

# Financial Management in the NHS

**NHS (ENGLAND) SUMMARISED ACCOUNTS 2003-04**

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

PREPARED JOINTLY BY THE NATIONAL AUDIT OFFICE AND THE AUDIT COMMISSION | HC 60-I Session 2005-2006 | 24 June 2005



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**14 June 2005**

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## SUMMARY



## Joint report by the National Audit Office and the Audit Commission

This report was prepared jointly by the National Audit Office and the Audit Commission. It incorporates the findings of:

- the National Audit Office from their audit work on the NHS summarised accounts, the Department of Health's resource account, other statutory health organisations with a national remit, and their value-for-money reports into the health sector;
- the Audit Commission's appointed auditors' work on the 2003-04 accounts of individual NHS organisations.

Through this joint perspective, the report outlines the financial issues facing individual NHS organisations now and in the future, together with an overview of the effects of these issues at a national level and the consequences for the national health economy.

**1** *Financial management in the NHS* is a report prepared jointly by the National Audit Office and the Audit Commission. It sets out the state of NHS finances in England in 2003-04, looks at current financial management and reporting issues, and briefly considers the most significant financial issues facing the NHS beyond 2003-04.

**2** In 2003-04 the NHS spent a total of £63 billion. Over the period of the five year settlement announced in the 2002 Budget (2002-03 to 2007-08), expenditure in the NHS is rising at an average of 7.3 per cent each year in real terms, bringing total annual expenditure to £76 billion in 2005-06 and reaching £93 billion by 2007-08, making healthcare the fastest growing area of public expenditure. At the same time, the Government has set out an ambitious reform programme, devolving responsibility with the establishment of NHS Foundation Trusts, introducing new contracts for nearly all NHS staff, developing the information technology infrastructure and changing the funding system for hospitals. Taken together, these issues place an unprecedented level of pressure on the NHS financial regime from 2004-05.

## Summary of financial performance in 2003-04

**3** The Department of Health achieved financial balance across the 600 local bodies of the NHS in 2003-04. However, compared to 2002-03 the number of bodies failing to achieve financial balance increased and there was also an increase in the number of bodies incurring significant deficits.

In summary:

- the aggregate underspend for all NHS bodies was £72 million (0.11 per cent of total expenditure) compared with an underspend of £96 million (0.18 per cent) in 2002-03 (**Annex 1**);
- 106 NHS bodies (18 per cent) failed to achieve in-year financial balance, compared with 71 (12 per cent) in 2002-03. 24 per cent of NHS Trusts did not achieve break-even and 14 per cent of Primary Care Trusts failed to keep expenditure within their revenue resource limit (**Figure 1**). In most cases the deficits were small both in absolute terms and in proportion to turnover;
- a small number of NHS bodies are struggling to manage large deficits. The number of significant deficits (of over 0.5 per cent of income or available revenue resources) increased, to 13 per cent from eight per cent in 2002-03. 12 NHS Trusts reported a deficit of over £5 million in 2003-04, compared to seven in 2002-03. Four Primary Care Trusts had revenue resource limit overspends of over £5 million compared to three in 2002-03. The number of bodies with significant deficits and the size of those deficits would have been greater without specific financial support either from Strategic Health Authorities or centrally; and
- No Strategic Health Authorities reported revenue overspends in 2003-04. However, Strategic Health Authorities have a target of delivering financial balance in aggregate across the NHS bodies within their area. Seven Strategic Health Authority areas reported an aggregate overspend in 2003-04 compared with six in 2002-03 (**Figure 2**).

**4** All NHS bodies with deficits not only need to take steps to achieve recurrent financial balance, but also have to recover deficits from previous years. Although a number of bodies may have a deficit in any one year, the hardest problems arise when the deficit which has been created is very significant or where there is a history of year on year or gradually increasing overspends. The first type is randomly distributed across the country, but there is some evidence of the latter being concentrated in a relatively few geographical areas (**Figure 2**). A measure of financial management success in the future will be the extent to which the number of areas with long standing problems grow or reduce. Those NHS bodies with the most severe financial problems may have to re-organise their services to achieve this.

## Audit of the 2003-04 Accounts

**5** As in 2002-03, the appointed auditors of individual NHS bodies did not qualify their opinion on the truth and fairness of the accounts of any Strategic Health Authority, Primary Care Trust, or NHS Trust. The Comptroller and Auditor General was therefore able to give an unqualified opinion on the truth and fairness of the summarised accounts for these bodies.

**6** The appointed auditors gave unqualified opinions on the regularity of expenditure on all of the Strategic Health Authority and Primary Care Trusts accounts, except for 53 Primary Care Trusts. These qualifications arose because of 42 breaches of resource limits and 13 instances of other irregular expenditure (two of these accounts were qualified both for resource limit breaches and for incurring other irregular expenditure). However, the Comptroller and Auditor General did not qualify his opinion on the summarised account of Primary Care Trusts since there are no overall resource limits for the aggregate expenditure of these organisations. He also gave an unqualified regularity opinion on the summarised account of Strategic Health Authorities.

**7** The findings of the appointed auditors are reported in more detail in **Part 2** and the financial performance of NHS organisations is reported in more detail in **Part 3**.

## 1 Performance and aggregate outcome of NHS bodies in 2003-04

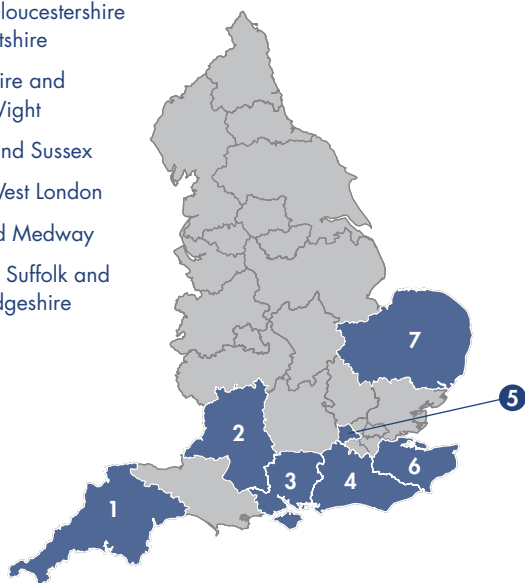
Type of NHS body	Number of bodies	Number breaking even in 2003-04	Number failing to break even in 2003-04	Aggregate surplus/underspend £million	Aggregate Deficit/overspend £million	Net total £million
Strategic Health Authorities	28	28	0	206	0	206
Primary Care Trusts	303	262	41	95	(91)	4
NHS Trusts	269	204	65	37	(175)	(138)
<b>Total</b>	<b>600</b>	<b>494</b>	<b>106</b>	<b>338</b>	<b>(266)</b>	<b>72</b>

Source: Audited accounts of individual NHS bodies

## 2 Strategic Health Authority areas with an aggregate overspend

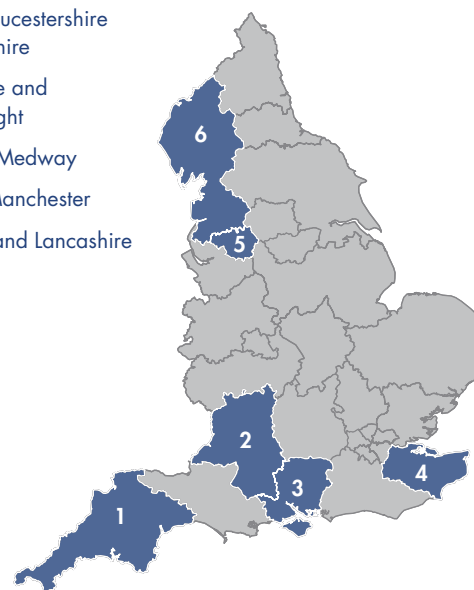
### 2003-04

- 1 South West Peninsula
- 2 Avon, Gloucestershire and Wiltshire
- 3 Hampshire and Isle of Wight
- 4 Surrey and Sussex
- 5 North West London
- 6 Kent and Medway
- 7 Norfolk, Suffolk and Cambridgeshire



### 2002-03

- 1 South West Peninsula
- 2 Avon, Gloucestershire and Wiltshire
- 3 Hampshire and Isle of Wight
- 4 Kent and Medway
- 5 Greater Manchester
- 6 Cumbria and Lancashire



Source: Audited accounts of individual NHS bodies

## Key themes for improved financial management

**8** Our report looks at four key financial management themes and makes specific recommendations aimed at both the Department and individual NHS bodies to aid improvement. The key themes, considered in more detail in **Part 4**, are:

- **The role of the Board.** The Board has a key role in improving financial management. Several recent examples of bodies incurring significant deficits illustrate the consequences of ineffective oversight or lack of financial acumen at Board level. Non-executives have an important part to play here. It is important that they include individuals with financial knowledge who could, for example, take a lead role on finance both in the Board and on the Audit Committee. We make recommendations to help Boards understand and challenge the financial information presented to them, and drive improvements in financial management.

### To increase the effectiveness of Board oversight, we recommend that:

- The NHS Appointments Commission should appoint individuals so that all Boards include non-executives with the appropriate financial management skills and experience.
- Board members need to take collective responsibility for financial matters and be able to understand, effectively challenge, and act on the financial information presented to them.
- Finance Directors and Chief Executives should present the Board with focused and timely financial information, clearly showing the overall financial position and highlighting the important issues that require action at Board level.
- Where a body incurs a deficit, the Board should satisfy itself that the reasons for the financial difficulties are understood and that a realistic recovery plan is in place which tackles the difficulties, and should monitor progress against the recovery plan.

- **Forecasting.** The annual pattern both for individual bodies and the NHS as a whole is for a significant overspend to be forecast in the autumn and early new year but for break even to be achieved at the year end. The fact that NHS bodies are not always able to accurately forecast their year end financial position during the course of the year, makes it difficult for them to take timely and appropriate action to achieve financial balance. The reasons for inaccurate forecasting are considered in detail in **Part 4**.

The introduction of Payment by Results and the use of independent healthcare providers will mean that for NHS Trusts the receipt of income will be less certain and therefore producing accurate forecasts more difficult. For Primary Care Trusts, Payment by Results will mean that expenditure is more volatile. Greater uncertainty will need to be matched by better risk management and better forecasting. All NHS bodies need to improve their performance in this area of financial management.

We examine the causes of inaccurate forecasting and make recommendations to increase the level of challenge to forecasts; to enhance budgeting procedures and the treatment of cost savings targets; and to agree funding earlier. Improvements within each of these areas would bring better financial management.

### To improve forecasting we recommend that:

- NHS bodies should continually test whether cost savings programmes are realistic. They should monitor progress against these programmes and include the most up to date position in their budgets and forecasts.
- NHS bodies should take full account of likely mitigating action when risks are reflected in forecasts. When reviewing the financial information presented to them by other NHS bodies, Strategic Health Authorities and the Department of Health should more robustly challenge the impact of the risks factored into forecasts.
- Boards should set realistic budgets at the start of the financial year, and understand and challenge the assumptions underpinning the budgets. NHS bodies should regularly review the budgets and profile them to reflect patterns of expenditure and income. Performance against budgets should be regularly monitored and variances explained and acted upon.

- **Earlier preparation of accounts.** The Department and all NHS bodies are working towards producing their annual accounts sooner after the year end. In 2003-04 there was a significant improvement in the quality and timeliness of the NHS bodies' annual accounts, but improvements in financial management, particularly in management accounting processes, are key to achieving the earlier production and audit of the annual accounts. Many commercial organisations produce monthly or even weekly accounts including balance sheet information, so as to keep a clear and current view of their overall financial position. NHS bodies may also find such an approach useful. We make recommendations on improving monthly management accounting processes, preparing for the production of the annual accounts, and liaising with the external auditors.

**To facilitate the production of annual accounts sooner after the year end, we recommend that:**

- The financial information produced throughout the year should closely reflect the standard and range of information required in the annual accounts and be produced shortly after the period end to which it relates. Such improved financial reporting procedures will also be required for NHS Trusts to apply successfully for NHS Foundation Trust status.
- Boards, Finance Directors, and budget holders should review the financial information presented to them and assess whether the picture presented is consistent with their knowledge of events.

- **Transparency.** Boards, managers and stakeholders would be helped by greater transparency of reporting, including in the annual accounts. In 2003-04, there was an improvement in the transparency of NHS Trust accounts, with the financial support received and its effect on the reported surplus or deficit more clearly shown. However, the effects of giving and receiving support were not as clearly reported in the accounts of Primary Care Trusts and Strategic Health Authorities.

**To make clear the extent of non-recurrent support, we recommend that:**

- In line with the Department's instructions for 2004-05 onwards, the amount of financial support received, and its nature, should be disclosed in the annual accounts of all NHS bodies.
- Internal financial reporting should highlight the use of non-recurrent funding and cost savings programmes and ensure the implications for the future financial position are made clear.

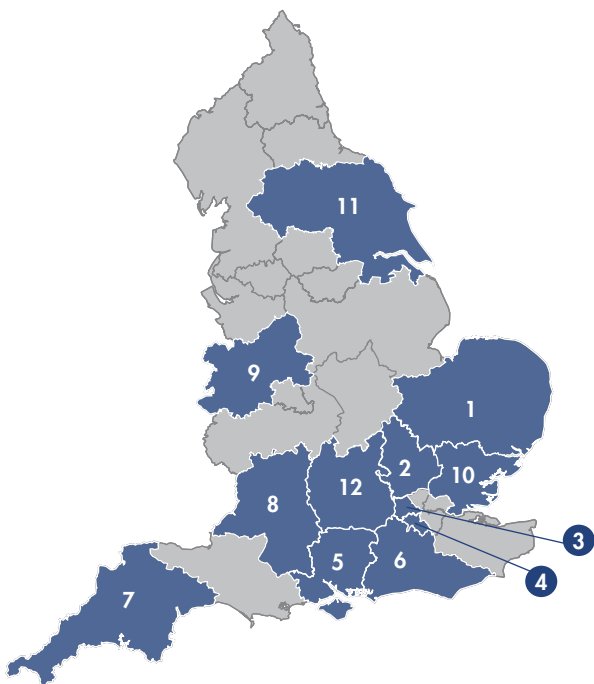
More detailed recommendations under each of these key themes are included in **Part 4**.

## Financial issues arising in 2004-05 and beyond

**9** There are a significant number of financial management issues that NHS bodies are facing for the first time in 2004-05.

**10** Some NHS bodies have experienced increased financial pressures in 2004-05, with auditors currently reporting concerns about financial standing at 32 per cent of NHS bodies and the NHS as a whole forecasting a financial deficit. However, the NHS has a history of forecasting significant deficits which do not materialise at the year end. In 2003-04, this pattern was followed and indeed the final aggregate position was a small underspend. It is therefore difficult to say with any certainty even at this late stage what the audited year-end financial position will be, although the Department is currently expecting a small deficit across the NHS as a whole, with an increase in 2004-05 in the number of individual bodies failing to achieve in-year financial balance. The Department is also estimating that at least 12 Strategic Health Authority areas will report an aggregate overspend in 2004-05 (**Figure 3**), compared with seven Strategic Health Authority areas in 2003-04 and six Strategic Health Authority areas in 2002-03 (**Figure 2**).

### 3 Strategic Health Authority areas currently predicted to overspend in 2004-05



#### 2004-05

- |                                       |  |
|---------------------------------------|--|
| 1 Norfolk, Suffolk and Cambridgeshire | 7 South West Peninsula                             |
| 2 Bedfordshire and Hertfordshire      | 8 Avon, Gloucestershire and Wiltshire              |
| 3 North West London                   | 9 Shropshire and Staffordshire                     |
| 4 South West London                   | 10 Essex   |
| 5 Hampshire and Isle of Wight         | 11 North and East Yorkshire and North Lincolnshire |
| 6 Surrey and Sussex                   | 12 Thames Valley                                   |

Source: Department of Health

**11** Key developments that will introduce new risks to financial balance in 2004-05 and beyond include the introduction of new contracts of employment for most NHS staff, the National Programme for IT and the implementation of Payment by Results.

**12** The first NHS Foundation Trusts were created on 1 April 2004. There are now 31 NHS Foundation Trusts some of which have been early implementers of Payment by Results in 2004-05, the new system of funding under which NHS Trusts will be paid a set tariff for each treatment they deliver. Only the NHS Trusts judged to be the best managed and most financially stable are licensed to become NHS Foundation Trusts, and even they are finding the going tough. NHS Foundation Trusts have had to change their approach to financial management significantly to cope with both Payment by Results and the more commercial financial regime under which they operate.

**13** When Payment by Results is implemented across the NHS from 2005-06, all NHS bodies will face the new financial risks that this system brings. In January the Department recognised the pressure placed on NHS financial management and the risk of financial instability by delaying the introduction of a key element of this new funding regime. From 1 April 2005, only elective admissions (around 30 per cent of a Trust's income) are covered by Payment by Results; emergency and out patient activity will now not be included until April 2006. Whilst we welcome this move in order to reduce the financial risks of introducing the system, it has meant that NHS bodies have had to revise their financial and operational plans for 2005-06 close to the start of the financial year, and will face further uncertainty if more changes are made to the implementation of Payment by Results.

**14** To minimise the risks arising from the forthcoming changes to the NHS financial regime, we recommend that the Department introduces a change management programme to support NHS bodies, similar to that accompanying other major changes such as the introduction of National Service Frameworks.

**15** The financial issues arising in 2004-05 and beyond are considered in more detail in **Part 5**.

## Conclusion

**16** Many NHS bodies need to improve their financial systems and financial management skills to meet the challenges of faster closing and improve their forecasting even under the existing financial regime. 2003-04 was a relatively stable year in terms of challenges facing NHS financial management but, despite this, a number of bodies found it difficult to manage resources effectively. Subsequent developments in 2004-05 and beyond mean that there will be increasing financial challenges which bodies will be expected to manage.

**17** Both Primary Care Trusts and NHS Trusts will need to further improve their skills around the strategic aspects of financial management to cope with financial forecasting and modelling under Payment by Results, in particular the identification and management of the new risks that the system will bring. Increased use of independent healthcare providers will further intensify the uncertainty about income levels and highlight the need for better financial management. NHS Trusts will also need to develop appropriate commercial finance skills, to be in a sound position to apply for Foundation Trust status.

**18** The National Audit Office and the Audit Commission are committed to working with the Department, Monitor (the Independent Regulator for Foundation Trusts), and NHS bodies to support the NHS in the considerable task of improving its financial management arrangements.

# PART ONE

## Introduction



## What this report is about

**1.1** Following the audit of the 2003-04 accounts of individual NHS organisations and of the summarised accounts of each type of NHS organisation, our report:

- outlines the results of the audits of individual NHS organisations and summarises the financial management issues faced by the NHS in 2003-04 (**Part 2**);
- summarises the aggregate financial performance of the NHS in 2003-04 and the financial performance of individual NHS organisations (**Part 3**);
- considers four key financial management and reporting themes (**Part 4**). The themes are: the role of the Board in helping to improve financial management; the need for improved financial monitoring and reporting procedures, looking specifically at the problems with forecasting; the requirement to, and challenges faced in, producing annual accounts sooner after the year-end ('faster closing'), and the transparency of the financial position reported to external stakeholders. We make recommendations under each theme to enhance the transparency of external financial reporting, facilitate 'faster closing', help to improve financial monitoring and reporting and increase Board awareness of financial management issues; and
- sets out the main financial management issues faced by NHS bodies in 2004-05 and beyond (**Part 5**).

**1.2** In *Achieving First-class Financial Management in the NHS*<sup>1</sup>, the Audit Commission concluded that first-class financial management has a vital role in delivering improvements to patient services. As expenditure by NHS organisations is set to increase significantly until 2008, accompanying a major programme to modernise NHS services and devolve responsibility to individual NHS bodies, there is a greater need to improve financial management arrangements in the NHS. The Audit Commission's assessment of financial management in the NHS is shown in **Figure 4**. Our report addresses a wide range of financial management issues, reflecting the fact that financial management is not solely about achieving financial balance although this is a key requirement. This has been recognised in the new system of assessment being developed by the Healthcare Commission to replace the current star ratings. It is intended that appointed auditors' judgements about a number of different aspects of financial management will feed into the Healthcare Commission's assessment.

<sup>1</sup> Audit Commission, *Achieving First-class Financial Management in the NHS: A Sound Basis for Better Healthcare* (April 2004).

## Structure and funding of the National Health Service

**1.3** Our report considers the performance of the following 600 NHS organisations:

- 28 Strategic Health Authorities – responsible for performance-managing the Primary Care Trusts and NHS Trusts within their area.
- 303 Primary Care Trusts – responsible for assessing the need for healthcare provision, planning and commissioning health services, and improving health.
- 269 NHS Trusts – responsible for providing secondary health care.

**1.4** Most of the funding for the NHS is provided by the Department of Health (the Department). The Department provides resources directly to Strategic Health Authorities and Primary Care Trusts. Primary Care Trusts pay NHS Trusts, primary healthcare providers, and private-sector healthcare providers for the healthcare that they commission from them. NHS Trusts also receive a small amount of funding directly from the Department and from other sources, such as local authorities and charitable donations. **Figure 5** summarises the accountability and funding arrangements in the NHS.

**1.5** Funding for the NHS is reported in the Department of Health’s consolidated resource account, which is audited by the Comptroller and Auditor General. The Department’s resource account for 2003-04 was laid before the House of Commons on 20 December 2004<sup>2</sup>.

**1.6** The individual accounts of Strategic Health Authorities, Primary Care Trusts, and NHS Trusts are audited by auditors appointed by the Audit Commission under the Audit Commission Act 1998. These appointed auditors provide an audit opinion on the annual accounts of each organisation.

**1.7** The Department produces accounts summarising the financial statements of each type of NHS organisation: Strategic Health Authorities, Primary Care Trusts and NHS Trusts, and the 310 charitable Funds Held on Trust. The Comptroller and Auditor General is required under the National Health Service Act 1977 to certify each of the summarised accounts and to lay copies of them, together with his report on them, before both Houses of Parliament. The Department’s Summarised Accounts for 2003-04, together with the Comptroller and Auditor General’s Certificates and Reports, were laid before the House on 21 June 2005<sup>3</sup>, accompanying this report.

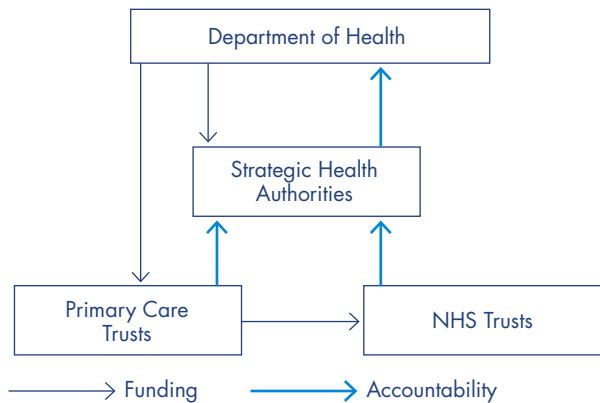
<sup>2</sup> Department of Health Resource Accounts 2003-04 [HC150].  
<sup>3</sup> NHS Summarised Accounts 2003-04 [HC 60-I].

### 4 Key findings from the Audit Commission’s assessment of financial management in the NHS

- The basics of financial management at most NHS bodies are sound and provide effective financial control for today’s health service, but financial management is broader and when it is at its best it can do more to enable improvements in patient services.
- Financial failures are rare, but they do occur and they provide important lessons for all NHS bodies.
- Financial planning, budget profiling, forecasting financial outturn, the quality of financial information and its use in decision-making all need to be improved.
- To implement the modernisation programme, NHS bodies will need better financial management arrangements and a wider range of financial management skills. Some will struggle to meet these new challenges.
- The current financial management capability of most Primary Care Trusts is inadequate to meet the challenges they face.

Source: Audit Commission, *Achieving First-class Financial Management in the NHS*

### 5 Structure of the NHS in England in 2003-04



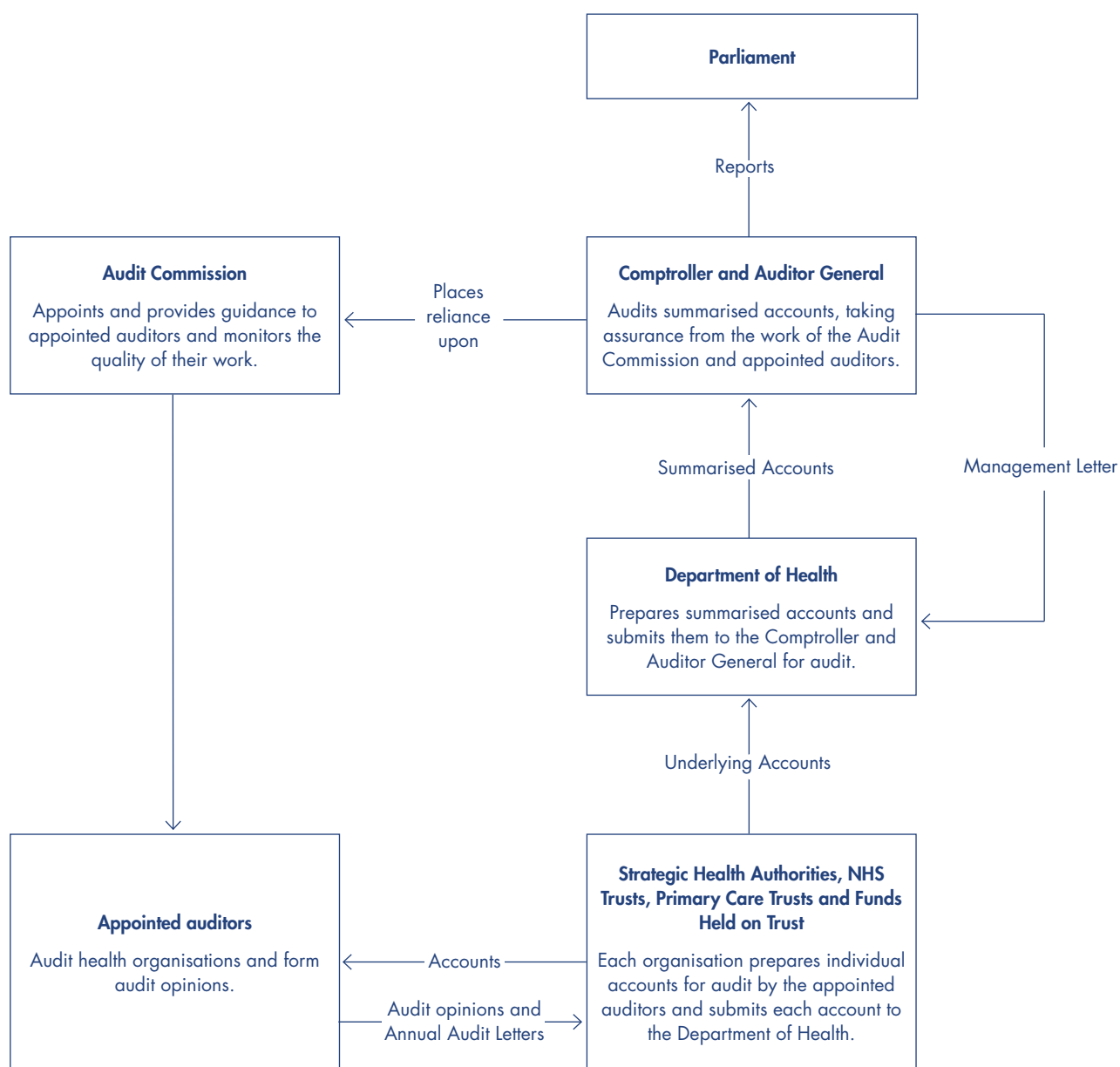
Source: National Audit Office

#### NOTES

- 1 Some funding also goes from the Department directly to NHS Trusts.
- 2 Primary Care Trusts also commission health care from primary healthcare providers and private-sector healthcare providers.

**1.8** The work undertaken by the Audit Commission’s appointed auditors means that the Comptroller and Auditor General can place reliance on it when undertaking the audit of the summarised accounts. **Figure 6** shows the audit arrangements for the underlying and summarised accounts of the NHS in 2003-04.

## 6 Audit arrangements in the National Health Service



Source: National Audit Office

## PART TWO

### Audit of the 2003-04 NHS accounts



**2.1** This part summarises appointed auditors' views on the financial management issues arising from the 2003-04 audits. The information has been gathered from audit opinions, audit reports and from a questionnaire auditors are required to complete for every NHS body. The part also highlights some of the key financial issues that arose during 2003-04.

## Audit reporting

**In 2003-04 auditors gave unqualified audit opinions on the truth and fairness of all NHS bodies' accounts and qualified their opinions on the regularity of expenditure at 53 Primary Care Trusts. Auditors also issued four Public Interest Reports, highlighting concerns over the financial standing of two NHS Trusts and two Primary Care Trusts.**

### Audit opinions on accounts

**2.2** Auditors are required to issue an opinion as to whether a body's accounts show a true and fair view of its state of affairs as at the year end and of its net resources or income and expenditure for the year. Where auditors decide that a body's annual accounts are likely to mislead people about its financial performance or position, they give a qualified opinion on those accounts, drawing attention to their concerns. In 2003-04 there were no qualifications of the accounts of NHS bodies on the grounds of truth and fairness. The Comptroller and Auditor General was therefore able to give an unqualified opinion on the truth and fairness of the summarised accounts of these bodies.

**2.3** Auditors are also required to give a regularity opinion on Primary Care Trust and Strategic Health Authority accounts which confirms whether in their view 'in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them'. In 2003-04, auditors qualified the regularity opinions of 53 Primary Care Trusts. **Figure 7** shows the breakdown of the causes of qualification. These consisted of 42 breaches of resource limits and 13 instances of other irregular expenditure, with two accounts qualified both for resource limit breaches and for incurring other irregular expenditure. All other irregular expenditure qualifications occurred because of problems in the governance arrangements of partnerships entered into under the Health Act 1999 between local authorities and NHS bodies. The Act includes a provision for partners to contribute resources to a pooled budget, which is then used to fund the partnership's agreed aims. The 13 Primary Care Trust irregularity qualifications related to three pooled budgets. No Strategic Health Authority regularity opinions were qualified.

**2.4** Failure to keep expenditure within agreed resource limits is a breach of a statutory financial duty, and hence should result in an automatic qualification of the regularity opinion for the individual bodies concerned. However, the Comptroller and Auditor General did not qualify his opinion on the summarised accounts of Primary Care Trusts since there are no overall resource limits for the aggregate expenditure of these organisations.

## 7 Primary Care Trust regularity qualifications

Cause of qualification	Number of Primary Care Trust regularity qualifications
Revenue resource limit breaches	39
Capital resource limit breaches	1
Other irregular expenditure	11
Revenue resource limit breach and irregular expenditure	2

Source: Analysis of audit opinions on Primary Care Trust accounts

**2.5** The Comptroller and Auditor General also gave an unqualified regularity opinion on the summarised accounts of the Strategic Health Authorities. He did not give a regularity opinion for the summarised accounts of NHS Trusts, since auditors are not required to report on the regularity of NHS Trust expenditure.

### Public reporting

**2.6** The Audit Commission Act 1998 provides auditors with the power to report where they have specific concerns arising from their audits:

- Section 8 requires auditors to consider whether, in the public interest, they should report on any matter coming to their notice; and
- Section 19 requires the auditor to refer matters to the Secretary of State if he or she has reason to believe that an NHS organisation has made a decision that involves, or may involve, unlawful expenditure.

**2.7** In addition, following increasing concerns about the financial standing and financial performance of NHS bodies, the Audit Commission issued an auditor briefing<sup>4</sup> which sought to:

- propose a reporting structure that will help auditors to demonstrate that they have responded to poor financial performance in a way that will assist the body to improve; and
- establish criteria to help auditors identify, on a consistent basis, when they should consider invoking their formal reporting powers.

<sup>4</sup> Audit Commission, *Audit Reporting of NHS Financial Performance* (September 2004).

<sup>5</sup> National Audit Office, *NHS (England) Summarised Accounts 2002-03* (April 2004) [HC 505].

**2.8** This guidance sets out the range of options open to the auditor where they have concerns about financial standing and financial performance.

**2.9** Since the Comptroller and Auditor General's last report on the NHS summarised accounts<sup>5</sup> auditors have issued a number of reports using these powers and guidance (**Figure 8**).

**2.10 Case Study 1** on the Mid Yorkshire Hospitals NHS Trust shows the circumstances that led to the auditor issuing a Section 8 Public Interest Report.

### Timeliness and quality of accounts

**Progress was made by NHS bodies in producing good-quality accounts for audit earlier than in previous years.**

**2.11** During 2003-04, the Department, the Audit Commission, the National Audit Office and the Healthcare Financial Management Association worked together to improve the quality and timeliness of the accounts and supporting working papers received from NHS bodies. Further pressure was placed on the NHS bodies because the final accounts timetable was brought forward by two weeks. Despite this additional pressure, the timeliness and quality of 2003-04 accounts improved significantly: as **Figure 9** shows, the majority of the accounts were received on time by auditors and were of sufficient quality. In the auditors' opinion, a total of 87 per cent of NHS bodies produced accounts of sufficient quality (62 per cent in 2002-03) and 86 per cent were submitted by the agreed deadline (68 per cent in 2002-03).

**2.12** The auditors also reported a significant improvement in the quality and timeliness of working papers supporting the figures included in the accounts. **Figure 10** shows that for Primary Care Trusts and Strategic Health Authorities and to a lesser extent NHS Trusts, there is still room for further progress. The quality or otherwise of working papers can have a considerable impact on the time taken to complete the audit, and is therefore a crucial element in bringing forward the date on which the accounts are certified and made publicly available.

## 8 Appointed auditors' reports

### Section 8 Public Interest Reports

The auditor of the Mid Yorkshire Hospitals NHS Trust issued a report on financial standing at the Trust (**Case Study 1**).

The auditor of Hammersmith and Fulham Primary Care Trust issued a report on the poor financial position of the PCT, commenting on the robustness of the PCT's response to its financial position, and the actions that the PCT needs to take to improve its position (**Case Study 3**).

The auditor of Bedfordshire Heartlands PCT issued a report setting out her concerns about the poor and deteriorating financial position of the PCT and the robustness of the PCT's approach to financial recovery planning. The report includes a number of actions the PCT needs to take to achieve and maintain financial balance.

*Source: Audit Commission*

The auditor of Surrey and Sussex Healthcare NHS Trust issued a report highlighting her view that the Trust's financial position, both in the short and long term, was extremely serious. The overall financial position had deteriorated significantly and had led to a substantial cash shortfall. The report made a number of recommendations on the actions the Trust should take to improve its financial performance.

### Section 19 Referrals

Qualifications of accounts on the basis of resource limit breaches constitute Section 19 referrals. There were 42 referrals corresponding to the qualified audit opinions in respect of 41 revenue and 1 capital resource limit breaches.

## Corporate governance

**Progress has been made by NHS bodies in demonstrating that they are managing key risks, but there is still room for improvement in managing all risks successfully.**

### Statements on Internal Control

**2.13** As part of the annual accounts, every NHS body is required to provide a Statement on Internal Control (a Statement). This describes the organisation's capacity to handle risk, and the risk and control framework in place. It also confirms that a review of the effectiveness of the system of internal control has been undertaken, and discloses any significant internal control issues.

**2.14** All NHS bodies prepared a Statement in accordance with Departmental guidance. NHS bodies were expected to embed risk management during the year, and the appointed auditors reported that only 11 per cent of NHS organisations were able to report that risk management processes were fully embedded for the whole year. However, following an assessment by Strategic Health Authorities, 96 per cent of NHS bodies were able to provide evidence that risk management processes were embedded by the end of the financial year, 31 March 2004.

**2.15** NHS bodies are required to disclose in the Statement any significant internal control issues identified during the year. 24 per cent of bodies identified significant internal control issues, which included:

- the inability to achieve financial balance in-year and on a recurring basis, and
- the lack of a sufficiently robust budgetary control system.

### Risk management

**2.16** NHS organisations face a number of diverse risks that could impact on the achievement of their organisational objectives, including the quality of care delivered to patients. Auditors reported that 93 per cent of NHS bodies had procedures in place to document the principal risks threatening the achievement of their key objectives, compared with 50 per cent in 2002-03 (**Figure 11**). Auditors also reported that 92 per cent of bodies had established arrangements that would enable them to address major risks.

**2.17** The Department required all NHS bodies to implement a mandatory Assurance Framework. This is based on a template developed by the Department, and aims to help bodies identify and manage their principal risks, as well as providing evidence to support the Statement on Internal Control.

## CASE STUDY 1

### Public Interest Report: The Mid Yorkshire Hospitals NHS Trust

In 2003-04, the Mid Yorkshire Hospitals NHS Trust reported an in-year deficit of £18.6 million, the largest deficit of all NHS bodies in 2003-04.

The Trust and the local health economy have long-standing service and financial issues, which the Trust had been able to manage in previous years through the receipt of one-off financial support and a variety of other non-recurrent solutions. However, these measures did not address the underlying problems.

The Trust, in conjunction with their auditors, has identified the main contributors to the deficit in 2003-04 as:

- Failure to adequately manage recruitment and retention difficulties leading to the use of high-cost bank and agency staff;
- the cost of meeting key NHS Plan waiting-time targets through premium-rate waiting list initiatives, including the use of the private sector; and
- the historic lack of adequate budget-setting and monitoring procedures, making it more difficult to identify, monitor and manage cost pressures. Progress has been made in this area during 2003-04 and beyond, but by this time the deficit had already arisen.

The timeline below shows the deterioration of the Trust's financial position during 2003-04 and the actions taken by the appointed auditor in respect of this.

May 2003

Trust Board approves budget for 2003-04 which identifies savings requirement of £19 million to achieve financial balance.

June 2003

Year end deficit of £8.7 million predicted.

August 2003

New Director of Finance takes up post.

October 2003

Director of Finance's review of financial position shows that year-end deficit could be as high as £34 million. Auditor issues Annual Audit Letter for 2002-03. This highlights Trust's financial position as cause for serious concern.

Source: Audit Commission

January 2004

Trust agrees plan to reduce year end deficit to £18 million.

February 2004

Auditor writes to Trust Board outlining actions to be taken by June 2004, and stating that if the actions are not taken by June, he will consider exercising the special reporting powers set out in the Audit Commission Act 1998.

July 2004

The Trust's 2003-04 annual accounts show a deficit of £18.6 million (£30.6 million if external support is removed).

September 2004

Auditor issues Section 8 public interest report because in his opinion insufficient progress had been made on the actions identified in his February letter. The auditor stresses the urgency of agreeing a recovery plan with the Department and the Strategic Health Authority.

November 2004

Trust Board considers a draft Service and Financial Recovery Plan setting out improvements to service, finance and organisational arrangements.

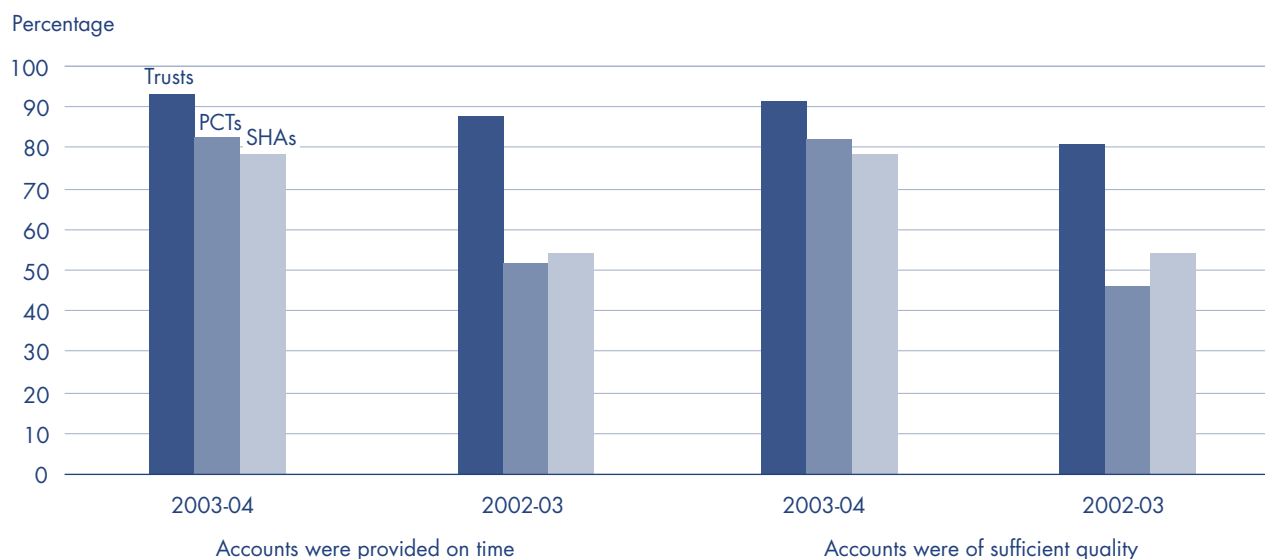
December 2004

The Healthcare Commission issues a report highlighting clinical concerns at the Trust and recommending that the Secretary of State takes special measures. The report recognises the issues of service configuration and financial deficit. It recommends that a phased and achievable financial recovery plan should be developed by the Trust and that support is given to achieve sustainable financial stability and to review and implement service changes.

January 2005

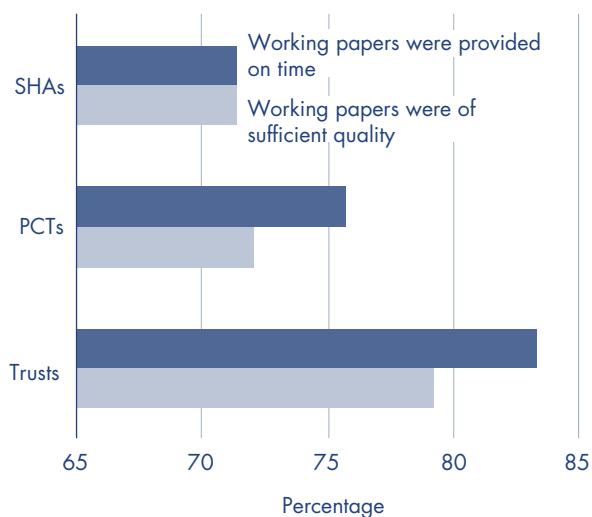
Trust Board approves the Service and Financial Recovery Plan, to be updated in the spring following completion of the Trust's 2005-06 business planning process.

**9** Most NHS bodies provided good-quality accounts by the agreed deadline



Source: Audit Commission analysis of appointed auditors' findings

**10** Most NHS bodies provided good-quality working papers by the agreed deadline



Source: Audit Commission analysis of appointed auditors' findings

**2.18** Following a review of the 2003-04 Statements, the Department informed Strategic Health Authorities that considerable improvements will be needed in the quality of the Assurance Frameworks for them to be effective management tools. The problems with the Assurance Frameworks identified by the Department included:

- lack of consistency with the recognised format;
- failure to map organisations' objectives to risks, controls and assurances;
- need for bodies to ensure that their Frameworks are embedded and dynamic, and that they provide regular information to Boards and are not viewed solely as a year-end exercise.

## 11 The majority of NHS bodies had procedures in place during 2003-04 to document and address principal risks

NHS Body	Principal risks are identified and documented	Arrangements are in place to address risks identified
	Number (%)	Number (%)
NHS Trusts	250 (93)	246 (91)
Primary Care Trusts	281 (93)	278 (92)
Strategic Health Authorities	28 (100)	27 (96)
<b>Total</b>	<b>559 (93)</b>	<b>551 (92)</b>

Source: Audit Commission analysis of appointed auditors' findings

## Financial management issues arising in 2003-04

There were significant financial issues which local NHS bodies had to address in 2003-04.

### Continuing care

**2.19** In February 2003, the Health Service Ombudsman published the report *NHS Funding for Long Term Care of Older and Disabled People*<sup>6</sup>. The report had implications for Primary Care Trusts because it found that some individuals had not received appropriate financial support from the former health authorities for aspects of the continuing care services they had received. Primary Care Trusts were required to refund any costs that had been inappropriately incurred. Primary Care Trusts began the process of identifying and reimbursing claimants in 2002-03 and this continued in 2003-04. Each Strategic Health Authority has published guidelines on how to apply the continuing care guidance issued by the Department in response to the Ombudsman's report.

**2.20** The steps taken by Primary Care Trusts to identify claimants vary, but the most common approaches have been by advertising in local newspapers and placing publicity material in nursing homes and GP surgeries.

Only 16 per cent of Primary Care Trusts failed to take steps to identify potential claimants. It is not possible to separately identify expenditure or provisions relating to continuing care in the summarised accounts. However, auditors estimated that in 2003-04, 132 Primary Care Trusts (44 per cent) had made payments totalling £18 million to claimants (£4 million in 2002-03) and that the provision held in Primary Care Trust accounts as at 31 March 2004 in respect of continuing care claims was £121 million, a decrease of £125 million from the previous year.

### Delayed discharge

**2.21** As a result of the Community Care (Delayed Discharges etc) Act 2003, from January 2004, if a patient remains in a hospital solely because supporting community care arrangements are lacking, the local authority is statutorily required to reimburse the relevant NHS Acute Trust. Of the 163 Trusts to which this legislation applies, 144 (88 per cent) have made arrangements to implement it and 30 Trusts have agreed that they will not charge the local authority, instead allowing them to invest the resources in developing the necessary community care arrangements. Auditors have estimated that for the three months of 2003-04 that the legislation was in operation, Trusts received a total of £4 million.

6 Health Service Ombudsman, *NHS Funding for Long Term Care of Older and Disabled People* [HC 399] (20 February 2003).

## Consultant Contract

**2.22** As part of the process of modernising NHS pay arrangements, the Department has agreed a new contract for consultants with the British Medical Association.

The new contract, which came into effect from 31 October 2003, should help NHS organisations move forward on a collaborative basis with the profession to support service improvement and help improve doctors' working lives. It differs from the previous contract in a number of important ways, with the content based upon a formal job plan agreed annually between the employing organisation and the consultant. All existing consultants have the opportunity to move onto the new contract at any time, and all new posts advertised after 31 October 2003 have been on the basis of the new contract. The Department estimates that over 80 per cent of all consultants are now working to the new contract.

**2.23** NHS bodies have received additional funding to pay for the costs of those consultants that have agreed to move to the new contract. The Department estimates that this will be some £250 million by 2005-06. The aim of the contract is to reward those NHS consultants who do most for the NHS and secure real changes in the way patient care is delivered. Some NHS bodies have indicated a belief that the funding provided by the Department was insufficient to deliver the contract. The Department believes the contract can be delivered within the resources available in the majority of NHS organisations, but have accepted that there are some cost pressures in the system, and for 2005-06 have adjusted the national tariff upwards by £150 million.

## Clinical negligence

**2.24** Clinical negligence is the term given to a breach of a duty of care by healthcare practitioners in the performance of their duties, and confirmed as such by the employing NHS body or through legal process. The NHS Litigation Authority<sup>7</sup> ('the Authority') is responsible for managing clinical negligence claims within the NHS on behalf of Primary Care Trusts and NHS Trusts, and accounts for the costs and liabilities associated with these claims. However, individual Primary Care Trusts and NHS Trusts retain their duty of care and the legal liability for cases arising.

**2.25** In 2003-04, the Authority paid out £422 million for all clinical negligence schemes (2002-03: £446 million).

**2.26** However, over a number of years the NHS expects to pay out £7.8 billion (at today's prices) in respect of known or expected claims, after taking into account the likelihood of settlement of those claims. These sums are shown as provisions in the Authority's accounts<sup>8</sup>. An additional £4.1 billion of claims are possible, but unlikely. These are shown as contingent liabilities in the Authority's accounts.

**2.27** Figure 12 shows the trend in provisions over the past five years.

**2.28** The provisions represent the value of claims received, at today's prices, calculated to reflect the probability of each claim being settled whenever that might occur. This includes an estimate made by actuaries of incidents incurred but not yet reported to the Authority.

**2.29** In calculating the amount payable at today's prices the Authority uses the Government's set discount rate. From 1 April 2003, this discount rate was reduced from 6 per cent to 3.5 per cent, increasing the expected amount payable in today's terms. If this new discount rate had been applied to the amounts payable as at 31 March 2003, the total provisions would have increased from £5.9 billion to £7.3 billion (see Figure 12). Hence, once the effects of the changed discount rate are taken into account, the increase since 2002-03 is £0.5 billion. However, whilst the provisions have been increasing over recent years, the amounts paid out to settle claims have remained stable.

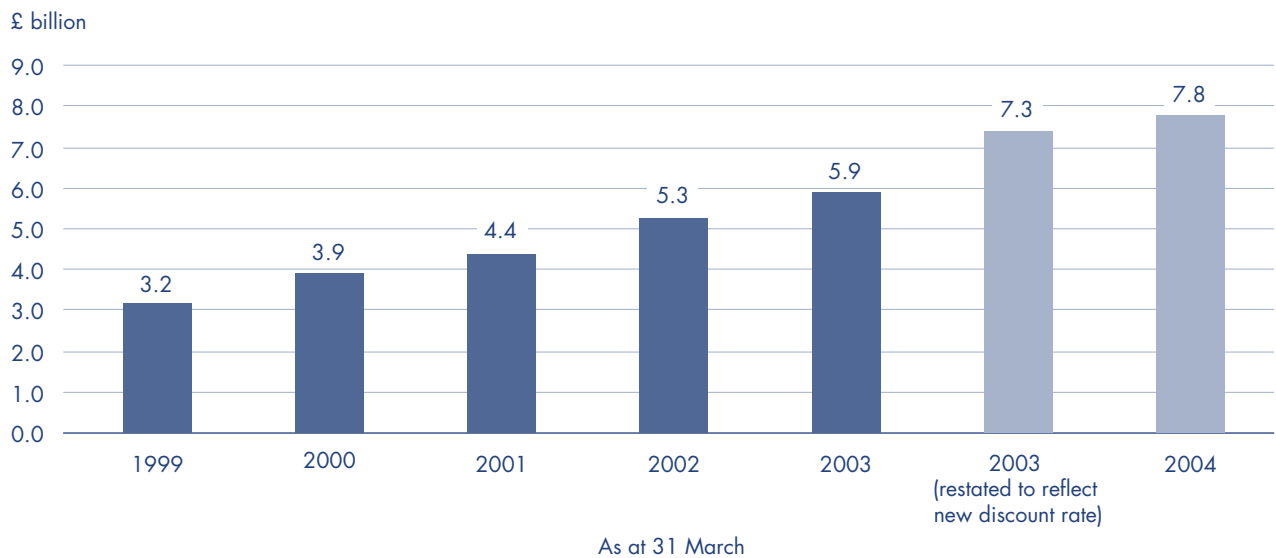
**2.30** On 30 June 2003, the Chief Medical Officer published his report into NHS Clinical Negligence *Making Amends – A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*. The report asked for views on a number of recommendations, including the setting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

**2.31** Many of the changes proposed in *Making Amends* will require primary legislation and will be taken forward when parliamentary time allows. In the meantime, the Department tells us that it will be announcing a statement of policy later in 2005 setting out its intentions. The Scheme will be overseen by a reconstituted version of the Authority.

<sup>7</sup> The NHS Litigation Authority is a Special Health Authority, set up under the NHS Act 1977 to administer clinical negligence and other pooled risk schemes for the NHS.

<sup>8</sup> *NHS Litigation Authority Annual Accounts 2003-04* [HC 777] (21 July 2004).

## 12 Provisions for clinical negligence within the NHS



Source: Summarised accounts of the Health Authorities, NHS Trusts, the National Blood Authority and the NHS Litigation Authority

### Programme Budgeting

**2.32** Programme Budgeting was launched nationally throughout the NHS in 2003-04. It is intended to increase transparency about how NHS bodies have spent their money, as well as addressing recommendations by the National Audit Office and HM Treasury that the Department provides a more meaningful analysis of expenditure within its resource account. For the first time, all Primary Care Trusts and Strategic Health Authorities were required to map their expenditure to 23 'Programme Budget Categories', based chiefly on medical conditions such as cancer and heart disease.

**2.33** The overall benefits of Programme Budgeting are considerable and include:

- showing where total NHS funds have been spent in a way that is useful and interesting to taxpayers;
- enabling expenditure on particular conditions to be assessed against National Service Frameworks and health outcomes;
- providing consistent data to compare one body's expenditure and performance with another's; and
- assisting Primary Care Trusts in planning the provision of services, thus supporting more effective budgeting and commissioning.

**2.34** The Department recognises that the implementation of Programme Budgeting will require ongoing refinement over several years, particularly in the way local information is collected, calculated, verified and summarised nationally. Ultimately, the Department intends that Primary Care Trusts and Strategic Health Authorities will publish their Programme Budgeting figures as an audited note to their annual accounts, thereby increasing transparency about their performance. This will not only be of interest to external stakeholders such as patient groups, but will also help Primary Care Trusts to assess and improve the effectiveness of their commissioning arrangements under Payment by Results.



## PART THREE

### Financial performance in 2003-04



**3.1** This part sets out the financial performance of the NHS in 2003-04, as reported in the individual NHS bodies' accounts and in the summarised accounts. It also examines the effects of financial support on bodies' reported financial position.

## Financial duties and targets

**3.2** The Department is responsible for ensuring that the NHS lives within the resources allocated to it by Parliament. Each individual NHS body also has a number of financial duties and targets. These include duties set out in statute and targets set by the Department, and vary according to the type of NHS body. The duties and targets and the performance of NHS bodies against these targets are set out in **Annex 2**.

**3.3** Each NHS Trust has a statutory duty<sup>9</sup> to 'ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account'. The Secretary of State for Health has interpreted this duty as being met if any deficit is recovered within the following two financial years. The Secretary of State may exceptionally extend the recovery period to four years.

**3.4** Strategic Health Authorities and Primary Care Trusts have a statutory duty<sup>10</sup> to contain their expenditure within set limits. Separate limits for revenue and capital expenditure and cash usage are set by the Secretary of State.

**3.5** In our report:

- Achieving an in-year surplus or break-even position for NHS Trusts; and
- Remaining within revenue resource limits for Strategic Health Authorities and Primary Care Trusts

will collectively be referred to as achieving financial balance.

## Aggregate performance of the NHS

**The Department met its target of achieving financial balance across all NHS bodies in 2003-04, but there was an increase in the number of local bodies not achieving this aim. The scale of deficits was also greater than in 2002-03.**

**3.6** In 2003-04, the Department met its target of ensuring that financial balance was achieved in aggregate across the individual organisations which comprise the NHS. The aggregate revenue underspend was £72 million, representing 0.12 per cent of the total revenue expenditure of £61 billion. This compares to an underspend of £96 million (0.18 per cent) in 2002-03. **Figure 13** shows the total aggregate gross and net performance by type of NHS organisation.

**3.7** **Annex 1** shows the performance of each type of NHS organisation by Strategic Health Authority area.

<sup>9</sup> Section 10 of the National Health Service and Community Care Act 1990.

<sup>10</sup> Sections 12 and 13 of the Government Resources and Accounts Act 2000.

### 13 Aggregate revenue outturn by type of NHS organisation

	2003-04			2002-03
	Aggregate surplus/ underspend £million	Aggregate deficit/ overspend £million	Net total £million	Net total £million
Strategic Health Authorities	206	0	206	96
Primary Care Trusts	95	(91)	4	93
NHS Trusts	37	(175)	(138)	(93)
Total	338	(266)	72	96

Source: Department of Health data based on audited accounts of individual NHS bodies

## Deficits and surpluses by type of NHS organisation

**3.8** Figure 14 shows the number of each type of NHS body failing to achieve financial balance.

**3.9** As in 2002-03, no NHS Trusts failed their statutory duty to break even taking one year with another, and no Strategic Health Authority failed to achieve financial balance. However, in 2003-04, there was an increase in the number of NHS Trusts and Primary Care Trusts failing to achieve in-year financial balance compared to 2002-03.

**3.10** The Department defines an NHS Trust's deficit as significant if it exceeds 0.5 per cent of total annual income. Using this measure, 49 NHS Trusts (18 per cent) incurred a significant deficit in 2003-04. This is an increase on 2002-03, when 40 NHS Trusts (15 per cent) incurred a significant deficit.

**3.11** Applying an analogous measure to revenue resource limit breaches of Primary Care Trusts, 27 Primary Care Trusts (9 per cent) breached their revenue resource limits by a significant amount. This is an increase on 2002-03 when 11 Primary Care Trusts (4 per cent) had a significant revenue overspend.

**3.12** Figure 15 shows the number of significant deficits (or overspends against the revenue resource limit for Strategic Health Authorities and Primary Care Trusts). Using the same measure of significance, it also shows the number of significant surpluses (or underspends against revenue resource limit for Strategic Health Authorities and Primary Care Trusts).

## Financial support

**3.13** The results stated above are after taking into account financial support and other mechanisms for ensuring that financial balance is achieved in aggregate across the NHS. Financial support is defined in the Department's Manual for Accounts<sup>11</sup> as 'additional income during the year, provided wholly to assist in managing financial problems.'

**3.14** For the first time in 2003-04, NHS Trusts were required to report in a note to their income and expenditure accounts the support received and its effect on the surplus or deficit for the year. NHS Trusts received support from one or more of the following sources:

- The NHS Bank
- Primary Care Trusts
- Strategic Health Authorities
- Transfers from capital to revenue

**3.15** The role of the NHS Bank and the support it provides is described further in **Annex 3**.

**3.16** NHS Trusts reported receiving a total of £344 million of support in 2003-04. In total, 79 Trusts received some support, with 21 of those Trusts receiving £5 million or more of support. **Figure 16** shows the NHS Trusts reporting receipt of £10 million or more of support, and the effect this had on their reported surplus or deficit.

**3.17** Comparative figures for 2002-03 are not available because not all organisations fully reported in their annual accounts the amount of support received.

<sup>11</sup> Department of Health, *NHS Trust Manual for Accounts 2003-04*, para. 4.1.

**14** Number of NHS organisations failing to achieve financial balance

	2003-04			2002-03		
	Failed to achieve financial balance		Total bodies	Failed to achieve financial balance		Total bodies
	Number	%		Number	%	
Strategic Health Authorities	0	0	28	0	0	28
Primary Care Trusts	41	14	303	21	7	304
NHS Trusts	65	24	269	50	18	275
Total	106	18	600	71	12	607

Source: Department of Health data based on audited accounts of individual NHS bodies

**15** Number of NHS organisations reporting a significant surplus or deficit

	Significant surpluses			Significant deficits		
	2003-04		2002-03	2003-04		2002-03
	Number	%	%	Number	%	%
Strategic Health Authorities	27	96	79	0	0	0
Primary Care Trusts	35	12	17	27	9	4
NHS Trusts	19	7	11	49	18	15
Total	81	14	17	76	13	8

Source: Department of Health data based on audited accounts of individual NHS bodies

**16** NHS Trusts receiving financial support of £10 million or more in 2003-04

NHS Trust	Reported surplus/ (deficit) £ million	Financial support included in reported surplus/(deficit) £ million	Surplus/(deficit) excluding financial support £ million
North Bristol	0.0	32.2	(32.2)
Oxford Radcliffe Hospitals	0.2	25.0	(24.8)
East Kent Hospitals	0.0	24.0	(24.0)
Ashford and St Peter's Hospitals	0.0	18.5	(18.5)
Mid Yorkshire Hospitals	(18.6)	12.0	(30.6)
St George's Healthcare	(0.7)	11.1	(11.8)
Royal United Hospital Bath	(2.0)	10.0	(12.0)

Source: Audited Accounts of NHS Trusts

### 3.18 Strategic Health Authorities and Primary Care

Trusts are required to report in their annual accounts any unplanned support received during the year. Unplanned support is defined as any funds given to manage financial problems that were not taken into account or planned at the start of the financial year.

**3.19** No Primary Care Trusts reported receiving unplanned support in 2003-04, compared to four receiving such support in 2002-03. No Strategic Health Authority required or received any financial support. Strategic Health Authorities and Primary Care Trusts are not required to report in their annual accounts any planned support received.

## Results of individual NHS bodies

### NHS Trusts

**3.20** In 2003-04, there were 12 NHS Trusts with a deficit exceeding £5 million. This is more than in 2002-03 when seven had a deficit of over £5 million, although the largest deficit in 2003-04 of £18.6 million is smaller than the largest deficit of £44.6 million in 2002-03. These results are stated after financial support is taken into account to ensure that they are comparable with the prior-year figures. When support is removed from the 2003-04

figures, the deficits arising are much larger. **Figure 17** shows the NHS Trusts reporting deficits of over £5 million in 2003-04 and 2002-03. It also shows the effect of support on the 2003-04 figures (comparatives are not available for 2002-03)

**3.21** The Mid Yorkshire Hospitals NHS Trust reported the largest deficit (£18.6 million) of all NHS bodies in 2003-04 (Case Study 1).

**3.22** Of the three NHS Trusts reporting in-year deficits of £10 million or more in 2002-03, all were successful in reducing their in-year deficit in 2003-04 once support is taken into account. Before support is taken into account, North Bristol NHS Trust and Royal United Hospital Bath NHS Trust significantly reduced their in-year deficit, whereas East Kent Hospitals NHS Trust's deficit increased. Whilst the reduction of the in-year deficit by North Bristol NHS Trust and Royal United Hospital Bath NHS Trust represents a significant achievement, both still have substantial in-year and underlying deficits. Achieving in-year break-even and then addressing the underlying deficit clearly represents a major challenge for bodies with such sizeable deficits. Bodies in such a situation generally have to make major changes to service delivery to achieve this. **Case Study 2** on North Bristol NHS Trust illustrates how an organisation can start to reduce a large deficit.

## 17 NHS Trusts with deficits of over £5 million

NHS Trust	2003-04		2002-03	
	Deficit £ million	Deficit before support £ million	NHS Trust	Deficit £ million
Mid Yorkshire Hospitals	(18.6)	(30.6)	North Bristol	(44.6)
Worcestershire Acute Hospitals	(12.8)	(12.8)	Royal United Hospital Bath	(24.8)
Maidstone and Tunbridge Wells	(9.0)	(9.0)	East Kent Hospitals	(11.4)
Brighton and Sussex	(7.9)	(11.4)	Worcestershire Acute Hospitals	(9.9)
Plymouth Hospitals	(7.8)	(11.0)	United Bristol Healthcare	(9.3)
Royal Wolverhampton Hospital	(7.6)	(7.6)	South Manchester University Hospitals	(7.0)
Royal Cornwall Hospitals	(5.8)	(15.3)	Royal Cornwall Hospitals	(5.2)
Essex Rivers Healthcare	(5.8)	(5.8)		
Southampton University Hospitals	(5.4)	(8.4)		
Kings Lynn and Wisbech Hospitals	(5.4)	(5.4)		
Buckinghamshire Hospitals	(5.2)	(9.2)		
Good Hope Hospital	(5.0)	(5.0)		

Source: Audited Accounts of NHS Trusts

## CASE STUDY 2

### North Bristol NHS Trust reduces deficit by £12 million

In the year to 31 March 2003, North Bristol NHS Trust reported the largest ever deficit in the NHS of £44.6 million.

In the year to 31 March 2004, the Trust reported an in-year surplus of £20,000 after receiving £32.2 million of external financial support (£18.1 million from the NHS Bank and £14.1 million from Primary Care Trusts).

Stripping out the external support, the Trust managed to reduce its deficit for the year from £44.6 million to £32.2 million, an improvement of £12.4 million. The improvement was net of new cost pressures of £3.8 million, so the actual savings achieved were £16.2 million.

The Trust notes that the main contributing factors to the reduction in deficit were:

- Reduction in agency staff costs (£5 million)
- Reduction in expenditure on private sector treatment to meet access targets (£2 million)
- Reduction in depreciation charge (£1 million)
- Additional income received for exceeding service level agreement activity level (£1 million)
- Rates rebate (£1 million)

The Trust still has to reduce its recurrent deficit by a further £32 million to achieve financial balance. It has a recovery plan in place which aims to eliminate the need for further external financial support beyond the end of 2007-08. It plans to make further savings in 2004-05 of £19.3 million. Since £11.5 million of this is required to meet new cost pressures, the in-year deficit is planned to reduce by a further £7.8 million. The largest individual contributors to the planned £19.3 million savings are:

- £2.5 million from increasing the Trust's capacity in orthopaedics through efficiency improvements thereby reducing the use of the private sector and waiting list initiatives to treat patients.
- £2.5 million from a planned reduction in nursing staff to benchmark levels and from further reductions in the use of bank and agency staff.
- £1.9 million from capital charge savings following revaluation of the estate by the District Valuer and projected forward future capital commitments.
- £1.0 million from bed reductions through reducing the length of patients' stay in hospital.
- £1.0 million from procurement savings.

Other savings will come from cost reductions in individual Directorates. The Trust is broadly on track with the recovery plan, and in December 2004 was projecting a year-end position (after support) of break-even.

Features of how the Trust is managing its recovery programme include the following:

- **Strong leadership** from the Chief Executive on the criticality of financial recovery.
- **Communication with Directorates:** Early in the process the Chief Executive and Finance Director made detailed presentations to Directorate teams on the need for financial recovery. These focused on reducing expenditure, improving the Trust's relatively poor efficiency levels and emphasising the key role of Directorates in financial recovery.
- **Realistic savings targets:** Savings targets are set by Directorate, taking account of the best available information on the scope for savings, including benchmarking information, reference cost comparisons, and known savings opportunities.
- **Monitoring of recovery:** There is a strong focus on project management and monitoring of recovery projects and Directorate savings targets, overseen by a Recovery Board, including Primary Care Trust representation.
- **Improvements in patient care processes:** There is a focus on sustainable improvements in patient care processes that increase quality of care as well as reducing costs – a process the Trust terms Operational Service Improvement.

## Primary Care Trusts

**3.23 Figure 18** shows that there were four Primary Care Trusts reporting overspends of more than £5 million against their revenue resource limit in 2003-04, compared to three in 2002-03.

**3.24** Hammersmith and Fulham Primary Care Trust reported the largest revenue resource limit overspend of all Primary Care Trusts in 2003-04. **Case study 3** describes the circumstances leading to the overspend and actions being taken to achieve a balanced financial position in the future.

## Performance of Strategic Health Authority areas

**3.25** In 2003-04, seven Strategic Health Authority areas reported an aggregate deficit across all the individual NHS bodies within their area. This compares to six areas reporting a deficit in 2002-03. **Figure 19** shows the Strategic Health Authority areas reporting an aggregate deficit in the bodies in their area in 2003-04 and 2002-03, both before and after support from the NHS Bank is taken into account.

**3.26** Only NHS Bank support is relevant in considering the effects of financial support on the whole Strategic Health Authority area as this is provided by the Department, a source external to the Strategic Health Authority area. Support provided by a Primary Care Trust or Strategic Health Authority to an NHS Trust in the same Strategic Health Authority area will have no net impact when the results of all bodies are aggregated across the area.

### 18 Primary Care Trusts reporting significant overspends

2003-04		2002-03	
Primary Care Trust	Overspend £million	Primary Care Trust	Overspend £million
Hammersmith and Fulham	(8.5)	Central Cornwall	(5.7)
Ipswich	(5.6)	North and East Cornwall	(5.5)
Dartford and Gravesham	(5.6)	West of Cornwall	(5.1)
North Devon	(5.4)		

Source: Audited Accounts of Primary Care Trusts

## CASE STUDY 3

### Hammersmith and Fulham Primary Care Trust

Hammersmith and Fulham Primary Care Trust has overspent annually since it was created in 2002. The accumulated deficit amounted to £10.2 million by the end of March 2004.

For 2003-04, the Primary Care Trust reported the largest revenue resource limit overspend of all Primary Care Trusts. In late 2003, it prepared a recovery plan to achieve breakeven for 2003-04, which required the delivery of £5.7 million savings. However, the Primary Care Trust was overly optimistic about the savings that could be achieved and, in the event, an £8.5 million overspend was incurred on a revenue resource limit of £201.6 million.

The deficit reflected:

- disputes with other NHS bodies over service costs and activity that were not settled in the Primary Care Trust's favour at arbitration (£3.2 million)
- unbudgeted cost pressures that emerged during the year (£2.3 million)
- cost commitments from predecessor bodies that the Primary Care Trust had hoped to challenge but was unsuccessful (£1.1 million)
- an impairment to the carrying value of a property (£1 million)
- a detailed exercise to agree debtor and creditor balances with other NHS bodies that identified invoices for which the Primary Care Trust had not accrued (£0.9 million).

The Primary Care Trust also reported weaknesses in its systems of financial and budgetary control, and capacity issues within the Finance Department, which affected its ability to monitor and control expenditure effectively during the year.

During 2004-05, the Primary Care Trust originally faced a potential deficit of £19 million, approaching 10% of its annual budget. Agreement was reached with the Strategic Health Authority to provide £14.5 million towards bridging the gap and the Primary Care Trust had until 31 March 2005 to deliver breakeven and address any other emerging pressures.

The Primary Care Trust has prepared a recovery plan that aims to deliver break-even for 2004-05 and the current estimated outturn is a small surplus of around £679,000. Nevertheless, more still needs to be done, and in the longer term, a cultural change is needed to balance available financial resources with service delivery objectives in order to achieve break-even on a sustainable basis.

Source: Audit Commission Public Interest Report, December 2004 and the Department of Health

## 19 Strategic Health Authorities reporting an aggregate deficit

Strategic Health Authority area	2003-04		Strategic Health Authority area	2002-03	
	After NHS Bank support	Aggregate outturn £million Before NHS Bank support		After NHS Bank support	Aggregate outturn £million Before NHS Bank support
South West Peninsula	(14)	(14)	Avon, Gloucestershire, and Wiltshire	(64)	(109)
North West London	(13)	(13)	South West Peninsula	(21)	(21)
Norfolk, Suffolk and Cambridgeshire	(10)	(10)	Kent and Medway	(20)	(20)
Hampshire and Isle of Wight	(9)	(9)	Greater Manchester	(5)	(5)
Kent and Medway	(5)	(22)	Cumbria and Lancashire	(2)	(2)
Surrey and Sussex	(5)	(45)	Hampshire and Isle of Wight	(1)	(1)
Avon, Gloucestershire and Wiltshire	(4)	(74)	Surrey and Sussex	7	(23)
Thames Valley	10	(15)			

Source: Department of Health data based on audited accounts of individual NHS bodies and Department of Health data on NHS Bank support

## PART FOUR

### Key themes for improved NHS financial management



**4.1** This part of our report highlights four themes identified as being important to the management and reporting of NHS finances. These are: the role of Boards in financial management, forecasting, earlier preparation of accounts and transparency. Whilst we recognise that financial management is better in some bodies than in others, this part of our report aims to identify best practice for all to apply.

## Role of Boards in financial management

**Examples of financial failure in some NHS bodies have highlighted the need for Boards and Chief Executives to understand fully their body's financial position and ensure that action is being taken to remedy any problems. Boards also need to drive improvements in financial management. To fulfil these responsibilities effectively, Board members need to enhance their financial skills.**

**4.2** This section looks at the role Boards play in achieving and sustaining sound financial management, and makes recommendations for Boards to improve the effectiveness of their oversight.

**4.3** Boards must be in a position to challenge constructively the financial and operational information they receive. This means they must understand the information presented to them and its implications for the organisation. They must also be able to identify risks to their corporate objectives, recognise the financial consequences and assess and monitor how effectively they are being addressed.

**4.4** The role of the Board includes the functions fulfilled by sub-committees of the Board. The sub-committees with a financial remit include the Audit Committee, Finance Committee, and Risk Management Committee. Each sub-committee needs to ensure it has the expertise to fulfil its specialist role effectively.

**4.5** Recent examples of financial failure have highlighted the importance of the role of the Board. The ineffective challenge of financial information at North Bristol NHS Trust has been identified as a key factor leading to its £44.6 million deficit in 2002-03. As Case Study 2 shows, effective leadership from the Chief Executive and high-level monitoring of progress against savings targets have been important factors in ensuring that financial recovery is achieved. **Case Study 5 in Part 5** reports that action was required in respect of the Board's role in the sudden deterioration in financial position at Bradford Teaching Hospitals NHS Foundation Trust.

**4.6** Events at Royal Wolverhampton Hospitals NHS Trust (**Case Study 4**), also illustrate the problems caused by lack of appropriate Board level understanding and challenge of the financial position.

## CASE STUDY 4

### Royal Wolverhampton Hospitals NHS Trust

In 2002-03, the Royal Wolverhampton Hospitals NHS Trust completed a five-year recovery plan one year early, and recorded a year-end surplus of £0.45 million. However, by November 2003, the Trust was forecasting a year-end deficit of £5.1 million, and ultimately recorded a deficit of £7.6 million. The forecast deficit for 2004-05 as at December 2004 was £9.4 million, even allowing for planned cost reductions of £6 million. The latest forecast as at May 2005, is a deficit of £9 million.

In response to the rapid deterioration in the Trust's financial position, the local Strategic Health Authority commissioned an independent review of its financial management and governance arrangements. The review identified a number of failings at the Trust, centred around two key areas:

- Reliance on non-recurrent funding sources to achieve financial balance for a number of years, leading to the apparently rapid deterioration in the financial position when such funding was no longer available; and
- Inadequate reporting and scrutiny within the accountability, financial reporting and committee structure.

The review found that the Trust's initial problems, caused by inadequate budget-setting and under-estimating of cost pressures, were compounded by a failure at Board level to identify and acknowledge the emerging overspend. In particular, the review suggested that:

- From the evidence available, the Audit and Governance Committee played little part in scrutinising financial plans or performance.
- There was a widely held view at the Trust that there was 'insufficient financial acumen' amongst the Non-executives on the Board.
- The Finance Director's monthly reports to the Board used non-standard accounting presentations and sparse narrative, resulting in a misleading view of the Trust's financial position. There appears to have been little challenge of the format of the Board finance report, despite its apparent lack of clarity.
- Despite the deficiencies in the Board finance report, the lack of challenge from the Board was surprising, given the other evidence (including advice from the external auditors) that the Trust faced financial difficulties.
- The management of the Trust lacked understanding of the impact of non-recurrent funding, meaning that they did not appreciate the financial difficulties that the Trust faced and therefore did not take action to remedy them.

Source: Independent review commissioned by Birmingham and the Black Country Strategic Health Authority<sup>12</sup>

**4.7** We make recommendations below of specific actions that Board members can take to help ensure they fulfil their responsibilities for the oversight of financial management and reporting. In addition, the joint Audit Commission and NHS Confederation Nexus Briefing<sup>13</sup> explains how Boards can ensure they are meeting their financial responsibilities.

## Forecasting

**NHS bodies find it difficult to forecast their year end financial position accurately during the financial year. This makes it difficult for them to take timely and appropriate action to achieve financial balance.**

**4.8** This section looks at how the year-end financial position was forecast by NHS bodies during 2003-04 and at the reasons why the final outturn position at a sample of

these bodies was different from the position forecast at the end of January 2004. The difficulties facing NHS bodies as they make forecasts are then examined, along with the consequences of inaccurate forecasting. We make recommendations to improve financial monitoring and reporting, and particularly forecasting.

## The reliability of NHS forecasting

**4.9** In *Achieving First-class Financial Management in the NHS*, the Audit Commission set out its concerns about the reliability of forecasting amongst NHS bodies. There appears to be a typical annual reporting cycle illustrated by **Figure 20**. Many NHS bodies go through this annual cycle as follows: little credence is given to financial information early in the financial year; then the body finds itself in danger of overspending; it takes corrective action; and ultimately achieves break-even.

12 Robert Tinston, Roger Townsend and David Whitaker, *An Independent Review of Financial Management & Governance at the Royal Wolverhampton Hospitals NHS Trust* (November 2004).

13 Audit Commission and NHS Confederation Nexus Briefing, *Good governance: good financial management* (June 2004).

**We recommend that Boards:**

## General

- Work effectively together, and encourage a high level of constructive challenge by both Executive and Non-Executive Directors.
- Take collective ownership of high-level financial issues and do not view finance as a specialist activity.
- Use those with relevant expertise, such as the Audit Committee, to consider and advise on more detailed financial issues.
- Consider the effectiveness of the whistleblowing arrangements in place for staff to report any irregularities, and monitor the action taken in respect of whistleblowing disclosures.
- Review the level of expertise, knowledge and staff turnover in the finance Department.
- Review the relationship with other NHS bodies, and the source and resolution of any disputes.

## Risk identification and management

- Understand which risks are incorporated in the financial forecast and their impact, and take a view on the likelihood of their resolution and stated impact.
- Assess whether the financial position takes account of all relevant risks or whether the impact of some risks has been omitted.
- Monitor the progress of risks and the action being taken to deal with them.
- Understand the link between operational and financial risks.

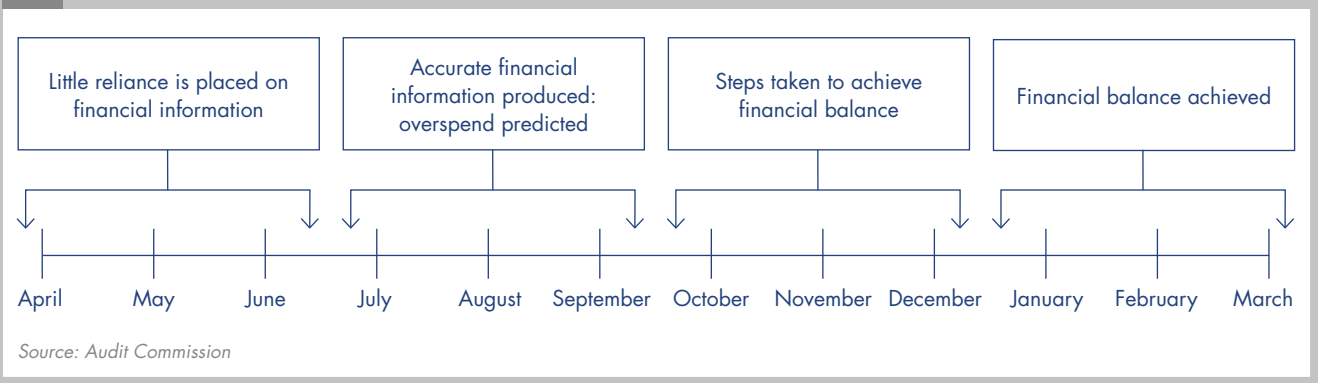
## Annual accounts

- Understand the position shown in the year-end accounts, including the impact and consequences of any financial support received.
- Understand the reason for any breach of statutory duties and monitor the action being taken in respect of these breaches.
- Understand the reason for any difference between the financial position reported to them throughout the year and the position at year end.
- Review the auditors' report to management and understand the significance of any errors found during the audit.
- Understand any significant accounting and audit issues arising and whether these were resolved sufficiently early in the process.
- Identify any issues reported in the annual audit letter that indicate weak financial management procedures, including the impact of any errors found, and assess whether appropriate action is being taken to remedy the weaknesses.
- Satisfy themselves that the reasons for any major disputes with other bodies about debtor or creditor balances or service level agreements are understood and being resolved.
- Monitor whether the accounts are produced and audited to the agreed timetable and investigate reasons for any delays.
- Review plans for producing accounts sooner after the year end.

## Management accounts

- Assess whether the position shown in financial reports is clear and understood by all Board members.
- Request that information on the cash and balance sheet position is provided and reconciled to the reported income and expenditure position.
- Request that the financial position reported throughout the year is in the same format as, or at least readily reconcilable to, the format of the published annual accounts.
- Monitor the length of time taken to produce financial information from the end of the period to which it relates and challenge the reason for any delays.
- Question whether all significant uncertainties in the financial position are clearly reflected and challenge the reasons for any uncertainties and the action being taken to resolve them.
- Monitor changes to the previously reported forecast of the year-end position and seek explanations where these changes are significant.
- Obtain assurance that the information reported to the Board is consistent with the management accounts.
- Understand how the budget has been set and enquire whether it is regularly updated.
- Understand how cost-savings targets have been set, including the level of involvement from budget holders.
- Challenge the likelihood of cost-savings schemes being achieved.
- Monitor the progress in achieving cost savings.
- Identify warning signs associated with specific risk factors, eg the emergence of cost pressures such as heavy use of agency staff.
- Request that any non-recurrent income is clearly identified and satisfy themselves that the current and future implications of this income are understood and managed.

**20** There is a typical annual forecasting and reporting cycle for NHS bodies



**4.10** As well as producing a financial forecast to be considered by the Board, every NHS body is required to report its forecast year-end outturn position to its Strategic Health Authority. This information must be submitted monthly and the body must note any assumptions included within the forecast position and any risks to achieving it.

**4.11** Each Strategic Health Authority aggregates the predicted position of all the NHS bodies in its area. It then makes its own assessment of the position and the extent to which the risks factored into the predicted outturn figures can be managed. The Strategic Health Authorities report both positions to the Department. The Department aggregates the reported positions from each Strategic Health Authority to give an overall forecast outturn figure for the whole NHS.

**4.12** The outturn figures predicted by individual NHS organisations and by Strategic Health Authorities during 2003-04 showed that an aggregate deficit outturn position was forecast in every month of 2003-04, although the actual outturn position at the year end was a small surplus. The most pessimistic view of the outturn was in the period from October to December 2003. A similar situation occurred in 2002-03: a forecast deficit throughout the year with financial balance achieved at year end. This trend appears to be repeating itself in 2004-05, although the Department predicts that the final audited position will be a small deficit across the NHS as a whole.

**4.13** The Department states that the pessimistic forecast of outturn is caused by NHS organisations factoring the full effect of risks into their forecasts, rather than the most likely effect of risks after mitigating action has been taken. This explains why the Strategic Health Authorities' forecast is less pessimistic than the individual NHS bodies'; they give greater consideration to the likely mitigating actions. An outturn position of aggregate financial balance is achieved by the year-end because successful mitigating action has been taken.

**4.14** At a national level, although the Department is able to make its own assessment of how pessimistic the forecast figures reported to it are, inaccurate forecasts reduce the usefulness of the information as a monitoring tool both at a national and local level.

**4.15** Also of concern was the number of NHS bodies failing to report to their own Board a realistic estimate of the year end position at the end of January 2004. The appointed auditors reported that eight Strategic Health Authorities, 49 Primary Care Trusts, and 25 NHS Trusts did not report a realistic year-end position to the Board when only two months from the year-end. Furthermore auditors reported that one Strategic Health Authority, 29 Primary Care Trusts and 18 NHS Trusts incurred 'unexpected' deficits at the year end.

**4.16** At a local level, NHS bodies are at risk of making decisions on the basis of inaccurate forecasts and therefore may be taking actions that are not actually required and which may have an adverse impact on the quality of services.

**Factors causing a change between forecast and actual outturn position**

**4.17** We asked the appointed auditors of those NHS bodies predicting a significant deficit at the end of January 2004 to note the factors that resulted in a change between the year-end forecast made at that time and the audited outturn position. In some cases, there was little change between the year-end position and the forecast. Where there was a change, there were instances of the financial position both improving and worsening. The factors resulting in a change fall into several distinct categories. The categories and reasons are set out in **Figure 21**.

## Barriers to effective forecasting

### Behavioural considerations

**4.18** In the past, NHS bodies have been able to benefit by predicting that they will fail to achieve financial balance, as this has helped them to secure financial support. Similarly, some organisations are reluctant to disclose that they are expecting to make a surplus in case it is reclaimed by the Strategic Health Authority to assist with financial problems elsewhere in the health economy, as described under the 'transparency' theme. Pessimistic forecasts can also arise out of a desire to avoid later criticism, should risks emerge that were not previously identified or savings plans not be achieved.

We recommend that the Department works with Strategic Health Authorities to ensure that forecasts are more robustly challenged. In particular, the identification and effects of risks and mitigating actions should be examined to ensure that a realistic position is forecast.

We recommend that NHS bodies, including Boards, develop their skills around the identification and management of financial risks and how they are reflected in the financial forecast. This should include making realistic assessments of the likelihood of cost savings schemes being achieved.

## 21 The reasons for inaccurate forecasting

Reason	Factors contributing to an improvement in the financial position	Factors contributing to a deterioration in the financial position
<p><b>Inaccurate forecasting</b> Actual costs turned out to be different from those forecast, other than as a result of conscious action.</p>	<ul style="list-style-type: none"> <li>■ overly pessimistic estimation of costs</li> <li>■ unplanned slippage in the timing of expenditure</li> </ul>	<ul style="list-style-type: none"> <li>■ higher than anticipated costs of implementing the consultants' contract</li> <li>■ increased costs of out of area placements</li> </ul>
<p><b>Successful cost-cutting exercises</b> Actual costs turned out to be lower than predicted as a result of a cost-cutting measure not factored into the forecasts.</p>	<ul style="list-style-type: none"> <li>■ steps had been taken to reduce expenditure on external placements</li> <li>■ planned slippage in the timing of expenditure</li> </ul>	
<p><b>Late agreement of funding</b> Additional funding was secured that was uncertain or could not be foreseen at month 10, or expected funding was not forthcoming.</p>	<ul style="list-style-type: none"> <li>■ increased funding received to cover the cost of the consultants' contract</li> <li>■ additional income received as a result of overperformance on contracts</li> </ul>	<ul style="list-style-type: none"> <li>■ income assumptions had been too optimistic</li> <li>■ arbitration cases not resolved in the organisation's favour</li> </ul>
<p><b>Financial support secured</b> As a result of predicting a deficit, financial support was secured.</p>	<ul style="list-style-type: none"> <li>■ transfers from capital to revenue</li> <li>■ the receipt of recurrent and non-recurrent income and financial support</li> </ul>	
<p><b>Accounting changes</b> Accounting adjustments were made which changed the level of revenue expenditure.</p>	<ul style="list-style-type: none"> <li>■ changes in accounting treatment resulted in reduced expenditure</li> <li>■ reclassification of capital expenditure previously coded as revenue.</li> </ul>	

Source: Appointed auditors of NHS bodies

## Budget setting and monitoring

**4.19** As noted in Figure 21, NHS bodies are sometimes unable to predict their costs accurately even over a short period of time. This may be due to genuine uncertainties in the costs caused by factors outside the organisation's control (which by their nature should be rare) or to unsophisticated cost identification and measurement, or inadequate budgeting techniques. Particular problems with budgeting also include the inaccurate profiling of budgets and failure to distinguish between recurrent and non-recurrent costs.

### We recommend that NHS bodies:

- set realistic budgets at the start of the financial year;
- profile their budgets to accurately reflect patterns of expenditure and receipt of income;
- review and challenge the accruals made on a monthly basis;
- correctly reflect the nature of non-recurrent income and expenditure in their forecast;
- incorporate the most up-to-date information on the progress of cost-saving programmes in their forecasts; and
- review previous forecasting performance and identify what improvements could be made.

## Late agreement of funding

**4.20** As shown in Figure 21, both financial support and income from service level agreements between Trusts and Primary Care Trusts are sometimes agreed very late in the year. In these circumstances the forecasting cannot be criticised since it should not and does not anticipate the unconfirmed receipt of income. However, it does mean that the forecast can be inaccurate, and may lead to unnecessary and unbeneficial last minute cost-cutting exercises as the body attempts to reach financial balance.

We recommend that NHS bodies finalise service level agreements at the start of the financial year.

## Earlier preparation of accounts

**The Department and the NHS have made progress in 2003-04 in delivering good-quality accounts to an earlier deadline. However, much needs to be done if the Department is to produce its consolidated audited accounts before the Parliamentary Summer Recess.**

**4.21** This section examines the production and audit of annual accounts sooner after the year-end, known as 'faster closing'. It outlines the benefits of producing annual accounts sooner after the year-end, the drive in the UK public sector to produce accounts earlier, the implications of faster closing for the Department of Health and NHS bodies, and how faster closing may be achieved in practice.

## Benefits of faster closing

**4.22** An organisation's accounts are of most relevance to the users of the accounts if they are available soon after the period to which they relate. There are also benefits to the organisation in producing and publishing its accounts earlier. These benefits include the impetus to improve management accounting procedures, resulting in higher-quality, more timely information which can be used to manage the business, and a reduced burden on staff resources at the year end when the final accounts are produced.

## Proposals for achieving faster closing

**4.23** Currently the average length of time from period-end to audit certification of the annual accounts for companies in the FTSE 100 is 58 days<sup>14</sup>. The Australian National Audit Office currently has a reporting timetable of 30 days from the end of the financial year for audit clearance of financial information<sup>15</sup>. The UK central government sector lags behind these timetables.

**4.24** HM Treasury has set a target for all Departmental resource accounts to be laid before the July Parliamentary Recess (approximately 110 days after the financial year end of 31 March) by 2005-06. To meet this target, the current timetable for producing and auditing the Department of Health's resource account would have to be brought forward by four months. Independently of the HM Treasury requirement for resource accounts, individual NHS bodies should also be aiming to bring their accounts production process forward to realise the advantages of faster closing, and to enable the Department to produce the NHS summarised accounts correspondingly earlier.

<sup>14</sup> National Audit Office, *Ready, Steady, Go...Faster Closing 2003-04* (October 2004).

<sup>15</sup> Ibid.

**4.25** In 2003-04, the timetable for the submission of individual underlying accounts to the Department was brought forward by two weeks. Despite this earlier timetable, the appointed auditors were able to report a significant improvement in the number of NHS organisations meeting this deadline (**Part 2**). This is encouraging, particularly since the quality of the accounts submitted for audit also improved.

**4.26** Even with these improvements in the timetable for individual NHS organisations, the Department will need to start consolidating the accounts of Strategic Health Authorities and Primary Care Trusts much earlier than the audited underlying accounts are currently available. For 2003-04, the audited accounts of Strategic Health Authorities and Primary Care Trusts were submitted to the Department on 16th July. Since the current timetable means that audited figures will not be available to produce the resource account before the Recess, the Department is considering using unaudited figures as a starting point to prepare the summarised and resource accounts in future years.

**4.27** If unaudited figures from local NHS bodies were used to compile the Department's accounts, the audit adjustments would need to be assessed by both the Department and the National Audit Office, as the Department's auditors, in order to identify any necessary amendments to the draft summarised and resource accounts before they were certified. This would require the audited underlying accounts to be submitted to the Department at least a month before the Parliamentary Recess, one month earlier than is currently the case.

### Accuracy of unaudited accounts

**4.28** The success of the Department's proposal to bring forward the timetable for the national accounts by using unaudited accounts will depend largely on the accuracy of these underlying unaudited accounts and the extent to which any changes are made as a result of the subsequent audit process. The Department already monitors and investigates significant audit adjustments in the accounts of NHS bodies. It asks each Strategic Health Authority to explain any large differences between the audited outturn figures of each NHS body and the predicted outturn figures reported to the Department in May.

We recommend that the Department identifies lessons arising from the audit adjustments and disseminates guidance to NHS bodies to help resolve such issues at an earlier stage in future.

### Faster closing and the audit process

**4.29** Achieving faster closing will also require the audit process to be brought forward. The time required to undertake the audit is reduced when good-quality accounts are presented for audit and where organisations have well developed financial controls operating throughout the year on which the auditors can rely. This allows the auditors to undertake a more efficient audit and to perform more of the audit work during the year rather than at the year end.

**4.30** The audit process can also be brought forward through the production and audit of comprehensive interim accounts. Where a complete set of interim accounts is prepared at the end of month nine, including full balance sheet and cashflow information, more of the audit can take place before the year-end. This will leave only three months' transactions to audit after the year end, plus changes in the balance sheet position. However, it will only be possible to undertake more work before the year end if the auditor can rely on the robustness of the processes and systems underpinning the production of the accounts.

**4.31** The production of comprehensive interim accounts also means that the year-end accounts can be produced much sooner and be of higher quality. The accounts need only be updated for changes in the final three months as most of the significant audit and accounting issues should have been identified and resolved at the interim audit. This will increase the reliability of unaudited accounts used to prepare the consolidated national accounts, and decrease the likelihood of major changes being required to both the draft underlying and national accounts before they are certified.

**4.32** In 2004-05, the production and audit of full interim accounts is being piloted in the Bedfordshire and Hertfordshire Strategic Health Authority area. Lessons learnt from this process will be identified and applied to other areas of the NHS.

**4.33** The Department, the National Audit Office and the Audit Commission have also identified good practice from those NHS bodies submitting accounts ahead of the required timetable in 2003-04 (**Figure 22**).

## 22 Good practice for faster closure of accounts

### Accounts preparation process and planning

- Preparation in advance, including detailed plans covering all responsibilities and contingency plans in case staff are absent. This ensures that key tasks are completed on time.
- Timetabling of Board meetings. This ensures that there is no delay in signing off the accounts once the audit is complete and ensures Board ownership of the accounts.
- Extension to the month-nine (December) reconciliation of balances with other organisations. This means that there are fewer disputed debtor and creditor balances that need to be resolved at the year-end.
- Active control account reconciliations throughout the year. This results in better financial control and fewer unresolved balances to investigate at year-end.

### Audit process

- Good working relationship with the external auditor, to ensure that all issues are discussed and resolved early and do not hold up sign-off of the accounts.
- Answering audit queries quickly. This reduces the time taken to complete the audit.
- Comprehensive and accurate working papers. This reduces the number of audit queries, speeding up the audit, and means that papers do not have to be revisited because adjustments have been made.
- Regular meetings between finance staff and the auditors to identify progress, particularly when there are staff absences. This ensures that the timetable does not slip.
- Involvement of the audit committee. This ensures independent oversight of the audit process.

### Learning process

- Post mortem to identify lessons for the next year. This allows continuous improvement and helps ensure that problems do not recur.
- Strategic Health Authority-wide meetings for disseminating good practice and receiving feedback from auditors. This allows wider sharing of good practice and provides an opportunity for issues affecting the local health economy to be resolved.

### We recommend that NHS bodies:

- Prepare monthly management accounts in the same format as year-end accounts, including balance sheet and cash flow information.
- Use the same accounting systems to produce both month-end management accounts and year-end statutory accounts.
- Adopt a pro-active approach to identifying issues which might involve significant adjustments to the accounts or involve significant judgement, and discuss these with their auditors at an early stage.
- Perform monthly reconciliation procedures throughout the financial year.
- Regularly agree balances with other bodies, particularly where these are likely to be contentious. This should include pooled budget arrangements.
- Obtain information for the accounts production, such as information on senior staff salaries, well in advance.
- Prepare a detailed accounts production timetable and agree it with their auditors and the audit committee.
- Make staff available to answer audit queries promptly, and have contingency plans in place to deal with unforeseen staff absences during the accounts preparation and audit process.
- Produce working papers to support the figures in the accounts that are complete and available in good time for the audit.
- Present the audit committee with the accounts and a commentary on the accounts that highlights the main features of the accounts and any key accounting issues and judgements.
- Use opportunities to learn from the accounts and audit process, for example, holding a review of the process with the auditors, attending Strategic Health Authority-wide meetings on improving the accounts production process, and taking advantage of other sources of guidance such as the Healthcare Financial Management Association's work on faster closing.

## Transparency

During 2003-04, there was improved reporting of the financial support received by NHS Trusts. However, disclosure of support needs to be extended so that the full extent and impact of support is transparent in the annual accounts of all NHS bodies.

**4.34** This section considers the transparency of external reporting. It looks at whether the use of financial support is clearly reported in the annual published accounts of NHS bodies. Financial support can be planned or unplanned; planned financial support refers to support identified at the start of the financial year whereas unplanned support refers to support required in response to unforeseen cost pressures arising during the financial year.

## NHS Trusts

**4.35** The notes disclosing financial support within NHS Trusts' 2003-04 accounts included some or all of the following information in addition to stating the amount of support:

- The source of support;
- The main reasons for support being required;
- Whether the support was planned or unplanned; and
- The existence of a recovery plan and timescale for achieving financial balance.

**4.36** The support is shown as income in the accounts and is not repayable. In most cases formal conditions are attached when support is granted. These include meeting targets to reduce the future need for support, making progress against the recovery plan, and realising cost savings in future years.

**4.37** In some cases, support is provided on the basis that the recipient Trust's income is reduced by a corresponding amount in the following year. Therefore whilst the support is not technically repayable and not shown as a creditor in the recipient Trust's 2003-04 account, the Trust will have to manage with reduced income in the following year.

## Primary Care Trusts

**4.38** Primary Care Trusts are required to report in their accounts any unplanned support they receive during the financial year. However in 2003-04, no Primary Care Trust reported receiving any such support. A number of Primary Care Trusts did however receive planned support, although there was no requirement to separately report this in their 2003-04 accounts. Planned support included funds from the NHS Bank. The Primary Care Trusts receiving NHS Bank support are listed in [Annex 3](#). In some, cases this additional funding was passed on to an NHS Trust in full, but in other cases the Primary Care Trust retained the funds for its own use.

**4.39** We reviewed a sample of Primary Care Trust Annual Reports. A number of these reported the receipt of support from sources other than the NHS Bank. This support came from other NHS bodies and capital-to-revenue transfers.

**4.40** As this other support was not clearly identified in the Primary Care Trusts' accounts, a note analogous to that introduced in the 2003-04 NHS Trust accounts would increase the transparency of Primary Care Trust accounts by clearly showing how much external support has contributed

to the reported outturn position. The Department has informed us that disclosure of planned support will be required in the 2004-05 Primary Care Trust accounts.

## Strategic Health Authorities

**4.41** No Strategic Health Authority required planned or unplanned support. However, the accounts of some Strategic Health Authorities include underspends transferred from NHS Trusts and Primary Care Trusts. This is due to the responsibility Strategic Health Authorities have for delivering financial balance across the organisations within their area. In order to achieve financial balance in aggregate, deficits arising must be offset by surpluses or underspends in other organisations.

**4.42** In some cases, surplus funds in one organisation are transferred directly to the organisation with the deficit, resulting in a lower deficit or break-even in the recipient organisation and a lower underspend in the donor organisation. In other cases, Strategic Health Authorities may deem that the situation is better managed by letting some or all of the deficit remain in the organisation in which it arises. In this case, the underspend to balance the deficit either remains in the organisation underspending or is surrendered to the Strategic Health Authority, which then reports the underspend in its own accounts. The reason for actually transferring the underspend is that the Strategic Health Authority can then ensure that the unspent funds are protected. This protection is required because there is frequently pressure within an organisation with an underspend to utilise fully any surplus funds. This would jeopardise the achievement of financial balance across the Strategic Health Authority area.

**4.43** The large aggregate underspend of Strategic Health Authorities shown in [Figure 13](#) and [Annex 1](#) is partly the result of an underspend by Strategic Health Authorities themselves, chiefly within Workforce Development Confederations. It is also partly as a result of Strategic Health Authorities recording in their own accounts underspends that have been surrendered by other organisations.

**4.44** Strategic Health Authorities are not currently required to report separately in their accounts any transfers of underspends from other organisations, although some do disclose the reason for having a large surplus in a note to their accounts or Annual Reports. Where such disclosure is not made voluntarily, it is difficult to assess the Strategic Health Authority's own performance. The Department is currently looking at ways in which it can address this issue for the future.

## PART FIVE

### Financial issues arising in 2004-05 and beyond



**5.1** There have been a significant number of financial management issues faced by NHS bodies for the first time in 2004-05. The creation of the first NHS Foundation Trusts from 1 April 2004 and the need for services to be commissioned from them using Payment by Results has meant that NHS bodies are having to change the way they operate financially. The introduction of the new contracts of employment and the National Programme for IT are also placing pressure on scarce resources. This part of our report outlines some of the likely financial issues arising and the key new developments in 2004-05 and beyond, as well as assessing their implications for financial management in the NHS.

## Financial standing

**The NHS faces significant financial pressures during 2004-05, which, coupled with the poor quality of bodies' financial forecasts, makes it difficult to conclude whether the NHS will achieve financial balance in 2004-05.**

**5.2** The indications are that financial standing will continue to be the most significant financial management issue facing NHS bodies in 2004-05. Auditors have reported that they have concerns about the financial standing of 189 NHS bodies (32 per cent). (**Figure 23**).

### **23** Bodies where auditors' reported concerns over financial standing

Type of NHS body	2004-05 Number of bodies (%)
Strategic Health Authority	1 (4)
Primary Care Trust	73 (24)
NHS Trust	115 (43)
<b>Total</b>	<b>189 (32)</b>

Source: Audit Commission

**5.3** Part 4 of our report considered the ability of NHS bodies to accurately forecast their end-of-year financial position. The pattern of NHS bodies collectively reporting a deficit during the financial year appears to be repeating itself. However, because of concerns about the robustness of the forecasts made during the year, it is not possible for us to conclude at this stage whether the NHS will achieve financial balance in aggregate by the 2004-05 year end. The Department of Health is currently forecasting a small deficit across the NHS as a whole.

## Payment by Results

**Payment by Results presents a real risk to financial stability, and will require NHS bodies to enhance their risk identification and forecasting skills.**

**5.4** Payment by Results is a new system for paying hospitals and other providers for the services they deliver. Instead of being commissioned through block agreements, with payment fixed regardless of the amount of activity provided, hospitals and providers will be paid for the actual activity they undertake. This represents a major change to NHS funding arrangements, and should bring the following benefits:

- more fairness and transparency in the way NHS Trusts and other providers are paid;
- rewards for efficiency and quality in providing services; and
- greater patient choice and more responsive services.

**5.5** Payment by Results is being introduced gradually over the period to 2007-08. Some NHS bodies began preparing in 2003-04 through cost and volume service level agreements. In 2004-05 there have been a number of early implementers of Payments by Results, primarily NHS Foundation Trusts and their main Primary Care Trusts. The Audit Commission is currently reviewing the early lessons that these bodies can offer other Primary Care Trusts and NHS Trusts as they prepare for implementation from 1 April 2005.

**5.6** Early evidence suggests that NHS bodies are in varying states of preparedness. For most NHS bodies, Payment by Results will present a real risk to financial stability in the coming years. The system will require particularly robust systems for forecasting and managing budgets, since it brings greater uncertainty to NHS bodies' income and expenditure streams. In particular:

- Primary Care Trusts will be committed to pay for all work done at full cost, even if demand proves higher than expected. Accurate forecasting and monitoring will therefore be crucial to maintain financial stability.
- NHS Trusts will be paid a pre-set national tariff for each service they provide, rather than a price based on their own costs. Although this will be an incentive to make cost savings to match the tariff, some Trusts will require rigorous efficiency improvements to do so.

- NHS Trusts' income will also be more susceptible to fluctuations in demand, since they will only be paid for actual activity delivered. Uncertainty over demand will increase further when patients are offered a choice of several possible providers from December 2005.

**5.7** In January 2005 the Department announced that it was delaying the introduction of a key element of Payment by Results. From 1 April 2005 only elective admissions (around 30 per cent of an NHS Trust's income) will be covered by Payment by Results, with emergency and outpatient activity now not being included until April 2006. The overall implementation timetable has not been affected, with 90 per cent of hospital care to be covered by Payment by Results by 2008-09. The change to the scope of Payment by Results in 2005-06 was made following an exercise to ascertain the stability of the NHS finance system as Payment by Results is introduced. This identified that non-elective and outpatient activity is not stable, making it harder to set the tariff. The delayed implementation reduces the level of financial risk faced by NHS bodies in 2005-06, but it has meant that NHS bodies have had to revise their financial and operational plans for 2005-06 close to the start of the financial year, and will face further uncertainty if more changes are made to the implementation of Payment by Results.

**5.8** NHS Foundation Trusts, which were awarded Foundation status partly because of their effective financial reporting and budgetary procedures, have found implementation of Payment by Results a significant challenge. The situation at Bradford Teaching Hospitals NHS Foundation Trust (Case Study 5) demonstrates that difficulties may arise even at these, better managed, Trusts and suggests that other NHS bodies will need to invest considerable effort to ensure that their financial and budgetary procedures are adequate when Payment by Results is introduced across the NHS from 2005-06.

## Foundation Trusts

**The first NHS Foundation Trusts began operating in 2004-05. The enhanced financial freedoms of NHS Foundation Trusts and their early implementation of Payment by Results have been a significant challenge, even for these, the best-managed Trusts. In order to achieve foundation status, NHS Trusts will have to further improve their financial management.**

**5.9** On 31 March 2004, Monitor (whose statutory name is “the Independent Regulator for NHS Foundation Trusts”) announced the first ten NHS Trusts authorised to operate as NHS Foundation Trusts from 1 April 2004. Ten more NHS Foundation Trusts were authorised from 1 July 2004; a further five in January 2005, and a further six from 1 April 2005. (Figure 24).

**5.10** NHS Foundation Trusts are free-standing, not-for-profit organisations with a duty to provide NHS services to NHS patients according to NHS standards and principles. They differ from existing NHS Trusts in three key respects:

- they have significantly more freedoms to decide locally how to meet their obligations, which covers a requirement to operate to national healthcare standards and targets. Freedoms include the ability to raise capital from both public and private sectors, where access to capital is determined by projected cash flows. They can also retain operating surpluses for investment for the benefit of NHS patients.
- they are more accountable to their local population, rather than to central government. NHS Foundation Trusts have a Board of Governors elected from and by local communities themselves; and
- they are authorised and regulated by Monitor.

## 24 NHS Foundation Trusts as at April 2005

### ● Authorised on 1 April 2004

1. Basildon and Thurrock University Hospitals
2. Bradford Teaching Hospitals
3. Countess of Chester Hospital
4. Doncaster and Bassetlaw Hospitals
5. Homerton University Hospital
6. Moorfields Eye Hospitals
7. Peterborough and Stamford Hospitals
8. Stockport
9. Royal Devon and Exeter
10. The Royal Marsden

### ● Authorised on 1 July 2004

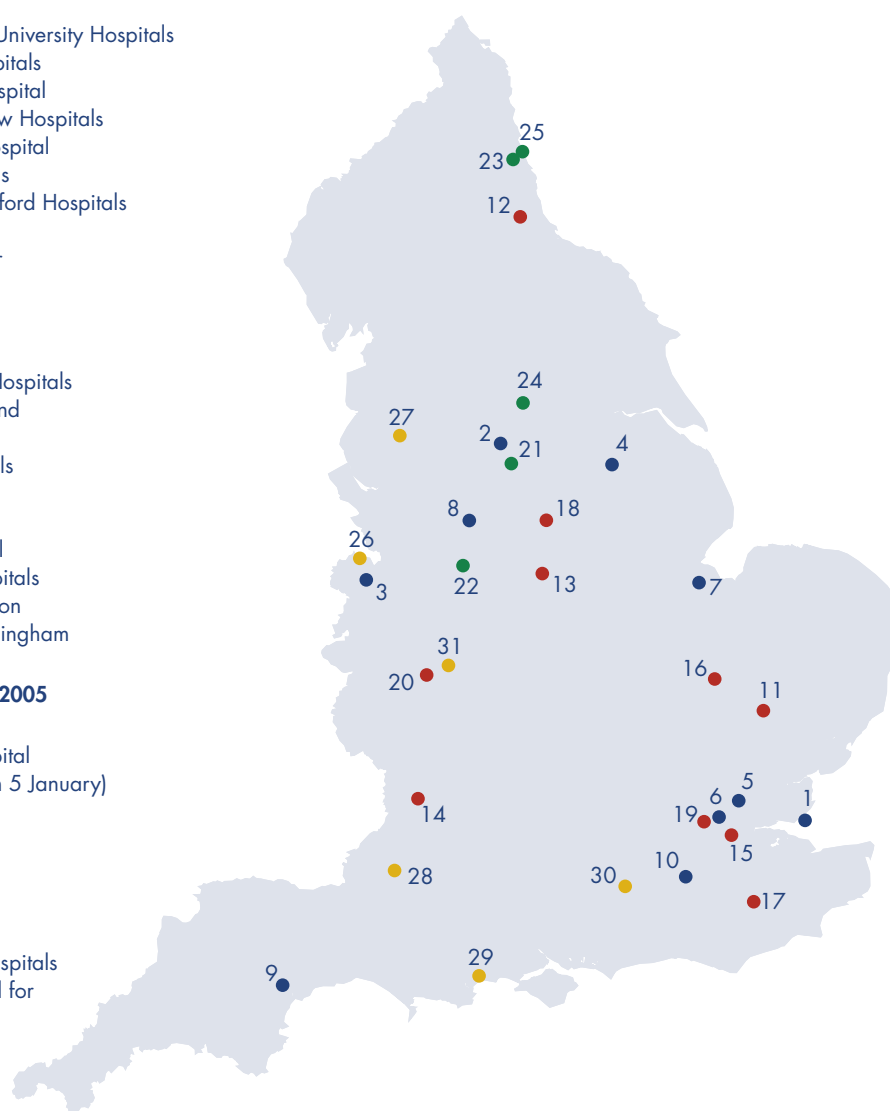
11. Cambridge University Hospitals
12. City Hospitals Sunderland
13. Derby Hospitals
14. Gloucestershire Hospitals
15. Guy’s and St. Thomas’s
16. Papworth Hospital
17. Queen Victoria Hospital
18. Sheffield Teaching Hospitals
19. University College London
20. University Hospital Birmingham

### ● Authorised on 1/5 January 2005

21. Barnsley Hospital
22. Chesterfield Royal Hospital
23. Gateshead Health (from 5 January)
24. Harrogate and District
25. South Tyneside

### ● Authorised on 1 April 2005

26. Liverpool Women’s
27. Lancashire Teaching Hospitals
28. Royal National Hospital for Rheumatic Diseases
29. Royal Bournemouth & Christchurch Hospitals
30. Frimley Park Hospital
31. Heart of England



Source: National Audit Office

**5.11** NHS Foundation Trusts are not performance-managed by Strategic Health Authorities. Monitor is responsible for overseeing NHS Foundation Trusts and ensuring they remain within their terms of authorisation and the legislation.

**5.12** This represents a real change to the financial regime that exists for other NHS bodies, particularly with the added complexity of the introduction of Payment by Results outlined above. One of the most significant challenges for NHS Foundation Trusts is the increased emphasis on the management and forecasting of income and cash. Under Payment by Results, the income received by NHS Foundation Trusts fluctuates according to the level of activity delivered. However a significant proportion of NHS bodies' costs are fixed or semi-fixed in nature and do not fluctuate with activity. Any unexpected downturn in activity will lead to the NHS Foundation Trust receiving less income and therefore, potentially, a shortage of cash. When NHS Foundation Trusts get into financial difficulties, the solutions have to be found internally as they do not have access to financial support received by other types of NHS bodies.

**5.13** At present, only NHS acute, specialist and mental health Trusts who are awarded a three star rating in the NHS Performance Ratings are invited to apply to become NHS Foundation Trusts. In addition, applicants must demonstrate to Monitor that they have:

- the organisational capacity to deliver their business plan;
- sufficient working capital for the next 12 months;
- satisfactory financial reporting procedures in place;
- the ability to generate a sustainable net income surplus by 2007-08, and maintain a reasonable cash position.

**5.14** To be authorised as an NHS Foundation Trust, an applicant must meet the criteria laid down in the Health and Social Care (Community Health and Standards) Act 2003, and Monitor's own criteria which reflect the need for an NHS Foundation Trust to be legally constituted, financially viable and sustainable, and well-managed. Monitor's assessment of applicants' financial stability is a critical factor in the success of the application. Monitor looks closely at how financial balance has been achieved. It looks beyond the figures reported in the

annual accounts and focuses on underlying performance. In this assessment the effects of factors such as receipt of non-recurring income, capital-to-revenue transfers and financial support received are removed.

**5.15** Although the performance and financial position of NHS Foundation Trusts are examined on a quarterly basis by Monitor, their increased financial freedom and the instability caused by Payment by Results heightens the need for effective internal reporting, financial forecasting and control mechanisms. Even the best managed NHS organisations – those that have been awarded three stars – are struggling to meet the standard expected by Monitor. And even though the situation at Bradford Teaching Hospitals NHS Foundation Trust (Case Study 5) is not typical of the other NHS Foundation Trusts, it nevertheless illustrates that robust budgeting and reporting procedures must be allied with pro-active, Board-level scrutiny of financial performance.

**5.16** As it is currently planned that all NHS Trusts will reach the standard to be in a position to apply for NHS Foundation Trust status, the remaining NHS Trusts should also be seeking to put adequate financial management mechanisms in place to achieve the standard expected by Monitor, including effective forecasting, reporting and analysis at Management Board level. By implementing such procedures now, NHS bodies will not only increase their future eligibility for NHS Foundation Trust status, but also equip themselves to manage more immediate challenges such as Payment by Results.

## National Programme for Information Technology

**The National Programme for IT is a major project that aims to create an information infrastructure that will improve patient care. NHS bodies will have to manage their resources carefully to ensure that they can meet the costs that are not centrally funded.**

**5.17** The National Programme for Information Technology (NPfIT) was established in October 2002. It is the largest ever UK public-sector IT project, with £2.3 billion set aside over the next three years and total contracts awarded to date (covering a period of seven to ten years) of £6.2 billion.

## CASE STUDY 5

### Bradford Teaching Hospitals NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust was one of the first wave of NHS Trusts to be authorised on 1 April 2004. By November 2004, it was forecasting a deficit of £11.3 million for the year ending 31 March 2005, compared with a budgeted surplus of £2.3 million - a variance against budget of £13.6 million, or 6% of total turnover. As the budgeted surplus had formed part of the Foundation Trust's terms of Authorisation, Monitor deemed that these terms had been breached and intervened formally in the Foundation Trust's affairs.

According to Monitor<sup>16</sup>, the Foundation Trust was aware of its developing financial problems in early April 2004. However, these problems only came to the attention of Monitor in August 2004, as a result of its first quarterly monitoring of the financial position of authorised NHS Foundation Trusts. The financial problem was reported by the executive management of the Foundation Trust to their Board in April, and the Board has admitted that their initial response to these problems was "insufficient".

The Recovery Plan submitted by the Trust did not, in Monitor's opinion, provide a credible or adequate response to the financial difficulties faced by the Trust. It lacked strategic vision and coherence and included some opportunistic proposals which did not attempt to address the underlying causes of the cost overruns.

Monitor's Board was not satisfied that the Trust's Chairman was exercising the requisite leadership and supervision of the Trust's Board and Executive management to ensure compliance with the Authorisation so that, with appropriate improvement planning and risk management, the Trust could move from financial deficit to surplus within a realistic timescale.

In December 2004, Monitor therefore took the decision to remove the then Chairman and appoint an interim Chairman for a six month period. The decision followed extensive discussions between Monitor and the Trust Board following a report by external professional advisers, Alvarez and Marsal, into the financial position at the Trust.

The Trust, which remains on monthly monitoring, submitted a revised Recovery Plan in April 2005, and has recently announced that it has made a permanent appointment to the post of Chairman which will take effect once the interim Chairman's appointment expires in June 2005.

Source: Monitor

**5.18** The Programme aims to create an information infrastructure for the NHS that will improve patient care by increasing the efficiency and effectiveness of clinicians and other NHS staff. Its key elements are:

- creating a NHS Care Records Service to improve the sharing of patients' records;
- making it easier for GPs and other primary care staff to book patients into the hospital of their choice. The 'Choice at Referral' initiative is the subject of a separate National Audit Office study, published in January 2005<sup>17</sup>;
- providing a system for the electronic transmission of prescriptions;
- providing GPs and Primary Care Trusts with evidence and feedback on the quality of care delivered to patients;
- storing and distributing digital images (such as X-rays) to support diagnosis and treatment;
- ensuring that the NHS IT infrastructure can meet its current and future needs.

**5.19** The central software and hardware costs of these core services will be funded nationally by the Department. However, there will be considerable additional costs borne by NHS bodies at local level. These include:

- additional, non-core services, such as pharmacy stock control and radiology information systems;
- local infrastructure upgrades, including data migration and provision of PCs, printers, mobile devices and networks powerful enough to run the new systems;
- change management, such as reconfiguring the working practices of GPs and consultants to accommodate the new systems;
- training and support for NHS staff in using the new systems.

16 Statement by Monitor, 26 November 2004.

17 National Audit Office, *Patient Choice at the Point of GP Referral* [HC 180] (19 January 2005).

**5.20** Although some additional non-recurrent support will be available from the Department and Strategic Health Authorities to help meet these local costs, a proportion will have to be covered by NHS bodies' own budgets. According to the Department, this should be feasible since NHS bodies will not now need to provide their own systems for core services such as electronic booking and care records. The Department states that the resultant savings can be offset against local implementation costs, although some NHS bodies have expressed concerns about possible shortfalls. The implementation of the Programme in the NHS will be examined by the National Audit Office in its forthcoming study on the National Programme<sup>18</sup>.

## New pay arrangements

**Significant changes are being made to the pay arrangements of most NHS staff. Implementing these changes is likely to create cost pressures for most NHS bodies.**

**5.21** Most NHS staff groups are in the process of receiving new contracts of employment. There is a new consultants' contract (considered in Paragraphs 2.22 and 2.23) and GPs agreed new pay arrangements in June 2003. The new Agenda for Change pay system agreed in November 2004 applies to all NHS staff except senior managers and those covered by the Doctors' and Dentists' Pay Review Body.

**5.22** Implementing new contracts of employment will be a major challenge for NHS bodies. The purpose of the new contracts is to develop an NHS workforce that supports service modernisation and supports the recruitment and retention of the NHS workforce. Inevitably there will be costs incurred in implementing the new contracts, and the challenge for NHS bodies is to ensure that the expected benefits of implementation are realised and deliver value for money in terms of the increased cost. For 2004-05 some NHS bodies have voiced concerns that the costs of implementation are proving higher than planned.

## The way forward

**The developments in 2004-05 and beyond mean that financial management in the NHS is facing unprecedented challenges. To meet these challenges, particularly those associated with operating in a more commercial environment, NHS bodies will need to improve significantly their financial management and financial forecasting skills.**

**5.23** The number of challenges facing NHS bodies is unprecedented, and meeting those challenges will depend on the effective management of finances. NHS bodies need to ensure that their financial management arrangements are adequate and capable of keeping pace with future developments. All Board members, both executives and non-executives, need to have the necessary knowledge, skills and approach to provide effective oversight and fulfil their financial management responsibilities in a changing environment.

**5.24** New financial management skills and competencies will be required. The job content of NHS finance staff will change, both in terms of the technical issues they face and the financial regime in which they work. The same is true for staff throughout the organisation with financial management responsibilities.

**5.25** Finance staff will need to improve their skills around the strategic aspects of financial management, including forecasting and modelling within the new financial regime, and develop commercial finance skills as more NHS Trusts are awarded Foundation status. The identification, assessment and mitigation of financial risk will also become increasingly important as NHS bodies face the realities of this more commercial environment, as will the need to develop sound financial systems, for example in respect of cash management and cashflow forecasting, to enable them to operate effectively in this environment.

To minimise the risks arising from the forthcoming changes to the NHS financial regime, we recommend that the Department develops a financial and management strategy to support NHS bodies, similar to that accompanying other major changes such as the introduction of National Service Frameworks.

**5.26** The National Audit Office and the Audit Commission are committed to working with the Department, NHS bodies and Monitor to support the NHS in the challenging task of improving its financial management arrangements.

<sup>18</sup> The National Audit Office study, due for publication in Summer 2005, will examine the Programme's procurement, value for money, implementation and progress to date.

# ANNEX 1

## Financial performance of the NHS by organisation type

Strategic Health Authority Area	Strategic Health Authorities 2003/04 Underspend/ (overspend) £ million	Primary Care Trusts		NHS Trusts		Overall	
		2003/04 Number	2003/04 Underspend/ (overspend) £million	2003/04 Number	2003/04 Surplus/ (deficit) £million	2003/04 £million	2002/03 £million
Avon, Gloucestershire and Wiltshire	1.7	12	(2.9)	13	(3.0)	(4.2)	(63.6)
Bedfordshire and Hertfordshire	1.4	11	0.0	7	0.6	2.0	25.0
Birmingham and the Black Country	5.9	12	8.5	13	(13.8)	0.6	14.4
Cheshire and Merseyside	5.2	15	4.5	18	0.3	10.0	3.4
County Durham and Tees Valley	1.4	10	1.3	5	(1.5)	1.2	3.5
Cumbria and Lancashire	10.6	13	2.2	10	(8.4)	4.4	(1.6)
Dorset and Somerset	5.1	9	3.6	8	0.1	8.8	4.2
Essex	9.6	13	(1.3)	8	(4.9)	3.4	4.8
Greater Manchester	9.0	14	3.6	14	0.6	13.2	(5.1)
Hampshire and Isle of Wight	0.1	10	(2.3)	7	(7.0)	(9.2)	(1.0)
Kent and Medway	7.1	9	(5.1)	7	(6.7)	(4.7)	(19.6)
Leicestershire, Northamptonshire and Rutland	4.6	9	6.2	5	(6.0)	4.8	14.7
Norfolk, Suffolk and Cambridgeshire	15.7	17	(16.9)	13	(9.2)	(10.4)	22.4
North and East Yorks and North Lincolnshire	1.4	10	0.1	7	0.1	1.6	2.2
North Central London	6.1	5	4.7	11	0.6	11.4	4.0
North East London	8.6	7	0.3	7	0.2	9.1	1.1
North West London	4.0	8	(9.3)	10	(7.6)	(12.9)	5.2
Northumberland, Tyne and Wear	13.1	6	(5.1)	9	0.5	8.5	15.9
Shropshire and Staffordshire	5.2	10	2.0	8	(3.7)	3.5	6.3
South East London	6.4	6	(3.3)	8	1.3	4.3	15.7
South West London	6.3	5	1.1	7	(0.6)	6.8	9.2
South West Peninsula	10.2	11	(12.3)	8	(12.1)	(14.2)	(20.6)
South Yorkshire	1.6	9	6.9	8	0.4	8.9	15.6
Surrey and Sussex	14.8	15	0.1	17	(20.3)	(5.4)	7.0
Thames Valley	4.2	15	11.4	13	(5.5)	10.1	7.8
Trent	6.4	19	3.7	11	0.8	10.9	14.5
West Midlands South	16.9	8	1.1	8	(12.7)	5.2	4.4
West Yorkshire	23.6	15	1.2	9	(20.0)	4.8	5.9
<b>Total</b>	<b>206.3</b>	<b>303</b>	<b>3.9</b>	<b>269</b>	<b>(137.6)</b>	<b>72.5</b>	<b>95.7</b>

### NOTE

Some rows do not total due to rounding.

## ANNEX 2

### Financial duties of NHS organisations

Strategic Health Authorities and Primary Care Trusts	NHS Trusts
Statutory	
<p>Contain expenditure, measured on an accruals basis, within approved revenue resource limits. A total of 41 Primary Care Trusts failed in this duty.</p> <p>Contain expenditure, measured on an accruals basis, within approved capital resource limits. Two Primary Care Trusts breached their capital resource limit.</p> <p>Remain within cash limits. No body was reported to have failed in this duty.</p>	<p>Break even taking one financial year with another. All NHS Trusts met the Department's interpretation of the statutory duty to break even, although 65 incurred an in-year deficit in 2003-04.</p>
Departmental	
<p>Achieve financial balance without the need for unplanned financial support. No Primary Care Trusts or Strategic Health Authorities disclosed any unplanned financial support.</p> <p>Apply the Better Payment Practice Code. No Strategic Health Authorities or Primary Care Trusts paid all bills within 30 days. However, 6 Strategic Health Authorities (21%) and 62 Primary Care Trusts (20%) paid 95% or more of bills within 30 days. The average number of bills paid within 30 days was 82% for Strategic Health Authorities and 85% for Primary Care Trusts.</p> <p>For Primary Care Trusts, to recover the full cost of their provider functions. A total of 22 Primary Care Trusts failed in this duty.</p>	<p>Break even each and every year. In 2003 04, 65 NHS Trusts failed to break even.</p> <p>Apply the Better Payment Practice Code. No Trusts paid all bills within 30 days. However, 59 Trusts (22%) paid 95% or more of bills within 30 days. The average number of bills paid within 30 days was 84%.</p> <p>Not to exceed the external financing limit set by the Department of Health. 16 Trusts overshot their external financing limit. The Department considers that only those Trusts who exceeded their individual limit by more than £10,000 have failed. On this basis 7 did so.</p> <p>Contain expenditure measured on an accruals basis, within approved capital resource limits. 15 of the 269 Trusts breached their capital resource limit. 10 breached their capital resource limit by more than the Departments' £50,000 de minimus limit.</p> <p>Absorb the cost of capital at a rate of 3.5 per cent. The average return was 3.6%. 91 Trusts did not achieve a 3.5% return on capital.</p>

- The legislation does not specify how the statutory duty to break even, taking one year with another, should be measured. The Department therefore bases its assessment on a method agreed in consultation with the NHS Trusts and their auditors.
- Where an NHS Trust reports a cumulative deficit, the duty is met if this deficit is recovered within the following two financial years.
- Exceptionally, extensions of up to a total of four years can be given to NHS Trusts, for example where recovery over two years would have unacceptable service consequences and a recovery plan has been agreed with the Department.
- The Department determines break-even to be achieved if an NHS Trust has a cumulative deficit no greater than 0.5 per cent of turnover.

## ANNEX 3

### The NHS Bank

The NHS Bank is a mutual organisation of the 28 Strategic Health Authorities, with a Management Board drawn from Strategic Health Authority Chief Executives and Directors of Finance. Its purpose is to support NHS organisations in maximising the use of resources across the NHS and over different financial years. In 2002-03, the NHS Bank existed in shadow form and in 2003-04 is continuing as an advisory body.

2003-04 was the second year in which the NHS Bank was responsible for deciding how the Department's special assistance fund should be allocated to Strategic Health Authority areas managing particular financial difficulties. In 2003-04, £152 million of planned support was provided by the Department to four Strategic Health Authorities on the basis of recommendations from the NHS Bank. **Figure 25** shows the Strategic Health Authority areas receiving support via the NHS Bank, and the effect of this support on the reported aggregate outturn across the Strategic Health Authority area.

The support was paid to Primary Care Trusts who either retained it to fund their own expenditure or passed it on to NHS Trusts as additional income.

The support does not have to be repaid to the Department. It is shown in the accounts as an increase in the revenue resource limit for Primary Care Trusts or as an increase in income for NHS Trusts. The support is generally provided to NHS Trusts on the basis that it is not repayable.

**25** Strategic Health Authority areas receiving NHS Bank Support in 2003-04

Strategic Health Authority	Amount of support £ million	Aggregate outturn after support £ million	Aggregate outturn before support £ million
Avon, Gloucestershire and Wiltshire	70	(4)	(74)
Surrey and Sussex	40	(5)	(45)
Thames Valley	25	10	(15)
Kent and Medway	17	(5)	(22)

Source: Department of Health

Although NHS Bank support is not repayable, it is supplied with the expectation that the recipient organisations will require reduced funding in future. In practice, this means that future resource allocations will be reduced. The future reductions might be to capital as well as revenue resource limits. There is a clear expectation that the organisations receiving support will achieve recurrent cost savings to recover their financial position and be in a position to deal with the reduced future resource allocations.

**Figure 26 overleaf** shows the individual NHS organisations that received funds in 2003-04.

**26** NHS Organisations receiving NHS Bank support in 2003-04

<b>Organisation</b>	<b>Support £ million</b>
Avon, Gloucestershire, and Wiltshire Strategic Health Authority Area	
North Bristol NHS Trust	18.1
Royal United Hospital Bath NHS Trust	10.0
Avon, Gloucestershire and Wiltshire Strategic Health Authority	10.0
Swindon Primary Care Trust	7.0
Bristol South and West Primary Care Trust	5.0
Kennet & North Wiltshire Primary Care Trust	3.9
United Bristol Healthcare NHS Trust	3.8
Bath & NE Somerset Primary Care Trust	3.0
North Somerset Primary Care Trust	2.8
South Wiltshire Primary Care Trust	2.0
West Wiltshire Primary Care Trust	1.9
South Gloucestershire Primary Care Trust	1.7
Bristol North Primary Care Trust	0.8
<b>Total for area</b>	<b>70.0</b>
Surrey and Sussex Strategic Health Authority Area	
Ashford & St Peters NHS Trust	18.7 <sup>1</sup>
Royal Surrey County NHS Trust	7.3
Surrey & Sussex NHS Trust	5.9
Brighton & Sussex University Hospitals NHS Trust	3.5
Frimley Park NHS Trust	2.7
Guildford and Waverley Primary Care Trust	2.0
<b>Total for area</b>	<b>40.0</b>
Thames Valley Strategic Health Authority Area	
Oxford Radcliffe NHS Trust	25.0
Kent and Medway Strategic Health Authority Area	
East Kent Hospitals NHS Trust	17.0
<b>Total</b>	<b>152.0</b>

Source: Department of Health

**NOTE**

<sup>1</sup> The Department states that the difference from the figure of £18.5 million shown in the accounts is due to £0.15m paid to North Surrey Primary Care Trust, which was passed to Ashford and St Peter's NHS Trust as contract income.