National Audit Office

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Financial Management in the NHS

NHS (ENGLAND) SUMMARISED ACCOUNTS 2004-05

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

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This report has been prepared for presentation to the Houses of Parliament under Section 98(4) of the National Health Service Act 1977.

John Bourn
Comptroller and Auditor General
National Audit Office

6 June 2006

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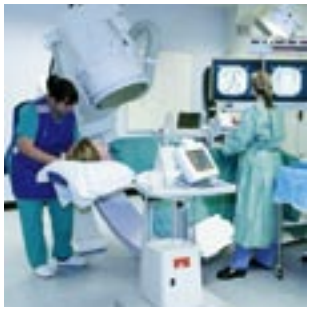


Photographs courtesy of Alamy.com, Justine Desmond Photography and Doncaster and Bassetlaw Hospitals NHS Foundation Trust. The Trust is committed to providing local, sustainable, excellent services.

In addition to the bodies specifically named in the report, the National Audit Office and the Audit Commission would like to thank the following organisations for their assistance: Dorset Healthcare NHS Trust, East Kent Hospitals NHS Trust, Nuffield Orthopaedic Centre NHS Trust, West Sussex Health and Social Care NHS Trust and Worthing and Southlands Hospitals NHS Trust.

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.

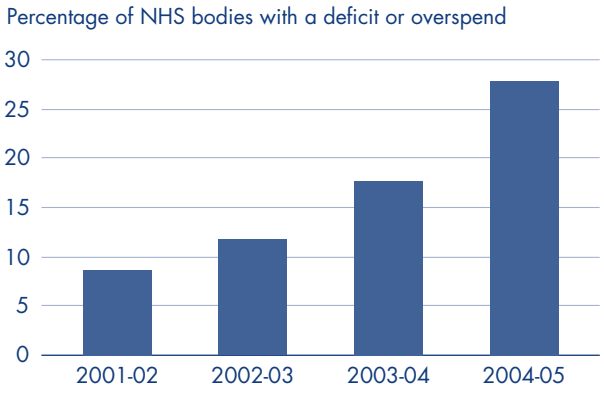
Summary of financial performance in 2004-05

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.

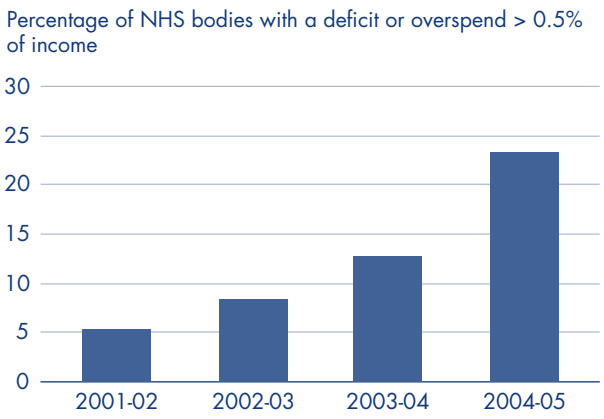
However, quantifying the role played by each is difficult.

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.

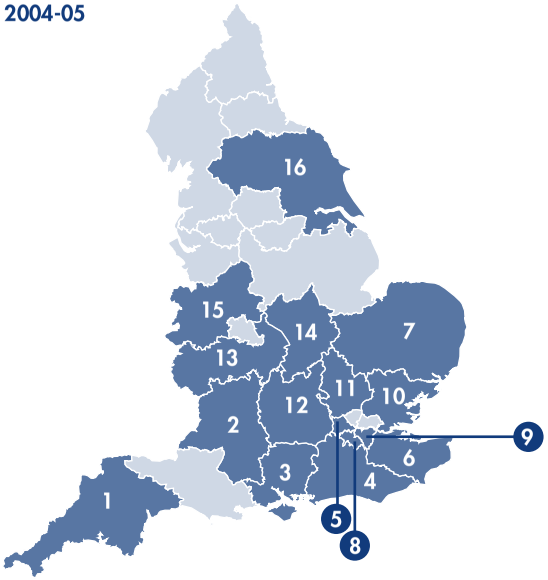
10 The Department applies the cross-Government Resource Accounting and Budgeting (RAB) framework to the NHS, which means that the funding and accountability relationship between HM Treasury and the Department is effectively mirrored in the Department's relationship with the Strategic Health Authorities. 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.

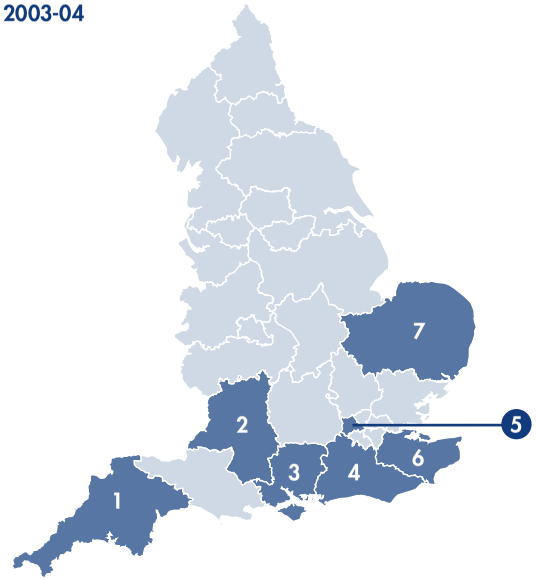
4 Strategic Health Authority areas with an aggregate overspend

2004-05



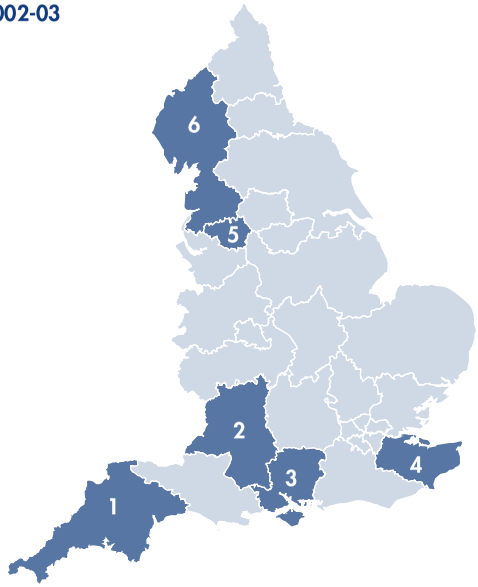
1 South West Peninsula
2 Avon, Gloucestershire and Wiltshire
3 Hampshire and Isle of Wight
4 Surrey and Sussex
5 North West London
6 Kent and Medway
7 Norfolk, Suffolk and Cambridgeshire
8 South West London
9 South East London
10 Essex
11 Bedfordshire and Hertfordshire
12 Thames Valley
13 West Midlands 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

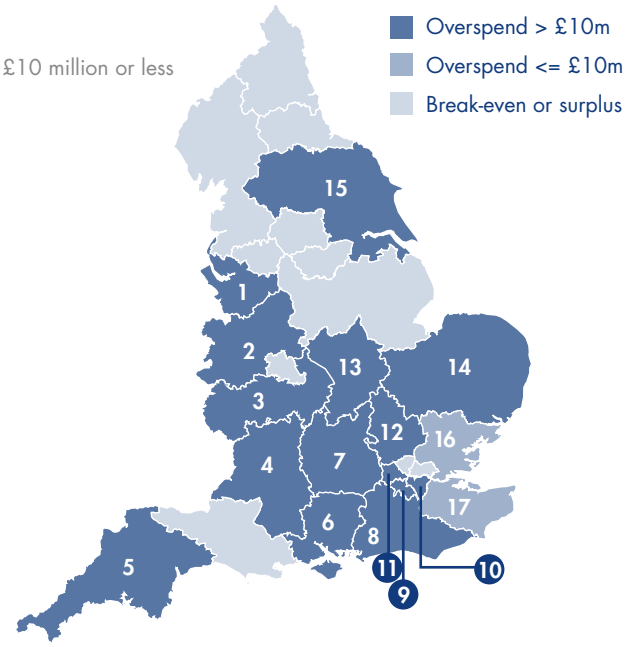
2005-06 unaudited year-end out-turn

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.

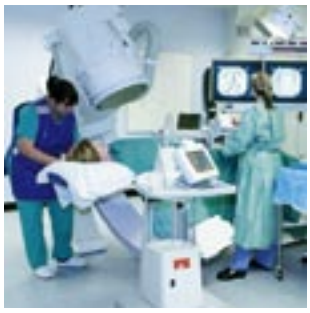
RECOMMENDATIONS

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.

PART ONE
Introduction

What this report is about

1.1 Following the audit of the 2004-05 accounts of individual NHS organisations, the summarised accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts, and the consolidated accounts of NHS Foundation Trusts, our report:

- summarises the aggregate financial performance of the NHS in 2004-05 and the financial performance of individual NHS organisations (Part 2).
- explores what is meant by deficits and overspends in the NHS finance regime, considers the circumstances in which NHS organisations fall into financial difficulties, and examines the ways in which some bodies have returned to financial balance (Part 3).
- outlines the results of the 2004-05 audits of individual organisations, and summarises the financial management issues faced by the NHS in 2004-05 (Part 4).
- sets out the main financial management issues faced by NHS bodies in 2005-06 and beyond (Part 5), including a commentary on the unaudited year-end financial position of the NHS in 2005-06.

Structure and funding of the National Health Service

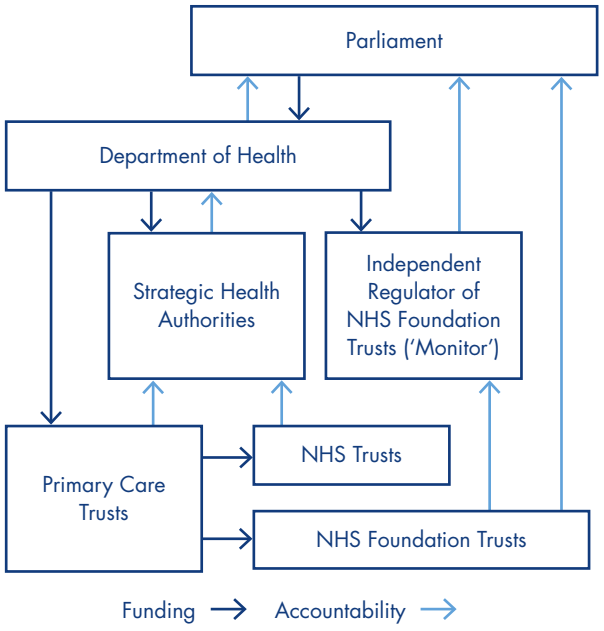
1.2 Our report considers the performance of the following 615 NHS organisations:

- 28 Strategic Health Authorities – responsible for performance-managing the Primary Care Trusts and NHS Trusts within their area.
- 303 Primary Care Trusts – responsible for assessing the need for healthcare provision, planning and commissioning health services, and improving health.
- 259 NHS Trusts – responsible for providing secondary health care. 15 of these NHS Trusts became NHS Foundation Trusts during the year.
- 25 NHS Foundation Trusts – responsible for providing secondary health care, but subject to a different financial, performance-management and audit regime from NHS Trusts. Ten of these bodies were NHS Foundation Trusts for the whole year, while 15 began 2004-05 as NHS Trusts but became NHS Foundation Trusts during the year.

1.3 The majority of funding for the NHS is provided by the Department of Health (the Department). The Department provides resources directly to Strategic Health Authorities and Primary Care Trusts. Primary Care Trusts pay NHS Trusts, NHS Foundation Trusts, primary healthcare providers, and private-sector healthcare providers for the healthcare that they commission from them. NHS Trusts and Foundation Trusts also receive a small amount of funding from the Department or other sources, such as local authorities and charitable donations.

1.4 **Figure 6** summarises the accountability and funding arrangements in the NHS.

6 Structure of the NHS in England in 2004-05 and 2005-06



Source: National Audit Office

NOTES

1 Some funding also goes from the Department directly to NHS Trusts and Foundation Trusts, chiefly for education, training and research.

2 Primary Care Trusts also commission healthcare from primary healthcare providers and private-sector healthcare providers, as well as social care from non-NHS providers.

3 Monitor is funded via the Department from funds voted by Parliament.

1.5 The funding provided to the NHS is reported in the Department's consolidated resource account, which is audited by the Comptroller and Auditor General. The Department's resource account for 2004-05 was laid before the House of Commons on 14 November 2005.[9]

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

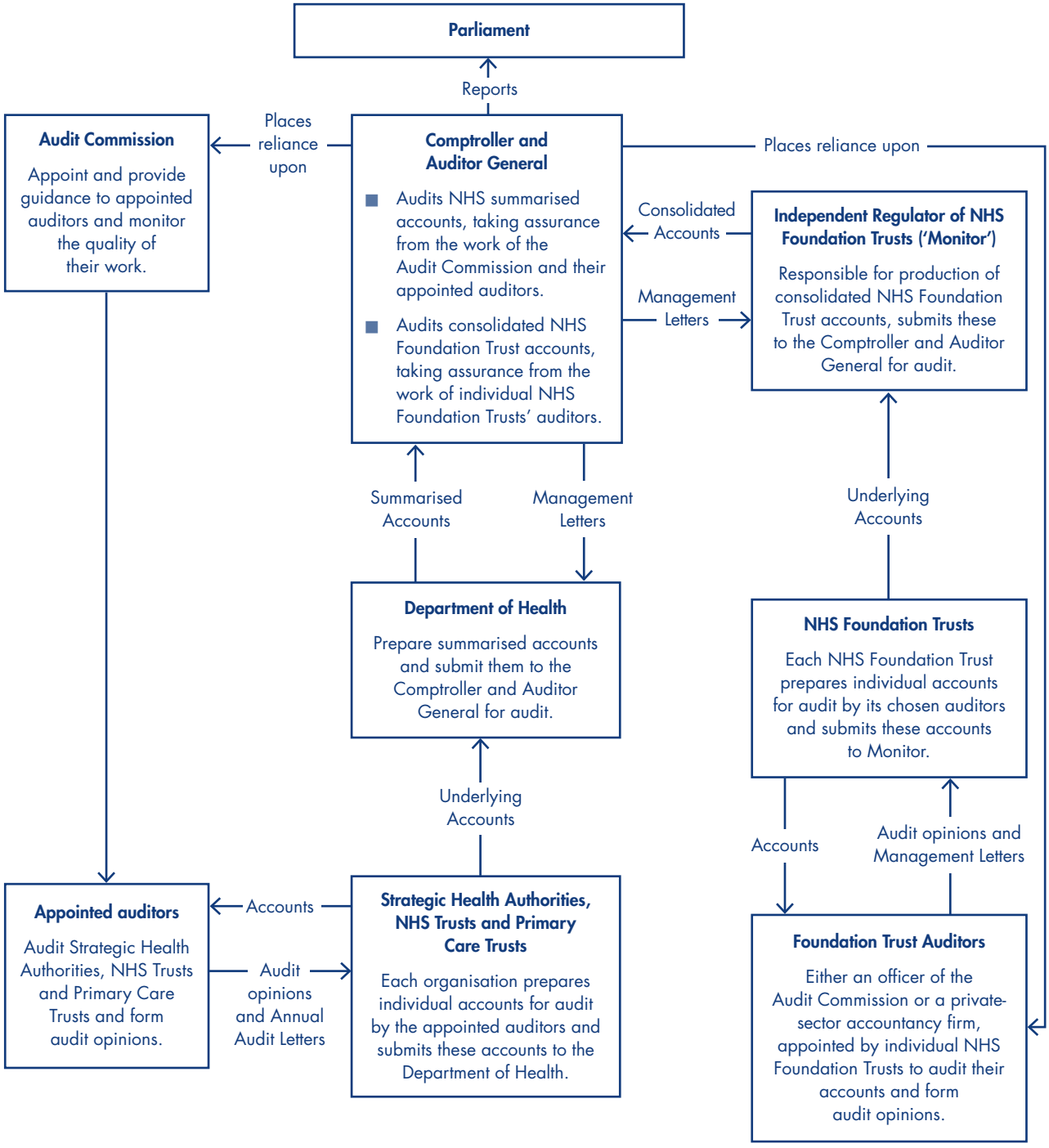
1.7 The Department produces accounts summarising the financial statements of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. The Comptroller and Auditor General is required under the National Health Service Act 1977 to certify each of the summarised accounts and to lay copies of them, together with his report on them, before both Houses of Parliament. The Department's Summarised Accounts for 2004-05, together with the Comptroller and Auditor General's Certificates and Reports, were laid before the House on 7 June 2006,[10] accompanying this Report.

1.8 The individual accounts of each NHS Foundation Trust are audited by auditors appointed by the Foundation Trust's Board of Governors. These individual accounts are consolidated by the Independent Regulator of NHS Foundation Trusts ('Monitor'), into a single account, which is audited by the Comptroller and Auditor General under an agreement with Monitor. This consolidated account is laid before both Houses of Parliament as part of Monitor's statutory reporting duty under the Health and Social Care (Community Health and Standards) Act 2003. The Consolidated Account of NHS Foundation Trusts for 2004-05 was laid before Parliament on 22 November 2005.[11]

1.9 **Figure 7** shows the audit arrangements for NHS bodies in 2004-05.

9 *Department of Health Resource Accounts 2004-05*, HC 668, 14 November 2005.
10 *NHS Summarised Accounts 2004-05*, HC 1092-II, 7 June 2006.
11 *Review and Consolidated Accounts of NHS Foundation Trusts 2004-05*, HC 622, 22 November 2005.

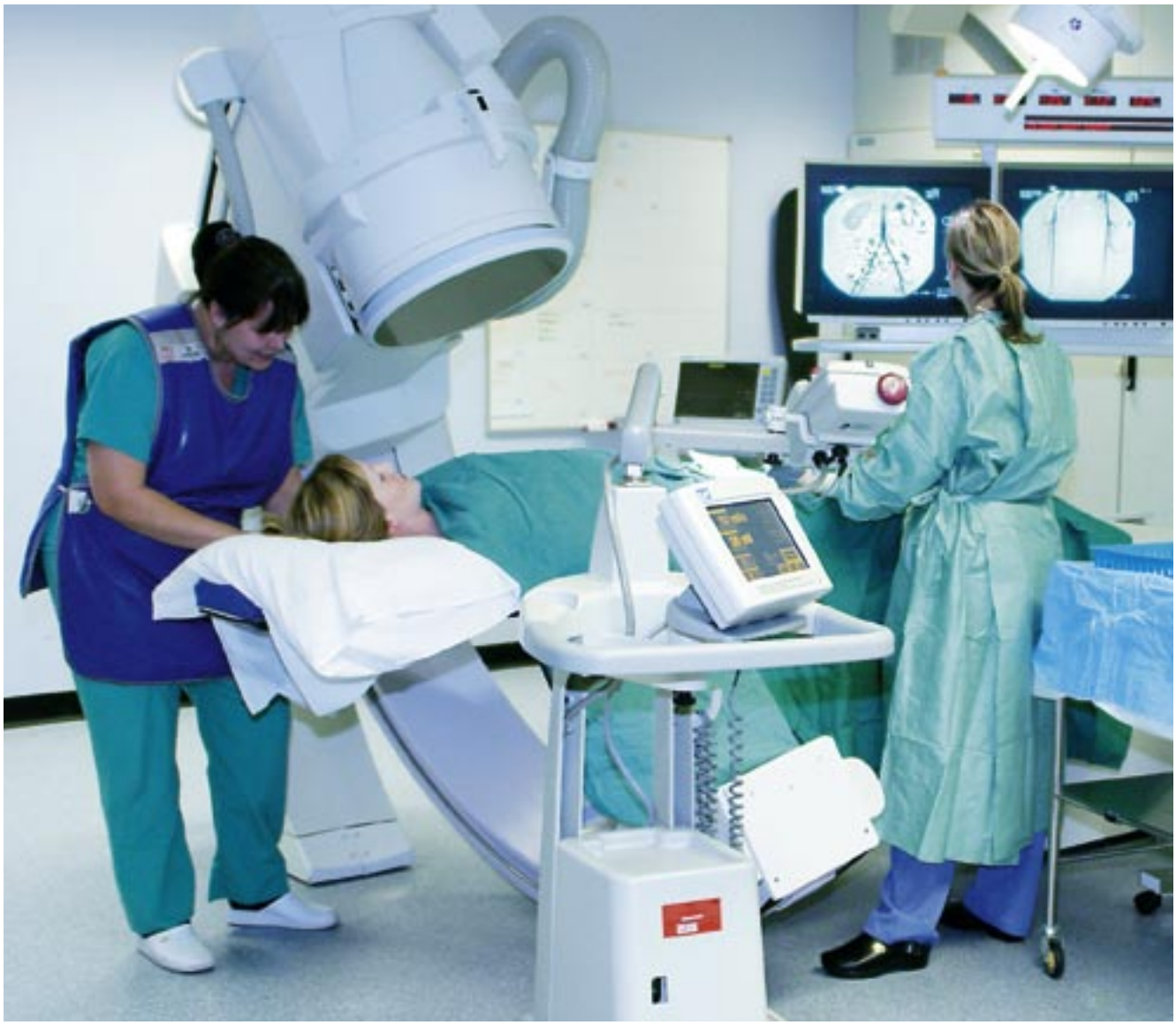
7 Audit arrangements in the National Health Service in 2004-05



Source: National Audit Office

PART TWO

Financial performance in 2004-05



2.1 This part sets out the financial performance of the NHS in 2004-05, as reported in the individual NHS bodies' accounts and in the NHS summarised accounts. It also examines the effects of financial support on bodies' reported financial position and outlines a number of issues around financial support. It raises concerns about the transparency of the current financial support regime, and reports on the action the Department is taking to improve this regime in future.

Financial duties and targets

2.2 The Department is responsible for ensuring that the NHS lives within the resources allocated to it by Parliament. Strategic Health Authorities, Primary Care Trusts and NHS Trusts also have a number of financial duties and targets. These include duties set out in statute and targets set by the Department, and vary according to the type of body. The duties and targets and the performance of these bodies against their respective targets are set out in Annex 2.

2.3 NHS Foundation Trusts are not subject to the same financial duties and targets as NHS Trusts. They have significantly more freedoms to raise capital from both public and private sectors and retain operating surpluses for investment to provide future services. They are also free from the statutory duty to break even, and hence reporting a deficit does not impact on their future income in the way it does for NHS Trusts (Part 3).

2.4 However, they must adhere to the conditions set out in their Terms of Authorisation, which include specific limits on the amount of debt finance they can raise and the proportion of their income that can be generated through private treatment charges (Annex 2). They are also subject to Monitor's Compliance Framework, which requires monitoring on at least a quarterly basis (monthly for high-risk trusts). They do not have access to NHS financial support, and are subject to a different accounting regime from other NHS bodies.

2.5 NHS Trusts each have a statutory duty[12] to 'ensure that their revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account'. The Secretary of State for Health has interpreted this duty as being met if any deficit is recovered within the following two financial years. The Strategic Health Authority may exceptionally extend the recovery period to four years.

2.6 Strategic Health Authorities and Primary Care Trusts have a statutory duty[13] to contain their expenditure within set limits. Separate limits for revenue and capital expenditure and cash usage are set by the Secretary of State.

12 Section 10 of the National Health Service and Community Care Act 1990.
13 Sections 12 and 13 of the Government Resources and Accounts Act 2000.

2.7 In our report:

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

will collectively be referred to as achieving financial balance. NHS Foundation Trusts do not have a statutory or Departmental duty to break even, and incurring a deficit does not necessarily mean a breach of their Terms of Authorisation.

Aggregate performance of the NHS

The Department did not meet its target of achieving financial balance across all NHS bodies in 2004-05. There was an increase in the number of individual bodies reporting a deficit or overspend, including a number of NHS Foundation Trusts. The scale of deficits was also greater than in 2003-04.

We remain concerned about the transparency of the current regime for financial support, but welcome action being taken by the Department to address these concerns.

2.8 In 2004-05, the Department did not meet its target of ensuring that financial balance was achieved in aggregate across the individual organisations which comprise the NHS. The aggregate revenue overspend, including NHS Foundation Trusts, was £251.2 million, representing 0.38 per cent of the total revenue expenditure of £66.3 billion. This compares to an underspend of £65.4 million (0.10 per cent) in 2003-04.[14] **Figure 8** shows the total aggregate gross and net performance by type of NHS organisation.

2.9 Annex 1 shows the performance of NHS organisations (excluding NHS Foundation Trusts) by Strategic Health Authority area.

Deficits and surpluses by type of NHS organisation

2.10 2004-05 saw an increase in the number of deficits reported by NHS bodies. This 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.

2.11 **Figure 9** shows the number of each type of NHS body (excluding NHS Foundation Trusts) reporting a deficit or overspend.

2.12 In 2004-05, one NHS Trust (Ashford and St Peter's NHS Trust) failed in its statutory duty to 'break even taking one year with another'.[15] Moreover, in 2004-05 there was an increase in the number of NHS Trusts and Primary Care Trusts failing to achieve in-year financial balance compared to 2003-04. For the first time since the creation of Strategic Health Authorities in 2002, one of these also failed to achieve in-year financial balance in 2004-05.

2.13 The Department defines an NHS Trust's deficit as significant if it exceeds 0.5 per cent of total annual income. Using this measure, 60 NHS Trusts (23 per cent) incurred a significant deficit in 2004-05. This is an increase on 2003-04, when 49 NHS Trusts (18 per cent) incurred a significant deficit.

2.14 Applying a similar criterion to revenue resource limit breaches by Primary Care Trusts, 75 Primary Care Trusts (25 per cent) breached their revenue resource limits by a significant amount. This is a considerable increase on 2003-04, when 27 Primary Care Trusts (nine per cent) had a significant revenue overspend.

2.15 **Figure 10 on page 20** shows the number of significant deficits (or overspends against the revenue resource limit for Strategic Health Authorities and Primary Care Trusts), excluding NHS Foundation Trusts (see paragraphs 2.30-2.33). Using the same measure of significance, it also shows the number of significant surpluses (or underspends against revenue resource limit for Strategic Health Authorities and Primary Care Trusts).

14 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.

15 Annex 2 details how this duty is interpreted by the Department.

8 Aggregate revenue out-turn by type of NHS organisation

	2004-05			2003-04
	Aggregate in-year surplus/underspend £ million	Aggregate in-year deficit/overspend £ million	Net total £ million	Net total £ million
Strategic Health Authorities	373.1	(0.4)	**372.7**	206.3
Primary Care Trusts	69.8	(335.1)	**(265.3)**	(3.2)[3]
NHS Trusts	61.0	(382.7)	**(321.7)**	(137.6)
NHS Foundation Trusts	3.9	(40.8)	**(36.9)**	N/A
Total	507.8	(759.0)	**(251.2)**	65.4

Source: Department of Health and Monitor data, and audited accounts of individual NHS bodies

NOTE

1 Some columns may not cast due to rounding.

2 There are significant differences between the accounting regime used by NHS Foundation Trusts and that used by other NHS bodies (paragraph 4.61). Care must therefore be taken in comparing their respective financial performance.

3 Primary Care Trusts originally reported an underspend of £3.9 million overall in 2003-04. However, a prior-period adjustment of £7.1 million at Kensington and Chelsea Primary Care Trust has changed this to a £3.2 million overspend, reducing the overall underspend of the NHS to £65.4 million in 2003-04. 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 aggregate overspend reported in the 2004-05 summarised accounts of Primary Care Trusts is £342.2 million, with an underspend of £3.9 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.

9 Number of NHS organisations (excluding NHS Foundation Trusts) reporting a deficit or overspend

	2004-05			2003-04		
	Reporting a deficit or overspend		Total bodies	Reporting a deficit or overspend		Total bodies
	Number	%		Number	%	
Strategic Health Authorities	**1**	**4**	28	**0**	**0**	28
Primary Care Trusts	**90**	**30**	303	**41**	**14**	303
NHS Trusts	**68**	**26**	259	**65**	**24**	269
Total	**159**	**27**	590[2]	**106**	**18**	600

Source: Department of Health data, and audited accounts of individual NHS bodies

NOTE

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' above while their subsequent performance as NHS Foundation Trusts is outlined in paragraphs 2.31-2.34. Thus the total number of NHS bodies at any given time was 600, and the number of NHS Trusts at year-end was 244.

Financial support

2.16 Financial support (which is not available to NHS Foundation Trusts) is defined in the Department's Manual for Accounts[16] as 'additional income during the year, provided wholly to assist in managing financial problems.' This can come from one or more of the following sources:

- The NHS Bank (Annex 4)
- Primary Care Trusts
- Strategic Health Authorities

2.17 The Department has made progress in making the NHS support regime more transparent. In particular, it has removed year-end flexibilities such as capital-to-revenue transfers, which previously allowed bodies to boost their in-year revenue position at the expense of longer-term investment. Following previous recommendations by the National Audit Office and the Audit Commission, it has also increased the specific disclosures of financial support required in local bodies' accounts. We welcome these developments, and look forward to further improvements in transparency from 2006-07, when the Department replaces the current support regime with a system of loans and deposits and further progress is made in allowing deficits to remain where they are incurred (paragraphs 2.26 and 2.27).

2.18 Following recommendations made in our previous report on NHS financial management,[17] from 2004-05 Strategic Health Authorities and Primary Care Trusts were required to report support received and its effect on their over or underspend for the year.

2.19 Strategic Health Authorities reported receiving a total of £6.8 million of support in 2004-05. In each case, this support was provided by other bodies within the Strategic Health Authority's own local health economy. **Figure 11** shows the three Strategic Health Authorities receiving support and the effect this had on their reported over or underspend for the year.

10 Number of NHS organisations (excluding NHS Foundation Trusts) reporting a significant surplus or deficit

	Significant surpluses			Significant deficits		
	2004-05		2003-04	2004-05		2003-04
	No.	%	%	No.	%	%
Strategic Health Authorities	**26**	**93**	96	**1**	**4**	0
Primary Care Trusts	**18**	**6**	12	**75**	**25**	9
NHS Trusts	**23**	**1**	7	**60**	**23**	18
Total	**67**	**11**	14	**136**	**23**	13

Source: Department of Health data and audited accounts of individual NHS bodies

11 Strategic Health Authorities receiving financial support in 2004-05

Strategic Health Authorities	Reported under/(over)spend £ million	Financial support included in reported under/(over) spend £ million	Under/(over) spend excluding financial support £ million
Essex	1.0	0.6	0.4
South West London	9.6	2.3	7.3
West Midlands South	(0.4)	3.9	(4.3)

Source: Audited accounts of Strategic Health Authorities

16 Department of Health, *NHS Trust Manual for Accounts 2004-05*, paragraph 7.17.
17 National Audit Office/Audit Commission, *Financial Management in the NHS: NHS (England) Summarised Accounts 2003-04*, June 2005, p. 5.

2.20 In 2004-05, Primary Care Trusts reported receiving a total of £204 million of support, either from the NHS Bank or from within their local health economy. In total, 77 Primary Care Trusts received such support, with three receiving amounts of £10 million or more. **Figure 12** shows the Primary Care Trusts reporting receipt of £10 million or more of support, and the effect this had on their reported over or underspends against revenue resource limits.

2.21 In 2004-05, NHS Trusts reported receiving a total of £393 million of support, either from the NHS Bank or from within their local health economy (2003-04: £344 million). In total, 73 Trusts reported receiving support, with 29 of those Trusts receiving £5 million or more. **Figure 13** shows the NHS Trusts reporting £10 million or more of support, and the effect this had on their reported surplus or deficit.

2.22 The above analysis is based on figures reported in a note to NHS bodies' accounts, which requires them to disclose the amount of financial support included in their reported out-turn. Although this new disclosure has improved the overall transparency of bodies' financial performance, we are concerned that in 2004-05 there was still inconsistency and ambiguity in classifying and reporting the complex funding flows within local health economies.

12 Primary Care Trusts receiving financial support of £10 million or more in 2004-05

Primary Care Trust	Reported under/(over)spend £ million	Financial support included in reported under/(over) spend £ million	Under/(over) spend excluding financial support £ million
Carlisle and District	0.1	15.0	(14.9)
Morecambe Bay	0.2	14.0	(13.8)
West Cumbria	0.2	11.9	(11.7)

Source: Audited accounts of Primary Care Trusts

13 NHS Trusts receiving financial support of £10 million or more in 2004-05

NHS Trust	Reported surplus/(deficit) £ million	Financial support included in surplus/(deficit) £ million	Surplus/(deficit) excluding financial support £ million
Mid Yorkshire Hospitals	(19.9)	30.0	(49.9)
Royal Cornwall Hospitals	13.6[1]	26.4	(12.8)
North Bristol	2.4	20.0	(17.6)
Oxford Radcliffe Hospitals	1.6	18.7	(17.1)
Essex Rivers Healthcare	0.3	14.0	(13.7)
Ashford and St Peter's Hospitals	0.1	13.0	(12.9)
St Helens and Knowsley Hospitals	0	12.0	(12.0)
South Tees Hospitals	(8.9)	12.0	(20.9)
Barnet and Chase Farm Hospitals	0	11.2	(11.2)

Source: Audited accounts of NHS Trusts

NOTES

1 See paragraph 2.24.

2 Rows may not cast due to rounding.

2.23 Although the Department believes that the majority of NHS bodies have utilised and reported support transparently and consistently, we are concerned that risks remain around the proper identification and disclosure of support, particularly where this is unplanned. In practice, it is extremely difficult to identify whether late adjustments to income and expenditure flows, for example adjustments to service level agreements between Primary Care Trusts and Trusts, actually constitute unplanned support instituted at short notice to deliver financial balance. There are a number of cases where such adjustments appear to correspond exactly to the amount required by a body to break even, suggesting that they were based not on actual activity levels but on the size of a deficit identified at the year-end.

2.24 Even where proper disclosure is made, unplanned support is sometimes used as a last-minute 'fix' to prevent bodies breaching statutory financial duties. In 2004-05, Royal Cornwall Hospitals NHS Trust received £15.5 million of unplanned support in addition to £10.9 million of planned support. This was precisely the figure required to eliminate its cumulative deficit of £13.6 million and hence meet its statutory duty to break even within four years (including an agreed extension). Although this arrangement was fully disclosed in the Trust's annual accounts, it is evident that the current regime allows bodies to receive financial support at short notice to avoid breaching statutory duties. This contrasts with the regime for NHS Foundation Trusts, which do not have access to such support to rescue the position at year-end.

2.25 Such practices appear at odds with the Department's stated intention that deficits remain where they are incurred.[18] Moreover, despite the requirement for NHS bodies to disclose the support they receive in their annual accounts, there is evidence that not all of them did so correctly in 2004-05.

2.26 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 overspending organisations and 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.

2.27 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.

Results of individual NHS bodies

Primary Care Trusts

2.28 There were 28[19] Primary Care Trusts reporting overspends of more than £5 million against their revenue resource limit in 2004-05, compared to five in 2003-04 **(Figure 14)**. The results are stated after financial support to ensure they are comparable with prior-year figures.

18 Statement by the Department to the Parliamentary Health Select Committee, 16 October 2003.

19 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.

14 Primary Care Trusts with overspends of over £5 million

2004-05			2003-04	
Primary Care Trust	Overspend £ million	Overspend before support £ million	Primary Care Trust	Overspend[1] £ million
Bedfordshire Heartlands	(14.5)	(14.5)	Hammersmith and Fulham	(8.5)
Hillingdon	(13.5)	(13.5)	Kensington and Chelsea	(8.3)[2]
Suffolk West	(12.5)	(12.5)	Ipswich	(5.6)
Kensington and Chelsea	(12.0)	(12.0)	Dartford and Gravesham	(5.6)
Kennet and North Wiltshire	(10.2)	(13.1)	North Devon	(5.4)
Ipswich	(10.1)	(12.3)		
New Forest	(8.6)	(12.1)		
Wandsworth Teaching	(8.2)	(8.2)		
Cambridge City	(7.6)	(7.6)		
Southern Norfolk	(7.2)	(9.8)		
Chelmsford	(7.1)	(11.2)		
North Stoke	(6.8)	(6.8)		
Fareham and Gosport	(6.8)	(8.0)		
North and East Cornwall	(6.7)	(7.9)		
Selby and York	(6.6)	(6.6)		
Suffolk Coastal	(6.2)	(7.9)		
Hounslow	(6.2)	(6.2)		
Yorkshire Wolds and Coast	(6.1)	(6.1)		
Luton Teaching	(6.0)	(6.0)		
Dacorum	(6.0)	(6.0)		
Guildford and Waverley	(5.9)	(5.9)		
West of Cornwall	(5.7)	(7.0)		
Central Cornwall	(5.3)	(6.8)		
North Norfolk	(5.3)	(7.0)		
North Devon	(5.3)	(5.3)		
North Somerset	(5.2)	(5.2)		
East Hampshire	(5.2)	(6.4)		
South West Oxfordshire	(5.2)	(5.2)		

Source: Audited accounts of Primary Care Trusts

NOTES

1 Financial support figures were not separately disclosed in the 2003-04 accounts of Primary Care Trusts (paragraph 2.18). The 2003-04 overspend figures therefore include financial support.

2 Kensington and Chelsea Primary Care Trust was required to make a prior-year adjustment to its accounts in 2004-05, increasing expenditure for 2003-04 by £7.1 million. The (£8.3 million) overspend for 2003-04 reflects this adjustment.

NHS Trusts

2.29 In 2004-05 there were 26 NHS Trusts with a deficit exceeding £5 million, compared with 12 in 2003-04. These results are stated after financial support is taken into account. When support is removed, some of the deficits are significantly larger. **Figure 15** shows the NHS Trusts reporting deficits of over £5 million in 2004-05 and 2003-04. It also shows the effect of support on these figures.

NHS Foundation Trusts

2.30 2004-05 was the first year of NHS Foundation Trusts, with 10 in operation for the full year and 15 more authorised during the year (see Part 4). The performance of these 15 as NHS Trusts prior to this change is included in Figures 9 and 10, on pages 19 and 20, and their subsequent performance within the NHS Foundation Trust figures in the following paragraphs.

2.31 There are important differences between the funding and accounting regime for NHS Foundation Trusts and for other NHS bodies, which mean that care must be taken in comparing reported performance (see paragraph 4.61). In particular, they do not have access to financial support (paragraphs 2.16 to 2.26), and must charge impairments (downward revaluations) to their income and expenditure account. Within this regime, 12 out of 25 NHS Foundation Trusts (48 per cent) reported deficits in 2004-05.

2.32 Applying the definition of 'significant' surpluses and deficits used above, three NHS Foundation Trusts (12 per cent) reported a surplus greater than 0.5 per cent of total income, while seven (28 per cent) incurred a deficit greater than 0.5 per cent of total income.

2.33 Four NHS Foundation Trusts reported a deficit of over £5 million in 2004-05. These are shown in **Figure 16**. To reflect the different treatment of impairments under the Foundation Trust regime, their effect on out-turn is also shown where applicable. These four NHS Foundation Trusts have all been implementing recovery plans during 2005-06. Unaudited year-end figures at Peterborough and Stamford, Bradford (Case Study 4) and Royal Devon and Exeter show a significantly improved financial performance in 2005-06 (see paragraph 5.7). The financial performance of University College London Hospitals deteriorated during the year and remains an area of specific concern for Monitor.

Performance of Strategic Health Authority areas

2.34 In 2004-05, 16 of the 28 Strategic Health Authority areas reported an aggregate deficit across all the individual NHS bodies within their area (which exclude NHS Foundation Trusts), compared to seven areas in 2003-04. Strategic Health Authorities are not responsible for performance-managing NHS Foundation Trusts, which are instead regulated by the Independent Regulator of NHS Foundation Trusts, Monitor. **Figure 17 on page 26** shows the Strategic Health Authority areas with an aggregate deficit in 2004-05 and 2003-04, both before and after support from the NHS Bank is taken into account.

2.35 Only NHS Bank support is relevant in considering the effects of financial support on the whole Strategic Health Authority area, as it originates from an outside source (the Department). Support provided by one body to another in the same Strategic Health Authority area will have no net impact when the results of all bodies are aggregated across the area.

2.36 NHS Foundation Trusts do not have access to financial support, either internally or from the NHS Bank, and those with surpluses do not provide financial support to other bodies.

15 NHS Trusts with deficits of over £5 million

2004-05			2003-04		
NHS Trust	Deficit £ million	Deficit before support £ million	NHS Trust	Deficit £ million	Deficit before support £ million
Surrey and Sussex Healthcare	(30.7)	(32.4)	Mid Yorkshire Hospitals	(18.6)	(30.6)
St George's Healthcare	(21.7)	(21.7)	Worcestershire Acute Hospitals	(12.8)	(12.8)
Mid Yorkshire Hospitals	(19.9)	(49.9)	Maidstone and Tunbridge Wells	(9.0)	(9.0)
Hammersmith Hospitals	(17.8)	(17.8)	Brighton and Sussex	(7.9)	(11.4)
Royal West Sussex	(15.5)	(15.5)	Plymouth Hospitals	(7.8)	(11.0)
North West London Hospitals	(11.7)	(11.7)	Royal Wolverhampton Hospital	(7.6)	(7.6)
Southampton University Hospitals	(11.6)	(18.5)	Royal Cornwall Hospitals	(5.8)	(15.3)
Royal Free Hampstead	(10.2)	(17.2)	Essex Rivers Healthcare	(5.8)	(5.8)
Shrewsbury and Telford Hospitals	(10.1)	(19.3)	Southampton University Hospitals	(5.4)	(8.4)
Brighton and Sussex University Hospitals	(10.0)	(13.0)	Kings Lynn and Wisbech Hospitals	(5.4)	(5.4)
West Hertfordshire Hospitals	(10.0)	(10.0)	Buckinghamshire Hospitals	(5.2)	(9.2)
Queen Elizabeth Hospital	(9.2)	(13.7)	Good Hope Hospital	(5.0)	(5.0)
Royal Wolverhampton Hospital	(9.0)	(9.0)			
South Tees Hospitals	(8.9)	(20.9)			
South Warwickshire General Hospitals	(8.8)	(11.6)			
East and North Hertfordshire	(8.6)	(11.6)			
Kings Lynn and Wisbech Hospitals[1]	(8.5)	(8.5)			
Bedford Hospital	(8.5)	(8.5)			
Plymouth Hospitals	(8.3)	(14.3)			
Sandwell and West Birmingham Hospitals	(7.8)	(7.8)			
Central Manchester and Manchester Children's University Hospitals	(7.7)	(10.7)			
West Suffolk Hospital	(7.6)	(7.6)			
The Lewisham Hospital	(7.5)	(7.5)			
Ipswich Hospital	(6.4)	(6.4)			
Hull and East Yorkshire Hospitals	(5.5)	(7.5)			
Weston Area Health	(5.2)	(5.2)			

Source: Department of Health data based on audited accounts of NHS Trusts

NOTE

1 This Trust was renamed Queen Elizabeth Hospital Kings Lynn NHS Trust in April 2005.

16 NHS Foundation Trusts with deficits of over £5 million

NHS Foundation Trust	Reported surplus/(deficit) £ million	Impairments recognised according to FRS 11 £ million	Deficit before impact of impairments £ million
Bradford Teaching Hospitals	(8.0)	–	(8.0)
Peterborough and Stamford Hospitals	(7.7)	–	(7.7)
Royal Devon and Exeter	(7.3)	(0.8)	(6.5)
University College London	(5.9)	(3.6)	(2.3)

Source: Audited accounts of NHS Foundation Trusts/Monitor

17 Strategic Health Authorities reporting an aggregate deficit

2004-05			2003-04		
Strategic Health Authority area	Aggregate out-turn £ million		Strategic Health Authority area	Aggregate out-turn £ million	
	After NHS Bank support	Before NHS Bank support		After NHS Bank support	Before NHS Bank support
Norfolk, Suffolk and Cambridgeshire	(69)	(69)	South West Peninsula	(14)	(14)
North West London	(65)	(65)	North West London[1]	(20)	(20)
Bedfordshire and Hertfordshire	(61)	(61)	Norfolk, Suffolk and Cambridgeshire	(10)	(10)
Hampshire and Isle of Wight	(40)	(40)	Hampshire and Isle of Wight	(9)	(9)
Surrey and Sussex	(33)	(53)	Kent and Medway	(5)	(22)
Shropshire and Staffordshire	(23)	(23)	Surrey and Sussex	(5)	(45)
South West London	(20)	(20)	Avon, Gloucestershire and Wiltshire	(4)	(74)
Essex	(14)	(14)	Thames Valley	10	(15)
South West Peninsula	(11)	(11)			
West Midlands South	(10)	(10)			
Avon, Gloucestershire and Wiltshire	(8)	(48)			
North and East Yorkshire and Northern Lincolnshire	(8)	(8)			
Thames Valley	(6)	(16)			
Kent and Medway	(2)	(2)			
Leicestershire, Northamptonshire and Rutland	(2)	(2)			
South East London	(1)	(1)			

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

NOTE

1 In 2004-05, Kensington and Chelsea Primary Care Trust was required to make a prior-year adjustment to its reported out-turn for 2003-04. The effect of this was to increase its reported deficit for 2003-04 by £7.1 million. This also increased the 2003-04 deficit across the North West London Strategic Health Authority area from 13 million to 20 million.

PART THREE

Returning to financial balance

3.1 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, and managing and recovering significant deficits can have a major impact on a body's ability to deliver services and meet performance targets

3.2 This part of our report explores what is meant by deficits and overspends in the finance regime for NHS Trusts (excluding Foundation Trusts), Primary Care Trusts and Strategic Health Authorities, considers the circumstances in which NHS organisations fall into financial difficulties, and examines the ways in which some bodies have returned to financial balance.

Background to deficits in the NHS

Current funding arrangements for the NHS are based on the Department's application of the Resource Accounting and Budgeting (RAB) regime to NHS bodies. Some bodies have expressed concerns that these arrangements make it difficult to recover deficits once these have been incurred. However, if a body does not recover a deficit itself, resources must be diverted from their intended recipients elsewhere in the system.

We have concerns that RAB is not applied consistently to local bodies, and that its effects on their financial performance are not sufficiently transparent.

NHS Trusts

3.3 The following terms are relevant in considering the financial regime for NHS Trusts:

- Retained (or 'in-year') Surplus/Deficit – the Trust's final surplus or deficit for the year after accounting for all operating expenses and interest;
- Cumulative Surplus/Deficit – the sum of the Trust's current and previous retained surpluses and deficits since 1997-98, when the current definition of Trusts' statutory break-even duty (Annex 2) was agreed. When a new NHS Trust is created it does not inherit the historic break-even performance of its predecessor organisations, as its cumulative break-even position is set to zero on its inception.

3.4 Under the cross-Government Resource Accounting and Budgeting framework (RAB) the Department has a statutory duty to remain within its resource limits from one year to the next. NHS Trusts are within the Department's Resource Budgeting boundary, and hence any failure by them to break even is charged against the Departmental Expenditure Limit (DEL). 'End-Year Flexibility' rules require DEL overspends and underspends to be carried forward into the following year, and hence any overall deficit by NHS bodies must be offset against other budgets or recovered in subsequent years to avoid breaching the DEL.

3.5 The Department applies the principles of RAB 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. Strategic Health Authority areas incurring a deficit (whether attributable to Trusts, Primary Care Trusts or the Strategic Health Authority itself) therefore have their overall resource allocation reduced by the amount of that deficit in the following year. Similarly, Strategic Health Authority areas which underspend have an increased level of resources available the following year.

3.6 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,[20] 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.

3.7 Strategic Health Authorities normally pass on the increase or decrease in resources to the NHS bodies responsible for incurring it. In the case of Trusts, this involves adjusting their service level agreements with Primary Care Trusts, which means that a deficit reported by an NHS Trust in one year is normally deducted from its contract income the following year. 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 5.37).

3.8 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. We make recommendations below to address this.

3.9 In addition to affecting the following year's income as outlined above, the Trust's in-year retained surplus or deficit is also posted to the balance sheet and carried forward to future years to give a cumulative position. This is used to assess whether the Trust has fulfilled its statutory duty to break even 'taking one year with another' (Annex 2). This duty is deemed to be met if a material[21] cumulative deficit is recovered within the following two financial years. Exceptionally, extensions of up to a total of four years can be given, subject to the Trust agreeing a recovery plan with the Strategic Health Authority.

3.10 The combination of a carried-forward cumulative deficit and a reduction in income the following year is often known as a 'double deficit'. By reducing Trusts' income to recover prior-year deficits, the Department aims to encourage these bodies to fulfil their break-even duty. However, a number of Trusts have expressed concerns to us that once financial balance has been lost, the resultant cut in income under the RAB regime makes recovery doubly difficult.

3.11 **Figure 18** illustrates how the RAB carry-forward would operate over a five-year period for an NHS Trust first incurring a deficit, then reducing expenditure to break-even in year two and post a surplus in year three. The deficit in year one creates a cumulative deficit of £10 million and also reduces year-two income by £10 million. Similarly, the £10 million surplus in year three both reverses the cumulative deficit and increases income in year four by £10 million. The effect of these movements on the Trust's cumulative position is shown on the bottom two lines. The example illustrates that if the required expenditure reduction can be achieved, the net adjustment to resources is nil and the 'double deficit' is effectively a timing issue.

20 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.

21 A material deficit is defined as greater than 0.5 per cent of total income.

18 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

Source: National Audit Office

19 NHS Trusts with the largest cumulative deficits as at 31 March 2005

NHS Trust	Cumulative deficit as at 31 March 2005 £ million	Number of years of material cumulative deficit (including 2004-05)	Anticipated year of recovery
North Bristol	(46.4)	4	To be agreed
Mid Yorkshire Hospitals	(40.7)	3	2006-07
Surrey and Sussex Healthcare	(35.5)	2	To be agreed
Royal United Hospital Bath	(27.7)	3	To be agreed
Worcestershire Acute Hospitals	(25.5)	4	To be agreed
St George's Healthcare	(23.6)	2	2007-08
Royal West Sussex	(22.2)	4	Post 2005-06
Hammersmith Hospitals	(18.4)	1	To be agreed
Royal Wolverhampton Hospital	(17.2)	2	2007-08
United Bristol Healthcare	(17.2)	4	To be agreed

Source: Department of Health data and audited accounts of NHS Trusts

NOTE

NHS Trusts reporting a material cumulative deficit are considered to have breached their statutory break-even duty 'taking one year with another' only if the deficit is not recovered in the following two years. If this is not achieved, they must agree a recovery plan and an anticipated date for recovery to secure an extension to their break-even period.

3.12 As at 31 March 2005, the total cumulative deficit across all NHS Trusts was £598 million (2003-04: £276 million). **Figure 19** shows the ten NHS Trusts with the largest cumulative deficits, as well as the number of successive years these Trusts have reported a material cumulative deficit. Their anticipated year of recovery, where this has been agreed with the relevant Strategic Health Authority, is also shown.

3.13 NHS Trusts with significant cumulative deficits will face considerable challenges to recover them. Clearing these deficits will require resources to be found from somewhere within the Department or 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.

3.14 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.

3.15 There is some evidence that the RAB regime and its implications are not currently well understood within the NHS. While current financial difficulties in the NHS cannot be ascribed solely to this, there is some evidence that local bodies would benefit from a clearer understanding of how the system operates and its interaction with national funding mechanisms. We make recommendations below to help address this.

Primary Care Trusts

3.16 Like NHS Trusts, Primary Care Trusts are within the Department's Resource Budgeting boundary, and hence if a Primary Care Trust overspends in a given financial year, its funding is reduced the following year for the reasons outlined above (paragraphs 3.4-3.5). Unlike NHS Trusts, however, Primary Care Trusts' spending is dictated by a revenue resource limit, which is set on an annual basis by the Secretary of State for Health.

3.17 Any overspend against a Primary Care Trust's revenue resource limit is recovered by reducing the revenue resource limit the following year. However, the 'double deficit' regime applied to Trusts, whereby the deficit is also posted to the balance sheet, does not apply to Primary Care Trusts. This means that cumulative figures such as those used to assess whether a Trust has broken even 'taking one year with another' are not relevant to Primary Care Trusts. Instead, a Primary Care Trust that overspends in a given year is immediately in breach of its statutory duty and will receive an automatic regularity qualification in the audit report on its annual accounts, as well as a reduction to its subsequent revenue resource limit.

Strategic Health Authorities

3.18 The regime for Strategic Health Authorities is similar to that for Primary Care Trusts, with bodies reporting an under- or overspend against their revenue resource limit. Again, any overspend results in an automatic regularity qualification and a reduction in future resources. However, the impact of any overspend on local healthcare is far less significant, since Strategic Health Authorities are not responsible for providing or commissioning services. To date, overspends by Strategic Health Authorities have been extremely rare, with only one reported since the creation of Strategic Health Authorities in 2002.

We recommend that the Department:

- provides detailed information and guidance to NHS Finance Directors, Boards and Audit Committees to ensure that relevant stakeholders within the NHS fully understand the RAB regime and its implications for financial balance;
- reviews the current arrangements for implementing the RAB carry-forward regime, with particular emphasis on the inconsistency of its application to local bodies and the lack of transparency around adjustments to income in the following year;
- amends the NHS Manuals for Accounts to require NHS bodies to show separately as a note to the accounts the increase or reduction in income as a result of the RAB carry-forward regime. This will allow users of the accounts to assess more accurately the in-year operational performance of the body, and the effect of the prior-year RAB carry-forward on current-year income;

- reviews the current and forecast cumulative position of NHS Trusts under existing funding arrangements, and considers formulating a detailed failure regime for NHS Trusts whose levels of debt mean they are no longer viable entities.

Why does a deficit matter?

Managing and recovering deficits can have a far-reaching impact on NHS bodies, potentially affecting their ability to deliver services, meet binding commitments, manage major initiatives and achieve the criteria for Foundation Trust status.

3.19 The technical processes outlined above are more than a paper-based accounting exercise. In the case of NHS Trusts and Primary Care Trusts, they can have a direct impact on a body's ability to deliver effective healthcare services and meet key performance targets.

Impact of cost cutting on service delivery

3.20 Pressure to recover a deficit and avoid breaching financial duties will mean NHS bodies are faced with difficult decisions, the results of which can impact on service delivery. This can include reducing capacity, for example through staff cuts, vacancy freezes or ward closures, or generating income through non-recurrent measures such as property disposals. Such measures, while providing temporary relief to financial pressures, may well impact on the body's performance against other key targets, such as access to services and waiting times.

3.21 Similarly, some Primary Care Trusts facing cost pressures and potential overspends have chosen not to fund more costly procedures and medications, leading to regional inequalities and restricting patients' access to potentially beneficial treatments. For example, in November 2005, three East Suffolk Primary Care Trusts with a combined overspend of £20 million[22] announced that they would be withholding access to some surgical procedures for patients deemed to be clinically obese.

Cash shortages

3.22 A significant deficit is likely to be accompanied by a shortage of cash, which will affect a body's ability to meet its financial commitments. As **Case Study 1** illustrates, an NHS body with a large underlying deficit and cash shortage may have to consider a range of drastic measures to continue operating.

3.23 Although a solution was found to the immediate pressures faced by Queen Elizabeth Hospital NHS Trust, a number of other NHS bodies considered deferring payment of tax and social security costs to HM Revenue & Customs in 2004-05, with a handful even struggling to pay staff wages.

CASE STUDY 1

Queen Elizabeth Hospital NHS Trust

Queen Elizabeth Hospital NHS Trust reported a deficit of £9.2 million in 2004-05 and, as at September 2005, was forecasting a deficit of up to £19.7 million for 2005-06.

Although the Trust had previously been able to secure sufficient support to manage its cash position until the year end, its cash shortfall had steadily increased, and was expected to reach £47 million by the end of 2005-06. The Trust had an agreed temporary borrowing limit of £15 million, originally due for repayment on 9 November 2005. At 31 October 2005, the Trust had secured a one month extension to the repayment period but this meant that, unless a further extension could be agreed, approximately £8 million would have had to be repaid in December 2005. In assessing how this might be achieved, the Trust actively considered withholding the following payments:

- Tax, National Insurance, superannuation £3 million
- PFI partners £2 million
- Creditors £3 million

To avoid this drastic action, the Trust and its Board worked with the local Strategic Health Authority, who in conjunction with the Department and the NHS Bank (Annex 4) devised a cash support strategy to address the situation. This meant that by February 2006 the Trust had secured sufficient cash brokerage to repay its temporary borrowing and meet its commitments to creditors.

Had this solution not been reached, withholding the £8m of payments would have had significant consequences, some of which could have impacted on patient care. For example:

- Non-payment of PFI partners could have resulted in the Secretary of State being petitioned for payment. There was a risk that the entire bond of £140 million could have become payable;
- Non-payment of invoices from drugs companies and other key suppliers could have resulted in future deliveries being withheld;
- HM Revenue & Customs could have imposed fines for late payment.

Source: Appointed Auditor's Public Interest Report (December 2005) and Queen Elizabeth Hospital NHS Trust

22 In 2004-05, Ipswich Primary Care Trust overspent by £10.1 million, Suffolk Coastal Primary Care Trust by £6.2 million and Central Suffolk Primary Care Trust by £3.8 million.

3.24 Such pressures are also reflected in NHS bodies' performance against the Better Payment Practice Code, which requires them to pay all valid non-NHS invoices within 30 days. On average, NHS Trusts with a deficit of over £5 million paid only 75 per cent of such invoices within 30 days – some eight percentage points below the national NHS average.[23] The NHS Trust with the highest retained deficit in 2004-05, Surrey and Sussex Healthcare, paid only seven per cent of bills by number and 28 per cent by amount within 30 days.[24]

3.25 These difficulties may lead to suppliers of goods and services charging interest on outstanding balances, or eventually withdrawing credit facilities altogether. For example, the Royal West Sussex NHS Trust has had to arrange payment plans with a number of its creditors, including a revised payment schedule with the contractors responsible for building its new Chichester Treatment Centre. This payment plan requires the Trust to pay interest to the contractor, thus increasing the overall cost of the project.[25] Similarly, contractors tendering for future work may increase their prices to cover the risk of non-payment, leading to reduced value-for-money on both capital projects and operating expenditure. In 2004-05, a total of 28 NHS bodies reported paying charges to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998, ranging from £1,000 to £40,000 and totalling £90,000.[26]

Diversion of management resources

3.26 Dealing with financial pressures and the resultant corporate distress diverts resources away from normal strategic and operational priorities. If a body's management are concerned chiefly with recovering a deficit and managing its side-effects (such as poor creditor relationships, see above), they may be unable to give sufficient attention to issues such as clinical performance or the forthcoming restructuring of the NHS (Part 5).

Future NHS Foundation Trust status

3.27 The importance of deficits is further heightened by the fact that every NHS Trust is expected to be in a position to apply for Foundation status by 2008. In assessing applicant Trusts' suitability for authorisation, Monitor scrutinises their financial position and performance, focusing on cash and working capital management, to identify risks to future financial stability. Under Monitor's assessment criteria, NHS Trusts will need to demonstrate that they are able to turn historical deficits into a substantial surplus and maintain a reasonable cash position. If they cannot do so, they will not be granted Foundation Trust status. Many NHS Trusts with large cumulative deficits will face significant challenges if they are to reverse these deficits within the required timeframe.

Causes of deficits

The financial pressures contributing to deficits are complex, and not always within the control of individual bodies. However, some bodies manage these pressures better than others.

3.28 NHS organisations should have financial management arrangements in place to ensure their financial objectives are achieved. The financial plans produced by NHS bodies should reflect any significant financial risks that they are exposed to, and set out a strategy for dealing with them within the resources likely to be available. The monitoring of budgets and the identification of variances should enable NHS bodies to take any corrective action required to return to financial balance.

3.29 In the past, some NHS bodies have implemented short-term, one-off measures to achieve recurrent financial balance, often wholly through accounting adjustments rather than operational changes or actions (Part 4). The impact of this is twofold: firstly, it only serves to defer financial problems to subsequent years rather than dealing with them as they arise; secondly, it creates and reinforces the perception that financial difficulties are the responsibility of the finance department, who will always generate solutions.

3.30 In 2004-05, appointed auditors reported that the issues which caused financial pressures and left some NHS bodies unable to manage within their current resources included:

- implementation of workforce contracts (the new contract for consultants, Agenda for Change and the new GMS contract[27]);

23 Source: National Audit Office analysis of NHS Trust performance data and individual accounts.
24 Source: Ibid.
25 The additional cost to the Trust of deferring payment of a single invoice for three months was £17,250. Source: *Audit Commission Public Interest Report,* June 2005 and Royal West Sussex NHS Trust.
26 Strategic Health Authorities incurred £1,000 in interest charges, NHS Trusts £70,000 in interest charges and Primary Care Trusts £18,000 in interest charges and £1,000 compensation for debt recovery. Source: National Audit Office analysis of NHS summarised account data.
27 The Department has estimated that in 2004-05 the Consultants' Contract cost £90 million more than anticipated, and that the General Medical Services Contract (see paragraphs 4.42f.) exceeded their forecast by a further £300 million. Source: Uncorrected transcript of oral evidence, HC 736-I, *Public Expenditure on Health and Personal Social Services 2005,* Health Select Committee, 1 December 2005. Subsequent analysis by the Department suggests a slightly smaller shortfall of £284 million on the GMS Contract.

- additional activity – some NHS Trusts reported undertaking additional activity over and above that specified in contracts, for which they did not receive additional income. Primary Care Trusts also reported increased costs as a result of over-performance;
- the requirement to meet waiting-time and other access targets – some NHS organisations have made achieving – or indeed exceeding – access targets a higher priority than financial balance; and
- unrealistic savings targets and efficiency programmes which have not been delivered.

3.31 Whilst factors such as these may place greater demands on financial management, individual NHS bodies should ordinarily be able to manage a reasonable level of unforeseen cost pressures. This ability is a basic element of good financial management, reflecting organisational agility and responsiveness to changing circumstances. And while there are external reasons why NHS organisations cannot always exercise complete control over their activities, they all operate in the same environment and are subject to the same or similar cost pressures. Given this, the scale of variation in financial performance implies that some NHS bodies have financial management and governance arrangements which mean that, when faced with financial pressures like those identified above, they have coped better than others.

Financial recovery plans

Robust financial recovery plans are a vital element of returning to financial balance. While most bodies with large deficits have a recovery plan, a significant number are not delivering all elements of their plans in practice. And while some bodies' financial recovery plans have been successfully designed and delivered, others have been based on unrealistic assumptions or short-term measures.

3.32 In health bodies where financial standing is a cause for concern, financial recovery plans (also known as 'turnaround plans') are an essential part of an overall strategy directed towards achieving recurrent financial balance. The aim of a financial recovery plan is to demonstrate a well structured, well planned and practical way forward that can achieve financial stability and sustainability.[28] Financial recovery plans can contain a programme of activities aimed at financial recovery, and whilst these tend to be focused on the individual body concerned, action may also be required at the health economy level.

3.33 NHS bodies in deficit may need to consider redesigning or reconfiguring services to achieve recurrent financial balance (Case Study 3). However, this tends only to occur where a robust recovery plan has been produced which underpins the redesign process.

3.34 Auditors assessed whether health bodies who had a year-end deficit position in 2004-05 had identified and understood the underlying causes of the deficit. **Figure 20 overleaf** shows that the vast majority of both NHS Trusts and Primary Care Trusts have plans in place to address the underlying causes of the deficit. However, a significant proportion of these bodies with plans (86 per cent for Primary Care Trusts, 79 per cent for NHS Trusts) are not delivering all the elements of their plans in practice. In auditors' opinions, two per cent of Primary Care Trusts and four per cent of NHS Trusts had not identified the causes of the deficit and had not yet developed a plan to return to financial balance.

3.35 When reviewing financial recovery plans auditors have reported a number of frequently occurring weaknesses including:

- Financial recovery plans are often viewed solely as the responsibility of the finance director and the finance department. If a financial recovery plan is to be successful it must be fully supported by the Board and senior management throughout the organisation.
- Some financial recovery plans do not attempt to address the underlying financial problems, but instead aim to put in place short-term, non-recurrent measures that will leave underlying problems unaddressed.
- Financial recovery plans often include unrealistic assumptions and unidentified or overly ambitious savings schemes.
- Financial recovery plans are not always agreed with stakeholders. It is rare that an organisation can take the necessary recovery action without the support of key stakeholders.
- Financial recovery plans are not seen as 'live' documents; organisations may fail to update them to take account of changed circumstances, or monitor progress against the plan and the need for any corrective action.

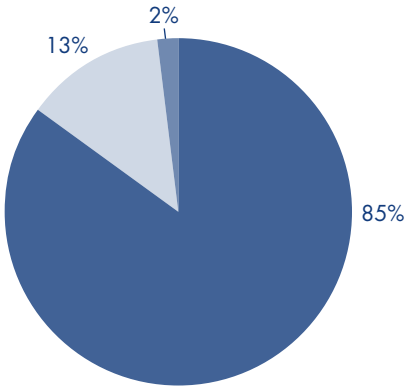
3.36 **Figure 21 overleaf** sets out some key questions that NHS bodies should consider when developing a financial recovery plan.

28 Healthcare Financial Management Association, *Financial Recovery Plans in the NHS* (2005).

20 Proportion of Primary Care Trusts and NHS Trusts which had identified and understood the underlying causes of their deficit and put plans in place to address them

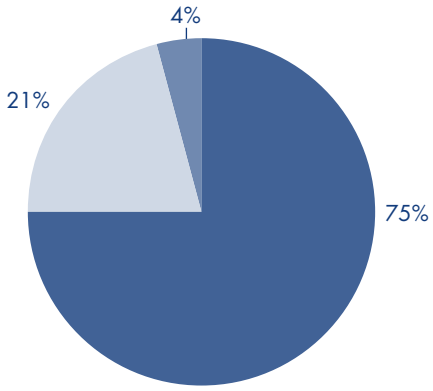
Primary Care Trusts

Based on 90 Primary Care Trusts which incurred deficits in 2004-05



NHS Trusts

Based on 68 NHS Trusts which incurred deficits in 2004-05



- The audited body has not identified the causes and no plan is in place
- There is a plan in place to address the underlying causes but not all elements are being delivered in practice
- There is a comprehensive plan in place that is proving to be delivered in practice

Source: Audit Commission

21 Questions for NHS bodies to consider when developing financial recovery plans

NHS bodies, either individually or collectively (at health economy level), should consider the following questions in developing financial recovery plans:

- Having identified a potential deficit or incurred a deficit in previous years, has the organisation produced a recovery plan based on realistic assumptions?
- Does the recovery plan include proposals to recover historic deficits as well as in-year overspending?
- Does the recovery plan take into account the impact of 'double deficits'?
- Does the recovery plan differentiate between recurrent and non-recurrent income and expenditure? What elements of the recovery plan are non-recurrent?
- What cost analyses have been undertaken to ascertain the main causes for the deficit? Does the recovery plan address these causes?
- What are the assumptions underlying the recovery plan? Are these assumptions realistic and do they take account of national and local developments?
- Has the recovery plan been developed by all the organisations within the health economy, with input from budget holders?
- Is the recovery plan understood and supported by all the organisations, managers and clinicians across the health economy?
- Is the recovery plan fully integrated into operational plans? Does the recovery plan set out responsibilities and timescales?
- Has a Financial Recovery Board been convened to oversee the development of the plan and its implementation?
- Does the recovery plan achieve recurrent financial balance within the three to five-year recovery period agreed with the Strategic Health Authority?
- What risk assessment and sensitivity analysis has been undertaken to assess the robustness of the recovery plan and the key spending and savings plans it contains?
- Is progress in delivering the recovery plan regularly reported to the Board? Is the recovery plan regularly updated to reflect changes in circumstances?

Source: Audit Commission

3.37 Recovery plans may need to include non-recurrent measures such as asset disposals to tackle cumulative deficits and relieve immediate pressures. However, these should be seen as a temporary means of maintaining service provision and returning to balance whilst more recurrent savings are identified and implemented.

Case Study 2 on Newcastle, North Tyneside and Northumberland Mental Health NHS Trust shows how a phased recovery plan can comprise a combination of non-recurrent measures to reverse a cumulative deficit and longer-term restructuring and cost-savings programmes to deliver recurrent financial balance.

CASE STUDY 2

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust

In the year ending 31 March 2003, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust reported a deficit of £1.9 million. In response to the financial position, the Trust developed a comprehensive four-year Recovery Plan, which aimed to bring the Trust to a recurring break-even position and to recover the deficit by 2006-07. The plan was developed collaboratively with commissioners and supported by the Strategic Health Authority.

In the year ended 31 March 2004 the Trust reported an in-year surplus of £0.3 million and in the year ended 31 March 2005 the Trust reported an in-year surplus of £1.7 million. This meant that the Trust had recovered the 2002-03 deficit two years earlier than planned.

A phased approach was taken to delivering recurring savings to ensure the continuation of effective service provision. This was achieved by ensuring the Recovery Plan took account of the phasing and included non-recurrent measures to bridge the gap. This allowed the Trust to achieve break-even and to recover the deficit while the recurring changes were being implemented.

Key components of the Recovery Plan can be described in two parts:

1 Recovery of underlying deficit (£1.9 million)

This was delivered through a combination of non-recurrent measures, including:

- Surplus on land sale;
- Planned slippage on developments programme;
- Strategic Health Authority support.

2 Recurring financial stability, ensuring continuation of service within budget

For this, the Trust initially identified a target of £2.7 million, although this was then reviewed annually and formed part of the continuing financial strategy. This was achieved through a combination of the following:

- Agreed additional one per cent investment from commissioners (£0.1 million);
- Re-design of services and revision of care pathways, which facilitated the development of specialist teams and ward closures in both Adult and Older Peoples Services (£2 million);
- Development of a strategy for non-payroll expenditure (£0.6 million).

Key features of how the Trust achieved its Recovery Plan include the following:

- Strong monitoring of the Recovery Plan and any other proposed savings by the Financial Recovery Group.
- Strong management buy-in and ownership throughout the individual services of the Trust.
- Establishment of a "Non-Pay Strategy Group" whose remit is to review all non-payroll expenditure and identify savings and efficiencies.
- Initiatives in the Recovery Plan were clearly laid out with targets timetabled.
- Working in partnership with the Strategic Health Authority and Commissioners to manage the financial position across the patch.
- Quality improvements made to patient services through re-engineering.
- "Spend to save" – recognition within the Trust that investment needed to be put into some services to realise long-term savings in others.

Whilst the Trust has recovered its deficit, it is continuing to address its cost base, recognising the need for forward planning and assessment of future risks. The Trust has now developed a three-year rolling financial strategy and has put measures in place to achieve future efficiencies with an aim to sustaining a financially viable service.

Source: Audit Commission Appointed Auditors/National Audit Office

Service reconfiguration and efficiency savings

3.38 In seeking to identify ways of delivering recurrent savings and financial balance, NHS bodies should consider the NHS Modernisation Agency's *10 High Impact Changes* **(Figure 22)**, full details of which are available on the Agency's website.[29] These initiatives have been shown to promote efficient use of resources and effective configuration of care pathways and services, all of which can generate positive financial outcomes. NHS bodies' recovery plans should therefore seek to realise efficiency savings in all relevant areas from the Agency's list.

3.39 **Case Study 3** on Hammersmith and Fulham Primary Care Trust illustrates how a body has redesigned care pathways and implemented significant cost savings as part of a successful recovery plan.

22 NHS Modernisation Agency's '10 High Impact Changes'

1. Treat day surgery as the norm for elective surgery
2. Improve access to key diagnostic tests
3. Manage variation in patient discharge
4. Manage variation in patient admission
5. Avoid unnecessary follow-ups
6. Increase the reliability of performing therapeutic interventions through a Care Bundle approach
7. Apply a systematic approach to care for people with long-term conditions
8. Improve patient access by reducing the number of queues
9. Optimise patient flow using process templates
10. Redesign and extend roles

Source: NHS Modernisation Agency

CASE STUDY 3

Hammersmith and Fulham Primary Care Trust

As outlined in our last report,[1] Hammersmith and Fulham Primary Care Trust incurred an £8.5 million overspend in 2003-04, and was facing a potential deficit of £19 million (almost one tenth of its annual budget) in 2004-05.

Following a Public Interest Report issued in December 2004, the Primary Care Trust developed a recovery plan which included £14.5 million of planned support from the Strategic Health Authority, some of which was recurrent and some non-recurrent.

Necessary actions identified in the Public Interest Report included:

- review the robustness of the 2004-05 recovery plan on an ongoing basis and take timely action to address emerging financial pressures and planned savings that are not realised;
- develop and implement rigorous systems of internal financial control which ensure that performance against budget is reported accurately and controlled effectively;
- develop a rigorous approach to medium and longer-term financial planning that balances service-delivery objectives with the duty to achieve financial break-even; and
- continue to build the capacity of the Primary Care Trust, in particular the finance department, to ensure that the financial affairs of the organisation are managed effectively and efficiently.

The Primary Care Trust has made considerable progress since the Public Interest Report. It exceeded the target in its agreed recovery plan in 2004-05, achieving a small surplus of £679,000. It expects to meet its financial targets again in 2005-06, which include delivering a further cost savings programme of £4.3 million and making a planned surplus of £700,000.

The Primary Care Trust's strategy for achieving this has been to combine both:

- Sustainable changes to its cost base to support its service strategy; and
- Substantial improvements in its financial control systems.

Source: Appointed Auditors/Hammersmith and Fulham Primary Care Trust/ National Audit Office

NOTE

1 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, p. 29.

29 http://www.wise.nhs.uk/cmsWISE/HIC/HIC+Intro.htm.

Cost base

In 2005-06, the Primary Care Trust re-examined its whole cost base and made sustainable savings in a number of areas.

A substantial part of the sustainable savings in the cost base have been realised as a result of the Primary Care Trust's service strategy to shift work from secondary to primary care. This strategy is designed both to benefit patients and to bring significant financial savings.

To date, savings have been achieved through, for example:

- Treating identified patient groups in GP surgeries or community clinics instead of in acute hospitals;
- Setting up a GP referral panel to review all referrals from one hospital consultant to another, and determine if patients would best be referred back to their GP rather than being seen by another hospital consultant.

The Primary Care Trust is continuing to develop this service strategy and is using its approach to practice-based commissioning (Part 5) to encourage all clinicians – doctors, nurses and therapists – to treat more patients in primary care where this would be clinically and financially beneficial. The aim is to set up "virtuous circles" in which carefully targeted investment leads to savings which in turn can provide new investment.

Financial control systems

Sustainable reductions in the cost base have been supported by improvements in internal financial controls. The Financial Control Action Plan, agreed and monitored by the Audit Committee, has been the main tool to prioritise and monitor implementation of improvements in financial control systems.

The 2004-05 Action Plan covered a range of fundamental requirements for good financial control such as:

- Recruitment of permanent finance department staff;
- Ensuring clear ownership of all budgets and identifying and monitoring key cost drivers;
- Improving accuracy of expenditure coding, and the timeliness and completeness of income and expenditure reporting;
- Improving the completeness of recording of invoices received and the speed of resolving disputes in relation to invoices receivable or payable;
- Ensuring that all billable income has been invoiced.

A new Action Plan was agreed with the Audit Committee for 2005-06 which covered:

- The development of training guides and training courses for budget holders;
- Regular monitoring of key financial control measures such as the speed of payment of creditors and receipt of debts.

In addition, the Primary Care Trust has transferred responsibility for negotiating contracts and monitoring service level agreements and Foundation Trust contracts from the Commissioning to the Finance Department. In this new role the finance department is improving:

- The clarity of the finance and activity arrangements for each service level agreement;
- The speed and accuracy of reporting from the acute Trusts;
- The robustness of the procedures for agreeing activity invoices.

Building finance capability

Finance capacity has been built with a number of changes since December 2004. The Finance Department has now been strengthened to a permanent complement of 12 staff, with nine qualified finance professionals and three under training. Most recently the department has been reorganised to:

- Focus more senior support on the commissioning finance area, which accounts for 75 per cent of the Primary Care Trust's own expenditure, and is responsible for the lead commissioning arrangements with the Hammersmith Hospitals NHS Trust (which accounts for nearly £200 million expenditure across the North West London sector);
- Support the implementation of practice-based commissioning and the development of a more business-like approach to the services directly provided by the Primary Care Trust.

The financial climate still provides challenges for the Primary Care Trust. However, the Primary Care Trust believes that it is laying a firm foundation to meet these challenges.

Role of Boards and management reporting

NHS Boards remain key players in delivering financial recovery and recurrent balance. They require expertise in both finance and healthcare, as well as robust management information on which to base decision-making. This information should be based on integrated financial and activity data, generated by fully trained information teams.

3.40 Our previous report made detailed recommendations about the role of NHS Boards in driving improvements in financial management,[30] and these recommendations remain valid for bodies seeking to restore and sustain financial balance. In particular, it is essential that the Board take collective ownership of financial issues and are provided with clear and robust financial information on which to base decision-making.

3.41 This information should encompass the balance sheet position as well as income and expenditure, including details of material intra-NHS balances. The Board should seek explanation and clarification of any disputed items or delays in signing service level agreements.

3.42 Cash flow figures should also be included, showing both year-to-date and forecast position. As outlined in paragraphs 3.22-3.25, cash pressures are the biggest threat to many bodies' continued operation, with many taking belated and drastic measures to manage the year-end position. Indeed, it is not only NHS organisations with an in-year deficit that experience cash shortages; a body reporting a relatively healthy income and expenditure position can also be short of cash if it has an underlying deficit, or has reported a deficit in previous years. Effective forecasting of cash flow alongside accruals allows cash shortfalls to be identified earlier in the year, and corrective action taken to mitigate their impact.

3.43 The effectiveness of all such financial information is greatly enhanced if it is linked to activity data. Under Payment by Results, which creates a much closer link between activity and funding, it is even more vital to integrate finance, activity and resource data, including sensitivity analysis where appropriate. This will require not only effective management accounting processes, but also robust systems for identification, coding and recording of activity. Possible methods of improving and integrating these systems include:

- Providing more detailed guidelines and training to information staff such as clinical coding teams.
- Ensuring clinical and information staff are aware that the way they record activity has a direct impact on finances, and hence ultimately on future service provision.

3.44 **Case Study 4** on Bradford Teaching Hospitals NHS Foundation Trust illustrates how new Board appointments and improved management reporting have helped the organisation recover from a serious deficit.

3.45 Our previous report highlighted the importance of non-executive directors providing the Board with additional financial and business expertise, appropriate challenge and an independent view. In addition to the recommendations made previously, it should be noted that non-executive directors drawn from outside the health sector can fulfil this role effectively only if they are properly briefed about relevant NHS issues and initiatives. Each body should aim to maximise not just the level of financial acumen amongst its non-executives, but also their knowledge of current clinical, operational and financial issues within the NHS. Bodies must regularly assess the background and experience of all their non-executive directors, and assess whether additional briefings and training sessions are required to maximise their effectiveness in the specific context of the NHS.

To improve the effectiveness of Boards and management reporting, NHS Bodies must:

- review all recommendations made in our previous report regarding Boards and management reporting, and ensure that these have been implemented;
- ensure that management reports and forecasts presented to Boards effectively integrate financial and activity data, enabling a rounded assessment of performance to be made;
- review at least annually the background, contribution and experience of all their non-executive directors, and assess whether additional briefings and training sessions are required to maximise their effectiveness in the specific context of the NHS.

30 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, p. 29.

CASE STUDY 4

Bradford Teaching Hospitals NHS Foundation Trust

As outlined in our previous report, Bradford Teaching Hospitals NHS Foundation Trust was one of the first wave of NHS Trusts to be authorised on 1 April 2004. By November 2004, it was forecasting a deficit of £11.3 million for the year ending 31 March 2005, compared with a budgeted surplus of £2.3 million. Monitor intervened in October 2004 to appoint external advisers to review the financial position of Bradford Teaching Hospitals and make recommendations for remedial action. Monitor also consulted extensively with the Trust's Board and Senior Management Team and considered their responses. After reviewing the resulting evidence, Monitor determined that it still had serious concerns.

Monitor therefore intervened again in December 2004 to remove the Chairman and appoint a new Chairman on an interim basis. This change was accompanied by concerted action to address the Trust's financial position, improve relations with the local health community and properly adjust to the cultural and organisational challenges of being an NHS Foundation Trust. Specific measures taken by the Trust included:

- improving the quality and timeliness of management reporting to enable earlier intervention;
- improving clinical coding;
- strengthening the Board through the permanent appointment of a new Chairman, Chief Executive and Chief Financial Officer.

The final financial position for 2004-05 was a £8 million deficit (some £3.3 million lower than forecast), while the Trust's unaudited year-end out-turn for 2005-06 shows a further reduction in its deficit, to £2.8 million (after restructuring costs). Furthermore the new team has instigated a more fundamental review of its operations to underpin the financial strength of the Trust for the longer term.

The experience of Bradford has further underlined the importance of NHS Boards understanding that they are fully accountable for the performance of their organisation. It has also emphasised the benefits of robust and timely management reporting, particularly in identifying, discussing and responding to cost pressures such as Payment by Results.

Source: National Audit Office/Monitor/Bradford Teaching Hospitals Foundation Trust Operating and Financial Review

Organisation-wide approach to financial balance

To meet the challenges with which they are currently faced, NHS bodies need to take an organisation-wide approach to financial management. Delivering financial balance must not be seen as a task for the finance department alone.

3.46 As a number of our case studies reflect, NHS organisations delivering or returning to financial balance often cite an organisation-wide approach as a key element of their success. This reflects the general principle outlined in our previous report,[31] that delivering financial balance must be seen as a collective responsibility rather than the remit of the Finance Director alone.

3.47 This more holistic approach to financial balance requires buy-in from a wide range of individuals across the organisation. Not just finance leads, but also senior clinicians and managers should be alive to new developments in their field which may impact on a body's finances. Clinicians and managers should work with specialist finance staff to quantify this impact, consider options and develop strategies to manage it. Some bodies have done so successfully by assigning a named qualified management accountant to each Operational Director. Although this may require increased expenditure to expand finance capacity, a number of bodies recovering or maintaining financial balance (for example Sunderland Teaching Primary Care Trust **(Case Study 5 overleaf)** and Hammersmith and Fulham Primary Care Trust (Case Study 3) cite a larger pool of qualified finance staff as a key element of their success.

3.48 For bodies striving to recover balance, this close co-operation is vital to identify savings and improve financial control. The creation of a dedicated financial recovery group, drawing on individuals from across the organisation rather than the finance function alone, can help to make recovery a key corporate priority and encourage a sense of wider ownership. Some bodies have also benefited from forming sub-groups to focus on specific areas of activity (such as non-pay expenditure, see Case Study 2).

31 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, p. 33.

CASE STUDY 5

Sunderland Teaching Primary Care Trust

Sunderland Teaching Primary Care Trust has met all its financial targets every year since it was created in 2002. The Trust serves a population of 283,000 and in 2004-05 spent over £375 million. In 2004-05, the Healthcare Commission rated it a three star Primary Care Trust for the second year running. The Audit Commission stated in its 2004-05 annual audit letter that the Primary Care Trust 'continues to manage its finances well'.

The Primary Care Trust identifies a number of factors in its successful track record of financial management:

- Finance is not considered an issue for the Director of Finance alone. The Board owns the organisation's financial agenda;
- The Primary Care Trust has an experienced and stable Board. There are good-quality staff throughout the organisation, with qualified finance staff for identified posts;
- There is a proactive, organisation-wide approach to financial management. The Primary Care Trust uses short-, medium- and long-term scanning to identify and head off potential difficulties. Finance and non-finance staff are encouraged to identify and raise issues, which stay on the agenda until they are resolved;
- The Primary Care Trust aims to be realistic. It forecasts the year-end position it expects but recognises and quantifies the risks;
- A high priority is given to finance professionalism. This applies to financial management but equally to financial reporting, with the appointed auditors commenting: 'As in previous years the PCT provided high-quality accounts with excellent supporting working papers.'

The Primary Care Trust has a philosophy of cooperation and partnership working. The tone is set by the Chief Executive and reinforced in all key Trust documents, for example in annual plans, annual reports and contracts with NHS Foundation Trust providers.

Source: Audit Commission Appointed Auditors/National Audit Office

3.49 All directorates within the organisation need to be aware of their responsibility for exercising financial control. For example, Human Resources should only authorise new posts in consultation with Finance, and with due regard to the body's authorised establishment. Similarly, information staff such as coding teams should be aware of the vital role of accurate activity data in financial management (see also paragraph 3.43), particularly with the roll-out of Payment by Results. Operational Directors, too, should consider all possible options before authorising potentially costly measures such as locum requisitions.

3.50 Individual budget-holders have a key role to play in delivering financial balance, and it is vital that they are both made aware of this responsibility and equipped with the guidance and training to fulfil it. We make recommendations below aimed at improving financial awareness and control amongst budget holders and maximising their contribution to financial balance.

3.51 Case Study 5 on Sunderland Teaching Primary Care Trust shows how an organisation has implemented some of the approaches outlined above, including wider ownership of the finance agenda and robust financial reporting, to deliver ongoing financial balance.

To help promote an organisation-wide approach to financial management, NHS bodies must:

- Ensure that there is clear accountability and ownership for all budgets (see Case Study 3).
- Assess whether budget-holders have the necessary skills and support for managing budgets, and address any gaps identified through appropriate training. This should be supported by a budget manual which is regularly updated and approved by senior management (see Case Study 3).
- Ensure that annual budgets are agreed, signed by budget holders and the Director of Finance, and approved by the Board at the start of the year. Related Local Delivery Plans and service level agreements should also be agreed, signed and reported to the Board by the start of the year. Budgets can only be approved with any certainty if the related Local Delivery Plans and service level agreements have also been agreed, and hence the large proportion of NHS bodies currently failing to do so (79 per cent of NHS Trusts and 83 per cent of Primary Care Trusts in 2004-05) is a concern (see Part 4).
- Review the skills and experience of staff responsible for preparing and assessing business cases, and where necessary ensure that they receive appropriate training in investment appraisal, costing, modelling and sensitivity analysis.
- Ensure that all managers responsible for delivering specific initiatives to time and budget have received appropriate training in project management, and that such support and skills are made available to all project teams.

- Review, and where necessary improve, organisational arrangements to promote constructive, ongoing dialogue between budget-holders (particularly clinical staff) and specialist finance staff. This should allow resultant queries to be answered quickly, and issues impacting on budgeted performance to be raised and resolved as early as possible.
- Provide staff responsible for identification, coding and recording of activity with detailed guidelines, training and other support to allow them to produce data and information that is fit-for-purpose.
- Ensure that clinical and information staff are aware that the way they record activity has a direct impact on finances, and hence ultimately on future service provision. The performance of these staff should be monitored, constructive feedback provided and corrective action taken where necessary.
- Consider whether increasing specialist finance capacity might deliver wider benefits in the organisation, for example by assigning a named qualified management accountant to each Operational Director.

Current developments

3.52 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. 102 statutory organisations were covered by this exercise, but where joint management arrangements are in place they are treated as one for the purpose of this work. These teams, which consisted of external consultants, reviewed the bodies' financial position and produced preliminary reports on what action could be taken to assist recovery.

3.53 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.

3.54 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.

3.55 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.

We recommend that the Department reviews the findings of the 'turnaround teams' contracted to undertake detailed work at a number of organisations in 2006, and disseminates the key lessons to all NHS bodies as soon as possible.

3.56 The Department is rolling out changes to the NHS financial regime for 2006-07 to address existing concerns around financial support and to clarify the position on the RAB carry forward regime. The Department has stated that key elements will include an end to financial support for overspending bodies and a new system of loans and deposits to replace the current system of cash brokerage (see paragraph 2.26).

3.57 A further feature of the new strategy is that NHS bodies will be encouraged to plan and budget for a surplus rather than break-even. This will represent a cultural change for the NHS, and we support the Department in encouraging more prudent financial planning, particularly given the increased risks brought by Payment by Results (paragraphs 4.45-4.51).

3.58 We await with interest further details of the Department's financial strategy, and will consider its implications and implementation as part of our future work on NHS financial management.

PART FOUR
Audit of the 2004-05 NHS accounts

4.1 This part summarises appointed auditors' views on the financial management issues arising from the 2004-05 audits. The information has been gathered from audit opinions, audit reports and from a questionnaire auditors are required to complete for every Strategic Health Authority, Primary Care Trust and NHS Trust. For NHS Foundation Trusts, the information is drawn from the Comptroller and Auditor General's audit of the consolidated accounts of NHS Foundation Trusts, as well as a financial review produced by Monitor.[32] This part of the report also highlights some of the key financial issues that arose during 2004-05.

Audit reporting

In 2004-05 auditors gave unqualified audit opinions on the truth and fairness of all Strategic Health Authorities, Primary Care Trusts, NHS Trusts and NHS Foundation Trusts. Auditors qualified their opinions on the regularity of expenditure at 92 Primary Care Trusts and one Strategic Health Authority.

Since our last report, auditors have issued 29 Public Interest Reports, highlighting concerns over financial standing in three Strategic Health Authority areas, 14 NHS Trusts and 19 Primary Care Trusts.

Despite the audit timetable being unchanged, appointed auditors reported a disappointing decline in the quality of accounts presented for audit.

Audit opinions on the accounts

4.2 Auditors are required to issue an opinion as to whether a body's accounts show a true and fair view of its state of affairs as at the year end and of its net resources or income and expenditure for the year. Where auditors decide that a body's annual accounts are likely to mislead people about its financial performance or position, they give a qualified opinion on those accounts, drawing attention to their concerns.

4.3 In 2004-05 there were no qualifications of the accounts of Strategic Health Authorities, Primary Care Trusts, NHS Trusts or NHS Foundation Trusts on the grounds of truth and fairness. The Comptroller and Auditor General was therefore able to give an unqualified opinion on the truth and fairness of the summarised accounts of Strategic Health Authorities, Primary Care Trusts, NHS Trusts, and on the consolidated account of NHS Foundation Trusts.

4.4 Auditors are required to give a regularity opinion on Primary Care Trust and Strategic Health Authority accounts which confirms whether in their view "in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them". In 2004-05, auditors qualified the regularity opinion of one Strategic Health Authority and 92 Primary Care Trusts. **Figure 23 overleaf** shows the breakdown of the causes of qualification. The Strategic Health Authority qualification related to a breach of the revenue resource limit. The qualifications on Primary Care Trusts' accounts consisted

32 *Review and Consolidated Accounts of NHS Foundation Trusts 2004-05*, HC 622, 22 November 2005, pp. 6-28.

of 83 breaches of revenue resource limits, one breach of a capital resource limit and two accounts qualified for both capital and revenue resource limit breaches. The remaining six Primary Care Trust qualifications related to irregular expenditure, five of these also being qualified for breaches of revenue resource limits.

4.5 One of the qualifications for irregular expenditure related to possible unlawful payments, and the remaining five occurred because of problems with the governance arrangements of one partnership entered into under the Health Act 1999 between local authorities and NHS bodies. The Act includes a provision for partners to contribute resources to a pooled budget, which is then used to fund the partnership's agreed aims.

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

4.7 The Comptroller and Auditor General also gave an unqualified regularity opinion on the summarised accounts of the Strategic Health Authorities. He did not give a regularity opinion for the summarised accounts of NHS Trusts or the consolidated accounts of NHS Foundation Trusts, since auditors are not required to report the regularity of these bodies' expenditure.

Public Reporting

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

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

4.9 Since the joint National Audit Office and Audit Commission report *Financial Management in the NHS 2003-04*,[33] issued in June 2005, 29 Public Interest Reports have been issued by appointed auditors. The total number of reports issued in 2005-06 was 25. This compares to four such reports in 2004-05, and one in 2003-04. All the Public Interest Reports issued have raised auditors' concerns about financial standing and are listed in **Figure 24**.

4.10 The circumstances leading to the auditor issuing a Public Interest Report are complex, and vary from organisation to organisation. There are, however, a number of common financial management themes, including:

- Inadequate financial and strategic planning, including failure to agree a balanced budget at the start of the financial year;
- Inadequate monitoring of the financial position, both at budget-holder and Board level;

23 Primary Care Trust and Strategic Health Authority regularity qualifications

Cause of qualification	Number of Primary Care Trust regularity qualifications		Number of Strategic Health Authority regularity qualifications	
	2004-05	2003-04	2004-05	2003-04
Revenue resource limit breach	83	39	1	0
Capital resource limit breach	1	1	–	–
Revenue resource limit and capital resource limit breach	2	0	–	–
Revenue resource limit breach and irregular expenditure	5	2	–	–
Other irregular expenditure	1	11	–	–
Total	**92**	**53**	**1**	**0**

Source: Analysis of audit opinions on Primary Care Trust and Strategic Health Authority accounts

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

- Unrealistic savings and efficiency programmes that have not delivered what was required;
- Failure to agree and implement a robust financial recovery plan;
- Weak governance arrangements, including inadequate challenge at Board level on the financial information presented; and
- Failure by the Board to recognise the seriousness of the position in timely fashion, and hence lack of prompt recovery action.

4.11 There are a number of lessons that NHS bodies can learn from these financial failures. Financial failure does not just happen 'out of the blue'. Before it occurs, there will be indicators of financial problems that are not acknowledged or addressed. To help with this, changes have been made to the local audit regime to ensure that auditors' views and judgments are communicated more starkly, and that NHS Boards receive the right messages from auditors on a clear and timely basis (see 'Auditors' Local Evaluation', Part 5). But NHS bodies must also take action, and to assist with this the Audit Commission is currently undertaking research to learn the lessons from financial failure. The report will be issued in Summer 2006, and will draw out the factors contributing to the failures, highlight the steps that could have been taken to prevent them and make recommendations to help prevent similar failures in other NHS bodies.

4.12 For NHS Foundation Trusts, Monitor's compliance regime attributes a risk rating to financial performance on a quarterly basis. The lowest financial risk rating is five and the highest is one. NHS Foundation Trusts with a financial risk rating of less than 3 move to a more intense monthly monitoring regime. The financial risk ratings aim to provide an early warning system for NHS Foundation Trusts, as in the case of Royal Devon and Exeter, Peterborough and Stamford Hospitals and Bradford Teaching Hospitals NHS Foundation Trust (Case Study 4).

4.13 In 2005-06, auditors issued 101 referrals to the Secretary of State for Health, under Section 19 of the Audit Commission Act 1998. These reports are set out in **Figure 25 overleaf**.

24 Public Interest Reports

Royal West Sussex NHS Trust (June 2005)

South Tees Hospitals NHS Trust (June 2005)

North Somerset Primary Care Trust (July 2005)

Weston Area Health NHS Trust (July 2005)

Kennet & North Wiltshire Primary Care Trust (July 2005)

Shrewsbury & Telford Hospitals NHS Trust (July 2005)

Southampton University Hospitals NHS Trust (July 2005)

New Forest Primary Care Trust (July 2005)

Hampshire & Isle of Wight Strategic Health Authority (July 2005)

Thames Valley Strategic Health Authority (July 2005)

West Wiltshire Primary Care Trust (August 2005)

Hounslow Primary Care Trust (August 2005)

Selby and York Primary Care Trust (September 2005)

Royal Wolverhampton Hospital NHS Trust (September 2005)

Hillingdon Primary Care Trust (November 2005)

Scarborough and North East Yorkshire Healthcare NHS Trust (November 2005) (Case study 6)

Trafford Healthcare NHS Trust (November 2005)

Queen Elizabeth Hospital NHS Trust (December 2005) (Case Study 1)

Cambridge City and South Cambridgeshire Primary Care Trusts (December 2005)

Surrey and Sussex Strategic Health Authority (December 2005)

Maidstone and Tunbridge Wells NHS Trust (January 2006)

Cheshire West Primary Care Trust (January 2006)

North Tees and Hartlepool NHS Trust (January 2006)

East Suffolk Primary Care Trusts (covers Central Suffolk PCT, Ipswich PCT and Suffolk Coastal PCT) (February 2006)

Suffolk West Primary Care Trust (February 2006)

George Eliot Hospital NHS Trust (April 2006)

Kensington and Chelsea Primary Care Trust (April 2006)

University Hospital of North Staffordshire NHS Trust (April 2006)

West Hertfordshire Quadrant (covers West Hertfordshire Hospitals NHS Trust, St Albans and Harpenden Primary Care Trust, Hertsmere Primary Care Trust, Watford and Three Rivers Primary Care Trust and Dacorum Primary Care Trust) (April 2006)

Source: Audit Commission appointed auditors' Public Interest Reports (www.audit-commission.gov.uk/pir/index.asp)

25 Referrals to the Secretary of State for Health

Qualifications of the regularity opinion (as considered above) on the basis of resource limit breaches constitute Section 19 referrals to the Secretary of State. There were 92 referrals corresponding to the qualified regularity opinions in respect of 92 revenue and capital resource limit breaches in 2004-05.

In 2005-06:

Four referrals have been made in respect of likely resource limit breaches by Primary Care Trusts (two of the referrals cover more than one Primary Care Trust). These Primary Care Trusts have also been issued with Public Interest Reports.

Four referrals were issued in respect of actual or likely future breaches of the statutory duty to break even at NHS Trusts. Two of these Trusts were also issued with Public Interest Reports.

One referral was issued in respect of potentially unlawful expenditure at a Strategic Health Authority.

Source: Audit Commission

Timeliness and quality of the accounts

4.14 There was no change to the final accounts timetable for Strategic Health Authorities, Primary Care Trusts and NHS Trusts in 2004-05, with the objective of further improving the quality of accounts submitted for audit. For the first time, the Department required these bodies to submit their unaudited accounts to them in full and, as **Figure 26** shows, the majority of accounts were received on time by auditors and the Department. In auditors' opinion, 87 per cent of NHS bodies (excluding Foundation Trusts) submitted accounts by the agreed deadline (86 per cent in 2003-04). Strategic Health Authorities made significant progress in 2004-05, with only one failing to submit accounts on time, compared to six in 2003-04. All NHS Foundation Trusts submitted accounts on time.

4.15 However, despite the final accounts timetable being unchanged, auditors reported an overall decline in the quality of accounts presented for audit by both Primary Care Trusts and NHS Trusts. In the auditors' opinion, a total of 75 per cent of bodies produced accounts of sufficient quality compared to 87 per cent in 2003-04 (Figure 26).

4.16 Regarding the quality and timeliness of working papers supporting the figures in the accounts, auditors reported no significant change except an improvement in timeliness by Strategic Health Authorities **(Figure 27)**. In light of HM Treasury's faster closure initiative (Part 5), we are concerned that there has been no improvement in the quality of working papers, and that the quality of the accounts presented for audit has actually worsened. As this can have a significant impact on the time taken to complete the audit, improvements are needed in order for earlier deadlines to be achieved.

Corporate Governance

Progress has been made by NHS bodies in the identification and management of risk, but further improvement to governance arrangements in partnerships continues to be necessary if they are to deliver the benefits of joined-up service delivery.

Statements on Internal Control

4.17 Since 2001-02 every NHS body has been required to prepare a Statement on Internal Control (Statement) as part of the annual accounts. This describes the body's capacity to handle risk, and the risk and control framework in place. It also confirms that the body has undertaken a review of the effectiveness of the system of internal control, and discloses any significant internal control issues.

4.18 As in 2003-04, all NHS bodies prepared a Statement in accordance with guidance issued by the Department (or by Monitor for NHS Foundation Trusts). 93 per cent of bodies (excluding NHS Foundation Trusts) complied with the requirement to have the necessary risk management and review processes, including assurance frameworks, in place throughout the entire financial year. All successful applicants for NHS Foundation Trust status are required to have effective risk management and review processes in place, including controls to address principal risks.

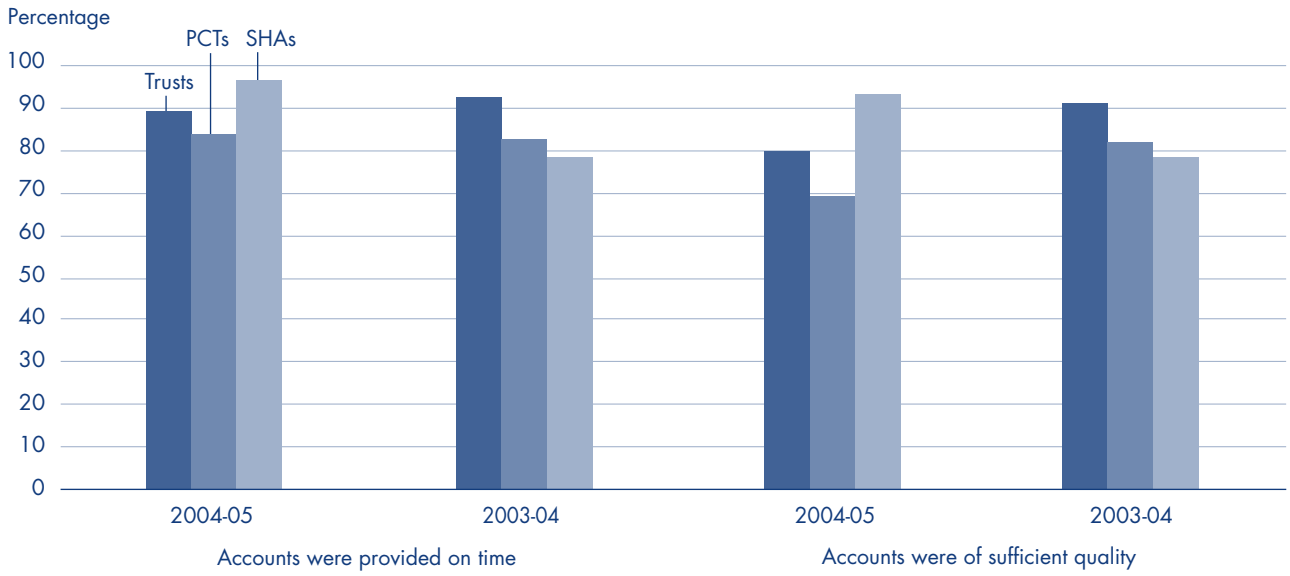
4.19 NHS bodies are required to disclose in the Statement any significant internal control issues identified during the year. 26 per cent of bodies (excluding NHS Foundation Trusts) identified significant internal control issues, which included:

- the inability to achieve financial balance in-year and on a recurring basis; and
- the need to further develop assurance frameworks.

4.20 Two NHS Foundation Trusts (eight per cent) identified significant internal controls issues which included:

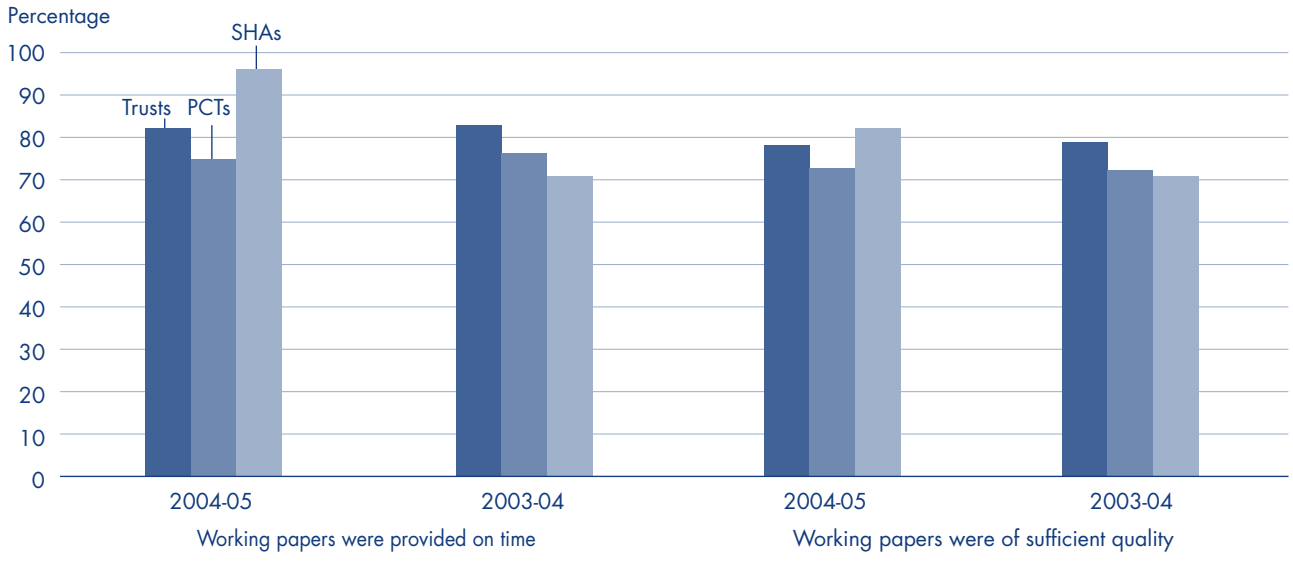
- concerns over financial balance (Bradford Teaching Hospitals, see Case Study 4); and
- delays to the implementation of an electronic patient records system (Homerton University Hospital).

26 Timeliness and quality of accounts



Source: Audit Commission analysis of appointed auditors' findings

27 Timeliness and quality of working papers



Source: Audit Commission analysis of appointed auditors' findings

Risk management

4.21 NHS bodies continue to face a wide range of risks to the delivery of their objectives, including their ability to deliver high-quality care to patients. Auditors reported that in their opinion 98 per cent of bodies (excluding NHS Foundation Trusts) had procedures in place by the year-end to identify and document the principal risks threatening the achievement of their key objectives **(Figure 28)**, compared with 93 per cent in 2003-04. Auditors also reported that in their opinion 94 per cent of bodies had established arrangements which would enable them to address their major risks.

4.22 Monitor state that, as the assessment and authorisation process for NHS Foundation Trusts focuses on risk management, and all Foundation Trusts were awarded at least level one in the Risk-Pooling Scheme for Trusts[34] in 2004-05, they believe that all NHS Foundation Trusts had identified and documented all their principal risks, and had arrangements in place to address them.

Partnerships

4.23 To deliver modern, integrated healthcare services, NHS bodies are increasingly using partnership arrangements, for example with local authorities and other public, voluntary and private-sector organisations. Comprehensive partnership agreements form the basis for better governance and management of risks in partnerships. Auditors reported that 26 per cent of Primary Care Trusts involved in partnership arrangements did not have a comprehensive signed partnership agreement in place throughout the financial year. Auditors also reported problems with the governance arrangements of partnerships at 55 per cent of Primary Care Trusts involved in partnership working, which included:

- deficiencies in budgetary control resulting in overspends;
- inadequate performance monitoring arrangements; and
- lack of financial monitoring and reporting by host organisations (often local authorities).

4.24 The Audit Commission published a national report in November 2005[35] which addresses governance of partnerships in the NHS and elsewhere, and considers how this can be improved.

Financial management issues arising during 2004-05

There were a number of significant financial management issues facing NHS bodies in 2004-05. Large adjustments were required to some bodies' draft accounts based on errors identified by appointed auditors. Current and forthcoming developments in the NHS will require increasingly high-quality financial management, governance and reporting arrangements. These arrangements form part of the assessment criteria for NHS Foundation Trusts, and have been critical success factors in their first year of operation.

Differences between the unaudited and audited accounts

4.25 It is usual for amendments to be made to a body's draft accounts as a result of the external audit. This can be to rectify mistakes or make adjustments to include additional, more up-to-date information which materially changes the financial position of the body. These adjustments tend to lead to increases and decreases in both income and expenditure, and therefore do not generally result in significant changes to the national position. However, this was not the case in 2004-05. The unaudited accounts (including Foundation Trusts) showed an overall deficit across the NHS of £133.9 million, which increased in the audited accounts to £251.2 million[36] **(Figure 29)**.

34 See below, Annex 6.
35 Audit Commission, *Governing Partnerships: Bridging the Accountability Gap,* November 2005.
36 A prior-year adjustment was made to the out-turn of Kensington and Chelsea Primary Care Trust in 2004-05, the effect of which was to increase the overall overspend for Primary Care Trusts by £7.1 million in 2003-04. 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. They therefore recognised all 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). 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.

28 The majority of Strategic Health Authorities, Primary Care Trusts and NHS Trusts had procedures in place during 2004-05 to document and address principal risks

NHS body	Principal risks identified and documented		Arrangements in place to address risks identified	
	Number	%	Number	%
NHS Trusts	257	99	248	96
Primary Care Trusts	298	98	282	93
Strategic Health Authorities	26	93	26	93
Total	**581**	**98**	**556**	**94**

Source: Audit Commission analysis of appointed auditors' findings

29 Comparison of NHS bodies' unaudited and audited out-turn for 2004-05

	Aggregate unaudited outturn £ million	Aggregate audited outturn £ million	Adjustment £ million
Strategic Health Authorities	381.5	372.7	(8.8)
Primary Care Trusts	(202.7)	(265.3)	(62.6)
NHS Trusts	(282.9)	(321.7)	(38.8)
NHS Foundation Trusts	(29.8)	(36.9)	(7.1)[1]
Total	**(133.9)**	**(251.2)**	**(117.3)**

Source: Department of Health, NHS Foundation Trust consolidation returns and audited accounts of NHS bodies

NOTE

1 Of the £7.1 million overall adjustment for NHS Foundation Trusts, £5.9 million is attributable to audit adjustments arising at University College London Hospitals NHS Foundation Trust. No other NHS Foundation Trust required adjustments of over £0.7 million.

4.26 The National Audit Office and the Audit Commission are concerned about the level of audit adjustments required during the 2004-05 audit. The three most significant causes for movements between the two set of accounts were prescribing expenditure, Agenda for Change and adjustments to service level agreements. Appointed auditors reported that there was evidence of inappropriate adjustments and/or omissions in 125 NHS bodies' accounts (21 per cent) in 2004-05. **Case Study 6 overleaf** outlines the circumstances at one such body.

4.27 At an individual NHS body level, not recognising the true financial position may mean bodies fail to take the necessary corrective action, or make decisions based on incorrect financial information. At Strategic Health Authority and national level it makes it more difficult to assess the financial situation and respond to it in timely fashion.

4.28 There is also a perverse incentive for NHS bodies (other than NHS Foundation Trusts) to underestimate the size of the deficit in their unaudited accounts. When an NHS body (other than an NHS Foundation Trust) overspends, the resources available to it are reduced the following year (Part 3). This deduction is based on the unaudited deficit with any significant difference in the audited position being adjusted the year after. Until 2005-06, there was a further incentive for bodies to underestimate deficits in their unaudited accounts, since the Healthcare Commission's 'star rating' assessment for financial balance was based on unaudited figures. However, the Healthcare Commission's annual health check will replace the 'star rating' system from 2005-06 and will include the Auditors' Local Evaluation score (see Part 5).

CASE STUDY 6

Scarborough and North East Yorkshire NHS Trust

Scarborough and North East Yorkshire Healthcare NHS Trust has had financial difficulties for a number of years. In 2004-05, the Trust was in year three of a financial recovery plan agreed with its main commissioner and the local Strategic Health Authority. Over the last four years the Trust had received financial support totalling £10 million from the Strategic Health Authority; in each case, the Trust had repaid this support in the year following its receipt. With this support, the Trust met its key NHS Plan waiting time targets for each year and its financial break-even target until 2004-05.

In 2004-05, it was recognised early in the year that there would be difficulties in achieving financial balance, following difficult negotiations with the Trust's main commissioner. The costs of national initiatives such as the consultant contract and reducing waiting time targets also created significant financial pressures, which became more apparent as the year progressed.

In November 2004, the Director of Finance reported to the Board that whilst the forecast year-end position was break-even, divisional overspends were expected to total £6.8 million by the end of the year. These overspends were expected to be partly offset by additional income, but during 2004-05 the Trust also considered a number of further measures to break even. These included a number of accounting adjustments. Before the accounts were prepared, the appointed auditor provided guidance that the proposed adjustments would not comply with accounting standards as set out in the NHS Trust Manual for Accounts.

The Director of Finance chose to disregard the auditor's view and prepared a balanced set of accounts. The draft accounts submitted for audit in May 2005 reported a year-end surplus of £20,000 and contained a number of inappropriate accounting adjustments and errors. Despite the existence of clear rules on large adjustments related to purchases made in previous years, the Trust hoped it could reduce in-year spending by reclassifying previously purchased medical instruments as stock and fixed assets. The accounts also contained examples of incorrect accounting treatment and inadequate checking procedures leading to significant errors. In the Public Interest Report, the auditor reported that a number of adjustments employed by the Trust were a device to achieve financial balance, rather than improve the accuracy of the accounts, and did not comply with accounting standards.

The corrections required to deal with the misstatements in the original accounts are set out below:

	£000
Surplus as reported in draft accounts	**20**
Previously purchased medical equipment incorrectly reclassified as fixed assets	(1,190)
Previously purchased medical equipment incorrectly reclassified as stock	(1,616)
Incorrect capitalisation of salaries	(286)
Overstatement of profit arising from asset sales	(266)
Revenue costs inappropriately classified as prepayments	(379)
Miscellaneous errors arising from inadequate checking procedures	(789)
Audited out-turn position	**(4,506)**

Following the completion of the audit, the accounts were corrected to show a deficit of £4.5 million on the income and expenditure account. In the auditor's opinion the desire to present a small surplus at the year end compromised the production of true and fair annual accounts.

Since the Public Interest Report was issued, the Trust has produced an action plan to implement the recommendations suggested by the appointed auditor. The plan has been approved by the Board and is currently being implemented.

Source: Appointed Auditor's Public Interest Report (November 2005)

4.29 The National Audit Office and the Audit Commission are working with the Department to ensure that large discrepancies between audited and unaudited accounts do not occur in 2005-06.

We recommend that the Department takes further steps to support finance staff throughout the NHS in complying with technical and professional accounting standards. As pressure increases to achieve and maintain financial balance, finance staff should feel secure and empowered to raise issues openly as they arise.

Prescribing expenditure

4.30 Adjustments to prescribing expenditure contributed significantly to the overall shift of £117.3 million between the unaudited and audited NHS accounts.

4.31 Pharmacists are reimbursed for the drugs they dispense by the Prescription Pricing Authority on behalf of Primary Care Trusts, who are then recharged for the payments made. The timetable for processing prescriptions means that Primary Care Trusts are recharged the cost of

the prescriptions on average two to three months after they are dispensed. As a result, all the expenditure on prescriptions dispensed in February and March, and some of those dispensed in January are not paid for until the following financial year. Primary Care Trusts therefore have to accrue for this expenditure in their accounts. As information on the actual expenditure incurred in the year is not received from the Prescription Pricing Authority until after draft accounts have been submitted, Primary Care Trusts estimate their costs for the final two to three months of the year. As the actual costs are known before the completion of the audit, we would expect Primary Care Trusts to make changes to these estimates, where there are material differences.

4.32 Auditors reported concerns that, in their opinion, 15 per cent of Primary Care Trusts had attempted to reduce prescriptions expenditure in the 2004-05 draft accounts in order to reduce overspend against revenue resource limits. It was reported that some NHS bodies had been advised by their Strategic Health Authorities to make adjustments to the year-end accrual, and in some cases these adjustments did not appear to be supported by the available information. These unsupported adjustments led to inconsistencies between opening and closing creditors and material misstatements in the accounts.

4.33 There were a large number of adjustments made to individual bodies' draft accounts as a result of material errors identified by auditors. Many of these errors came to light when auditors compared the level of accrued expenditure in the draft accounts with the actual amounts notified by the Prescription Pricing Authority.

Agenda for Change

4.34 Arrangements for the new Agenda for Change pay system were rolled out nationally for staff on national contracts from 1 December 2004, with a backdated implementation date of 1 October 2004. During 2004-05 NHS bodies undertook work to match staff to their new pay bands and complete the process of assimilating staff to the new system, with a deadline for all NHS staff to be assimilated by October 2005. This was not fully achieved, although the Department reports that 98.7 per cent of NHS staff had been assimilated by March 2006.[37]

4.35 *Financial Management in the NHS 2003-04*[38] highlighted that implementing these significant changes to the pay arrangements of NHS staff was likely to create cost pressures for most NHS bodies in 2004-05.

4.36 NHS bodies were required to reflect in the 2004-05 accounts their liabilities for pay backdated to 1 October 2004, and the Department issued guidance to NHS bodies that liabilities should be calculated and recorded in accordance with Financial Reporting Standard 12. However, auditors reported concerns that nine per cent of NHS Trusts and Primary Care Trusts did not follow the Department's guidance and accounted inappropriately for Agenda for Change liabilities. In many cases NHS bodies had disclosed a contingent liability in their draft accounts when a provision should have been recorded. There had also been under reporting of provisions, where the provision had been based on the funding available instead of the actual liability.

Intra-NHS balance agreements

4.37 For 2004-05, the agreement of balances at the end of month nine of the financial year was extended to include all NHS bodies, not just those within the same Strategic Health Authority area. NHS Trusts were also required for the first time to agree income and expenditure balances as well as debtors and creditors, both at month nine and at the year end.

4.38 Auditors reported that one of the reasons for considering some NHS bodies' accounts to be of insufficient quality in 2004-05 was that significant discrepancies in intra-NHS balances had not been resolved. This resulted in late adjustments to service level agreements which delayed the completion of the audit and – in addition to the factors considered above – contributed to the overall shift between the unaudited and audited NHS accounts. Auditors had concerns over the process of finalising service level agreements in 2004-05, reporting that 79 per cent of NHS Trusts and 83 per cent of Primary Care Trusts did not have signed service level agreements in place with their main commissioning or provider bodies at the start of the financial year. Some of these agreements were not signed until the end of the year, and some were not signed at all.

37 This figure excludes NHS Foundation Trusts.
38 National Audit Office/Audit Commission, *Financial Management in the NHS: NHS (England) Summarised Accounts 2003-04*, June 2005, p. 46.

4.39 Disputes and inconsistencies over individual bodies' intra-NHS balances also have a significant impact at a national level on the summarised accounts. If NHS bodies do not treat such balances appropriately and consistently at local level, there is a risk that key figures in the summarised accounts cannot be effectively verified. In 2004-05, considerable additional work had to be undertaken by the National Audit Office to gain sufficient assurance over intra-NHS balances reported in the summarised accounts.

4.40 It is important that local bodies improve their processes and work with auditors to resolve these issues more quickly in future. Organisations which fail to do so will not only hamper progress towards faster closure (Part 5), but also expose themselves to greater operating risk by relying on inaccurate or out-of-date information for decision-making.[39]

Revaluation of the NHS Estate

4.41 The NHS Estate is subject to revaluation every five years and the valuation is undertaken by the District Valuer. The last revaluation took place on 1st April 2005 but, in order to ensure that NHS bodies had up-to-date information for the preparation of the 2005-06 capital charge estimates, the valuation was undertaken during the early part of 2004. All NHS bodies received draft valuations by July 2004. Where material impairments (downward revaluations) were identified in the draft valuations, bodies were required to reflect these in their 2003-04 accounts. All other valuation adjustments were required to be accounted for as at 31 March 2005.

4.42 Although NHS bodies received the results of the 2005 revaluation exercise in July 2004, appointed auditors found that there were a number of unresolved differences between the valuations in some bodies' 2004-05 draft accounts and information received from the District Valuer. This caused delays in the completion of the audit, as in some instances the District Valuer was required to provide revised valuations at a late stage. NHS bodies need to account for changes in asset valuations as soon as they are known, so that differences can be identified and resolved during the year rather than at the year end. The preparation of monthly management accounts, including balance sheet information, would assist in this process.

General Medical Service contracts

4.43 Under the new General Medical Services (GMS) contract, introduced on 1 April 2004, a new way of allocating funds to GPs and other primary care professionals was introduced. The new GMS is an individual contract between a practice and the primary care organisation (normally a Primary Care Trust). The contract rewards GPs for quality of care, and incentives are provided to treat patients at the surgery rather than at the hospital.

4.44 Appointed auditors considered the financial management arrangements relating to the implementation of new workforce contracts in selected Primary Care Trusts[40] where the implementation of the GMS contract was considered to be a high audit risk. In 70 per cent of these bodies, auditors found arrangements specifically in relation to the new GMS to be fairly robust, but 67 per cent of the Primary Care Trusts audited had not estimated the financial impact of the new contract in the medium term. However, it should be noted that Primary Care Trusts based their forecast of GMS costs on figures provided by the Department. The actual cost to the NHS of implementing the new GMS contract was approximately £300 million higher than the Department's forecast.[41] This was mainly due to practices exceeding the anticipated performance on the Quality and Outcomes Framework and Out of Hours.[42] Whilst this is a positive outcome from a patient care perspective, it has caused financial pressures in some organisations.

4.45 It is crucial that the Department works with Primary Care Trusts to identify accurately the financial impact of the new contract, both for current and future years, as resource allocation decisions will be made on the basis of these calculations. Primary Care Trusts should ensure that they have the required data, have undertaken medium-term spending forecasts and have assessed the impact on other budgets.

39 Our previous report examines in more detail the risks to bodies of using inaccurate information for management reporting and forecasting. See *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04,* pp. 32-35.

40 Workforce contracts audits were only undertaken at bodies that were considered to be at greater risk. Therefore the findings cited here are based on a 'skewed' sample set and do not necessarily represent the national picture.

41 Source: Uncorrected transcript of oral evidence (HC 736-I) *Public Expenditure on Health and Personal Social Services 2005,* Health Select Committee, 1 December 2005. Subsequent analysis by the Department suggests a slightly smaller shortfall of £284 million.

42 Out of Hours services are covered in detail in the National Audit Office report *The Provision of Out-of-Hours Care in England,* HC 1041, 5 May 2006.

Payment by Results

4.46 As identified in our last report, the introduction of Payment by Results brings significant change to the NHS financial regime. By introducing a single rules-based system across the NHS, which pays hospitals for the work they do, the new payment system is intended to increase the fairness and transparency of payments to NHS Trusts and other providers, to reward efficiency and to facilitate patient choice. It also brings an unprecedented level of risk for both commissioners and providers, and greater potential for financial instability. It requires better data and stronger financial management within NHS bodies, in particular robust medium-term planning and budgeting.

4.47 In 2004-05, there were a number of early implementers of Payment by Results, primarily NHS Foundation Trusts and the Primary Care Trusts which commission from them. The Audit Commission report *Early Lessons from Payment by Results*,[43] published in October 2005, set out the experiences of early implementers, and identified important factors behind operating successfully in the new environment.

4.48 The early implementers have welcomed the better basis for planning and managing their business which Payment by Results provides, and are mostly positive about the change. However, it is clear that the early implementers have been challenged by the new system and the potential for Payment by Results to destabilise local health economies has certainly been felt. In some cases, it has exposed underlying financial difficulties and raised further concerns about the adequacy of financial management arrangements in the NHS. The ease with which bodies have adapted has depended upon their underlying financial stability. Health economies with an underlying historic deficit have found that Payment by Results has tended to increase financial pressure and polarise organisational interests, leading to disputes. In-year changes in the design and implementation of the system have exacerbated the challenges, increasing uncertainty and impacting on financial and operational plans.

4.49 To reduce the risk of financial instability, a number of local variations on Payment by Results were applied in some local health economies, including the use of caps and floors on activity levels. NHS bodies had valid concerns that the level of risk inherent in the policy design is too great, particularly in the case of non-elective activity where it is more difficult to influence volumes and control payments.

4.50 Many of the difficulties with Payment by Results in 2004-05 stemmed from poor planning and inconsistent assumptions about activity levels between parties. Financial planning must be underpinned by a common set of expectations and joint planning assumptions. Strategic Health Authorities should be facilitating this process, as well as thoroughly reviewing the financial impact of Payment by Results on individual organisations and the health economy. In addition, improvement in medium-term planning and forecasting is still a priority. At acute Trusts, costing systems need to be strengthened, with organisations investing time in understanding how costs change, and in particular the trigger points for significant additional costs. At Primary Care Trusts, the presence of robust systems to manage demand and monitor payments has proven crucial to managing the financial position.

4.51 Experience in 2004-05 also highlighted the ongoing need for improvements in data quality. For example, incomplete coding of diagnoses or procedures can result in a loss of income for NHS Trusts and NHS Foundation Trusts. Work is under way to develop a national assurance framework to help reduce the risk of incorrect payments due to inaccurate data.

4.52 Finally, the more successful early implementers have recognised that Payment by Results requires a change in culture across the organisation, not just in finance. The implications need to be well understood outside the finance department, particularly by clinicians, so that the risks can be better managed and the benefits realised. We consider the need for NHS bodies to expand awareness of financial matters throughout the organisation in Part 3.

Clinical Negligence

4.53 Clinical negligence is the term given to a breach of a duty of care by healthcare practitioners in the performance of their duties, and confirmed as such by the employing NHS body or through legal process. The NHS Litigation Authority[44] ('the Authority') is responsible for managing clinical negligence claims within the NHS on behalf of Primary Care Trusts, NHS Trusts and NHS Foundation Trusts. It accounts for the costs and liabilities associated with these claims, collecting annual contributions from each NHS body to cover the anticipated payments for the financial year. However, individual NHS bodies retain their duty of care and the legal liability for cases arising.

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

44 The NHS Litigation Authority is a Special Health Authority, set up under the NHS Act 1977 to administer NHS clinical negligence liabilities and promote risk management. Its remit has since been expanded to include schemes and risk management for non-clinical liabilities and the provision of information on human rights case law.

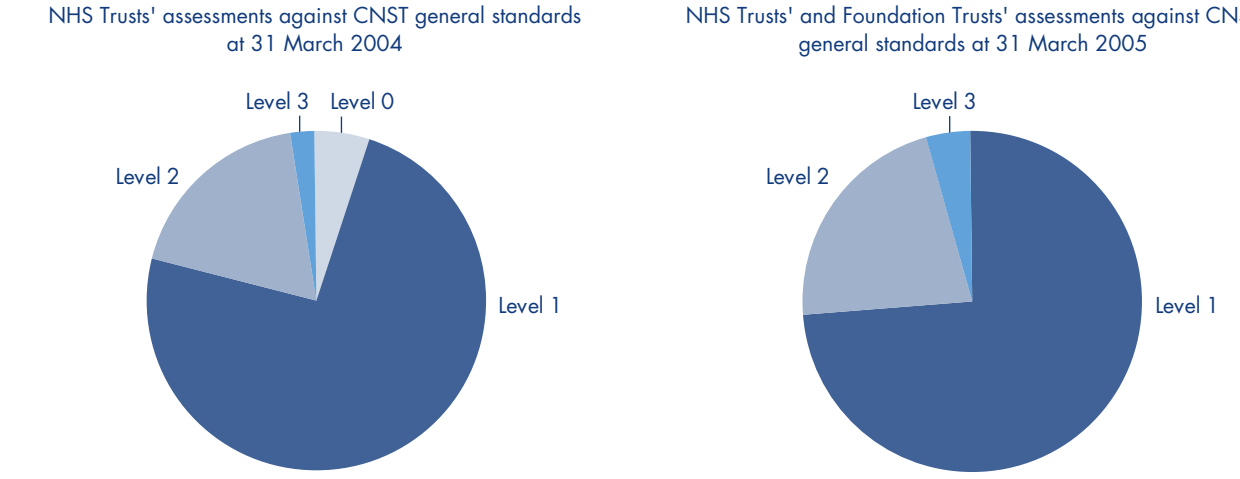
4.54 In 2004-05, the Authority paid out £503 million for all clinical negligence schemes (2003-04: £422 million). However, there was a drop in the actual number of claims made, from 6,251 in 2003-04 to 5,609[45] in 2004-05.

4.55 The NHS expects to make future payments totalling £6.9 billion (at today's prices) in respect of known or expected claims (2003-04: £6.3 billion). £2.8 billion of this is expected to be paid within the next five years. These sums are shown as provisions in the Authority's accounts.[46] An additional £3.1 billion of claims are possible, but unlikely, and these are shown as contingent liabilities in the Authority's accounts. The provisions represent the value of claims received, at today's prices, calculated to reflect the probability of each claim being settled whenever that might occur. This includes an estimate made by actuaries of liabilities incurred but not yet reported to the Authority. Whilst provisions have been increasing steadily over recent years, amounts actually paid out to settle claims have fluctuated, showing a five per cent decrease from 2003 to 2004 and a 19 per cent increase between 2004 and 2005.

4.56 The Authority's *Framework Document*[47] requires it to provide incentives for NHS bodies to improve cost-effective clinical and non-clinical risk management. In delivering this objective, the Authority requires NHS bodies to participate in its risk management programme. This includes assessment by independent assessors against a number of risk management standards addressing clinical, non-clinical and organisational risks. Most standards are awarded from Level Zero (weakest) to Level Three (strongest), and the higher a Trust's rating, the lower the contributions it pays to the Authority under the relevant scheme.

4.57 More than 500 assessments were completed during 2004-05 and the overall outcome showed a significant improvement over previous years. Under the standard relevant to clinical negligence risk, the proportion of Trusts achieving Level One or above rose from 95 per cent in 2003-04 to 100 per cent in 2004-05. The proportion achieving Levels Two or Three also rose, from 21 per cent in 2003-04 to 26 per cent in 2004-05[48] **(Figure 30)**.

30 NHS Trusts' assessments against CNST general standards in 2004 and 2005



Source: NHS Litigation Authority

45 The figures cited include claims made under the Clinical Negligence Scheme for Trusts (CNST), Existing Liabilities Scheme (ELS) and Ex-Regional Health Authority Scheme (Ex-RHAs) scheme. They exclude claims made under the Property Expenses Scheme (PES) and Liability to Third Parties Scheme (LTPS) since these do not pertain to clinical negligence (see Annex 6).

46 *NHS Litigation Authority Report and Accounts 2004-05*, HC 149, 21 July 2005. The amounts cited include the Authority's provisions under the CNST, ELS and Ex-RHAS, but exclude PES and LTPS (see Annex 6).

47 NHS Executive, *The National Health Service Litigation Authority: Framework Document*, 1996.

48 2004-05 figures include NHS Foundation Trusts, but exclude Ambulance Trusts, since these are now assessed against a separate NHSLA ambulance standard.

4.58 After a fundamental review in 2004 of its approach to standards and assessments, the Authority has decided that the content of its standards should be revised to create a single set of standards for each type of NHS trust incorporating organisational, clinical and non-clinical health and safety risks. These new standards are intended to be fully operational from April 2008.

4.59 Following the Chief Medical Officer's consultation on reforming compensation arrangements in the NHS,[49] the NHS Redress Bill was published in October 2005. Its aim is to establish an NHS Redress Scheme and place a duty on providers and commissioners of hospital services to ensure patients receive a consistent, speedy and appropriate response to clinical negligence. The scheme will cover lower-value claims (£20,000 or less), and will aim to offer patients a rapid and cost-effective alternative to litigation.

NHS Foundation Trusts

4.60 NHS Foundation Trusts are free-standing, not-for-profit organisations with a duty to provide NHS services to NHS patients according to NHS standards and principles. They are authorised and regulated by Monitor (whose statutory name is the Independent Regulator of NHS Foundation Trusts), and can borrow commercially, retain surpluses and invest to improve services for patients.

4.61 25 NHS Foundation Trusts were in operation during 2004-05: 10 for the entire year, a further 10 from 1 July 2004 and five more from January 2005. A further seven were established in 2005-06, and eight more to date in 2006-07: three from 1 May 2006 and five more from 1 June 2006. **Figure 31 overleaf** shows the 40 NHS Foundation Trusts in existence as at 1 June 2006.

4.62 NHS Foundation Trusts operate under a different financial and accounting regime from NHS Trusts. This is chiefly because Monitor aims to bring NHS Foundation Trusts in line with UK Generally Accepted Accounting Practice (UK GAAP), thus providing greater transparency and comparability with the commercial sector in the UK. The key differences are that NHS Foundation Trusts do not have access to brokerage or financial support, and that they must account for impairments (downward revaluation of assets) in accordance with Financial Reporting Standard 11. This latter difference means that impairments are charged directly to the income and expenditure account rather than being offset to the revaluation reserve or covered by offset funding from the Department, as is the case with NHS Trusts. The full adoption of Financial Reporting Standard 11 caused £7.9 million of impairments to be charged to the income and expenditure accounts of NHS Foundation Trusts in 2004-05. These impairments reduced the 'bottom-line' performance of NHS Foundation Trusts in a way which they would not for NHS Trusts. A further caveat on comparability is that NHS Foundation Trusts were operating under 'Payment by Results' (paragraphs 4.45-4.51) in 2004-05, which meant that their income increased or decreased based on actual activity rather than being fixed under block contracts. These fluctuations in income under Payment by Results would not have applied to NHS Trusts. Care should therefore be taken in comparing the performance of the two types of body. The financial performance of both NHS Trusts and NHS Foundation Trusts is outlined in more detail in Part 2.

4.63 As part of Monitor's statutory reporting duty under the Health and Social Care (Community Health and Standards) Act 2003, it produced an operating review of NHS Foundation Trusts to accompany the first consolidated account of these bodies in 2004-05.[50] The key findings regarding financial management and governance were:

- NHS Foundation Trusts faced a challenging year with the adjustment to a new regulatory regime and the implementation of new initiatives such as Payment by Results and Agenda for Change.
- The disciplines of NHS Foundation Trust status are pushing organisations towards higher standards of financial management.
- NHS Foundation Trusts understand the importance of strong corporate governance, with Boards responding effectively to their new responsibilities.
- The role of non-executive directors is crucial; they must possess a range of experience and expertise, particularly of a financial nature.

49 Sir Liam Donaldson, *Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*, June 2003.
50 *Review and Consolidated Accounts of NHS Foundation Trusts 2004-05*, HC 622, 22 November 2005.

31 NHS Foundation Trusts as at 1 June 2006

Authorised on 1 April 2004

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

Authorised on 1 July 2004

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

Authorised on 1-5 January 2005

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

Authorised on 1 April 2005

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

Authorised on 1 June 2005

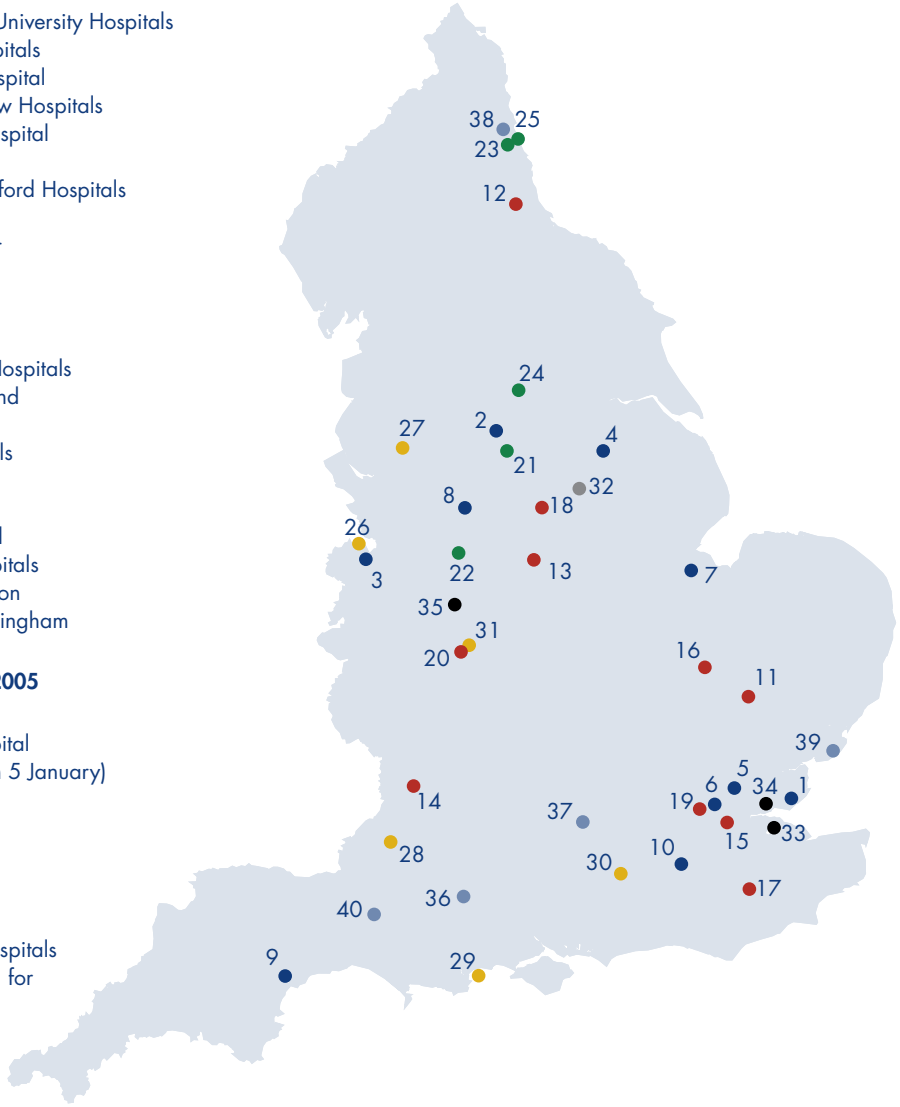
32 Rotherham

Authorised on 1 May 2006

33 Oxleas
34 South Essex Partnership
35 South Staffordshire Healthcare

Authorised on 1 June 2006

36 Salisbury
37 Royal Berkshire
38 The Newcastle upon Tyne Hospitals
39 Southend University Hospitals
40 Yeovil District Hospital



Source: National Audit Office

4.64 It is not only NHS Foundation Trusts which must seek to achieve sound financial management and governance. All NHS bodies must develop the requisite skills and structures, not least because it is expected that every NHS Trust will be in a position to apply for NHS Foundation status by 2008. By addressing this need now through appropriate Board appointments, transparent reporting and a culture of constructive challenge, NHS Trusts can reap immediate rewards as well as increasing their future eligibility for Foundation status.

Private Finance Initiative Projects

4.65 The Government's NHS Plan of July 2000 stated that over the next ten years there would be major investment in new NHS buildings, with an extended role for the Private Finance Initiative (PFI). As at November 2005, there were almost 130 actual or planned PFI schemes across the NHS, with an estimated capital value of £18.3 billion **(Figure 32)**. Of these, 76 projects were either operational or the contract had been signed. The majority of schemes are in the acute hospital sector, which accounts for over 90 per cent of the estimated capital value of health PFI projects.

4.66 The Department and HM Treasury envisage that PFI will remain the major vehicle for delivering capital investment in acute services in the NHS. After completion of a reappraisal currently being undertaken by Strategic Health Authorities, it is expected that the NHS will remain the largest single user of PFI in government.

4.67 In 2004-05, £385 million was paid in annual charges to the contractors on the 43 contracts (with a capital value of £1.9 billion) which were operational. This included £322 million on 19 of the bigger first-wave hospital PFI contracts. The new facilities at those hospitals had been operational for 18 months or more at 31 March 2005.

4.68 **Figure 33 overleaf** shows the Department's estimated aggregate of future payments under the 76 PFI contracts which are either operational or which have been signed up to November 2005. It excludes schemes at preferred bidder stage or at an earlier stage in the procurement process. If and when these schemes are approved, the committed payments will rise above the levels shown.

32 Number and Capital Value of Actual and Projected PFI Schemes as at November 2005

	Acute Hospital Trusts		Other Trusts		Total	
Project Stage	No.	Capital value (£ billion)	No.	Capital value (£ billion)	No.	Capital value (£ billion)
Operational in 2004-05	29	1.6	14	0.3	43	1.9
Contract Signed	22	3.5	11	0.4	33	3.9
Preferred Bidder Stage[1]	15	4.8	4	0.1	19	4.9
Future Schemes[1]	26	7.2	6	0.4	32	7.6
Total	**92**	**17.1**	**35**	**1.2**	**127**	**18.3**

Source: Department of Health

NOTE

1 These figures are taken from the September 2005 bi-annual budgetary return to Treasury from the Department of Health. All planned schemes depend upon continuing support in the form of Strategic Health Authority investment plans. The exact capital figures for future schemes and those at preferred bidder stage may therefore be subject to change.

4.69 At local level, any large-scale hospital-building project can create cost pressures and increase financial risk, since it commits an organisation to pre-determined levels of capacity and fixed costs over a number of years. This may reduce the organisation's ability to respond flexibly to changing activity trends, or to reduce costs by service reconfiguration and restructuring. For NHS Trusts, the introduction of Payment by Results and Choice (paragraphs 4.45-4.51) rather than block contracts brings increased uncertainty over both activity levels and income. As PFI unitary charges can represent a significant proportion of a Trust's fixed costs (see Case Study 1 on Queen Elizabeth Hospital NHS Trust), bodies with PFI commitments must have sufficient flexibility elsewhere in their cost base to accommodate fluctuations in activity and income.

4.70 As **Figure 34** shows, the financial performance of NHS Trusts in 2004-05 does not reflect any immediate correlation between the distribution of surpluses or deficits and the presence of PFI projects. Of the 259 NHS Trusts (excluding NHS Foundation Trusts) operating in 2004-05, 36[51] were making unitary payments under PFI schemes. 11 of these (31 per cent) reported a deficit, while 25 (69 per cent) reported break-even or surplus. This is a slightly higher incidence of deficits than amongst the 223 NHS Trusts without PFI schemes, where 57 bodies (26 per cent) reported a deficit. However, the relatively small number of NHS Trusts currently operating PFI schemes means that purely statistical comparisons should be treated with caution.

4.71 The National Audit Office will be examining PFI projects and their financial implications for the NHS in more detail as part of their work on the 2005-06 NHS accounts.

33 Estimated aggregate payments under signed PFI contracts

Year	Payment (£ million)	Year	Payment (£ million)	Year	Payment (£ million)	Year	Payment (£ million)
2005-06	474	2012-13	977	2019-20	1,162	2026-27	1,381
2006-07	623	2013-14	1,002	2020-21	1,191	2027-28	1,415
2007-08	725	2014-15	1,027	2021-22	1,220	2028-29	1,451
2008-09	826	2015-16	1,052	2022-23	1,251	2029-30	1,487
2009-10	907	2016-17	1,079	2023-24	1,282	2030-31	1,524
2010-11	930	2017-18	1,106	2024-25	1,314	2031-32	1,419
2011-12	953	2018-19	1,133	2025-26	1,347	2032-33	1,111

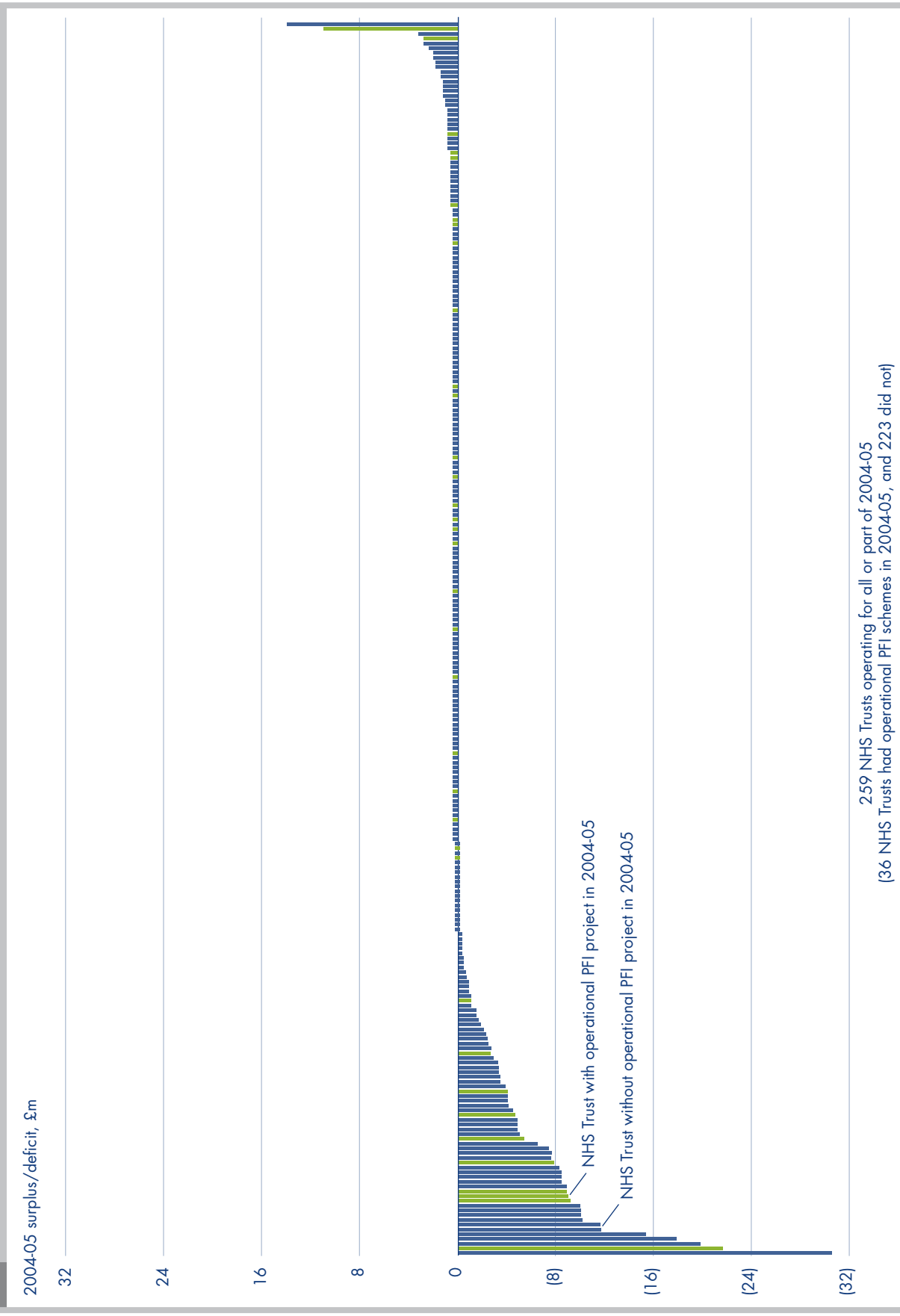
Source: Department of Health, based on data as at November 2005

NOTE

Figures used are in cash (undiscounted) terms. Payments after 2030-31 are lower because early contracts will have ended.

51 This figure includes all NHS Trusts, including ambulance trusts and mental health trusts, and excludes Primary Care Trusts. It therefore includes some bodies from the 'Other Trusts' column in Figure 34, and hence will not equal the number of 'Acute Hospital Trust' schemes cited in the first column.

34 Distribution of PFI projects across NHS Trusts by 2004-05 out-turn



Source: National Audit Office analysis of Department of Health Data

PART FIVE

Financial issues arising in 2005-06 and beyond

5.1 This part of our report outlines the unaudited year-end position of the NHS in 2005-06. It also considers some of the financial issues arising and the key developments in 2005-06 and beyond, as well as assessing their implications for financial management in the NHS.

Financial standing

The NHS continued to face significant financial pressures in 2005-06, leading to concerns about financial standing at over half of NHS bodies (excluding NHS Foundation Trusts).

The unaudited year-end out-turn figures for the NHS indicate an overall deficit (including NHS Foundation Trusts) of £536 million.

5.2 The achievement of financial balance continued to be a considerable challenge for a significant number of NHS bodies in 2005-06. As **Figure 35** shows, auditors have reported that they have concerns about financial standing at 348 NHS bodies (excluding NHS Foundation Trusts) (59 per cent).

5.3 New year-end figures provided by the Department indicate that the aggregate position of the NHS for 2005-06 (excluding NHS Foundation Trusts) is a deficit in the region of £512 million **(Figure 36 overleaf)**. As stated in Part 4,[52] we have concerns about the movement observed between the unaudited and audited accounts in 2004-05, and hence these unaudited 2005-06 figures should also be treated with caution.

5.4 A total of 17 Strategic Health Authority areas (which exclude NHS Foundation Trusts since these are not performance-managed by Strategic Health Authorities) report an aggregate deficit, with 15 deficits greater than £10 million (Figure 5).

5.5 These unaudited figures show 31 per cent of NHS bodies (including Foundation Trusts) predicting a deficit, compared to 28 per cent in 2004-05.[53] They also show an increasing number of individual bodies with significant deficits. These include 102 Primary Care Trusts and 66 NHS Trusts, all of which report an unaudited deficit / overspend greater than 0.5 per cent of total income / revenue resource limit. The unaudited 2005-06 in-year deficit for NHS Trusts takes the cumulative deficit for the sector (Part 3) to an estimated £1.1 billion.

35 Bodies where auditors' reported concerns over financial standing in 2005-06

Type of NHS body	Number of bodies	%
Strategic Health Authority	6	21
Primary Care Trust	174	57
NHS Trust	168	65
Total	**348**	**59**

Source: Audit Commission

52 See Part 4, paragraphs 4.24-4.28.
53 If FoundationTrusts are excluded, the figures are 31 per cent for 2005-06 and 27 per cent for 2004-05.

36 NHS bodies' 2005-06 forecast year-end position by Strategic Health Authority Area

Strategic Health Authority Area	Strategic Health Authority	Primary Care Trusts	NHS Trusts	Total
	Unaudited year-end under/ (Over)spend £ million		Unaudited year-end surplus/ (Deficit) £ million	£ million
Avon, Gloucestershire and Wiltshire	11.4	(37.1)	(15.8)	(41.5)
Bedfordshire and Hertfordshire	19.3	(66.5)	(60.7)	(107.9)
Birmingham and the Black Country	31.3	5.9	(18.1)	19.1
Cheshire and Merseyside	3.2	(20.6)	0.9	(16.6)
County Durham and Tees Valley	46.7	(13.2)	(33.5)	0.0
Cumbria and Lancashire	33.1	6.9	(5.8)	34.1
Dorset and Somerset	5.5	4.7	0.7	11.0
Essex	11.1	(16.7)	(0.5)	(6.0)
Greater Manchester	10.0	7.1	22.9	40.1
Hampshire and Isle of Wight	4.4	(14.7)	(14.7)	(25.0)
Kent and Medway	15.4	(14.5)	(5.1)	(4.2)
Leicestershire, Northamptonshire and Rutland	6.2	(31.4)	(2.8)	(27.9)
Norfolk, Suffolk and Cambridgeshire	15.7	(78.5)	(37.6)	(100.4)
North and East Yorkshire and Northern Lincolnshire	28.4	(48.5)	(19.6)	(39.6)
North Central London	22.6	1.4	(17.1)	6.9
North East London	19.0	6.7	(24.3)	1.5
North West London	21.9	(68.0)	(37.7)	(83.8)
Northumberland, Tyne and Wear	17.2	1.1	1.4	19.7
Shropshire and Staffordshire	10.4	(21.1)	(25.7)	(36.5)
South East London	16.6	(3.9)	(61.1)	(48.4)
South West London	13.6	(21.7)	(36.4)	(44.5)
South West Peninsula	13.3	(4.4)	(27.2)	(18.3)
South Yorkshire	27.3	6.4	2.9	36.7
Surrey and Sussex	12.2	(15.3)	(82.0)	(85.0)
Thames Valley	17.8	(33.6)	(17.0)	(32.8)
Trent	30.1	(0.8)	(12.6)	16.7
West Midlands South	9.2	(0.1)	(27.7)	(18.6)
West Yorkshire	51.0	(5.2)	(6.4)	39.4
Total	**524.0**	**(475.6)**	**(560.5)**	**(512.1)**

Source: National Audit Office analysis of Department of Health data

NOTE

Some columns may not cast correctly due to rounding

5.6 Auditors also reported concerns that some NHS bodies were facing a shortage of cash (see paragraphs 3.22-3.25) as the year-end approached.

5.7 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 £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.

Payment by Results

In 2005-06, Payment by Results was rolled out across most of the NHS, and remains one of the most significant challenges for NHS financial management.

5.8 For the first wave of NHS Foundation Trusts (those authorised by 1 July 2004) and early adopter NHS Trusts, Payment by Results was implemented across elective, non-elective and outpatient activity from 1 April 2004. For those authorised between 1 July 2004 and 1 April 2005, it was implemented across these same categories of activity from 1 April 2005. Payment by Results was implemented by all acute Trusts and Primary Care Trusts for elective inpatient care only from 1 April 2005.

5.9 For NHS acute Trusts excluding early adopters, 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.

5.10 Payment by Results has remained one of the biggest challenges for NHS financial management in 2005-06. There is still concern about the ability of NHS to manage the financial risks, particularly given the increasing number of organisations and health economies experiencing financial difficulty in 2004-05 and 2005-06.

5.11 To reduce the level of risk and enable local organisations to better manage their finances, a number of variations on Payment by Results continued to operate locally in 2005-06, despite being inconsistent with national policy. Some of these variations were agreed with the Department and some were not.

5.12 While it is important that changes in the policy framework are minimised, the NHS should expect further refinements while the system is stabilising, which will inevitably impact on their financial and operational plans. NHS bodies need to identify this as a risk and factor it into their planning.

Practice-based commissioning

Since 1 April 2005 all GP practices have been able to commission services on behalf of their patients. GP practices and Primary Care Trusts need to work together to ensure that the benefits of practice-based commissioning are realised, and the risks mitigated.

5.13 In introducing practice-based commissioning, the Department is enabling General Practitioners (GPs) to make referrals and treatment decisions that best fit patients' needs. Since April 2005 every GP practice has had the right to request from their Primary Care Trust an indicative commissioning budget. Under this arrangement Primary Care Trusts continue to be legally responsible for commissioning.

5.14 By allowing GP practices and other groups of primary care clinicians to hold indicative budgets, the Department expects practice-based commissioning to inject some financial prudence into decision-making. In doing so this policy is expected to resource and incentivise practices to:

- manage demand;
- implement innovative clinical practices; and
- increase clinical engagement.

5.15 The Department expects practice-based commissioning to drive through more effective primary care commissioning, that will generate savings or 'efficiency gains' and bring about significant improvements in patient care. Under practice-based commissioning, practices will be allowed to offer more care in the practice, through new services in the community and pharmacies, and through joint arrangements with hospitals and other providers. Under *Commissioning a Patient Led NHS*,[54] the timetable for implementation was accelerated and Primary Care Trusts are now expected to make arrangements for universal coverage of practice-based commissioning by December 2006.[55]

5.16 Practice-based commissioning creates a new set of risks for NHS bodies, particularly Primary Care Trusts and GP practices. Many Primary Care Trusts have identified that they have shortfalls in their baseline budgets which will require significant cost savings and changes to delivery to maintain existing service levels. Potential financial risks under practice-based commissioning are also high if Primary Care Trusts fail to implement robust financial management and associated arrangements, especially in relation to:

- **Budget-setting arrangements** – In the past, budgets have tended to be set on the basis of historical activity, which often tended to favour high referrers and penalise GP practices which were managing their referral and admission activity. The Department intends that Primary Care Trusts and practices will move to a 'fair shares' approach over time.[56] This will require both parties to agree locally the pace of change towards this new approach.
- **Devolving indicative budgets to practices** – Primary Care Trusts and practices will need to work together to ensure that relevant systems and support are in place for budget monitoring and budgetary control. Primary Care Trusts will want to monitor the financial impact of practice-based commissioning by tracking practice level expenditure, ideally by services and outcomes.
- **Good-quality data** – the validation of actual referral data (including discharge summaries) will require Primary Care Trusts to work closely with GP practices. Both Primary Care Trusts and practices will particularly need to monitor referral decisions as part of demand management.
- **Risk management and governance arrangements** – Primary Care Trusts and practices will need to work together to develop a range of safeguards to manage new financial and clinical risks arising from practice-based commissioning.

5.17 The Audit Commission is currently considering the above issues as part of a national study on the financial management aspects of practice-based commissioning. A series of reports are planned for publication during 2006-07.

Earlier preparation of accounts ('Faster Closure')

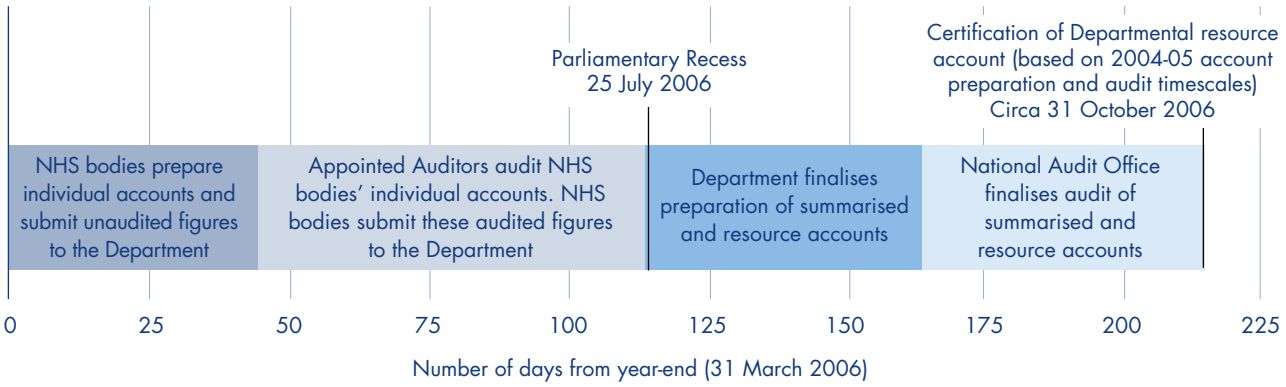
The Department will not succeed in laying its accounts before the Parliamentary Recess in 2006. Significant improvements are required in the account preparation timetable, and the National Audit Office and Audit Commission are working to assist local bodies and the Department in achieving them.

5.18 As outlined in our last report,[57] HM Treasury has set a target for all Departmental resource accounts to be laid before the July Parliamentary Recess by 2005-06. The Department's 2004-05 resource account was certified by the Comptroller and Auditor General on 2 November 2005, 24 days earlier than in 2003-04. However, this timetable would have to be brought forward by a further 15 weeks for the account to be laid in time for the Parliamentary Recess.

5.19 Preparation and audit of the Department of Health resource account is particularly complex since it involves consolidating the summarised accounts of all NHS Primary Care Trusts and Strategic Health Authorities, as well as a number of Special Health Authorities. As can be seen from **Figure 37**, the timetable which the Department considers achievable for these bodies to submit audited data for the summarised and resource accounts in 2005-06[58] will not allow sufficient time to prepare and audit these accounts before the Parliamentary Recess (25 July 2006). The Department therefore informed HM Treasury in October 2005 that it will be unable to meet the pre-recess deadline for 2005-06.

54 Department of Health, *Commissioning a Patient-Led NHS*, July 2005.
55 Department of Health, *Practice-based Commissioning: Achieving universal coverage*, January 2006.
56 Ibid.
57 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, pp. 36-8.
58 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.

37 The current accounts timetable for NHS bodies will not allow time to prepare and audit the Department's resource account before the Parliamentary Recess



Source: National Audit Office

5.20 The National Audit Office and Audit Commission continue to hold discussions with the Department to secure further advances in the timetable at a local and national level. However, to allow the pre-Recess deadline to be achieved, local NHS accounts must be prepared and audited much more rapidly. 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. External auditors will, in parallel, review their own audit processes to identify any areas where improvement may be possible.

5.21 As outlined in Part 4 of this report, there are a number of issues which will need to be resolved if the accounts timetable for local bodies is to be brought forward significantly. These include:

- finalising intra-NHS balances earlier to minimise disputes and provide the necessary audit assurance for key figures in the national accounts (paragraphs 4.36-4.39);
- improving the quality of in-year forecasting and management accounts to allow month-nine figures to be used for audit purposes before the year end;
- reducing the large discrepancies and errors identified by auditors, which resulted in an overall movement of £110 million between the unaudited and audited accounts (excluding NHS Foundation Trusts) in 2004-05 (paragraphs 4.24-4.28).

5.22 Our previous report made detailed recommendations to help NHS bodies meet the challenges of faster closing,[59] and these recommendations remain valid in 2005-06 and beyond. Further guidelines, as well as case studies illustrating best practice, are contained in the National Audit Office publication *Ready, Steady, Go… A Practical Guide for preparing for Faster Closing*, available on the National Audit Office website.[60]

5.23 It is vital that NHS Boards, Executive Directors and Finance staff scrutinise their accounts preparation processes in the light of these recommendations and identify possible areas for improvement. The key to rapid production of high-quality year-end accounts is robust, regular and comprehensive in-year management information, incorporating cashflow and balance sheet figures and agreed intra-NHS balances where appropriate. By producing management information of sufficiently high quality to form the basis of annual accounts, NHS bodies will not only speed progress towards faster closing, but also reap the benefits of tighter in-year financial control.

59 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, p. 38.
60 http://www.nao.org.uk/guidance/faster_closing_2.pdf.

To achieve faster closure of accounts, NHS bodies should:

- review their arrangements for the production of annual accounts, and identify lessons learned from the audit adjustments required in 2004-05. The need to comply with NHS Manuals for Accounts should not be compromised in order to produce a more favourable financial position. Any issues that could be considered contentious should be discussed with auditors at an early stage;
- work with the Department to take a more rigorous approach to the agreement of intra-NHS balances. NHS bodies should make agreeing these balances part of the monthly financial reporting cycle. All NHS bodies should resolve disagreements more quickly. The Department should issue clear guidance about the action that should be taken when there is a disagreement over balances and transactions, and Strategic Health Authorities should arbitrate where necessary;
- review their accounts preparation and audit processes in the light of recommendations made in our previous report[61] and the National Audit Office guide to Faster Closing[62]. Any means of advancing these processes, such as the production of more robust in-year financial information to inform early audit work and account preparation, must be identified and implemented as quickly as possible.

Mergers and the impact of redundancy and severance payments

The implementation of *Commissioning a Patient-led NHS* has the potential to destabilise the NHS. Strategic Health Authorities and Primary Care Trusts need to ensure that financial control and accountability does not suffer during this period of change.

5.24 *Commissioning a Patient-led NHS*, issued by the Department in July 2005, outlined the importance of improving commissioning in the NHS and set out proposals for organisations to ensure they are fit for purpose to deliver the reform programme currently under way. In April 2006, the Department announced that from 1 July 2006, the number of Strategic Health Authorities will be reduced from 28 to 10, including a single Strategic Health Authority for London. From October 2006, the number of Primary Care Trusts in England will be reduced from 303 to 152, and from 1 July 2006 many of the existing 29 NHS Ambulance Trusts will merge into 12, with separate management arrangements for the Isle of Wight.

5.25 In addition to developing stronger organisations, the reconfiguration of Strategic Health Authorities and Primary Care Trusts is expected to deliver £250 million savings from administration costs for reinvesting in front-line services. This will lead to a reduction in the number of management and administration posts.

5.26 This could affect all activities of NHS bodies both at a strategic and operational level. A key message from previous mergers is that the operational performance of most organisations suffers both during the merger process and immediately afterwards. The potential risks and threats to the maintenance of services and financial management are significant. Service plans may be disrupted, established performance-management procedures may be affected and internal financial controls and separation of duties may be compromised. This is likely to have direct consequences on the overall financial management of the organisation; as a result, it is important that NHS bodies take early action to recognise and plan for the risks that will be faced. It is also a difficult time for NHS staff, and due to restructuring or performance issues, NHS bodies will need to review workforce requirements, particularly in respect of senior managers.

5.27 A clear message from both private and public-sector mergers is the need for immediate leadership from the top to provide consistency of purpose and direction. The scale of the management task of transition is often underestimated. Top management will have to decide where to focus its effort, taking care to ensure that service delivery continues while the future is planned for. **Figure 38** lists the key themes on which attention should be focussed.

61 *Financial Management in the NHS – NHS (England) Summarised Accounts 2003-04*, p. 38.
62 National Audit Office, *Ready, Steady, Go… A Practical Guide for preparing for Faster Closing*, October 2004.

38 Key areas for management attention during restructuring

Strategy and leadership

- How are the strategic aims and the values of the new organisation being developed?
- Have the public and other stakeholders been involved?
- How have the benefits of the new organisation been defined and communicated? Has as much information as possible about goals, direction and benefits of the changes been disseminated through the organisation to all grades of staff? Have staff been allowed to feed back on the process and have their questions answered?

Transition planning

- Has management assembled a transition team to help with detailed planning and implementation?
- Is there a practical and workable project plan which identifies both the volume of the issues and the timescales involved, and translates these into key tasks and target dates? Is the plan being monitored with clear milestones set and reported?
- How will the organisation ensure that service delivery is maintained in the run-up to merger?

Staffing issues

- Have decisions been taken on staff changes consequent on the merger and steps taken to reassure staff who will stay?
- How are the competencies, skills, knowledge and experience required being assessed?
- What arrangements are being made for redeployment, severance, redundancy and early retirement?
- Have temporary staff been deployed with care in key finance functions? It should be recognised that they have different goals and incentives from full time staff, and that the consequences of their decisions are likely to occur after their departure.

Financial and Governance procedures

- How will effective financial management and the operation of fundamental internal controls be maintained?
- How will the organisation ensure that budgets are not spent inappropriately?
- Will there be a need for part-year accounts?
- Have respective responsibilities of the Accountable Officers and Audit Committees of the old and the new body been confirmed and understood? Where a new body is being formed, the Audit Committee should be set up as soon as possible.
- Have risk registers been updated to set out the key risks associated with merging, together with contingency plans should these risks materialise? Risk registers should be regularly reviewed by Audit Committees and transition teams.
- Do key finance staff have the necessary knowledge and data to carry out merger accounting, such as prior-year comparative figures for the functions being merged, balances and transactions between the merging bodies, all of which will need eliminating for prior-year comparatives?
- Has appropriate action been taken to align accounting policies and finance systems in advance of the merger? Has consideration been given to the need to align the chart of accounts and management accounts of each body in advance of the merger?

Information management and technology

- Have systems critical to the continuous delivery of services immediately after a merger, and ones which will need to be integrated over time been identified?
- How will the organisations deliver an uninterrupted IT service and minimise the disruption caused by merging incompatible IT systems?
- Have key information systems been identified?

Source: National Audit Office/Audit Commission

5.28 The National Audit Office and the Audit Commission are both involved in discussions with the Department on arrangements for redundancy and severance payments and the impact this will have on the NHS. Key to this will be the application of relevant accounting standards to ensure that liabilities are recognised and accounted for as they arise.

5.29 It will also be important for the NHS to address the perception that valued and needed staff will be leaving the NHS as part of the restructuring, appropriately recompensed for their loss of office, only to reappear some short time later employed elsewhere or as contractors. This will require close attention at both the local and national level if the best use is to be made of the human and financial resources available to the NHS.

To prepare for the impact of mergers and restructuring, NHS bodies must:

- make financial management and the establishment of required systems and processes an early priority at Board level. Primary Care Trusts and Strategic Health Authorities need to take steps to ensure that financial control is not weakened during the period of instability. It is vital that routine financial management processes are not compromised, resulting in poor-quality final accounts or a loss of control over expenditure;
- recognise and respond to the need for financial management skills throughout the new organisations. Of particular importance is the requirement for Board members to have the skills and experience to enable them to provide financial leadership to the new organisation;
- ensure that the expected benefits arising from the restructuring are being delivered and realised in practice. Monitoring systems should be established to ensure that this is the case and action needs to be taken when the expected benefits are not being delivered.

Auditors' Local Evaluation

For 2005-06, auditors will make an assessment of NHS Trust and Primary Care Trust performance in five areas, and this assessment will feed into the Healthcare Commission's annual healthcheck. NHS bodies should use the assessments as a guide to focus their attention on the areas most in need of improvement.

5.30 In March 2005 the Healthcare Commission published its new framework for assessing the performance of NHS Trusts and Primary Care Trusts. The star rating system will be replaced by an annual health check, which will include two scores – one for quality and one for use of resources. This use of resources assessment will be made by the Audit Commission's auditors under the Auditors' Local Evaluation framework, which has been subject to consultation with NHS bodies at various stages of its development. The assessment will allow auditors to give a view on NHS bodies' performance in a similar manner to the Comprehensive Performance Assessment in local government.

5.31 Auditors' Local Evaluation assesses NHS bodies' performance in the areas covered by the Audit Commission Code of Audit Practice:

- Financial Reporting
- Financial Management
- Financial Standing
- Internal Control
- Value for Money

The assessments made by auditors on these five areas will be converted to one overall score by the Audit Commission and this score will provide the Use of Resources element of the annual health check for NHS Trusts and Primary Care Trusts. For NHS Foundation Trusts, the Healthcare Commission will use Monitor's financial risk rating to provide the Use of Resources assessment. Strategic Health Authorities are not subject to the annual health check, nor will they receive an Auditors' Local Evaluation in 2005-06.

5.32 Auditors will use the following scale to score each of the five areas:

- 1 – below minimum requirements – inadequate performance
- 2 – only at minimum requirements – adequate performance
- 3 – consistently above minimum requirements – performing well
- 4 – well above minimum requirements – performing strongly

To enable auditors to score the areas on a consistent basis, Key Lines of Enquiry have been developed for each area and are set out in Annex 5.

5.33 In developing the Auditors' Local Evaluation framework, the Audit Commission has widened the basis of assessment from a sole focus on whether financial balance has been achieved (the assessment under the star rating system) to assessing all aspects of financial management and how good the arrangements are for securing value for money. The assessment will provide NHS bodies with a clear analysis of the areas where – in their auditor's opinion – improvement is needed.

5.34 Parts of the assessment are already under way and the results will be passed to the Healthcare Commission in the summer with a view to publishing the health check results in October 2006. Further information on Auditors' Local Evaluation is available on the Audit Commission's website.[63]

The way forward

5.35 The financial challenges facing NHS bodies continue to grow, although some NHS bodies appear to respond to these challenges more effectively than others. The number of NHS bodies failing to achieve financial balance appears to be increasing, along with the size of the deficits. With support from the Department, NHS bodies must take determined action now to take control of their finances and live within their means. The focus on keeping financial control should be of paramount concern as the NHS enters a period of restructuring to implement *Commissioning a Patient-led NHS*.

5.36 Auditors reported concerns about the level of resources available or the capabilities of finance staff at 28 per cent of organisations. They also had concerns about the financial management capabilities of general management at 30 per cent of organisations, and about non-executive directors at 25 per cent of organisations. NHS financial management arrangements will only be improved if the requisite skills[64] are present not just in the finance department, but throughout the organisation. Developing and deploying these skills to support financial balance must be a key priority for all NHS bodies, both now and in future.

5.37 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.

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

63 http://www.audit-commission.gov.uk/kloe/healthkloe.asp

64 The Audit Commission has produced a discussion paper, *World-Class Financial Management*, to stimulate debate across public services and among finance professionals about what standards of financial management the public sector should aspire to over the longer term. Its key themes include the development of financial skills and robust financial planning and decision-making.

ANNEX ONE

Financial performance of the NHS by organisation type

Strategic Health Authority Area	Strategic Health Authority	Primary Care Trusts	
	2004-05 Underspend/(overspend) £ million	Number	2004-05 Underspend/(overspend) £ million
Avon, Gloucestershire and Wiltshire	20.2	12	(24.8)
Bedfordshire and Hertfordshire	2.0	11	(37.5)
Birmingham and the Black Country	20.5	12	13.8
Cheshire and Merseyside	6.5	15	0.5
County Durham and Tees Valley	7.1	10	1.8
Cumbria and Lancashire	15.8	13	3.2
Dorset and Somerset	5.4	9	1.6
Essex	1.0	13	(14.1)
Greater Manchester	33.3	14	9.2
Hampshire and Isle of Wight	0.1	10	(26.6)
Kent and Medway	5.4	9	(7.1)
Leicestershire, Northamptonshire and Rutland	2.2	9	(2.3)
Norfolk, Suffolk and Cambridgeshire	16.3	17	(63.0)
North and East Yorkshire and Northern Lincolnshire	13.9	10	(12.4)
North Central London	22.5	5	0.8
North East London	11.9	7	(4.6)
North West London	6.0	8	(31.2)
Northumberland, Tyne and Wear	18.4	6	0.4
Shropshire and Staffordshire	10.5	10	(18.7)
South East London	11.0	6	(1.5)
South West London	9.6	5	(9.9)
South West Peninsula	5.9	11	(21.7)
South Yorkshire	13.1	9	2.4
Surrey and Sussex	32.1	15	(5.3)
Thames Valley	16.3	15	(22.4)
Trent	21.0	19	(0.1)
West Midlands South	(0.4)	8	(0.3)
West Yorkshire	45.1	15	4.6
Total	**372.7**	**303**	**(265.3)**

NHS Trusts		Overall	
Number	2004-05 Surplus/(Deficit) £ million	2004-05 £ million	2003-04 £ million
13	(3.3)	(7.9)	(4.2)
7	(25.5)	(61.0)	2.0
13	(20.3)	14.0	0.6
17	(0.9)	6.1	10.0
5	(8.4)	0.6	1.2
10	(8.3)	10.7	4.4
8	(0.7)	6.4	8.8
7	(0.9)	(14.0)	3.4
13	(12.5)	30.0	13.2
7	(13.0)	(39.5)	(9.2)
7	(0.5)	(2.2)	(4.7)
5	(1.4)	(1.6)	4.8
12	(22.7)	(69.5)	(10.4)
7	(10.0)	(8.4)	1.6
10	(20.3)	3.1	11.4
6	0.2	7.5	9.1
10	(39.8)	(65.0)	(20.0)
9	2.2	21.0	8.5
8	(14.5)	(22.7)	3.5
8	(10.0)	(0.5)	4.3
6	(19.9)	(20.1)	6.8
7	4.3	(11.5)	(14.2)
7	0.6	16.1	8.9
17	(59.9)	(33.2)	(5.4)
13	0.2	(5.9)	10.1
11	(4.6)	16.4	10.9
8	(9.2)	(9.8)	5.2
8	(22.8)	26.9	4.8
259	**321.7**	**(214.2)**	**65.4**

NOTES

1 Some rows or columns may not cast correctly due to rounding.

2 Numbers of NHS Trusts include bodies which became NHS Foundation Trusts during the year, and these bodies' performance as NHS Trusts is included in the NHS Trust surplus/(deficit) column. Their performance as NHS Foundation Trusts is not included in the table, since Strategic Health Authorities are not responsible for performance-managing NHS Foundation Trusts.

3 The prior-year figure for the North-West London Strategic Health Authority area 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 is to increase the 2003-04 regional deficit from £12.9 million to £20.0 million, and to reduce the overall 2003-04 NHS surplus from £72.5 million to £65.4 million. 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 as expenditure in 2004-05 rather than 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.

ANNEX TWO

Financial duties of NHS organisations

Strategic Health Authorities and Primary Care Trusts	NHS Trusts
Statutory	
Contain expenditure, measured on an accruals basis, within approved revenue resource limits. **A total of 90 Primary Care Trusts (30 per cent) and one Strategic Health Authority (four per cent) failed in this duty in 2004-05**.	Break even taking one financial year with another[1]. **In 2004-05, 258 NHS Trusts (99.6 per cent) met the Department's interpretation of the statutory duty to break even, although 68 (26 per cent) incurred an in-year deficit. One NHS Trust (0.4 per cent) did not meet the statutory duty to break even**.
Contain expenditure, measured on an accruals basis, within approved capital resource limits. **Three Primary Care Trusts (1 per cent) breached their capital resource limit in 2004-05**.	
Remain within cash limits. **No body was reported to have failed in this duty in 2004-05**.	
Departmental/Regulatory	
Achieve financial balance without the need for unplanned financial support. **No Primary Care Trusts or Strategic Health Authorities disclosed any unplanned financial support in 2004-05**.	Break even each and every year. **In 2004-05, 68 NHS Trusts (26 per cent) failed to break even**.
Apply the Better Payment Practice Code. **In 2004-05, no Strategic Health Authorities or Primary Care Trusts paid all bills within 30 days. However, seven Strategic Health Authorities (25 per cent) and 57 Primary Care Trusts (18 per cent) paid 95 per cent or more of bills within 30 days. On average, 85 per cent of bills were paid within 30 days by both Strategic Health Authorities and Primary Care Trusts**.	Apply the Better Payment Practice Code. **In 2004-05, no Trusts paid all bills within 30 days. However, 52 Trusts (20 per cent) paid 95 per cent or more of bills within 30 days. The average number of bills paid within 30 days was 83 per cent**.
For Primary Care Trusts, to recover the full cost of their provider functions. **A total of 29 Primary Care Trusts (10 per cent) failed in this duty in 2004-05**.	Not to exceed the external financing limit set by the Department of Health. **In 2004-05, 15 Trusts (six per cent) overshot their external financing limit. The Department considers that only those Trusts who exceeded their individual limit by more than £10,000 have failed. On this basis 12 (five per cent) did so**.
	Contain expenditure measured on an accruals basis, within approved capital resource limits. **In 2004-05, 16 of the 259 Trusts (six per cent) breached their capital resource limit. 12 breached their capital resource limit by more than the Department's £50,000 de minimus limit**.
	Absorb the cost of capital at a rate of 3.5 per cent. **The average return for the 244 full-year Trusts[2] in 2004-05 was 3.4 per cent, although 134 of these (55 per cent) did not achieve a 3.5 per cent return on capital**.

NHS Foundation Trusts

Statutory

Contain the proportion of income derived from private patient charges below the 'private patient cap' (the proportion of total income derived from such charges before authorisation). **No NHS Foundation Trusts breached their private charges cap in 2004-05**.

Not to dispose of any protected property (as designated in the Trust's terms of authorisation) without the approval of the regulator. **No NHS Foundation Trusts disposed of protected property in 2004-05**.

Contain borrowing within the limits set in the Trust's Terms of Authorisation. **No NHS Foundation Trust exceeded its borrowing limits in 2004-05**.

Remain a going concern, as defined by relevant accounting standards, at all times. **No NHS Foundation Trust failed to remain a going concern in 2004-05**.

Remain fully compliant with all aspects of their Terms of Authorisation. **One NHS Foundation Trust failed to remain fully compliant with its Terms of Authorisation in 2004-05**.

NOTES

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

2 Capital cost absorption duty is an annual measure. Thus NHS Trusts that became Foundation Trusts part way through the year did not achieve 3.5 per cent.

ANNEX THREE

NHS bodies with overspends or qualified regularity opinions in 2004-05

Strategic Health Authorities

An overspend against capital or revenue resource limits by a Strategic Health Authority automatically results in a qualified regularity opinion on its annual accounts on the grounds of irregular expenditure. One Strategic Health Authority overspent against revenue resource limits in 2004-05, and its accounts received a qualified regularity opinion from its appointed auditors as a result:

Strategic Health Authority	2004-05 Over/(under)spend £000
West Midlands South	(390)

Source: Audited accounts of individual Strategic Health Authorities

No Strategic Health Authority accounts were qualified on the grounds of truth and fairness.

Primary Care Trusts

An overspend against capital or revenue resource limits by a Primary Care Trust automatically results in a qualified regularity opinion on its annual accounts on the grounds of irregular expenditure. In 2004-05, 83 Primary Care Trusts overspent against revenue resource limits, one against capital revenue resource limits and two against both revenue and capital resource limits. Six Primary Care Trusts' accounts received regularity qualifications for other irregular expenditure, five of these also being qualified for breaches of revenue resource limits. Unless otherwise stated, the Primary Care Trusts below were qualified for an overspend against revenue resource limits only:

Primary Care Trust	2004-05 (Over)/underspend £000
Bedfordshire Heartlands	(14,536)
Bexley Care Trust	(2,749)
Billericay, Brentwood and Wickford	(1,123)
Blackwater Valley and Hart	(2,676)
Broadland	(4,444)
Burntwood, Lichfield and Tamworth`	(2,111)
Cambridge City (capital and revenue resource limit overspend)	(7,621)
Cannock Chase	(1,235)
Canterbury and Coastal	(2,276)
Central Cornwall	(5,294)
Central Suffolk (irregular expenditure and revenue resource limit overspend)	(3,837)
Charnwood and North West Leicestershire	(1,200)
Chelmsford	(7,144)
Cherwell Vale	(4,404)
Cheshire West	(548)
Chiltern and South Bucks	(1,494)
Colchester	(1,470)
Cotswold and Vale	(4,809)
Dacorum	(6,002)
Dartford, Gravesham and Swanley	(1,086)
East Elmbridge and Mid Surrey	(2,563)
East Hampshire	(5,199)
East Lincolnshire	(4,483)
Eastbourne Downs	(964)
Eastleigh and Test Valley South	(1,283)
Fareham and Gosport	(6,757)
Guildford and Waverley	(5,887)
Harrow	(969)
Havering	(3,258)
Hertsmere	(4,897)
Hillingdon	(13,470)
Hounslow	(6,171)

Primary Care Trust *(continued)*	2004-05 (Over)/underspend £000
Huntingdonshire	(1,516)
Ipswich (irregular expenditure and revenue resource limit overspend)	(10,118)
Isle of Wight	(361)
Kennet and North Wiltshire	(10,159)
Kensington and Chelsea	(12,042)
Kingston	(1,853)
Leicester City West	(957)
Luton	(6,038)
Maidstone Weald	(3,714)
Maldon and South Chelmsford	(1,489)
Medway Teaching	(196)
Mid Hampshire	(826)
Milton Keynes	(4,860)
New Forest	(8,592)
Newbury and Community	(114)
Newcastle Under Lyme	(597)
North and East Cornwall	(6,668)
North Birmingham	(1,339)
North Devon	(5,263)
North East Oxfordshire	(1,938)
North Hampshire	(890)
North Hertfordshire and Stevenage	(3,860)
North Norfolk	(5,294)
North Somerset	(5,202)
North Stoke	(6,810)
Norwich	(108)
Oldbury and Smethwick	(179)
Selby and York	(6,598)
South and East Dorset	(2,424)
South Cambridgeshire (capital and resource limit overspend)	(2,583)
South East Hertfordshire	(446)
South Leicestershire	(966)
South Stoke	(1,719)
South West Oxfordshire	(5,172)
South Western Staffordshire	(3,750)
South Wiltshire	(1,535)
Southern Norfolk	(7,152)
Southampton City (capital resource limit overspend only)	–
St Albans and Harpenden	(2,493)
Staffordshire Moorlands	(3,725)
Suffolk Coastal (irregular expenditure and revenue resource limit overspend)	(6,174)
Suffolk West (irregular expenditure and revenue resource limit overspend)	(12,510)
Sussex Downs and Weald	(1,819)
Swale	(449)
Thurrock	(755)
Vale of Aylesbury	(4,916)
Waltham Forest	(192)
Wandsworth Teaching	(8,237)
Watford and Three Rivers	(3,623)
Waveney (irregular expenditure and revenue resource limit overspend)	(1,533)
Welwyn Hatfield	(128)
West Gloucestershire	(3,110)
West Norfolk	(1,482)
West of Cornwall	(5,669)
West Wiltshire	(2,803)
Windsor, Ascot and Maidenhead (irregular expenditure only)	108
Witham, Braintree and Halstead	(3,141)
Wycombe	(429)
Wyre Forest	(1,968)
Yorkshire Wolds and Coast	(6,116)

Source: Audited accounts of individual Primary Care Trusts

No Primary Care Trust accounts were qualified on the grounds of truth and fairness in 2004-05.

NHS Trusts

Auditors are not required to report on the regularity of NHS Trusts' expenditure, and therefore there is no regularity opinion on their annual accounts. 68 NHS Trusts reported in-year deficits in 2004-05:

NHS Trust	2004-05 In-year surplus/ (deficit) £000
Addenbrookes (from 1 July 2004, Cambridge University Hospitals NHS Foundation Trust)	(995)
Airedale	(3,288)
Bedford Hospital	(8,480)
Birmingham Women's Healthcare	(264)
Bolton Hospitals	(2,706)
Brighton and Sussex University Hospitals	(10,035)
Buckinghamshire Mental Health	(1,049)
Burton Hospitals	(2,507)
Cambridgeshire and Peterborough Mental Health Partnership	(348)
Central Manchester and Manchester Children's University Hospitals	(7,727)
Dartford and Gravesham	(1,146)
Devon Partnership	(535)
East and North Hertfordshire	(8,557)
East Lancashire Hospitals	(4,025)
East Sussex Hospitals	(4,983)
George Eliot Hospital	(786)
Good Hope Hospital	(3,576)
Great Ormond Street Hospital	(557)
Hammersmith Hospitals	(17,819)
Hampshire Ambulance Service	(2,537)
Heatherwood and Wexham Park Hospitals	(4,186)
Hinchingbrooke Health Care	(1,566)
Hull and East Yorkshire Hospitals	(5,461)
The Ipswich Hospital	(6,443)
Kettering General Hospital	(1,721)
King's College Hospital	(2,734)
Kings Lynn and Wisbech Hospitals (from 1 April 2005, Queen Elizabeth Hospital Kings Lynn)	(8,499)
Lancashire Teaching Hospitals	(2,882)
Medway	(279)
Mid Essex Hospital Services	(2,299)
Mid Staffordshire General Hospitals	(2,158)
Mid Yorkshire Hospitals	(19,876)
University Hospitals of Morecambe Bay	(1,548)

NHS Trust *(continued)*	2004-05 In-year surplus/ (deficit) £000
North Middlesex University Hospital	(4,106)
North West London Hospitals	(11,744)
Northern Devon Healthcare	(991)
Plymouth Hospitals	(8,317)
Queen Elizabeth Hospital	(9,186)
Queen Mary's Sidcup	(4,608)
Royal Bournemouth and Christchurch	(250)
Royal Brompton and Harefield	(3,217)
Royal Free Hampstead	(10,217)
Royal National Orthopaedic Hospital	(3,793)
Royal United Hospital Bath	(946)
Royal West Sussex	(15,483)
Royal Wolverhampton Hospital	(9,016)
Sandwell and West Birmingham Hospitals	(7,806)
Scarborough and North East Yorkshire Healthcare	(4,506)
Shrewsbury and Telford Hospitals	(10,115)
South Tees Hospitals	(8,898)
South Warwickshire General Hospitals	(8,783)
Southampton University Hospitals	(11,579)
Southport and Ormskirk Hospital	(1,189)
St George's Healthcare	(21,656)
St Mary's	(3,219)
Surrey and Sussex	(30,657)
The Lewisham Hospital	(7,505)
Trafford Healthcare	(3,490)
University College London Hospital	(4,930)
United Lincolnshire Hospitals	(4,913)
Walsall Hospitals	(1,845)
West Dorset General Hospitals	(448)
West Hertforshire Hospitals	(9,978)
West Middlesex University Hospital	(3,991)
West Midlands Ambulance Service	(203)
West Suffolk Hospitals	(7,638)
Weston Area Health	(5,154)
Wrightington, Wigan and Leigh	(743)

No NHS Trust accounts were qualified in 2004-05.

NHS Foundation Trusts

NHS Foundation Trusts do not have a statutory duty to break even, nor are auditors required to report on the regularity of NHS Foundation Trusts' expenditure. In addition, the NHS Foundation Trust funding and accounting framework is not directly comparable with that of other NHS bodies (see paragraph 4.61, Part 4). Within this framework, 12 NHS Foundation Trusts reported in-year deficits in 2004-05:

NHS Foundation Trust	2004-05 In-year surplus/(deficit) £000
Basildon and Thurrock University Hospitals	(571)
Bradford Teaching Hospitals	(7,989)
Cambridge University Hospitals	(2,979)
City Hospitals Sunderland	(2,822)
Countess Of Chester Hospital	(285)
Derby Hospitals	(685)
Gloucestershire Hospitals	(3,782)
Guy's and St. Thomas's	(608)
Papworth Hospital	(147)
Peterborough and Stamford Hospitals	(7,746)
Royal Devon and Exeter	(7,322)
University College London Hospitals	(5,863)

Source: Audited accounts of individual NHS Foundation Trusts

No NHS Foundation Trust accounts were qualified in 2004-05.

ANNEX FOUR

The NHS Bank

The NHS Bank is a mutual organisation of the 28 Strategic Health Authorities, with a Management Board drawn from Strategic Health Authority Chief Executives and Directors of Finance. Its purpose is to support NHS organisations in maximising the use of resources across the NHS and over different financial years.

2004-05 was the third year in which the NHS Bank was responsible for deciding how the Department's special assistance fund should be allocated to Strategic Health Authority areas managing particular financial difficulties. In 2004-05, £70 million of planned support was provided by the Department to three Strategic Health Authorities on the basis of recommendations from the NHS Bank. **Figure 39** shows the Strategic Health Authority areas receiving support via the NHS Bank, and the effect of this support on the reported aggregate outturn across the Strategic Health Authority area.

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

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

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

Figure 40 shows the individual NHS organisations that received funds in 2004-05.

39 Strategic Health Authority areas receiving NHS Bank Support in 2004-05

Strategic Health Authority	Amount of support £ million	Aggregate out-turn after support £ million	Aggregate out-turn before support £ million
Avon, Gloucestershire and Wiltshire	40	(12)	(52)
Surrey and Sussex	20	(33)	(53)
Thames Valley	10	(6)	(16)

Source: Department of Health

40 NHS Organisations receiving NHS Bank support in 2004-05

Organisation	Support £ million
Avon, Gloucestershire and Wiltshire Strategic Health Authority Area	
North Bristol NHS Trust	20.0
Royal United Hospital Bath NHS Trust	9.4
Bristol South and West Primary Care Trust	2.0
Kennet and North Wiltshire Primary Care Trust	2.9
Swindon Primary Care Trust	3.9
West Wiltshire Primary Care Trust	1.8
Total for area	**40.0**
Surrey and Sussex Strategic Health Authority Area	
Ashford and St Peter's Hospitals NHS Trust	13.0
Royal Surrey County Hospital NHS Trust	7.0
Total for area	**20.0**
Thames Valley Strategic Health Authority Area	
Oxford Radcliffe Hospitals NHS Trust	10.0
Total for area	**10.0**
Total	**70.0**

Source: Department of Health

ANNEX FIVE

Auditors' Local Evaluation: Key Lines of Enquiry

Ref	Area	Key question	Key line of enquiry
1	Financial Reporting	How good are the organisation's financial accounting and reporting arrangements?	The organisation produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers. The organisation promotes external accountability.
2	Financial Management	How well does the organisation plan and manage its finances?	The organisation's medium-term financial strategy/plan, budgets and capital programme are soundly based and designed to deliver its strategic priorities. The organisation manages performance against budgets. The organisation manages its asset base.
3	Financial Standing	How well does the organisation safeguard its financial standing?	The organisation manages its spending within the available resources.
4	Internal Control	How well does the organisation's internal control environment enable it to manage its significant business risks?	The organisation manages its significant business risks. The organisation has arrangements in place to maintain a sound system of internal control. The organisation has arrangements in place that are designed to promote and ensure probity and propriety in the conduct of its business.
5	Value for Money	How good are the organisation's arrangements for managing and improving value for money?	The organisation has put in place proper arrangements for securing strategic and operational objectives. The organisation has put in place proper arrangements to ensure that services meet the needs of patients and taxpayers, and for engaging with the wider community. The organisation has put in place proper arrangements for monitoring and reviewing performance, including arrangements to ensure data quality. The organisation has established arrangements for managing its financial and other resources which demonstrate that value for money is being managed and achieved.

Source: Audit Commission

ANNEX SIX

Glossary of terms used in the report

Agenda for Change	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 NHS staff, except the most senior managers and those covered by the Doctors' and Dentists' Pay Review Body.
Auditor's Local Evaluation (ALE) score	A new framework used by the Audit Commission's appointed auditors to assess NHS bodies' performance on five key areas. (Annex 5). ALE scores form the 'Use of Resources' component of the Healthcare Commission's annual health check.
Better Payment Practice Code	A code of best practice applied to NHS bodies, whereby all non-NHS trade creditors should be paid within 30 days of receipt of goods or a valid invoice, unless other payment terms have been agreed.
Capital Resource Limit	A body's approved limit on capital expenditure for a given year, applicable to Strategic Health Authorities, Primary Care Trusts and NHS Trusts.
Choice (at the point of referral)	A policy designed to allow patients to choose a convenient place, date and time for hospital appointments. Choice is supported by Payment by Results (q.v.), which allows the funding for treatments to follow the patient to their chosen provider.
Clinical Negligence Scheme for Trusts (CNST)	A scheme handling clinical negligence claims against member NHS bodies where the incident took place on or after 1 April 1995. Membership is voluntary, although all NHS Trusts (including NHS Foundation Trusts) and Primary Care Trusts in England currently belong to the scheme. The costs of the scheme are met by membership contributions.
Commissioning a Patient-led NHS	A Department of Health paper outlining a policy change in the way healthcare services are commissioned. The number of Strategic Health Authorities and Primary Care Trusts will be reduced and the main function of Primary Care Trusts will change from providers to commisssioners of healthcare services. The aim is to move from an NHS service that does things to and for its patients to one that is patient-led.
Departmental Expenditure Limit (DEL)	A set of firm plans over three years relating to a specific part of a Government 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.
Elective procedure	A planned, non-emergency procedure.
Existing Liabilities Scheme (ELS)	A scheme handling clinical negligence claims made against the NHS in England where the incident took place before April 1995. Since April 2000, all ELS claims have been handled by the NHS Litigation Authority.

Ex-Regional Health Authority Scheme (Ex-RHAS)	A scheme that covers any clinical liabilities incurred by the Regional Health Authorities before their abolition in April 1996.
Faster closure	The acceleration of the timetable for the preparation and submission of annual resource accounts by Government departments. From 2005-06, it is intended that resource accounts will be signed, certified and laid before Parliament prior to the Summer Recess.
General Medical Services Contract	A framework for providing individual funding to GP practices. There are two elements, a basic payment for every practice and further payments for specified quality measures and outcomes (see also 'Quality and Outcomes Framework').
Liabilities to Third Parties Scheme (LTPS)	A scheme that covers non-clinical "third party" liabilities such as public and employers' liability claims.
Monitor	The Independent Regulator of NHS Foundation Trusts (q.v.), responsible for authorising, monitoring and regulating NHS Foundation Trusts. It is independent of the Department of Health and accountable to Parliament.
NHS Foundation Trusts	NHS Foundation Trusts are a key part of the reform programme in the NHS. They are autonomous organisations, free from central Government control, but provide healthcare according to the core NHS principles of free care, based on need and not ability to pay. They decide how to improve their services, and can retain surpluses or borrow money to support these investments. They also aim to establish strong links with their local communities, for example through local people becoming members and governors, and hence to shape their healthcare services around local needs and priorities. They are authorised and regulated by Monitor (q.v.).
NHS Litigation Authority (NHSLA)	A Special Health Authority responsible for handling negligence claims made against NHS bodies in England.
NHS Trusts	Organisations responsible for running hospitals and providing secondary healthcare.
Non-elective procedure	An unplanned hospital admission (i.e. emergency or urgent), not previously arranged.
Out of Hours	The out-of-hours period is 18.30-08.00 on weekdays, and all weekends and bank holidays. The new General Medical Services contract allows GPs to choose not to provide 24-hour care for their patients. It is the responsibility of Primary Care Trusts to ensure that all patients have access to out-of-hours services, either by providing the care themselves or hiring other organisations to do it.
Payment by Results	A funding system designed to ensure that NHS finances are deployed directly in line with patient treatment. It requires Primary Care Trusts to pay service providers based on a nationally agreed tariff for actual activity undertaken, rather than fixed-price block contracts.
Practice-based commissioning	A new system whereby individual or groups of general practices directly commission healthcare using their own budgets. Primary Care Trusts will oversee this process.

Primary Care Trusts (PCTs)	The bodies responsible for assessing the need for healthcare provision, planning and commissioning health services and improving health. There are currently 303 Primary Care Trusts.
Property Expenses Scheme (PES)	A scheme that covers "first-party" losses by NHS bodies such as property loss or damage. It is a voluntary scheme, funded through members' contributions.
Public Interest Report (PIR)	A report issued in the public interest on any significant matter coming to the auditor's notice during the course of an audit. It is their duty to bring the matter to the attention of the audited body and the public.
Quality and Outcomes Framework (QOF)	A system of standards, assessment and incentives relating to the quality of care delivered to patients by general practitioners. The framework measures practice achievement against a range of clinical-based evidence indicators and against a range of indicators covering practice organisation and management. Practices score points according to their level of achievement against these indicators, and practice payments are calculated from points achieved.
Regularity of Expenditure	A fundamental requirement that resources granted by Parliament may only be used for their authorised purpose. 'Irregular' expenditure results in a qualified regularity opinion on the body's statutory accounts. It applies to Strategic Health Authorities and Primary Care Trusts, but not to NHS Trusts or Foundation Trusts.
Resource Accounting and Budgeting (RAB)	A system of accounting and budgeting that applies to Government the principals of accruals accounting that are universal in the commercial world. It is based on expenditure incurred and income earned in an accounting period, rather than cash payments and receipts.
Revenue Resource Limit (RRL)	A body's approved limit on revenue expenditure for a given year, applicable to both Strategic Health Authorities and Primary Care Trusts.
Risk Pooling Schemes for Trusts (RPST)	A standard aimed at ensuring that all NHS organisations have a rigorous risk management process that covers all risks embedded within their system of internal control. Level 0 represents the weakest risk-management arrangements, and Level 3 the strongest. The RPST standard was withdrawn at the end of March 2005. However, key elements of the standard will be incorporated into the revised approach to NHSLA standards and assessments.
Star Rating System	The Healthcare Commission's previous system for assessing NHS bodies' performance, both operational and financial. The star rating system has been replaced by the annual health check in 2005-06.
Strategic Health Authorities (SHAs)	The bodies responsible for performance-managing the Primary Care Trusts and NHS Trusts within their area. There are currently 28 Strategic Health Authorities.
Terms of Authorisation	The terms granted on establishment as a NHS Foundation Trust. These include a statement on the public interest purpose of the organisation and set out the conditions under which it will operate.

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