National Audit Office

Financial Management in the NHS: Report on the NHS Summarised Accounts 2007-08

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

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11 December 2008

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SUMMARY

1 The National Health Service (NHS) had a surplus of £1.67 billion in 2007-08, representing approximately two per cent of total available resources. At the start of the financial year, the Department set the NHS the target of delivering a combined surplus and contingency of around £0.9 billion. During the year the contingency was not required and the surplus grew as a result of NHS organisations exceeding savings plans and a reduction in the price of generic medicines. The surplus has been carried forward into 2008-09 and the Department has committed to making it available to the NHS for spending in future years.

2 A surplus was planned so that the NHS would have the financial headroom to provide flexibility to respond to future financial pressures or changing priorities. A key change from 2006-07, when a surplus of £515 million was reported, is that in 2007-08 only 11 of 340 NHS organisations, or three per cent, reported a deficit (2006-07: 22 per cent reported a deficit). In 2006-07 the surplus was concentrated in the Strategic Health Authorities, which are administrative bodies, with the Primary Care Trust and NHS Trust sectors remaining in deficit. All sectors are now in surplus and Audit Commission evaluations found that the quality of financial management at individual NHS organisations improved during 2007-08. The Healthcare Commission has also reported in its Annual Health Check that the quality of the services provided by the NHS improved in

2007-08. NHS staffing figures are collected on an annual basis covering the year to September; the latest available figures show that staffing levels remained stable in the year to September 2007, but non-emergency hospital procedures increased by five per cent, and the number of consultations at GP practices increased by two per cent.

3 The NHS planned for a level of surplus to provide financial stability, ensuring that the system could absorb cost pressures that may emerge during the year without having to make short term savings to cover them or risking a slip back into deficit. The growth in the surplus in year meant individual organisations were faced with a choice of increasing spending or retaining the surplus to carry forward for future years. With the expected level of progress being in line with national healthcare targets, NHS organisations judged that running such a surplus was unlikely to threaten delivery against those targets.

4 The Department and the NHS are facing a number of challenges for 2008-09, and the surplus generated and better financial management should, if maintained, help with the financial implications of meeting them. There is a focus on giving the NHS more independence from central control, through increasing the number of NHS Trusts attaining NHS foundation trust status, and a new NHS performance regime should provide more incentives for NHS organisations to become more effective at a local level. The recommendations in Lord Darzi's NHS Next Stage Review will, when implemented, introduce changes to the financial regime, including making quality of care a factor in how providers of NHS healthcare are funded. These and other changes will have a direct financial impact on the NHS.

5 This report looks at the financial performance of, and financial management in, the NHS during 2007-08. It also explains some of the issues which are likely to provide financial challenges for the NHS in 2008-09 and beyond. Where the report refers to the performance of the NHS it covers the performance of Strategic Health Authorities, Primary Care Trusts and NHS Trusts, as reported in the NHS summarised accounts. The report also contains an analysis of the financial performance of NHS foundation trusts; the text makes clear where the commentary is referring to both the NHS sectors and the foundation trust sector.

Conclusion

6 All government departments have to manage their spending against their available resources. Delivery of a surplus or a deficit is an indicator of how well they have managed their resources. Delivery of a surplus is not, however, the only indicator. Good financial management is also about meeting delivery targets within the resources available. The NHS surplus of £1.67 billion in 2007-08 was considerably in excess of the planned surplus. In terms of delivery of healthcare, however, the surplus reflects good resource utilisation rather than a failure to deliver. The NHS was able to make good progress against its national healthcare targets set out in the NHS Operating Framework whilst delivering more cost savings than had been planned. The NHS also provided more healthcare activity in 2007-08 than in previous years, and the quality of that healthcare as rated by the Healthcare Commission improved.

7 The increase in the surplus has coincided with an improvement in the standard of financial management in the NHS. Evidence collected as part of the Audit Commission Auditors' Local Evaluation shows that almost double the proportion of NHS organisations were performing well or strongly in financial management compared to 2006-07. In particular, there was more evidence of financial plans being linked to strategic objectives, and that senior managers and clinicians were more engaged in managing performance against budgets. Nevertheless, the surplus was significantly higher than initially forecast. Although the surplus funds have remained within the NHS, the Department's intention for 2008-09 is that the accumulated balance should be retained at the same level as at the end of 2007-08. The surplus funds generated in 2007-08 are, therefore, not planned to be spent by the NHS until at least 2009-10.

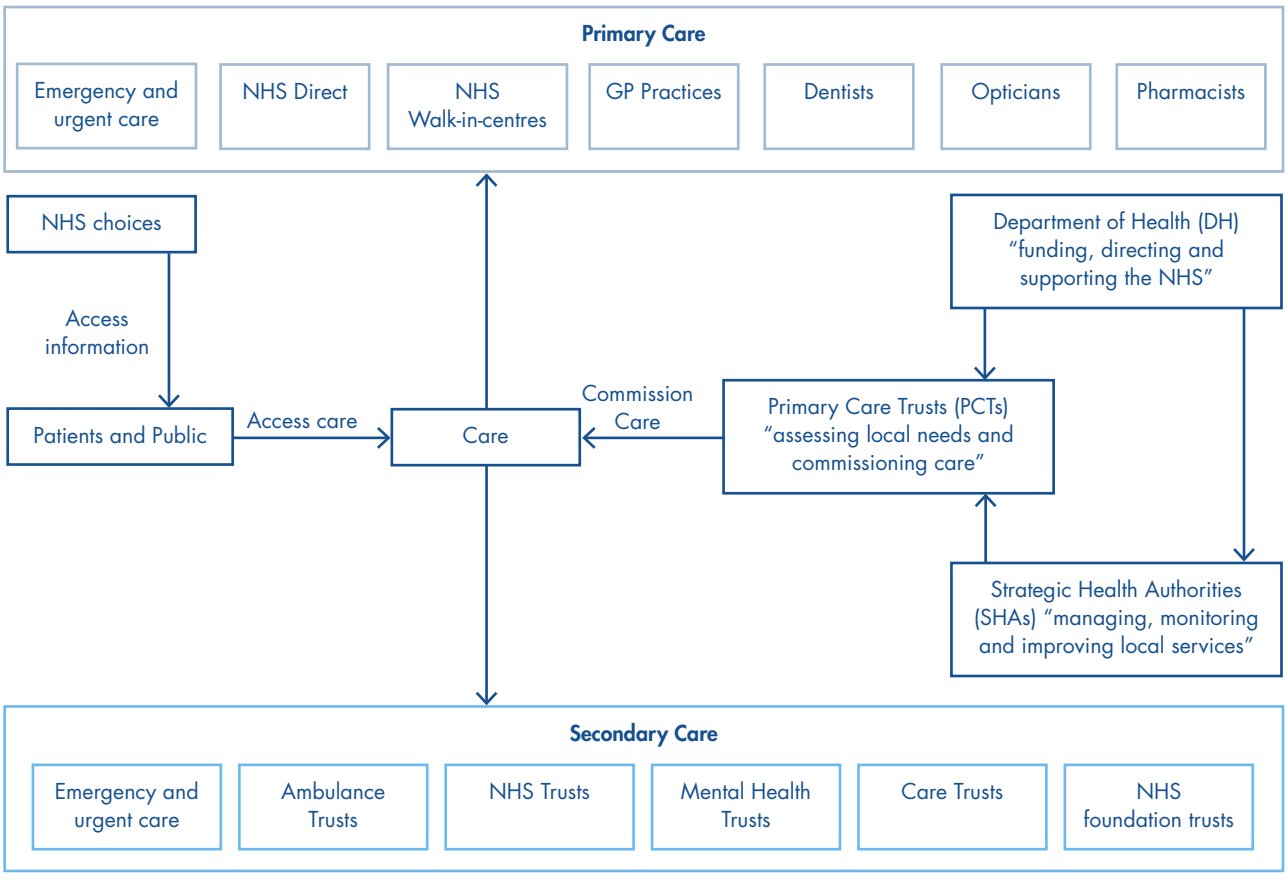
PART ONE

NHS organisation and accountability

1.1 The Department of Health (the Department) is responsible for delivering a comprehensive health service in England through the NHS. The healthcare delivered by the NHS can be broadly categorised in two ways, primary care and secondary care **(Figure 1)**.

1.2 Primary care covers community-based health services that are usually the first point of contact that patients make with the health service. Primary care services are provided by General Practitioner (GP) surgeries, dentists, opticians, pharmacists, NHS walk-in centres and through NHS Direct.

1 The NHS in England system in 2007-08



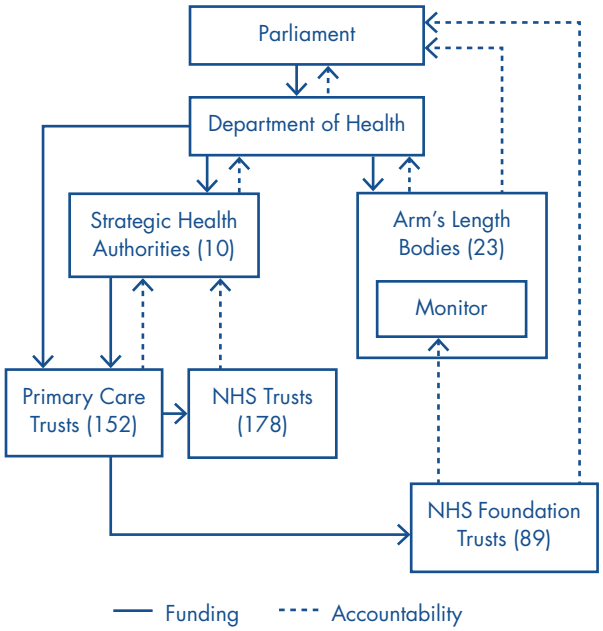
Source: Website.nhs.uk and National Audit Office

1.3 Secondary Care is the care provided by NHS Trusts and NHS foundation trusts. It includes hospital-based care such as planned appointments, planned day surgery or emergency care. Other NHS Trusts provide more specialised services, such as mental health care services, or ambulance services. Secondary care often takes place following a referral from a primary health care professional. Patients are able to view the NHS Choices website to access information on these healthcare providers and as a result make an informed decision on how they wish to receive hospital or other secondary care.

NHS Organisational Structure and Accountability

1.4 There are a number of different types of organisation directly involved in the administration and delivery of health services in England. **Figure 2** shows the main funding and accountability relationships between the Department and NHS bodies. NHS care is also delivered by independent providers, although funding and control over that care remains within the NHS system. **Figure 3 overleaf** sets out the accountability and audit arrangements for the Department and NHS bodies.

2 Funding and accountability relationships in the NHS



Source: National Audit Office

NOTES

1 Numbers in brackets are the numbers of each type of organisation as at 31 March 2008.

2 Monitor is an executive Non-Departmental Public Body. The Department has fully acknowledged the operational independence of Monitor and that neither it nor NHS foundation trusts are subject to direction by the Secretary of State.

The Department of Health

1.5 The Department of Health's (the Department's) overall aim is to improve the health and well-being and care of people in England. One of its key roles is to set direction for the NHS, for adult social care and public health. Setting direction for the NHS involves formulating strategy and policy, promoting appropriate legislation and regulation, allocating resources, and communicating that strategy to the NHS. Each year, the Department publishes the NHS Operating Framework which sets out the key objectives for the financial year ahead and the strategies in place to achieve them. In 2007-08 the key development priorities for the NHS set out in the Operating Framework were (i) to achieve a maximum wait of 18 weeks from GP referral to start of treatment, (ii) to reduce rates of MRSA and other healthcare associated infections, (iii) to reduce health inequalities and promote health and well-being, and (iv) to achieve financial health.

1.6 The Department is responsible for managing the ten Strategic Health Authorities against finance and operational targets which are agreed with each Strategic Health Authority in respect of their health economy. The Department does not directly manage the individual Primary Care Trusts or NHS Trusts, although it may intervene if it considers it necessary.

Strategic Health Authorities

1.7 Strategic Health Authorities are statutory bodies responsible for the system and performance management of the NHS (excluding NHS foundation trusts), acting as local headquarters on behalf of the Department of Health. Their main functions are to provide strategic leadership for the health service in their geographical areas and to ensure that the local health system operates effectively. They are responsible for overseeing the financial and service performance of all Primary Care Trusts and NHS Trusts within a geographical area (the Strategic Health Authority health economy). Strategic Health Authorities are also responsible for the organisational and workforce development of Primary Care Trusts and NHS Trusts in their areas.

Primary Care Trusts

1.8 Primary Care Trusts are statutory bodies responsible for leading their local health systems. They work with providers of healthcare (primary care providers, NHS Trusts and NHS foundation trusts) and local authorities. Primary Care Trusts commission and contract with providers for services and hold them to account. Primary Care Trusts may also directly provide community-based primary care where this is shown to provide value for money, although the provider arm of a Primary Care Trust is required to operate at arm's length from the commissioner arm and recover the full cost of such operations.

NHS Trusts

1.9 NHS Trusts are responsible for the provision of health care. Some NHS Trusts provide a range of health care through general hospitals; others provide more specialist services such as mental health services or ambulance services. NHS Trusts providing general care, known as acute NHS Trusts, may operate and administer one or more hospitals and other locations providing secondary care.

NHS foundation trusts

1.10 NHS foundation trusts are public benefit corporations[1] with a duty to provide NHS services to NHS patients according to NHS standards and principles.

3 Accountability and Responsibilities of bodies in Figure 2

Type of organisation	Chief Executive designated as:	Primary Accountability	Statutory Financial Duties	Auditors
Department of Health	Permanent Secretary is the Principal Accounting Officer NHS Chief Executive is an Additional Accounting Officer	Secretary of State and Parliament	Remain within limits set through Parliamentary supply process	Comptroller and Auditor General
Strategic Health Authority	Accountable Officer	Department of Health and Secretary of State	Remain within capital and revenue resource limits, and cash limits	Audit Commission or auditors appointed by the Audit Commission
Primary Care Trust	Accountable Officer	Strategic Health Authority, Department and Secretary of State	Remain within capital and revenue resource limits, and cash limits	Audit Commission or auditors appointed by the Audit Commission
NHS Trust	Accountable Officer	Strategic Health Authority, Department and Secretary of State	Break even taking one year with another, usually over a three year period	Audit Commission or auditors appointed by the Audit Commission
NHS Foundation Trust	Accounting Officer	Parliament Monitor Also accountable to the Board of governors and the members of the FT.	Remain a going concern Operate efficiently, effectively and economically Contain borrowing within limits set by Monitor Contain private patient income within a pre-determined limit set by its terms of authorisation	At the discretion of the NHS foundation trust
Arm's Length Body	Accounting Officer	Parliament	Where funded by the Department, to remain within capital and revenue resource limits, and cash limits	Comptroller and Auditor General

Source: National Audit Office

1 A public benefit corporation is a body corporate with a constitution, in respect of NHS foundation trusts, in line with Schedule 7 of the National Health Service Act 2006.

NHS Trusts may, with the approval of the Secretary of State, apply for foundation trust status to Monitor, the Independent Regulator of NHS Foundation Trusts. Following a successful application, NHS foundation trusts have more financial freedoms than NHS Trusts, including the powers to borrow commercially and retain surpluses, although they are bound to operate within terms of authorisation set by Monitor when they are approved. As well as their direct accountability to Parliament (Figure 3), NHS foundation trusts are locally accountable to their members and its Board of Governors.

1.11 Membership of an NHS foundation trust is a distinctive feature of its governance arrangements and forms a direct link with patients, members of the public, staff and local stakeholders. Members, whether patient, staff or public have the opportunity to influence strategy of the NHS foundation trust by electing or standing for election as governors. As at 31 March 2008 the 89 NHS foundation trusts had 1.12 million members.

1.12 NHS foundation trusts operate outside of the NHS performance regime and are regulated directly by Monitor. They have trading relationships with Primary Care Trusts as NHS foundation trusts provide healthcare and related services commissioned by those bodies. The Secretary of State may not issue directions to NHS foundation trusts.

Arm's Length Bodies

1.13 The Department also has a number of Arm's Length Bodies. These organisations regulate the health and social care system, improve standards, protect public welfare and support local services. As at 31 March 2008 there were 23 such bodies, including the National Institute for Health and Clinical Excellence (NICE) and the Health Protection Agency. This number has fallen from 38 over the last four years as a result of the Arm's Length Body review.[2] There will be further reductions in number when the Care Quality Commission, created on 1 October 2008, takes on the functions of three Arm's Length Bodies which will be dissolved on 31 March 2009, namely the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection.

Financial Reporting of the NHS

1.14 Strategic Health Authorities, Primary Care Trusts and NHS Trusts are required by statute to prepare accounts which are audited by Audit Commission appointed auditors. The auditors must give an opinion as to whether the accounts are true and fair and, except for NHS Trusts, whether the income and expenditure have been incurred in accordance with Parliament's intentions (known as the regularity opinion). There is no statutory requirement for a regularity opinion on the accounts of NHS Trusts. The Department is required to prepare three sets of accounts which summarise the results of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. These summarised accounts are required to present a true and fair view and, except for NHS Trusts, be regular. The summarised accounts are presented to Parliament; the individual accounts of NHS organisations are not.[3]

1.15 NHS foundation trusts are required to prepare accounts and, as they have Accounting Officers and are directly accountable to Parliament for all resources under their control regardless of source, present those accounts directly to Parliament. One of the financial freedoms of NHS foundation trusts is the power to appoint their own auditor. About 43 per cent of NHS foundation trusts appoint the Audit Commission; the rest use one of the private accountancy firms. Auditors are required to give an opinion on whether the accounts are true and fair; as for NHS Trusts there is no statutory requirement for a regularity opinion. Monitor is required to prepare a report to Parliament which summarises the financial performance of NHS foundation trusts, but this requirement is not further defined in statute nor is there a requirement for audit. Monitor chooses to prepare a full consolidation of the accounts of NHS foundation trusts in compliance with accounting standards, and each year asks the Comptroller and Auditor General to audit those consolidated accounts before they are presented to Parliament.

1.16 This report looks at the financial performance of, and financial management in, the NHS. Part two examines the financial performance of the NHS, and NHS foundation trusts, in 2007-08 and at what the NHS achieved during the year. Part three examines the quality of financial management and financial reporting in the NHS during 2007-08 and looks at some of the financial management issues which arose during the year. Part four takes a forward look, examining the financial strategy for the NHS in 2008-09 and how the NHS is performing financially so far against that strategy, and explains some of the issues which are likely to provide financial challenges for the NHS in 2008-09 and beyond.

2 Department of Health, *Reconfiguring the Department of Health's arm's length bodies*, July 2004.
3 NHS Direct converted from an Arm's Length Body to an NHS Trust on 1 April 2007. As NHS Direct delivers a national service, the legislation to convert NHS Direct included the provision that it would remain directly accountable to Parliament. The Chief Executive has retained Accounting Officer status, and the accounts of NHS Direct are audited by the Comptroller and Auditor General and presented to Parliament.

PART TWO

Financial Performance of the NHS 2007-08

2.1 This part of the report looks at the funding available to the NHS in 2007-08, the Department's financial strategy for that funding, the financial performance of the NHS and the services delivered by the NHS. It also considers the financial performance of NHS foundation trusts.

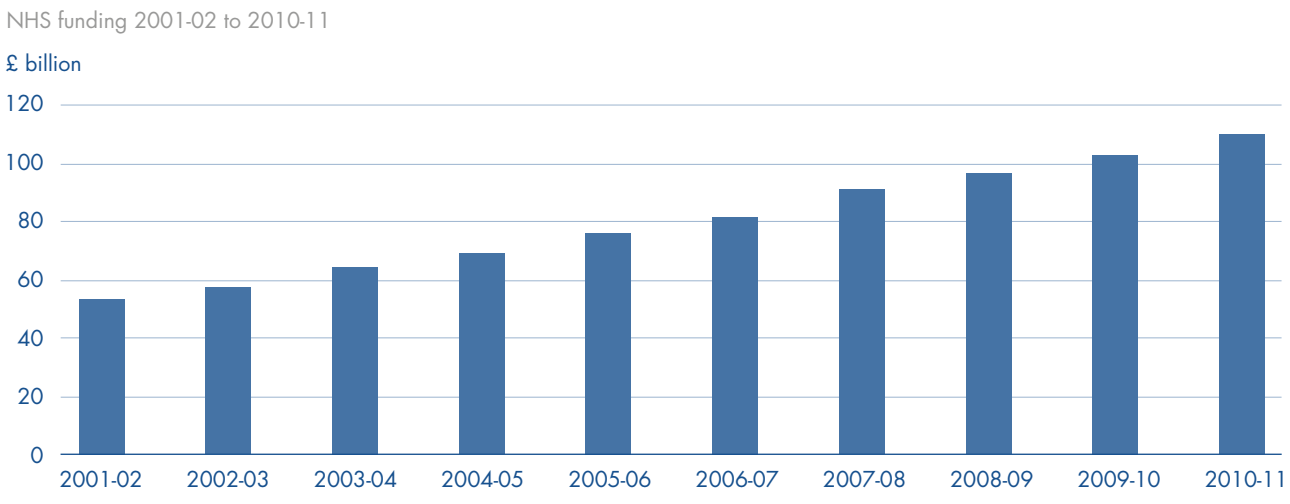
Funding of the NHS in 2007-08

2.2 The resources available to the NHS increased from £53.5 billion in 2001-02 to £90.7 billion in 2007-08. The 2007-08 financial year saw the last of the large increases in funding arising from the Spending Review in 2004 which gave the NHS annual increases of about nine per cent in cash terms. Public health spending in the UK overall in 2007-08 represented 7.3 per cent of UK Gross Domestic Product. Spending on the NHS in England in 2007-08 represented almost £1,700 per head.[4]

In September 2007, the Comprehensive Spending Review (CSR) 2007 announced further planned increases to NHS funding averaging four per cent in real terms over the period up to 2010-11, increasing planned funding to almost £110 billion. Four per cent real terms growth compares to an average of 2.1 per cent across government **(Figure 4)**.

2.3 The resources being made available to the NHS over the three year period of the CSR 2007 include an amount of £4.17 billion which represented the Department's forecast cumulative capital underspend at September 2007. This capital underspend was surrendered on the basis that it would be reissued as capital resources in the settlement. There was underspending of 43 per cent and 40 per cent in the capital budgets in 2005-06 and 2006-07, mainly because of delays in the National Programme for IT, and because expenditure did not

4 Funding of the NHS in cash terms will more than double in the ten years from 2001-02 to 2010-11



Source: Departmental Report 2008

4 HM Treasury, Public Expenditure and Statistical Analyses 2008, and Department of Health, Financial Planning and Allocations.

keep pace with the 20 per cent annual increase in the capital resources available to the NHS. In 2007-08, the Department moved from a system where each NHS organisation received a formula-based capital allocation, to one where individual capital budgets were agreed based on expenditure plans. This system has introduced more discipline into capital expenditure and helped to reduce the capital underspend in 2007-08 to £521 million, or 22 per cent.

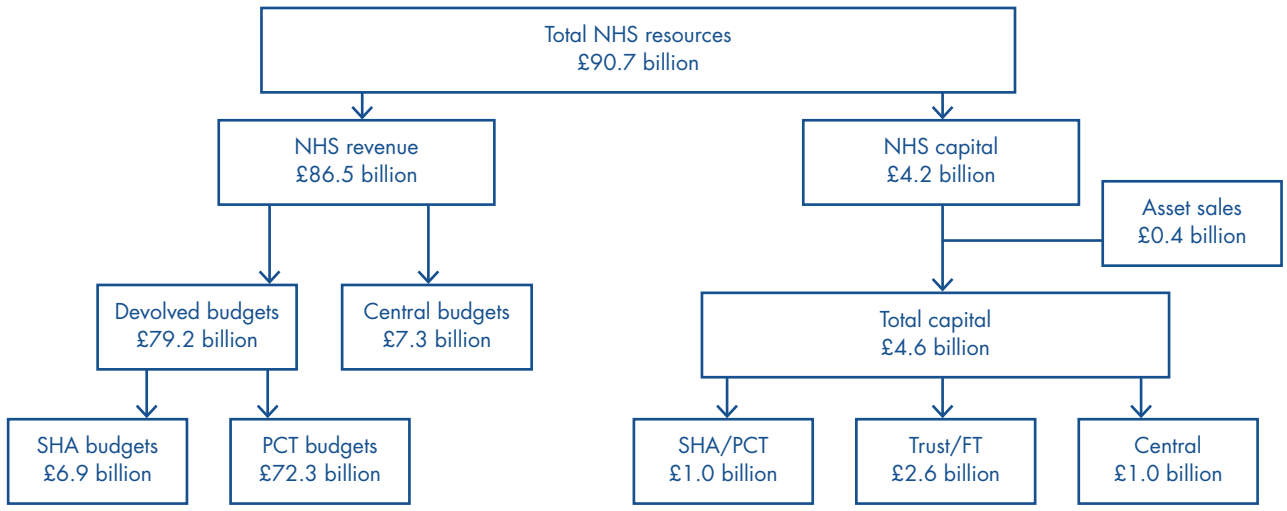
2.4 Of the total resources available to the NHS of £90.7 billion in 2007-08, planned revenue expenditure was £86.5 billion and planned public capital expenditure was £4.2 billion. In addition to public capital, private capital totalling £1.2 billion was invested in NHS infrastructure during 2007-08, by way of Private Finance Initiative schemes. Of the planned revenue expenditure, over 90 per cent is devolved to NHS organisations **(Figure 5)**. More than 90 per cent of the devolved budgets are allocated directly to Primary Care Trusts, who in turn fund NHS Trusts and NHS foundation trusts for services commissioned.

2.5 The revenue allocations to individual Primary Care Trusts are based on a weighted capitation formula. The aim of this formula is to ensure that there is sufficient funding to provide equal access for equal need in all parts of the country, and to reduce avoidable health inequalities. The key determinant of need is the size of the population for which Primary Care Trusts are responsible, which is then adjusted to take into account the age related need, additional need (over and above that accounted for by age), and unavoidable geographic variations in the cost of providing services (the "market forces" factor). The weighted capitation formula determines the target allocation for each Primary Care Trust, but not the actual allocation. Movement towards target allocations are over a number of years in order to minimise financial instability in the NHS and recognise that there are unavoidable cost pressures that Primary Care Trusts will need to meet. Actual allocations therefore depend on how quickly the Primary Care Trusts are moved towards their target allocations through distribution of additional funding – the "pace of change" policy. The pace of change is decided by Ministers for each allocations round. Final annual allocations are designed to ensure that the trend in allocations is always towards the target allocations, at the same time ensuring that all Primary Care Trusts receive appropriate increases. In 2007-08, the average increase in allocations was 9.4 per cent in cash terms over 2006-07.

2.6 Strategic Health Authorities are given individual allocations by the Department designed to cover their running costs, the workforce development costs for clinical and related professions, and the training and education needs of their local NHS. Approximately 80 per cent of Strategic Health Authority expenditure is incurred on such costs for their NHS bodies.

2.7 Central budgets are managed by the Department, and include funding for Arm's Length Bodies and the National Programme for IT. In addition, these budgets are used to meet demand-led expenditure, such as the funding for dentistry and ophthalmology services.

5 Allocation of NHS resources 2007-08



Source: Adapted from Departmental Report 2007

2.8 A number of key terms are used when describing the performance of the NHS (excluding NHS foundation trusts) in total, and of the various types of organisation. This part of the report looks at the performance of the NHS against its planned income and expenditure. The key terms, which are defined in **Box 1**, relate to this performance.

Overall Financial Performance of the NHS 2007-08

2.9 The Department's financial strategy for the NHS (excluding NHS foundation trusts) in 2007-08 was set out in its Operating Framework.[5] The Department does not set financial strategy for NHS foundation trusts. The Framework required delivery of a net surplus across the NHS of £250 million, a significant reduction in the value of the gross deficit, and for almost all organisations to be in financial balance on a monthly basis by the end of the year. The planned surplus represented about one third of one per cent of total available resources.

2.10 All NHS organisations had also been asked by the Department to create a 0.5 per cent contingency (equivalent to at least £526 million) in their financial plans. In addition, towards the end of 2006-07 the financial regime of NHS Trusts was amended by the Department so that NHS Trusts were not subject to income variations as a result of their financial performance in the previous year (the 'double deficit' scenario). The NHS was required to plan for a further £140 million surplus in order to fund these changes to the financial regime.

2.11 These measures, together with the planned surplus of £250 million, meant that the Department expected the NHS to generate a surplus of no less than £916 million, or about one per cent of resources. The surplus was set at a level to provide financial stability, ensuring that the system could absorb cost pressures that may emerge during the year without having to make short term savings to cover them or slip back into deficit. Within fixed spending limits that cannot be exceeded it is appropriate that a reasonable measure of contingency is built into initial financial plans. Where contingency funds are not required, this can lead to an underspend.

2.12 The NHS, excluding NHS foundation trusts, delivered a final net surplus of £1.67 billion in 2007-08, representing approximately two per cent of total available resources. The Department was aware that the planned surplus was likely to be significantly exceeded at an early stage during 2007-08. Reported forecast financial data from the NHS predicted a surplus of £983 million at the end of quarter one, rising to a predicted surplus of £1.8 billion at quarters 2 and 3.

2.13 The predicted surplus at quarter 2 of £1.8 billion, reported in November 2007, turned out to be an accurate forecast of the final financial position. At this point the NHS was also predicting that it would meet many of its operational targets. The growth in the surplus in year meant individual organisations were faced with a choice of increasing spending or retaining the surplus to carry forward for future years. Individual organisations had to evaluate the benefit of bringing forward healthcare activity against the possibility of lower value for money through rushing to spend, and the risks of increasing the recurrent costs of the organisation without certainty about future income and losing flexibility to respond to future cost pressures. With the expected level of progress being made against national healthcare targets, NHS organisations took the decision to accumulate the surplus where this did not threaten delivery against those targets.

BOX 1

Definition of terms used in this report

For the NHS as a whole or for NHS Trusts, the excess or shortfall of planned resources over actual expenditure for the year is known as a **surplus** or **deficit**

The aggregate of all individual surpluses or underspending reported by the NHS is known as the **gross surplus** (or for individual deficits/overspending, the **gross deficit**)

The aggregate of the gross surplus and gross deficit is known as the **net surplus** or **net deficit**

Breakeven or **financial balance** is where income equals expenditure

Source: National Audit Office and Audit Commission

6 Planned, expected and final surplus generated by the NHS in 2007-08

Planned Surplus £m	Expected Surplus £m	Final Surplus £m
250	916	1,674

Source: National Audit Office

NOTE

The surplus of £1.674 billion reported in figures 6 and 7 includes the surplus reported by NHS Direct. The figure published by the Department of £1.667 billion excludes NHS Direct.

5 Department of Health, *the NHS in England: the operating framework for 2007-08*, December 2006.

2.14 The increase between the planned and final surplus arose for a number of reasons. Many NHS organisations were able to meet or exceed the savings required to generate a 0.5 per cent contingency from the achievement of cost improvement plans during the year. The number of NHS organisations who were forecasting a deficit halved during the year, from 22 to 11. Finally, there was a reduction in the prices of generic medicines charged to Primary Care Trusts which was not known when the financial plans for 2007-08 were being drawn up.[6]

2.15 The Department has given a commitment to the NHS that the full amount of the surplus will be carried forward and made available to the NHS. This commitment means that the surplus will be used to deliver healthcare, although that healthcare will be deferred to future years. The commitment does, however, allow the NHS to plan ahead for how best to use those funds.

2.16 The surplus in 2007-08 also means that the NHS does not start 2008-09 in the position of having to pay back overspends. As a result the entire NHS revenue allocation of £92.5 billion is available to the NHS to spend in 2008-09. The Department's financial strategy for 2008-09 is based on the NHS spending all of its allocated resources, with the surplus accumulated in 2007-08 remaining available for spending in 2009-10 and beyond.

Composition of the Surplus in 2007-08

2.17 The net surplus of £1.67 billion, representing two per cent of total available resources, is an increase from 2006-07, when the NHS had a net surplus of £515 million, or 0.6 per cent of total available resources. In 2006-07, the surplus was held mainly in Strategic Health Authorities, which are administrative bodies. The service delivery parts of the NHS, Primary Care Trusts and NHS Trusts, remained in deficit **(Figure 7)**. In 2007-08, the Strategic Health Authorities have retained a similar level of surplus, but Primary Care Trusts and NHS Trusts have also returned to surplus **(Figure 8 overleaf)**.

2.18 Of the 340 NHS organisations, 324 delivered a surplus, 5 broke-even and just 11 NHS organisations recorded a deficit in 2007-08 (Figure 6).[7] The 11 NHS organisations in deficit represent three per cent of NHS organisations, down from 22 per cent in 2006-07 (82 organisations).

2.19 The eleven NHS organisations reporting a deficit recorded a gross deficit of £124 million, a significant reduction on the gross deficit of £917 million reported by the 82 NHS organisations recording a deficit in 2006-07. The 324 NHS organisations reporting a surplus (including NHS Direct) recorded a gross surplus of £1,799 million, an average of £5.6 million per NHS organisation (2006-07: 287 NHS organisations recorded a gross surplus of £1,431 million, an average of £5.0 million). With the average level of surplus in individual NHS organisations increasing by just 10 per cent, much of the improvement in financial standing over 2006-07 is therefore attributed to NHS organisations previously in deficit turning around their financial positions. In addition, only five organisations were not in monthly financial balance by the end of the financial year.

7 Financial Performance of NHS organisations in 2007-08 and 2006-07

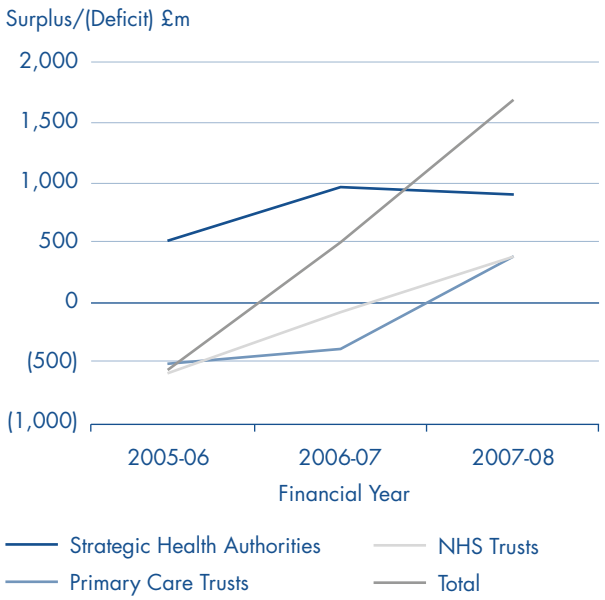
	Surplus/(Deficit)	Number of organisations			
2007-08	**£m**	**Surplus**	**Breakeven**	**Deficit**	**Total**
Strategic Health Authorities	903	10	0	0	10
Primary Care Trusts	391	146	2	4	152
NHS Trusts	380	168	3	7	178
	1,674	**324**	**5**	**11**	**340**
2006-07					
Strategic Health Authorities	962	10	0	0	10
Primary Care Trusts	(370)	109	1	42	152
NHS Trusts	(77)	168	2	40	210
	515	**287**	**3**	**82**	**372**

Source: National Audit Office analysis of NHS summarised accounts

6 Department of Health, *the Quarter*, November 2007.

7 Of these 178 NHS Trusts, 30 achieved NHS foundation trust status during the year. Their results covering the period 1 April 2007 to their date of conversion are included. There were 151 NHS Trusts remaining at 31 March 2008. This includes NHS Direct, which converted from an Arm's Length Body to an NHS Trust on 1 April 2007.

8 Financial Performance of NHS organisations 2005-06 to 2007-08



Source: National Audit Office analysis of NHS Summarised Accounts

Regional Performance of the NHS 2007-08

2.20 The financial performance of a Strategic Health Authority health economy is comprised of the financial position of the Strategic Health Authority itself and the individual Primary Care Trusts and NHS Trusts under its responsibility. All of the ten Strategic Health Authority health economies reported a surplus in 2007-08, compared to eight in 2006-07, and all ten reported an improvement in their financial standing in 2007-08 **(Figure 9)**.

Detailed Financial Performance of the NHS 2007-08

2.21 The ten Strategic Health Authorities were allocated a combined resource limit of £5.97 billion for 2007-08. The ten organisations reported total expenditure of £5.07 billion resulting in a net underspend of £903 million, which is a 15 per cent underspend against their combined revenue resource limits (2006-07: 19 per cent underspend against a combined revenue resource limit of £4.94 billion). These limits include the running costs of the ten organisations, but the majority of expenditure, totalling £4.15 billion, was for the

9 NHS financial performance 2005-06 to 2007-08 by Strategic Health Authority

Strategic Health Authority	2005-06 Surplus/(Deficit) £m	2006-07 Surplus/(Deficit) £m	2007-08 Surplus £m	Surplus as a % of resource limit	Change from 2006-07 £m
North East	21	75	129	2.9	54
North West	58	189	317	2.7	128
Yorkshire and the Humber	34	131	259	3.2	128
East Midlands	(13)	68	130	2.1	62
West Midlands	(38)	61	153	1.9	92
East of England	(234)	(153)	85	1.1	238
London	(174)	93	285	2.2	192
South East Coast	(94)	(43)	85	1.4	128
South Central	(59)	38	75	1.4	37
South West	(49)	56	149	2.0	93
Total	**(547)**	**515**	**1,667**	**2.1**	**1,152**

Source: Department of Health

NOTE

1 Figures for 2005-06 may not sum due to rounding. The figures for 2007-08 exclude results for NHS Direct as it is a national body and not performance managed by a Strategic Health Authority.

funding of NHS training and education known as Multi Professional Education and Training, or MPET, the budgets for which are directly controlled by Strategic Health Authorities. The MPET expenditure has seen a significant rise from 2006-07, when expenditure was approximately £3.4 billion.[8]

2.22 During 2006-07, Strategic Health Authorities retained up to three per cent of resources allocated to Primary Care Trusts. A net total of £825 million was still retained by Strategic Health Authorities at 31 March 2007, which contributed to their 2006-07 surpluses. The Secretary of State gave a commitment that these resources would be returned to Primary Care Trusts, probably within the spending review period (i.e. over a three year period to 2010-11).

2.23 In 2007-08, £686 million of these resources were returned to Primary Care Trusts meaning that £139 million of resources relating to 2006-07 remained lodged with Strategic Health Authorities at 31 March 2008. During 2007-08, Primary Care Trusts lodged £651 million of their 2007-08 allocations with their Strategic Health Authorities. Overall, this means that at 31 March 2008 the ten Strategic Health Authorities were holding £790 million of Primary Care Trust allocations. In 2008-09 it is not expected that Strategic Health Authorities will retain Primary Care Trust resources as in previous years. However, Primary Care Trusts can once again chose to make voluntary lodgements with Strategic Health Authorities, or can agree that earlier contributions will not be returned, but may instead be used by other NHS organisations which provide direct patient services to the population served by that Primary Care Trust.

2.24 In 2007-08 Primary Care Trusts had a total revenue limit of £72.36 billion. Net operating expenditure was £71.97 billion resulting in an underspend of £391 million. Primary Care Trusts were required to pay back the £370 million deficit they reported in 2006-07 during 2007-08, meaning that they generated a £761 million in-year surplus. Just four Primary Care Trusts (three per cent) reported a deficit in 2007-08; the gross deficit for these four organisations was £45 million. In 2006-07, 42 Primary Care Trusts (28 per cent) reported a combined gross deficit of £636 million.

2.25 The 178 NHS Trusts reported a net surplus of £380 million in 2007-08, an improvement in financial standing of £457 million from the £77 million deficit that NHS Trusts reported in 2006-07. The 30 NHS Trusts who achieved NHS foundation trust status during the year had to meet Monitor's assessment criteria and so were towards the top end of financial performance. Just seven NHS Trusts (four per cent) reported a deficit in 2007-08; the gross deficit for these organisations was £79 million. In 2006-07, 40 NHS Trusts (19 per cent) reported a combined gross deficit of £281 million. NHS Acute Trusts in particular have shown a significant turnaround, improving from a £133 million deficit in 2006-07 to a £290 million surplus in 2007-08. All of the other NHS Trust sectors (mental health, ambulance and learning disability trusts) also reported a net surplus in 2007-08.

2.26 Appendix 2 to this report provides more detail on the financial performance of the NHS in 2007-08.

NHS Foundation Trusts Financial Performance 2007-08

2.27 The 89 NHS foundation trusts as at 31 March 2008 had a net surplus of £395 million for the 2007-08 financial year on income of £16.2 billion. This surplus is in addition to the £1.67 billion NHS surplus. To facilitate a comparison with NHS Trusts it is necessary to adjust for certain items which are funded differently. The main difference arises when assets such as buildings are assessed as having a lower value than that shown on the balance sheet. The asset is said to be impaired. NHS foundation trusts report the difference between the original value and the assessed value as an exceptional item and the difference is charged as expenditure for the year. The value of the asset in the balance sheet is then adjusted downwards to the assessed value. NHS Trusts also reduce the value of assets in the balance sheet when they are impaired, but the amount of the reduction does not affect the 'bottom line' of their accounts, as in 2007-08 they were provided with additional funding to cover the expenditure costs of impairments. On a like-for-like basis with NHS Trusts, the NHS foundation trust surplus would have been £528 million.

2.28 Financial performance of NHS foundation trusts is shown in **Figure 10 overleaf** and is reported in the same way that Monitor reports it; that is before impairments, exceptional items and profits or losses on disposal of fixed assets. Only one NHS foundation trust, the Royal National Hospital for Rheumatic Diseases, ended the year with a deficit. The largest surplus, of £56.8 million, was reported by Guy's and St Thomas' NHS foundation trust. Most NHS foundation trusts reported a surplus between zero and £10 million in 2007-08. Figure 10 shows the distribution of financial performance for NHS foundation trusts in 2007-08, and the top and bottom five financial performers.

8 Strategic Health Authority summarised accounts 2007-08.

2.29 Monitor also reports the financial performance of NHS foundation trusts using a measure called EBITDA – earnings before interest, tax, depreciation and amortisation. This is a measure of financial performance, expressed as a percentage margin, which excludes the financial impact of financing and asset changes, and is used by Monitor as a proxy for operating efficiency. The aggregate EBITDA margin of NHS foundation trusts in 2007-08 was 8.1 per cent, up from 6.8 per cent in 2006-07. The main reason for the increase in the margin reported by NHS foundation trusts in 2007-08 was that they delivered cost savings of around 3.1 per cent of costs (representing savings of about £500 million); these savings were ahead of efficiency savings of 2.5 per cent which had been built into plans.

2.30 NHS foundations trusts have no statutory duty to break even and can plan for surpluses for reinvestment in services. The final surplus of £395 million compares with a planned surplus of £163 million. NHS foundation trusts had also planned for cash balances of £1.0 billion at the year end to support significant capital investment over the next few years. In fact, at the year end the 89 organisations were holding £2.3 billion in cash and cash equivalents, with the increase due to slippage in investment plans and more cash being generated through trading than planned (including advance receipts of approximately £280 million from Primary Care Trusts for services to be delivered by NHS foundation trusts in 2008-09).

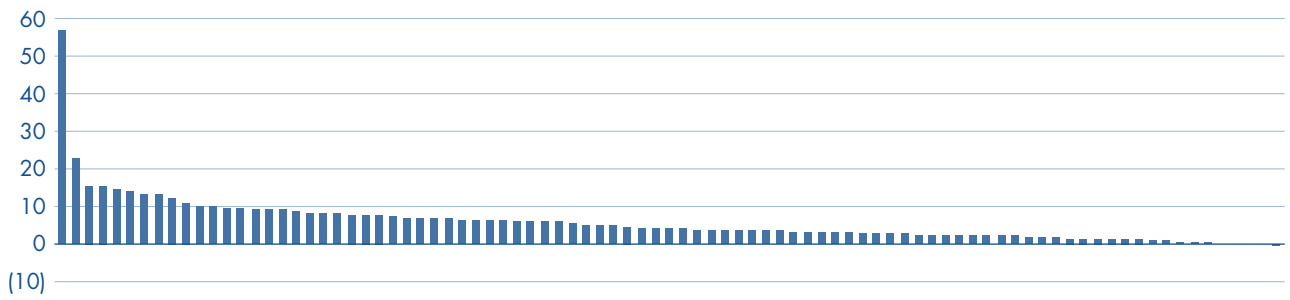
What has the NHS delivered?

2.31 Primary Care Trusts increased the value of the healthcare they commissioned as reported in their accounts by £5.3 billion, or eight per cent in 2007-08 over the previous year **(Figure 11)**. Of this increase, £4.3 billion extra was commissioned from NHS providers (including NHS foundation trusts), an increase of seven per cent over the previous year, £0.4 billion extra was commissioned from local authorities (an increase of 30 per cent), £0.05 billion extra was commissioned from the voluntary sector (an increase of 18 per cent) and £0.6 billion extra was commissioned from the independent sector, an increase of 18 per cent over the previous year.

2.32 NHS Trusts receive the majority of their income from Primary Care Trusts and are paid for their work through a mixture of locally negotiated contracts and through Payment by Results. Under Payment by Results, providers are paid for the number and type of patients treated, in

10 NHS foundation trust financial performance 2007-08

Distribution of NHS foundation trust financial performance 2007-08



Each bar represents the reported financial position of an NHS foundation trust in 2007-08

Top five surplus in NHS foundation trusts

NHS foundation trust	Surplus/(deficit) £m
Guy's and St Thomas'	56.8
Heart of England	22.9
Kings College	15.5
University College London	15.4
Chelsea and Westminster	14.6

Bottom five surplus in NHS foundation trusts

NHS foundation trust	Surplus/(deficit) £m
Norfolk and Waveney Mental Health	0.2
Tameside	0.1
Tavistock and Portman	0.1
Greater Manchester West Mental Health	0.0
Royal National Hospital for Rheumatic Diseases	(0.4)

Source: Monitor

accordance with national rules and a national tariff. In 2007-08, NHS Trusts received £29.8 billion of income for commissioned healthcare and £3.4 billion from other sources, including £1.8 billion from MPET funding in respect of the reimbursement of costs of relevant staff under training and associated infrastructure. It is not meaningful to compare these figures with 2006-07 given the changing numbers of NHS Trusts. The direct costs of operations in 2007-08 were £32.1 billion, with the most significant costs being staff costs of £20.8 billion and clinical supplies of £4.4 billion. NHS Trusts purchased £295 million worth of healthcare from non-NHS bodies.[9]

2.33 Activity levels in the NHS continued to rise in 2007-08. Consultations at GPs rose by two per cent from 289 million to 295 million. The number of elective admissions (planned, non-emergency) rose by 5.4 per cent from 2006-07 and the number of emergency admissions rose by 0.4 per cent. These figures are based on admissions purchased by the NHS, and therefore include procedures performed by NHS foundation trusts. Average in-patient waiting times fell from 7.4 weeks in March 2007 to 5.6 weeks in March 2008. Median in-patient waiting times fell from 6.2 weeks to 4.5 weeks over the same period. Average waiting times for first out-patient appointments fell from 3.7 weeks in March 2007 to 2.9 weeks in March 2008. Median out-patient waiting times fell from 3.2 weeks to 2.6 weeks over the same period.

2.34 These changes were despite little movement in the numbers of staff working in the NHS. The full-time equivalent number of doctors rose by 1.5 per cent in the year to 30 September 2007, with no change in the number of qualified nurses, and a fall of one per cent in the numbers of administrative staff.[10]

The quality of care delivered by the NHS (including NHS foundation trusts) in 2007-08

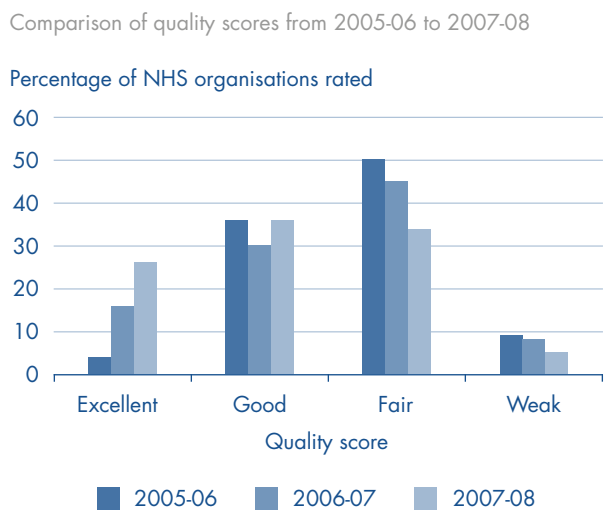
2.35 The overall quality of care provided by NHS organisations is rated by the Healthcare Commission as part of its Annual Health Check. This check assesses NHS organisations against a number of national standards and healthcare priorities. The proportion of NHS organisations (including NHS foundation trusts) rated as excellent improved from 16 per cent in 2006-07 to 26 per cent in 2007-08. The proportion rated good or excellent increased to 62 per cent in 2007-08, compared with 46 per cent in 2006-07 and 40 per cent in 2005-06 **(Figure 12)**.

11 Value of healthcare commissioned by Primary Care Trusts 2006-07 and 2007-08

	2006-07 £bn	2007-08 £bn	Change £bn	Change %
Primary healthcare	18.6	19.2	0.6	3
Secondary healthcare	46.9	51.6	4.7	10
Other healthcare	0.4	0.4	–	0
Commissioned healthcare	**65.9**	**71.2**	**5.3**	**8**
Commissioned from:				
NHS providers	61.2	65.5	4.3	7
Local authorities	1.5	1.9	0.4	30
Independent sector	2.8	3.4	0.6	18
Voluntary sector	0.37	0.42	0.05	15
Commissioned healthcare	**65.9**	**71.2**	**5.3**	**8**

Source: National Audit Office analysis of NHS Summarised Accounts

12 Healthcare Commission Annual Health Check quality ratings 2005-06 to 2007-08



Source: Healthcare Commission

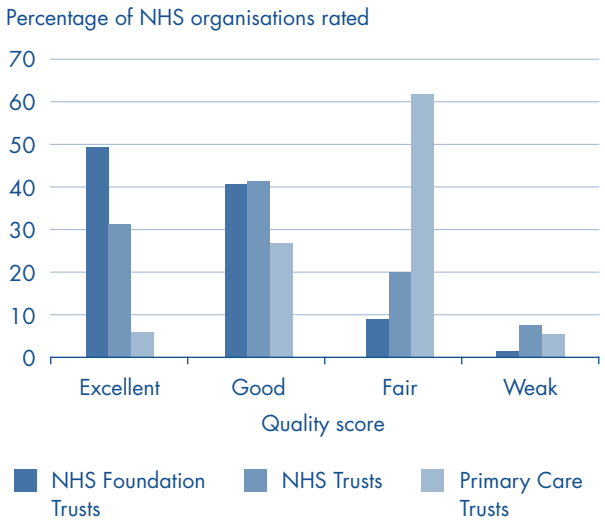
9 NHS Trust summarised accounts 2007-08.
10 Knowledge and Intelligence Division, Department of Health.

2.36 NHS foundation trusts were rated more highly according to the Healthcare Commission than NHS Trusts **(Figure 13)**. Primary Care Trusts received the lowest ratings overall, but this assessment may be partly explained by the relatively high number of targets against which they are assessed. For example, the Healthcare Commission will take into account performance of Primary Care Trusts against up to 17 existing national targets; whereas NHS mental health trusts have just one such target.

2.37 Mental health trusts received the highest quality ratings when compared with other types of NHS Trust or NHS foundation trust **(Figure 14)**. Ambulance trusts received the lowest ratings, with three out of eleven rated as weak. An acute NHS foundation trust is twice as likely to be rated excellent as an acute NHS trust **(Figure 15)**. Around two-thirds of mental health trusts are rated excellent, regardless of whether they are NHS foundation trusts or not.

2.38 The NHS made progress against the key priorities set by the Department in the Operating Framework for 2007-08. **Box 2** sets out the progress against these priorities. Despite the overall progress, the NHS still faces some challenges to meet its key priorities. For example, national targets are now being met on reducing healthcare associated infections, but some organisations have yet to achieve their local target.

13 Comparison of 2007-08 quality score for NHS foundation trusts, NHS Trusts and Primary Care Trusts



Source: Adapted by the National Audit Office from Healthcare Commission Annual Health Check data

2.39 The NHS has delivered more healthcare in 2007-08, with the same number of staff, and the quality of that healthcare has improved, according to the Healthcare Commission. The NHS has also made good progress against its national healthcare delivery targets. Good financial management is about delivery against targets within the resources available. In meeting its targets whilst creating a surplus, the NHS has shown good resource utilisation, not a failure to deliver. The surplus does, however, represent resources deferred for front-line healthcare to future years. Part four includes discussion of the Department's intention that the NHS should maintain the same level of surplus until 2009-10 at the earliest.

BOX 2

Progress against NHS priorities[1]

The 18 week referral to treatment target means that by December 2008 no patient will wait longer than 18 weeks unless they have chosen to do so or it is clinically appropriate to wait longer. Milestones against this target were set for 2007-08 such that by March 2008, 85 per cent of admitted patients and 90 per cent of non-admitted patients would begin treatment within 18 weeks of referral. By March 2008 the achieved numbers across the NHS were 87 per cent and 93 per cent respectively. NHS foundation trusts achieved figures of 89 per cent and 94 per cent respectively.

On MRSA, the target was to achieve a 50 per cent reduction by 31 March 2008 on the number of infections compared with the 2003-04 baseline. Achieving this target would mean a monthly average of no more than 321 new cases. Successful delivery against this target was measured by comparing the average monthly figure in the quarter ending June 2008 with the average monthly figure in 2003-04. The Department reported that in the three months to June 2008 the NHS had achieved a reduction of 57 per cent against the 2003-04 baseline.

On health inequalities, the target is to reduce inequalities in health outcomes by 10 per cent by 2010, as measured by infant mortality and life expectancy at birth. A total of 70 Local Authority areas (which map wholly or partially onto 62 Primary Care Trust areas) have been designated as Spearhead areas. These are the areas with the worst health and deprivation indicators and generally have lower life expectancy than the rest of England. Based on 2005-07 data, only 47 per cent of Spearhead areas are on track to narrow the gap in life expectancy rates by 2010 for either males or females or both. This is an improvement from the 2004-06 data, which showed that 41 per cent were on track.

Source: Department of Health Quarter reports

NOTE

1 The information in Box 2 has not been audited.

14 Quality score for 2007-08 for NHS foundation trusts, NHS Trusts and Primary Care Trusts

NHS Foundation Trusts

	Excellent	Good	Fair	Weak	Total
Acute	30	30	7	1	68
Mental Health	14	6	1	0	21
Total	**44**	**36**	**8**	**1**	**89**

NHS Trusts

	Excellent	Good	Fair	Weak	Total
Acute	21	49	25	6	101
Mental Health	23	8	3	1	35
Ambulance	2	5	1	3	11
Other	1	0	1	1	3
Total	**47**	**62**	**30**	**11**	**150**

Primary Care Trusts

Excellent	Good	Fair	Weak	Total
9	41	94	8	152

Source: Adapted by the National Audit Office from Healthcare Commission Annual Health Check data

15 Proportion of NHS organisations rated as excellent on quality 2007-08

Rated as excellent	Percentage
Mental Health Foundation Trusts	67
Mental Health NHS Trusts	66
Acute Foundation Trusts	44
Acute NHS Trusts	21
Ambulance NHS Trusts	18

Source: Adapted by the National Audit Office from Healthcare Commission Annual Health Check data

PART THREE

Financial Management in the NHS

3.1 This part of the report examines the quality of financial management in the NHS, including the quality of financial forecasting, financial management within individual NHS organisations (excluding NHS foundation trusts) and financial reporting. It also looks at how the Department provides leadership over NHS finances, the process by which finances are controlled, and some specific financial management issues arising during 2007-08.

Why financial management is important to the NHS

3.2 Strong financial resource management is central to ensuring that the Department and the NHS deliver their objectives efficiently and effectively. Financial resources need to be converted into public services that meet the expectations of service users, whilst also providing the taxpayer with value for money. In addition to their current activities, effective resource management can also help departments meet future challenges. For instance, our ageing population will change how resources will need to be allocated across the public sector.

3.3 In the NHS, there is some correlation between the financial standing of an NHS organisation and the quality of care that it provides as rated by the Healthcare Commission in its Annual Check. In both 2005-06 and 2006-07 those organisations rated as weak or fair on quality of services were, on average, in deficit. In both years those organisations rated as excellent on quality of service were, on average, in surplus. An NHS organisation reporting a deficit is therefore on average likely to be providing health care of lower quality than those in surplus. In 2007-08 there were too few NHS organisations reporting a deficit (see part two) for statistically significant analysis to be performed, although the Department has recognised that NHS organisations that are good in one area tend to perform well in all areas.

Leadership and oversight of NHS finances

3.4 The NHS Chief Executive is an Additional Accounting Officer for the Department of Health. He is responsible for leading the NHS and is chief adviser to the Secretary of State on the NHS. The Permanent Secretary of the Department, as the Principal Accounting Officer for the Department, is responsible for the totality of the sums voted for health by Parliament, but he places reliance on the Chief Executive of the NHS in discharging those responsibilities in terms of the NHS. This relationship is set out in a Memorandum of Understanding between them, which was approved by the Departmental Board in January 2008.

3.5 The Chief Executive of the NHS is responsible for ensuring the proper management of monies voted by Parliament and for financial management and reporting of the NHS. He is supported in this role by the NHS Management Board, which is a sub-committee of the Departmental Board. The NHS Management Board is chaired by the NHS Chief Executive and includes Strategic Health Authority Chief Executives and senior staff from the Department. As well as supporting the NHS Chief Executive in discharging his responsibilities, the NHS Management Board provides leadership for the NHS, manages performance and shapes policy and strategy for the NHS. The Departmental Board considers financial strategy for the NHS as well as for the Department, and receives status reports on NHS financial and operational performance. Decisions on the allocation of NHS resources are taken by Ministers.

3.6 Strategic Health Authorities have some discretion as to how they manage the financial performance of the NHS bodies (excluding NHS foundation trusts) in their health economies. As a minimum, each has a medium-term financial strategy which encompasses the whole health economy within its areas of responsibility. Strategic Health Authorities have arrangements to assure themselves that commissioners of services can afford their plans and that NHS Trusts are financially viable. They also seek assurance that all agreements and contracts are in place and organisations have agreed their budgets by the start of the year.

3.7 Strategic Health Authorities also have responsibility for helping their NHS Trusts prepare for and make successful applications for foundation trust status. In order for an NHS Trust to make a successful application for foundation trust status, the Trust needs to demonstrate good financial standing and financial stability. In recent years there have been significant differences in the financial standing of different parts of the NHS in England. NHS Trusts located in regions with a history of stronger financial performance have been better placed to make the transition to foundation status. As a result, there are significant regional differences in the numbers of NHS foundation trusts. In the North East, 70 per cent of trusts are foundation trusts, whereas in the South East just 12 per cent of trusts are foundation trusts. **Figure 16 overleaf** shows the number and location of NHS foundation trusts as at 31 March 2008; the numbers indicate the order in which they were authorised with the higher numbers representing the most recently authorised.

Financial Forecasting by the NHS

3.8 The Departmental publication *The Quarter* contains each individual NHS organisation's financial forecasts for the year, along with forecasts for each Strategic Health Authority health economy and the overall forecast for the NHS. These forecasts exclude those for NHS foundation trusts on which Monitor reports separately. Generally, the Department's forecasts for the NHS are published six to eight weeks after the end of the period to which they relate. The Department has published detailed NHS financial forecasts quarterly since the beginning of 2006-07. These publications have significantly enhanced the transparency of NHS finances.

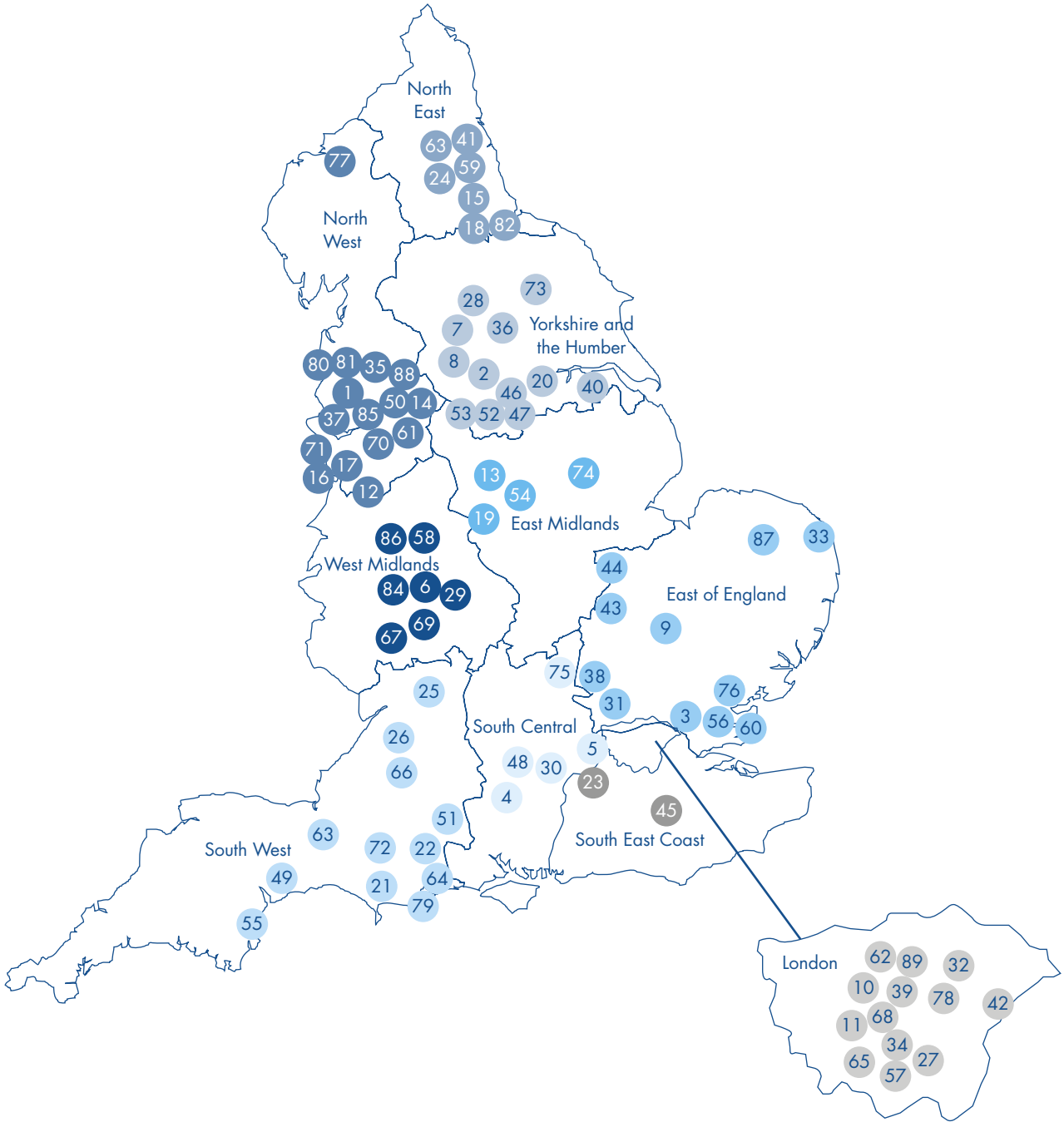
3.9 The quarter one report summarising NHS performance for the first three months of the financial year forecast a surplus of £983m for 2007-08. By the end of quarter two this forecast had risen to £1.8 billion and remained at that level at quarter three. By the end of the year, the actual surplus reported had reduced to £1.67 billion. In comparison with previous years, the forecast from quarter two onwards was fairly stable and accurate when compared with the final financial position; but the scale of the predicted surplus was still not reported until halfway through the year.

3.10 **Figure 17 on page 23** examines the aggregate quarterly forecasts for each type of NHS organisation. It compares the predicted position at each quarter end with the actual financial position at the year end. It shows that Primary Care Trusts and NHS Trusts produced more accurate forecasts as the year progressed. Strategic Health Authorities produced the most variable forecasts, and their forecasts heavily influenced the overall NHS position. This is mainly because NHS organisations are able to lodge resources with the Strategic Health Authority, meaning that most of the variability in the health economy rests with the Strategic Health Authority. Overall, the accuracy of forecasts improved during the year, which is to be expected as more actual financial data becomes available. In both 2005-06 and 2006-07, however, the largest movement in the forecast financial position for the year occurred between quarter three and the year end.

Financial Management of Primary Care Trusts and NHS Trusts

3.11 The Audit Commission assesses standards of financial management in NHS bodies. 93 per cent of organisations (282) met the Audit Commission's minimum standards when auditors assessed whether budgets and the capital programme were soundly based and designed to deliver strategic priorities. 65 per cent of organisations (195) were found to be performing well or strongly. This outcome is an improvement from 2006-07, when 20 per cent of organisations (66) did not meet minimum standards and only 37 per cent of organisations (125) were performing well or strongly.

16 Location of NHS foundation trusts at 31 March 2008



Source: Monitor

NOTE

The circles on the map show the geographical location of each NHS foundation trust. The numbers represent when they were authorised; with the higher numbers being the more recently authorised.

3.12 The organisations performing strongly produced financial plans and could demonstrate how they contributed to the achievement of their strategic objectives. Furthermore, senior managers and clinicians were involved in managing financial performance against budgets. Of those organisations not meeting minimum requirements, auditors identified that the most common weaknesses were an unrealistic, or absent, medium-term financial plan, a high level of unspecified savings, poor budget monitoring and ineffective action to address overspending, poor financial training for non-executive directors, and for those organisations with a significant asset base, a poorly maintained asset register and unrealistic estates strategy.

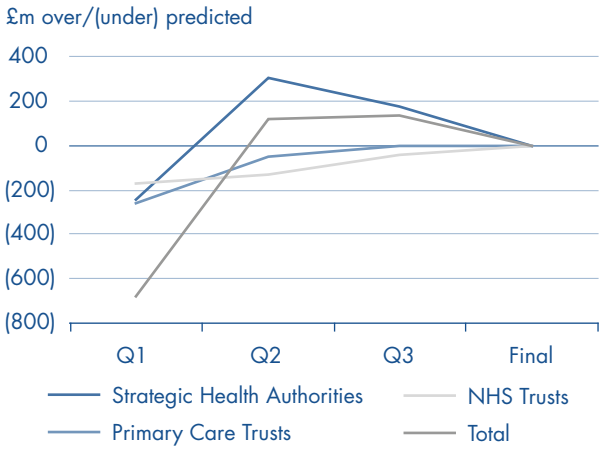
NHS Monitoring of Performance against Budgets

3.13 The auditors also examined how NHS organisations (excluding NHS foundation trusts) managed their financial performance against budgets. They found that performance has improved for a second year, across all NHS sectors, with just two per cent of Primary Care Trusts (three organisations) and three per cent of NHS Trusts (five organisations) failing to meet minimum standards. 13 per cent (40 organisations) achieved the highest possible score (level 4, or performing strongly) in 2008, compared to five per cent (17 organisations) in 2007. 59 per cent of NHS bodies (178) scored level 3 (performing well) in 2008, compared with 42 per cent (141 organisations) in 2007[11].

3.14 Financial management is strongest at mental health and learning disability trusts, where 92 per cent (34 trusts) achieved at least level 3. Acute trusts showed the most variation, with the highest number of organisations failing to achieve minimum standards, but also the largest proportion of organisations performing strongly **(Figure 18)**.

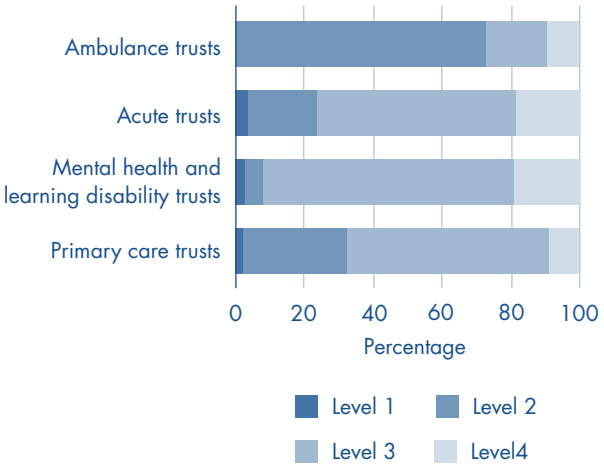
3.15 For those NHS bodies not achieving level 3 or 4, defined as at or below minimum requirements, the auditors identified some common practices which contributed to the lower scores. Auditors identified several common weaknesses at organisations not meeting minimum requirements. These included cases where a profiled budget was not input at an appropriate level of detail; budgets were not reviewed and updated monthly to reflect revisions to resource allocations and activity throughout the year; material variances between actual and budgeted expenditure were not monitored and addressed; regular training on financial issues was not provided for non-executive directors and other non-finance staff.

17 Comparison between forecasts at each quarter during 2007-08 with final financial position



Source: Audit Commission, compiled from information in the Quarterly reports

18 Results of auditors' assessment of NHS bodies' financial management arrangements for managing performance against budgets in 2007-08



Source: Audit Commission

NOTE

Detailed information on the Auditors' Local Evaluation in given in Appendix 1. Level 1 represents inadequate performance. Level 2 is adequate performance, with Level 3 performing well and Level 4 performing strongly.

11 Audit Commission, *Auditors' Local Evaluation 2007-08 Summary results for NHS trusts and primary care trusts*, October 2008.

NHS Financial Reporting

3.16 The quality of financial reporting is linked to the quality of financial management. Good financial management includes production of accurate, timely management financial information which in turn assists with the quality of year end accounts. NHS organisations have a statutory duty to publish audited annual accounts and to issue an annual report on their financial performance and a range of other indicators. Auditors review the quality of financial reporting at Primary Care Trusts and NHS Trusts. There are two main elements of the assessment: whether the organisation produces annual accounts in accordance with relevant standards and timetables, supported by comprehensive working papers; and how well the organisation promotes external accountability. The detailed results for 2007-08 were published in October 2008.[12]

3.17 There has been a clear improvement in financial reporting, for both NHS trusts and Primary Care Trusts. This improvement reflects NHS bodies' considerable efforts to enhance financial reporting alongside a shorter timetable for the preparation of financial statements. Overall, four per cent of NHS bodies failed to meet minimum standards, compared to 16 per cent in 2006-07. Seven per cent of NHS bodies are performing strongly, compared to one per cent in 2006-07. The most commonly identified weaknesses at NHS bodies failing to achieve minimum standards were poor quality working papers supporting the accounts, a high level of material or non-trivial errors, and incomplete annual reports.

Audit findings affecting the NHS surplus

3.18 The overall net change between the draft NHS summarised accounts and the final NHS summarised accounts was an increase in the surplus of £12 million in 2007-08. This compares with overall net adjustments to draft accounts of £4 million in 2006-07, £35 million in 2005-06 and £115 million in 2004-05. The identification of errors by the auditors is part of the normal audit process. Auditors would consider qualification of accounts only where material errors were not adjusted. The level of unadjusted errors found by auditors was not considered to be material either to the individual accounts of NHS organisations or to the summarised accounts; these unadjusted errors totalled £47 million. The most commonly occurring errors involved the capitalisation of assets, provisions and accruals. The Audit Commission has analysed the nature of the errors, adjusted and unadjusted, identified in the draft accounts of NHS organisations and will be publishing these on their website.[13]

Audit findings not affecting the NHS surplus

3.19 The NHS, excluding NHS foundation trusts, held cash of £881 million at the year end, compared with £184 million at the previous year end. NHS Trusts held £852 million of this amount. Of the total NHS cash figure of £881 million, £862 million was held at the Office of the Paymaster General (OPG). The Department has confirmed that no taxpayers' funds are at risk as a result of the recent financial crisis.

3.20 Strategic Health Authorities and Primary Care Trusts have a statutory duty to remain within cash limits set by the Department. Cash balances are reduced when organisations make prepayments. Prepayments are payments in advance to third parties for services delivered in the next financial year. Many prepayments were made as part of standard business operations, for example the prepayment of rent, rates and utilities. The auditor will, however, consider whether any payments have been made in advance of need, that is, outside the normal course of business. We have judged that at a national level the total amount relating to payments made in advance of need is not material to the summarised accounts.

3.21 At the organisational level, auditors have to consider Treasury principles, which state that payments in advance of need should be exceptional, require advance Treasury approval for most central government bodies, and should only be considered if there is a value for money case for doing so, for example where a discount is offered for early payment. Auditors judged that two Primary Care Trusts had made payments in advance of need that were irregular and qualified the regularity opinion on their accounts.[14]

12 Audit Commission, *Auditors' Local Evaluation 2007/08 Summary results for NHS trusts and primary care trusts*, October 2008.
13 www.audit-commission.gov.uk.
14 Norfolk Primary Care Trust and Great Yarmouth and Waveney Primary Care Trust.

Financially Challenged Trusts

3.22 From the final quarter of 2006-07 the Department replaced the previous system of cash brokerage with a loans system, where NHS Trusts unable to meet cash commitments could borrow from the Department, paying interest of the amount of the loan. The Department has developed a formal designation of 'Financially Challenged' for NHS Trusts, based on their ability to service these loans. The Department defines an NHS Trust as financially challenged if it meets either of the following criteria:

- It requires a cash loan but it and its Strategic Health Authority are unable to provide sufficient assurance of its ability to generate the required level of surplus to repay a loan over a reasonable period; or
- It already has a working capital loan, but defaults on its terms, most probably by moving into deficit and so not being able to make planned repayments from generated surpluses.

3.23 Strategic Health Authorities are responsible for monitoring the financial performance of NHS Trusts to ensure that the above criteria are not triggered. If a criterion is triggered, the Department will intervene directly to determine corrective action on a case by case basis. In 2006-07 the Department designated 17 NHS Trusts as financially challenged trusts. Once an NHS Trust has been so designated, they are required to work with their Strategic Health Authorities to develop proposals to enable the Department to be repaid the maximum amount of cash advanced over a reasonable period. By the end of 2007-08, ten had agreed ways to repay their debts and are expected to do so within five years. They have worked with their Strategic Health Authorities and are now considered to be in a financially sustainable position and are therefore no longer classified as financially challenged.[15]

3.24 Seven trusts continued to be designated as financially challenged as at 31 March 2008 and more work will need to be done by these organisations, in conjunction with their Strategic Health Authorities and the Department, to improve their financial performance to enable them to service cash loans. Not all financially challenged trusts are reporting deficits **(Figure 19)** and not all NHS Trusts in deficit are classed as financially challenged.

19 Performance of financially challenged trusts

Trust	Surplus/ (Deficit) 2007-08 £000	Surplus/ (Deficit) 2006-07 £000
Barking, Havering and Redbridge Hospitals NHS Trust	(35,621)	(16,844)
Bromley Hospitals NHS Trust	(17,920)	(10,002)
Hinchingbrooke Healthcare NHS Trust	(16,037)	(13,354)
Queen Elizabeth Hospital NHS Trust	(3,125)	(7,244)
Queen Mary's Sidcup NHS Trust	(2,877)	(1,790)
The Lewisham Hospital NHS Trust	3,771	2,042
Whipps Cross University Hospital NHS Trust	828	(10,467)

Source: Audit Commission

15 Department of Health, *the Quarter*, June 2008.

PART FOUR

Financial Issues for 2008-09

4.1 This part of the report examines the financial issues facing the Department and the NHS in 2008-09 which may affect the financial performance of and financial management within the NHS. These issues include changes to the financial strategy for the NHS, changes to the financial reporting framework and timetable for 2008-09, and further system reforms which will need to be taken into account in the financial management of the service.

Financial strategy for the NHS in 2008-09

4.2 The resources available to the NHS in 2008-09 are £96.2 billion. Total NHS spending is calculated as the revenue budget of £92.5 billion, plus the capital budget of £4.6 billion, less depreciation of £0.9 billion which is netted off to avoid double counting. Capital resources are to be supplemented by planned asset sales of £0.3 billion and planned private capital expenditure of £1.4 billion. Revenue resources have increased by £6.0 billion over 2007-08, with Primary Care Trusts receiving increases of 5.5 per cent in their revenue allocations.

4.3 The Department's intention was that allocations for Primary Care Trusts for 2009-10 and 2010-11 would be finalised in the summer of 2008. However, the Advisory Committee on Resource Allocation (ACRA), an independent committee which advises the Secretary of State on the development of the allocation formula, requested and was granted an extension to its review of the formula. To allow the NHS to plan while ensuring that ACRA had time to finalise its recommendations, the decision was made to announce allocations for 2008-09 only. The funding formula was frozen and all Primary Care Trusts received the same percentage uplift of 5.5 per cent in their 2008-09 allocations. The Department, in its NHS Operating Framework for 2008-09, has said that no Primary Care Trust should feel prevented from entering into three year contracts up to 2010-11 with local partners. The delay does, however, introduce a level of financial uncertainty for Primary Care Trusts, and there is a risk that they might adopt an overly cautious approach to contracting for healthcare in 2009-10 and beyond until allocations are announced. Revenue allocations post 2008-09 were announced in the Operating Framework for 2009-10, as part of the wider planning framework for the NHS.[16]

4.4 Of the total NHS surplus of £1.67 billion in 2007-08, £380 million was generated by NHS Trusts. The remaining £1,294 million surplus was generated by Strategic Health Authorities and Primary Care Trusts. The £1,294 million total figure is made up of ten area surpluses, each corresponding to the surplus generated by a Strategic Health Authority and those Primary Care Trusts within its control. This surplus was added to the 2008-09 funding available for Strategic Health Authorities and Primary Care Trusts.[17] In its NHS Operating Framework for 2008-09, the Department has required each Strategic Health Authority to generate an area surplus in 2008-09 of at least the same level that it had in 2007-08.[18] NHS Trusts are also expected to generate surpluses to recover from legacy deficit positions and to service working capital loans, although the amount of surplus required to achieve this is not specified.

4.5 The strategy gives Strategic Health Authorities more financial freedoms for the management of funds within their areas, such as the determination of any contingency funds to be generated by NHS organisations under their control and any resources to be lodged at the Strategic Health Authority from Primary Care Trust allocations. The

16 Department of Health, *NHS Operating Framework 2009-10*, December 2008.
17 The surplus returned was £1,244 million as it is based on draft accounts and further minor corrections are made to take into account the difference between draft and final accounts from the previous financial year.
18 Department of Health, *the operating framework for the NHS in England 2008-09*, December 2007.

surplus generated in 2007-08 means that the NHS has its entire 2008-09 allocation available to spend, although the requirement for each Strategic Health Authority to generate a surplus of at least the level generated in 2007-08 means that the NHS cannot in addition to its 2008-09 allocations spend the surplus from 2007-08. For an individual organisation to spend some of the carried forward underspend, another organisation within the same Strategic Health Authority area must underspend an equivalent amount from their allocated 2008-09 funding. A surplus can provide flexibility, but needs careful management to avoid the risk that any front-line benefit that could be obtained from those resources is unduly deferred. The Department's financial strategy for 2008-09 of generating a surplus of at least the 2007-08 level means that those surplus funds generated in 2007-08 will not be available for front-line care until at least 2009-10.

Financial Performance of the NHS in 2008-09

4.6 The Department is forecasting that the NHS will report a surplus for the year of £1.73 billion at the end of quarter two 2008-09, almost unchanged from the forecast surplus of £1.75 billion reported at the end of quarter one.[19] This represents a five per cent increase in the surplus compared with the end of the 2007-08 financial year. NHS financial forecasts at the end of the first quarter of a financial year have historically predicted a less favourable financial position than is actually reported at the year end. In 2006-07 a first quarter predicted surplus of £18 million turned into a final surplus of £515 million, and in 2007-08 a first quarter predicted surplus of £983 million became a final surplus of £1.67 billion. NHS financial forecasts have become more accurate over the last year, with forecasts remaining reasonably stable from the second quarter of 2007-08 onwards. If this stability is maintained the surplus will not rise beyond the currently predicted level.

Financial Reporting Issues for 2008-09

Faster delivery of the Department's and the NHS accounts

4.7 The Department of Health faces a significant challenge laying its resource accounts before the parliamentary summer recess. As well as preparing accounts for core departmental activities, it is required to consolidate the results of 10 Strategic Health Authorities, 152 Primary Care Trusts and nine Arm's Length Bodies. As a result, the Department has to date not been able to lay its resource accounts before the summer recess. Its 2007-08 departmental resource accounts were laid on 9 October 2008.

4.8 The Department is making a concerted effort to lay the Resource Account for 2008-09 before the summer recess on 15 July 2009. It has set up steering groups with all relevant parties, including the NHS and auditors, and agreed a project plan and timetable to support the achievement of this goal. NHS bodies will need to ensure they have the arrangements to meet this challenging timetable and that the quality of the draft accounts and working papers submitted to auditors does not suffer because of the reduced closedown period. The Department will need to ensure that its consolidation processes are fit for the purpose of faster delivery, including the challenge arising from the need for the majority of the audits of consolidated bodies to have been completed prior to the resource account being completed and laid. The appointed auditors will work with and support the Department in achievement of this goal to deliver before summer recess in 2009.

International Financial Reporting Standards

4.9 In common with all government departments, the Department of Health will be required to implement International Financial Reporting Standards (IFRS) from 1 April 2009. IFRS will be a technical challenge across the public sector, but the financial implications for the Department and the NHS will also be significant, as the new accounting rules are likely to mean that most infrastructure assets procured under the Private Finance Initiative (PFI) will have to be recognised on NHS balance sheets. This treatment will have implications both for the capital funding of the Department and for the way in which the NHS financial regime operates. The Department has estimated that the financial impact of bringing PFI schemes currently operating, and those under construction, on NHS balance sheets to be £4 billion and £5 billion respectively. The estimated value of schemes notified by the NHS to the Department as being in the pipeline or under procurement is £2.5 billion, down from £7 billion a year ago. The Treasury has confirmed that budgets will be adjusted as necessary to allow the continuation of agreed PFI and public capital programmes.

19 Department of Health, *the Quarter*, November 2008.

Impact of Ongoing Reforms on Financial Management in 2008-09

Increase in the size of the NHS foundation trusts sector

4.10 The Department, in the NHS Next Stage Review final report, has reaffirmed its commitment to NHS foundation trusts and stated that it wishes to accelerate the rate at which existing NHS Trusts achieve NHS foundation trust status.[20] Thirty NHS Trusts achieved foundation trust status during 2007-08, taking the number of NHS foundation trusts to 89 at 31 March 2008. A further 23 have been successful in the first eight months of 2008-09, meaning that there are 112 NHS foundations trusts at 1 December 2008. As at 31 March 2008 there were 178 NHS Trusts, of which all but those where continued Secretary of State oversight is required, for example those with high security facilities, will be expected to attain foundation status in the future.

4.11 Monitor reports that the pass rate for successful first time applications for foundation status in 2007-08 was 61 per cent, down from 65 per cent the previous year. One of the reasons for unsuccessful applications highlighted by Monitor is the failure to demonstrate effective financial reporting to, and oversight by, the board.[21] Strong financial management is therefore important for those NHS Trusts making applications for foundation status to meet the requirements for successful applications set by Monitor. The best prepared NHS Trusts have already attained foundation status, and it may be harder for the remaining NHS Trusts to meet the criteria set down by Monitor. Strategic Health Authorities can also play an important role in ensuring that their NHS Trusts address any financial weaknesses which may threaten a future successful application.

Primary Care Trusts

4.12 The NHS Operating Framework for 2008-09 required all Primary Care Trusts to review their requirements for community services and use this process to consider all the options for models of provision. Whilst doing this, Primary Care Trusts were asked to separate that part of the organisation which provides care from the part which purchases care from other providers. Service level agreements should be set up with these provider arms under the same business and financial rules as for other providers.

4.13 Six Primary Care Trust schemes are involved in a pilot project to explore the feasibility of the NHS foundation trusts option for community services. As part of this project, they have separated their Primary Care Trust provider function from the rest of the Primary Care Trust to create autonomous provider organisations, (APOs). This is in order to have evidence of at least twelve months autonomous operation before submitting an application to the Department of Health and Monitor. The six APOs are Ashton, Leigh and Wigan Community Healthcare, Cambridgeshire Community Services, Liverpool Primary Care Trust, Middlesbrough, Redcar and Cleveland Community Services, Oldham Community Health Services, and South Birmingham Provider Organisation. These organisations would operate as stand-alone organisations which could potentially apply for foundation trust status. In its annual report for 2007-08, Monitor states that it expects the first assessments on these bodies in 2009-10 with the first community foundation trusts authorised in 2010. Other options for provider arms include remaining within the Primary Care Trust with the appropriate arrangements in place, the social enterprise model and integration with other services or organisations.

4.14 The financial management and governance implications of the community foundation model are wide ranging. Primary Care Trusts and their APOs will need to disaggregate the financial statements and will need to establish separate governance arrangements in order for the APOs to provide the evidence required by the Department of Health and Monitor that it has operated autonomously for at least twelve months. The numbers of Primary Care Trusts were halved as a result of Commissioning a Patient-led NHS, and the Department will need to ensure that it does not just double the number of NHS organisations and thereby increase management and running costs.

NHS Performance regime

4.15 The Department published *Developing the NHS Performance Regime* in June 2008.[22] This report was produced partly as a result of the Healthcare Commission report[23] into the running of Maidstone and Tunbridge Wells NHS Trust. It reflected a perceived need for a more systematic and transparent approach to managing performance across the NHS (excluding NHS foundation trusts which are outside of the scope of this regime, but subject to Monitor's compliance framework). The new regime sets out the role of providers in maintaining

20 Department of Health, *the NHS Next Stage Review*, June 2008.
21 Monitor, *Annual Report and Accounts 2007-08*, July 2008.
22 Department of Health, *Developing the NHS Performance Regime*, June 2008.
23 Healthcare Commission, *Investigation into outbreaks of Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust, October 2007.

standards and driving quality improvements in service delivery, and the role of Primary Care Trusts as commissioners in holding providers to account for service delivery through contracts. Primary Care Trusts and Strategic Health Authorities together have a role as 'system managers' in supporting recovery.

4.16 The regime introduces the concept of challenged organisations. The NHS Chief Executive will publicly designate organisations as challenged and subject them to intervention at board level. A Primary Care Trust or NHS Trust will be designated as challenged where it fails to address underperformance within a defined period (likely to be nine months). Underperformance is not defined explicitly but the example given is that of Primary Care Trusts or NHS Trusts rated as weak on Quality of Care and Use of Resources by the Healthcare Commission in their Annual Health Check.

4.17 NHS organisations with poor financial management are therefore at risk of direct intervention by the Department, should they trigger one of the criteria in the performance regime. In respect of Primary Care Trusts, intervention might include replacement of the board, outsourcing some or all of its functions, or takeover by another Primary Care Trust. NHS Trusts could face closure or asset disposal, outsourcing of services of management, or acquisition by another NHS organisation.

System reforms

4.18 In June 2008, the final report *High Quality Care for All*, the NHS Next Stage Review final report by Lord Darzi was published.[24] This report announces a change of emphasis for the NHS. For the last ten years, the NHS has prioritised capacity building and focused on increasing the quantity of care delivered, and it has been given the necessary resources to do so. The NHS Next Stage Review focuses on quality of care. Quality is defined in the Review as clinically effective, personal and safe, with an emphasis on patient choice and renewed focus on prevention of ill-health.

4.19 The Review introduces a significant change to the financial regime. In future, a quality element will be introduced into how NHS organisations are funded, moving away from the current system which is based purely on quantity. Payments will be according to tariffs based on best practice rather than the current average cost basis. NHS organisations will also have to produce 'quality accounts' as well as their financial accounts.

4.20 The Review recommendations will also need to be implemented alongside the continued implementation of existing system reforms. The way that Payment by Results is operated will need to be reformed to include a quality element in the amounts that providers receive for performing healthcare. Practice-based Commissioning, which seeks to improve the way that GPs in particular commission healthcare by helping them to understand the financial consequences of decisions, will also be affected by the switch of emphasis to quality.

4.21 The changes to the financial regime arising from these reforms are not yet clear, which introduces a level of uncertainty into the financial plans of NHS organisations. Sound financial management will be key to meeting these challenges.

24 Department of Health, *NHS Next Stage Review*, June 2008.

APPENDIX ONE

Audit of the NHS 2007-08

Results of the Audits 2007-08

1 The Comptroller and Auditor General is the statutory external auditor of the summarised accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. The Audit Commission, or its appointed auditors, are the external auditors of the individual accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts. Under the Audit Commission's *Code of Audit Practice*[25], auditors are required to give an opinion on whether the NHS body's annual accounts are true and fair and to provide a conclusion on the arrangements that the NHS body has established for securing economy, efficiency and effectiveness in the use of resources, known as the Value for Money (VFM) conclusion. For Strategic Health Authorities and Primary Care Trusts auditors are also required to give a regularity opinion, which confirms that the expenditure and income of the body have been applied to the purposes intended by Parliament. NHS Trusts do not currently receive a regularity opinion. Results of the audits are given in figure **Box 3**.

Value for Money conclusions for 2007-08

2 The Value for Money (VFM) conclusion is based on the auditor's assessment of an NHS organisation against 12 criteria specified by the Audit Commission. Auditors apply a yes/no assessment to these criteria. If the assessment against each of the criteria is yes, auditors will give an unqualified VFM conclusion. If the assessment against any of the 12 is no, auditors give a qualified VFM conclusion. This qualified conclusion can be either an 'except for' conclusion, where there are some 'no' assessments but the overall arrangements are not in doubt; or an 'adverse' conclusion where the auditor considers that the criteria with assessments of 'no' give rise to doubts around the overall arrangements.

3 In 2007-08 auditors qualified the VFM conclusions of 46 (14 per cent) NHS bodies. This was a significant improvement in performance over 2006-07 when there were 147 VFM qualifications, representing 43 per cent. 10 per cent of NHS bodies had 'except for' VFM conclusion qualifications (31 per cent in 2006-07) and four per cent of NHS bodies had an adverse VFM conclusion (12 per cent in 2006-07).

4 The two most common criteria assessed as not being achieved were that the body has put in place a medium-term financial strategy, budgets and a capital programme that are soundly based and designed to deliver its strategic priorities; and that the body has put in place arrangements for the management of its asset base.

BOX 3

Results of the audits of the NHS 2007-08

The Comptroller and Auditor General issued an unqualified opinion on the summarised accounts of Strategic Health Authorities, Primary Care Trusts and NHS Trusts.

Auditors did not qualify their opinions on the grounds of truth and fairness at any Strategic Health Authority, Primary Care Trust or NHS Trust in 2007-08. This was also the case in 2006-07 and 2005-06.

In 2007-08, auditors qualified their regularity opinions at six Primary Care Trusts (four per cent). Of the six qualifications, four were for breach of revenue resource limits and two were for making irregular prepayments (these prepayments required the Primary Care Trust to draw down cash from the Department of Health in advance of need, which is only permitted where there is a value for money business case). This is an improvement on the 43 Primary Care Trusts (28 per cent) in 2006-07. In 2007-08 auditors did not qualify the regularity opinion of any Strategic Health Authority.

Source: National Audit Office and Audit Commission

25 Audit Commission, *Code of Audit Practice*, 2005.

Public Reporting

5 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 (public interest reports); and
- Section 19 requires the auditor to refer matters to the Secretary of State if he or she has a reason to believe that an organisation has made a decision that involves, or may involve, unlawful expenditure.

Public Interest Reports

6 In 2007-08 auditors issued four public interest reports to NHS bodies (11 in 2006-07). All of these reports were in respect of the poor financial standing of the bodies involved. In 2006-07, nine of out of 11 reports were in respect of the poor financial standing of the bodies involved. Of the remaining two public interest reports, one was in respect of a failure in corporate governance and poor financial standing, and the other was in respect of routine alterations made to ambulance response times. To date, in 2008-09 one public interest report has been issued by auditors **(Figure 20)**, in respect of weaknesses in procurement.

Section 19 referrals

7 Auditors issued 18 reports under Section 19 relating to 2007-08 performance (57 in 2006-07). Twelve were issued on NHS Trusts and were in respect of the trusts failing in their 2007-08 duty to break even taking one year with another. Six were issued on Primary Care Trusts. Four of the six were due to failures to achieve the 2007-08 Revenue Resource Limit. The remaining two were issued in respect of incorrect authorisations of special severance payments and unauthorised payments to a third party.

20 Public Interest Reports issued since 31 March 2007

Public interest reports issued in 2007-08 and to date in 2008-09

NHS organisation	Subject matter
2007-08	
Kingston Primary Care Trust	Poor financial standing
North Lincolnshire Primary Care Trust	Poor financial standing
Yorkshire Wolds and Coast Primary Care Trust	Poor financial standing
Hinchingbrooke Health Care NHS Trust	Poor financial standing
2008-09	
Whipps Cross University Hospitals NHS Trust	Weaknesses in procurement

Source: Audit Commission

Auditors' Local Evaluation

8 The Audit Commission's Auditors' Local Evaluation (ALE) assesses how well NHS Trusts and Primary Care Trusts manage and secure value for money from their financial resources. It stems from the auditors' statutory duty to satisfy themselves that NHS bodies have proper arrangements for securing economy, efficiency and effectiveness (value for money). ALE scores draw on auditors' work throughout the year. Auditors follow an agreed process to reach scored judgements that:

- drive improvement by giving clear messages about adequate, good and excellent performance;
- enable comparisons to be made between audited bodies; and
- seek to identify and share good practice on a timely basis.

Background to Auditors' Local Evaluation (ALE)

9 The ALE process requires auditors to reach scored judgements for five key themes: financial reporting, financial management, financial standing, internal control and value for money. These 5 themes are underpinned by 13 key lines of enquiry (KLOEs) or high level questions, which are in turn supported by detailed audit criteria that describe adequate, good and excellent performance.

10 The scores arrived at for each of the themes are used by the Audit Commission to calculate an overall score which forms the Use of Resources (UoR) part of the Healthcare Commission's Annual Health Check for NHS Trusts and Primary Care Trusts. The UoR score sits alongside the quality of services assessment in the Annual Health Check. Monitor provides the Use of Resources score for NHS foundation trusts.

11 The scores for each of the five key themes are calculated based on the average of the scores for the KLOEs within that key theme. The score given ranges from level 1, inadequate performance, to level 4 which indicates that the body is performing strongly. The overall ALE / UoR score is determined by the Audit Commission based on the scores awarded for the five themes **(Figure 21 overleaf)**.

21 Rules for determining scores for the ALE themes and the overall score

ALE scoring scale for the five key themes

Score/level	Description
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.

Rules for determining the overall ALE/Use of Resources score

Score	Rules
1	If the score of any of financial management, financial standing or value for money is 1.
2	Financial management, financial standing and value for money must each score at least 2.
3	No score below 2. Financial management, financial standing and value for money must each score at least 3.
4	No score below 3. At least two of the scores for financial management, financial standing and value for money must be 4.

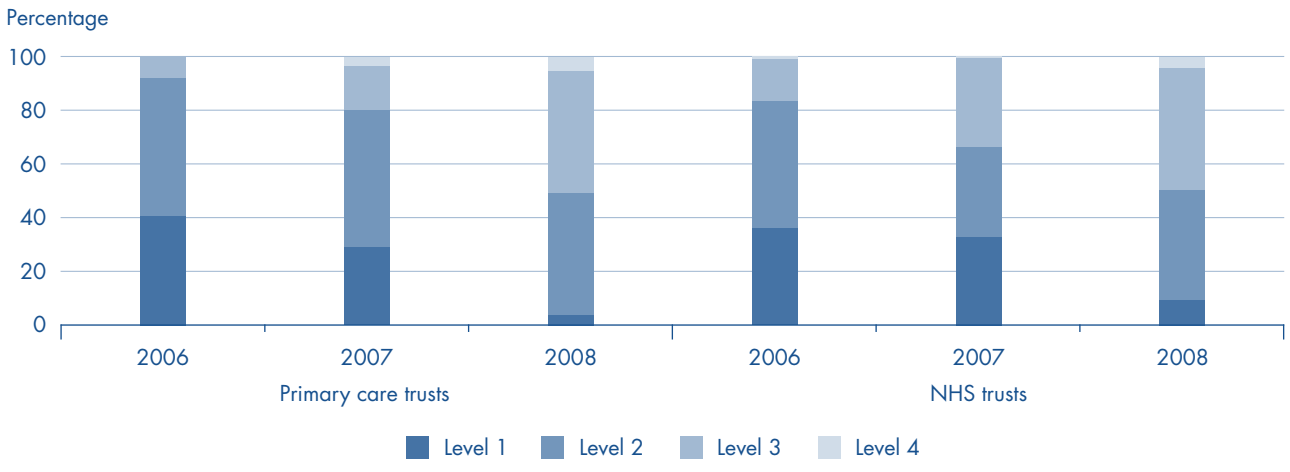
Source: Audit Commission

Summary of Auditors' Local Evaluation Findings

12 ALE was introduced in 2005-06 and this is the third year of results. The overall picture is one of significant improvement over the three years assessed. Performance has improved strongly in 2007-08 and this success can be attributed primarily to the return to financial balance of all but a small minority of NHS organisations. Ninety-three per cent (282) of NHS organisations assessed met or exceeded minimum standards for their overall use of resources. Fifty per cent (151) of NHS organisations were assessed to be performing well or strongly in their use of resources. Only 7 per cent (20) of NHS organisations failed to meet the minimum standards **(Figure 22)**.

13 The reasons for failure were a combination of inadequate financial standing and financial management arrangements. Performance varied across England. The NHS organisations in North West Strategic Health Authority achieved the highest average score overall. The average overall score of NHS organisations in Yorkshire and the Humber Strategic Health Authority was lowest. NHS London has the highest proportion of NHS organisations performing strongly but the also has the highest proportion failing to achieve minimum standards. Use of resources scores for individual NHS organisations were published by the Audit Commission in October 2008.[26]

22 Overall Use of Resources scores 2005-06 to 2007-08



Source: Audit Commission

NOTE

Detailed information on the Auditors' Local Evaluation in given in Appendix 1. Level 1 represents inadequate performance. Level 2 is adequate performance, with Level 3 performing well and Level 4 performing strongly.

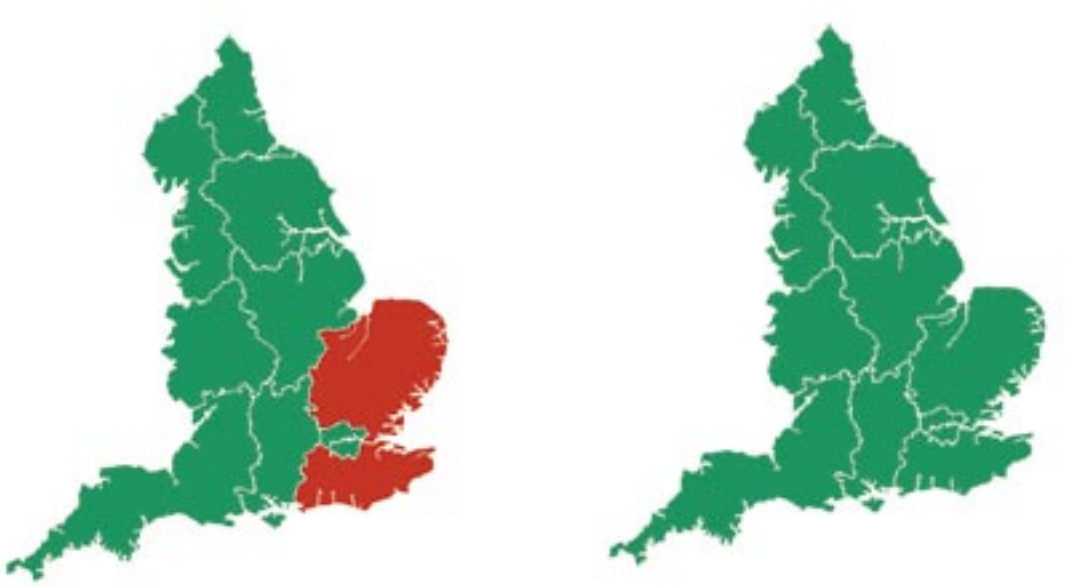
26 Audit Commission, *Auditors' Local Evaluation 2007-08 Summary results for NHS trusts and primary care trusts*, October 2008.

APPENDIX TWO

Detailed Financial Performance of the NHS 2007-08

Financial Performance of Strategic Health Authorities 2006-07 and 2007-08

2006-07 **2007-08**



Financial Performance of Primary Care Trusts 2006-07 and 2007-08

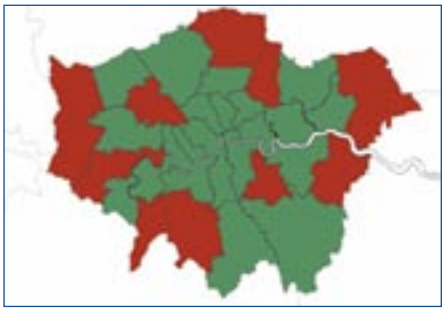
2006-07

2007-08

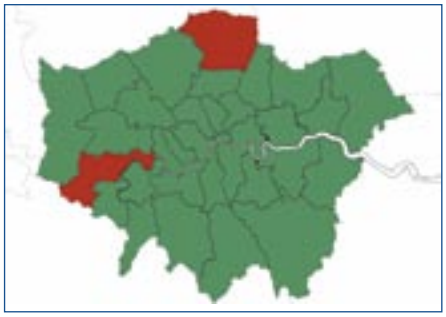
Surplus or breakeven

Deficit

London



London



Primary Care Trusts in 2007-08 reporting underspends over £10 million and all overspends

Primary Care Trusts	Underspend £000	Primary Care Trusts	(Overspend) £000
Barking and Dagenham	20,753	North Yorkshire and York	(18,226)
South West Essex	19,351	Enfield	(13,308)
Redbridge	18,664	Buckinghamshire	(11,574)
Wolverhampton City	13,833	Hounslow	(1,940)
Westminster	11,875		
Liverpool	10,644		

Financial Performance of NHS Trusts 2006-07 and 2007-08

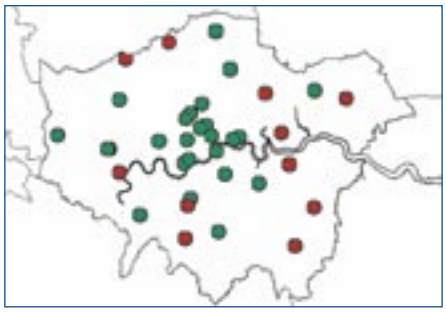
2006-07

2007-08

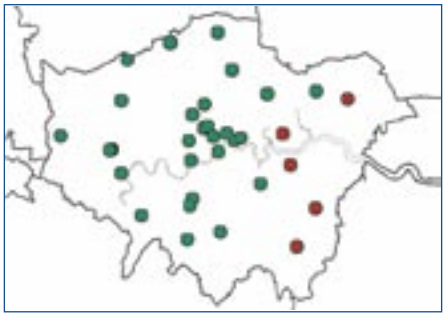
Surplus or breakeven

Deficit

London



London



NHS Trusts in 2007-08 reporting surpluses in excess of £10 million and all deficits

NHS Trusts	Surplus £000
Southampton University Hospitals	17,944
South Tees Hospitals	17,280
Barts and the London	16,416
United Bristol Healthcare	12,809
Imperial College Healthcare	12,750
Plymouth Hospitals	12,698
United Lincolnshire Hospitals	12,488
Royal Free Hampstead	10,724
Dudley Group of Hospitals	10,524
The Royal West Sussex	10,466
East London NHS FT	10,428
North Tees and Hartlepool	10,061

NHS Trusts	(Deficit) £000
Barking, Havering and Redbridge Hospitals	(35,621)
Bromley Hospitals	(17,920)
Hinchingbrooke Healthcare	(16,037)
Queen Elizabeth Hospital	(3,125)
Queen Mary's Sidcup	(2,877)
Newham University Hospital	(2,269)
Hertfordshire Partnership	(1,522)

NOTE

East London, and North Tees and Hartlepool became NHS foundation trusts during the year. The results shown are from 1 April 2007 to the date of conversion to foundation status.

GLOSSARY

Accountable Officer	In Strategic Health Authorities, Primary Care Trusts and NHS Trusts, the person accountable to Parliament through the NHS Chief Executive for the stewardship of the resources within the control of the Trust. The Accountable Officer has personal responsibility for signing the accounts, and is usually the most senior person in the organisation.
Accounting Officer	In Central Government and NHS foundation trusts, the person who may be called directly to account in Parliament for the stewardship of the resources within the control of the organisation of which they are appointed is the Accounting Officer. The Accounting Officer has personal responsibility for signing the accounts, and is usually the most senior person in the organisation.
Annual Health Check	A comprehensive assessment and rating of the performance of each NHS Trust in England, covering a wide range of areas from quality of care to how well Trusts manage their finances, undertaken by the Healthcare Commission.
Autonomous Provider Organisation (APO)	NHS organisations providing primary community care services, created out of existing Primary Care Trust activities.
Arm's Length Bodies	Organisations overseen by the Department but who operate at arm's length, with accountability direct to Parliament.
Auditors' Local Evaluation (ALE)	A framework used by the Audit Commission's appointed auditors to assess NHS bodies' performance on five key areas. ALE scores form the 'Use of Resources' component of the Healthcare Commission's Annual Health Check.
Better Care, Better Value productivity metrics	A set of productivity metrics based around 15 high-level indicators of efficiency that identify potential areas for improvement in efficiency. These indicators can be used locally to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care and to generate ideas on how to achieve these savings. The indicators are primarily aimed at commissioners and acute hospital providers.
Cash limit	A body's approved limit on cash for a given year. Known as the external financing limit for NHS Trusts.
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 were reduced and the main function of Primary Care Trusts changed from providers to commissioners of healthcare services. The aim was to move from an NHS service that does things to and for its patients to one that is patient-led.

Comprehensive Spending Review (CSR)	The process where budgets for government departments are set for a three year cycle.
EBITDA	Earnings before interest, tax, depreciation and amortisation. This is a measure of financial performance, expressed as a percentage margin, which excludes the financial impact of financing and asset changes, and is used by Monitor as a proxy for the operating efficiency of NHS foundation trusts.
Elective admission	A planned, non-emergency admission.
Healthcare Commission	A Non-Departmental Public Body which reports directly to Parliament on the state of healthcare in England and Wales.
International Financial Reporting Standards (IFRS)	A set of principles based accounting standards for entities to use in preparing their accounts. The public sector is required to adopt these standards from 1 April 2009.
Key Lines of Enquiry (KLOE)	High level questions, each supported by detailed audit criteria, used by the Audit Commission as part of the Auditors' Local Evaluation.
Monitor	The Independent Regulator of NHS Foundation Trusts, responsible for authorising, monitoring and regulating NHS foundation trusts. It is independent of the Department of Health and accountable to Parliament.
MPET	The Multi Professional Education and Training Budget, controlled by Strategic Health Authorities and used to provide workforce training and development for all NHS staff.
NHS Foundation Trusts	NHS foundation trusts 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.
NHS Next Stage Review	A review of the way NHS delivers patient care, led by Lord Darzi.
NHS programme funds	Resources for specific central NHS programmes such as workforce training and education. These funds are not allocated to individual Primary Care Trusts, but retained and allocated by Strategic Health Authorities.
NHS Trusts	Organisations responsible for running hospitals and providing secondary healthcare. There are several types, includes Acute Trusts (general hospitals), Mental Health and Learning Disability Trusts, Ambulance Trusts (provide emergency vehicles), Care Trusts (provide both NHS delivered and local authority delivered care).
NHS Summarised Accounts	Accounts showing the consolidated financial performance of NHS organisations. There are three sets of accounts, showing the consolidated performance of Strategic Health Authorities, Primary Care Trusts and NHS Trusts respectively.
Non-elective admission	An unplanned hospital admission (i.e. emergency or urgent), not previously arranged.

Payment by Results (PBR)	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 (PBC)	A system whereby individual or groups of general practices directly commission healthcare using their own budgets. Primary Care Trusts oversee this process.
Private Finance Initiative (PFI)	A policy introduced by the Government in 1992 to harness private sector management and expertise in the delivery of public services, while reducing the impact of public borrowing.
Primary Care	Front-line services delivered by for example GPs and dentists. Often the first point of contact with the NHS for a patient.
Primary Care Trusts	The bodies responsible for assessing the need for healthcare provision, planning and commissioning health services and improving health.
Productivity	The relationship between production of an output and one, some, or all of the resource inputs used in accomplishing the assigned task. It is measured as a ratio of output per unit of input.
Regularity	A fundamental requirement that resources granted by Parliament may only be used for their authorised purpose, within the revenue, capital and cash limits agreed. '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.
Revenue limit	A body's approved limit on revenue expenditure for a given year, applicable to both Strategic Health Authorities and Primary Care Trusts.
Secondary Care	Can be elective (planned) or non-elective (emergency) and often in delivered in hospitals. Usually follows referral from a primary care health professional.
Statutory duty	A duty set out in the relevant legislation.
Strategic Health Authorities	The bodies responsible for performance-managing the Primary Care Trusts and NHS Trusts within their area.
Strategic Health Authority areas or economies	The aggregate of the Primary Care Trusts and NHS Trusts within a Strategic Health Authority's geographical catchment area, including the Strategic Health Authority itself.
Total available resources	The total funding available to the NHS in any financial year.
Top-slicing	The process whereby a proportion of funds included in Primary Care Trust allocations are withheld by the Strategic Health Authority.
True and fair	The audit opinion which confirms that the accounts are free from material error and material bias.

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