

Health

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Learning the lessons from financial failure in the NHS

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Summary

This report focuses on the small minority of NHS trusts and primary care trusts (PCTs) which have experienced significant, and in some cases rapid, financial failure. It is not a commentary on the financial pressures that many NHS organisations are currently facing or on those with small deficits which may be a sign of more systemic problems. These issues are explored in our recent joint report with the National Audit Office (NAO), *Financial Management in the NHS 2004/05*. However, specific organisational issues can play a large part in whether the challenges that many experience develop into major problems for a small minority. Significant financial failure always starts with a deficit but most organisations with deficits do not go on to experience significant failure.

This report examines what lessons can be drawn from organisations that have failed and what management action might prevent such failure in the future or aid recovery. We reviewed recently issued public interest reports and independent reviews in some detail to identify common themes and trends. We particularly focused on the 25 public interest reports issued by auditors in 2005/06, which all expressed serious concerns about NHS organisations' financial standing. Not all the factors leading to financial failure identified in the report were experienced by each of the organisations we reviewed. But we found a considerable degree of consistency, suggesting that lessons from past failures, if understood and acted upon, can reduce the risk of future occurrence. Some lessons apply to individual organisations, some to the wider operation of the system. While NHS foundation trusts do not have accountability to strategic health authorities (SHAs) and the Department of Health, they will nevertheless recognise that the lessons for individual organisations apply equally to them. Therefore all NHS organisations could benefit from considering the lessons set out in this report.

A key theme from our review is that financial failure is inseparable from wider organisational failure. Financial problems are often thought to be isolated from other aspects of management but money can be a symbol of wider difficulties. Received wisdom is often that boards have concentrated on access targets and standards of patient care at the expense of financial discipline, or that quality lapses are caused by limited funding. Neither is correct. Boards have a responsibility to balance financial performance, achieve access targets and appropriate standards of quality and safety. We found that the re-introduction of sound governance, financial, corporate and clinical, following a failure can result in an improvement in patient care.

We found that the origins of financial failure in the organisations we reviewed typically lay in ineffective management and weak or inadequate board leadership. The report identifies three crucial aspects of board-level culture that suggest trouble may be ahead:

- inadequate calibre of leadership, particularly in the key posts of chief executive and finance director;
- lack of board cohesion and inability to challenge, frequently compounded by a high turnover of board directors, both executive and non-executive, impeding the board's ability to work effectively as a team; and
- the board's eye being off the ball. We found this typically meant the board had other time-consuming business: the after-effects of a merger (or the preliminary stages of the next one), a large building project, responsibility for a shared service or consortium, or any combination of these.

These factors were often compounded by weaknesses in the information available to the organisation, particularly in financial monitoring and the forecasting of the year-end position.

Some boards surrendered to the view that the problem lay elsewhere within the local health system, usually on the other side of the commissioner/provider divide. Others looked for future funding increases to resolve their difficulties, with some NHS trusts believing that Payment by Results (PbR) will mean significant and justified income growth even if it is known that the local commissioners also have a deficit. The effect is for the organisation and its management to believe they are not in charge of their own destiny, waiting for external solutions rather than searching out internal improvements.

Even where boards operate better, operational problems were separated from financial ones with the finance director expected to solve them. Increasingly, this led to a reliance on short-term fixes: asset disposals, slippage and the use of non-recurrent funds to cover recurring (and growing) deficits, and borrowing from other NHS organisations. Finance directors rose to the challenge, but the results were damaging in the medium term with underlying imbalances not being addressed. The withdrawal of brokerage and other measures has led to increasing transparency in the reality of organisations' financial position, which some have been poorly placed to meet. Financial problems are operational ones. They require cost structures, service design and productivity to be addressed in detail.

We also found, among this small minority of organisations we reviewed, a tendency for the medical leadership and other senior clinicians to be disengaged from the core management processes of the trust. This dislocation, if allowed to continue over a period of years, appears to be a reliable indicator of impending financial trouble. It is, after all, clinicians who spend most of the NHS's money.

We encountered a common view that in some PCTs management capacity and capability had been weak from when they were first created, leaving a legacy of mediocre management. Trusts sometimes also attributed their difficulties to the actions of the local PCTs, thereby externalising the problem. Whatever the merits of individual cases, we noted a marked absence of explicit financial analysis underpinning key commissioning decisions. This tends to fuel mistrust among providers and is a cause for concern. There is also little experience of success in turning round PCTs that have experienced significant failure. This is partly because PCTs are relatively new. More importantly, however, the majority of their funds are committed to contracts with external providers that often cannot easily be changed without changing the way in which treatment and care is delivered and by influencing GP referral patterns. Experience gained in returning to recurrent financial balance and recovering significant PCT deficits needs to be widely shared.

NHS organisations sometimes attributed their deficit to the actions of their SHA in parking responsibility for a health community's financial problem with an individual organisation for convenience, rather than on the merits of the case. Some organisations may be right in this view. But the net result has been to reduce the sense of accountability of individual organisations for their financial position. It has been possible for health economies to take shelter within historically opaque, and sometimes complex, financing arrangements and attribute blame to each other. Current performance management and financing systems have not proved effective either. All the organisations involved in our study were submitting regular financial and performance information up the line to the SHA and Department of Health. And all board members were subject to some form of assessment and appraisal.

Perhaps unsurprisingly we found that in the organisations we visited the route to effective recovery appeared to lie in reversing areas of weakness. The general immediate pathway can be summarised as:

- the improvement of management capacity and capability, sometimes by the replacement of key personnel;

- recognition of the problem and the implementation of internal measures to address it rather than looking for external solutions;
- the undertaking of immediate measures to curb expenditure, sending a signal that the management team is back in charge;
- imposition of tight accountability structures and processes, often coupled with the creation of a cadre of senior clinicians committed to the organisation's survival and willing to take on budget management responsibilities; and
- in short ensuring that the basics of good financial management are in place, including the provision of accurate financial information and the re-introduction of financial control. The findings of internal and external auditors should be reviewed to ensure that any weaknesses are addressed.

For the medium to longer term, improving the information available to the organisation and strengthening risk management, including internal audit, are important. More radical and extensive reconfiguration of services may also be needed where they are poorly placed to meet healthcare needs with the money, staff and buildings available. These problems cannot be avoided. But reconfiguration is not a substitute for sound local management. Sound local management must come first, reconfiguration can then follow.

Recommendations

The report makes a number of recommendations for NHS bodies, the Department of Health, the NHS Appointments Commission and internal auditors. We have also identified a number of financial, governance and local environmental indicators that can point to risk of failure. These indicators are set out in **Box A, overleaf**. When using the indicators it must be recognised that no one indicator is crucial: it is the composite effect that is important, along with the direction of travel and rate of change.

Box A

Financial performance

The indicators need to be considered in absolute terms and in comparison with peer groups, but perhaps most importantly how, and how fast, they change over time. A reasonable set of indicators might be:

- ratio of financial support received (either resource or cash) to total income;
- ratio of non-recurrent income to total income;
- ratio of current assets to current liabilities;
- performance against the Better Payments Practice Code;
- ratio of number and value of invoices raised being queried to total number and value of invoices raised;
- rate of increase in projected deficit;
- rate of increase in exchequer expenditure – irrespective of apparent availability of income to support expenditure; and
- unidentified savings as proportion of total budgeted spend. This relates to the proportion of expenditure still outstanding at different stages of the financial year.

Governance

It is important to identify signs of deteriorating corporate governance that indicate a potential for failure. A reasonable set of indicators might be:

- failure to act after previous audit concerns about financial standing or financial management;
- failure to set and agree budgets to a clear, routine annual timetable;
- evidence of senior clinicians being dislocated from the formal management structure and not owning financial recovery plans;
- an organisational history of failing to deliver cost improvements or of heroic assumptions being made on what can be delivered based on previous performance;
- poor establishment controls, demonstrated by rapid increases in either permanent or temporary staff; and

- turnover of more than two director-level posts (or the same post turning over more than once) within the past year or vacancies for significant periods.

Environmental

It would appear important to have indicators of factors in an organisation's immediate environment that leave it more prone to failure. On the basis of our research these might reasonably be:

- a significant proportion of service level agreements not finalised;
- a forthcoming organisational merger, or a significant merger within the last two years;
- current participation in a very large capital building project; and
- leadership of a significant consortium on behalf of other NHS organisations.

Source: [Audit Commission](#)

There are also some lessons for the Audit Commission and its appointed auditors. These include continuing to ensure that auditors' warnings about their concerns over an organisation's financial standing or governance arrangements are both timely and clearly expressed. The research undertaken for this report and its key findings will help to inform the Commission's work on reviewing the financial management and accounting regime in the NHS.

For the boards and executive management of all NHS bodies

- The risk indicators described within this report should be regularly reviewed as a key tool for identifying risk of financial failure.
- Structured training and support for non-executives and executives, individually and as a group, should be undertaken to enable them to become more effective in their roles and offer constructive challenge within the board.
- The new *NHS Audit Committee Handbook* should be rigorously adopted. It includes a number of important recommendations that strengthen NHS audit committees, broaden their remit and ensure a focus on strong financial management.
- Decisions to undertake shared service or consortium leadership responsibilities, unless trivial, should always be a matter for board decision and should always be based on an objective analysis of financial and corporate governance risk.

- In organisations where a finance director undertakes other major organisational responsibilities (such as information management, performance management and commissioning) the board should explicitly consider whether they may be distracted from carrying out their core role and, if necessary, take steps to ensure that this is not the case.

For the boards and executive management of NHS trusts

- Senior clinicians should form part of the mainstream budget holding and budgetary accountability structure of all NHS trusts.

For the boards and executive management of PCTs

- Notwithstanding the introduction of practice based commissioning, the principal business of PCTs should always be seen as commissioning. This is because of the very material resources at risk within commissioning portfolios and the long-term commitments that commissioning entails.
- PCTs should publish the financial rationale underpinning all significant changes in commissioning policy and all commissioning decisions involving the investment of significant new resources, alongside any consideration of social or clinical issues.

For SHAs and the Department of Health

- The metrics for assessing in-year financial performance should be reviewed alongside how they should trigger performance management action. Earlier, sharper intervention would have helped in a number of cases.
- SHAs should introduce, where they have not already done so, systems for ensuring the accuracy of the monitoring returns by PCTs and NHS trusts.
- SHAs should routinely compare the income assumptions of NHS providers within their boundaries with the spending assumptions of NHS commissioners, and actively pursue resolution of any material differences alongside prompt closure of service level agreements.
- When mergers of NHS organisations are expected to achieve significant financial savings, the financial analysis and timescale supporting these expectations are made public during the consultation process.

- The burden placed on NHS management capacity by large building projects, and by private finance initiatives (PFIs) in particular, should be explicitly recognised. How the risks to effective management of the whole organisation will be addressed should form a key criterion for judging whether intended schemes should proceed.

For the NHS Appointments Commission

- Consideration should be given to how a faster appointment process for new non-executive directors, working within time limits that recognise the potential exposure of NHS bodies with board-level vacancies, could be achieved. Ideally any non-executive vacancy should be filled within a maximum of three months when prior notice of departure is given. We also recommend that these time limits continue to apply during periods of significant organisational change.
- Swift action should be taken to replace chairs and non-executive directors from boards where it is clear that there has been a failure of governance. The relevant legislation may need to be reviewed to enable such action to be taken.
- The assessment and appraisal process that occurred in those organisations which have failed financially should be reviewed in order to determine what lessons can be drawn for the system as a whole.

For internal auditors

- An active and ongoing review of the actions being taken by management to address the financial standing concerns should be maintained throughout the year, using the indicators presented in this report to highlight areas of risk and the effectiveness of management action.
- Concerns about financial standing, including highlighting any reluctance or delay on the part of management in implementing recommendations that affect financial standing should be regularly discussed with external auditors.

1

Introduction

Financial deficit and financial failure

- 1 In recent months we have seen increasing public concern about the prevalence of financial deficits in NHS organisations and, in some cases, across whole health systems.
- 2 The environment in which NHS bodies operate has always been complex, and boards and managers have always had to decide between competing priorities. Increased investment has come with expectations that patient access to treatment and care will improve. At the same time, increased competition and patient choice have introduced new areas of uncertainty and financial risk for providers. However, this complexity in no way diminishes the statutory duty of NHS trusts and PCTs to break even.
- 3 In spite of the very significant levels of government funding that the NHS has received over the last three years, a pattern of NHS trusts and PCTs failing to achieve financial balance has persisted and become more marked. A financial deficit does not, however, imply that financial failure is imminent. All financial failures begin with a deficit; not all deficits end in financial failure.
- 4 This report focuses on the small minority of NHS organisations that have failed financially. It examines what lessons can be drawn from organisations that have failed and what management action might prevent such failure in the future or aid recovery.

What constitutes financial failure?

- 5 For the purposes of this report, financial failure should be taken to mean where an organisation has experienced a rapid or major deterioration in its financial position or has consistently failed to address growing overspending resulting eventually in the position becoming unsustainable. In some cases the organisation has been unaware of its financial position or that it was deteriorating. One pragmatic sign of when an organisation may be deemed to have failed or be failing is the issue, by the organisation's external auditors, of a public interest report outlining concerns about financial standing.

Box B

Public interest reports

In the course of audits, under the Audit Commission Act 1998, auditors must consider whether to issue a report in the public interest. Section 8 of the 1998 Act states:

‘In auditing accounts required to be audited in accordance with this Act, the auditor shall consider:

- (a) whether, in the public interest, he should make a report on any matter coming to his notice in the course of the audit, in order for it to be considered by the body concerned or brought to the attention of the public; and
- (b) whether the public interest requires any such matter to be made the subject of an immediate report rather than a report to be made at the conclusion of the audit.’

While public interest reports can in principle raise a broad range of issues, the power is most frequently used when there are concerns about the financial standing of an NHS body.

Source: Audit Commission

- 6 The number of public interest reports has increased markedly over the last two years and includes health economies as well as individual organisations. In 2004/05, four reports were issued (Mid Yorkshire Hospitals Trust, September 2004; Hammersmith and Fulham PCT, December 2004; Bedfordshire Heartlands PCT, March 2005; and Surrey and Sussex Healthcare NHS Trust, March 2005). In 2005/06, the total number of public interest reports issued by auditors was 25 (**Table 1, overleaf**). This increase was influenced by guidance to auditors clarifying their responsibilities (**Ref. 1**).

Table 1**Public interest reports issued by auditors for NHS trusts, PCTs and SHAs in 2005/06**

NHS trusts	PCTs	SHAs
Royal West Sussex (June 2005)	North Somerset (July 2005)	Hampshire and Isle of Wight (July 2005)
South Tees Hospitals (June 2005)	New Forest (July 2005)	Thames Valley (July 2005)
Weston Area Health (July 2005)	Kennet and North Wiltshire (July 2005)	Surrey and Sussex (December 2005)
Shrewsbury and Telford Hospital (July 2005)	Hounslow (August 2005)	
Southampton University Hospitals (July 2005)	West Wiltshire (August 2005)	
Royal Wolverhampton Hospital (September 2005)	Selby and York (September 2005)	
Scarborough and North East Yorkshire (November 2005)	Hillingdon (November 2005)	
Trafford Healthcare (November 2005)	Cambridge City and South Cambridge (December 2005)	
Queen Elizabeth Hospital (December 2005)	Cheshire West (January 2006)	
Maidstone and Tunbridge Wells (January 2006)	Suffolk West (February 2006)	
North Tees and Hartlepool (January 2006)	East Suffolk (covers Central Suffolk, Ipswich and Suffolk Coastal PCTs) (February 2006)	

7 **Table 2** sets out the financial performance of these PCTs and NHS trusts over the past three years. The reported in-year financial position for these organisations has generally worsened over the past three years with a corresponding increase in the financial support received in-year.

Table 2**Financial history of NHS trusts and PCTs with public interest reports issued in 2005/06**

Organisation	Reported surplus/(deficit) for year (£000)			Financial support ¹ received in year (£000)		
	2002/03	2003/04	2004/05	2002/03	2003/04	2004/05
North Tees and Hartlepool NHS Trust	23	6	66	750	4,000	6,500
Royal West Sussex NHS Trust	(1,349)	(3,572)	(15,483)	0	2,600	0
Royal Wolverhampton NHS Trust	457	(7,612)	(9,016)	0	0	0
Scarborough and North East Yorkshire NHS Trust	32	62	(4,506)	3,400	3,500	1,800
Shrewsbury and Telford NHS Trust ^{II}	–	(418)	(10,115)	–	5,316	9,157
Southampton University Hospital NHS Trust	160	(5,418)	(11,579)	0	2,950	6,900
South Tees NHS Trust	74	(1,712)	(8,898)	3,400	5,950	12,000
Trafford Healthcare NHS Trust	2	(744)	(3,490)	1,720	1,800	2,989
Weston Area Health NHS Trust	(190)	(1,514)	(5,154)	1,872	0	0
Maidstone and Tunbridge Wells NHS Trust	(4,040)	(8,968)	87	520	0	9,700
Queen Elizabeth Hospital NHS Trust	7,213	917	(9,186)	7,200	8,000	4,473
Cambridge City PCT	577	(2,881)	(7,621)	0	0	2,400
Central Suffolk PCT	5	(1,831)	(3,837)	0	0	1,000
Cheshire West PCT	4	105	(548)	0	1,820	7,613
Hillingdon PCT	22	(672)	(13,470)	0	0	0
Hounslow PCT	(1,599)	(373)	(6,171)	0	2,500	0

Continued overleaf

Organisation	Reported surplus/(deficit) for year (£000)			Financial support ¹ received in year (£000)		
	2002/03	2003/04	2004/05	2002/03	2003/04	2004/05
Ipswich PCT	(413)	(5,598)	(10,119)	0	0	2,184
Kennet and North Wiltshire PCT	671	(2,067)	(10,159)	7,200	9,400	5,411
North Somerset PCT	251	(1,452)	(5,202)	3,067	2,905	0
New Forest PCT	10	(1,326)	(8,592)	0	2,000	3,500
Selby and York PCT	52	7	(6,598)	0	0	2,500
South Cambridge PCT	1,357	6	(2,583)	0	0	4,700
Suffolk Coastal PCT	(432)	(3,480)	(6,174)	0	0	1,700
Suffolk West PCT	(1,581)	(4,423)	(12,510)	0	0	0
West Wiltshire PCT	1,471	37	(2,803)	1,650	3,683	1,809
Total	2,777	(52,921)	(173,661)	30,779	56,424	86,336

Note I: Financial support is defined in the Department of Health's Manual for Accounts as 'additional income during the year, provided wholly to assist in managing financial problems'. Therefore, without receipt of financial support the reported position would be worse. Since 2004/05 there has been a requirement for financial support to be disclosed in the accounts. Planned financial support for 2002/03 and 2003/04 has therefore been identified from public interest reports and annual reports and may not be complete.

Note II: Shrewsbury and Telford NHS Trust did not exist in its current form in 2002/03.

Source: Audited accounts, public interest reports and annual reports

- 8 The aggregate overspend for all NHS bodies (including foundation trusts) for 2004/05 was £251.2 million (**Ref. 2**). The deficit for the 25 NHS bodies in the above table amounts to £173.7 million in 2004/05 (approximately 70 per cent of the total net overspend).

- 9 There has been much discussion about the application of the resource accounting and budgeting (RAB)¹ regime to NHS bodies and in particular the issue of double deficits for trusts. Our review of those organisations set out in **Table 2** and their financial performance from 2002/03 to 2004/05 indicates that not all the trusts had their income reduced in the year following a deficit and, of those that did, most of them received financial support to cover the reduction either in part or in full. What is clear is that the application of RAB did not cause the financial problems of the organisation we reviewed, but it may have made it more difficult for some to achieve financial balance in the years following the organisation incurring a significant deficit, particularly where there was no compensating receipt of financial support. As part of the Commission's review of the NHS financial management and accounting regime we will be exploring how RAB is implemented in the NHS and the merits of passing the income reduction down to individual NHS bodies.

Roles and responsibilities

- 10 All the NHS organisations covered by this report are statutory bodies in their own right, constituted in accordance with statute and within a framework of formal accountability to the Secretary of State for Health.
- 11 The board of a statutory NHS body has a duty to ensure that business is conducted in accordance with law, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. Its chairman and non-executive directors are responsible for monitoring the executive management (**Ref. 3**), and are held to account by the Secretary of State in discharging this responsibility. They are appointed by the NHS Appointments Commission, which also operates a system of performance appraisal for each individual chair and non-executive director.

¹ RAB is the financial management framework in place across central government. The Department of Health applies the principles of RAB to the NHS. In summary, if a trust reports a deficit in one year, its income is reduced by that amount the following year. In addition to affecting the following year's income, the trust's in-year deficit is posted to the balance sheet and carried forward to future years to give a cumulative position. This cumulative position is used to assess whether the NHS trust has achieved its statutory duty to 'break even taking one year with another'. The combination of a carried forward cumulative deficit and a reduction in income the following year is often known as a double deficit. Further details on RAB and its application to NHS bodies are contained in the NAO/Audit Commission report *Financial Management in the NHS 2004/05* (**Ref. 2**).

- 12 There is also a specific requirement for an audit committee to contribute independently to the board's overall process for maintaining efficient and effective internal control and risk management.
- 13 The chief executive of a statutory NHS body is responsible to its board for the management of the organisation. In addition, as accountable officer, the chief executive is responsible for the proper stewardship of public money and assets within the organisation. It is a requirement that the executive directors will include a properly qualified finance director to support the chief executive in undertaking these duties.
- 14 It follows that accountability for financial management and financial failure in NHS bodies rests squarely with the board of that body. It is the duty of each NHS body to ensure that proper governance structures, financial systems and reporting processes are in place for the discharge of their accountability including performance management, audit and risk management arrangements. This duty falls equally on all members of each board, whether executive or non-executive.
- 15 The responsibilities of auditors in respect of NHS organisations are derived from statute, principally from the Audit Commission Act 1998, and from the Commission's *Code of Audit Practice (Ref. 4)* covering the audit of local NHS bodies. Auditors are required to audit the financial statements and give their opinion, including:
 - whether they give a true and fair view of the financial position of the audited body and its expenditure and income for the year in question;
 - whether they have been prepared properly in accordance with relevant legislation and applicable accounting standards; and
 - for SHAs and PCTs, on the regularity of expenditure and income.
- 16 Auditors also review whether the statement on internal control has been presented in accordance with relevant requirements; and have a responsibility to satisfy themselves that audited bodies have put in place proper arrangements to secure economy, efficiency and effectiveness in their use of resources. In meeting this responsibility auditors review and, where appropriate, examine evidence that is relevant to the audited body's corporate performance management and financial management arrangements and report on these arrangements.

- 17 Auditors must maintain their independence from the bodies that they audit and consequently the audit role cannot include providing financial advice or consultancy to the audited body. Auditors do not act as a substitute for the organisation's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.
- 18 The responsibilities of SHAs in respect of system management are:
- acting as banker for PCT reserves, including responsibility for meeting overall financial control totals for their areas;
 - performance management;
 - organisational and system development, including the full implementation of system reform, the term used to describe the introduction of PbR, NHS foundation trusts, patient choice and other measures;
 - approval of business cases for capital development within delegated limits;
 - arbitration between NHS trusts and PCTs where necessary; and
 - oversight of mergers, including ensuring effective processes of engagement and consultation (**Ref. 5**).

There is widespread acceptance of these roles and responsibilities, but financial failure still occurs.

Methodology

- 19 We approached our research for this report in the following way:
- We reviewed recent public interest reports and independent reviews in some detail, identifying what appeared to be common themes and issues.
 - We identified a list of 12 organisations where we felt further, more detailed investigation might prove useful. We chose a representative mix of NHS trusts, PCTs and SHAs, including organisations from the same geographical area so that we could examine the whole health economy dynamic.
 - We then invited those organisations to take part. One NHS trust declined, on the basis that it was the subject of a forthcoming independent review and hence our

investigation might be inappropriate; and one PCT delayed participation on account of local merger pressures. All other organisations took part wholeheartedly.

- We interviewed a total of 40 senior people from the chosen organisations and their stakeholders. These included current and former chief executives, finance directors, chairs, chairs of audit committees and other non-executive directors, clinical staff, and internal and external auditors. The precise mix was left to the individual organisation. Nearly all interviews were conducted face-to-face; in a few instances we used telephone interviews.
 - We analysed a variety of written material from the organisations in question, including board reports, audit committee agendas and minutes, and the work programmes of internal and external auditors. Our prime objectives were to ascertain the priorities to which organisations appeared to be working; assess the adequacy of the financial information on which decisions were based; and review the effectiveness of management interventions.
 - We identified and interviewed a number of people, with backgrounds in health service management, service improvement and in academic research, each of whom had specific expertise in the field.
- 20 When considering the information collected from the interviews, we have been mindful of the fact that generally the views received were from those individuals new to the organisation concerned and who were therefore not in post at the time of the failure. We are aware of the tendency for individuals to criticise their predecessors and have balanced that by seeking the views of people in post at the time of the failure, independent sources (such as internal and external auditors) and the available documentation.
- 21 We then drew together information and views from all the above sources to produce our own analysis and report. It should be noted that not all the factors leading to financial failure identified in the report were experienced by each of the organisations we visited.

Structure of this report

- 22 The Commission's discussion paper *World Class Financial Management* (Ref. 6) is structured around five key themes of financial management:
- financial governance and leadership;
 - financial planning;
 - finance for decision making;
 - financial monitoring and forecasting; and
 - financial reporting.
- 23 We have used these themes, with their broad correspondence with the annual financial cycle, to organise the various lessons that have emerged from our research. Financial failure often appears to find its roots in the deterioration in one or more of the above, and structured review of performance in each area, including the use of the indicators proposed in Chapter 3, offers a potentially useful early warning of the risk of failure. Similarly, the climb out of financial failure often appears to begin with concrete action in a number of these categories, particularly in financial governance and leadership and in the reporting systems that underpin it.
- 24 We also draw conclusions and make recommendations that apply to specific types of NHS organisations, and to the ways that local health communities and health systems work together as a cohesive whole.
- 25 Finally, it is important to remember that financial failure in the NHS is relatively rare – in any system with some 600 organisations a small minority are perhaps inevitably likely to be in financial difficulty. Our report also looks at the history of some organisations. It is not a commentary on their current financial position or their current capacity or capability.

2

Learning the lessons from financial failure

Financial governance and leadership

- 26 The quality of financial governance and leadership within an organisation is critical to its success or failure. The principal cause of an organisation failing financially is the absence of adequate financial leadership and the failure of good financial governance. In the words of *World Class Financial Management*, ‘good basic systems, processes and controls are also important, but it is the overall financial culture of the organisation that really makes the difference’ (Ref. 6).
- 27 Our research suggests that this overall financial culture revolves, in practice, around three key aspects:
- the calibre, credibility and commitment of those accountable for financial strategy and governance, particularly the chairman, chief executive and finance director;
 - the ability of the board as a whole to operate cohesively and offer constructive, supportive challenge on financial matters; and
 - the extent to which the board and top management are distracted by other apparent priorities, allowing financial performance to drift.
- 28 Weakness in any of these areas contributes significantly to risk of failure.

Calibre of leadership

- 29 When interviewing NHS trusts recovering from financial failure, we regularly encountered a belief among new executive teams and also among non-executives, clinicians and auditors that the previous management team had in some way lost its grip of the organisation. In nearly every case, the former management team of the organisations we visited was no longer in place. We frequently heard that the previous directors, often appointed during the 1990s had skills that were adequate and effective in the NHS culture at that time, but which could not cope with the challenges of the current NHS.
- 30 New executive teams perceived, in several of the organisations we visited, that before their arrival, struggling executives were left for too long without adequate support and investment, nor were they subject to proper performance management and holding to account.

- 31 Among the successor management teams in failed PCTs, we frequently found a consensus that the previous management was of insufficient calibre for the challenges facing the organisation, and a belief that this was in some way inevitable given the circumstances in which PCTs were formed and their top teams recruited. Previous chief executives and finance directors in particular were seen as not up to the demands placed upon them, either in terms of their breadth of knowledge and experience, their managerial expertise, their status and influencing skills, or any combination of these.
- 32 Conversely, within organisations recovering from financial failure, we noted a perception, especially among non-executive directors and senior clinicians, that management had now got a grip. This new-found managerial strength generally brings respect, especially where it is driven by values centred on improved patient care. In several organisations, clinicians were perfectly clear in attributing successful recovery to firm management.

‘We were burying our head in the sand. We’d lost our feedback loop – we knew we’d lost it but there was so much going on. The choices had to be made. It was a fair and open process, and now we’re getting a better handle on clinical information too – what we’re spending the money on.’

Associate Medical Director, NHS trust

‘The mood of the organisation has moved from denial, “we’re not overspent, but under funded”, to constructive engagement in the recovery plan process. Clinical chiefs are represented on the Recovery Plan Steering Group and recently volunteered their own perspective and new ideas, so demonstrating their complete commitment to the process.’

An acute NHS trust Service and Financial Recovery Plan

- 33 We observed that re-imposing managerial control was often associated with an improvement in other key aspects of organisational performance. There is a perception in some quarters that NHS bodies, faced with numerous and sometimes conflicting targets, need to juggle and prioritise between them; and that if financial equilibrium takes a lower priority than, for instance, patient access, that may be a reasonable trade-off in some local circumstances. This view of NHS management suggests that improving the quality of the patient experience generally entails extra, unaffordable cost. This is not the case.

- 34 In one organisation that we visited, financial failure was accompanied by failure to achieve access targets and breakdowns of clinical care quality. This has also occurred elsewhere.

‘In 2003, the Healthcare Commission had identified failings in the PCT in meeting key NHS targets: financial management, outpatient waiting times, total time in A&E, inpatient waiting times.’

Public interest report, Kennet and North Wiltshire PCT, July 2005

At some of the NHS trusts we visited the re-imposition of sound governance and accountability structures, which typically form an early stage on the route to financial recovery, led to an immediate improvement in other aspects of organisational performance.

- 35 At Mid Yorkshire Hospitals NHS Trust, a Healthcare Commission review of gastroenterology services led to the imposition of special measures in December 2004 (now withdrawn). This occurred while the Trust was already in very serious financial difficulty. The Trust had received a zero star rating for two consecutive years and was failing to meet headline access targets. Performance in these areas improved, not worsened, as financial governance tightened.
- 36 Good financial governance forms a coherent whole with good corporate governance and good clinical governance.

‘Financial issues cannot be considered in isolation of other service and performance issues that the Trust is facing and also a long-term approach is required to deliver sustainable improvement.’

An acute NHS trust Service and Financial Recovery Plan

Board cohesion and ability to challenge

- 37 We found that, within NHS trusts, a frequent factor pointing to an increased risk of financial failure is the departure of a high-profile, long-established and often charismatic organisational leader. Often this individual had become virtually synonymous with the organisation within the local NHS and within the local news media.

‘The former chief executive had charisma and respect – he saw the big picture very well and he often succeeded. That’s his picture downstairs in the entrance’.

Audit manager

38 Among the short-term consequences of such a departure we found:

- a vacuum among other board directors, who, having become used to forceful leadership, are unaccustomed to critical challenge; and
- a reluctance to assimilate any bad news about the organisation, and particularly about its financial predicament. Some attribute this, with hindsight, to bad news being inconsistent with the carefully built image of the trust being a successful, expanding organisation.

39 In parallel, a further common factor suggesting increased risk is a churning of board-level staff following a period of relative stability. A consistent theme among NHS organisations facing financial failure appears to be a lack of stable, permanent appointments at chief executive and finance director level.

‘During the course of 2004, the PCT had a number of changes of leadership including three chairmen within the calendar year. The third of these chairmen, appointed after the decision to integrate the management teams of the PCTs, resigned with effect from July 2005...’

Public interest report, Cambridge City PCT, December 2005

40 The Higgs report, published in 2003, considered the governance responsibilities of boards and the role of the chair and non-executive directors in governing an organisation. The report was written with the private sector in mind, but nevertheless is relevant to public sector boards. It emphasised that non-executive directors should ‘constructively challenge and contribute to the development of strategy’ and ‘should satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible’ (Ref. 7). Effective boards need to display high levels of trust and challenge (Ref. 8).

41 The role of the non-executive director is vital for constructive challenge at board level. However, we heard in numerous failing organisations that board members simply did not have the skills or the knowledge to challenge the chief executive or the finance director on financial matters. Where the calibre of non-executive directors is, or has been inadequate, a culture of routine challenge of financial assumptions and financial performance is commonly visibly absent.

- 42 This weakness is compounded when the churning of board-level staff includes non-executive appointments. During periods of major change, such as mergers, non-executive vacancies can go unfilled for an extended period. While it is important that proper processes are followed when filling non-executive vacancies, it should not be forgotten that periods of strategic change are precisely when independent voices within the boardroom are most important.

‘The period of weak financial forecasts coincided with a reduced level of financial scrutiny by the Board because the Trust lost three non-executives...’

Public interest report, Weston Area Health NHS Trust

- 43 **We recommend** that:

- The appointment process for new non-executive directors is accelerated, so that organisations are not left with depleted boards for extended periods. We recognise the need for a thorough and open selection process for non-executive directors, but this must be balanced against the need for boards to work effectively. Where non-executive vacancies are known about in advance the aim should be to fill the vacant posts within three months. Seeking to keep to such a timetable is particularly important during periods of significant organisational change, when the need for effective non-executive directors is, if anything, greater.
- Swift action should be taken to replace chairs and non-executive directors from boards where it is clear that there has been a failure of governance. Our understanding is that the removal of non-executive directors on the grounds of poor performance can be a lengthy legal process. We recommend that the appointment processes are reviewed to identify whether there is scope for amending the arrangements for removal of non-executives where necessary.
- A review of the assessment and appraisal process that occurred in those organisations which have failed financially in order to determine what lessons can be drawn for the system as a whole.

- 44 If a potential source of weakness lies in non-executive directors who are unable or unwilling to challenge, the same applies to other executive directors. Although executive directors have voting rights and carry shared responsibility for decisions, there is frequently a culture of respect for professional turf and a reluctance to tread on board colleagues’ toes. Deference to the professional skills of the finance director mirrors a

similar deference within the board to the clinical expertise of the medical director and the director of nursing.

- 45 This respect can leave the finance director isolated. There is frequently an expectation that if the problem is financial in nature, the finance director will identify and deliver a creative financial solution. Moreover, many finance directors within the NHS accept this challenge willingly, taking some personal pride in engineering a financial fix to see the organisation across the fiscal year-end intact.
- 46 We found that this behaviour, sometimes described as talent at ‘playing the system’ and ‘having a deep back pocket’, commonly lies behind an organisation’s deterioration into financial failure, with a succession of short-term financial fixes eventually failing to disguise the fact that the NHS trust or PCT is living beyond its means.
- 47 **We recommend** board development programmes for both executive and non-executive directors that encourage supportive challenge within the boardroom. This needs to encompass both personal skills and knowledge, including corporate and clinical governance responsibilities, and team development. The programme should:
- be based on an annual self-diagnosis and review of board members’ individual strengths and areas of weaknesses, a summary of which informs the business plan;
 - comprise both individual development and team development; and
 - form part of the personal development plans of each non-executive and executive director.

Distractions

- 48 In a number of organisations we were told that, during the period immediately prior to financial failure, management had its eye off the ball. This prompts the question of where management had its eye at the time.
- 49 In the organisations we visited we found three areas of distraction consistently taking up a large amount of time, within the board as a whole and especially of the chief executive and finance director:
- a merger or reconfiguration, either of trusts or of sites and services within a trust;
 - a large building project; and
 - responsibility as host body for another, often substantial, NHS entity.

- 50 The risk of distraction is proportionately greater when the finance director has responsibilities that extend beyond finance. It is not uncommon, for instance, for the finance director of an NHS body also to be responsible for information systems, commissioning and contracting, procurement or estate management, or any combination of these areas. **We recommend** that the finance director role should not be burdened unreasonably with other major organisational responsibilities.
- 51 Merger and reconfiguration are facts of life within the NHS, as they are with many other public bodies. The ability of a forthcoming merger to distract management attention is widely acknowledged. However, they can also divert significant amounts of management time long after the formal process of the merger is complete. This is especially the case:
- when a merger of NHS trusts forms an administrative umbrella beneath which hospital sites, or specialties spanning more than one hospital site, are expected to consolidate; and
 - when financial savings are expected to be released as a consequence of a merger.
- 52 It is not uncommon for at least one entity going into a merger to have an underlying financial deficit which is either not transparent, or which is expected to be eliminated. This potentially places a new organisation in deficit from the outset.
- 53 Moreover, once the merger is processed and a deficit becomes apparent to its new owner, there is no effective ability to re-open negotiations or to trace what has happened, which leads to a lack of acceptance about the problem.

‘We know now that the hospital was £2.1 million adrift at the point of transfer. But accurate hard financial data quickly becomes hard to find. Staff go, so you can’t ask questions or backtrack. After the transfer, nobody wants to know.’

Vice-chair, NHS trust

- 54 In the commercial sector many mergers do not achieve their intended aims for a number of years and it is common for costs and inefficiencies arising from the merger process to exceed any planned short-term savings. If this is the case where organisations come together for overtly financial reasons, and responsible boards demand full due diligence checks before proceeding, it is perhaps unsurprising that mergers in the NHS take a considerable period of time to settle, and do not always achieve their savings targets. NHS mergers can be embarked upon without any transparent published financial analysis

in support of local reconfiguration plans. It is also unsurprising that mergers and reconfigurations, once under way, absorb a large amount of board directors' time.

55 We recommend that when mergers of NHS organisations are expected to achieve significant financial savings, the financial analysis and timescale supporting these expectations are made public during the consultation process. We would expect the relevant NHS boards to consider, and form a view on:

- the recurrent financial position of the pre-merger organisations;
- the feasibility of any financial savings;
- the cost (and opportunity cost) associated with the diversion of management effort; and
- the risks, whether corporate or clinical, associated with pursuing the merger.

These considerations should be formally minuted before any decision to proceed to merger is made.

56 We noted a marked correlation between the presence of a large building project, whether based on incremental growth of a hospital or a big bang approach to renewal via a PFI scheme, and a trust's decline into financial failure. This applies equally to PCT management of community hospitals.

57 This is no doubt due in part to the amount of senior time that such schemes demand. This is appropriate: it would arguably be irresponsible to delegate the handling of long-term strategic change to more junior staff. But we found evidence of boards giving priority to capital projects above the day-to-day running of the NHS trusts and the issues they were facing.

58 The burden is partially due to the extended period of time that the planning, designing and funding processes can take. Often the gestation period for a large building project covers many years, as a NHS trust prepares its healthcare service strategy encompassing existing facilities and sites, potential new locations and a complex, integrated transition path.

‘The Trust has for some time pursued a PFI scheme for the redevelopment of the New Cross Hospital site. The preliminary case for investing in improved buildings and facilities for acute services... was submitted... in December 2000... Since the SOC (strategic outline business case) there has been a great deal of change to the nature and cost of the scheme...’

Public interest report, Royal Wolverhampton Hospitals NHS Trust, September 2005

The PFI scheme was a fast way to get a big hospital built, but a huge distraction for key people. The chief executive, finance director and chairman were always in London...’

NHS trust clinical director

- 59 **We recommend** that the burden placed on NHS management capacity by large building projects, and by PFI in particular, is recognised. Management capacity and how the risks to effective management of the whole organisation will be addressed should form a key criterion for judging whether intended schemes should proceed. We would expect business plans that include the development of large capital schemes to incorporate:
- a proper assessment of the senior management time that planning the development is likely to consume in-year;
 - a statement on the opportunity cost for management;
 - a quantified risk analysis; and
 - details of how the risks will be addressed.
- 60 We also found recently completed capital building projects being blamed for driving unaffordable long-term expenditure levels, although this should be considered as part of the outline business case for the project. The attraction of the big building project, both to local NHS management and across the wider community, makes it difficult to withdraw from negotiations or reshape the vision once strategic approval has been gained and detailed discussions are underway. This carries a clear risk of commitment to spending levels based on optimistic future income assumptions, ambitious savings arising from improved operational efficiency, or both.
- 61 We noted a pattern of the responsibility for (often very substantial) support functions being assigned to an NHS body, under a sharing or consortium arrangement, without any matching transfer of management resources. It is often tempting for senior management

to take on such responsibilities. However, there is some evidence that leading a shared service or consortium can often be a material distraction. It also seems more likely, in most circumstances, to increase financial risk rather than offer an avenue for reducing it.

‘In addition, the PCT was the host of the Wiltshire Shared Services Consortium and commissioned its services from three separate areas. It had dealt with this agenda with a finance team that had suffered from vacancies and extended absences and inexperience.’

Public interest report, Kennet and North Wiltshire PCT, July 2005

- 62 We recommend** that decisions to undertake shared service or consortium leadership responsibilities, unless trivial, should always be a matter for board decision and should always be based on an objective analysis of financial and corporate governance risk. The shared service needs clear governance arrangements that work effectively and are understood by all partners.
- 63** A factor in the majority of the PCTs we visited was a tendency to focus on the provider rather than the commissioner role. This seems to be a particular risk where a majority of senior managers have come from a former community trust, that is, a provider organisation, rather than a former primary care group or health authority.
- 64** The principal business of PCTs is commissioning in view of the very material resources at risk within commissioning portfolios and the long-term commitments that commissioning entails. The creation of new PCTs and the development of fitness for purpose assessments provides an opportunity to reinforce PCT capability in this area. **We recommend** performance management of PCTs should focus mainly on commissioning.

Financial planning

- 65** One of the hallmarks of organisations approaching failure appears to be a breakdown of any meaningful strategic financial planning. The organisation, at senior level, begins to focus largely on short-term tactics to achieve financial balance.
- 66** Our research suggests that key risk factors surrounding financial planning are:
- a board and management team which believe the organisation’s problems to have been largely externally created and beyond their control;

- reliance on short-term financial fixes;
- reluctance to commit to key financial decisions such as timely budget-setting;
- a lack of engagement by clinicians in the organisation's main governance processes;
- an absence of sound review and failure to implement audit recommendations; and
- inaction pending the introduction of PbR.

The problem lies outside the organisation

- 67 Individual NHS organisations do not operate in a vacuum and are affected by the actions of other NHS bodies. In the organisations we reviewed some of the NHS organisations attributed their deficit to the actions of their SHA in parking responsibility for a health community's financial problem with an individual organisation for convenience, rather than on the merits of the case. Some organisations may be right in this view and there are examples to illustrate that problems have been created outside the organisations affected. In addition to this we found cases where there was an absence of sound strategic financial planning across local health economies.
- 68 In the organisations we reviewed it was not uncommon for there to be a belief that inequitable funding was the cause of the problem and for it to dominate the management culture of the organisation concerned. We found:
- an insistence that the root cause of a financial problem lay outside the organisation and elsewhere within the local NHS. In the case of NHS trusts this typically attributes blame to the local commissioning body and the way it uses its budget, though where a number of NHS trusts serve the same population, it can also take the form of assuming other NHS trusts receive an unjustified share of resources;
 - an associated belief that commissioners do not pay properly for the workload that hospital clinicians actually perform, but that crucially this injustice will in time be rectified by PbR and hence there is no need to take any action to reduce the trust's cost base in the interim; and
 - in the case of commissioners, a belief that local acute providers are manipulating activity data to justify claims for additional income, irresponsibly encouraging demand among patients for inpatient treatment and care, or both.

In each of the cases outlined above the effect is to render the organisation and its management as relatively powerless in the short term and not fully in charge of its own destiny.

- 69 Rather less common is an attribution of any financial injustice to national resource allocation policy and methodology. Although some point to funding formulae, suggesting they fail to recognise the particular pressures of their geographical region or specific local circumstances, it seems more common to assign blame to other local NHS bodies and the individuals who manage them.

Short-term solutions to underlying deficits

- 70 It has sometimes been possible to mask an imbalance between income and expenditure with one-off or short-term expedients:
- asset sales to raise cash (and similar means of raiding the balance sheet to generate short-term liquidity);
 - accounting adjustments that push the problem into the next financial year;
 - diverting non-recurrent resources to provide temporary financial cover; and
 - the receipt of financial support or ‘brokerage’.
- 71 Many NHS bodies have used these methods to achieve breakeven at the end of the year and therefore ‘good news today’ at the expense of sustainable long-term solutions.
- 72 Proper management of the NHS’s massive property portfolio has rightly been a prominent strand of financial policy for many years, and this has brought large gains in the form of more efficient asset usage and the release of land and buildings that are no longer needed for their original purposes. However, in an earlier environment of freer transfers between capital and revenue allocations, this led to a degree of reliance on non-recurrent income released through property disposals. As this source of income has been squeezed in recent years, because of a dwindling pool of surplus assets and through tighter policies on capital to revenue transfers, its absence has left some NHS organisations struggling to find a replacement.
- 73 Moreover, income from property sales has always been unpredictable in terms of both quantum and timing. Reliance upon it has also been inextricably linked to dependence on brokerage and similar financial devices when a gap between plan and reality begins to open up.

- 74 The NHS has also been able, for some years, to rely on slippage on new developments, both capital and revenue, to manage in-year financial pressures. Such tactics are possible in times of growth. An absence of credible strategic routes to financial balance, coupled with pressure within the overall NHS funding system to achieve a balance each year, has made slippage an intrinsic part of the system; indeed, prudent treasury management can mean introducing delays to capital schemes in anticipation of a need for slippage.

‘Between 2000/01 and 2002/03 the Trust was able to achieve its in-year breakeven duty as a direct result of being able to support its income and expenditure account by utilising revenue funding associated with capital schemes that had not come into commission. This is commonly referred to as ‘slippage’... The reduction in slippage and absence of other non-recurrent funding restricted the Trust’s ability to manage the underlying position and it consequently reported a £7.6 million deficit in 2003/04.’

Public interest report, Royal Wolverhampton Hospitals NHS Trust, September 2005

- 75 Non-recurrent funding is also occasionally released by the Department of Health during the financial year: sometimes with some form of earmarking. In acute NHS trusts with a strong local connection to the armed forces, for instance, the Iraq war was specifically mentioned as a source of readily available non-recurrent funding. Boards and finance directors have learned that success in bidding for such funds, the use of which is not always robustly monitored, is often a simpler method of achieving financial balance, rather than by the reduction of costs. However, reliance on non-recurrent funding to address underlying long-term problems is insidious and leaves an organisation vulnerable.
- 76 Finally, financial support from the Department of Health or from SHAs has been an intrinsic part of the NHS funding system. Much has been written about such support and brokerage and the culture of dependence that this creates. We found that in failing organisations the dependence on brokerage was absolute, with recovery planning focusing to an unhealthy degree on the precise profiling of future borrowing and the schedule of repayments.
- 77 The withdrawal of brokerage and other measures has led to increasing transparency in the reality of organisations’ financial position, which some have been poorly placed to meet.

Budgeting and financial planning

78 We found the following common attributes in organisations approaching financial failure:

- budgets that included significant financial assumptions, most notably on in-year efficiency savings or on income growth, which were unsupported by robust financial analysis or implementation plans and had little credibility, even within the organisation;

‘...In 2005/06 £37 million (24 per cent) of savings plans were not specified by June, in 2004/05 the figure was £21.4 million (15 per cent), and in 2002/03 £6 million (6 per cent).’

Public interest report, Surrey and Sussex SHA, December 2005

- a seeming inability to prepare a budget until the financial year is already in progress, thereby reducing the likelihood of bringing a savings plan to fruition. Late adoption of a budget contravenes the standing financial instructions of NHS bodies, yet is not uncommon;

‘For both 2003/04 and 2004/05 nearly all health organisations in Thames Valley finalised their budgets after the financial year had begun, with the majority being agreed during or after May of the year in question. Organisations were therefore managing their financial positions against a draft budget for the first quarter of the year; this undermines effective budget monitoring, management and reporting.’

Public interest report, Thames Valley SHA, July 2005

- the pattern, already noted, of a lack of constructive challenge at board level when adopting a budget; and
- significant unidentified savings, coupled with vague or heroic assumptions about the achievability of savings. **Table 3**, overleaf, shows the level of unidentified savings at the Kennet and North Wiltshire PCT in the early part of 2005/06. Note that allocating a savings target to a budgetholder or another organisation does not constitute identifying the saving: it still has to be achieved.

79 We also found it common for budgeting and financial planning to be disconnected from the other key planning functions of the organisation, including capacity and demand management, the planning of clinical activity and human resource management. Planning and budgeting should be linked directly to an organisation’s other strategic and corporate planning processes.

Table 3**Kennet and North Wiltshire PCT unidentified savings in early 2005/06**

Unidentified savings equate to material risk.

Savings scheme (some savings have not yet been identified)	£m
Changes in commissioning of healthcare services, eg, GP incentive scheme	4.4
Cost improvement schemes, eg, review of purchasing	3.4
Changes to managing patient demand of hospital services	2.8
Central savings, eg, holding and removing some vacant posts	2.6
Cash releasing savings – 1.7 per cent deducted from funds allocated to trusts	2.0
Cash releasing savings – deducted from budgets of the PCT's budgetholders	1.4
Unidentified – expected to be identified by 31 July 2005	1.9
Total	18.5

Source: Public interest report, Kennet and North Wiltshire PCT, July 2005**Engagement of clinicians**

- 80** In failing NHS organisations it is striking how often clinical leaders, whether organised in formal clinical directorates or under another management model, have become disengaged from the core management processes of the organisation. In numerous instances we found medical management structures that had no real accountability for resource usage, and had minimal identifiable overlap with the core business structures of the organisation.
- 81** Conversely, we found that where real financial recovery was beginning, the process is closely linked to the establishment of new medical management arrangements and the direct ownership of income and expenditure budgets by clinicians. In practice this typically involves in acute NHS trusts:
- a structure with a limited and manageable number of meaningful clinical directorates – typically less than ten in total;
 - a formal selection process for clinical directors, often involving competition within specialties;

- clinical directors becoming directly accountable to the chief executive and board for the financial performance of their budgets; and
- a set of supporting management and information arrangements to make clinical leadership a reality.

82 The importance of genuine clinical ownership of the financial situation cannot be overstated. **We recommend** management action to ensure senior clinicians form part of the mainstream budgetholding and budgetary accountability structure of all NHS provider bodies. While not wishing to advocate specific organisational structures or schemes of delegation, we would expect boards to:

- assess, and report on, the degree of engagement (as opposed to agreement) that senior clinicians demonstrate in respect of key corporate decisions;
- assess the capabilities of senior clinicians to fulfil budget management responsibilities and the action being taken by boards to remove any shortcomings, with reference to investment in clinical management skills, the inclusion within job plans of adequate management sessions, and the inclusion of business-related skills in personal development plans; and
- review the actual ability of senior clinicians to control expenditure and income within their spheres of management, by reference to the standing financial instructions and scheme of budgetary delegation in force.

Audit and continuous review

83 In soundly managed organisations, continuous review of organisational performance, and of the financial planning process itself, is accepted as standard practice. Essential components of continuous review include:

- an active role for both internal and external audit, and either prompt compliance with recommendations or prompt dialogue about their significance and usefulness;
- an active role for the audit committee, and a proactive style among its members; and
- processes and culture that support challenge from non-executive directors.

84 In the organisations we visited internal audit plans seemed appropriate given the circumstances of the organisation. We found evidence of internal audit drawing management's attention to risk of financial failure. Internal audit reports highlighting shortcomings in governance or in budgetary control were issued, and implementation of

their recommendations was considered at audit committee meetings. However, we found that the nature of internal audit plans, which typically provide a combination of systems coverage and reviews of key areas, means that financial standing can emerge as a by-product of other areas of investigation (such as budgetary control or income accruals). Moreover, we observed that successful influence seemed to depend heavily on the personal relationship between the head of internal audit and the executive management of the organisation (or, in one case, the chair of the audit committee) rather than the formal process – especially in organisations where the audit committee was relatively ineffective.

‘Audit can force the issue by a tracker system, reporting to the audit committee. We can escalate to the chair, and did so. The evidence was there in various audit reports, maverick purchasing, poor budgetary management – but ultimately it’s for management to take action.’

Head of Internal Audit, NHS trust

- 85 We recommend** that internal auditors (as part of their work on underlying financial systems and processes):
- maintain an active and ongoing review of the actions being taken by management to address the financial standing concerns throughout the year, using the indicators presented in this report to highlight areas of risk and the effectiveness of management action;
 - maintain a regular (at least quarterly) dialogue with external auditors on any concerns about financial standing, recording conclusions in writing and reporting them to the organisation’s audit committee; and
 - highlight to external auditors any reluctance or delay on the part of management in implementing recommendations that affect financial standing.
- 86** In every case we investigated, the issue of a public interest report was preceded by warnings from external auditors about the financial situation of the organisation, often over a period of many months. Yet it is noticeable that sometimes the issuing of a public interest report appears to have come as a shock to the non-executive directors and the board as a whole. It would appear that failure to comply with, or failure to fully comprehend the significance of, audit warnings about financial standing may in itself be a significant warning sign of approaching financial failure.

87 External auditors need to:

- ensure that they use plain words when issuing informal warnings of concerns about financial standing, in keeping with the seriousness of such messages;
- ensure that warnings of concerns about financial standing are issued promptly as soon as concerns become apparent, and include a deadline for action by the organisation (and for escalation if no action is evident); and
- make use of their right of direct access to boards, chairmen and chairs of audit committees should they feel their warnings are not being heeded.

88 In several of the organisations we visited, the new management described the former audit committee as disempowered, supine or moribund. The new *NHS Audit Committee Handbook* (Ref. 9) has a number of significant recommendations, including:

- frequency of meetings to be determined by business need;
- a more focused financial scrutiny role; and
- an extended portfolio of activities, encompassing review of all risk and disclosure statements and underlying assurance processes.

These should go some way to strengthening the audit committee role.

89 **We recommend** and support rigorous adoption of the new *NHS Audit Committee Handbook* (Ref. 9). Boards should monitor, and report on, the competence and effectiveness of the audit committee in line with the self-assessment checklist that forms Appendix B to the handbook. This consists of 57 specific criteria covering composition, establishment and duties; compliance with law and regulation; internal control and risk management; internal audit; external audit; annual accounts; administrative arrangements; and a range of other issues.

Payment by Results

90 PbR, the new tariff-based funding system for acute care, was only introduced in full for all organisations from 1 April 2006 although it has been operating for foundation trusts from 2004/05. It has therefore played little part in recent financial failures. However, the extra logistical demands of implementing PbR were a contributory factor to the financial problems at Bradford Hospitals NHS Foundation Trust. It has also contributed to strained relationships in one area which has experienced significant financial difficulty.

‘...Relationships between the PCTs and their main provider have been exceptionally challenging over the past year as all parties seek to come to grips with the challenge of successfully implementing PbR...’

Public interest report, Cambridge City PCT and South Cambridge PCT, December 2005

Overall, however, PbR should increase transparency and encourage greater efficiency as well as enabling commissioners and providers to have more straightforward discussions about activity and cost. Early experience of implementing PbR was fully discussed in our 2005 report *Early Lessons from Payment by Results* (Ref. 10).

- 91 However, the prospect of PbR has, in some cases, led to unreal expectations. Just as one of the props to which struggling organisations cling is a belief that they are underfunded, a common belief among failing organisations is that, in time, the PbR system will raise their income to ‘the level we have always deserved’.

‘PbR was going to solve the problem, according to some directors. But there just wasn’t enough money in the system to pay for everything that we were doing.’

New chair, NHS trust

- 92 This belief is commonly maintained even where it is plain that the whole local health system is struggling financially and that significant extra funds therefore are unlikely to be made available.

‘PbR will not lead to more resources nationally within the system and cannot be relied upon by trusts and PCTs to resolve the underlying financial problem. Instead it will lead to different ways of distributing resources within the economy.’

Public interest report, Surrey & Sussex SHA, December 2005

- 93 The belief that ‘PbR will give us the income we deserve’ is ultimately disabling, for it suggests no action to cut back the expenditure base of a failing organisation is needed. Its presence at senior level within any NHS trust increases the risk of financial failure.

Finance for decision making

- 94 The decisions an organisation takes determine its cost structure. Whether they relate to staffing and the cost commitment that comes with employment, or whether they involve fixed assets and equipment, it is vital that organisations:
- consider carefully the cost structures they are creating; and
 - understand the nature of their current cost base – its flexibility, its rigidity and the way that its costs relate to its activity.

- 95 We found that failing organisations typically:

- demonstrate a low awareness of the relationship between activity and cost, and often make little explicit linkage between their financial and their activity reporting systems;
- make key investment decisions on the basis of limited information; and
- do not use robust project management methods.

We also found that the quality and presentation of data within failing organisations is sometimes poor. Where there is a culture of taking decisions without sound information there is no incentive to improve data quality or presentation.

Costing and cost awareness

- 96 A common characteristic of many NHS organisations that get into financial difficulties is an absence of adequate understanding of costs and their relationship with clinical activity.
- 97 Costing remains a relatively undeveloped area in many NHS trusts and PCTs. This applies both at the level of cost behaviour and at the level of simple information about the cost of supplies, staffing and other aspects of care delivery. The use of reference costs and Healthcare Resource Group groupings as the basis of the new tariff, for all its deficiencies, has brought about a much keener understanding of the cost of individual procedures within hospitals, but the same understanding has yet to extend to the detail of NHS spending.
- 98 An inevitable consequence is that clinicians and administrative staff, working at the level where resources are committed, are frequently unaware of the costs of drugs, sterile supplies and other items of equipment, and have no means of making judgements about value for money. Lack of information linking actual cost with the commitment of resources is one of the particular hallmarks of organisations heading out of financial control.

‘Managers can’t save money on their own, and need to communicate with people on the shop floor opening packets of stuff. Look at how non-stock supplies are ordered: often by ward clerks who don’t see the implications. We centralised ordering with directorate managers, and told people why. Count the pennies.’

NHS trust divisional manager

- 99 We found that in one NHS trust that was making real inroads into its financial deficit, there had been a conscious, and very effective, strategy to let staff know the cost of everything.
- 100 The same applies to staff costs. Recovering organisations challenge all aspects of expenditure on staff, in detail, within directorates. One acute NHS trust particularly encourages lateral thinking about getting the maximum value from staff and the way they work, and reports deriving savings of £200,000 through skill-mix changes within a directorate, accepted with little opposition because staff and unions knew and understood the trust’s financial predicament.

Investment appraisal

- 101 ‘Strategic and operational decisions must be based on a proper and thorough assessment of the financial and wider business implications. This includes an understanding of the benefits that can be expected from allocating resources to certain projects and activities.’ (Ref. 6)
- 102 The absence of transparent investment arrangements is noticeable wherever financial failure has taken place. The Independent Inquiry into the financial failure at Shrewsbury and Telford Hospital NHS Trust noted that ‘Bids for expenditure on developments were insufficiently examined. Laxity occurred in respect of the identification of full costs for developments and the sources of income.’ (Ref. 11)
- 103 This applies to investment decisions taken within NHS provider bodies on the organisation of care provision, and also to the commissioning of treatment and care. The latter weakness is a particular cause for concern, in that:
- commissioning decisions determine the future pattern of care delivery, sometimes for many years, and hence have a very material impact on the efficiency and effectiveness of resource use; and
 - the financial environment of recent years, with exceptional levels of growth, have made material investment decisions commonplace.

‘We built a purpose-built day unit but it never opened – we didn’t have the revenue.’

Head of Midwifery, NHS trust

- 104** Although we were not explicitly reviewing PCT commissioning arrangements, in the organisations we visited we were often surprised at a lack of transparency surrounding key commissioning decisions, especially those that involved funding new models and care to be delivered by the PCT’s own provider arm or within primary care. We found that such decisions could arouse an unhealthy degree of scepticism from acute hospital management, and in one instance were linked directly to perceived underfunding of the local acute NHS trust.
- 105** **We recommend** that NHS commissioning organisations should be required to publish the financial rationale underpinning all significant changes in commissioning policy and all commissioning decisions involving the investment of significant new resources alongside any social or clinical considerations. We would expect to see:
- as a minimum, publication of the **costs** and **savings** anticipated for all major commissioning changes, both for the commissioning organisation and for the health economy as a whole; and
 - a statement, with risk analysis and timescales, of how any savings are to be achieved.

Programme and project management

- 106** It is accepted good practice with any new project or strategy to monitor the speed and success of its implementation, and to devise indicators to assess performance and the realisation of expected benefits.
- 107** We found that in NHS organisations struggling to achieve a financial balance, there was a tendency to establish a programme of individual projects aimed at making financial savings, but without:
- the wherewithal for effective project management, with no investment in either specific project management skills and systems or in appropriate training; or
 - the related structures for project oversight, monitoring and coordination.
- 108** As with deficiencies in budgeting and budgetary control identified earlier, any sense of empowerment for delivery combined with accountability for doing so was lacking. It often seemed that the projects had never actually been expected to succeed.

‘...The savings schemes were at different stages of planning or implementation. A number did not yet have project plans for delivery and a number are of medium or high risk of not being implemented or fully implemented.’

Public interest report, Kennet and North Wiltshire PCT, July 2005

Financial monitoring and forecasting

- 109** Financial monitoring and forecasting are the essential processes for making sure that budgets and plans are turned into reality: not just in aggregate, but for each part of the plan.
- 110** *World Class Financial Management (Ref. 6)* observed that ‘In the public sector, top management too often does not focus on financial performance until well into the financial year, at which point it will forecast significant variances from the plan. This in turn prompts a period of fire fighting to bring spending back in line before achieving a bottom line outturn in line with the plan.’
- 111** We found lack of timely monitoring of financial performance to be a major contributory factor to financial failure. Specifically, we noted that the acceptability of late budget-setting already described is linked with late identification of planned savings, late identification of major variances and late reporting to top management.
- 112** In respect of both internal and external monitoring, getting the basics right emerges as crucial.

Internal monitoring

- 113** Budgetary control, shorthand for the set of internal structures and processes that monitor adherence to financial plans and intervene to address significant deviation from plan, is a key aspect of sound financial governance in any organisation. Unless financial performance is monitored throughout the year, and budgetholders held to account for their actions, boards can have little assurance that the plans they set are being implemented.
- 114** We found that crucial steps on the road to recovery are:
- the introduction, or re-introduction, of a clear scheme of budget delegation with defined levels of accountability and powers to commit expenditure;
 - good, prompt reporting to budgetholders of the current income and expenditure position; and

- calling budgetholders to account promptly for any variations, and requiring corrective action rather than mere explanation of the cause of the variance.

115 These are the time-honoured basics of budgetary control, and it is noticeable that getting these basics right tends to be the effective route to recovery. Conversely, any dilution of them in anticipation of a strategic solution only serves to prolong the organisation's crisis.

'We've put the plug in the bath, made the problems clear for everyone to see. The budgets were a waste of time. Get the basics right: reconciliations, reports, cash and working capital.'

NHS trust finance director

116 Getting the basics right also often requires very different ways of working within the organisation's finance function. To be effective, finance needs to be connected directly to the core business of an organisation, not operating separately.

'Service is everyone's business; finance is everyone's business. So we're backing up the clinical directors with finance teams. Eighty per cent of our time is theirs.'

NHS trust finance director

117 However, organisational plans encompass more than money. The core activities of any business determine its financial performance. In the NHS it is the provision of healthcare that drives expenditure, and an annual plan that does not integrate clinical activity plans with income and expenditure budgets will always be fragile. Similarly, a monitoring process that does not align budgetary control with activity monitoring is unlikely to be effective. Robustness comes from integrating finance and activity.

118 NHS trusts pursuing recovery are strongly advised to integrate financial and service recovery plans, even where the monitoring and reporting systems to support integration are not fully developed. This is a priority both in terms of shared ownership and to avoid reversion to short-term financial fixes.

'People weren't grasping the nettle... our systems weren't robust enough to pick up the level of risk.'

NHS trust medical director

119 Strength is also derived from the integration of human resource information. This is particularly so for NHS bodies, since healthcare is labour intensive and staff costs tend to form a large proportion of overall expenditure. **Table 4** sets out the numbers of whole time equivalent (WTE) employees at NHS trusts and PCTs who were issued with public interest reports in 2005/06. The average number of persons employed has generally increased over the past three years. This trend has occurred despite a worsening reported in-year financial position and increased financial support received by these organisations over the same time period (Chapter 1).

Table 4

Numbers of whole time equivalent (WTE) employees at NHS trusts and PCTs issued with public interest reports in 2005/06

Organisation	Average number of employees (WTE)		
	2002/03 ^I	2003/04	2004/05
North Tees and Hartlepool NHS Trust	3,531	3,713	3,781
Royal West Sussex NHS Trust	2,058	2,107	2,281
Royal Wolverhampton NHS Trust	4,029	4,352	4,419
Scarborough and North East Yorkshire NHS Trust	2,122	1,790	1,958
Shrewsbury and Telford NHS Trust ^{II}	3,617	3,825	3,883
Southampton University Hospital NHS Trust	6,432	6,723	6,733
South Tees NHS Trust	5,235	5,878	5,899
Trafford Healthcare NHS Trust	1,889	1,940	1,796
Weston Area Health NHS Trust	1,151	1,296	1,449
Maidstone and Tunbridge Wells NHS Trust	4,046	4,440	4,414
Queen Elizabeth Hospital NHS Trust	2,150	2,348	2,354
Cambridge City PCT	358	462	639
Central Suffolk PCT	311	332	370
Cheshire West PCT	430	467	542
Hillingdon PCT	1,010	1,014	986

Organisation	Average number of employees (WTE)		
	2002/03 ^I	2003/04	2004/05
Hounslow PCT	579	626	581
Ipswich PCT	243	277	364
Kennet and North Wiltshire PCT	1,096	1,182	1,186
North Somerset PCT ^{III}	269	306	346
New Forest PCT	733	781	744
Selby and York PCT ^{III}	1,360	1,419	1,472
South Cambridge PCT	173	178	282
Suffolk Coastal PCT	249	284	322
Suffolk West PCT	355	435	463
West Wiltshire PCT	595	627	672
Total	44,021	46,802	47,936

Note I: The contracted hours method of calculating WTE numbers was required to be used in 2003/04 and 2004/05. NHS trusts and PCTs who had calculated the WTE differently in previous years were required to recalculate 2002/03 prior year comparatives. Where the figures for 2002/03 differed between the 2002/03 accounts and the comparative figures included in the 2003/04 accounts, the latter has been taken in the above analysis for consistency with subsequent years unless indicated otherwise.

Note II: Shrewsbury and Telford NHS Trust came into existence from 1 October 2003.

Note III: The 2002/03 figures for North Somerset PCT and Selby and York PCT are taken from 2002/03 accounts as the 2002/03 comparative figures per the 2003/04 accounts were nil. These 2002/03 figures may be calculated on a different basis to subsequent years (see note I above).

Source: Audited accounts

- 120 We found that a breakdown of establishment control was a factor among some of the NHS trusts that were failing, and its re-introduction is typically a key step on the road to recovery.

‘Much of [the 2005/06] improvement results from the early implementation of strict vacancy control arrangements on 1 March 2005. As a result, staff numbers have reduced since February 2005 by 218 WTE; with minimal spend to date or planned on redundancy payments.’

An acute NHS trust Service and Financial Recovery Plan

- 121 This goes beyond the crude vacancy freeze, although imposing a vacancy freeze can serve as a plain signal of management’s intent to assert control. It is a statement that major spending decisions, and decisions to engage staff represent a significant long-term commitment to spend, will only be taken within a proper framework of accountability. It also makes prompt, active monitoring of workforce expenditure possible.

‘We now have monthly workforce information, including agency and excess hours, to set alongside our finance and performance data. It’s not yet weekly, though we insist on monitoring agency nursing weekly with agency usage running at around 140 WTE. You can get an organisation out of denial, but delivery is in the muck and bullets of detail.’

Finance director, NHS trust

- 122 If they are to be adequate for the task, monitoring systems, and the staff that operate them, need to match the scale and complexity of the organisation’s needs. Seeking significant savings in finance, information systems and human resource management because of economies of scale following a merger or not recognising that growth in an organisation needs to be matched with an increased infrastructure can be self-defeating.

‘... A significant increase in turnover with income increasing from £125 million (2000/01) to around £200 million (2004/05)... has led to increasing demands on a finance function which has not seen a commensurate increase in its staffing numbers, investment in its financial systems or processes. We believe that this lack of capacity within the finance function has contributed to it not being able to meet the financial management standards that are expected of a trust of this size and complexity.’

Public interest report, Royal Wolverhampton Hospitals NHS Trust, September 2005

External monitoring

- 123** All individual NHS organisations have a chain of accountability that leads ultimately to government, and are answerable via this external route. There is a very real need to integrate internal and external accountability processes, both for efficiency and to ensure consistency. ‘Information produced for both internal and external purposes should be derived from the core financial systems. The benefits of using one key system is that it ensures there is only one version of the truth and that decisions throughout the organisation are being made consistently on the basis of the same information.’ (Ref. 6)
- 124** SHAs have a key role in both failure and recovery, and have a unique ability to apply direct pressure to NHS trusts and PCTs that are not performing.
- 125** In their monitoring role, however, they have a further obligation: to identify potential organisational failures before they happen, so that they can manage whole health systems effectively. We believe that earlier, sharper intervention coupled with stronger leadership of the local health economy would have helped in a number of cases. We have already pointed to factors in an organisation which are likely to increase the risk of failure and to which SHAs should be alert – a merger, major building project, management and board turnover, vacancies at board level and hosting significant shared services while the organisation faces major management challenges in its own right.
- 126** SHAs also routinely receive information on financial and service performance. But such information has not always prompted the necessary intervention or may have given a misleading impression. We are concerned that the robust style of management, favoured by some SHAs, may have encouraged some NHS bodies to conceal the reality of their financial problems until it is too late to avoid failure. SHAs should consider their approach to performance management and consider whether an alternative approach would help to ensure that they receive open and honest financial monitoring reports.
- 127** **We recommend** that SHAs introduce, where they have not already done so, structures for verification of the formal messages supplied in monitoring returns by NHS bodies. These should include:
- hard indicators, including analysis of the actual cash position of individual organisations as compared with the reported income and expenditure position and forecast; the range of early indicators specified in the next chapter; and other appropriate local indicators. These indicators should be integrated with the formal

monitoring processes, and their use (and conclusions based upon them) should be recorded and subject to audit verification; and

- soft indicators, including the creation of informal networks that can accommodate ‘no blame’ analysis of financial issues.

128 SHAs can also add value by having a proactive oversight of the mutual interdependency of NHS trust and PCT plans and budgets, and those of other healthcare providers. We were surprised to find, in one incidence of trust and PCT failure, no evidence that the incompatibility of their spending plans had been identified at SHA level.

129 We recommend that SHAs routinely compare the activity and income assumptions of NHS providers within their boundaries with the assumptions of NHS commissioners, and actively pursue resolution of any material differences alongside prompt closure of service level agreements. We would suggest that the following should normally prompt intervention by SHAs under the terms of the NHS operating framework:

- any bottom line financial variance in excess of 0.5 per cent;
- any inability to reconcile income and spending assumptions
- the presence of significant external income assumptions that are inconsistent with previous years’ actuals; and
- delays and difficulties in completing service level agreements.

‘The SHA role isn’t clear. They just said “sort it out”. But there’s no commissioning strategy here.’

Chair of Audit Committee, NHS trust

Financial reporting

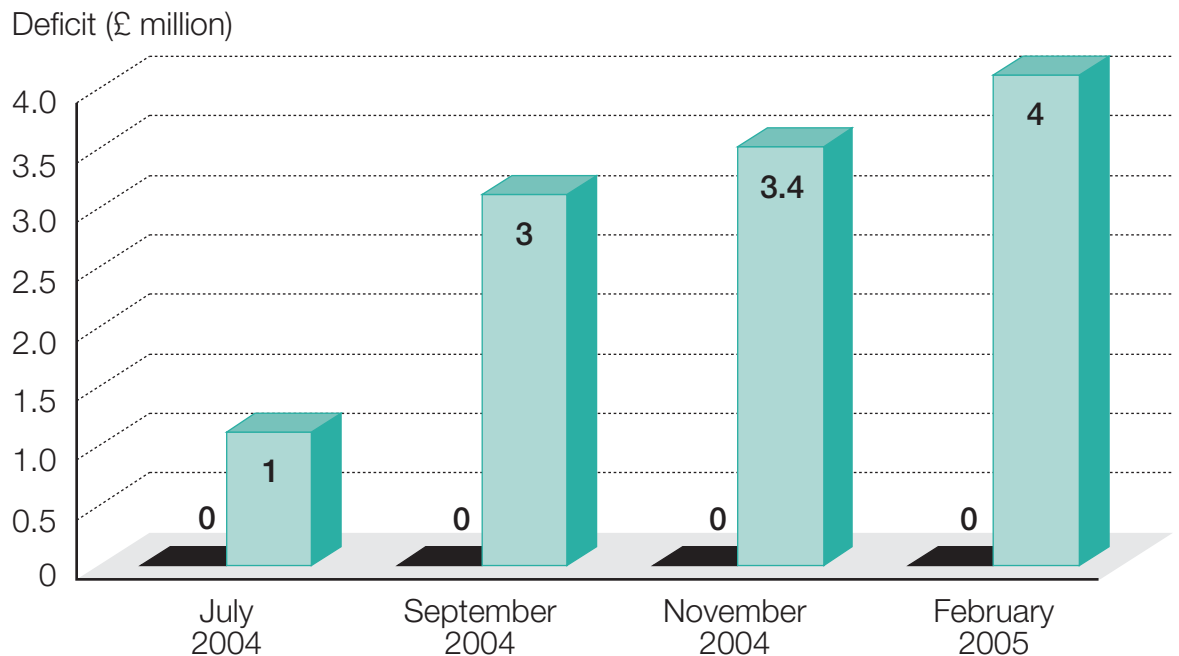
130 *World Class Financial Management (Ref. 6)* notes that financial reporting needs to be tailored to the needs of the user or stakeholder; must be timely; and should be open, clear and concise. It comments critically on deficiencies in public sector reporting, such as the production of end of year accounts being commonly seen as a one-off exercise. It also insists that the same principles of reporting apply within the organisation, including the provision of reports to individual budgetholders.

Meeting user needs

- 131** Partly because of the culture of year-end financial fixes referred to above (see paragraphs 70-77), there can be an expectation of significant month 13 variances, and a consequent reluctance to treat in-year outturn forecasts as reliable. Pre-audit year-end accounts sometimes offer the first reliable statement of financial outturn.
- 132** **Figure 1** illustrates the difference between forecast outturns reported to the board of one NHS trust in 2004/05 and the total deficit that was building in the background. The final deficit, which took account of a number of accounting adjustments, was £4.5 million; yet as late as March the board was being advised of a breakeven forecast.

Figure 1

Forecast and actual deficit 2004/05 – Scarborough and North East Yorkshire NHS Trust



n Financial position reported to the board

n Actual overspend against budget

Source: Public interest report, Scarborough and North East Yorkshire NHS Trust, 2005

- 133** A similar pattern can be seen in the reporting of forecast outturn to the Board of Weston Area Health Trust in 2004/05. It took until midway through 2004/05 for the likelihood of a deficit to be reported, and it took the arrival of a new finance director for the forecast deficit to be reported at a realistic level, although even then, there were late fluctuations.

Table 5

Weston Area Health NHS Trust's financial forecasts in 2004/05

Financial forecasts were not reliable.

Date of Board meeting	Forecast outturn £m
June 2004	Breakeven (first Acting Director of Finance)
July 2004	Breakeven
August 2004	Breakeven
September 2004	Breakeven
October 2004	1.7 deficit
November 2004	1.7 deficit
December 2004	3.8 deficit
January 2005	3.8 deficit
February 2005	5.4 deficit (second Acting Director of Finance)
March 2005	3.9 deficit
Actual outturn	5.2 deficit

Source: Public interest report, Weston Area Health NHS Trust, July 2005

- 134** Good financial reporting requires the disciplines associated with year-end reporting to be replicated throughout the year. In particular there is no reason why the production, and interpretation, of balance sheets and cash flow schedules should not form part of routine financial reporting at NHS trust and PCT board level.
- 135** One impact of the year-end accounting process being separate from monthly management accounting appears to be a common belief in the organisations that we reviewed, especially among clinical managers, that revenue deficits are somehow manipulated out of existence at the end of each financial year and do not have to be repaid. This misunderstanding was reinforced by:
- a common lack of any internal accountability for budget overspends;

- reliance on the finance director to manage the financial year-end so that key financial targets are met;
- the practice of not reporting and analysing deficits clearly and unambiguously in NHS trusts' annual reports and accounts;
- reliance on gloss and euphemism; and
- a near-universal failure to understand resource accounting and budgeting.

136 As well as prompt, clear reporting on the actual financial position within organisations, there is a clear need for explanation of the practical realities of the financial regime within which NHS organisations work.

Timeliness

137 The absence of timely board reporting of financial issues (both routine or identifying significant issues) serves as an important indicator of financial risk. We found that although a failing organisation is typically aware, in general terms, that it is heading into financial difficulty, and that there is a trail of audit comment and recommendation to provide written evidence, the specifics of failure are often not presented until they are undeniable and hence until it is too late to correct the trend.

'The board was not properly informed of the increasing deficits until December 2004. In October 2004, the position reported to the private section of the Board meeting was a best case/worst case scenario of £0.1 million surplus or £3.5 million deficit but with a most likely position of £1.3 million deficit, although the formal forecast by the Trust was a deficit of £1.7 million. It was not until late 2004 and early 2005 that the full picture began to emerge.'

Public interest report, Weston Area Health NHS Trust

Open, clear and concise reporting

138 The purpose of financial reporting is to communicate. However, many of the board finance reports we reviewed seemed expressly designed to discharge accountability without effective communication of the salient facts. Moreover, it is still not common practice to supplement written reporting with visual presentation, with graphical or diagrammatic design, and with other methods of ensuring that the message gets across. The point of reporting is to empower the board to act.

‘Governance reports received by the Trust Board should focus on the key issues and avoid being “telephone directories” of indigestible detail.’

Recommendation of Independent Inquiry: Shrewsbury and Telford Hospital NHS Trust, October 2005

- 139 The same holds true for reporting to budgetholders within the organisation. We found it noticeable that organisations that are successfully involving senior clinicians in recovery, and that insist on holding budgetholders to account, take considerable pride in the information packs that are circulated within the organisation. These have been the subject of conscious planning and design and often coordinate financial, activity and workforce information in innovative ways.

3

Identifying and recovering from financial failure

Identifying NHS bodies at serious risk of financial failure

140 The joint Audit Commission and NHS Confederation briefing paper, *Good Governance: Good Financial Management* published in June 2004 (**Ref. 12**), identified some warning signs of impending financial failure. Our further research has largely confirmed these. But we have also identified some additional points. We list below indicators that are associated with potential failure which we consider it would be prudent for boards and performance managers at SHA and national level to keep in mind and monitor. A number of these are external to the organisation. We have grouped them into three categories – financial performance, governance and environmental.

Financial performance

- 141** These indicators need to be considered in absolute terms and in comparison with peer groups, but perhaps most importantly how, and how fast, they change over time. A reasonable set might be:
- ratio of financial support received (either resource or cash) to total income;
 - ratio of non-recurrent income to total income;
 - ratio of current assets to current liabilities;
 - performance against the Better Payments Practice Code;
 - ratio of number and value of invoices raised being queried to total number and value of invoices raised;
 - rate of increase in projected deficit;
 - rate of increase in exchequer expenditure – irrespective of apparent availability of income to support expenditure; and
 - unidentified savings as proportion of total budgeted spend. This relates to the proportion of expenditure still outstanding at different stages of the financial year.

Governance

- 142 The evidence of this report suggests it is equally important to identify signs of deteriorating corporate governance that indicate a potential for failure. A reasonable set might be:
- failure to act after previous audit concerns about financial standing or financial management;
 - failure to set and agree budgets to a clear, routine, annual timetable;
 - evidence of senior clinicians being dislocated from the formal management structure and not owning financial recovery plans;
 - an organisational history of failing to deliver cost improvements or of heroic assumptions being made on what can be delivered based on previous performance;
 - poor establishment controls, demonstrated by rapid increases in either permanent or temporary staff; and
 - turnover of more than two director-level posts (or the same post turning over more than once) within the past year or vacancies for significant periods.

Environmental

- 143 Separately, it would appear important to have indicators of factors in an organisation's immediate environment that leave it more prone to failure. On the basis of our research these might reasonably be:
- a significant proportion of service level agreements not finalised;
 - a forthcoming organisational merger, or a significant merger within the last two years;
 - current participation in a very large capital building project; and
 - leadership of a significant consortium on behalf of other NHS organisations.
- 144 We recommend that boards and SHAs regularly consider the above indicators when reviewing an organisation's financial position and the risks it faces. No single indicator is crucial: it is the composite effect that is important, along with the direction of travel and rate of change (**Ref. 8**).

Management actions likely to lead to effective recovery

- 145** On the evidence of our research across a number of NHS bodies, there appears to be a considerable degree of similarity around what works in setting an organisation on the road to financial recovery. This is more evident in NHS trusts than PCTs which are new bodies with a different set of problems and controls and where there is little history of failure and recovery to draw on.
- 146** The five key steps are:
- increasing the management capacity and capability, often by strengthening the management team, including the replacement of some members;
 - recognition of the problem and instituting internal measures to address it rather than looking for external solutions. This can often be helped by the introduction of external review and external catalysts;
 - immediate measures to curb expenditure. Such measures are often accused of having a random impact and of affecting successful as well as struggling directorates. However, they are important for two reasons: to demonstrate that action is possible, and to send a signal that the management team is back in charge of the organisation; and
 - the imposition of tight accountability structures and processes, including a focus on cost control. In NHS trusts the re-introduction of routine budget monitoring and accountability processes is often coupled with the creation of a cadre of senior clinicians committed to the organisation's recovery and willing to take on budget management responsibilities.
 - These four steps should be combined with an insistence on there being no strategic solution to a financial problem until the basics of good financial management are in place.
- 147** The introduction of external turnaround teams took place after the research for this report. We have therefore made no judgement about their success but there are signs that such external experience can be a helpful complement to the five steps set out above.

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