NHS
Shared Business Services

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Board reporting for integrated care boards (ICBs)

Considerations for best practice

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The role of the ICB

A change of approach

Since NHS trusts were created in the early 1990s, each NHS body has had to manage its own financial position and report to its own board. Now, the Health and Care Act 2022 has introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties. In some ways, financial reporting will not change as NHS bodies will still need to report to their own board and to the regulators. In other ways, everything will change as decisions will need to be made with a view to their impact on the wider system and the financial impact of those decisions will impact on partner organisations.

In establishing integrated care partnerships (ICPs), the Act also reflects the fact that healthcare is not provided in a vacuum and the wider system includes local authorities, non-NHS providers and the third sector. This briefing does not consider financial reporting at this level but focuses on the NHS bodies as they will have to achieve financial balance this financial year.

Cultural change will be required for these organisations to work together to meet their new statutory duties. Organisations that have, until now, been working independently and in competition with one another will need to work together and cooperatively. To achieve this, board members of all the affected bodies will need to forge new working relationships based on openness and honesty.

Now is the time to consider what information will be required to manage financial performance across organisations and to ensure that information can be collected on a consistent and timely basis from all organisations. This briefing is intended to provide a starting point for those discussions.

New statutory requirements

The Health and Care Act 2022 established ICBs as independent statutory bodies. The overall general function of ICBs is 'arranging for the provision of services for the purposes of the health service in England'.

ICBs have general functions to:

- promote the NHS Constitution
- exercise its functions effectively, efficiently, and economically
- secure continuous improvement in the quality of healthcare services and outcomes
- reduce inequalities in relation to access to healthcare but also with respect to outcomes
- promote:
    - involvement and enabling patient choice
    - innovation in the provision of health services
    - research and the use of evidence from research
    - education and training.
- securing the provision of health services in an integrated way with other health related services as well as social care services
- achieve climate change targets.

The Act also introduced a duty for all NHS bodies – ICBs, NHS England and provider trusts, to have regard to the wider effect of decisions in relation to:

- the health and well-being of the people of England
- the quality of services provided to individuals
- efficiency and sustainability in relation to use of resources.

Ahead of each financial year, the ICB and its partner NHS providers must prepare:

- a five-year plan setting out how the ICB will exercise its functions, discharge its general duties and meet its financial duties
- a plan setting out the ICB's, and its partner NHS providers, planned capital resource use.

NHS providers remain separate statutory bodies with their own functions and duties as set out in the current legislation. The role of NHS England, the Care Quality Commission and auditors has not changed under the new Act – ICBs do not have a formal regulatory role in relation to NHS providers. However, in accordance with the *NHS oversight framework*[1] ICBs will co-ordinate NHS support interventions within their systems working in partnership with NHS England. This will be formalised through a memorandum of agreement between NHS England regional offices and ICBs.

Financial duties

In summary, both capital and revenue expenditure incurred by ICBs each year will need to remain within the limits set for that year. NHS England may specify by direction what counts as expenditure incurred during the year in relation to meeting this duty.

NHS England may also set joint financial objectives for ICBs and their partner NHS provider bodies. These objectives could apply to all ICBs, specific ICBs or particular types of ICBs. In each case the objective will apply to the partner NHS bodies of the affected ICB.

Each ICB and its partner NHS bodies will have to exercise their functions with a view to ensuring that capital and revenue expenditure does not exceed the limits specified by NHS England for the year.

The Act says that where NHS providers are partners to more than one ICB, their income and expenditure will need to be apportioned between the ICBs in accordance with a direction from NHS England. However, currently, NHS providers are mapped to only one ICB for financial planning and reporting purposes[2], so this is not a practical issue. The assessment of system financial balance will be based on this mapping of each provider body to a single ICB. Each individual NHS body will report their position based on their total income and expenditure that will include contracts and arrangements with commissioners outside of their host ICB.

The role of the board

The ICB board

NHS boards ensure that the NHS body fulfils its functions and objectives while getting the best value possible out of the resources available to it. In relation to meeting financial duties the ICB board will have a dual role:

- to ensure that the ICB meets its own financial duties as an organisation
- to ensure that the ICB and its partner NHS providers meet the joint financial duty.

To do this, the board needs to be provided with relevant information in a form and of a quality appropriate to meet both duties on a timely basis. Financial reports need to be fair, balanced, and understandable.

Partner NHS bodies

NHS partner bodies also have a new responsibility to have regard to the effect that their decisions have on the impact on the wider system. They are also be expected to work with the ICB to ensure that the system as a whole meets its joint financial duty.

Boards should therefore consider what changes need to be made to the reports that they receive to ensure that these duties are met. This will include clearly identifying where a decision made in relation to the NHS body will have an impact on other parts of the NHS and what that impact may be.

Equally, the financial reports need to consider the impact of the financial performance of the NHS body on the system financial position. Risk assessments will also need to reflect wider system risks and potential conflicts between the decision that results in the optimum outcome for the NHS body against a different decision that has the best outcome for the wider system.

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[1] NHS England, *NHS oversight framework 2022/23*, June 2022
[2] NHS England, *Revenue finance and contracting guidance for 2022/23*, April 2022

Financial performance

This briefing focuses on the new requirement for ICBs and partner NHS bodies to achieve financial balance. Given the financial pressures that NHS bodies are currently under, it is expected that this will be a key focus for all organisations in 2022/23. However, achieving financial balance does not necessarily mean that the best use has been made of the resources available. Over the longer term, the focus on population health and health inequalities is likely to mean that there will be a change in the way that resources are spent. As the resource allocation is always constrained, it is likely to mean that the money spent in some areas or on some services will reduce as more money is spent elsewhere. Changing where resources are allocated will require different financial information – this is highlighted at the end of this briefing.

For the ICB

The financial report for the ICB itself should follow best practice for financial reporting for any entity. It should therefore include:

- a summary statement of comprehensive net expenditure (SOCNE) showing performance for the month and to date against plan. This will reflect all the services that the ICB commissions including primary care, continuing care, the better care fund as well as secondary healthcare
- key income and expenditure metrics, such as staff costs split by type against plan, expenditure against material contracts, commissioning costs by type of healthcare or healthcare provider
- balance sheet[3] to date against prior year and plan
- key balance sheet metrics – debtor days, creditor days, better payment practice code metrics
- cash position to date and cash flow forecast
- a forecast year-end net expenditure position against plan/ budget, including an assessment of the underlying financial position
- supporting narrative highlighting the key concerns and risks
- a summary of the cost improvement programme/ waste reduction plan and performance to date highlighting key concerns
- performance against finance and use of resource metrics under the *NHS oversight framework*
- capital expenditure to date against plan and capital forecast.

A decision will need to be made whether to report the financial position to the board for the ICB as a whole or by place. It may be that the decision to report at a place level will be made once systems and processes are more embedded. However, even if place-based reporting is not adopted immediately, the information that may be required should be considered when establishing reporting arrangements to ensure that the necessary information can be collected and reported when the time comes.

For the wider system

ICBs and their NHS partner bodies are expected to ensure that the system remains in financial balance. This means that where one body in the system incurs a deficit then the others will need to make equal surpluses, so the system remains in balance.

To ensure that this requirement is met, the financial performance of the NHS bodies that are partners to the ICB will need to be reported so that the system financial position can be assessed:

- a summary income and expenditure account by NHS body to allow for an assessment of the financial performance of the system including:
  - performance to date
  - a forecast position that takes into account the underlying financial position a summary of the cost improvement programme/ waste reduction plan and performance by partner body to date highlighting key risks

[3] This is formally the statement of financial position (SOFP) but is more commonly referred to as a balance sheet.

    - performance against finance and use of resource metrics by partner body under the NHS oversight framework
- a summary of the capital expenditure incurred by system partner to date:
    - against the plan to date
    - the forecast position against the full year plan.
- clear identification of any material non-recurrent transactions that will impact, positively or negatively, on the financial performance for the year but not on an on-going basis
- the recurrent underlying financial position to date for each organisation and for the system including:
    - the likely impact on forecasts and short to medium term plans
    - what this means for each organisation individually as well as the system overall.

As system financial balance is essentially the sum of the surpluses and deficits, the focus of the ICB will be on the bottom-line position. However, to understand where costs are being incurred, financial reports may also include expenditure incurred for that system to date – the analysis of that information will need to be agreed locally but it may be that it is cut in more than one way:

- by type of expenditure, usually, pay split between substantive and agency costs and non-pay
- by service line/ population health segment/ programme cost[4] – this will allow the board to understand where resources are being spent, particularly where those services are being provided by more than one entity in the system.

It will also be important for ICBs and partner bodies to understand the full financial picture for each of the bodies in the system, so balance sheet metrics such as debtor days, creditor days, the liquidity ratio should be reported. A decision will need to be made as to whether the full balance sheet for each NHS partner body would be helpful as well. These will help with an assessment of the risk of the financial position changing over time.

This information will be reported to NHS England monthly, those returns, and the summary information received back from NHS England should be used as the basis for the board reports.

To be considered best practice, financial reporting must be:

- **Transparent** – all NHS members of the system will need to agree what financial information will be provided to the ICB and other system organisations. That financial information must be the same as the information being reported internally (and to regulators) so there are no surprises for system partners. It may be that access could be provided to other NHS bodies' financial systems with appropriate permissions for view only in place. This would be full open book accounting. Experience of integrated working to date is that relationships are critical for the trust required for organisations to work together to achieve financial balance.
- **Timely** – all members will need to agree on a monthly reporting timetable that aligns with the regulatory reporting requirements. Ideally, the system finance reports will be produced from the monthly reports to NHS England. Best practice is to work from a single version of the truth.
- **Consistent** – all members will need to agree a common set of accounting policies for monthly financial reports. While all NHS bodies comply with IFRS when preparing their annual report and accounts, the policies adopted for management accounting purposes are not prescribed. The ICB and its member NHS providers will need to agree policies relating to those areas of the financial report that require judgement or estimation such as accruals, reserves, provisions, and depreciation. The system wide financial reports must also be consistent with the reports made to individual bodies' boards as well as the regulator.
- **Understandable** – the numbers should be supported by a plain English narrative explanation of why material issues have occurred and what action either has been taken or is being taken as a result.
- **Benchmarked** – usually financial reports set out performance against the budget or the plan agreed at the start of the financial year. It may be that the budget or plan will change during

[4] Commissioning bodies used to produce programme budgeting data. This was then produced by the NHS RightCare initiative. These were both national initiatives with standard classifications for healthcare services. In the absence of a national programme, ICBs may develop their own population segmentation.

the year. Where this is the case, the board report should provide a reconciliation between the original plan and the revised plan along with an explanation of the movement.

- **Focused** – boards should be presented with the information that they need to make decisions. Therefore, the narrative should present the facts but also identify where decisions need to be made.
- **Forward looking** – finance reports present historic data but this should be used to look ahead so the report should include forecasts that consider the full range of likely outcomes. The assumptions underpinning those forecasts and the likelihood of assumptions materialising should be documented.
- **Risk based** – the focus of the narrative should be on those issues that are considered highest risk for the ICB and ICS.
- **Consistent with operational reports** – the financial report should support the operational reports provided to boards so where operational changes have taken place, the financial impact should be identifiable.

There are practical issues to consider:

- simple presentation issues are important – such as right alignment of columns of numbers, consistent units (£000 or £m), white space, use of graphics, trend analysis
- many financial reports use RAG ratings but they can be distracting and usually only relate to a change between periods - graphics and trend analysis should be considered. NHS bodies are using statistical process control (SPC) charts for financial reporting[5] – this allows them to see trends and to identify where action needs to be taken. SPC for financial reporting works best at the detailed level – for example, looking at staff costs and triangulating that with staffing levels and outcomes. SPC also requires a minimum of 15 data points. It is a methodology to be explored once ICBs have been operating for some time
- the use of jargon and acronyms – there is bound to be some use of NHS terminology, and while these are NHS reports there will be interest from non-NHS bodies that form part of the integrated care partnership (ICP) so jargon should be explained. In the same way that accounting policies need to be agreed, common definitions and references may need to be agreed
- the NHS financial regime is complex and often financial reports refer to 'technical adjustments' or 'nationally managed issues' but this implies that the ICB and related NHS providers are not the masters of their own destiny. Therefore, consideration should be given to how much of the financial regime needs to be understood in detail to be able to assess the financial performance of the ICB and the wider system.

Other considerations

Cost information across the system

In order to determine whether the plan for population health is appropriately supported by the resource allocation, the ICB will need to understand how where costs in the system are being incurred.

When producing system healthcare plans, the population will have been segmented to identify at risk groups[6]. Ideally, cost data across the whole system will be available for each segment – this will include the costs incurred in relation to that population segment by primary care providers, non-NHS providers, all secondary care providers (including community, mental health, specialised and ambulance) as well as local authorities. However, this information is unlikely to be available, so the focus is initially likely to be on the acute care costs as they have the most developed costing programmes.

Cost data will need to be reconciled to and consistent with the financial performance reported to the board.

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[5] FutureNHS, *Making data count - finance* (login is required)
[6] HFMA, *What finance data is required to drive value at a population level*, June 2019

Population health and health inequalities

Going forward, financial data will need to be linked to health inequality and population health data to ensure that resources are allocated where they are most needed. As board reports are developed for the new ICBs, consideration should be given to the data that is currently available and how that can be linked to financial information and how that will be reported to the board.

'Ring fenced' or specific costs

The Health and Care Act introduced a new duty for the Secretary of State to report to Parliament the amount of expenditure incurred, and expected to be incurred, by NHS England and ICBs in relation to mental health year on year. This information will also have to be disclosed in the individual bodies' annual reports. This means that expenditure on mental health will need to be separately identifiable by both NHS England and ICBs. It will be a local decision whether this information is reported to the board as a key performance metric.

The better care fund will continue to be the main mechanism for moving funds between health and social care. Section 75 requires that memorandum accounts are prepared by the host of each pooled budget – therefore a summary of the material section 75 agreements should be reported to the board of the ICB.

Other allocations will be ringfenced to be spent on specific initiatives. Where these are material, they may need to be reported separately to the ICB board.

Capital

Since 2021/22, capital allocations have been made to systems at the start of the financial year. The system will then allocate that capital to NHS provider bodies. Capital is a scarce resource with an absolute annual limit on expenditure at the national level – it is therefore important that capital programmes are closely monitored at a system level to ensure that all available capital is used in the year.

Each NHS body in receipt of part of the system wide capital allocation should report progress by project including:

- the original expected cost of the project
- date of contract
- expenditure to date – capital and revenue
- progress against the planned timescale including an explanation of slippage
- forecast spend to the end of the financial year, and the end of the project.

Where underspends or slippage is identified, early decisions will need to be made to identify projects that can be started early. This means that the capital programmes for all NHS bodies will need to be shared, along with risk assessments of the implications, to patient outcomes and system priorities, of not undertaking the work. As part of this, the immediate and long-term revenue implications of each project should be identified as that information will be needed as part of the allocation process.

The capital allocations should be aligned to system priorities rather than organisational priorities. It may mean that some providers in a system get what is perceived to be less than their share because the focus is on achieving an outcome that requires capital investment elsewhere. As part of this process, the efficient use of assets across the system should be considered. The impact of IFRS16 *leases* on the capital departmental expenditure limit (CDEL) will be different for intra-group arrangements so it may be that capital demand could be met by using assets already owned by NHS bodies without incurring additional capital expenditure.

Cash

Best practice reporting will require the ICB to report its own cash balances and cash flows to the board. Each ICB will have a cash limit and NHS England continues to have a duty to operate within its cash limit. If so, it is likely that the cash management arrangements will continue to work in a similar way to they do now with NHS England setting an annual cash drawdown requirement for each ICB based on the revenue allocation.

On a wider system basis, the ICB may also want to understand the cash position of its partner NHS provider bodies. There is no mechanism for partner NHS bodies in an ICB to move cash around the system – NHS providers will still need to apply to the DHSC via NHS England for cash support. However, cash is often called the 'canary in the coal mine' in relation to financial reporting. Therefore, understanding the cash position of all of the NHS bodies in a system will inform the ICB's assessment of the system's financial position and could be an early warning of financial difficulties.

Losses and special payments

All NHS bodies are required to report losses and special payments in accordance with HM Treasury's *Managing public money*[7]. This applies equally to ICBs so will need to be included in board reports[8].

Conclusion

This briefing is intended to provide a starting point for discussions on how financial performance can be reported and managed on a system wide basis. We will continue to work with members to develop and share good practice as ICBs become established.

[7] HMRC, *Managing public money*, updated March 2022
[8] FutureNHS, *ICB losses and special payment guidance*, updated May 2022 (login is required)

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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