National Audit Office

audit commission

Financial Management in the NHS

NHS (ENGLAND) SUMMARISED ACCOUNTS 2004-05

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REPORT BY THE COMPTROLLER AND AUDITOR GENERAL PREPARED JOINTLY BY
THE NATIONAL AUDIT OFFICE AND THE AUDIT COMMISSION
| HC 1092-I Session 2005-2006 | 7 June 2006

SUMMARY

Joint report by the National Audit Office and the Audit Commission

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

- the findings of the National Audit Office from their audit work on the NHS summarised accounts, the consolidated account of NHS Foundation Trusts, the Department of Health's resource account and other statutory health organisations with a national remit;
- the findings from the Audit Commission's appointed auditors' work on the accounts of individual NHS organisations; and
- the unaudited NHS revenue out-turn for 2005-06 as reported by the Department of Health and Monitor, with brief analysis and commentary by the National Audit Office and the Audit Commission.

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

1 *Financial management in the NHS* is a report prepared jointly by the National Audit Office and the Audit Commission. It looks in detail at the 2004-05 revenue position, examines current financial management and reporting issues, and considers the most significant financial issues facing the NHS in 2005-06 and beyond, as well as the Department and Monitor's unaudited estimates of the 2005-06 financial position. It is a follow-up to our joint report issued in June 2005,[1] and many of the recommendations made remain valid to the NHS in that report. The Department of Health has responded to our recommendations by improving the transparency of the NHS accounts, but the level of implementation of the recommendations by individual NHS bodies will only become clear once auditors have completed their 2005-06 Auditors' Local Evaluation assessment.

2 In 2004-05 the NHS in England spent a total of £69.7 billion. Over the period of the five-year settlement announced in the 2002 Budget (2002-03 to 2007-08), expenditure in the NHS is rising at an average of 7.3 per cent per annum in real terms, bringing total annual expenditure to £76.4 billion in 2005-06 and reaching £92.6 billion by 2007-08. Healthcare therefore remains the fastest growing area of public expenditure.

1 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, HC 60-I, 24 June 2005.

3 Increased spending on the NHS has been accompanied by a challenging set of service and performance targets, covering waiting times, access and health outcomes. These include reducing maximum inpatient waiting times to six months by the end of 2005, and maximum waiting times for a first outpatient appointment to three months (13 weeks) by the end of 2005. Alongside service improvements, the Government gave a commitment in the NHS Plan[2] to improve the pay and conditions of NHS staff, and 30 per cent of the £6.7 billion funding increase in 2004-05 has been directed towards this.

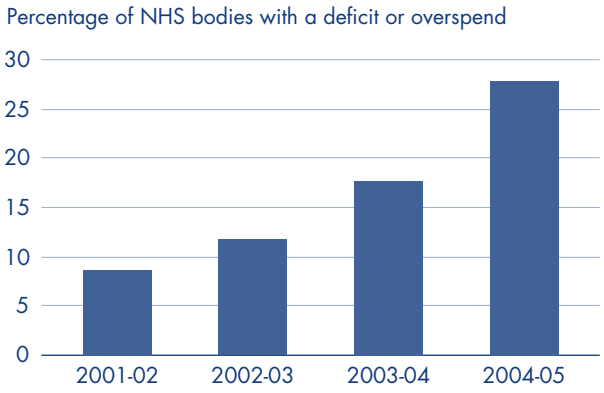
Summary of financial performance in 2004-05

4 In 2004-05, the Department reported a deficit across the NHS as a whole – the first time since 1999-2000 that the NHS has failed to break even overall. Compared to 2003-04, there was an increase in the number of bodies with a deficit or overspend, and more of these deficits and overspends were significant in size **(Figures 1 and 2)**. The increase in deficits can be attributed to a combination of:

- steady progress in recent years towards more transparent NHS financial reporting; and
- some deterioration in underlying performance.

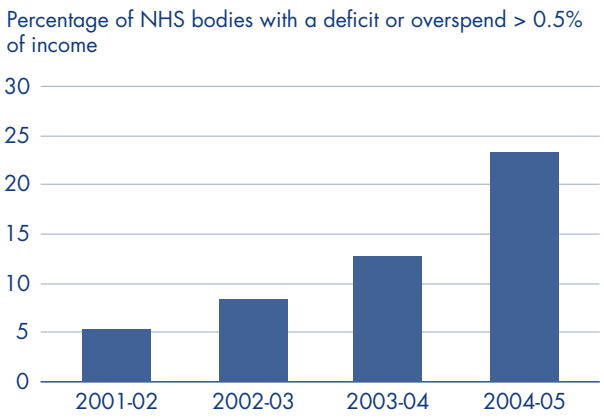
However, quantifying the role played by each is difficult.

1 The proportion of NHS bodies with a deficit or overspend is increasing



Source: National Audit Office analysis of NHS summarised account data/accounts of individual NHS bodies including Foundation Trusts

2 The proportion of NHS bodies with a significant deficit or overspend is increasing



Source: National Audit Office analysis of NHS summarised account data/accounts of individual NHS bodies including Foundation Trusts

2 Department of Health, *The NHS Plan, A Plan for Investment, A Plan for Reform* (2000).

5 In summary:

- The aggregate overspend for all NHS bodies (including Foundation Trusts) was £251.2 million (0.38 per cent of total revenue expenditure) compared with an underspend of £65.4 million (0.10 per cent) in 2003-04[3] **(Figure 3 overleaf)**;
- 171 NHS bodies (including Foundation Trusts) out of 615 (28 per cent) recorded a deficit or overspend in 2004-05, compared with 106 out of 600 (18 per cent) in 2003-04.
- 68 out of 259 NHS Trusts (26 per cent) failed to break even in 2004-05. 90 out of 303 Primary Care Trusts (30 per cent) failed to keep expenditure within revenue resource limits. One Strategic Health Authority failed to keep expenditure within its revenue resource limit.
- NHS Foundation Trusts are subject to the compliance regime of the Independent Regulator of NHS Foundation Trusts ('Monitor'). They have a different accounting, funding and accountability framework from other NHS bodies and do not have a statutory break-even duty (Annex 2). Within this framework, 12 NHS Foundation Trusts recorded a deficit in 2004-05.
- An increasing number of NHS bodies incurred in-year deficits. The number of significant in-year deficits (of over 0.5 per cent of income or available revenue resources) increased to 23 per cent from 13 per cent in 2003-04.
- 28[4] Primary Care Trusts had revenue resource limit overspends of over £5 million, compared to five[5] in 2003-04.
- 26 NHS Trusts reported a deficit of over £5 million in 2004-05, compared to 12 in 2003-04.
- Four out of 25 NHS Foundation Trusts (three after adjusting for impairments) reported a deficit of over £5 million in 2004-05, their first year of operation.
- The number and size of significant deficits amongst NHS Trusts, Primary Care Trusts and Strategic Health Authorities would have been greater without specific financial support either from within the local health economy or centrally. However, the financial support available to local bodies has reduced from previous years, since Strategic Health Authorities retained more of their surpluses rather than distributing them to help eliminate deficits (Annex 1).
- In addition to in-year deficits, a number of NHS Trusts also have significant cumulative deficits. These deficits will need to be recovered if Trusts are to fulfil their statutory break-even duty and, ultimately, meet the criteria for achieving Foundation status. The total cumulative deficit across NHS Trusts as at 31 March 2005 was £598 million (2003-04: £276 million).

6 Strategic Health Authorities have a target of delivering financial balance in aggregate across the NHS bodies within their area (except for NHS Foundation Trusts, which are regulated separately by Monitor). 16 out of 28 Strategic Health Authority areas incurred an aggregate overspend in 2004-05, compared with seven in 2003-04 and six in 2002-03 **(Figure 4 on page 5)**. Strategic Health Authorities are not responsible for performance-managing NHS Foundation Trusts, and hence Foundation Trusts' results are excluded from this analysis (see also Annex 1).

Returning to financial balance

7 The £251.2 million aggregate deficit across the NHS in 2004-05 was relatively small in the context of £66.3 billion of revenue expenditure (0.38 per cent), and indeed 72 per cent of NHS bodies achieved break-even or a surplus in 2004-05. However, almost a quarter of NHS bodies reported a deficit greater than 0.5 per cent of income. Where an organisation has overspent by a large amount, restoring a financially balanced position can have an impact on service delivery.

3 The 2003-04 underspend figure reflects a prior-year adjustment made to the out-turn of Kensington and Chelsea Primary Care Trust in 2004-05. The effect of this adjustment was to increase the Primary Care Trust deficit by £7.1 million, and hence reduce the overall NHS underspend by the same amount. The Department was not required to adjust for this in the NHS summarised accounts since the sum is not material by value in the context of those accounts. It therefore recognised the £7.1 million of expenditure in 2004-05 rather than adjusting the figure for 2003-04. Thus the overall NHS deficit reported in the 2004-05 summarised accounts and consolidated accounts of NHS Foundation Trusts is £258.3 million (£221.4 million for the summarised accounts and £36.9 million for Foundation Trusts), with a surplus of £72.5 million for 2003-04. However, for the purposes of this report we have adjusted the figures to ensure that the actual local position is accurately reflected in the detailed analysis.

4 Dacorum Primary Care Trust was required to make a prior-period adjustment to its accounts in 2004-05, reclassifying 1.2 million of 2003-04 expenditure to 2004-05 and therefore increasing its 2004-05 overspend from £4.8 million to £6.0 million. The Department were not required to adjust for this figure in the NHS summarised accounts since it is not material by value. Hence the Department's summarised account figures show the number of Primary Care Trusts with overspends greater than £5 million as 27 rather than 28.

5 This figure has been adjusted from four to five to reflect the prior-year adjustment made at Kensington and Chelsea Primary Care Trust, which increased its 2003-04 deficit from £1.2 million to £8.3 million.

3 Performance and aggregate outturn of NHS bodies in 2004-05

Type of NHS body	Number of bodies in existence for year or part of year	Number with break-even/ surplus in 2004-05	Number reporting a deficit/ overspend in 2004-05	Aggregate surplus/ underspend £ million	Aggregate deficit/ overspend £ million	Net total £ million
Strategic Health Authorities	28	27	1	373.1	(0.4)	372.7
Primary Care Trusts	303	213	90	69.8	(335.1)	(265.3)
NHS Trusts	259	191	68	61.0	(382.7)	(321.7)
NHS Foundation Trusts	25 [1]	13	12	3.9	(40.8)	(36.9)[2]
Total	**615** [1]	**444**	**171**	**507.8**	**(759.0)**	**(251.2)**

Source: Audited summarisation data/accounts of individual NHS bodies

NOTES

1 Ten NHS Foundation Trusts were in operation for the full year and 15 NHS Trusts became NHS Foundation Trusts partway through 2004-05. The performance of these 15 prior to this change is included within 'NHS Trusts', and their subsequent performance within 'NHS Foundation Trusts'. Thus the total number of bodies at any given time was 600.

2 Foundation Trusts' aggregate deficit is £29 million after adjusting for the impact of impairments.

8 The reasons for the financial difficulties of NHS bodies are complex, and cannot be attributed solely to poor financial management, although this can be a contributing factor. A number of NHS bodies reported to us that they experienced cost pressures arising from national initiatives such as the implementation of the new Agenda for Change pay system, the consultant contract, the new General Medical Services (GMS) contract and the need to meet performance targets for access and service provision. All organisations have faced cost pressures, but some have been able to manage these better than others.

9 Organisations that have significant deficits are also likely to be short of cash, which will affect their ability to meet their financial commitments. In 2004-05, a small number of NHS bodies considered deferring payment of tax and social security costs to HM Revenue & Customs, with a handful even struggling to pay staff wages. For those organisations with the most serious financial problems, dealing with financial pressures and the resultant corporate distress diverts resources and management attention away from normal operational and strategic priorities.

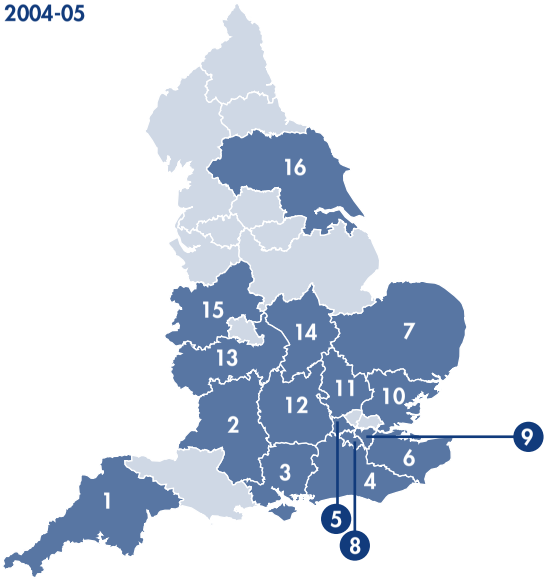
10 The Department applies the cross-Government Resource Accounting and Budgeting (RAB) framework to the NHS, which means that the funding and accountability relationship between HM Treasury and the Department is effectively mirrored in the Department's relationship with the Strategic Health Authorities. Under the RAB framework, organisations that incur an over or underspend in a given year carry it forward into the following year. This means that if an organisation consumes a million pounds more than its available resources in a given year, the resources available for it to spend the following year are reduced by the same amount. Equally, an organisation which underspends has an increased level of resources available to it in the following year.

11 RAB operates on the principle that, if one part of the system overspends within a fixed resource limit, then another must underspend by an equal amount to avoid that resource limit being breached. This means that finding the resources to cover deficits incurred within the NHS will inevitably have an impact somewhere in the system. The alternatives to individual bodies repaying their own deficits through RAB resource reductions are either that the Department withholds resources to cover the deficit centrally,[6] or that NHS bodies with a surplus lose unspent resources rather than carrying them forward. As the Department allows underspending NHS bodies to keep resources that they have not consumed, it requires overspending bodies to reduce their costs and repay the overspend themselves.

6 For 2006-07, the Department has announced that it will require Primary Care Trusts to lodge reserves with Strategic Health Authorities, who will be expected to deliver overall balance across their region. This will effectively allow Strategic Health Authorities to absorb the effect of the RAB regime and allow time to achieve financial recovery.

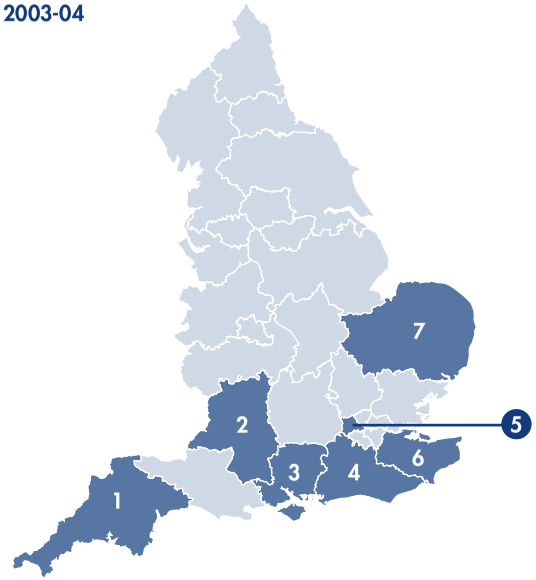
4 Strategic Health Authority areas with an aggregate overspend

2004-05



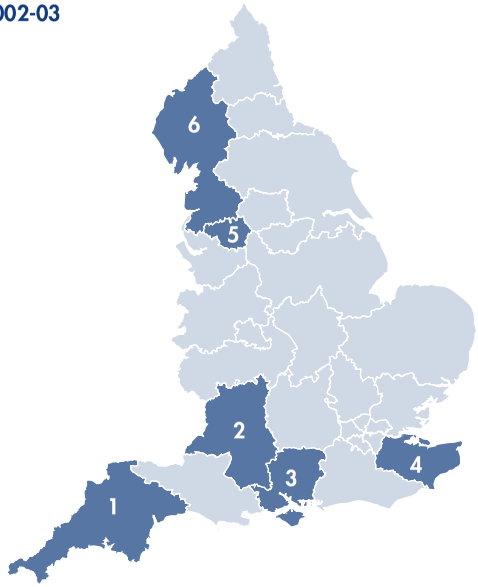
1 South West Peninsula
2 Avon, Gloucestershire and Wiltshire
3 Hampshire and Isle of Wight
4 Surrey and Sussex
5 North West London
6 Kent and Medway
7 Norfolk, Suffolk and Cambridgeshire
8 South West London
9 South East London
10 Essex
11 Bedfordshire and Hertfordshire
12 Thames Valley
13 West Midlands South
14 Leicestershire, Northamptonshire and Rutland
15 Shropshire and Staffordshire
16 North and East Yorkshire and Northern Lincolnshire

2003-04



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

2002-03



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

Source: National Audit Office

12 Whilst the principles of this system are consistent with the financial duties of the NHS and the Department, we are concerned that Strategic Health Authorities have applied the regime differently across the country. This has led to uncertainty within the NHS about the fairness and consistency of the RAB system as applied to local bodies. A more consistent application of the carry-forward regime to local bodies would promote greater understanding of the system within the NHS, and increase comparability between local bodies' performance. However, there is an inherent tension between applying the system rigidly and universally, and allowing Strategic Health Authorities to manage regional health economies according to local circumstances. These issues will be examined in more detail as part of the Audit Commission's forthcoming review of the NHS financial management and accounting regime (paragraph 39).

13 Notwithstanding the tension between consistent application and flexible management of the local position, more transparency is required in bodies' accounts to show the effect of RAB carry-forward adjustments, and the extent to which these have been applied in individual cases.

14 NHS Trusts face an additional challenge, since their in-year surplus or deficit not only affects their income the following year, it is also carried forward to give a cumulative position, which is used to assess whether the Trust has fulfilled its statutory break-even duty (Annex 2). NHS Trusts therefore still have to break-even taking one year with another, but with reduced income. This is known in the NHS as a 'double deficit'. NHS Trusts have expressed concern that once financial balance has been lost, the resultant cut in income makes recovery – and achievement of the statutory duty – doubly difficult. Primary Care Trusts and Strategic Health Authorities are subject to a different financial regime. Although their income is similarly reduced the year after a deficit has been incurred, there is no break-even duty and therefore no 'double deficit'. In 2004-05, NHS Foundation Trusts which reported a deficit in their last period as an NHS Trust did not have their income reduced as a result, and those which ended the year in surplus did not have their income increased in the following year.

15 A number of NHS Trusts have significant cumulative deficits, and will face considerable challenges to recover them. Clearing these deficits will require resources to be found from somewhere within the NHS, and hence if the bodies themselves do not repay them, other funds will have to be diverted away from their intended recipients. The Department therefore believes that these cumulative deficits should not be written off, since this would provide no incentive for organisations to return to financial balance and avoid deficits in future. They also believe it would not be fair to take resources from one part of the NHS to support overspending organisations in another.

16 The Department should consider the long-term implications of this stance. For a minority of bodies, it will not be feasible to recover their cumulative deficits without some form of financial assistance from the Department. From 2006-07, the Department plans to replace the brokerage system for NHS Trusts with a system of loans and deposits, and this will enable those organisations with significant cumulative deficits to remain solvent. However, the ability to demonstrate a financially sustainable position within three years is a key criterion for achieving NHS Foundation Trust status. If the Department intends not to clear Trusts' historic debt using resources from elsewhere in the system, it will need to consider how these organisations will reach the standard required to achieve Foundation Trust status. The Department should also consider formulating a detailed failure regime for NHS Trusts whose levels of debt mean they are no longer viable entities.

17 In health bodies where financial standing is a cause for concern, financial recovery plans are essential. NHS bodies with significant deficits need to consider redesigning or reconfiguring the provision of services to achieve recurrent financial balance. Evidence suggests that this only tends to occur where a robust recovery plan has been produced which underpins the redesign process and is fully integrated with other service and financial plans.

18 Part 3 considers what is meant by deficits in the NHS finance regime, explores the circumstances in which NHS bodies fall into financial difficulties and examines the ways in which some NHS bodies have returned to financial balance.

NHS Foundation Trusts

19 NHS Foundation Trusts operate under a different legal framework from the rest of the NHS. They are autonomous organisations, public benefit corporations, which cannot be directed by the Secretary of State. They are not subject to the performance-management regime of the Strategic Health Authorities, and do not have the same financial duties and targets as NHS Trusts. The Board of Directors of an NHS Foundation Trust is accountable to its Board of Governors and to Parliament for its performance. Monitor, the Independent Regulator of NHS Foundation Trusts, oversees the Foundation Trust sector and scrutinises how NHS Foundation Trusts are meeting their obligations, for example to meet national healthcare targets and standards and to operate effectively, efficiently and economically.

20 As part of the application process, aspiring NHS Foundation Trusts are subject to a robust assessment of their finances and must demonstrate that they are financially viable and have the management capacity and capability to operate in the new regime. In return, they have significantly more freedoms, including the ability to raise capital from both private and public sectors and to retain operating surpluses for investment in services to be delivered in the future. They are also free from the statutory duty to break-even, and therefore reporting a deficit does not impact on their future income in the way it does for NHS Trusts. However, they must adhere to the conditions set out in their Terms of Authorisation and Monitor's compliance regime. This means that all NHS Foundation Trusts are monitored against achievement of their financial plans and if there is a deterioration of performance which causes a fall in financial risk ratings, Monitor intensifies its monitoring of the organisation concerned. Monitor has powers to intervene in the running of an NHS Foundation Trust where a deterioration in performance amounts to a significant breach of its Terms of Authorisation. NHS Foundation Trusts can plan to incur a deficit. However, in 2004-05 not all the deficits incurred were planned for, and four in particular were significantly larger than expected.

Audit of the 2004-05 Accounts

21 As in 2003-04, the appointed auditors of individual NHS bodies did not qualify their opinion on the truth and fairness of the accounts of any Strategic Health Authority, Primary Care Trust or NHS Trust. The Comptroller and Auditor General was therefore able to give an unqualified opinion on the truth and fairness of the summarised accounts for these bodies.

22 The auditors of individual NHS Foundation Trusts did not qualify their opinion on the truth and fairness of any of these accounts, and the Comptroller and Auditor General gave an unqualified opinion on the truth and fairness of the consolidated account of NHS Foundation Trusts.

23 The appointed auditors gave qualified opinions on the regularity of expenditure at one Strategic Health Authority because of a breach of resource limits. They gave qualified opinions on the regularity of expenditure at 92 Primary Care Trusts because of 91 breaches of resource limits and six instances of other irregular expenditure (five of these six were qualified both for resource limit breaches and for incurring other irregular expenditure).

24 Appointed auditors reported a disappointing reduction in the quality of accounts submitted for audit. The most worrying aspect was the size of the movement between the unaudited and audited accounts, which in 2004-05 increased the overall deficit across the NHS (including NHS Foundation Trusts) by £117.3 million, from £133.9 million to £251.2 million.

25 The three most significant causes for this were prescribing expenditure, Agenda for Change and adjustments to service level agreements. Auditors reported evidence of inappropriate adjustments or omissions in 125 bodies' accounts (21 per cent) in 2004-05. At an individual body level, not recognising the true financial position may mean that bodies fail to take the necessary corrective action. At Strategic Health Authority and national level it makes managing the position more difficult.

26 The financial performance of NHS organisations is reported in more detail in Part 2, and the findings of the appointed auditors are reported in more detail in Part 4.

Financial issues arising in 2005-06 and beyond

27 There were a significant number of financial management issues that NHS bodies faced for the first time in 2005-06.

28 Achieving financial balance remained a challenge for a significant number of NHS bodies in 2005-06, with auditors reporting concerns about financial standing at 59 per cent of NHS bodies (excluding NHS Foundation Trusts). Unaudited year-end figures suggest that the deficit for 2005-06 is in the region of £536 million (£512 million excluding NHS Foundation Trusts), and that 31 per cent of NHS bodies (including Foundation Trusts) are predicting a deficit, compared to 28 per cent in 2004-05. As **Figure 5 overleaf** shows, 17 Strategic Health Authority areas (excluding NHS Foundation Trusts) are predicting an overall deficit, 15 in excess of £10 million. In Part 4 we highlight our concerns about the shift observed in 2004-05 between NHS bodies' unaudited and audited out-turn, and hence these figures should be treated with caution.

29 Unaudited year-end figures provided by Monitor predict a deficit of £24.4 million across the Foundation Trust sector, consisting of a gross surplus of £29.6 million and a gross deficit of £54.0 million. This represents a

5 Strategic Health Authority areas predicting an overspend in 2005-06

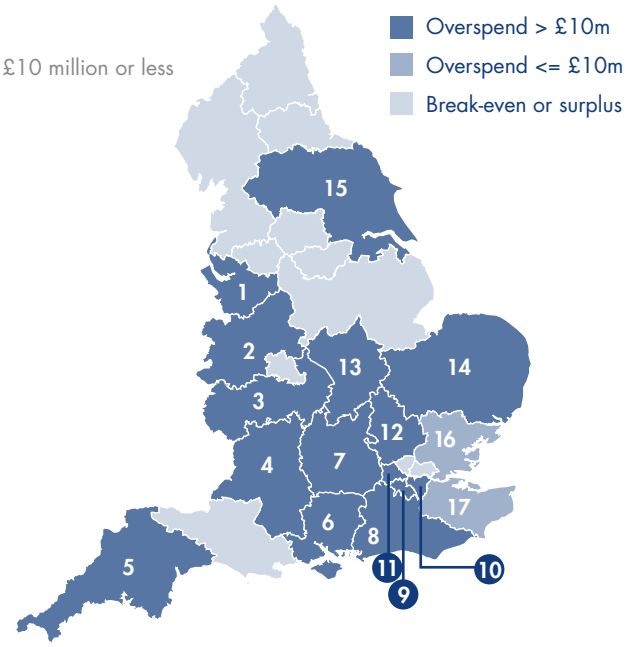
2005-06 unaudited year-end out-turn

Areas with overspend > £10 million

1 Cheshire and Merseyside
2 Shropshire and Staffordshire
3 West Midlands South
4 Avon, Gloucestershire and Wiltshire
5 South West Peninsula
6 Hampshire and Isle of Wight
7 Thames Valley
8 Surrey and Sussex
9 South West London
10 South East London
11 North West London
12 Bedfordshire and Hertfordshire
13 Leicestershire, Northamptonshire and Rutland
14 Norfolk, Suffolk and Cambridgeshire
15 North and East Yorkshire and Northern Lincolnshire

Areas with overspend of £10 million or less

16 Essex
17 Kent and Medway



Source: National Audit Office analysis of Department of Health data

£4 million variance against plan. 19 Foundation Trusts are predicting a surplus, and 13 a deficit. Excluding the performance of University College London Hospitals, which has an unaudited year-end deficit of £35.9 million, the remaining 31 NHS Foundation Trusts are predicting an aggregate £11.5 million surplus. The three NHS Foundation Trusts which incurred the largest deficits in 2004-05 (Bradford Teaching Hospitals (Case Study 4), Peterborough and Stamford Hospitals and Royal Devon and Exeter, see paragraph 2.33) have all been implementing recovery plans and report an unaudited aggregate deficit of £3.2 million for 2005-06, compared to an audited deficit of £22.9 million in 2004-05.

30 HM Treasury's 'Faster Closure' initiative requires all Departmental resource accounts to be laid before the July Parliamentary Recess by 2005-06. However, the timetable that the Department considers achievable for NHS bodies to submit audited data for the summarised and resource accounts in 2005-06[7] will not allow sufficient time to prepare and audit these accounts before the Recess. The Department has therefore informed HM Treasury that it will be unable to meet the pre-recess deadline for 2005-06.

31 The National Audit Office and the Audit Commission continue to discuss with the Department measures that will secure further advances in the timetable at a local and national level. However, a number of issues will need to be resolved if the accounts timetable for local bodies is to be brought forward significantly. In particular, it is vital that NHS Boards, Executive Directors and finance staff scrutinise their accounts preparation processes to reverse the recent decline and improve the quality of accounts submitted for audit.

32 Key developments that will increase the risks to financial balance in 2005-06 and beyond include the extension of Payment by Results and the implementation of *Commissioning a Patient-led NHS*. While the Department has introduced these policies to provide drivers to improve efficiency and financial performance, they also introduce additional risk.[8]

33 Payment by Results was implemented for Wave 1 NHS Foundation Trusts from 1 April 2004 across elective, non-elective and outpatients, and from 1 April 2005 for Wave 1a NHS Foundation Trusts authorised by that date. It was implemented by all acute Trusts and Primary Care

7 Strategic Health Authorities and Primary Care Trusts are required to submit unaudited summarisation data by 15 May 2006 and audited figures by 24 July 2006. Source: Department of Health, *NHS Manual for Accounts 2005-06,* October 2005, p. 35.
8 These findings are set out in more detail in the Audit Commission report *Early Lessons from Payment by Results*, published in October 2005.

Trusts, for elective inpatient care only, from 1 April 2005. For non-NHS Foundation Trusts, the Department deferred implementation for non-elective inpatient activity and outpatient care until 1 April 2006, thus giving these bodies more time to prepare the necessary systems and resources to manage in the new environment. Payment by Results continues to be one of the biggest challenges for NHS financial management. Patient Choice – introduced for elective care from 1 January 2006 – coupled with Payment by Results increases the potential for financial instability for all NHS bodies.

34 *Commissioning a Patient-led NHS,* issued by the Department in July 2005, has signalled the start of a new and major wave of mergers and rationalisation of Primary Care Trusts and Strategic Health Authorities. A key message from previous mergers is that the operational performance of most organisations suffers both during the merger process and in the period immediately afterwards. NHS bodies must take early action to recognise and plan for the financial risks that will be faced.

35 In late June 2005, the Secretary of State and NHS Chief Executive wrote to the Chairs and Chief Executives of all NHS bodies in deficit, reminding them of their responsibility to deliver financial balance. In December 2005, the Department contracted 'turnaround teams' to review 98 NHS bodies identified as facing particular financial difficulties. These teams reviewed the bodies' financial position and produced preliminary reports on what action could be taken to assist recovery.

36 The Department tells us that 25 of the 26 bodies deemed to be at particular risk now have turnaround support on the ground to help improve efficiency and cut costs, while the remaining one has a clearly defined timetable for securing this support. A further 37 bodies are expected by the Department to ensure that they secure additional expertise to deliver financial turnaround. Of these 37, the Department tells us that 32 now have appropriate support on the ground.

37 All of the 98 organisations have produced recovery plans to deliver recurrent financial balance, and these are currently being reviewed by Strategic Health Authority area Turnaround Directors and management teams, prior to being released to the National Programme Office. The National Programme Office is intended to provide an independent and qualified view as to whether turnaround plans are viable, quantifiable and – critically – that implementation translates into improved financial results. As at 23 May 2006, the National Programme Office had formally received 11 plans from organisations within the Turnaround cohort. The Department expects the majority of plans to be received by mid-June 2006.

38 We welcome the Department's efforts both to reaffirm local-level responsibility for financial balance, and to identify and address the challenges facing local bodies. The work of 'turnaround teams' has the potential to generate detailed good practice applicable to the wider NHS, and we recommend that any lessons learned are disseminated to all NHS bodies as soon as possible.

39 The Secretary of State for Health has asked the Audit Commission to undertake a review of the NHS financial management and accounting regime. The review will examine in more detail some of the issues covered in this report, and will involve commenting on the current regime and recommending changes that enable and encourage the NHS and individual bodies within it to operate on a sound and sustainable financial footing.

40 The Department tells us that it has taken significant steps to make the NHS financial system more transparent from 2006-07. These include ending the practice of providing financial support to organisations which are overspending, which in the past has helped to mask deficits. This planned removal of support is consistent with Payment by Results, whereby income for providers should be determined by the actual activity they deliver, and the resulting transparency should allow financial problems to be identified and addressed more easily.

41 The Department is also formalising the system by which cash is moved between organisations. The current system, based on brokerage, is not transparent, and does not provide the appropriate incentives for organisations to manage their cash flow effectively. From 2006-07, the Department plans to replace the brokerage system for NHS Trusts with a system of loans and deposits, which should make it clear when an organisation has required external financing to remain solvent. The Department believes that requiring bodies to pay interest on the loans and deposits should also encourage effective cash management.

42 We welcome these initiatives as a means of increasing the transparency of NHS bodies' year-end position and performance, and look forward to seeing evidence of their implementation as we audit the 2006-07 accounts.

43 The financial issues arising in 2005-06 and beyond are considered in more detail in Part 5.

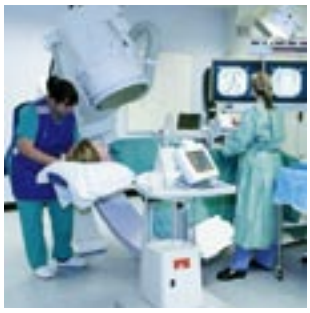
RECOMMENDATIONS

Many NHS bodies are facing significant financial pressures, but the challenges facing the NHS as a whole continue to grow. In particular, additional resources available to the NHS will begin to reduce, and the NHS is facing further re-organisation during 2006-07. Alongside this, the public will expect the NHS to continue to improve their access to prompt and good-quality healthcare.

In light of these challenges, it is more crucial than ever that all NHS bodies have strong financial management and governance arrangements in place. Bodies will need to consider the risks they face, and the skills they have available, to manage these pressures more effectively and allow service outcomes to be maintained and improved.

To assist in this process, the National Audit Office and the Audit Commission highlight four key recommendations based on good practice identified within the NHS. These are supported by a number of detailed action points which can be found in the main body of the report. Our recommendations are:

- Those NHS bodies that are able to react to financial and other risks most effectively do so because they have support and commitment from all parts of their organisation, and have effective governance arrangements in place. We therefore recommend that bodies develop a whole-organisation approach to managing risks, particularly in delivering financial balance. Awareness and ownership of these risks must be shared between Boards, clinicians, finance staff, and NHS staff more generally.
- NHS bodies are preparing for the impact of mergers and restructuring, as well as implementing Payment by Results and other national initiatives. It is vital that financial control is not weakened during this period of instability, for example as a result of changes in key members of staff and Boards. We therefore recommend that the financial management of these changes, and the identification of skills needed to respond to them, be made an early, Board-level priority.
- The current NHS financial regime should continue to evolve to ensure that it provides the right incentives and reporting arrangements to support long-term financial sustainability. This will require rigorous and transparent funding and reporting arrangements, and we commend the Department's recently announced changes, which include introducing a more Foundation Trust-like regime for NHS Trusts. To further ensure transparency and comparability between bodies' financial performance, the effect of the RAB carry-forward regime on their income should be clearly disclosed in their annual accounts.
- Advances are required in the accounts preparation and audit timetable to secure the faster closing of local NHS accounts, and hence the national accounts produced by the Department. We therefore recommend that NHS bodies review their accounts production processes with their auditors so that possible areas for improvement, such as agreeing balances and transactions with other parts of the NHS, are identified and acted upon early in the process.



Conclusion

44 The most significant financial challenge facing NHS Trusts and Primary Care Trusts is the achievement of recurrent financial balance or, in the case of NHS Foundation Trusts, remaining 'financially viable' and within their Terms of Authorisation. It is imperative for those NHS bodies with relatively small deficits to take action now to prevent the problem escalating. Experience indicates that once an NHS body incurs a significant deficit, it becomes increasingly difficult to return to financial balance, particularly where management's attention is focused on resultant short-term pressures rather than longer-term financial balance. NHS bodies should use the assessments provided by auditors under the new Auditors' Local Evaluation framework to address the weaknesses within their financial management arrangements. This will become increasingly important for those NHS Trusts intending to apply for Foundation Trust status, who should combine the Auditors' Local Evaluation framework with the joint Department and Monitor 'Whole Health Economy Diagnostic' programme to identify necessary improvements.

45 Financial balance (and financial recovery for those organisations in deficit) can only be achieved with the support and commitment of all parts of an organisation. The majority of finance departments do provide a good service, but this on its own is not enough. The effective management of finances – and the skills this requires – must be spread throughout NHS organisations, and no longer seen as the sole preserve of the finance function. For those organisations that have deficits of a significant size, the only way to return to financial balance will be through effective operational action and service redesign – both at local level and across health economies – to identify and deliver the efficiency savings required. This means that finance staff, managers, clinicians and Board members all need to work together. In short, financial management needs to become everyone's business.

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