Achieving first-class financial management in the NHS

A sound basis for better healthcare
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As an independent watchdog, we provide important information on the quality of public services. As a driving force for improvement in those services, we provide practical recommendations and spread best practice. As an independent auditor, we monitor spending to ensure public services are good value for money.

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Introduction

Why has this report been written?

This report is being published by the Audit Commission now because we believe that financial management in the NHS needs to improve significantly over the coming years in order for the benefits of current and extra funding to be realised fully and to address the challenges ahead.

Although effective financial management has always been important in the NHS, it has never been more important than now. This is because the scale and complexity of the challenges faced by NHS bodies are unprecedented. Along with significant increases in NHS funding comes a demand for reform and modernisation aimed at transforming services for patients – not just providing more of the same. So, as well as delivering day to day, NHS organisations must also deliver a huge programme of change.

Sound financial management is a fundamental building block of successful, high-quality health services. This is because in the NHS, financial management is not just about recording and monitoring expenditure, but about planning to meet new challenges, knowing how money is being spent, whether it is giving good value and how extra investment can best be used to improve services (including redesigning them and providing new ones), and meeting needs most appropriately. Where this is done well, organisations can focus on the quality of and improvements in service delivery; where it is done badly, services are provided in an atmosphere of crisis and retrenchment that undermines day-to-day quality and inhibits change and development.

Getting the basics right is crucial. Effective decision-making processes supported by robust planning, budget setting and monitoring clearly all go towards providing a strong platform from which to work. Despite this, many NHS organisations could do more to provide this platform and some struggle to achieve it. This report therefore sets out what constitutes good financial management, reviews its current state in the NHS, giving examples of good and bad practice from around the country, and identifies the challenges to come.
In the future, good housekeeping will not be sufficient. Increasing plurality of provision, changing financial flows and new forms of contracting will change radically the demands on NHS chief executives, finance directors and others involved in planning and delivering services. It will strengthen the requirement to know how money is being spent and what improvement extra investment will bring. The systems, structures and skills needed to succeed in this environment will look very different from those we have been used to in the past. Even NHS organisations whose financial and performance management is regarded as strong today cannot afford to stand still; and those finding it difficult now will struggle to progress in the future.

This report lays down a challenge to the NHS (and to ourselves as regulators) to set and reach standards against the demands of the future rather than of the present. Making the necessary progress will not be easy, nor will it be achieved overnight. This report does not claim to provide all the answers. But by identifying the challenges ahead it will help set an agenda and in doing so provide the first step towards achieving major advances in the quality, consistency and sophistication of financial management in the NHS for the long-term good of patients and taxpayers.

For whom has it been written?
This report has been written primarily for chief executives, directors of finance and other board members to help them raise the profile of financial management across their organisations. It will also be of interest to any NHS staff that have responsibility for financial management.

How should it be used?
NHS bodies should use this report to review their existing approaches to financial management and to inform their discussions about the nature and shape of financial management in the rapidly changing NHS. The report sets out the financial management skills that NHS bodies need to be developing to meet the rapidly changing world of healthcare.

Research behind this report
This report is based on field visits to ten NHS bodies (including strategic health authorities (SHAs), primary care trusts (PCTs) and NHS trusts). The Commission is grateful to everybody who participated in the field visits, not only for the examples they provided of current practice, but also for their insights.

The report draws on an analysis of NHS audited accounts for 2002/03 and information gathered from a questionnaire that auditors are required to complete for every NHS audited body.
Audit reports, annual audit letters and public interest reports have been reviewed for details of financial management activities, both good and bad.

An advisory group commented on the initial specification for the project and reviewed the findings of the study (Appendix 1). The Audit Commission gratefully acknowledges this assistance. Responsibility for the contents of this report, however, rests solely with the Audit Commission.

Report structure

Chapter 1 – What is good financial management?
Chapter 2 – The current state of NHS financial management
Chapter 3 – Improving financial management
Chapter 4 – NHS financial management in the future
Chapter 5 – The Audit Commission's financial management agenda in the NHS
What is good financial management?

Introduction

1 Financial management is the term used to encompass all the activities within an organisation that are concerned with the use of resources and that have a financial impact. The Chartered Institute of Public Finance and Accountancy (CIPFA) has defined financial management for public bodies as follows (Ref. 1):

> Financial management is the system by which the financial aspects of a public body’s business are directed and controlled to support the delivery of the organisation’s goals.

This definition is based on the one used in the 1992 Cadbury Report (Ref. 2), the key aspect being that financial management should support the achievement of the organisation’s aims and objectives.

2 Financial management is central to an organisation’s decision-making process and as such it is an essential part of the overall performance management of an organisation. The financial management processes within NHS bodies provide information that is used to:

- direct the activities of the organisation;
- control the activities of the organisation;
- report and discharge accountability; and
- utilise resources efficiently and effectively.

3 In short, it is a core part of management and a fundamental success factor in achieving organisational objectives (Exhibit 1).
Exhibit 1
The role of financial management with an NHS body

Financial management plays a key role in supporting the delivery of organisational objectives.

What is good financial management?

Good financial management arrangements are essential if NHS bodies are to meet their objectives and deliver effective healthcare to patients. There are some clear characteristics of good financial management arrangements, which are set out in Box A. Such arrangements provide information that enables organisations to be properly directed and controlled. They enable organisations to demonstrate how well money is being spent and then report it appropriately. Organisations that have good financial management processes will be better able to redesign and improve services. They will be able to predict the improvement in quality and quantity of services which extra spending will bring and be able to track the results accordingly. They will be in a position to get better services from existing levels of spending. Having good financial management arrangements should also help managers to identify where things are going wrong and to respond to them in both the short and the medium term.

Note: * Denotes a dimension in the CIPFA model (paras 7-10).

Source: Audit Commission
Box A
Characteristics of good financial management

Financial planning
- Service and financial planning are integrated.
- Expenditure is tracked to services and outputs or outcomes.
- Spending decisions are underpinned by analysis of service or population need.
- Various options for achieving the most cost-effective service outcome are considered.
- The costs of in-year developments or pressures such as National Institute for Clinical Excellence (NICE) guidance are accurately forecast and planned for.
- New service developments are accurately costed.
- The organisation responds to changes in demand and targets resources to areas of need.
- Financial data and management information supports good strategic decision-making and performance management.
- Medium-term financial plans are produced.

Budget setting
- Budgets are set in accordance with the aims and objectives of the organisation.
- Budgets are accurately profiled.

Budget reporting and monitoring
- Budget monitoring reports are timely and accurate.
- Financial forecasts are consistent with the year-end position.
- Budgetholders are held accountable for managing their budgets.
- Variances from budget are identified and investigated, and proper corrective action is taken on a timely basis.
- Service delivery staff are given appropriate financial training to help them to understand budgets and monitoring reports.
- All budgetholders are aware of the effect their decisions have on the financial position of the body.

Financial control
- The organisation has an effective framework of internal financial control.
- Key business risks are identified and managed.

Treasury management
- Treasury management functions are accurate, timely and efficient.
- The requirements of the Better Payment Practice Code are complied with.
Board reporting

- The board receives regular and accurate accruals-based financial information including the risks to the financial position and how they are being managed.
- The board receives regular and accurate balance sheets.
- Cost improvements are identified as part of budget setting and performance against them is reported to the board.
- Investment in service improvements is tracked and performance against planned outputs/outcomes is reported to the board.
- There is a direct link between service delivery – activity and quality developments – and financial reporting.

Financial reporting

- Statutory and other financial duties are performed.
- External audit reports are free from concerns about the quality and timeliness of final accounts and supporting working papers.
- The same systems and processes are used to produce both the management accounts and the financial accounts.

General

- All finance positions are filled by appropriately trained staff.
- Managers, clinicians and budgetholders are provided with information about how well service policies and priorities are being delivered.
- Financial management arrangements are regularly reviewed to ensure ‘fitness for purpose’.
- The organisation identifies future developments that will impact on financial management, including the wider health agenda (for example, patient choice and payment by results) and proactively manages them.
- Developing capacity to identify opportunities and threats to good financial management in a rapidly changing environment.

Source: Audit Commission

5 The Department of Health (DH) has defined what it considers to be the key elements of financial management in the NHS in its financial management standard. The standard includes twelve criteria that NHS bodies are required to meet and is discussed in more detail later in this paper (page 33, Box C).

6 There are many stakeholders in financial management in the NHS (Exhibit 2). In order to fulfil the changing expectations of stakeholders and to remain ‘fit for purpose’, the financial management arrangements within an organisation must be continually reviewed and improved.
Exhibit 2
Financial management stakeholders

There are many stakeholders in financial management in the NHS.

7 There is a considerable amount of work under way in this area. CIPFA is working on a model of financial management in the public services (due to be published in May 2004), which will help organisations to identify how well they perform. CIPFA’s model recognises that high-performing organisations consistently demonstrate strengths in leadership, financial management and in managing performance. The model sets out what is good practice and organisations can test themselves against the model. The model is structured around three styles of financial management:

- **securing stewardship** – this is about getting the basics right and having an emphasis on control, probity and meeting regulatory requirements;
- **supporting performance** – this is about being responsive to customers, being efficient and effective and having a commitment to improving performance; and
- **enabling transformation** – this is about being strategic and customer-led, future-orientated, proactive in managing change and risk, outcome-focused and receptive to new ideas.

Source: Audit Commission
The model is organised by four organisational dimensions:

- **leadership** – which focuses on strategic direction and business management and the impact on financial management of the vision and involvement of the board and senior managers;
- **people** – which includes both the competencies and the engagement of staff;
- **processes** – which examines the organisation’s ability to design, manage, control and improve its financial processes to support its policy and strategy; and
- **stakeholders** – which deals with the relationships between the organisation and those with an interest in its financial health, whether government, inspectors, taxpayers, suppliers, customers or partners.

The model poses a number of questions covering all three styles and four organisational dimensions. The Audit Commission has been involved in developing the model and recommends that NHS bodies use it to assess how good their financial management arrangements are and to highlight areas for improvement.

**Who is responsible for financial management?**

While the majority of the financial management activities might take place within an organisation’s finance department, financial management is not the sole responsibility of finance staff. It must be recognised that while an effective finance department is essential for the delivery of good financial management, it is not a sufficient factor on its own. The board has a key role in overseeing the financial management activities within the organisation and ensuring that spending decisions are sound and will secure the expected improvements in services, as well as ensuring that financial balance is achieved. In undertaking these functions board members will be guided by the chief executive and the director of finance.

In all NHS bodies the chief executive is the accountable officer and is ultimately responsible for the finances of the organisation and answerable to the Permanent Secretary/Chief Executive of the NHS. The director of finance also has a special role in relation to financial management, and has a responsibility to ensure that sound practices and procedures are in place. In addition to the chief executive and finance director, any members of staff who are responsible for planning, managing services and budgets, ordering stock, authorising expenditure (for example, booking temporary staff) or consuming resources (for example, clinicians) have a role in the financial management process.
The current state of NHS financial management

Financial management arrangements in the NHS need to improve to ensure that the benefits of current and extra funding are realised fully in improved service delivery. While many NHS bodies are good at the basics of financial management, auditors have reported a number of concerns about the overall quality of financial management, specifically:

- the view that exists in some NHS bodies that central government targets are in direct competition with the achievement of financial balance. In particular there is insufficient prioritisation of funding to support organisational aims and objectives;
- the lack of focus on financial management issues during periods of restructuring;
- the re-allocation of funding around a health economy can mask underlying financial problems within an individual body and undermines sound financial management;
- the lack of financial management capacity, particularly at PCTs;
- underdeveloped integration of financial and service planning and NHS bodies’ inability to direct resources to service priorities;
- the reduction in quality of financial management information as a result of the introduction of financial shared service organisations;
- an overall lack of financial management capacity, for example, a lack of awareness among service managers of the financial implications of their actions;
- the cost improvement programme (CIP) being identified from non-recurring sources, which stores up problems for future years;
- insufficient funding being blamed for failure to achieve financial balance;
- the increase in the number of bodies that incurred deficits in 2002/03 and inaccurate forecasting of the year-end position throughout the year; and
- poor-quality accounts and supporting working papers, frequently not produced by the required deadline.

The challenges ahead mean that financial management is going to become much more important in the future. NHS bodies need to ensure that their current financial management arrangements are improved and that they have sufficiently skilled staff and appropriate systems to enable them to tackle the future challenges.
Current financial management challenges

Financial management in the NHS is at the heart of a series of complex, dynamic relationships which NHS managers have to manage if they are to deliver high-quality services to patients and other service-users.

A number of factors influence financial management within the NHS. Some are within the control of individual NHS bodies, some are not. Some are issues that affect NHS bodies now, others will affect them more strongly in the future (Exhibit 3). Information on the qualitative aspects of financial management has been gathered from auditors’ views on the 2002/03 audits.

Exhibit 3
Financial management challenges for NHS bodies
NHS bodies currently face a range of financial management challenges, and the number and complexity of the challenges will increase in the future.

Central government targets in the NHS
As well as the range of financial targets discussed below, NHS bodies are also required to meet a number of other service access targets set by the DH. These targets are wide-ranging, reflect the requirements of the NHS Plan and other initiatives and are aimed to ensure that high-quality health services are provided throughout the NHS. Different objectives are interlinked and meeting one objective may affect performance in another.
This means that NHS bodies have to evaluate the range of options open to them to achieve targets and ensure that there are sufficient resources available to fund the option selected. How NHS bodies go about dealing with this difficult issue is crucial. Some NHS bodies seek to make a trade-off between the achievement of operational targets and financial balance. However, those bodies that have good financial management arrangements recognise that the achievement of financial balance is not something that can be compromised. Financial balance is the context in which NHS bodies must operate and is not an option!

Different approaches to meeting targets can mean that the NHS body does not make best use of the resources available. Sometimes additional funding is received from the DH late in the financial year and as NHS bodies are unable to carry forward funds from one year to the next they are under pressure to use the funds in the year they are allocated. Where this happens the additional money might not be spent in the most economic and efficient way, and costs per patient or per treatment are higher than if these funds had been allocated earlier in the year because of the higher cost of additional staff and evening and weekend working. Equally, if there are ‘spot’ purchases of treatment from the private sector these will invariably be at a higher price than if provided by the NHS. NHS bodies must also recognise that any change to planned activity levels will have an effect on the financial position.

**Structural reorganisation**

One significant factor affecting financial management in the NHS in recent years has been the level of structural reorganisation that has taken place. Most of this change has been as a result of the Health Act 1999 and the NHS Reform and Health Care Professions Act 2002 (which implemented the proposals contained in the paper Shifting the Balance of Power, Ref. 3). In aggregate these Acts have resulted in 413 new bodies being created. Most NHS bodies have experienced some sort of structural reorganisation since 1997. These reorganisations have had implications for financial management:

- there has been a lack of focus on financial management issues – senior management attention has been diverted as they concentrate on managing the reorganisation and ‘eyes have been taken off the financial ball’;
- there is a lack of financial history – it is difficult to undertake accurate financial forecasting if an organisation is new and does not have comparable financial information from preceding periods;
- financial systems have had to be developed or integrated – resources have been diverted into installing new systems;
- there is a lack of ownership of inherited financial problems;
- additional costs have been incurred, such as redundancy payments, relocation expenses and costs of harmonising computer systems;
- there is a ‘knowledge gap’ – NHS staff have moved around the NHS sometimes leaving little or no local knowledge; and
lack of experienced finance staff – the demand for top level finance staff has increased due to the increase in the number of NHS bodies.

20 One consequence of the establishment of an increased number of smaller commissioners (PCTs) is that they are not individually big enough to manage the significant financial issues that are likely to arise. A trust may have a number of commissioner PCTs and financial solutions will have to be worked through and agreed by all parties. NHS bodies need to work harder at collaborative working, including the pooling of funds, to overcome these difficulties.

The role of the SHA and the health economy

21 SHAs are required to performance-manage the NHS organisations within their health economy, which includes their financial performance. The nature of the relationship between the SHA and the NHS body will vary from organisation to organisation, but all parties must understand clearly their respective roles.

22 The funding for NHS bodies does not flow via SHAs, but goes directly from the DH to PCTs. This means that SHAs themselves can do little in terms of allocating additional resources, but they should play a strong role in influencing the financial direction of organisations.

23 NHS bodies are increasingly required to work in partnership with other bodies within their health economy. This can affect the financial management of organisations as the SHA may seek to encourage bodies to release resources to others within the community with deficits. Each SHA works towards keeping expenditure of the bodies in the health economy within a ‘control total’ and while this helps all bodies achieve financial balance, it can mask underlying financial problems and results in ‘shifting the goal posts’ for the NHS bodies involved, as well as risking compromising sound financial planning and budgeting. The resources received are usually repayable the following financial year and therefore the financial problem is deferred to the following year, rather than being dealt with. It could also be perceived that poorly controlled bodies receive a ‘reward’ of additional funding at the year-end at the expense of the well-managed bodies, creating a perverse incentive to aim not to achieve financial balance.

Planning

24 There has recently been a change in the way NHS bodies are required to plan their activities. Planning in the past has been done annually, with the DH requiring NHS bodies to produce several plans. The DH’s Priorities and Planning Framework (PPF) (Ref. 4) issued in October 2002 now requires NHS bodies to produce three-year local delivery plans (LDPs) which set out the short-, medium- and long-term service development plans for each health community. They focus on the health and social priorities identified by the DH and feature:

- plans for service changes, increases in capacity and their affordability;
plans for how activity levels and costs will change, with milestones and monitoring arrangements; and

identification of risks to delivery, and agreed contingency arrangements to ensure that targets are met.

To support the development of LDPs, the DH also informs PCTs of their allocations for the three-year period (Ref. 5). The LDP should be underpinned by a financial strategy that shows how resources will be deployed and value for money achieved.

Data from the NHS Plan year 3 audit suggests that, while the development of LDPs has been very good (80 per cent of NHS trusts rated as strong or fairly strong on the LDP process) the ability to deliver the plan is of concern. Auditors assessed NHS trusts’ performance on key areas of the LDP; 64 per cent of trusts (Exhibit 4) who returned data (15 per cent of NHS trusts did not return data) were considered to be in a weak or fairly weak position on financial stability, and this may impact on their ability to support service delivery during the three years outlined by the plan. New service developments in a financially weak health economy may also be at risk. Evidence from the Audit Commission’s recent study of PCTs and redesign demonstrates that the development of alternative care pathways is limited by a PCT’s financial position (Ref. 6).

Exhibit 4

The financial stability of LDPs

Based on auditors’ assessments, the financial stability of LDPs is a cause for concern.

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Note:
Strong: There are strategies in place to resolve underlying financial pressures. There is a clear link between LDP trajectories and the financial plan. There is investment in place to support the achievement of trajectories.
Fairly strong: There is reasonable confidence that financial balance will be achieved. The link between LDP trajectories and financial position could be clearer.
Fairly weak: There is a high risk of required savings not being achieved. There is uncertainty about the availability of funds to support LDP trajectories.
Weak: Financial pressures are unresolved. Recovery plans are not robust. There is little confidence that financial resources will be sufficient to support LDP trajectories.

Source: Audit Commission
Three-year allocations are new to the NHS and it might take time for PCTs to develop the skills to implement the LDP. While the new approach has allowed health economies to plan spending over the medium-term, NHS bodies are still constrained by yearly resource limits and the need to meet annual statutory financial targets. Also a significant percentage of funds are held in central DH budgets and are not distributed at the beginning of the financial year, which causes funding uncertainties. Auditors have reported that it would be helpful if PCTs released funds earlier to NHS trusts as well as providing earlier information on the level of funds to be provided and their purpose.

Use of financial shared service organisations

As a result of the structural changes within the NHS there has been a significant growth in the number of financial shared services organisations. The size and roles of these organisations vary but in all cases they lead to the position where one organisation is wholly or partially dependent on another for the provision of one or more financial services (such as creditor payments, payroll and treasury management). Although NHS bodies can ask other organisations to carry out financial activities on their behalf, the responsibility for the production of annual accounts, budget statements and board reports cannot be delegated outside the organisation.

Auditors’ views have confirmed that a notable factor in the quality of financial management arrangements is how the body manages its relationship with its shared service provider. When there is confusion about the roles and responsibilities of the different parties, imprecise service level agreements (SLAs) and a ‘hands-off’ approach by the NHS body, then financial risks increase and in extreme cases NHS bodies can lose financial control.

Financial management capacity

Since the implementation of Shifting the Balance of Power and the increase in the number of NHS bodies, auditors have reported concerns about the quality of financial management skills at NHS bodies. Auditors expressed concern about inadequate staffing and management capacity in relation to finance at 34 per cent of PCTs, at 21 per cent of SHAs and at 14 per cent of NHS trusts.

Cost improvement programme (CIP)

All NHS bodies are required to prepare an annual CIP, identifying potential savings. How good bodies are at identifying items for the CIP and then achieving savings is a significant part of financial management in the NHS. Over-ambitious plans, unforeseen cost pressures or inadequate management action can contribute to the CIP not being achieved and affect financial balance. Some bodies routinely identify non-recurring costs for CIP and consequently do not address their longer-term cost pressures.
PPP/PFI-related projects including NHS LIFT

Public-Private Partnerships (PPPs) are a key element of the Government’s strategy for delivering high-quality, modern public services. PPPs range from joint ventures to outsourcing, and the Government has particularly encouraged public sector bodies to procure assets and services through the Private Finance Initiative (PFI). Consequently NHS bodies will continue using this source of funds to finance the building of new hospitals (and GP surgeries in the case of NHS LIFT).

NHS bodies entering into PFI schemes find that considerable demands are placed on all aspects of their financial management, from the costing of activities in the business case to the complex accounting arrangements.

Financial performance

The importance of financial management is recognised in the range of statutory financial duties and targets which NHS bodies are required to meet. The duties and targets vary according to the type of NHS body and are set out in Appendix 2. All NHS bodies are required to report their performance against statutory duties and targets in their annual accounts.

All NHS trusts are required by Section 10 of the National Health Service and Community Care Act 1990 to 'ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to the revenue account'. This duty has been interpreted to mean that over a three- (or exceptionally five-) year period, trusts are required to achieve break-even position in their income and expenditure account, that is, their income must match their expenditure.

SHAs, most special health authorities and PCTs are required to comply with the Government Resources and Accounts Act 2000 and have a statutory obligation to contain their expenditure within a set limit. This limit, called the resource limit, is set by the DH. Separate resource limits are set for capital and for revenue expenditure. The other financial duties and targets are concerned with the control of cash and the cost of capital.

The achievement of financial balance is one of a number of key targets in the NHS Performance Ratings (Ref. 7). In this case financial balance is defined as the ‘achievement of the financial position shown in the 2002/03 plan without the need of unplanned financial support’. The source of this information is the Month 12 forecast financial returns. Trusts and PCTs with the highest levels of performance receive a performance rating of three stars, and are rewarded with greater autonomy from DH control. This means that they are subject to less frequent SHA and DH monitoring, have additional freedoms and are eligible to apply for foundation trust status (trusts only). There is therefore an incentive for NHS bodies to reach financial balance, and additional planned support may be received from other bodies (SHAs and the DH) to help them achieve this.
In 2002/03, 18 per cent of trusts incurred an in-year deficit, compared with 16 per cent the previous year. The total amount of the deficit was £176 million, which is 0.53 per cent of total operating expenditure and an increase of £106 million on the previous year (Exhibit 5).

Exhibit 5
Annual deficits incurred by NHS trusts since 1994/95
Annual deficits increased significantly in 2002/03.

For the cumulative position at the end of March 2003, 160 trusts (58 per cent) reported a surplus, while 115 (42 per cent) reported a deficit. The cumulative deficits carried forward into the next financial year totalled £502 million (Exhibit 6) and under resource accounting this cumulative deficit does have to be recovered.
Exhibit 6
Total cumulative deficits at NHS trusts since 1997/98
The cumulative trust deficit as at 2002/03 was £502 million.

From 2002/03 NHS trusts are required to include a note to the accounts which sets out the financial support received by the trust wholly to assist in managing financial problems. In 2002/03 30 trusts reported receiving additional financial support of £116 million. If the additional financial support had not been received 25 per cent of trusts would have incurred deficits. In total 40 per cent of trusts included an additional note in their accounts setting out uncertainties about their financial position (for example, stating that break-even had only been achieved because of financial assistance received).

Notwithstanding the concerns about the financial position, auditors reported that 97 per cent of trusts reported the financial position to the board on a timely and frequent basis, with 93 per cent reporting clear, accurate and detailed information.
PCTs

In 2002/03 21 PCTs (7 per cent) failed to achieve their statutory duty to keep expenditure within their resource limit, with a total overshoot of £30 million. This is a deterioration since 2001/02 when all PCTs kept expenditure within the resource limit. For the remaining PCTs the total undershoot against resource limits was £121 million. Thirty-one per cent of PCTs included an additional note in their accounts setting out uncertainties about their financial position.

Ninety-six per cent of PCTs reported the financial position to the board on a timely and frequent basis, with 83 per cent reporting clear, accurate and detailed information.

SHAs

All 28 SHAs kept expenditure within their resource limits and achieved financial balance in 2002/03. The total undershoot against resource limits was £96 million.

The aggregate outturn position for all SHAs, PCTs and NHS trusts was a net surplus of £93 million. The NHS as a whole therefore ‘broke even’, even if individual bodies within it did not.

Year-end flexibility

NHS bodies do have a degree of financial flexibility at year end to help them achieve their targets, but are constrained by a number of factors not experienced by organisations in the private sector. As well as achieving financial targets, NHS bodies face restrictions on income that can be deferred to the following year and on capital expenditure. The introduction of resource accounting and budgeting has meant that NHS commissioners have less flexibility to move resources between bodies because of the new requirement to keep accrued expenditure within a limit.

NHS bodies at different times have used the following approaches in order to achieve the year-end targets:

- cancelled or deferred capital spending from one financial year to another, and requested a capital to revenue transfer so that the funding could be used on revenue expenditure (ie general running costs);
- slowed down the payment of bills to achieve cash targets;
- ‘frozen’ recruitment and relied on vacancies above planned levels;
- used non-recurrent ‘one-off’ funding to deliver ongoing commitments;
- initiated additional cash-releasing efficiency savings programmes;
- deferred expenditure on service improvements;
- received financial assistance (trusts only). Trusts may receive additional income provided wholly to assist in managing financial problems. This income is not repayable; and
received resource limit brokerage (SHAs and PCTs only). Adjustments to resource limits can be made so that resources are redistributed to those bodies in danger of breaching their resource limit. This adjustment can be planned or unplanned and is matched by a corresponding reduction in resource the following year.

Manipulating activities around the year-end, to bring forward income from, or delay expenditure to, the following financial year stores up problems for subsequent years and means that the achievement of targets (both financial and operational) in those years will be more difficult. Bodies that undertake this ‘aggressive performance management’ are misrepresenting reality by accounting inappropriately to hide underlying financial problems rather than addressing them.

There are good reasons why NHS bodies might not achieve financial balance in a particular year, for example, where costs incurred in one year are not recovered by income until a future year. For example, the majority of PCTs who breached their resource limit in 2002/03 did so because they were required to provide for future liabilities, but did not receive funding to match the provisions made. It is important that where financial balance has not been achieved the body is aware of the underlying causes and has a realistic financial recovery plan in place to restore financial balance.
Improving financial management

49 All NHS bodies need good financial management arrangements if they are to meet the demanding challenges set by the Government in the NHS Plan and to prepare themselves for the proposed changes to the financial regime being introduced by payment by results and patient choice. Auditors’ views on the last round of audits are that improvements in financial management arrangements will be needed if NHS bodies are to meet these new challenges.

50 Findings from the field visits and the views of auditors at those bodies considered to be good at financial management have highlighted that they are not doing anything different or more time-consuming than others. But what they are doing, they are doing well and in an organisational culture that recognises the importance of, and is supportive of, financial management.

How financial management can be improved

51 The following good practice points have been drawn together from site visits, discussions with NHS staff and auditors’ accumulated experience, and are considered below by each financial management process (Exhibit 7).

Exhibit 7
Financial management processes
Based in auditors’ assessments, most NHS bodies can make improvements to their financial management processes.

Source: Audit Commission
Effective financial planning is essential to support the delivery of financial management. Financial plans are more than a forward forecast of likely revenue and committed expenditure, but should link these to policy considerations and local circumstances (Case study 1). NHS bodies are used to undertaking option appraisal for capital schemes but the practice is not so widespread for revenue projects. The key issues for the financial plan are:

- What level of resources will be available and what resources will be needed to support the LDP?
- How are resources currently being used and with what degree of efficiency?
- How will spending need to change to reflect corporate priorities in the future?
- What options are available to provide the desired outcome? Can services be redesigned or provided more cost-effectively in other settings?
- How do existing resources need to be used more effectively to meet the organisation’s objectives?
- What other commitments will affect the financial plan (for example, pay rises, pension fund contributions and early retirements)?
- How much income is available for new policy initiatives? What implications will this have for existing services?
- How will cost improvement targets be dealt with?
- How much financial risk is inherent in the plan and how will realised risks be managed?

A financial plan should cover both revenue and capital planning to:

- show explicitly the revenue consequences of capital projects over a number of years; and
- consider specific issues such as PFI, which shift costs from capital to revenue and make future calls on the budget that may compete with other service spending plans.

When making financial plans NHS bodies should consider how the extra investment in the NHS can best be used to improve services and meet needs most appropriately. Different approaches to spending can lead to better outcomes; for example, spending on assistive technology for chronic disease patients might be a better alternative than providing more hospital beds. Effective financial planning is about continually reviewing how resources are allocated to services and predicting the benefits gained from the use of those resources.
Budget setting

Once an organisation has a financial plan it needs to be translated into a budget for the year ahead. Setting a budget in this way will ensure that resources are allocated in line with the organisation’s aims and objectives. Without consistency and clear linkages between the strategic objectives, service plans and the outputs to be secured, financial plans and the annual budget, the objectives of the organisation are unlikely to be achieved.

Most NHS organisations use a combination of budget-setting methods. Traditionally in the NHS the incremental approach to budget setting is used, where budgets are rolled forward year on year and adjusted for new developments and inflation. Some NHS bodies use zero-based budgeting where the budget is built up from scratch each year. In reality most NHS organisations use a combination of both.

When budgets are set it is essential that:

- there is a robust budget preparation timetable;
- they are linked to financial plans and reflect organisational objectives;
- they are set before the beginning of the financial year and are approved by the board;
- they are based on realistic projections about pay, inflation, corporate priorities and known cost pressures;
- they are restructured to reflect the changes taking place within the organisation;
- the reasons for, and consequences of, both over and underspending in previous years are taken into account when setting budgets;
- revenue budgets include the effects of capital transactions;
- they include the full year effect of changes introduced part-way through the previous year;
- all available information about future developments is taken account of in setting budgets;
- operational and financial responsibilities are aligned;
- the budgetholder leads the budget-setting process and has ownership of the budget concerned;
- savings in the budget should be specific, identified, and allocated to an individual to achieve, and achievement of them should be planned and actively managed;
- a risk assessment should be made of the likelihood and possible impact of the loss of particular funding sources, or of an increase in costs or essential expenditure during the year;
- they are appropriately profiled across the financial year, reflecting the expected peaks and troughs of income and expenditure; and
- they are in recurrent balance.
Budget reporting and monitoring

Budgetholders need to be identified who have the necessary authority to take and implement decisions about resource utilisation. The reporting of performance against the budget and the corrective action taken as a result is an essential element of financial management in the NHS. Budget reporting to budgetholders should be in sufficient detail to ensure that all significant variances are identified so that any necessary corrective action can be properly identified. It should be linked to information about performance and service improvements.

While the nature and format of budget monitoring information varies between different levels in the organisation, the overriding factors must be that the information is timely and accurate. To ensure accurate monthly financial reports, financial commitments should be recognised as soon as possible and be reflected in the monthly reports. Without accurate budget reporting at budgetholder level, costs cannot be properly controlled.

Current best practice in reporting to budgetholders is that the information should be available online, accruals-based, linked to activity data, and highlighting future trends based on an assessment of risk.

Additionally, NHS bodies should ensure that budgetholders receive continuous training to ensure that they have sufficient skills to undertake the task of budget management and are well supported by professional finance staff (Case study 2).

One issue that exercises NHS bodies is the identification and achievement of the CIP. A common approach is to allocate savings on a pro rata basis across all budgets. NHS bodies should consider whether a different approach would be more appropriate. The Commission suggests that the application of CIP should take account of the achievement of organisational objectives and may therefore need to be applied differentially. In particular NHS bodies should take a planned approach to the identification of CIP and target areas that are known to be inefficient. Others adopt a very structured approach to identifying and achieving savings (Case study 3).

Case study 3

Achieving savings

A trust recognised early on in 2002/03 that achieving financial balance would be a significant challenge. The board agreed that no cuts should be made to services nor should the quality of patient care be compromised by the achievement of financial balance.

To address the problem a management taskforce was created, called the Efficiency Group. The aims of the Efficiency Group were to identify areas where costs could be reduced and to make recommendations about how financial balance could be achieved. The Group was a subgroup of the board and had non-executive director representation.
As a result £2 million savings were identified and delivered. The main savings arose from tightening the controls around the use of bank and agency staff, but other smaller savings were realised.

The Group is successful because it monitors the delivery of the savings, and the recommendations it makes are supported by the board.

Source: Audit Commission

**Board reporting**

NHS boards need financial information to properly direct the organisation. This information has to be accurate and timely so that the board can take early and corrective action where necessary. The form and content of board financial reports will vary and it is for the board to identify the format, content and frequency of the financial information that it is to receive. The type of information which boards should receive has been identified by the DH (Box B), and how this has been put into practice at one PCT is shown in Case study 4.

**Box B**

**Financial information that should be reported to the board**

- Achievement of financial duties
- Activity levels linked to financial data
- Annual accounts, external audit opinions and reports
- Balance sheet strength
- Cash management, performance against capital and revenue resource limits
- Compliance with the Better Payment Practice Code
- Fraud reports
- In-year income and expenditure position and year-end forecasts
- Losses
- Management costs
- Performance against the external financing limit (EFL)
- Performance of outsourced services
- Progress against internal and external audit recommendations
- Progress on major capital schemes
- Staffing and establishment reports

Source: DH
NHS bodies should augment this information by reporting the value obtained from NHS investments. For example, when money is invested in a specific service, does that additional funding deliver what was expected in terms of increased quality and quantity of services? Providing the board with this information reinforces the need to have robust systems for appraising different models of service delivery and methods of tracking the outcomes. The board should also be regularly updated and advised on the nature and development of new systems within the NHS (such as payment by results) so that they are able to understand their potential impact and are better prepared to manage the real impact when implementation has taken place.

**Case study 4**

**Financial reporting to the board**

A PCT recognises that providing the board and professional executive committee (PEC) with high-quality, reliable monthly financial information is essential if all their targets (both financial and operational) are to be achieved. The information regularly reported to the board includes:

- performance against statutory duties and targets;
- a summary of performance against resources and budgets;
- the financial risks that the PCT faces;
- performance on all agreements;
- financial performance of provider activities;
- performance of hosted services;
- performance against the Better Payment Practice Code;
- forecast prescribing outturn by GP practice;
- forecast balance sheet for the year end and following year; and
- forecast of revenue considerations for the following year.

The PCT has also taken steps to ensure that all board and PEC members have sufficient financial awareness to understand the information they receive and to challenge the finance director where necessary.

*Source: Audit Commission*

The Public Audit Forum (which brings together the public audit agencies in the UK on a purely advisory basis to provide a focus for developmental thinking about public audit) has identified principles that should be applied to management information, which are relevant to both board reporting and budget performance reporting (Ref. 8). Management information should be:

- timely;
- accurate and reliable;
- produced only once;
- relevant to users’ responsibilities;
66 While the financial report to the board is usually prepared by the finance department, it is important to recognise that finance staff are able to influence relatively little of what is actually spent. Organisations can encourage ownership and true responsibility by ensuring that budgetholders and operational managers draft the narrative for their areas of responsibility within the finance report.

67 Ultimately the board report must contain the correct information, presented in a way that non-executive directors can understand. Understanding the finances can be a daunting task for many non-executive directors and they may fail in a critical part of their role if reports are confusing.

68 The financial performance of most organisations will fluctuate during the year and NHS bodies are no exception to this. Financial performance is usually monitored on a monthly basis through the production of budget monitoring reports, balance sheets and other information supplied to the board.

69 Feedback from auditors suggests that NHS bodies tend to fall into one of four categories:

- those that report financial balance throughout the year and at year end;
- those that report a deficit at some stage during the year, but ultimately achieve financial balance at year end;
- those that report a deficit during the year and fail to achieve financial balance at year end; and
- those that report financial balance throughout the year, but ‘discover’ a year-end deficit.

70 Financial information produced at the beginning of the financial year is often regarded as less reliable than that produced later on in the year. While there may be more uncertainty, for example agreements might not have been signed between PCTs and trusts, it is essential that NHS bodies monitor and control their expenditure throughout the financial year and accurately forecast what the position is likely to be. Many NHS bodies go through a typical annual cycle, year after year, as follows: little credence is given to financial information early in the financial year; then the body finds it is in danger of overspending; it takes corrective action; and ultimately achieves break-even (Exhibit 8). This cycle means that there is a perpetual sense of crisis within some NHS bodies year after year. This is exacerbated by the pressure on NHS bodies to achieve annual targets without any ability to carry forward funding where necessary.
Exhibit 8

A typical outturn reporting cycle

Some NHS bodies fall into a typical cycle of reporting their outturn position.

71 A key task is to recognise at an early stage when the body is at risk of not achieving financial balance and communicating that message to budgetholders and the board so that appropriate action can be taken. If this warning is untimely patient services can suffer because of precipitative action taken which may not be necessary. There must be careful consideration of the relative risks of acting to protect the financial position and of ending the year with a significant overspend (Case study 5). The key message to all NHS bodies must be that financial management is a year-round process, which is as important at the beginning of the financial year as it is at the end.

Case study 5

Fluctuations in predicted financial position

In its audited accounts for 2002/03 a trust reported a deficit of £250,000. Yet in earlier reports to the SHA it had forecast an overspend at the year end of £10 million, which later increased to £21 million.

There had been a breakdown in governance at the trust which led to the increase in the forecast overspend. The auditor had been critical in the 2001/02 Annual Audit Letter and in a report on the trust’s financial health issued in October 2002.

A number of factors contributed to the deficit, principally:

- there were many years of rolled forward budgets, which failed to reflect planned resources and activity accurately;
- budgets were poorly profiled to reflect seasonal spending patterns;
- basic control procedures were not evident, especially with respect to controlling establishment levels and the use of bank and agency staff;
- poor interfaces between financial systems and reporting packages resulted in a high degree of manipulation to produce meaningful data for budgetholders; and

Source: Audit Commission
over 47 per cent of procurement took place through unofficial channels.

To overcome their financial difficulties, the trust sought to dispose of assets and secure sanction from the DH for a ‘capital to revenue transfer’ to wipe out its short-term revenue problems.

The trust accelerated the sale of some land to generate short-term cash to support the revenue problem. The DH consented to the capital to revenue transfer. There were no accounting/legal arguments with which to challenge the transfer. However, the prudence of selling capital assets to meet short-term revenue shortfalls is clearly questionable and does nothing to address the underlying financial issues.

The trust has prepared a financial recovery plan, which identified an additional cumulative deficit of £45 million for the three years 2003/04 to 2005/06, of which £8 million is an annual recurrent deficit. There is much still to be done to ensure that the trust returns to recurrent break-even to meet its break-even duty.

Source: Audit Commission

Auditors have reported that forecasting techniques need to be improved. NHS bodies need to ensure that they accurately forecast throughout the year what the year-end position will be to avoid unnecessary changes to the delivery of services to patients. It is recognised that NHS bodies are sometimes hindered in predicting what the year-end position will be because allocations are released from the DH late in the financial year.

Financial reporting

All NHS bodies have a statutory duty to produce annual accounts (Section 98(2) National Health Service Act 1977, as amended). The form and content of the accounts is prescribed by the Secretary of State for Health, but is largely consistent with UK generally accepted accounting practice. The production of the statutory annual accounts is the principal means by which NHS bodies discharge their accountability to taxpayers and users of services for their stewardship and use of public money. The production of the key information for the annual accounts needs to be regarded as an ongoing process during the year that is part of financial management and should be used to keep senior budgetholders and board members informed on a regular basis.

Improving the quality of final accounts and supporting working papers is essential. Auditors have reported that there has been a significant reduction in the quality of accounts and working papers in recent years, particularly for the 2002/03 accounts (Exhibit 9).
Areas of concern in the production of 2002/03 accounts

There is substantial room for improvement in the quality and timeliness of NHS accounts.

In order to improve the quality of budget reporting and the timeliness of financial reporting, NHS bodies should consider integrating financial and management reporting. Traditionally NHS bodies have produced budget reports to manage and run the organisation effectively and separate financial statements to report their annual financial performance to external stakeholders. Aligning the two reporting methods would lead to better quality management information, because not only will accruals and provisions be more accurate, but also the year-end financial statements should be produced more quickly. There is also the additional benefit that board members and budgetholders are more likely to recognise and have ownership of the financial position set out in the final accounts as it will be similar to the monthly information produced (Case study 6).

Case study 6
Arrangements for producing annual accounts

Although the PCT was only established on 1 April 2002, it has quickly proved to have excellent arrangements for the production of annual accounts. The 2002/03 accounts were produced within four weeks of the year end and required no amendments as a result of the audit. The PCT attributes its success to the following:

- a finance directorate that recognises the importance of ‘getting the basics right’;
- the same processes and staff used to produce both the monthly management accounts and the annual accounts;
balance sheet reporting is done each month, not just at year-end;

the finance director insists that financial reports are produced directly from the ledger, rather than being developed on spreadsheets from information produced by the ledger;

they have a proactive approach to addressing final accounts issues, instead of waiting for guidance from the DH. This means that resource implications are known at an earlier stage;

robust final accounts closedown timetables are in place and are complied with; and

the board is committed to the provision of accurate and timely financial information.

Source: Audit Commission

Other good practice points on financial reporting are:

- staff should have opportunities to attend training on new financial reporting developments;
- there should be an appropriately qualified member of staff with responsibility for keeping up to date with new developments and ensuring that knowledge is disseminated to relevant staff;
- invoice and funding disputes should be identified and resolved quickly;
- a written timetable and guidelines for the closure of accounts should be available and updated as soon as policies are changed;
- potentially contentious issues should be discussed with the external auditor as soon as possible; and
- the potential impact of new developments should be assessed in advance of the year end.

The aim for NHS bodies should be that financial accounts are produced by the required deadline and require minimal change as a result of the audit. This will become increasingly important – and increasingly difficult – as the national NHS final accounts timetable is brought forward.

Treasury management

Treasury management is about ensuring that there is sufficient cash to pay the bills. Typical treasury management activities include: management of receipts and payments; borrowings and investments; and the monitoring of cashflow in general to ensure that liabilities can be met. NHS bodies are limited in the range of borrowing and investing activities that they are permitted to enter into. For example, they are only allowed to keep a maximum of £50,000 in commercial bank accounts; the remainder must be kept within Office of Paymaster General accounts. All NHS bodies are required to keep cash expenditure within limits prescribed by the DH.
Most NHS bodies have appropriate treasury management systems in place, given the restriction on activities that they have the powers to undertake in this area. However, all NHS bodies should ensure that:

- cash balances are kept only at minimum levels (in accordance with DH guidance);
- regular cashflow forecasts are produced to highlight peaks and troughs;
- bank reconciliations are carried out on a regular basis;
- debts are collected promptly;
- invoice disputes are resolved in a timely manner; and
- invoices are paid in accordance with the Better Payment Practice Code.

The key concern must be always to have enough cash to enable the organisation to function, without holding excessive balances. One of the early signs of financial management difficulties is a slowdown in the time taken to pay bills because of cash shortfalls. The monitoring of the speed of payments is a key role for senior management and should be reported to board members. At NHS foundation trusts these skills plus others relating to debt management and corporate finance will be required (see paras 102-104).

Financial control

NHS boards are accountable for having high standards of financial stewardship, probity and public accountability. To do this the board must ensure that an effective system of internal financial control is in place.

The NHS has been at the forefront of corporate governance initiatives in the public sector in recent years. In each NHS organisation the chief executive – in their capacity as accountable officer – is required to sign an annual statement on internal control (SIC). The SIC sets out how the body manages the risks that could prevent it from achieving its objectives. The statement also confirms whether the system of internal control has been reviewed for effectiveness. In signing the SIC the chief executive will consider the organisation’s performance against the three core controls assurance standards, one of which is concerned with financial management and is supported by 12 criteria (Box C).

Box C

Financial management standard – key criteria

Criterion one

Financial objectives for the organisation are clearly defined, approved by the board, and conform to DH requirements.

Criterion two

Board-level responsibility for financial management is clearly defined and is supported by clear lines of financial accountability throughout the organisation.
**Case study 7**

**Devolved financial control**

A trust has a devolved finance structure. Financial managers are based in clinical directorates – alongside budgetholders – with only ‘professional’ responsibility to the finance director. There is a central team within the finance department that is responsible for the production of the monthly budget monitoring reports and who liaise regularly with the finance managers. The system works well with financial skills being spread throughout the trust and financial plans, option appraisals and reports being prepared on a more informed basis.

The trust recognises that this approach works well when financial balance is being achieved. When problems occur, the finance director has reserved the right to review the reporting arrangements of finance managers, which has in the past resulted in their reverting back to reporting solely to him, and then when the issue is resolved transferring back to reporting to line managers. This process has been used sparingly but effectively when tackling particular difficulties.

Source: Audit Commission

**Criterion three**

There is an audit committee overseeing the financial aspects of governance.

**Criterion four**

Standing Financial Instructions, based on the departmental model and updated to reflect current requirements, have been formally adopted by the board, and promulgated throughout the organisation.

**Criterion five**

Financial risk management processes exist throughout the organisation.

**Criterion six**

There is an effective and documented system of internal control for all financial management systems.

**Criterion seven**

There is an adequately resourced, trained and competent finance function.

**Criterion eight**

All employees, including managers and the board, are provided with adequate information, instruction and training on financial management.

**Criterion nine**

The board reviews the effectiveness of its system of internal control for financial management at least annually.

**Criterion ten**

The board receives regular reports on financial performance and activity, it is made aware of significant risks and determines and takes appropriate action.

**Criterion eleven**

The head of internal audit provides an annual assurance to the audit committee on the effectiveness of the organisation’s financial arrangements based on this standard.

**Criterion twelve**

The organisation can demonstrate that it has done its reasonable best to meet its key financial objectives.

Source: DH

Organisations should aim to devolve responsibility for controlling budgets as closely as possible to those who take the decisions about using resources. The centre of an organisation needs to have effective systems in place so that it is aware of actual and projected expenditure against budgets and is able to take action quickly should there be evidence of unexplained or unauthorised variances (Case study 7).
Ensuring value for money

When putting together financial plans NHS bodies should consider how to get better value for money from existing spending and how to ensure value for money from new resources. To put themselves in a position to achieve this NHS bodies need to create ways of working based on openness, transparency and a willingness to learn. It is not sufficient to apply these approaches to deciding how to apply increases in resources – it needs to extend to how existing resources are used.

NHS bodies need to understand the relationship between inputs and outputs, not only in terms of themselves but also for others so that they are able to benchmark their performance and be in a position to set themselves realistic targets for improvement (Case study 8).

Case study 8
Understanding the relationship between inputs and outputs

The auditor and the trust worked together to identify areas of comparatively high expenditure. The approach was to investigate each of the main components of total expenditure, by using existing information sources – the annual accounts for a high-level analysis of expenditure, the supporting trust financial returns (TFRs) for speciality expenditure, unit cost and length of stay, reference costs for healthcare resource group (HRG) analysis and the DH online system for comparative analysis and reporting (OSCAR). The trust found:

- its medical inpatient costs were some £8 million higher than those of similar trusts;
- cardiology spending was over £1 million more than its comparators;
- cardiac catheterisation accounts for nearly £900,000 of the £1 million higher spending; and
- it appears that the trust has a longer length of stay for this procedure.

![Graph showing length of stay (days) for different trusts, with a note indicating that this trust has a longer length of stay. Source: OSCAR.](source: OSCAR)
This analysis raises the very focused question – Why is the length of stay for cardiac catheterisation twice as high as average? It quantifies the financial opportunity of reducing the length of stay to the average (almost £1 million per year) and gives the trust a starting point to discuss and investigate this very specific issue, which it is now doing.

Source: Audit Commission

A recent Commission study on the role of PCTs in shaping and supporting general practice has highlighted that the funds available to general practices within most PCT study sites visited varied widely (Ref. 9). Funds were not related to indicators of need, for example patient numbers. In the general practice sites visited the median expenditure per registered patient was £74, but it ranged from £51 to £106 (Exhibit 10). PCTs need to understand better the expenditure and cost drivers at practices, why apparently similar practices can have widely different spending patterns and how they can use their powers and influence to secure more equitable resource allocation.

Exhibit 10

Expenditure on general practice*

Funds available to general practices within PCTs vary widely.

<table>
<thead>
<tr>
<th>Expenditure per registered patient</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
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</table>

Note: *All income sources except premises and prescribing, i.e. Non Discretionary and Discretionary General Medical Services, Personal Medical Services and Hospital and Community Health Services. Inclusion of premises costs changes the numbers but not the extent of variation; for example median expenditure per registered patient including premises costs was £78 and £74 excluding them.

Source: Audit Commission study sites – 286 practices in 8 PCTs
One of the most problematic areas is reviewing how existing services are provided. Consideration of benchmarking information – like that contained in Exhibit 10 and Case study 8 – can provide a valuable insight into which service areas should be reviewed as it is unlikely to be feasible to carry out a total zero-based budgeting exercise across all functions in a single year. However, it may be possible to undertake a series of rolling reviews of current services, the choice of reviews being influenced by either centrally driven initiatives or by benchmarking information. The aim of such reviews should be to appraise options for providing improved services so that board members can take decisions about service and financial plans on a more informed basis. A key factor is to obtain people with the necessary skills and breadth of knowledge – either as employees or bought in – who are able to apply innovation or new developments in the local setting.

Learning from financial management failure

Auditors’ experience shows that financial management failures tend to occur not because of insufficient income, but due to a combination of:

- failure of basic financial controls;
- ineffective financial monitoring systems;
- lack of financial awareness among board members;
- dysfunctional relationships between board members and senior managers;
- lack of ability within the finance department and overstretched finance staff;
- lack of financial awareness throughout the organisation; and
- lack of ownership of, and leadership on, financial issues.

The DH has identified that the key to resolving financial failings is to take early and effective action (Ref. 10). Identifying when things are beginning to go wrong is essential. The internal controls that NHS bodies have in place should help to prevent financial failures from occurring – but they are not always in place and operating effectively. NHS bodies must be mindful of the following early indicators that a breakdown in financial management is occurring or may be about to occur:

- unexpectedly high levels of cash being paid out and the cash position not being consistent with the reported income and expenditure position;
- monthly budget statements that are inconsistent with what was expected;
- savings to achieve the CIP not being fully identified;
- SLAs not being agreed until well into the financial year nor the financial consequences of the eventual agreement being adequately planned for;
- ‘heroic’ assumptions made about the achievability of budget and assumptions underpinning the budget;
Lessons can be learnt by studying instances of financial failure (Case study 9).

Case study 9
Financial failure

In April 2002 a trust reported a forecast outturn deficit for 2001/02 of £1 million. In July 2002 the trust Chief Executive advised the SHA that the overspend would be closer to £2.7 million. Within a matter of a few weeks the trust finance director indicated to the SHA that the final audited outturn was a deficit of £6.2 million.

In the meantime the trust continued its daily business arrangements, reporting its financial position to the SHA on a monthly basis:

<table>
<thead>
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<th>Month</th>
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</tbody>
</table>

During the year the board received reports indicating high levels of reserves. These included several commentaries that indicated that positive progress was being made in implementing cost improvements. In addition, income was inflated to cover expenditure which was intended to be funded by proposed efficiency savings or other income generation. This gave a misleading position statement on the cumulative financial position of the trust, and its forecast outturn.

There was no evidence that the trust finance director was subject to any challenge at an executive level before the monthly monitoring reports were tabled at the finance committee or board. But subsequent enquiries showed that both executive directors and board members considered that budget reports were confusing and misleading in both content and style and were overly detailed. The board had failed to put in place effective corporate risk assessment and management processes. There was a lack of sufficient challenge of the executive team, despite the indications of risks arising.
The overspend can be attributed to a range of items shown in the following chart.

The deficit arose through the combination of a failure to realise ambitious cost-efficiency savings and additional costs incurred as a result of increased activity to meet national targets.

The significant and rapid deterioration in the reported deficit demonstrated the problems arising from a serious breakdown in governance arrangements and financial control. The executive had been overly optimistic in its forecasts. Directorates appear not to have agreed the level of efficiency or cost savings required, and the finance director was responsible for significant savings areas, which were not within his direct control. Finance staff had been aware for some time that there was a cashflow problem because the trust was delaying payment to creditors.

The trust had been facing some fundamental issues relating to service delivery and financial management issues during 2002/03. Some of these issues were there in previous years, and it is evident that there were a number of significant risks to the trust that were not fully recognised in its budget setting or financial monitoring and reporting process.

Source: Audit Commission
NHS financial management in the future

Factors influencing financial management in the NHS

NHS bodies that have good financial management arrangements anticipate the potential demands on their financial systems, skills and staff as well as the impact on their financial resources. In short, financial management arrangements are regularly reviewed to ensure that they remain ‘fit for purpose’. The pace of change in the NHS is accelerating and there are a range of forthcoming changes, discussed in more detail in the rest of this section, which will test NHS bodies’ financial management arrangements (Exhibit 11).

Exhibit 11
Challenges affecting financial management in NHS bodies over the next few years

Financial management arrangements will need to improve to meet these new challenges.

Source: Audit Commission
The modernised NHS

Patient choice

Delivering the NHS Plan (Ref. 11) set out the requirement that patients and their GPs will be able to book appointments at both a time and a place that is convenient to the patient. This might include local NHS hospitals or NHS hospitals elsewhere, treatment centres, private hospitals or even hospitals abroad. Patient choice at the point of GP referral is planned to be available for all patients requiring elective surgery from December 2005. Some pilot schemes are already in operation for those patients who have waited more than six months for elective surgery, and the DH has stated that from summer 2004 patients who will wait more than six months for elective surgery will be offered the choice of moving to another hospital for faster treatment.

Delivering patient choice will require significant changes in the way the NHS commissions and provides services. When PCTs develop their commissioning plans and SLAs for 2004/05 they will have to take into account the fact that some patients will be able to choose to have their treatment in an alternative hospital. The SLAs will have to be sufficiently flexible to allow patients to exercise choice. Where patients do exercise choice the funding from the PCT will move with them, away from the original hospital to the new hospital that will actually treat the patient. The funding that transfers will be the national tariff (as discussed below). When patient choice is fully implemented, PCTs will commission services from a wider range of providers and they will have to develop a commissioning strategy which allows patients to choose the time and place of their treatment.

The introduction of patient choice increases the complexity and level of risk in the commissioning and financial arrangements of both PCTs and NHS providers. It will mean applying financial management skills in an increasingly uncertain environment and will require staff to have financial modelling skills, and systems which can provide information very quickly in a flexible format.

Payment by results

Reforming NHS Financial Flows was published by the DH in October 2002 and sets out a programme for moving to a new system of paying healthcare providers, based on payment by results (Ref. 12). The new system has been introduced to support the changes in the NHS whereby care will be delivered by a diverse range of providers responding to patients’ needs and choices (the patient choice initiative). Under the new system the flow of funds will be linked to activity and there will be a standard national price tariff, adjusted for local differences in pay and input prices, for most services over the medium term.

There will be a phased approach to the introduction of payment by results from 2003/04 to 2005/06 when it is envisaged that 60 per cent of commissioned activity will be covered by the new system.
The key issue that will cause concern for NHS bodies is the risk of financial instability. NHS providers (and private healthcare providers) will receive the standard tariff for activity that they undertake and this may differ from the cost of delivering that activity. There will inevitably be some providers for whom the activity undertaken costs more than they are being paid and therefore the provider will have to review its costs with a view to reducing them. Conversely, providers whose costs are below the tariff will have ‘surplus’ funds to reinvest in service improvement.

An additional cause for concern for NHS bodies is the variable quality of the data used to calculate reference costs. In a recent Audit Commission report on data quality auditors reported a mixed picture across NHS bodies (Ref 13). Costs were generally identified and calculated reasonably accurately by most bodies reviewed, but activity information, particularly at PCTs and mental health trusts, was generally unreliable.

Payment by results is the single biggest change to the NHS financial regime in recent years. Its impact should not be underestimated as it will have a significant influence on how financial management is undertaken at NHS bodies. The new system is likely to increase the demands of boards and budgetholders alike for accurate and timely management accounting and budgetary control information and improvements in the quality of clinical coding. In particular there will be a greater focus on the relationship between financial and activity information. Therefore improving the quality and timeliness of costing information should be a priority for many NHS providers as reliable cost data is essential if the national tariff is to function successfully.

To reflect the importance of this topic for the future management of health services, we intend to publish a separate report in early summer setting out our findings and their implications for the NHS and the DH in introducing the payment by results system of funding.

Public expectations

The expectations that the general public have of the NHS are increasing. Significant extra resources have been allocated to the NHS and there is quite rightly an expectation that the extra investment will lead to an improvement in the quality of services provided. NHS bodies will need to develop financial management arrangements to ensure that resources are used in the most cost-effective way that maximises the improvements in the quality of services and outcomes for patients. Systems will need to be developed to enhance the quality of the planning process, to identify how the extra money has been spent and evaluate whether the best use has been made of the funds available.
Getting ready for foundation trust status

The Health and Social Care Act received Royal Assent in November 2003 and the first NHS Foundation Trusts were established on 1 April 2004. They are a different type of NHS body. They are still part of the NHS and are freestanding legal entities – in line with other NHS bodies – but they are not subject to Secretary of State direction. Instead they are held to account locally by the communities they serve. They have different governance structures that reflect the different relationships with patients, staff, and the local community. They will also be given additional freedoms, such as the ability to retain proceeds from asset disposals and to retain any operating surpluses.

As a minimum, NHS trusts are required to have been given three stars in the NHS performance ratings before they can apply for foundation trust status. The DH has stated that one of the criteria for assessing applications is financial management, specifically that there is evidence of a sound underlying financial position as well as a track record of good financial management (Ref. 14).

As well as satisfying the eligibility criteria, NHS trusts hoping to gain foundation trust status will have to prepare themselves for the new financial regime that they will have to operate within. Foundation trusts will have to be prepared for:

- legally enforceable contracts rather than SLAs with commissioners;
- corporate finance issues, such as borrowing from the private sector;
- a new framework for capital investment and borrowing;
- the creation of subsidiaries;
- new governance structures and arrangements for internal control;
- new audit arrangements; and
- the lack of financial support packages that are currently enjoyed by some NHS bodies.

Financial information

Programme budgeting

The Commission is currently working with the DH in developing its programme budgeting project. The aim of the project is to identify what the NHS spends on programmes of care based on medical conditions across organisational boundaries. Traditionally the NHS has reported expenditure on the basis of inputs, for example pay and non-pay items; however, programme budgeting will help to provide information on what taxpayers are getting for the money they invest in the NHS.
Eventually a database will be established that will provide a detailed analysis of spending patterns over time. The database will help to identify the health gain that is obtained from investment and provide an insight into the most effective way of investing in services in the future; this will require a significant change to the way services are costed and accounts currently produced.

It is expected that in the medium term this information will form part of the audited accounts of PCTs.

**Bringing forward the accounts timetable**

HM Treasury (the department responsible for overseeing the financial activities of government departments) has proposed that all government departments should have completed their accounts by the parliamentary summer recess (mid-July). To comply with this timetable, the NHS accounts timetable will need to change radically so that audited accounts are available by the end of May.

For 2002/03 the accounts deadlines for NHS bodies were 31 July (for PCTs and SHAs) and 8 August (for NHS trusts). NHS bodies found these deadlines challenging with only 68 per cent (PCTs, 53 per cent; SHAs, 54 per cent; trusts, 88 per cent) being received on time and to an appropriate standard in 2002/03, which is a deterioration compared to previous years. The DH has confirmed that for 2003/04 the final accounts deadlines will be brought forward by two weeks.

The proposed significant shift in the accounts timetable to the end of May will require a wholesale change in the way annual accounts are prepared, with many current year-end procedures becoming routine in-year activities.

**National IT programme**

In May 2002 the DH published Delivering 21st Century IT Support for the NHS – National Strategic Programme (Ref. 15). The document sets out a £5 billion investment programme marking a major change to more centralised planning and provision of IT and establishing a National Programme for IT (NPfIT). Since then funding for the central programme has been announced of £400 million for 2003/04, £700 million for 2004/05 and £1.2 billion for 2005/06.

NPfIT focuses on improving patients’ experience and the delivery of care and services. There are four key components:

- electronic appointment booking;
- an electronic care records service including a national ‘data spine’;
- an electronic prescribing service; and
- an underpinning IT infrastructure to support the national applications and local systems.
The NHS Care Records Service is the core component of the national programme. It will enable the capture, management, sharing and use of patient and clinical information.

National Application Service Providers (NASPs) have been awarded contracts to develop the core national systems. To implement the programme, five local service providers (LSPs) have been awarded contracts to provide IT services to five geographic clusters of NHS bodies across the country.

There will be issues around contracting, project management, service management, financial flows and systems implementation. A programme of this size inevitably carries risks and these risks are about far more than IT. In particular, the programme is a major element of NHS modernisation and will be accompanied by changes in service delivery. The successful implementation of the programme should enable more timely and tailored information about patient referrals and treatments to support the provision of better financial management information to decision-makers.

New commissioning arrangements

Implementing the new GMS contract

The DH's publication, *Delivering Investment in General Practice – Implementing the New GMS Contract* (Ref. 16), published in December 2003, sets out the arrangements for the implementation of the new general medical services (GMS) contract. From 1 April 2004, PCTs have a new duty to secure the provision of primary medical services, having greater flexibility to commission from both within and outside the NHS. The new arrangements also, among other changes, entitle GPs to withdraw from providing out-of-hours services, placing responsibility on PCTs to identify and commission alternative out-of-hours services.

Responsibility for the bulk of contract funding will lie with PCTs who, from April 2004, receive cash limited allocations, which replace the existing GMS non-cash limited arrangements. Contractors will also now be able to earn incentive payments for good practice, with PCTs having responsibility for agreeing these and incorporating them into indicative budgets.

The changes to the GMS contract, linked to the replacement of the Statement of Fees and Allowances (the Red Book) with a Statement of Financial Entitlements (SFE), will place further financial management burdens on PCTs. Financial reporting, treasury management and budgeting processes will all need to be amended to reflect these new arrangements.
NHS dentistry – transition to local commissioning

The Health and Social Care Act 2003 contains provisions that devolve the responsibility for commissioning and contracting for NHS dentistry from the DH to PCTs. From 1 April 2005 the budget for general dental services, which is currently managed as a central non-discretionary budget, will be devolved to PCTs. While it is envisaged that the Dental Practices Board (and its successor new special health authority) will make the payments to dentists, PCTs will need to consider how the commissioning and financial management arrangements will work.

New contracts of employment – changes to pay structures

Future changes to the pay structure of NHS staff are likely to have a significant impact on the finances of NHS bodies. A new contract for consultants has already been introduced and the ‘Agenda for Change’ initiative (Ref. 17) intends to radically change the pay and management structures of the NHS by simplifying the complicated Whitley pay arrangements and will cover all the staff working in the NHS except doctors, dentists and very senior managers when it is implemented from October 2004.

The introduction of Agenda for Change will mean that finance departments will benefit from a simpler payroll system, with the associated benefit that costing and budgeting will also be made easier and therefore more accurate. Any change in costs associated with the introduction of Agenda for Change and the new consultant contract must be accurately costed (including any protection arrangements) and reflected in financial plans. Accurately costing the new contracts of employment is likely to provide a significant challenge for NHS bodies who will also have to ensure that budgets and payroll systems are able to cope with the requirements of the new system.

Financial management skills required

The demands made on the financial management skills of NHS staff will change in line with the new challenges outlined above. The funding and structural changes over the last few years have created new demands upon those responsible for financial management – not least by expanding the range of people for whom financial management is a key element of their responsibilities. However, as a clear indication of the dynamic context for financial management, there are more changes on the horizon, which are likely to pose even greater challenges to all those involved with NHS finances. The key issue for the NHS is being prepared as much as possible for the impact of these changes, and in particular working through the implications of the patient choice and payment by results initiatives.
The response of the NHS to these fundamental changes must be at a strategic level which involves appreciating not only the quality of the health services being provided but also how the cost of these compares with national tariffs and those of similar bodies. The relatively stable financial flows between commissioners and providers – with changes mainly being around the margins – can no longer be taken for granted. Given the intention to make the finances follow the patient’s choice then PCTs will not be in a position to guarantee funding to providers. Indeed, one of the stated aims of these changes is to create a position where there is a plurality of provision. PCTs in particular will face the challenge of having resources allocated according to capitation arrangements yet expenditure being driven by a fee basis. The need for people skilled in innovative commissioning and demand management of healthcare will increase.

The result will be the need for first-class financial management – along the lines set out in this paper – that links clearly to more intelligent use of performance data and information management, service and workforce planning and an ability to enhance managerial capacity and capability, particularly for smaller NHS bodies.

As a result new financial management skills and competencies will be required. For finance staff in the NHS not only will the job content change in terms of the technical issues with which they will have to contend, but the context within which they are discharging their responsibilities will also change. The same is true for staff throughout the organisation with financial management responsibilities.

The financial management skills that will be required in the future will involve the following (Box D):

- better understanding of resource utilisation;
- better knowledge of cost make-up, costing techniques and cost drivers;
- interpersonal and presentational skills to support robust challenge;
- benchmarking skills;
- better understanding of risk management, in particular identifying and minimising risk;
- the ability to link different sources of management information, for example, costing information, activity data and financial information;
- project management skills;
- corporate finance (for NHS foundation trusts);
- better understanding of the link between financial and activity information and improved interpretation of financial and other data;
- financial modelling skills; and
- better treasury management skills, in particular around cashflow forecasting, borrowing, lending and raising debtors and creditors.
Box D  
Summary of financial management skills required in the future

<table>
<thead>
<tr>
<th>Development</th>
<th>Skills required</th>
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<tbody>
<tr>
<td>Payment by results</td>
<td>Costing</td>
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<td></td>
<td>Knowledge of cost behaviour</td>
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<td>Benchmarking</td>
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<td>Risk management</td>
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<td></td>
<td>Project management</td>
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<td></td>
<td>Interpretation of financial information</td>
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<td></td>
<td>Strong interpersonal skills</td>
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<td>Financial forecasting and modelling</td>
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<td></td>
<td>Treasury management</td>
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<td>Programme budgeting</td>
<td>Costing</td>
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<td></td>
<td>Interpretation of financial information</td>
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<td>Bringing forward the accounts timetable</td>
<td>Technical skills</td>
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<td></td>
<td>Project management</td>
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<tr>
<td>New contracts of employment</td>
<td>Costing</td>
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<td></td>
<td>Systems development</td>
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<td></td>
<td>Evaluation of perceived benefits</td>
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<tr>
<td>Patient choice</td>
<td>Costing</td>
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<td></td>
<td>Commissioning skills</td>
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<td></td>
<td>Financial forecasting and modelling</td>
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<tr>
<td></td>
<td>Risk management</td>
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<tr>
<td>Foundation trusts</td>
<td>Corporate finance skills including treasury management, investments,</td>
</tr>
<tr>
<td></td>
<td>presentation of business cases</td>
</tr>
<tr>
<td></td>
<td>Risk management</td>
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<tr>
<td>PPP/PFI projects</td>
<td>Costing</td>
</tr>
<tr>
<td></td>
<td>Project management</td>
</tr>
<tr>
<td></td>
<td>Financial forecasting and modelling</td>
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<tr>
<td>Implementing the new GMS contract</td>
<td>Commissioning skills</td>
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<tr>
<td></td>
<td>Financial forecasting and modelling</td>
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<tr>
<td>NHS dentistry – transition to local commissioning</td>
<td>Commissioning skills</td>
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<tr>
<td></td>
<td>Risk management</td>
</tr>
<tr>
<td>National IT programme</td>
<td>Project management</td>
</tr>
<tr>
<td></td>
<td>Evaluation of perceived benefits</td>
</tr>
</tbody>
</table>

Source: Audit Commission
The development of these skills is required in addition to those needed to deliver good financial management as set out in Part 2, and the need to ensure that the financial management skills are updated to maximise the benefit from technological advances (Exhibit 12).

Exhibit 12
Hierarchy of NHS financial management skills
NHS staff will need new financial management skills to meet the challenges ahead.

Above all, NHS bodies need to ensure that members of staff are adaptable, proactive and fully equipped to deal with the financial management challenges ahead. The following will help NHS bodies to identify whether the necessary steps are being taken:

- Have the financial management skills required to fulfil the organisation’s objectives been identified?
- Is the organisation proactive in identifying future financial management training needs?
- Does the organisation make use of and fully support the finance staff development initiatives introduced by the DH?
- Has there been a training needs assessment to identify the shortfall between what will be required and what is currently available within the organisation?
- Does the organisation encourage staff to attend courses and conferences on new financial management developments?
- Are internal training courses held to update staff on new financial management developments and requirements?
- Does the organisation work in partnership with other organisations to share experiences, such as in the use of secondments, work shadowing and information sharing?
- Does the organisation work with other NHS bodies to pool scarce financial management skills?
This paper has highlighted that effective financial management arrangements are fundamental to commissioning and providing successful health services. Our work and the experience of auditors across the country have shown that there are many examples of good practice in all sectors of the NHS.

However, financial management arrangements in most NHS bodies could be improved. In some they are clearly inadequate to meet the demands of the present day, let alone those that will be encountered in the future.

With planned changes in financial flows, greater plurality of provision and more ‘commercial’ contracting models it is clear that the standard and nature of financial management will need to change significantly if the benefits of modernisation are to be realised in full.

As we said in our recently published strategy, (Ref. 18) the Audit Commission is determined to use its continuing role as the financial regulator for NHS bodies to drive up the quality of financial management. We intend to increase our emphasis on this area to help the NHS meet the future demands for better and increasingly sophisticated financial management. In doing this we propose to increase the focus of local auditors on this issue by working with CIPFA and others to develop standards for practice that can be used to produce a scored judgement, allowing NHS bodies to measure their progress over time in this area.

To support this process we will be reflecting the importance of financial management in the drafting of a new Code of Audit Practice in 2005. In the meantime we will be providing audit tools and training to auditors and to audited bodies to begin the process of improvement.

The Commission is committed to helping all those faced with the considerable challenge of improving healthcare to be better equipped to meet that challenge and to report independently upon whether the intended aim is being achieved.
As part of our commitment to Strategic Regulation we are committed to working with the Commission of Healthcare Audit and Inspection (The Healthcare Commission), DH, NHS bodies and others to ensure that the Commission and its appointed auditors can add most value and secure improvement. Over the next three years we will:

- Continue to promote sound financial management as the basis for improvement in services, by helping NHS bodies understand their strengths and weaknesses in financial management and the associated financial aspects of corporate governance, developing clear criteria to do so and providing consistent comparative information on the results as an aid to improvement and focusing work.

- Support the introduction of new funding arrangements by enabling local auditors to assess and report on the local systems upon which NHS bodies will rely – in particular those to be used for the patient choice and payment by results initiatives.

- Support SHAs by providing each one with an overview, covering the whole health economy, of financial management and governance within the organisations for which they are responsible.

- Review financial management in the NHS nationally and conduct relevant studies. We will shortly be consulting with stakeholders on a programme of proposed national studies, which will include a study on the implementation of payment by results.

- Develop financial management tools for NHS managers which will help them assess and understand the state of financial management at their organisation and what needs to be done to improve.

- Revise the statutory Code of Audit Practice to give an increased emphasis on the need for auditors to focus on NHS bodies’ overall performance and financial management arrangements.

- Develop revised guidance for auditors about the circumstances in which it is appropriate for them to use their powers of referring matters to the Secretary of State and reporting publicly where they have serious concerns about the financial standing of an NHS body.

- Engage with professional bodies and other stakeholders to share and disseminate best practice in financial management.

Given the challenges ahead for NHS boards, managers and frontline staff we believe that both the NHS and we as the financial regulator must ‘up our game’ in order to ensure that public funds are spent effectively and required improvements in services are delivered.

While auditing the accounts of NHS bodies will clearly remain an important part of what auditors do in the future, this report represents the first step towards increasing the emphasis of auditors’ work at the local level on supporting the improvement of the management of finance and performance.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountable officer</strong></td>
<td>Nominated officer at each NHS body, normally the chief executive, who carries personal responsibility for financial management.</td>
</tr>
<tr>
<td><strong>Commissioner</strong></td>
<td>NHS body, usually a PCT, that is purchasing healthcare services for its population.</td>
</tr>
<tr>
<td><strong>Cost improvement programmes (CIPs)</strong></td>
<td>A series of actions identified by an NHS body which are intended to reduce costs or improve efficiency. The programme should be established to meet both DH minimum targets for efficiency improvement and internal requirements to secure income and expenditure balance.</td>
</tr>
<tr>
<td><strong>Cumulative financial position</strong></td>
<td>Result of income compared with expenditure, taking account of all previous years’ financial results.</td>
</tr>
<tr>
<td><strong>General medical services (GMS)</strong></td>
<td>Medical services provided by a general practitioner.</td>
</tr>
<tr>
<td><strong>In-year financial performance</strong></td>
<td>Result of income compared with expenditure, ignoring any impact of the previous years’ financial results.</td>
</tr>
<tr>
<td><strong>Non-recurring funds</strong></td>
<td>A one-off allocation of funds.</td>
</tr>
<tr>
<td><strong>Patient choice</strong></td>
<td>A DH initiative to provide patients with a choice about where and when they receive their treatment.</td>
</tr>
<tr>
<td><strong>Payment by results</strong></td>
<td>The new financial system within the NHS that covers payments made by commissioners to providers of services. The payments will be on a fixed national tariff basis.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>NHS body, usually a trust or PCT, but can also be another public sector body such as a local authority social services department or private sector supplier of services.</td>
</tr>
</tbody>
</table>
Appendix 1 – Advisory group

John Grimes
Director of Finance
North and East Yorkshire & Northern Lincolnshire Strategic Health Authority
(representing the NHS Confederation)

Lynn Hine
Director
PricewaterhouseCoopers

Kevin Orford
Director of Finance and Performance
West Midlands South Strategic Health Authority

Simon Perks
Director of Operations
Queen Mary’s Sidcup NHS Trust

Dr James Robertson
Director
National Audit Office

Paul Taylor
Formerly Director of Finance
Worcestershire Acute NHS Trust
(Representing the HFMA)

Keith Wright
Formerly Director of Finance
Northern DHSC, Department of Health

Jon Billings
Keith Douthwaite
Emma Knowles
Audit Commission
Appendix 2 – Financial duties and targets of NHS bodies

<table>
<thead>
<tr>
<th>Duty or target</th>
<th>Description</th>
<th>Applicable to:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>NHS trusts</td>
</tr>
<tr>
<td>Break-even</td>
<td>To achieve a break-even position on income and expenditure taking one year with another.</td>
<td>✓</td>
</tr>
<tr>
<td>Revenue resource limit (RRL)</td>
<td>A statutory duty to keep revenue expenditure within a predetermined resource limit.</td>
<td>x</td>
</tr>
<tr>
<td>Capital resource limit (CRL)</td>
<td>A statutory duty to keep capital expenditure within a predetermined resource limit.</td>
<td>✓</td>
</tr>
<tr>
<td>Financial balance</td>
<td>To achieve operational financial balance each year – defined as not exceeding the resource limit excluding ‘unplanned financial assistance’ received.</td>
<td>x</td>
</tr>
<tr>
<td>Cash limit</td>
<td>A duty not to spend more than the cash allocated to the body. There is a combined limit for both revenue and capital.</td>
<td>x</td>
</tr>
<tr>
<td>External financing limit (EFL)</td>
<td>A cash limit on ‘net external financing’ and determines how much more (or less) cash is generated from operations than can be spent in a year.</td>
<td>✓</td>
</tr>
<tr>
<td>Full-cost recovery</td>
<td>To demonstrate full cost recovery on an accruals basis in relation to [the PCT’s] ‘provider’ functions.</td>
<td>x</td>
</tr>
<tr>
<td>Capital cost absorption rate</td>
<td>To absorb capital costs in full through a charge calculated at 3.5 per cent of the average relevant net assets of the body. NHS trusts pay this charge as a public dividend to the Treasury via the DH.</td>
<td>✓</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>To pay all non-NHS trade creditors within 30 days of receipt of goods or valid invoice (whichever is later).</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: Audit Commission
References


Performance Breakthroughs – Improving Performance in Public Sector Organisations

This report looks at the practical ways in which organisations can effectively manage and improve their performance. It has been written to help managers learn what works in performance management, why it works and how best to implement it. The report also addresses some of the most difficult problems that organisations typically encounter.

National report, 2002
ISBN 186240 396 1, stock code GAR2858

Connecting with Users and Citizens

This report contains a collection of good practice case studies from local government, health and criminal justice setting out how organisations have tackled the challenges in consulting, communicating with and involving service users. The report also summarises they key learning points from the case studies and explores the main features of effective consultation and involvement.

Management paper, 2003
ISBN 186240 413 5, £25, stock code GMP2907

Recruitment and Retention – A Public Service Workforce for the 21st Century

This report explores the recruitment and retention problems among public service organisations. It highlights the key reasons why potential, current and former public sector workers join or leave a public sector job, as well as sharing good practice and learning.

National report, 2002
ISBN 186240392 9, £25, stock code GAR2848

A Focus on General Practice

General practice is one of the most widely used public services, accounting for high levels of patient satisfaction. This report is the first in a series of primary care papers published by the Audit Commission. It pulls together published and unpublished data to show the current strengths and weaknesses of general practice in England.

Policy paper, 2002
ISBN 1862403740, £18, stock code GPP2779

Achieving the NHS Plan

Using key targets from the NHS Plan of July 2000, auditors appointed by the Audit Commission assessed every NHS trust in England on their performance and their capacity to improve. This latest report from the Audit Commission now presents an overview of their findings. In addition to providing a comprehensive assessment of NHS performance, supported by a range of case studies, the report examines the ability of the service to deliver further improvements.

National report, 2003
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