HFMA How It works briefing
March 2018

Understanding the financial position

Getting the most out of financial reports

Introduction

The NHS is facing challenging times financially. The reasons are varied and complex and there is no single solution to the problem. It is the role of finance teams to report the financial position, but meeting the financial challenge is everyone's problem.

The current focus is on achieving control totals, but the financial position is more complex than one single metric. Properly grasping the financial health of an organisation requires a review of the financial statements as a whole. If the financial position is not properly understood there is a risk that financial failure may not be identified until it is too late for action to be taken to rectify it.

This briefing will be of interest to anyone wanting to understand how the financial statements fit together and why the statement of financial position (SOFP)[1], is very important. It supplements two HFMA briefings for non-executive directors and lay members on how to review and scrutinise the numbers[2].

The governing body should 'satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust

[1] The SOFP is also known as the balance sheet
[2] HFMA, *How to review and scrutinise the numbers during the year*, October 2017 and HFMA, *How to review and scrutinise the numbers*, May 2017

and defensible. [3]' This briefing is intended to help members of the governing body do this.

While every care had been taken in the preparation of this briefing, the HFMA cannot in any circumstances accept responsibility for errors or omissions and are not responsible for any loss occasioned to any person or organisation acting or refraining from action as a result of any material in it.

The risk of not looking at the accounts as a whole

Currently, the key measurement of financial performance is achieving control totals, but the risk of focusing on that single metric and not considering the whole financial picture is that other indicators of financial failure might be missed until it is too late to take action.

Financial reports for in-year reporting as well as at the year-end should include a statement of comprehensive income (SOCI), statement of financial position (SOFP) and cash flow forecast. Performance against the prompt payment code requirements should also be regularly reported. It may also be helpful for governing bodies to be presented with a statement which explains the movements in balances on the SOFP.

Consider the following example - the reported surplus or deficit is in line with the plan and meets the control total. However, if the level of payables (creditors) is going up month on month then questions need to be asked. The rising level of indebtedness means that the NHS body is not paying its bills as quickly as it once was, which is an early indicator of financial distress. This problem may also be reflected in the NHS body's performance against the *Prompt payment code*[4] which requires all public sector bodies to pay their bills within 30 days. Not paying bills may improve cash flow in the short term, but could result in suppliers refusing to supply goods or services until they are paid or, in a worst case scenario, going bust themselves. It is something that senior management and members of the governing body should be asking questions about.

This briefing is intended to explain why the full set of financial statements is important and what questions should be asked when they are being prepared and reviewed. It includes the following sections:

- NHS bodies' financial targets
  - control totals
  - the Department of Health and Social Care
  - NHS England and clinical commissioning groups
  - NHS trusts
  - NHS foundation trusts
- financial statements and reports
  - financial statements
  - preparation of financial statements
- warning signs
  - receivables

[3] This is a quote from the Higgs report *Review of the role and effectiveness of non-executive directors*, 2003 which is referred to in the Audit Commission's report *Learning the lessons from financial failure in the NHS*, 2006

[4] The Code is available here - www.promptpaymentcode.org.uk/. For NHS bodies, the DHSC *Group accounting manual* requires performance against the target to pay all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice to be reported as a note to the accounts. Compliance with this requirement is considered to be payment of 95% of invoices within 30 days or agreed contract terms.

- payables
- provisions
- cash and working capital
- negative net assets.

NHS bodies' financial targets

All NHS bodies have financial targets and duties and achieving these is often the focus of any discussion on the financial position of an NHS body. Financial duties are either statutory which means they are enshrined in legislation or administrative which means they are imposed by HM Treasury or the Department of Health and Social Care (DHSC).

Control totals

In 2015/16, for the first time ever, the NHS in England very nearly overspent its entire budget. In response, NHS England and NHS Improvement published *Strengthening financial performance and accountability in 2016/17*[5].

This introduced various measures to improve the financial performance of NHS organisations, including some additional funding and the move from one-year to two-year contracts and plans.

It also introduced a new administrative target for all trusts and CCGs, known as a financial control total[6]. The control total is the minimum level of financial performance which each NHS body's chief executive and governing body are held accountable for delivering.

As part of the planning process, each NHS body in England is required to forecast the surplus or deficit it can achieve each year. NHS Improvement and NHS England determine a control total for each NHS body that, when aggregated, will result in the NHS meeting its national financial targets. NHS bodies then decide whether to accept their control total or not – usually based on the closeness of the control total to their forecast surplus or deficit for the year.

For trusts, one of the key requirements for accessing the sustainability and transformation fund (STF)[7] is accepting and meeting the control total on a quarterly and annual basis. Bodies which exceed their control total (by making a higher surplus or lower deficit than planned) receive additional funds.

While control totals were formally introduced two years ago, the financial focus in the NHS has always been on the bottom line. This is driven in part by the financial duties, statutory and administrative, which NHS bodies are required to meet.

The focus on control totals can create a perverse incentive to review the SOFP to report an improved financial performance without actually making any savings. For example, reducing provisions, as described in the final section of this paper, improves the position against the control total but increases financial risks in the medium term for that organisation. This is why it is important that financial reports to governing bodies include the SOFP and that those governing bodies understand the movements in balances month on month, ask questions if there are unexplained movements and raise any concerns.

[5] NHS England and NHS Improvement, Strengthening financial performance and accountability in 2016/17, July 2016

[6] As integrated care systems develop, they will be expected to deliver system wide control totals.

[7] From 2018/19, instead of the STF, there will be two funds - the commissioner sustainability fund (CSF) and provider sustainability fund (PSF). Delivering the financial control total will still be a requirement for accessing both funds.

The Department of Health and Social Care (DHSC)

Each year, Parliament votes on the funds which will be made available to the DHSC. These funds are split into four categories:

- revenue departmental expenditure limit (RDEL) – expenditure on running costs which the organisation can plan and control
- revenue annually managed expenditure (RAME) – expenditure which cannot be reasonably subject to firm, multi-year limits - for example, pensions and welfare benefits
- capital departmental expenditure limit (CDEL) – expenditure on items which have a useable life of more than a year – for example, buildings and equipment
- capital annually managed expenditure (CAME) – expenditure on capital assets which cannot be managed by the organisation – for example, impairments due to changes in market values.

The DHSC then allocates these funds to the non-departmental public bodies such as NHS England and the Care Quality Commission. While the funds are distributed to these organisations, the DHSC is statutorily required to keep total revenue expenditure within the RDEL and total capital expenditure within the CDEL[8].

NHS England and clinical commissioning groups (CCGs)

NHS England receives funds from the DHSC and allocates them to CCGs[9]. CCGs are required by statute to:

- keep expenditure within the revenue resource limit (RRL[10])
- keep expenditure within the capital resource limit (CRL[11]).

NHS England also has a statutory cash limit and cannot spend any more cash than that each year. To achieve this requirement, NHS England manages the level of cash accessed by CCGs via a process called maximum cash drawdown.

NHS trusts

NHS trusts have a statutory duty to break-even taking one year with another[12]. This means that over a period, usually three years, the expenditure of the NHS trust must not exceed its income. They also have three administrative duties which relate to capital expenditure and financing, to:

- achieve a target external financing limit[13]
- achieve a capital cost absorption rate[14] of 3.5%
- keep capital expenditure within its CRL.

NHS foundation trusts

NHS foundation trusts do not have any financial targets set out in statute. However, NHS Improvement use a set of financial ratios to assess their financial sustainability and efficiency. From

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[8] For more information on the allocation process see our briefing *How it works: The Department of Health and NHS England allocation process*, March 2017
[9] HFMA, *How it works: The clinical commissioning group allocation process*, March 2017
[10] Equivalent to the RDEL
[11] Equivalent to the CDEL
[12] Guidance on this statutory duty and what it means in practice is currently being developed by NHS Improvement
[13] The EFL is, in effect, a borrowing limit to allow the DHSC to control the cash spent by NHS trusts
[14] This is a requirement for NHS bodies to make a payment of 3.5% of their net assets to the DHSC – it is met by making the PDC dividend payment each year

October 2016 NHS trusts are also subject to this assessment by NHS Improvement. The ratios are used to give each trust a 'finance and use of resources score' ranging from 1 (best) to 4 (worst).

Financial statements and reports

Financial statements

NHS bodies have a statutory duty to prepare an annual report and accounts to demonstrate how they have met their statutory and administrative financial duties. The production of the annual report and accounts is the principal means by which NHS bodies discharge their accountability to taxpayers and users of services for their stewardship of public money.

During the year, financial reports are not as detailed as those in the annual report and accounts, but they are prepared in accordance with the same principles.

In the full annual report and accounts there are four prime financial statements:

- SOCI[15] – this is the statement which shows the running costs for the year, it is prepared on an accruals basis so it will include income and expenditure which has not yet been received or paid out in cash, but which relates to the period in question
- SOFP – this is a snapshot at 31 March of the assets and liabilities of the NHS body
- statement of cash flows – this statement shows how cash has moved in and out of the NHS body in the year and the change in its cash balance over the year
- statement of changes in taxpayers' equity – this statement shows the movement in the body's reserves.

The statement of cash flows shows the financial incomings and outgoings between two points in time – like all of the prime financial statements it is historic. For in-year reporting, the historic position needs to be supplemented by accurate and timely forecasts, particularly in relation to cash[16].

The example below shows the interaction between the four statements.

Example 1

A member of staff joins a CCG on 1 March and works for the full month. They are paid monthly, in arrears, on the last working day of the month.

The staff member is paid £1,000 on 31 March but the amount due to HM Revenue and Customs (HMRC) for the tax paid by the FT (£150) and the employee (£200) is not paid until April.

= £100

SOCNE - employee benefits will include £1,350 (£1,200 in salaries and wages, £150 in social security costs). This is the amount of expenditure in the year.

On 31 March this transaction will be reflected in the accounts as follows:

SOFP - current payables will include a balance for £350 owed to HMRC. This is the amount owed by the CCG in relation to this staff member at the year end.

SOCF - the cash outflow of £1,000 (paid to the member of staff) will be reflected here (£1,350 worth of expenditure is included within the operating surplus/deficit for the year but it is reduced by the increase in payables of £350 which is owed to HMRC at the year end).

SOCITE - the cost of this staff member will be reflected in the net operating expenditure for the year.

[15] NHS providers prepare a SOCI, the DHSC, NHS England and CCGs prepare a statement of comprehensive net expenditure (SOCNE)

[16] HFMA, Financial forecasting in the NHS, July 2016

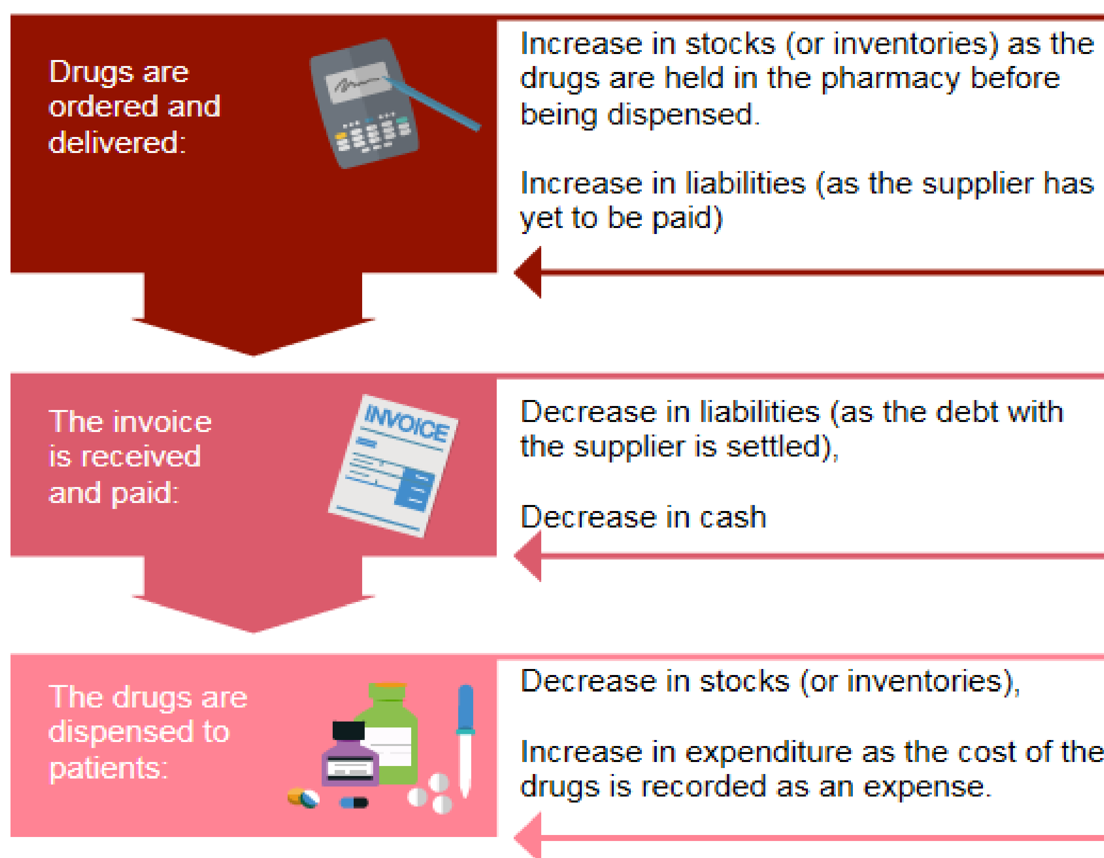
Preparation of financial statements

To understand the accounts as a whole and how the prime financial statements relate to each other, there are two concepts that must be understood:

- double entry bookkeeping
- the use of judgements and estimates.

Double entry bookkeeping

This is a concept which often puts off those who have not had any accountancy training, as well as some who have! However, it simply means that for every financial transaction two entries are made in the accounts. For example, buying food for patients will result in an increase in the expenditure recorded by the NHS body and an equal decrease in the amount of cash it has. But it is rare for an NHS body to pay for anything in cash, so usually such a transaction will be recorded in a series of double entries:

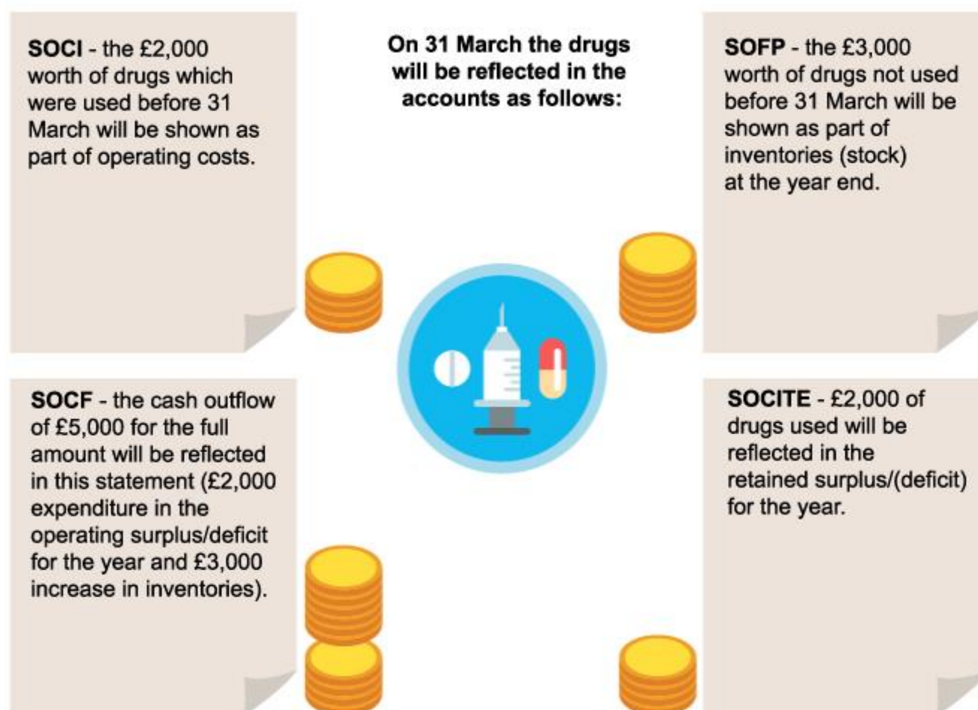


To understand the full impact of any financial transaction, both sides need to be considered. In this case, the impact on the control total when the expenditure is recorded as an expense in the SOCI[17] as well as the changes in stocks, liabilities and cash recorded in the SOFP[18].

The second example illustrates how all four of the primary financial statements are impacted by every financial transaction.

[17] The SOCI may also be referred to as the income and expenditure account. It is the operating surplus/ deficit which is recorded in this statement which is, with some adjustment, used for assessing performance against the control total.

[18] The SOFP is also referred to as the balance sheet.



Judgements and estimates

In the NHS, accounts are prepared in accordance with *International financial reporting standards*[19] (IFRSs). These standards apply to the preparation of the published year-end accounts but it is best practice for all in-year accounts to be prepared on the same basis.

IFRSs include a *Conceptual framework for financial reporting*[20] that sets out the concepts that underlie the preparation and presentation of the accounts. The framework states in paragraph OB11:

'To a large extent, financial reports are based on estimates, judgements and models rather than exact depictions.'

The Framework and the accounting standards that make up IFRSs establish the concepts which underlie those judgements and estimates, but the preparation of financial reports does require finance staff to apply those concepts in practice. It is the role of finance staff to make those judgements and estimates with integrity and objectivity[21]. It is the role of the governing body to 'satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible.'[22]

The UK auditing standards[23] assume that management's ability to override controls will always create an audit risk of material misstatement. Auditors will always undertake audit work in relation to controls and, in particular, the risk that management might override those controls in order to report a misstated financial position. Judgements and estimates are, by their very nature, made by senior

[19] Unaccompanied versions of the standards are available from www.ifrs.org/. These standards do not include the basis for conclusions, illustrative examples and any other accompanying information. Registration is required

[20] www.ifrs.org/issued-standards/list-of-standards/conceptual-framework/

[21] Paragraph 100.5 of the Code sets out the fundamental principles a professional accountant must comply with. The Code is available from www.ethicsboard.org/iesba-code. Sign in is required

[22] This is a quote from the Higgs report *Review of the role and effectiveness of non-executive directors*, 2003 which is referred to in the Audit Commission's report *Learning the lessons from financial failure in the NHS*, 2006

[23] *International standard on auditing 240: the auditor's responsibility relating to fraud in an audit of financial statements* available from www.frc.org.uk/auditors/audit-assurance/standards-and-guidance/2016-auditing-standards

management and there are limited controls that can be put in place to ensure that they are appropriate.

In the examples given above, the financial transactions were straightforward and the records are exact depictions. In NHS accounts, the main areas of estimation and judgement include:

- valuation of non-current assets, such as property, plant and equipment and intangible assets
- income recognition
- measurement of provisions and accruals.

In each case, the range and likelihood of all possible outcomes, as well as the consequences of decisions made, need to be understood and agreed.

Non-current assets

There are many judgements and estimates relating to non-current assets. In the NHS, the value of non-current assets shown on the SOFP are based on a valuation rather than their cost. For property, plant and equipment, this means that a professional valuer is engaged to assess a modern equivalent asset valuation for each site. The modern equivalent asset is based on an assessment of service potential rather than the value of actual bricks and mortar. This means judgements need to be made about what services the NHS body needs to provide and how, and where, they would provide them from if they were starting with a blank piece of paper.

Non-current assets are also depreciated over their useful asset lives. No-one can know how long any particular building or piece of equipment will be in use, so useful asset lives are estimated based on past experience and understanding of the estate.

Both non-current asset valuation and their assessed useful lives have an impact on SOCI:

- the depreciation charge which is taken to the SOCI each year is calculated by dividing the asset valuation by its estimated asset life – the lower the valuation and longer the life, the lower the depreciation charge
- all NHS providers have to pay a public dividend capital (PDC) dividend payment of 3.5% of the value of its net assets to the DHSC each year – the lower the value of non-current assets, the lower the PDC dividend payment.

There are other consequences of these decisions. Depreciation is a non-cash charge to revenue which reflects the cost of using a non-current asset over its life. All things being equal, at the end of an asset's life the organisation will have generated a cash surplus equal to the depreciation charges made to revenue against that asset over its life. This cash surplus can then be used to purchase a replacement asset. Depreciation charges are based on the assessed useful economic life of an asset and its value.

Some NHS bodies have made judgements and estimates which reduce the depreciation charge and therefore improve the bottom line by using the lower of a range of non-current asset valuations and the higher of the range of asset lives. However, the consequence of this is that there is less capital resource generated through depreciation charges, which causes problems when an organisation is looking to replace assets.

Income recognition

Accounting standards require that income is only recognised once it is earned. Income in relation to the delivery of goods is usually fairly straightforward – goods are ordered and delivered, at the point that the goods are accepted the related income is earned. For services, and some goods, it can be less clear. Services are delivered over a period of time, so a judgement has to be made as to when the income is earned. Also, services may be priced on a variable basis (on the number of hours delivered, the quality of service delivered, the outcome of a particular service) so assumptions need to be made as to the amount of income earned, based on the service that has been delivered to date.

In the UK, auditing standards assume that there is an audit risk of material misstatement due to fraudulent reporting relating to revenue recognition. This is because there may be pressures or incentives on management to report higher levels of income where income generation is a performance measure. Auditors always carry out audit work in relation to that audit risk unless they can rebut it, if for example, the income stream for the audited body is very simple and straightforward.

NHS bodies have multiple income streams for the provision of services and there may be pressure on management to report a particular bottom line. The recognition of income can be manipulated by making assumptions about whether it has been earned, when it has been earned and its collectability. For income related to clinical services, the coding of services provided can be subjective. The same risks also apply to the recognition of expenditure especially in relation to provisions and accruals.

Provisions and accruals

A provision is established when an event has happened in the past that the organisation knows will result in a payment at some point in the future. However, exactly when or how much that payment will be is uncertain.

In accounting terms, provisions are defined as liabilities of uncertain timing or amount. That uncertainty means that the establishment and measurement of all provisions is based on judgements and estimates.

For example, an employee has an accident at work and brings a legal claim against the NHS body. The NHS body determines that it is at fault for the accident. The actual cost or timing of any cash pay-out is not known but the NHS body needs to account for it now as that is when the accident happened.

There are several points at which estimates and judgments need to be made:

- when the accident occurred – to determine whether the NHS body is at fault and may need to make a compensation payment
- when the claim is made – to decide whether the claim might be successful or not
- when it is decided that a provision is required because it is more probable than not a payment will have to be made:
    - how much the pay-out is likely to be
    - how likely the payment is going to be and whether a provision or an accrual is made
    - when the payment is likely to have to be made.

In the year that the provision is established then a charge is made to the SOCI although the cash payment may not be made for years.

Once the cash payment is made, the provision is written off and any difference between the cash payment and the provision written back to the SOCI. If the provision is under-estimated then when the pay-out is made there will be an additional charge to the SOCI for the NHS body to bear.

There may be other, unintended consequences when provisions are reviewed. For example, changes to holiday pay accruals by strictly enforcing annual leave carry forward policies may actually force staff to take time off before the financial year end which could result in the need to employ more agency staff to cover for the staff on leave.

For NHS bodies, there is an additional complication when determining whether a liability is an accrual or a provision. In terms of the body's accounts the impact is the same – an accrual is simply a payment which the body is more certain that it will make. However, in terms of the government accounts, the establishment of a provision is a charge against the RAME and it is only when the cash

payment is made that there is an impact on RDEL. As the control totals are linked to RDEL this makes the judgement as to whether the liability is an accrual or a provision all the more important.

Warning signs

In the introduction to this briefing we set out the example where the reported surplus or deficit is in line with the plan and meeting the control total, but the level of payables is increasing. Payables is not the only balance on the SOFP which needs to be considered.

Receivables

If the level of receivables (debtors) is going up month on month then it may be that that NHS body will not be paid for all of the work that they have done and the income that they are showing in their books will not be recovered.

Questions should be asked about how overdue these payments are, as well as the level of impairments of receivables[24].

Listings of aged debt over 90 days may be helpful to identify any problem areas. They should be reviewed regularly by senior staff in the finance department. The debtor days ratio measures how quickly cash is being collected – it is calculated as trade receivables/turnover x 365. NHS bodies will have to calculate this regularly to understand what is 'normal' for them and to look at the overall trend. They may want to benchmark against other, similar, NHS bodies.

Payables

The level of payables (creditors) may also be going up month on month. This means that the NHS body is not paying its bills as quickly as it used to, which can be an early indicator of financial distress. As discussed earlier, this may also be reflected in the NHS body's performance against the *Prompt payment code* which requires all public sector bodies to pay their bills within 30 days. This is why it is important that performance against this standard is reported to, and considered by, the governing body on a regular basis.

Provisions

The level of provisions may be going down month on month (or year by year). This may be because liabilities are being paid or are becoming more certain so are being moved to accruals, but it could also mean that judgements and estimates are being revised so that the provisions are lower.

A reduction to the amount of a provision will have a one-off positive impact on the bottom line but could result in a higher impact when the liability is discharged or have unintended consequences such as the holiday pay example given above. This type of benefit to the bottom line is not cash backed, so it does not resolve cashflow problems and could exacerbate them when the provision is due to be paid.

Cash and working capital

Cash balances may be going down month on month or short-term borrowing may be increasing month on month. This may indicate that savings plans, or other initiatives, are not cash backed (for example, reducing depreciation charges) so are benefitting the bottom line position against the control total, but are not releasing any cash savings.

It is vital that cash balances are maintained in order to be able to continue to pay staff and purchase necessary goods and services. When NHS foundation trusts were first established, the mantra was

[24] Also known as bad debt provisions

that ‘cash is king’ because the metrics that Monitor[25] used to assess financial performance focused on balances in the SOFP, particularly working capital balances.

Working capital is the money and assets that an organisation can call upon to finance its day-to-day operations - for example, paying wages, overheads and buying inventory. It consists of current assets less current liabilities:

	Inventories
plus	receivables
plus	cash and cash equivalent
less	payables
less	short-term (less than a year) borrowings
less	short-term provisions

All working capital balances should be actively managed. The implications of movements in these balances have been discussed above, but management of working capital should ensure that there is sufficient cash for the NHS body to operate. An example of working capital management is around inventory - poor control of inventory could lead to higher levels being held than necessary, which has a knock-on effect on the amount to cash being available to pay payables.

NHS bodies who do not have sufficient working capital to continue to operate will have to take out short-term loans or working capital facilities. While it is technically possible for NHS foundation trusts to access such funds from banks, NHS bodies are strongly encouraged to borrow from the DHSC via either NHS Improvement or NHS England.

Increasing levels of short-term borrowing is another warning sign that an NHS body may be in financial difficulty.

Negative net assets

The SOFP is a statement in two halves – the top half shows all of the assets owned by an NHS body and liabilities which it owes. These sum to the total net assets of the organisation. The bottom half shows how those net assets have been financed – in the case of NHS bodies, this is the taxpayers’ equity. The usual expectation, particularly in the commercial world, is that there will be more assets than liabilities. A negative balance (more liabilities than assets) would be a warning sign that the entity may not be a going concern[26].

NHS bodies may have a negative balance for good reason. Most CCGs, for example, have more liabilities than assets. This is because they do not hold any non-current assets and are not income generating entities. Their role is to commission healthcare - in effect to spend money - so they have comparatively more liabilities than assets.

NHS providers on the other hand are income generating entities. As at 31 March 2017, about a dozen NHS provider bodies had more liabilities than assets. The reasons for this should be understood by the governing body of those entities and may need to be explained in the annual report and accounts. It may be for good reason, for example, the NHS provider has a PFI scheme which means that its non-current assets are offset by liabilities to the PFI provider.

For all NHS bodies, the level of net assets should be kept under review. An overall decline may be another indication that the NHS body is in financial distress.

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[25] Monitor is the statutory regulator of NHS foundation trusts – it has operated as part of NHS Improvement since 1 April 2016

[26] Going concern is the assumption that an organisation will continue to operate for the foreseeable future. See HFMA *Going concern – Assessment and reporting requirements in difficult times*, October 2016

Conclusion

It is important that the financial position is reported and discussed, including consideration of the SOFP and metrics other than control totals. All senior managers and governing body members need to understand the financial position and the basics of how financial statements are prepared. This includes all of the financial statements and the judgements and estimates used when preparing them.

The following questions are intended to start this process.

The finance team

Do your in-year financial reports include:

- a statement of comprehensive income/ net comprehensive expenditure?
- a statement of financial position?
- cash flow statement?
- cash forecast?

Do you report the following:

- performance against prompt payment code?
- debtor days/ aged debtors?
- an explanation of movements in working capital balances?

Have changes in estimates and judgements been documented, discussed with appropriate management and, where material, disclosed in the annual report and accounts?

Governing bodies

If you have concerns about the financial reports presented to you, have you raised them?

Have you asked the questions set out the HFMA briefing *How to review and scrutinise the numbers during the year*?

Have you reviewed the final annual report and accounting using the HFMA briefing *How to review and scrutinise the numbers*?

Have you considered whether the annual report and accounts include appropriate disclosures in relation to going concern?

Other related HFMA briefings

How to review and scrutinise the numbers during the year, October 2017

www.hfma.org.uk/publications/details/how-to-review-and-scrutinise-the-numbers-during-the-year

How to review and scrutinise the numbers – guidance for governing bodies/ audit committee members, May 2017

www.hfma.org.uk/publications/details/how-to-review-and-scrutinise-the-numbers

Going concern – assessment and reporting requirements in difficult times, October 2016

www.hfma.org.uk/publications/details/assessment-and-reporting-requirements-in-difficult-times

2017/18 year-end reminders, February 2018

www.hfma.org.uk/publications/details/2017-18-year-end-reminders

Financial forecasting in the NHS, July 2016

www.hfma.org.uk/publications/details/financial-forecasting-in-the-nhs

NHS foundation trust accounts - a guide for non-executives, April 2010

www.hfma.org.uk/publications/details/nhs-foundation-trust-accounts-a-guide-for-non-executives-(2010)

NHS trust accounts - a guide for non-executives, April 2010

www.hfma.org.uk/publications/details/nhs-trust-accounts-(2010)

The guides to NHS foundation trust and NHS trust accounts were published in 2010 and there have been changes to accounting and reporting requirements since then. For instance, NHS bodies no longer have a donated asset reserve or a government grant reserve. There have also been changes to the regulatory framework, so NHS foundation trusts no longer have a private patient cap or a prudential borrowing limit. However, overall, these guides remain useful and the questions they pose remain pertinent.

Introductory guide - CCG annual report and accounts, April 2014

www.hfma.org.uk/publications/details/introductory-guide-ccg-annual-report-and-accounts-(2014)

This guide was published in 2014 for newly established CCGs. As with the other guides, reporting and accounting has changed but the guidance remains useful and the questions pertinent.