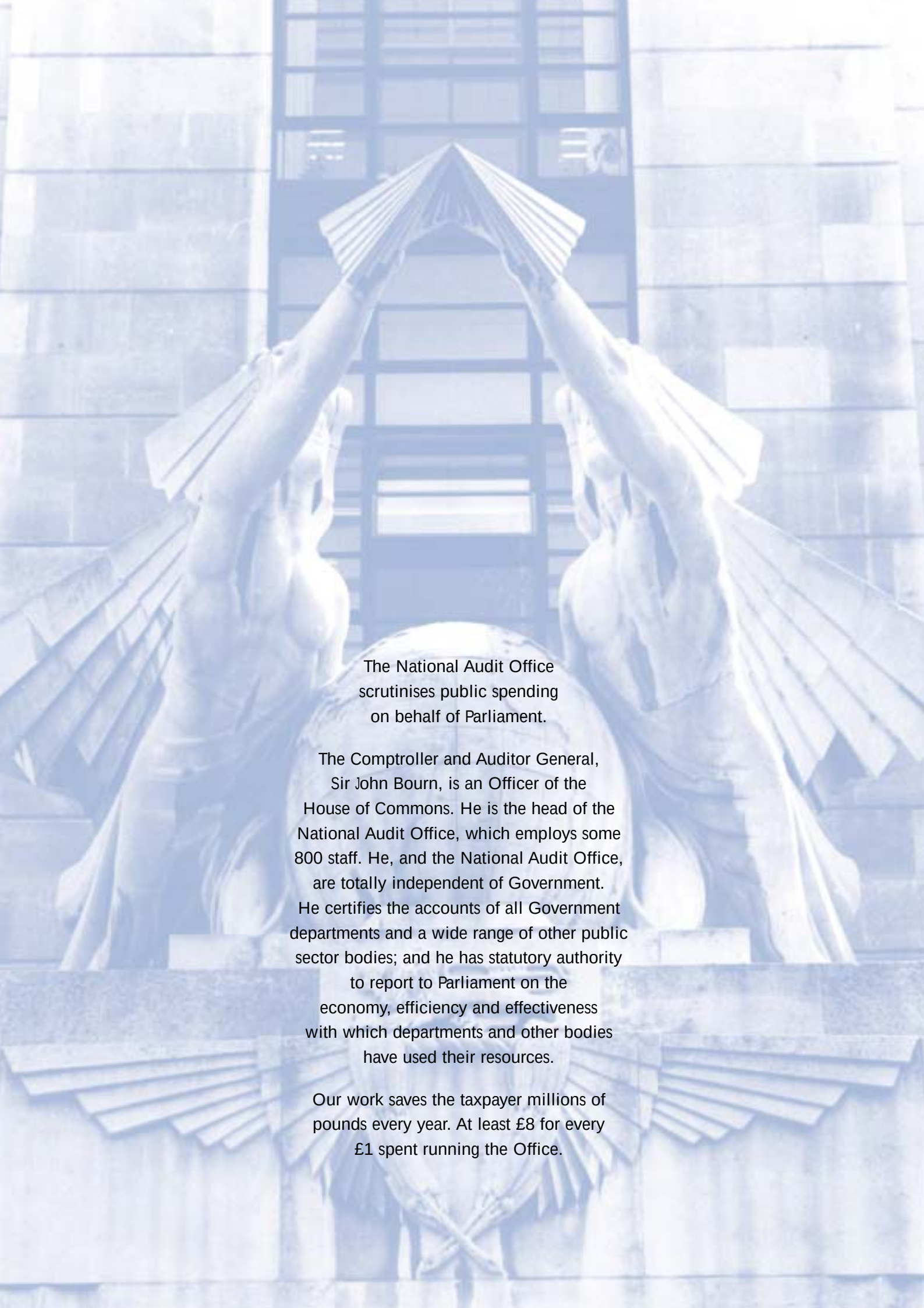
NATIONAL AUDIT OFFICE

NHS (England) Summarised Accounts 2002-2003

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 505-I Session 2003-2004: 28 April 2004



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John Bourn **National Audit Office**
Comptroller and Auditor General **26 April 2004**

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Contents

executive summary

Part 1 - Audit of the summarised accounts

1 Under "Shifting the Balance of Power", the Department's programme to implement The NHS Plan[1], the NHS underwent a number of structural changes during 2002-03. The main changes have been the creation of Strategic Health Authorities, the abolition of the Department's Directorates of Health and Social Care, which has increased the performance management role of the Strategic Health Authorities; and an increase in the number, and an enhanced role, of Primary Care Trusts.

2 The Department of Health (the Department) prepares summarised accounts for the NHS in England, which for 2002-03 covered the:

- 28 Strategic Health Authorities;
- 304 Primary Care Trusts;
- 275 NHS Trusts;
- 320 charitable funds held on trust;
- 18 Special Health Authorities; and
- the Dental Practice Board.

3 The appointed auditors gave unqualified true and fair audit opinions on the accounts of all the underlying organisations.

4 Appointed auditors were also required to express an opinion on the regularity of the activities of Strategic Health Authorities, Primary Care Trusts, special health authorities and the Dental Practice Board. In 2002-03, they provided unqualified regularity opinions on all but sixteen Primary Care Trusts and the pharmaceutical services and general dental services financial statements.

5 On the basis of my assessment of the work of the appointed auditors, and my audit of the Department, I have given unqualified true and fair opinions on all of the 2002-03 summarised accounts. However, I have qualified my regularity opinion on seven special health authorities and the Dental Practice Board. These bodies breached their statutory duty to contain their use of resources within the amount specified for them in relation to the year by the Secretary of State.

6 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 compared to last year. The Department received 87 per cent of the 626 audited accounts within the agreed deadlines. The Treasury have proposed that Departmental resource accounts should be prepared and audited prior to the Parliamentary summer recess by 2005-06. To achieve this, the preparation and auditing of the accounts of underlying NHS bodies and the summarised accounts needs to be significantly accelerated.

1 The NHS Plan: A plan for investment. A plan for reform, Department of Health, July 2000.

7 Since my last report, appointed auditors issued two public interest reports under Section 8 and one referral to the Secretary of State under Section 19 of the Audit Commission Act 1998.

8 From 2003-04, I assumed direct responsibility for the audit of the existing Special Health Authorities from the Audit Commission. A statutory instrument will be necessary to transfer responsibility for new Special Health Authorities created, pending the amendment of primary legislation to bring the audit arrangements of new Special Health Authorities in line with existing bodies. These arrangements will also lead to the cessation of summarised accounts for most Special Health Authorities, apart from those which are not included within Central Government Accounts.

9 The Health and Social Care (Community Health and Standards) Act 2003 created NHS Foundation Trusts. The Independent Regulator of NHS Foundation Trusts will prepare and lay before Parliament an annual report which provides an overall summary of the accounts of NHS Foundation Trusts.

10 Subject to the passing of legislation, the Department currently proposes that the final Funds Held on Trust summarised account will be prepared and presented for my audit for 2003-04.

Part 2 - Managing the finances of the NHS

Section 1 - Did the NHS achieve its financial targets in 2002-03?

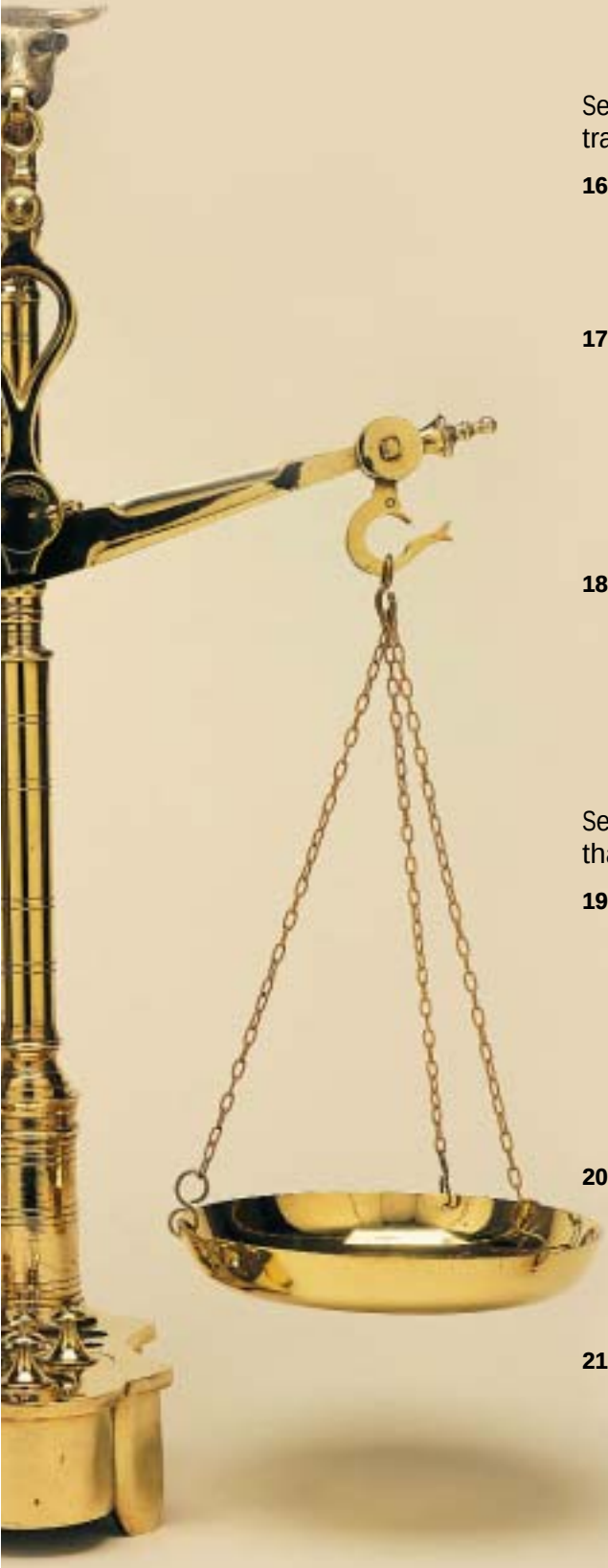
11 In 2002-03, the Department of Health met its target of ensuring that financial balance was achieved in aggregate across 607 individual NHS organisations spending a total of £53.5 billion. The aggregate underspend across all NHS bodies was £96 million, or 0.18 per cent of total expenditure.

Section 2 - Do individual organisations reporting large deficits put at risk the achievement of financial balance across the NHS?

12 As in previous years, this aggregate underspend was achieved despite variable performance in individual NHS organisations. Of the 607 bodies, 71 (12 per cent) did not achieve financial balance compared to 50 out of 577 bodies (nine per cent) last year. Of these 71 bodies, significant deficits (where the deficit exceeds 0.5 per cent of revenue resource limit or total annual income) arose in 51 (eight per cent) compared to 31 (five per cent) last year. In particular, three Primary Care Trusts and seven NHS Trusts reported in-year deficits of over £5 million and six NHS Trusts had a cumulative deficit (for statutory break-even purposes) of over £10 million as at 31 March 2003.

13 Organisations have a duty to make good deficits arising. Where there are large and cumulative deficits, this represents a significant challenge to the individual bodies themselves. Also, at the aggregate level, if these are not matched by surpluses elsewhere, large deficits in organisations may put at risk the achievement of overall financial balance of the National Health Service.

14 Sound corporate governance arrangements are an essential component of good financial management. The example of North Bristol NHS Trust illustrates the impact of poor financial management and corporate governance procedures. In 2002-03, the Trust reported a deficit of £44.6 million, the largest deficit ever incurred by an NHS organisation. The true scale of the deficit was not reported to the Trust Board until the final part of the financial year, leaving little opportunity for remedial action to be taken.



15 Factors leading to these significant deficits have been investigated by the bodies themselves and lessons are being learnt for the future. Recovery plans are in place in most organisations reporting deficits, and achievement against the plans is monitored by their Strategic Health Authority.

Section 3 - Is the effect of financial support on the financial position transparent and is its use appropriate?

16 The results for the year for each organisation are stated after taking into account financial support. Financial support is a tool used by the Department to reallocate resources to help NHS organisations achieve financial balance. It can either be planned or unplanned.

17 It is useful to identify where planned support has been used because most forms of support are non-recurrent or carry risks. This may have implications for the achievement of financial balance in future years. The need for unplanned support represents a greater risk to bodies as it is caused by factors which had not been planned for. However, in 2002-03, the amount, source and use of planned and unplanned support was not comprehensively reported in the underlying accounts of individual NHS organisations.

18 Without support, a greater number of individual organisations would have failed to achieve financial balance. From 2003-04 the Department will be restricting the use of unplanned financial support, and surpluses and deficits will remain where they arise. This clarity should act as a further incentive for NHS organisations to manage within budget. This would not impact on the overall position of the NHS.

Section 4 - Does the Department have systems in place to ensure that financial balance is achieved across the NHS?

19 The Department has high-level controls in place to monitor the achievement of financial balance across the NHS, with the detailed monitoring of NHS Trusts and Primary Care Trusts delegated to Strategic Health Authorities. The Department uses the Strategic Health Authority commentary on individual bodies, financial performance and forecasts for the purpose of its overall performance management of the NHS. The role of the Strategic Health Authorities in notifying the financial forecasts, and associated risks, to the Department is therefore crucial.

20 Strategic Health Authorities have procedures in place to ensure that robust budgets are set and to verify the reliability of monthly outturn figures reported to them. An understanding of the risks faced and the extent to which they are factored into the reported figures is an important of element of understanding the overall position.

21 Sound corporate governance arrangements in individual NHS organisations are required to underpin the Department's high-level monitoring and for the control and management of the individual organisations themselves. No Strategic Health Authority, NHS Trust or Primary Care Trust had fully embedded risk management arrangements in place by 31 March 2003 to allow them to report a full statement on internal control for the whole of 2002-03. The Department requires all organisations to have an assurance framework in place by 31 March 2004, which will act as evidence for the statement on internal control.

Clinical negligence

22 The financial impact of paying clinical negligence claims places increasing pressure on the Department's limited resources. The NHS paid out some £446 million to settle clinical negligence claims in 2002-03, the same amount as in 2001-02. Provisions for the probable future cost of clinical negligence within the NHS amounted to £5.89 billion at 31 March 2003, an increase of £0.64 billion since 31 March 2002. Of the £5.89 billion, some £0.67 billion is expected to be paid out in 2003-04.

Fraud in the NHS

23 The Department has arrangements in place to tackle fraud, however more can be done to estimate the total levels of fraud across all activities and thus help target prevention and detection better.

24 A Special Health Authority, the NHS Counter Fraud and Security Management Service, was established on 1 January 2003 as the successor body to the NHS Counter Fraud Service, established in September 1998 with the remit of tackling losses due to fraud and corruption in the NHS. The target set, to reduce pharmaceutical patient fraud by 50 per cent by 2002-03, has been exceeded. The figure in 1998-99 was £117 million and is now £47 million, representing a 60 per cent overall reduction. Pharmaceutical, dental and optical patient fraud has been reduced from £170 million in 1998-99 to £87 million by the end of 2002-03.

Section 5 - Will planned developments in the NHS have a significant impact on the way finances are managed in future?

25 The funding allocated to the NHS is increasing. The creation of Foundation Trusts and payment by results will have significant implications for the way the NHS is managed and financed. The Department is working with the NHS to implement these changes.

Part 1

Audit of the 2002-03 Summarised Accounts

Preparation of the Accounts

1.1 The Department of Health (the Department) prepares summarised accounts for the National Health Service (NHS) in England. For the financial year 2002-03 these accounts covered:

- 28 Strategic Health Authorities;
- 304 Primary Care Trusts;
- 275 NHS Trusts;
- 320 charitable funds held on trust;
- 18 Special Health Authorities; and
- the Dental Practice Board.

The changing structure of the National Health Service in England

1.2 The Department of Health sets the overall direction and secures resources for the National Health Service. Under "Shifting the Balance of Power", the Department's programme to implement *The NHS Plan*[2], the NHS underwent a number of structural changes during 2002-03. The main changes were the creation of Strategic Health Authorities; the abolition of the Department's Directorates of Health and Social Care, leading to an increase in the performance management role of the Strategic Health Authorities; and an increase in the number, and enhanced roles, of Primary Care Trusts.

1.3 In line with *The NHS Plan*, Primary Care Trusts have become the lead organisations in assessing need, planning and commissioning all health services and improving health.

1.4 Strategic Health Authorities have a more strategic role and are responsible for performance managing NHS organisations within their area. The current 28 Strategic Health Authorities were established on 1 April 2002. From 1 October 2002 they ceased to have responsibility for commissioning health services when remaining responsibilities passed to Primary Care Trusts. The Strategic Health Authorities provide a key link between the NHS and the Department.

1.5 Primary Care Trusts and NHS Trusts are accountable to Strategic Health Authorities, which are in turn accountable to the Department **(Figure 1)**.

Funding of the National Health Service

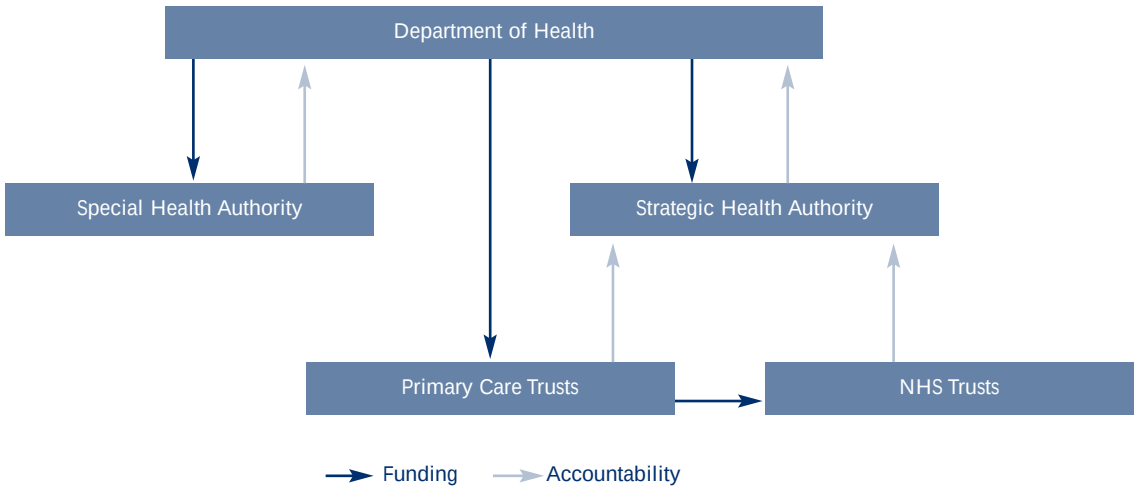
1.6 Most of the funding for the NHS is provided by the Department of Health. The Department allocates resources directly to Primary Care Trusts who then pay NHS Trusts and primary healthcare providers for the healthcare that they commission from them. The Department's target is that Primary Care Trusts will control more than 75 per cent of the NHS budget from 2003-04 onwards.

1.7 Funding is allocated to Primary Care Trusts on a weighted capitation basis. This means that the allocation takes account of the relative healthcare needs of the population served, such as the size of the population, the age distribution and the cost of providing services in the area. This allocation process is described in more detail in the Department's document *Resource Allocation: Weighted Capitation Formula*[3].

1.8 NHS Trusts receive most of their funding from Primary Care Trusts, but they also receive smaller amounts directly from the Department for specific projects, and from other non-NHS sources such as income from car parking charges and insurers in connection with road traffic accidents.

2 *The NHS Plan: A plan for investment. A plan for reform, Department of Health, July 2000.*
3 *Resource Allocation: Weighted Capitation Formula, Department of Health, 31 March 2003.*

1 Current structure of the NHS in England



NOTE

Some funding also goes from the Department directly to NHS Trusts.

Source: National Audit Office

Audit Arrangements in the National Health Service

1.9 Funding for the NHS is reported in the Department's consolidated Resource Account, which is subject to my audit. The Department's Resource Account for 2002-03 was laid before the House of Commons on 19 January 2004 [HC 191, 2003-04].

1.10 The individual accounts of Strategic Health Authorities, Primary Care Trusts, most Special Health Authorities and the Dental Practice Board report expenditure incurred against a resource limit and a separate capital limit set for each of them by the Department. They have a duty, under Sections 97AA and 97E of the National Health Service Act 1977, to contain expenditure within these limits. The accounts of NHS Trusts and some Special Health Authorities report either a surplus or a deficit for the year, depending on whether their total expenditure is within, or exceeds, their income.

1.11 The individual accounts of each organisation are audited by auditors appointed by the Audit Commission 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 to lay copies of them, together with my report on them, before both Houses of Parliament.

1.12 **Figure 2** shows the audit arrangements for the underlying and summarised accounts of the NHS in 2002-03.

1.13 My examination in 2002-03 included reviewing the Department's process for summarising the information from the underlying accounts, and assessing the reliability of the information contained in the audited underlying accounts by:

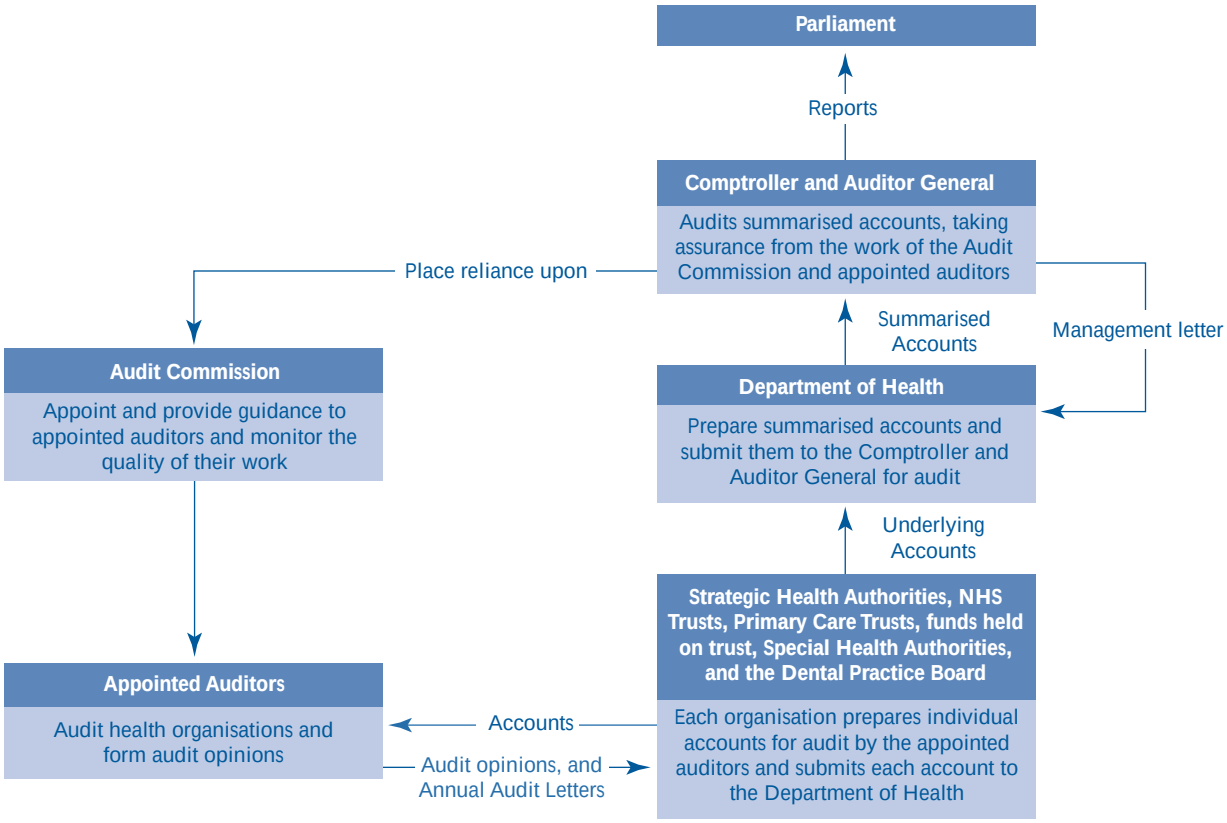
- reviewing the work of the auditors appointed by the Audit Commission;
- scrutinising their reports and findings; and
- ensuring that acceptable quality-control policies and procedures over the appointed auditors' work existed and operated effectively.

Findings of the Appointed Auditors

1.14 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 2003 and of its income and expenditure for the year.

1.15 The appointed auditors gave unqualified opinions that the accounts of all individual Strategic Health Authorities, Primary Care Trusts, NHS Trusts, Special Health Authorities and the Dental Practice Board reflected a true and fair view of their state of affairs as at 31 March 2003 and of their income and expenditure for that year. As a result I was also able to give unqualified true and fair view opinions on the summarised accounts for these bodies.

2 Audit arrangements in the National Health Service



Source: National Audit Office

Breaches of Regularity

1.16 For all organisations included within the Department's Resource Accounts, the 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".

1.17 In 2002-03, the appointed auditors gave unqualified regularity opinions on all but sixteen Primary Care Trusts and the pharmaceutical services and general dental services financial statements. Where the opinions were qualified, this was because of irregular expenditure (seven cases) or because organisations failed in their statutory duty to contain expenditure within their resource limits (fourteen cases, three of which were also qualified on the basis of irregular expenditure).

1.18 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 erroneous claims on the pharmaceutical services financial statement; and the
- the 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.

1.19 The financial statements for the pharmaceutical services and general dental services are not separately published, but are incorporated into the summarised accounts of the Primary Care Trusts.

1.20 Five Primary Care Trusts were given qualified regularity opinions for incurring irregular expenditure, totalling £5.1 million. The irregular expenditure all arose within the five Suffolk Primary Care Trusts which purchased mental health and learning disability services from Suffolk County Council. The expenditure was irregular because no agreements were in place under Section 31 of the Health Act 1999 for the discharge of Primary Care Trust functions by a County Council. The Department has confirmed that an agreement has been signed by the Primary Care Trusts in relation to this expenditure for 2003-04.

1.21 Under Section 97 of the National Health Service Act 1977, Strategic Health Authorities, Special Health Authorities, Primary Care Trusts and the Dental Practice Board have a statutory financial duty to ensure that the use of their resources in a financial year does not exceed the amount specified for them in relation to that year by the Secretary of State. Separate limits are set for revenue and capital resources. Where the Secretary of State does not set a limit, the limit is deemed to be zero.

1.22 In the case of fifteen organisations, the appointed auditors qualified their regularity opinion on the accounts because either the revenue or capital resource limit had been breached. I separately reviewed the performance of each Strategic Health Authority, Primary Care Trust, Special Health Authority and the Dental Practice Board against the limits set by the Department in 2002-03. As shown in **Figure 3**, I found that a total of 24 organisations had breached their revenue resource limit and 21 organisations had breached their capital resource limit in 2002-03, with two organisations breaching both limits.

1.23 Failure to keep expenditure within agreed revenue and capital resource limits is a breach of a statutory financial duty and should therefore result in an automatic qualification to the regularity opinion even when the amounts may not appear to be significant. The appointed auditors have not been consistent in the conclusions that they have reached on this issue in 2002-03. For the future, the Audit Commission will remind their appointed auditors of the requirements in this area.

1.24 In the case of Primary Care Trusts and Strategic Health Authorities, I have not qualified my opinion on the summarised accounts since there are no overall resource limits for the sum of these organisations. I have however qualified my opinion on the summarised accounts for the seven individual Special Health Authorities and the Dental Practice Board which breached either their revenue or capital resource limits.

1.25 The Department has investigated the reasons for these breaches, and management arrangements have been revised and appropriate measures put in place to prevent a recurrence in future years.

Referrals to the Secretary of State

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

3 Breaches of resource limits in 2002-03

Revenue Resource Limit breaches		Capital Resource Limit breaches	
Twenty-one Primary Care Trusts	**£30.2 million**	**Twelve Primary Care Trusts**	**£7.2 million**
		Four Strategic Health Authorities	**£0.8 million**
Three Special Health Authorities	£0.1 million	The Dental Practice Board and four Special Health Authorities	£0.5 million
■ Mental Health Act Commission		■ National Patient Safety Agency	
■ Health Development Agency		■ National Clinical Assessment Authority	
■ National Treatment Agency		■ Retained Organs Commission	
		■ NHS Litigation Authority	
24 organisations	**£30.3 million**	**21 organisations**	**£8.5 million**

Source: National Audit Office analysis of Department of Health figures

1.27 Since my last Report [HC493, 2002-03], one such referral has been issued. In January 2004, the appointed auditor referred an ambulance trust to the Secretary of State over the increase in the Chief Executive's pay prior to his retirement. The auditor expressed concerns over the decision-making process, record keeping and legality of the increase.

1.28 The Strategic Health Authority has investigated this case and made recommendations designed to prevent inappropriate behaviour; however, the case is on-going.

Reports in the Public Interest

1.29 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, two such reports have been issued in March 2003 to:

- Avon, Gloucestershire and Wiltshire Strategic Health Authority; and
- West Yorkshire Metropolitan Ambulance Service NHS Trust.

1.30 The report to the Avon, Gloucestershire and Wiltshire Strategic Health Authority drew attention to the auditor's concerns about the financial standing of the NHS organisations within the Strategic Health Authority's area. I refer in more detail to these concerns, and the action taken on Avon, Gloucestershire and Wiltshire Strategic Health Authority, later in my report (paragraph 2.20).

1.31 The report to West Yorkshire Metropolitan Ambulance Service NHS Trust noted deficiencies in arrangements to adequately project-manage the roll out of a significant part of a major new Departmental initiative, NHS Professionals; and the financial difficulties which arose as a consequence of this. The aim of this initiative is to help hospitals better manage temporary shortages of nurses and locum doctors.

1.32 The Department has since established NHS Professionals as a Special Health Authority, with a remit to provide a national service within the NHS and to the NHS, helping Trusts locally to manage their temporary staffing needs cost-effectively. NHS Professionals will be subject to the same monitoring and performance-management arrangements as all other Special Health Authorities. Although presently funded directly by the Department, it is intended that NHS Professionals will be self-financing in the longer term.

Faster Closing

1.33 Under the "Faster Closing" initiative, HM Treasury requires government departments to progressively bring forward the timetable for production and audit of their Resource Accounts. The ultimate aim, to be achieved by 2005-06, is for all Resource Accounts to be prepared and audited prior to the Parliamentary summer recess.

1.34 To achieve this aim, the preparation and audit of the accounts of underlying NHS bodies and the summarised accounts needs to be significantly accelerated. Whilst the Department is taking steps to do so, much remains to be done. In their reports to bodies' management, the appointed auditors drew attention again this year to delays in producing the underlying accounts, and also to a reduction in the quality of the accounts and supporting working papers. In 2002-03, the Department received the accounts of 82 organisations (13 per cent) after the agreed deadline. Of these, 30 were received 1 working day late, 25 between 1 and 5 working days late and the remaining 27 more than 5 working days late. The last account was received 11 weeks late. As in previous years, some of the problems resulted from the significant restructuring of the health sector during the year, particularly in the Primary Care Trust sector.

1.35 As part of their role in managing performance in the NHS, from 2003-04 the Department has tasked Strategic Health Authorities to monitor whether Primary Care Trusts and NHS Trusts have appropriate processes in place such that good-quality draft accounts, with adequate supporting working papers, are submitted to the appointed auditors within the agreed deadlines. To help in this, Strategic Health Authorities are to ensure that there is early agreement of transactions and balances between the bodies within their area. For the 2003-04 accounts, a working group has been established, which includes a Strategic Health Authority Director of Finance, to suggest means of achieving earlier close downs.

Working with the NHS, the Audit Commission and the National Audit Office, the Department should continue to identify ways of progressively accelerating the timetable for the production and audit of the underlying and summarised accounts to meet HM Treasury's ultimate timetable.

Future Changes in Audit Arrangements

1.36 Under the Government Resources and Accounts Act 2000 (Audit of Special Health Service Bodies) Order 2003, from 2003-04 I assumed from the Audit Commission direct responsibility for the audit of the existing Special Health Authorities and the Dental Practice Board. My staff have been in discussion with the Audit Commission, the Special Health Authorities and the Dental Practice Board to agree and coordinate transfer arrangements.

1.37 A further statutory instrument will be necessary to transfer responsibility to me for the audits of those Special Health Authorities created since the passing of the 2003 Order. This currently includes the NHSU, NHS Professionals, NHS Direct and the NHS Pensions Agency, and will be necessary to ensure the consistency of audit arrangements pending the amendment of primary legislation.

1.38 Part of these arrangements will lead to the cessation of summarised accounts for most of the Special Health Authorities, but the accounts and annual reports of each will be submitted directly to Parliament by the bodies themselves. Summarised accounts will continue to be prepared for my audit for those Special Health Authorities which are not included within Central Government Accounts.

1.39 The Health and Social Care (Community Health and Standards) Act 2003 created the concept of NHS Foundation Trusts. NHS Foundation Trusts' Boards of Governors will appoint their own external auditors. Each NHS Foundation Trust will lay its accounts before Parliament. The Independent Regulator of NHS Foundation Trusts is required to prepare an annual report which will provide an overall summary of the accounts of NHS Foundation Trusts, and this summary will be laid before Parliament.

1.40 Using the Regulatory Reform Act 2001, the Department proposes to remove the requirement to submit individual 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. These individual accounts will, however, continue to be submitted to the Charity Commission. Subject to the passing of this legislation, the Department proposes that the final summarised account for Funds Held on Trust will be prepared and presented for my audit for 2003-04.

Part 2

Financial Performance of the NHS in 2002-03

Section 1: Did the NHS achieve its financial targets in 2002-03?

In 2002-03, the Department of Health had to ensure that financial balance was achieved in aggregate across 607 individual NHS organisations spending a total of £53.5 billion.

2.1 The Department is responsible for ensuring that the NHS lives within the resources voted to it by Parliament, whilst ensuring that those resources are used as fully and as efficiently as possible to achieve agreed objectives. Containing total expenditure within the resources voted by Parliament is referred to in this report as achieving financial balance in aggregate.

2.2 In 2002-03, the Department had to ensure that financial balance was achieved in aggregate across the 607 individual organisations which comprise the NHS, namely the 28 Strategic Health Authorities, the 304 Primary Care Trusts and the 275 NHS Trusts. In total, these 607 organisations spent some £53.5 billion in 2002-03 (£47 billion in 2001-02).

The Department met its target of achieving financial balance in 2002-03. The aggregate underspend across all NHS bodies was £96 million, or 0.18 per cent of total expenditure.

2.3 In 2002-03, the Department met its target of achieving financial balance across the NHS. The aggregate revenue underspend was £96 million, which represents 0.18 per cent of total expenditure. This compares to an underspend of £71 million (0.15 per cent) in 2001-02.

2.4 As in previous years, the aggregate underspend was achieved despite variable performances in individual NHS organisations. **Figure 4** summarises the total gross and net performance by type of NHS organisation.

Of the 607 NHS organisations, 71 (12 per cent) did not meet their individual targets of achieving financial balance.

2.5 Each individual NHS organisation has a number of financial duties, both statutory and departmental. Their main financial duty is to keep expenditure within the resources available. **Appendix 2** lists the statutory and departmental financial duties of each type of NHS organisation, and summarises the performance against these duties in 2002-03.

2.6 In this report, when referring to individual NHS organisations, remaining within agreed revenue resource limits and breaking even for the financial year will collectively be referred to as achieving financial balance. Underspends against the revenue resource limit (in the case of Strategic Health Authorities and Primary Care Trusts) and surpluses (in the case of NHS Trusts) will collectively be referred to as surpluses. Overspends against the revenue resource limit (in the case of Strategic Health Authorities and Primary Care Trusts) and deficits (in the case of NHS Trusts) will collectively be referred to as deficits.

2.7 Eighty-eight per cent of NHS organisations achieved financial balance in 2002-03, compared with 91 per cent in 2001-02. The breakdown of organisations failing to achieve financial balance is shown by type of organisation in **Figure 5**.

2.8 Of the 71 organisations which did not achieve financial balance in 2002-03, significant deficits arose in 51. The Department defines a significant deficit as one which exceeds 0.5 per cent of the revenue resource limit (for Strategic Health Authorities and Primary Care Trusts) or 0.5 per cent of total income (in the case of NHS Trusts). Using the same definition of significant, 104 organisations achieved a significant surplus in 2002-03. **Figure 6** shows significant surpluses and deficits by type of organisation. The Department accepts that there are a number of legitimate reasons for organisations having a significant surplus, for example to offset deficits incurred in previous years.

4 Surpluses and deficits in NHS organisations

	2002-03 £ million surplus/ underspend	2002-03 £ million deficit/ overspend	2002-03 £ million Net total	2001-02 £ million Net total
Strategic Health Authorities	96	0	96	100[1]
Primary Care Trusts	123	(30)	93	11
NHS Trusts	83	(176)	(93)	(40)
Total	**302**	**(206)**	**96**	71

NOTE

1 2001-02 figures refer to Health Authorities.

Source: National Audit Office analysis of audited accounts of individual organisations (Appendix 1)

5 Financial performance against revenue limits in 2002-03

	2002-03 Failed to achieve financial balance No.	2002-03 Failed to achieve financial balance Per cent	2002-03 Total no. of bodies	2001-02 Failed to achieve financial balance No.	2001-02 Failed to achieve financial balance Per cent	2001-02 Total no. of bodies
Strategic Health Authorities[1]	0	0%	28	0	0%	95
Primary Care Trusts	21	7%	304	0	0%	164
NHS Trusts	50	18%	275	50	16%	318
Total	**71**	**12%**	**607**	50	9%	577

NOTE

1 2001-02 figures refer to Health Authorities.

Source: Audited accounts of individual organisations

6 Significant Surpluses or Deficits

	Significant surpluses No.	Significant surpluses Per cent	Significant deficits No.	Significant deficits Per cent
Strategic Health Authorities	22	79%	0	0%
Primary Care Trusts	53	17%	11	4%
NHS Trusts	29	11%	40	15%
Total	**104**	**17%**	**51**	**8%**

Source: Audited accounts of individual organisations

2.9 The increase in the number of organisations incurring deficits (71 in 2002-03 compared with 50 in 2001-02, Figure 5), and the increased variability of performance (Figure 6) is a concern, particularly in the context of the wide-scale financial changes to be introduced in the NHS over the coming years. The Department considers that surpluses provide Strategic Health Authorities with the flexibility to deliver overall balance across their local health economies. Letting deficits lie where they are incurred ensures transparency.

2.10 The failure of some individual organisations to achieve financial balance did not prevent the Department from achieving overall financial balance in aggregate across the NHS in 2002-03. However, individual failures may pose a risk to the overall achievement of financial balance and are significant to the individual organisations themselves. In **Section 2**, I examine the reasons why deficits arise, the action taken to deal with deficits, and the impact on the whole health economy of organisations in deficit. A significant factor in the

deterioration in performance of Primary Care Trusts in 2002-03 was the reorganisations which took place during the financial year and the significant number of new organisations with the resultant lack of organisational knowledge and diversion of management attention.

2.11 Financial support is a tool used by the Department to help NHS organisations achieve financial balance. In **Section 3**, I describe what constitutes financial support and examine whether the effect of planned and unplanned support on the financial position is transparent and whether its use is appropriate.

2.12 To ensure that overall financial balance is achieved across the NHS, despite the variable performance of individual organisations, the Department has systems and procedures in place to monitor progress against targets throughout the year. I describe these procedures in more detail in **Section 4**.

Section 2: Do individual organisations reporting large deficits put at risk the achievement of financial balance across the NHS?

Eight per cent of NHS organisations reported significant deficits in 2002-03. Three Primary Care Trusts and seven NHS Trusts reported in-year deficits of over £5 million and six NHS Trusts had a cumulative deficit of over £10 million as at 31 March 2003. If not matched by surpluses elsewhere, large deficits in organisations may put at risk the overall financial balance of the National Health Service.

Six Strategic Health Authorities failed to achieve their supplementary duty of achieving financial balance in aggregate across their local healthcare areas.

2.13 As I have reported in Section 1, whilst the majority of NHS organisations achieved, or substantially achieved financial balance in 2002-03, eight per cent of individual NHS organisations reported significant deficits (Figure 6).

2.14 Of the 21 Primary Care Trusts which failed to achieve financial balance in 2002-03 (Figure 5), the overspends against revenue resource limit ranged from £3,000 to £5.7 million (up to 4.1 per cent of the revenue resource limit). Three Primary Care Trusts had overspends of more than £5 million **(Figure 7)**. This represents 54 per cent of the total deficit of £30 million incurred by Primary Care Trusts in 2002-03 (Figure 4). All of the Primary Care Trusts overspending by more than £5 million were within the South West Peninsula Strategic Health Authority area.

2.15 Of the 50 NHS Trusts which failed to achieve financial balance in 2002-03 (Figure 5), the in-year deficits ranged from £2,000 to £44.6 million (0.01 per cent to 20.5 per cent of total annual income). Seven NHS Trusts reported deficits of over £5 million **(Figure 8)**. This represents 64 per cent of the total deficit of £176 million incurred by NHS Trusts in 2002-03 (Figure 4). Three of these NHS Trusts (North Bristol, Royal United Hospital Bath, and United Bristol Healthcare) were in the Avon, Gloucestershire and Wiltshire Strategic Health Authority area.

7 Primary Care Trusts with overspends of more than £5 million

Primary Care Trust	Overspend £ million	Overspend As percentage of revenue resource limit
Central Cornwall	5.7	3.3%
North and East Cornwall	5.5	4.1%
West of Cornwall	5.1	3.8%

Source: Department of Health

8 NHS Trusts with overspends of more than £5 million

NHS Trust	Deficit in 2002-03 £ million	Deficit as percentage of annual income
North Bristol	44.6	16.1%
Royal United Hospital Bath	24.8	20.5%
East Kent Hospitals	11.4	4.1%
Worcester Acute Hospitals	9.9	5.4%
United Bristol Healthcare	9.3	3.5%
South Manchester University Hospitals	7.0	3.6%
Royal Cornwall Hospitals	5.2	3.0%
Total	**112.2**	

Source: Department of Health

2.16 NHS Trusts have a statutory duty to break even taking one year with another. The legislation does not identify how this should be measured, and the Department considers this target to be met if a deficit in one year is recovered within the following two financial years. In exceptional circumstances this recovery period can be extended to four years. As at 31 March 2003, six NHS Trusts had cumulative deficits (for statutory break-even purposes) of over £10 million **(Figure 9)**. The figure also shows the number of years for which a continuous cumulative deficit position has existed.

9 NHS Trusts with cumulative deficits (for statutory break-even purposes) of more than £10 million

NHS Trust	Cumulative deficit as at 31 March 2003 £ million	Years for which continuous cumulative deficit has existed
North Bristol	48.8	2
Royal United Hospital Bath	24.8	1
Barnet and Chase Farm Hospitals	19.9	4
United Bristol Healthcare	17.3	3
East Kent Hospitals	11.4	1
Worcestershire Acute Hospitals	11.3	2

Source: Department of Health

Most of the bodies in deficit had identified the causes of those deficits.

2.17 The Audit Commission's survey of the appointed auditors of individual NHS organisations found that all but two of the 21 Primary Care Trusts in deficit and all but three of the 50 NHS Trusts in deficit had identified the causes for those deficits. The main causes were noted as being:

- the high cost of using agency staff to deal with recruitment and retention difficulties;
- the increase in prescribing costs; and
- the costs of meeting targets in the NHS Plan, particularly where private sector care is purchased to achieve targets.

2.18 The causes of deficits are identified and recognised as risks to financial balance in individual organisations' financial plans and monthly performance returns. In those Strategic Health Authorities which successfully delivered financial balance across their healthcare area as well as meeting operational targets, a significant factor in achieving this was the existence over the financial period of sound internal management practices and good financial discipline.

2.19 Although no individual Strategic Health Authority failed to achieve financial balance in 2002-03, six failed to achieve their supplementary duty of achieving financial balance in aggregate across their local healthcare areas. **Figure 10** shows these Strategic Health Authorities and the amount of the aggregate deficit across their local areas, expressed as a value and as a percentage of their total resources.

The factors leading to significant deficits have been investigated and lessons are being learnt for the future.

2.20 The largest deficits in 2002-03 occurred in organisations within the Avon, Gloucester and Wiltshire, and South West Peninsula Strategic Health Authority areas. The reasons for these deficits are set out in **Figures 11 and 12** respectively. Despite these challenges, the Department expects that all organisations should plan for and deliver financial balance.

10 Strategic Health Authority areas reporting deficits

Strategic Health Authority area	Net deficit across Authority area	
	£ million	Percentage of resources
Avon, Gloucestershire and Wiltshire	63.6	1.85%
South West Peninsula	20.6	0.84%
Kent and Medway	19.6	0.89%
Greater Manchester	5.1	0.11%
Cumbria and Lancashire	1.6	0.05%
Hampshire and the Isle of Wight	1.0	0.04%
Total	**111.5**	

Source: NAO analysis of figures in audited accounts of individual organisations (Appendix 1)

11 Causes of the deficit in the Avon, Gloucester and Wiltshire Strategic Health Authority area

The specific problems in North Bristol NHS Trust are noted in **Case Study 1**.

Other problems affecting the organisations in Bristol were:

- ***Configuration of services.*** Bristol has three hospital sites, with some duplication of services across the sites. Structural changes are required to deliver efficiencies, but progress in reconfiguring the sites has been slow.
- ***Reorganisation of the NHS.*** The creation of Strategic Health Authorities and Primary Care Trusts resulted in a loss of focus on performance management which failed to identify and address the problems at an early stage.

Specific problems faced by the Royal United Hospital Trust, Bath include:

- ***Dispersed, rural population served by Community Hospitals.*** The Trust serves a geographically dispersed population, and includes a large number of community hospitals resulting in relatively high costs.
- ***Organisation of the local NHS.*** Four Primary Care Trusts commission services from the Trust, leading to difficulties in formulating a coherent strategy.

Source: National Audit Office

2.21 In response to the scale of the financial difficulties in the Avon, Gloucestershire and Wiltshire Strategic Health Authority area, the Audit Commission's appointed auditor produced a Public Interest Report on the situation. As stated in Part 1 of my Report (paragraph 1.29), Section 8 of the Audit Commission Act 1998 requires the appointed auditors to consider whether, in the public interest, they should report on any matter coming to their notice. The Audit Commission's report on the Avon, Gloucester and Wiltshire Strategic Health Authority raised concerns about the size of the deficits arising, the actions taken by the local NHS bodies to tackle the deficits, and the further actions required to restore financial balance. The Strategic Health Authority itself commissioned a report into the situation in the North Bristol NHS Trust, to examine the reasons why such a large deficit had accumulated **(Case Study 1)**.

Organisations have a duty to make good deficits arising. Where there are large and cumulative deficits, this represents a significant challenge.

2.22 The first priority for organisations that are in deficit is to achieve recurrent in-year financial balance. Once this has been achieved, measures have to be taken to make good the accumulated deficit. Since this entails generating a surplus in future years it represents a significant challenge for organisations currently failing to achieve in-year financial balance.

12 Causes of deficits in the Primary Care Trusts in the South West Peninsula Strategic Health Authority area

The deficits in the South West Peninsula are concentrated in Cornwall. The following factors contributed to the deficits in the Primary Care Trusts reporting deficits:

- Above-average activity. Above-average activity in certain areas, including primary care and accident and emergency services, resulting in higher than average costs. The population has relatively high access rates to surgery, including cardiac interventions and joint replacements, compared to national averages.
- Prescribing costs. Prescribing costs are comparatively high due to a higher than average demand for expensive new and specialist treatments.
- Dispersed rural population. Factors include: a rural and isolated population, served by a large number of Community Hospitals; concerted political and public opposition to closure of Community Hospitals makes it harder to rationalise services.
- Geography of Cornwall. The rural population and geography makes it comparatively expensive to provide ambulance services. Cornwall has a single county bordering it, limiting the scope for pooling resources with neighbouring services. There is low staff turnover, with many staff at the top of the payscale.
- Commitment of resources to reduce waiting lists. There has been increased expenditure on long waiting lists to meet waiting list targets, with plans put in place before these commitments were fully matched by resources.
- Health and Social Care. Social Services spend is the lowest in the country and it is therefore expected that there is a transfer of care to the NHS usually in Community Hospitals.

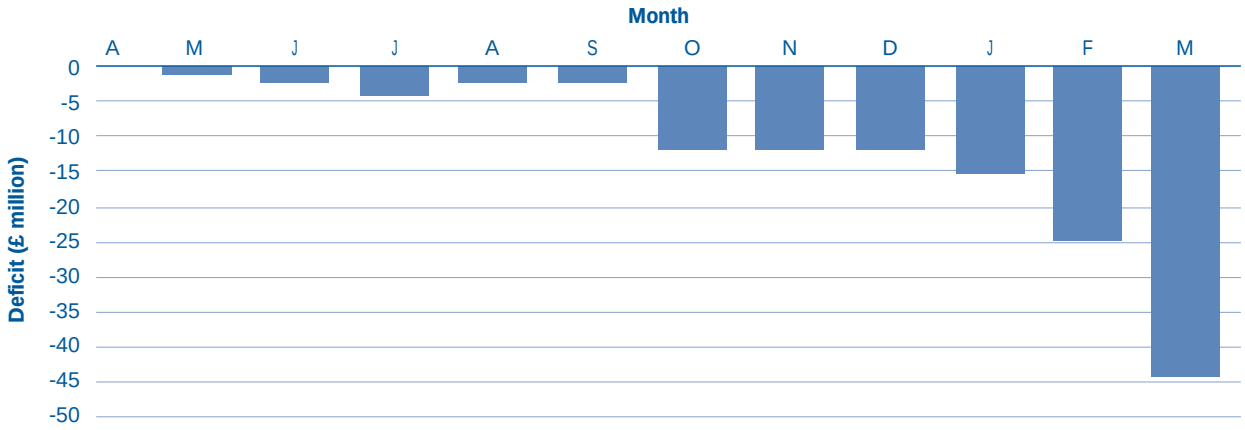
Source: National Audit Office

2.23 The statutory break-even duty for NHS Trusts is to break even taking one year with another over a three-year period. In line with Departmental requirements, all organisations reporting a deficit in 2002-03 are planning to break even in 2003-04.

2.24 For 2003-04, the Department granted the Avon, Gloucestershire and Wiltshire Strategic Health Authority permission to defer repayment of £90 million of its accumulated deficit. To produce a balanced financial plan for 2003-04 and assist with the delivery of the required savings plan, it was also promised £70 million support from the NHS Bank. Without this support from the NHS Bank, the Strategic Health Authority is not expected to be able to achieve financial balance across the area until 2006-07. Only then will the area be in a position to start repaying its deficit and also the support received from the NHS Bank.

CASE STUDY 1: NORTH BRISTOL NHS TRUST

In 2002-03, North Bristol NHS Trust incurred an in-year deficit of £44.6 million. The deficit is significant not just for its size, but for the rapid deterioration in the reported financial position during the year. The figure below shows the forecast outturn position as reported to the Trust's Board throughout 2002-03:



In response to concerns about North Bristol NHS Trust, Avon, Gloucestershire and Wiltshire Strategic Health Authority undertook a Financial and Governance Review of the Trust. The Review outlines in detail how the situation arose and makes recommendations on lessons to learn and recovery action to be taken.

The Review concluded that the true financial position was not clear to either the Trust's Board, the Strategic Health Authority or the Trust's internal auditors. There was a lack of transparent financial reporting. The reports to the Board were unclear and were not understood by Board members. The true position was hidden by creating a reserve to show assumed income and cost savings which were subsequently not realised.

The Board reports did not include information on the cash or balance sheet positions, which would have indicated that there were problems. The Trust was managing significant cash problems, required substantial cash brokerage in the year, and was severely delaying payments to its creditors.

The lack of effective challenge of the finance reports at senior executive and Board level raises questions about the corporate governance arrangements in place. There was a large audit adjustment to the 2001-02 accounts, which finally reported a £6.2m deficit and this, along with the issues that the Trust was facing relating to its capacity to serve patients, should have indicated that the Trust was already in a difficult position requiring particularly careful monitoring.

The lack of whistleblowing arrangements has also been highlighted as a concern. Other finance staff were aware of the problems faced, but their concerns were not addressed.

The main reasons given for the £44.6 million deficit were the high costs of using nursing staff provided by NHS Professionals and private-sector agencies, unachieved savings and the cost of reducing waiting lists.

Had the true position been known earlier, it is likely that action could have been taken to tackle the problems identified and avoid such a sizeable deficit. At the very least, an awareness and assessment of the true risks would have allowed the Board to take better informed decisions on how to manage the situation.

What is being done to manage the situation?

Since spring 2003, North Bristol NHS Trust has a new Chief Executive and Finance Director. There is a recovery plan in place setting out how the deficit will be reduced and systems improved. There is close scrutiny of the Trust by Avon, Gloucestershire and Wiltshire Strategic Health Authority. This includes meeting at least monthly with the Director of Finance, and a range of other measures to ensure improved reliability of the position reported, including cash forecasts.

The Avon, Gloucestershire and Wiltshire Strategic Health Authority area submitted a plan to the NHS Bank detailing the measures to be taken to achieve financial recovery. Performance against this is monitored by the NHS Bank, with the granting of NHS Bank funds contingent on achieving break-even.

Source: North Bristol NHS Trust report, produced for Avon, Gloucestershire and Wiltshire Strategic Health Authority, August 2003

2.25 Avon, Gloucestershire and Wiltshire Strategic Health Authority is currently in discussions with the Department about how its statutory duty will be met since, in 2002-03, three organisations (North Bristol NHS Trust, United Bristol Healthcare Trust and Weston Area Health Trust) are all in their third year of failing to repay deficits. The Strategic Health Authority can extend this period to five years.

2.26 Avon, Gloucestershire and Wiltshire Strategic Health Authority commissioned an independent report which recommended improvements in financial and governance arrangements within its NHS organisations, including:

- improved and more transparent financial reporting mechanisms to Boards, including information on cash and balance sheet positions;
- the establishment and promotion of whistle blowing policies;
- the development of robust financial recovery plans to deal with adverse financial positions and improve financial systems; and
- close scrutiny of financial positions and regular progress monitoring.

2.27 In addition, the Strategic Health Authority has:

- developed and implemented a robust financial framework for the 2004-05 local delivery plans, including the close scrutiny and challenging of all financial plans;
- required and reviewed in detail the financial recovery plans of all organisations in a deficit position;
- allied to the above, made a submission to the NHS Bank which will be subject to detailed scrutiny (by the Bank);
- undertaken a comprehensive internal restructuring exercise, which has resulted in a new "top team" and a review of detailed Directorate structures, including a rationalisation of performance management; and
- linked to the above, introduced stronger and tighter performance management arrangements, including the development of a new performance management framework and the re-engineering of financial performance monitoring systems.

Recovery plans are in place in most organisations reporting deficits and their achievement is monitored.

2.28 NHS Trusts in financial deficit are required to have recovery plans. Primary Care Trusts with financial difficulties, including, but not restricted to, those overspending against their revenue resource limits, are also required to have a plan in place to address their financial position. These recovery plans must be agreed with the Strategic Health Authority, which monitors progress made against the plans using a range of measures, including regular meetings with NHS Trust and Primary Care Trust Chief Executives and Finance Directors, to ensure that the recovery plans are on target.

2.29 The Audit Commission's survey of appointed auditors asked them to consider whether those NHS Trusts and Primary Care Trusts in financial difficulty had a recovery plan in place, and whether the plan was robust and achievable and agreed with key stakeholders. A trust is deemed by the Department to be in financial difficulty if it has an in-year or cumulative deficit.

2.30 The results of the survey of the appointed auditors for the bodies reporting the largest in-year and cumulative deficits are shown in **Figure 13**.

2.31 Not all organisations which require recovery plans have them in place. The main reasons given by the appointed auditors for organisations not having a recovery plan in place were:

- no formal recovery plan but issues of concern noted and being resolved;
- organisation ceased to exist on 31 March 2003 or is in final year of operation;
- recovery plan still being developed.

2.32 The most common reasons given by the appointed auditors for not considering recovery plans to be robust were:

- the inclusion of unidentified savings schemes;
- gaps in the recovery plan;
- plan not completed in time for the auditors' review;
- plan not agreed with stakeholders;
- organisation has had limited success to date in achieving the targets in the recovery plans;
- achievement of the recovery plan is high risk.

13 Recovery plans in NHS bodies with the largest deficits

NHS Body	Deficit/overspend in 2002-03 £ million	Cumulative deficit £ million	Recovery plan in place?	Plan robust and achievable?
North Bristol	44.6	48.8	Yes	See note 1
Royal United Hospital Bath	24.8	24.8	Yes	See note 1
East Kent Hospitals	11.4	11.4	Yes	No - agreed with stakeholders but may not be achievable
Worcestershire Acute Hospitals	9.9	11.3	Yes	No - £3m unidentified savings as at September 2003
United Bristol Healthcare	9.3	17.3	Yes	See note 1
South Manchester University Hospitals	7.0	5.7	Yes	No - separate Audit Commission study notes that savings unachievable without further action by Trust
Royal Cornwall Hospitals	5.2	7.7	Yes	Yes
Central Cornwall PCT	5.7 3.3 per cent of resource limit	5.2	Yes	
North and East Cornwall PCT	5.5 4.1 per cent of resource limit	3.9	Yes	
West of Cornwall PCT	5.1 3.8 per cent of resource limit	2.5	Yes	

NOTE

1 Due to the scale of the financial difficulties faced, the appointed auditors are undertaking further specific work on these recovery plans to help ensure that they are achievable.

Source: Audit Commission survey of appointed auditors

Financial balance is achieved in aggregate by offsetting individual deficits with surpluses generated elsewhere. Surpluses can generally be reclaimed by the organisation generating the surplus for use in future years.

2.33 Strategic Health Authorities are required to achieve financial balance in aggregate across their local areas. This means that one or more NHS organisations within a Strategic Health Authority area can be required to make a surplus so as to offset a deficit arising in another NHS organisation within the same area. The NHS organisations in a local health area tend to work together as a community, with organisations willing to report a surplus to support those expecting a deficit. The Strategic Health Authorities may also offer incentives for organisations to achieve surpluses.

2.34 In general, organisations making a surplus are permitted to carry forward that surplus for use in future years. They do not therefore lose out by having to report a surplus.

2.35 There are no targets to limit the extent of any surpluses achieved. Organisations generally require all the resources available to them to deliver their operational targets and will therefore aim to fully utilise their resources each year. However, it may be necessary for an organisation to make a surplus to offset deficits arising in other organisations in the area or to make good deficits incurred in the past. In 2002-03, four organisations underspent against their revenue resource limits by more than £10 million **(Figure 14)**.

2.36 This does not cause the Department any concerns, as it considers this to be a matter of timing and ensuring the most efficient use of resources over the three-year period of Local Delivery Plans. To ensure that best use is made of resources in year, end-year flexibility arrangements allow expenditure to be carried forward into the next financial year, thus ensuring NHS organisations do not utilise any potential underspendings on low-priority areas simply to use up allocations.

14 Organisations reporting surpluses of more than £10 million

Organisation	Underspend	
	£ million	Percentage of resources
Northumberland, Tyne & Wear Strategic Health Authority	12.6	16.7%
West Midlands South Strategic Health Authority	12.5	18.0%
West Hertfordshire Hospitals NHS Trust	11.7	5.5%
Bracknell Forest Primary Care Trust	11.2	13.2%

Source: National Audit Office review of audited accounts

Sound corporate governance arrangements are an essential component of good financial management.

2.37 Early recognition of factors that may lead to financial difficulties, and the willingness and ability to take prompt action to manage those factors, are essential to the achievement of financial balance. This is even more important for organisations already managing financial difficulties, since the tight financial regime means that they are unlikely to be able to build any contingencies into their plans. The example of North Bristol NHS Trust shows how the financial position can rapidly deteriorate where there is a lack of corporate governance procedures and reporting to the organisation's management board is inadequate.

2.38 The Department also has a key role to play in ensuring that procedures are in place for identifying those organisations in financial difficulty and for ensuring that appropriate action is being taken to rectify the situation. The Department has already recognised that good corporate governance arrangements at the level of individual NHS organisations are an essential element of achieving this, and it is working with NHS organisations to ensure that these are in place by 31 March 2004 at the latest.

Section 3: Is the effect of financial support on the financial position transparent and is its use appropriate?

Financial support is a tool used by the Department to help NHS organisations achieve financial balance. It can either be planned or unplanned.

2.39 As I have described in Section 1, each individual organisation within the NHS is required to achieve financial balance. Financial plans and budgets are prepared before the start of the financial year with this target in mind. Where a shortfall is identified between expected funding or income and the cost of delivering planned outputs, a means of achieving financial balance must still be identified. The way in which this is done is through the use of financial support.

2.40 The term financial support is used within the NHS to refer to ways in which any expected shortfall between budgeted income and budgeted expenditure can be bridged so as to achieve financial balance. Planned support is identified before the start of the financial year and is approved as part of the budget-setting process. Unplanned support is only required when shortfalls arise unexpectedly during the course of the year or where original plans cannot be met.

2.41 Financial support, whether planned or unplanned, represents additional sources of funds that may be available to individual NHS organisations and includes the following:

- use of the Special Assistance Mutual Fund (NHS Bank, **Appendix 3**);
- transfers of surplus or unused funds from another part of the NHS;
- transfers from capital to revenue budgets;
- transfers from centrally managed budgets.

In addition, achievement of cost savings helps an organisation make more efficient use of existing income levels.

2.42 These sources of financial support and achievement of cost savings can be non-recurrent (for one year only) or recurrent (ongoing). They, and the risks associated with each, are described in more detail in **Figure 15**.

2.43 Planned support is the name given to these additional sources of funds where the need for them has been recognised in the financial plan in place at the start of the financial year. Unplanned support is where the need for additional funds was not identified at the start of the financial year.

15 Types of recurrent and non-recurrent financial support and cost savings

Special Assistance Mutual Fund The Department has some central funds available for distribution to Strategic Health Authority areas facing specific difficulties. The Department takes advice on the distribution of these funds from the NHS Bank, a mutual organisation of the 28 Strategic Health Authorities (Appendix 3). £100 million was allocated between three Strategic Health Authorities in 2002-03 and £152 million between four Strategic Health Authorities in 2003-04.	***Risk*** Funds are allocated on an annual basis and therefore represent non-recurrent funding. The funds may be withheld if conditions set on allocation are not met. Withholding allocated funds does not affect overall NHS financial balance since funds not distributed would remain as a centrally held surplus; however, it would affect the reported position in the individual organisations concerned.
Unused resources in other parts of the health system Underspends in other parts of the health system may be used to provide additional resources to those NHS organisations that require additional funds. This is via an adjustment to a service level agreement and the increase in funding may be reversed in the following year subject to the discretion of the Strategic Health Authority. The nature of any such arrangements should be fully disclosed in the annual accounts of the organisation, which are subject to audit by the appointed auditors.	***Risk*** Organisations receiving such additional funds must reduce costs in the following financial year subject to the agreement of the Strategic Health Authority. This increases the financial pressure on such organisations in the following year because they not only have to fund the activities for which these funds were obtained (unless the additional funds were required for a one-off purpose), but they may also, subject to the Strategic Health Authority discretion, have to reduce costs as well.
Capital to revenue virement Resources intended for capital expenditure may instead be used for revenue expenditure. The amount of such transfers (or virement) from capital to revenue budgets is limited. HM Treasury decides overall totals permitted for each government department, including the Department of Health. In 2002-03, £92 million capital to revenue virement was used in the NHS; this was within the amount agreed by Treasury. Under revised Treasury rules, from 2004-05 capital to revenue virement will no longer be permitted.	***Risk*** Since capital to revenue virement will no longer be possible, organisations currently using capital to revenue virement as a source of revenue funding will have to identify other sources of funding in future years. In 2002-03, after transferring £92 million from capital to revenue budgets, the NHS was still under-spent on its capital budget by £60 million. Therefore at an aggregate level, the use of resources for revenue rather than capital purposes did not lead to cutbacks in NHS capital spend; however, it may have had implications for individual organisations.
Use of central budgets The Department may make allocations of funding from central budgets for specific purposes, for example to reduce Accident and Emergency waiting times. Organisations meeting their targets without spending the full amount of the central budget allocated to them may use the remainder to fund other activities.	***Risk*** Central budgets for specific activities may only be available for a single financial year, or they may be fully committed in any one year so that there is no scope for releasing unspent funds for more general activities. Any organisation receiving such funds in one year cannot therefore guarantee that it will receive the same funding in future years.
Cost savings By planning to deliver services more efficiently, organisations may make cost savings without reducing their outputs. In 2003-04, 21 per cent of cost savings assumed in budgets had not been specifically identified to individual projects.	***Risk*** The planned level of savings may not be achieved. Where organisations are reliant on cost savings to achieve financial balance, this puts the achievement of financial balance at risk. Where cost savings are achieved in one year, the same levels of savings, where not recurring, may not be possible in future years.

Source: National Audit Office

2.44 Unplanned support may be required because:

- financial planning or financial controls are poor, resulting in an unexpected adverse variance from the budgeted position; or
- the risks (identified at the start of the year) of failing to achieve the required levels of planned support have in fact materialised, and additional funding from other sources is therefore required to achieve financial balance; or
- events occur which are so far out of the ordinary that they could not reasonably have been anticipated at the planning stage. By its nature, this situation occurs rarely.

Planned financial support is a legitimate way of allocating resources to where they are required in order to achieve financial balance. It is useful to identify where planned support has been used because most forms of financial support are non-recurrent or carry risks. This has implications for the achievement of financial balance in future years.

2.45 Planned support is normally factored into organisations' budgets at the start of the year and is therefore a legitimate way of ensuring that resources are allocated to where they are needed to achieve planned outputs, whilst at the same time ensuring that financial balance is achieved across the NHS as a whole. However, since financial support represents an additional source of funding for organisations over and above the recurrent funding made available each year, its use, even where planned, has possible implications for future years at the individual organisational level. This is because the same types of, or level of, financial support may not be available from one year to the next, and also because some kinds of financial support are not guaranteed. Also, where organisations rely on the identification of recurrent cost savings to achieve a balanced budget, there is a risk that levels of savings achieved in one year may not be achieved in the next year.

2.46 **Figure 16** shows the aggregate outturn position of the three Strategic Health Authority areas receiving support from the Special Assistance Mutual Fund in 2002-03. It also shows their outturn position had they not received these funds.

2.47 Two of the Strategic Health Authority areas would have reported a larger deficit position if the support had not been available and no other corrective action taken. However, in the case of Bedfordshire and Hertfordshire, due to better than expected financial performance, these funds were not essential for them to achieve financial balance across the Strategic Health Authority area but enabled it to achieve recovery earlier than planned, resulting in no further NHS Bank support in 2003-04.

To gain a full understanding of an organisation's financial position, it is important to analyse the use of financial support and its associated implications. In 2002-03, the amount and source of planned and unplanned support was not comprehensively reported in the underlying accounts of individual NHS organisations as required.

2.48 For the first time, in 2002-03 the Department required NHS Trusts to report the level of financial support received (both planned and unplanned) in their accounts, and the effect of this support on the reported surplus or deficit position. A narrative describing the reason for, and sources of, support was also required. The amounts reported, and the narrative, were to be agreed between the NHS Trust, the relevant Strategic Health Authority and the auditors. In practice however, full implementation of this requirement was variable, with some organisations failing to fully report the planned and unplanned support utilised.

2.49 An Audit Commission survey of the appointed auditors of individual NHS organisations found that 95 Primary Care Trusts and 111 NHS Trusts included additional disclosures in their accounts due to uncertainty over their financial standing. The information given included:

- the amount and sources of non-recurrent funding and of cost savings applied in reaching the reported financial position;
- the amount of surplus funds transferred from other organisations and used in reaching the reported financial position, together with the fact that this was repayable;
- reference to the financial position in 2003-04 and beyond; the action being taken to achieve financial balance; the nature of the risks to the organisation's financial position; and
- in the case of NHS Trusts, instances where the statutory break-even period was extended from three to five years.

16 Impact of Special Assistance Mutual Fund on Strategic Health Authority areas in 2002-03

Strategic Health Authority area (Strategic Health Authority, Primary Care Trusts and NHS Trusts)	Aggregate surplus / (deficit) across Strategic Health Authority area before Special Assistance £ million	Special Assistance received £ million	Aggregate surplus / (deficit) across Strategic Health Authority area after Special Assistance £ million
Avon, Gloucestershire and Wiltshire	(108.6)	45.0	(63.6)
Surrey and Sussex	(31.8)	30.0	(1.8)
Bedfordshire and Hertfordshire	0.0	25.0	25.0

Source: NAO analysis of figures in audited accounts and Department of Health data on amount and distribution of the Special Assistance Mutual Fund

From 2003-04 the Department will be restricting the use of unplanned financial support. Surpluses and deficits will remain where they arise, and this clarity should act as a further incentive for NHS organisations to manage within budget.

2.50 From 2003-04, the Department will be restricting the use of unplanned financial support, which will only be available in exceptional circumstances to deal with events that could not reasonably have been foreseen. Under normal operating circumstances, unplanned support will not be available to reduce an unexpected deficit. This will increase the transparency of financial reporting because unplanned support will no longer be available as a means of transferring resources from an organisation in a surplus position to one unexpectedly in a deficit position.

2.51 The use of unplanned support does not in itself bring an increased risk to achieving financial balance. It is the circumstances surrounding the need for unplanned support that threaten financial balance, both in individual organisations and in aggregate. The removal of unplanned support as an option for mitigating a deteriorating financial situation should act as a further incentive to identify such potential circumstances in advance and to develop strategies to deal with them.

It is important to understand where and why unplanned financial support has been used, so that any instances of poor financial management can be identified and appropriate action taken.

2.52 The Department has identified that fifteen organisations, four Primary Care Trusts and eleven NHS Trusts, received a total of some £26 million unplanned support in 2002-03.

2.53 As shown in **Figure 17**, some organisations would have failed to achieve financial balance without the use of unplanned financial support. If this unplanned financial support were not available, organisations would need to take alternative action to bring about financial balance. Depending on the scale of the forecast deficit, it may not always be possible to take sufficient corrective action by the end of the financial year.

Section 4: Does the Department have systems in place to ensure that financial balance is achieved across the NHS?

The Department has high-level controls in place to monitor whether financial objectives are being met.

2.54 The Department requires every NHS organisation to budget for delivery of financial balance or better and to show how they plan to meet the break-even objective. The Department performs a central check at the start of the year of every organisation's financial plans and budgets to ensure that this requirement is met.

2.55 To monitor progress against these financial plans, all NHS organisations are required to report current performance and forecast year-end outturn figures to the Department on a monthly basis. Figures for Primary Care Trusts and NHS Trusts are aggregated by the Strategic Health Authorities who then report the figures to the Department. The Department uses the Strategic Health Authority commentary for the purpose of overall performance management of the NHS. The Department's Management Board receives a report every month showing the aggregate position across the NHS. This allows the Department to identify promptly any areas where there are problems and if necessary to meet with individual Strategic Health Authorities to discuss remedial action.

17 In-year financial performance in 2002-03 before the inclusion of unplanned financial support

	Achieved financial balance		Failed to achieve financial balance		Total
	No.	Per cent	No.	Per cent	
Strategic Health Authorities	28	100%	0	0%	28
Primary Care Trusts	281	92%	23	8%	304
NHS Trusts	216	79%	59	21%	275
Total	**525**	**86%**	**82**	**14%**	**607**

Source: National Audit Office

Strategic Health Authorities play a key role in ensuring that budgets are accurate and outturn figures are reliable.

2.56 Under the new structure of the NHS, responsibility for ensuring that the NHS is performing well has been delegated to Strategic Health Authorities. The Strategic Health Authorities are responsible for monitoring the performance of the Primary Care Trusts and NHS Trusts in their local areas.

2.57 Strategic Health Authorities must ensure that each NHS organisation achieves its financial duties and they work with individual NHS organisations in their area to help them achieve this. If this is not achieved in each organisation, Strategic Health Authorities have a duty to ensure that financial balance is achieved in aggregate across their local area.

2.58 Strategic Health Authorities are responsible for helping organisations put together their budgets and for ensuring that the budgets are robust and realistic. A key part of ensuring that the budgets are realistic is to identify risks to the achievement of those budgets, and to form a view on the likelihood of those risks being realised. This allows a more informed interpretation of the figures submitted and an understanding of the likelihood of the planned position being achieved. The main risks to the financial position noted in 2002-03 were:

- increases in staff costs (pay increases for existing staff and the cost of using agency staff and increased overtime to deal with recruitment and retention difficulties);
- increases in the cost of prescribing drugs;
- non-achievement of cost savings programmes.

2.59 Strategic Health Authorities are also responsible for verifying the reliability of the monthly figures reported by each NHS organisation. They use a number of means to achieve this:

- comparison of the figures with other data, for example reported activity or staffing levels;
- comparison of the forecast position with that reported in the previous month and scrutiny of the explanations for any unexpected variances;
- reconciliation of income and expenditure figures with the reported cash position;
- periodic examination of particular figures, such as provisions, in closer detail;
- consideration of the extent to which forecast figures factor in risks; and
- comparison of forecast figures to outturn figures for the previous year.

2.60 Strategic Health Authorities also form a view on the accuracy of the reported forecast year-end positions within their local area, the significant risks to achievement of the budget and the extent to which individual problems or pressures can be managed.

2.61 The Department's policy of delegating responsibility to the Strategic Health Authorities means there is significant reliance on the ability of Strategic Health Authorities to manage the NHS organisations within their area effectively. Since 2002-03 was the first year in which Strategic Health Authorities have operated, it will be important for the Department to closely monitor the effectiveness of each Strategic Health Authority's performance management arrangements. The Department intends to use the three-year Local Delivery Plans to monitor Strategic Health Authorities' performance.

The identification and management of risk is a key factor in ensuring that financial targets are met.

2.62 In both 2001-02 and 2002-03, the forecast position during the course of the year was an aggregate deficit, whereas the forecast (and actual) position at the year end was a small surplus. The Department's explanation for the fluctuating position during the year is that NHS organisations have a tendency to forecast on the basis that adverse risks will materialise rather than on the actual likelihood that they will materialise, and that they do not always factor the effects of corrective management action into their forecasts.

2.63 The large number of forecast deficits during 2002-03 was partly a result of the structural reorganisations taking place at that time. Primary Care Trusts were new to their role and the Department noted that the tendency to forecast on the basis of worst case scenarios was heightened. The Department also noted that the pessimistic forecasts may in some cases have been attempts to secure additional central resources.

2.64 It is important both for individual organisations and the Department to factor in risks when predicting forecast outturn figures, and this inevitably involves some degree of judgement about the impact of risks, the likelihood of their occurrence, and the effectiveness with which these risks can be managed. The reporting of risks to the Department via the Strategic Health Authorities allows the Department to understand the nature and seriousness of the risks faced and to interpret the figures reported to it. However, where forecasting across the NHS is poor, and has not adequately factored in the actions being taken to mitigate risks identified, this makes it more difficult for the Department to identify and focus on areas where additional management action is required.

For a number of organisations there were variances between the forecast surplus and deficit figures at month twelve and the final outturn figures subsequently reported in the audited accounts.

2.65 Another measure of the reliability of monthly reported outturn figures is the extent to which forecast figures at the year end vary from the actual figures reported in the final audited accounts. Four Strategic Health Authorities, eleven Primary Care Trusts and five NHS Trusts had variances of more than £1 million between the forecast surplus or deficit at month twelve and the figure subsequently reported in their audited annual accounts.

2.66 The Department requested explanations for variances of more than £250,000 between the forecast year-end surplus or deficit and the figure in the audited accounts. The main reasons for the variances identified were adjustments arising out of the audit process, including:

- changes to provisions;
- changes to the accounting treatment of finance leases or private finance initiative (PFI) assets; and
- adjustments to deferred income.

2.67 Other reasons for the variances were:

- the finalisation of figures to be included for financial support arising as a result of the transfer of underspends from elsewhere within the NHS; and
- late increases in the revenue resource limit which were not known about at the time of the month twelve forecast.

No Strategic Health Authority, NHS Trust or Primary Care Trust had fully embedded risk management arrangements in place by 31 March 2003. It is likely that most NHS bodies will have achieved this by the end of the financial year 2003-04.

2.68 The identification and monitoring of risk and the robustness of financial reporting arrangements within individual organisations are essential for underpinning the internal control framework (including financial controls) across the NHS and for the reporting of key issues to Strategic Health Authorities and the Department.

2.69 To achieve this, individual NHS organisations are required to have adequate corporate governance arrangements in place. A description of the organisation's corporate governance arrangements and the effectiveness of its internal control framework must be included in the Statement on Internal Control which forms part of each organisation's audited accounts. In 2002-03, no Strategic Health Authority, Primary Care Trust or NHS Trust was able to report full compliance with Treasury requirements to have fully embedded arrangements in place throughout the financial year. Although all organisations had made progress, most had a number of actions still to complete in order to ensure that their risk management processes and systems of internal control were fully effective. In these Statements on Internal Control, individual NHS organisations were required to report the target date for implementing the necessary outstanding actions. In all organisations, this work will continue in 2003-04, so 2004-05 will be the earliest period for which they will be able to report full compliance for the whole of the financial year.

2.70 The largest category of actions still to be completed related to the establishment of fully operational and embedded risk management systems. To assist NHS organisations in implementing risk management systems, the Department has issued guidance on the purpose and key elements of a sound risk management system, and is requiring all organisations to have an assurance framework in place by 31 March 2004. These frameworks should assist organisations in identifying and monitoring risks and in obtaining assurance that the mechanisms in place to address risks are robust. The key elements of the assurance framework are shown in **Figure 18**. Strategic Health Authorities are responsible for monitoring progress in implementing assurance frameworks in the organisations in their area.

18 Assurance framework

The assurance framework involves the following stages:

- Identifying the organisation's principal objectives;
- Identifying the main risks to achievement of those objectives - these should be reviewed periodically as risks may change over time;
- Identifying controls in place to mitigate identified risks;
- Obtaining assurance that the controls are operating effectively - assurance can be obtained from a variety of sources, including management checks, internal audit, clinical reviews, Commission for Health Improvement and Commission for Healthcare Audit and Inspection reviews, and the work of the external auditors;
- Reporting to the Board where assurance has been obtained, and where there are gaps in controls;
- Taking action to address gaps in controls and assurances.

Source: Department of Health

The NHS's probable liability arising from claims for clinical negligence continues to rise, along with the associated costs of making provisions and meeting claims. This places increased pressure on the Department's limited resources.

2.71 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 costs for clinical negligence claims continues to be a major challenge facing the NHS and represents a significant drain on resources away from patient care.

2.72 From 1 April 2002, the NHS Litigation Authority[4] ("the Authority") fully took over responsibility for managing clinical negligence claims within the NHS on behalf of Primary Care Trusts and NHS Trusts, to ensure consistency in the handling of such claims. The Authority also accounts for the costs and liabilities associated with these claims, which fall under three main schemes **(Figure 19)**.

2.73 Individual Primary Care Trusts and NHS Trusts continue to report their respective positions regarding clinical negligence in notes to their accounts and they continue to pay annual contributions to the Authority based on forecast levels of claim payments. This administrative arrangement does not affect these organisations' duty of care nor the legal liability for cases arising.

2.74 Although the indications are that numbers of claims are increasing, for the first time the Authority is reporting all cases of clinical negligence rather than cases above an excess limit. Also, the Authority now includes Primary Care Trust cases that had been dealt with by medical defence organisations for Primary Care Groups **(Figure 20)**.

2.75 In 2002-03, the Authority paid out some £446 million in cash for all clinical negligence schemes - the same amount as in 2001-02 **(Figure 21)**.

2.76 The NHS expects to pay out £5.89 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 (2001-02: £5.25 billion). These sums are shown as provisions in the summarised account for the NHS Litigation Authority. An additional £3.2 billion of claims are possible, but unlikely (2001-02: £3.1 billion). These are shown as contingent liabilities in the summarised account.

2.77 **Figure 22** shows the trend in provisions over the past five years.

19 The clinical negligence schemes in England

Scheme	Description
Clinical Negligence Scheme for Trusts (CNST)	Under this risk pool, member organisations pay annual contributions to the Authority, which administers and settles claims on their behalf. Contributions are based on the Authority's risk assessment of the individual member organisation, taking account of their claims history and the field in which the organisation operates.
Existing Liabilities Scheme (ELS)	This scheme covers clinical incidents which occurred before 1 April 1995, the date when the CNST first became available. Most ELS liabilities derive from predecessor organisations to the Strategic Health Authorities, although some were incurred by early NHS Trusts. Since April 2000, all ELS claims, regardless of value, have been handled centrally by the Authority. The scheme is funded by the Department of Health.
Ex-Regional Health Authority Scheme	This scheme covers clinical liabilities arising from the former Regional Health Authorities.

Source: NHS Litigation Authority

20 The number of clinical negligence claims outstanding is apparently increasing

	No.
Claims open at 1 April 2002	7,628
New claims in 2002-03	10,582
Claims closed in 2002-03	(6,037)
Claims open at 31 March 2003	12,173

Source: NHS Litigation Authority

2.78 The provisions 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.

2.79 In calculating the amount payable at today's prices the Authority uses the Government's set discount rate. From 1 April 2003, this discount rate was reduced from 6 per cent to 3.5 per cent. It is estimated that the discount rate change alone will increase provisions in 2003-04 by a further £1.39bn.

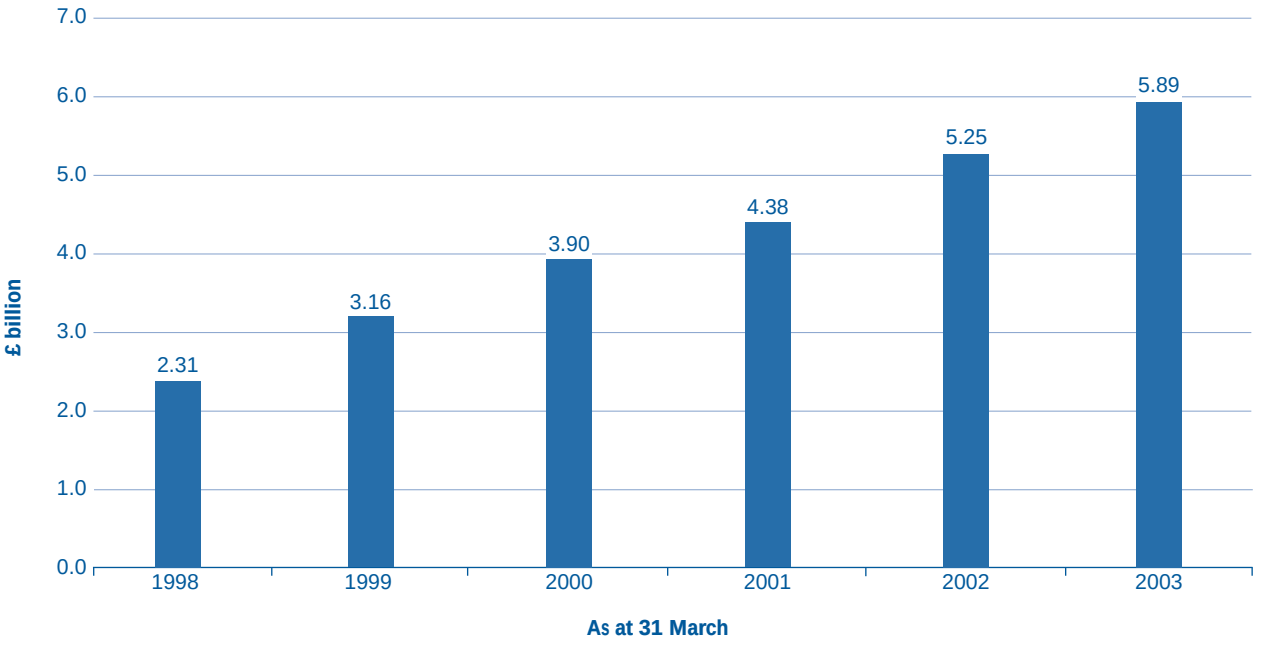
4 *The NHS Litigation Authority is a Special Health Authority, set up under the NHS Act 1977 to administer clinical negligence and other pooled risk schemes for the NHS.*

21 Total paid out by NHS organisations on clinical negligence claims

	2002-03 £ million	2001-02 £ million	2000-01 £ million
NHS Litigation Authority			
Clinical Negligence Scheme for Trusts (CNST)	**175**	83	23
Ex-Regional Health Authority Scheme	**2**	4	7
Existing Liabilities Scheme (ELS)	**269**	343	228
NHS Litigation Authority total	**446**	430	258
NHS Trusts			
CNST (and ELS for 2000-01)	**0**	16	157
Total paid out by NHS organisations on clinical negligence claims	**446**	446	415
CNST contributions to NHS Litigation Authority from NHS Trusts	**(221)**	(41)	(50)

Source: NHS Litigation Authority

22 Provisions for clinical negligence within the NHS



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

2.80 **Figure 23** shows the financial periods in which the NHS expects to pay out the estimated £5.89 billion provided for in the accounts.

2.81 For the Clinical Negligence Scheme for Trusts (CNST), the Authority collects sufficient annual contributions from each NHS Trust to cover the anticipated payments for the financial year, with any shortfall or excess being adjusted in the following year. In 2002-03, the Authority paid out £175 million under the Scheme, and collected contributions of £221 million from NHS Trusts. Contributions are based on the Authority's risk assessment of the individual NHS Trust, which takes into account its previous claims history and the field in which it operates.

2.82 The Authority allows discounts in contributions if NHS Trusts achieve at least level one in the Authority's risk management standards. The NHS Litigation Authority is encouraging trusts at all levels to improve, but it is particularly focusing on those Trusts assessed at level zero. As at 31 October 2003, 19 per cent of NHS Trusts had not achieved level one status and only four NHS Trusts had achieved the maximum level three.

23 Expected timing of settlement of clinical negligence liabilities

		Within one year	1 - 5 years	Over 5 years	Total
Expected timing of settlement of clinical negligence liabilities	**2002-03**	**£0.67 billion**	**£1.54 billion**	**£3.67 billion**	**£5.89 billion**
	2001-02	£0.51 billion	£1.10 billion	£3.64 billion	£5.25 billion

Source: NHS Litigation Authority

24 Number of NHS Trusts assessed at each level against the NHS Litigation Authority's risk management standards

Risk Management Level	Discount attracted as a percentage of total contributions	No. of Trusts as at 31/10/03	No. of Trusts as at 31/3/03
Level 0	0	**39**	53
Level 1	10%	**176**	177
Level 2	20%	**46**	41
Level 3	30% with effect from 1 April 2003.	**4**	4

NOTE

There are also five NHS Trusts which are in effect new bodies from 1 April 2003 and have yet to be classified.

Source: NHS Litigation Authority

2.83 Information, as at 31 October 2003, on NHS Trusts at each level and the corresponding discounts in contributions payable is shown in **Figure 24**.

2.84 On 30 June 2003, the Chief Medical Officer published his report into NHS clinical negligence *Making Amends - A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*. The report asked for views on a number of recommendations, including the setting up of a NHS Redress Scheme.

2.85 The proposals for reform in the consultation paper seek to ensure that:

- the emphasis of the NHS is directed at preventing harm, reducing risks and enhancing safety so that the level of medical error is reduced;
- there is a better co-ordinated response to harm and injury resulting from health care, including investigation, support, remedial treatment and care where needed and fair recompense or redress is affordable and reasonably predictable in the way it operates;
- the system for providing redress acts as an incentive on healthcare organisations and their staff to improve quality of care and patient safety.

2.86 The consultation closed on 17 October 2003 and the Chief Medical Officer is considering the responses received.

The Department has arrangements in place to tackle fraud; however, more can be done to estimate the total levels of fraud across all activities and thereby help better target prevention and detection.

2.87 The NHS is vulnerable to fraud in a number of different guises, including:

- 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; and
- fraud committed by those providing services or materials to the NHS, such as drugs, staff and equipment.

2.88 The NHS Counter Fraud and Security Management Service was established on 1 January 2003 as the successor body to the NHS Counter Fraud Service. This Special Health Authority is responsible for countering fraud and corruption in the NHS.

25 Estimates of Primary Care fraud

	1998-99	1999-00	2000-01	2001-02	2002-03
Pharmaceutical Patient Fraud	£117m	£69m			£47m
Pharmaceutical Contractor Fraud	£9.5m	£8.5m			
Dental Patient Fraud		£40.3m	£30m		
Optical Patient Fraud		£13.25m		£10.17m	

Source: Counter Fraud and Security Management Service

2.89 **Figure 25** shows the estimated levels of fraud for specific areas analysed by year to which the estimate relates.

2.90 This means the target set by the Department, to reduce pharmaceutical patient fraud by 50 per cent by 2002-03, has been exceeded. The figure in 1998-99 was £117 million and is now £47 million, representing a 60 per cent overall reduction. Pharmaceutical, dental and optical patient fraud has been reduced from £170 million in 1998-99 to £87 million by the end of 2002-03.

2.91 In my Report on the 2001-02 NHS Summarised Accounts, I asked the NHS Counter Fraud Service to consider what additional steps could be taken to obtain an overall estimate of fraud across the NHS as a matter of priority. The Department has informed me that a system to measure fraud locally at Strategic Health Authority and Primary Care Trust level is being developed. This will firstly concentrate on identifying the estimated fraud within payroll expenditure and then move on to other significant areas of expenditure

Section 5: Will planned developments in the NHS have a significant impact on the way finances are managed in future?

The amount of funds allocated to the NHS is increasing. The creation of Foundation Trusts and payment by results will have significant implications for the way the NHS is managed and financed. The Department is working with the NHS to implement these changes.

2.92 The amount of funds allocated to the NHS is increasing. Under government plans, increases promised to the Department will amount to a 62 per cent growth in expenditure over the five-year period from 2002-03 to 2007-08. Public spending on health is estimated to increase from 6.6 per cent to 8.1 per cent of GDP over this period.

NHS Foundation Trusts

2.93 On 31 March 2004, the Office of the Independent Regulator for Foundation Trusts announced the first ten NHS Trusts which had been successful in their applications to become NHS Foundation Trusts. There are 52 other Trusts which hope to become NHS Foundation Trusts during 2004-05.

2.94 Foundation Trusts will be independent public benefit corporations, a new type of statutory body, and will continue to be part of the NHS with a duty to co-operate with other NHS organisations.

2.95 The main aim of creating Foundation Trusts is to devolve power and accountability to local organisations. Foundation Trusts will have a Board of Governors representative of stakeholders. They will continue to treat NHS patients according to NHS principles and standards but will have greater freedom over how they achieve national standards and targets.

2.96 Foundation Trusts will have a number of financial freedoms which NHS Trusts do not have:

- **Borrowing.** Foundation Trusts will be able to borrow from public and private sources for capital investment. Each trust will be allocated a borrowing limit set by the Independent Regulator, based on ability to service and repay the loan per the Prudential Borrowing Code.
- **Surpluses.** Foundation Trusts will be able to retain operating surpluses for investment in patient care.

2.97 Only NHS Trusts awarded the maximum three stars in the Commission for Health Improvement ratings were initially permitted to apply for Foundation Trust status. The quality of financial management is one of the criteria taken into account in the ratings, and a separate assessment of financial status and financial management is made in the application for Foundation Trust status to ensure that only those NHS Trusts assessed as having good financial management are allowed the extra financial freedoms of Foundation Trusts.

2.98 Foundation Trusts will not be performance managed by Strategic Health Authorities, but will be subject to regulation by an Independent Regulator, who will issue each Foundation Trust with an operating licence and monitor compliance with the terms of the licence. Foundation Trusts will be subject to inspection by the new Commission for Healthcare Audit and Inspection.

Payment by results

2.99 The system for paying NHS Trusts for the patient care they deliver is being changed. Standard national costs are being introduced for each type of treatment and in future NHS Trusts will receive funding based on the number of treatments that they deliver at the appropriate national tariff for the treatment type.

2.100 This system of funding is being introduced incrementally. In 2003-04, national tariffs will only be used to fund increases in activity over 2002-03 levels for a limited number of treatment types. In 2004-05, the tariffs will again be paid only for growth in activity, but will be applicable to a much wider number of treatment types. From 2005-06, national tariffs will be used to fund all activity for most treatment types. For Foundation Trusts, these arrangements will be introduced a year earlier, with all activity for most treatment types funded according to the national tariffs.

2.101 Payment by results represents a fundamental change in the way that NHS Trusts are financed, and will have a significant impact on the financial management of all NHS Trusts. At least initially, many NHS Trusts will find that the standard tariff differs from the cost of delivering the corresponding treatment, resulting in the creation of either a surplus or deficit. It is essential that NHS Trusts use the introductory period to establish budgetary and cost control procedures to deal with the new system of funding. Accurate costing of treatment types will become increasingly important, both to inform the levels at which the national tariffs are set, and so that individual NHS Trusts can predict whether they will make a surplus or a loss on each treatment type and act to reduce costs on loss-making treatments.

Appendix 1 Total surplus /(deficit) in 2002-03 by organisation type

Strategic Health Authority area	Strategic Health Authority	Primary Care Trusts		NHS Trusts		Overall
	Value £ million	Number	Value £ million	Number	Value £ million	Value £ million
Avon, Gloucestershire and Wiltshire	7.4	12	8.5	13	(79.5)	(63.6)
Bedfordshire and Hertfordshire	0.4	11	5.9	7	18.7	25.0
Birmingham and the Black Country	5.3	12	10.3	15	(1.2)	14.4
Cheshire and Merseyside	0.2	15	0.7	18	2.6	3.4
County Durham and Tees Valley	0.2	10	2.6	5	0.7	3.5
Cumbria and Lancashire	0.0	13	0.6	11	(2.2)	(1.6)
Dorset and Somerset	0.5	9	1.1	8	2.6	4.2
Essex	3.9	13	0.8	9	0.2	4.8
Greater Manchester	0.1	14	1.3	14	(6.5)	(5.1)
Hampshire and Isle of Wight	0.8	10	0.3	7	(2.2)	(1.0)
Kent and Medway	0.0	9	(0.4)	8	(19.3)	(19.6)
Leicestershire, Northamptonshire and Rutland	4.8	9	9.8	5	0.1	14.7
Norfolk, Suffolk and Cambridgeshire	5.9	17	10.5	13	6.0	22.4
North and East Yorkshire and North Lincolnshire	0.4	10	1.7	7	0.1	2.2
North Central London	4.6	5	2.9	11	(3.5)	4.0
North East London	1.1	8	(0.2)	7	0.2	1.1
North West London	3.6	8	2.3	10	(0.7)	5.2
Northumberland, Tyne and Wear	12.6	6	4.6	9	(1.3)	15.9
Shropshire and Staffordshire	3.1	10	7.0	9	(3.8)	6.3
South East London	8.2	6	1.5	8	6.0	15.7
South West London	2.7	5	4.1	7	2.4	9.2
South West Peninsula	0.0	11	(16.0)	8	(4.6)	(20.6)
South Yorkshire	5.0	9	10.4	8	0.2	15.6
Surrey and Sussex	1.2	15	0.3	16	5.5	7.0
Thames Valley	1.2	15	15.3	14	(8.7)	7.8
Trent	9.2	19	5.2	11	0.2	14.5
West Midlands South	12.5	8	0.9	8	(9.0)	4.4
West Yorkshire	1.5	15	0.8	9	3.6	5.9
Total	**96.4**	**304**	**92.8**	**275**	**(93.5)**	**95.7**

Source: Department of Health

Appendix 2 Financial duties of NHS organisations

Strategic Health Authorities and Primary Care Trusts	NHS Trusts
Statutory	
Contain expenditure, measured on an accruals basis, within approved revenue resource limits. **A total of 21 Primary Care Trusts failed in this duty.**	Break even taking one financial year with another. **All NHS Trusts met the Department's definition of break even, although 50 incurred an in-year deficit in 2002-03.**
Contain expenditure, measured on an accruals basis, within approved capital resource limits. **All but 12 bodies achieved this duty.**	
Remain within cash limits. **All Strategic Health Authorities and Primary Care Trusts achieved this duty.**	
Departmental	
Achieve financial balance without the need for unplanned financial support. **A total of 23 Primary Care Trusts did not achieve financial balance without the need for unplanned financial support. These 23 organisations required unplanned support totalling £2.5 million.**	Break even each and every year. **In 2002-03, 50 NHS Trusts failed to break even.**
Apply the Better Payment Practice Code. **75 per cent of Strategic Health Authorities and 69 per cent of Primary Care Trusts failed this target.**	Absorb the cost of capital at a rate of six per cent. **The average return for 2002-03 was 6.2 per cent (2001-02: 6.1 per cent). The Department considers that only Trusts achieving less than 5.5 per cent fail the duty and 21 failed on this basis (2001-02: 17 NHS Trusts).**
For Primary Care Trusts, to recover the full cost of their provider functions (an accounting duty). **A total of 39 Primary Care Trusts failed in this duty.**	Not to exceed the external financing limit set by the Department of Health. **In 2002-03, NHS Trusts overshot by £44.9 million the national limit of £4 million credit (2001-02: £6.1 million within the limit of £370 million). The Department considers that only Trusts which exceed their individual limits by more than £10,000 have failed. On this basis 10, or 3.6 per cent, did so, a deterioration on 2001-02 (5 NHS Trusts, 1.6 per cent).**
	Contain expenditure, measured on an accruals basis, within approved capital resource limits. **A total of 10 NHS Trusts breached their capital resource limit by more than the Department's £50,000 de minimus limit.**
	Apply the Better Payment Practice Code. **A total of 58 per cent of NHS Trusts failed this target.**

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:

- 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.

Appendix 3 The NHS Bank

1 The NHS Bank is a mutual organisation of the 28 Strategic Health Authorities. Its purpose is to support NHS organisations in maximising the use of resources across the NHS and over different financial years by:

- Facilitating progression to a point where all health systems can deliver NHS Plan targets and key financial targets without external financial assistance;
- Utilising available flexibilities and creating appropriate incentives to enable the most advantageous financial outcomes for all 28 Strategic Health Authorities.

2 In 2002-03, the NHS Bank existed in shadow form and its role was to advise the Department on the distribution of the £100 million Special Assistance Mutual Fund allocated by the Department to Strategic Health Authority regions facing particular financial difficulties.

3 In 2003-04, the Bank is continuing as an advisory body with an expanded role. Its responsibilities in 2003-04 are in the following areas:

- Special Assistance Fund - administering the special assistance fund for providing grants to Strategic Health Authorities managing particular financial difficulties. The NHS Bank will decide on the allocation of funds and monitor progress of the organisations receiving funds against their performance improvement plans.
- Capital Brokerage - facilitating the redistribution of capital funds amongst Strategic Health Authorities to better match funding with need. Strategic Health Authorities can lend funds to other Strategic Health Authorities to match the timing of different capital investment programmes.
- Cash Brokerage - managing the programme of cash brokerage to provide cash flexibility across the NHS.

4 The NHS Bank has a Management Board drawn from Strategic Health Authority Chief Executives and Directors of Finance. It also has a technical support group consisting of representatives from Strategic Health Authorities, Primary Care Trusts and NHS Trusts. There is a Departmental representative on both the Management Board and technical support group.

Special Assistance Fund

5 **Figure 26** shows the amount of special assistance available in 2002-03 and 2003-04 and its allocation to Strategic Health Authorities:

26 Special Assistance Mutual Fund allocations

Strategic Health Authority	Allocation of funds £ million
2002-03	
Avon, Gloucestershire and Wiltshire	45
Surrey and Sussex	30
Bedfordshire and Hertfordshire	25
Total	**100**
2003-04	
Avon, Gloucestershire and Wiltshire	70
Surrey and Sussex	40
Thames Valley	25
Kent and Medway	17
Total	**152**

Source: Department of Health

6 Certain conditions must be met for Strategic Health Authorities to be eligible to apply for Special Assistance:

- There must be a commitment to delivering performance targets;
- The problem leading to funding being required must be different in scale and nature to that faced by other organisations;
- There must be a realistic plan for resolution of the problem that has led to the funds being required. This is known as the 'Performance Improvement Plan'.

7 Applicants must make their records available for examination by the NHS Bank. The NHS Bank employs external consultants to verify the reported financial position and to consider the achievability of the Performance Improvement Plan. The NHS Bank decides whether any conditions should be attached to the funds and monitors progress against these conditions and the Performance Improvement Plans.

8 Allocations from the Special Assistance Fund to Strategic Health Authorities are decided at the start of the year and form part of planned financial support. However, the funds are conditional and will only be released if certain conditions, for example cost savings, are met by the Strategic Health Authorities.

9 In 2002-03, all allocations were distributed to the Strategic Health Authorities towards the end of the financial year. The Department can withhold funds if the conditions are not met. This does not affect the overall balance across the NHS since the funds held centrally would offset the increased local deficits which would inevitably arise.