file

cc: DHSS.
B. Ingham
J. Vereker.

JD.

10 DOWNING STREET

THE PRIME MINISTER

11 October 1982

Dear Ralph.

I have discussed with Norman Fowler your proposal for an inquiry into the affairs of the National Health Service. We have concluded that a wide-ranging and necessarily time-consuming inquiry into all aspects of NHS management and organisation would take us forward neither fast nor far enough. There have already been two major, independent inquiries over the last decade, one by management consultants in the early '70s and another by a Royal Commission from 1976 to 1979, and I do not want this Government to add to the stockpile of analyses, but to drive forward a programme of reform.

Norman Fowler has already taken a number of initiatives to this end over the last year, directed in particular at the use and control of manpower. The new District Health Authorities, which have this year taken over the local management of the Service, will work within a much tighter system for setting objectives and securing accountability for their achievement. The planning and control of manpower has been strengthened through timely supply of manpower information which will now be on a quarterly basis, and by the introduction of new arrangements for setting Health Authority manpower targets and use of performance indicators in reviewing manpower levels.

A good deal of use has already been made of managerial and specialist expertise from outside the Service - for example, by appointing people from industry and business as chairmen of the new

/ Health

BMH.

Health Authorities, and in the programme of management scrutinies being developed under the guidance of Sir Derek Rayner.

The right course now, in my view, is to build incisively on the action that has already been taken. Accordingly Norman Fowler proposes to follow this up shortly with the establishment of a major manpower inquiry, which will bring in a high level outsider supported by his own team and management consultants to help him drive these initiatives forward and to assess what more is needed.

The emphasis needs to be on effective action for the future, but Norman Fowler will also be making available shortly to the relevant parliamentary committees an analysis of the use of resources in the NHS responding to questions which you and other parliamentary colleagues have rightly been asking. This work will also be available to and come under scrutiny by the management inquiry.

I attach a table of data as a foretaste of this: it shows what massive increases there have been in our investment in the NHS over the past 20 years, how the manpower has grown in consequence and how the nature of the service being given to the public has also changed, with an especially big growth in day patient activity. This is the field which the management inquiry will need to work over very thoroughly, for as you point out the potential benefits from greater economy in non-medical manpower are very large.

You also seek an inquiry into the performance of the Exchequer and Audit Department in regard to National Health Service matters. The main responsibility for the detailed National Health Service audit lies not with the Comptroller and Auditor General but with the statutory auditors appointed by the Department of Health and Social Security. Norman Fowler has recently set in hand a review of these arrangements. He also has under review the accounting conventions.

/ So far as

So far as the performance of the Comptroller and Auditor General and the qualifications and effectiveness of the Exchequer and Audit Department are concerned these are matters which have been extensively reviewed over the last few years. Substantial changes have been made, and particularly, the Department has obtained more qualified staff and continues to do so.

The Comptroller and Auditor General reports to Parliament, who refer his requests to the Public Accounts Committee and you can of course make your criticisms known to that Committee. The Government has often enough been accused (and wrongly) of interfering in the Comptroller and Auditor General's conduct of his responsibilities. On a matter of this sort it must be for the Public Accounts Committee, rather than for the Government, to respond to you. In all these circumstances, I believe it would be wrong to set up a new inquiry into the past performance of the audit machinery.

Yours ever

Margaret

Ralph Howell, Esq., M.P.

NUMBERS (THOUSANDS) ENGLAND

Activity	1961	1971	1976	1980
Hospital Services				
In-patient cases+ (including day cases)	4,035	5,171	5,735	6,341
Increase during period (% change)		1,136(28%)	564(3%)	606(13%)
Out-patient attendances (including accident emergency	40,133	46,260	45,473	48,296
Increase during period (% change)		6,127(15%)	-787(-2%)	2,823(8%*)
Regular day patient attendances	445	2,839	4,671	5,289
Increase during period (% change)		2,394(538%)	1,832(65%)	618(17%*)
Community Health Services				
Health visiting - cases attended	N/A	4,201	3,887	3,817
Increase during period (% change)		N/A	-314(-7%)	-70(-2%*)
Home nursing - persons nursed	1,341	1,670	2,780	3,421
Increase during period (% change)		329(25%)	1,110(66%)	641(30%*)
Hospital and Community Health Services Activity ϕ - % change		28%	5%	12%* (1981)

Manpower (whole-time equivalent**)	1961	1971	1976	1981 (provisional)
Medical and dental	19	27	33	37
Increase during period (% change)		8(42%)	6(22%)	4(12%)
Nursing and midwifery	239	309	360	388
Increase during period (% change)		70(29%)	51(17%)	28(8%)
Professional and technical	25	39	52	63
Increase during period (% change)		14(56%)	13(33%)	11(21%)
Administrative and Clerical	47	69	95	105
Increase during period (% change)		22(47%)	26(38%)	10(11%)
Ancillary	142	168	174	172
Increase during period (% change)		26(18%)	6(4%)	-2(-1%)
Others	31	37	42	45
Increase during period (% change)		6(19%)	5(14%)	3(7%)
Total NHS directly employed staff	503	648	755	811
Increase during period (% change)		145(29%)	107(17%)	56(7%)

Expenditure (£ million November 1980 prices)				
NHS gross current expenditure	N/A	7618.8	8811.9	9609.5
Increase during period (% change)		N/A	1193.1(16%)	797.6(9%)

/*/†/** see notes overleaf

Notes

+ Statistics on day cases are not available prior to 1972. The same growth rates have been assumed for day cases and in-patients before this date.

* The growth rates given here relate to the period 1976-81 to enable comparison with manpower and activity figures. Activity figures for 1981 are not yet available and the votes have been based on an extrapolation of trends in 1976 to 1980.

Ø This combined growth rate has been derived by weighting the rates of change in the various services by their expenditure share in the base year 1980.

** Figures for 1981 (except Medical and Dental) are provisional. All figures exclude DEB and PPA staff, locum medical/dental staff, agency nursing staff and nursing cadets. The exclusion has been necessary to construct a consistent series covering the period 1961 to 1981. The figures used here cover over 97 per cent of NHS staff in 1971 and 1981.

Figures prior to 1974 have been adjusted to reflect the changes in 1974 when local authority staff providing community health services were incorporated into the NHS. Adjustments have also been made to reflect changes in the basic working week between 1961 to 1981. Mr Howell's analysis of manpower/acitivity figures are misleading for a number of reasons.

i. Figures quoted by Mr Howell for the years 1960, 1970 and 1980 are a mixture of headcounts and whole-time equivalents. The proportion of part-time staff has increased significantly since 1960. (For example the headcount figure of 1,228,000 for the UK in 1980 is equivalent to 990,000 wte).

ii. Mr Howell has treated the transfer of staff from local authorities in 1974 as a true increase without adjusting the figures for earlier years and figures throughout have not been adjusted to take into account changes in working hours.

iii. In comparing these manpower figures to occupied beds over the period, Mr Howell is concentrating on one area of patient activity only - in-patient, and ignoring other areas (eg out-patients, day cases, day patients, community services) which have expanded over the period. More importantly beds are not a good measure of activity. As the activity figures show, more patients have been treated through a reducing number of beds resulting in a more intensive use of resources and lower average costs per case. The aim of the NHS is not to fill beds but to treat more patients and this is not reflected in the bed figures.

I have great sympathy with Ralph Howell's views.
I have been using some of his figures.
A management exercise may be a good idea but,

cc: Mr. Butler
Mr. Gow
Mr. Sparrow, CPRS

PRIME MINISTER

Here is the letter that Ralph Howell promised to send. I understand that Ian Gow has persuaded him to keep it private.

He makes three points:

(a) He would like you to set up an immediate inquiry to look specifically at the National Health Service. He does not want the inquiry to look more widely at the public sector as a whole.

(b) He wants the inquiry to be carried out by independent outsiders. He clearly would not be happy with an inquiry by the CPRS.

(c) He wants the inquiry to examine the performance of the Exchequer and Audit Department. He appears to think that the Department is supposed to ensure the effectiveness and efficiency of the National Health Service, and he considers that the Department have failed in this task. This seems to me to be a misunderstanding of the role of C&AG and his Department.

We will let you have a draft reply after the discussion on 9 September. But it seems likely that Ralph Howell may not be satisfied with the promise of an inquiry by the CPRS into the growth of public sector manpower generally, and you may have to have another meeting with him.

CM

3 September 1982

VR

cc JV
BI
Non type reply for PM

Godt. Nach

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

M Scholar Esq
10 Downing Street

4 October 1982

Dear Michael

You wrote to me on 6 September, enclosing copies of letters which the Prime Minister had received from Mr Ralph Howell MP, proposing an Inquiry into the National Health Service.

The Prime Minister and my Secretary of State discussed the question of an independent Management Inquiry at their meeting on 9 September. They agreed that what was needed was a Management Inquiry which would build on the initiatives already taken by my Secretary of State and would formulate and introduce a progressive programme of action supplementing those initiatives. They agreed that it would not be profitable to have a wide-ranging analytical inquiry, which would require extensive consultation and offer no prospect of early action. My Secretary of State has now submitted a formal proposal to the Prime Minister - his minute of today.

My Secretary of State originally proposed to announce the Management Inquiry when the NHS dispute had been settled. Since this is not now immediately in prospect he is inclined to announce the intention to have an Inquiry as soon as possible. It will not be practicable to make a full announcement, however, until the leader has been secured and consulted, so he would not propose to refer to it in more than general terms. I accordingly attach a suggested draft reply to Mr Howell which indicates that a further initiative is being considered without being specific: we assume that it would go soon after any general announcement.

The table referred to in the draft reply is the one that Sir Kenneth handed to you when he visited No 10 with the Secretary of State and I enclose a further copy (very slightly amended).

Yours ever,

David

D J CLARK
Private Secretary

MS

C

Pl type reply for PM

SUGGESTED DRAFT REPLY TO MR HOWELL

I have discussed with Norman Fowler your proposal for an inquiry into the affairs of the National Health Service. We have concluded that a wide-ranging and necessarily time-consuming inquiry into all aspects of NHS management and organisation would take us forward neither fast nor far enough. There have already been two major, independent inquiries over the last decade, one by management consultants in the early '70s and another by a Royal Commission from 1976 to 1979 and I do not want this Government to add to the stockpile of analyses, but to drive forward a programme of reform.

Norman Fowler has already taken a number of initiatives to this end over the last year, directed in particular at the use and control of manpower. The new District Health Authorities, which have this year taken over the local management of the Service, will work within a much tighter system for setting objectives and securing accountability for their achievement. The planning and control of manpower has been strengthened through timely supply of manpower information which will now be on a quarterly basis, and by the introduction of new arrangements for setting Health Authority manpower targets and use of performance indicators in reviewing manpower levels.

A good deal of use has already been made of managerial and specialist expertise from outside the Service - for example by appointing people from industry and business as chairmen of the new Health Authorities, in the programme of management scrutinies being developed under the guidance of Sir Derek Rayner, and in the experimental use of commercial auditors for the audit of the National Health Service accounts.

The right course now, in my view, is to build incisively on the action that has already been taken. Accordingly Norman Fowler proposes

to follow this up shortly with the establishment of a major manpower inquiry, which will bring in a high level outsider supported by his own team and management consultants to help him drive these initiatives forward and to assess what more is needed.

The emphasis needs to be on effective action for the future, but Norman Fowler will also be making available shortly to the relevant parliamentary committees an analysis of the use of resources in the NHS responding to questions which you and other parliamentary colleagues have rightly been asking. This work will also be available to and come under scrutiny by the management inquiry.

I attach a table of data as a foretaste of this: it shows what massive increases there have been in our investment in the NHS over the past 20 years, how the manpower has grown in consequence and how the nature of the service being given to the public has also changed, with an especially big growth in day patient activity. This is the field which the management enquiry will need to work over very thoroughly, for as you point out the potential benefits from greater economy in non-medical manpower are very large.

~~So far~~

~~I am~~

You also seek an inquiry into the performance of the Exchequer and Audit Department in regard to National Health Service matters. The main responsibility

cc FM

CF/4R

Pl s.v. with DHSS draft

MCS 23/9

Treasury Chambers, Parliament Street, SW1P 3AG
01-233 3000

M C Scholar Esq.
Private Secretary
10 Downing Street
London SW1

22 September 1982

Dear Michael,

In your letter to David Clark of 6 September about Mr Ralph Howell's letter of 31 August to the Prime Minister you asked for a contribution from the Treasury touching on Mr Howell's Exchequer and Audit Department points. I enclose that contribution.

2. The Exchequer and Audit Department was the subject of a Management Review in 1978 which has led and is leading to considerable changes. Training for professional qualifications is being given special attention and the number of qualified staff is increasing all the time.

3. The role of the C & AG has also been the subject of much Parliamentary attention over several years and the Government's White Paper on the subject (Cmnd 8323) which, inter alia, left the NHS arrangements as they are, was not well received. Delicate neogitations are still in progress over this White Paper and a new review now would be positively embarrassing.

4. Finally, Mr Howell has not sent you all of his correspondence with Mr Downey about the provision of information. We have seen other letters which indicate that Mr Downey has done as much as he properly can to satisfy Mr Howell. The point at issue here is whether the C & AG may use information derived from his access to departmental papers for purposes other than his audit reports to Parliament and the PAC. The Government's forthcoming reply to the TCSC will specifically reject this. If MP's want information about departments' business they can and should obtain it from those departments or their Ministers. Mr Howell says that he has written to Sir Kenneth Stowe, as Mr Downey advised, and we understand that he has had a full reply from him.

5. For all these reasons the draft reply, which has been cleared by the Financial Secretary, declines Mr Howell's proposals, but sympathetically.

6. I am copying this letter to David Clark (DHSS), Gerry Spence (CPRS) and Richard Hatfield (Cabinet Office).

Yours,
Jill Rutter

JILL RUTTER

DRAFT REPLY ON E & AD ASPECTS OF
MR HOWELL'S LETTER OF 31 AUGUST

The main responsibility for the detailed ~~NHS~~ National Health Service audit lies not with the ~~C & AG~~ Comptroller and Auditor General but with the statutory auditors appointed by the Department of Health and SOcial Security. Norman Fowler has recently set in hand a review of these arrangements. He also has under review the accounting conventions.

2. As for Mr Downey's response to your questions about linen losses he is in fact right to point you in the direction of the Department for the answers to your questions and I note that you have approached Sir Kenneth Stowe accordingly.

3. So far as the performance of the Comptroller and Auditor General and the qualifications and effectiveness of the Exchequer and Audit Department are concerned these are matters which have come under full review over the last few years. Substantial changes have been made, and particularly, the Department has obtained more qualified staff and continues to do so.

4. I am sure it would be wrong to set up a new inquiry into the past performance of the audit machinery, though I understand the feelings which led you to suggest it. The C & AG reports to Parliament who refer his requests to the Public Accounts Committee and you can of course make your criticisms known to that Committee. The Government has often enough been accused (and wrongly) of interfering in the C & AG's conduct of his responsibilities. On a matter of this sort it must be for the PAC to respond to you, rather than the Government.

Sent

Sarhead

20 September 1982

I am writing on behalf of the Prime Minister to thank you for your two letters of 31 August. I am sorry we have not acknowledged these before now.

The Prime Minister saw these immediately, and has put certain work in hand. I hope that you will have your reply soon after her return from the Far East.

M. C. SCHOLAR

Ralph Howell, Esq., M.P.

CONFIDENTIAL

c.c. Mr. Mount

CPRS
CO
HMT.

10 DOWNING STREET

From the Private Secretary

6 September, 1982.

Dear David,

I attach copies of 2 letters which the Prime Minister has received from Mr. Ralph Howell MP, following her meeting with him early last month. You will see that Mr. Howell proposes that the Prime Minister set up an immediate Inquiry into the National Health Service, that the Inquiry should be carried out by independent outsiders, and that it should also examine the performance of the Exchequer and Audit Department.

The Prime Minister has commented that she has great sympathy with Mr. Howell's views; and, as you know, she has deployed on a number of occasions recently some of the figures which he has produced. She has also further commented that a management Inquiry may be a good idea for the Health Service. The Prime Minister has it in mind that the Cabinet discussion of longer term public expenditure options (set for Thursday, 9 September) may well throw up some suggestions as to how Mr. Howell's proposals might be replied to; she has also considered the possibility of asking the CPRS to conduct an Inquiry into efficiency in the public service, not only in the National Health Service, but also in the other public welfare services. It seems clear, however, that a CPRS Inquiry on these lines would not meet Mr. Howell's concern; particularly if, as would seem desirable, such an Inquiry would need to be confidential within the Government.

B/F

I would be grateful if you could let me have a draft reply for the Prime Minister's signature as soon as possible after the discussion on 9 September. I would be grateful, too, if Jill Rutter (HM Treasury), to whom I am copying this letter and attachments, would let me have a contribution to the draft reply touching upon Mr. Howell's Exchequer and Audit Department points. I am also copying this letter to Gerry Spence (CPRS), and Richard Hatfield (Cabinet Office).

Yours sincerely,

Michael Scholar

David Clark, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

Mr. Scholar
We spoke. I see from Mr. Howell's second letter below that he has already submitted his minute to the TCSC. Did we know that before? and do we know what they have done with it?
FER
6.9.

10 DOWNING STREET

MR. BUTLER

Here is a copy of Ralph Howell's letter, and my note to the Prime Minister. You will probably want to wait until after the meeting on 9 September before deciding how to respond to this, but there is one point that you may want to raise with the Prime Minister; that is, when to consult the DHSS and the Treasury (the latter, given Ralph Howell's remarks about the E&AD).

Mr Butler

So far as I know all we knew abt the TCSC was what RH's letter says. Mr Kemp tells me that after some manoeuvring TCSC are designing into public sector manpower
PTO

3 September 1982

as a whole, the Tsy are doing a paper. They will call for witnesses etc.

This does not, as I see it, overturn the alleged privacy of RH's approach to the PM.

Pl see my letter to DHSS.

MLS 7/9

RALPH HOWELL, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

31st August 1982

The Rt. Hon. Mrs. Margaret Thatcher, M.P.
Prime Minister

Dear Prime Minister.

Thank you very much for seeing me in early August and giving me so much of your valuable time.

I was very pleased that you recognised the need for an urgent and full inquiry into the National Health Service as a whole and I enclose my formal letter requesting that such an inquiry be set up.

I do hope that you will, in the first place, set up an inquiry separately into the National Health Service. If an inquiry were made into the Public Sector generally, I am convinced it would be very long drawn out and would also lose a considerable degree of impact. An examination of the Public Sector as a whole would achieve much better results after the findings of the National Health Service inquiry had been absorbed and understood.

Secondly, I believe that this inquiry should be conducted by independent individuals in the same way as the Falklands Inquiry which you have instituted. I believe, very strongly, that it would be quite wrong to ask any organisation in any way connected with the Civil Service or the Government to investigate this matter.

May I respectfully remind you of the action you took immediately on becoming aware of the aggression against the Falklands. First you took positive action to prepare the forces to regain possession and then you promised Parliament that you would institute a full and independent inquiry. Therefore, I hope you will not only institute the inquiry that I have requested but that you will similarly take necessary and immediate action to ensure that the British people are able to make full and proper use of the National Health Service which belongs to them and to no other separate faction.

RALPH HOWELL, M.P.

31st August 1982

In my opinion the chaotic state of the National Health Service is more serious than the Falklands invasion. The aggression that Britain and British subjects suffered in the Falklands is small compared to the aggression, suffering and intimidation being perpetrated by the militants within the National Health Service, not only against those who need treatment but also against those sound people engaged in the National Health Service who desperately want to get on with their work.

When you consider that the people of this Country are being forced to pay for overmanning of over 500,000 staff, costing at least £10,000 in overall costs each - £5,000M of their hard-earned taxes wasted in each year - and then that they are denied proper medical services when in need, I believe you will agree that this matter is one of the most urgent which confronts the Nation.

During the Falklands campaign your bold, courageous action brought you ever-increasing support from a huge majority of the British people. There is no doubt in my mind that the time has come when you must stop listening to the weak-kneed councillors of caution around you, and repeat the bold decisions you took to restore freedom to the 1800 Falklanders, and restore freedom and democracy to the 56 million people of Britain.

Yours ever

Ralph

RALPH HOWELL, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

31st August 1982

The Rt. Hon. Mrs. Margaret Thatcher, M.P.
Prime Minister
10 Downing Street
London SW1

Dear Prime Minister,

I wish to make a formal request to you to institute an immediate and full inquiry into :-

1. The affairs of the National Health Service, and

2. The performance of the Exchequer & Audit Department with regard to National Health Service matters.

I base my request on the evidence which I have already submitted to the Treasury and Civil Service Committee, a copy of which I enclose (Annex "A"). I would point out that my request to the Treasury and Civil Service Committee is for an inquiry into overmanning in the Public Sector generally and I hope that action will be taken when Parliament reassembles.

1. My request to you is for an inquiry specifically into the National Health Service and mismanagement therein.

The following facts prove that there is no effective control of the National Health Service :-

(i) There is no Chairman or titular head of the National Health Service.

(ii) No one person is in overall executive control of any Health Authority or Hospital within the National Health Service.

Consequently there can be no effective overall management, budgetary, manpower, inventory or audit control either generally, at area or hospital level.

31st August 1982

The figures set out in Annex "B" show the extent of overmanning in the National Health Service.

Annex "C" draws attention to the losses shown in the Statement of Accounts which I believe warrant very careful scrutiny, bearing in mind that losses from theft, fraud, etc., of only .01% are, in my view, impossible. The explanation by the Comptroller & Auditor General that only certain losses appear in Statement 8 is unacceptable - see his letter of 25th June, 1982. (Annex "D")

I also enclose a copy of the Hospital Inventories Report 1967 (Annex "E") and would draw your attention to page 4, paragraph 10 (i) and (ii), and to the fact that the Report of 1982 merely recommends the continuation of the 1967 policies stating that "they remain a sound basis of good practice".

I believe these documents are ample evidence that there is no proper inventory control. The fact that the Daily Telegraph Article has never been refuted, plus reports which constantly circulate regarding National Health Service losses, indicate that very considerable losses are being sustained.

2. I also formally request that you instigate an inquiry into the Exchequer & Audit Department on the following grounds :-

a) The failure of past and present Comptrollers & Auditors General to quantify or arrest the overmanning which has occurred in the National Health Service during the last twenty years.

b) The unsatisfactory presentation of National Health Service Accounts.

c) The lack of qualifications of the Comptroller & Auditor General and also his recruitment and that of his predecessors from the Civil Service itself when, as I see it, his duty is to sit in judgement on the activities of the Civil Service and other public bodies, and to be totally independent.

d) The fact that only a small proportion of the staff are chartered accountants and none of those who are auditing the accounts of the National Health Service are chartered accountants.

31st August 1982

e) The extraordinary statement by the Comptroller & Auditor General in his letter of 23rd July, 1982, paragraph 3, regarding maintaining confidentiality (Annex "F") Parliament is his client and it is quite improper for him to maintain confidentiality for the National Health Service against Parliament itself.

I would also like to draw your attention to the Report of the Comptroller & Auditor General, National Health Service Accounts 1980-81 :-

"2. The Act empowers me to examine the accounts of individual health authorities, etc., and the records relating to them. I direct this examination mainly to the effectiveness of their procedures for financial control and for securing efficiency and economy in the use of resources".

It is my submission that the Comptroller & Auditor General has failed to carry this out.

For all these reasons I ask you to institute immediate inquiries into these two related matters.

Yours ever

Ralph

TR 245

ANNEX "A"

MANPOWER AND AUDIT CONTROL IN THE PUBLIC SECTOR

Note by Mr. Ralph Howell

I SUBMIT :

1. General Public Sector Manpower Facts 1960 - 1980.

2. NHS MANPOWER and related facts.

3. NHS ACCOUNTS 1980-81. Statement 8.
   Losses (1) and (4)
   Daily Telegraph Report - 16.4.82.
   Hospital Inventory Report - 2.6.82.

4. Comptroller & Auditor General Staff employed on NHS Audit.
   Prime Ministers reply - 22nd June (Col.67/68)
   18th May (Col.68/69)
   Chartered Accountants dealing with NHS - NIL.

NOTE : Although the papers relate to manpower, accounts, auditing and losses in the NHS, I am merely using the NHS as an example of what is happening generally in the Public Sector.

These submissions prove that :

(a) There is inadequate control of manpower.

(b) The Comptroller & Auditor General and his staff are inadequately qualified and have insufficient information to audit the accounts.
As far as I have been able to ascertain the allegations made in the Daily Telegraph Article have never been refuted and the Internal Report which I have submitted indicates that there is inadequate inventorial control.

(c) The special relationship between the C.A.G. and P.A.C. has failed to monitor efficiency within the NHS or produce accurate NHS accounts.

Therefore, I request that the Treasury and Civil Service Committee should urgently enquire into thewhole area of both manpower and audit control of the Public Sector. I repeat, I have used the NHS as an example - an enquiry is needed into the Public Sector generally.

STATISTICAL SECTION
HOUSE OF COMMONS LIBRARY
LONDON SW1A OAA

direct line
01-219 3622

switchboard
01-219 3000

12th March 1982

GFL/SJW

Dear Mr. Howell,

Statistics of manpower in the public services

I have been asked to reply to your enquiries. Miss Tanfield will be replying separately to the points about unemployment.

1. The Civil Service

	Thousands, full-time equivalent at 1st April		
	Non-industrial staff	Industrial staff	Total
1960	379.7	262.8	642.5
1970	493.0	207.8	700.8
1980	547.7	157.4	705.1

The Post Office is excluded throughout, but the coverage of the figures has changed during the period because of alterations in the scope of the definition of the Civil Service.

Sources: Annual Abstracts of Statistics, 1970, Tables 138 and 139; 1981, Table 6.5

2. National Health Service, Local Authorities, Public Corporations

	Thousands at mid-year		
	NHS	Local authorities	Public Corporations
1960	n.a.	1,821	1,865
1961	575	1,870	2,200
1970	741	2,559	2,025
1980	1,228	3,027	2,036

In these figures, part-timers are counted as whole units, unlike those of the Civil Service given above. With these figures also, there were changes in definition during the period.

Sources: Economic Trends, Feb. 1976, p.123; Nov. 1979, p.98; Dec. 1981, p.94.

/...

Table 2 Teaching and non-teaching staff of education departments, Great Britain and England and Wales

Thousands

		1960(a)	1970	1974	1975 Old basis	1975 New basis	1976	1980
Great Britain								
Lecturers and teachers:	full-time	336.0	453.0	561.6			587.6	603.7
	part-time	76.0	155.4	181.1			152.8	151.4
	total	412.1	608.4	742.7			740.4	755.1
	total f.t.e.(b)						623.0	635.8
Other education dept. staff:	full-time	88.5	201.8	237.2			252.5	226.2
	part-time	99.6	394.6	473.5			529.0	521.1
	total	188.1	596.4	710.7			781.5	747.3
	total f.t.e.						481.1	452.2
All staff, full-time and part-time:	crude totals	600[illegible]	1,204.8	1,453.4			1,521.9	1,502.8
	total f.t.e.						1,104.2	1,088.0
England and Wales								
Lecturers and teachers:	full-time	298.3	406.8	505.2	515.9	517.1	527.9	540.8
	part-time	74.3	147.3	171.5	186.4	160.4	144.6	145.7
	total	372.6	554.1	676.7	702.3	677.5	672.5	686.5
	total f.t.e.					552.8	560.2	570.7
Other education dept. staff:	full-time	80.5	181.1	210.9	220.0	222.1	222.6	201.0
	part-time	90.4	370.4	443.9	486.4	490.4	495.4	484.2
	total	170.9	551.5	654.8	706.4	712.5	718.0	683.3
	total f.t.e.					432.6	435.4	410.0
All staff, full-time and part-time:	crude totals	543.5	1,105.6	1,331.6	1,408.7	1,390.0	1,390.5	1,369.7
	total f.t.e					985.4	995.6	980.8

Note: (a) excluding canteen staff who are included in subsequent years. "Other" education staff in Great Britain rose by 150,700 between 1960 and 1961 (a rise of 105,000 in the total of part-time women separately) and most of this rise is probably accounted for by the inclusion of canteen staff.
(b) full time equivalent.

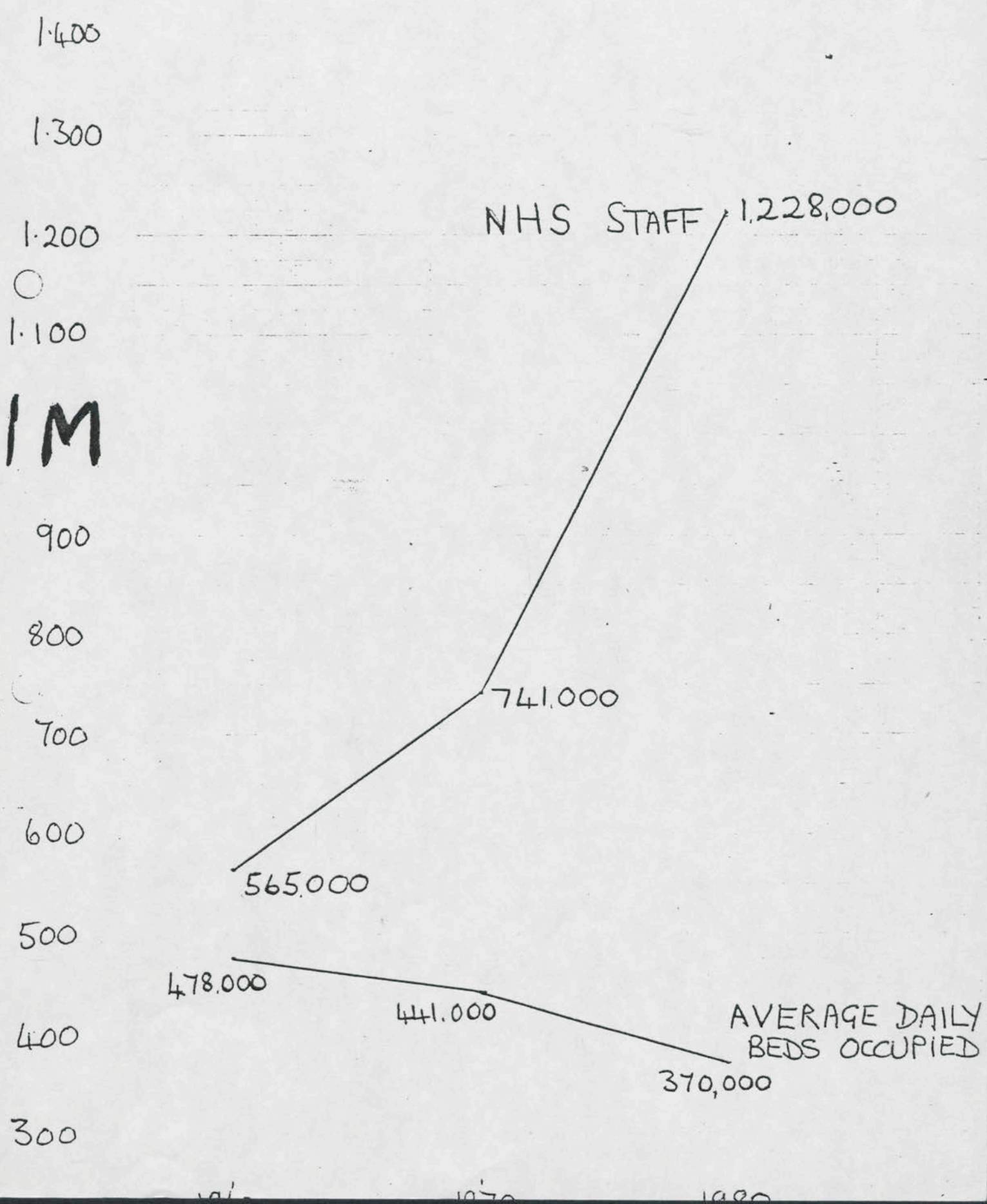
Sources: Ministry of Labour/Department of Employment Gazette, Dec. 1960, p.468; Nov. 1970, p.1028; Dec. 1974, p.1141; Nov. 1976, p.1252; Nov. 1977, p.1218; Dec. 1977, p.1372; and Dec. 1981, p. S11 and S13.

Local Authority Financial Statistics, England and Wales. 1976/77, p.8 and 1979/80, p.51.

THOUSANDS

RALPH HOWELL, M.P.

ANNEX 'B'



IS THE NATIONAL HEALTH SERVICE OUT OF CONTROL ?

In the Conservative Manifesto of 1979 we said -

"In our National Health Service standards are falling - there is a crisis of morale - too often patients' needs do not come first. It is not our intention to reduce spending on the Health Service - indeed we intend to make better use of what resources are available. So we will simplify and decentralise the service and cut back bureaucracy".

It is generally accepted that in 1960 our National Health Service was unequalled in the World.

Nobody could make such a claim today.

The facts below show what has been happening in the last twenty years and how we have failed to alter the general direction of overmanning, restrictive practices and falling standards.

	1960	1970	1980	Source
Total U.K. population.	52,559,000	55,522,000	56,010,000	
Population covered by NHS.*	98.11%	96.43%	93.61%	HANS.1.12.81 Col. 88.
Total Staff.	565,000	741,000	1,228,000	
INCREASE Population between 1970 & 1980			- 488,000	
INCREASE Staff		" " "	487,000	

* The numbers of people joining BUPA and similar private schemes has now reached 4,000,000 (1,250,000 in 1960) and is increasing rapidly.

	1960	1970	1980	
HOSPITAL WAITING LISTS (England only)	401,216	493,330	611,748	HANS.18.1.82 Col. 49/50.

	1960	1970	1980
Average daily no. of beds occupied (U.K.)	478,000	441,000	370,000
Ratio of staff to occupied bed.	1.2	1.7	3.3

BREAKDOWN OF STAFF

Totals of Staff (Great Britain) (WHOLETIME EQUIVALENTS)

	1960	1970	1980 (Provisional)	Source
Medical & dental	19,919	27,301	46,450	1960 & 1970 figs. Library 21.1.82.
Nursing & midwifery.	236,711	343,682	448,870	1980 HANS. 23.11.81
Other	n.a.	387,228	468,235	Col. 270.

Totals of Staff (Great Britain) (WHOLETIME EQUIVALENTS)

	1979	1980 (Prov)	Increase	Source
Medical & dental	45,150	46,450	1,300	
Nursing & midwifery.	437,405	448,870	11,465	
Professional & tech.	71,407	77,500	6,093	
Works	6,856	7,085	229	
Maintenance.	25,655	26,100	445	
Admin. & clerical	121,900	124,890	2,990	
Ambulance	20,177	21,035	858	HANS. 23.11.81 Col. 270.
Ancillary	211,114	211,625	511	
Totals	939,664	963,555	23,891	

INCREASES

		Source
May 1979	939,664	
Est. 1981/82	981,200	HANS. 23.11.81 Col. 270.
INCREASE	41,536	
LATEST FIGURE	67,000	HANS. 19.1.82. Col. 152.

QUESTIONS WHICH SHOULD BE ASKED

WHY when we have more than 200,000 nurses over and above the 236,000 employed in 1960, do we still need to increase nurses at the rate of 11,000 a year?

WHY increase administrators by nearly 3,000 between 1979 and 1980?

WHY did we need to increase ambulance personnel by nearly 1,000 between 1979 and 1980?

Further facts which demonstrate the lack of control of National Health Service expenditure :-

	1960	1970	1980	
	£m	£m	£m	
NHS Expenditure	863	1,954	11,444	Leon Brittan's reply 8.6.82
% of GDP	3.4	3.8	5.1	

Number of staff employed by Exchequer & Audit Dept. on NHS audit.	34	Prime Ministers reply 18.5.82. Cols. 68/69.
Chartered Accountants	Nil	
Qualified members of Chartered Institute of Public Finance & Accountancy.	3	
Passed Departmental Training examinations.	14	
Undergoing training.	17	

Computers in NHS		
Number of computers installed since 1960.	Not known.	Prime Ministers reply 16.3.82.
Cost of computers installed since 1960.	Not known.	
Register of computers in NHS to be established in JUNE 1982.		Kenneth Clarke's reply 7.4.82.

NHS STAFF - Number of Grades of staff.	5,000	Geoffrey Finsberg's reply 19.5.82.

Is there any overall target for the eventual size of the National Health Service or is it totally out of control?

Is the overmanning which has occurred in advance of the proposed reorganisation of the National Health Service, a repeat performance of what happened in Local Government reorganisation in 1972?

The increase of 67,000 in National Health Service personnel has cancelled out the reduction of 56,000 which the Government has laboriously achieved in the Civil Service.

After two and a half years the overall reduction in public sector manpower is less than 1%.

The firm monetary policies have succeeded in effectively reducing overmanning in the private sector.

The effect on the public sector has been abysmal.

ANNEX "C"

STATEMENT 8 (England)

STATEMENT OF LOSSES, ETC.

YEAR ENDED 31 MARCH 1981

	Number of cases	Amount	Recoveries
		£	£
1. Losses of cash due to:			
(*a*) theft, fraud, etc.	669	72,986	1,005
(*b*) overpayments of salaries, wages, fees and allowances	769	210,836	1,976
(*c*) other causes, including unvouched or incompletely vouched payments, overpayments other than those included under 1(*b*); loss by fire (other than arson); physical cash losses and losses of stamps, or similar cash equivalents	1,101	63,527	866
2. Fruitless payments (including abandoned capital schemes)	229	52,128	108
3. Bad debts and claims abandoned:			
(*a*) Road Traffic Act claims	36,486	111,964	859
(*b*) other	16,788	13,733,738	12,295
4. Stores losses (equipment and property) due to:			
(*a*) theft, fraud, arson, etc.	3,254	833,478	13,003
(*b*) incidents of the service (as a result of fire, flood, etc., motor vehicle accidents, damage to vehicles)	5,144	2,686,242	144,821
(*c*) other causes	3,414	724,499	243,009
5. Compensation payments (made under legal obligation)	2,825	3,440,227	448,569
6. *Ex gratia* payments:			
(*a*) extra-contractual payments to contractors	60	374,070	44
(*b*) compensation payments (including payments to patients and staff for loss of personal effects)	6,692	251,299	2,052
(*c*) private street works charges	2	2,101	—
(*d*) other payments	185	22,487	60
7. Extra-statutory and extra-regulationary payments	4,550	204,735	615
	82,168	22,784,317	869,282

NOTES:

(i) Included at item 3(*b*) is an amount of £13,288,000 in respect of an abandoned claim and item 6(*a*) includes a related payment of £98,655 both of which arose through a contractor going into liquidation. Item 6(*a*) also contains an amount of £163,740 in respect of a separate but similar case. Item 4(*b*) contains six cases each in excess of £75,000 and amounting to £1,026,133 due to fire damage. Item 5 includes 3 cases each in excess of £75,000 and totalling £508,263.

(ii) One area health authority included an entry of £1,490,500 (Cr) at item 4(*a*) in its Statement of Losses in order to adjust a larger entry recorded in a previous year. To avoid distorting the national figures this adjustment has been omitted from the above statement.

(iii) Sample checks by Family Practitioner Committees of prescription forms on which patients have claimed exemption from dental, optical and prescription charges indicate a loss estimated to be of the order of £2,177,000 from non-payment of charges due. This sum is not however included in the foregoing statement.

NATIONAL HEALTH SERVICE

DAILY TELEGRAPH

16.4.82 p14

LINEN THEFTS COST HEALTH SERVICE £1m A YEAR

By CON COUGHLIN

THE National Health Service is losing at least £1 million a year in stolen linen because of inadequate security arrangements, it was claimed yesterday.

Sheets, blankets and nappies are being stolen by staff, patients and visitors because few, if any, checks are made on them.

Mr Ernest Parkinson, district security advisor for Camberwell Health Authority, said health authorities expected to lose at least 10 per cent. of their linen each year through theft.

Speaking at a conference organised by the International Association for Hospital Security, Mr Parkinson said: "It is impossible to estimate exactly how much linen is stolen each year because there are no methods of strict stock control.

"The Health Service estimates it lost more than £1 million in linen last year, but this is a conservative figure. With proper security measures these thefts could be avoided."

Petrol check

At one hospital staff had to buy an extra 40 sheets, 50 blankets, 50 pillow slips, 20 counterpanes and 20 draw sheets each month to compensate for the losses. In one district half the stocks of baby nappies were lost in a year.

Mr Ken Sneath, principal Health Department auditor, said that at one hospital large quantities of petrol were stolen regularly. The fraud was only discovered by looking at how many miles hospital vehicles were doing to the gallon. The average was found to be two miles to the gallon.

Overseas calls

At a mental hospital a charge nurse was found to have ordered £500 worth of cigarettes for patients who did not smoke. Some nurses had relatives overseas and made long-distance telephone calls which could cost £200 a time.

Mr Parkinson said the Health Service needed to take a more realistic attitude to security, with more security staff and more [illegible]

[illegible] even," he said

HOSPITAL INVENTORIES

1. A Working Party was established in the North Western Region to review the Ministry of Health report on "Hospital Inventories".

2. The group felt that the principles contained in the 1967 report remained a sound basis for good practice.

3. It was therefore considered superfluous to go through the whole process again when the advantages and disadvantages of inventories had been thoroughly examined and clearly set out in the 1967 report.

4. It was felt that a number of additional factors were now of relevance:-

   (a) the use of computer facilities and mathematical techniques in determining stock levels, store layouts, and for the provision of costing and budgetary information can all contribute towards achieving better overall control.

   (b) whilst accepting the general arguments proffered against the maintenance of traditional inventories it was felt that high value, desirable items of stock and equipment should be the subject of some form of inventory style logging and checking procedures.

   (c) the use of computerised inventory systems can enable much of the "routine slog" to be taken out of the compilation, update and maintenance of inventories.

   (d) the periodic, independant review of procedures for ordering, receiving, storing and disposing of goods and equipment is an essential element in achieving sound controls. It is felt that Internal Audit has a role to play here.

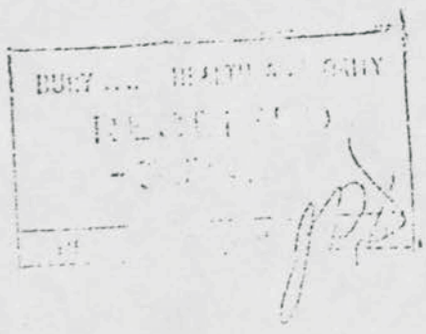
   (e) the maintenance of inventories encourage staff to be aware of the need for adequate control of property.

5. The North Western group, felt that the 1967 report should be re-issued and the attention of Health Authorities drawn to the need to encourage staff to be concerned with:-

   (a) the security of property,

   (b) the avoidance of loss,

   (c) the need for economy in the use of resources.



Comptroller and Auditor General

18·5·82
(Cols 68/69)

Mr. Ralph Howell asked the Prime Minister, pursuant to her answer to the hon. Member for Norfolk, North, 19 April, *Official Report*, c. 19, what is the total number of staff of the Comptroller and Auditor General; how many of these people are qualified accountants; and if she will list separately the qualifications of the 36 staff of the Comptroller and Auditor General who are employed on the audit of the National Health Service.

The Prime Minister: The present staff of the Comptroller and Auditor General for England, Scotland and Wales numbers 766, of whom 621 are audit staff, and the remainder supporting staff. The Department has 60 staff who are qualified as members of accountancy bodies. A further 235 are at various stages of training for such qualifications.

Thirty-four audit staff are currently employed on the audit of the National Health Service in England, Scotland and Wales. Of these, 14 have passed the departmental training examination; three are qualified members of CIPFA; and 17 are undergoing training for that qualification. The Comptroller and Auditor General for Northern Ireland employs four staff on NHS audit and their qualifications are: one FCCA; one ACIS and two unqualified.

Comptroller and Auditor General

22·6·82
(Cols 67/68)

Mr. Ralph Howell asked the Prime Minister (1) pursuant to her answer to the hon. Member for Norfolk, North 18 May, *Official Report* c. 68-69, how many of the present staff of the Comptroller and Auditor General for England, Scotland and Wales, are chartered accountants, split between those who audit within *(a)* the Civil Service, *(b)* local government, *(c)* the National Health Service and *(d)* all other Government bodies;

(2) pursuant to her answer to the hon. Member for Norfolk, North 18 May, *Official Report* c. 68-69, if she will give details of the qualifications of the 60 staff employed by the Comptroller and Auditor General who are qualified as members of accountancy bodies, and also state how many are chartered accountants.

The Prime Minister: The Comptroller and Auditor General currently employs 63 staff who are qualified as members of accountancy bodies, as follows:

	Staff
Institute of Chartered Accountants	8
Association of Certified and Corporate Accountants	7
Chartered Institute of Public Finance and Accountancy	40
Institute of Cost and Management Accountants	8
The eight members of the Institute of Chartered Accountants are assigned to audits in the following areas:	
Civil Service	6
National Health Service	NIL
Other Government Bodies	2

The C&AG does not undertake audits within local government; these are the responsibility of the District Audit Service or commercial accountancy firms.

ANNEX "D"

EXCHEQUER AND AUDIT DEPARTMENT
AUDIT HOUSE VICTORIA EMBANKMENT
LONDON EC4Y ODS

Comptroller and
Auditor General
Gordon Downey C.B.

GSD 464

25 June 1982

Ralph Howell Esq MP
House of Commons
London SW1

Dear Mr. Howell,

REPORTING OF LOSSES IN NHS SUMMARISED ACCOUNTS

You asked David Myland on the telephone on 23 June for information on a number of points relating to the NHS Summarised Accounts for 1980-81.

2. On the question of the relationship of the Losses Statement (Statement 8) to the main expenditure statement in the Summarised Accounts of Health Authorities in England, any cash losses, overpayments, compensation payments etc arising in the financial year will be charged in the main statement as revenue or capital expenditure, and will be reflected in one of the other Statements which analyse expenditure to objective heads eg Statement 2. But these losses, compensation payments etc are not identified in those Statements. This follows long-standing practice in the Appropriation Accounts, where losses and special payments are charged to normal subheads and not identified therein, but included in overall Losses Statements appended to the Accounts. The practice of opening special losses subheads in accounts was dropped in 1961 with the concurrence of the Public Accounts Committee; this was because such subheads were misleading as they covered cash losses only to the extent of sums relating to the year of account, and they did not include all categories of cash loss. Furthermore stores losses, and claims abandoned, could not be included in such subheads. On the other hand a Losses Statement can exhibit the full amount of all losses coming to light in the year, whether relating to cash lost or disbursed in that year or an earlier year, fraud in any year, losses of stores etc acquired in an earlier year, and shortfalls in receipts in the current or earlier years. Thus the reader can see at one point the entire picture for a year, and does not need to search through the accounts for a series of disconnected items. Even if the current year cash element of losses were shown in the Statements relating to the various services within the NHS, this would not provide a complete breakdown of losses. Notes would have to be added to reflect earlier year, stores, etc items. And to do so would run counter to the further simplification of Losses Statements in

/the Appropriation

the Appropriation Accounts which the PAC have recently endorsed in their Eighteenth Report of the present Session.

3. You expressed doubt whether the 1980-81 figures relating to cash and stores losses due to theft, fraud etc, were representative of the actual level of such losses in the NHS. The position is that Statement 8 is compiled by aggregating similar statements prepared by each of the individual health authorities. Those authorities maintain accounting systems under which they are required to record all such losses which come to light, and their annual losses statements form part of their accounts which are subject to independent audit and certification by the DHSS Statutory Auditors. E&AD carry out test checks to verify the work of those auditors and are satisfied on that basis that in general it can be relied on to ensure that Health Authorities produce sound figures for incorporation in the Summarised Accounts.

4. In the past both the statutory auditors and E&AD have found evidence of weakness in the stores and inventory control and stocktaking procedures of individual health authorities. But the health authorities have made improvements and we have no current evidence that this has led to a material understatement in the level of reported losses.

5. You enquired whether it was possible to secure a breakdown under subjective heads of the total cost of the NHS, so that you could compare the level of losses against the level of relevant expenditure. I can confirm that DHSS prepare this information for their own internal use, but do not publish it, and it does not form part of the accounts audited by E&AD. Accordingly I suggest that you should approach DHSS directly for any details you require.

Yours sincerely,

Gordon Downey

GORDON DOWNEY

RALPH HOWELL, M.P.

21st July 1982

Gordon Downey Esq., CB,
Comptroller & Auditor General
Exchequer & Auditor Department
Audit House
Victoria Embankment
London EC4Y ODS

Dear Mr. Downey

I am experiencing some difficulties in understanding the National Health Service Accounts 1980-81, and I am particularly concerned at the very small amount which is shown for theft, fraud, etc. under items 1-4, Statement 8. These amounts total less than one million, which is roughly .01% of total expenditure. I understand that in normal business a 1% loss from such causes is recognised as extremely good.

When I met you and Mr. Myland in June, Mr. Myland mentioned a report into linen or laundry losses - I cannot remember which. Since our meeting I have tried unsuccessfully to find such a report. I would be most grateful for any information you can give me on the subject.

I telephoned you recently and I asked if the report in the Daily Telegraph on 16th April, 1982, concerning £1m linen losses, had been refuted by you or your Department or by the National Health Service. I would be grateful if you would confirm or deny whether this statement, reputed to have been made by Mr. Sneath, Principal Health Department Auditor, has been refuted.

Yours sincerely

ANNEX "E"

MINISTRY OF HEALTH

WORKING PARTY ON HOSPITAL INVENTORIES

REPORT

WORKING PARTY ON HOSPITAL INVENTORIES

Chairman: L. B. JACQUES, F.C.A., Ministry of Health.

Hospital Service Members

J. D. BANKS, M.A., F.H.A., House Governor,
King's College Hospital.

Miss E. A. BELL, S.R.N., S.C.M., R.N.M.S., R.M.P.A.,
Regional Nursing Officer, East Anglian Regional
Hospital Board.

Miss R. M. JONES, S.R.N., R.S.C.N., S.C.M., Matron,
Bristol Royal Hospital

MOSTYN DAVIES, F.S.S., F.H.A., Secretary and Supplies Officer,
Mid Glamorgan Hospital Management Committee.

J. K. RHODEN, F.H.A., M.Inst.P.S., Supplies Officer,
Enfield Group Hospital Management Committee.

M. S. RIGDEN, F.C.A., F.H.A., Treasurer,
Sheffield Regional Hospital Board.

D. SHERREN, F.C.A., Treasurer,
The London Hospital.

B. G. SPENCER, F.C.A., F.I.M.T.A., F.H.A., Treasurer,
Tunbridge Wells Group Hospital Management Committee.

H. W. WHITE, O.B.E., F.H.A., F.C.C.S., J.P., Secretary,
South Western Regional Hospital Board.

Departmental Members

J. ALLAN, Ministry of Health

Miss M. S. HARDIE, " "

H. G. JONES, " "

Miss M. C. SCHURR, " "

G. W. H. WOODMAN, " "

J. S. DICK, (Observer) Scottish Home & Health Department

R. B. REEVE, (Secretary), Ministry of Health.

Miss S. P. WHITE, S.R.N., S.C.M., attended two meetings in place of Miss BELL; other Ministry officers attended as necessary.

CONTENTS

I. INTRODUCTION

1. We held five meetings between March and September, 1967.

2. Our terms of reference were "to examine the present procedure for the preparation, maintenance and checking of hospital inventories, to consider to what extent the procedure provides an effective measure of control over hospital property and to make recommendations as to any improvements considered to be necessary having regard to present conditions in the hospital service and the need to conserve manpower".

3. We were helped in our task by a report on hospital inventory controls of a research team of the Association of Hospital Treasurers which appeared in the October, 1966 issue of Hospital Service Finance, the official journal of the Association. This report proposed a master list of inventory items to which hospital authorities would be free to add other items which were small in bulk but of significant value.

II. BACKGROUND TO THE PROBLEM

Existing guidance to hospital authorities

4. The N.H.S. (Hospital Accounts and Financial Provisions) Regulations, 1948 - regulation 23 states that hospital authorities "shall maintain inventories of such articles of equipment, not held on store charge, and in such form as the Minister may from time to time require".

5. R.H.B.(50)17/H.M.C.(50)17/B.C.(50)15 set out the lines upon which such inventories should be prepared, maintained and checked, and classified hospital equipment into three groups for inventory purposes, as follows:-

Group 1 - Permanent or fixed equipment, i.e. equipment:-

(i) fixed permanently to the building and not subject to removal, or

(ii) fixed to the building but subject to removal and having long life, e.g. boilers, lifts, machinery, pumps, etc.

Group 2 - Furniture and surgical, diagnostic and therapeutic apparatus, comprising:-

(i) movable equipment having a more or less fixed location in the hospital,

(ii) items having sufficient individuality and size to be easily identified and controlled,

(iii) items having a minimum life of 5 years, i.e. beds, chairs, desks, office machines, sterilizers, operating tables, oxygen tents, mobile and portable X-ray equipment, etc.

Group 3 - Utensils, instruments and bedding, covering:-

(i) equipment having no fixed location and subject to requisition or use by various departments,

(ii) items small in size,

(iii) items having a life of less than 5 years, i.e. bedpans, dressing jars, syringes, catheters, glassware, pots and pans, sheets, blankets, bedding, etc.

6. Items in Group 1 were specifically excluded from inventories. Items in Group 2 were required to be placed on inventories but hospital authorities were given discretion as regards categories of articles falling within Group 3. It was visualised that most items falling within Group 3 would appear ultimately on inventories but authorities were asked to have regard to what was practicable in particular hospitals. Heads of departments, ward sisters, etc., were to be responsible for the custody, upkeep and regular checking of inventories. The Chief Financial Officer was to have general responsibility for the system and for independent test checks. The guidance also included a suggested form of inventory and a list of items which would normally appear on inventories. The list was not exclusive.

7. R.H.B.(50)H.M.C.(50)80/B.C.(50)76 issued seven months later recognised that the preparation of inventories would require increases in administrative staffs. It asked authorities to use wide discretion in the selection of Group 3 items for inclusion in inventories and to aim to have a system of at least limited inventories in operation in 1952.

8. H.M.(54)45. Progress in preparing inventories was slow owing to limitations in staff and accommodation and also doubts as to the effectiveness of inventories. These difficulties and doubts were recognised in the circular which went on to ask that in hospitals where no inventories had been set up, authorities should concentrate on completing, as a minimum requirement, inventories of those classes of equipment most vulnerable to loss, viz., bedding and linen, hardware, and articles small in bulk but of high value. The scope of these "minimum" inventories was to be extended as opportunity arose. The "minimum" inventories were required to be completed by the end of 1955. At the beginning of 1955 (H.M.(55)7) the Ministry asked for progress reports on the preparation and maintenance of "minimum" inventories.

9. No further progress reports have been asked for and, apart from linen, no further general guidance has been given on the question of inventories. Although H.M.(54)45 urged the setting up of "minimum" inventories at those hospitals where none existed it did not specifically modify the general requirements of R.H.B.(50)17/H.M.C.(50)17/BC(50)15 and those authorities which had inventories already in operation were asked to extend their scope in the light of what was practicable.

10. In December, 1956, the Ministry asked the Central Health Services Council for advice on the laundering of linen with particular reference to the need to avoid infection and to maintain adequate control over linen stocks. The matter was referred to a Committee of the Central Health Services Council and their Report on Hospital Laundry Arrangements made two major recommendations:-

(i) that counting of soiled linen in wards and departments should cease; and

(ii) that where ward stocks were reduced to a single day's requirements ward inventories and, as an experiment, total linen inventories should be discontinued together with the counting of all soiled linen; where these conditions did not prevail a proportion of hospitals should, as an experiment, be allowed to discontinue ward inventories and soiled linen counting.

11. The Committee considered that the system of ward inventories and movement recording had not only failed to achieve its objects but was uneconomic. In the light of this criticism the Ministry issued new guidance on the control of linen (H.M.(61)52); this relaxed the requirement to maintain hospital linen inventories where alternative procedures were in operation based on the control of issues from stores and/or central linen room.

12. The Ministry's recommendation that the control of linen in use in hospitals should be effected entirely by means other than inventories went further than those made by the Committee on Hospital Laundry Arrangements. Although linen has always been the main source of losses because it is in constant circulation and changing hands in the process, there was at that time no review of the inventory system as a whole. Other items continued in theory, if not in practice, to be subject to the inventory procedures laid down some 13 years before in R.H.B.(50)17/H.M.C.(50)17/B.G.(50)15.

III. CONTROL OF PROPERTY OUTSIDE THE HOSPITAL SERVICE

Government Departments and the Armed Services

13. The Ministry of Public Building and Works does not keep a permanent record of furniture, etc., issued for use in Government Departments but control is exercised over issues. Stricter control is exercised by individual Departments over typewriters, dictation machines, etc., and all property released for the personal use of Ministers and senior officials in their own homes. In the Ministry of Health there is a card for each machine or piece of equipment on which movements are recorded. Annually a statement is required from the registered holder of a machine that he still has it in his custody and any discrepancies are investigated.

14. In Service hospitals comprehensive inventory systems cover, generally speaking, everything except "consumable" items and equipment is placed on the personal charge of inventory holders. Responsibility for the care of equipment can be enforced ultimately by deductions from pay under the provisions of the Army Act, etc.

15. In the Services generally the tendency is to omit from inventory records items below a certain value, usually £3 but as high as £25 in some establishments.

Local Government

16. There is great divergence of practice in the keeping of inventories in residential homes, schools, etc. Enquiries of 13 authorities have revealed that in one authority's area all items are included in inventories whereas another includes only portable and valuable items worth £25 or more, together with other important items if attractive for resale or individual use. In between these extremes the other 11 authorities use individual limits of value ranging from £2 to £10 or more for particular items.

Hotel organisations and commercial firms

17. Information has been obtained from two large hotel organisations, one operated by a nationalised undertaking and the other by a commercial firm. In both organisations the control of property is based on comparison of actual stocks at periodical stocktakings with pre-determined stock levels. Any excessive use or losses then revealed are investigated. The prevention of pilfering is regarded as essentially a matter for security measures to be decided by local management and not as requiring inventory controls.

18. The only items recorded on inventories are furniture, office machines and electrical equipment. Furniture is checked against the hotel inventory every five years in the hotels operated by the nationalised undertaking; in the commercial organisation it is recorded at each hotel on a residual value basis.

19. Information has also been obtained from three other large commercial organisations including one operating holiday camps; none of these relies on a system of inventory control but "inventories" are made at the holiday camps at the beginning and end of each season. Experience has shown that the level of losses does not justify the employment of staff to maintain and check inventory records.

IV. SPECIAL FEATURES OF THE HOSPITAL SERVICE

Arguments for and against the traditional system of control by inventories in hospitals

20. Departmental inventories have some theoretical advantages. If properly maintained an inventory system can be used:-

(i) to assess the extent of losses and locate their source;

(ii) as a deterrent to carelessness, to encourage discipline and foster a sense of responsibility in management;

(iii) as a form of reference of the location and extent of hospital equipment;

(iv) as an historical record.

21. On the other hand the following arguments against the inventory system are frequently raised in the hospital service:-

(i) it does not prevent losses. Prevention as distinct from detection of losses can be achieved only by physical controls and the Ministry has already expressed the view (paragraph 6 of H.M.(54)45) that an inventory will not in itself serve to reduce losses except to the extent that it inculcates a greater sense of responsibility in all staff;

(ii) it does not reveal when losses occurred or who was responsible and therefore provides no help in investigating them;

(iii) it is unreliable as a means of revealing the extent of losses. Discrepancies revealed on checking may arise not from actual loss but from failure to amend the inventory in respect of items condemned but not replaced, or transferred from one ward or department to another, or sent away for repair. Valuable items are invariably missed long before an inventory check is due;

(iv) any properly maintained inventory is costly in terms of staff time; in particular heavy demands are made on the time of nursing staff and major interruptions of hospital activity occur when inventories are checked. For articles in general use a simultaneous check throughout a hospital is needed;

(v) the principle of fixing responsibility on heads of departments and ward sisters for the custody of a large number of items of equipment cannot be adhered to in practice. Much movement of medical equipment takes place and no one person can be in charge throughout the 24 hours in a day. This is in contrast to stores and cash which can and should be locked up in the absence of the person responsible;

(vi) departmental inventories can only be effective if in the last resort personal responsibility for equipment can be enforced, when inventory holders are deemed negligent, by deducting from their pay the value of the missing items. There is statutory authority for such deductions in the Armed Services but no equivalent authority in the hospital service.

22. The case against attempting to achieve control over hospital equipment by the traditional system of comprehensive ward and departmental inventories, with responsibility resting at that level, seems to be overwhelming. It is certainly a fact that the efforts to induce hospitals to introduce and maintain a comprehensive inventory system were clearly recognised by the Ministry to have failed when in 1954 in circular H.M.(54)45 it was acknowledged that partial inventories existed in only about half the hospitals in the service. No general guidance has been issued since then and it is common knowledge that inventories, where they exist, are rarely properly maintained or checked. Some hospital authorities have abandoned them altogether.

23. This situation reflects not only the doubts which have existed for some years in the hospital service about the value of the traditional system but also the practical difficulties of operating it within a service in which demands on staff are constantly increasing, which often lacks suitable accommodation for equipment, and uses an increasing amount of highly specialised medical equipment which is continually being moved from one ward or department to another.

24. The sense of personal responsibility of ward sisters and other staff for equipment has also been conditioned by the increasing use of disposable articles and by a more loosely knit staffing structure. The latter is due to the extended employment of part-time staff, the shorter working week and longer leave allowances which in turn have given rise to more shift working and the employment of more relief staff.

The extent of losses revealed by the present system

25. The total value of items on inventories is not known. Figures of inventory "losses" recorded cannot be accepted at their face value for the reasons mentioned in paragraph 21(iii) of this Report and because they only reflect such checking as is being done. However in 1962/63, the last year in which separate figures were kept, they were recorded as running at the annual rate of £87,000 in England and Wales. Surpluses of £28,000 were also recorded in that year.

26. The most recent figures available are the total "stocktaking losses" recorded in 1965/66. These amounted to £149,000 and included "losses" arising from inventory checks; recoveries and surpluses amounted to £100,000.

V. RECOMMENDED FORMS OF CONTROL OVER HOSPITAL PROPERTY

What should be Management's aims?

27. In our view to verify:-

(i) that the number of items in use is adequate to enable the hospital to function efficiently;

(ii) that these items are available for use when and where required;

(iii) that these items are not being replaced more often than necessary;

(iv) that excessive stocks are not accumulating.

How can these aims be achieved?

28. In general we consider they can be achieved:-

(i) by systematically determining and periodically reviewing the numbers of each item of equipment required by each hospital, ward or department and ensuring that they are available;

(ii) by examining requisitions and analysing issues from stores and direct purchases in relation to expected usage to ensure that these numbers are maintained at the same level, unless an approved change of practice results in a need for the original numbers to be increased or decreased;

(iii) by appropriate arrangements for the security, upkeep, condemnation and subsequent disposal of equipment;

(iv) by fostering cost-consciousness among staff using equipment by bringing to their notice information about its cost;

(v) by publicising the action to be taken immediately a loss is suspected;

(vi) in relation to certain valuable items of long life by also instituting modified inventory procedures based on periodic physical checks.

29. The measures above require to be exercised at two levels. At the "local" level responsibility for the care of equipment falls naturally on those who use it and the measures are intended to encourage them to take care and to report missing articles promptly. "Central" responsibility must be exercised by senior administrative officers who should watch the use of equipment both as a measure of effective hospital operation and as part of financial economy. Our specific proposals are made in the following paragraphs of this Report.

Classification of equipment

30. For control purposes equipment can be divided into three main groups; the first comprises items of limited life where control can be based on scrutiny of issues; the second comprises items of long life which are not susceptible to this kind of control; and the third comprises items falling within either of the first two groups which are issued on loan or are otherwise outside the direct control of a hospital authority.

Control over items of limited life

(a) Scrutiny of issues

31. The regular examination of all requisitions from wards and departments should give early warning of possible misuse or loss of equipment. Where this appears to have occurred all issues of the items concerned to individual wards and departments should be analysed and compared with a pre-determined standard of usage assessed by the hospital authority; this will indicate in which wards and departments excessive use is apparently occurring. This kind of exercise should be more positive and fruitful than the maintenance and checking of inventories because it will also yield information about the suitability and quality of equipment and thus help to obtain maximum value from the use of resources.

32. A responsible officer should undertake the regular examination of the requisitions referred to in paragraph 31 above; this should normally take place before issue is authorised but the precise arrangements will depend on the circumstances. Where it appears that a loss has occurred local procedures should provide for immediate notification to the Treasurer who should then consider, in conjunction with the officers concerned, what further action is necessary.

33. The control exercised by the regular examination of requisitions and the analysis of certain issues should be supplementary to the normal application of budgetary control and to the regular use of information about costs.

(b) Determination of holdings of linen

34. In paragraph 28(i) of this Report we recommend that levels of holdings should be determined for all items; in the case of linen the stock in a central linen room should be determined in the light of the requirements of each item ascertained over a reasonable period, allowing for the incidence of laundry deliveries and Bank Holidays.

35. Stocks in wards and departments should be topped up daily to the pre-determined level by issues from the central linen room.

36. Where it is impossible to have a central linen store the basic stock in each ward and department should be no more than sufficient to cover the longest period during which the laundry is closed plus the laundry turnover time. It may be necessary to have a reserve stock under separate control for use at week-ends or Bank Holidays.

37. The same principles should be applied to patients' clothing.

Control over items of long life

38. There are some items of long life which are not susceptible to controls based on "issues", but which are attractive and portable and are therefore potentially vulnerable to theft. For those items some specific system of control by physical check seems inescapable despite all the weaknesses of such systems to which we have drawn attention in paragraphs 21-24 above. These weaknesses will be minimised if the items needing to be scheduled for physical check are kept to a minimum, if advantage is taken of any scheduling already required for other purposes and if staff time can be reduced by eliminating written communications designed to keep central and departmental records in step.

39. We accordingly recommend the setting up of a simple Register of Special Equipment which would include the kind of items listed in the Appendix to this Report and any others of a similar nature which a hospital authority consider it essential to add. The Register would show separately those items which normally remain within the control of a ward or department, for whose oversight (but not maintenance of the Register) heads of departments and ward sisters should accept responsibility, and those in general use within a hospital, which would be included in a general list and for which the hospital secretary or other senior officer should be himself responsible. The articles should be checked regularly against the Register at least once a year by the responsible officers (see paragraph 41).

40. It should not, however, be necessary to include on the Register items subject to special security measures, such as cheque-signing machines, postage franking machines, fire-fighting equipment and radio-active [illegible] a hospital authority is satisfied that the arrangements made are adequate preventive maintenance in accordance with the advice given in H.M.(65)24.

or arrangements made under contract for the regular servicing of equipment, achieve all the objectives of these recommendations, equipment covered by those arrangements may be omitted from the Register; discrepancies discovered during planned maintenance checks should be notified by the Engineer to the appropriate responsible officer, but heads of departments should still be made responsible for reporting losses as soon as they are discovered and the Treasurer should be informed. The Treasurer would need to make occasional test checks of the equipment.

41. The following procedures are recommended for the preparation and maintenance of the Register of Special Equipment and for checking the items included in it (references to the hospital secretary should be read as applying to any senior officer who may be designated to perform these functions by a hospital authority):-

(i) the initial preparation of the Register of Special Equipment should be the responsibility of the hospital secretary under the supervision of the group administration. The contents of each list should be agreed with the person to be held responsible for the equipment. Where an article has a serial number this should be recorded.

(ii) it may be found convenient to keep the Register in loose-leaf form, the folios being serially numbered and subject to the normal security arrangements for numbered documents. Each folio would relate to items under the control of a named officer and a copy of it, preferably by photocopy or other automatic process, should be given to that person as an indication of his responsibility.

(iii) additions to and deletions from the Register should also be the responsibility of the hospital secretary, who should see the relevant documentary evidence. To avoid internal correspondence, the amended folios could also be automatically copied, dated, and the duplicate copy sent to the named officer concerned in substitution for the earlier copy, which should then be destroyed.

(iv) each named officer responsible for items in the Register should be required to undertake a check of the items at least annually, to certify to the hospital secretary that this has been done and to report the result. Any discrepancies, including any arising from the hospital secretary's own check of items included in the general list mentioned in paragraph 39, should be notified immediately they are discovered in accordance with local procedures; the Treasurer should be among those so informed.

(v) the Treasurer should be responsible for independent test checks in conjunction with the persons responsible for the equipment, and for general supervision of the system.

Control over other items

42. In addition a record of the following items should be maintained:-

(i) equipment, other than minor items, on temporary loan to patients;

(ii) equipment on personal loan to staff;

(iii) furniture and other contents of furnished lettings.

In each case a receipt and undertaking to return the equipment should be obtained and one copy of the receipt and undertaking filed on the patient's case notes or the employee's personal record; a duplicate copy should be held by the hospital secretary or other senior officer who should arrange periodically for the existence and serviceability of the equipment to be checked.

VI. SECURITY ARRANGEMENTS.

43. In H.M.(63)52 the Ministry asked hospital authorities to continue to apply a number of security and control measures and specific reference has been made in paragraphs 34 to 37 of this Report to the determination of linen holdings. An essential feature of any security arrangements is that there should be a clear understanding by all concerned of the action to be taken and the persons to be informed when items of value are missed.

44. Wherever practicable articles should be marked as hospital property and where they are on personal charge they should be individually identifiable, e.g., by a number or other mark. The Main Report of the Specification Working Group on Bed Linen (paragraph 24) recommends that interweaving of linen should be discontinued but there remains the need, as a security measure, for satisfactory modern methods of marking.

45. The Committee of the Central Health Services Council on Hospital Laundry Arrangements suggested in their Report (paragraph 60) that an extension of the practice of employing security officers might be useful but the Ministry have made no recommendation on this subject.

46. In our view the employment of security officers or the engagement under contract of security organisations is a matter for local discretion. Hospital authorities will need to consider what measures are appropriate and economical bearing in mind the location of premises, ease of access and any special security risks, such as premises unoccupied at night or at weekends. They will no doubt also take into account the benefits to staff and to good order generally which can be provided by such officers and organisations. If such appointments are made they do not remove the responsibility of hospital officers for the checking of equipment records and the reporting of losses, nor the responsibility of the Treasurer for the system and its effectiveness.

47. Hospital authorities should also give consideration to the part internal audit staff may be able to play in preventing losses by, for example, drawing attention to defects in systems of control, by reviewing independently rates of issues from stores and by identifying apparently excessive demands from wards and departments which may arise from the need to replace goods lost.

48. It is important that procedures for the disposal of obsolete and unserviceable equipment should cover all items and that condemned articles should be branded, removed to safe custody pending disposal, or physically destroyed, so that they cannot be produced again as requiring replacement. The branding should not however interfere with the conversion of condemned articles to other uses.

VII. SUMMARY OF RECOMMENDATIONS

(a) Control over items of limited life

49. Each hospital authority should systematically determine and periodically review the numbers of each item of equipment required by each

hospital, ward or department and ensure that they are available (paragraph 28(i)).

50. All requisitions from wards and departments should be regularly examined by a responsible officer (paragraphs 28(ii), 31 and 32).

51. Where there appears to have been misuse or loss of equipment, all issues of the items concerned to individual wards and departments should be analysed and compared with a predetermined standard of usage assessed by the hospital authority (paragraphs 28(ii) and 31).

(b) Control over items of long life

52. Certain items of long life which are also attractive and portable should be included in a simple Register of Special Equipment and they should be checked regularly at least once a year (paragraphs 28(vi), 39 and 41(iv)); such items may however be omitted from the Register if a hospital authority is satisfied that regular inspections for maintenance or other purposes achieve the same objective (paragraph 40).

53. A senior officer, normally the hospital secretary, should be responsible for the Register of Special Equipment (paragraph 41).

(c) Control over other items

54. A record should be kept of equipment issued on loan and in furnished lettings; a receipt and undertaking to return such equipment should be obtained and it should be subject to periodic checks (paragraph 42).

(d) General

55. The employment of security officers should be a matter for local discretion; hospital authorities should however consider the part which security officers or organisations and internal audit staff may be able to play in preventing losses (paragraphs 28(iii), 46 and 47).

56. Condemned articles should be branded, removed to safe custody pending disposal, or physically destroyed (paragraphs 28(iii) and 48).

57. Cost-consciousness among staff using equipment should be fostered by bringing to their notice information about its cost (paragraph 28(iv)).

58. There should be a clear understanding by all concerned of the action to be taken and the persons to be informed when items of value are missed. The Treasurer should be among those so informed (paragraphs 28(v), 32, 40, 41(iv) and 43).

59. The Treasurer should continue to be responsible for independent test checks and for general supervision of the system (paragraphs 41(v) and 46).

Reservation by Mr. J. D. Banks in respect of paragraphs 38 to 41.

I agree with the main body of the Report but wish to make the following reservation.

The Working Party accepts that the arguments set out in paragraphs 21 to 24 present an overwhelming case against attempting to achieve control over hospital equipment by the "traditional" system of inventories.

Paragraphs 27 to 37 develop a reasonable system of control of certain classes of articles by control or scrutiny of issues, but this method is only applicable to articles which are regularly issued.

Paragraph 38 states that for items of long life some system of control by physical check seems inescapable, despite the weaknesses of such systems, to which attention is drawn in paragraphs 21 to 26. I cannot agree with this. These paragraphs set out reasons why control by physical check is ineffective and is not worth the expense of attempting; and they are as applicable to the "Register of Special Equipment" now proposed as to any "traditional" inventory in the past. The "Register of Special Equipment" is a new name for a list which would be largely the same as the old inventory of articles small in size and large in value, which has been found ineffective, and I cannot see any reason why the Register should be any less damned by the arguments in paragraphs 21 to 26 than any other inventory.

It seems to me entirely illogical to prove the invalidity of the inventory system and then recommend the setting up of an inventory in each hospital.

I think that the Working Party has found a partial solution to the problem inthe encouragement of planned preventive maintenance and the use, for inventory purposes, of lists used in connection with contract maintenance of equipment. These lists will be kept up to date because they are in active use and will provide an effective means of control over a proportion of the items in question.

In my view, the Working Party would have done better to recommend action directed towards increasing the proportion of the items that are controlled through maintenance records. I recommend that hospitals should be required to overhaul their maintenance arrangements, which would have the double effect of improving both maintenance and control and would reduce to a minimum the number of items for which, it should be admitted, no effective method of control exists. I think it would be franker to make this admission than to seek to resuscitate, for lack of anything better, an inventory system discredited by the Report itself.

Items suitable for inclusion in a Register of Special Equipment

Adding machines
Auroscopes
Balances
Blankets - electric
Calculating machines
Cameras and associated equipment
Cine equipment
Clocks - portable, electric
Dictating machines
Fans - electric
Film projectors and equipment
Fires - portable, electric
Floor polishers
Gauges
Hair driers
Hedge trimmers - electric
Irons - portable, electric
Kettles - electric
Meters (for testing)
Microscopes
Mowers
Ophthalmoscopes
Photocopying machines - portable
Radios and radiograms
Razors - electric
Record players
Sewing machines
Sphygmomanometers
Spin driers
Stop watches
Tape recorders
Television sets
Toasters - electric
Tools - portable, electric
Typewriters
Vacuum cleaners
Washing machines - portable

Notes:

(i) This list is intended to be exemplary and not exhaustive - see paragraphs 38 to 40.

(ii) Where equipment becomes obsolescent but continues to have some limited use, e.g., for training purposes or as a stand-by item, any entry in the Register should be annotated to indicate that the equipment is obsolescent.

ANNEX "F"

EXCHEQUER AND AUDIT DEPARTMENT
AUDIT HOUSE VICTORIA EMBANKMENT
LONDON EC4Y ODS

Comptroller and
Auditor General
Gordon Downey C.B.

GSD 501

23 July 1982

Ralph Howell Esq MP
House of Commons
London SW1A OAA

Dear Mr. Howell,

Thank you for your letter of 21 July about linen losses in the National Health Service.

2. As I told you by telephone the other day, I am afraid I am not in a position to provide you with the detailed information you require. In the first place, as you know, although E&AD staff have a right of access to the NHS authorities, the extent of our detailed audit of them is limited. My specific statutory responsibility is to audit the summarised accounts, leaving the DHSS statutory auditors to examine the accounts of the individual authorities. It is therefore the DHSS that has ready access to detailed information on losses.

3. As I also explained to you the other day, however, such information as is available to my Department on linen losses has come to us on the basis of our audit access to the DHSS and the NHS. I am free to make use of this information in reporting to Parliament but am not empowered to divulge it to others. This does, of course, reflect the normal confidential relationship between auditor and client. It follows that, although I cannot speak for anyone else, my Department has neither confirmed nor denied the statement attributed to Mr Sneath.

4. To overcome these difficulties I did, as you know, speak to Sir Kenneth Stowe, Permanent Secretary of the DHSS. He said that he would be very pleased to give you any assistance he could over this matter of linen losses and I suggested that you should pursue your enquiries with him. I am not sure whether you have done so, but I do feel that this is the only way that you will be able to

/get the

get the additional information you require. If you would like me to pass your letter on to Sir Kenneth Stowe with a request that he should reply to you, I will willingly do so. Alternatively, you may wish to get in touch with him direct.

Yours sincerely,

Gordon Downey

GORDON DOWNEY

RALPH HOWELL, M.P.

10th August 1982

Gordon Downey Esq., CB,
Comptroller & Auditor General
Exchequer & Auditor Department
Audit House
Victoria Embankment
London EC4Y ODS

Dear Mr. Downey

I have received your letter of 23rd July regarding losses in the NHS, in reply to my letter of 21st July.

With reference to paragraph (3) I am very surprised that you state "this does, of course, reflect the normal confidential relationship between auditor and client" - I understand you to mean that the DHSS and/or the NHS are your clients. I do not see it this way. I would have thought that Parliament itself is your client and that you are working in the interests of the nation as a whole in trying to ensure that the Bodies for which you are responsible, in your capacity of Comptroller & Auditor General, are maintaining proper accounts. If the DHSS and/or the NHS are your clients and you have to maintain normal confidentiality between auditor and client, then I feel you make it impossible for any Member of Parliament to carry out his job properly in trying to establish whether or not the accounts of any such body are in order.

I would also like to point out that you have not commented on the first paragraph of my letter in which I state that theft, fraud, etc. under items 1 & 4, Statement 8, amount to roughly .01% of total expenditure. Would you now send me details of the component amounts of each area health authority and any other authority included in items 1 & 4, which go to make up those figures, and would you also show the combined totals of items 1 & 4 as a percentage of overall expenditure for NHS in England. I would then be grateful if you could compare this percentage with all other such losses included in the accounts of other government bodies and authorities for which the Exchequer & Audit Department is responsible.

I would be grateful for your views on the miniscule amount shown for theft, fraud, etc. in the accounts and whether you would agree that 1% is considered to be extremely good for normal losses in such organisations.

10th August 1982

Regarding your letter of 25th June, I find this very difficult to follow. Can you list the type of losses which are contained in Statement 8 of the overall NHS Accounts (England) and also the type of losses which would be included in the individual health authorities accounts and which are not shown in the principal statement of accounts. How is it possible for anybody, yourself included, to have any idea of what the overall losses are since it seems to me that they are never brought together in one statement and why do you condone the fact that the losses shown in Statement 8 are quite meaningless in giving a true picture of actual losses.

In paragraph (4) of your letter of 25th June you state "In the past both the statutory auditors and E.& A.D. have found evidence of weakness in the stores and inventory control and stocktaking procedures of individual health authorities" But in the Hospital Inventories Report of 2 June (?July), 1981, it was stated "A Working Party was established in the North Western Region toreview the Ministry of Health report on "Hospital Inventories". The group felt that the principles contained in the 1967 report remained a sound basis for good practice". This seems to contradict your comments in the remainder of paragraph (4).

With reference to paragraph (5), I cannot see how you can check the affairs of the NHS without a breakdown under subjective heads. Again, I would welcome your comments on this point.

I am also writing to Sir Kenneth Stowe as you suggested.

Yours sincerely

REPORT OF THE COMPTROLLER AND AUDITOR GENERAL

Accounts and audit

1. These accounts comprise:

(i) summarised accounts prepared by the Department of Health and Social Security and the Welsh Office from the accounts of health authorities and Boards of Governors;

(ii) the accounts of the Dental Estimates Board and the Prescription Pricing Authority; and

(iii) summarised accounts of trust funds held by special trustees, health authorities and Boards of Governors.

The accounts of the individual bodies are audited by auditors appointed by the Secretaries of State (the "statutory auditors"). Section 98 of the National Health Service Act 1977 requires me to examine, certify and report on these summarised and other accounts. My examination includes a continuing review of the nature and extent of the statutory audit and scrutiny of the auditors' reports.

2. The Act empowers me to examine the accounts of individual health authorities, etc., and the records relating to them. I direct this examination mainly to the effectiveness of their procedures for financial control and for securing efficiency and economy in the use of resources. My resulting observations are contained in paragraphs 2 to 64 of my Report on the Appropriation Accounts (Volume 8: Classes XI and XII) 1980–81.

3. Similar accounts for Scotland are published separately.

Gordon Downey
Comptroller and Auditor General

Exchequer and Audit Department
3 March 1982

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PRICING AUTHORITY

ENDED 31 MARCH 1981

1979–80 £	PAYMENTS	£
	6. (*a*) Salaries, wages, etc., of all employed staff, including national	
7,029,537	insurance contributions (Authority's share)	8,797,849
406,486	(*b*) Superannuation contributions (Authority's share)	506,352
	7. Other expenses	
12,953	(*a*) Travelling and subsistence expenses of staff	12,700
8,997	(*b*) Travelling and subsistence expenses, etc., of members	9,950
74,114	(*c*) Purchase, construction, adaptation, etc., of premises	18,577
36,479	(*d*) Repair, maintenance, decoration, etc., of existing premises	28,415
351,612	(*e*) Rent, rates, heating, lighting, cleaning, etc.	438,357
59,218	(*f*) Furniture and equipment	53,114
61,165	(*g*) Stationery and printing	84,353
37,724	(h) Postage and telephones	54,107
36,423	(*i*) Incidental expenses	42,890
8,114,708		10,046,664
	8. Agency:	
460	(*a*) Printing for the Department	227
138,870	(*b*) Computer project: salaries and administration	159,532
8,254,038	TOTAL PAYMENTS	10,206,423
52,876	9. Balance, being cash in hand at 31 March 1981	26,417
£8,306,914	TOTAL	£10,232,840

Kenneth Stowe
Accounting Officer

30 November 1981

I have examined the above Account on the lines recorded in my Report, I have obtained all the information and explanations that I have required, and I certify, as the result of my audit, that in my opinion the above Account is correct.

Gordon Downey
Comptroller and Auditor General

For Report of Comptroller and Auditor General see page 36.