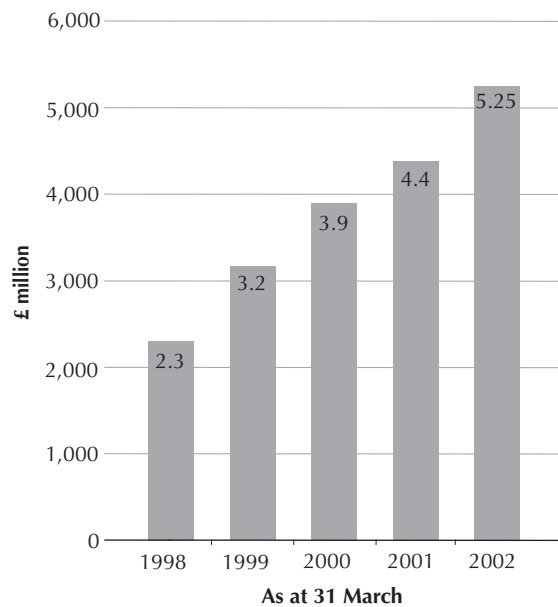
Source: NHS Litigation Authority

Provisions for clinical negligence

Total liabilities

6.7 The NHS expects to pay out £5.25 billion, at today's prices, over a number of years in respect of known or expected claims - after taking into account the likelihood of settlement of those claims (2000-2001: £4.4 billion). These sums are shown as provisions in the summarised accounts. An additional £3.1 billion of claims are possible, but unlikely (2000-2001: £4.0 billion). These are shown as contingent liabilities in the summarised accounts. **Figure 15** shows the trend in provisions over the past five years.

15 Provisions for clinical negligence within the NHS



Source: Summarised accounts for health authorities, Primary Care Trusts, the National Blood Authority and the NHS Litigation Authority

6.8 The provisions have been calculated in accordance with Financial Reporting Standard 12 and represent the value of claims received, at today's prices, calculated to reflect the probability of each claim being settled whenever that might occur. This includes an estimate made by actuaries of incidents incurred but not yet reported to the Authority.

6.9 The change in provisions is largely due to two factors:

- The main change in the value of provisions arose this year because of revised assumptions applied by the actuaries in calculating estimates. For example, data collected by the NHS Litigation Authority shows that the period from incident to claim was longer than previously anticipated and their actuaries adjusted their calculations accordingly.

The transfer of the Existing Liabilities Scheme and Clinical Negligence Scheme for Trusts claims to the Authority initiated this re-examination;

- The Authority reported a decrease in new claims, from 4,115 in 2000-2001 to 2,068 in 2001-2002 for the Clinical Negligence Scheme for Trusts. During the year, the Authority closed 1,287 Clinical Negligence Scheme for Trusts' cases (2000-2001: 1,547) and agreed damages in 1,154 claims leaving only legal costs outstanding.

6.10 **Figure 16** shows the periods in which the NHS expects to pay out the £5.25 billion in settlement of claims provided for.

Average times taken to settle claims

6.11 The average times taken from claim against the NHS Trust or health authority to settlement are set out below (**Figure 17**). This is an improvement from the 1999-2000 figures I estimated⁷ for the Existing Liabilities Scheme.

Public Accounts Committee

6.12 Following the Government's response to the Committee of Public Accounts report *Handling Clinical Negligence Claims in England* (thirty seventh report, 2001-2002) in October 2002, the Department and the Authority have been developing further initiatives to streamline the claims process. Initiatives taken include:

- Increased use of mediation;
- Expedition in the disposal of claims; and
- Reduction in legal costs and disbursements incurred in dealing with claims.

6.13 The Department intends to issue a report which will describe its proposals to the reform of clinical negligence, and may address the Committee of Public Accounts' recommendations.

Administration of the Clinical Negligence Scheme for Trusts

6.14 To further streamline management of clinical negligence claims, from 1 April 2002 responsibility for the administration of the Clinical Negligence Scheme for Trusts transferred to the Authority. This means that all alleged incidents of clinical negligence occurring across the NHS, including those previously dealt with directly by NHS Trusts, are now administered and accounted for by the Authority.

6.15 To account for the transfer, NHS Trusts, health authorities and Primary Care Trusts removed from their accounts all remaining provisions and contingent liabilities as at 31 March 2002 (£1.4 billion), and the Authority reassessed the liabilities and included an appropriate provision (£0.8 billion) for the cases transferred. The difference in the value of provisions transferred is due to the Authority reassessing each case on its transfer to the Authority.

6.16 Individual NHS Trusts, health authorities and Primary Care Trusts continue to report their respective positions regarding clinical negligence in notes to their accounts and NHS Trusts and Primary Care Trusts will continue to pay annual contributions to the Authority. Furthermore, this administrative arrangement does not affect these organisations' duty of care nor the legal liability for cases arising.

16 Expected timing of payment of clinical negligence liabilities

	Within one year	1 - 5 years	Over 5 years	Total
Expected timing of payment of clinical negligence liabilities	£0.51 billion	£1.10 billion	£3.64 billion	£5.25 billion

Source: NHS Litigation Authority

17 The average time until claims are settled

	Existing Liabilities Scheme		Clinical Negligence Scheme for Trusts
	Claims settled in 2001-2002	Claims settled in 1999-2000	Claims settled in 2001-2002
Average time taken from claim to claim settlement	3.89	5.5 years	1.27 years

Source: NHS Litigation Authority

⁷ *Handling Clinical Negligence Claims in England (HC 403, 2000-2001), paragraph 2.15.*

Other provisions

6.17 The accounts of NHS organisations also disclose significant other provisions for liabilities, most notably for pensions relating to former directors and staff, restructuring, and other legal claims (**Figure 18**).

6.18 Restructuring provisions total some £63 million at the end of 2001-02, up by some £11 million since last year. These primarily relate to the costs of early retirements and redundancies and reflect the effects of the implementation of the NHS Plan on the structure and staffing of the NHS. In addition, the restructuring of the health sector has contributed to the increase of £17 million in provisions for pensions of former Directors and staff.

6.19 Provisions for other legal claims have risen by over £21 million since 2000-2001. These claims include personal injury claims, claims by contractors and claims by employees. The Department considers that this increase of over 23 per cent is due to the more people in society resorting to legal action and significant increases in the level of damages being awarded.

18 Other NHS Provisions

	Pensions to former Directors and staff	Other legal claims	Restructuring	Other	Total	Total 2000-01
	£ million	£ million	£ million	£ million	£ million	£ million
Health Authorities	193.5	43.3	41.5	78.8	357.1	329.0
Primary Care Trusts	6.8	2.6	1.3	4.5	15.2	2.5
NHS Trusts	168.6	67.5	17.7	70.9	324.7	317.4
Special health authorities	13.5	0.2	3.4	75.7	92.8	84.1
Total	382.4	113.6	63.9	229.9	789.8	733.0
2000-2001	365.3	92.3	52.7	222.6	732.9	

Source: Accounts of individual NHS organisations