Health

July 2006

audit commission

Audit Commission review of the NHS financial management and accounting regime

A report to the Secretary of State for Health

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Design and production by the Audit Commission Publishing Team

First published in July 2006 by the Audit Commission for local authorities and the National Health Service in England, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

Summary

The NHS is a unique and complex organisation. It comprises some 600 different organisations, each with its own responsibilities and operating to different sets of financial rules and incentives. They interact with each other and also contract with independent providers ranging from GPs to private hospitals. The financing and accounting regime is similarly unique and complex. Major parts of the current arrangements were introduced in 1990 but new developments have been superimposed on them. They have been primarily designed to ensure that neither individual bodies nor the NHS as a whole overspend. They also aim to support the NHS collectively and individual bodies within it to operate economically, efficiently and effectively.

Our review has taken place against three important developments which have demonstrated both the weaknesses in the current system and the need for change. First, many of the flexibilities that enabled bodies to meet their statutory duties not to overspend, have either been eroded or have disappeared for good reason. Over time there has also been less of a focus on financial management both nationally and in some organisations. In some cases financial problems have been obscured, although they are increasingly being made more transparent. A growing number of organisations have incurred deficits of increasing size, which has resulted in the NHS overall overspending by £536 million according to the unaudited accounts for 2005/06. Furthermore, it appears to be increasingly hard for organisations to recover financially.

Second, the introduction of Payment by Results, foundation trusts (FTs), independent sector treatment centres, patient choice, practice based commissioning and the reorganisation of strategic health authorities (SHAs) and primary care trusts (PCTs) all carry new financial risks and will have profound effects on the financial regime and financial management in the NHS. The financial management and accounting regime has not kept pace with these developments. New approaches will be required. Finance staff will need new skills and even greater professionalism.

Third, like the rest of the public sector, the NHS faces lower rates of expenditure growth from 2008/09 and must focus more on efficiency and effectiveness if it is to improve and keep pace with demand. The financial regime could be further developed in order to support this.

Our recommendations are designed to address these issues. They are based on a substantial body of previous Audit Commission work and published reports which we have

not sought to replicate here. We have also consulted widely in the course of the review and have received help and advice from many sources, most particularly from our NHS Financial Management Advisory Group and PricewaterhouseCoopers who conducted research on our behalf. We believe that there is a broad consensus for our proposals. There is much on which to build as many of the changes we propose are developments of existing arrangements. Key changes which we consider should be introduced are:

- resource accounting and budgeting (RAB) is incompatible with the NHS trusts' financial regime and should not be applied to those organisations. The Department should instead establish a national buffer so that it can meet its obligations and trusts can then operate as intended. Such a buffer will in any event be needed as the number of FTs grows, as the Department must cover any aggregate net deficit which they may incur. The buffer would not be distributed to individual NHS bodies. Individual trusts which have suffered RAB adjustments without any compensating financial support should have the funds returned to them. We do not believe that there are many such cases.
- NHS trusts should move onto a financial regime that gives greater emphasis to cash and liquidity and has transparent arrangements for borrowing for both investment and working capital. This will help in the preparation for FT status and give greater financial clarity for individual organisations.
- Planning and financing arrangements which put PCTs in a much stronger position to manage their financial risks.
- Support for organisations' capital development and other working capital needs should be provided. This should be arranged via a separately identifiable, professionally staffed banking arrangement within the NHS. This would also provide loans for capital developments and all other working capital needs as well as receive cash and pay interest on cash deposits from NHS bodies. This should build on the Trust Financing Facility for FTs.
- There should be a more effective and swifter mechanism for identifying and dealing with financial distress, with clear trigger points and matched intervention strategies. We set out what these might be.
- The NHS Manuals for Accounts should be reviewed, made less prescriptive and more principle based and brought more closely in line with UK Generally Accepted Accounting Principles (GAAP). This would also have the benefit of making NHS finance staff less reliant on specific Department of Health instructions and more reliant on their own professionalism.

- The Department of Health and SHA oversight and management could be improved by addressing the way in which policy initiatives are costed, the Payment by Results tariff is developed and given greater certainty over the medium term, and relevant guidance is issued promptly to the service. There should also be reductions in the quantity of data required while at the same time improvements should be made to its quality.
- Specific steps should also be taken to improve the skills of finance staff and the capacity and capability of boards.

We have made detailed recommendations on each of these issues as well as proposed a number of other changes.

Three themes run throughout our report. First, there is a tension between the performance of individual organisations and the overall performance of the NHS either within a local health economy or nationally. Individual organisations can, for example, find that their surpluses are taken and used to support others with deficits. Those with financial problems can find them obscured within complex local financing arrangements. Both can dilute accountability. We believe that organisations' sense of accountability will increase if the financing regime is made simpler and more transparent and the individual bodies are made more self-standing and less affected by others' performance.

Second, many of the issues and problems raised with us have been cultural. These include, for example, late setting of budgets or service level agreements; long, drawn out and poorly managed arbitration procedures; submission of reports to SHAs and the Department which are inconsistent with reports to the organisation's own boards; the belief that finance is the sole responsibility of the finance director and the way in which failure has been dealt with. Financial discipline and sound financial management are fundamental to any organisation. Our recommendations address these issues but leadership in each organisation and across the NHS as a whole will be important here. It will also be important to recognise that some modest level of underspending is both essential and inevitable – no organisation can operate prudently without some reserves.

Third, there is a need for much better medium-term planning to make the best use of the resources available. This requires the support of all staff. The engagement of frontline clinicians in both planning and finance is crucial. Practice based commissioning is the vehicle for achieving this in PCTs and is key to its development. But the same is true in trusts as well.

We recognise that a number of our recommendations may entail additional cost, particularly in relation to the establishment of the buffer and elimination of the element of trust deficits caused by RAB adjustments. We have not been able to estimate these within the time and information available to us. We have, however, shown how the buffer might be set. On the basis of earlier work, we also do not believe that the level of RAB adjustment has been significant. Nonetheless, further work needs to be done before final conclusions can be drawn about these recommendations.

We have also identified a number of areas for further work, particularly in relation to the banking arrangements we propose and the regime for PCT finance and financial recovery. PCTs are relatively new, they are facing a new commissioning environment including the introduction of practice based commissioning which is likely to have a significant impact on the way in which they operate. We believe, however, that this is an important area, particularly in relation to their ability to jointly commission services with local authorities. We would be very willing to work with the Department and others on these issues.

Our proposals are wide-ranging and will take time to implement. We have not been able to assess the transition path. We believe that this is for the next stage, once our recommendations have been considered.

Finally, many of the recommendations we make are linked. We believe that the overall effect of implementing them would enable the NHS and individual bodies within it to operate on a sound and sustainable financial footing. They would:

- ensure that the Department of Health meets it commitments to HM Treasury and the taxpayer while enabling trusts to operate in a more business-like way;
- bring greater clarity to the financing system both for individual organisations and for the NHS as a whole;
- improve further the professionalism of NHS finance staff; and
- increase the capacity and capability of individual bodies to manage their affairs and at the same time increase their accountability for doing so.

They would not of themselves prevent NHS bodies from incurring deficits. But they would put NHS trusts and PCTs in a better position not to do so and, importantly, give them a better prospect of recovery. They should also put NHS trusts and PCTs in a better position to achieve value for money for the taxpayer and consistent reliably funded services for patients.

1

Introduction

1 The Secretary of State asked the Audit Commission in April 2006 to undertake a review of the NHS financial management and accounting regime by July, and to recommend changes that:

- enable and encourage the NHS and individual bodies within it to operate on a sound and sustainable financial footing;
- support the identification of financial problems and facilitate recovery;
- promote clear and transparent accountability; and
- support individual organisations to develop the necessary financial management capacity and capability to operate effectively.

The full terms of reference for the review are set out in Appendix 1.

2 Our review takes place against a backdrop of three important developments within the NHS.

3 First, individual bodies within the NHS have found themselves under increasing financial pressure. Although the majority continue to meet their statutory duty to achieve financial balance, a growing minority have been unable to do so. A small minority of trusts and PCTs account for the bulk of the current NHS deficit (70 per cent of the gross deficit is in 11 per cent of the organisations)[1] but there has been a trend over the past four years for the number of organisations with deficits to increase and for the size of those deficits to grow. In 2005/06, the unaudited figures show that 31 per cent of NHS bodies (including NHS FTs) incurred a deficit, with the NHS overall overspending by £536 million (approximately 0.8 per cent of the revenue resources available to the NHS), compared with an overspend of £252 million in 2004/05. The Department of Health has acted to reduce both the number and size of deficits in 2006/07, including introducing turnaround teams in those organisations with the most severe financial problems. But financial management capacity and capability and the nature of the incentives within the system to promote sound financial health remain of concern.

1 Department of Health, *NHS Financial Performance 2005/06*.

4 Second, the shape and nature of the NHS is changing. The introduction of FTs, independent sector treatment centres, Payment by Results and patient choice will produce a more commercial style approach among providers. Changes on the provider side are being matched by changes for commissioners with the restructuring of PCTs and SHAs and the introduction of practice based commissioning. These developments will have profound effects on both the financial regime and financial management arrangements for the Department of Health and for NHS bodies. There is a richer array of incentives for improved efficiency and better service provision but the financial risks are sharper. Such risks will also present in new and clearer ways, for example financial distress, and will need to be addressed differently. This new regime is evolving as each development rolls out and becomes embedded. The next three years will be a period of transition, with 2006/07 a year of major change. The financial regime needs to address both the transitional period and the longer term. Staff will also need to develop new skills.

Payment by Results is a funding system designed to ensure that NHS finances are deployed directly in line with patient treatment. It requires PCTs to pay service providers based on a nationally agreed tariff for actual activity undertaken, rather than fixed-price block contracts.

Practice based commissioning entitles practices and other groups of primary care clinicians to hold an indicative budget for commissioning health services on behalf of their patients. PCTs remain legally responsible for finances and contracting with providers, for the overall commissioning strategy and for the implementation of practice based commissioning.

5 Third, it is widely expected that the current rate of growth in expenditure on the NHS will reduce after the next comprehensive spending review from the current level of annual real terms increases of around 7.5 per cent to rather less than that. The NHS, however, must continue to meet the challenges of rising expectations, new technology and an ageing population and build on the gains made by continuing to address existing weaknesses in service provision. To do so, the NHS must re-establish a focus on greater cost efficiency and improved effectiveness. The financial regime must support and encourage this.

6 Our report seeks to address these issues, making a series of recommendations which we believe will enable NHS financial management and accounting to support the NHS as it develops. We believe that there needs to be a clear, consistent relationship between

finance, the principles by which the NHS is to operate and the other management mechanisms that underpin it.

7 In undertaking this review we have drawn on previous Audit Commission work and reports, including those undertaken jointly with the National Audit Office (NAO). We have not sought to replicate previous work undertaken by the Commission or others, but have included a bibliography of material which has provided an evidence base for this review (Appendix 2). We have also drawn on the experience and knowledge of NHS managers, finance staff and auditors in the field; on evidence from Monitor; on the work of the Healthcare Financial Management Association (HFMA), including *Laying the Financial Foundations for Success: 10 Point Plan to Build a Financially Stable Future for the NHS*, which it published in the course of this review; and on the input of senior executives and non-executives within the NHS. We have also been greatly helped by PricewaterhouseCoopers who undertook research on our behalf and commented from their own knowledge and expertise. We have also been advised in the course of the review by our own NHS Financial Management Advisory Group, whose terms of reference and membership are listed at Appendix 3. We are grateful for all the support and contributions we have received. Inevitably in the time available we have not been able to cover every aspect in detail or necessarily reached definitive conclusions on all points. But we believe this report and the recommendations made provide a clear way forward and encourage the development of a financial management and accounting regime that will be better suited to the needs of the NHS as it develops.

2

Financial risk, financial incentives and financial management

8 The NHS is unique. NHS expenditure at £84 billion is similar to the entire gross domestic product of Thailand. Overall responsibility for the service rests with the Secretary of State. It is almost entirely tax funded and must meet all potential (unlimited) demand within an annual financial limit. Local responsibility for ensuring that services are available rests with PCTs, which are directly accountable via SHAs to the Secretary of State. PCTs receive approximately 80 per cent of their funds directly from the Department, but have their own independently appointed boards and their own set of statutory responsibilities. PCTs provide some services themselves but they commission most, sometimes jointly with local authorities, via contracts or service level agreements with:

- independent contractors (GPs, dentists, pharmacists and optometrists);
- NHS trusts (which are themselves accountable to the Secretary of State in the same way as PCTs, but which have a different statutory and financial regime);
- FTs (which work under a separate financial and accountability framework and are not subject to direction by the Secretary of State); and
- private and voluntary sector providers.

Fuller details of the current arrangements are set out in **Box A** and **Appendix 4**.

Box A

Summary of the NHS financial regime

Department of Health

The Treasury sets the Department of Health's budget every two years for a three-year period, with one year's overlap. This takes place after the Department has submitted proposals to the Treasury setting out its expenditure plans covering the three-year period, in line with public service agreement (PSA) objectives.

The budget is divided between two departmental expenditure limits (DELs), one for capital and one for revenue spending. The Department is allocated resource and capital budgets by the Treasury. Along with all other government departments, the Department of Health is required to comply with the RAB regime. As well as limits on

the amounts of expenditure on revenue and capital, the Department of Health is also subject to controls on its cash.

Once the budget has been agreed, the Department determines how much should be allocated to the NHS via general allocations and how much is retained in central budgets. Most of the funding for the NHS is allocated to PCTs according to the relative needs of their populations. The weighted capitation formula is used to determine a PCT's target share of available resources to enable them to commission similar levels of healthcare for populations with similar healthcare needs. The Department is also responsible for setting limits (revenue, capital, cash and external financing) for individual NHS bodies. While there is no requirement for the principles of RAB to apply to NHS trusts and FTs, their financial performance affects the Department's DEL. In some cases the Department and SHAs have sought to manage this by applying RAB to some NHS trusts.

Strategic health authorities

SHAs were established in 2002/03 to become the local headquarters of the NHS. There were 28 SHAs in place during 2005/06 but this reduced to 10 from 1 July 2006.

SHAs receive funding for two purposes: their own management and workforce development. SHAs are allocated revenue and capital resource limits (RRL and CRL) by the Department, which they must keep their annual expenditure within. SHAs also have a statutory duty to not spend more than the cash allocated to them. Under RAB, SHA areas incurring a deficit have their overall resource allocation reduced by the amount of that deficit in the following year. SHAs normally pass on the increase or decrease in resources to the NHS bodies responsible for incurring it.

SHAs are responsible for performance managing the individual NHS bodies within their health economies (except for FTs). SHAs are required to deliver financial balance across all the organisations within their health economy and sometimes facilitate the movement of resources and cash around the system.

Primary care trusts

At the end of 2005/06 there were 303 PCTs in England but this will reduce to 152 from October 2006, as *Commissioning a Patient-led NHS* is implemented. PCTs contract services from GPs and dentists; commission services from hospitals; and provide out of hospital care such as that provided by community nurses.

The main source of funding for a PCT is the allocation from the Department, in the form of a RRL and a CRL, which set out the resources available to individual PCTs for

the year. PCTs also have a statutory duty to not spend more than the cash allotted to them. PCTs are also required to meet departmental duties on capital and full cost recovery on their provider functions.

The principles of RAB are applied to PCTs, so if a PCT overspends in one financial year, its resource limit is reduced by the amount of the overspend in the following year.

NHS trusts

The majority of a trust's revenue funding comes through the commissioning process with PCTs and other NHS trusts.

There are statutory financial duties NHS trusts are required to achieve; break-even (taking one year with another, over a three- or a five-year period) and to keep capital expenditure within their CRL. They are also required to meet departmental duties on capital and external financing.

There is no requirement for the principles of RAB to apply to an NHS trust, although it has been applied in some cases.

Foundation trusts

There are currently 40 FTs. FTs are not subject to control from the Department or the SHAs. Instead these functions are executed through a board of directors and a board of governors, made up of patients and members of the public. External monitoring and regulation of FTs is undertaken by the Independent Regulator of NHS Foundation Trusts (Monitor).

Most of an FT's income is gained from agreements reached with local PCTs to provide locally relevant services for NHS patients. FTs can raise capital from both the public and private sectors within affordable borrowing limits.

The main financial target for FTs is to remain solvent; they are allowed to incur deficits and re-invest surpluses. FTs are not affected by RAB.

9 Each of these bodies works under a different set of financial rules and incentives and is responsible for its own management. But they must also work collectively to meet national, regional and local service and financial goals and have to manage their risks accordingly. The structure and interplay between the various organisations and levels is complex. Incentives for one part of the system can have a significant effect on other parties and there can be (and are) tensions between them. There are also trade-offs that have to be made. What is clear, however, is that the current approach to managing risk, the incentives under which different bodies work and the arrangements for effective financial management at each level of the system, are not adequate for current and future needs.

10 Appropriate allocation and successful management of financial risk are key elements of any system. Much of the NHS financial regime has been developed to seek to ensure that expenditure nationally and in individual bodies matches the funds available as closely as possible, while not overspending. The public expects that maximum value will be obtained for the money made available; they also expect that money will not be left unspent. The Treasury also requires that the Department of Health, like all other government departments, does not exceed the resources made available to it in any given year.

11 The responsibility to manage within the resources available has been passed down to individual NHS bodies. SHAs have a responsibility to ensure that the organisations within their control achieve financial balance both individually and across the health economy. PCTs have a statutory duty not to exceed their annual resource limits. NHS trusts have a statutory responsibility to break-even taking one year with another (which is interpreted as being over a three- or, exceptionally, five-year period). However, in 2001/02, to coincide with the introduction of RAB, the Department also introduced an administrative requirement for trusts to break-even in each and every year: a requirement which has been further underlined by its inclusion as a key target in star ratings and subsequently in the Healthcare Commission's annual health check.

RAB is a system of accounting and budgeting that applies to government, based on expenditure incurred and income earned during an accounting period. RAB is considered in detail in Chapter 3.

12 Achieving financial balance both nationally and locally relies on sound financial management. Historically it also rested on three other factors:

- a high profile in performance management terms for the achievement of financial balance, nationally and locally and within individual organisations which were under the direct control of the Department of Health and SHAs;
- significant flexibilities available to individual organisations, for example, the ability to transfer capital to revenue and to extend waiting times to ease financial pressures; and
- the ability to cover financial problems by moving funds between organisations.

13 Each of these factors has been diluted or altered, often for positive reasons, by relatively recent policy changes. The performance management profile of financial balance was reduced in recent years as greater weight was given to the achievement of service improvements. The importance of achieving financial balance has now been reasserted. However, the introduction of FTs has introduced a new dynamic. They operate under a different regime and have no specific duty to break-even. Financial balance is less important in the short to medium term than achieving a cash surplus, although it is likely that individual FTs will need to break-even over the longer term and indeed make surpluses if they are to remain viable. Moreover, FTs are not subject to Secretary of State direction or SHA performance management. However, the net surplus or deficit incurred by FTs in any year counts towards the Department of Health's net surplus or deficit for RAB purposes. The size of the surplus/deficit may be immaterial when there are relatively few FTs, but will become a more significant factor as the numbers grow. Moreover, the Department must also cover pound for pound the cost of any FT capital spend from its DEL, although it has no control either over the borrowing limits set by Monitor for each FT, nor over the amounts actually spent by each trust. Again, such an arrangement may be immaterial when there are relatively few FTs and significant capital funds have been made available to the NHS, but over time the risks are likely to increase and the Department needs an effective way of managing them.

Departmental expenditure limit

The DEL is a set of firm plans over three years relating to a specific part of the Department's expenditure. The DEL is intended to cover all running costs and programme expenditure, including relevant non-cash items such as depreciation, cost of capital charges and provisions.

14 The financial flexibilities available to the Department, PCTs and NHS trusts have been, or are in the process of being, reduced in six important ways:

- The Department and individual NHS bodies receive separate allocations for capital and revenue and may not vire funds from capital to revenue. Such an approach ensures proper levels of investment in the NHS infrastructure and contributes to the achievement of the Chancellor's golden rule on matching borrowing and investment over the life of the economic cycle, but at the same time has reduced flexibility.
- Although some years ago, the inclusion of virtually all NHS spend within cash limits, which particularly affected primary care, has had a significant effect.
- There has been much greater emphasis on achieving nationally set standards of service provision. This can reduce the flexibility available to individual organisations although it is clear that most trusts and PCTs manage both to meet the standards and achieve financial balance.
- An increasing proportion of funds are now subject to formal contracts. The main change here is in relation to FTs. Agreements between PCTs and NHS trusts are not legally binding, but rest on service level agreements which may be more easily altered and adjusted. About 50 per cent of PCT expenditure is accounted for by acute care and the majority of this will gradually become subject to legal contracts as the numbers of FTs and independent sector providers grow. The terms of such contracts and also the service level agreements with NHS trusts are also defined more rigorously and uniformly under Payment by Results. Block contracts which effectively guaranteed payment almost regardless of actual volumes of activity and which were based on local negotiations that balanced hospital costs against PCT affordability have now been replaced in the acute sector with set prices under a national tariff linked directly to the volume of work done. This should improve provider efficiency, support patient choice and sharpen commissioning. However, NHS organisations now have less room for manoeuvre locally on how much must be paid (or received) while controls over the number of patients treated are relatively weak. This is a particular issue for PCTs as our reports on Payment by Results have demonstrated.
- PFI and other private public partnerships pose similar issues for a number of bodies, as a percentage of the body's expenditure is committed to the annual payment to the PFI provider over a long period. However, the overall impact is much smaller as the proportion of expenditure involved is much less.

- The requirement which the Department of Health places on NHS trusts to break-even in each and every year.

As well as managing within its DEL expenditure limits, the Department of Health must also now meet Treasury set controls on near-cash and non-cash. It has not yet proved necessary for the Department to apply these controls to NHS organisations, but they limit the Department's room for manoeuvre.

Non-cash relates to items that do not actually involve the exchange of cash. Depreciation, for example, is treated as expenditure of NHS bodies to charge for the cost of an asset over the life of that asset, but does not involve the actual payment of cash.

Near-cash is spending that turns into cash or creditors quickly. It is basically expenditure less non-cash items. The majority of revenue expenditure in NHS organisations is near-cash, such as pay and pension costs.

15 These changes are not wrong in themselves either individually or collectively. There is good justification for each one. However, their collective impact is to reduce flexibility and thereby place a much higher premium on effective financial planning (both over the short and medium term) and good financial and risk management nationally and locally. It is our view, as set out in previous reports, that these skills and processes at the Department, at SHAs or at PCTs or individual trusts have not kept pace with the general tightening of the financial regime.

16 The NHS has been very adept at moving money between organisations in order to hide or fix financial problems through a system of brokerage. Such an approach does not affect the overall financial position of the NHS, but it does affect individual institutions and can have perverse effects and incentives, including for organisations that have managed their funds well. However, the Department has increasingly adopted a policy of greater transparency and leaving deficits where they were incurred. This is welcome as it enables financial problems to be identified and addressed. But such greater transparency has not yet been matched by a clear failure regime, which would involve identifying organisations in financial distress at an early stage, stabilising them and then helping or enabling them to recover, if necessary with associated changes in service provision. Current ways of providing financial support can be less than clear. The mechanisms are evolving, but need further refinement and codification.

17 The way in which the financial risks are managed can have perverse effects and be at odds with other policies. The requirement not to overspend nationally means that individual organisations and health economies are set control totals for spending, which are separate from their allocations and budgets. These can relate directly to an organisation's or health economy's recovery plan. However, they are also a statement of what each SHA, PCT and NHS trust must itself do financially in order to contribute to the collective financial well-being of the NHS. They tend to be set after the start of the financial year and also alter during the year as financial circumstances across the NHS change. This has a number of effects:

- Planning is made more difficult. PCTs have been given three-year allocations in order to give them greater certainty and facilitate planning, but in reality control totals and the duty to remain within an annual resource limit take clear precedence.
- Individual organisations are less in control of their own destiny and may therefore feel less accountable for their performance. As one PCT director of finance in the course of our review put it: 'We made a surplus last year and had planned to spend that with our allocation. Because of the top slice just prior to the commencement of the financial year, the SHA has required us to give up 3 per cent of our allocation, additionally, a request was received part way through the financial year asking the PCT to achieve a similar surplus to last year; we are still awaiting details from the Department on whether a proportion of the centrally allocated budgets will be top-sliced. I am now being criticised by the SHA for not having a detailed £12 million cost improvement programme, but as I said to them, I didn't need one until they came along'.
- Individual PCTs may find cooperation with their partner local authorities more difficult as they are less able to commit to joint arrangements. Local authorities have been experiencing specific problems in relation to older people budgets and special educational needs which have been jointly funded. Ineffective joint working and difficulties in developing cross-cutting priorities through local area agreements, has resulted in slower progress being made in important services for individuals and communities.
- Funds allocated to individual areas to meet health needs may not be spent on those needs. Managers have to operate under two parallel and potentially conflicting performance management systems – a requirement to meet the health needs of their population and spend the money available and a requirement to underspend in order to deliver a surplus to meet overspends elsewhere.

- There are few, if any, incentives to deliver a surplus if that surplus cannot be spent but must be made available to meet overspends elsewhere. And while organisations with surpluses may be able to use them in future years, this is not guaranteed. Trusts cannot utilise surpluses achieved prior to their statutory break-even period, without failing their statutory duty.
- There can be some disincentives to accurate reporting if it is clear that extra effort will be required in order to achieve collective financial balance – those breaking even or achieving small surpluses have often been required to do more in order to provide cover for deficits elsewhere. There is a tendency for finance directors and organisations to forecast small deficits in the clear knowledge and expectation that they will in fact break-even. There are also incentives for SHAs to intervene and fix problems across a health economy on the basis of expediency rather than on the financial merits of the case or to address the underlying financial problems. Such actions reduce the accountability of individual organisations and can perpetuate problems.

18 The current management of financial risks worked effectively for some time, albeit with perverse effects, although no system will be wholly free of these. More importantly, however, some of the foundations on which it relied have shifted, the weaknesses have become starker and new risks have emerged. These have also emphasised some current weaknesses in financial management both nationally and locally.

19 Developments are needed nationally and locally. The steps being taken in 2006/07 to address the financial problems of some individual organisations, the current restructuring of PCTs and SHAs and the move towards foundation status for NHS trusts provide a number of opportunities for improvement. There will, however, continue to be choices in how and at what level risks are managed. There are no easy answers to some of the problems posed. The following two chapters set out the options for change to the financial regime and its accompanying accounting and reporting requirements, with recommendations as to how these should be taken forward. We then go on to set out the financial management improvements which we think need to be made in order to support wider developments in the NHS and to meet the challenges they pose.

3

The financial management regime

20 Chapter 2 outlined some of the weaknesses of the current financial regime in its management of risk and in the incentives that it offers. This chapter sets out the options for addressing these and our conclusions in relation to:

- the application of RAB to the NHS;
- the NHS trust financial regime;
- the PCT financial regime;
- financing and financial support; and
- failure regimes.

Application of resource accounting and budgeting to the NHS

21 The NHS budget is governed by HM Treasury's RAB regime. An annual DEL is usually set for three years at a time, and the budget within which the NHS as a whole is required to operate forms part of the DEL of the Department of Health. There are separate DELs for capital and revenue.

22 If the Department underspends in any year, the amount of the underspend can be added to its DEL for the following year; if it overspends, the DEL for the following year is reduced accordingly. The Department passes down to SHAs, and SHAs pass down to PCTs, the responsibility to stay within the annual revenue budget, and annual adjustments are made for any underspends or overspends, reflecting the way in which the Department's own DEL is adjusted.

23 The DEL is similarly affected if an NHS trust overspends. But, because trusts are funded through service level agreements with PCTs, rather than through allocation of resources, the Department has no direct means of clawing back the overspend. Instead, it reduces its SHA control totals by an amount corresponding to the net overspend of the NHS trusts in each SHA area. SHAs in turn reduce their control totals for PCTs, which deduct a corresponding amount from the payments they make to NHS trusts.

24 NHS trusts are at the same time statutorily required to break-even taking one year with another over a three- or, exceptionally, five-year period. Any deficit or surplus is therefore carried forward in their balance sheet with the requirement that any deficit is matched by a surplus within the three- or five-year period and that any surplus is used during that period. The interplay for trusts in deficit between RAB adjustments and their own statutory financial regime has become known as the double deficit. The way in which this works is set out in the following stylised examples, **Table 1 and 2**, overleaf.

Table 1

Illustrative example of retained and cumulative surpluses and deficits under the RAB carry-forward regime

	Year 1 £m	Year 2 £m	Year 3 £m	Year 4 £m	Year 5 £m
Income before RAB adjustment	100	100	100	100	100
RAB adjustment to income based on prior-year retained surplus or deficit	0	(10)	0	10	0
Income after RAB adjustment	100	90	100	110	100
Expenditure	(110)	(90)	(90)	(110)	100
Retained surplus/(deficit) for the year	(10)	0	10	0	0
Cumulative surplus/(deficit) brought forward	0	(10)	(10)	0	0
Cumulative surplus/(deficit) carried forward	(10)	(10)	0	0	0

Note 1: The trust makes a deficit in year 1 and its income in year 2 is reduced by an equivalent amount. The deficit in year 1 is also carried forward in the trust's balance sheet into year 2. This is its cumulative deficit. In order to turn its position around in year 2 the trust has to cut its expenditure by £20 million. If it succeeds in doing this it will break-even in year but will not eliminate its cumulative deficit. In the third year its usual level of income (£100 million) is restored but it cannot increase its expenditure if it is to recover its cumulative deficit and meet its statutory duty to break-even taking one year with another.

Note 2: In this example, the trust has curtailed its expenditure and met its statutory break-even duty. In the fourth year it receives under RAB an extra £10 million income which matches the surplus it made in year 3. Here it can either spend up to the new level or achieve a surplus which would be carried forward in its balance sheet. Its income in the following year (4) would also be increased by that surplus. In this case, however, it spends up to the £110 million and breaks even in year. Its income is then restored to its normal level of £100 million. The example illustrates that if the required expenditure reduction can be achieved, the net adjustment to resources over the five-year period is nil and the double deficit is effectively a timing issue, although the resulting profiling of expenditure and income is unusual. The example also assumes that trusts reporting a surplus receive additional resource the following year and this is not always the case.

Source: National Audit Office/Audit Commission

Table 2

Illustrative example of retained and cumulative surpluses and deficits under the RAB carry-forward regime – a trust that does not succeed in turning around its deficit

	Year 1 £m	Year 2 £m	Year 3 £m	Year 4 £m	Year 5 £m
Income before RAB adjustment	100	100	100	100	100
RAB adjustment to income based on prior-year retained surplus or deficit	0	(10)	(20)	(30)	(40)
Income after RAB adjustment	100	90	80	70	60
Expenditure	(110)	(110)	(110)	(110)	(110)
Retained surplus/(deficit) for the year	(10)	(20)	(30)	(40)	(50)
Cumulative surplus/(deficit) brought forward	0	(10)	(30)	(60)	(100)
Cumulative surplus/(deficit) carried forward	(10)	(30)	(60)	(100)	(150)

Note 1: In this example the trust does not succeed in reducing its expenditure and recovering its initial deficit of £10 million. It also does not receive any financial support. The income reduction and the in-year deficit get steadily larger. Each year's deficit is carried forward and added to the balance sheet giving a cumulative deficit of £150 million over the period. Over a five-year period it will have spent £50 million more than its normal income but its actual income will have been reduced by £100 million. This trust would rapidly incur significant liquidity problems.

Source: National Audit Office/Audit Commission

25 RAB adjustments can clearly make the task of recovery more difficult and are inconsistent with the trust financial regime, but it is not clear in practice how far they have been applied. In *Learning the Lessons from Financial Failure in the NHS* we found that the organisations we reviewed (which had incurred significant deficits) did not in practice have the RAB adjustment applied to them. Any RAB effect was typically more than covered by additional income made available to the trust specifically for that purpose. We are aware that RAB adjustments have been made in some cases without any compensating financial support. Not only is this inconsistent with the philosophy underpinning the trust

financial regime, the variable application of this policy has contributed to a sense of unfairness. We consider that the RAB regime should not be applied to NHS trusts. However trusts should still be required to recover deficits through generating surpluses in order to achieve their break-even duty although this will have consequences for the way in which the Department manages its own position.

26 RAB adjustments for PCTs are consistent with their financial regime, although there are questions about the capacity of individual organisations to recover a significant overspend in one year. We consider this issue further at paragraph 57, in the PCT finance section of this chapter.

27 The Department of Health and the overall NHS budget will continue to be subject to RAB in common with other government departments. The issue is how the Department can best manage its risks, while at the same time ensuring that individual organisations operate under a fair and appropriate set of financial incentives. We believe that there are essentially three options for the future:

- For RAB adjustments to be passed on to each organisation either routinely, which would guarantee consistency, or with individual circumstances being taken into account by SHAs, which may provide appropriate flexibility at the local level but can also be perceived as unfair. This was essentially the system which operated up to and including 2005/06.
- For SHAs effectively to top slice PCT allocations and hold a reserve at that level, using it to ensure that the health economy as a whole breaks even and that the financial position of each organisation is appropriately managed – essentially the approach in 2006/07.
- The Department itself holds a reserve to ensure that its (and the NHS's) obligations are met but in such a way that the performance of individual bodies has less impact on their peers. Such a reserve would not be allocated, but would instead be a buffer held at the Department.

There is, theoretically, a potential further option of individual NHS organisations providing a matching surplus for any deficit they made in the previous year. This would resolve the problem but clearly carries significant risks in practice and we have therefore discounted it.

28 These options highlight different approaches to managing the NHS. The first emphasises its corporate and national character as a single unit of management; the second emphasises the importance of the regional unit; and the third more clearly distinguishes

between national obligations and individual local performance, although the two are inevitably linked.

29 The first option has been applied but has resulted in inconsistency and perceived unfairness. The second option is likely to be effective in the short term, although it can have perverse effects as individual bodies are less likely to feel in control of their own affairs, particularly as the individual regional units have become much larger encompassing several health economies, which may bear little relationship to one another. Both options would also mean applying the regime to NHS trusts which is inconsistent with their funding regime.

30 Moreover, neither option addresses the introduction of FTs and their different financial regime as set out in Chapter 2, whereby the aggregate bottom line FT deficit/surplus is charged to the Department's DEL. Within the current policy framework in relation to FTs the Department may have little choice other than to introduce a buffer. Adjusting individual PCT allocations for the deficits/surpluses of their providers when they have little ability to pass on such changes does not seem an attractive option and is inconsistent with the philosophy of the regime.

31 The third option comes with potential downsides.

- First, in order to create the buffer, less money will need to be allocated to the NHS than would otherwise have been the case, which will therefore be an additional cost pressure. However, if the buffer is not used it will be returned in the following year under RAB rules to the Department and would therefore represent only a one-off cost.
- Second, if the buffer is not required the NHS as a whole will also be permanently underspent. Both the NHS and external commentators would need to accept this. So would government itself.
- Third, it is not guaranteed to succeed, as the buffer may be insufficient, although neither the NHS, nor the Department, will be in a worse position as a result than they otherwise would have been without the buffer.
- Fourth, the presence of a buffer might encourage the belief that it could be used to ease any local overspending problems or to fund new developments or central initiatives. This would be a mistake. The buffer is not a contingency reserve in the usual sense. Spending the buffer would nullify its intent.

32 We believe that establishing a buffer would be an appropriate way of separating NHS trusts from the operation of RAB. It would also be a fairer and more prudent way of managing any potential aggregate net FT deficits. When allied with the other changes we propose we also believe that financial responsibility and local accountability would be increased rather than diminished.

33 The size of the buffer is a matter of judgement. It can be changed year on year in the light of experience. If, in the light of experience, the buffer has for example been overestimated the excess funds it contains can be released in the following year when the money is returned to the Department under the RAB rules. We consider that the following factors should be taken into account:

- historical trends in levels of under/overspending nationally (the unaudited net overspend in 2005/06 amounted to only some 0.8 per cent of NHS spend);
- the current and projected in-year position – the aim for 2006/07 is to achieve financial balance across the NHS as a whole, with surpluses and deficits cancelling each other out;
- progress on recovery plans for individual bodies that are receiving assistance from turnaround teams;
- the robustness of responses to the trust diagnostics which assesses their future financial position and which will have been undertaken in most, if not all, NHS trusts by the turn of the year; and
- capacity within the system to create the buffer. It may, for example, be easier to do this at the start rather than the end of a three-year allocation period, or to establish an appropriate amount over a two- rather than one-year period.

34 **The RAB regime should not be applied to NHS trusts, furthermore any element of the deficit which had resulted from RAB adjustments should be eliminated through provision of cash backed income.** Where a trust suffered a reduction in income but was given additional public dividend capital (PDC) to enable it to maintain its cash position, the new income should be used to retire older PDC. The RAB adjustment should be able to be drawn from local documents (there is currently no requirement for the effect of RAB to be disclosed in the accounts). Where it is not evident from source documents there should be no write off. The rationale for this is that RAB adjustments have been applied inconsistently and that suspending the system partway through will mean that the eventual additional income they would receive under RAB would not be forthcoming. We have not been able to calculate the impact of this proposal in the time available to us but

would be willing to do further work with the Department on this point in order to assess fully the financial impact and feasibility of this proposal.

Public dividend capital (PDC) is a form of long-term government finance which was initially provided to NHS trusts when they were first formed to enable them to purchase the trust's assets from the Secretary of State. Additional capital expenditure is funded as PDC. There is also temporary PDC which is issued to assist with short-term cash flow timing problems. A dividend is payable by trusts to the Exchequer to cover the expected return on the Secretary of State's investment.

35 **In our opinion the Department should establish a central buffer fund to absorb any short-term deficits incurred by NHS trusts and NHS FTs and to repay any elements of cumulative deficits caused by the application of RAB.** Further work would need to be done to assess the size of such a buffer, but we believe that, taking account of the above factors, it would constitute only a very small proportion of NHS resources.

NHS trust financial regime

36 The NHS trust finance regime was first introduced in 1990 and although there have been changes since then it remains fundamentally the same. Details of the current regime are set out in Box A and Appendix 4. Although it has stood the test of time, our review and those who contributed to it have pointed to a number of weaknesses or issues which will need to be resolved. These are:

- The financing regime does not encourage NHS trusts to improve their efficiency. Trusts are not currently allowed to utilise surpluses beyond their statutory break-even period. They may also be required to surrender an in-year surplus if the NHS needs it to offset a deficit elsewhere.
- The policy aim is to enable all trusts to apply for foundation status. FTs have a different financing regime. The next three to four years can be regarded as transitional, as NHS trusts move towards foundation status. There are arguments that existing NHS trusts should be preparing themselves for the new regime.
- Cash management is underdeveloped and access to funds for the short- or long-term needs lacks clarity. The source and nature of, and terms on which such funds have been provided has not always been clear.
- Some trusts have weak balance sheets and liquidity problems that will need to be resolved if they are to become FTs. In some cases the liquidity problems will need to be resolved more quickly than that in order for NHS trusts to meet their commitments.

- The financial position of some trusts has deteriorated significantly. As our report on *Learning the Lessons from Financial Failure in the NHS* showed, despite the wealth of information regularly provided to SHAs and the Department there was no early intervention or adequate measures for dealing with incipient or actual failure, which might have prevented further worsening of the situation and more speedy recovery.

Liquidity refers to the ease with which assets can be turned into cash.

37 There are, however, a number of developments on which to build:

- the FT finance regime clearly provides the future model for all trusts. All NHS trusts are also undergoing an assessment of their suitability for foundation status and will have a development programme to take them towards that goal; and
- the Department is developing clearer arrangements for access to financial support through a system of loans.

38 **We consider that there would be merit in moving all NHS trusts onto a financial regime which gave greater emphasis to cash and liquidity and had transparent arrangements for borrowing for both capital and revenue purposes. We are aware that the Department has been considering such a move and we believe that this would also help in preparation for foundation status. There should be no change to the formal statutory requirements given that this is intended to be a transitional phase.** The essence of this approach would be:

- preparation of medium-term (three year) plans covering service developments, capital requirements, proposed productivity gains, borrowing requirements and repayment schedules. These would in practice be similar to those required by Monitor from FTs and should incorporate the programme emerging from each trust's diagnostic assessment for moving to FT status;
- annual business plans, modelled on FT lines, with tighter monitoring against the plan. The annual and three-year plans would be approved by the SHA and form the basis of the Department's own financial planning and for the RAB buffer set out previously. Both sets of plans should be based on common planning assumptions for the local health economy;
- borrowing limits set by the SHA on the basis of the plans but in accordance with nationally set metrics, which take account of the available revenue income and the balance sheet position of the borrower;

- transparent, formal borrowing to be used to cover long- and short-term requirements for both revenue and capital;
- the ability of trusts to borrow outside their limits in circumstances determined by the SHA and if necessary approved by the Department. Such circumstances should include where the trust is in financial distress, or potentially in an invest to save programme, although in both cases, judgements about the capacity and capability of the management team to deliver the plan, as well as close scrutiny of the proposal and tighter monitoring, would be required;
- interest rates set at a fair, but not penal, rate; and
- encouragement of trusts to develop surpluses and be allowed to keep and utilise them.

39 Many of the features of this approach are in place or in the process of being put into place. However, in making this proposal we are mindful of three points which will need to be addressed:

- The capacity of NHS bodies to prepare and adhere to robust medium term plans. This has been a weakness, as has been demonstrated by auditors' initial work on local delivery plans and also in the recent results from the ALEs where the absence of a robust medium-term financial strategy was a relatively common finding. Greater investment and training in this area will be required. This is necessary to achieve FT status. There is experience on which to build from FTs and also from the trust diagnostic assessments.
- The capacity of trusts to develop surpluses in order to enable borrowing. The performance of FTs in this respect has been mixed, although it is still relatively early days in the programme. Monitor has, however, questioned whether trusts will be able to achieve adequate surpluses under the current tariff in order to replace their assets. This is an issue which will need to be faced as the FT programme rolls out.
- The trust diagnostic programme has shown that some trusts do not have the financial capacity or management capability to work within this framework. It seems to us, however, that moving trusts onto this regime would more clearly identify the improvements which would need to be made in both financial and managerial terms.
- While recognising that consistently incurring deficits is incompatible with sound financial management, the emphasis would shift from whether a trust has an in-year deficit to whether the trust is performing according to its agreed financial plan and the robustness of its overall financial position.

Auditors' local evaluation (ALE) is a new framework used by the Audit Commission's appointed auditors to assess NHS bodies' performance on five key areas (financial reporting, financial management, financial standing, internal control and value for money). ALE scores form the use of resources component of the Healthcare Commission's annual health check. The first ALE results will be published in October 2006.

40 We have considered the advantages and disadvantages of restructuring the balance sheets of those trusts that have accumulated significant deficits. We are aware that this is a controversial issue and there has been a debate about the benefits that restructuring trust balance sheets would bring and the circumstances when it would be appropriate. There are two consequences of having a cumulative deficit which can cause NHS trusts difficulties. First, it may mean that the trust will fail its statutory duty to break-even taking one year with another. Whether this is the case or not will depend on when the relevant deficits and surpluses were incurred. Second, a trust with a significant cumulative deficit may also be short of cash. Whether or not this is the case will depend on a number of factors including the position when the trust was created, whether there have been any asset sales, debtor and creditor levels and current levels of cash and external financing limit (EFL) brokerage.

An external financing limit (EFL) is a cash limit on net external financing. The purpose of the EFL is to assist with the control of cash expenditure by NHS trusts. The EFL for each trust is set by the Department and determines how much more (or less) cash than is generated from its operations the trust can spend in a year and is closely linked to the cash required to fund capital schemes.

When trusts have a cash shortfall (usually where its expenditure exceeds its income) they seek to supplement their cash with borrowing, usually by obtaining additional public dividend capital (PDC) from the Department. Alongside this EFLs are brokered (via SHAs), which allows trusts to draw down additional cash via the issuing of additional PDC. This is, in effect, borrowing but is not reflected as such in a trust's balance sheet.

41 Cumulative deficits are represented on the balance sheet within the income and expenditure reserve. It should be noted that the balance in the income and expenditure reserve is not always a direct reflection of current or even recent financial performance of the trust and is often a factor of how the trust was created. For example, when trusts have merged in the past the clock has started again in terms of meeting the statutory duty, regardless of the inherited position from the predecessor organisation. There are also

examples of a trust receiving income specifically in order that it meets its statutory break-even duty only for it to remain in a very weak position and to incur further deficits, as the underlying problems have not been recognised and addressed.

Retained or in-year deficit is the trust's final position for the year after accounting for all operating expenses and interest. It is, therefore, the amount the NHS organisation's expenditure exceeds their income for that year.

Underlying deficit or surplus is the financial position a trust would be in if one-off income or expenditure is excluded. A trust may have achieved break-even for the year but only by receiving some additional income, such as financial support. Although the trust would have a nil retained or in-year deficit, there would still be an underlying deficit which would need to be addressed in order to prevent overspending in future years.

Cumulative or accumulated deficit is the amount income exceeds expenditure, taking account of the financial results from all previous years.

42 To eliminate these cumulative deficits the trust could receive an allocation of funds from the Department or they could receive additional PDC (in theory a capital reconstruction could take place, where a deficit is written off against PDC). Both of these options have a real cost to the NHS and would have to be funded from current resources. It could also be seen as letting trusts off the hook and condoning failure. If a restructuring was to take place it would involve taking funds from elsewhere in the NHS when the Department would have already relied on surpluses generated by others in previous years to help balance the NHS's books overall. Furthermore, our understanding is that when considering FT applications Monitor is primarily concerned with whether organisations have sufficient liquidity, their most recent financial performance and whether they are sustainable over the medium term.

43 We do not therefore recommend that the Department should simply restructure NHS balance sheets to eliminate deficits. But, having a deficit can have serious consequences for both the immediate and longer-term financial viability of the trust. The Department needs to deal with these consequences, concentrating first on each trust's cash position and their future financial robustness as opposed to their past weaknesses. This does not in any way undermine the importance of trusts' break-even duty. NHS trusts need to have robust plans in place to return to recurrent financial balance and generate the necessary surplus to meet that statutory break even duty. This may include the need to ensure that difficult decisions are taken about the restructuring of services so that the position of the trust remains viable.

Alternatively, PCTs (and SHAs) could explicitly accept that some services will cost more than the tariff and, if they are deemed to be necessary in the light of local healthcare needs and choices, to be funded accordingly from within the PCT's allocation.

44 There would, however, remain the question of how a trust's income and expenditure deficit had affected the balance sheet. Some NHS trusts will have permanently resolved any cash shortfall problem arising (for example via asset sales or as a result of receiving non-repayable cash support) but some will have only been able to resolve the issue temporarily through management of working capital and/or EFL brokerage.

45 The issue is whether there are medium- to longer-term implications for the trust which will affect its future financial position. For example, if there was EFL brokerage that could not be returned, any resultant PDC that has been drawn down would have to be reflected as a loan in the balance sheet. These will either need to be paid off by the trust, rescheduled over a longer period, or, in exceptional circumstances and then only in part, written off where perhaps, for example, there is a new management team and the future viability of the trust can only be secured in that way. These issues can only be addressed trust by trust.

46 The effect on liquidity of cumulative deficits should be dealt with by the operation of a transparent borrowing system to ensure that these organisations are able to meet their commitments. This is considered further later in this chapter.

PCT financial regime

47 The PCT financial regime is very different from that of trusts. They have three year allocations but also have annual resource limits which they are statutorily required to keep within. They are not therefore allowed to 'break-even taking one year with another'. Their funding arrangements and their relationship to the Department of Health also mean that their revenue accounts take the form of operating cost statements rather than income and expenditure accounts (which are required for trusts). The current arrangements are set out in Box A and Appendix 4.

48 There was much less consensus in the course of our review on whether and how the regime should be developed. This is in part a reflection of the relative newness of PCTs but it also, in our view, stems from a comparative lack of certainty as to how PCTs will develop as the new structures are introduced. Fitness for Purpose assessments, practice based commissioning and other developments will also have an impact. We think this is an area for further work.

49 The financing regime must match and support the wider structural and management arrangements. In essence the issue is whether the real unit of financial accountability is the SHA, where funds can effectively be moved between individual PCTs in order to meet particular pressures and absolute primacy is given to the SHA's control total (which is, in effect, the route adopted in 2006/07, albeit in exceptional circumstances); or whether PCTs, which would still be subject to performance management, are made more self-standing with a greater range of locally determined targets, and therefore more accountable for their own decisions and performance in meeting health needs, with the emphasis on making maximum use of the three-year allocation for the PCT's own population. Although these may not be mutually conflicting approaches and the past two years have sought to marry them, this can, as we noted earlier, result in PCTs receiving different and conflicting messages, weaken accountability and make potential cooperation with local agencies more difficult.

50 There may also be subsidiary policy questions about the extent to which PCTs will run provider arms and therefore may need greater access to capital in order to facilitate a shift from secondary to primary care by, for example, developing intermediate care and community hospital facilities, which may not be suitable for LIFT or other public private partnership arrangements.

Local Investment Finance Trusts (LIFT) is an initiative designed to assist in the regeneration of primary care services in deprived areas. LIFTs are public private partnerships (PPP) schemes.

51 However, there are a number of points where we believe immediate further consideration should be given to the regime and its operation.

52 As outlined above, PCTs are subject to RAB, principally because they receive allocations directly from the Department. They do not identify accumulated deficits on their balance sheets. RAB adjustments are fully consistent with their financial regime. Annual adjustments for small deficits may cause relatively few problems, particularly if PCT allocations are increasing rapidly year on year. However, it is probable that PCTs will have more difficulty in recovering larger deficits than trusts. Payments for family health services, including the drugs bill, cannot be adjusted. They are not in control of the payment terms under Payment by Results, except through SHA intervention and have only relatively weak controls over patient volumes. It is also likely to take time to introduce demand management measures and make them more effective. Unless PCTs have the ability to

negotiate caps and floors on referrals as set out in our reports on Payment by Results, other forms of risk management will be required.[l]

53 These points put a premium on sound financial planning over the short and medium terms and on risk management. The fitness for purpose assessments currently being undertaken provide both an assessment of the current position and a framework for future development. But they need to be followed through. **Key components of the way forward need to be:**

- The establishment of a common set of planning assumptions for a health economy that are shared between providers, PCTs and practice based commissioners.
- The development of sound medium-term commissioning plans that explicitly address service development, efficiency, equity of provision and risk management which would include sensitivity analysis. Such plans should as a minimum span three years to match allocations but could usefully extend to five years. The plans should be peer reviewed. They should also be benchmarked against programme budget and activity information in order to assess progress on commissioning more efficiently.
- Medium-term plans should be supported by annual business plans which need to be approved before the start of the year which then enables contracts and service level agreements also to be agreed before the start of the year.
- The plans need to be informed and supported by practice based commissioners. Sound financial management in PCTs requires full engagement with practice based commissioning. Only then can there be clinical sign up to referral management and patient pathway modernisation plans. The plans therefore need to address how engagement is to be achieved and how practice based commissioning will be supported with the resources and information required. They should also set out the incentive structure and how risks and rewards within it will be covered.
- Key clinical pathways agreed between the PCT, practice based commissioners and providers. There are in excess of ten million admissions in the NHS each year, covering 586 different types of care conditions. However, approximately 50 per cent of admissions are accounted for by just 50 of these conditions. The point here is that

l Audit Commission, *Early Lessons from Payment by Results*, 2005.

there should be no surprise changes to treatment patterns for example, as happened recently with the rapid increase in admissions for less than 24 hours for non-elective care, which carried both clinical and financial consequences.

- The plans and their implementation need to be supported by sound and assured information flows which allow timely action. This is a critical component. It is evident from recent cases of financial failure that such information has not been available. We make further more specific recommendations about this in Chapter 5.
- The contracts and service level agreements which implement the annual business plan must ensure that PCTs are appropriately covered for the risks which they face within the overall parameters of national policy. We have referred before to the possibility of local negotiation of caps and floors on activity and of trigger points for action. Even if this approach is not adopted contracts will still need to address information requirements, assurances about data quality, coding changes, changes to clinical pathways internal to the trust (for example, on consultant to consultant referrals) and arbitration arrangements.
- Both annual and medium-term plans need to be rigorously monitored in proportion to the risk that they represent.

54 This approach will require significant development in the capacity and capability of PCTs. It also requires improvements in their ability to develop and support practice based commissioning which is key to successful financial management. The development programme which emerges from the fitness for purpose assessments will help to do this. But we consider that the development of PCTs, including their capacity to support practice based commissioning, should be a key component of SHA performance management. Furthermore, from 2006/07 we shall be including an assessment of PCT commissioning capacity within ALE. It would also be helped by the development of suitable benchmarks which would then enable PCTs more clearly to judge their own performance and also allow more consistent application of intervention strategies.

55 Better planning and more rigorous monitoring could be supported by three further points which should be considered:

- First, that **the Department should set the allocations and agree three-year funding objectives with SHAs and through them PCTs, during which time the basic financial regime should remain the same.** Any resource limit adjustments should be made well in advance of the financial year and any further adjustments

made in accordance with specified criteria. The objective should be to provide stability of financial regime, allocations and resource limits over the period.

- Second that **the plans themselves could identify the need for the resource allocations and associated resource limits to be flexed over the three-year period.** A medium-term financial strategy linked to three-year allocations may not sit easily with managing spending within annual resource limits down to the last pound. Within their three-year allocations, PCTs may need to be able to phase expenditure to achieve service and efficiency objectives. Higher spending in the first year may be needed in order to reconfigure services and achieve savings in the second or third year. PCTs cannot plan to overspend their annual resource limit and therefore this could only legitimately be done by formally adjusting the resource limit in the first year with a counterbalancing reduction in the second or third year. Such an approach has its dangers as the subsequent savings may not be achieved and the approach might also be used to hide financial problems. It could therefore only be applied at the start of a three-year period, on the basis of an agreed and robust plan which management can deliver. It would also be essential that the changes could be accommodated within the overall departmental resource envelope or, alternatively, within the implied envelope for each SHA.
- **PCTs should be encouraged to develop modest reserves by underspending against their resource limits in order to offset possible overspends later and also to ensure best use of resources.** Under RAB this underspend would result in an increase in the PCT's resource limit the following year. To be effective PCTs must receive a guarantee that any underspends will be returned to them the following year. We are aware that a policy which encourages underspends and effectively the building of reserves will mean initially at least less money being spent on actual provision of care and that this may also affect the setting of priorities. However, no organisation can operate prudently without some element of financial reserve.

56 We believe that these three points when allied with the kind of planning outlined above would enable PCTs to make maximum use of the opportunities and flexibilities offered by three-year allocations.

57 About one third of PCTs overspent in 2005/06. For some PCTs the size of the overspends have been increasing for a number of years. As we have noted, RAB adjustments are consistent with the PCT financial regime but, in some cases, the size of the overspend and the reduction in income the following year may require smoothing over a period of

years. We have not had sight of the recovery plans for those PCTs which have incurred significant overspends against their resource limits or of their experience of recovery. We have not therefore been able to formulate a view on whether there is a need for a different financing approach. In principle, however, we believe that PCTs will need access to working capital to enable the consequences of significant overspend to be managed over the period of a recovery programme. We set out below how this could be achieved. We consider however that the question of financial recovery arrangements for PCTs with recurring significant overspends should be left open and be subject to future work.

Financing and financial support

58 The proposals set out above will also in our view need to be allied with a more transparent approach to providing finance and financial support to make them effective and to improve individual organisational accountability. There is a number of functions to be undertaken:

- Providing funds for capital investment. This is currently undertaken via allocations for NHS trusts and PCTs but, for NHS FTs, Monitor sets borrowing limits and the FTs borrow within these from commercial banks or from the Trust Financing Facility which is part of the Department of Health and provides loans on a commercial basis. The Financing Facility's operation and its interest rates are analogous to the Public Works Loan Board to which local authorities have access. Our proposals for a capital regime for NHS trusts which is similar to that for FTs would require a similar financing arrangement. Capital for PCTs might be provided on a similar basis. This would have the benefit of enabling PCTs more readily to invest, for example, in community hospitals and other facilities where current individual allocations may be too constraining. However, the prior policy question of whether PCTs should continue to have significant provider functions would first need to be addressed.
- Providing cash for working capital. There are currently three approaches for NHS trusts and PCTs – management within the organisation (for example, by slipping capital developments and using the cash available from this to meet current cash pressures); local arrangements between organisations, some of which may be brokered or sanctioned by the SHA; and a national trawl which seeks to identify those with excess cash and those with cash shortfalls and to redistribute between the two. NHS FTs make separate arrangements in line with commercial practice. We believe that accountability within organisations would be strengthened and the financial position of individual

organisations made clearer if all cash needs from external sources were met by loans. The accounting arrangements would follow from this. This would mean having a central or regional financing office that operated according to clear rules (like the Trust Financing Facility for NHS FTs) to which individual NHS trusts or PCTs would effectively be required to apply when in need of working capital for both short- and medium-term purposes. This would replace local and national cash brokerage.

- Provision of grants to organisations requiring financial support. This is currently usually undertaken by the NHS Bank – a group of SHA chief executives who decide on the provision of strategic assistance to organisations with severe financial problems. The NHS Bank also decides on the terms of the arrangements but these can include a grant. Changes to these arrangements are closely connected with the development of a failure regime which we consider below. Overall, however, we consider that a system of repayable cash loans and/or changes to pricing arrangements in the tariff would be clearer, fairer and provide better incentives than the provision of grants.
- Receipt of cash deposits. This is not currently undertaken but would be part of a move to encourage the development of surpluses and better cash management on the one hand and a system of loans for working capital on the other. Interest should be paid on the deposits.

Public Works Loan Board lends money from the National Loans Fund to local authorities and other prescribed bodies, and collects repayments on loans made.

Working capital is the current assets and liabilities (debtors, stock, cash and creditors) required to facilitate the operation of an organisation.

59 **We consider that these functions should be drawn together into a formal banking arrangement in a separately identifiable institution in order to match the more transparent financing and borrowing regime.** It should build on and incorporate the Trust Financing Facility for NHS FTs. But it would be important to recognise that the institution would not be like a commercial bank. It would, for example, be inappropriate to charge interest according to risk or to foreclose on loans to organisations because of the possible effects these would have on service provision. The institution may also itself be unable to generate funds in order to provide loans, as cash deposits from organisations in surplus may well not meet the requirements for loans. In the Commission's view, the banking function should operate as a proper institution within the NHS. It need not be established as a separate authority and it could operate either at national or at regional (SHA) level. The important points

are that it should be identifiable; staffed by experienced personnel, including some with relevant commercial banking expertise; and have defined functions and rules of operation. It should aim to provide a more clearly separate, objective and rigorous assessment of ongoing financial performance. Because the banking function would only be lending to and taking deposits from organisations within the NHS, its operations would not affect the overall financial position of the NHS or the Department's DEL.

60 There is much work to be done on the detail to establish both the feasibility and the best form of the arrangement. Specific points which would need to be considered further, however, are:

- the nature of reporting lines and staffing arrangements;
- how the bank would be funded if cash deposits were insufficient. One possibility is that it could use the cash from the buffer held by the Department against RAB deficits to meet the working capital needs of organisations in difficulty;
- how the terms of any interest payments might be set and the implications this might have for competition between NHS trusts, NHS FTs and independent sector providers; and
- the part which the banking function might play in any failure regime.

Failure regimes

61 Our remit excluded the development of a failure regime for individual NHS trusts. However, we consider that the proposals in this review and our previous work have a number of implications for the development of such a regime. The points below also take account of the fact that closing or radically reducing services is unlikely to be possible in the short term or, in many cases, over the longer term too.

62 **There needs to be a more effective and swifter mechanism for identifying and dealing with financial distress with clear trigger points and matched intervention strategies.** Our proposals for a more transparent and formal borrowing and lending regime should also enable the NHS to deal more effectively with such cases, as should the recommendations in our report on *Learning the Lessons from Financial Failure in the NHS*. Monitor's approach also provides a possible model. The Department should establish a clear set of trigger points giving early warning of impending difficulties and these should be applied consistently by SHAs. Trigger points might include:

- failure to make agreed capital or interest payments;
- departure from the business plan above set thresholds;
- breach of financial ratios set for the borrowing regime (NHS trusts only);
- a major dispute with a provider or commissioner putting financial balance at risk;
- failure to make agreed payments to other NHS bodies or a deterioration in the Better Payment Practice Code performance; or
- a drop in quality indicated by the Healthcare Commission health check or other external review, which may be indicative of wider governance problems.

63 Depending on the severity of the financial problems encountered, appropriate responses for NHS trusts (in escalating order) might include one or a combination of the following:

- temporary adjustment of the financial ratio requirements (where the issue was clearly being dealt with);
- rescheduling of repayments, with closer monitoring, subject to a formal recovery plan being put in place;
- temporary waiver of interest payments, which would only be agreed as part of a turnaround package (as now);
- capitalisation of debt in the form of PDC (recognising that debt cannot be repaid);
- capital reconstruction by writing off a major income and expenditure deficit against PDC (subject to Treasury approval, which historically has been given only very rarely); or
- local agreement, sanctioned by the SHA, of higher than tariff payment for essential services which cannot otherwise be supported. This would be a long-term solution on the basis that other services would be funded at tariff and had been reconfigured to the maximum extent possible to meet local needs.

64 The procedure for PCTs would need to be different and the scope for making changes is more limited. The responses could include rescheduling of any interest payments (or conversely provision of cash support under agreed terms) and, potentially, local adjustments to the tariff sanctioned by the SHA.

65 **We also consider that there should be more explicit and in some cases tougher consequences for dealing with personnel issues associated with financial distress**. These are considered more fully in Chapter 5 on governance issues.

4

Accounting and financial reporting

66 A transparent financial regime depends on clear internal and external financial reporting, which in turn needs to be underpinned by proper accounting. In our opinion the current financial reporting regime in the NHS has not been updated to reflect the changes in the way the funds flow around the NHS and is not currently fully in line with UK Generally Accepted Accounting Practice (UK GAAP). The changes proposed in Chapter 3 to the financial regime will also have implications for NHS financial reporting. This chapter considers:

- how external financial reporting accounting can be improved, including how it could be brought more in line with UK GAAP; and
- the changes that are required to improve internal financial reporting.

UK Generally Accepted Accounting Practice (UK GAAP) has no statutory or regulatory authority or definition. There is, however, a general consensus among the accounting profession that it is founded upon:

- the accounting and disclosure requirements of the Companies Act 1985 (as amended by the Companies Act 1989);
- pronouncements by the Accounting Standards Board (ASB) principally comprising accounting standards – statements of standard accounting practice (SSAP) and financial reporting standards (FRS) – and Urgent Issues Task Force (UITF) abstracts; and
- the body of accumulated knowledge built up over time and promulgated in (for example) textbooks, technical journals and research papers.

External financial reporting

67 The production of the statutory annual accounts[I] is the principal means by which NHS bodies discharge their accountability to taxpayers and users of services for their stewardship of public money. The form and content of the accounts is prescribed by the Secretary of State for Health, or Monitor for FTs, and both require HM Treasury approval.

I All NHS bodies have a statutory duty to produce annual accounts (NHS trusts, PCTs and SHAs – Section 98(2) National Health Service Act 1977, as amended, for NHS foundation trusts – paragraph 25(1) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003).

68 NHS bodies are expected to adhere to the accounting standards issued or adopted by the ASB. However, the government has the final say on how these standards are applied to the public sector, including NHS bodies. HM Treasury has developed a Financial Reporting Manual (FReM) setting out how the accounting standards should be implemented in the public sector. The Department of Health produces Manuals for Accounts for SHAs, PCTs and NHS trusts that are generally consistent with the requirements of the FReM and which NHS bodies are required to follow. Monitor produces a similar manual for NHS FTs, called the NHS Foundation Trust Financial Reporting Manual. These manuals are updated each year. The accounting treatment set out in the Manuals for Accounts is largely consistent with UK GAAP, but there are some departures and these are considered in this chapter.

69 Clear financial reporting and good financial management would be greatly assisted by the common application of accounting and reporting standards. This would help to improve understanding of financial matters both inside and outside the NHS, make it easier for the Department to manage the overall budget within RAB limits and reduce the scope for manipulation. **We recommend that the Manuals for Accounts governing SHAs, PCTs and NHS trusts should be brought fully into line with UK GAAP. The only differences that should remain are those which relate to NHS specific accounting issues, such as PDC.** The NHS Foundation Trust FReM has recently been reviewed and brought into line and provides a useful starting point.

70 Specific consideration should be given to the following issues:

- FRS 11 requires downward revaluations arising when assets are brought into use to be charged to the income and expenditure account (other than in certain narrowly defined circumstances). The Manuals for NHS trusts and PCTs permit them to charge downward adjustments to the revaluation reserve where the effect is expected to be short term and in practice almost always take advantage of this exception. We recognise that addressing this would have a cost, but it should result in a clearer understanding of the consequences of failing to properly maintain assets.
- NHS trusts currently recognise income in the period in which the relevant service is delivered. Application Note G of FRS 5 states that income should be recognised in the period in which it is earned, and this practice is followed by FTs. As block contracts (the income from which is not related to any specific activity) are replaced by Payment by Results it will become more important to adopt a consistent approach.

- NHS trusts have occasionally in the past been instructed to capitalise assets on a group basis, even when the assets have been individually of low value, not functionally interdependent and outside the management control of the NHS. GAAP would require such assets to be charged to the income and expenditure account.
- Before the introduction of RAB, PCTs were encouraged to take responsibility for large and unexpected provisions made by NHS trusts, to avoid the trusts going into deficit as a result of charging those provisions to income and expenditure. Arrangements of this sort are still in existence.

FRS 11 (Impairment of fixed assets and goodwill) is a financial reporting standard that sets out the accounting treatment and policies for the impairment of fixed assets and goodwill.

FRS 5 (Reporting the substance of transactions) is a financial reporting standard that sets out the accounting treatment and policies for the assets and liabilities to be included on the balance sheet, based on the substance of the transactions.

71 The elimination of variances from GAAP where there is no obvious justification for them, is not just a matter of good housekeeping. It also conveys an important message about the financial culture in the NHS – that the NHS is subject to the same sort of financial disciplines as other organisations and aims to minimise the use of rules that are peculiar to the NHS and can be manipulated for reasons of short-term expediency.

72 As well as making it easier to compare NHS accounting to commercial accounting and best practice, fewer departures from UK GAAP will mean that the Department of Health can take a different approach when producing the Manuals for Accounts. Currently there appears to be a view that there is an 'NHS method of accounting', which can be adjusted to fit departmental objectives rather than a robust approach to the implementation of UK GAAP. This perception needs to be reversed and NHS finance staff should consider UK GAAP to be the primary source of guidance for the preparation of annual accounts. NHS staff should become less reliant on specific instructions from the Department of Health and more reliant on their own professionalism. **The Department should consider whether its Manuals for Accounts should be changed to be less prescriptive and more principles based. This is consistent with the approach taken by Monitor and will help to shift the focus on to the application of UK GAAP**.

73 The Department is developing a new capital regime which should encourage a long-term approach to the management of long-term assets. As part of this development the capital accounting manual should be merged with the Manuals for Accounts (as is already the case in the FT sector). **The Department should finalise its draft capital regime and working capital proposals and issue formal guidance to NHS bodies on its operation. The Department should consider whether the financial information monitoring (FIMs) returns need to reflect the changing policy in relation to working capital management.**

74 There are at present significant differences between the ways in which the Department, SHAs, PCTs, NHS trusts and FTs present their accounts. Some of these differences follow from whether the organisation sits within the resource accounting boundary and therefore have resource limits (this applies to SHAs, PCTs and the Department itself). We have already commented on these differences in Chapter 3 and they cannot be changed unless the statutory position of these organisations is changed. It is however our view that lay readers of the accounts find the format of the NHS trust accounts easier to understand.

75 As well as ensuring alignment with UK GAAP more can be done to improve the financial information published by NHS bodies. For PCTs, much work has been done on the development of programme budgeting, which identifies PCT expenditure on a number of different medical conditions. This information has been prepared by PCTs since 2003/04 and is reported in the Department's accounts, but has not been published at individual PCT level, although it has been the Department's intention that this should happen. A decision was taken to delay implementation of this initiative until costing systems provide sufficiently robust data. Publishing this information would allow the public to see, in a more meaningful way, how their local PCT spends and prioritises the resources available to it. **The Department should now require the programme budgeting information to be disclosed as a note within the PCT accounts. An assessment will have to be made of the likely implications of including this information in the accounts, in terms of cost and time taken to produce and audit or review the information.**

76 The auditing and publishing of programme budgeting data will help to drive improvements in the quality of the underlying data and will help to emphasise improvements in value for money, as well as encourage debate on how best to use limited resources. Publishing more meaningful financial information that explicitly relates costs to outputs and bringing NHS accounting into line with UK GAAP will help to ensure that the financial information provided by different organisations can be related and compared

and will enhance financial management. But more needs to be done to ensure that NHS bodies are accountable for their financial performance.

77 Until now the annual reports produced by NHS organisations contain little more than the financial information mandated by the Department in the Manual for Accounts, although this is changing with the requirement for NHS bodies to produce an Operating and Financial Review (OFR). Annual reports are generally prepared some time after the accounts have been finalised and board involvement in their preparation tends to be limited. Public awareness of how public services are configured tends to lag many years behind the structures in place. While people are able to relate to a local council or a local hospital, there is little understanding of what a PCT does. Our view is that the accountability of PCTs to their local communities is a concept with little real meaning for most people. The current reconfiguration provides an opportunity to make this accountability real.

Operating and Financial Review must be included in the annual reports of NHS bodies from 2005/06, complying with the Accounting Standard Board's Reporting Standard 1: Operating and Financial Review. The content of the OFR is determined by an organisation's directors.

78 As a starting point, each organisation should aim to produce an annual report that addresses the needs of its different stakeholders. PCTs and most trusts have multiple user groups with different information needs, and the annual report should address each of these. The new configuration of PCTs means that their boundaries are more closely aligned with those of local authorities, and it may make sense for separate reports to be produced for separate local authority areas. These could incorporate a local authority perspective, reflecting the fact that local authorities now have a scrutiny role in health, and are able to contribute their views on performance against healthcare standards. It would also enable the public to see more clearly the joint contribution that has been made by PCTs and local authorities to the well-being of their community. **The Department should include in the Manual for Accounts some best practice guidance on annual reporting and should reinforce the requirement for NHS bodies to produce their annual report at the same time as their accounts in line with best practice in the private sector and the wider public sector. NHS organisations should assess their stakeholders' information requirements and ensure that these are addressed in their annual reports.**

79 The Audit Commission and the NAO have commented in recent years on the need for the timeliness and the quality of the annual accounts and supporting documentation to be improved.[I, II] The majority of NHS accounts are of sufficient quality and are produced on time. In 2004/05 auditors reported that 75 per cent of NHS bodies produced accounts of a sufficient quality and 87 per cent of NHS bodies produced accounts by the required deadline, however performance has deteriorated when compared with previous years. The Commission has worked with the Department and the NAO during 2005/06 in order to improve the quality of the final accounts produced by NHS bodies and will report later this year whether this has been achieved.

80 An organisation's accounts are of most relevance to the users of the accounts if they are available soon after the end of the period to which they relate. There are also benefits to the organisation in producing and publishing its accounts earlier. These benefits include the impetus to improve management accounting procedures, resulting in higher-quality, more timely information that can be used to manage the business, and a reduced burden on staff resources at the year end when annual accounts are produced. HM Treasury has set a target for all departmental resource accounts to be laid before the July Parliamentary Recess by 2005/06 and it has been recognised that the Department will not meet the HM Treasury deadline in 2005/06. Preparation and audit of the Department of Health resource account is particularly complex because it involves consolidating the summarised accounts of all PCTs, and SHAs, and some special health authorities. Any changes to the financial reporting regime need to recognise these complexities, while also ensuring that the Department and NHS bodies are able to work towards meeting HM Treasury's requirements.

81 At a practical level, as bodies move towards more formal interim reporting, both internal and external auditors will be in a position to undertake their programmes of work earlier in the cycle, reducing the burden and pressure of work in the period leading up to the submission of accounts. This could also lead to greater reliance being placed on the unaudited draft accounts, allowing the Department and NAO to begin their own work on the consolidated accounts at a much earlier stage. **The Department should enter into early discussions with both the NAO and the Commission on the current risks associated with such an approach and how quickly the NHS could move to such a process.**

I NAO/Audit Commission, *Financial Management in the NHS 2003/04*, June 2005.

II NAO/Audit Commission, *Financial Management in the NHS 2004/05*, June 2006.

Internal financial reporting

82 In line with these improvements to the reporting of published information, the Commission believes that internal financial reporting arrangements also need to be strengthened. In the Commission's opinion the financial reporting that is undertaken in some NHS organisations at present is not fit for purpose and does not support good decision making. Contributory factors to this are varied and include the poor quality of underlying data, the inability of IT systems to produce the information that is needed, under-skilled finance staff and a lack of challenge from senior managers and boards.

83 A consistent theme arising from recent Commission reports and the public interest reports issued by appointed auditors is the need for more robust internal financial reporting to NHS boards. During the review we considered whether it would be appropriate to develop a template for all NHS organisations to use when reporting to their boards, but we decided against this as any report needs to reflect local circumstances and be tailored to its users' needs and expectations. There are, however, some underlying principles that should be considered when developing robust board finance reports, which all organisations should consider and use to challenge their own processes. These are set out in **Box B**.

Box B

The qualities of a good board finance report

A good financial report needs to:

- be transparent and understandable to a non-financial board member;
- have a clear structure and be coherent;
- agree to underlying financial data on the general ledger;
- focus on matters that are relevant;
- set out clearly the financial risks;
- link clearly to performance and operational activity; and
- set out clearly the actions that are being taken to address issues and what further action is required.

In our opinion a board finance report should have the following key elements:

- an analysis of the current financial position against budgeted position. The analysis should include the financial data, an explanation of key variances, detail on key risks to the position and actions that are being taken to address variances and key risks;
- an analysis of forecast year end financial position;
- a balance sheet;
- analysis of debtors and creditors;
- an analysis of cash flow and a cash flow forecast;
- an analysis of capital expenditure;
- the numbers of staff employed; and
- the current and forecast achievement of key financial targets.

84 Most internal financial reporting is currently focused on income and expenditure, with little or no analysis of balance sheet movements, working capital or cash flow. There is a danger that, without regular balance sheet reporting, income and expenditure may be mis-stated because balance sheet movements resulting from depreciation, stock movements or changes in provisions have been overlooked or not properly understood. In the Commission's view, all NHS bodies should move to monthly balance sheet reporting as soon as possible. Major provisions should be reviewed as necessary and changes in stock balances included where there are unusual movements. Each quarter this process should include agreeing key intra-NHS balances (selected according to the size of contract) and a full assessment of provisions and stock balances should be undertaken every six months. This will enable the Department to produce summarised half-year accounts for the NHS as a whole, with the intention that this will eventually be undertaken on a quarterly basis. This will help to meet the HM Treasury requirement of earlier accounts production. **NHS organisations should review the content of their monthly Board reports and ensure that a monthly balance sheet is prepared and reported to the board. The Department should develop an action plan for the production of summarised half-year accounts, with a view to moving towards quarterly accounts in due course.**

85 With funding flows within the NHS becoming more transparent and cash surpluses and shortfalls being managed through the banking function, trusts and PCTs will also need to develop their capacity to analyse and forecast their capital and cash requirements, and NHS boards should spend time considering these. As a minimum, each organisation should be preparing three-day, weekly and monthly cash flow forecasts. Board reports should also include liquidity ratios and capital planning and cash flow forecasting should be closely linked.

86 These changes will help to promote a more commercial approach, including better debt management and the implementation of better purchasing and payment systems. For NHS trusts, they will ease the transition to foundation status. For trusts and PCTs alike they will encourage the development of service level agreements that specify clear payment terms and are less open to dispute.

87 Boards of NHS trusts also need to understand better how different parts of their businesses perform financially. They are often unable to determine, by site or by service, which areas are profit-making and which are loss-making. PCTs should compare their financial performance with others to identify how much they spend on commissioning particular types of services and whether the health of their population has improved as a result. Most NHS bodies link activity and finance in their budget monitoring reports and board reports. Those that do not routinely do this need to take immediate steps to improve the quality of the information that they provide, and, where necessary, recruit staff with the relevant skills. They should also review their IT systems and consider upgrading these if they are unable to provide the information required.

88 Even where costing is well developed, NHS bodies should review the way in which the business is stratified for costing purposes, as this may not always reflect the management structures in place. This process may also prompt new questions about the reasons why some services and some sites are more cost-effective than others.

89 In all cases, information should be presented to the board to inform strategic financial planning. Where there is clear evidence that a service or site is not cost-effective, the board needs to understand the reasons for this and decide on its course of action. This may involve discontinuing or changing delivery of a particular service or a particular site. If a board decides to continue with a service that is not financially viable, even after cost-saving measures have been implemented, it should have a clear rationale for doing so. **The Department should encourage all NHS bodies to analyse financial**

performance by service type and (where multiple locations are involved) by site to understand how each part of the organisation performs financially. PCT and trust boards should consider the differences between services as part of the annual planning cycle and take explicit decisions which take full account of the financial viability of services based on robust costing information.

5

Financial management and governance

90 The changes proposed in the previous chapters must be supported by steps to improve the financial management and governance of the NHS if the progress sought is to be brought about. This has three aspects:

- departmental and SHA oversight and management of the system;
- recruiting and developing staff with the right skills; and
- strengthening financial governance arrangements in individual institutions.

Departmental and SHA oversight and management

91 In the course of our review we have found frequent reference to five specific areas which are causes for concern and which need to be addressed. These are:

- the costing of policy initiatives;
- the development and operation of the tariff for Payment by Results;
- the availability of relevant guidance;
- the management of the business cycle; and
- the management of information.

92 Criticism over the **costing of policy initiatives** is not new. Nor is it wholly valid. It is clear for example that the Department made strenuous efforts properly to cost recent pay awards for NHS staff with help and advice from the service. In the case of Agenda for Change there was also extensive trialling among early implementers, partly in order to refine both the process and the costs. The costs of the pay awards, however, have been higher than expected, although it needs to be remembered that even small changes in percentage terms can run to significant sums because of the size of the NHS – one-quarter of one per cent of the paybill is approximately £65 million. And there are also clearly difficulties in taking account of the many and varied circumstances of the 600 or so organisations in the NHS. We do not doubt however that costing can be improved and we are aware of steps being taken within the Department to do so. But, we consider that important points here which should not be overlooked are that the process is, as far as

possible, more transparent; that the service has more confidence in it and can therefore be more confident about the outcome; and that the risks and the mitigation of those risks are more clearly acknowledged and understood. We do not pretend that this is easy. But **we propose that possible steps to achieve this would be:**

- **ensuring that the NHS organisations involved in the development of initiatives and their costings are named (this would build on the fact that such involvement is anyway routine);**
- **setting out draft costings in any consultation process so these can be seen and if necessary challenged more widely;**
- **identifying key dependencies or variables;**
- **acknowledging risks and setting out possible mitigations;**
- **piloting changes; and**
- **formally signing off the final costings at the launch of initiatives (by the Department's finance director) which would include a response to any consultation comments, a report on any pilots and the final set of workings.**

Agenda for Change is a pay and reform package aimed at ensuring that NHS staff are paid on the basis of equal pay for work of equal value. It applies to all directly employed staff, except the most senior managers and those covered by the Doctors' and Dentists' Pay Review Body.

93 **Similar points can be made about the development and operation of the tariff for Payment by Results.** There has been a review of the tariff-setting process in the light of the problems surrounding the 2006/07 tariff, which has sought to ensure that the tariff is published earlier and that it is road tested before final publication to ensure that any errors are identified and corrected. We welcome these developments. However, there remains a need to ensure that the service has confidence and understands the underlying figures and the rationale for any changes. **The aim should be to place the tariff on the same footing as resource allocation, where, although individual organisations might disagree with the results and mount their own case for change, the figuring and the process were well understood. We think that this could be helped by:**

- **an external advisory group which would give published advice to Ministers;**
- **published criteria for making changes within the structure;**

- **a clear process for gathering comments and proposals for the next round and making a response to those proposals; and**
- **some external assurance on the figuring and rationale underlying the final tariff.**

94 We also have concerns about the potential volatility of the funding flows between NHS organisations, particularly through the tariff. There can be no certainty and plans must be tested against different scenarios and assumptions. However, year-on-year changes in the detailed Payment by Results tariff can have a potentially significant affect on trusts' decisions to invest or disinvest. Trusts that make decisions in one year that specific services are profitable or unprofitable and respond accordingly may find themselves having to reverse those decisions following the release of the next year's tariff. The level of volatility is much less for entire hospitals than for groups of treatments. It would be helpful to signal a medium-term strategy for changes to the tariff both as a whole and for individual components. This would give trusts more confidence about service development and measures to improve efficiency. It would, for example, be possible to target particular areas of the tariff over a two- to three-year period for either greater investment or efficiency gains and to announce both the intentions and expected end points in advance.

95 There are also wider issues to resolve about the tariff which have become increasingly evident in this review as well as from earlier work, particularly in relation to payment for capital and replacement of assets and its role in any regime for financial failure. As we noted in our first report on Payment by Results,[l] the tariff includes an average cost of capital of about 8 per cent but for individual hospitals the actual cost varies between 4 and 15 per cent. Some of the higher costs have been met through transitional funding but the longer-term issue remains and is linked to questions raised by Monitor as to whether the tariff will enable assets to be replaced. The tariff is currently essentially geared to repay average costs and for trusts to break-even. It also includes an expectation of efficiency gains. In such circumstances it may be difficult for trusts to make surpluses and renew assets without either increasing activity or making higher than expected efficiency gains both of which would currently put downward pressure on the tariff in the following year(s). **We consider these points merit further study in the context of tariff development to ascertain both their validity and the size of any impact.**

l Audit Commission, *Introducing Payment by Results*, July 2004.

96 It has also become clear to us that the tariff is an important component of any failure regime. SHAs have the power in exceptional circumstances to suspend or adjust the operation of the tariff. Whether and how the tariff is adjusted will be an important part of any failure regime for PCTs. The converse is also true for trusts if services are deemed essential and would not otherwise be financially viable.

97 The **availability of relevant guidance** at the right time is important for both planning and sound financial management. We have already referred to the tariff for 2006/07 and the steps which the Department is taking to ensure that it is both timely and accurate for 2007/08. But there are other examples where guidance is either late or could be made more easily available. These range from allocations to planning guidance and amendments to the Manual for Accounts. **As a matter of principle NHS organisations should have the material necessary and adequate time to plan and prepare budgets for the start of the financial year. We see no reason why they should not be put on a par with local authorities, which must set and publish their budgets and council tax levels before the start of the financial year in question. We recommend that the Department sets, publishes and sticks to a timetable to achieve this in consultation with the service.** Such a timetable could also apply to the Manuals for Accounts and other reporting requirements. Adoption of our recommendation that the Manuals are brought together and based more on principles would make this easier.

98 The prompt availability of the relevant guidance is the first step in **sound management of the business cycle**. The quid pro quo is that it would be reasonable then to require that PCTs and NHS trusts set budgets and agree service level agreements with each other which are signed off by the board before the start of the year. This is currently the intention but it often does not happen. The ALE takes failure to set budgets before the start of the year into account in reaching a judgement on an organisation's overall financial performance. We have considered whether it would be right to go further than this and recommend that there should be formal penalties for failure to set budgets and agree service level agreements. However, we do not think that this would be appropriate or workable. Setting robust budgets before the start of the year should be a matter of concern to boards and a matter of professional pride for management. So too should agreement of contracts and service level agreements. Not achieving these basic points should be regarded as a sign of a weak organisation and poor management practice both nationally and locally.

99 Management of the business cycle would also be helped by having a more formalised system of arbitration for disputes over service level agreements. This should include setting out in advance criteria for arbitration and the information which will be required. There should also be a charge on the parties seeking arbitration in order to ensure that the cases considered are both serious and genuine. Arbitration panels should also include external out of area representation to ensure the fairness of proceedings. Contracts with FTs already often provide for independent arbitration. A test of fairness and suitability of service level agreement arbitration arrangements would be whether FTs were willing to join them. The recently issued Code of Conduct addresses these and other points. This is an important development which we welcome, but its success needs to be monitored.

100 Good-quality data is the essential ingredient for reliable performance and financial information to support decision making. The data must be fit for purpose, representing in an accurate and timely manner the organisation's activity. At the same time a balance needs to be struck between the importance of the purpose for which the information is intended and the cost of collecting the data to the necessary level of accuracy, detail and timeliness. NHS bodies need to determine their information priorities and put in place arrangements to secure the appropriate quality of data. Sound **information management** is critical to successful financial management. Our work has identified four areas where improvements could be made:

- First, the Department and SHAs regularly collect detailed financial information from each NHS trust or PCT through its FIMs returns. Each submission contains a number of different schedules as shown in Appendix 5. These returns have grown incrementally. There should be no doubt about the financial position of the NHS or of individual institutions within it or their direction of travel. However, as we noted in our report on *Learning the Lessons from Financial Failure in the NHS*, such information is not necessarily acted upon promptly. We have already indicated that there should be a clearer set of trigger points for action and intervention. **We also recommend that the Department continue to review the data collected for its own and SHA monitoring purposes and should take the opportunity of the new SHAs to do so from a zero base, focusing on key metrics.** We note that Monitor collects on a quarterly basis five key financial metrics for FTs (which are weighted and combined together to form financial risk rating) alongside a balance sheet, income and expenditure account and cash flow statement. FTs are also required to report on an exception basis if there are risks to compliance with their Authorisation.

- Secondly, the data collected is not necessarily reliable and can be adjusted or qualified as it passes up the line to the Department. Accuracy can also vary. As we have noted, there can be a tendency for forecasting bias. **As a matter of principle, there must be no difference between information reported within the organisation to its board and information reported to the SHA and Department.** The timeliness, reliability and consistency of reporting is a matter of professional pride as well as technical expertise, which can be tested and verified.
- Thirdly, accurate finance data needs to be complemented by accurate activity and other data. This is particularly relevant to Payment by Results where payments are reliant on accurate activity and coding data. We are currently piloting an assurance framework for Payment by Results and will report to the Department in the autumn on the outcome and possible roll out. However, the issue goes wider than data for Payment by Results. The key to better quality information to support performance management and accountability lies with the actions individual NHS bodies and the Department take to foster a culture which values the quality of data. Such a culture, which is central to an effective performance management system, must be lived out at the very top of, and pervade, the whole organisation. The NHS needs to revisit the standards for data quality that should support organisations in: defining their priorities for data quality; helping them to assess their arrangements for securing good-quality data as the basis for their performance reporting; and developing working practices which deliver these objectives. There is currently no programme of assurance on data quality in the NHS and the core standards only refer to data quality obliquely.[l] **We recommend that there should be a clearer, more obviously relevant standard on data quality and a programme of assurance to reinforce it.**
- Fourthly, the implementation of Payment by Results and the use of a national tariff has focussed NHS bodies' attention on activity levels, the need to link activity and financial information, costing systems and how costs compare to the national tariff. NHS trusts are required to produce reference cost information annually, although this information is not audited and not published. In our opinion there should be **an independent review of NHS trusts' reference costs and this information should be published.**

l Core Standard C9 is 'Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required'.

Reference costs: NHS organisations are required to submit a schedule of costs of healthcare resource groups (groups of similar clinical procedures that require approximately similar levels of resource input) to allow direct comparison of the relative costs of different providers. The results are published in the National Schedule of Reference Costs.

Recruiting and developing staff with the right skills

101 Good financial management needs well-qualified and experienced finance staff. However this is not enough on its own. The Commission's experience is that those organisations that take financial management seriously ensure that financial management skills are spread throughout the organisation, including among executive and non-executive directors, managers and budget holders – in short all those who have an influence over how resources are used. In particular, all board members (including non-executive directors) need to have sufficient understanding of the strategic and operational implications of financial matters in order to provide an appropriate level of challenge.

NHS finance staff

102 Responsibility for the development of the finance staff within NHS organisations rests with the relevant finance director and the SHA finance director. There is a National Finance Staff Development Board that offers a framework for local use and is the responsibility of the SHA finance directors. The work of the Board is informed and delivered through the NHS Finance Staff Development Network, a national resource which supports all finance staff (from those with no qualifications up to finance directors). The aim of the Board is to ensure that each NHS organisation has staff with the appropriate qualifications and competencies in place and to help all finance staff plan their own careers, become good managers and understand the business of the NHS. We are aware that the current intention is to replace the Board by a collaborative arrangement between the ten new SHA finance directors.

103 As at 30 June 2005 there were 16,992 finance posts within local NHS bodies (including NHS FTs).[I] The breakdown is set out in **Table 3**, overleaf.

I This information has been obtained from the National Staff Development Board. It relates to staff in post as at 31 June 2005 and not whole time equivalents. 18 organisations are missing from the analysis, but nevertheless the results are considered to be a representative split between the different types of NHS finance employees.

Table 3
Numbers of NHS finance staff

Type of finance staff	Number of positions
CCAB qualified	3,358
CCAB student	2,126
AAT qualified	1,005
AAT student	834
Other staff	8,502
Vacancies	1,167
Total number of positions	16,992

104 The figures show that approximately one in five finance staff members are CCAB qualified, which seems a reasonable skill mix. The vacancy levels are a concern in some specific areas. The total number of vacant posts equates to approximately 7 per cent of the total workforce, with the highest level of vacancies in London and parts of the south east, with one SHA reporting a vacancy level of 12.6 per cent for the bodies in its health economy.

Consultative Committee of Accountancy Bodies (CCAB) is a committee of the six major accountancy professional bodies in the UK and Ireland. 'CCAB qualified' therefore denotes that an accountant is a member of one of these organisations.

The CCAB itself provides a forum in which matters affecting the profession as a whole can be discussed and coordinated and enables the profession to speak with a unified voice to government.

105 **Table 4** below shows the split of the finance workforce between different types of NHS body. It should be noted that the figures do not take account of any involvement in national shared service arrangements or other outsourcing of elements of the finance function. The analysis is interesting and highlights that the average number of CCAB qualified staff is lowest in PCTs. A more in-depth analysis revealed that there are a number of PCTs that only have one qualified member of staff, although the reorganisation of PCTs this autumn should provide an opportunity to address this. Also of interest are the average numbers of finance staff and the average number of CCAB qualified staff in FTs, which is significantly higher than for other types of NHS organisations. This may be a

function of relative size, but if this pattern is repeated as more NHS trusts become FTs, it is likely that the NHS will experience significant finance staff shortages.

Table 4
Analysis of finance staff by type of NHS organisation

Type of NHS body	Numbers of CCAB qualified	Numbers of CCAB students	Numbers of AAT students and qualified	Numbers of 'Other' finance staff	Total	Average number of finance staff per type of NHS body	Average number of CCAB qualified per type of NHS body	Percentage age of finance staff that are CCAB qualified
SHA	204	54	22	74	354	12.6	7.3	57.6
PCT	1,106	648	554	1,770	4,078	14.0	3.8	27.1
NHS trust	1,661	1,184	1065	6,276	10,186	38.9	6.3	16.3
FT	387	240	198	1,549	2,374	67.8	11.1	16.3
Total	3,358	2,126	1,839	9,669	16,992	27.5	5.4	19.8

106 The routes into NHS finance vary. Many of today's senior finance managers entered the NHS as graduate finance trainees, either as part of a national training scheme currently managed by the NHS Institute for Skills and Innovation (a sister scheme to the general management scheme) or under individual schemes at local NHS body level. Some finance staff take the alternative route of gaining accounting technician status (AAT) before undertaking their professional qualifications.

107 The national training scheme is a structured scheme with approximately 200 posts at any one time. The scheme lasts for three years and offers a combination of college placements, tailor-made courses and work experience. The scheme is structured to ensure that students experience working in different types of NHS organisations and in different finance roles. The national scheme accounts for approximately 10 per cent of the CCAB trainees. In the last recruitment round for the national training scheme there were 2,300 applicants for 65 places. The scheme is currently being reviewed to consider how it can be updated to reflect the requirements of the new NHS environment.

108 In the Commission's opinion some aspects of finance staff development should be reconsidered. We welcome the review of the national training scheme, but we believe that the level and nature of support available for all trainees (particularly for those trainees not on the national scheme) should be looked into. **The work experience element of the scheme should be considered, to maximise the depth of experience obtained and to ensure that NHS employers benefit from employing trainees on work experience.** Our view is that all CCAB trainees in the NHS should receive a structured training programme that includes exposure to a variety of different roles.

109 In November 2004 the Finance Staff Development Board issued a learning and development strategy *Healthy Options: Local Solutions, Local Choice*. The paper set out the planned strategic approach of the Board to the future development of the finance function and made it clear that SHA finance directors have a key role in ensuring the appropriate recruitment, training and professional development of finance staff. The reconfiguration of the SHAs will provide an opportunity to clarify and formalise this important financial leadership role. **The Department should review the operation finance staff training at both a national and local level and use the SHA reconfiguration as an opportunity to develop the national and other schemes at SHA level.**

110 There is also a need to improve post-qualification training and professional development of finance staff at all levels. This should cover technical training, job-related training and skills development. The Finance Development Board recently issued *The Role of the Finance Director in a Patient-led NHS: a Guide for NHS Boards*. The guide is a useful reminder that, while the generic responsibilities of finance directors for financial governance and assurance, for business and commercial advice and as an executive director of the board are not new, the context and the emphasis have changed. We are aware that the Department and Monitor are currently establishing a training and development programme for finance staff in FTs and there may be scope for a similar programme to be rolled out across the NHS. There is also a need for a development programme to enable senior finance staff to make the transition from department head to board member. Such a programme should focus on building strategic skills. **The Department should develop a range of training and development programmes for qualified finance staff, including a mandatory Continuing Professional Development (CPD) programme to ensure that staff can deliver to the higher standards now required.**

111 Our view is that improved training and development programmes should, over time, provide NHS organisations with most of the skills they need. The recently issued *Financial Assurance Standards for NHS Finance Teams* and the ALE provide good frameworks for assessing where there are deficiencies in performance. However, there will always be a need to introduce new people with new ideas and, in the short term, there appears to be a shortage of commercial skills and experience among finance teams that are largely home-grown. These skills need to be brought in sooner rather than later as NHS trusts move to foundation status and the new financial regime makes greater demands. **The Department should promote a greater flow of commercial finance skills into the NHS through the development of exchange programmes**.

112 PCTs in particular need to develop some very specific skills to address the challenges of practice based commissioning and Payment by Results. The key skills for PCTs in the future will be in commissioning and demand management. While basic commissioning skills are in place at most PCTs, not all have the specific skills needed to commission strategically and to manage legally binding contracts. The reduction in the number of PCTs will help to concentrate those skills that do exist, but a wider repertoire of skills will need to be developed at each of the new PCTs. These include the ability to assess local needs and decide priorities, to redesign local services around these priorities and to manage the performance of providers. Many of these skills will need to be shared across the finance and commissioning functions.

113 At the same time, demand management (including tackling the issue of growing emergency admissions) will assume a greater importance, particularly in areas of better health. The changes that have been introduced over the last three years have already absorbed more resources than expected, and PCTs will need to develop a more sophisticated approach if they are to maintain equilibrium in the future. **PCT 'fitness for purpose' reviews should be used to undertake skills and needs assessments of the commissioning arrangements that will be in place in the new configuration of PCTs. Any concerns should be raised with the new PCTs' chairs and chief executives and the peer groups that have been formed for the reviews used to support implementation of the subsequent action plans. The Department should develop training for commissioning staff to cover both the policy issues and the skills needed to commission strategically.**

Non-finance staff

114 The Commission has in recent reports focused on the requirement for finance skills to be spread throughout organisations. As well as the need for the skills of NHS finance staff to be developed to meet the challenges of the new NHS environment, increased financial awareness is also required at clinician and general manager level. Our experience is that there is a wide disparity of financial management competency and it would be helpful for NHS bodies, particularly the new PCTs and SHAs, to undertake an assessment of the skills within their organisations. A requirement of Agenda for Change is that financial responsibilities of posts and the knowledge and skills needed are now required to be contained within job descriptions. In our opinion a structured training programme covering financial issues needs to be in place for non-finance staff. **We are aware that the Department has increased the emphasis on financial management skills by extending the remit of the National Finance Staff Development Board to cover staff in general management. In our opinion the successor to the Board should see this as a key priority.**

115 The Commission has also emphasised the need for clinicians to become more involved in the financial management arrangements in their organisations and to take ownership for the resources they consume. It is, after all, clinicians who spend most of the NHS's money. Lack of engagement of clinicians in the core management processes of the organisation was a feature in a number of the organisations we reviewed as part of the research for *Learning the Lessons from Financial Failure in the NHS*. In that report we made a small number of recommendations on the steps NHS organisations can take to ensure senior clinicians form part of the mainstream budget holding and budgetary accountability structures. It is our view that practice based commissioning cannot work without the engagement of clinicians. In our booklet *Early Lessons in Implementing Practice Based Commissioning*, we reviewed how successful PCTs had been in engaging with clinicians and it is clear that this area is going to be a significant challenge for PCTs. We will be following up these reports with a further report looking at how finance staff and clinicians can engage better on financial issues. This report will be issued in Spring 2007.

Strengthening financial governance

116 As well as recruiting and developing staff with the right sort of skills, NHS organisations also need to strengthen their governance arrangements to improve understanding of key financial issues.

117 Chapter 4 argued for changes to the reporting of financial information to enable boards to make coherent strategic decisions, in which the financial consequences of different options are modelled alongside other consequences. Not all boards, however, have the capability to act in this strategic way, even if the necessary information is available to them. We are aware that the Department and the NHS Appointments Commission provide some training and guidance to support non-executive directors. All non-executives need to take advantage of this, particularly those who do not have a financial background.

118 Guidance issued by the NHS Appointments Commission sets out clearly that making sure that the finances of the organisation are managed properly with accurate information is a key responsibility of an NHS non-executive director. The NHS Appointments Commission requires that candidates for non-executive posts should have experience at a senior level in a number of areas, including finance, governance and strategic planning. All non-executive directors should have an annual performance review by the Chair. This includes a self assessment and an assessment by the Chair against objectives within standard criteria and the setting of objectives for the following year. Development needs are identified and monitored through the annual appraisal process. The Appointments Commission has a national training board supported by a network of regional boards to provide advice on training needs. Training for non-executive directors is provided nationally and locally, with courses on NHS finance run on the behalf of the NHS Appointments Commission by the HFMA. There is an induction event for all new non-executives, which covers financial issues.

119 The FT diagnostic provides an opportunity for trusts to consider the balance of skills on boards. It would be helpful if SHAs were to review completed diagnostics, to identify local themes for training requirements. The reconfiguration of SHAs and PCTs provides an opportunity to reconsider the mix of skills on the boards of these bodies and to take action to fill any gaps. **We welcome the skills profile for boards which has been set out by the NHS Appointments Commission and which is in line with that for FTs.**

120 An important source of information and assurance for boards that is currently under used is the internal audit function. In our opinion many organisations select their internal audit providers on the basis of cost alone, without taking sufficient account of quality or value for money. Boards should ensure that the internal audit programme is based on the organisation's own risk assessment, informed by the external auditor's views on areas for review. Our experience is that some internal audit reviews are under-resourced, and their scope is too limited to offer adequate assurance to the Board. This may not always be obvious to the board or audit committee, which believes that it is receiving a higher level of assurance than is in fact the case.

121 Once an internal audit programme has been approved, it should be managed and delivered. Audit committees should not approve variations to a programme that is underway, for example by dropping some projects simply to compensate for cost over-runs on others. Where internal auditors lack the capacity to undertake a particular project in full and to budget additional resources should be procured.

122 Audit committees should ensure that they understand the value that they are receiving from internal audit work and should assess the effectiveness of internal audit on an annual basis. **The Department should develop and provide training for non-executive directors on the integrated governance handbook and best practice risk management processes to help boards and audit committees to use internal audit appropriately. All NHS bodies should ensure that their internal audit programmes are driven by a proper process of risk assessment, that projects are scoped to cover all key issues in an area, and that the effectiveness of internal audit is reviewed regularly.**

123 Good financial governance needs to be underpinned by performance management arrangements that support and encourage excellent performance. In our view there is a need for a more consistent approach to the treatment of poorly performing executive directors. Currently, it is common for an executive who is removed from his or her post on performance grounds, to either be seconded or re-employed by another NHS organisation (or the Department itself) or alternatively be given consultancy work within the NHS. In our opinion this sends the wrong message. The high penalty of removal from post creates an incentive for covering up poor performance and the routine use of redeployment blurs the distinction between weak performers and those individuals who could perform effectively under different circumstances. Furthermore without adequate performance assessments, training and support there is a substantial risk that poor

performance will simply be repeated in a new setting. **In the Commission's view, redeployment should be used much more sparingly. The Department should develop revised guidance on executive director appraisal, including a formal rating system and detailed guidelines for the treatment of poor performance. These should encourage early consideration of additional training and other support, a move to a more appropriate post (but only with additional training and support) and a recognition that in come cases termination of employment is the most appropriate option.**

124 Finally the issue of poor performing non-executive directors (including chairs) should be considered. Our understanding is that the removal of non-executive directors on the grounds of individual poor performance can be a lengthy legal process. In circumstances of poor performance, non-executive directors are often encouraged to resign, to avoid formal action having to be taken against them. **We recommend that the legal basis for appointments be reviewed to see if there is scope for removing non-executives on the grounds of corporate as well as individual failure.**

6

Conclusions and recommendations

Conclusion

126 The current financial regime, though complex, has worked relatively successfully over many years, but the NHS environment has changed and the regime now needs to change accordingly. Much of the financial management and accounting regime dates back to 1990 with new developments superimposed on to it. Weaknesses in the regime have become increasingly evident. Departmental and SHA actions, which are taken for the good of the NHS collectively nationally or locally, but which can also be influenced by expediency, can cut across the accountability of individual organisations for their own performance (for example by requiring that trusts or PCTs give up surpluses to fund problems elsewhere). They can also obscure the real position for example by the way in which financial support is provided and cash is brokered around the system. In any case, the introduction of the Payment by Results tariff, FTs and a greater element of competition require both new skills and different approaches.

127 Our report sets out a number of recommendations to address these issues. It also makes proposals to improve Department of Health and SHA oversight of the system and the ability of organisations to work within it by identifying improvements which could be made to Department costings, the operation of the tariff, data, provision of timely guidance, the skills of finance staff, the capacity and capability of boards, and the understanding and commitment of frontline staff.

128 Many of the recommendations are linked. They also build on many strengths and existing developments. We believe that implementing the recommendations set out in this report will result in a fairer, more transparent regime, with NHS bodies better able to manage their affairs. NHS bodies will also be less affected by failures elsewhere in the system and will therefore become more accountable for their own financial performance.

129 The overall effect of implementing the recommendations would be that the NHS and individual bodies within it to operate on a sound and sustainable financial footing. They would:

- ensure that the Department of Health meets it commitments to HM Treasury and the taxpayer while enabling trusts to operate in a more business-like way;
- bring greater clarity to the financing system both for individual organisations and for the NHS as a whole;

- further improve the professionalism of NHS finance staff; and
- increase the capacity and capability of individual bodies to manage their affairs and at the same time increase their accountability for doing so.

130 They would not of themselves prevent NHS bodies from incurring deficits. But they would put trusts and PCTs in a better position not to do so and, importantly, give them a better prospect of recovery. They should also put trusts and PCTs in a better position to achieve efficiency gains.

Recommendations

131 The recommendations made in this report are set out below.

Resource accounting and budgeting

- The RAB regime should not be applied to NHS trusts. In our opinion the Department should establish a central buffer fund to absorb any short-term deficits incurred by NHS trusts and NHS FTs.
- To ensure that all NHS trusts are treated consistently we recommend that any element of the deficit which had resulted from RAB adjustments should be eliminated through provision of cash backed income.

Trusts

- We consider that there would be merit in moving all NHS trusts onto a financial regime which gives greater emphasis to cash and liquidity and has transparent arrangements for borrowing for both capital and revenue purposes.

Primary care trusts

- The Department should set the allocations and agree three-year funding objectives with SHAs and through them PCTs during which time the basic financial regime should remain the same.
- The plans themselves could identify the need for the resource allocations and associated resource limits to be flexed over the three-year period.
- PCTs should be encouraged to underspend against their resource limits in order to offset possible overspends later and also to ensure best use of resources.

Financing and financial support

- We consider that the Department should establish an NHS banking function to enable a more transparent financing and borrowing regime.

Failure regimes

- There needs to be a more effective and swifter mechanism for identifying and dealing with financial distress with clear trigger points and matched intervention strategies.
- There should be more explicit and in some cases tougher consequences for dealing with personnel issues associated with financial distress

External financial reporting

- The Manuals for Accounts governing SHAs, PCTs and NHS trusts should be:
  - brought fully into line with UK GAAP;
  - combined with the Capital Accounting Manual; and
  - less prescriptive and more principles based.
- The Department should now require the PCT programme budgeting information to be disclosed as a note to the accounts.
- The Department should include in the manual for accounts some best practice guidance on annual reporting and should reinforce the requirement for NHS bodies to produce their annual report at the same time as their accounts in line with best practice in the private sector and the wider public sector.

Internal financial reporting

- The Department should develop an action plan for the production of summarised half-year accounts, with a view to moving towards quarterly accounts in due course.
- The Department should finalise its draft capital regime and working capital proposals and issue formal guidance to NHS bodies on its operation.
- The Department should encourage NHS trusts to analyse financial performance by service type and (where multiple locations are involved) by site to understand how each part of the business performs financially.

Departmental oversight and management

- The Department should make their costing processes more transparent. We propose that possible steps to achieve this would be:
  - ensuring that the NHS organisations involved in the development of initiatives and their costings are named (this would build on the fact that such involvement is anyway routine);
  - setting out draft costings in any consultation process so these can be seen and if necessary challenged more widely;
  - identifying key dependencies or variables;
  - acknowledging risks and setting out possible mitigations;
  - piloting changes; and
  - formally signing off the final costings at the launch of initiatives (by the Department's finance director) which would include a response to any consultation comments, a report on any pilots and the final set of workings.
- The tariff should be set on the same basis as resource allocations, where, although individual organisations might disagree with the results and mount their own case for change, the figuring and the process were well understood. We think that this could be helped by:
  - an external advisory group which would give published advice to Ministers;
  - published criteria for making changes within the structure;
  - a clear process for gathering comments and proposals for the next round and making a response to those proposals; and
  - some external assurance on the figuring and rationale underlying the final tariff.
- The Department should publish and stick to a timetable for the release of planning guidance to NHS bodies.
- The Department should continue to review the data collected for its own and SHA monitoring purposes and should take the opportunity of the creation of the new SHAs to do so from a zero base, focusing on key metrics.
- There should be a clearer, more obviously relevant standard on data quality and a programme of assurance to reinforce it.
- There should be an independent review of NHS trusts' reference costs and this information should be published.

Recruiting and developing staff with the right skills

- The Department should review the operation of the finance trainee scheme at both a national and local level and use the SHA reconfiguration as an opportunity to develop the national and other schemes at SHA level.
- The Department should develop a range of training and development programmes for qualified finance staff, including a mandatory Continuing Professional Development (CPD) programme to ensure that staff can deliver to the higher standards now required.
- The Department should promote a greater flow of commercial finance skills into the NHS through the development of exchange programmes.
- PCT 'fitness for purpose' reviews should be used to undertake skills and needs assessments of the commissioning arrangements that will be in place in the new configuration of PCTs. The Department should develop training for commissioning staff to cover both the policy issues and the skills needed to commission strategically.

Strengthening financial governance

- The Department should develop and provide training for non-executive directors on the integrated governance handbook and best practice risk management processes to help boards and audit committees to use internal audit appropriately.
- All NHS bodies should ensure that their internal audit programmes are driven by a proper process of risk assessment, that projects are scoped to cover all key issues in an area, and that the effectiveness of internal audit is reviewed regularly.
- Redeployment should be used much more sparingly. The Department should develop revised guidance on executive director appraisal, including a formal rating system and detailed guidelines for the treatment of poor performance.
- We recommend that the legal basis for appointments be reviewed to see if there is scope for removing non-executives on the grounds of corporate as well as individual failure.

Future work required

132 Our review has highlighted that the management of NHS finance is complex and involves interplay between a number of different bodies, with different financial regimes, reporting arrangements, objectives and incentives. It must be recognised that making changes to one element of the regime will inevitably have an impact elsewhere in the system and this needs to be kept in mind as the recommendations are reviewed and implemented.

133 Given the short time available to us to undertake the review we have not been able to be definitive in all the areas covered in the report and we believe that there are some issues that would merit more detailed investigation. These are:

- the size of the buffer required to provide the Department of Health with some protection against the aggregate performance of NHS bodies (including NHS FTs) and to eliminate the impact RAB has had on the NHS trusts it has been applied to. Chapter 3 sets out some of the factors that should be considered when identifying the size of any potential buffer, in our view these could usefully be considered further;
- a more detailed review of the information currently collected and used by SHAs and the Department of Health in order to monitor financial performance. Currently, a considerable amount of information is collected and our view is that it is not all used;
- the financial regime for PCTs, specifically the incentives and levers available to PCTs and the need for a failure regime for PCTs;
- the practical considerations in establishing a banking function, specifically the reporting lines and staffing arrangements, how the bank would be funded if the surpluses lodged with it were insufficient and the bank's role in relation to NHS organisations in serious financial difficulties; and
- data quality in the NHS, in particular the development of a coherent set of data quality standards and a programme of assurance to reinforce them.

134 The Commission would welcome the opportunity to discuss with the Secretary of State and the Department of Health the details contained in the report and how the further work identified above may be taken forward.

Appendix 1: Terms of reference

Purpose

The Secretary of State has requested that the Audit Commission undertake a review of the NHS financial management and accountancy regime. The review has been commissioned as a result of the current financial position of the NHS as a whole and in particular the number of NHS bodies with deficits. The objectives of the review are to consider and comment on the current regime and recommend changes that:

- enable and encourage the NHS and individual bodies within it to operate on a sound and sustainable financial footing;
- support the identification of financial problems and facilitate recovery;
- promote clear and transparent accountability; and
- support individual organisations to develop the necessary financial management capacity and capability to operate effectively.

Scope of work

The remit of the review will include how these regimes work within SHAs, PCTs and NHS trusts. It is intended that the report will specifically cover:

- the current NHS financial regime, including how the RAB regime is applied to NHS bodies;
- the financial reporting regime (as set out in the NHS Manuals for Accounts) and its transparency;
- the accountability framework;
- the financial management capacity and capability of NHS organisations, including the quality of reporting to boards and the information available to them; and
- the role and work of internal audit.

The review will build on previous work undertaken by the Audit Commission and other bodies but will also involve additional research and analysis.

Constraints

The report and the recommendations made within it will recognise that the Department of Health and NHS bodies are required to operate within the overall accounting framework set by HM Treasury.

The overall level of NHS funding, the formula for allocating funds to PCTs, or the development of a failure regime for individual NHS trusts will not fall within the remit of the review.

The report will not consider the financial framework for NHS FTs, other than from the perspective of preparing NHS trusts for gaining FT status or how lessons from that framework might be applied elsewhere in the NHS.

Governance arrangements

The research and development of the report will be undertaken by the Commission with the assistance of external consultants, where appropriate. In doing so, the Commission will be advised by its NHS Financial Management Advisory Group (which includes representation from the Department, the NAO, Monitor, the Healthcare Commission and NHS bodies). The Commission will invite a representative from HM Treasury to join the Group and assist with the report's development.

Reporting arrangements

The Commission will provide a report to the Secretary of State. The report will make a series of practical recommendations to the Secretary of State on how the regime could be improved. The report will be published.

Timescale

It is intended that a report will be submitted to the Secretary of State before the Summer recess (25 July 2006). Where necessary it will identify where further work needs to be done.

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Appendix 3: The Commission's NHS Financial Management Advisory Group

Objectives

To facilitate the coordination of work on NHS financial management, to achieve the shared aim of helping NHS bodies to improve their financial management arrangements. Also, to provide advice to the Commission on NHS financial management issues.

Terms of reference

- To provide a forum for the sharing of issues about NHS financial management.
- To ensure that knowledge of the various organisations' work on financial management is shared and that activity is coordinated and not duplicated.
- To identify opportunities for the various organisations to work together, where collectively more could be achieved than could be achieved by organisations working independently.
- To provide advice to the Commission on its NHS financial management work.

Way of working

- The group provides a source of independent expert comment on NHS financial management but is advisory only and does not form part of the Commission's management processes.
- Members can send substitutes when unable to attend any meeting.
- Members are able to consult with colleagues on relevant issues and to report back to the bodies they represent as they consider appropriate. Confidential matters would be clearly identified.
- The group will meet two or three times a year.

Membership

Professor Peter Smith (Chair) – Commissioner and Director of the Centre for Health Economics at the University of York

Steve Bundred – Chief Executive, Audit Commission

Steven Corbishley – Director NHS Financial Audit, National Audit Office

Richard Douglas – Finance Director, Department of Health

Jennifer Dixon – Commissioner and Director of Health Policy, King's Fund

Peter Dixon – Chair, University College Hospitals NHS Foundation Trust

Martin Evans – Managing Director, Audit, Audit Commission

Steve Freer – Chief Executive, Chartered Institute of Finance and Accounting (CIPFA)

Colin Gentile – Finance Director, St George's Healthcare NHS Trust

Kate Handy – District Auditor, Audit Commission

Stephen Hay – Chief Operating Officer, Monitor

Victoria Howes – Healthcare Economist, Healthcare Commission

Emma Knowles – Financial Management Specialist, Audit Commission

Sir Thomas Legg – Commissioner and Chair, Hammersmith Hospitals NHS Trust

Andy McKeon – Managing Director, Health, Audit Commission

Mark Millar – Finance Director, Essex Strategic Health Authority

David Moss – Commissioner and Programme Director for NHS Pay Reform, Department of Health

Bill Moyes – Executive Chairman, Monitor

Kevin Orford – Director of Finance, Performance and Commissioning and Deputy Chief Executive, East Midlands Strategic Health Authority

Tim Parker – Commissioner and Chief Executive, Automobile Association

Peter Shanahan – Finance Director and Deputy Chief Executive, University Hospital Birmingham NHS Foundation Trust

Adrian Towse – Director, Office of Health Economics and Non-executive Director and Chair of the Governance Committee, Oxford Radcliffe Hospitals NHS Trust

Alison Tonge – Finance Director and Deputy Chief Executive, Stockport Primary Care Trust

Appendix 4: The current financial framework

NHS trusts

Background

NHS trusts were formed from 1991 onwards as a result of the NHS and Community Care Act 1990. In 2005/06 there were 234 NHS trusts, including mental health, ambulance and specialist NHS trusts.

All NHS trusts have a trust board which is collectively responsible for promoting the success of the organisation by directing and supervising its affairs. The trust board includes both executive and non-executive members. Non-executives work as members of the board team with the executive members (such as the chief executive, finance director and medical director).

When NHS trusts were first formed they were provided with public dividend capital (PDC), to enable them to purchase the trust's assets from the Secretary of State. PDC is, therefore, a form of long-term government finance. A dividend is payable by trusts to the Exchequer to cover the expected return on the Secretary of State's investment.

Funding

The majority of revenue funding is received as a result of the commissioning process with PCTs and other NHS trusts. Increasingly services are being commissioned under the Payment by Results regime. Contracts are not legally binding, their form is set out in Section 4 of the NHS and Community Care Act 1990. NHS trusts cannot take PCTs to court for non-payment, equally, PCTs cannot take NHS trusts to court for non-performance of contracts. Disputes are settled by the Secretary of State via SHAs. Other sources of income include:

- private patients;
- road traffic act income;
- patient transport (ambulance trusts); and

- income generation schemes which use surplus capacity to generate income to be used for healthcare purposes.

Capital financing applies over two time horizons. Originating capital relates to the PDC NHS trusts received to fund the assets transferred to them under the NHS and Community Care Act 1990, outlined above. NHS trusts also receive annual capital allocations for new and replacement asset purchases. A CRL is set for NHS trusts which they are required to keep their annual capital expenditure within. This is explained in more detail under statutory duties.

NHS trusts are required to manage their expenditure within a preset external financing limit or EFL. The purpose of the EFL is to control the cash expenditure of the NHS as a whole to the level agreed by Parliament. The EFL sets how much more or less cash than is generated from its operations the trust can spend in the year. The EFL is explained in more detail under statutory duties.

Statutory and departmental duties

NHS trusts have statutory financial duties as well as secondary departmental duties. These duties are summarised in the table below.

Duty	Description
Break-even	**To achieve a break-even position on income and expenditure taking one year with another.** Section 10 of the NHS and Community Care Act 1990 states that 'Every NHS trust shall ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account'. This is taken to mean that NHS trusts should break-even over a three year rolling period. Exceptionally, this may be extended to a five year period with the agreement of the SHA.
Capital resource limit (CRL)	**NHS bodies are required to keep capital expenditure within a predetermined CRL.** The CRL is a relatively new financial requirement as it was introduced with the implementation of RAB. The CRL limits the amount of capital expenditure an NHS trust can incur in the financial year. An initial CRL is issued by the Department at the start of the year although adjustments can be made during the year. The calculation of the CRL is linked to the calculation of the EFL.

Duty	Description
External financing limit (EFL)	**A cash limit on net external financing and determines how much more (or less) cash is generated from operations than can be spent in a year.** The EFL is set once the NHS trust's capital expenditure plans have been approved. The EFL is based on the trust's external financing requirement (EFR) which is calculated based on capital requirements (capital expenditure plus a working capital requirement) less internally generated resources (depreciation charged to the income and expenditure account plus any income and expenditure surplus after payment of PDC dividends plus cash proceeds from the disposal of assets). The EFL is, essentially, a cash-based control and, while it is called a limit, it operates as a target that must be hit each year.
Capital cost absorption rate	**To absorb capital costs in full through a charge calculated at 3.5 per cent of the average relevant net assets of the body. NHS trusts pay this charge as a public dividend to the Treasury via the Department.** The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. NHS trusts are required to absorb the cost of capital (effectively the dividend paid on PDC) at a rate of 3.5 per cent of average net relevant assets. Relevant net assets are calculated as the total capital and reserves of the NHS trust less the donated asset reserve, the government grant reserve and cash balances in the Office of the Paymaster General accounts. If the calculation of PDC dividends over relevant net assets is not within the 3-4 per cent range then the trust is deemed to have failed this duty.
Better Payments Practice Code	**To pay all non-NHS trade creditors within 30 days of receipt of goods or valid invoice (whichever is later).** The target of the better payments practice code is to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note: Shading indicates a statutory duty. Non-shading indicates a departmental duty.

Format of accounts

The accounts of an NHS trust comprise:

- income and expenditure account (all revenue transactions are reflected in this statement which shows the net surplus/deficit made by the body in the year);
- balance sheet;
- cash flow statement;
- statement of total recognised gains and losses; and
- associated notes – in addition to usual UK GAAP disclosures NHS trusts have to report against their financial duties (break-even, CRL and EFL) and their performance in paying creditors, they also have to disclose any losses and special payments over £250,000 and balances with other government departments.

The accounts also include the auditor's report, the statement of directors' responsibilities, the statement on internal control and the accountable officer's statement.

Resource accounting and budgeting

NHS trusts have a statutory duty to break-even taking one year with another. Therefore, in the years following a deficit their statutory duty requires that they recover that deficit either by reducing expenditure or increasing income, thereby generating a surplus.

Local application of RAB means that where a NHS trust has incurred a deficit, the SHA may reduce the revenue resource limit for the associated PCT who, in turn, may reduce the NHS trust's income by the same amount. As the NHS Trust still has to achieve its break-even duty, it still has to recover the cumulative deficit brought forward, even though it is now operating with reduced income. This is known as the 'double deficit' issue.

NHS foundation trusts

Background

NHS FTs were created as a result of the Health and Social Care (Community Health and Standards) Act 2003 and are independent public benefit corporations. This is intended to achieve far greater local ownership and involvement of patients, the public and staff rather than control from the Department.

NHS trusts are required to apply to achieve FT status. The Independent Regulator of Foundation Trusts (Monitor) reviews the applications and if the application is successful, Monitor issues an operating licence. As at 1 June 2006 there were 40 FTs.

FTs are not subject to control from the Department or SHAs. Instead their functions are executed through a board of directors, which in turn is responsible to a board of governors. The board of governors is made up of elected individuals from a wide stakeholder and community membership, the majority of whom are required to be patients (current or previous) of the FT or members of the public living in the FT's natural catchment area.

Funding

Like NHS trusts, most of the income received by FTs is derived from agreements reached with local PCTs to provide locally relevant services for NHS patients. Payment by Results has been fully applied to FTs.

FTs have new financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows. These limits are, therefore, based on affordability. FTs are also permitted to retain financial surpluses to invest in the delivery of new NHS services.

Statutory and departmental duties

There are no financial duties for FTs set out in the Act, other than the requirement to ensure that the proportion of total income made up of private patient income is no greater than the proportion it was in 2002/03 (or the base year if the NHS trust did not exist in 2002/03). The Act also requires Monitor to establish a prudential borrowing code but does not state that FTs have to follow it. The financial duties of FTs are set out in the terms of their authorisation.

As part of the NHS, FTs are still required to exercise proper governance, probity and responsibility for public funds. FTs are allowed to incur deficits and re-invest surpluses, and operate on a similar basis to commercial organisations. Under their authorisation, FTs are required to 'operate effectively, efficiently and economically and as a going concern' and to 'comply with a range of operational and financial requirements'. The main financial target for FTs is, therefore, to remain solvent.

Format of accounts

The accounts of an NHS FT comprise:

- income and expenditure account (all revenue transactions are reflected in this statement which shows the net surplus/deficit made by the body in the year);
- the balance sheet;
- the cash flow statement;
- the statement of total recognised gains and losses; and
- associated notes – in addition to usual UK GAAP disclosures FTs have to report against their financial duties (private patient income and performance against the prudential borrowing code), they also have to disclose any losses and special payments over £250,000 and balances with other government departments.

The accounts include the auditor's report, the statement of accounting officer's responsibilities and the statement on internal control. The accounts of an FT are laid before Parliament which other NHS accounts are not.

Resource accounting and budgeting

FTs are not directly affected by the RAB regime. However, at least two of the NHS foundation trusts that became operational part way through 2004/05 were invoiced by their local PCT (on the instruction of the SHA) for the deficit they recorded in their final period as an NHS trust. This was disputed and finally agreement was reached that it was not necessary to pay as there was no requirement in the NHS contract between the NHS trust and the PCT to recover deficits in this way. Had the invoice been enforceable then the NHS trust would have had to accrue for the liability in its final period which would have doubled the deficit. This is an issue which has not been formally resolved, although we are not aware of any instances of it occurring in 2005/06.

Strategic health authorities

Background

SHAs were established in 2002/03 following the NHS Reform and Health Care Professions Act 2002 and are the local headquarters of the NHS. There were 28 SHAs in place during 2005/06. However, as a result of *Commissioning a Patient-led NHS*, from 1 July 2006, the number of SHAs reduced to ten. The aim is for fewer, more strategic organisations to deliver stronger commissioning functions, leading to improved services for patients and better value for money for the taxpayer.

The role of SHAs includes performance managing the NHS locally, on behalf of the Department, thereby ensuring successful delivery of services. SHAs themselves are not responsible for providing any health services.

Funding

SHAs need funding for two purposes: their own management and workforce development. The amount of funding each SHA receives for its own management purposes is determined by designating a baseline of £4.3 million for each SHA and then additional specific allocations above this, for population bases over two million and any other national costs such as Agenda for Change and pension increases. This funding for the SHA's own management covers items such as staffing, accommodation and office expenses.

Workforce development relates to the planning and development of the healthcare workforce, as well as the delivery of government workforce targets. Workforce development confederations (WDC) were charged with leading on these activities, but these confederations merged with their associated SHAs from 1 April 2004. Some are now known as workforce development directorates (WDD).

SHAs are allocated revenue and capital resource limits by the Department, as well as a cash limit, which they must keep their annual expenditure within. The cash limit covers both revenue and capital. Requirements to remain within these limits are explained in more detail under statutory duties.

Statutory and departmental duties

SHAs have statutory and departmental financial duties they are require to achieve each year. These duties are summarised in the table below.

Duty	Description
Revenue resource limit (RRL)	**A statutory duty to keep revenue expenditure within a predetermined resource limit.** Section 97AA of the NHS Act 1977 states that 'It is the duty of every Health Authority and every Special Health Authority to ensure that the use of their resources in a financial year does not exceed the amount specified for them in relation to that year by the Secretary of State'. This section was inserted into the 1977 Act by Section 12 of the Government Resources and Accounts Act 2000. SHAs are set a RRL by the Department, which specifies the total revenue resource available to the SHA for the year.
Capital resource limit (CRL)	**NHS bodies are required to keep capital expenditure within a predetermined CRL.** The Department sets a CRL for each SHA, which specifies the total capital resources available to the SHA for the year.
Cash limit	**A duty not to spend more than the cash allocated to the body. There is a combined limit for both revenue and capital.** The Department sets an annual cash limit for each SHA. SHAs are required to keep their cash expenditure during the year within this set limit.
Financial balance	**To achieve operational financial balance each year – defined as not exceeding the resource limit excluding unplanned financial assistance received.** Operational financial balance is defined as not exceeding the SHA's resource limit when unplanned financial support is taken into account.
Better Payments Practice Code	**To pay all non-NHS trade creditors within 30 days of receipt of goods or valid invoice (whichever is later).** SHAs should aim to pay all NHS and non NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note: Shading indicates a statutory duty. Non-shading indicates a departmental duty.

Format of accounts

The accounts of a SHA comprise:

- operating cost statement (OCS) – all revenue transactions except parliamentary funding are reflected in this statement which shows the net operating costs of the body;
- the balance sheet, this includes the general fund which is where parliamentary funding is shown;
- the cash flow statement;
- the statement of total recognised gains and losses; and
- associated notes – in addition to usual UK GAAP disclosures SHAs have to report against their financial duties (RRL and CRL) and their performance in paying creditors, they also have to disclose any losses and special payments over £250,000 and balances with other government departments.

The accounts include the auditor's report, the statement of directors' responsibilities, the statement on internal control and the accountable officer's statement.

Funding is shown as parliamentary funding in the general fund on the balance sheet of SHA accounts rather than in the OCS. The general fund represents the total assets less liabilities of the SHA, to the extent that it is not represented by other reserves and financing items. The main items that go through the general fund are the net parliamentary funding received in the year and the total from the OCS (in other words, expenditure in year less miscellaneous income). Where a SHA overspends or underspends against its RRL, the impact is shown in the general fund.

Resource accounting and budgeting

Under RAB, SHA areas incurring a deficit have their overall resource allocation reduced by the amount of that deficit in the following year. This applies whether the deficit in the SHA area is attributable to NHS trusts, PCTs or the SHA itself. Similarly, SHA areas that underspend have an increased level of resources available the following year.

SHAs normally pass on the increase or decrease in resources to the NHS bodies responsible for incurring it (SHAs pass on the resource adjustment to PCTs who may in turn pass it on to the appropriate NHS trust). Any overspend by the SHA against their RRL results in the qualification of the regularity opinion and a reduction in future resources.

Primary care trusts

Background

PCTs were established following the Health Act 1999. In 2005/06 there were 303 PCTs in England. PCTs are key to all aspects of the NHS as they contract for services from GPs, dentists and pharmacists; commission services from hospitals both in the NHS and independent sector; and provide out of hospital care such as through community nurses and health visitors. A small number of PCTs are also providers of mental health services both in hospitals and in the community. As a result of *Commissioning a Patient-led NHS*, the number of PCTs in England will reduce to 152 in October 2006.

All PCTs have a board which is collectively responsible for promoting the success of the organisation by directing and supervising its affairs. The board includes both executive and non-executive members. Non-executives work as a member of the board team with the executive members (such as the chief executive, finance director, public health director and the chair of the Professional Executive Committee (PEC)). There must be at least four health professionals within the executive board members. The PEC comprises a variety of health and social care professionals and is responsible for the day-to-day running of the PCT.

Funding

The main source of funding for PCTs is allocations from the Department. Resources are allocated to each PCT by the Department based on a standard allocation formula. These resources allocated to PCTs are in the form of RRLs and CRLs, and they set out the total resources available to individual PCTs for the year. PCTs have a statutory duty to keep expenditure within their allocated CRLs and RRLs.

The resources allocated to the NHS in any year may be different to the actual cash allocated. This is because the Treasury adjusts the resources for estimated debtors and creditors to calculate the cash allocated. In addition to meeting the resource limits, PCTs also have a statutory duty to not spend more than the cash allotted to them. For this requirement, PCTs are allocated a single cash limit, combining revenue and capital.

Statutory and departmental duties

PCTs have both statutory and departmental financial duties they are required to achieve each year. The following table summarises these duties.

Duty	Description
Revenue resource limit (RRL)	**A statutory duty to keep revenue expenditure within a predetermined resource limit.** Section 97E(1) of the NHS Act 1977 states 'It is the duty of every primary care trust to ensure that the use of their resources in a financial year does not exceed the amount specified by them in relation to that year by the Secretary of State'. This section was inserted into the 1977 Act by Section 12 of the Government Resources and Accounts Act 2000. PCTs are set a RRL by the Department, which specifies the total revenue resources available to the PCT for the year.
Capital resource limit (CRL)	**NHS bodies are required to keep capital expenditure within a predetermined CRL.** The Department sets a CRL for each PCT, which specifies the total capital resources available to the PCT for the year.
Cash limit	**A duty not to spend more than the cash allocated to the body. There is a combined limit for both revenue and capital.** The Department sets an annual cash limit for each SHA. SHAs are required to keep their cash expenditure during the year within this set limit.
Financial balance	**To achieve operational financial balance each year – defined as not exceeding the resource limit excluding unplanned financial assistance received.** The achievement of operational financial balance is a departmental rather than a statutory duty placed on all PCTs. This is defined as not exceeding their resource limit when unplanned resource support is excluded from the resource limit.

Duty	Description
Better Payments Practice Code	**To pay all non-NHS trade creditors within 30 days of receipt of goods or valid invoice (whichever is later).** The target for PCTs is to pay all NHS and non-NHS trade creditors within 30 calender days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.
Full cost recovery	**To demonstrate full cost recovery on an accruals basis in relation to the PCT's provider functions.** Each PCT must demonstrate that it has achieved full cost recovery in relation to its provider functions. This is akin to break-even for NHS trusts (outlined above) and is intended to provide a level playing field for all NHS providers. Basically this duty means that provider activities must not be subsidised by commissioning funds.

Note: Shading indicates a statutory duty. Non-shading indicates a departmental duty.

Format of accounts

The accounts of a PCT comprise:

- operating cost statement (OCS) – all revenue transactions except parliamentary funding are reflected in this statement which shows the net operating costs of the body;
- the balance sheet, this includes the general fund which is where parliamentary funding is shown;
- the cash flow statement;
- the statement of total recognised gains and losses; and
- associated notes – in addition to usual UK GAAP disclosures PCTs have to report against their financial duties (RRL, CRL and full cost recovery) and their performance in paying creditors, they also have to disclose any losses and special payments over £250,000 and balances with other government departments.

Funding is shown as parliamentary funding in the general fund on the balance sheet of PCT accounts rather than in the OCS. The general fund represents the total assets less liabilities of the PCT, to the extent that it is not represented by other reserves and financing items. The main items that go through the general fund are the net parliamentary funding received in the year and the total from the OCS (in other words, expenditure in year less

miscellaneous income). Where a PCT overspends or underspends against its RRL, the impact is shown in the general fund.

The accounts include the auditor's report, the statement of directors' responsibilities, the statement on internal control and the accountable officer's statement.

Resource accounting and budgeting

The principles of RAB apply to PCTs. Consequently if a PCT overspends in one financial year, its funding is reduced in the following year. PCT expenditure is dictated by a revenue resource limit (RRL) which is set on an annual basis by the Secretary of State for Health. Any overspend against a PCT's RRL is, therefore, recovered by reducing the RRL the following year. Similarly, if a PCT underspends against its RRL, then its RRL is increased in the following year.

Appendix 5: NHS financial information monitoring (FIMs) returns submitted to the Department of Health

PCT in-year monitoring returns

Table PCT01 Summary of PCT Financial Performance/Key Data

Table PCT02 Summary of Resource and Cash Limit Adjustments

Table PCT03 Inter Authority transfers (IATs)

Table PCT04 Operating Cost Statement

Table PCT05 Balance Sheet

Table PCT06 Cashflow Statement

Table PCT07 Performance Against Statutory Duties

Table PCT08 Provider Full Cost Recovery Duty

Table PCT09 Analysis of Gross Operating Costs

Table PCT11 Better Payment Practice Code

Table PCT12 Provisions for Liabilities and Charges

Table PCT13 Capital Expenditure – Analysis of Projects

Table PCT 14 Cost Improvement Programmes

Table PCT15 Efficiency of Cash Forecasts and Requisitions

Table PCT16 Analysis of Changes In Income & Expenditure Growth

Table PCT17 Summary of Workforce, Paybill and Agency Spend (1)

Table PCT18 Summary of Workforce, Paybill and Agency Spend (2)

NHS trust in-year monitoring returns

Table T01 In-year Monitoring Key Data

Table T02 Income and Expenditure Account

Table T03 Balance Sheet as at 31 March 2007

Table T04 Cash Flow Statement

Table T05 Better Payment Practice Code

Table T05 Better Payment Practice Code

Table T06 Break-even Duty

Table T07 Capital Expenditure/Income Statement

Table T08 CCA/EFL & CRL Performance

Table T09 Cost Improvement Programmes

Table T10 Provisions for Liabilities and Charges

Table T11 Analysis of Changes in Income & Expenditure Growth

Table T12 Summary of Workforce, Paybill and Agency Spend (1)

Table T13 Summary of Workforce, Paybill and Agency Spend (2)

SHA in-year monitoring returns

Table SHA01 Summary of SHA Financial Performance/Key Data

Table SHA02 Summary of Forecast Resource and Cash Limit Adjustments

Table SHA03 SHA Inter Authority Transfers

Table SHA04 Movements on SHA Capital Reserves

Table SHA05 Operating Cost Statement

Table SHA06 Balance Sheet

Table SHA07 Cashflow Statement for Year Ended 31 March 2007

Table SHA08 Financial Performance and Parliamentary Funding

Table SHA09 Calculation of Capital Charge Interest

Table SHA10 Better Payment Practice Code

Table SHA11 Provisions for liabilities and charges

Table SHA12 Capital Expenditure

Table SHA13 SHA Economy Capital Summary

Table SHA14 Summary of Workforce, Paybill and Agency Spend

Table SHA15 NHS Income and Expenditure Matrix

Table SHA16 SHA Summary: NHS Trust Loans/Deposits and PCT Cash Limit Adjustments

Submission timetable

SHAs consolidate the information provided by the NHS organisations in their area (excluding NHS FTs) and are expected to report to the Department of Health at:

- Plan (with a different set of forms),
- Month 4 (Forecast Outturn as at 31 July),
- Month 7 (Forecast Outturn as at 31 October)
- Month 10 (Forecast Outturn as at 31 January; and
- Month 12 (Forecast Outturn as at 31 March).

Intermediate collection at Months 3, 5, 6, 8, 9, 11 and 11+ are also collected from SHAs. However, as circumstances dictate, a full collection may be requested in place of any of these intermediate collections.

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